Drug Strategies

FACING FACTS

DRUGS AND THE FUTURE OF WASHINGTON, DC

Facing Factsis part of a series of city profiles supported by a grant from the Robert Wood Johnson Foundation that includes Detroit, Michigan and Santa Barbara, California. Local support for Facing Factswas provided by the Bonderman Family Foundation and the Fannie Mae Foundation. Drug Strategies also has produced profiles of alcohol, tobacco and other drug problems in Arizona, California, rural Indiana, Kansas, Massachusetts, Ohio and South Carolina.

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I. A Profile of Washington, D.C.

This report is designed to inform residents of Washington, D.C., local officials, members of Congress and U.S. policymakers about the dimensions of the problems caused by alcohol, tobacco and other drugs in the city, and about public and private initiatives to reduce these problems. The report focuses on:

- use and abuse of alcohol, tobacco and other drugs
- crime related to alcohol and other drugs
- the impact of drug use and abuse on health
- costs of drug use and abuse
- Washington, D.C.'s response to these problems

Every day, tens of thousands of nonresidents visit Washington, D.C. Some contribute to local markets for alcohol sales and illicit drug dealing. Although this profile acknowledges the interdependence of urban and suburban drug abuse trends in the metropolitan area, it focuses on the District of Columbia itself.

This profile also acknowledges the difficulty of comparing the District to states, because the District's fiscal and administrative structures are different from those of constitutionally independent states. For example, the District's crime patterns and demographic composition resemble those of other large cities far more than comparably populated states. On the other hand, the District has certain fiscal and management responsibilities, such as the Medicaid program, that are usually reserved for state or county governments. Therefore, while we provide some national, state and city-level comparisons to place District figures into context, whenever possible we use local trends, as they provide the best comparisons for the city itself.

Drug Strategies will distribute Facing Facts broadly in Washington, D.C. to elected officials, researchers, business leaders, private organizations, government agencies, educators, community groups and the media. National distribution will include members of Congress and mayors of other major cities. We hope the report will increase public understanding of drug abuse problems in the District of Columbia and generate political and financial support for more effective policies and programs.

In preparing this report, Drug Strategies consulted numerous D.C. and federal government agencies and nongovernmental organizations. A distinguished Advisory Panel guided the project, including representatives from public and private agencies with drug abuse responsibilities. Interviews with federal and local officials, community leaders, and representatives from treatment and prevention programs helped provide a comprehensive picture of public and private initiatives. While we are grateful for the insight and wisdom of those who contributed to our research, Drug Strategies is solely responsible for the content of this report.

Key Findings

Since the 1980s, drug abuse and violence have scarred the image of the District of Columbia. During the 1990s, falling budgets and government mismanagement undermined efforts to address the city's alcohol, tobacco and other drug problems. All these drugs remain easily accessible.

Washington, D.C. has not spent all of the funding available to fight drug abuse in recent years, and the city has not deployed its resources as effectively as possible. Cooperation among city agencies and with neighboring jurisdictions has been inadequate. Although the District has created one of the nation's most comprehensive databases on offender drug use, policymakers have generally lacked vital information on the city's drug use trends.

During the past decade, the city has overemphasized criminal justice at the expense of prevention and treatment, which are both in short supply. The results: although Washington spends more per capita on law enforcement than any other city in the country, crime rates remain high. Most of this crime is driven by alcohol and other drugs. Yet the city spends only $42.45 per capita on prevention and treatment—compared to $1,257 per capita on criminal justice—and regularly releases addicted prisoners without providing the treatment they need.

It is time for a fresh start, and there are many reasons to believe the District will now be able to confront its drug abuse problems more effectively. Crack use is waning, and the murder rate is falling. The federal government has assumed funding responsibility for most of the District's criminal justice system, contributing the District's $445 million budget surplus posted in 1998. Alice Rivlin, the chair of

the presidentially appointed District of Columbia Financial Responsibility and Management Assistance Authority (known as the Control Board) has been well received by local and national leaders. New police chief Charles Ramsey brings a reputation for strong management skills and innovative approaches to policing. And Anthony Williams, the new mayor, has started his term with broad political support and substantial goodwill in Congress.

Three in four D.C. residents are optimistic about the city's future—a sentiment expressed equally across each of the city's eight wards, by both African American and white residents. ***Peter D. Hart Research Associates, 1998***

These changes provide an ideal opportunity to develop a comprehensive response to the city's drug problems, as part of broader fiscal and administrative improvements in District government. Nonetheless, tremendous challenges lie ahead, and unless the city's alcohol, tobacco and other drug problems are effectively addressed, they may undermine other reforms.

To help meet these challenges, Facing Factsoffers policy recommendations in five key areas: criminal justice, prevention, treatment, information and leadership.

Criminal Justice. Drug use is widespread among criminal offenders throughout the city's justice system, but few offenders receive drug treatment while in prison, on probation or on parole. Much of the District's criminal justice system has been put under federal control. The District, Congress, and the relevant federal agencies must ensure access to drug treatment for all offenders in need.

Prevention. D.C. residents place a high priority on drug prevention, but few consider current efforts to be adequate. The District should bolster prevention activities on several fronts by raising alcohol and tobacco excise taxes, restricting alcohol and tobacco advertising in areas accessible to children, increasing enforcement against alcohol and tobacco sales to children, implementing school-based prevention programs that are proven to be effective, and providing strong support for needle exchange programs to prevent the spread of HIV and AIDS. For its part, Congress should end its prohibition on the use of local revenues to fund needle exchange efforts in the District.

Treatment. Despite treatment's proven effectiveness in reducing drug use and drug-related crime, publicly funded treatment is scarce in the District. Funding for treatment services should be increased significantly. At the same time, Medicaid eligibility and coverage should be expanded to ensure access to drug treatment services for all of the District's lower income residents. Providing treatment services through an insurance model would fold drug treatment into comprehensive health services and reduce dependence on inconsistent treatment funding. Continuity of care, which is crucial to long-term treatment success, should be built into contracts with treatment providers.

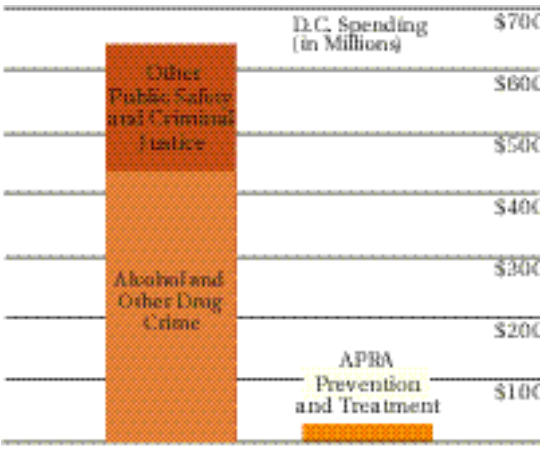
Information. Data on alcohol, tobacco and other drug use and its consequences in the District have been gathered only sporadically in recent years, and the lack of accurate, current information has seriously hampered policy planning. The District must build its capacity for data gathering and policy analysis that spans agency boundaries. The District should establish its own state-of-the-art, interdisciplinary research facility to plan and evaluate drug policies and programs, to determine how much money needs to be spent and how best to spend it.

Leadership. The wide-ranging effects of alcohol, tobacco and other drugs in the District require that the government's response be formulated at the highest level—including the mayor, relevant department heads, the D.C. Council, and while it exists, the Control Board. To sustain leadership, one official who reports directly to the mayor must be empowered to coordinate the city's overall drug abuse response, bring all the necessary players to the table and increase interagency cooperation.

Context

Washington, D.C. faces a complex array of social, economic and political challenges, and understanding them is vital, because they provide the underlying context for the city's drug abuse problems and impacts. (The Appendix provides a more detailed discussion.)

D.C. Has Spent Far More on Drug-Related Criminal Justice than on Prevention and Treatment



D.C. Addiction Prevention and Recovery Administration, 1998
Fair Budget Coalition, 1998

Demography. Urban flight and a high mortality rate have reduced the District of Columbia's tax base. The city is racially and ethnically diverse, but most residents live in wards where one racial group outnumbers others by at least six to one. Similarly, while Washington is a wealthy city, its wealth is distributed unevenly, and one in six city residents lives in poverty. Areas where poverty rates exceed 30 percent are inhabited almost exclusively by African Americans.

Public Image. In the 1980s, Washington gained notoriety following the onset of the crack cocaine epidemic and an unprecedented surge in homicides. Today, that reputation continues to dominate the city's national image. Close to home, the District is often singled out as the source of drug problems throughout the greater metropolitan area, but city health and criminal justice officials note that residents of nearby suburban communities help sustain local drug markets.

Economic and Fiscal Constraints. Since 1994 the unemployment rate among D.C. residents has been 60 percent higher than the national average, and double that of the surrounding region. In addition, the revenue most states use to help fund public programs is significantly restricted in the city. Forty-one percent of the assessed property value in the District is exempt from property taxes, primarily because the land belongs to the federal government. And the city is prohibited from taxing commuters, who take home 60 percent of the income earned there.

Federal Authority. Tensions dominate the relationship between the District of Columbia and Congress. The Constitution gives Congress authority to govern the city, although District residents do not have voting representation in Congress. In April 1995, due to budget shortfalls and mismanagement in District agencies, Congress created the District of Columbia Financial Responsibility and Management Assistance Authority (known as the Control Board). Five presidential appointees were empowered to write the city budget, hire and fire personnel, and direct some city agencies, including the public schools and police department. The 1997 National Capital Revitalization and Self-Government Improvement Act transferred authority over nine other city departments to the Control Board and mandated significant changes in the criminal justice system.

By the end of 2001, all sentenced felons in the District will be in the custody of the federal Bureau of Prisons. The federal government will pay for incarcerating them, while the District will be responsible for juveniles, misdemeanants and felons awaiting sentencing. The court system remains under local management but is funded by the federal government. By 2000, a new federal agency will assume responsibility for probation, parole and supervised release. The shift to federal funding of much of the District's criminal justice system will contribute to net savings for the city of about $170 million a year through 2002.

New Leadership. In March 1999, Congress and the President returned to the District's elected leaders the governing powers that had been stripped away by the 1997 Revitalization Act and vested in the Control Board. With passage of the new D.C. Management Restoration Act, Mayor Anthony Williams resumed control of all D.C. government operations, and the D.C. Council regained its authority to approve mayoral appointees without Control Board intervention. Unless Congress chooses to dissolve it sooner, the Control Board will maintain an oversight role until the city has balanced its budget for two more consecutive years.

II. Drug Abuse in Washington, D.C.

In 1995, alcohol and other drug abuse cost the nation $276 billion (including health care expenditures, premature death, impaired productivity, motor vehicle crashes, crime and social welfare costs), according to the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Based strictly on the District's share of the U.S. population, costs to the city would be about $600 million, but numerous indicators suggest a much greater price. For example:

- Heavy drinking is 50 percent more prevalent among D.C. adults than among adults nationwide.
- Alcohol-related mortality in D.C. is double the national rate, as is the percentage of residents who need alcohol and other drug treatment.
- Nationwide, crime and criminal justice account for nearly one-third of alcohol and other drug abuse costs. The District's crime rate is double the national rate, its murder rate is eight times the national rate, and D.C. residents are incarcerated at twice the national rate.

Extrapolating from these indicators leads to the conclusion that the costs of alcohol and other drug abuse to the District probably exceed $1.2 billion—double the population-based figure. Approximately $700 million of these costs are related to alcohol and $500 million to other drug abuse. Adding $520 million in tobacco-related illness would raise the total costs to at least $1.7 billion annually—about $3,250 per resident.

Any attempt to reduce these costs must begin with a current assessment of the District's drug abuse problems. Unfortunately, citywide surveys of adult alcohol and other drug use in the District have not been conducted since 1993, severely hampering policy planning. However, local and federal agencies plan to conduct surveys in 1999 and 2000 which will provide critical new information to help guide policy and program decisions. The following overview is based on the best figures now available.

Alcohol

Key Findings

- **Heavy drinking is far more prevalent among Washington's adults than nationwide.**
- **The city's alcohol licensing practices and high density of alcohol outlets encourage street-corner drinking and related problems, especially in African American neighborhoods.**
- **The city has far too few Alcohol Beverage Control (ABC) investigators to prevent sales to minors.**
- **The District's alcohol excise tax rates are among the lowest in the country, and revenues are not earmarked for prevention, treatment or law enforcement efforts to reduce alcohol-related problems.**

Alcohol Use in the District. The District has the third highest per capita alcohol consumption rate in the country, based on 1995 alcoholic beverage sales figures compiled by NIAAA. Drinking in Washington totals 3.89 gallons of pure alcohol per person annually—equivalent to nearly three six-packs of beer per person every week. Only Nevada and New Hampshire consume more alcohol per capita.

The city's high alcohol consumption is often attributed to tourists and commuters. But even if nonresidents accounted for one-third of the alcohol consumed in the city, per capita consumption by city residents would still exceed the national average by 20 percent. According to a survey of Americans' drinking habits conducted in 1997 for the Robert Wood Johnson Foundation (RWJF), heavy drinking is 50 percent more prevalent among District adults than among adults nationwide.[1]

[1] The RWJF survey defined "heavy drinking" as five or more drinks in a day, four or more times a month. The results may actually understate the prevalence of heavy drinking in the District because the definition of heavy drinking does not take into account beer sold in 40-ounce containers, which makes up 26 percent of beer consumed in the city. While a survey respondent who reports having two or three beers is not engaging in heavy drinking if the beers are in regular-sized containers, he or she would be engaging in heavy drinking if they were in 40-ounce containers. The survey did not ask respondents about container size, only the number of drinks.

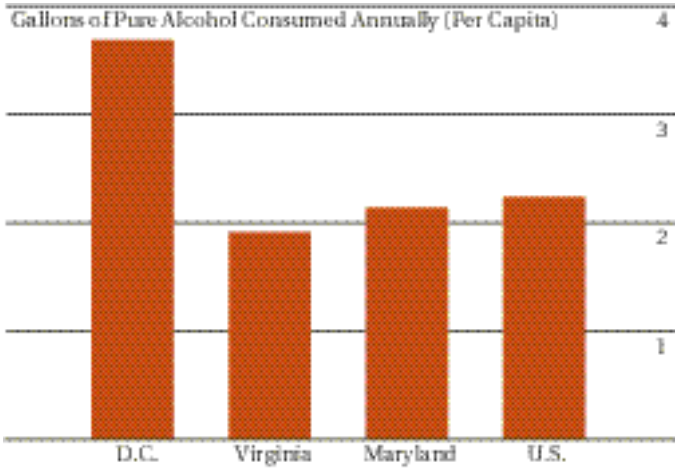
In contrast to District adults, the city's high school students' drinking rates are below the national average, according to the U.S. Centers for Disease Control and Prevention (CDC). In 1997, 38 percent of D.C. high school students reported drinking in the month before the survey, compared to half of high school students nationwide.

Half of District adults personally know someone with a drinking problem—including at least 40 percent of adults in every ward—and 35 percent know someone who regularly uses illicit drugs. *Peter D. Hart Research Associates, 1998*

Teen drinking in the District reflects generally lower rates among African American youth nationally. Fewer than one in five D.C. teens reported binge drinking (at least five drinks at a time) in the past month—about half the national rate for teens overall, but very close to the national rate among African American teens (16 percent). However, the absence of school dropouts from the CDC surveys means that actual drinking rates among District teens are probably higher.

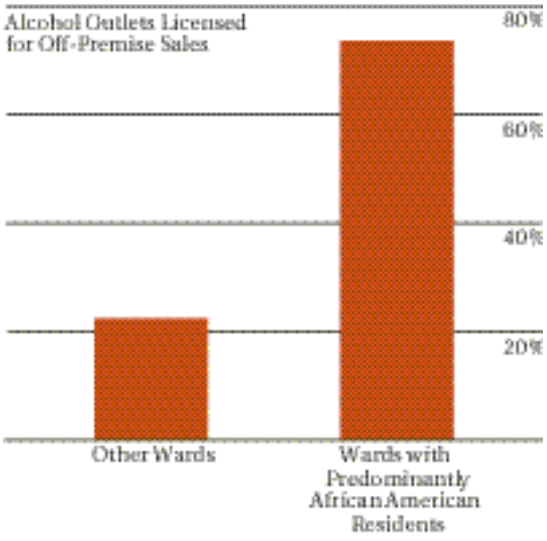
Specific data on college student drinking are not available for Washington, D.C., but experts believe that practices among D.C. students probably reflect national patterns, and those patterns are cause for concern. At least 43 percent of college students nationally are binge drinkers. Seventy percent report past-month drinking, with a weekly average of five drinks per student.

