

# Recent Drug Abuse Trends in the Seattle-King County Area

*Caleb Banta-Green,<sup>1</sup> T. Ron Jackson,<sup>2</sup> Michael Hanrahan,<sup>3</sup> Kris Nyrop,<sup>4</sup> Steve Freng,<sup>5</sup> Susan Kingston,<sup>6</sup> Ann Forbes,<sup>7</sup> David Albert,<sup>8</sup> Arnold F. Wrede,<sup>8</sup> Richard Harruff,<sup>9</sup> Greg Hewett,<sup>9</sup>*

## ABSTRACT

Over the past 7 to 10 years, the average number of drugs used among those attending emergency departments or dying from drug-related causes has increased by 17 and 27 percent, respectively. Much of the increase in the number of drugs involved in deaths is related to prescription medications, such as sedatives/anxiolytics/depressants and prescription opiates. Cocaine continues to be a major drug of abuse among those arrested and seen in EDs, while cocaine-related deaths are near the lowest level in 10 years. Heroin/opiate-related deaths are near the low point for the past 10 years; ED mentions remain unchanged, while new admissions to treatment have declined. Prescription opiate mentions in emergency departments have declined somewhat, while deaths involving prescription opiates continued to climb. Methamphetamine indicators have mostly leveled off at higher levels, while deaths are at a new high. MDMA use appears to have peaked in 2000–2001, with a subsequent decline. Use of muscle relaxants was examined, and while use is reported in the community, the level of morbidity and mortality is relatively low. Hepatitis B and C infections are widespread among injection drug users (IDUs). HIV prevalence and incidence remain low among IDUs.

## 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:

<sup>1</sup> Alcohol and Drug Abuse Institute, University of Washington

<sup>2</sup> Evergreen Treatment Services

<sup>3</sup> HIV/AIDS Program, Public Health – Seattle & King County

<sup>4</sup> Street Outreach Services

<sup>5</sup> Northwest High Intensity Drug Trafficking Area

<sup>6</sup> Project NEON, Public Health – Seattle & King County

<sup>7</sup> Washington State Alcohol and Drug Help Line

<sup>8</sup> Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services

<sup>9</sup> Medical Examiner's Office, Public Health – Seattle & King County

## Data Sources

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

- **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 Counties 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, 2003. Data are included for all treatment admissions that were funded by public funds. Department of corrections and private pay clients (primarily methadone) are included.
- **Drug-related mortality data** were provided by the King County Medical Examiner (ME). Data for the second half of 2003 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.
- **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 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). Preliminary data are included from 2003. 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. The latest data are complete through 2003.
- **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.
- **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 law enforcement seizures. These data include the top 25 drugs identified in 2003.
- **Data on infectious diseases related to drug use**, including the human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and hepatitis, were provided by two 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, Washington State (2001 through 2003), and the United States (2000 through 2002) are provided by Public Health-Seattle and King County (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 2000 and 2003.
- **Drug-related help-line 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 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 population in 2002, up 42 percent from 1995 (not statistically significant) (exhibit 1a). During this same time, the rate of ED mentions for all illegal drugs increased 31 percent, the rate of increase for ED visits for any reason was 9 percent, and the rate of increase for drug episodes for illegal and legal drugs was 12 percent (not statistically significant). An average of 1.9 drugs were mentioned per episode in 2002, up 17 percent from 1995 indicating an increase in poly-drug/medication use. Cocaine was the most common illegal drug mentioned in emergency departments in the Seattle area and was second only to alcohol-in-combination among all substances identified.

In 2003, 39 percent of all people newly admitted to treatment mentioned cocaine as one of the top three drugs that they used, down from 45 percent in 1999 (exhibit 2). A higher proportion of women than men in 2003 were using cocaine—45 percent of all women admitted to treatment and 36 percent of all men (exhibit 3). Adults mentioned cocaine much more often than youth, 44 percent compared to 9 percent in 2003 (exhibit 7). Cocaine was the most commonly mentioned illicit drug in 2003 among adults.

Cocaine-involved deaths returned to lower levels in 2003 following peaks in 2002 and 2000 (exhibits 5 and 6). Over the long-term, cocaine-involved deaths are up, with 52 in 2003 compared with 24 in 1987. One in five deaths in which cocaine is identified are related solely to cocaine, according to medical examiner data from 1997 through 2003 (exhibit 7). Of the 490 cocaine-involved deaths during this period, 94.4 percent were ruled accidental, with 4.4 percent noted to have an undetermined cause of death, a very high proportion similar to amphetamines and just above the level of accidental deaths for heroin/opiates (exhibit 8).

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, respectively. At

the same time, the amount seized fluctuated in each of those semi-annual periods, from a high of 5,378 pounds in the first half of 2001, down to 37 pounds in the first half of 2002, and up to 414 pounds in the first half of 2003.

In 2003, 37 percent of arrestees had urine tests positive for cocaine, similar to levels seen in 2002 and higher than levels for 2000 and 2001 (exhibit 9). Cocaine and marijuana were identified with the same frequency in 2003. It is important to note, however, that cocaine is retained in urine for up to 4 days, compared to 20 for cannabinoids. 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 12 months prior to arrest. Use levels in the prior 30 days were 21 percent for crack and 13 percent for powder.

Toxicology tests on law enforcement drug seizures in 2003 reveal that 45 percent of such tests done at the Seattle area lab were positive for cocaine, compared with 22 percent for the rest of the State (exhibit 10). The proportions for methamphetamine were roughly the inverse, demonstrating the substantial hold that cocaine continues to have in the urban Seattle area.

The NW HIDTA reported that the street prices of cocaine were \$50–\$100 per gram, \$550–\$900 per ounce, and \$10,000–\$25,000 per kilogram. Intelligence reports indicate that powder cocaine is increasingly more available in King County and other areas of the State. Crack cocaine is found mainly in the major metropolitan regions.

The number and proportion of cocaine-related calls to the ADHL for adults increased in the first half of 2003, while youth numbers remained fairly stable. Cocaine was 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 that for cocaine among illegal drugs in King and Snohomish Counties. The overall trend in rates was flat for the past 8 years, with 2001 representing a brief dip to the lowest level seen in this timeframe (exhibit 1a).

The proportion of new patients in treatment who mentioned heroin as one of their top three drugs of choice declined from 26 percent to 20 percent from 1999 to 2003 (exhibit 2). 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. More women than men reported using heroin: 24 percent versus 17 percent in 2003 (exhibit 3). Few youth, 2 percent in 2003, mention heroin use at admission to treatment (exhibit 4).

Deaths involving heroin are near their lowest level since 1992, with 62 such deaths in 2003 ( $n=58$ ) (exhibits 5 and 6). A spike in heroin-associated mortality was evident around 1998, when there was a peak of 144 heroin-involved deaths, 65 of which were due to heroin alone (exhibit 7). This spike was during a time of relatively high-purity heroin, 21 percent, compared to 10 percent in 2003 (exhibit 11).

The primary 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.

Opiates were identified in approximately 10 percent of adult male arrestees' urine tests for each of the years from 2000 to 2002, and their presence declined to 7 percent in 2003 (exhibit 9). In the prior 12 months, 9 percent of arrestees reported heroin use, with 6 percent reporting such use in the prior month, according to data gathered in the second quarter of 2003.

Calls to the ADHL from January to June 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 by the U.S. Customs Service are infrequent, with those in the first half of 2003 similar to prior years: three seizures totaling less than 9 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.

Data for King County from the Northwest HIDTA for 2003 showed the following prices for Mexican black tar heroin: \$30–\$150 per gram, \$400–\$900 per ounce, \$8,000–\$10,000 per pound, and \$16,000–\$25,000 per kilogram.

## Other Opiates/Prescription Opiates

For the purposes of this report, “other opiates/prescription opiates” include codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oxycodone, propoxyphene, sufentanil, tramadol, hydromorphone, pharmaceutical morphine, acetylmethadol, and the “narcotic analgesics/combinations” reported in the DAWN ED data.

The rate of narcotic analgesics/combinations-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 analgesics/combinations-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 1b). Narcotic analgesics were the most common class of drugs mentioned among the psychotherapeutic and central nervous system (CNS) drug categories. Methadone was the type of narcotic most commonly identified, constituting 21 percent of all narcotic mentions. However, the number of methadone-involved mentions declined by nearly one-third from 2001. Oxycodone-involved mentions represented 18 percent of narcotic-involved ED visits in 2002. Trends in oxycodone varied by formulation: oxycodone in combination with acetaminophen (e.g., Percocet®) stayed level for the prior 8 years, while oxycodone as the sole drug (e.g., OxyContin®) increased from a rate of 0 to 11 per 100,000 from 1995 to 2002.

Approximately 2 percent of people admitted to treatment mentioned prescription opiates as their primary drug. The number of treatment admissions for prescription opiate use increased from 343 in 1999 to 921 in 2003 for adults and from 6 to 41 for youth during the same time period. 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 analyses also indicate that private-pay methadone treatment clients are more likely to report prescription opiate use than those who receive public funding.

Other opiates were identified in 84 deaths in 2003 (exhibit 6), 5 of which involved no other drugs (exhibit 7). The total number of prescription opiate-involved deaths has tripled since 1997; this increase is due almost entirely to prescription opiates in combination with other drugs. The most common

types of other opiates in drug-involved deaths in 2003 were methadone ( $n=47$ ), hydrocodone (12), and oxycodone (14); this represented an increase for methadone and hydrocodone, but a decrease for oxycodone from 2002 to 2003 (exhibit 12).

What constitutes a prescription opiate-related death is unclear, however, particularly among opiate-tolerant individuals. Issues of tolerance, potentiation with other drugs, and overlapping therapeutic and lethal dose levels complicate assigning causation in prescription opiate-involved fatalities. The cause of death in 11 percent of deaths involving prescription opiates in 1997–2003 was ruled to be undetermined (exhibit 8). The source and form of prescription opiates involved in deaths are often undetermined as well.

