DISTRICT OF COLUMBIA EPIDEMIOLOGICAL PROFILE:

CONSEQUENCES OF ILLICIT DRUG, ALCOHOL, AND TOBACCO USE

March 15, 2007

Prepared by

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ACKNOWLEDGEMENTS

We would like to thank the members of the DC Epidemiological Outcomes Workgroup for their efforts over the past year. Your dedication to understanding and addressing drug use and the consequences of drug use in the District make this report possible. Your patience and willingness to work through this process, review the consequences included, and plan for the future are commendable.

Special thanks are offered to Jerome Robinson at Pre-trial Services; Joe Gfroerer and his staff at the Office of Applied Studies at SAMHSA; Gail Maureen Hansen at the HIV/AIDS Administration; Anne Grant at the Metropolitan Police Department; Ethel Holland, RN, Viral Hepatitis Coordinator for the DC Department of Health; staff at the Washington/Baltimore HIDTA; Dr. Fiona Couper at the Office of the Chief Medical Examiner; and Rob Fleming for regularly supplying us with data and reviewing our materials.

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EXECUTIVE SUMMARY: DISTRICT OF COLUMBIA EPIDEMIOLOGICAL PROFILE

This report represents the first prevention-focused epidemiological profile for the District of Columbia (District, DC). The formation of this report provided the first opportunity for substance abuse professionals and policymakers to develop a method for identifying and prioritizing consequences of illicit drug, alcohol, and tobacco use in the District. The report was prepared by staff at the Addiction Prevention and Recovery Administration (APRA) and the Center for Substance Abuse Research at the University of Maryland (CESAR), College Park. Funding was provided by the Center for Substance Abuse Prevention (CSAP) at the Substance Abuse and Mental Health Services Administration (SAMHSA). The report was designed using the first two steps of the CSAP logic model which included identifying substance use consequences and consumption patterns (see Appendix 2). Policy recommendations were suggested based on the information provided in this report. The recommendations will be submitted to the Mayor's Interagency Task Force on Substance Abuse Prevention, Treatment and Control to be considered for inclusion in the Citywide Comprehensive Substance Abuse Strategy for the District of Columbia. This report will also be used to guide future funding decisions for grant awards by APRA.

During the first year of this project, the District expanded its DCEOW, produced a profile, and designed an innovative process for prioritizing the consequences and developing recommendations for the Task Force. After providing a brief overview of current prevention programming in the District, this report describes each of the consequences, recommendations from the DCEOW, and related consumption indicators.

The District's Approach

Nearly 1 in 10 residents in the District of Columbia (approximately 60,000) are addicted to illegal drugs and/or alcohol. At least one-half (26,000–42,000) of these individuals have co-occurring substance abuse and mental health disorders. APRA works to address this problem through a results-oriented methodology that utilizes a science-based approach to substance abuse prevention and treatment. APRA combines three fundamental elements to provide effective and innovative strategies in a continuum of care: prevention, treatment, and aftercare. APRA is also building alliances with other agencies to provide wrap-around recovery support services. The Office of Prevention and Youth Services (OPYS), within APRA, is responsible for prevention in the District. OPYS funds and manages an array of primary and secondary prevention efforts that are school, community, and media focused to strengthen community and individual resilience against initiating or continuing drug or alcohol abuse.

APRA currently funds 19 prevention programs which service 942 DC residents. The 19 prevention programs include 14 indicated and 5 selective intervention programs targeting individuals at risk for developing an addiction (disorder). The majority of those participating in

these prevention programs are young African Americans. Almost three-quarters of the youth participants are teens aged 13 to 18.

Expanding the DCEOW

The DC Epidemiological Outcomes Workgroup (DCEOW) was originally convened in March 2005 at the request of the Mayor's Interagency Task Force on Substance Abuse Prevention, Treatment and Control (the Task Force). The members were interested in strengthening DC's data sources and gaining a more complete and accurate understanding of drug trends in the District. The current DCEOW mission statement is as follows:

> *Monitor the use of alcohol, tobacco, and other drugs and the consequences of their use in DC to identify and prioritize the District's prevention needs. To achieve this end, the DCEOW will oversee the collection, interpretation, and dissemination of data that quantifies substance use and its consequences.*

Producing an Epidemiological Profile

During the first year of the grant, the primary goal was the development of the District's first epidemiological profile. The profile was designed to combine all available data for consequences related to illicit drug, alcohol, and tobacco use in the District of Columiba and link them to consumption indicators. The process for developing the profile included holding quarterly meetings of the DCEOW, identifying more than 150 indicators of substance abuse, and identifying and scoring the consequences of illicit drug, alcohol, and tobacco use. Each indicator was assessed for inclusion in this report based on its availability, validity, consistency, sensitivity, and the availability of attributable fractions. As a result of this assessment, nine consequences of illicit drug, alcohol, and tobacco use were included in this report. Each consequence section is organized around the three key questions that must be answered in order to develop data-driven prevention programs:

1. What are the most significant consequences of illicit drug use in the District of Columbia for which data is currently available?
2. Based on the data available, which consequences are of highest priority for the District of Columbia?
3. In addressing the consequences, what consumption indicators should be monitored to assess progress?

Highlights from the key findings on these consequences are provided below.

Consequences of Illicit Drug Use

Four major consequences were identified and assessed using the process described in the report. The highlights from the illicit drug section are as follows:

- Property Crime
  - An estimated 5,843 drug-related property crimes were reported to police in 2005.
  - Although the District's rates for property crimes have decreased, they remained consistently higher than the national rates.

    - The estimated numbers of drug-related burglaries and motor-vehicle thefts have decreased since 2003.
- AIDS
    - The rate of AIDS case reports in the District was holding steady at more than 12 times the national rate.
    - Nearly 1 in 4 cumulative AIDS prevalent-cases (3,912 cases) were IDU-related in 2004.
    - AIDS cases were most likely to be African-American males aged 20-44.
    - The AIDS incident cases increased 15% from 2001 to 2004.
- Hepatitis B & C
    - The acute hepatitis B rate in the District increased slightly in 2004.
    - More than half of the 19 acute hepatitis B cases were male and nearly three-quarters were African American.
    - The 1,655 cases of chronic hepatitis C were most likely to be Black, male, and between the ages of 40 to 59 when diagnosed.
    - Attributable fractions indicated that approximately 1 in 3 acute hepatitis B and 1 in 5 chronic hepatitis C cases were drug-related.
- Past Year Drug Abuse or Dependence
    - An estimated 16,000 District residents reported past year abuse or dependence in 2004.
    - The estimated number of District residents who reported abuse or dependence decreased 24% from 2002 to 2004.
    - More than half of the District residents who reported past year abuse or dependence were adults age 26 or older.

An average of 38,000 persons aged 12 or older reported use of marijuana between 2002 and 2005, while 20,000 reported use of an illegal drug other than marijuana in the past year. Trends related to illicit drug use among high school students somewhat decreased between 2003 and 2005. Reported use of marijuana was much higher than cocaine and inhalants for high school students in 2005. Cocaine use among the adult arrestee population was much higher than for opiates and PCP between 2001 and 2005.

Consequences of Alcohol Use

Four major consequences were identified and assessed using the process described in the report. The highlights from the alcohol section are as follows:

- Violent Crime
    - Although violent crime rates in the District decreased in 2001, they remained nearly three times higher than the national rates.
    - There were an estimated 1,358 alcohol-related violent crimes in the District in 2005.
    - Nearly 1 in 3 murders/non-negligent manslaughters and aggravated assaults were alcohol-related.
    - The estimated number of alcohol-related homicides, forcible rapes, robberies, and aggravated assaults decreased steadily since 2003.
- Alcohol-related Fatal Motor Vehicle Crashes
    - More than 40% of all fatal crashes were alcohol-related.
    - The number of alcohol-related fatalities increased from 44% in 2004 to 50% in 2005.
    - Drinking drivers involved in fatal crashes were most likely to be male and aged 21 to 29.
- Past Year Alcohol Abuse or Dependence
    - An estimated 45,000 District residents reported past year abuse or dependence in 2004.

- An estimated 45,000 DC residents aged 12 or older reported past year alcohol abuse or dependence in 2003-2004; this is a slight decrease from 2002.
- The District and National trends were similar for the percentage of residents who reported alcohol dependence or abuse in the past year. The percentage remained steady at approximately 9-10 percent since 2002.

- Chronic Liver Disease
  - There were 41 alcohol liver disease deaths in the District in 2003, more than 4 times the number of deaths from other cirrhosis liver disease.
  - Alcohol liver disease deaths in the District were most likely to occur in males, African Americans, and middle aged adults (35 to 54 years of age).

An average of 269,000 DC residents aged 12 or older reported alcohol use, while 126,000 reported binge alcohol use in the past year between 2002 and 2005. Overall, reports of alcohol use among DC high school students have been decreasing. In 2005, about 23 percent of high school students in the District of Columbia reported illegal use of alcohol, while over 9 percent reported binge drinking on at last one occasion in the past 30 days. In 2005, nearly one quarter of high school students rode in a car when the driver had been drinking and 4% reported driving a car after drinking in the past 30 days.

Consequences of Tobacco Use

One major consequence was identified and assessed using the process described in the report. The highlights from the tobacco section are as follows:

- Tobacco-related Mortality
  - There were 284 lung cancer deaths and a combined total of 127 chronic obstructive pulmonary disease and emphysema deaths in the District in 2003.
  - Lung cancer deaths in DC were most likely to occur in males, African Americans, and individuals aged 65 and over
  - COPD and emphysema deaths were slightly more likely to occur in females.
  - Nearly all (80-90%) of the lung cancer, COPD, and emphysema deaths were attributable to tobacco.

An average of 139,000 DC residents aged 12 or older reported tobacco use between 2002 and 2005. Reports of tobacco use among DC high school students steadily decreased since 1999. High school students in the 11^{th} grade reported more tobacco use in the past 30 days compared to 9^{th}, 10^{th}, and 12^{th} graders. In 2005, nearly 10 percent of DC high school students reported cigarette use in the past 30 days.

Prioritizing Consequences

To ensure that the prevention process remains data-driven, the DCEOW piloted a new method for prioritizing the consequences of illicit drug, alcohol, and tobacco use. For the first time, District substance abuse professionals and policymakers went beyond separate discussions of individual data sets and prioritized a series of consequences utilizing a consistent set of criteria. The four consequences of both illicit drug and alcohol use and the one consequence of tobacco use, were scored by 14 core members of the DCEOW using six criteria:

1. Number of people directly affected

2. Prevalence
3. District/National comparison
4. Number indirectly affected
5. Cost
6. Changeability.

After reviewing the data and criteria provided, each member was asked to vote if the consequences should be a high or low priority. The results recorded were distinct enough to divide the consequences into three priority categories. The "overall priority" for each consequence was identified as high, medium, or low. The priority level was determined by the number of individuals who elected each of the consequences as high or low.

The results demonstrate that drug-related arrests, AIDS, violent crime, motor vehicle crashes, and past year illicit drug or alcohol abuse or dependence have been assessed as a high priority in the District of Columbia, followed by property crime, Hepatitis C, and tobacco mortality which, based on the core members' assessment, are a medium priority. Hepatitis B was ranked lowest with nearly all core members assessing it as a low priority. Liver disease mortality was also determined to be a low priority.

Planning for Year 2

Research and Recommendations

In year 2, we will build on our accomplishments to expand the efforts of the DCEOW. Plans for year 2 include the investigation of 74 additional indicators that will be used to develop additional consequences such as child abuse/neglect, domestic violence, suspensions/expulsions, incident and prevalent HIV cases, driving under the influence, age of first use, and the impact of alcohol and drug use on pregnant women and their babies.

The DCEOW provides two categories of recommendations: recommendations for additional research and recommendations for the Task Force.

Additional research:

1. Analysis of recidivism amongst drug and alcohol using offenders
2. Assessment of arrest location and residence of the illicit drug and alcohol related offenders to further support the Metropolitan Police Department's hotspots initiative
3. Geo-mapping of variables such as unemployment, crime, arrests, drug markets/organizations, treatment admissions, and prevention programs related to illicit drug and alcohol use
4. Analysis of causal connections between illicit drug and alcohol consumption and consequences
5. Assessment of the relationship between the sex trade and illicit drug use
6. Needs assessment of people currently being treated for vs. people needing treatment for Hepatitis C
7. Analysis of the relationship between the age of first use of illicit drugs and alcohol, the amount and types of drugs used, and the likelihood of developing dependency problems
8. Assessment of co-occurring illicit drug or alcohol use and mental illness

9. Geo-mapping of variables such as treatment admissions and prevention programs related to tobacco use
10. Analysis of the relationship between the age of first use of tobacco, the frequency of tobacco use, and the likelihood of developing dependency problems

Task Force Recommendations:

Criminal Justice

1. Involve court services in all program planning and referral processes
2. Develop mechanisms, such as mapping and de-confliction services provided by the MPD and the Washington/Baltimore HIDTA, to identify and monitor high risk areas and vendors in the city
3. Develop mechanisms to track offender residence and place of crime for drug and alcohol-related arrestees
4. Develop mechanisms to collect more detailed information for crimes related to illicit drug and alcohol use
5. Develop and support resources, such as civil legal actions, for identifying and resolving environmental factors conducive to drug trafficking and crime

Public Health

1. Support and expand outreach programs for youth including sexually transmitted disease (STD) and alcohol education
2. Expand support for drug testing programs in criminal justice and education settings
3. Improve coordination and communication between city agencies to ensure that individuals identified as drug and alcohol users can be monitored across agencies and that they receive the services they need
4. Develop and conduct an annual DC survey on substance use and health (formerly the household survey) to monitor illicit drug, alcohol, and tobacco use and health related decision making by DC residents
5. Improve and expand the collection of data on HIV and Hepatitis diagnoses
6. Improve and expand the collection of data on drug and alcohol use by pregnant women, babies born drug positive, and drug-related child abuse/neglect cases to ensure that DC's children are protected and supported as they become healthy, productive adults
7. Initiate data collection processes to monitor drug, alcohol, and tobacco use on college and university campuses
8. Support and expand outreach programs for youth and nicotine education

INTRODUCTION

This report represents the first prevention-focused epidemiological profile for the District of Columbia (District, DC). The formation of this report provided the first opportunity for substance abuse professionals and policymakers to develop a method for identifying and prioritizing consequences of illicit drug, alcohol, and tobacco use in the District. The report was prepared by staff at the Addiction Prevention and Recovery Administration (APRA) and the Center for Substance Abuse Research at the University of Maryland (CESAR), College Park. Funding was provided by the Center for Substance Abuse Prevention (CSAP) at the Substance Abuse and Mental Health Services Administration (SAMHSA). The report was designed using the first two steps of the CSAP logic model which included identifying substance use consequences and consumption patterns (see Appendix 2). Policy recommendations were suggested based on the information provided in this report. The recommendations will be submitted to the Mayor's Interagency Task Force on Substance Abuse Prevention, Treatment and Control to be considered for inclusion in the Citywide Comprehensive Substance Abuse Strategy for the District of Columbia. This report will also be used to guide future funding decisions for grant awards by APRA.

This report was prepared with data provided by the DC Epidemiology Outcomes Workgroup (DCEOW) members and includes five key sections:

1. The District at a Glance
2. The District's Approach
3. Consequences of Illicit Drug Use
4. Consequences of Alcohol Use
5. Consequences of Tobacco Use

The first section, the District at a Glance, provides an overview of the population characteristics and substance abuse in the District of Columbia. The District's Approach section examines current prevention services, the formation of the DCEOW, and the process of developing this report. Sections 3, 4, and 5 include consequences of illicit drug, alcohol, and tobacco uses which were selected based on discussions with DCEOW members and an assessment of nearly 150 consequences, or indicators, of substance use by CESAR. Recommendations for future reports the Mayor's Task Force, as well as related consumption patterns, are also provided for each of the three consequence sections.

THE DISTRICT AT A GLANCE
AREA DESCRIPTION:
OVERVIEW OF DC POPULATION CHARACTERISTICS

The nation's capital is home to approximately 570,898 people residing in 8 wards (see Appendix 3) that remain largely distinguishable by race and economic status (U.S. Bureau of the Census, 2001 update). The northwest sector of the city, which includes all of wards 1 and 3 and the majority of ward 4, is home to residents who are more likely to be wealthy and White. The northeast and southeast sectors, which include most of wards 5, 6, 8, and all of ward 7, are home to residents who are more likely to be poor and African-American. The majority of the District's population is African American (57 percent). Nearly one-third of the population is White (31.1 percent), and the remainder (11.9 percent) are primarily Hispanic or Asian (U.S. Bureau of the Census, 2000 Census).

The population of the District is comparable to the overall national population characteristics. One in five District residents is less than 18 years of age. Slightly more than 12 percent of District residents are age 65 or older. The District of Columbia has slightly more females (52.6 percent) than males (47.4 percent), which is also consistent with national percentages. However, more than one-third (39.1 percent) of adults age 25 or older in the District have at least a bachelor's degree which is higher than the 24.4 percent nationwide.

Data from the 2000 census also revealed several population changes in the District of Columbia since 1990. The total population of the District of Columbia decreased 5.7 percent during the 1990s, from 606,900 in 1990 to 572,059 in 2000. The number of African Americans residing in the District decreased 14.1 percent. However, increases were reported in the number of Asians (including Pacific Islanders) living in the District (38.6 percent increase), and the number of Hispanic residents living in the District (37.4 percent increase) between 1990 and 2000. The White population increased by only 2 percent during this same time period.

OVERVIEW OF SUBSTANCE ABUSE IN THE DISTRICT OF COLUMBIA

Alcohol and drug abuse costs the District of Columbia approximately $1.2 billion per year. In fiscal year (FY) 2004, the city spent approximately $333 million to address the problem. Only four percent ($13.4 million) of the budget for substance abuse in 2004 was spent on prevention services.

Nearly 1 in 10 residents in the District of Columbia (approximately 60,000) are addicted to illegal drugs and/or alcohol. At least one-half (26,000–42,000) of these individuals have co-occurring substance abuse and mental health disorders. The 2000 District of Columbia Household Survey indicated that first-time drug use occured at an earlier age (early teen years) in the District compared to the nation (Citywide Comprehensive Substance Abuse Strategy for the District of Columbia 2003). In addition, the Addiction Prevention and Recovery Administration (APRA) reported that 40 percent of the 1.3 million annual emergency room visits were related to alcohol and drug abuse.

In 2004 through 2005, cocaine/crack, heroin, and marijuana continued to be the main illicit drug problems in the District of Columbia. Cocaine remained one of the more serious drugs of abuse in the District, as evidenced by the fact that more adult arrestees tested positive for cocaine than for any other drug in 2005. The cocaine/crack related arrests in 2005 slightly increased from 2004 as reported by the Metropolitan Police Department. Cocaine was also found on more seized items that were examined for traces of drug substances than any other drug in 2005. In 2004, opiates (including heroin) were related to a larger number of drug-related deaths than cocaine. Overall, juvenile arrestees were more likely to test positive for marijuana than for any other drug.

Use of PCP, methamphetamines, and club drugs were also reported in the District in 2005 and 2006. The test results from the DC Pretrial Services Agency indicated that PCP (phencyclidine) positives increased slightly in 2005 for both adults and juveniles, however, in early 2006, PCP positives for juveniles began to decline. Towards the end of 2006, PCP rates for adult arrestees began to increase ending with an average of about 9 percent of adult arrestees testing positive for PCP in 2006. Arrest data from the Metropolitan Police Department showed slight increases in arrests related to PCP in 2005. While other parts of the country have seen shifts in the use of methamphetamine, its use remains low and confined to isolated communities in DC. The use of club drugs like methylenedioxymethamphetamine (MDMA) also appeared to be on a continuous decline.

The Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA) identified 42 drug trafficking organizations operating in Washington, DC. The most frequently seized drugs by HIDTA initiatives were marijuana, cocaine, and heroin (Washington/Baltimore HIDTA 2007 Threat Assessment). Information from the Department of Justice's National Drug Intelligence Center (NDIC) mentioned that the District has a wide variety of drug transportation options, including an extensive highway system, three major airports, and rail and bus systems. While both NDIC and ethnographic information suggest that traffickers extensively use all of these options, DC appeared to be a secondary drug distribution center; most drugs intended for distribution in DC were distributed first to larger cities, such as New York and Miami.

THE DISTRICT'S APPROACH
PREVENTION SERVICES IN THE DISTRICT OF COLUMBIA

The Addiction Prevention and Recovery Administration (APRA) is the District's primary state agency on alcohol, tobacco, and other drug abuse prevention and treatment. APRA provides and supports comprehensive substance abuse treatment and prevention services in DC. Therefore, APRA plays a key role in reducing the consequences of substance use in DC.

The APRA philosophy is multi-faceted and multi-targeted. It follows a results-oriented methodology that utilizes a science-based approach to substance abuse prevention and treatment. APRA combines three fundamental elements to provide effective and innovative strategies in a continuum of care: prevention, treatment, and aftercare. APRA is also building alliances with other agencies to provide wrap-around recovery support services.

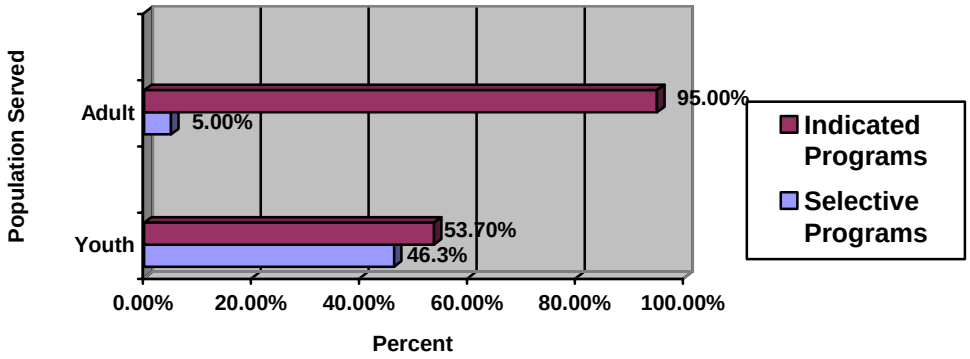
The Office of Prevention and Youth Services (OPYS), within APRA, is responsible for prevention in the District. OPYS funds and manages an array of primary and secondary prevention efforts that are school, community, and media focused to strengthen community and individual resilience against initiating or continuing drug or alcohol abuse.