D.C. Consumes Far More Alcohol Per Person than the National Average



National Institute on Alcoholism and Alcohol Abuse, 1997

Most Alcohol Outlets in Predominantly African American Wards Sell for Off-Premise Consumption



U.S. Bureau of the Census, 1997
D.C. Department of Consumer and Regulatory Affairs, 1998

Drinking is by far the biggest drug abuse problem among the District's Latino residents. A 1998 report prepared for the Mayor's Office on Latino Affairs and the D.C.AddictionPrevention and Recovery Administration (APRA) found that Latinos in the District are nearly twice as likely to be problem drinkers than other District residents. In focus groups, Latino residents stressed that the custom of binge drinking was brought from their countries of origin, where heavy drinking is seen as sociable. The practice creates a cultural context which may condone alcohol abuse and calls for targeted prevention efforts.

Alcohol Licensing and Availability. The District of Columbia has one licensed liquor store for every 1,950 residents—nearly triple the ratio in neighboring Prince George's County and 11 times the ratio in neighboring Arlington County. Studies indicate that the number of alcohol outlets in a community (e.g., liquor store, convenience store, restaurant, bar or club) is often associated with the frequency of costly alcohol-related problems, such as motor vehicle crashes, rates of violent assaults and cirrhosis deaths.

Sales of alcohol for off-premise consumption create additional problems, such as street-corner drinking, which degrade neighborhoods. Beer Marketer's Insights (an industry newsletter) estimates that less than 30 percent of all beer sales for on-premise consumption in the District are attributable to African Americans, even though this group comprises 63 percent of city residents.

Licensing practices in Washington, D.C. may increase the likelihood of alcohol-related problems, particularly in African American neighborhoods. The 1997 RWJF survey found that 58 percent of D.C. residents favor the right of local communities to pass their own laws controlling the sale and consumption of alcohol, even if those laws are stricter than D.C. or federal laws.

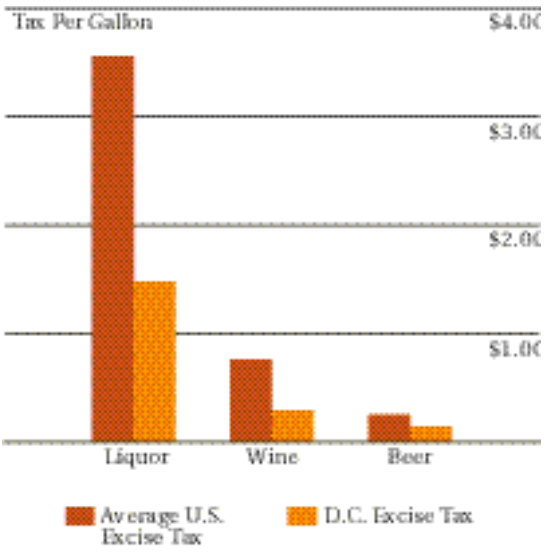
Bootleggers in the City

Bootlegging (primarily after-hours sales by licensed outlets and sales without a license) is common in the District, according to the Metropolitan Police Department. Often operating out of their cars during the hours when licensed outlets are closed, bootleggers provide round-the-clock access to alcohol in ways that are almost impossible for ABC investigators to monitor.

Reducing Youth Access to Alcohol. Police enforcement efforts against underage drinking are concentrated in the Metropolitan Police Department's (MPD) Second District, which includes five universities and the bars of Georgetown. Undercover Alcohol Beverage Control (ABC) investigators work with police officers to enforce the law, monitoring from the sidelines as volunteer minors attempt to purchase alcohol illegally at licensed outlets.

Under a U.S. Department of Transportation grant, 194 outlets were targeted by ABC-Metropolitan Police Department operations from May through September 1998, resulting in 338 citations for sales to minors. According to investigators, the vast majority of sellers cited for violations do not check a young buyer's ID.[2]

D.C. Alcohol Excise Tax Rates Are a Fraction of U.S. Averages



U.S. General Accounting Office, 1998

ABC imposes escalating penalties on violators, ranging from a $1,500 fine and three-day suspension for a first offense to a $4,500 fine and 10-day suspension for a third offense. An outlet committing four violations within a five-year period faces revocation of its alcohol license.

The problem is that ABC has only four investigators responsible for monitoring the District's more than 1,500 licensed outlets, so proprietors know they face little chance of detection. In fiscal year (FY) 1997, 32 licenses were suspended (for one to 10 days) because of illegal sales to minors—only about eight suspensions per investigator for the entire year. ABC plans to hire 12 additional investigators by spring 1999, six of whom will focus on illegal sales to minors.

The Impact of Alcohol Taxes. Like most states, Washington, D.C. imposes excise taxes (based on alcohol content) and sales taxes (based on price) on alcoholic beverages. According to a 1998 report by the U.S. General Accounting Office (GAO), the District's combined alcohol taxes (excise and sales) are higher than in many states.

[2] More than three in four D.C. residents believe that stores and bars are not careful enough in preventing teenagers from buying alcohol, according to the 1997 Robert Wood Johnson Foundation survey. Participants in a 1998 Latino community meeting on underage drinking complained that some outlets sell beer to Latino youth on credit, and insert individual cigarettes in the rings of the six-pack.

They also result in marginally higher prices for most alcoholic beverages than in Maryland and Virginia.

Nonetheless, raising alcohol excise taxes would help reduce drinking, especially among youth, whose limited resources make them particularly sensitive to price increases, according to the GAO report. While the District's alcohol sales taxes are among the nation's highest—8 percent for off-premise consumption and 10 percent for on-premise—the city's alcohol excise tax rates are among the lowest in the country. The District ranks sixth lowest for wine (30¢ per gallon) and ninth lowest for beer (9¢ per gallon). No state has a lower liquor excise tax, which has been $1.50 per gallon since it was reduced by 25 percent in 1978.

Moreover, the District's excise taxes are not indexed for inflation, so their value erodes over time. For example, the current excise tax on liquor is worth only 45 percent of its value in 1978, when the tax was last changed. The city's excise taxes amount to about 1¢ per 12-ounce beer and 6-ounce glass of wine, and 2¢ per shot of liquor.

Seventy-five percent of District residents would favor increasing alcohol taxes by 5¢ per drink, if the revenues were used to pay for programs to prevent underage drinking and to treat alcohol problems, according to the 1997 RWJF survey.[3] A dozen states earmark a portion of their alcohol excise tax revenues for prevention and treatment programs. In contrast, all revenues from Washington's alcohol excise and sales taxes—millions of dollars per year—go to the city's general fund (except for 10 percent of on-premise alcohol sales taxes, which are earmarked for the Washington Convention Center Authority Fund).

In 1997, the District's alcohol and tobacco excise tax revenues surpassed $24 million (despite low alcohol tax rates), an amount equal to the D.C. Addiction Prevention and Recovery Administration's entire treatment and prevention budget for the year.

Tobacco

Key Findings

- **While higher cigarette excise taxes have helped reduce cigarette sales and generated $150 million since 1990, this revenue is not earmarked for prevention and treatment.**
- **The District's funds from the national tobacco settlement—more than a billion dollars over the next 25 years—should be targeted toward reducing smoking, drinking and other drug use.**
- **Despite improved monitoring of tobacco sales to minors, District youth still have easy access to cigarettes, and smoking is a growing problem among them.**
- **The District's tobacco licensing agency needs the authority to impose fines and suspend or revoke a license because of sales to minors.**

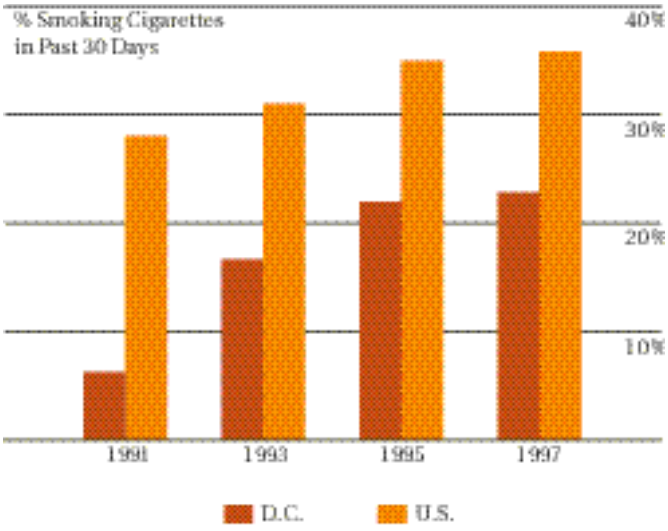
Tobacco Use in the District. Past-month smoking among D.C. high school students increased from 17 percent to 23 percent between 1993 and 1997. Although the 1997 rate is substantially lower than the national average (36 percent), it is identical to the rate for African American high school students nationwide.

Smoking rates among District adults are lower than nationwide rates. According to the CDC's Behavioral Risk Factor Surveillance System, about one in five adults in the city smoked cigarettes in 1996 compared to the national rate of 23 percent and the national African American rate of 24 percent.

Tobacco Excise Taxes and Revenues. The District's current cigarette excise tax, adopted in 1993, is much higher (65¢ per pack) than the national average (38¢ per pack) and reflects a four-fold increase from the 1990 rate (17¢ per pack). Only eight states have higher cigarette excise taxes.

[3] In a 1974 strategy paper aiming to reduce D.C. alcohol taxes, the District of Columbia Alcohol Beverage Industry noted that four of the city's five excise tax increases between 1954 and 1969 had immediately preceded or accompanied declines in consumption.

D.C. Teen Smoking Rates Rising



Youth Risk Behavior Surveillance System, U.S. Centers for Disease Control and Prevention

The District's high tax has helped reduce sales significantly. In 1990, 54 million packs of cigarettes were sold in Washington, D.C.—107 packs for every resident age 15 and older. In 1997, that number declined to 54 packs per resident.

Since 1990, cigarette excise taxes have generated more than $17 million annually for the city. However, these funds go the city's general fund and are not designated for prevention or treatment.

In November 1998, the city accepted an invitation to join the $206 billion out-of-court national settlement with the tobacco industry, which could provide the District with an estimated $1.2 billion over the next 25 years. To defray the costs of the settlement, tobacco companies have already raised cigarette prices by 45¢ per pack.

Reducing Youth Access to Tobacco. Under the 1992 Synar Amendment to the federal Substance Abuse Prevention and Treatment Block Grant legislation, all 50 states and the District of Columbia must reduce illegal sales of tobacco products to minors or risk losing federal drug abuse prevention and treatment funds. The District must reduce noncompliance to 25 percent by the year 2000.

Addiction Prevention and Recovery Administration (APRA) officials monitor illegal tobacco sales using teens posing as potential buyers. During more than 1,000 random compliance inspections throughout the city in 1998, teens under 18 were able to purchase tobacco products in 34 percent of tobacco outlets—a drop from the 1996 rate of 51 percent. However, this encouraging reduction contrasts with 1997 CDC findings that 67 percent of D.C. high school students who purchased cigarettes reported that they were not asked to show proof of age. The data suggest that experienced teen smokers can purchase cigarettes without detection far more frequently than is apparent in staged monitoring activities with volunteer youth.

In 1999, APRA will begin a new round of inspections funded through a contract with the U.S. Food and Drug Administration (FDA). APRA will present evidence of violations to the FDA, which will use its authority under federal law to assess fines against vendors ranging from $250 for the second offense to $10,000 for the fifth offense.

Under D.C. law, selling tobacco to a minor is a misdemeanor, punishable by a maximum fine of $500 or 30 days in jail (and $1,000 or 90 days in jail for a subsequent offense). The Metropolitan Police Department is responsible for enforcing the law, but officers rarely make such arrests. Allowing the police to simply issue a misdemeanor citation rather than having to conduct a full-fledged arrest could increase the level of enforcement significantly.

The D.C. Department of Consumer and Regulatory Affairs (DCRA) issues licenses to sell tobacco in the city, but lacks the authority to impose fines or to suspend and revoke a license because a vendor has sold to minors. The FDA's ability to impose steep fines against repeat offenders may go far to reduce sales of tobacco to minors in the District. But local officials suggest that even more could be achieved by enabling DCRA to impose fines and to suspend and revoke the licenses of vendors who sell to minors, in the same way that Alcohol Beverage Control (ABC) investigators can regulate alcohol licensees who engage in underage sales.

Illicit Drugs

Key Findings

- **Teenage marijuana and cocaine use are increasing in Washington.**
- **District teens can easily obtain illicit drugs, at school and in their neighborhoods.**
- **As of 1993, adult cocaine and heroin use rates in the District were twice the national averages.**
- **Today, one in three city residents knows someone who regularly uses illicit drugs.**

Illicit Drug Use in the District. In 1997, half of D.C. high school students had tried marijuana—a dramatic increase over the 12 percent of 1991. This increase is consistent with national trends, including rates among African American teens. While District teens report lower rates of cocaine use than do youth nationwide, past month cocaine use among D.C. students (2.6 percent) more than doubled from 1995 to 1997. In 1997, fewer than 3 percent of D.C. teens reported having ever injected drugs such as heroin. However, snorting high-purity heroin is reportedly on the rise among teens and young adults in the District and other U.S. cities. As for inhalants, in 1997, 11 percent of D.C. youth reported having tried them, compared to 16 percent nationwide.

One in four D.C. high school students said they were offered, sold or given an illicit drug while on school property in 1997, up 56 percent since 1993.

The most recent comprehensive surveys of illicit drug use among District adults were conducted by NIDA from 1990-1992 as part of the Washington, D.C., Metropolitan Area Drug Study (DC*MADS). The federal Substance Abuse and Mental Health Services Administration (SAMHSA) also has unpublished D.C. prevalence data for 1991-1993. DC*MADS found that in 1991, 6 percent of city residents had used illicit drugs in the preceding month—the same as the national rate. Past month marijuana use among D.C. adults in 1991 was about the same as the national rate, as were estimates of past month illicit drug use from 1991 through 1993 (7 percent vs. 6 percent). However, past month cocaine use and past year heroin use were about double the national rate from 1990 through 1993.

The D.C. Addiction Prevention and Recovery Administration (APRA) is planning to conduct a household survey of residents in 1999. In addition, the National Household Survey on Drug Abuse, scheduled for release by SAMHSA in the year 2000, will include separate prevalence estimates for each state and the District of Columbia.

Addiction Among the Homeless

Chronic, untreated drug abuse is far more common among the homeless than in the general population. In 1991, according to NIDA, 39 percent of homeless people in the District had used illicit drugs within the past month, including 33 percent who used cocaine. Seventy-five percent were drinkers, including 30 percent who consumed at least five drinks daily. Local experts report that drug abuse is more prevalent among the homeless than the 1991 figures suggest.

Availability of Illicit Drugs. The supply of illicit drugs in the District is facilitated by the proximity of three commercial airports and Interstate 95—the highway to New York City and Miami, the major East Coast wholesale drug distribution centers. Moreover, federal and local law enforcement agencies have identified more than 40 major drug trafficking organizations in the Washington-Baltimore corridor and more than 350 supporting organizations.

The Metropolitan Police Department enforces laws against illicit drug sales and possession, and the Major Narcotics Branch focuses on apprehending drug suppliers. The police have identified approximately 60 drug sales "hot-spots" in the District, many of which lie along the city's border with Maryland's Prince George's County. Washington's and Prince George's police have initiated a joint surveillance and enforcement program funded by the Office of National Drug Control Policy.

More than half of adults in Washington have seen or heard about drugs being sold in their neighborhood, and about one-third consider it a serious problem. *Peter D. Hart Research Associates, 1998*

Prevention Programs

Promising Programs

Facing Factshighlights a number of promising programs that reflect innovation in prevention, treatment, criminal justice and the workplace, many of which were suggested by members of our Advisory Panel. While the programs described are not an exhaustive list, they represent the diverse funding strategies, collaborations and designs implemented throughout the District. Wherever possible, the report highlights programs which are based on research and have demonstrated effectiveness in reducing alcohol, tobacco or other drug use.

