Recent Drug Abuse Trends in the Seattle-King County Area

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Caleb Banta-Green,[1] Susan Kingston,[2] Steve Freng,[8] Geoff Miller[4],Michael Hanrahan,[3] T. Ron Jackson,[5] Ann Forbes,[6] Arnold F. Wrede[7], Richard Harruff,[9] Greg Hewett,[9] Kris Nyrop,[10] Mark McBride[11]

ABSTRACT

Cocaine continues to be a major drug of abuse among those arrested and seen in emergency departments while deaths are lower than in 2002. Heroin/opiate deaths are near the low point for the past 10 years; ED mentions remain high as does demand for treatment. Prescription opiates in emergency department and deaths have declined somewhat following several years of dramatic increases, while sales to pharmacies and hospitals continue to climb. Methamphetamine indicators remain elevated, though most have leveled off or declined slightly. MDMA use appears to have peaked in 2000-2001 with gradual declines subsequently. Local survey data indicate high levels of club drug use among respondents at raves and MSM surveyed at bars and bathhouses/sex clubs. IDU surveyed in jail reported persistent risk behaviors involved in drug preparation and injecting practices.

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.

The authors' affiliations are as follows:
[1] Alcohol and Drug Abuse Institute, University of Washington
[2] Project NEON Public Health – Seattle & King County
[3] HIV/AIDS Program Public Health – Seattle & King County
[4] King County Mental Health, Chemical Abuse and Dependency Services Division
[5] Evergreen Treatment Services
[6] Washington State Alcohol and Drug Help Line
[7] Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services
[8] Northwest High Intensity Drug Trafficking Area
[9] Medical Examiner's Office, Public Health – Seattle & King County
[10] Street Outreach Services
[11] U.S. Customs Service

Data Sources

- **Emergency department (ED) drug mentions data** were derived from the Drug Abuse Warning Network (DAWN), Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA), for 1995 through 2002. A drug "mention" indicates that the patient identified the substance as something he or she had recently taken; it may or may not have been the reason for the ED visit. Available data are for King and neighboring Snohomish County combined.

- **Treatment admissions data** were extracted from the Washington State Department of Social and Health Services' 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 from January 1, 1999, through December 31, 2002. Data are included for all treatment admissions that were funded by public funds. Department of Corrections and clients who did not receive any public funds at the time of treatment entry are excluded.

- **Drug-related mortality data** were provided by the King County Medical Examiner (ME). Information about drug-caused deaths in King County is presented by half-year from January 1, 1994, through June 30, 2003. Data for the first half of 2003 are preliminary. The data include deaths directly caused by licit or illicit drug overdose and exclude deaths caused by poisons. Therefore, 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.

- **Arrestee drug testing data** were obtained from the Arrestee Drug Abuse Monitoring (ADAM) program. As part of the National Institute of Justice's (NIJ's) ADAM program, King County's urinalysis results for 2000 to June 2003 are included in the narratives for cocaine, opiates, marijuana, phencyclidine (PCP), and stimulants (methamphetamine). All data are for adult male arrestees only.

- **Illegal drug price, purity, production, trafficking, distribution, and availability data** were provided by four sources. Heroin price and purity data for the United States and Seattle are from the Drug Enforcement Administration's (DEA) Domestic Monitor Program (DMP). Data presented are from the first half of 2001, the most current data available.
- Data from the U.S. Customs Service relating to the seizures for all illegal drugs are included for January 2001, to June 2003.
- Other relevant data are from the Northwest High Intensity Drug Trafficking Area (NW HIDTA). Pursuant to its designation by the Office of National Drug Control Policy, the NW HIDTA produces a Threat Assessment for the region on an annual basis. Data for 1998 through October 2003 are from all Federal, State, and local law enforcement agencies and narcotics task forces in the region, and the Western States Information System (WSIN).
- The source of methamphetamine production data is 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**, including the human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and hepatitis, were provided by three sources. The Sexually Transmitted Disease (STD) Clinic, Public Health – Seattle & King County (PHSKC) provided data on clients' drug use, health status, and health behaviors for October 2000 to February 2003. Another 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, Washington State (July 2000 through June 2003), and the United States (January 2000 through December 2002) are provided by PHSKC, the Washington State Department of Health, and the Federal Centers for Disease Control and Prevention (CDC). HIV cases were reported to PHSKC or the Washington Department of Health between July 2000 and June 2003.

- **Washington State Alcohol/Drug Help Line (ADHL)** provides confidential 24-hour telephone-based treatment referral and assistance for Washington State. Data are presented for January 2001 to June 2003 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.

- **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

The rate of cocaine involved ED mentions was 164 per 100,000 in 2002, up 42 percent from 1995 (not statistically significant). During this same time the rate of ED mentions for all illegal drugs increased 31 percent, while the rate of increase for ED visits for any reason was 9 percent and the rate of increase for drug episodes, illegal and legal drugs, was 12 percent (not statistically significant). The larger increase for drug-involved mentions than drug abuse episodes indicates that more drugs are mentioned on average in recent years than in the past, an increase in poly-drug/medication use.

The proportion of ED mentions involving cocaine, relative to all illegal drugs has increased somewhat in recent years (tests of statistical significance are not available). Thirty nine percent of mentions were for cocaine in 2002, similar to the 40 percent in 2001, but higher than the 33 percent seen in 1997, the lowest level in the past eight years. Cocaine is the most common illegal drug mentioned in emergency departments in Seattle and is second only to alcohol-in-combination among all substances identified.

The proportion of treatment admissions for which cocaine was the primary drug of abuse have declined from 13.7 percent to 12.6 percent from 1999 to 2002. Males and female primary admissions for cocaine are evenly split (exhibit 2). Only two percent of admissions are for youth under 18. Almost half, 47 percent, of cocaine treatment admissions are for African Americans, despite African Americans representing 21 percent of all treatment admissions, and only five percent of the county population. This disproportionately high level of African Americans has been consistent since 1999. Cocaine was the second most common illegal drug mentioned when primary, secondary or tertiary drugs of abuse are considered together with 39.6 percent of all people admitted to treatment reporting use.