Funded Programs and People Served

APRA allocates annual funds to public and private organizations responsible for adolescent and adult substance abuse prevention and recovery efforts. APRA currently funds 19 prevention programs that service 942 DC residents. The 19 prevention programs include 14 indicated and 5 selective intervention programs targeting individuals at risk for developing an addiction (disorder). Indicated intervention programs are defined by SAMHSA as programs that target individuals in "high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels." Selective intervention programs are defined by SAMHSA as a program that targets individuals or a subgroup of the population whose "risk of developing a disorder is significantly higher than average."

Of the 19 total prevention programs funded by APRA, 16 are youth programs for DC residents under 21 years of age and 3 are adult programs for those residents 21 years of age and older. The youth programs are more likely to be indicated than selective, 14 programs compared to 2 respectively. However, indicated and selective programs have nearly the same number of youth participants as seen in Figure 1. For adults, there are 2 selective programs and 1 indicated program funded by APRA. Almost all of the adult participants (95%) are in indicated programs (see Figure 1.)

Figure 1: Composition of Adult and Youth Participation in APRA-Funded Indicated and Selective Programs, 2006



SOURCE: Developed by CESAR from FY06 Minimum Data Set (MDS) data submitted to APRA by the prevention

Although youth programs are designed to service DC residents who are less than 21 years of age, almost three-quarters of the youth participants are between the ages of 13 and 18 (see Figure 2). Adult programs provide services to individuals 21 years of age and older, however, only three percent of the total adult population in APRA-funded programs is 55 years of age or older (see Figure 3).

Figure 2: Age Composition of Youth Participants in APRA-Funded Programs, 2006 (n = 778)

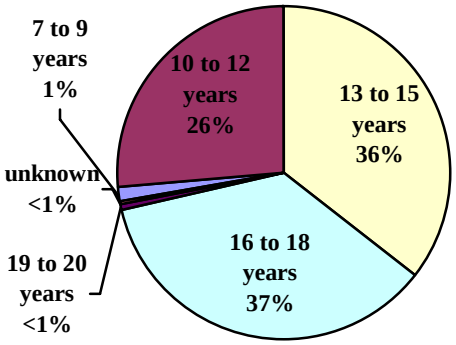
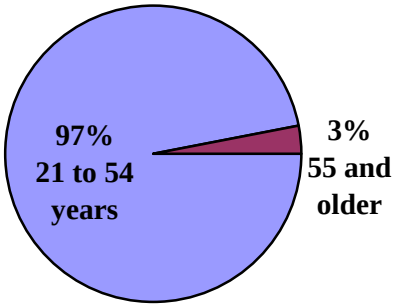


Figure 3: Age Composition of Adult Participants in APRA-Funded Programs, 2006 (n = 164)



SOURCE: Developed by CESAR from FY06 Minimum Data Set (MDS) data submitted to APRA by the prevention programs in August 2006.

The District of Columbia encompasses more than 120 neighborhoods. These neighborhoods are subsequently divided into advisory neighborhood commissions which advise the District government on issues related to zoning, social service programs (including potential recovery program sites), health, police protection, sanitation, recreation, and alcohol vending licenses. There are 37 advisory neighborhood commissions in the District's eight wards. Table 1 provides the distribution of the percent of participants in APRA-funded programs for each ward. Almost one-half of all youth participants in APRA-funded programs reside in Wards 7 and 8 combined, while nearly three out of four of all adult participants in APRA-funded programs reside in Ward 8 alone.

Table 1: Participants in APRA-Funded Programs, by Ward, 2006

Ward	Participants in APRA-Funded Programs			
	Adult		Youth	
	No.	Percent	No.	Percent
1	1	0.6	110	14.1
2	1	0.6	57	7.3
3	0	0.0	3	0.4
4	2	1.2	82	10.5
5	2	1.2	94	12.1
6	5	3.0	43	5.5
7	27	16.5	174	22.4
8	118	72.0	204	26.2
Unknown	8	4.9	11	1.4
Total	164	100.0	778	99.9*

* <100% due to rounding

SOURCE: Developed by CESAR from FY06 Minimum Data Set (MDS) data submitted by the prevention programs to APRA in August 2006.

There is little variation in the racial component of participants in youth and adult APRA-funded programs. As seen in Figure 4 and 5, nearly all of the youth (82.4%) and adult (95%) participants in APRA-funded substance abuse prevention programs are African American. Asian American/Pacific Islanders account for 7.7 percent of youth participants and three percent of the adult participants. Hispanics are not represented in the adult programs although account for 8.3 percent of participants in the youth programs. A very small percentage of the youth (0.3%) and adult (2%) participants are Caucasian.

Figure 4: Racial Composition of Youth Participants in APRA-Funded Programs, 2006 (n=778)

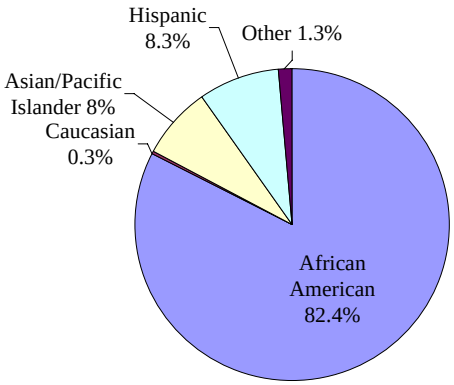
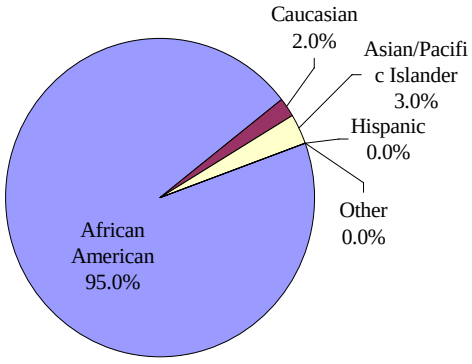


Figure 5: Racial Composition of Adult Participants in APRA-Funded Programs, 2006 (n=164)



SOURCE: Developed by CESAR from FY06 Minimum Data Set (MDS) data submitted to APRA by the prevention

2006 Prevention Strategy

DC is well aware of the value of prevention programs in reducing the consequences of substance abuse. The District's current comprehensive strategy for addressing substance abuse includes a total of four goals. The first goal, which drives this report, focuses specifically on prevention and reads as follows:

Educate and empower DC residents to live healthy and drug-free lifestyles.

The data and recommendations presented in this report will be used to focus and monitor the progress of the District in reaching this goal. The information in this report will also be used to identify specific actions to achieve the following four objectives:

- Expand prevention activities through coalitions and neighborhood organizations.
- Increase the effectiveness of prevention activities through the development and strengthening of a planning, implementation, and evaluation infrastructure.
- Increase the utilization of appropriate evidence-based environmental strategies to change individual and community norms.
- Increase the effectiveness of the District's prevention workforce by training youth development and prevention professionals to implement effective prevention strategies.

DCEOW PROCESS

DC Epidemiology Workgroup

The DC Epidemiological Outcomes Workgroup (DCEOW) was originally implemented at the request of the Mayor's Interagency Task Force on Substance Abuse Prevention, Treatment and Control (the Task Force). The Task Force is an executive-level task force responsible for preparing and recommending a citywide substance abuse strategy and overseeing the city's substance abuse policies and interagency and intergovernmental substance abuse activities. The Mayor specifically charged the Task Force with *enhancing the effectiveness of the city's health, social service, and criminal justice system* and *establishing well-defined performance measures that will facilitate an assessment of costs and benefits in investments in substance abuse prevention, treatment, and control*. The DCEOW, which operates under the auspices of APRA, was created to provide the Task Force with the data and analysis necessary to fulfill these goals. The DCEOW includes experts in the District who are concerned with the city's substance abuse problems.

The DCEOW first convened in March of 2005. The members were interested in strengthening DC's data sources and gaining a more complete and accurate understanding of drug trends in the District. Consequently, individual members presented data and perceptions on drug-related issues to the workgroup. At this time, the workgroup also focused on identifying data sources with specific indicators that monitored the prevalence and incidence of substance use and addiction and co-occurring disorders, identifying and understanding emerging trends, and assessing substance abuse and mental health prevention and treatment needs and resources in the District.

Meetings of the DCEOW were held quarterly in 2005. During these meetings, representatives from a variety of DC agencies, including APRA, presented data and information about treatment programs for specific populations. The following agencies presented on various drug-related topics:

1. CESAR presented on drug trends and patterns in the District.
2. Pre-trial Services presented on drug test results.
3. The Office for Applied Studies (OAS) at the U.S. Substance Abuse and Mental Health Association (SAMHSA) presented on the National Survey on Drug Use and Health (NSDUH) data.
4. The DC Metropolitan Police Department presented on drug-related crime.
5. The Administration for HIV Policy and Programs presented on injection drug use (IDU)-related AIDS cases.
6. The Washington/Baltimore HIDTA presented on drug seizures, drug-related crime in the District, and drug trafficking, including various maps illustrating patterns of drug-related issues in the District.

Throughout this process, new interagency relationships developed and were fostered. Prevention professionals in the District expressed the value of utilizing data-driven programs. The workgroup showed enthusiasm for the opportunity to explore local data and to make policy and program recommendations to city officials.

In the meantime, APRA received funding from SAMSHA for the DCEOW to focus on more specific goals and data sources related to prevention. The original DCEOW members convened to construct a mission statement for the new direction of the DCEOW. The current DCEOW mission statement is as follows:

> *Monitor the use of alcohol, tobacco, and other drugs and the consequences of their use in DC to identify and prioritize the District's prevention needs. To achieve this end, the DCEOW will oversee the collection, interpretation, and dissemination of data that quantifies substance use and its consequences.*

During the first eight months of the grant there were two DCEOW meetings. The first meeting was an organizational meeting. A review of the charter (see Appendix 4) drafted by APRA and CESAR was conducted and goals (see text box below) and objectives were finalized during this first meeting. CESAR presented data collected for the June 2006 Community Epidemiology Workgroup (CEWG) meeting held by the National Institute on Drug Abuse. CESAR represents the District of Columbia at the CEWG and prepares semi-annual reports which are shared with the DCEOW. The five original sub-committees and responsibilities were reorganized: the steering committee is now responsible for organizing DCEOW meetings, the leading indicators and reports committee is now responsible for preparing the epidemiological profile, and a training committee, research committee, and prevention committee were also formed at the first meeting.

DCEOW Goals

APRA is committed to the use of data to inform policy and allocate public substance abuse and mental health resources. Although DC has succeeded in bringing key stakeholders together in the Task Force and the DCEOW, substantial work remains to be done to standardize data collection and monitoring. Accordingly, APRA will charge the DCEOW with five primary goals:

1. Determine and monitor the scope of substance abuse and substance abuse-related problems and mental illness in DC and its eight Wards.
2. Identify newly emerging drugs of abuse and related problems.
3. Facilitate data driven decision-making throughout DC to assure the effective and efficient use of resources.
4. Provide a means of disseminating and sharing accurate and timely assessments of local alcohol and drug use trends and related problems.
5. Support the ongoing development of a city prevention plan as a part of the drug strategy of the Mayor's Task Force.

The second meeting of the DCEOW was designed to begin work on the epidemiological profile. At this meeting, CESAR gave a presentation on the U.S. Center for Substance Abuse Prevention (CSAP) logic model (based on information from a training conducted with the NE CAPT; see Appendix 2), we reviewed model state profiles, discussed local prevention planning efforts, and brainstormed potential data sources and consequences to include in the profile. Also during this process, meetings and trainings provided by CSAP were attended by group members.

DCEOW members also participated in the CEWG meeting, and met with epidemiology outcomes workgroup members from neighboring states.

It has been established that the current DCEOW is responsible for collecting, interpreting, and disseminating information necessary to develop data-driven prevention strategies. In addition, the current DCEOW provides the Task Force with the data necessary to establish baseline outcome objectives for change and to annually monitor change in those outcomes. APRA uses data provided by the current DCEOW to establish prevention funding priorities and to monitor and evaluate the outcomes of funded prevention programs/initiatives. Assistance in the coordination of the current DCEOW and data analysis, management, and dissemination is provided by CESAR. Howard University's Center for Drug Abuse Research will develop and conduct additional research based on the recommendations provided in the first DC Epidemiological Profile.

Developing the State Epidemiology Profile

The primary goals for the first year of the DCEOW were to identify the major consequences of illicit drug, alcohol, and tobacco use for the District of Columbia and to detect consumption patterns related to the identified consequences. The collection of these items completed the first two steps of the CSAP logic model presented in Appendix 2. With this information, the first epidemiological profile was created for the District of Columbia. The process used to prepare the profile included the following steps:

1. Held quarterly DCEOW meetings to collaborate with local representatives in identifying possible indicators, data sources, and data needs.
2. Prepared a database by domain of all potential indicators.
3. Assessed each indicator for inclusion.
4. Identified a working set of consequences/indicators for inclusion in the first state epidemiological profile.
5. Identified a working set of indicators to address in year two.
6. Prepared consequences of illicit drug use for scoring by DCEOW members.
7. Prepared and submitted a draft profile.
8. Developed a method for identifying funding priorities and made recommendations for the Task Force.
9. Prepared and submitted the final report.

A number of potential substance-related indicators were identified by CSAP, CESAR, and by workgroup members at the quarterly meetings. The potential indicators covered all eight applicable national outcome measure (NOM) domains established by CSAP including (CSAP deemed "stability in housing" and "perception of care" as not applicable to prevention):

1. Access/Capacity
2. Crime and Criminal Justice
3. Employment/Education
4. Reduced Morbidity
5. Retention
6. Social Connectedness
7. Use of Evidence-Based Practices
8. Cost Effectiveness

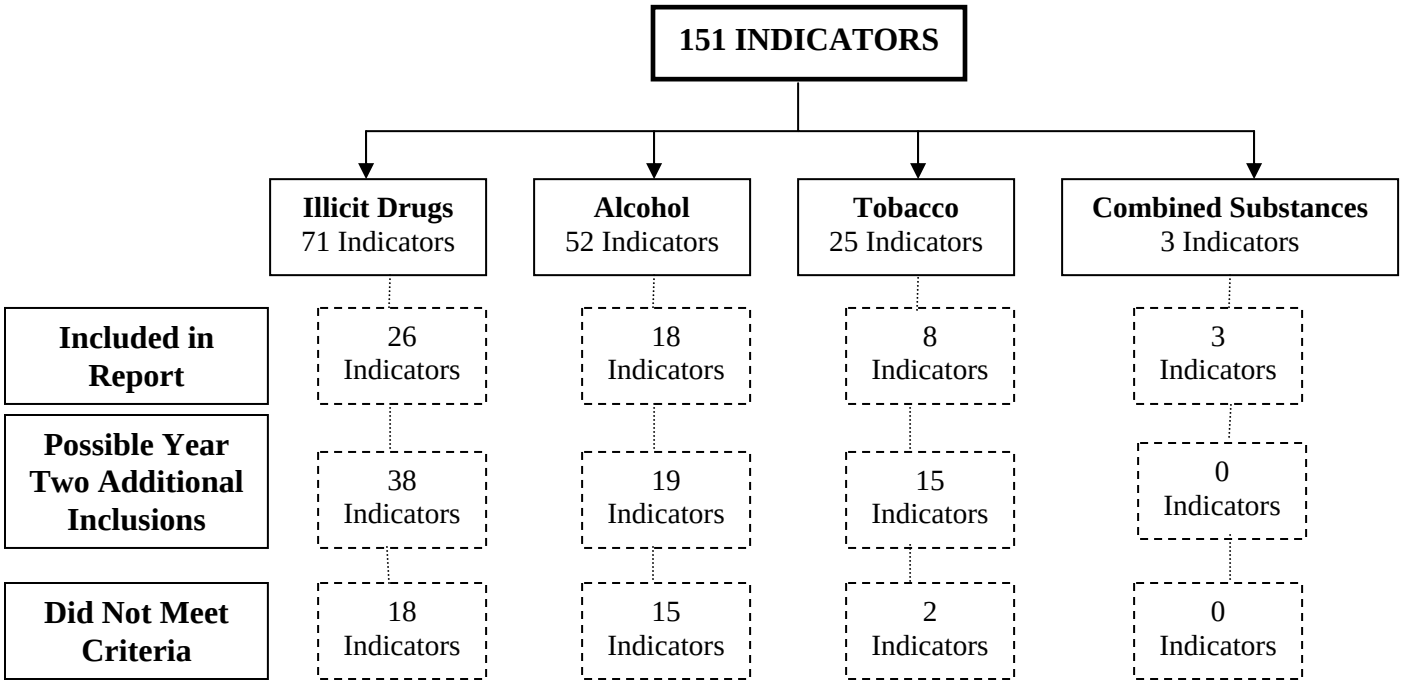
The initial database of potential indicators included a total of 151 indicators to be examined for inclusion in this report. The indicators were categorized to fit into one of the eight domains and were also categorized based on its association with illicit drug, alcohol, and tobacco use, or an association with a combination of all three substance types.

CESAR assessed each of the 151 indicators for inclusion in this report. Due to the limitations of various data sources and barriers in obtaining data, each indicator was assessed for:

1. Availability
2. Validity
3. Consistency
4. Sensitivity
5. Availability of attributable fractions (relation to substance use)

The list of 151 indicators, after a thorough assessment of each using the above criteria, was reduced to 55 indicators within seven NOM domains for this report (see Appendix 5). Figure 6 demonstrates the results of assessing the indicators. There were 71 indicators assessed in relation to illicit drugs. Of the 71 indicators, 26 were included in this report covering 5 NOM domains, 38 indicators (including HIV and various adult substance use indicators) have potential to be included in a subsequent (year 2) report (data is available although was not obtained in time for this report; or it is unknown whether data is available and if found might be appropriate for a future report), and 18 indicators did not meet the inclusion criteria as described above. There were 52 indicators assessed in relation to alcohol. Of the 52 alcohol-related indicators, 18 were included in this report and covered 6 of the NOM domains. Of the 34 remaining alcohol-related indicators, 19 have potential to be included in a subsequent (year 2) report, while 15 indicators did not meet inclusion criteria for this report. For tobacco, 25 indicators were assessed for inclusion in this report. Of the 25 tobacco-related indicators, 8 were included in this report and covered 4 of the NOM domains. Of the remaining 17 tobacco-related indicators, 15 have potential for inclusion in a future report, while only 2 were excluded from inclusion in the current report. Finally, three indicators, related to all three substances combined (substances could not be separated for analyses), were assessed and included in this report covering two of the NOM domains.

Figure 6: Indicator Diagram



All indicators included in this report have been organized into broader consequence categories (Table 2). The 26 illicit-drug related indicators were combined into four consequences. The 18 alcohol-related indicators included in this report were also organized into four consequence categories, while all 8 tobacco-related indicators have been organized into one consequence labeled "mortality." The three indicators related to the combination of substances were used to explain the current prevention services offered in the District in the previous "District at a Glance" section of this report.

Table 2: DC Epidemiological Profile: 2006 Consequences and Consumption Indicators for Illicit Drugs, Alcohol, and Tobacco

	Consequences	**Consumption**
Illicit Drugs	1. Crime/Arrests 2. AIDS 3. Hepatitis 4. Abuse/Dependence	1. Marijuana and Illicit Drug Use 2. Use among High School Students 3. Positive Drug Screens from adult Arrestees
Alcohol	1. Violent Crime 2. Abuse/Dependence 3. Motor-Vehicle Crashes 4. Chronic Liver Disease Mortality	1. Alcohol Use/Binge Use 2. Underage Alcohol Consumption 3. Underage Drinking and Driving
Tobacco	1. Mortality	1. Tobacco and Cigarette Use 2. Consumption by High School Students

CONSEQUENCES OF ILLICIT DRUG USE

This section was developed to address three key questions regarding illicit drug use in the District of Columbia:

4. What are the most significant consequences of illicit drug use in the District of Columbia for which data is currently available?
5. Based on the data available, which consequences are of highest priority for the District of Columbia?
6. In addressing the consequences, what consumption indicators should be monitored to assess progress?

The answers to each of the three questions are essential in order to develop data-driven prevention programs.

Using the process described in Developing the State Epidemiology Profile (pages 14–15), four consequences have been assessed and included in this section: property crimes and drug-related arrests, AIDS, hepatitis, and past year illicit drug abuse or dependence. Each of the four consequences includes several indicators that met inclusion criteria as previously defined. Wherever possible, data with comparable national measures was selected for inclusion and presented in this report.

For each consequence, the data provides an in-depth look at District level prevalence and severity, and ward level data when available, as well as, various demographic characteristics. Within each consequence, charts and tables are used to present the data along with key findings, and in some cases, additional relevant information. Each consequence is divided into five sections:

1. Identified Indicators
2. National vs. DC Comparisons
3. Prevalence/Severity
4. Time Trends
5. Ward Data (based on data availability)

At the end of the section, recommendations and consumption patterns are provided. The recommendation section displays prioritization results from an assessment of all illicit drug consequences provided in this report to be utilized by the Mayor's Interagency Task Force for future funding discussions. Lastly, tables providing data on each of the illicit drug consumption indicators is included and will be used to assess progress in addressing the consequences in the future.

Consequence: Property Crimes and Drug-Related Arrests

Identified Indicators

For this consequence category, we included five indicators that are a part of the crime and criminal justice CSAP NOMs domain. The data presented within each of the five indicators allows us to assess the prevalence of both drug-related property crime and arrests in the District of Columbia.