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.

Prescription opiates represented 78 of the 3,212 exhibits (2.4 percent) tested by the Seattle area toxicology laboratory on samples submitted by local law enforcement. For the remainder of the State excluding the Seattle area lab, 400 of the 12,332 samples (3.3 percent) were positive for prescription opiates.

## Marijuana

Marijuana continues to be one of the most widely used illicit substances in the area. ADAM data show that 37 percent of arrestees tested positive for the drug during 2003, similar to prior years (exhibit 9). Fifty-five percent and 44 percent of arrestees reported marijuana use in the prior 12 months and 30 days, respectively, in the second quarter of 2003.

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

One-half of people entering drug treatment mentioned current use of marijuana as one of their top three drugs, similar to the prior 4 years (exhibit 2). A higher proportion of males than females reported marijuana use, 54 versus 44 percent in 2003 (exhibit 3). Marijuana was the only major illicit drug for which a smaller proportion of users were female. Marijuana use was reported at far higher levels by youth than adults, 92 and 43 percent, respectively (exhibit 4).

Law enforcement seizures of marijuana in 2003 constituted similar proportions of all toxicology lab drug tests done in the Seattle area (17 percent) and in the rest of Washington (16 percent) (exhibit 10).

Marijuana has been surpassed by cocaine as the drug most commonly cited among all callers to the ADHL. Marijuana represented 21 percent of the calls, while cocaine represented 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 to 21 percent between the second half of 2002 and the first half of 2003.

HIDTA data collected from King County law enforcement show the following prices for marijuana: \$10–\$40 per gram, \$250–\$500 per ounce, and \$2,200–\$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 marijuana plants seized increased 50 percent to 66,806 in 2003, compared to 2002. Approximately two-thirds of these plants were from outdoor grow operations. The number of growing operations seized by law enforcement increased from 342 to 445.

## Stimulants

DAWN ED mentions for amphetamines in Seattle-King County peaked in 2000 and 2001 at 32 and 33 per 100,000 population, respectively, and declined to 21 per 100,000 in 2002 (exhibit 1a). Those age 18–25 were most likely to mention amphetamine use, followed by 26–34-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 ED episodes, the Seattle area ranked third in the nation for methamphetamine, after Los Angeles and San Diego. As with amphetamines, methamphetamine users were most likely to be between 18 and 25, followed by 26–34-year-olds.

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

Amphetamines were the primary drug for those entering treatment for less than 1 percent in 2003, similar to past years. The proportion of treatment admissions for methamphetamine as a drug of abuse increased substantially from 1999 to 2001 and leveled off in 2002 at 14 percent (exhibit 2). A higher proportion of female than male admissions were for methamphetamine, with 17 percent of females and 12 percent of males citing methamphetamine as a drug of abuse (exhibit 3). Of all the illicit drugs, the proportion of youths and adults reporting methamphetamine abuse were the most similar, at 10 and 15 percent, respectively, in 2003 (exhibit 4). In 2003, methamphetamine use among males who identified as gay, bisexual, transsexual or questioning of their sexual identity was more than double that of those identified as heterosexual, 24 percent compared to 11 percent; for females the difference was minor (20 versus 17 percent) (exhibit 13).

The proportion of calls to the ADHL that originated in King County and concerned methamphetamine remained stable during the first half of 2003. Among the total number of calls, 15.6 percent concerned methamphetamine during the period, similar to the proportion in 2002. The proportions of methamphetamine-related calls specifically attributed to adult (16 percent) and youth callers (14 percent) 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 in 2003, statistically unchanged from prior years: 11 percent in 2002 and 2001 and 9 percent in 2000 (exhibit 9). Twenty percent and 14 percent reported use of methamphetamine in the prior 12 months and 30 days, respectively, during the second quarter of 2003.

The 18 amphetamine-involved deaths in 2003 were the highest since at least 1987, when there were zero deaths (exhibit 5). From 1997 to 2003, there were 70 amphetamine-involved deaths (exhibit 6), of which 65 were determined to be methamphetamine. Almost one in three deaths in which amphetamines were identified was related to just the single drug, a relatively high proportion of deaths and second only to heroin/opiates (exhibit 7). Whites (89 percent) and males (79 percent) predominated methamphetamine-involved deaths from 1997 to 2003. Accidental/overdose deaths represented 94 percent of amphetamine deaths from 1997 to 2003 (exhibit 8).

Methamphetamine incidents peaked in 2001 statewide, in King County, and in Pierce County to the South (which has the largest number of labs in the State), but they continued to increase in Snohomish County (immediately to the north of King County) (exhibit 14). In King County, there were 202 incidents in 2003, down from 271 in 2001, but still up substantially from 1990, when there were 6 incidents (exhibit 14). Generally, methamphetamine incidents have increased in rural areas and declined in urban areas.

It is 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.

Tests on evidence submitted by law enforcement to the to the Seattle-area State Toxicology Laboratory indicate that 29 percent of all drugs tested were methamphetamine, substantially different than the findings for the rest of the State, in which 51 percent of tests were positive for methamphetamine (exhibit 10). In addition, for both regions a little less than 1 percent of tests were positive for pseudoephedrine, a precursor of methamphetamine.

Local street prices of methamphetamine in Seattle-King County were \$30–\$100 per gram, \$500–\$1,100 per ounce, and \$5,000–\$15,000 per pound.

A novel method of methamphetamine distribution resulted in an arrest in the Seattle area in December 2003. Methamphetamine-soaked paper was sent to an inmate, who then sold it to other inmates who apparently consumed the paper much like LSD on blotter paper.

The 2004 Threat Assessment compiled by NW HIDTA reports that analysis of samples collected by

local DEA agents found purity of methamphetamine to average 45 percent, up from 30 percent in FY 2002 and FY 2001 throughout Washington.

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 reported 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), diphenhydramine (Benadryl) diazepam (Valium), hydroxyzine pamoate (Vistaril), lorazepam (Ativan), meprobamate (Equanil), oxazepam (Serax), phenobarbital, promethazine (Phenergan), secobarbital (Seconal), temazepam (Restoril), triazolam (Halcion), and zolpidem (Ambien).

The rate of ED mentions per 100,000 population that involved depressants—anxiolytics, sedatives and hypnotics—declined to 67 per 100,000 in 2002 down from a peak of 86 per 100,000 in 2001 (exhibit 1b). 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. Demographic data were unavailable.

Depressants were the primary drug for less than one percent of treatment clients in 2003 and in recent years. Treatment admission data for depressants are limited to where they are noted as the primary drug.

In the 71 depressant-involved deaths in 2003, 103 depressants were identified, an increase from 72 depressants identified in the 54 deaths in 2002 (exhibit 15). Single-drug deaths involving depressants were relatively infrequent from 1997 to 2003, constituting just 7 percent of depressant-involved deaths (exhibit 7). Suicide rates were much higher among those with depressants in their system: 24 percent, compared to 8 percent on average for all drugs (exhibit 8). Diazepam continued to be the most commonly detected depressant, although diphenhydramine equaled diazepam in 2003 with 26 identifications of each (exhibit 15). Promethazine was the third most common depressant identified,

and it increased steadily from zero in 1997 to 9 in 2003. Of the 28 deaths in which promethazine was identified, 17 included methadone. Note that the DAWN/Multum lexicon identifies promethazine as an “other substance,” “respiratory agent,” while the King County medical examiner classifies it as a “tranquilizer/sleeping aid.” It is often prescribed for its anti-nausea effects, although its sedative effects can be dangerous with other depressants. It was decided to include it in the depressant category for CEWG reporting purposes.

Key informants note that promethazine is often used by those on methadone to potentiate the high. Benzodiazepines, e.g., clonazepam and diazepam, are purchased on the street for three reasons: (1) to get high on, (2) to potentiate other drugs, and (3) for “home detoxes” whereby users, of heroin in particular, try to stop using on their own.

Law enforcement exhibits tested by the State toxicology laboratory showed that 1.2 percent ( $n=38$ ) of exhibits from the Seattle-area lab were benzodiazepines (i.e., alprazolam, diazepam, and clonazepam) and that 0.9 percent (105) of exhibits from the rest of the State were benzodiazepines.

### Hallucinogens, Club Drugs, and Dextromethorphan

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, methylenedioxymethamphetamine (MDMA) (ecstasy), gamma hydroxybutyrate (GHB), gamma butyrolactone (GBL), ketamine, and nitrous oxide. Dextromethorphan, commonly found in over-the-counter cough medicines, can have dissociative effects at high dosages.

The rates of ED mentions for these classes of drugs (e.g., 4 per 100,000 population for MDMA) were low, compared to 65 per 100,000 for marijuana and 164 per 100,000 for cocaine in 2002. The rank order for the rates of ED mentions for these drugs from the most common to the least in 2002 was PCP, MDMA, GHB, miscellaneous hallucinogens (mushrooms), LSD, inhalants, ketamine and Rohypnol<sup>®</sup> (exhibit 1c).

PCP-involved mentions 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 PCP 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. One-half of PCP-involved mentions were African-American in 2002; extensive missing data in the 1990s precludes race trend comparisons. Those aged 18–25 consistently constituted the largest group of PCP users.

ED mentions of MDMA continued to decline steadily. The peak of mentions was in 2000; the rate was 6 per 100,000 a fourfold 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 age 18–25. In the mid- and late 1990s, those age 18–25 represented the only group using with any frequency. In 2000, use increased among all groups, most notably 6–17-year-olds and 26–34-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. Dextromethorphan is considered a respiratory agent in the lexicon that DAWN uses, DAWN lists 31 drugs that include dextromethorphan in combination, with one additional listing for dextromethorphan alone. The number of mentions totaled 39 in 2002, a very small number of people.