Of the 23 cocaine-involved deaths in the first half of 2003, 5 involved only cocaine. The other drugs most commonly detected were opiates (n=13), alcohol (n=10), and other opiates (n=4). In the short term, cocaine deaths are down from a recent peak of 47 in the first half of 2002 and over the longer term, cocaine deaths are lower than the level seen through most of the past decade (exhibit 3).

The number of cocaine seizures by the U.S. Customs Service remained fairly steady with 16 in the first half of 2003, similar to 2001 to 2002, when there were 19 to 13 per half-year period. At the same time, the amount seized has fluctuated in each of those semi-annual periods, from a high of 5,378 pounds, down to 37 pounds in the first half of 2002 and up to 414 pounds in the first half of 2003.

Data for the first two quarters of 2003 indicate that 36 percent of arrestees had positive urine tests for cocaine, similar to levels seen in 2002 and a bit higher than levels for 2000 and 2001. Self report data from the second quarter of 2003 point to the form of cocaine used. Crack cocaine was used by 26 percent of all arrestees interviewed and powder cocaine by 21 percent in the past 12 months. Use levels in the prior 30 days were 21 percent for crack and 13 percent for powder.

The NW HIDTA reported that the street prices of cocaine were $45–$100 per gram, $450–$800 per ounce, and $14,000–$28,000 per kilogram. Intelligence reports indicate that powder cocaine is increasingly more available in King County and other areas of the State.

The number and proportion of cocaine related calls to the Alcohol and Drug Helpline (ADHL) for adults increased in the first half of 2003 while youth numbers remained fairly stable. Cocaine is the most common drug cited by adults—33 percent for the first half of 2003 (n=603), on track to surpass 2001 and 2002. For teenagers, cocaine was the third most common drug mentioned, with 27 calls, representing 10 percent, similar to 2001 and 2002.

Heroin

The rate of heroin-involved ED mentions is second only to cocaine among illegal drugs. The overall trend in rates is flat for the past eight years, with 2001 representing a brief dip to the lowest level seen in this time frame. As a proportion of all illegal drugs heroin mentions represented 30 percent (exhibit 1).

The number and proportion of primary heroin treatment admissions dropped between 2000 and 2001 with these lower numbers being sustained into 2002 when 14 percent of admissions were for heroin. The high level of treatment admissions in the recent past was related to funding availability, not changes in demand for treatment, which has remained high.

Men represent a majority of heroin treatment admissions, 58 percent in 2002, similar to past years. Less than one percent of heroin treatment admissions are for youth. The main ethnic group among primary heroin addicts is White (64 percent) followed by African American (19 percent), Hispanic (7 percent) and Native American (3.5 percent). The proportion of all treatment admittees who mentioned heroin as one of their top three drugs of abuse totaled 18.5 percent in 2002.

In four of the 29 opiate involved deaths the only drug detected was an opiate. Cocaine was the most common drug identified in opiate involved deaths (n=13), followed by alcohol (n=11), other opiates (n=9), and depressants (n=6). In five of the six depressant and opiate involved deaths diazepam was present (e.g. Valium). Opiate involved deaths are down in both the short and the long term (exhibit 3). The 29 deaths for the first half of 2003 is the second lowest death total for a half-year reporting period in 10 years. The peak was 87 deaths in the second half of 1998.

The primary form of heroin on the streets is Mexican black tar. 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.

Opiates have been identified in approximately 10 percent of adult male arrestees' urine tests for each of the years from 2000 to 2002. A short term, non-statistically-significant decline was seen from the first to the second quarter of 2003, from 9 to 5 percent. In the prior 12 months, 9 percent of arrestees reported heroin use, with 6 percent in the prior month, according to data gathered in the second quarter of 2003.

Calls to the ADHL from January to June of 2003 for heroin represented 14 percent of all drug-related calls, slightly higher than the 9 and 11 percent seen in 2001 and 2002 respectively. Teens were less likely to call about heroin. Only 3 percent of calls by teens were related to heroin.

Heroin seizures are infrequent by the U.S. customs service, with the first half of 2003 similar to prior years, three seizures totaling less than nine pounds. The major trafficking route is believed to involve the interstate highway system from the southwestern United States, once the product has crossed the Mexican border. It is believed there is not much heroin trafficking across the Washington-Canadian border in either direction.

The DEA reports that declining heroin purity was first noted in 2000, and purity has remained at lower levels. The average purity of 14 samples collected by the DMP in Seattle was 10.3 percent during January–June 2001; this is similar to the 12.7 percent purity for the 23 samples collected during all of 2000. All samples for which a country of origin could be determined were found to be Mexican.

Data for King County from the Northwest HIDTA for 2002 showed the following prices for Mexican black tar heroin: $25–$100 per gram, $450–$900 per ounce, $6,000–$10,000 per pound, and $11,500–$20,000 per kilogram.

Other Opiates/Narcotics

For the purposes of this report, "other opiates/ narcotics" include codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oxycodone, propoxyphene, and the narcotic analgesics/combinations reported in the DAWN ED data.

The rate of narcotic involved ED mentions decreased by 21 percent in 2002 from the peak in 2001, while longer term it increased 85 percent from 1995 to 2002. Narcotic involved ED mentions, 95 per 100,000 in 2002, were more common than marijuana involved mentions, 65 per 100,000 and less common than heroin involved mentions 128 per 100,000 (exhibit 1). Narcotics are the most common class of drugs mentioned among the psychotherapeutic and CNS drug categories. Methadone was the type of narcotic most commonly identified, constituting 21 percent of all narcotic mentions, however methadone involved mentions declined by a third from 2001. Oxycodone involved mentions represented 18 percent of narcotic involved ED visits in 2002. Trends in oxycodone vary by formulation: oxycodone in combination with acetaminophen (e.g. Percocet) has stayed level for the past eight years, while oxycodone as the sole drug (e.g. OxyContin) has increased from a rate of 0 to 11 per 100,000.