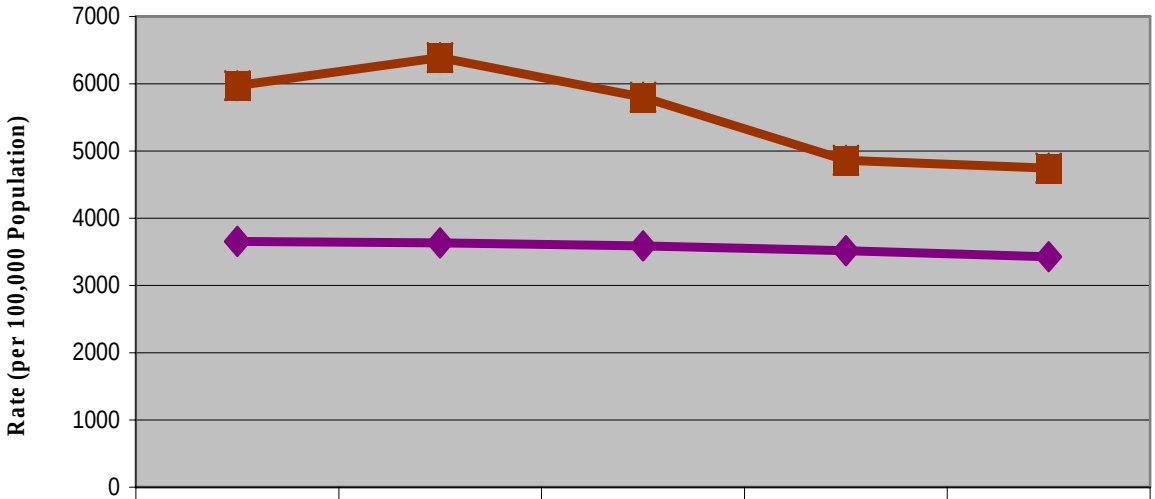
- Property crime
  - burglaries
  - larcenies
  - motor vehicle thefts
- Arrests
  - drug distribution
  - drug possession

These five indicators were selected in accordance with CSAP requirements. The purpose of these selected indicators is to describe a major consequence of illicit drug use related to crime. The following chart (Figure 7) compares property crime rates in the District of Columbia and the United States over the past five years. The subsequent tables take an in-depth look at DC property crime and drug-related arrest prevalence, trends, and severity. The two drug-related arrest indicators may not provide a complete understanding of the problem in the District of Columbia. To achieve a fuller understanding of drug-related arrests, additional information has been included from the Washington/Baltimore HIDTA and the National Forensic Laboratory Information System (NFLIS).

Throughout this section, attributable fractions, provided by CSAP, have been used to explain the number of incidents that are related to illicit drug use. These attributable fractions are in the form of percentages and explain the percent of incidents or cases that are estimated to be drug-related. The attributable fractions are national averages and may vary by geographical region or subpopulations. The attributable fractions for property crimes are based primarily on self-reports of incarcerated perpetrators of the crimes.

National vs. DC Comparisons

Figure 7: Annual Property Crime Rates per 100,000 Population for the District of Columbia and the United States, 2001 – 2005



	2001	2002	2003	2004	2005
District of Columbia	5,972.8	6,389.4	5,800.3	4,859.1	4,747.0
United States	3,658.1	3,630.6	3,591.2	3,514.1	3,429.8
State/National Ratio*	1.63	1.76	1.62	1.38	1.38

NOTES: Property crimes are offenses of burglary, larceny/theft, and motor vehicle theft. Property crime rate refers to the number of reported offenses per 100,000 population.
*State/National Ratio = State Rate/National Rate.
SOURCE: FBI, Uniform Crime Reports as prepared by the National Archive of Criminal Justice. Index of Crime in the United States: Tables 1 & Table 5.

- DC rates have decreased since 2002, although remained somewhat steady in 2004 and 2005.
- Nationally, the rate of property crimes decreased slightly from 2001 to 2005.
- For years 2001–2005, DC rates have been consistently higher than the National rates.

Prevalence/Severity in 2005

Table 3: Number of Property Crimes Reported in the District of Columbia Including Rate per 100,000 Population and Number Estimated to be Drug-Related, by Type of Crime, 2005

	Property Crimes			
	No. of Offenses Reported*	**Rate (per 100,000 pop)**	**Estimated % that are Drug-Related****	**Estimated No. that are Drug-Related**
Type of Crime	25,200	4,577.5	--	5,843
Type of Crime				
Burglary	3,571	648.7	30.0%	1,071
Larceny/Theft	14,162	2,572.5	30.0%	4,249
Motor Vehicle Theft	7,467	1,356.4	7.0%	523

NOTES: No attributable fraction is available for total number of property crimes that are drug-related. The total estimated number of property crimes that are drug-related was calculated by summing the estimated numbers for each type of crime.
Rate based on the estimated population in DC in 2005. The census bureau calculated 2005 state growth rates using the revised 2004 state/national population estimates and the 2005 provisional state/national population estimates.
*Number of offenses reported was derived from the most recent data available, which was a report by the Metropolitan Police Department in December 2006. Representative of the most current figures from DC, these figures are not equal to those in the FBI Uniform Crime Report.
**Estimates of the percent of drug-related property crimes taken from the State Epidemiological Data System (SEDS).
SOURCE: The District of Columbia Metropolitan Police Department's crime report from December 2006. Populations used were U.S. Bureau of the Census provisional estimates as of July 1 of each year as on the FBI UCR website.

- More than 23 percent of all property crimes reported in DC in 2005 are estimated to be drug-related.
- Nearly 1 out of every 3 burglaries and larcenies reported in DC in 2005 can be attributed as drug-related.
- Approximately 75 percent of the estimated drug-related crimes in DC in 2005 are larcenies.
- Seven percent of all motor vehicle thefts can be attributed as drug-related.

Time Trends 2001–2005

Table 4: Property Crimes Reported During the Past Five Years in the District of Columbia Including Rate per 100,000 Population and Number Estimated to be Drug-Related, by Type of Crime, 2001 – 2005

Year	Total Property Crimes		
	No. of Reported Crimes*	Rate (per 100,000 pop.)	Estimated No. Drug-Related Crimes
2001	35,191	6,154.2	8,724
2002	35,238	6,172.4	8,463
2003	31,581	5,605.6	7,278
2004	25,835	4,667.4	5,880
2005	25,200	4,577.5	5,843

Year	Burglary			Larceny/Theft			Motor Vehicle Thefts		
	No. of Reported Crimes*	Rate (per 100,000 pop.)	Estimated No. Drug-Related Crimes**	No. of Reported Crimes*	Rate (per 100,000 pop.)	Estimated No. Drug-Related Crimes**	No. of Reported Crimes*	Rate (per 100,000 pop.)	Estimated No. Drug-Related Crimes***
2001	4,947	865.1	1484	22,274	3,895.3	6,682	7,970	1,393.8	558
2002	5,167	905.1	1550	20,903	3,661.4	6,271	9,168	1,605.9	642
2003	4,670	828.9	1401	17,362	3,081.7	5,209	9,549	1,694.9	668
2004	3,943	712.3	1183	13,756	2,485.2	4,127	8,136	1,469.9	570
2005	3,571	648.7	1071	14,162	2,572.5	4,249	7,467	1,356.4	523

NOTES: No attributable fraction is available for total number of property crimes that are drug-related. The total estimated number of property crimes that are drug-related was calculated by summing the estimated numbers for each type of crime.
Rate based on the estimated population in DC for each year. For example, the census bureau calculated 2005 state growth rates using the revised 2004 state/national population estimates and the 2005 provisional state/national population estimates. This process was completed for all years.
*Reported crime totals were derived from the most recent data available, which was a report by the Metropolitan Police Department in December 2006. Representative of the most current figures for DC, these figures are not equal to those in the FBI Uniform Crime Report.
**30% of all burglary and larceny/theft crimes are estimated to be drug-related which was taken from the State Epidemiological Data System (SEDS).
*** 7% of all motor vehicle thefts are estimated to be drug-related which was taken from the State Epidemiological Data System (SEDS).
SOURCE: The District of Columbia Metropolitan Police Department's crime report from December 2006. Populations used were U.S. Bureau of the Census provisional estimates as of July 1 of each year as on the FBI UCR website.

- The total number of property crimes reported between 2002 and 2005 consistently decreased.
- There were an estimated 5,843 drug-related property crimes in DC in 2005.
- The estimated number of total drug-related property crimes decreased approximately 22 percent from 2003 to 2005 which is attributed to the drop in total property crimes reported.
- The estimated number of drug-related burglaries and larcenies has decreased from 2001 to 2005 which is attributed to the drop in total property crimes reported during this time.
- Since 2001, the estimated number of drug-related motor vehicle thefts was highest in 2003.
- The estimated number of drug-related motor vehicle thefts has decreased in the past 2 years which is attributed to the decrease in total motor vehicle thefts reported.

Drug-Related Arrests 2001 – 2005 and Other Relevant Data

Table 5: Juvenile and Adult Arrestees during the Past Five Years in the District of Columbia, by Number of Arrests and Percentages of Drug-Related Arrests by Type of Violation and Substance, 2001 – 2005

	Number of Juvenile and Adult Arrestees														
	Total Population of Arrestees					Juveniles (Under 18)					Adults (18+)				
	2001	2002	2003	2004	2005	2001	2002	2003	2004	2005	2001	2002	2003	2004	2005
Type of Arrest															
Total Arrests (All Causes)	49,656	45,606	45,338	51,044	51,570	2,636	2,432	2,562	2,957	2,925	47,020	43,174	42,776	48,087	48,645
Total Drug-Related Arrests	7,053	6,423	6,804	8,394	8,050	448	347	314	356	308	6,605	6,076	6,490	8,038	7,742
Drug-Related Arrests (%)	14.2	14.1	15.0	16.4	15.6	17.0	14.3	12.3	12.0	10.5	14.0	14.1	15.2	16.7	15.9
Percentage of Drug-Related Arrests, by Type of Violation															
Possession-Related Arrests (%)	44.0	43.0	48.8	51.6	50.6	26.8	24.5	24.2	24.4	28.6	45.2	44.1	50.0	52.8	51.5
Sales*-Related Arrests (%)	56.0	57.0	51.2	48.4	49.4	73.2	75.5	75.8	75.6	71.4	54.8	55.9	50.0	47.2	48.5
Percentage of Drug-Related Arrests, by Drug Type															
Opium/Cocaine**-Related Arrests (%)	53.2	52.4	50.0	51.5	55.6	43.3	45.5	42.7	39.6	43.2	53.9	52.8	50.4	52.0	56.1
Marijuana-Related Arrests (%)	40.8	40.1	40.4	39.9	40.5	55.6	50.7	51.6	57.9	55.2	39.8	39.5	39.9	39.1	39.9
Other Non-Narcotics-Related Arrests (%)	3.1	4.2	5.0	3.4	3.9	0.7	3.7	4.5	2.0	1.6	3.2	4.3	5.0	3.4	4.0

NOTES: All figures in table represent total arrests not charges. Drug-related arrests are based on data from the DC Metropolitan Police Department adapted from Criminal Justice Information System (CJIS) data. Data is determined by the highest charge associated with the arrest. Synthetic narcotics-related arrests were not reported for juveniles, and resulted in percentages less than 0.001 for adults, therefore, were not included in table. Total Arrests (All Causes) were taken from data adapted by CESAR from data provided by the DC Metropolitan Police Department on Sept. '05, Jan. '06, and Dec. '06. Drug-related arrest percentages may not add up to 100% each year due to rounding error and other drug-types not included in table.

*Includes both possession-related arrests and sales/manufacturing-related arrests

**Opium/Cocaine=Opium or Cocaine and Derivatives.

SOURCE: Adapted by CESAR from data provided by the DC Metropolitan Police Department on Sept. '05, Jan. '06, and Dec. '06.

- The percentage of total arrests that were drug-related has been somewhat consistent (14.1%-16.4%) over the past five years.
- Over the past five years, the percent of total arrests for each drug type have been relatively consistent across all drug categories.
- Total drug-related arrests for juveniles decreased between 2001 and 2005.
- Juveniles were most often arrested for sales/manufacturing and for marijuana-related incidents.
- Adult arrests have been rather evenly distributed between possession and sales/manufacturing over the past five years.
- Adults were most likely to be arrested for opium/cocaine-related incidents than any other drug type.

Additional Related Information

- According to the Washington/Baltimore HIDTA drug seizure data, HIDTA initiatives seized nearly $26 million worth of drugs in the District of Columbia during 2005.
- Marijuana and powder cocaine accounted for 99 percent of the seizures in DC totaling 4,859.2 kilograms in 2005.
- Other drugs seized by the HIDTA initiative in 2005 included heroin, crack, methamphetamine, and MDMA.
- Nearly three-quarters (73%) of the seized items tested through the National Forensic Laboratory Information System in fiscal year 2006, were found positive for traces of cocaine or marijuana. Only 8 percent of the seized items were found positive for traces of heroin. All other drugs accounted for fewer than 4 percent of the positive tests.

Consequence: AIDS

Identified Indicators

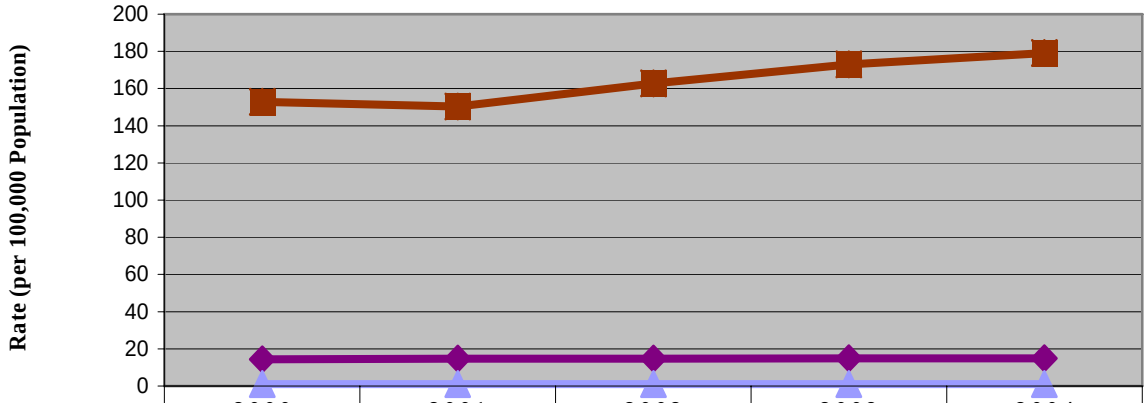
For this consequence category, we assessed four indicators in the reduced morbidity CSAP NOMs domain. The data presented within each of the four indicators allows us to assess new incidents and the prevalence of AIDS in the District of Columbia.

- Incident AIDS cases
- Incident AIDS cases determined by two types of exposure: injection drug use (IDU) and men who have sex with men and who are also injection drug users (MSM/IDU)
- Prevalent AIDS cases
- Prevalent AIDS cases determined by two types of exposure: IDU and MSM/IDU

These four indicators were selected in accordance with CSAP requirements. The purpose of these selected indicators is to describe a major health consequence of illicit drug use. The following chart (Figure 8) compares AIDS case report rates for the District of Columbia and the United States over the past five years. The subsequent tables take a closer look at District trends from 2000 – 2004 and 2004 AIDS cases. HIV case data was not available; therefore, only AIDS case data was used for this consequence category.

National vs. DC Comparisons

Figure 8: Annual AIDS Case Report Rate per 100,000 Population for the District of Columbia and the United States, 2000–2004



	2000	2001	2002	2003	2004
District of Columbia	152.9	150.4	162.7	173.1	179.2
United States	14.4	14.7	14.8	15.0	14.9
HP 2010 Target	1.0	1.0	1.0	1.0	1.0
State/National Ratio*	10.62	10.23	10.99	11.54	12.03

NOTES: HP 2010 = Healthy People 2010
*State/National Ratio = State Rate/National Rate.
SOURCE: HIV/AIDS Surveillance Report, 2001 – 2004. Volumes 12-16, Centers for Disease Control and Prevention (CDC): Table 2 and Table 14.

- The National rate of AIDS case reports per year has been holding steady.
- The District rate of AIDS case reports was more than 12 times higher than the National rate for 2004.
- The District AIDS rate increased steadily from 150.4 per 100,000 in 2001 to 179.2 per 100,000 in 2004.
- Healthy People 2010 suggested a goal of only 1 new AIDS case report per 100,000 residents per year for DC.

Additional Relevant Information

- There are approximately 40,000 new HIV diagnoses Nationwide each year.
- In 2004, Blacks accounted for 20,965 (49%) of the estimated number of AIDS cases diagnosed in the United States, although they represented only 12.3% of the U.S. population. (CDC's *MMWR*, February 3, 2006)
- In 2002, the most recent year for which these data are available, HIV/AIDS was also among the top three causes of death for Black men aged 25 to 54 years and among the top four causes of death for Black women aged 25 to 54 years. (CDC's *MMWR*, February 3, 2006)
- HIV/AIDS was the leading cause of death for Black women aged 25 to 34 years. (CDC's *MMWR*, February 3, 2006)
- The 2004 rate of AIDS diagnoses for Blacks was nearly 10 times the rate for whites and three times the rate for Hispanics. (CDC's *MMWR*, February 3, 2006)

Prevalence/Severity in 2004

Table 6: Cumulative AIDS Cases in the District of Columbia Including Rate per 100,000 Population, by Gender, Race/Ethnicity, Age, and Type of Exposure, 2004

	Cumulative AIDS Cases		
	No.	Percent	Rate (per 100,000 pop.)
District of Columbia	16,165	100.0	2825.76
Gender			
Male	12,718	78.7	4,721.5
Female	3,412	21.1	1,127.2
Missing	35	0.2	n/a
Race/Ethnicity*			
African-American	7,445	81.8	1,301.4
White	1,271	14.0	222.2
Asian/Pacific Islander	43	0.5	7.5
American Indian/ Alaskan Native	11	0.1	1.9
Hispanic	333	3.6	58.2
Age**			
<13	181	1.1	208.6
13-19	89	0.6	181.5
20-34	5,473	33.9	3,563.5
35-44	6,462	40.0	7,370.2
45-54	2,958	18.3	3,927.8
55-64	771	4.8	1,548.7
65+	196	1.2	280.4
Missing	35	0.2	n/a
Type of Exposure***			
MSM	3,362	20.8	n/a
IDU	3,912	24.2	n/a
Heterosexual	4,122	25.5	n/a
No Risk Reported	4,251	26.3	n/a
Pediatric	n/a	n/a	n/a
Missing	518	3.2	n/a

NOTES: Rates based on 2000 Census Bureau population of each demographic category in DC.
MSM = Men who have sex with men.
IDU = Injection drug use.
*Excludes people with 2 or more races and where race was unknown. The number of cases and percentages were taken from the Bureau of Surveillance and Epidemiology. For this section n = 9,103.
**Age at diagnosis for AIDS cases as of December 31, 2004.
***Risk not specified and missing data are not included in the distribution of percentages. Percentages of exposure category were taken from the Bureau of Surveillance and Epidemiology. Number of cases calculated by CESAR based on this percentage. Due to this calculation we have not provided a rate. For this section n = 16,165.
SOURCE: Bureau of Surveillance and Epidemiology, Administration for HIV Policy and Programs, DC Department of Health. "HIV in the District of Columbia: A Surveillance Update" provided by Gail Maureen Hansen and Dr. Amanda Castel. Populations taken from the U.S. Bureau of the Census, 2000 Census.

- More than three-quarters of the cumulative AIDS cases in the DC were male.
- More than 80 percent of the cumulative AIDS cases in DC were African American.
- Three-quarters of the AIDS prevalent-cases in DC were aged 20 to 44–40 percent were aged 35 to 44.
- District AIDS cases were most likely African American males aged 20 to 44.
- Nearly 1 in 4 cumulative AIDS cases in the District were injection drug use (IDU)-related (3,912 cases).

Time Trends 2000 – 2004

Table 7: AIDS Incident Cases in the District of Columbia, by Year of Diagnosis, 2000–2004

Year	AIDS Incident Cases in the District of Columbia
	No.
2000	873
2001	863
2002	926
2003	965
2004	992

SOURCE: HIV/AIDS Surveillance Report, 2001 – 2004. Volumes 12-16, Centers for Disease Control and Prevention (CDC): Table 2 and Table 14.

- The least number of AIDS incident cases (863) for the last 5 years of available data, was reported in 2001.
- The number of AIDS incident cases steadily increased since 2001.
- The number of AIDS incident cases increased 15 percent from 863 in 2001 to 992 in 2004.

Ward Data 2004

Table 8: Cumulative AIDS Cases in the District of Columbia Including IDU-Related and Prevalence Rate per 100,000 Population, by Ward, 2004

Ward	AIDS Cases			
	Cumulative AIDS Cases		IDU-Related Exposure*	AIDS Prevalence Rate*
	No.	Percent	No.	Per 100,000
1	2,752	17.02		
2	2,477	15.32		
3	489	3.03		
4	1,517	9.38		
5	2,038	12.61		
6	2,228	13.78		
7	1,411	8.73		
8	1,595	9.87		
Missing	1,658	10.26		
Total	16,165	100.00		

NOTES: AIDS cases are by ward of residence at initial diagnosis.
*Data not available at the time this report was submitted. Data will be added when obtained from source.
SOURCE: Bureau of Surveillance and Epidemiology, Administration for HIV Policy and Programs, DC Department of Health. "HIV in the District of Columbia: A Surveillance Update" provided by Gail Maureen Hansen and Dr. Amanda Castel.

- More than 2000 cumulative AIDS cases were reported in each of four wards (1, 2, 5, and 6) in 2004.
- Wards 1, 2, 5, and 6 accounted for 59 percent of the cumulative AIDS cases for DC in 2004.
- Ward 3 reported the least number of cumulative AIDS cases (489) for 2004.

Consequence: HEPATITIS

Identified Indicators

For this consequence category, we included two indicators which are a part of the reduced morbidity NOMs domain. The data presented within each of the two indicators allows us to assess both new incidents and prevalence of acute hepatitis B and chronic hepatitis C in the District of Columbia.

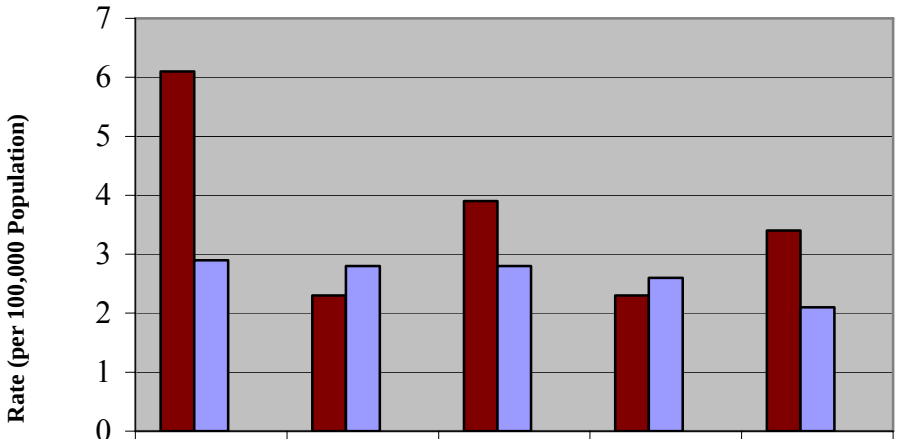
- Incident acute hepatitis B cases
- Incident chronic hepatitis C cases

These two indicators were selected in accordance with CSAP requirements. The purpose of these selected indicators is to describe a major health-related consequence of illicit drug use. The following chart (Figure 9) compares acute hepatitis B case report rates in the District and the United States over the past five years. The subsequent tables take a closer look at District trends from 2000–2004 and 2004 demographic profiles for acute hepatitis B and chronic hepatitis C cases.