The total number of deaths involving these drugs increased steadily to 12 in 2003, up from 2 in 1997 (exhibit 6). Over the course of this timeframe, there were 29 deaths, 5 related to a single drug (exhibit 7). Of these five single-drug deaths, four involved MDMA, and one included GHB. The average age of dextromethorphan-involved deaths was 44; it was 24 for MDMA, and 28 for GHB. Of the 18 deaths involving DXM, an average of 4.7 drugs were identified; 14 involved some combination of heroin/opiate (identified 4 times), prescription opiate (identified 8 times) or cocaine (identified 7 times). The number of deaths involving DXM increased from 2 in 1997 to 11 in 2003. Of the seven MDMA-involved deaths, four involved MDMA alone, with the three other deaths involving either methamphetamine or cocaine.

Treatment admissions for hallucinogens, inhalants, and PCP were all well under 1 percent of total admissions in 2003.

ADAM data for drugs in this category are limited to PCP. In 2003, 5 percent of arrestees tested positive for PCP, the highest level since 2000 and the fifth highest level among all cities in which the ADAM program was present in 2003 (exhibit 9). Two percent of those interviewed in 2003 said they had used PCP in the prior 3 days. PCP generally remains detectable

in urine for about 8 days and for up to 30 days in chronic users.

State toxicology testing of law enforcement evidence shows that MDMA is the fifth most common drug detected at the Seattle lab ( $n=44$ , 1.4 percent) and the ninth most common for the rest of the State ( $n=67$ , 0.5 percent) (exhibit 10). The related compound MDA was detected less often in Seattle (10, 0.3 percent) and the rest of the State (15, 0.1 percent). PCP was found in 29 samples (0.9 percent) in Seattle, but it was not among the top 25 drugs for the rest of the State.

Calls to the ADHL regarding MDMA continued 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.

Doses of ecstasy average \$20 in King County and throughout much of the State.

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 6-month reporting periods. In the first 6 months of 2003, four seizures totaled 32 pounds, the largest of which was 28 pounds.

### **Other Drugs of Note—Muscle Relaxants and Tri-Cyclic Antidepressants**

#### *Muscle Relaxants*

Muscle relaxants are a category of drug that is often overlooked in the investigation of drug abuse trends. In past reports these medications were categorized as “other drugs” and not discussed. These drugs can have potent sedating effects in addition to their impact on muscle tissue. Use of muscle relaxants in combination with other depressants such as alcohol or benzodiazepines is contraindicated.

Key informants note that cyclobenzaprine (e.g., Flexeril) and carisoprodol (e.g., Soma) are purchased on the street with the intent of using them to get high.

Mortality data show a small but increasing presence of such substances in drug-involved deaths (exhibit 16). From 1997 to 2003, there were 30 deaths in which a muscle relaxant was identified, increasing from 2 to 11 during this timeframe. Cyclobenzaprine (16 mentions) and carisoprodol (13 mentions) were

most commonly identified in deaths during this timeframe. In all such deaths, other drugs were also identified. The race of all decedents was Caucasian, the only drug type for which a single race was represented. DAWN ED data show a fairly steady level of muscle relaxant mentions, with a rate of 7 per 100,000 in 2002 (exhibit 1b).

Carisoprodol was the only muscle relaxant identified in toxicology analysis of law enforcement evidence, with 10 items (0.3 percent) in the Seattle lab and 21 items (0.2 percent) for the rest of the State. NW HIDTA reports that carisoprodol is the sixth most common substance identified in impaired drivers, according to the State Toxicology Lab in 2003.

### *Antidepressants*

The term “antidepressant” indicates the original indication for prescribing the medication when it was introduced on the market, but current indications for use often are very different. Antidepressants are very diverse drugs in terms of their effects, ranging from heavily sedating to mildly stimulating. Tricyclic antidepressants (e.g., amitriptyline, doxepin, nortriptyline, imipramine) are an older class of medications that are now most commonly used for treating insomnia or pain. Tricyclics identified in polydrug deaths peaked in 2003 at 32 mentions, with an average of 18 per year in the preceding 6 years (exhibit 17). The number of antidepressants of all types identified in deaths during this timeframe increased from 23 to 78. A large proportion of these deaths involved SSRI anti-depressants (e.g., sertraline, fluoxetine, citalopram) which, because of their physical effects, are unlikely to contribute to deaths in which they are identified.

All analyses for this report exclude deaths due only to antidepressants, the majority of which involve tricyclics, because the local work group determined these medications are rarely used as drugs of abuse.

### *Summary*

These additional categories of drugs were investigated in order to apply the scrutiny given to prescription opiates in past reports to additional categories of prescription drugs. In the course of these analyses, the complexities associated with the categorization and the effects of these drugs became evident. That is, medications such as muscle relaxants were not tracked in the past when they were “lumped” with a broad range of other drugs, such as nonprescription analgesics and anticonvulsants. In the case of drugs categorized as “antidepressants,” it became clear that many of these medications in fact

were very strong sedatives (i.e., tricyclic antidepressants), and that old categorization schemes obscured actual effects and current uses of these medicines. At this point, it does not appear these classes of drugs are of great significance in the overall morbidity and mortality associated with drug abuse. However, the local work group will continue to monitor these drugs as it is only possible to detect emerging trends if the elements necessary for detection are in place.

### 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 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 fewer of injecting drug users (IDUs) who are not men who have sex with men (MSM) in King County are infected with HIV. Compared to White IDUs, infection rates appear to be 2–3 times higher among African-American and Hispanic IDUs and 5–6 times higher among American Indian and Alaska Native IDUs. IDUs who are homeless or unstably housed are twice as likely to be HIV positive as are those who have permanent housing. Out-of-treatment IDUs are twice as likely to be HIV positive as IDUs who are enrolled in treatment. 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 0.5 percent per year.

Among methamphetamine-injecting MSM Public Health data indicate that up to 47 percent are HIV infected. Fourteen percent of MSM/IDUs who primarily inject drugs other than methamphetamine are HIV positive. Prevalence of HIV among non-amphetamine injecting MSM/IDUs is comparable to the rate observed among MSM in general in King County. HIVIS data indicate that 2.5 percent (95 percent CI: 1.1–4.5) of non-infected MSM/IDUs 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 more than 4,000 IDUs by Public Health’s HIV-AIDS Epidemiology Program since 1994 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.

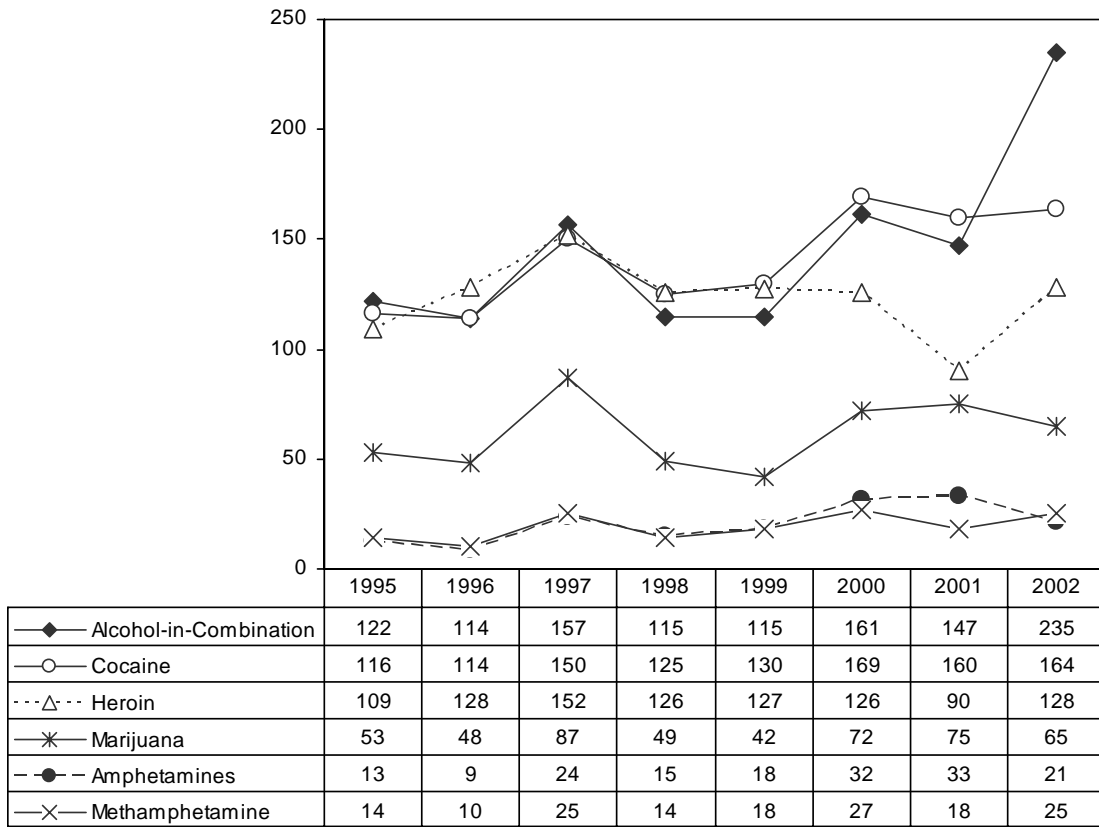
In addition to injection drug use, studies conducted by Public Health–Seattle & King County’s STD Clinic indicate use of methamphetamine by means other than injection, as well as inhalation of poppers (amyl nitrite), may be significant risk factors for HIV acquisition and transmission among men who have sex with men. Among 1,547 MSM who were tested from October 2000 through February 2003, those who reported nitrite 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 the need 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 18.