Needle Exchange Policy

Injection drug users and their sexual partners are the fastest growing group of new HIV and AIDS cases in Washington, D.C. To help curb HIV transmission and reduce drug use, the Whitman-Walker clinic initiated a needle exchange program—an approach recommended by the American Medical Association, the National Academy of Science, the American Academy of Pediatrics and the American Bar Association. In 1996, Whitman-Walker, a community-based AIDS services provider, piloted a needle exchange program in which participants received clean needles by trading in their used ones. Funded by city revenues, by 1998 the program was operating five days a week from 12 mobile sites around the city and exchanging 8,000-10,000 needles a week for 2,000 injection drug users. Drug users were also referred to treatment programs and provided free HIV tests. Consistent with findings nationwide, participants in the Whitman-Walker program reported significantly fewer HIV risk behaviors and less drug use. Reductions included a 29 percent drop in the number of drug injections, an 18 percent drop in heroin use, and a 50 percent drop in crack use compared to the month prior to entering the program. Nevertheless, in October 1998, Congress barred the District of Columbia from funding needle exchange programs, and prohibited all federal funding for any organization that operates a needle exchange program in the District. As a result of the ban, Whitman-Walker's $220,000 needle exchange program closed. Whitman-Walker and local health advocates recently announced the formation of Prevention Works, Inc., a new, privately-funded organization, whose sole purpose will be to carry out a local needle exchange program. To learn more, call Prevention Works at (202) 939-7820.

Fighting Drugs by Helping Kids

Washington's Anacostia and Congress Heights neighborhoods are plagued by the city's highest rates of documented drug use and associated violence, plus many other socioeconomic difficulties. Covenant House Washington, a non-profit Catholic organization, helps address these problems by providing comprehensive programs for troubled youth aged 16 to 21. Since 1995, Covenant House Washington has reached nearly 13,000 children with after-school tutoring, meals, transportation, employment and GED training, spiritual counseling, life skills classes, career exploration activities and legal services. Each child is assigned a service manager to develop a long-term plan and act as the child's advocate. Children can also join a leadership group (the Anacostia Youth Congress) or travel to Europe through the Young Ambassador Program. Covenant House Washington helps sponsor youth rap sessions and forums which allow local youth to discuss drug abuse, violence and related issues with various audiences, including local policy makers. Covenant House Washington also provides a 24-hour hotline and a Mobile Outreach Support Team that patrols neighborhoods for four hours every evening. Housing and related services are available for neglected youth and young mothers and their children. Covenant House, which has headquarters in New York, is the largest privately-funded child care agency in the United States. For additional details about Covenant House Washington, call (202) 610-9600.

Coalition Confronts Tobacco

Every day, approximately 3,000 U.S. teens start smoking, even though they cannot legally purchase cigarettes. The Centers for Disease Control and Prevention (CDC) estimates that unless teen smoking rates drop dramatically, more than 5 million of today's youth will die from smoking-related

diseases, including nearly 5,000 D.C. youth. Since 1997, the 'Cause Children Count Coalition ('CCCC), part of the D.C. Smokeless State initiative, has sought to lower teen smoking rates through education, leadership training and media activities. Using materials from the American Cancer Society, 'CCCC runs a tobacco prevention and advocacy pilot program in four city schools. Weekly classes address the physical and environmental effects of tobacco, and raise awareness about the marketing practices of the tobacco industry. In 1997 'CCCC introduced a bill in the D.C. Council to prohibit outdoor tobacco advertising near facilities where children congregate. The November 1998 tobacco settlement bans tobacco advertisements larger than 14 square feet, but permits smaller signs outside retail establishments. 'CCCC launched an anti-tobacco advertising campaign in Metro buses, bus shelters, newspaper ads and flyers. Currently, the Coalition is developing tobacco control strategies for churches with the help of the Congress of National Black Churches. 'CCCC is funded by the Robert Wood Johnson Foundation, Bell Atlantic, the D.C. Department of Health and the Cafritz Foundation. To learn more about the 'Cause Children Count Coalition, call (202) 986-4500.

Filling a Void for Latino Youth

The support and guidance of adult role models can play a crucial role in helping young people avoid drugs. Hermanos y Hermanas Mayores (Big Brothers/Big Sisters) provides these important mentors for Latino youth. The program matches adult volunteers—after a rigorous screening process—with Latino youth in single-parent families, and then encourages one-on-one relationships to develop on their own. According to an evaluation of the national Big Brothers/Big Sisters program conducted between 1992 and 1995, youth who participate are 46 percent less likely to start using illegal drugs and 27 percent less likely to start drinking than nonparticipating youth. Minority participants are 70 percent less likely to start using illegal drugs than their nonparticipating peers. Funded by the United Way, private foundations and individuals, Hermanos y Hermanas Mayores-Washington, D.C. is one of ten Big Brothers/Big Sisters of America programs specifically designed for the Latino population. Since 1904, Big Brothers/Big Sisters of America has developed more than 500 local agencies. For more information on Hermanos y Hermanas Mayores, call (301) 587-0021.

After-School Activities Help Kids Succeed

Approximately one-third of all violent juvenile crimes occur between 3:00 p.m. and 7:00 p.m., when many children are unsupervised. After-school programs can help keep kids out of trouble. In 1991, Myrtle Loughry started The Children's Center in an Anacostia housing project plagued with drug use and crime. Ms. Loughry had no trouble finding youth who could benefit from an after-school safe haven. The Children's Center, now housed at Wilkinson Elementary School, serves 75 children. On weekdays during the school year, the program offers homework assistance, computer education, arts and crafts, organized team sports, and a mid-afternoon snack. The program operates from 3:15 p.m. to 7:00 p.m. The Center also works with students' primary teachers to help build individualized education plans. The summer program runs from 11:30 a.m. to 6:30 p.m., and includes field trips, a parent-child project, and camping opportunities. Both programs are free to participants. For several years, the D.C. Public Schools Lunch Program donated lunches for summer program participants through a collaboration with D.C. Hunger Action. The Children's Center is funded primarily by the Bonderman Family Foundation. To learn more, call (202) 610-5443.

III. Impact on Crime

Drug abuse and crime are closely intertwined in Washington, D.C. The majority of arrestees in the District test positive for illicit drugs at the time of arrest. Alcohol and other drugs are significant factors in many homicides in the city. Drug offenders comprise nearly 30 percent of the D.C. prison population and serve twice as much prison time as drug offenders nationwide.

Criminal justice partnerships providing drug treatment to offenders are known to reduce recidivism and drug use among offenders. However, both in prison and in the community, treatment historically has been inadequate in the District. Indeed, while nearly 70 percent of all arrestees test positive for illicit drugs at the time of arrest, fewer than 10 percent of criminal offenders receive drug treatment.

To remedy this problem, the District has launched innovative efforts such as a drug court and pretrial testing with graduated sanctions. Results are very promising, and efforts are now underway to expand access to quality services.

Arrests and Drugs

Key Findings

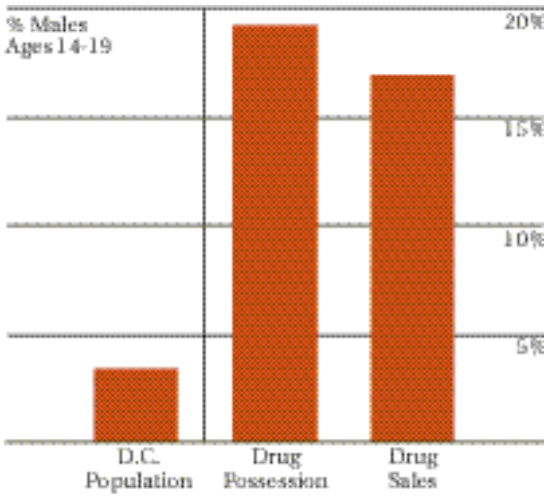
- **Although drug arrests have declined among District adults since the early 1990s, they are rising among youth.**
- **Drug use is pervasive among arrestees in the city regardless of offense.**
- **Nonresidents account for the majority of arrests for driving under the influence (DUI) in the District.**

The Metropolitan Police Department has made nearly 72,000 arrests for drug offenses since 1990, an average of 150 drug arrests every week.

Trends in Adult Drug Arrests. Between 1990 and 1997, adult arrests for drug offenses in Washington, D.C. dropped 23 percent, from 8,849 to 6,799. Eighty-seven percent of these arrests were for drug possession. Drug arrests made in 1997 were predominantly for cocaine and heroin (57 percent) and marijuana (42 percent). Adults between ages 18 and 24 accounted for about half of marijuana arrests, one-quarter of arrests for cocaine or heroin possession, and 29 percent of cocaine or heroin sales arrests.

Juvenile Drug Arrests Reveal Risks to Youth. In 1997, 617 youth were arrested for drug offenses, a 37 percent increase over 1992. As with adults, most juvenile drug arrests are for possession (89 percent), not sales. In 1997 cocaine and heroin arrests comprised 52 percent of juvenile drug arrests, and marijuana 47 percent. Boys aged 14 to 19 comprise just 3 percent of the District's population but account for 19 percent of all drug arrests in the city.

Teen Males Overrepresented in Drug Arrests



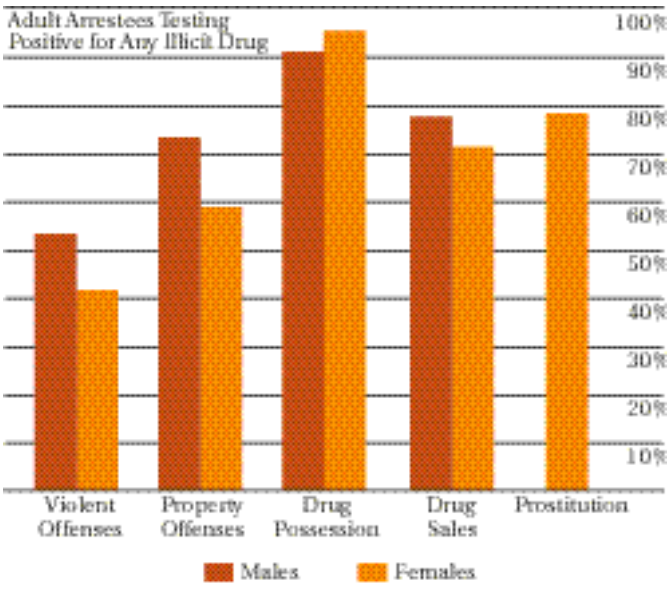
D.C. Metropolitan Police Department, 1997
U.S. Bureau of the Census, 1997

Stemming Youth Drug Sales

According to a 1990 RAND study, at least half of teenage drug dealers in the District at the height of the crack cocaine epidemic also had drug habits. Fewer than one in five had a high school diploma. The report concluded that the best way to reduce drug sales by youth would be to reduce the demand for drugs through prevention and treatment.

Drug Use Among Arrestees. In 1997, more adult males arrested in the District tested positive for an illicit drug than did male arrestees nationwide (69 percent vs. 67 percent), and the same was true of juvenile male arrestees

Drug Use Widespread Among D.C. Arrestees

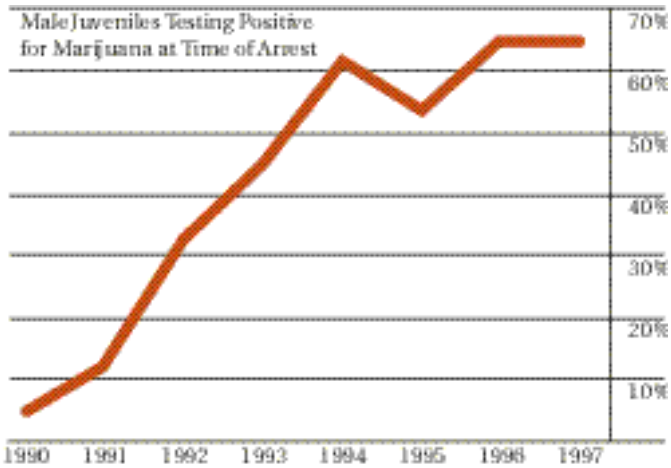


U.S. Arrestee Drug Abuse Monitoring Program, 1998

(66 percent vs. 59 percent). But among women, the rate was lower than average (57 percent vs. 67 percent).

Cocaine use has decreased significantly among offenders. In 1997, 39 percent of women arrested in the city tested positive for cocaine, compared to 74 percent in 1989. The pattern holds true for adult men and juvenile boys. However, in 1997, more than 64 percent of Washington's juvenile arrestees tested positive for marijuana, compared to just 6 percent in 1990.

Marijuana Use Has Increased Significantly Among Juvenile Arrestees



U.S. Arrestee Drug Abuse Monitoring Program (formerly Drug Use Forecasting), 1991-1998

Drinking and Driving. In 1996, 2,788 people were arrested in the District for driving while intoxicated (DWI) or driving under the influence (DUI)—a 23 percent drop from 1993.[4] Between 1992 and 1996, drunk driving arrests in the city involved more nonresidents (63 percent) than residents (37 percent). Of the nonresident arrestees, three in five were from Maryland or Virginia.

Forty-seven percent of residents placed on probation for DUI/DWI in 1997 tested positive for an illicit drug while on probation; almost half also had prior drug or alcohol arrests in the city.

Approximately 75 percent of Washington's drunk driving offenders are eligible for diversion rather than prosecution. Those who complete the program (which includes education on drunk driving hazards, relapse and family patterns of alcohol abuse) can avoid a conviction and its consequences, such as higher auto insurance premiums. In 1998, 891 people enrolled in the diversion program, 729 of whom completed it.

Making the Grade?

In 1993 Washington received a "C" in a national report card published by Mothers Against Drunk Driving (MADD), which evaluates DUI laws and policies across the country. While MADD's evaluation highlighted the city's strengths in record-keeping and activities for youth, it called for improvement in enforcement, prevention, legislative action and regulatory control. MADD was unable to evaluate several aspects of the city's DUI response, due to lack of data or unresponsiveness from city officials. D.C. will be included in MADD's year 2000 report card.

[4] Effective March 1999, drivers in the District with a blood alcohol concentration (BAC) level of .08 grams per deciliter or more are, by law, driving while intoxicated (DWI). Drivers with a BAC level higher than zero but less than .08 can be charged with driving under the influence (DUI). Drunk driving charges in the District can include alcohol and other drug use, and offenders commonly use both.

Alcohol- and Other Drug-Related Violence. The District's homicide rate has fallen by a third since 1996 but remains among the highest of any U.S. city. Since 1985, murders in the District have occurred at triple the rate in 17 comparably sized cities.[5]

Alcohol abuse, illicit drug trafficking and drug use are often linked to homicides. Between 1992 and 1997, the Metropolitan Police Department classified one-third of city murders with known motives as "drug-related." Data on the number of alcohol-related homicides in the District are not available, but other indicators suggest that the incidence in D.C. is at least as high as the national rate. Nationwide, 45 percent of imprisoned murderers report having been drinking heavily at the time of their offense, and heavy drinking is 50 percent more prevalent among District adults than among adults nationwide. Therefore, conservatively estimated, at least two-thirds of District homicides appear related to alcohol and other drugs.

The crack cocaine epidemic which began in the mid-1980s was a key factor in the rising homicide rate. Adult-run heroin markets were destabilized by younger, more violent crack dealers. Homicides more than tripled as the epidemic unfolded, rising from 148 in 1985 to 482 in 1991. Although cocaine use has declined, the District's 260 murders in 1998 still exceeded by 75 percent the number of murders in 1985, before crack hit the streets.

Courts and Sentencing

Pretrial Drug Testing. Washington was the first city in the country to test arrestees for drugs as a condition of pretrial release. Since 1983, defendants testing positive for drugs upon arrest also have had regularly scheduled drug tests prior to their court dates, with results forwarded to the judge. Juvenile offenders and parents charged in child abuse and neglect cases are also subject to court-ordered drug testing.