Throughout this section, attributable fractions, provided by CSAP, have been used to explain the number of incidents that are related to illicit drug use. These attributable fractions are in the form of percentages and explain the percent of incidents or cases that are estimated to be alcohol-related. The attributable fractions are national averages and may vary by geographical region or subpopulations.

National vs. DC Comparisons

Figure 9: Rate per 100,000 Population of Acute Hepatitis B Cases for the District of Columbia and the United States, 2000–2004



	2000	2001	2002	2003	2004
District of Columbia	6.1	2.3	3.9	2.3	3.4
United States	2.9	2.8	2.8	2.6	2.1
State/National Ratio*	2.10	0.82	1.39	0.88	1.62

NOTES: *State/National Ratio = State Rate/National Rate.
SOURCE: *Hepatitis Surveillance,* National Notifiable Infectious Diseases Surveillance System at the Center for Disease Control and Prevention, U.S. Department of Health and Human Services, September 2006.

- The National rate of acute hepatitis B cases decreased slightly in 2004 after remaining relatively steady for four years.
- The DC acute hepatitis B rate fluctuated between 2000 and 2004 reaching a high of 6.1 cases per 100,000 people in 2000 and a low of 2.3 cases per 100,000 people in both 2001 and 2003.
- The DC acute hepatitis B rate increased slightly in 2004 to 3.4 per 100,000 people which was higher than the 2004 National rate.

Prevalence/Severity in 2004

Table 9: Acute Hepatitis B Cases for the District of Columbia Including Rate per 100,000 Population, by Gender, Race/Ethnicity, and Age, 2004

	Acute Hepatitis B Cases		
	No.	**Percent**	**Rate (per 100,000 pop.)**
District of Columbia	19	100.0	3.32
Gender			
Male	11	57.9	4.1
Female	8	42.1	2.6
Unknown	0	0.0	n/a
Race/Ethnicity			
Black	14	73.7	4.1
White	4	21.1	2.3
Asian	0	0.0	n/a
Alaskan/Native American	0	0.0	n/a
Hispanic*	n/a	n/a	n/a
Unknown/Other		5.3	n/a
Age**			
<10	0	0.0	n/a
10-19	0	0.0	n/a
20-29	6	31.6	5.7
30-39	3	15.8	3.2
40-49	5	26.3	6.2
50-59	4	21.1	6.3
60 +	1	5.3	1.1
Unknown	0	0.0	n/a

NOTES: Rates based on 2000 Census Bureau population of each demographic category in DC.
* Diagnosed acute hepatitis B data for Hispanics was not available at this time.
**Data represents age at diagnosis.
SOURCE: Hepatitis Registry & the National Electronic Telecommunications System for Surveillance (NETSS), DC Department of Health. "District of Columbia Department of Health Acute Hepatitis A & B Demographics 2000 – 2004," provided by Ethel Holland RN, MSN, Viral Hepatitis Coordinator. Populations taken from the U.S. Bureau of the Census, 2000 Census.

- In 2004, there were 19 cases of acute hepatitis B reported in the District of Columbia.
- More than half of the acute hepatitis B cases were male and nearly three-quarters of the acute hepatitis B cases were Black.
- Nearly half of the acute hepatitis B cases (47.4%) were aged 20 to 39 and over one-quarter (26.3%) were aged 40 to 59.

Prevalence/Severity in 2004

Table 10: Chronic Hepatitis C Cases for the District of Columbia Including Rate per 100,000 Population, by Gender, Race/Ethnicity, and Age, 2004

	Chronic Hepatitis C Cases		
	No.	Percent	Rate (per 100,000 pop.)
District of Columbia	1,655	100.0	289.3
Gender			
Male	1,074	64.9	398.7
Female	574	34.7	189.6
Unknown	7	0.4	n/a
Race/Ethnicity			
Black	848	51.2	247.0
White	45	2.7	25.6
Asian	1	<0.1	6.6
Alaskan/Native American	1	<0.1	58.4
Hispanic	11	0.7	24.5
Unknown/other	760	45.9	n/a
Age*			
<10	6	0.4	8.8
10-19	2	0.1	2.9
20-29	35	2.1	33.4
30-39	103	6.2	108.6
40-49	641	38.7	790.1
50-59	689	41.6	1,081.4
60+	177	10.7	192.7
Unknown	2	0.1	n/a

NOTES: Rates based on 2000 Census Bureau population of each demographic category in DC.
*Data represents age at diagnosis.
SOURCE: : Hepatitis Registry & the National Electronic Telecommunications System for Surveillance (NETSS), DC Department of Health. "District of Columbia Department of Health Chronic Hepatitis C Demographic 2000 – 2004," provided by Ethel Holland RN, MSN, Viral Hepatitis Coordinator. Populations taken from the U.S. Bureau of the Census, 2000 Census.

- In 2004, there were 1,655 cases of chronic hepatitis C reported in the District of Columbia.
- Nearly two-thirds of the chronic hepatitis C cases in DC were male.
- Half of the chronic hepatitis C cases in DC were Black while most of the remaining cases (45.9%) were of unknown race/ethnicity.
- More than three-quarters (80.3%) of chronic hepatitis C cases were aged 40 to 59 when diagnosed and 1 in 10 were aged 60 or older when diagnosed.

Time Trends 2000 – 2004

Table 11: Estimated Number of Drug-Related Acute Hepatitis B and Chronic Hepatitis C Cases in the District of Columbia, by Year of Diagnosis, 2000 – 2004

Year	Acute Hepatitis B Cases	
	Total No. of Cases	Estimated No. of Drug-Related Exposure Cases (30% of all cases)
2000	35	11
2001	13	4
2002	22	7
2003	9	3
2004	19	6

Year	Chronic Hepatitis C Cases	
	Total No. of Cases	Estimated No. of Drug-Related Exposure Cases (20% of all cases)
2000	1,436	287
2001	2,572	514
2002	2,245	449
2003	2,086	417
2004	1,655	331

NOTES: Drug-related exposure includes injection drug users (IDU) and men who have sex with men and are also injection drug users (MSM/IDU)
SOURCE: Hepatitis Registry & the National Electronic Telecommunications System for Surveillance (NETSS), DC Department of Health. "District of Columbia Department of Health Acute Hepatitis A & B Demographics 2000 – 2004," and "District of Columbia Department of Health Chronic Hepatitis C Demographic 2000 – 2004," provided by Ethel Holland RN, MSN, Viral Hepatitis Coordinator.

Acute Hepatitis B

- Approximately 1 in 3 acute hepatitis B cases (30%) and 1 in 5 chronic hepatitis C cases (20%) are drug-related.
- The number of acute hepatitis B cases in DC fluctuated between 2000 and 2004 ranging from a high of 35 cases in 2000 to a low of 9 cases in 2003.
- There were 19 incidences of acute hepatitis B cases in 2004 of which an estimated 6 were drug-related.

Chronic Hepatitis C

- The number of chronic hepatitis C incident cases steadily decreased from 2,572 in 2001 to 1,655 in 2004 (36%).
- An estimated 331 chronic hepatitis C cases were drug-related in 2004.

Ward Data 2004

Table 12: Acute Hepatitis B Cases, by Ward, 2004

Ward	Acute Hepatitis B Cases	
	No.	Percent
1	2	10.53
2	3	15.79
3	1	5.26
4	2	10.53
5	3	15.79
6	3	15.79
7	3	15.79
8	0	0.00
Unknown*	2	10.53
Citywide	19	100.00

NOTES: *Includes cases that were not linked to any specific ward.
SOURCE: Hepatitis Registry & the National Electronic Telecommunications System for Surveillance (NETSS), DC Department of Health. "District of Columbia Department of Health Acute Hepatitis A & B Demographics 2000 – 2004," provided by Ethel Holland RN, MSN, Viral Hepatitis Coordinator.

- In 2004, reported acute hepatitis B cases were distributed across 7 of the 8 wards.
- Wards 2, 5, 6 and 7 all reported 3 acute hepatitis B cases each which was the highest number reported across wards.
- Only one ward, Ward 8, had no acute hepatitis B cases reported.
- Two of the nineteen acute hepatitis B cases were not linked to any specific ward.

Consequence: Any Illicit Drug Abuse or Dependence in Past Year

Identified Indicators

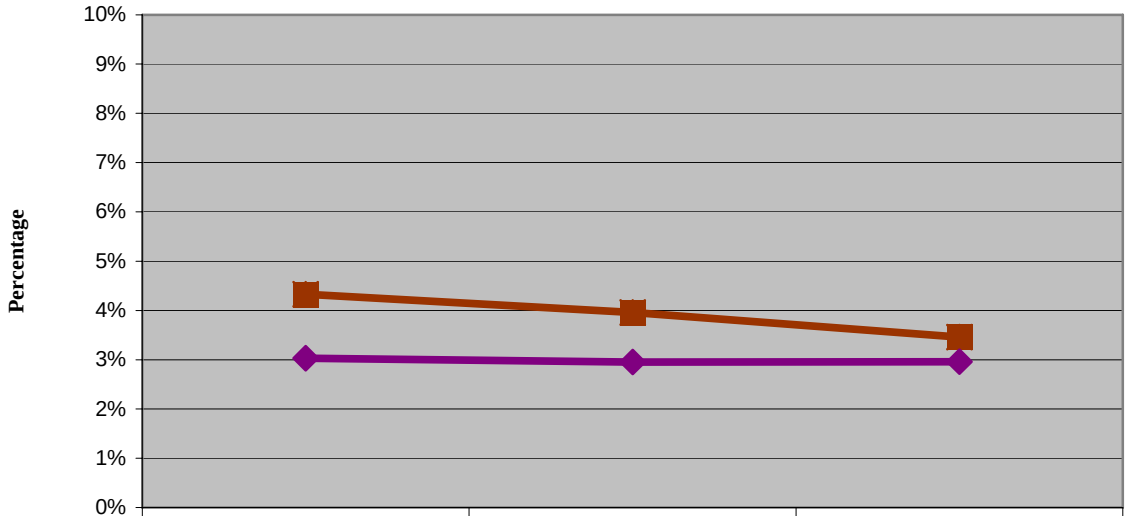
For this consequence category, we included one indicator that is a part of the reduced morbidity CSAP NOMs domain. The data presented for this indicator allows us to assess the estimated number of persons meeting DSM-IV criteria for drug abuse or dependence in the District of Columbia.

- Persons aged 12 or older meeting DSM-IV criteria for drug abuse or dependence

This indicator was selected in accordance with CSAP requirements. The purpose of this indicator is to describe a major consequence of continued illicit drug use. The following chart (Figure 10) compares residents aged 12 or older who reported any illicit drug abuse or dependence in the District of Columbia and the United States over the past five years. The subsequent tables examine DC trends from 2002–2004, as well as, 2004 estimates of illicit drug abuse or dependence in DC residents 12 years of age or older.

National vs. DC Comparisons

Figure 10: Percentage of Residents Aged 12 or Older Who Reported Abuse or Dependence of Illicit Drugs in the Past Year for the District of Columbia and the United States, 2002–2004



	2002	2002-2003	2003-2004
District of Columbia	4.33%	3.96%	3.46%
United States*	3.03%	2.95%	2.96%

NOTES: Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutic medications used non-medically. Abuse or dependence is based on the definitions found in the 4th Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).
*The District estimates are based on a survey-weighted hierarchical Bayes estimation approach. Although statewide estimates were produced prior to 2002, the data are not comparable to data collected in and after 2002 because of a change in survey methods. The U.S. estimates are the weighted average of the hierarchical Bayes estimates across all States and the District of Columbia and typically are not equal to the direct sample-weighted estimate for the Nation.
SOURCE: Substance Abuse and Mental Health Administration (SAMHSA), Office of Applied Studies, National Survey on Drug Use and Health, 2002–2004.

- The District of Columbia had a larger percentage of residents reporting any illicit drug abuse or dependence from 2002–2004 than Nationwide.
- The percentage of residents in the District reporting any illicit drug abuse or dependence decreased from approximately one percent from 2002 to 2004 while the national percentages remained about the same.

Prevalence/Severity in 2003 – 2004

Table 13: Estimated Number of DC Residents Aged 12 or Older Who Reported Abuse or Dependence of Illicit Drugs in the Past Year, by Age, Gender, and Race/Ethnicity: Annual Averages Based on 2003 and 2004 Surveys

	DC Residents Reporting Illicit Drug Abuse or Dependence	
	Estimated No.	**Percent**
District of Columbia Total	16,000	3.5
Age		
12-17	1,000	4.0
18-25	6,000	8.3
26 or Older	9,000	2.5
Gender		
Male		
Female		
Race/Ethnicity		
Not Hispanic or Latino		
White		
African American		
American Indian or Alaskan Native		
Native Hawaiian or Other Pacific Islander		
Asian		
Two or More Races		
Hispanic		

NOTES: Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutic medications used non-medically. Abuse or dependence is based on the definitions found in the 4th Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Remaining data will be added when it is received.
SOURCE: Substance Abuse and Mental Health Administration (SAMHSA), Office of Applied Studies, National Survey on Drug Use and Health, 2003 and 2004.

- An estimated 16,000 DC residents reported past year substance abuse or dependence between 2003 and 2004.
- Over 50 percent of the total estimated number of DC residents reporting past year abuse or dependence was adults age 26 or older.

Time Trends 2000–2004

Table 14: Estimated Number and Percentage of DC Residents Aged 12 or Older Who Reported Abuse or Dependence of Illicit Drugs in the Past Year, by Survey Year(s), 2002–2004

Year	DC Residents Aged 12 or Older Reporting Illicit Drug Abuse or Dependence	
	Estimated No.	Percent of Population Aged 12+
2002	21,000	4.33
2002-2003	19,000	3.96
2003-2004	16,000	3.46

NOTES: Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutic medications used non-medically. Abuse or dependence is based on definitions found in the 4th Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Percentage based on population estimates.
The District estimates are based on a survey-weighted hierarchical Bayes estimation approach. Although statewide estimates were produced prior to 2002, the data are not comparable to data collected in and after 2002 because of a change in survey methods.

SOURCE: Substance Abuse and Mental Health Administration (SAMHSA), Office of Applied Studies, National Survey on Drug Use and Health, 2002–2004.

- The percentage of DC residents reporting abuse or dependence of illicit drugs decreased from 4.33% in 2002 to 3.46% in 2003–2004.
- The estimated total number of DC residents aged 12 or older, who reported abuse or dependence of illicit drugs in the past year, decreased from 21,000 in 2002 to 16,000 in 2003–2004.
- The percentage of the population aged 12+ decreased about one percent during this time from 4.33 percent to 3.46 percent.

Ward Data 2002–2004

Table 15: Percentage of Any Illicit Drug Abuse or Dependence in the Past Year among Persons Aged 12 or Older in the District of Columbia, by Ward: Annual Averages Based on 2002, 2003, and 2004 Surveys

	DC Residents Reporting Illicit Drug Abuse or Dependence Aged 12+
	Estimate* (%)
District of Columbia	4.00
Ward	
1	4.24
2	4.29
3	3.08
4	3.6
5	4.34
6	3.95
7	4.32
8	4.42

NOTE: Any illicit drug includes marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or any prescription-type psychotherapeutic used nonmedically. Abuse or dependence is based on definitions found in the 4th edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-IV).
*Estimates are based on a survey-weighted hierarchical Bayes estimation approach.
SOURCE: Substance Abuse and Mental Health Administration (SAMHSA), Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

- An average of 4.00 percent of DC residents aged 12 or older have reported illicit drug abuse or dependence between the three survey years.
- Ward 4 had the lowest estimated percent of residents who reported illicit drug abuse or dependence between 2002 and 2004, while Ward 8 reported the largest percent of residents at 4.42 percent.
- Wards 1, 3, and the majority of ward 4 are home to residents who were more likely wealthy and white, and are associated with two of the three lowest percentages of residents who were abusing or dependent on illicit drugs.
- Ward 6 is one of four wards which are home to residents who are more likely poor and African-American and was associated with one of the lowest percentages of residents who were abusing or dependent on illicit drugs (3.95%).

RECOMMENDATIONS REGARDING ILLICIT DRUG USE

This report serves as a foundation or platform on which to base future discussions about funding and program priorities for the District of Columbia. The report highlights four consequences of illicit drug use which were included using the selection criteria described in DCEOW Process section (pages 25–26). The DCEOW members agree that there are many additional consequences related to illicit drug use that remain to be analyzed. In future years, as funding permits, the illicit drug use consequences will be expanded to include these additional items. In addition, further research will be conducted to explore questions raised by the data provided in this report.

For this first report, the illicit drug use consequences were discussed and prioritized by the DCEOW in March 2007. The purpose of prioritizing the consequences was to develop a data-driven plan for year two and to provide recommendations to the Task Force. In order to meaningfully prioritize the illicit drug use consequences, property crimes and drug related arrests, as well as hepatitis B and hepatitis C, were discussed as separate consequences. The prioritization process involved five steps:

1. A review of the data provided in the report
2. An assessment by core members to determine the priority status (high or low) of each consequence in the District of Columbia
3. A discussion of each consequence to identify additional elements to be analyzed in year two
4. A discussion of each consequence to provide recommendations for consideration by the Task Force
5. A review of the final prioritization results

These steps were completed by 14 core members of the DCEOW on March 1, 2007. These members represented various agencies including public health, criminal justice, academia, and public policy. The prioritization process will be further developed in year 2 as additional data is assessed for inclusion in the profile. Once the initial consequences have been further developed and additional consequences have been added, more specific program and policy level recommendations will be possible. For year 1, the recommendations will focus on additional data analyses and research to be conducted in year 2. Nine additional recommendations are provided for the consideration of the Task Force. These recommendations are intended to guide the Task Force in the development of the District's comprehensive strategy for substance abuse prevention, treatment and control.

Year 1 Prioritization of Illicit Drug Use Consequences

As shown in Table 16, the results recorded from the assessment by core members of the DCEOW on March 1, 2007, were distinct enough to divide the illicit drug use consequences into three priority categories. The "overall priority" for each consequence was identified as high, medium, or low. The priority level was determined by the number of individuals who elected each of the consequences as high or low. The results demonstrate that drug-related arrests, AIDS, and past year illicit drug abuse or dependence have been assessed as a high priority in the District of Columbia, followed by property crime and Hepatitis C which, based on the core members' assessment, are a medium priority. Hepatitis B was ranked lowest with nearly all core members assessing it as a low priority.

Table 16: Prioritization of Illicit Drug Use Consequences in the District of Columbia

CONSEQUENCES	High Priority	Low Priority	Undecided	Overall Priority
Property Crimes	8	5	1	MEDIUM
Drug-Related Arrests	10	4	0	HIGH
AIDS	14	0	0	HIGH
Hepatitis B	0	13	1	LOW
Hepatitis C	8	6	0	MEDIUM
Past Year Abuse or Dependence	11	0	0	HIGH

Year 2 Indicators and Recommendations for Additional Research

In year 2, the DCEOW will continue to monitor the initial consequences. Within year 2, more ward specific data is planned as is the exploration of an additional 38 indicators within six CSAP domains: crime and criminal justice, employment/education, reduced morbidity, retention, social connectedness, and cost effectiveness. These indicators will be used to develop such consequences as child abuse/neglect, domestic violence, drug-related suspensions/expulsions, incident and prevalent HIV cases, and the impact of drug use on pregnant women and their babies. These consequences explore profound and long lasting effects of drug use on District residents and the agencies that serve them. These additional consequences will be added to subsequent reports as data is identified and assessed for inclusion using the specified criteria. The additional consequences will provide the DCEOW with a deeper understanding of the effects of illicit drug use in the District and will also enable the DCEOW members to identify target populations for prevention programs. The additional information will enable members to begin formulating more concrete connections between illicit drug consumption and related consequences adding the ability to make recommendations about funding specific types of programs.

In addition to the indicators described above, the DCEOW core members recommend that additional research be developed and conducted on the following eight topics:

1. Analysis of recidivism amongst drug using offenders
2. Assessment of arrest location and residence of the illicit drug related offenders to further support the Metropolitan Police Department's hotspots initiative
3. Geo-mapping of variables such as unemployment, crime, arrests, drug markets/organizations, treatment admissions, and prevention programs related to illicit drug use
4. Analysis of causal connections between illicit drug consumption and consequences
5. Assessment of the relationship between the sex trade and illicit drug use
6. Needs assessment of people being treated vs. people needing treatment for Hepatitis C
7. Analysis of the relationship between the age of first use of illicit drugs, the amount and types of drugs used, and the likelihood of developing dependency problems
8. Assessment of co-occurring illicit drug use and mental illness

These additional research studies will be undertaken by DCEOW involved agencies including APRA, CESAR, Howard University's Center for Drug Abuse Research, CSOSA, and the Washington/Baltimore HIDTA as funding and time allow.