---

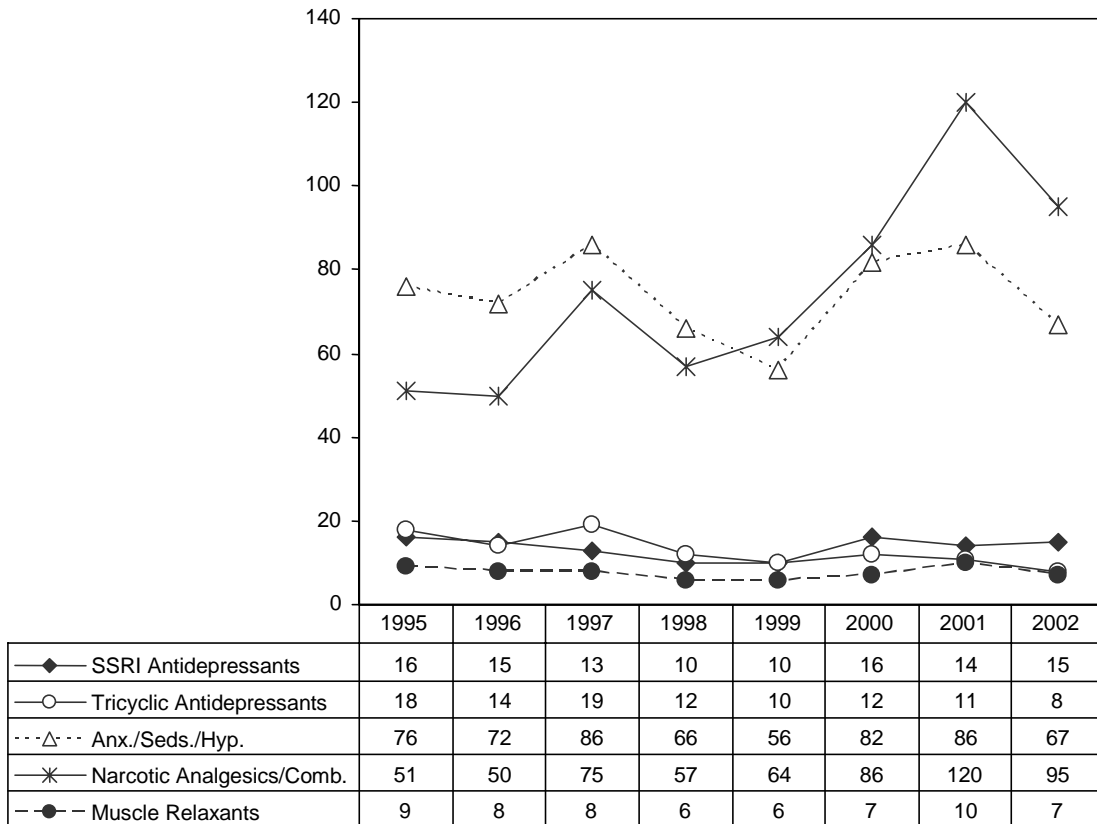
*For inquiries concerning this report, please contact Caleb Banta-Green, MPH, MSW, Alcohol and Drug Abuse Institute, University of Washington, 1107 NE 45th St, Suite 120; Seattle, WA 98105, Phone: (206) 685-3919, Fax: (206) 543-5473, E-mail: <calebbg@u.washington.edu>, Web: <http://adai.washington.edu> or Ron Jackson, MSW, Evergreen Treatment Services, Phone (206) 223-3644, E-mail: [ronjack@u.washington.edu](mailto:ronjack@u.washington.edu).*