Approximately one percent of people admitted to treatment mentioned prescription opiates as their primary drug. Only data on use of prescription opiates as the primary drug are available. Past analyses showed that 15 percent of those admitted to methadone maintenance programs in 2001 reported prescription opiates as one of the three main drugs they were currently using. These past analyses also indicate that private pay methadone maintenance clients are more likely to report prescription opiate use than those who receive public funding, private pay clients are not included in analyses in this paper. Two-thirds of treatment admissions were for women, by far the largest proportion of female users among

any class of drugs. Only two of the 70 patients were under the age of 18 in 2002. The majority, 79 percent, were White, with 9 percent African American in 2002. The general demographic patterns have been consistent since 1999.

Other opiates were identified 41 times in 38 deaths, of which only four involved no other drugs during the first half of 2003. The most common co-ingestents were depressants (n=16), opiate/heroin/morphine (n=9), alcohol (n=5), and cocaine and amphetamine, each with four mentions. The most common types of other opiates were methadone (n=19), hydrocodone (n=7) and oxycodone (n=5). The 41 other opiate mentions declined slightly from the peak of 47 in the second half of 2002. The number of mentions of methadone is consistent with the prior year while the number of oxycodone mentions is down compared to the second half of 2002 (n=7) and the first half of 2002 (13). 2002 was the peak year for oxycodone-involved deaths.

What constitutes a prescription opiate related death is unclear, however, particularly among methadone-tolerant individuals. Issues of tolerance, potentiation with other drugs, and overlapping therapeutic and lethal dose levels complicate assigning causation in prescription opiate-involved fatalities.

DEA data on sales of prescription opiates to hospitals and pharmacies reveal a 229 percent increase in methadone and a 235 percent increase in oxycodone from 1997 to 2002, with increases seen in each year. At the same time, sales of hydromorphone (e.g. Dilaudid) increased 41 percent, and those for hydrocodone (e.g. Vicodin) increased 79 percent. Note that these data for methadone only include prescriptions for pain written by physicians; they do not include methadone provided in opiate treatment programs.

Marijuana

Marijuana continues to be one of the most widely used illicit substances in the area. ADAM data show that 39 percent of arrestees tested positive for the drug during the first half of 2003, similar to prior years. Fifty five percent and forty four percent of arrestees reported marijuana use in the past 12 months and 30 days, respectively.

DAWN ED data indicate that marijuana remains the third most common illegal drug mentioned (Exhibit 1) with a rate of 65 per 100,000. This rate is lower than that in 2001, 75 per 100,000, and up slightly from 1995 when it was 53 per 100,000 (not statistically significant). 15 percent of illegal drug mentions involved marijuana in 2002. Approximately 84 percent of those who mention marijuana were also using other drugs at the time of the ED visit.

Treatment admissions for a primary marijuana problem increased from 17.6 percent to 20.1 percent of all treatment admissions form 1999 to 2002. Males represented 71 percent of marijuana admissions, a proportion similar to that seen in past years (exhibit 2). Youth have consistently represented a majority of admissions for marijuana, 61 percent in 2002. Among youth admitted to treatment, marijuana was the most common primary drug of abuse, 70 percent in 2002. For adults, conversely, marijuana was the least common major drug of abuse mentioned, 9.5 percent in 2002. Combining primary, secondary and tertiary drugs of abuse reveals how commonly marijuana is mentioned with 92 percent of youth and 42 percent of adults mentioning marijuana as one of their top three drugs in 2002.

Marijuana has been surpassed by cocaine as the drug most commonly cited among all callers to the Alcohol/Drug Help Line. Marijuana represents 21 percent of the calls, while cocaine represents 30 percent of calls. A substantial difference between adults and teens is evident, with approximately three times the percentage of teens (53 percent) as adults (16 percent) calling about marijuana during the first half of 2003. The total number of calls to the Help Line, including for marijuana, decreased again in the first half of 2003. The percentage of all calls citing marijuana declined slightly from 24 percent to 21 percent between the second half of 2002 to the first half of 2003.

HIDTA data collected from King County law enforcement show the following prices for marijuana: $10 per gram, $250–$300 per ounce, and $2,300–$4,000 per pound. Price depends on the quality and a variety of other factors, but “BC Bud” from British Columbia, Canada, is widely available and the most expensive of the marijuana varieties available in King County.

The number of seizures of marijuana, 230, is the lowest in the past two and a half years, but the amount seized is the second largest amount during this timeframe, 9,225 pounds. Even with the additional diligence of U.S. Customs at the Canadian border, “Marijuana produced in Washington, Canada and Mexico is available throughout the state,” according to the Northwest HIDTA Threat Assessment (2003).

Stimulants

DAWN ED mentions for amphetamines in Seattle-King County peaked in 2000 and 2001 at 32 and 33 per 100,000 and declined to 21 per 100,000 in 2002 (exhibit 1). Those 18 to 25 are most likely to mention amphetamine use, followed by 26 to 34 year olds.

Methamphetamine rates peaked in 2000, declined in 2001, and rose again in 2002 to 25 per 100,000 an 81 percent increase relative to 1995. As a proportion of E.D. episodes the Seattle area ranked third in the nation for methamphetamine, below Los Angeles and San Diego. As with amphetamines, methamphetamine users are most likely to be between 18 and 25, followed by 26 to 34 year olds.

Whites represent the majority of amphetamine mentions, 72 percent, and methamphetamine mentions, 76 percent, in 2002. Overall, amphetamines and methamphetamine are mentioned in the ED less frequently than cocaine, heroin, and marijuana. The forms and source of amphetamines, prescription or street drug, are unknown.

Amphetamines were the primary drug for those entering treatment for 0.5 percent in 2002 (n=33), similar to past years. A substantial minority of primary amphetamine users are youth, with 42 percent in 2002. Seventy percent were White in 2002, consistent with prior years. Approximately half of primary amphetamine users are female.