Recommendations for the Mayor's Task Force

In addition to the Year 2 indicators and recommendations for additional research described above, the DCEOW core members offer twelve recommendations to the Mayor's Interagency Task Force in the areas of criminal justice and public health. The Task Force is strongly encouraged to pursue each of these recommendations to ensure that DC agencies are provided with the resources they need to protect city residents and provide them with the services they need. The data collected and analyzed by the DCEOW will be used to monitor the outcomes of these efforts by assessing illicit drug use and related consequences in the District by utilizing the indicators in this report and CSAP's prevention NOMs. Recommendations to the Task Force include:

Criminal Justice

1. Involve court services in all program planning and referral processes
2. Develop mechanisms, such as mapping and de-confliction services provided by the MPD and the Washington/Baltimore HIDTA, to identify and monitor high risk areas and vendors in the city
3. Develop mechanisms to track offender residence and place of crime for drug-related arrestees
4. Develop mechanisms to collect more detailed information for crimes related to illicit drug use
5. Develop and support resources, such as civil legal actions, for identifying and resolving environmental factors conducive to drug trafficking and crime

Public Health

1. Support and expand outreach programs for youth including sexually transmitted disease (STD) education
2. Expand support for drug testing programs in criminal justice and education settings
3. Improve coordination and communication between city agencies to ensure that individuals identified as drug users can be monitored across agencies and that they receive the services they need
4. Develop and conduct an annual DC survey on substance use and health (formerly the household survey) to monitor illicit drug use and health related decision making by DC residents
5. Improve and expand the collection of data on HIV and Hepatitis diagnoses
6. Improve and expand the collection of drug use by pregnant women, babies born drug positive, and drug-related child abuse/neglect cases to ensure that DC's children are protected and supported as they become healthy, productive adults
7. Initiate a more comprehensive data collection process to monitor illicit drug use on college and university campuses

ILLICIT DRUG CONSUMPTION PATTERNS

For this section, we included indicators that would be useful in monitoring the consequences of illicit drug use. The indicators with the most complete data have been arranged in tables to analyze trends of various substances and age groups. The consumption tables included in this report do not provide a complete understanding of the illicit drug use patterns for all drug substances in the District of Columbia. To achieve a fuller understanding of illicit drug consumption patterns and demographic characteristics, additional information has been included to better examine illicit drug consumption.

Illicit Drug Consumption Patterns

Table 17: Past Month Marijuana and Illicit Drug Use among Persons Aged 12 or Older in the District of Columbia, by Gender and Age: Numbers in Thousands, Annual Averages Based on 2002 – 2005 Surveys

Age by Gender	Past Month Substance Use by DC Residents Aged 12 and older	
	Marijuana (No. in Thousands)	Illicit Drugs Other Than Marijuana* (No. in Thousands)
Total**	38	20
Male		
12-17	1	1
18-25	8	2
26-34	7	3
35-44	2	3
45-54	2	***
55-64	***	***
65 or Older	***	***
Female		
12-17	1	1
18-25	7	3
26-34	4	1
35-44	2	2
45-54	2	1
55-64	***	***
65 or Older	***	***

NOTES: *Illicit drugs other than marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically.
** Row total may not equal column total due to the missing data in select age groups.
***Low precision, no estimate reported.
SOURCE: Substance Abuse and Mental Health Administration (SAMHSA), Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004 and 2005.

- Between 2002 and 2005, an average of 38,000 DC residents aged 12 and older reported marijuana use in the past 30 days, while 20,000 reported illicit drug use in the 30 days prior to completing the survey.
- Nearly 20,000 male residents reported marijuana use in the past 30 days.
- Nearly three quarters of males who reported marijuana use in the past 30 days were between 18 and 34 years of age.
- For males, 60 percent who reported illicit drug use other than marijuana were between 26 and 44 years old.
- Nearly 44 percent of the females who reported marijuana use in the past 30 days were 18 to 25 years old.
- Nearly 38 percent of females reporting illicit drug use were 18 to 25 years of age while another 25 percent were between 35 and 44 years old.

Additional Relevant Information

- Between 2002 and 2005, an average of 13,000 individuals in DC aged 12 or older reported using a needle in their lifetime to inject a drug that was not prescribed, or was taken for the experience or feeling it caused.
- Between 2002 and 2005, an average of 2,000 individuals in DC aged 12 or older reported using a needle to inject drugs in the past 30 days.
- On average, three times more males than females reported using a needle to inject drugs between 2002 and 2005 in the District of Columbia.

Illicit Drug Consumption Patterns

Table 18: Marijuana Consumption and Use Prior to Age 13 for High School Students in the District of Columbia, by Sex and Grade, 1999, 2003, and 2005

	Marijuana Use by High School Students in DC					
	Used marijuana one or more times during the past 30 days (%)			Tried marijuana prior to age 13 (%)		
	1999	2003	2005	1999	2003	2005
Total	25.7	23.5	14.5	12.3	12.6	9.1
Sex						
Male	29.0	28.6	15.0	16.8	16.3	10.7
Female	22.8	18.9	14.0	8.3	9.2	7.7
Grade						
9th	19.6	23.9	11.0	15.1	13.6	9.1
10th	27.8	24.1	14.4	11.6	13.6	10.0
11th	26.1	20.1	19.0	12.9	10.1	9.8
12th	32.8	25.1	15.6	8.1	12.2	7.1

SOURCE: Youth Risk Behavior Survey System (YRBSS), National Center for Chronic Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

- In 2005, the percent of high school students who reported use of marijuana in the past 30 days was nearly half the percent that reported use in 1999.
- The percent of high school students who reported trying marijuana before the age of 13 also decreased between 1999 and 2005
- Between 1999 and 2003, the percent of high school males who reported use of marijuana prior to age 13 remained somewhat constant before decreasing in 2005.
- In 2003, a slight increase occurred in the percent of females who reported use of marijuana prior to 13 years of age.
- Overall, reports of marijuana use for high school students decreased between 1999 and 2005.
- In 1999 and 2003, a larger percent of 12^{th} graders reported marijuana use in the past 30 days, while in 2005, a larger number of 11^{th} graders reported past 30 day use.
- Between 1999 and 2003, there was an increase in the percent of 10^{th} and 12^{th} graders who reported marijuana use prior to age 13.
- In 2005, the percent of high school students who reported marijuana use prior to age 13 decreased.

Additional Relevant Information

- In 2005, nearly 2 percent of high school students in DC reported use of cocaine, including powder, crack, or freebase, steroid pills or shots without a doctor's prescription, methamphetamines, or heroin at least once in their life.
- In 2005, about 5 percent of high school students in DC reported sniffing glue, breathing the contents of aerosol spray, inhaling paints or sprays, or using ecstasy to get high at least once in their life.
- Between 2003 and 2005, the percent of 11^{th} and 12^{th} grade students reporting use of any substance in their life decreased (except for glue and inhalants for 11^{th} graders which remained constant).
- Between 2003 and 2005, the percent of 10^{th} graders reporting use of glue, inhalants, or steroid pills/shots in their lifetime increased while use of all other substances decreased.

Illicit Drug Consumption Patterns

Additional Relevant Information (continued)

- Between 2003 and 2005, the percent of 9th graders who reported use of marijuana, glue, inhalants, or ecstasy decreased while use of all other substances increased.
- In 2005, 9th graders reported a higher percentage of use for all substances, except for ecstasy in which 11th graders reported the highest percentage of use in lifetime, compared to all other grades.
- A larger percent of high school males (1.6%) compared to females (0.3%) reported use of some form of cocaine including powder, crack, or freebase one or more times during the past 30 days in 2005.
- Overall between 1999 and 2005, use of cocaine, including powder, crack, or freebase one or more times during the past 30 days has slightly decreased for both high school males and females.
- In 2005, a larger percent of 9th graders (1.7%) reported use of cocaine including powder, crack, or freebase one or more times during the past 30 days compared to 10th, 11th, and 12th graders in which less than 1 percent of students in each grade level reported use of any form of cocaine in the past 30 days.
- In 2005, more male high school students (2.0%) than female high school students (0.6%) reported use of a needle to inject illegal drugs one or more times in their lifetime.
- In 2005, 12th graders reported no use of injecting illegal drugs with needles in their lifetime compared to 1.7 percent of 9th graders, 1.5 percent of 10th graders, and 1.2 percent of 11th graders.
- Overall, reports of using needles to inject illegal drugs decreased slightly for all high school grade levels between 1999 and 2005 except for 9th graders which nearly tripled since 1999 (0.6% to 1.7%).

Illicit Drug Consumption Patterns

Table 19: Percentage of Adult Arrestees Who Tested Positive for Opiate, PCP, and Cocaine, by Year, 2001–2005

Substance	Percent of Adult Arrestees Testing Positive				
	2001	2002	2003	2004	2005
Opiates	10	10	10	10	9
PCP	13	14	13	6	8
Cocaine	34	35	35	37	37

NOTE: The District of Columbia Pretrial Services Agency does not test 100% of arrestees for drug substances. Percentages shown are of adult arrestees actually tested for drug substances. For more in-depth DC Pre-trial Services Agency data, see CESAR Fax, Vol. 16, Issue 10, March 12, 2007.
SOURCE: DC Office of Forensic Research, Pretrial Services Agency, January 2007.

- Cocaine use remained much higher among adult arrestees between 2001 and 2005 compared to use of PCP and opiates.
- The percentage of adult arrestees who tested positive for opiates and cocaine has remained somewhat steady over the past 5 years.
- The percentage of adult arrestees who tested positive for PCP decreased between 2003 and 2004 although a slight increase was reported in 2005.

Additional Relevant Information

- In 2006, PCP rates continued to somewhat increase with 9 percent of the adult arrestee population testing positive.
- Testing for use of amphetamines within the adult arrestee population began in April of 2006.
- Since April 2006, the percent of positive amphetamine tests for the adult arrestee population has fluctuated with the lowest percent recorded in April 2006 (1.80%) and the highest percent recorded in October 2006 (3.40%).
- More recently, 3.2 percent of the adult arrestee population tested positive for amphetamines in February 2007.
- Pretrial services in the District of Columbia test juvenile arrestees for THC (marijuana) in addition to cocaine and PCP.
- Between 2001 and 2004, juvenile arrestees who tested positive for THC decreased 8 percent (57% to 49%) with a 1 percent increase between 2004 and 2005.
- Juvenile arrestees who tested positive for cocaine remained somewhat steady between 2001 and 2005 with the lowest percent reported in 2004 (3%) and the highest percent reported in 2002 (6%).
- Juvenile arrestees who tested positive for PCP greatly decreased since the 13 percent recorded in 2001 to only 3 percent in 2005.
- In fiscal year 2005, 13 percent of drug users, compared to 6 percent of non-drug users identified by the DC Pretrial Services Agency, were charged with “failure to appear.”

CONSEQUENCES OF ALCOHOL USE

This section was developed to address three key questions regarding alcohol use in the District of Columbia:

1. What are the most significant consequences of alcohol use in the District of Columbia for which data is currently available?
2. Based on the data available, which consequences are of highest priority for the District of Columbia?
3. In addressing the consequences, what consumption indicators should be monitored to assess progress?

The answers to each of the three questions are essential in order to develop data-driven prevention programs.

Using the process described in Developing the State Epidemiology Profile (pages 25–26), four consequences have been assessed and included in this section: violent crimes, alcohol-related fatal motor vehicle crashes, past year alcohol abuse or dependence, and chronic liver disease mortality. The four consequence categories include several indicators determined to meet inclusion criteria as previously defined. Wherever possible, data with comparable national measures was selected for inclusion and presented in the report.

For each consequence, the data provides an in-depth look at District level prevalence and severity, and ward level data when available, as well as, various demographic characteristics. Within each consequence, charts and tables are used to present the data along with key findings, and in some cases, additional relevant information. Each consequence is divided into five sections:

1. Identified Indicators
2. National vs. DC Comparisons
3. Prevalence/Severity
4. Time Trends
5. Ward Data (based on data availability)

At the end of the section, recommendations and consumption patterns are provided. The recommendation section displays prioritization results from an assessment of all illicit drug consequences provided in this report to be utilized by the Mayor's Interagency Task Force for future funding discussions. Lastly, tables providing data on each of the illicit drug consumption indicators is included and will be used to assess progress in addressing the consequences in the future.

Consequence: Violent Crimes

Identified Indicators

For this consequence, we assessed four indicators in the crime and criminal justice CSAP NOMs domain. The data presented within each of the four indicators allows us to assess the prevalence of violent crime as a consequence of alcohol use in the District of Columbia.

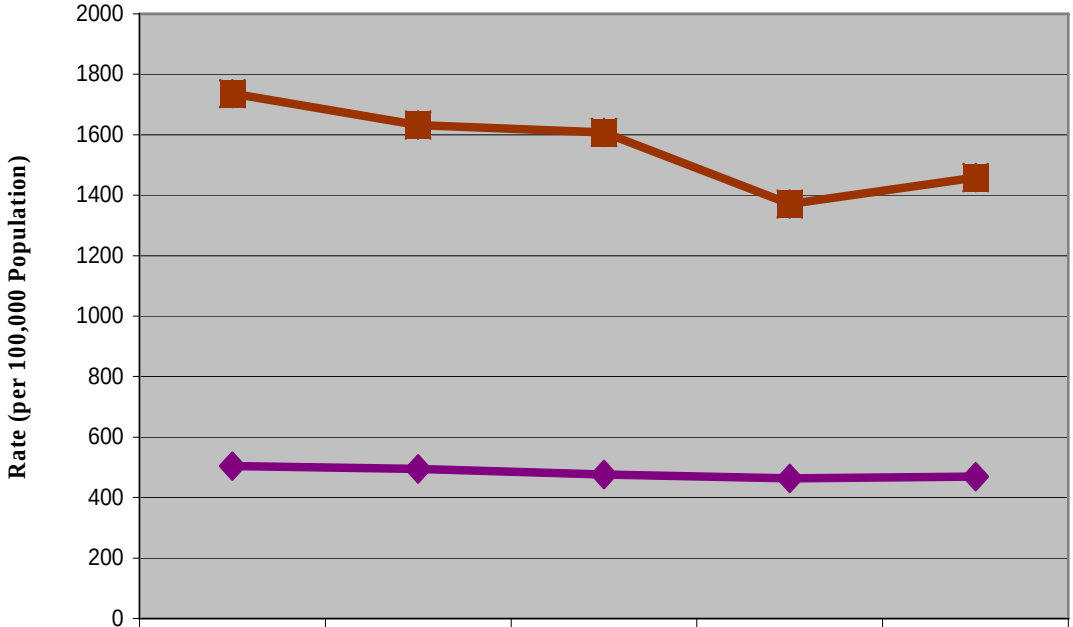
- Homicide
- Forcible rape
- Robbery
- Aggravated assault

These indicators were selected in accordance with CSAP. The purpose of these selected indicators is to describe a major consequence of alcohol use related to crime. The following charts (Figures 11 and 12) compare violent crime rates in the District of Columbia and the United States over the most recent five years of data availability. The subsequent tables take an in-depth look at violent crime in DC and the relationship to alcohol use by examining each of the four indicators.

Throughout this section, attributable fractions provided by CSAP, have been used to explain the number of incidents or cases that are related to alcohol use. These attributable fractions are in the form of percentages and explain the percent of incidents or cases that are estimated to be alcohol-related. The attributable fractions are national averages and may vary by geographical region or subpopulations. The attributable fractions for violent crimes are based primarily on self-report of incarcerated perpetrators of the crimes.

National vs. DC Comparisons

Figure 11: Annual Violent Crime Rates per 100,000 Population in the District of Columbia and the United States, 2001–2005



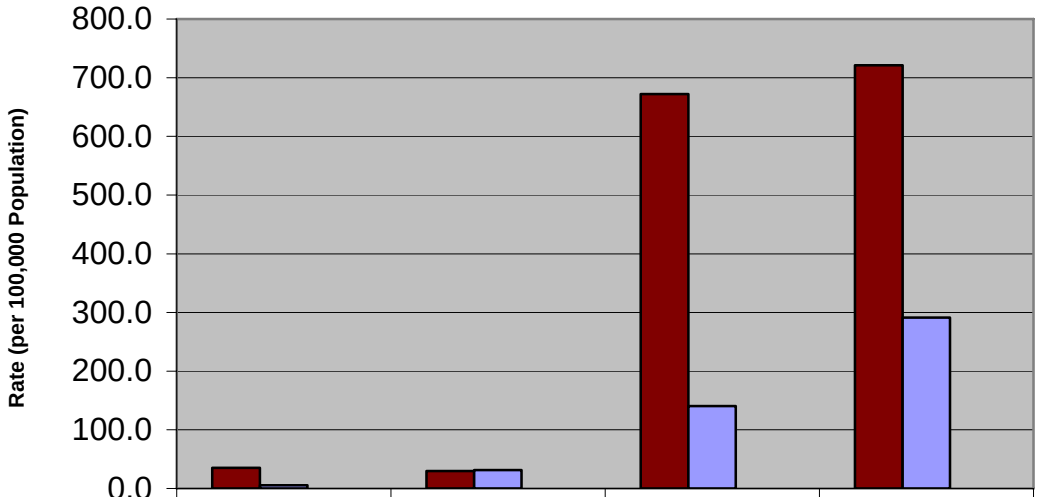
	2001	2002	2003	2004	2005
District of Columbia	1736.7	1,632.9	1,608.1	1,371.2	1,459.0
United States	504.5	494.4	475.8	463.2	469.2
State/National Ratio*	3.44	3.30	3.38	2.96	3.11

NOTES: Violent crimes are offenses of homicide, forcible rape, robbery and aggravated assault. Violent crime rate refers to the number of reported offenses per 100,000 population.
*State/National Ratio = State Rate/National Rate.
SOURCE: FBI, Uniform Crime Reports as prepared by the National Archive of Criminal Justice. Index of Crime in the United States: Table 1 & Table 5.

- Overall, violent crime rates decreased in the District of Columbia between 2001 and 2005; however, a slight increase was reported between 2004 and 2005.
- Nationally, violent crime rates steadily decreased between 2001 and 2005 before slightly increasing by six persons per 100,000 between 2004 and 2005.
- DC rates have been consistently higher than the National rates over the past five years.
- DC rates are nearly three times greater than the National rates in each of the past five years.

National vs. DC Comparisons

Figure 12: Violent Crime Rates per 100,000 Population in the District of Columbia and the United States, by Type of Violent Crime, 2005



	Homicide	Forcible Rape	Robbery	Aggravated Assault
District of Columbia	35.4	30.2	672.1	721.3
United States	5.6	31.7	140.7	291.1
State/National Ratio*	6.32	0.95	4.78	2.48

NOTES: Total violent crimes are offenses of homicide, forcible rape, robbery and aggravated assault combined. Violent crime rate refers to the number of reported offenses per 100,000 population.
*State/National Ratio = State Rate/National Rate.
SOURCE: FBI, Uniform Crime Reports as prepared by the National Archive of Criminal Justice. Index of Crime in the United States: Table 1 & Table 5.

- For the District of Columbia and the US, violent crime rates were higher for robberies and aggravated assaults in 2005 compared to homicides and forcible rapes.
- The rates for homicides, robberies, and aggravated assaults per 100,000 individuals in the District of Columbia in 2005 were higher than the National rates; however, the rate of forcible rapes in the District was lower in the District compared to the National rate.
- The homicide rate in DC was over six times the National rate in 2005, while the robbery rate was more than four times the National rate.

Prevalence/Severity in 2005

Table 20: Number of Alcohol-Related Violent Crimes Reported in the District of Columbia Including Rate per 100,000 Population and Number Estimated to be Alcohol-Related, by Type of Crime, 2005

	Violent Crimes			
	No. of Offenses Reported*	**Rate (per 100,000 pop.)**	**Estimated % that are Alcohol-Related****	**Estimated No. that are Alcohol-Related**
Total Violent Crimes	7,717	1,401.8	---	1,358
Type of Crime				
Homicide	196	35.6	30.0%	59
Forcible Rape	165	30.0	23.0%	38
Robbery	3,502	636.1	3.0%	105
Aggravated Assault	3,854	700.1	30.0%	1,156

NOTES: No attributable fraction is available for total number of violent crimes that are alcohol-related. The total estimated number of violent crimes that are alcohol-related was calculated by summing the estimated numbers for each type of crime.
Rate based on the estimated population in DC in 2005. The census bureau calculated 2005 state growth rates using the revised 2004 state/national population estimates and the 2005 provisional state/national population estimates.
*Number of offenses reported was derived from the most recent data available, which was a report by the Metropolitan Police Department in December 2006. Representative of the most current figures from DC, these figures are not equal to those in the FBI Uniform Crime Report.
**Estimates of the percent of alcohol-related violent crimes taken from the State Epidemiological Data System (SEDS).
SOURCE: The District of Columbia Metropolitan Police Department's crime report from December 2006. Populations used were U.S. Bureau of the Census provisional estimates as of July 1 of each year as on the FBI UCR website.

- Nearly 8,000 violent crimes were reported in the District of Columbia in 2005, and it was estimated that almost 1,500 are alcohol-related.
- Majority of violent crimes reported in the District in 2005 were aggravated assaults and robberies; however, only about 100 robberies were attributed to alcohol use compared to nearly 1,200 aggravated assaults.

Time Trends 2001 – 2005

Table 21: Violent Crimes Reported in the District of Columbia during the Past Five Years Including Rate per 100,000 Population and Number Estimated to be Drug-Related, by Type of Crime, 2001–2005

Year	Total Violent Crimes		
	No. of Reported Crimes*	Rate (per 100,000 pop.)	Estimated No. Alcohol-Related Crimes
2001	9,193	1,607.7	1,726
2002	9,109	1,595.6	1,707
2003	8,839	1,568.9	1,597
2004	7,336	1,325.3	1,360
2005	7,717	1,401.8	1,358

Year	Homicide			Forcible Rape			Robbery			Aggravated Assault		
	No. of Reported Crimes*	Rate (per 100,000 pop.)	Estimated No. Alcohol-Related Crimes**	No. of Reported Crimes*	Rate (per 100,000 pop.)	Estimated No. Alcohol-Related Crimes***	No. of Reported Crimes*	Rate (per 100,000 pop.)	Estimated No. Alcohol-Related Crimes****	No. of Reported Crimes*	Rate (per 100,000 pop.)	Estimated No. Alcohol-Related Crimes**
2001	232	40.6	70	181	31.7	42	3,777	660.5	113	5,003	874.9	1,501
2002	262	45.9	79	262	45.9	60	3,731	653.5	112	4,854	850.2	1,456
2003	248	44.0	74	273	48.5	63	3,836	680.9	115	4,482	795.5	1,345
2004	198	35.8	59	218	39.4	50	3,057	552.3	92	3,863	697.9	1,159
2005	196	35.6	59	165	30.0	38	3,502	636.1	105	3,854	700.1	1,156

NOTES: No attributable fraction is available for total number of violent crimes that are alcohol-related. The total estimated number of violent crimes that are alcohol-related was calculated by summing the estimated numbers for each type of crime.
Rate based on the estimated population in DC for each year. For example, the census bureau calculated 2005 state growth rates using the revised 2004 state/national population estimates and the 2005 provisional state/national population estimates. This process was completed for all years.
*Reported crime totals were derived from the most recent data available, which was a report by the Metropolitan Police Department in December 2006. Representative of the most current figures for DC, these figures are not equal to those in the FBI Uniform Crime Report.
**30% of the total number of crimes is estimated to be alcohol-related as reported by the State Epidemiological Data System (SEDS).
***23% of the total number of crimes is estimated to be alcohol-related as reported by the State Epidemiological Data System (SEDS).
****3% of the total number of crimes is estimated to be alcohol-related as reported by the State Epidemiological Data System (SEDS).
SOURCE: The District of Columbia Metropolitan Police Department's crime report from December 2006. Populations used were U.S. Bureau of the Census provisional estimates as of July 1 of each year as on the FBI UCR website.