**Exhibit 1a. Rates of ED Mentions in King and Snohomish Counties for Major Drugs: 1995–2002**



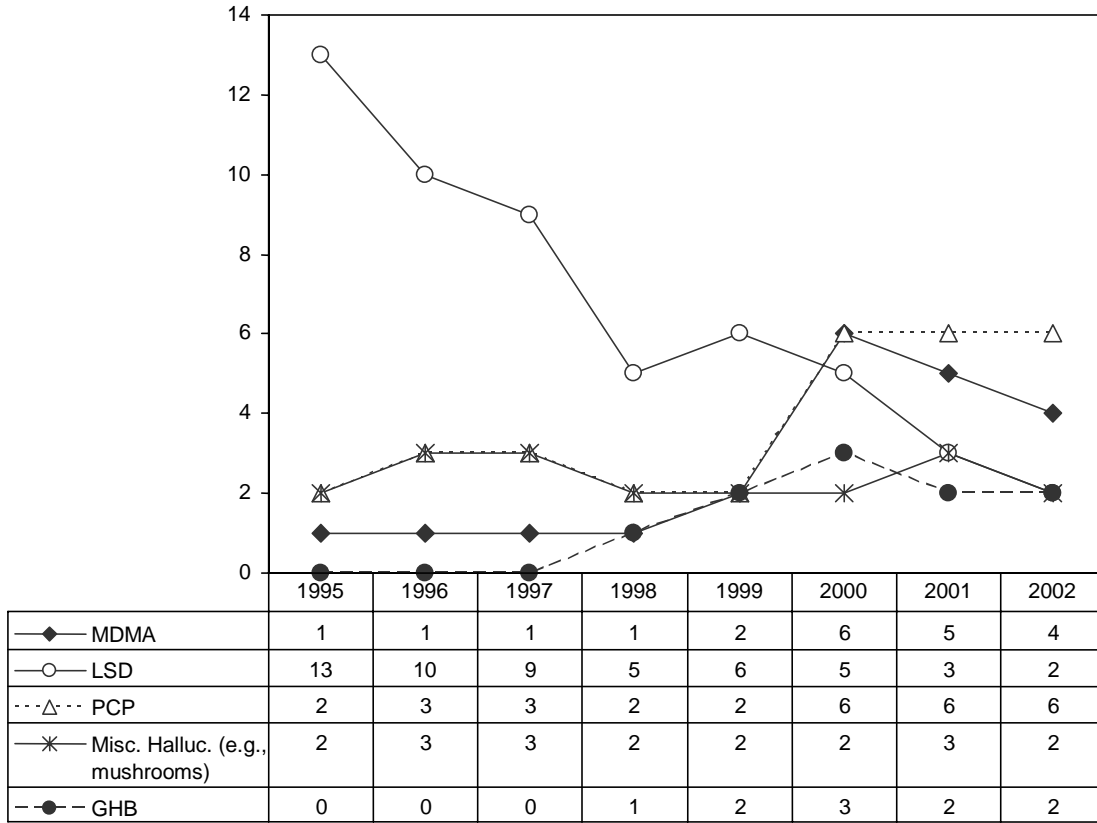
SOURCE: DAWN, OAS, SAMHSA

**Exhibit 1b. Rates of ED Mentions in King and Snohomish Counties for Prescription Drugs: 1995–2002**



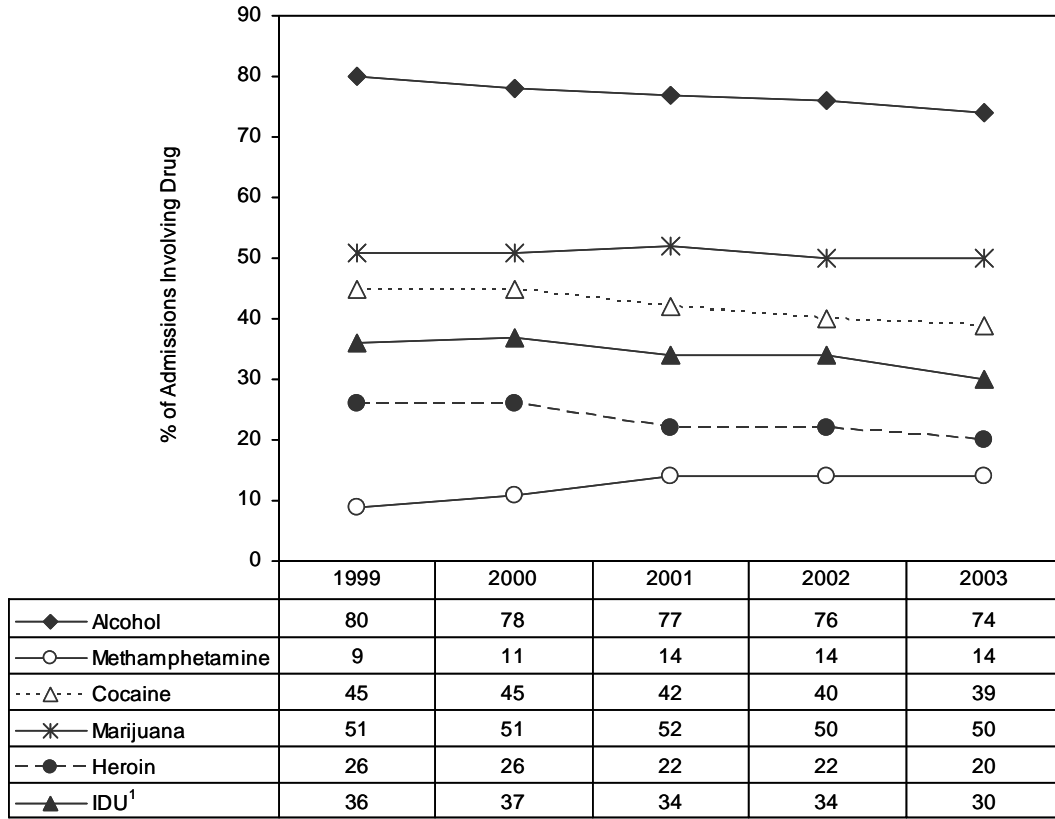
SOURCE: DAWN, OAS, SAMHSA

**Exhibit 1c. Rates of ED Mentions in King and Snohomish Counties for Club Drugs/Hallucinogens: 1995–2002**



SOURCE: DAWN, OAS, SAMHSA

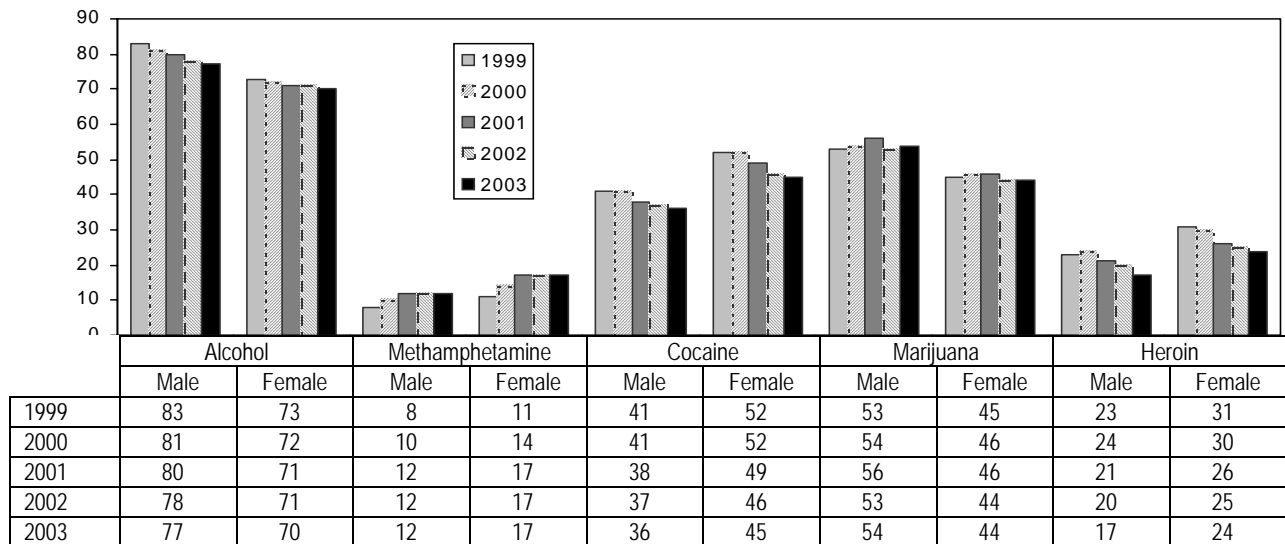
**Exhibit 2. Drug Treatment Admissions for Primary, Secondary, or Tertiary Use of Selected Drugs by Youth and Adults Combined in King County, Washington: 1999–2003**



<sup>1</sup>Injection drug use (ever).

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

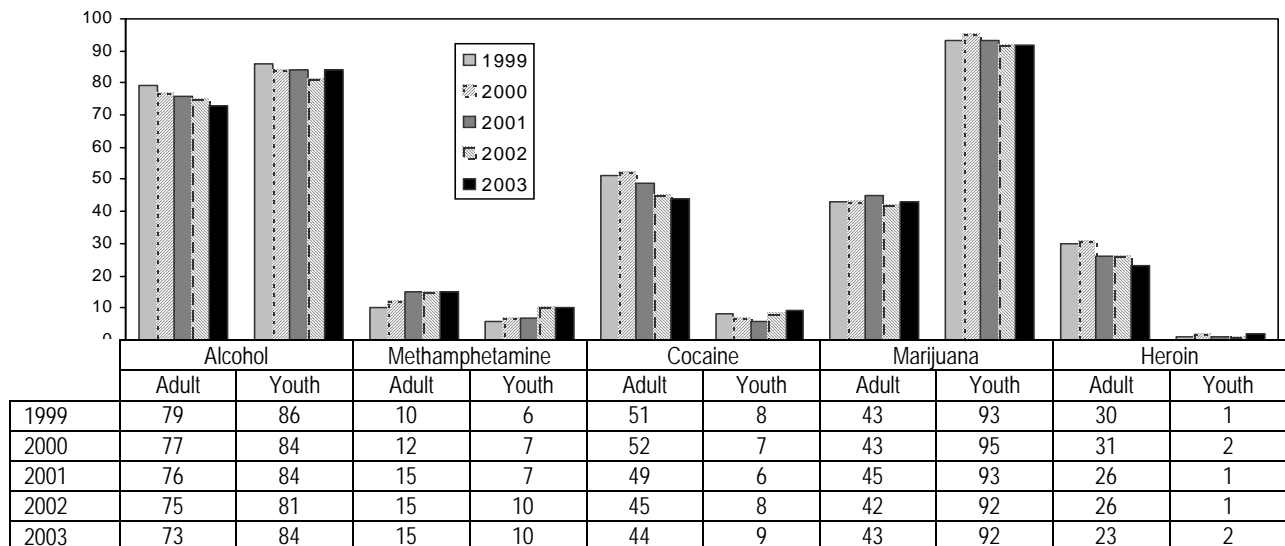
**Exhibit 3. Drug Treatment Admissions for “Any Use of Drug” by Gender and Percent in King County, Washington: 1999–2003<sup>1</sup>**



<sup>1</sup>In 2003, there were 1,393 youth treatment admissions and 7,397 adult treatment admissions.

SOURCE: WA State Division of Alcohol and Substance Abuse, DSHS, Treatment Analyzer data analysis tool

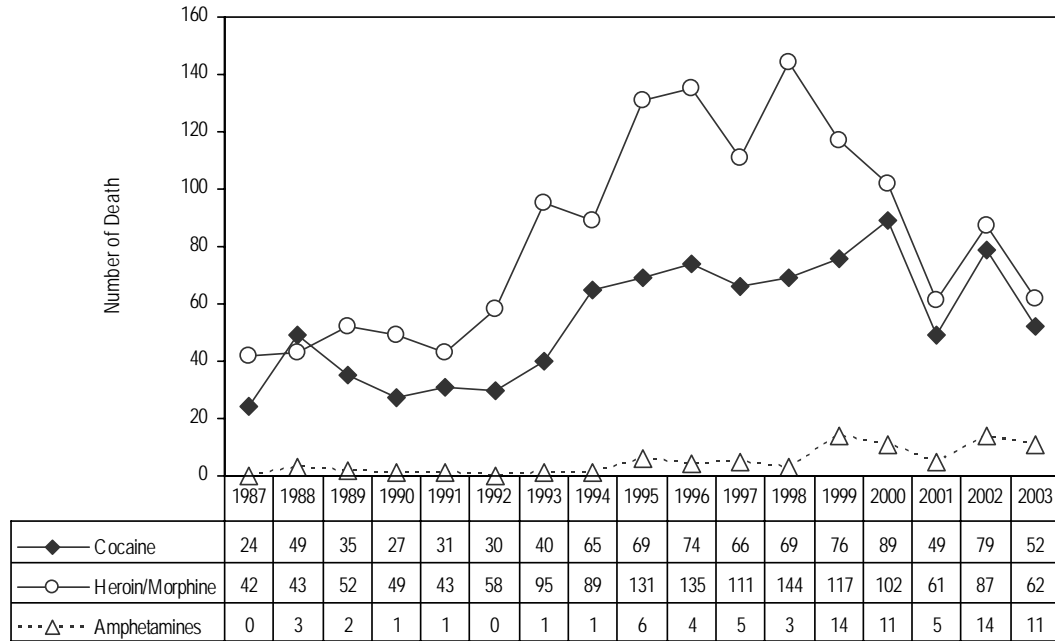
**Exhibit 4. Drug Treatment Admissions for “Any Use of Drug” Among Youth and Adults in King County, Washington, by Percent: 1999–2003<sup>1</sup>**



<sup>1</sup>In 2003, there were 1,393 youth treatment admissions and 7,397 adult treatment admissions.

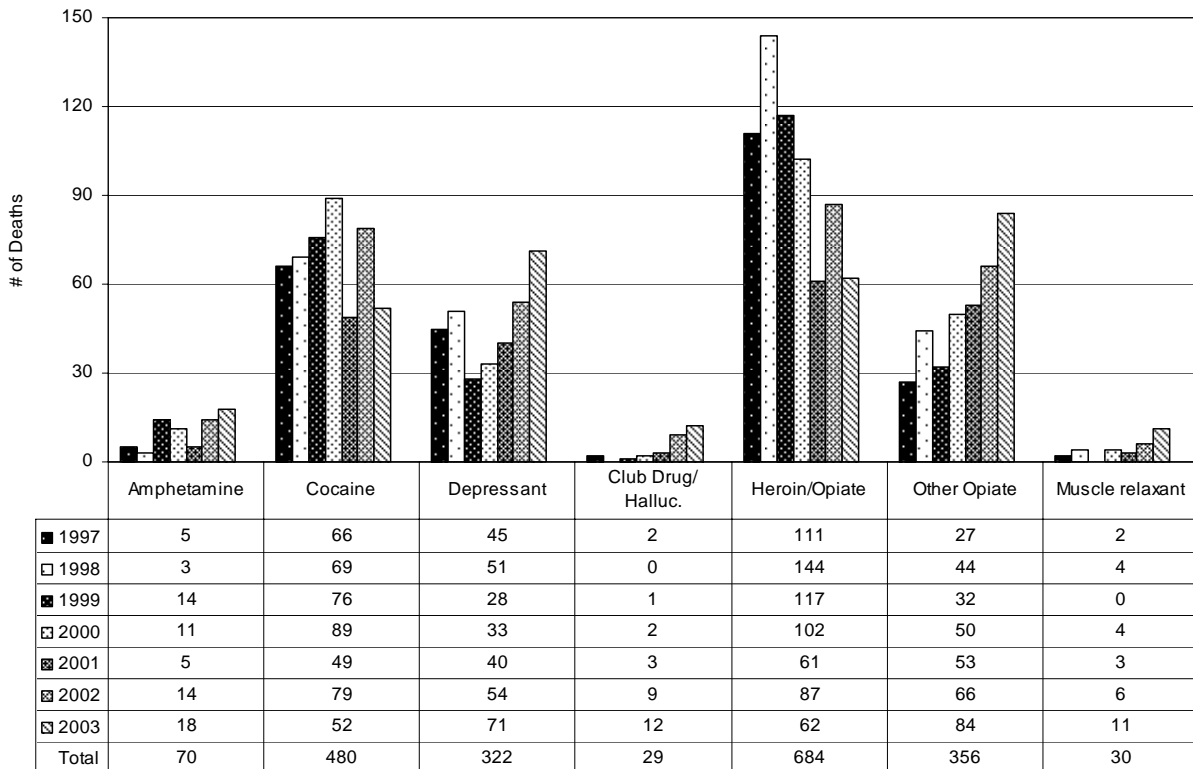
SOURCE: WA State Division of Alcohol and Substance Abuse, DSHS, Treatment Analyzer data analysis tool