The number and proportion of treatment admissions for methamphetamine as the primary drug has increased substantially from 1999 to 2001 and leveled off in 2002 at 8.5 percent of treatment admissions. The proportion of males and females was equal for methamphetamine treatment admissions from 2000 to 2002, in 1999 55 percent of admissions were for men. A large majority, 88 percent, of patients were white, similar to past years. This is a much higher proportion of Whites than for any other major drug and a similar proportion to hallucinogens. Youth represented 10 percent of primary treatment admissions for methamphetamine, a higher proportion than for alcohol, heroin or cocaine (exhibit 2). Use of methamphetamine as one of their three primary drugs was mentioned by 15 percent of clients in 2002.

The proportion of calls to the ADHL that originated in King County regarding methamphetamine remained stable during the first half of 2003. Among the total number of calls, 15.6% concerned methamphetamine during the period, as did the total number of such calls throughout 2002. The proportions of methamphetamine-related calls specifically attributed to adult (16%) and youth callers (14%) also remained stable and comparable. Methamphetamine also remained the third most common illegal drug identified by adult and youth callers.

The percentage of male arrestees in the Seattle-King County ADAM program who tested positive for methamphetamine was 12 percent and 13 percent in the first and second quarters of 2003, statistically unchanged from prior years: 11 percent in 2002 and 2001 and 9 percent in 2000. Twenty percent and 14 percent reported use of methamphetamine in the prior 12 months and 30 days respectively.

The nine amphetamine-involved deaths equals the number from the preceding half year and is exceeded only by the 12 deaths in the second half of 1999. The long-term trend is upward. Three of the nine amphetamine involved deaths were due to only one drug. Other opiates (n=4) and cocaine (n=3) were the most commonly detected other drugs. Methamphetamine was the form of amphetamine specifically identified in all nine deaths.

Local street prices of methamphetamine in Seattle-King County were $20–$100 per gram, $350–$1,200 per ounce, and $5,000–$15,000 per pound.

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 reports that the number of statewide incidents continues to decline, following a trend that was first noted in 2002. The total number of statewide incidents through October 2003 numbered 1,263, suggesting a likely total for the year of approximately 1,500 which represents a 12% decrease from the 2002 total of 1,697 and a 25% decrease from the 2001 total of 1,886. The statewide decline has been most pronounced in the urban counties although increases, attributed primarily to law enforcement pressure in populous areas, have been reported in rural communities. It is also important to note that these data do not indicate the manufacturing methods or the quantities manufactured at the site of individual incidents. Anecdotal reports from law enforcement indicate that large-scale labs represent a minority of manufacturing labs in the State.

Similarly, the number of methamphetamine incidents reported in Seattle-King County has declined, with a total of 173 reported for the period ending October 31, 2003. This suggests a likely total of

approximately 210 for the year, representing a 15% decrease from the 2002 total of 241, a 29% decrease from the 2001 total of 271, and a return to the level of activity reported in 2000. In spite of this decreasing trend, King County continues to rank second in the State of Washington for the number of activities associated with methamphetamine manufacturing.

Law enforcement sources and other informants report a continuing increase in the amount and prevalence of "ice" within the community, thought to be related both to an on-going increase in smoking as the preferred route of administration among users and to an on-going increase in the importation and availability of methamphetamine produced in other regions, particularly California and Mexico. Some law enforcement sources suggest that the increase in importation has more than offset the decreases in local methamphetamine incidents.

There were no methamphetamine seizures by the U.S. Customs Service at the border from January to June 2003, continuing the trend of infrequent and small seizures at the border: 17 seizures (totaling 8 pounds) in 2002 and 18 seizures (totaling 3 pounds) in 2001. Other Federal agencies report 46 kilograms seized in 2001 compared to a total of 127 kilograms in 2002, while local law enforcement agencies seized a total of 114 kilograms in 2001 and a total of 199 kilograms in 2002 in Washington State.

Depressants

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

ED mentions involving depressants—anxiolytics, sedatives and hypnotics— declined to 67 per 100,000 in 2002 down from a peak of 86 per 100,000 in 2001. Three-quarters of mentions were for benzodiazepines, similar to recent years. Depressants rank below cocaine, heroin, and narcotic analgesics/combinations, and are similar to marijuana in terms of the number of mentions (exhibit 1). Demographic data are unavailable.

Depressants were the primary drug for less than one percent of clients in 2002 (n=50) and in recent years. Treatment admission data for depressants are limited to where they are noted as the primary drug. Though the overall numbers are small, this represents a substantial proportional increase from recent years. 'Major tranquilizers' represented 62 percent of depressant mentions. In 2002, 60 percent were male and 46 percent were youth. The proportion of youth began increasing in 2001. Only 48 percent were White, with 26 percent African American.

Twenty-four deaths involved depressants and just two of them involved no other drugs. Among these 24 deaths, 38 different depressants were detected. The form of depressant most common was diazepam (n=13). The most common co-ingestent was other opiates, which were identified in 16 of the deaths, followed by opiates (n=6), and alcohol (n=4). The 38 mentions of depressants is the highest since at least 1994 (the year of earliest available data), and is approximately three times the number seen in the mid-1990's.

Hallucinogens and Club Drugs

Hallucinogens include lysergic acid diethylamide (LSD), mescaline, peyote, psilocybin (mushrooms), phencyclidine (PCP), and inhalants. "Club drugs" is a general term used for drugs that are popular at nightclubs and raves, including the hallucinogens, MDMA (ecstasy), GHB, gamma butyrolactone (GBL), ketamine, and nitrous oxide.

Combined ED mentions for these classes of drugs totaled 17 per 100,000 in 2002, compared to 25 per 100,000 for marijuana and 164 per 100,000 for cocaine. The rank order from the most common to the least in 2002 was PCP, MDMA, GHB, miscellaneous hallucinogens (mushrooms), LSD, inhalants, ketamine and Rohypnol (exhibit 1).