- Between 2001 and 2004, the total number of violent crimes reported to the DC Metropolitan Police Department steadily decreased; however, an increase of about 400 reported violent crimes, all of which were robberies, took place between 2004 and 2005.
- In 2005, decreases occurred in the number of reported homicides, forcible rapes, and aggravated assaults in the District.
- The number of reported homicides steadily decreased in the District since 2002.
- The number of reported forcible rapes peaked in 2003 with a total of 273 reported and since decreased to 165 reports in 2005.
- The number of reported aggravated assaults continued to decrease each year since 2001.

Consequence: Alcohol-Related Fatal Motor Vehicle Crashes

Identified Indicators

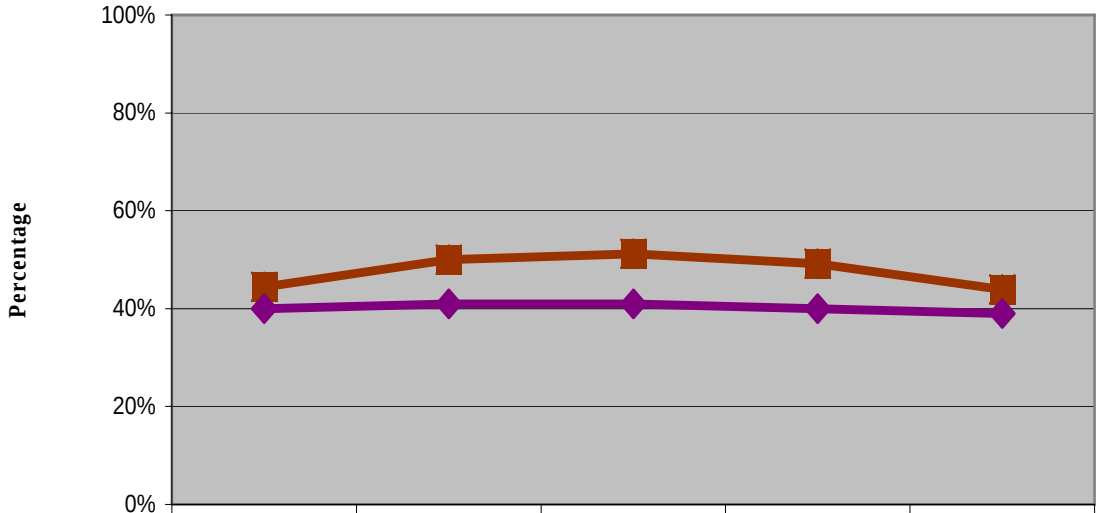
For this consequence, we assessed four indicators in the crime and criminal justice CSAP NOM domain. The data presented within each of the indicators allows us to assess the prevalence of motor vehicle accidents as a consequence of alcohol use in the District of Columbia.

- Fatal motor-vehicle crashes
- Fatalities resulting from motor-vehicle crashes
- Drinking drivers involved in fatal crashes
- Drinking drivers killed in crashes

These indicators were selected in accordance with CSAP. The purpose of these selected indicators is to describe a major health consequence of alcohol use. The following chart (Figure 13) compares the percentage of fatal alcohol-related motor vehicle crashes for the District of Columbia and the United States over the most recent five years of available data. The subsequent tables take an in-depth look at motor vehicle crashes in the District related to alcohol use by examining fatalities, drinking drivers, and characteristics of fatal motor-vehicle crashes.

National vs. DC Comparisons

Figure 13: Percentage of Fatal Motor-Vehicle Crashes that were Alcohol-Related in the District of Columbia and the United States, 2000–2004



	2000	2001	2002	2003	2004
District of Columbia	44.4%	50.0%	51.2%	49.2%	43.9%
United States	40%	41%	41%	40%	39%

NOTES: Percentage of alcohol-related fatal crashes in which at least one driver, pedestrian, or cyclist had been drinking (Blood Alcohol Concentration >0.00). The National Traffic Safety Administration (NHTSA) has estimated driver blood alcohol concentration levels when alcohol test results are unknown.
SOURCE: Fatality Analysis Reporting System (FARS), National Highway Traffic Safety Administration (NHTSA), U.S. Department of Transportation. National Highway Traffic Safety Administration (NHTSA), Traffic Safety Fact Sheets, Alcohol, 2000 – 2004.

- In each year between 2000 and 2004, the number of alcohol-related fatal crashes ranged between 43.9 percent in 2004 to 51.2 percent in 2002 for the District of Columbia.
- Nationally, about 40 percent of all fatal crashes were alcohol-related in each year between 2000 and 2004.
- The District of Columbia consistently remains higher than the National percentage for the percent of fatal crashes that are alcohol-related.

Prevalence/Severity 2005

Table 22: Fatal Crashes, Fatalities from Crashes, and Fatal Crash Characteristics for the District of Columbia, 2005

	Incidents	
	No.	**Percent***
Fatal Crashes		
All Fatal Crashes	44	100.0
All Alcohol-Related Fatal Crashes	22	50.0
Fatalities from Crashes		
All Fatalities from Crashes	48	100.0
All Alcohol-Related Fatalities from Crashes	26	54.2
Fatal Crash Characteristics**		
Fatalities where Highest BAC in Crash was .08+	21	43.8
Driver Fatalities	19	39.6
Motorcycle Rider Fatalities	6	12.5
Pedestrian Fatalities	16	33.3
Passenger Car Crash Fatalities	15	31.3
Light Truck/Van Crash Fatalities	7	14.6
Single Vehicle Crash Fatalities	34	70.8
Speeding Involved Crash Fatalities	17	35.4
Crash at Intersection Fatalities	10	20.9

NOTES: Total number of fatal crashes and fatalities resulting from fatal crashes in which at least one driver, pedestrian, or cyclist had been drinking (Blood Alcohol Concentration >0.00). The National Traffic Safety Administration (NHTSA) has estimated driver blood alcohol concentration levels when alcohol test results are unknown.
* Percentage of each fatal crash characteristic is the number of fatalities for the characteristic/all fatalities from crashes in 2005.
Percentages for fatal crash characteristics will not equal 100% because there may be more than one fatality per crash and more than one characteristic assigned to each fatality.
**Fatal crash characteristics include fatalities from crashes where alcohol was either involved or not involved.
SOURCE: Fatality Analysis Reporting System (FARS), National Highway Traffic Safety Administration (NHTSA), U.S. Department of Transportation.

- In 2005, 44 fatal crashes occurred in the District of Columbia in which half were related to alcohol.
- In 2005, there were 48 fatalities from motor-vehicle crashes and over half (54.2%) were fatalities from crashes in which at least one driver, pedestrian, or cyclist involved in the incident had been drinking alcohol.
- Of the 48 fatalities in DC in 2005, 21 were involved in crashes where the highest blood alcohol concentration was 0.08 or greater.
- Of the 48 fatalities in 2005, 19 drivers involved in the motor-vehicle crashes were killed.
- In 2005, 16 pedestrians and six motorcycle riders were killed in motor-vehicle crashes in the District of Columbia.
- In the District of Columbia, over 70 percent of fatalities occurred in single vehicle crashes in 2005.

Time Trends 2001 – 2005

Table 23: Fatal Motor-Vehicle Crashes in the District of Columbia Including All Fatal Crashes and Alcohol-Related Fatal Crashes, by Year, 2000–2004

Year	Fatal Crashes in the District of Columbia		
	Total No. All Crashes	Total No. Alcohol-Related	Percent Alcohol-Related
2000	45	20	44.4
2001	58	29	50.0
2002	43	22	51.2
2003	63	31	49.2
2004	41	18	43.9

NOTES: Number of fatal crashes in which at least one driver, pedestrian, or cyclist had been drinking (Blood Alcohol Concentration >0.00). The National Traffic Safety Administration (NHTSA) has estimated driver blood alcohol concentration levels when alcohol test results are unknown.
SOURCE: Fatality Analysis Reporting System (FARS), National Highway Traffic Safety Administration (NHTSA), U.S. Department of Transportation.

- Since 2000, the number of fatal crashes in the District has fluctuated with the lowest number reported in 2004 (n=41) and the largest number reported in 2003 (n=63).
- The lowest number of alcohol-related fatal motor-vehicle crashes was reported in 2004 (n=18); however, it was 43.9 percent of all fatal crashes in the District during that year.
- The percent of fatal crashes that were related to alcohol has decreased from 51.2 percent in 2002 to 43.9 percent in 2004.

Time Trends 2001 – 2005

Table 24: All Fatalities and Alcohol-Related Fatalities from Motor-Vehicle Crashes in the District of Columbia Including Alcohol-Related Fatality Rate per 100,000 Population, by Year, 2000–2004

Year	Motor-Vehicle Fatalities in the District of Columbia			
	All Fatalities	Alcohol-Related Fatalities		
	No.	No.	Percent	Rate (per 100,000
2000	48	20	41.7	3.5
2001	68	34	50	6.0
2002	47	24	51.1	4.3
2003	67	35	52.2	6.3
2004	43	19	44.2	3.4

NOTES: Number of fatalities in which at least one driver, pedestrian, or cyclist had been drinking (Blood Alcohol Concentration >0.00). The National Traffic Safety Administration (NHTSA) has estimated driver blood alcohol concentration levels when alcohol test results are unknown. Rate based on the estimated population in DC for each year. For example, the census bureau calculated 2005 state growth rates using the revised 2004 state/national population estimates and the 2005 provisional state/national population estimates. This process was completed for all years.
SOURCE: Fatality Analysis Reporting System (FARS), National Highway Traffic Safety Administration (NHTSA), U.S. Department of Transportation. Population estimates taken from the U.S. Bureau of the Census.

- The highest number of motor-vehicle fatalities (n=68) occurred in 2001; however, the largest percent (52.2%) deemed to be alcohol-related occurred in 2003 in the District of Columbia.
- In 2004, 43 individuals died in motor-vehicle crashes and 19 were alcohol-related.
- In 2004, 44.2 percent of all motor-vehicle fatalities occurred when at least one driver, pedestrian, or cyclist involved in the incident had a blood alcohol concentration equal to or greater than 0.01.
- Nearly 4 people out of every 100,000 residents in the District of Columbia died in alcohol-related motor-vehicle crashes in 2004.

Time Trends 2001 – 2005

Table 25: All Drivers and Drinking Drivers Killed in Fatal Crashes in the District of Columbia, by Year, 2001–2005

	Drivers Killed in Fatal Crashes in the District of Columbia		
	No. of Drivers Killed in Fatal Crashes	No. of Drivers who had been Drinking Alcohol and Killed in Fatal Crashes	
Year	No.	No.	Percent
2001	34	16	47.1
2002	28	12	42.9
2003	35	17	48.6
2004	25	9	36.0
2005	19	12	63.2

NOTES: Number of fatalities in which the driver had been drinking (blood alcohol concentration >0.00). The National Traffic Safety Administration (NHTSA) has estimated driver blood alcohol concentration levels when alcohol test results are unknown.
SOURCE: Fatality Analysis Reporting System (FARS), National Highway Traffic Safety Administration (NHTSA), U.S. Department of Transportation.

- In 2005, 19 drivers were killed in motor-vehicle crashes and 12 (63.2%) had a positive blood alcohol concentration.
- The lowest number of fatalities for drivers who had been drinking alcohol occurred in 2004 with nine reported deaths of drinking drivers –36.0 percent of all driver fatalities for that year.
- Overall, the number of drivers killed in motor-vehicle crashes decreased between 2001 and 2005; however, the percent of drivers killed who had been drinking increased from 47.1 percent to 63.2 percent between 2001 and 2005.

Time Trends 2000 – 2004

Table 26: Drinking Drivers Involved in Fatal Crashes in the District of Columbia, by Gender and Age, 2000–2004

	Number & Percentages of Drinking Drivers Involved in Fatal Crashes									
	2000		2001		2002		2003		2004	
	# Alc-Rel.	% of All Alc-Rel.	# Alc-Rel.	% of All Alc-Rel.	# Alc-Rel.	% of All Alc-Rel.	# Alc-Rel.	% of All Alc-Rel.	# Alc-Rel.	% of All Alc-Rel.
All Fatal Crashes	45	100.0	58	100.0	43	100.0	63	100.0	41	100.0
All Alcohol-Related Fatal Crashes	20	44.4	29	50.0	22	51.2	31	49.2	18	43.9
Gender										
Male	13	27.8	26	38.5	20	35.1	25	33.5	15	25.6
Female	3	25	4	23.9	2	16.9	2	11.7	3	26.7
Age										
Under 21	2	25.7	3	36.3	2	28.3	4	30.0	1	6.2
21-29	6	32.4	12	42.1	10	40.8	12	29.7	12	45.8
30-34	3	22.7	3	30.9	4	31.7	3	31.3	1	12.0
35-54	5	30.6	10	44.1	6	27.6	7	26.4	2	14.7
55 and Over	1	8.6	2	12.0	*	4.0	2	47.5	*	2.0

NOTES: The National Traffic Safety Administration (NHTSA) has estimated driver blood alcohol concentration levels when alcohol test results are unknown. This estimated number creates a fraction of a whole individual which is rounded to the nearest whole number for purposes of this table. Total alcohol-related fatal crashes may not equal column totals for demographics due to the presence of missing data and/or error due to rounding.
*Number is great than 0.0, but less than 0.5.
SOURCE: Fatality Analysis Reporting System (FARS), National Highway Traffic Safety Administration (NHTSA), U.S. Department of Transportation.

- Over the past five years, the largest number of fatal crashes occurred in 2003 (n=63), while the lowest number occurred in 2004 (n=41).
- The number of alcohol-related fatal crashes also peaked in 2003 (51.2%) before decreasing in 2004 to 43.9 percent of fatal crashes being alcohol-related.
- Males were consistently involved in more fatal accidents when drinking than females over the past five years.
- Most recently, in 2004, five times more male drivers than female drivers (15 and 3 respectively) were involved in fatal accidents in which alcohol was involved; however, in 2004 the percent of women drinking and involved in fatal crashes was slightly higher than that of males for the first time.
- In 2000, 2002, and 2004, a larger percentage of individuals aged 21 to 29 were involved in alcohol-related fatal crashes than any other age group; in 2001 and 2003, older age groups accounted for higher percentages of alcohol-related fatal crashes (35-54 and 54+ respectively).
- In 2004, almost half of individuals aged 21 to 29 involved in fatal crashes were under the influence of alcohol at the time.
- The percentage of individuals under the age of 21 involved in alcohol-related motor vehicle crashes decreased in 2004 compared to the previous four years.

Consequence: Any Alcohol Abuse or Dependence in Past Year

Identified Indicators

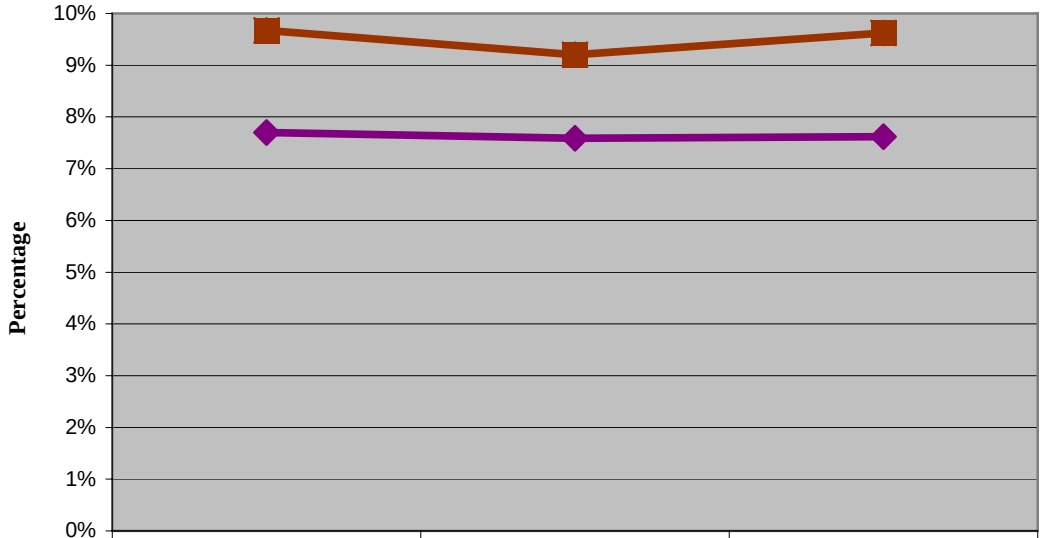
For this consequence category, we included one indicator that is a part of the reduced morbidity CSAP NOMs domain. The data presented for this indicator allows us to assess the estimated number of persons meeting DSM-IV criteria for alcohol abuse or dependence in the District of Columbia.

- Persons aged 12 or older meeting DSM-IV criteria for alcohol abuse or dependence

This indicator was selected in accordance with CSAP requirements. The purpose of this indicator is to describe a major consequence of continued alcohol use. The following chart (Figure 14) compares residents aged 12 or older who reported any alcohol abuse or dependence in the District of Columbia and the United States over the past five years. The subsequent tables examine DC trends from 2002–2004, as well as, 2004 estimates of alcohol abuse or dependence in DC residents 12 years of age or older.

National vs. DC Comparisons

Figure 14: Percentage of Residents Aged 12 or Older Who Reported Alcohol Abuse or Dependence in the Past Year for the District of Columbia and the United States, 2002–2004



	2002	2002-2003	2003-2004
District of Columbia	9.67%	9.20%	9.62%
United States*	7.70%	7.59%	7.62%

NOTES: Abuse or dependence is based on the definitions found in the 4th Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).
*The state estimates are based on a survey-weighted hierarchical Bayes estimation approach. Although statewide estimates were produced prior to 2002, the data are not comparable to data collected in and after 2002 because of a change in survey methods.
The U.S. estimates are the weighted average of the hierarchical Bayes estimates across all States and the District of Columbia and typically are not equal to the direct sample-weighted estimate for the Nation.
SOURCE: Substance Abuse and Mental Health Administration (SAMHSA), Office of Applied Studies, National Survey on Drug Use and Health, 2002 – 2004

- DC percentages for individuals who reported alcohol abuse or dependence remained steady.
- Nationally, the percentage of individuals who reported alcohol abuse or dependence also remained stable between 2002 and 2004.
- Although DC and the US have followed the same pattern over the past three years, DC percentages are consistently higher than the National rates.

Prevalence/Severity in 2003 – 2004

Table 27: Estimated Number and Percentage of DC Residents Aged 12 or Older Who Reported Alcohol Abuse or Dependence in the Past Year, by Age, Gender, and Race/Ethnicity: Annual Averages Based on 2003 and 2004 Surveys

	DC Residents Aged 12 or Older Reporting Alcohol Abuse or Dependence	
	Estimated No.	**Percent of Residents Aged 12+**
District of Columbia	45,000	9.62
Age		
12-17	1,000	3.47
18-25	11,000	16.19
26 or Older	33,000	8.92
Gender		
Male		
Female		
Race/Ethnicity		
Not Hispanic or Latino		
White		
African American		
American Indian or Alaskan Native		
Native Hawaiian or Other Pacific Islander		
Asian		
Two or More Races		
Hispanic		

NOTES: Abuse or dependence is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Remaining data will be added when it is received.
SOURCE: Substance Abuse and Mental Health Administration (SAMHSA), Office of Applied Studies, National Survey on Drug Use and Health, 2003 and 2004.

- Nearly one-tenth of DC residents aged 12 years or older reported past year alcohol abuse or dependence during 2003 and 2004.
- Nearly 17 percent of DC residents 18 to 25 years reported past year alcohol abuse or dependence during 2003 and 2004.
- An estimated 45,000 DC residents reported past year alcohol abuse or dependence between 2003 and 2004
- Over 2 percent of the estimated number of DC residents who reported past year alcohol abuse or dependence during 2003 and 2004 were underage drinkers (aged 12 to 17 years).

Time Trends 2000 – 2004

Table 28: Percentage and Estimated Number of DC Residents Aged 12 or Older Who Reported Alcohol Abuse or Dependence in the Past Year, by Survey Year(s), 2002 – 2004

Year	DC Residents Aged 12 or Older Reporting Alcohol Abuse or Dependence	
	Estimated No.	Percent of Residents Aged 12+
2002	47,000	9.67
2002-2003	44,000	9.20
2003-2004	45,000	9.62

NOTE: Abuse or dependence is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). The state estimates are based on a survey-weighted hierarchical Bayes estimation approach. Although statewide estimates were produced prior to 2002, the data are not comparable to data collected in and after 2002 because of a change in survey methods.
SOURCE: Substance Abuse and Mental Health Administration (SAMHSA), Office of Applied Studies, National Survey on Drug Use and Health, 2002–2004.

- An estimated 45,000 DC residents aged 12 or older reported past year alcohol abuse or dependence in 2003-2004; this is a slight decrease from 2002.
- The percent of DC residents aged 12 or older who reported abuse or dependence of alcohol in the past year remained about the same from 2002 to 2004.