Key Findings

- **Although Washington tests offenders for drugs as a condition of pretrial release, the test-result database is a largely untapped source of information, including data on which offenders with chronic drug problems received treatment.**
- **The proportion of felons imprisoned for drug offenses in Washington substantially exceeds the average among the 50 states, and convicted drug offenders in Washington serve twice as much prison time as the national average.**

However, the pretrial release database is a largely untapped source of information. Despite inadequacies in the data, Drug Strategies was able to study some recidivism patterns and addiction treatment needs among some defendants on pretrial release in 1996.[6] Thirty-seven percent of defendants charged with drug offenses had previous drug convictions, as did 31 percent of those charged with property offenses, 25 percent of those charged with public order offenses and 11 percent of those charged with violent offenses. Among those with previous convictions for any offense, drug use was common prior to their 1996 arrest: 66 percent had tested positive for cocaine, 23 percent tested positive for opiates, and 35 percent tested positive for PCP at least once. Two-thirds of these repeat offenders tested positive in at least half of their drug tests.

Pretrial release defendants who know they are being monitored for drug use by the court have strong incentives to stop using. Judges can use positive drug tests to revoke a defendant's pretrial release or to impose a tougher sentence. Under these conditions, a defendant's

[5] Young African American men have borne the brunt of D.C.'s violence. In 1993, black men aged 18 to 24 comprised 33 percent of all murder victims in D.C., even though they made up only 3 percent of the city's population. The homicide victimization rate for this group peaked in 1991 at nearly 800 per 100,000—higher than the casualty rate of U.S. military personnel serving during the Vietnam War (665 per 100,000).

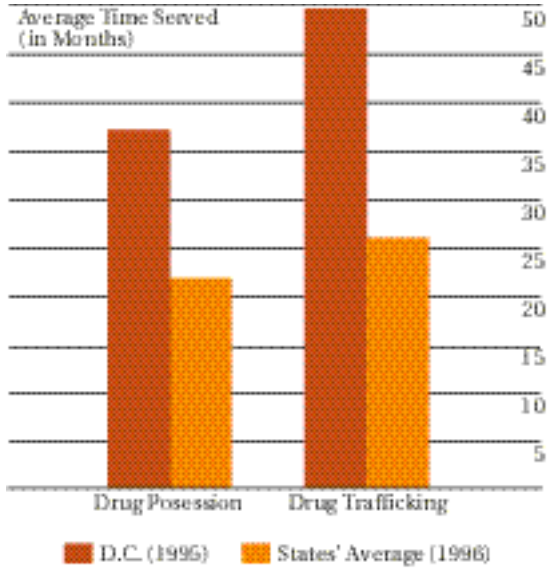
[6] Analysis included arrestees who were drug tested at the time of initial lock-up (voluntarily, prior to any court-ordered test). Between 60 and 80 percent of offenders generally are tested. In working with pretrial release data from the first half of 1996, Drug Strategies discovered that treatment information was not recorded consistently, and sentence length was recorded in general rather than specific terms (e.g., offenders with sentences ranging from one to five years all received the same code). These limitations made it impossible to explore many of the research questions such a data set could potentially illuminate.

continuing drug use is a good indicator of a chronic drug habit which the defendant cannot control.

Among defendants given at least five drug tests while on pretrial release, two-thirds tested positive at least half the time. These defendants have drug habits they cannot stop even with powerful incentives to do so. (Only one in four defendants on pretrial release never tested positive for illicit drugs).

Providing court-supervised treatment to defendants with chronic drug problems would be a cost-effective strategy for reducing recidivism and drug use.[7] Unfortunately, the pretrial database does not indicate how many of this group received treatment.

D.C. Drug Offenders Serve More Prison Time than the National Average



National Corrections Reporting Program, 1996

Tough Sentences for Drug Trafficking. Of the 7,687 imprisoned felons in Washington in 1997, 29 percent were convicted of drug offenses, compared to 21 percent of prisoners in the 50 states. Convicted drug offenders in Washington serve an average of four years in prison—twice as long as the average time served in the states, and 20 percent longer than the average time served in federal prisons. In the District, incarcerating drug offenders costs $164 million annually.

Unlike most states, the District does not mandate minimum sentences for nonviolent drug offenses. Since mandatory minimum drug laws were repealed by the D.C. Council in 1994, the number of D.C. inmates serving mandatory minimum sentences has dropped from 973 to 180. For a first offense for selling heroin or cocaine, the maximum prison sentence in the District is 30 years, the same as the states' average. By comparison, D.C. penalties for marijuana sales are fairly light; 42 states impose longer sentences than the District's one year maximum.

Sentencing provisions in the 1997 Revitalization Act will result in stiffer penalties for drug offenders. Under the 1997 Act, sentences for second and subsequent drug offenses committed after August 2000 must follow the "truth-in-sentencing" standard enacted in the federal Violent Crime Control and Law Enforcement Act of 1994. The law requires that prisoners serve at least 85 percent of the sentence imposed without parole. For repeat cocaine or heroin dealers in the District, application of the 85 percent rule to the maximum allowable penalty would result in 51 to 60 years in prison. A repeat conviction for selling cocaine or heroin to a minor could result in life in prison if the maximum penalty is applied (153 to 180 years).

Sentencing for Drug Possession. The city's penalties for drug possession are lighter than in most states. Cocaine or heroin possession carries a maximum penalty of six months in jail in the District, compared to the states' average of 8½ years. Marijuana possession also carries a maximum penalty of six months in jail, compared to the states' average of more than two years.

In November 1998, District residents voted on a ballot initiative that would legalize marijuana use by seriously ill

[7] The link between drug abuse and crime is not new, and the District's own history has shown that increasing drug treatment capacity can reduce crime. Beginning in 1970, the Nixon administration—in search of quick reduction in crime—sponsored a rapid expansion in the availability of drug treatment in the District. By the end of 1970, the District's new Narcotics Treatment Administration (NTA) was treating more than 2,500 people. That year, the national crime rate rose 11 percent, but crime in the District fell 5 percent, with most of the reduction occurring after the NTA had become fully operational. The success in Washington spurred the Nixon administration to increase treatment capacity in other cities. In 1972, the national crime rate fell 3 percent—the first decline in 17 years—and the District's crime rate dropped 27 percent.

residents if recommended by a physician. However, the results remain unknown because Congress has barred the city from spending any FY 1999 money on activities related to the initiative, including counting the vote. The District government has filed suit in federal court to override the congressional action and permit the results to be released, arguing that Congress has violated the free speech rights guaranteed to District residents by the First Amendment. The court's decision was still pending in March 1999. If the court has not ruled by October 1, 1999, and if Congress does not extend the ban, the District will be free to count and certify the medical marijuana vote using FY 2000 funds.

Offender Supervision and Treatment

Key Findings

- **Few prison inmates and probationers in the District receive the drug treatment they require.**
- **Keeping inmates in jail waiting for treatment costs the city hundreds of thousands of dollars per year.**
- **Those who complete court-supervised or prison-based treatment consistently show reduced drug use and recidivism.**
- **Drug testing and threats of sanctions are powerful tools for reducing drug use, yet only about 4 percent of the District's probationers and parolees are subject to regular drug testing.**
- **New programs underway in the District will help address these shortcomings.**

Sentenced Offenders. Drug treatment is currently available only for prisoners held at the facility in Southeast D.C. run by the private Corrections Corporation of America (CCA). CCA provides therapeutic community (TC) programs that serve 256 inmates, with a waiting list of 50 to 75 inmates for the adult male program.[8]

By the end of 2001, all of the District's sentenced felons will be in the custody of the federal Bureau of Prisons (BOP), which is required to provide treatment to addicted prisoners on demand.[9] Interim data from a 1998 evaluation of BOP's residential programs show that six months after release, inmates who completed treatment were 73 percent less likely to be rearrested and 44 percent less likely to use drugs than those who were eligible for treatment but did not participate.

In about half of probation sentences the court requires participation in drug treatment. Judges base their sentencing decisions on an offender's pretrial drug tests, drug use history and a formal assessment of treatment need (using the Addiction Severity Index). Limited treatment availability, however, prevents the majority of offenders who are referred for treatment from receiving services. Currently, only 17 percent of the 4,600 offenders referred for drug treatment actually receive it. Some offenders mandated into treatment must remain in jail while waiting for beds to become available.[10] New contracts to provide 120 residential treatment beds and 200 outpatient slots for offenders were awarded in August 1998; now operational, these new slots may help alleviate the long waits.

The Promise of D.C.'s Drug Court. Drug courts send nonviolent drug abusing offenders to intensive court-supervised treatment instead of probation or prison. Research has shown that drug courts can substantially reduce drug use and criminal behavior while offenders participate in the program and reduce recidivism by one-third to one-half after completion.

The D.C. Superior Court Drug Intervention Program (or drug court) was established in 1993 as a collaborative

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[8] Until 1997, the D.C. Department of Corrections provided TC treatment at its medium security Central Facility in Lorton, Virginia. The contract for this program, which served 236 inmates, expired in August 1997 and has not been renewed.

[9] In 1997, fewer than 10 percent of federal inmates nationwide participated in BOP's 42 residential treatment programs, which provide a minimum of 500 hours of treatment.

[10] At mid-year 1998, for example, 159 D.C. residents on probation or parole were on waiting lists for court-mandated drug treatment, and another 45 inmates remained incarcerated awaiting inpatient placement or treatment assessment. Keeping this group of inmates in jail rather than in treatment costs taxpayers an additional $41,850 for one month; added costs for a full year exceed $500,000.

effort among criminal justice agencies. The demonstration project included a treatment track (providing treatment closely supervised by the court), a sanctions track (providing graduated sanctions for pretrial release violations such as positive drug tests), and a standard court docket, with random assignment of eligible offenders to each track.

Preliminary results from a 1997 evaluation by the Urban Institute found that offenders in the treatment and sanctions tracks were more likely to be drug-free the month before sentencing (20 percent and 32 percent, respectively) than those in a standard court docket (13 percent). Moreover, participants in the graduated sanctions docket had significantly fewer arrests in the year following sentencing than those in the standard docket. Urban Institute researchers anticipate that the final report will confirm the positive findings of the preliminary study.

Building on lessons learned from this demonstration project, the D.C. drug court has now combined the treatment and sanctions tracks. The program is available to misdemeanor and nonviolent felony defendants. The D.C. Superior Court also has a federal grant to start a juvenile drug court, which is expected to open in 1999.

The District's Treatment HIDTA. Established in 1994, the Washington-Baltimore High Intensity Drug Trafficking Area (HIDTA) program is one of only four "treatment" HIDTAs in the country. In addition to law enforcement activities to reduce drug trafficking, the program funds a variety of drug abuse treatment programs for offenders; about one-third of the funds support direct treatment services.

Like the drug court, the HIDTA program uses frequent drug testing and immediate court-imposed jail sanctions to discourage offenders from resuming drug use. Although the average HIDTA client has a history of frequent arrests, an evaluation of 1,700 participants in drug treatment during 15 months in 1996-1997 found that during treatment only 12 percent of participating offenders were arrested for new crimes, compared to a national rearrest rate of 50 percent for comparable offenders.

In FY 1998, the HIDTA program provided $1.2 million to place 120 offenders in residential treatment and nearly 500 offenders in outpatient treatment in the District. However, as part of the October 1998 reauthorization legislation for the federal Office of National Drug Control Policy, Congress prohibited the use of HIDTA funds to establish new treatment programs or expand existing ones.

Expanding Testing and Treatment for Criminal Offenders. According to the Trustee for the District's Court Services and Offender Supervision Agency (CSOSA), each year about 3,000 felons return to the community with minimal transition assistance or supervision. In FY 1998 almost half of parolees and probationers tested positive for drug use at least once. Yet less than 5 percent of the District's 11,000 probationers and less than 2 percent of the 7,000 parolees are currently subject to regular drug testing.

Historically, effective offender supervision has been impeded by the lack of intermediate responses. Offenders typically come before the court only after multiple violations, when full revocation of pretrial release or probation often results. Based on the drug court model, CSOSA plans to institute graduated sanctions for specific violations and to expand treatment capacity significantly. Currently, offenders on probation or parole compete with members of the general public for limited treatment capacity.

Implementation of CSOSA's plans will depend on congressional funding. For FY 1999, Congress appropriated only $3.4 million of the $9.2 million requested for the city's drug court and drug testing, and none of the $5.6 million requested for offender treatment. Of the $102 million appropriated for CSOSA for FY 1998-99, Congress provided no funding specifically for treatment. The Trustee, however, allocated $876,000 for treatment in 1998 and $750,000 in 1999.

The 1994 California Drug and Alcohol Treatment Assessment (CALDATA) found that every dollar invested in treatment yielded $7 in taxpayer savings, primarily due to reduced crime and criminal justice costs.

Criminal Justice Programs

Giving Youth Better Choices Than Drugs

With a staff that includes former convicts and recovering drug abusers, the Alliance of Concerned Men focuses on changing the attitudes of youth living in D.C.'s drug- and crime-infested neighborhoods. Formed in 1991 by alumni of the District's Eastern High School, the Alliance offers drug education classes, visits to drug treatment programs, job training, tutoring, life-skills sessions, workshops and child reunion for incarcerated fathers. Youth are referred to the program by community organizations, the courts, the Metropolitan Police Department and the D.C. Housing Authority. The Alliance also has a successful history of reducing gang violence, which is often related to drug sales. In 1997, the Alliance brokered a truce between gangs in the Benning Heights Public Housing neighborhood, ending a string of gang-related homicides in that area. To date, there have been no more gang-related murders in Benning Heights. With offices in the Northwest and Southeast quadrants of the District, the Alliance served up to 500 youth in 1997. For more information, call (202) 645-5097.

Preventing Abuses Among Female Inmates

At least half of all women in state prisons suffer from alcohol and other drug abuse, and up to 88 percent are victims of domestic violence and sexual or other physical abuse. The National Women's Law Center created the Women in Prison Project (WPP) in 1990 to empower women with education and legal advocacy. WPP (now run by the D.C. Prisoners Legal Services Project) helps end the cycle of drug addiction and sexual and physical abuse. In 1995, WPP published a resource guide for incarcerated women, followed by a 1998 manual entitled An End to Silence: A Women Prisoners' Handbook on Identifying and Addressing Sexual Misconduct. The first of its kind, the handbook informs incarcerated women across the U.S. about accessible legal services and information about inappropriate sexual conduct in prisons. To date, WPP has provided free legal counseling and advocacy to more than 1,500 women incarcerated by the D.C. Department of Corrections and the federal Bureau of Prisons. For more information, call (202) 775-0323.

Making Anti-Drug Laws Hit Home

Washington lawyers do not need a courtroom to fight drug crimes. Just ask the Young Lawyers Section of the Bar Association. Based on the premise that drug dealing leads to other neighborhood crimes and lowers property values, a group of 40 volunteer attorneys formed Operation Crackdown. They work with community groups to force nuisance property owners to eliminate drug activity by evicting problem tenants, installing outdoor lighting and hiring security guard to patrol the property. Operation Crackdown also provides free legal assistance to disgruntled neighbors. During its first three years, Operation Crackdown handled 70 cases and closed 15 crack houses. Ninety-seven percent of the complaints never reached the civil courts because the threat of a lawsuit was enough to make property owners comply. Recently, Operation Crackdown attorneys helped enact an emergency bill—the Drug-Related Nuisance Abatement Act of 1998—that will make it easier to sue homeowners who allow drug-related activity on their properties. To learn more, call (202) 828-3643.

Mobile Counseling for Prostitutes

Every night, about 500 prostitutes work the streets of the nation's capital. Drug use is pervasive among them, and only one advocacy organization in the city addresses their needs: Helping Individual Prostitutes Survive (HIPS). Every Friday and Saturday from 10:30 p.m. until 5:00 a.m., HIPS workers travel the streets in a mobile unit, dispensing condoms, coffee, cocoa and on-the-spot professional counseling. In addition to referring prostitutes to drug treatment programs and other resources, HIPS provides free HIV testing (one-fourth of Washington's prostitutes are HIV-positive), a 24-hour hotline, a drop-in center, food, clothing and legal help. Each year HIPS makes an estimated 3,000 contacts with prostitutes in the city. Since the organization's creation in August 1993, HIPS has helped some 100 teenagers escape from prostitution. A sergeant from the Metropolitan Police Department serves on the HIPS' Board of Directors to ensure cooperation between the program and law enforcement. For more information, call (202) 543-5262.