PCP involved mentions have remained at a higher level of 6 per 100,000 from 2000 to 2002, up from 2 per 100,000 in 1995. In 2002, 83 percent of mentions involved other drugs, a high proportion and similar to prior years. The proportion of females increased from 8 to 30 percent from 1995 to 2002. Half of PCP involved mentions were African American in 2002, extensive missing data in the 1990's precludes race trend comparisons. Those 18 to 25 consistently constitute the largest group of PCP users.

ED mentions of MDMA continued to decline steadily. The peak of mentions was in 2000 with a rate of 6 per 100,000 a four-fold increase from the prior year. In 2002 the rate was 4 per 100,000. The majority of users in recent years appear to be White males ages 18 to 25. In the mid and late 1990's those

18 to 25 represented the only group using with any frequency. In 2000, use increased among all groups, most notably 6 to 17 year olds and 26 to 34 year olds.

With regards to other drugs identified in the ED, LSD involved visits continued to decline in 2002, while mentions of GHB and mushrooms remained relatively steady.

There were six MDMA involved deaths from 1999 to 2002 and three GHB involved deaths in 2002. Marking the current reporting period as the first time since 1998 with no hallucinogen or club drug involved deaths.

Treatment admissions for hallucinogens, inhalants and PCP were all well under one percent of total admissions in 2002, with 29, 6 and 12 admissions respectively. Despite these very small numbers, general demographic patterns have held fairly stable. Hallucinogen use was reported primarily by White, males, a majority of whom were youth, except in 2002 when a majority were adult. Most inhalant users were adult males, with variable ethnic backgrounds over the four-year period of available data. PCP users were predominately black, 80 percent, similar to anecdotal data from throughout the U.S. presented at the national CEWG meeting in December of 2003. And, though the numbers are tiny for PCP, the number of admissions consistently went up from two in 1999 to 12 in 2002, an increase that parallels ED mentions.

ADAM data for drugs in this category are limited to PCP. In the second quarter of 2003 eight percent of arrestees tested positive for PCP, the highest level since 2000, and much higher than the less than one percent seen in the prior quarter. Additional use frequency data are not provided for PCP.

Calls to the ADHL regarding MDMA continue to decrease substantially from 218 in 2001, to 104 in 2002 to 20 in the first half of 2003 for callers of all ages. LSD, not frequently mentioned in 2001 or 2002, was mentioned only once in the first half of 2003. Collectively these drugs represented just 2 percent of all calls, compared with 6 percent in 2001.

Other information concerning patterns of use remains anecdotal. Prices for ecstasy, GHB, PCP, and LSD remained stable from the past year (e.g., a 150–250-milligram tablet of MDMA sells for $20–$30), and ecstasy quality remains inconsistent. Among gay and bisexual men, the blended use of ecstasy, GHB, and amyl nitrite ("poppers"), especially in combination with recreational, non-prescription use of Viagra, continues as a significant trend in dance and sex venues. Anecdotal reports of young MSM injecting ketamine have increased recently.

A community-based survey was conducted in the Summer of 2003 by the University of Washington Alcohol and Drug Abuse Institute in conjunction with Public Health-Seattle & King County. Self-administered surveys were gathered in gay bathhouses and sex clubs (n=135; median age 40), gay bars (n=100; median age 37), raves (n=310; median age 20), and youth drug treatment agencies (n=64; median age 17), lifetime use of club drugs was much higher than in the general population: MDMA use was reported by 25 percent, 47 percent, 78 percent and 37 percent respectively. GHB use was reported by 9 percent of those sampled at bathhouses/sex clubs, 19 percent at gay bars, 30 percent at raves and 3 percent at youth treatment agencies. Proportions for LSD were 32 percent, 37 percent, 54 percent and 16 percent, for ketamine 9 percent, 21 percent, 31 percent and 6 percent for bathhouse/sex club, gay bar, raves and youth treatment agencies. Lifetime use of 'research chemicals', such as '2C-T7' and 'foxy methoxy' was only reported with any frequency by rave attendees (21 percent).

The U.S. Customs Service first provided data indicating seizures of MDMA in the first half of 2002. The number of seizures and amount of product seized, while never huge, has continually decreased over the three six-month reporting periods. In the first six months of 2003 there were four seizures, totaling 32 pounds, the largest of which was 28 pounds.

INFECTIOUS DISEASES RELATED TO DRUG ABUSE

Excepting male drug injectors who also have sex with men, 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 sero-surveys conducted in methadone treatment centers, correctional facilities and through street and community-targeted sampling strategies over this period indicate that 4% or fewer of non-MSM/IDU in King County are infected with HIV. Compared to white IDU, infection rates appear to be 2-3 times higher among African-American and Hispanic IDU and 5-6 times higher among American Indian and Alaska Native IDU. IDU who are homeless or unstably housed are twice as likely to be HIV positive as are those who have permanent housing. Out-of-treatment IDU are twice as likely to be HIV positive compared to IDU who are enrolled in treatment. Recent data from a CDC-funded HIV Incidence Study (HIVIS, 1996-2001), suggest that

the rate of new infections among non-MSM/non-IDU in King County is less than 0.5% per year.

Among methamphetamine injecting MSM, Public Health data indicate that up to 47% are HIV infected. Fourteen percent of MSM/IDU who primarily inject drugs other than methamphetamine are HIV positive. Prevalence of HIV among non-amphetamine injecting MSM/IDU is comparable to the rate observed among MSM in general in King County. HIVIS data indicate that 2.5% (95% CI: 1.1-4.5) of non-infected MSM/IDU become infected each year. This is the highest incidence rate of all at-risk populations in King County, accounting for an estimated 20-80 new infections a year.