**Exhibit 5. Drug-Involved Deaths in King County, Washington, Related to Illicit Drugs: 1987–2003**



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

**Exhibit 6. Drug-Involved Deaths in King County, Washington, Related to Illicit and Prescription Drugs: 1997–2003**



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

**Exhibit 7. Single and Multidrug-Involved Deaths<sup>1</sup> in King County, Washington: 1997–2003**

Drug Involved	1997	1998	1999	2000	2001	2002	2003	Total	% Single Drug
Alcohol									
Single drug	7	8	5	5	4	2	8	39	
Multidrug <sup>2</sup>	NA	NA	NA	NA	NA	NA	NA	NA	
Amphetamine									
Single drug	2	1	6	2	1	3	7	22	31%
Multidrug	3	2	8	9	4	11	11	48	
Cocaine									
Single drug	12	8	13	31	8	16	9	97	20%
Multidrug	54	61	63	58	41	63	43	383	
Heroin/Opiate									
Single drug	53	65	50	41	16	19	7	251	37%
Multidrug	58	79	67	61	45	68	55	433	
Club Drug/ Hallucinogen <sup>3</sup>									
Single drug	0	0	1	0	2	1	1	5	17%
Multidrug	2	0	0	2	1	8	11	24	
Depressant/Sedative/ Anxiolytic									
Single drug	6	5	5	4	1	0	3	24	7%
Multidrug	39	46	23	29	39	54	68	298	
Other Opiate									
Single drug	1	12	7	10	8	5	5	48	13%
Multidrug	26	32	25	40	45	61	79	308	
Muscle Relaxant									
Single drug	0	0	0	0	0	0	0	0	0%
Multidrug	2	5	1	4	3	6	10	31	

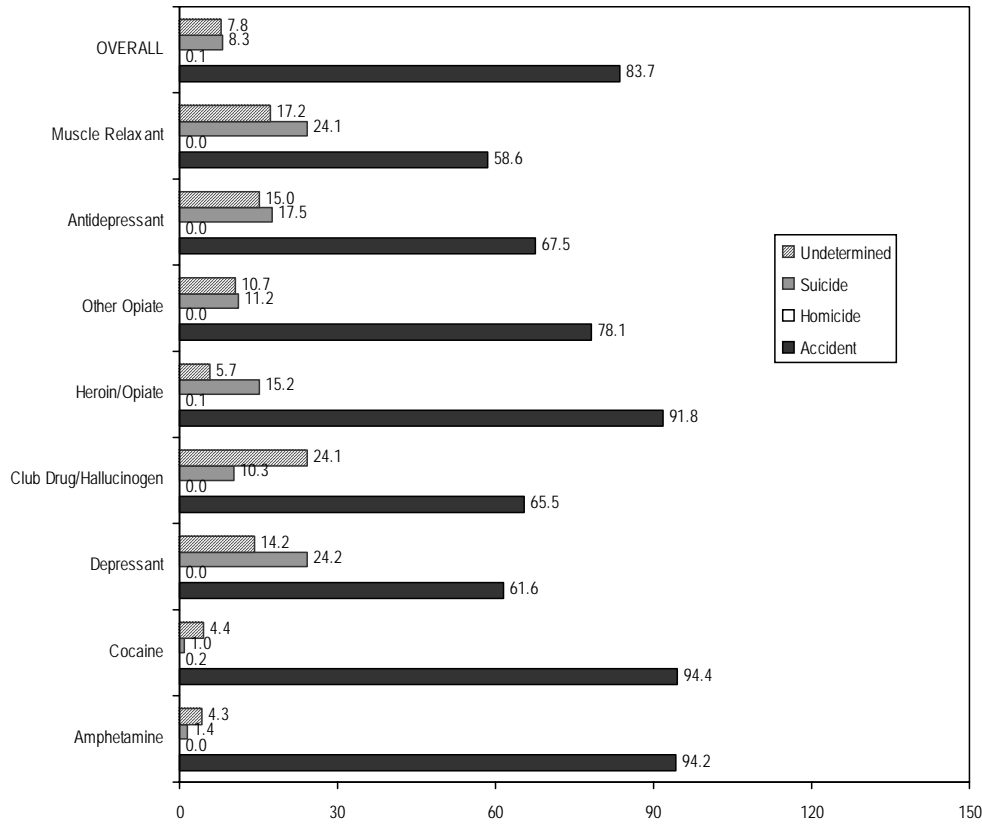
<sup>1</sup>Antidepressant single-drug deaths are excluded from analyses.

<sup>2</sup>Alcohol-in-combination deaths inconsistently recorded across time.

<sup>3</sup>Club Drug/Hallucinogen: PCP, MDMA, GHB/GBL, mescaline, peyote, dextromethorphan.

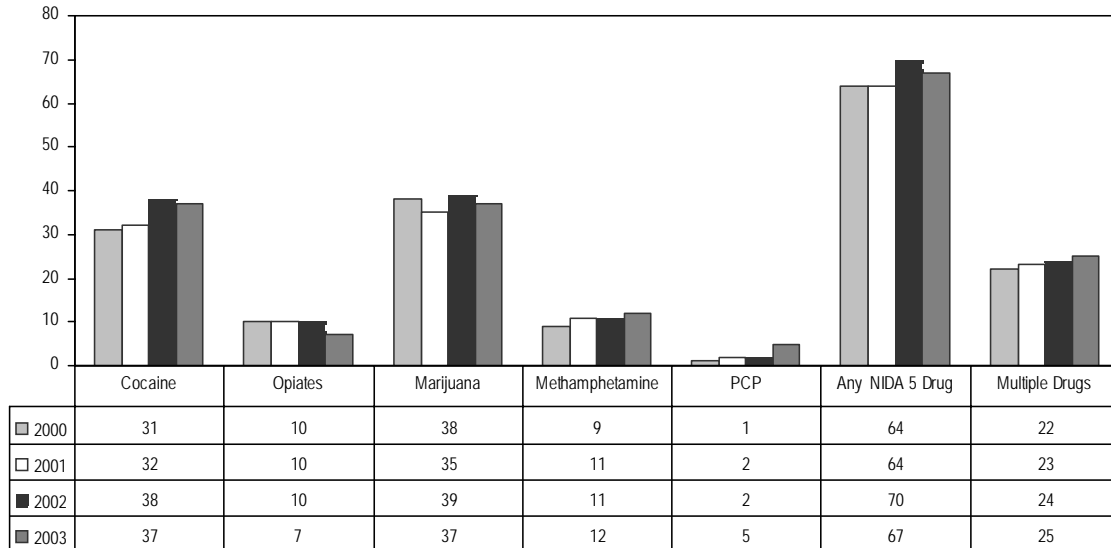
SOURCE: Medical Examiners Office, Public Health – Seattle & King County

**Exhibit 8. Manner of Death for Drug-Involved Deaths in King County, Washington, by Percent: 1997–2003**



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

**Exhibit 9. Urine Drug Screen Results Among New Arrestees in King County Jails: 2000–2003**



SOURCE: ADAM, NIJ

**Exhibit 10. National Forensic Lab Information System, Drug Test Results for Law Enforcement Seizures in Seattle and the State of Washington: 2003**

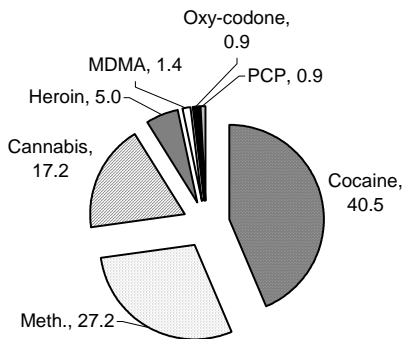
Drug Test Results on Law Enforcement Submissions to Seattle Area Lab (Top 25 Substances)

Substance	Count	Percent
Cocaine	1300	40.5
Meth.	872	27.2
Cannabis	551	17.2
Heroin	161	5.0
MDMA	44	1.4
Oxy-codone	29	0.9
PCP	29	0.9
Hydrocodone	23	0.7
Pseudoephedrine	22	0.7
Psilocin	21	0.7
Clonazepam	17	0.5
Methadone	13	0.4
Diazepam	13	0.4
Cathinone	11	0.3
Carisoprodol	10	0.3
3,4-Methylenedioxyamphetamine	10	0.3
Non-Controlled Non-Narcotic Drug	10	0.3
Acetaminophen	9	0.3
Alprazolam	8	0.3
Amphetamine	8	0.3
Caffeine	8	0.3
Morphine	7	0.2
Codeine	6	0.2
Methandrostenolone (Methandienone)	4	0.1
Ketamine	2	0.1
Total	3188	99.3
Total Items Reported	3212	

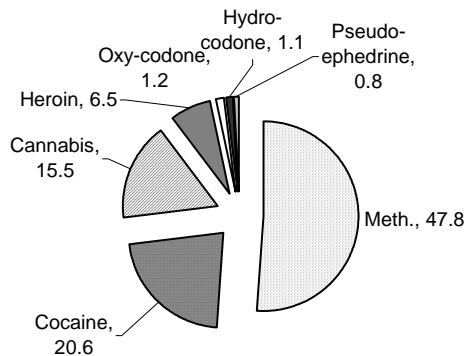
Drug Test Results on Law Enforcement Submissions to WA State Labs Excluding Seattle Area Lab (Top 25 Substances)