Ward Data 2002–2004

Table 29: Percentage of Alcohol Abuse or Dependence in the Past Year among Persons Aged 12 or Older in the District of Columbia, by Ward: Annual Averages Based on 2002, 2003, and 2004 Surveys

	DC Residents Reporting Alcohol Abuse or Dependence Aged 12+
	Estimate
District of Columbia	9.39
Ward	
1	11.47
2	11.92
3	10.73
4	7.58
5	8.11
6	9.45
7	7.36
8	7.58

NOTES: Estimates are based on a survey-weighted hierarchical Bayes estimation approach. Abuse or dependence is based on definitions found in the 4th edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-IV).
SOURCE: Substance Abuse and Mental Health Administration (SAMHSA), Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

- An average of 9.39 percent of DC residents aged 12 or older have reported alcohol abuse or dependence between 2002 and 2004.
- Ward 7 had the lowest estimated percent of residents (7.36%) who reported alcohol abuse or dependence between 2002 and 2004, while Ward 2 reported the largest percent of residents with 11.92 percent.
- Wards 1, 3, and the majority of ward 4 are home to residents who are more likely wealthy and white, and were associated with two of the three highest percentages of residents who were abusing or dependent on alcohol.
- The majority of Wards 5, 6, 8 and all of Ward 7, are home to residents who are more likely poor and African-American and were associated with some of the lowest percentages of residents who were abusing or dependent on alcohol.

Consequence: Chronic Liver Disease Mortality

Identified Indicators

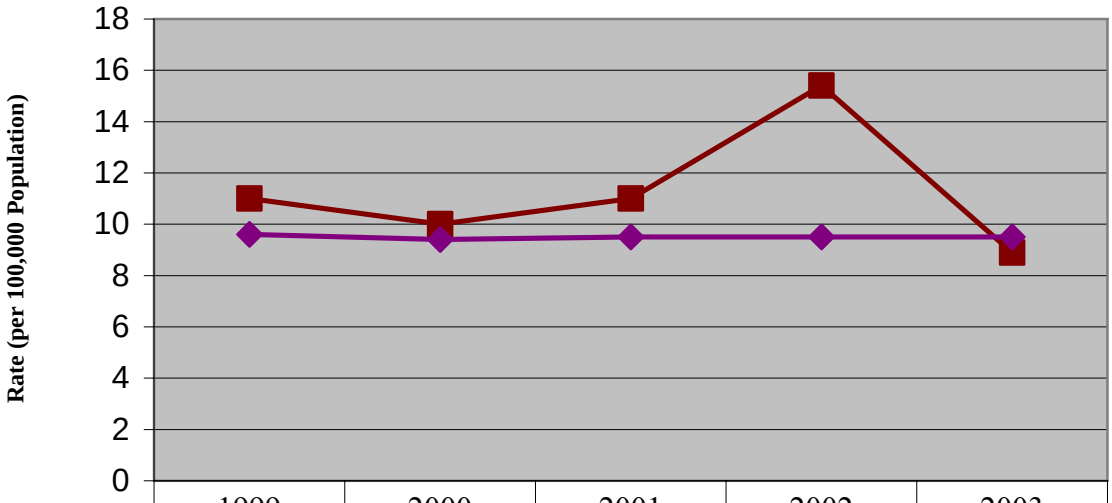
For this consequence, we assessed two indicators in the reduced mortality CSAP NOMs domain. The data presented within each of the indicators allows us to assess the prevalence of chronic liver disease as a consequence of alcohol use in the District of Columbia.

- Chronic Liver Disease
  - Alcoholic Liver Disease
  - Other Cirrhosis of the Liver

These indicators were selected in accordance with CSAP. The purpose of these selected indicators is to describe a major health consequence of alcohol use. The following chart (Figure 15) compares mortality rates for these indicators in the District of Columbia and the United States over the most recent five years of data availability. The subsequent tables take an in-depth look at DC deaths related to chronic liver disease by examining gender, race, and ages affected by these diseases.

National vs. DC Comparisons

Figure 15: Chronic Liver Disease Death Rate per 100,000 Population for the District of Columbia and the United States, 1999 – 2003



	1999	2000	2001	2002	2003
District of Columbia	11	10	11	15.4	8.9
United States	9.6	9.4	9.5	9.5	9.5
State/National Ratio*	1.15	1.06	1.16	1.62	0.94

NOTES: Chronic Liver Disease includes alcoholic liver disease and other cirrhosis of the liver diseases.
Rate based on population estimates that were prepared by the National Center for Health Statistics (NCHS) in collaboration with the U.S. Census Bureau for specific demographic groups.
*State/National Ratio = State Rate/National Rate.
SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics National Vital Statistics System as reported in the Mortality Detail Files. Multiple Cause of Death, 1999-2001[CD-ROM]. Hyattsville, MD, Author, (Special data file), 2003. Annual number of deaths with ICD-9 codes 571.0-571.9 or ICD-10 codes K70 and K73-K74 as underlying cause of death. Population estimates from the U.S. Bureau of the Census.

- In 2002, the District of Columbia experienced an increase in the rate of deaths due to liver disease, but this rate decreased sharply to a five year low of 8.9 deaths per 100,000 residents in 2003.
- Over the past five years of available data, the United States death rate due to liver disease remained somewhat consistent (between 9.4 and 9.5 per 100,000 residents).
- In 2003, the District of Columbia experienced a rate less than the Nation for the first time in the past five years.

Prevalence/Severity 2003

Table 30: Deaths from Alcoholic Liver Disease and Other Cirrhosis of the Liver in the District of Columbia, by Gender, Age, and Race/Ethnicity, 2003

	Deaths from Liver Disease in the District of Columbia								
	Total			Alcoholic Liver Disease			Other Cirrhosis of the Liver		
	No.	Percent	Rate (per 100,000 pop.)*	No.	Percent	Rate (per 100,000 pop.)*	No.	Percent	Rate (per 100,000 pop.)*
Total	50	100.0	8.96	41	100.0	7.35	9	100.0	1.61
Gender									
Male	35	70.0	13.28	29	70.7	11.00	6	66.7	2.28
Female	15	30.0	5.10	12	29.3	4.08	3	33.3	1.02
Age									
0-34	2	4.0	0.72	2	4.9	0.72	0	0.0	0.00
35-54	23	46.0	14.66	20	48.8	12.75	3	33.3	1.91
55-64	14	28.0	25.87	11	26.8	20.33	3	33.3	5.54
65+	11	22.0	16.24	8	19.5	11.81	3	33.3	4.43
Race/Ethnicity									
Black	45	90.0	13.72	37	90.2	11.28	8	88.9	2.44
White	4	8.0	1.97	4	9.8	1.97	0	0.0	0.00
Native American	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
Asian/Pacific Islander	1	2.0	6.04	0	0.0	0.00	1	11.1	6.04
Hispanic	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00

NOTES: Rate based on population estimates that were prepared by the National Center for Health Statistics (NCHS) in collaboration with the U.S. Census Bureau for specific demographic groups.
SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics National Vital Statistics System as reported in the Mortality Detail Files. Multiple Cause of Death, 1999-2001[CD-ROM]. Hyattsville, MD, Author, (Special data file), 2003. Annual number of deaths with ICD-9 codes 571.0-571.9, or K70 and K73-K74 as underlying cause of death. Population estimates from the U.S. Bureau of the Census.

- In 2003, deaths from alcoholic liver disease accounted for more than four times the deaths from cirrhosis of the liver.
- Males accounted for a larger number of chronic liver disease deaths in 2003 compared to females.
- Blacks and Whites accounted for nearly all alcoholic liver disease deaths in 2003; however, Blacks and Asian/Pacific Islanders accounted for all other cirrhosis of the liver deaths.
- In 2003, individuals aged 35 to 54 accounted for nearly half of all alcoholic liver disease deaths, while individuals aged 55 to 64 accounted for nearly one quarter of the chronic liver disease deaths in the District.
- For individuals aged 35 and older, the same number of deaths occurred in each age category although those aged 55 to 64 had a higher rate per 100,000 (5.54) compared to the younger and older individuals (1.91 and 4.43 respectively).

Time Trends 1999 – 2003

Table 31: Chronic Liver Disease Deaths in the District of Columbia, by Gender, Age, and Race/Ethnicity, 1999 – 2003

	Chronic Liver Disease Deaths in the District of Columbia									
	1999		2000		2001		2002		2003	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Total	57	100.0	57	100.0	63	100.0	88	100.0	50	100.0
Gender										
Male	34	59.6	36	63.2	45	71.4	55	62.5	35	70.0
Female	23	40.4	21	36.8	18	28.6	33	37.5	15	30.0
Age										
< 34	0	0.0	0	0.0	1	1.6	0	0.0	2	4.0
35-54	24	42.1	25	43.9	32	50.8	50	56.8	23	46.0
55-64	16	28.1	12	21.1	14	22.2	24	27.3	14	28.0
65+	17	29.8	20	35.1	16	25.4	14	15.9	11	22.0
Race/Ethnicity										
Black	41	71.9	43	75.4	48	76.2	77	87.5	45	90.0
White	15	26.3	11	19.3	12	19.0	9	10.2	4	8.0
Native American	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Asian/Pacific Islander	1	1.8	0	0.0	2	3.2	0	0.0	1	2.0
Hispanic	0	0.0	3	5.3	1	1.6	2	2.3	0	0.0

NOTES: Chronic liver disease deaths include both alcoholic liver disease and cirrhosis of the liver deaths.
SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics National Vital Statistics System as reported in the Mortality Detail Files. Multiple Cause of Death, 1999-2001[CD-ROM]. Hyattsville, MD, Author, (Special data file), 2003. Annual number of deaths with ICD-9 codes 571.0-571.9, or K70 and K73-K74 as underlying cause of death. Population estimates from the U.S. Bureau of the Census.

- The number of chronic liver disease deaths peaked in 2002 with 88 deaths and decreased to the lowest number recorded in the past five years of available data in 2003.
- Males consistently account for a larger number of chronic liver disease deaths compared to females, with the largest disproportion occurring in 2001.
- Blacks accounted for the majority of all chronic liver disease deaths in the District.
- Black deaths related to chronic liver disease remained somewhat constant for all years except 2002 when a large increase (11.3%) occurred.
- Individuals aged 35-54 consistently account for a larger proportion (42-57%)of the total chronic liver disease deaths in the District than any other age range.

RECOMMENDATIONS REGARDING ALCOHOL USE

This report serves as a foundation or platform on which to base future discussions about funding and program priorities for the District of Columbia. The report highlights four consequences of alcohol use which were included using the selection criteria described in the DCEOW Process section (pages 25–26). The DCEOW members agree that there are many additional consequences related to alcohol use that remain to be analyzed. In future years, as funding permits, the alcohol use consequences will be expanded to include these additional items. In addition, further research will be conducted to explore questions raised by the data provided in this report.

For this first report, the alcohol use consequences were discussed and prioritized by the DCEOW in March 2007. The purpose of prioritizing the consequences was to develop a data-driven plan for year two and to provide recommendations to the Task Force. The prioritization process involved five steps:

1. A review of the data provided in the report
2. An assessment by core members to determine the priority status (high or low) of each consequence in the District of Columbia
3. A discussion of each consequence to identify additional elements to be analyzed in year two
4. A discussion of each consequence to provide recommendations for consideration by the Task Force
5. A review of the final prioritization results

These steps were completed by 14 core members of the DCEOW on March 1, 2007. These members represented various agencies including public health, criminal justice, academia, and public policy. The prioritization process will be further developed in year 2 as additional data is assessed for inclusion in the profile.

Once the initial consequences have been further developed and additional consequences have been added, more specific program and policy level recommendations will be possible. For year 1, the recommendations will focus on additional data analyses and research to be conducted in year 2. Eight additional recommendations are provided for the consideration of the Task Force. These recommendations are intended to guide the Task Force in the development of the District's comprehensive strategy for substance abuse prevention, treatment and control.

Year 1 Prioritization of Alcohol Use Consequences

As shown in Table 32, the results recorded from the assessment by core members of the DCEOW on March 1, 2007, were distinct enough to divide the alcohol use consequences into two priority categories (high and low). The priority level was determined by the number of individuals who elected each of the consequences as a high or low priority. The results demonstrate that violent crime, motor vehicle crashes, and past year abuse or dependence have been assessed as a high priority in the District of Columbia. Liver disease mortality was determined to be a low priority as a consequence of alcohol use in the District of Columbia.

Table 32: Prioritization of the Consequences of Alcohol Use in the District of Columbia

CONSEQUENCES	High Priority	Low Priority	Undecided	Overall Priority
Alcohol				
Violent Crimes	11	2	1	HIGH
Motor Vehicle Crashes	13	1	0	HIGH
Past year Abuse or Dependence	13	0	1	HIGH
Liver Disease Mortality	0	12	2	LOW

Year 2 Indicators and Recommendations for Additional Research

In year 2, the DCEOW will continue to monitor the initial consequences. Within year 2, more ward specific data is planned as is the exploration of an additional 19 indicators within six CSAP domains: crime and criminal justice, employment/education, reduced morbidity, retention, social connectedness, and cost effectiveness. These indicators will be used to develop such consequences as injury from motor-vehicle crashes, driving under the influence, child abuse/neglect, domestic violence, drug-related suspensions/expulsions, and the impact of alcohol use on pregnant women and their babies, health care costs, and social costs. These consequences explore profound and long lasting effects of alcohol use on District residents and the agencies that serve them. These additional consequences will be added to subsequent reports as data is identified and assessed for inclusion using the specified criteria. The additional consequences will provide the DCEOW with a deeper understanding of the effects of alcohol use in the District and will also enable the members to identify target populations for prevention programs. The additional information will enable members to begin formulating more concrete connections between alcohol consumption and related consequences adding the ability to make recommendations about funding specific types of programs.

In addition to the indicators described above, the DCEOW core members recommend that additional research be developed and conducted on the following seven topics:

1. Analysis of recidivism amongst alcohol using offenders
2. Assessment of arrest location and residence of the alcohol-related offenders
3. Analysis of causal connections between alcohol consumption and consequences
4. Geo-mapping of variables such as unemployment, crime, arrests, treatment admissions, and prevention programs related to alcohol use
5. Analysis of the relationship between the age of first use of alcohol, the amount of alcohol used, and the likelihood of developing dependency problems
6. Assessment of co-occurring alcohol use and mental illness
7. Examine why District rates of alcohol use are much higher than the overall national rate

These additional research studies will be undertaken by DCEOW involved agencies including APRA, CESAR, Howard University's Center for Drug Abuse Research, CSOSA, and the Washington/Baltimore HIDTA as funding and time allow.

Recommendations for the Mayor's Task Force

In addition to the Year 2 indicators and recommendations for additional research described above, the DCEOW core members offer eight recommendations to the Mayor's Interagency Task Force in the areas of criminal justice and public health. The Task Force is strongly encouraged to pursue each of these recommendations to ensure that DC agencies are provided with the resources they need to protect city residents and provide them with the services they need. The data collected and analyzed by the DCEOW will be used to monitor the outcomes of these efforts by assessing drug use and the consequences of drug use in the District by utilizing the indicators in this report and CSAP's prevention NOMs.

Criminal Justice

1. Involve court services in all program planning and referral processes
2. Develop mechanisms to track residence and place of crime for alcohol-related arrestees
3. Develop mechanisms to collect more detailed information for crimes related to alcohol use

Public Health

1. Support and expand outreach programs for youth and alcohol education
2. Improve coordination and communication between city agencies to ensure that individuals identified as alcohol users can be monitored across agencies and that they receive the services they need
3. Develop and conduct an annual DC survey on substance use and health (formerly the household survey) to monitor alcohol use and health related decision making by DC residents
4. Improve and expand the collection of data on alcohol use by pregnant women, babies born with fetal alcohol syndrome, and alcohol-related child abuse/neglect cases to ensure that DC's children are protected and supported as they become healthy, productive adults
5. Initiate a more comprehensive data collection process to monitor alcohol use on college and university campuses

ALCOHOL CONSUMPTION PATTERNS

For this section, we included indicators that would be useful in monitoring the consequences of alcohol use. The indicators with the most complete data have been arranged in tables to analyze trends for various demographic groups. The consumption tables included in this report do not provide a complete understanding of the alcohol use patterns in the District of Columbia. To achieve a fuller understanding of alcohol consumption patterns and demographic characteristics, additional information has been included to better examine alcohol consumption.

Alcohol Consumption Patterns

Table 33: Past Month Alcohol Use among Persons Aged 12 or Older in the District of Columbia, by Gender and Age: Numbers in Thousands, Annual Averages Based on 2002–2005 Surveys

Age by Gender	Past Month Alcohol Use	
	Any Alcohol Use (No. in Thousands)	Binge Alcohol Use* (No. in Thousands)
Total**	269	126
Male		
12-17	2	1
18-25	23	17
26-34	36	23
35-44	27	14
45-54	27	14
55-64	***	***
65 or Older	***	***
Female		
12-17	2	1
18-25	25	13
26-34	36	16
35-44	25	9
45-54	18	5
55-64	***	***
65 or Older	***	***

NOTES: *Binge alcohol use is defined as drinking five or more dinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.
** Row total may not equal column total due to the missing data in select age groups.
***Low precision, no estimate reported.
SOURCE: Substance Abuse and Mental Health Administration (SAMHSA), Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004 and 2005.

- Between 2002 and 2005, an average of 269,000 DC residents aged 12 or older reported any alcohol use in the past 30 days.
- Between 2002 and 2005, an average of 126,000 DC residents aged 12 or older reported binge drinking in the past 30 days.
- Any alcohol use and binge alcohol use was highest among male and female individuals aged 26 to 34 years old.
- Between 2002 and 2005, an average of 4,000 males and females between 12 and 17 years old, residing in the District of Columbia, reported alcohol use in the 30 days prior to completing the survey.
- Between 2002 and 2005, an average of 2,000 males and females between 12 and 17 years old, residing in the District of Columbia, reported binge alcohol use in the 30 days prior to completing the survey.

Alcohol Consumption Patterns

Additional Relevant Information

- Between 2003 and 2004, an estimated 210,000 DC residents aged 12 or older perceived drinking five or more drinks once or twice a week as a great risk.
- Almost 47 percent of individuals aged 26 or older perceived great risk in drinking five or more drinks once or twice a week compared to over 43 percent of residents aged 12 to 17 and over 35 percent of residents aged 18-25.
- In 2003, which is the most recent data available, the sale of ethanol (alcohol) in gallons per capita for the DC population aged 14 and older was 3.84 gallons per person.
- In 2003, more gallons of spirits (hard liquor) were sold per capita compared to beer and wine.

Alcohol Consumption Patterns

Table 34: Underage Alcohol Consumption among High School Students in the District of Columbia, by Gender and Grade, 1999, 2003, and 2005

	Underage Alcohol Consumption by High School Students in the District of Columbia								
	At least one alcoholic drink on one or more of the past 30 days (%)			Binge drinking* on one or more of the past 30 days (%)			First drink of alcohol (more than a few sips) prior to age 13 (%)		
	1999	2003	2005	1999	2003	2005	1999	2003	2005
Total	36.7	33.8	23.1	14.9	10.3	9.2	27.9	27.8	18.2
Gender									
Male	36.6	37.7	21.7	17.5	12.9	10.1	31.4	30.2	19.6
Female	37.0	30.4	24.5	12.6	8.0	8.5	24.8	25.6	17.0
Grade									
9th	29.9	31.3	20.4	11.4	7.8	7.3	36.0	35.3	20.6
10th	33.7	36.9	20.5	13.0	12.8	7.2	22.4	31.5	18.4
11th	40.4	26.7	27.7	16.2	9.8	8.8	29.1	18.8	18.0
12th	48.6	41.2	25.8	22.3	11.6	15.7	21.0	21.6	12.5

NOTES: *Five or more alcoholic drinks in a row, within a couple of hours.
SOURCE: Youth Risk Behavior Survey System (YRBSS), National Center for Chronic Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

- In 2005, about 23 percent of high school students in the District of Columbia reported illegal use of alcohol, while over 9 percent reported binge drinking on at least one occasion in the past 30 days.
- In 2005, 18 percent of high school students in DC reported alcohol use prior to 13 years of age.
- Overall, the percent of high school students in the District of Columbia who reported any use of alcoholic beverages and binge drinking decreased since 1999.
- In 2005, a higher percent of females reported at least one alcohol drink (24.5%) compared to males (21.7%); however, males reported a higher percent of binge drinking (10.1%) compared to females (8.5%).
- A larger percent of males reported using alcohol for the first time before age 13 (19.6%) compared to females (17.0%).
- In 2005, a larger percent of 11th graders (27.7%) followed by 12th graders (25.8%) reported at least one drink in the past 30 days.
- In 2005, a larger percent of 12th graders (15.7%) reported an episode of binge drinking in the past 30 days compared to nearly 9 percent of 11th graders and over 7 percent of 9th and 10th graders.
- In all three survey years, a larger percent of 9th graders reported drinking alcohol for the first time prior to age 13 compared to 10th, 11th, and 12th graders.

Alcohol Consumption Patterns

Table 35: Percentage of High School Students in the District of Columbia Who Reported Riding in a Car with a Drinking Driver and Driving after Drinking, by Gender and Grade, 1999, 2003, 2005

	High School Students Riding in and Driving Motor Vehicles when Alcohol is Involved					
	Rode with a driver who had been drinking on one or more occasion in the past 30 days (%)			Drove after drinking on one or more occasion in the past 30 days (%)		
	1999	2003	2005	1999	2003	2005
Total	31.4	29.1	24.1	7.6	7.2	4.0
Sex						
Male	34.4	31.9	24.8	11.8	8.2	4.9
Female	28.9	26.4	23.1	3.8	6.3	3.1
Grade						
9th	26.3	29.3	23.4	3.6	5.6	3.5
10th	32.7	30.5	22.4	7.5	8.1	3.2
11th	34.9	25.9	25.3	10.2	6.1	3.5
12th	33.0	29.7	26.3	11.3	9.1	6.7

SOURCE: Youth Risk Behavior Survey System (YRBSS), National Center for Chronic Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

- In 2005, nearly one quarter of high school students in the District of Columbia reported riding in a car in the past 30 days with a driver who had been drinking alcoholic beverages.
- In 2005, 4 percent of high school students in the District of Columbia reported drinking and driving within the 30 days prior to completing the survey.
- In 2005, almost 7 percent of high school seniors reported drinking and driving in the 30 days prior to completing the survey.
- The percent of students who reported that they rode in a car in the past 30 days when the driver had been drinking has decreased since 1999.
- The percent of students who reported that they drove after drinking in the past 30 days also decreased since 1999.