IV. Impact on Health

Alcohol, tobacco and other drugs affect the health and well-being of District residents who use them as well as those who do not, while adding to the city's health care costs. Drug abuse plays a significant role in automobile accidents, chronic illness, hospital emergency room visits, newborn health problems, mental illness and the spread of infectious disease. Drug abuse contributes to the city's unusually high death rate, which is 41 percent above the national average.

Drug-Related Illness and Death

Key Findings

- **A large proportion of the city's emergency room visits are related to drug abuse.**
- **Smoking is extremely costly to the District's health, in terms of both lives and dollars.**

Emergency Room Visits. Out of 1.2 million ER visits in the Washington metropolitan area each year, an estimated 457,000 patients are under the influence of alcohol at the time of their visit. In 1996, illicit drugs were a factor in 18,448 ER visits in the Washington metropolitan area (including the suburbs), according to the Drug Abuse Warning Network (DAWN). Cocaine, which accounted for 54 percent of ER drug episodes in 1989, accounted for 30 percent in 1996 but remains the leading cause of drug emergencies in the city. Next is heroin, causing 13 percent of ER drug visits in 1996.

Tobacco-Related Deaths and Costs. Smoking is the leading preventable cause of premature death in Washington and the nation. Smoking-attributable conditions (such as cancer, heart disease and sudden infant death syndrome) cause more than 1,700 deaths annually in the city, according to the CDC. Indeed, the CDC projects that 4,927 youth in the District today will die prematurely due to smoking.

Smoking costs the District about $520 million annually, including $315 million in direct medical care and $205 million in productivity loss and premature death. At $680 for every adult resident, the District's medical costs attributable to smoking exceed the national average by nearly 80 percent.

Alcohol and Other Drug Deaths. Between 1990 and 1995, at least 426 people in the District died of alcohol-related diseases. An additional 137 people died from other drug-related causes during that period, according to the CDC. These are conservative estimates which only include deaths directly attributable to alcohol or other drug use; drug abuse also contributes to deaths attributed to other causes, such as fatal burns, suicides, homicides and infant deaths.

Between 1988 and 1996, 540 people died in traffic crashes in the District, almost half of which involved alcohol use by at least one driver. The National Highway Traffic Safety Administration estimates direct and indirect costs for each such fatality at $2.85 million.

The number of fatalities related to drinking and driving is not carefully measured in the District. In 1996, only 19 percent of drivers involved in fatal accidents in the city were tested for alcohol—less than half the national testing rate (44 percent).

Impact on Children

Key Findings

- **Parental drug abuse is involved in the overwhelming majority of the District's child abuse, neglect and foster care cases.**
- **Foster care for children whose parents have addictions costs the city tens of millions of dollars annually.**
- **Caring for low birth weight infants exposed to alcohol and other drugs during pregnancy costs an additional $6 million each year.**

Child Welfare Cases and Addiction. In Washington, D.C., parents accused of abuse and neglect are drug tested as a condition of pretrial release. The drug test results become part of the court record and can be used in making custody determinations at trial.

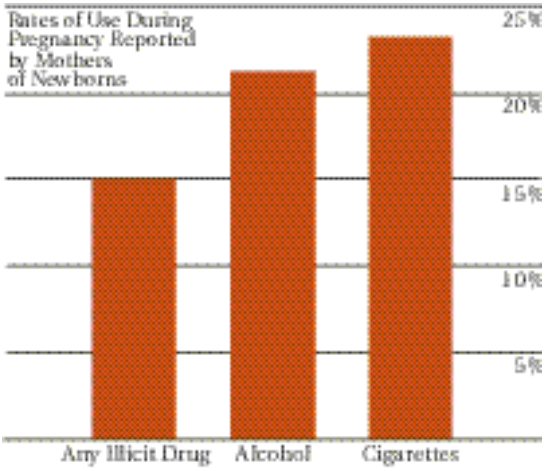
Among the District's 2,500 child protective cases, 85 percent involve a parent who abuses alcohol or other drugs. Similarly, parental drug abuse is a factor in 75 percent of the child foster care cases in Washington,

D.C., according to the Metropolitan Washington Council of Governments. The figures are consistent with a U.S. General Accounting Office report, which found that parental alcohol and other drug abuse contributes to 78 percent of foster care cases nationwide.

Washington's expenditures for alcohol and other drug-related foster care cases range from $11 million to $24 million annually. Children in the foster care system are also at increased risk for later drug use and delinquency.

Impact of Drugs on Newborns. One in seven pregnant women admitted for delivery at city hospitals in 1992 tested positive for illicit drugs, according to NIDA's Washington, D.C., Metropolitan Area Drug Study. Based on self-reports, nearly 15 percent of new mothers reported using illicit drugs during their pregnancy, 21 percent reported drinking alcohol, and 23 percent reported smoking cigarettes.

Drug Use Common During Pregnancy in D.C.



Washington, D.C. Metropolitan Area Drug Study, National Institute on Drug Abuse, 1996

The study found that babies of women who smoked during pregnancy were four times more likely to be low birth weight than the babies of mothers who did not smoke. Rates of low birth weight also increased for babies whose mothers used alcohol and other drugs during pregnancy.

The cost of neonatal intensive care for low birth weight newborns ranges from $25,000 to $35,000 per child. Approximately 14 percent of babies born in the District are low birth weight (1,187 in 1996), and at least 20 percent of them have been exposed to alcohol, tobacco or other drugs before birth. Caring for these infants costs the city at least $5.9 million each year.

Like many cities, the District does not track the number of babies born with fetal alcohol syndrome (FAS), a birth defect that is commonly overlooked and underestimated nationwide. A single FAS case costs about $1.4 million over a lifetime.

HIV and AIDS

Key Findings

- **One in three AIDS cases in Washington is linked to drug use.**
- **Among those living with AIDS in Washington, drug-related cases cost more than $10 million each year for health care alone.**
- **Despite these alarming figures, Congress has prohibited the city from using locally-raised revenues for needle exchange programs which have been shown to reduce HIV infections among addicts without increasing drug use.**
- **Alcohol and other drug use place Washington's high percentage of sexually active teens at greater risk for HIV infection.**

Prevalence. The eighth leading cause of death nationally, AIDS, which disproportionately affects drug users, is the third leading killer in Washington. The city's AIDS death rate is more than seven times the national average (120 per 100,000 compared to 16 per 100,000).[11]

[11] AIDS is the leading cause of death among city residents aged 30 to 44, accounting for 46 percent of all deaths. In addition to the more than 5,000 people in the city living with AIDS, an estimated 10,000-12,000 other residents have HIV (the virus which causes AIDS). The District is expected to begin tracking HIV cases in 1999 in order to meet new CDC guidelines.

A growing percentage of the city's AIDS cases are the result of injection drug use (IDU). By the end of 1997, 36 percent of AIDS cases in the city were linked to IDU, compared to 24 percent in 1993. The drug-related AIDS cases diagnosed in 1997 will generate lifetime health care costs exceeding $34 million dollars.

African Americans constitute nearly all (97 percent) of the AIDS cases diagnosed among injection drug users between 1994 and 1997. In populations with unusually high rates of drug use (e.g., the homeless, criminal offenders, young adults), the risk of contracting AIDS is greater.

Drug-related cases among those living with AIDS in the District generate at least $10.4 million in health care costs annually.

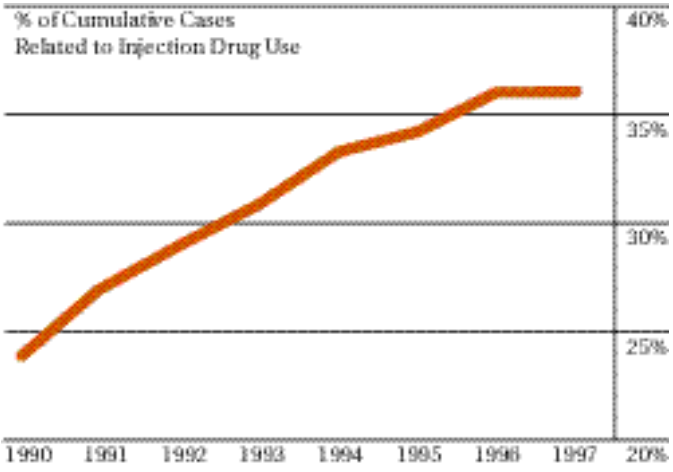
AIDS Prevention Through Needle Exchange. Beginning in 1996, the D.C. government funded a needle exchange program run by the Whitman-Walker Clinic, a community-based provider of AIDS services. The program, which reached an estimated 3,000 injection drug users, reduced needle sharing among participants by two-thirds.

Since October 1998, Congress has prohibited the city from using local funds for needle exchange programs. The ban also prohibits any federally funded organization from operating a needle exchange program in the city, even if the program is financed strictly with private funds. As a result, Whitman-Walker's $220,000 needle exchange program closed, although a fiscal impact study found that failing to provide needle exchange would cost the city $8.3 million annually.

In October 1998, Whitman-Walker and local health advocates formed Prevention Works, Inc., a privately funded organization to operate a local needle exchange program. The program, licensed by the D.C. Health Department, began operating in December 1998. Its future will depend on sustained financial support from the private sector.

AIDS Risks for Youth. Alcohol and other drug use can lower inhibitions and lead to high-risk behavior, including reduced condom use. Although 91 percent of Washington's teenagers report being taught about HIV and AIDS in school, and 73 percent say a parent or other adult family member has discussed the topic with them, a high percentage are still at risk for AIDS.

D.C. AIDS Cases Increasingly Linked to Drug Use



D.C. Administration for HIV/AIDS

A majority of teens in the city are sexually active (53 percent vs. 35 percent nationally). While 68 percent of those who are sexually active say they use condoms, in 1997, 21 percent of city teenagers reported using alcohol or other drugs at the time of their last intercourse; this drug use decreases the likelihood of condom use. Teens in Washington are also three times more likely than teens nationwide to have intercourse before age 13 (21 percent vs. 7 percent) and more than twice as likely to have at least four sexual partners (38 percent vs. 16 percent)—factors which also increase their risk for contracting HIV.

Workplace Programs

Students KEEP Away From Drugs It is illegal to sell drug paraphernalia, such as rolling papers and bongs, when one knows they will be used to consume illicit drugs. That's why residents of Anacostia took action to deter merchants from selling these items. The Associates for Renewal in Education and Kramer Middle School developed Project KEEP (Kramer Elevating Education about Prevention). In 1995, Project KEEP identified stores that sold loose cigarettes and cigars to minors, who later filled them with marijuana. Kramer students designed posters illustrating the product they discouraged stores from carrying. The Anacostia Coordinating Council held a community meeting attended by business owners, city officials, police officers and citizens. Community organizations donated the posters, as well as certificates of cooperation and multilingual flyers for a community-awareness rally. Merchants who agreed to stop selling the targeted items were listed on the promotional posters as campaign participants. For more information, call (202) 610-7263.

Cooking Up Jobs for Recovering Addicts Beyond feeding the homeless, D.C. Central Kitchen offers recovering addicts just what they need to prevent relapse: job training. In a 12-week course, the group turns homeless recovering drug abusers into certified safe food handlers ready for food service careers. During the course—which includes random drug testing—chefs and guest speakers instruct the trainees on everything from food sanitation procedures to punctuality. Two hundred participants have graduated from the training program since 1990. Nine in ten obtain full-time jobs upon graduation. Graduates also staff a mobile kitchen that provides meals and drug abuse counseling to three emergency shelters. D.C. Central Kitchen prepares 3,000 meals for the needy every day. Individuals, foundations, businesses and the United Way support D.C. Central Kitchen, which recently won a grant worth nearly $2 million from the U.S. Department of Labor to open job-training sites for 1,275 District welfare recipients. For details, call (202) 234-0707 or visit the Kitchen's web site at www.dccentralkitchen.org.

Fighting Drugs Is Child's Play Washington's businesses and communities are joining forces to reclaim drug-infested neighborhoods through KaBoom!, a national project that builds playgrounds. KaBoom! brings corporations, architects, construction consultants and community organizers together to create safe playgrounds which provide alternatives to drugs. Each company adds its own touch to the playgrounds. Nike, for instance, has donated safety surfacing from recycled shoes, and Home Depot has provided building materials. Corporate partners participate in park clean-ups and help celebrate the ground-breaking of new playgrounds. The project also helps sponsors build employee teamwork. KaBoom! has built 50 playgrounds in Washington, funded by Black Entertainment Television, the Children's Defense Fund, Freddie Mac, the Enterprise Foundation, Home Depot, Nations Bank, the Neighborhood Design Center and Nike. KaBoom! will build 1,000 playgrounds nationwide by the year 2000. Contact KaBoom! at (202) 659-0215 or visit the organization's web site at www.kaboom.org.

Ready to Work, Able to Recover Many blue-uniformed workers in Georgetown, Adams Morgan and other D.C. neighborhoods are recovering addicts; their work for Ready, Willing & Able, a work and housing program for the homeless and unemployed, helps them stay clear of drugs. Funded by private contributions and city, federal and corporate contracts, the program enables participants to earn up to $6.50 per hour in construction, food service, data management, mail delivery and housing maintenance jobs. Kenilworth Parkside Management, P & R Enterprises, Velocity Grill in the MCI Center, and Ronald Reagan National Airport have all hired workers from the program. Participants live in group homes, attend 12-step drug recovery meetings, and are tested for drugs throughout the program. Ready, Willing & Able matches up to $1,000 of personal savings if workers maintain sobriety, find private employment and secure unsubsidized housing; two in three participants complete the program. A year later, 85 percent continue to be employed. To learn more, call (202) 986-3800.

V. Prevention and Treatment

The paucity of information in this section of the report reflects the prevailing situation in the District: far too little in the way of prevention and treatment to address the scope of the problem.

Numerous studies have demonstrated the cost-effectiveness of prevention and treatment, including a 1994 RAND report which concluded that drug treatment was seven times more cost-effective than law enforcement in reducing cocaine use. Nonetheless, publicly funded treatment is scarce in the District, as are current data on the treatment needs of D.C. residents.

Even without stronger data, long waiting lists for existing treatment programs clearly indicate that current efforts are not meeting the city's needs.

Prevention

Key Findings

- **The District's prevention activities are limited, and their effectiveness remains unknown.**
- **Key questions must be addressed regarding prevention education in the city schools.**
- **The overwhelming majority of District residents place a high priority on drug prevention, but few consider existing programs adequate.**

In addition to the cigarette excise tax hike, which is a proven deterrent to smoking, the District is implementing several innovative prevention approaches. However, little is known about the effectiveness of publicly funded prevention efforts in the District, due to lack of evaluation.

Since 1991 city residents have donated more than $550,000 to local organizations involved in drug prevention through a contribution box on the D.C. income tax form. Indeed, a 1997 survey conducted for the Control Board found that 78 percent of District residents gave drug prevention a high priority. However, only 10 percent rated existing programs as excellent or good.

Community coalitions are critically important to Washington's drug abuse prevention activities. Two examples of such coalitions are Fighting Back and the National Capital Prevention Network.

Fighting Back, operated by the Marshall Heights Community Development Organization and funded by the Robert Wood Johnson Foundation, aims to reduce the sale and use of drugs through community revitalization projects, such as refurbishing rundown buildings, cleaning up parking lots and creating new jobs. The National Capital Prevention Network, a coalition of seven programs and agencies, provides a comprehensive approach to prevention through alternative activities, community mobilization projects, technical assistance and culturally specific programs for youth.

The D.C. Addiction Prevention and Recovery Administration (APRA) has primary responsibility for alcohol, tobacco and other drug prevention activities through its Office of Prevention and Youth Services (OPYS). OPYS uses information dissemination, prevention education, alternatives for at-risk youth, problem identification and referral, community-based programs and environmental approaches.

OPYS has Prevention Centers in Wards 1, 2 and 8 that are operated in partnership with the Department of Housing and Community Development. Early education and intervention programs for adults, youth and families administered by OPYS reach an estimated 200,000 residents annually, including about 100,000 youth. During 1998 OPYS spent $1.9 million for alcohol and other drug prevention in the District.