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

Public Health conducted interviews and HIV serology surveys among 1,811 IDU booked into two King County jail facilities between August 1998 and December 2002 to assess HIV prevalence and risk behaviors. Rates of infection were comparable to other local studies, but the survey revealed persistent risk in drug preparation and injection practices in this population. Ninety-three percent of inmates interviewed reported having injected within the last six months. Of these, two-thirds injected two or more times per day and about one-quarter reported having injected with more than 10 different people. Nearly two-thirds reported injecting with a syringe previously used by someone else and over one-quarter had injected with two or more different people's used syringes in the last six months. Seventy-six percent reported re-use of another's cooker to melt drugs and 62% reported sharing syringes to divide drugs (backloading) to divide drugs.

In addition to injection drug use, studies conducted by Public Health – Seattle & King County's STD Clinic indicate use of methamphetamine by means other than injection, as well as inhalation of poppers (amyl nitrate), may be significant risk factors for HIV acquisition and transmission among men who have sex with men. Among 1,547 MSM who were tested from October 2000 through February 2003, those who reported nitrate use were nearly twice as likely to be HIV infected compared to non-infected MSM, while MSM who reported non-injection use of methamphetamine use in the last year were 1.5 times more likely to be infected. These findings, though not as dramatic as the association between injection drug use among MSM and HIV infection, are reason for concern and action. Previously reported STD Clinic data showed that use of methamphetamine and ecstasy among local MSM was significantly associated with increased number of sex partners and contracting gonorrhea. Together, these data suggest a need for further study of the role drug use is playing in the sexual transmission of HIV among MSM in the Seattle area, and for HIV prevention interventions that specifically target MSM who use drugs by means other than injection. More detailed information on HIV/AIDS in King County and other counties in the State is presented in exhibit 5.
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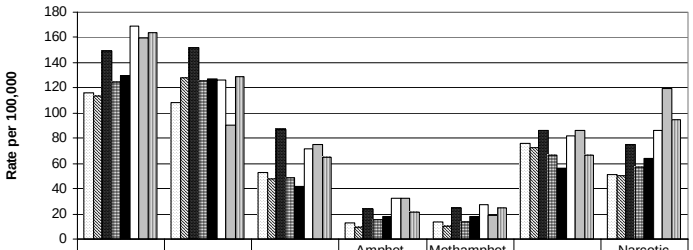
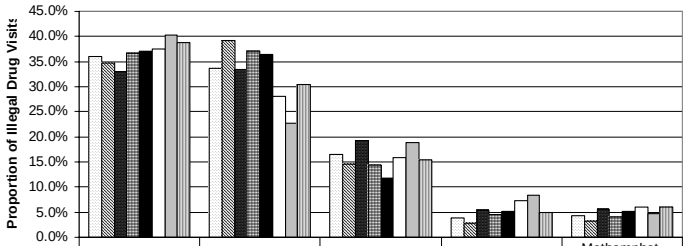
For inquiries concerning this report, please contact Caleb Banta-Green, MPH, MSW, Alcohol and Drug Abuse Institute, University of Washington, 1107 NE 45th St, Suite 120; Seattle, WA 98105, Phone: (206) 685-3919, Fax: (206) 543-5473, E-mail: <calebbg@u.washington.edu>, Web: <http://adai.washington.edu>.

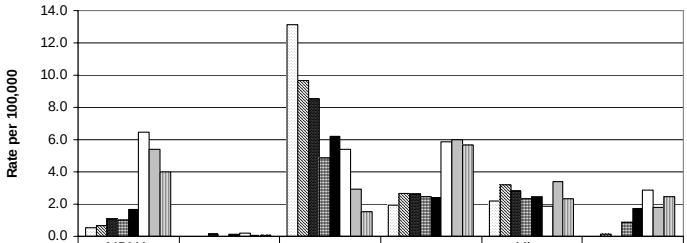
Exhibit 1: Emergency Department Drug Mentions King and Snohomish Counties



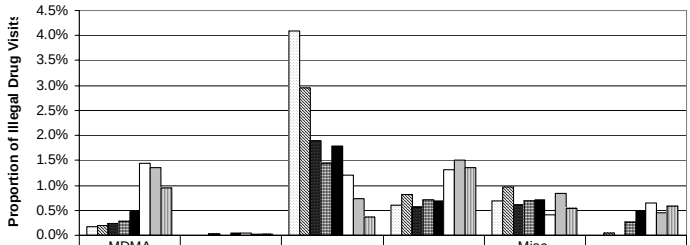
	Cocaine	Heroin	Marijuana	Amphet-amines	Methamphet-amine	Depressants	Narcotic analgesics
1995	116	109	53	13	14	76	51
1996	114	128	48	9	10	72	50
1997	150	152	87	24	25	86	75
1998	125	126	49	15	14	66	57
1999	130	127	42	18	18	56	64
2000	169	126	72	32	27	82	86
2001	160	90	75	33	18	86	120
2002	164	128	65	21	25	67	95



	Cocaine	Heroin	Marijuana	Amphet-amines	Methamphet-amine
1995	35.9%	33.7%	16.5%	3.9%	4.3%
1996	34.8%	39.3%	14.6%	2.9%	3.2%
1997	33.0%	33.5%	19.2%	5.3%	5.5%
1998	36.7%	37.0%	14.3%	4.5%	4.1%
1999	37.1%	36.4%	11.9%	5.1%	5.2%
2000	37.5%	28.0%	15.9%	7.2%	6.1%
2001	40.2%	22.8%	18.8%	8.3%	4.7%
2002	38.9%	30.5%	15.4%	5.0%	5.9%



	MDMA (Ecstasy)	Ketamine	LSD	PCP	Misc. hallucinogens	GHB
1995	0.5	0.0	13.1	1.9	2.2	0.0
1996	0.6	0.0	9.7	2.7	3.2	0.2
1997	1.1	0.1	8.6	2.6	2.8	0.0
1998	1.0	0.0	4.9	2.4	2.3	0.9
1999	1.6	0.2	6.2	2.4	2.5	1.8
2000	6.5	0.2	5.4	5.9	1.9	2.9
2001	5.4	0.0	2.9	6.0	3.4	1.8
2002	4.0	0.0	1.5	5.7	2.3	2.5