CONSEQUENCES OF TOBACCO USE

This section includes one consequence category for tobacco. The consequence includes several indicators determined to meet inclusion criteria as previously defined. Wherever possible, data with comparable national measures was selected for inclusion and presented in the report. The data provides an in-depth look at District level prevalence and severity, and ward level data if available, as well as, various demographic characteristics. Within each consequence, charts and tables are used to present the data along with key findings, and in some cases, additional relevant information. Each consequence is divided into five sections:

1. Identified Indicators
2. National vs. DC Comparisons
3. Prevalence/Severity
4. Time Trends
5. Ward Data (based on data availability)

At the end of this section, relevant consumption patterns and recommendations are provided. Tobacco use consumption patterns for the District, and in some cases national data, are included to support the data provided. Data-driven program and policy recommendations for the District are also included, based on all information provided in this section.

Consequence: Tobacco-Related Mortality

Identified Indicators

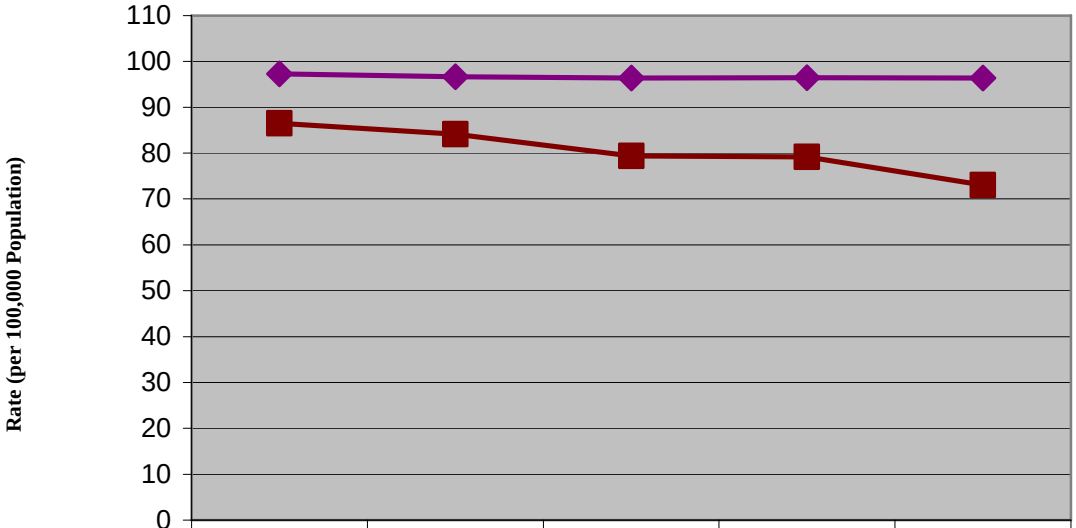
For this consequence, we included 2 indicators that are a part of the reduced mortality CSAP NOMs domain. The data presented within each of the indicators allows us to assess the prevalence of both lung disease and lung cancer as a consequence of tobacco use in the District of Columbia.

- Lung Cancer
- COPD (Chronic Obstructive Pulmonary Disease) and Emphysema

These indicators were selected in accordance with CSAP. The purpose of these selected indicators is to describe a major health consequence of tobacco use. The following chart (Figure 16) compares mortality rates for these indicators in the District of Columbia and the United States over the most recent five years of data availability. The subsequent tables take an in-depth look at DC deaths related to COPD and emphysema and lung cancer by examining gender, race, and ages affected by these diseases.

National vs. DC Comparisons

Figure 16: Annual Death Rate per 100,000 Population for Deaths from Lung Cancer, COPD, and Emphysema in the District of Columbia and the United States, 1999 – 2003



	1999	2000	2001	2002	2003
District of Columbia	86.5	84.1	79.4	79.2	73
United States	97.3	96.7	96.4	96.5	96.4
State/National Ratio*	0.9	0.9	0.8	0.8	0.8

NOTES: Rates based on population estimates that were prepared by the National Center for Health Statistics (NCHS) in collaboration with the U.S. Census Bureau for specific demographic groups.
*State/National Ratio = State Rate/National Rate.
SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics Mortality Detail Files. Multiple Cause of Death, 1999-2001[CD-ROM]. Hyattsville, MD, Author, (Special data file), 2003. Annual number of deaths with ICD-10 codes J40-J44 , J47 and C34 as underlying cause of death. Population estimates taken from the U.S. Bureau of the Census.

- Since 1999, the DC death rate related to COPD, emphysema, and lung cancer steadily decreased.
- In the past five years, DC reported the largest decrease in the death rate related to COPD, emphysema, and lung cancer between 2002 and 2003.
- Nationally, the death rate related to COPD, emphysema, and lung cancer remained fairly stable (96.4–97.3) and consistently higher than the District over the past five years.
- The state/national ratio has also remained fairly consistent (0.8–0.9) over the past five years of available data.

Prevalence/Severity 2003

Table 36: Deaths from Lung Cancer and COPD and Emphysema in the District of Columbia, by Gender, Age, and Race/Ethnicity, 2003

	Deaths from Lung Disease in the District of Columbia								
	Total: All Cause of Death			Deaths from Lung Cancer			Deaths from COPD and Emphysema		
	No.	Percent	Rate* (per 100,000 pop.)	No.	Percent	Rate* (per 100,000 pop.)	No.	Percent	Rate* (per 100,000 pop.)
District of Columbia	411	100.0	73.68	284	100.0	50.91	127	100.0	22.77
Gender									
Male	225	54.7	85.35	165	58.1	62.59	60	47.2	22.76
Female	186	45.3	63.22	119	41.9	40.44	67	52.8	22.77
Age									
0-34	2	0.5	0.72	0	0.0	0.00	2	1.6	0.72
35-54	46	11.2	29.32	42	14.8	26.77	4	3.1	2.55
55-64	69	16.8	127.49	59	20.8	109.02	10	7.9	18.48
65+	294	71.5	434.01	183	64.4	270.15	111	87.4	163.86
Race/Ethnicity**									
Black	306	74.5	93.27	221	77.8	67.36	85	66.9	25.91
White	100	24.3	49.27	60	21.1	29.56	40	31.5	19.71
Native American	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
Asian/Pacific Islander	3	0.7	18.11	2	0.7	12.07	1	0.8	6.04
Hispanic	2	0.5	4.23	1	0.4	2.12	1	0.8	2.12

NOTES: Rate (per 100,000 population) based on population estimates that were prepared by the National Center for Health statistics (NCHS) in collaboration with the U.S. Census Bureau for each specific demographic group.
SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics Mortality Detail Files. Multiple Cause of Death, 1999-2001[CD-ROM]. Hyattsville, MD, Author, (Special data file), 2003. Annual number of deaths with ICD-10 codes J40-J44 , J47 and C34 as underlying cause of death. Population estimates taken from the U.S. Bureau of the Census.

- Overall, in 2003, total deaths from lung cancer were more than twice that of COPD and emphysema.
- In 2003, male deaths from lung cancer were higher than deaths for females, while female deaths from COPD and emphysema were slightly higher than COPD and emphysema deaths for males.
- In 2003, more Blacks died from lung cancer, COPD, and emphysema than all other race categories.
- Blacks represented about 62 percent of the District's population in 2003, but accounted for 77.8 percent of lung cancer deaths and nearly 67 percent of COPD and emphysema deaths.
- Deaths from lung cancer, COPD, and emphysema occurred most often in individuals aged 65 years or older.

Time Trends 1999 – 2003

Table 37: Deaths from Lung Cancer in the District of Columbia Including Rate per 100,000 Population, by Gender, Age, and Race/Ethnicity, 1999–2003

	Deaths from Lung Cancer in the District of Columbia				
	1999	**2000**	**2001**	**2002**	**2003**
Total	299	319	314	326	284
Rate	57.6	55.8	54.9	57.1	50.4
Gender					
Male	171	171	186	198	165
Female	128	148	128	128	119
Age					
< 34	0	2	1	0	0
35-54	44	51	41	44	42
55-64	61	61	57	71	59
65+	194	205	215	211	183
Race/Ethnicity					
Black	236	256	239	256	221
White	61	60	72	66	60
Native American	0	1	0	0	0
Asian/Pacific Islander	1	1	2	3	2
Hispanic	1	1	1	1	1

NOTES: Rate (per 100,000 population) based on population estimates that were prepared by the National Center for Health Statistics (NCHS) in collaboration with the U.S. Census Bureau for specific demographic groups.
SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics Mortality Detail Files. Multiple Cause of Death, 1999-2001[CD-ROM]. Hyattsville, MD, Author, (Special data file), 2003. Annual number of deaths with ICD-10 code C34 as underlying cause of death. Population estimates taken from the U.S. Bureau of the Census.

- The number of deaths from lung cancer in the District of Columbia has fluctuated over the past five years; however, 2003 had the least number of lung cancer deaths reported (n=284) during this time period.
- The rate of lung cancer per 100,000 residents in the District of Columbia fluctuated over the past five years with the lowest recorded rate also in 2003.
- Although both males and females experienced an increase in lung cancer deaths between 1999 and 2001, the number of deaths has since decreased.
- Lung cancer deaths among Blacks account for three to four times more than deaths among White individuals each year for the past five years, although Blacks accounted for less than twice the White population in DC.
- Lung cancer deaths for individuals aged 65 or older experienced a slight decrease in 2003 compared to the number of deaths in 1999.
- Individuals aged 65 or older consistently remained the leading age group by which lung cancer deaths occurred.

Time Trends 1999 – 2003

Table 38: Deaths from COPD and Emphysema in the District of Columbia Including Rate per 100,000 Population, by Gender, Age, and Race/Ethnicity, 1999 – 2003

	Deaths from COPD and Emphysema in the District of Columbia				
	1999	**2000**	**2001**	**2002**	**2003**
Total	150	162	140	126	127
Rate	28.9	28.3	24.5	22.1	22.5
Gender					
Male	82	86	65	75	60
Female	68	76	75	51	67
Age					
< 34	0	0	0	0	2
35-54	10	4	5	6	4
55-64	13	11	17	21	10
65+	127	147	118	99	111
Race/Ethnicity					
Black	100	106	86	85	85
White	48	55	50	39	40
Native American	0	1	0	0	0
Asian/Pacific Islander	1	0	1	2	1
Hispanic	1	0	3	0	1

NOTES Rate (per 100,000 population) based on population estimates that were prepared by the National Center for Health Statistics (NCHS) in collaboration with the U.S. Census Bureau for specific demographic groups.
SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics Mortality Detail Files. Multiple Causes of Death, 1999-2001[CD-ROM]. Hyattsville, MD, Author, (Special data file), 2003. Annual number of deaths with ICD-10 codes J40-J44 and J47 as underlying cause of death. Population estimates taken from the U.S. Bureau of the Census.

- The number of deaths from COPD and emphysema in the District of Columbia fluctuated over the past five years; however, 2002 had the lowest number of lung cancer deaths reported during this time period.
- The rate of COPD and emphysema per 100,000 residents in the District of Columbia fluctuated over the past five years with the lowest recorded rate in 2002.
- Although both males and females experienced a decrease in COPD and emphysema deaths between 1999 and 2003, male deaths from COPD and emphysema were lowest in 2003 (n=60) while the female rate was lowest in 2002 (n=51).
- COPD and emphysema deaths among Blacks accounted for nearly twice that of deaths among Whites for each year in the past five years.
- COPD and emphysema deaths for individuals aged 65 or older slightly decreased in 2003 compared to the number of deaths in 1999 with the highest number of deaths reported in 2000.
- Individuals aged 55–64 years of age experienced a peak in 2002 with 21 COPD and emphysema deaths which decreased to 10 deaths in 2003.
- Individuals aged 65 or older consistently remain the leading age group by which lung cancer deaths occurred.

RECOMMENDATIONS RELATED TO TOBACCO USE

This report serves as a foundation or platform on which to base future discussions about funding and program priorities for the District of Columbia. This section highlights one consequence of tobacco use which was included using the selection criteria described in the DCEOW Process section (pages 25–26). The DCEOW members agree that there are additional consequences related to tobacco use that remain to be analyzed. In future years, as funding permits, the tobacco use consequences will be expanded to include these additional items. In addition, further research will be conducted to explore questions raised by the data provided in this report.

For this first report, the tobacco use consequence was discussed and assessed by the DCEOW in March 2007. The purpose of assessing the consequence was to develop a data-driven plan for year two and to provide recommendations to the Task Force. The assessment process involved five steps:

1. A review of the data provided in the report
2. An assessment by core members to determine the priority status (high or low) of each consequence in the District of Columbia
3. A discussion of each consequence to identify additional elements to be analyzed in year two
4. A discussion of each consequence to provide recommendations for consideration by the Task Force
5. A review of the final assessment results

These steps were completed by 14 core members of the DCEOW on March 1, 2007. These members represented various agencies including public health, criminal justice, academia, and public policy. The prioritization process will be further developed in year 2 as additional data is assessed for inclusion in the profile. Once the initial consequence has been further developed and additional consequences have been added, more specific program and policy level recommendations will be possible. For year 1, the recommendations will focus on additional data analyses and research to be conducted in year 2. Three additional recommendations are provided for the consideration of the Task Force. These recommendations are intended to guide the Task Force in the development of the District's comprehensive strategy for substance abuse prevention, treatment and control.

Year 1 Prioritization of Tobacco Use Consequences

Table 39 displays the results from the assessment by core members of the DCEOW on March 1, 2007. The priority level was determined by the number of individuals who elected the consequence as a high or low priority. An equal number of core members felt mortality should be high and low. Therefore, mortality was the only tobacco-related consequence and was deemed a medium priority within the District of Columbia.

Table 39: Assessment of the Consequence of Tobacco Use in the District of Columbia

CONSEQUENCES	High Priority	Low Priority	Undecided	Overall Priority
Tobacco				
Mortality	5	5	4	MEDIUM

Year 2 Indicators and Recommendations for Additional Research

In year 2, the DCEOW will continue to monitor the current consequence. Within year 2, more ward specific data is planned as is the exploration of an additional 17 indicators within five CSAP domains: retention, social connectedness, employment/education, reduced morbidity, and cost effectiveness. These indicators will be used to develop such consequences as exposure to advertisement, tobacco-related expulsions/suspensions, frequency of smoking, age of first smoking experience, peer influence, health care costs, and social costs. These consequences explore profound and long lasting effects of tobacco use on District residents and the agencies that serve them. They will be added to subsequent reports as data is identified and assessed for inclusion using the specified criteria. The additional consequences will provided the DCEOW with a deeper understanding of the effects of tobacco use in the District and will also enable the members to identify target populations for prevention programs. The additional information will enable members to begin formulating more concrete connections between tobacco consumption and related consequences adding the ability to make recommendations about funding specific types of programs.

In addition to the indicators included in this report, the DCEOW core members recommend that additional research be developed and conducted on the following two topics.

1. Geo-mapping of variables such as treatment admissions and prevention programs related to tobacco use
2. Analysis of the relationship between the age of first use of tobacco, the frequency of tobacco use, and the likelihood of developing dependency problems

These additional research studies will be undertaken by DCEOW involved agencies including APRA, CESAR, Howard University's Center for Drug Abuse Research, CSOSA, and the Washington/Baltimore HIDTA as funding and time allow.

Recommendations for the Mayor's Task Force

In addition to the Year 2 indicators and recommendations for additional research described above, the DCEOW core members offer three recommendations to the Mayor's Interagency Task Force in the areas of criminal justice and public health. The Task Force is strongly encouraged to pursue each of these recommendations to ensure that DC agencies are provided with the resources they need to protect city residents and provide them with the services they need. The data collected and analyzed by the DCEOW will be used to monitor the outcomes of these efforts by assessing drug use and the consequences of drug use in the District by utilizing the indicators in this report and CSAP's prevention NOMs.

Public Health

1. Initiate data collection processes to monitor tobacco use on college and university campuses
2. Support and expand outreach programs for youth and nicotine education

3. Develop and conduct an annual DC survey on substance use and health (formerly the household survey) to monitor tobacco use and health related decision making by DC residents

TOBACCO CONSUMPTION PATTERNS

For this section, we included indicators that would be useful in monitoring the consequences of tobacco use. The indicators with the most complete data have been arranged in tables to analyze trends for various demographic groups. The consumption tables included in this report do not provide a complete understanding of the tobacco use patterns in the District of Columbia. To achieve a fuller understanding of tobacco consumption patterns and demographic characteristics, additional information has been included to better examine tobacco consumption.

Tobacco Consumption Patterns

Table 40: Past Month Tobacco Use among Persons Aged 12 or Older Residing in the District of Columbia, by Gender and Age: Numbers in Thousands, Annual Averages Based on 2002–2005 Surveys

Age by Gender	Past Month Tobacco Use	
	Tobacco* (No. in Thousands)	Cigarettes (No. in Thousands)
Total**	139	123
Male		
12-17	2	1
18-25	14	12
26-34	18	15
35-44	15	12
45-54	14	13
55-64	***	***
65 or Older	***	***
Female		
12-17	1	1
18-25	13	12
26-34	15	13
35-44	12	11
45-54	10	10
55-64	***	***
65 or Older	***	***

NOTES: *Tobacco includes cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco.
** Row total may not equal column total due to the missing data in select age groups.
***Low precision, no estimate reported.
SOURCE: Substance Abuse and Mental Health Administration (SAMHSA), Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004 and 2005.

- Between 2002 and 2005, an average of 139,000 DC residents 12 years of age or older reported using tobacco in the 30 days prior to completing the survey, while 123,000 reported specifically cigarette use in the past 30 days.
- DC male and female residents aged 26 to 34 reported the highest numbers of tobacco and cigarette use compared to all other age groups.
- Between 2002 and 2005, an average of 3,000 DC residents under the age of 18 illegally used tobacco while an average of 2,000 reported illegal cigarette use.

Additional Relevant Information

- In 2002, which is the most recent data available, the number of packs of cigarettes taxed at the wholesale level per capita (persons aged 18 or older) in the District of Columbia equaled 50.5 packs per individual for the year.

Tobacco Consumption Patterns

Table 41: Tobacco Consumption by High School Students in the District of Columbia, by Gender and Grade, 1999, 2003, and 2005

	Tobacco Consumption by High School Students					
	Used some form of tobacco one or more of the past 30 days (%)			Smoked cigarettes one or more of the past 30 days (%)		
	1999	2003	2005	1999	2003	2005
Total	23.3	14.7	10.7	19.9	13.2	9.2
Gender						
Male	25.9	16.5	11.1	21.0	14.6	9.7
Female	21.2	13.2	10.4	19.0	12.0	8.8
Grade						
9th	22.1	12.2	10.3	17.8	10.9	8.7
10th	20.0	18.1	9.3	15.0	16.1	7.9
11th	26.2	14.0	14.0	25.1	12.8	11.5
12th	27.3	14.3	8.7	24.4	12.7	8.6

SOURCE: Youth Risk Behavior Survey System (YRBSS), National Center for Chronic Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

- In 2005, nearly 11 percent of high school students in the District of Columbia reported use of at least one form of tobacco in the past 30 days prior to completing the survey.
- In 2005, nearly 10 percent of high school students in the District of Columbia reported cigarette use in the past 30 days.
- Although somewhat similar, in 2005 slightly more males than females reported tobacco use and specifically cigarette use.
- In 2005, a higher percentage of 11th graders reported tobacco and cigarette use compared to 9th, 10th, and 12th grades.
- Overall, use of tobacco and cigarettes by high school students decreased since 1999.

Additional Relevant Information

- In 2005, 2 percent of high school students in the District of Columbia reported smoking 20 or more cigarettes in the past 30 days.
- In 2003, the United States reported 10.7 percent of births were from mothers who smoked during pregnancy; however, only 3.7 percent of births in the District of Columbia were born from mothers who smoked.

CONCLUSION

In conclusion, the DCEOW accomplished its goals for year 1. In year 2, we will review the epidemiological profile, and increase consistency in reporting and fill data gaps where possible. Our first step is to revise the demographic data for each of the indicators to make them consistent across drug types and consequences. To initiate this process, we developed Table 42 to illustrate the demographic data included in this report and the gaps that remain to be filled.

In addition to this process, we will also investigate the additional indicators targeted for year 2 as described in the illicit drug, alcohol, and tobacco recommendations sections and work to develop expanded ward level data.

Table 42: Demographic Variables Included in Epidemiological Profile, by Consequence, 2007

	Drug Categories	**Gender**		**Age**		**Race/Ethnicity**	
		Variable	**Included**	**Variable**	**Included**	**Variable**	**Included**
Property Crime: Burglary, Larceny/Theft, Motor Vehicle Theft	Illicit Drugs Alcohol (to be added)	M F T		<18 >18 18-25 26-49 50+		African American Caucasian Asian/Pac Island AI/AN Hispanic Non-Hispanic	
Drug-related Arrests	Illicit Drugs Alcohol (to be added)	M F T		<18 >18 18-25 26-49 50+	√ √	African American Caucasian Asian/Pac Island AI/AN Hispanic Non-Hispanic	
AIDS	Illicit Drugs	M F T	√ √	<18 >18 18-25 26-49 50+	√ √ √ √	African American Caucasian Asian/Pac Island AI/AN Hispanic Non-Hispanic	√ √ √ √ √

Hepatitis	Illicit Drugs	M F T	√ √	<18 >18 18-25 26-49 50+	√ √ √ √	African American Caucasian Asian/Pac Island AI/AN Hispanic Non-Hispanic	√ √ √ √ √
Past Year Abuse or Dependence	Illicit Drugs Alcohol	M F T		<18 >18 18-25 26-49 50+	√ √ √ √	African American Caucasian Asian/Pac Island AI/AN Hispanic Non-Hispanic	
Violent Crime	Alcohol Illicit Drugs (to be added)	M F T		<18 >18 18-25 26-49 50+		African American Caucasian Asian/Pac Island AI/AN Hispanic Non-Hispanic	
Alcohol-related Fatal Motor Vehicle Crashes	Alcohol	M F T	√ √	<18 >18 18-25 26-49 50+	√ √ √ √	African American Caucasian Asian/Pac Island AI/AN Hispanic Non-Hispanic	
Chronic Liver Disease Mortality	Alcohol	M F T	√ √	<18 >18 18-25 26-49 50+	√ √ √ √	African American Caucasian Asian/Pac Island AI/AN Hispanic Non-Hispanic	√ √ √ √ √

Tobacco-related Mortality	Tobacco	M F T	√ √	<18 >18 18-25 26-49 50+	√ √ √ √	African American Caucasian Asian/Pac Island AI/AN Hispanic **Non-H**ispanic	√ √ √ √ √
Drug Mortality	Illicit Drugs	(to be added)					