Three in four parents with children in D.C. public schools say that expanding after-school and summer recreation programs for youth would be very effective in reducing drug problems in the city.
Peter D. Hart Research Associates, 1998

Each year, the D.C. Public Schools offer drug prevention programs, which are funded primarily through federal Safe and Drug-Free Schools and Communities (SDFSC) funds ($2 million in 1998). Placing a heavy emphasis on implementing a Peaceable Schools Model in every school, the city devotes 75 percent of these funds to

violence prevention and 25 percent to drug prevention programs, spending an annual total of $19.23 per pupil. Some public schools currently use the Students Taught Awareness and Resistance (STAR) drug prevention program, which research has shown to be effective in reducing alcohol, tobacco and marijuana use. But the research on Drug Abuse Resistance Education (D.A.R.E.), the program implemented in most of the city's public schools, shows no sustained effects on drug use.

Treatment

Key Findings

- **Drug treatment is not easy to find in the District.**
- **The city's treatment budget has dropped 28 percent since 1993, and contracting problems have further reduced treatment capacity.**
- **The District's methadone maintenance services have been particularly hard hit, and more people are waiting for methadone than for any other form of treatment.**
- **For drug abusers who do complete treatment, results are impressive. If replicated widely, effective treatment services will lead to significant cost savings.**

Changes in Medicaid and Managed Care. Medicaid restructuring, currently underway in Washington, D.C., will affect delivery of all health services, including alcohol and other drug treatment. The first step (implemented in October 1998) increased the number of residents eligible for Medicaid by raising the income cutoff to twice the federal poverty rate for families with children ($32,900 for a family of four). By October 1999 the District is planning to expand coverage to childless couples and individuals.

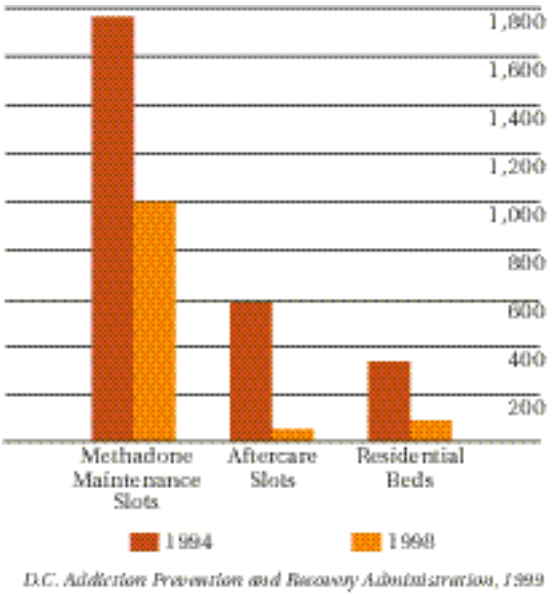
Newly eligible Medicaid recipients will be enrolled in managed care, which will include a standard drug abuse treatment benefit. Recipients requiring additional treatment services that are not covered will receive them through a Medicaid fee-for-service structure. D.C. officials hope that over the long term, all drug abuse treatment will move to a managed care system.

The District currently spends $24 million annually for outpatient drug abuse treatment and related services for uninsured and underinsured residents. With the proposed insurance expansions, funding for these services will more than double within two years.

A private sector approach to addressing the shortage of treatment slots was initiated in September 1998 by the Marshall Heights Community Development Organization. Funded by the Robert Wood Johnson Foundation's Fighting Back program, Marshall Heights has contracted with Providence Hospital to provide 100 treatment slots. The program, designed to serve residents of Ward 7, also accepts clients from other sections of the District. It is a comprehensive treatment program with an aftercare component and free child care. Marshall Heights and Providence Hospital expect that the program will become self-sufficient, 12 to 18 months after becoming operational, by utilizing funds from Medicaid and the criminal justice system.

Rather than fund city agencies (which can run out of funds before services are delivered), officials involved in the Medicaid restructuring hope to shape a new system in which treatment dollars follow clients. The Marshall Heights-Providence Hospital initiative is a good example of

District's Treatment Capacity Dropping



D.C. Addiction Prevention and Recovery Administration, 1999

this type of funding mechanism. The majority of treatment funding will be paid through Medicaid, although APRA will retain funds to continue special outreach and prevention initiatives and to fill any remaining services needs. APRA would shift its focus to certifying providers, monitoring the quality of care and possibly serving as a gatekeeper for services to chronic patients.

Difficulty Estimating Treatment Needs. In 1989, APRA (at that time called the Alcohol and Drug Abuse Services Administration) completed a drug abuse treatment needs assessment for Washington. Based on 1986 data, the study estimated that between 94,500 and 125,500 city residents were drug abusers (15 to 20 percent of the population), including 60,000 people abusing multiple drugs. Since then, these figures have formed the basis for agency estimates of treatment needs, with annual adjustments made to account for population changes.

These annual projections have been flawed, and without reliable data, accurately estimating Washington's treatment needs has been impossible. APRA's current estimate of 65,000 people in the District who need treatment may underestimate the need by tens of thousands of people.[12]

A 1998 treatment needs assessment for Latino residents in the District found that although 4,700 were problem drinkers and chronic illicit drug users in 1997, only 644 received treatment (14 percent). The study also found that treatment needs in the Latino community would be better met by expanding bilingual and bicultural programs in Latino neighborhoods. No comparable study has been done for the general population.

Treatment Services. In Washington, D.C. alcohol abusers account for 16 percent of treatment admissions, compared to 54 percent nationwide. Conversely, addicts on methadone maintenance comprise 23 percent of admissions in the city, compared to 6 percent nationally. According to the National Association of State Alcohol and Drug Abuse Directors, there were 14,546 drug abuse treatment admissions in the city in 1995 (1,870 for alcohol, 3,321 for methadone maintenance, and 9,355 for other drug treatment).

Like other social service agencies, APRA's budget has been hard hit by the city's financial problems. In FY 1998, $20.9 million was spent on publicly funded treatment in the District, compared to $29 million in FY 1993. APRA currently has only 2,220 treatment slots—a 50 percent drop from 1994—with more than 1,100 people on waiting lists. The number of methadone maintenance slots dropped from 1,780 to 860, residential treatment beds from 357 to 98, and aftercare slots from 600 to 50.

Additional treatment slots could be available; however, expired contracts with some service providers were not renewed, leaving the city with insufficient capacity to meet the high demand for publicly funded treatment. Contracting problems and budget cuts are blamed for the city's failure to provide much-needed youth treatment, therapeutic community beds and additional detoxification.

Only one in ten D.C. residents consider treatment to be readily available in the city, compared to one in four nationwide. ***Peter D. Hart Research Associates, 1995 and 1998***

The Office of National Drug Control Policy has called for an expansion of methadone maintenance programs nationwide in response to the recent increases in heroin use. In an average month, 90 percent of the people on APRA's waiting list are in line for methadone maintenance. APRA's FY 1999 budget includes funding for a new 360-slot methadone maintenance program that will serve some clients currently on the waiting list.

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[12] The 1989 treatment figures were based not on surveys but on extrapolations from national data. It is unclear whether the original study estimated "treatment need" or "risk of abuse" as these terms are used synonymously in the report. Only alcohol abusers have been counted in the adjusted annual projections. Thus, the figure of 65,000 drug abusers (which is widely cited) clearly underestimates current treatment needs. If 15 to 20 percent of current city residents need alcohol and other drug treatment (as they apparently did in the 1989 estimates), then 78,000 to 104,000 people need treatment now—13,000 to 39,000 more than APRA's current estimate.

Since 1994, a treatment needs assessment funded by the Center for Substance Abuse Treatment has been planned for the District but has not yet been carried out. In December 1998, APRA concluded a report on Social Indicators of Substance Abuse in Washington, D.C. The report analyzes demographic and socioeconomic indicators associated with drug abuse in the city, but it does not estimate the prevalence of drug abuse or the city's treatment needs.

APRA also provides services to probationers and parolees required to participate in treatment, further limiting access for the general public. Criminal offenders can easily fill the city's treatment slots on their own, but they must also wait. At the end of 1998, some 600 of the 1,100 people on treatment waiting lists were criminal offenders.

There are currently no residential treatment beds in the city for youth, nor are alcohol and prescription drug abuse among the elderly addressed. The homeless need opportunities for assessment and treatment in shelters and mobile units. Existing services also fail to meet the treatment needs of the dually diagnosed, Latinos and pregnant and parenting women.

The city's Latino population suffers from the lack of bilingual treatment programs, and inadequate outreach efforts and support networks within the community. In an effort to address these problems, in 1998 APRA awarded $609,000 to the Council on Latino Affairs to develop services targeting the Latino community.

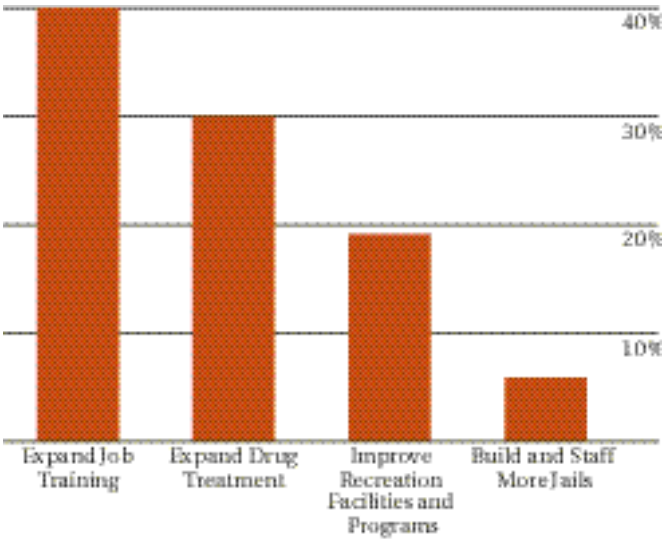
Sixty percent of the District's drug abusers also have psychiatric disorders, and more than half of patients in treatment for mental disorders in the city need drug treatment. These patients frequently have numerous problems, such as homelessness, unemployment and poor social functioning. The challenges of dual diagnosis are complicated by the fact that mental health and drug treatment are administered by different agencies with separate funding, professional orientations and areas of expertise. In 1999, the D.C. Commission on Mental Health Services (CMHS) launched a pilot program to integrate treatment services for clients with co-occurring addiction and mental health disorders. The program will cross-train about half of the city's mental health providers on how to provide simultaneous, standardized addiction and mental health treatment to the dually diagnosed. CMHS also operates a small inpatient program which serves about 250 dually diagnosed clients annually. Four Community Mental Health Centers in the city also provide day treatment, but they do not track the number of dually diagnosed clients served. APRA's FY 1999 budget includes a new day treatment program for 150 dually diagnosed clients, but this program will reach only a fraction of those in need.

To address youth drug abuse and underage drinking, two in three Washington residents favor devoting more funds to education, prevention and treatment, compared to one in five who support more funds for law enforcement. ***Peter D. Hart Research Associates, 1998***

Treatment Results in the District. In 1997, the Center for Substance Abuse Research at the University of Maryland conducted the D.C. Treatment Initiative. Completing both residential and aftercare components of treatment was the critical factor in predicting outcomes. At the six- month follow-up, clients completing both components were far less likely than those who completed only the residential phase to be rearrested (9 percent vs. 31 percent) and to test positive for cocaine (18 percent vs. 53 percent).

Since two-thirds of APRA clients have arrest records and three-quarters have no legal source of income, the potential benefits of successful treatment are enormous. If these outcomes can be replicated throughout the city's treatment system, significant savings in criminal justice and social welfare costs will be realized.

How D.C. Residents Would Spend More Funds to Reduce Illegal Drug Abuse



Peter D. Hart Research Associates, 1998

Treatment Programs

A New Beginning at Second Genesis

Research shows that drug treatment in therapeutic communities (TCs) is successful. Second Genesis, a nonprofit agency, provides treatment at five facilities, serving approximately 400 clients annually in the Washington metropolitan area. Treatment is available for adolescents and adults, including pregnant and post-partum women. For 25 years, Second Genesis has provided TC and outpatient services in the District. In the early 1990s, the National Institute on Drug Abuse funded a Second Genesis demonstration project at St. Elizabeths Hospital primarily to serve Ward 8 residents. Second Genesis also provided TC services as part of the District of Columbia Treatment Initiative (DCI). Clients who completed DCI were less likely than a comparison group to be rearrested and more likely to be drug-free at 6-month and 36-month follow-up. Second Genesis currently provides outpatient treatment for clients referred by the U.S. District Court and the U.S. Bureau of Prisons; this program serves about 200 clients per year—half of those served by Second Genesis throughout the metropolitan area. Representatives of some 40 foundations and businesses are on the Second Genesis Corporate Advisory Board, including Giant Food, Marriott International, General Motors, Bell Atlantic, American Express, Pepsi-Cola, and Saks Fifth Avenue. For more details, call (301) 656-1545.

A Clean House

In 1977, Oxford House, Inc. opened its first Washington, D.C. house for recovering addicts on North Hampton Street. Initially, neighbors were concerned about the new residents. But Oxford House made them an offer: "If you still don't like us by the end of our lease, we'll move out." Two years later, the Oxford House residents renewed the lease and in 1987 celebrated their 10th anniversary with 70 neighbors. Oxford Houses offer recovering alcoholics and other drug addicts an unlimited stay in financially self-sufficient, self-run group homes. Six or more recovering addicts rent the houses with the help of congressionally mandated state loans. New residents must be approved by 80 percent of the current ones. All residents pay an average weekly rent of $76.61 and must remain clean and sober. Those who relapse are evicted. Over a 12-year period, 81 percent of Oxford House residents remained clean and sober, according to a study by the Catholic University of America School of Social Work. As of 1998, Washington was home to 20 Oxford Houses, which have helped more than 8,000 recovering addicts. Since the first Oxford House began in 1974 in Silver Spring, Maryland, 683 others have opened their doors across the United States. For further information, call (301) 587-2916.

Helping Mothers Stay Sober

Women who live with their children during residential drug treatment tend to stay in treatment longer, increasing their odds of remaining clean. That's why the Mother and Child Program at House of Ruth provides homeless mothers a place to stay and overcome their drug addiction while focusing on self-sufficiency and child care. The two-year residential program serves pregnant, postpartum and parenting women who have completed detoxification and remained sober for 30 days. Ninety-five percent of participants sustained sobriety for at least six months while in the program, according to a 1997 evaluation. Women attend individual and group sessions on substance abuse, parenting, health issues, relapse prevention, personal empowerment and house responsibilities. Equally important is the required savings plan for post-graduation housing set-up (30 percent of income after paying a $20 monthly fee to House of Ruth) which helps prevent homelessness following treatment. The Mother and Child Program is one of 11 programs that the House of Ruth offers to impoverished women throughout the city. The nonprofit organization serves 200 women and 200 children every day at 11 locations. To learn more about House of Ruth, call (202) 667-7001.

Treatment Programs

Programs at Work for Troubled Youth

Sasha Bruce Youthwork offers much-needed help for children and families at risk for drug abuse, including Necessary Interventions for Adolescents (NIA), an outpatient drug treatment program for teenage substance abusers. NIA includes counseling, peer support groups, anger management sessions, AIDS prevention education and tutoring. The District's only emergency shelter for homeless children and teens, Youthwork also houses 11 other programs, including a home for teenage mothers, a court diversion program and a learning center. These programs have shown great promise. For example, 95 percent of Sasha Bruce residents return home or to alternative placements, compared to 66 percent of youth from other federally subsidized shelters. And the diversion program has a re-arrest rate of only 18 percent, compared to 65 percent for the city's juvenile justice system overall. Sasha Bruce Youthwork is supported by grants from the federal government, the District of Columbia, the Fannie Mae Foundation, United Way and private donations. To learn more, call (202) 675-9340.