	MDMA (Ecstasy)	Ketamine	LSD	PCP	Misc. hallucinogens	GHB
1995	0.2%	0.0%	4.1%	0.6%	0.7%	0.0%
1996	0.2%	0.0%	3.0%	0.8%	1.0%	0.0%
1997	0.2%	0.0%	1.9%	0.6%	0.6%	0.0%
1998	0.3%	0.0%	1.4%	0.7%	0.7%	0.3%
1999	0.5%	0.0%	1.8%	0.7%	0.7%	0.5%
2000	1.4%	0.0%	1.2%	1.3%	0.4%	0.6%
2001	1.4%	0.0%	0.7%	1.5%	0.9%	0.5%
2002	0.9%	0.0%	0.4%	1.3%	0.5%	0.6%

SOURCE: Adapted from DAWN, OAS, SAMHSA

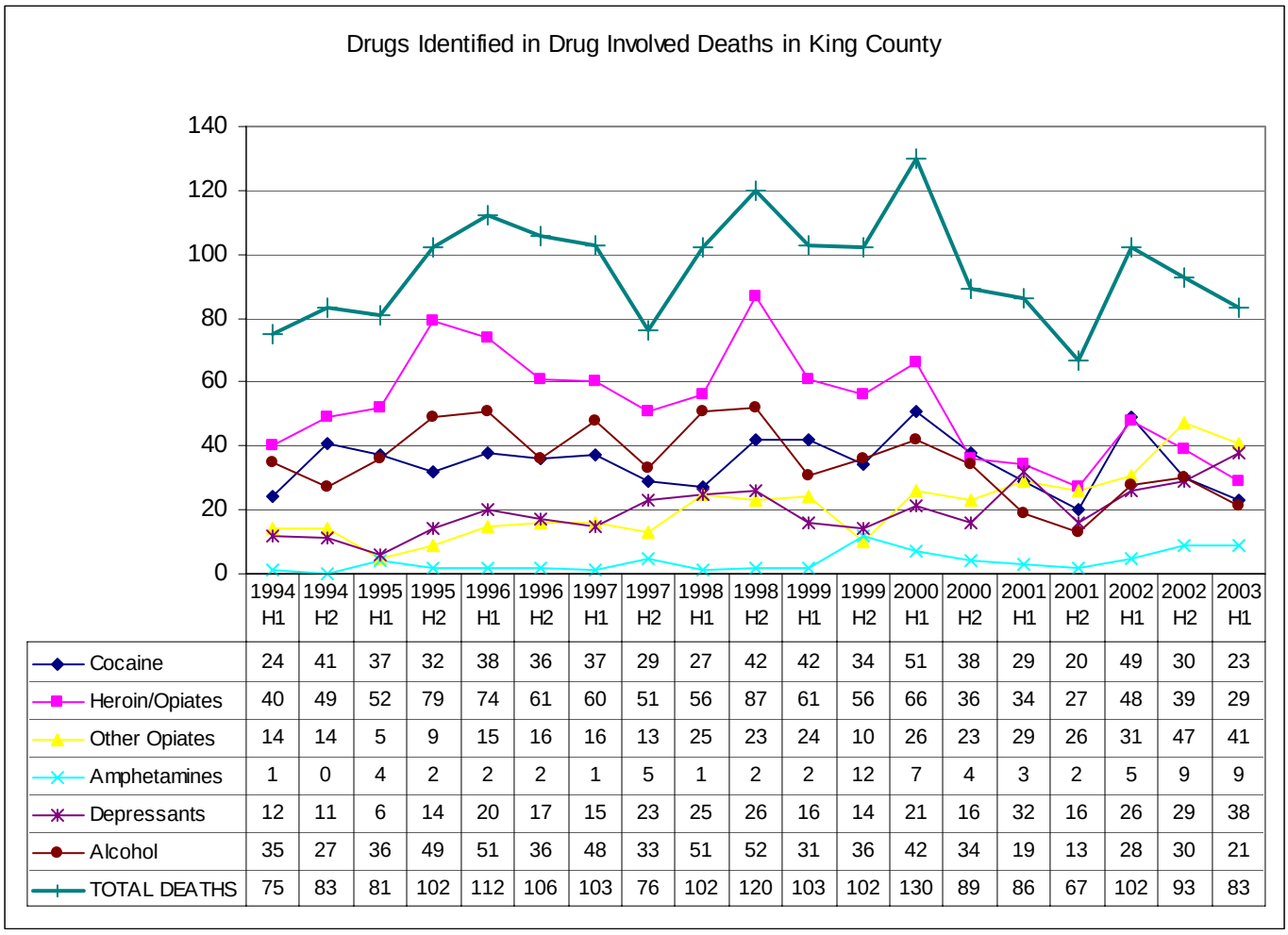
Exhibit 2. Demographic Characteristics of Alcohol/Drug Treatment Admisions[1] in Seattle-King County by Primary Drug 2002