Substance	Count	Percent
Meth.	5892	47.8
Cocaine	2540	20.6
Cannabis	1913	15.5
Heroin	800	6.5
Oxy-codone	150	1.2
Hydro-codone	136	1.1
Pseudo-ephedrine	96	0.8
Psilocin	67	0.5
MDMA	67	0.5
Non-Controlled Non-Narcotic Drug	63	0.5
Methadone	51	0.4
Diazepam	46	0.4
Amphetamine	41	0.3
Clonazepam	36	0.3
Psilocybin	36	0.3
Morphine	34	0.3
Codeine	29	0.2
Acetaminophen	23	0.2
Alprazolam	23	0.2
Sodium Bicarbonate	23	0.2
Cannabinol	22	0.2
Caffeine	22	0.2
Carisoprodol	21	0.2
Methylphenidate	16	0.1
MDA	15	0.1
Top 25	12162	98.6
Total Items Reported	12332	

State Patrol Drug Seizure Tests Seattle Lab 2003

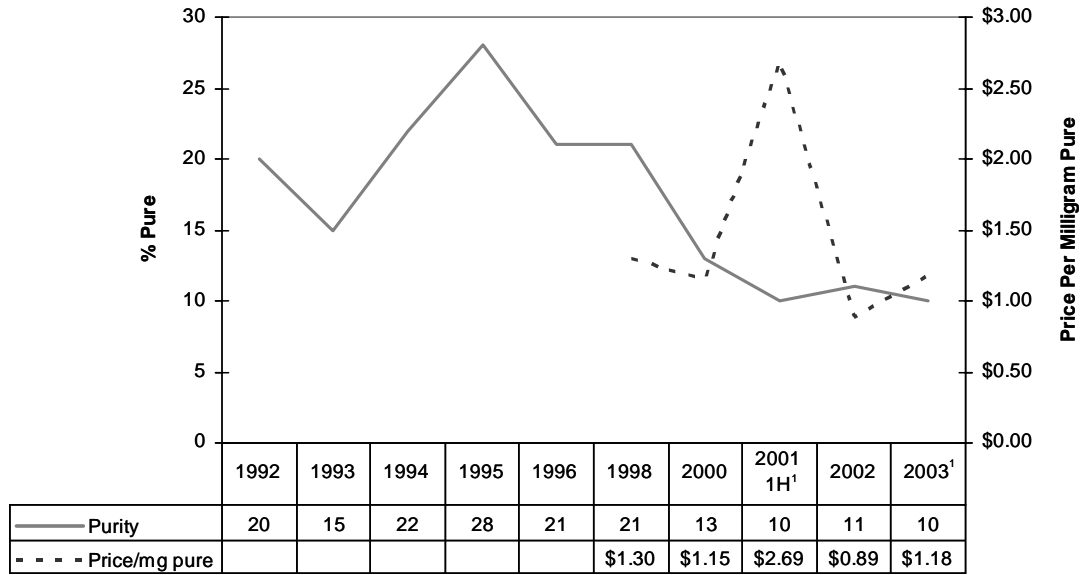


State Patrol Drug Seizure Tests WA State, Excluding Seattle, 2003



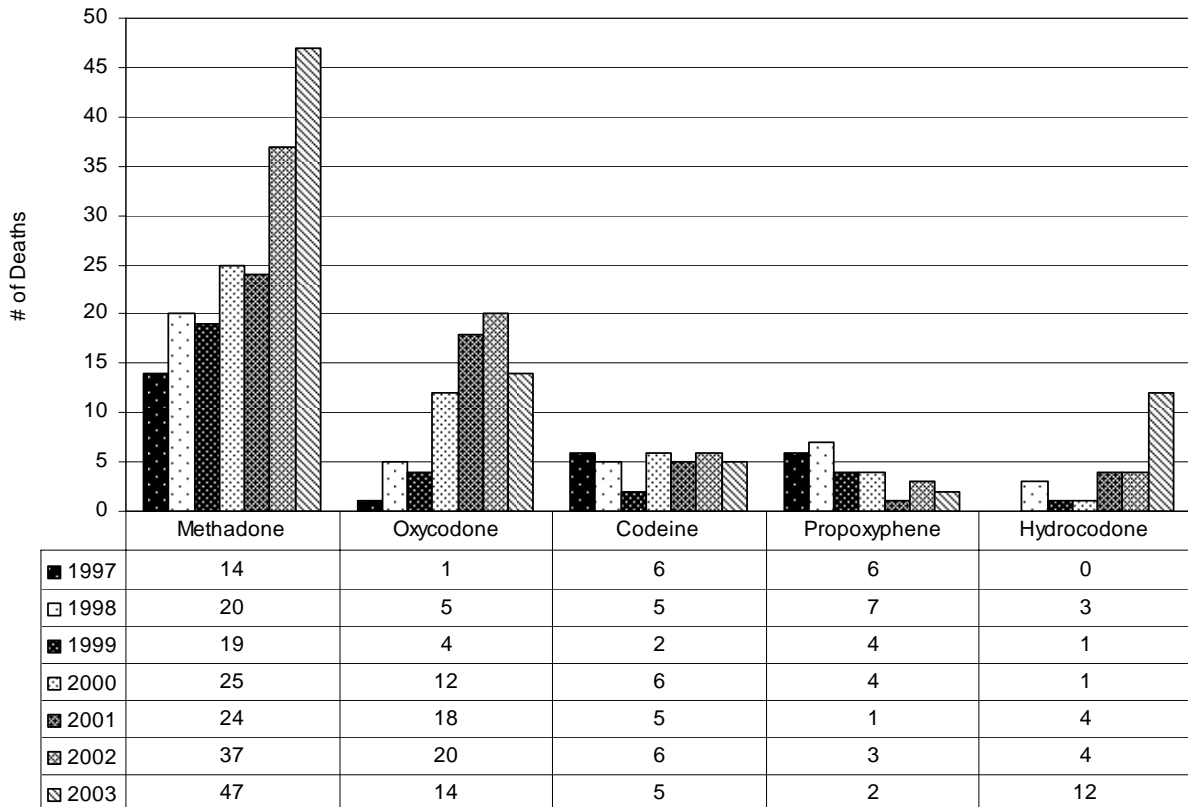
SOURCE: National Forensic Lab Information Systems, Data obtained from the Washington State Patrols, Forensic Toxicology Laboratory

**Exhibit 11. Heroin Prices and Purity in Seattle: 1992–2003**



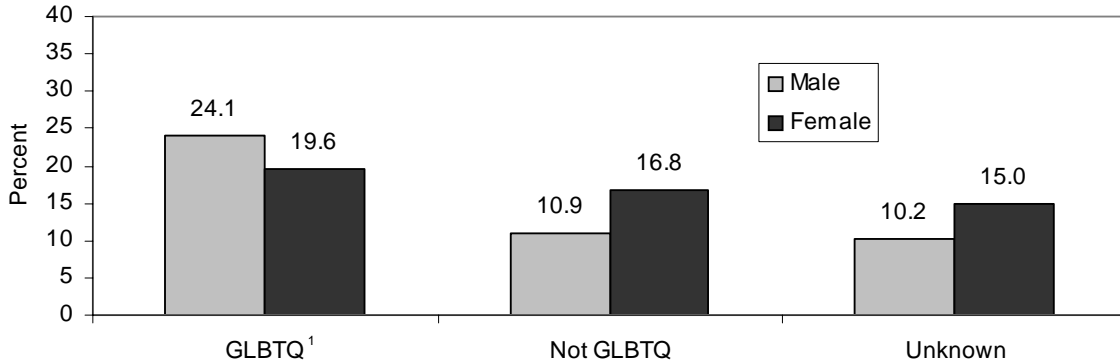
<sup>1</sup>NOTE: 2001 and 2003 data are based on preliminary findings.  
 SOURCE: Drug Enforcement Administration, Domestic Monitor Program, used with permission.

**Exhibit 12. Prescription Opiate<sup>1</sup>-Involved Deaths in King County, Washington: 1997–2003**



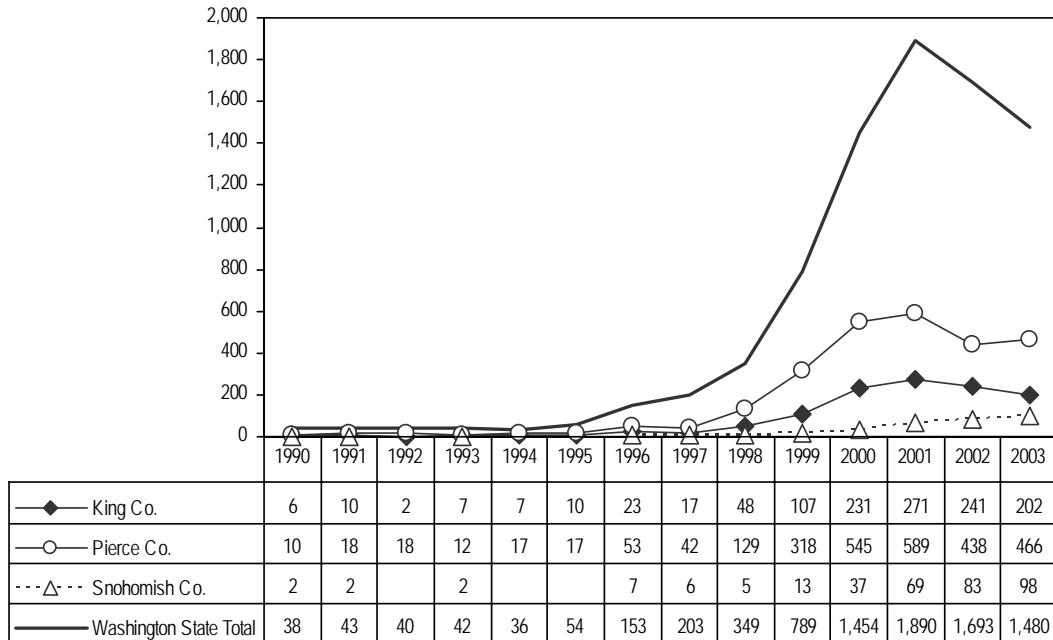
<sup>1</sup>Note: These five drugs represent 86 percent of prescription opiate-involved deaths.  
 SOURCE: Medical Examiners Office, Public Health- Seattle & King County