Congregations in Action

Father George Clements, founder of One Church-One Child and One Church-One Inmate, felt religious organizations weren't used sufficiently to help reduce the nation's drug problems. His solution was to develop a program called One Church-One Addict, a national community treatment program that provides support to recovering drug abusers and helps them avoid relapse. Launched in 1994, One Church-One Addict mobilizes churches, synagogues, temples and mosques to become involved in the lives of recovering addicts. Volunteers learn to teach relapse prevention, refer individuals to treatment programs, and serve as role models and extended families to "adopted" addicts. To date, One Church-One Addict has enrolled 300 faith communities and "adopted' approximately 400 addicts nationwide. The program also hosts sobriety celebrations, or "recovery revivals," to recognize the efforts of addicts, volunteers and drug abuse professionals. This D.C.-based program has become a national movement. One Church-One Addict is supported by grants from the U.S. Department of Housing and Urban Development and the Robert Wood Johnson Foundation. For further information, call (202) 789-4333.

A Community Fights Back

Ward 7 has more households on public assistance than any other ward in Washington, D.C. In 1978, following a middle-class exodus to Maryland's Prince George's County, Ward 7 residents formed the Marshall Heights Community Development Organization (MHCDO) to stimulate new economic opportunity. Since its inception, the nonprofit organization has created 300 jobs at a new shopping center and spawned a $147 million investment in housing developments and community revitalization projects. With support from the Robert Wood Johnson Foundation, in 1992, MHCDO also established Washington's "Fighting Back" initiative to reduce demand for illegal drugs throughout Ward 7. The organization currently focuses on providing drug treatment and aftercare services to addicts through its Substance Abuse Treatment Program. Created in conjunction with Providence Hospital, the 32-week outpatient program provides child-care and aftercare services, including employment counseling, life-skills and job training, internships, job search and follow-up services. The program receives referrals from local health, housing, welfare and social service agencies, as well as the D.C. Superior Court. For more information, call MHCDO at (202) 397-7300.

VI. Looking to the Future

To address the multiple social, economic, health and criminal justice consequences of alcohol, tobacco and other drug problems, the District needs strong policies and programs that balance prevention, treatment and criminal justice strategies. In some cases, the District must receive cooperation and assistance from the federal government and surrounding jurisdictions.

Since drugs exacerbate a myriad of other problems in the District, effectively addressing drug problems could improve many aspects of life in the city. The city's new leadership is well-positioned to begin capitalizing on numerous lessons that have been learned through research and hard experience, both in Washington and nationwide. Seizing this opportunity now can revitalize the District's efforts for years to come.

The following policy recommendations, addressed to District and federal government leaders, are intended to build on areas of recent progress while also addressing key areas of concern.

Criminal Justice

Drug use is widespread among criminal offenders throughout the city's justice system and is closely linked to violent crime. Currently, few offenders receive treatment while in prison, on probation or on parole. Much of the District's criminal justice system has been put under federal control. The District, Congress, and the relevant federal agencies must ensure access to drug treatment for all offenders in need.

Federal funding of the D.C. court system and federal jurisdiction over the District's sentenced felons, both stipulated by the 1997 Revitalization Act, will contribute to net savings for the city of about $170 million a year through 2002. A portion of these savings should be dedicated to ensuring access to drug treatment for those offenders remaining in the District's custody. Sentenced felons will be in the custody of the federal Bureau of Prisons, where drug treatment should prove more accessible than has been the case under the D.C. Department of Corrections.

The District's innovative drug court and the federal High Intensity Drug Trafficking Areas (HIDTA) program combine regular testing with swift, escalating sanctions to discourage offenders from resuming drug use. These measures—and even the mere threat of them—have proven effective deterrents for many offenders. The new D.C. Court Services and Offender Supervision Agency (CSOSA) intends to build on the work of the drug court and HIDTA. Therefore:

- The District should ensure access to drug treatment for addicted criminal offenders remaining under District jurisdiction.
- Congress and the U.S. Justice Department should ensure access to drug treatment for addicted prisoners placed under jurisdiction of the federal Bureau of Prisons.
- Congress should overturn its ban on using High Intensity Drug Trafficking Area (HIDTA) funds to establish new treatment programs or expand existing ones.
- Congress should support the D.C. Court Services and Offender Supervision Agency's (CSOSA) plans to expand drug testing and treatment for offenders.

Prevention

The District's hike in cigarette excise taxes has had a preventive impact, as cigarette sales have fallen, but alcohol excise taxes remain among the nation's lowest.

Overall, little is known about the effectiveness of Washington's publicly funded prevention efforts, due to lack of evaluation. For example, certain of the drug prevention programs used in the D.C. public schools have shown no sustained effects on drug use. One prevention effort that is clearly inadequate is the District's Alcohol Beverage Control (ABC) activities to prevent alcohol sales to minors; the program is severely limited by the small number of investigators.

Although HIV prevention efforts have saved countless lives in the District and elsewhere, Congress has prohibited the District from using locally raised public funds for needle exchange programs, thus leaving the future of

these prevention programs in doubt. Meanwhile, District residents have signaled their commitment to increased drug prevention by donating hundreds of thousands of dollars to local prevention organizations when paying income taxes. Therefore:

- The District should increase alcohol excise taxes significantly.
- The District should index both alcohol excise taxes and cigarette excise taxes to inflation.
- Alcohol and tobacco excise tax revenues should be earmarked for prevention and treatment programs.
- The District's tobacco settlement money should also be dedicated to alcohol, tobacco, and other drug prevention, and to tobacco-related heath care.
- The District's prevention efforts should include restrictions on tobacco and alcohol advertising in areas accessible to children.
- The D.C. Department of Consumer and Regulatory Affairs (DCRA) should be authorized to impose fines and suspend and revoke the licenses of vendors who sell tobacco to minors.
- Although an increase from four to 16 Alcohol Beverage Control (ABC) investigators is underway, the sheer number of licensed alcohol outlets in the District (more than 1,500) requires an even greater ABC presence.
- The large number of alcohol outlets in the District, and their concentration in certain neighborhoods should be addressed directly. Neighborhood referenda in other cities give residents the ability to limit the number of alcohol outlets in their neighborhoods.
- District schools should implement prevention programs based on research and with proven track records, starting in the earliest grades.
- Schools should also initiate systematic evaluation to determine the efficacy of these programs.
- Schools should coordinate their efforts closely with after-school programs, coalition activities, and the D.C. Addiction Prevention and Recovery Administration's (APRA) prevention efforts to produce a comprehensive prevention strategy.
- The Mayor and the D.C. Council should encourage strong private sector support for the District's needle exchange program, and Congress should end its prohibition on the use of local D.C. revenues to fund the needle exchange program.

Treatment

Despite treatment's proven effectiveness in reducing drug use and drug-related crime, publicly funded treatment is scarce in the District. So, too, are current data on the actual treatment needs of D.C. residents. Long waiting lists for existing treatment programs make it clear that current efforts are inadequate. Therefore:

- Direct District funding for treatment services should be significantly increased.
- The District should proceed with proposed expansions in Medicaid eligibility and coverage that would ensure access to drug treatment services for all of the city's lower income residents. Providing treatment services through an insurance model would fold drug treatment into comprehensive health services and reduce dependence on inconsistent agency funding levels.
- Continuity of care, which is crucial to long-term treatment success, should be built into contracts with treatment providers.

Information

Data on alcohol, tobacco and other drug use and its consequences in the District have been gathered only sporadically in recent years, and the lack of accurate, current information has seriously hampered policy planning. Although a federal survey will soon update the District's

prevalence data, the District must build its own capacity for data gathering and policy analysis.

The pretrial release drug test data gathered by the District is often described as the nation's most comprehensive source of data on offender drug use and its relationship to criminal recidivism and sentencing outcomes. However, coding problems and missing data have severely limited the value of this promising resource. Therefore:

- To plan and evaluate drug policies and programs, to determine how much money needs to be spent and how best to spend it, the District should establish its own state-of-the-art research facility, capable of continuous data gathering and interdisciplinary analysis.
- Research on the prevalence of drug use and its consequences should extend beyond typical household surveys to include populations known to be at high risk, such as homeless and institutionalized persons.
- The District should eliminate problems of improper coding and missing data from its pretrial services drug test database.
- The District should consistently test for alcohol and other drug involvement in traffic accidents and fatalities.

Leadership

The wide-ranging effects of alcohol, tobacco and other drugs in the District require that the government's response be formulated at the highest level—including the mayor, relevant department heads, the D.C. Council, and while it exists, the Control Board. Therefore:

- To sustain leadership, the District government should create a new cabinet agency, perhaps a "drug czar," or an interdepartmental council. In any case, one high-level official who reports directly to the mayor must be empowered to coordinate the city's overall drug abuse response, bring all the necessary players to the table and increase interagency cooperation.
- The mayor should ensure that drug issues receive the attention they require in Congress.
- District leadership should work with leaders in surrounding counties to ensure coordinated prevention, treatment and law enforcement efforts.
- Government leaders should make sure to involve community leaders in planning and implementing programs.

Appendix

The Context of Drug Abuse Problems in Washington, D.C.

Demography. Washington, D.C., which covers 68 square miles, is home to 523,000 people. Urban flight and a high mortality rate have reduced the city's tax base. Washington's population has dropped significantly since it peaked at 800,000 in the 1950s. Many former city residents now live in Maryland and Virginia suburbs. However, the District's population decline is slowing and renewed growth is expected to begin by 2005.

The city is racially and ethnically diverse. Almost two-thirds of residents are African American; one-third are white (including 7 percent of residents who identify as Hispanic, but are included in these categories); while 3 percent are Asian or Native American. As new population growth occurs over the next decade, the percentage of African American residents is expected to decline gradually, while the percentage of white and Hispanic residents rises. Indeed, the number of Hispanic and Asian residents has increased 26 percent since 1990.

Sixty percent of city residents live in wards where one racial group (either African American or white) outnumbers the other by at least six to one (Wards 3, 4, 5, 7 and 8). Hispanic residents are also geographically concentrated; 61 percent live in Wards 1 and 2, and Hispanics comprise no more than 8 percent of residents in any of the other wards. Even in areas where Hispanics are most concentrated in the District (24 percent of residents in Ward 1), they remain a minority.

Washington, D.C. is a wealthy city, but its wealth is distributed unevenly. Although per capita income is 44 percent higher than the national average, one in six city residents lives in poverty, and one in four children lives in extreme poverty (family income less than half the federal poverty level). Fifty percent of families with children are headed by single parents. One in seven teens aged 16 to 19 neither attends school nor works—55 percent higher than the national average.

Income gaps often correspond to racial divisions in the city. Areas in which poverty rates exceed 30 percent are inhabited almost exclusively by African Americans. The $64,800 median household income in Ward 3 (where 80 percent of residents are white) exceeds the city's median income ($39,800) by 63 percent. In contrast, Ward 8, the city's poorest, is 90 percent African American with a median household income of $26,300.

Public Image. Washington, D.C. is a federal city, the capital of the world's oldest democracy. Home to world-renowned political, historical and cultural institutions, the District attracts more than 20 million visitors a year. In the 1980s, the city gained notoriety following the onset of the crack cocaine epidemic and an unprecedented surge in homicides. The city's reputation for drug abuse and violence continues to dominate its national image. In a 1998 nationwide survey, seven in 10 Americans rated drug abuse as a serious problem in the District. Half of D.C. residents say that drug dealing and drug abuse among youth are serious problems in their neighborhoods, compared to 27 percent of Americans overall.

The District of Columbia is often singled out as the source of drug problems throughout the greater metropolitan area because drug trafficking is thought to be concentrated in the city. However, city health and criminal justice officials note that residents of surrounding suburban communities play an active role in sustaining local drug markets, often purchasing illicit drugs as well as alcohol while they are in the city.

Local Economy. The District of Columbia's economy depends primarily on tourism and government employment. In 1997, visitors spent $4.2 billion in the District, a 20 percent increase over 1995. Nearly 615,000 people work in the city (including nonresidents), but since 1994 the unemployment rate among D.C. residents has been 60 percent higher than the national average, and double that of the surrounding region.

One in three people who works in the District is a federal government employee. Washington area firms garner $23 billion in federal government contracts annually, supporting jobs for 200,000 workers in the region. However, only 3,000 of those jobs are in the District and two-thirds of those are filled by suburban commuters. Service industries such as medicine, education, professional organizations and legal services account for 70 percent

of private sector jobs in the city. Wholesale and retail sales jobs comprise another 13 percent. The city's 19 colleges and universities enroll 78,000 students and include the city's two largest private sector employers, Georgetown University and The George Washington University.

Fiscal Constraints. The D.C. government administers and funds welfare, public health and public safety. The revenue most states use to help fund these programs (including property, business and commuter taxes) is significantly restricted in the city. For example, 41 percent of the total assessed property value in the District is exempt from property taxes, primarily because the land belongs to the federal government. In 1997, people employed in the city but residing elsewhere took home $21.4 billion—60 percent of the income earned in the city. Congress does not permit the D.C. government to collect taxes on non-resident earnings, although commuter taxes are legal in every state.

Federal Authority in the District. The Constitution gives Congress ultimate authority to govern the city, although District residents do not have voting representation in Congress.[13] The Home Rule Act of 1974 created a locally elected government with legislative authority, including an elected Mayor, D.C. Council and School Board. However, Congress preserved its constitutional authority over legislation enacted by the D.C. government, including the city's budget. In April 1995, with the District government unable to pay its bills, Congress created the District of Columbia Financial Responsibility and Management Assistance Authority (better known as the Control Board), consisting of five Presidential appointees empowered to write the city budget, hire and fire personnel, and direct some city agencies.

The 1997 National Capital Revitalization and Self-Government Improvement Act (known as the Revitalization Act) provided a measure of financial relief by transferring the District's pension shortfall to the federal government; increasing the federal contribution to D.C. Medicaid payments by 40 percent; and transferring court costs and most prison system costs to the federal government. At the same time, however, Congress ended the annual federal payment to the city, worth $660 million each year since 1995. Overall, the Revitalization Act is expected to save the District $170 million a year from 1999 through 2002. The new law also transferred authority over nine major city departments (including Corrections, Public Works, Health, and Human Services) from the Mayor and Council to the Control Board. It also mandated significant changes in the local criminal justice system affecting corrections, the courts, parole, offender supervision and sentencing.

City Agencies. Several public agencies in Washington, D.C. administer programs that address alcohol, tobacco and other drug problems. The D.C. Addiction Prevention and Recovery Administration (APRA) provides publicly-funded drug abuse prevention and treatment services, and administers federal block grant programs. Initially under the authority of the Department of Human Services and now under the Department of Health, APRA's director has never been a cabinet-level official.

Law enforcement and criminal justice agencies play a significant role in the city's strategies to address drug abuse, including the Metropolitan Police Department, the Superior Court of the District of Columbia, the Trustees for Corrections and for the Court Services and Offender Supervision Agency, and the Office of the U.S. Attorney for the District of Columbia. Other agencies with important responsibilities related to alcohol, tobacco and other drugs include the Department of Human Services' Child and Family Services Agency (foster care) and Youth Services Administration (juvenile justice); the Department of Health's Administration for HIV/AIDS and Preventive Health Services Administration; the Department of Consumer and Regulatory Affairs' Alcohol Beverage Control Division; the Office of Corporation Counsel; the Housing Authority; and the Public Schools' Student Intervention Services Branch.

[13] Nor is Congress particularly attuned to the characteristically urban issues that confront D.C. residents. Fewer than one in six members of the 106th House of Representatives represents an urban district. Among Republicans, the House majority party, only nine of 223 members represent urban districts, and none of the 10 Republicans serving on subcommittees with jurisdiction over D.C. represents an urban district.