	Alcohol			Cocaine			Heroin			Methamphetamine			Marijuana			All Other Drugs		
	N	Col %	Row %	N	Col %	Row %	N	Col %	Row %	N	Col %	Row %	N	Col %	Row %	N	Col %	Row %
Gender																		
- Male	2,094	70.86	45.12	456	50.28	9.83	601	58.01	12.95	308	50.24	6.64	1,027	70.68	22.13	155	58.1	3.33
- Female	861	29.14	33.24	451	49.72	17.41	435	41.99	16.8	305	49.76	11.78	426	29.32	16.45	112	41.9	4.34
Age																		
- Youth	230	7.78	18.11	16	1.76	1.26	6	0.58	0.47	60	9.79	4.72	887	61.05	69.84	71	26.6	5.6
- Adult	2,725	92.22	45.71	891	98.24	14.95	1,030	99.42	17.28	553	90.21	9.28	566	38.95	9.5	196	73.4	3.28
Ethnicity																		
- White	1,562	52.86	39.33	306	33.74	7.7	661	63.8	16.64	542	88.42	13.65	729	50.17	18.35	172	64.4	4.33
- Black	513	17.36	33.38	428	47.19	27.85	198	19.11	12.88	5	0.82	0.33	351	24.16	22.84	42	15.7	2.76
- Asian	165	5.58	51.89	33	3.64	10.38	8	0.77	2.52	7	1.14	2.2	93	6.4	29.25	12	4.5	3.76
- Native American	239	8.09	60.35	38	4.19	9.6	36	3.47	9.09	11	1.79	2.78	63	4.34	15.91	9	3.4	2.26
- Hispanic	295	9.98	51.94	46	5.07	8.1	72	6.95	12.68	19	3.1	3.35	118	8.12	20.77	18	6.7	3.17
- Multiple Race	68	2.3	33.83	25	2.76	12.44	26	2.51	12.94	16	2.61	7.96	58	3.99	28.86	8	3.0	4
- Other	113	3.82	47.28	31	3.42	12.97	35	3.38	14.64	13	2.12	5.44	41	2.82	17.15	6	2.2	2.52
Total	2,955	100	40.87	907	100	12.54	1,036	100	14.33	613	100	8.48	1,453	100	20.09	267	100	3.71

[1] This is a duplicated count of admissions to all modalities of service and for all public funding excluding private facilities and department of corrections.

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

Exhibit 3. Drugs Identified in Drug-Caused Deaths in Seattle-King County by Number: January 1994–July 2002[1]



	1994 H1	1994 H2	1995 H1	1995 H2	1996 H1	1996 H2	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
Cocaine	24	41	37	32	38	36	37	29	27	42	42	34	51	38	29	20	49	30	23
Heroin/Opiates	40	49	52	79	74	61	60	51	56	87	61	56	66	36	34	27	48	39	29
Other Opiates	14	14	5	9	15	16	16	13	25	23	24	10	26	23	29	26	31	47	41
Amphetamines	1	0	4	2	2	2	1	5	1	2	2	12	7	4	3	2	5	9	9
Depressants	12	11	6	14	20	17	15	23	25	26	16	14	21	16	32	16	26	29	38
Alcohol	35	27	36	49	51	36	48	33	51	52	31	36	42	34	19	13	28	30	21
TOTAL DEATHS	75	83	81	102	112	106	103	76	102	120	103	102	130	89	86	67	102	93	83

[1] More than one drug is often identified per individual drug overdose death; table excludes poison-related deaths.
[2] The amphetamines identification category includes methamphetamine but does not include MDMA.

SOURCE: Medical Examiner, Public Health—Seattle and King County

Exhibit 4. Demographic Characteristics of Persons With HIV Diagnoses, Including AIDS, in Seattle-King County, Other Washington Counties, Washington State, and the United States: Through June 30, 2003, Data Reported as of October 31, 2003

Persons Diagnosed with HIV infection, including those with AIDS

	King County HIV including AIDS	Other WA Counties HIV including AIDS	Washington State HIV including AIDS	United States** AIDS only
Cumulative Diagnoses of HIV, including AIDS	8,879	4,741	13,620	886,575
Cumulative HIV or AIDS Deaths	3,911	2,029	5,940	501,669
Number currently living with HIV, including AIDS	4,968	2,712	7,680	384,906

	King County* HIV including AIDS 07/2000 - 06/2003		Other WA Counties* HIV including AIDS 07/2000 - 06/2003		Washington State* HIV including AIDS 07/2000 - 06/2003		United States** AIDS only 01/2000 - 12/2002	
Case Demographics	Number	Pct	Number	Pct	Number	Pct		
Gender:								
Male	890	89%	432	78%	1,322	85%	92,057	73.88%
Female	115	11%	119	22%	234	15%	32,546	26.12%
Age:								
<13	1	0%	0	0%	1	0%	---	
13-19	9	1%	9	2%	18	1%	---	
20-29	216	21%	107	19%	323	21%	---	
30-39	471	47%	223	40%	694	45%	---	
40-49	240	24%	144	26%	384	25%	---	
50-59	54	5%	46	8%	100	6%	---	
60+	14	1%	22	4%	36	2%	---	
Race/Ethnicity:								
White	617	61%	353	64%	970	62%	35688	28.64%
Black	219	22%	80	15%	299	19%	62116	49.85%
Hispanic	103	10%	70	13%	173	11%	24694	19.82%
Asian/Pacific Islander	37	4%	21	4%	58	4%	1307	1.05%
Native American	18	2%	19	3%	37	2%	579	0.46%
Multi-Race	6	1%	0	0%	6	0%	N/A	
Unknown	5	0%	8	1%	13	1%	219	0.18%
Exposure Category:								
Male-male sex	651	65%	258	47%	909	58%	49316	39.58%
Injecting drug user	64	6%	76	14%	140	9%	31849	25.56%
IDU & male-male sex	61	6%	36	7%	97	6%	5914	4.75%
Heterosexual contact	123	12%	90	16%	213	14%	35239	28.28%
Blood product exposure	3	0%	1	0%	4	0%	877	0.70%
Mother at risk/has AIDS	1	0%	0	0%	1	0%	311	0.25%
Undetermined/other	102	10%	90	16%	192	12%	1097	0.88%
Total HIV Cases diagnosed in last 3 years	1005	100%	551	100%	1,556	100%	124,603	100.00%

* These cases were diagnosed with HIV infection between July 2000 and June 2003, and reported to Public Health - Seattle & King County or the Washington Department of Health as of 10/31/2003.

**United States HIV data is not currently available in a format consistent with the Washington data.
In addition, U.S. AIDS data do not include age distributions by year of diagnosis.
The most current available national AIDS data are through December 2002.

Technical note
The US data do not show specific incidence estimates for hemophilia or transfusion cases for 2000-2002, these numbers were interpolated from earlier incidence data.