**Exhibit 13. Drug Treatment Admissions by Sexual Orientation and Methamphetamine Use in King County, Washington: 2003**



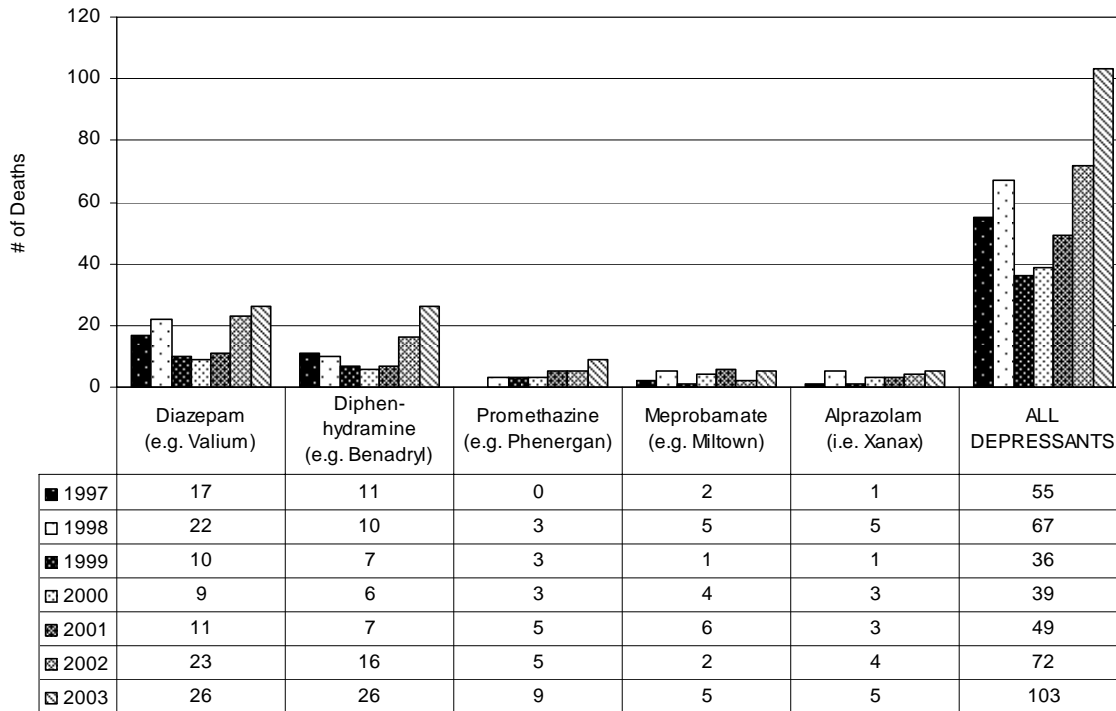
<sup>1</sup>GLBTQ=Gay, lesbian, bisexual, transsexual, and questioning of sexual identity.  
 SOURCE: Washington State TARGET data system—Structured Ad Hoc Reporting System.

**Exhibit 14. Methamphetamine Incidents Reported by the Washington State Department of Ecology: 1990–2003**



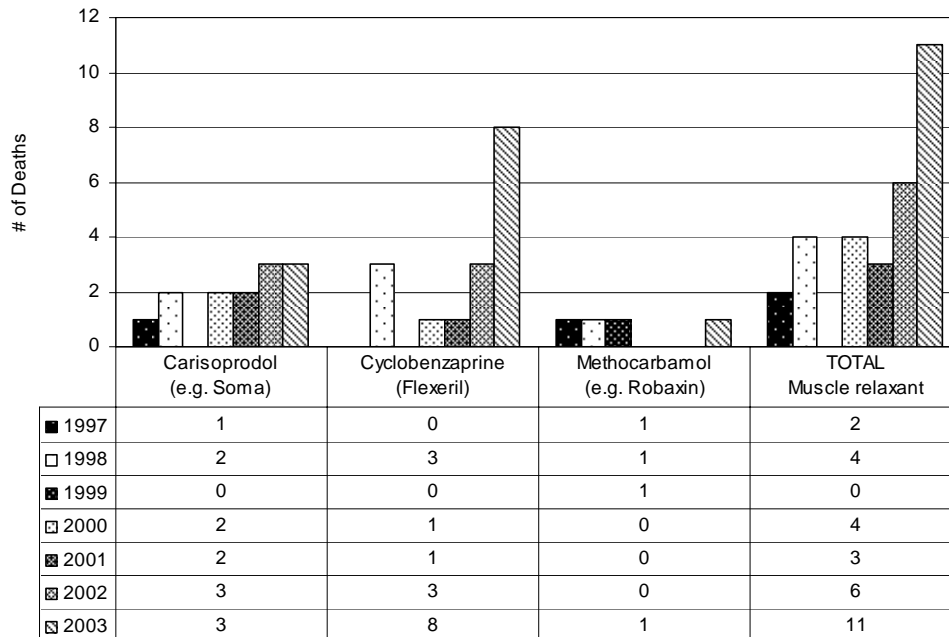
SOURCE: Washington State Department of Ecology

**Exhibit 15. Depressant/Sedative/Anxiolytic-Involved Deaths in King County, Washington: 1997–2003**



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

**Exhibit 16. Muscle Relaxant-Involved Deaths in King County, Washington: 1997–2003**



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

**Exhibit 17. Antidepressant-Involved Deaths in King County, Washington: 1997–2003**

Antidepressant	Type	Effect	Current Indications for Prescribing	'97	'98	'99	'00	'01	'02	'03	Total
Amitriptyline	Tri-cyclic	Sedating	Insomnia/Pain	5	14	4	5	3	7	7	45
Doxepin	Tri-cyclic	Sedating	Insomnia	2	2	4	1	4	5	4	22
Trazodone	Mixed	Sedating	Insomnia	2	3	1	3	5	4	2	20
Sertraline	SSRI	Mild Stimulant	Depression	2	4	2	2	2	0	3	15
Fluoxetine	SSRI	Mild Stimulant	Depression	2	2	3	2	1	3	5	18
Citalopram	SSRI	Neutral	Depression	0	0	2	0	4	3	9	18
Tri-cyclic Antidepressant	Tri-cyclic	Sedating	Insomnia/Pain	14	26	15	19	15	21	32	142
All Antidepressants	Mixed	Mixed	Mixed	23	40	29	32	40	47	78	289

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

**Exhibit 18. Persons Diagnosed with HIV Infection, Including Those With AIDS: 2001–2003**

	King County <sup>1</sup>		Other WA Counties <sup>2</sup>		Washington State <sup>1</sup>		United States <sup>2</sup>	
	HIV including AIDS		HIV including AIDS		HIV including AIDS		AIDS only	
Cumulative Diagnoses of HIV, including AIDS	9,022		4,839		13,861		886,575	
Cumulative HIV or AIDS Deaths	3,943		2,050		5,993		501,669	
Number currently living with HIV, including AIDS	5,079		2,789		7,868		384,906	
Case Demographics	King County <sup>1</sup> HIV including AIDS 01/2001–12/2003		Other WA Counties <sup>1</sup> HIV including AIDS 01/2001–12/2003		Washington State <sup>1</sup> HIV including AIDS 01/2000–12/2003		United States <sup>2</sup> AIDS only 01/2000–12/2002	
	Number	Percent	Number	Percent	Number	Percent		
Gender:								
Male	847	89%	425	80%	1,272	86%	92,057	73.88%
Female	100	11%	109	20%	209	14%	32,546	26.12%
Age:								
12 and younger	0	0%	1	< 1%	1	< 1%	---	---
13–19	9	1%	9	2%	18	1%	---	---
20–29	205	22%	110	21%	315	21%	---	---
30–39	446	47%	205	38%	651	44%	---	---
40–49	214	23%	141	26%	355	24%	---	---
50–59	58	6%	42	8%	100	7%	---	---
60 and older	15	2%	26	5%	41	3%	---	---
Race/Ethnicity:								
White	594	63%	345	65%	939	63%	35688	28.64%
Black	188	20%	83	16%	271	18%	62116	49.85%
Hispanic	104	11%	62	12%	166	11%	24694	19.82%
Asian/Pacific Islander	31	3%	22	4%	53	4%	1307	1.05%
Native American	20	2%	16	3%	36	2%	579	0.46%
Multi-Race	6	1%	0	0%	6	< 1%	N/A	---
Unknown	4	< 1%	6	1%	10	1%	219	0.18%
Exposure Category:								
Male-male sex	625	66%	246	46%	871	59%	49316	39.58%
Injecting drug user	59	6%	74	14%	133	9%	31849	25.56%
IDU & male-male sex	63	7%	35	7%	98	7%	5914	4.75%
Heterosexual contact	104	11%	100	19%	204	14%	35239	28.28%
Blood product exposure	4	< 1%	0	0%	4	< 1%	877	0.70%
Mother at risk/has AIDS	0	0%	1	< 1%	1	< 1%	311	0.25%
Undetermined/other	92	10%	78	15%	170	11%	1097	0.88%
<b>Total HIV Cases diagnosed in last 3 years</b>	<b>947</b>	<b>100%</b>	<b>534</b>	<b>100%</b>	<b>1,481</b>	<b>100%</b>	<b>124,603</b>	<b>100.00%</b>

<sup>1</sup>These cases were diagnosed with HIV infection between January 2001 and December 2003, and reported to Public Health – Seattle & King County or the Washington Department of Health as of 03/31/2004.

<sup>2</sup>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 U.S. data do not show specific incidence estimates for hemophilia or transfusion cases for 2000–2002; these numbers were interpolated from earlier incidence data.

SOURCE: Public Health – Seattle & King County, the Washington State Department of Health, and the Federal Centers for Disease Control and Prevention