Washington, D.C. Resources

D.C. Government Agencies

Alcohol Beverage Control Board . . . . . (202) 727-7375
Office of the Corporation Counsel . . . . . (202) 727-6248
- Criminal Division. . . . . (202) 727-9813
- Family Services Division. . . . . (202) 727-3839

D.C. Council . . . . . (202) 724-8000
Department of Corrections . . . . . (202) 673-7316
Department of Health . . . . . (202) 645-5556
- Addiction Prevention and Recovery Administration . . . . . (202) 727-9394
- Administration for HIV/AIDS . . . . . (202) 727-2500
- Commission on Mental Health Services . . . . . (202) 364-3422
- HIV Testing Hotline . . . . . (202) 332-3926
- Office of Maternal and Child Health . . . . . (202) 645-5620
- Preventive Health Services Administration . . . . . (202) 673-5550
- State Center for Health Statistics. . . . . (202) 442-5865

Department of Human Services. . . . . (202) 279-6002
- Family Services Agency . . . . . (202) 842-0888
- Youth Services Administration . . . . . (301) 497-8100

D.C. Financial Responsibility and Management Assistance Authority . . . . . (202) 504-3400
Housing Authority. . . . . (202) 535-1500
- Office of Public Safety . . . . . (202) 535-2575

Office of the Mayor . . . . . (202) 727-2980
Metropolitan Police Department. . . . . (202) 727-1010
- Community Relations. . . . . (202) 727-0783
- Major Narcotics Branch. . . . . (202) 727-4424

Public Schools . . . . . (202) 724-4222
- Office of the Superintendent . . . . . (202) 442-5885
- School Auxiliary Support Services . . . . . (202) 442-5057

Superior Court of the District of Columbia . . . . . (202) 879-1010
Office of the Trustee for Corrections. . . . . (202) 305-9611
Office of the Trustee for the Court Services and Offender Supervision Agency . . . . . (202) 616-1092
- Pretrial Services Agency. . . . . (202) 727-2914
- Public Defender Service. . . . . (202) 879-1226

U.S. Congress

House Appropriations Committee, D.C. Subcommittee
- Chair, Representative Ernest J. Istook (R-Oklahoma). . . . . (202) 225-2132
- Ranking Member, Representative James P. Moran (D-Virginia) . . . . . (202) 225-4376

House Government Reform and Oversight Committee, D.C. Subcommittee
- Chair, Representative Tom Davis (R-Virginia) . . . . . (202) 225-1492
- Ranking Member, Delegate Eleanor Holmes Norton (D-D.C.). . . . . (202) 225-8050

Senate Appropriations Committee, D.C. Subcommittee
- Chair, Senator Kay Bailey Hutchison (R-Texas) . . . . . (202) 224-5922
- Ranking Member, Senator Richard J. Durbin (D-Illinois) . . . . . (202) 224-2152

Senate Governmental Affairs Committee, D.C. Subcommittee
- Chair, Senator George V. Voinovich (R-Ohio). . . . . (202) 224-3353
- Ranking Member, Senator Richard J. Durbin (D-Illinois) . . . . . (202) 224-2152

Federal Government Agencies

Centers for Disease Control and Prevention . . . . . (404) 639-3311
National Institute of Justice. . . . . (202) 307-2942
National Institute on Alcohol Abuse and Alcoholism . . . . . (301) 443-3860
National Institute on Drug Abuse . . . . . (301) 443-1124
Office of National Drug Control Policy . . . . . (202) 395-6735
Office of the U.S. Attorney for the District of Columbia. . . . . (202) 514-7566
Substance Abuse and Mental Health Services Administration . . . . . (301) 443-8956

Non-Governmental Organizations

Alliance of Concerned Men . . . . . (202) 645-5097
Catholic Charities . . . . . (202) 526-4100
'Cause Children Count Coalition . . . . . (202) 986-4500
Center for Science in the Public Interest. . . . . (202) 332-9110
Center for Substance Abuse Research . . . . . (301) 403-8329
Community Prevention Partnership . . . . . (202) 898-4700
Covenant House Washington . . . . . (202) 610-9600
D.C. Action for Children. . . . . (202) 234-9404
D.C. Agenda . . . . . (202) 223-2598
D.C. Prisoners Legal Services Project . . . . . (202) 775-0323
Hermanos y Hermanas Mayores (Big Brothers/Big Sisters). . . . . (301) 587-0021
Latin American Youth Center . . . . . (202) 319-2225
Latino Council on Alcohol and Tobacco . . . . . (202) 265-8054
Marshall Heights Community Development Organization . . . . . (202) 397-7300
Metropolitan Washington Council of Governments . . . . . (202) 962-3200
Mothers Against Drunk Driving . . . . . (214) 744-6233
National Capital Coalition to Prevent Underage Drinking. . . . . (202) 265-8922
National Center on Institutions and Alternatives . . . . . (703) 684-0373
National Council on Crime and Delinquency. . . . . (202) 638-0556
Operation Crackdown . . . . . (202) 828-3643
Prevention Works . . . . . (202) 939-7820
The Urban Institute. . . . . (202) 833-7200
Washington Legal Clinic for the Homeless . . . . . (202) 872-1494
Washington Regional Alcohol Program. . . . . (703) 893-0461
Whitman-Walker Clinic . . . . . (202) 797-3500
Youth Law Center . . . . . (202) 637-0377

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This is a partial list of the sources used in *Facing Facts*. Detailed citations are available on Drug Strategies' website: www.drugstrategies.org

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Data Tables

Alcohol Consumption

(gallons of pure alcohol per capita)

	1990	1991	1992	1993	1994	1995
Beer						
D.C.	1.42	1.44	1.64	1.56	1.56	1.56
U.S.	1.34	1.29	1.29	1.28	1.26	1.25
Wine						
D.C.	0.77	0.62	0.72	0.75	0.76	0.74
U.S.	0.33	0.30	0.30	0.29	0.29	0.29
Spirits						
D.C.	1.97	1.87	1.77	1.58	1.57	1.58
U.S.	0.78	0.71	0.71	0.68	0.66	0.64
All Alcoholic Beverages						
D.C.	4.16	3.93	4.13	3.89	3.89	3.89
U.S.	2.45	2.30	2.31	2.25	2.21	2.17

Source: National Institute on Alcohol Abuse and Alcoholism

Drug Use by High School Students

	1991	1993	1995	1997
Cigarettes				
Lifetime	65%	62%	67%	68%
Past Month	6%	17%	22%	23%
Smokeless Tobacco				
Past Month	4%	2%	1%	3%
Alcohol				
Lifetime	70%	74%	69%	71%
Past Month	36%	41%	36%	38%
Binge	14%	16%	13%	18%
Marijuana				
Lifetime	12%	29%	43%	52%
Past Month	6%	18%	25%	29%
Cocaine Powder				
Lifetime	2%	2%	1%	4%
Past Month	2%	1%	1%	3%
Crack Cocaine/Freebase				
Lifetime		1%	1%	3%
Illegal Steroids				
Lifetime	5%	2%	2%	4%
Injection Drugs				
Lifetime	2%	2%	0%	3%
Inhalants				
Lifetime			11%	11%

Source: Youth Risk Behavior Surveillance System, U.S. Centers for Disease Control and Prevention

Cigarette Excise Taxes

	1990	1991	1992	1993	1994	1995	1996	1997
Tax Rate (per pack)	17¢	30¢	50¢	65¢	65¢	65¢	65¢	65¢
# Packs Sold (per capita)	107	97	93	82	70	66	61	54
Revenue (in millions)	$9	$10	$17	$21	$22	$20	$19	$19

Sources: U.S. Bureau of the Census; D.C. Office of Tax and Revenue

Liquor Excise Tax Rate

(tax per drink containing 1.5 ounces of liquor)

	1978	1985	1995	1998
Actual D.C. Excise Tax Rate	1.8¢	1.8¢	1.8¢	1.8¢
Inflation-Adjusted Tax Rate*	1.8¢	2.6¢	3.6¢	3.9¢

* Based on the food and beverages Consumer Price Index for urban consumers.

Sources: U.S. Bureau of Labor Statistics
D.C. Office of Tax and Revenue
Center for Science in the Public Interest

Note: Already very low compared to rates in most states, the District's alcohol excise taxes continually lose value because they are not indexed to the inflation rate. Since 1978, when the liquor tax was lowered from 2.3¢ to 1.8¢ per drink, inflation has eroded 55 percent of the tax's value. Had it been pegged to inflation in 1978, the liquor tax rate would now be nearly 4¢ per drink, rather than 1.8¢. The District's beer and wine excise taxes have also lost value since they were last changed in 1989 and 1990, respectively.

Deaths from Drug-Related Diseases

	1991	1992	1993	1994	1995	1996	1997
HIV/AIDS	443	532	604	695	664	562	243
Lung Cancer	332	352	371	406	366	327	313
Alcohol-Related Liver Disease	56	75	74	43	38	35	30

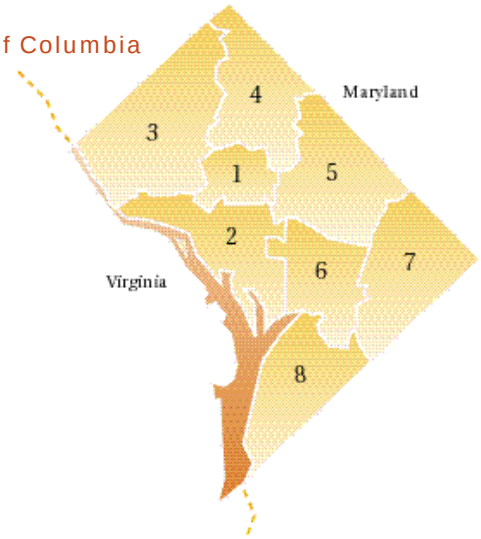
Source: D.C. State Center for Health Statistics

Income and Drug-Related Indicators

	D.C.	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
1997 per capita income	$27,214	$23,916	$35,703	$56,577	$22,603	$18,667	$25,032	$16,107	$11,710
1997 homicide death rate (per 10,000 residents)	4.45	4.45	1.86	0.27	3.19	5.32	6.81	8.41	7.02
1996 low birth weight rate (per 1,000 live births)	142	121	119	63	137	179	149	165	166
1997 new IDU-related AIDS cases (per 10,000 residents)	6.30	4.86	3.35	<.55	5.65	5.62	4.94	6.39	8.39
Percent of D.C. adults who personally know a city resident with an alcohol problem	49%	46%	40%	41%	51%	59%	55%	54%	48%
Percent of D.C. adults who personally know a city resident who regularly uses illegal drugs	35%	37%	27%	20%	41%	37%	38%	37%	45%

Sources: D.C. Office of Planning/State Data Center, 1998
D.C. State Center for Health Statistics, 1998
D.C. Administration for HIV/AIDS, 1998
Peter D. Hart Research Associates, 1998

District of Columbia by Ward



Alcohol Outlets

	D.C.	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
Total Number of Licensed Outlets	1,556	264	609	153	103	137	206	43	41
Restaurants & Taverns	890	142	484	110	30	24	95	4	1
Percentage	57%	54%	79%	72%	29%	18%	46%	9%	2%
Liquor & Convenience Stores	666	122	125	43	73	113	111	39	40
Percentage	43%	46%	21%	28%	71%	82%	54%	91%	98%

Note: "Restaurants & Taverns" also includes hotels, nightclubs and private clubs.

Source: D.C. Department of Consumer and Regulatory Affairs, 1998

Treatment Capacity

	1994	1995	1996	1997	1998	% Decrease
Total APRA Beds and Slots	4,467	3,834	3,034	2,039	2,219	- 50.3%
Treatment Beds	462	239	215	195	160	- 65.7%
Inpatient	105	60	35	35	62	- 41.0%
Residential	357	179	180	160	98	- 72.5%
Treatment Slots	4,005	3,595	2,819	1,844	2,059	- 48.6%
Outpatient	1,625	1,725	1,364	834	1,009	- 37.9%
Methadone Maintenance	1,780	1,470	1,205	960	1,000	- 43.8%
Aftercare	600	400	250	50	50	- 92.9%

Source: D.C. Addiction Prevention and Recovery Administration

Drug-Related Emergency Room Mentions (Washington, D.C. Area)

	1988	1989	1990	1991	1992	1993	1994	1995	1996
Mentions									
Any Drug	29,310	24,839	17,943	18,234	18,329	21,692	25,222	20,373	18,448
Cocaine	8,478	7,854	4,788	4,572	4,236	4,275	4,849	3,541	3,340
Heroin	2,433	1,761	1,334	1,480	1,512	1,414	1,261	1,301	1,492
Marijuana	2,105	1,660	915	959	1,159	2,102	2,712	2,065	1,904

Source: Drug Abuse Warning Network, U.S. Substance Abuse and Mental Health Services Administration

Drug-Related AIDS Cases

	1991	1992	1993	1994	1995	1996	1997
New AIDS Cases							
Total AIDS Cases	957	1,089	1,317	1,216	1,002	1,022	763
Total IDU* Cases	329	403	537	557	401	479	337
Percent IDU*	34%	37%	41%	46%	40%	47%	44%
Cumulative Cases							
Total AIDS Cases	4,223	5,312	6,629	7,845	8,847	9,869	10,632
Total IDU* Cases	1,127	1,530	2,067	2,624	3,025	3,504	3,841
Percent IDU*	27%	29%	31%	33%	34%	36%	36%

*IDU=cases related to injection drug use

Source: D.C. Administration for HIV/AIDS

Medical Examiner Data on Drug-Related Deaths (Washington, D.C. Area)

	1992	1993	1994	1995
Total	231	259	242	233
Male	169	201	169	176
Female	62	58	73	57
Type of Drug				
Alcohol-in-combination	117	119	71	79
Cocaine	92	101	110	99
Heroin/Morphine	89	109	82	91

Source: Drug Abuse Warning Network, U.S. Substance Abuse and Mental Health Services Administration

Drug Arrests, 1997

	All Ages	Age 11-17	Age 18-24	Age 25-44	Age 45+
Total Drug Arrests	7,416	617	2,446	3,670	683
Sales	921	67	292	487	75
Cocaine/Heroin	617	39	165	352	61
Marijuana	283	28	122	122	11
Other	21	0	5	13	3
Possession	6,495	550	2,154	3,183	608
Cocaine/Heroin	3,552	280	832	1,950	490
Marijuana	2,831	264	1,284	1,175	108
Other	112	6	38	58	10

Source: D.C. Metropolitan Police Department

D.C. Arrests by Place of Residence and Drug Test Results, 1996

Zip Code of Residence[2]	Ward of Residence	Arrests for Any Offense[3]	DRUG TESTS WHILE ON PRETRIAL RELEASE[1] Positive for Cocaine	Positive for Opiates	Positive for PCP
20005	2	52	52%	6%	6%
20024	2	162	1%	10%	17%
20016	3	29	28%	8%	15%
20012	4	75	46%	14%	13%
20018	5	177	55%	19%	13%
20003	6	262	55%	22%	15%
20032	8	687	47%	10%	20%
20009	1 or 2	383	48%	13%	12%
20010	1 or 4	510	50%	13%	16%
20007	2 or 3	24	33%	10%	10%
20011	4 or 5	556	51%	13%	13%
20017	4 or 5	93	56%	13%	17%
20002	5 or 6	963	53%	16%	13%
20019	6 or 7	806	45%	12%	19%
20020	7 or 8	833	48%	14%	20%
20008	1, 2 or 3	25	21%	0%	8%
20001	1, 2 or 6	897	56%	13%	15%

Source: D.C. Pretrial Services Agency

[1] No tests for marijuana or alcohol were conducted.

[2] Only zip codes with at least 20 arrests are shown; 24 additional zip codes are not shown.

[3] Includes arrestees who were drug tested voluntarily at the time of initial lock-up in the first half of 1996.

Drug Use by Arrestees

	1989	1990	1991	1992	1993	1994	1995	1996	1997
Adult Males									
Any Illicit Drug	67%	56%	59%	60%	60%	64%	64%	66%	69%
Marijuana	12%	7%	11%	20%	26%	30%	32%	40%	39%
Cocaine	59%	48%	49%	44%	37%	38%	35%	33%	33%
Heroin	12%	13%	10%	11%	10%	9%	8%	9%	10%
Adult Females									
Any Illicit Drug	83%	73%	75%	72%	71%	67%	65%	58%	57%
Marijuana	10%	7%	6%	8%	9%	10%	18%	23%	19%
Cocaine	74%	65%	68%	64%	62%	55%	46%	40%	39%
Heroin	25%	19%	16%	19%	21%	13%	16%	11%	11%
Juvenile Males									
Any Illicit Drug		21%	25%	37%	51%	64%	58%	67%	66%
Marijuana		6%	11%	32%	47%	61%	54%	65%	65%
Cocaine		16%	16%	9%	7%	9%	4%	4%	4%

Source: U.S. Arrestee Drug Abuse Monitoring Program (formerly Drug Use Forecasting)

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Drug Strategies, a nonprofit research institute, promotes more effective approaches to the nation's drug problems and supports private and public initiatives that reduce the demand for drugs through prevention, education, treatment and law enforcement.

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