



Profile of Injury In San Francisco

The San Francisco Injury Center
San Francisco Department of Public Health
December, 2004

Funded by a grant from the National Center for Injury Prevention and Control, CDC,
R49/CCR903697-15



UCSF San Francisco Injury Center



Department of Public Health

To the People of San Francisco:

Good injury prevention programs are data-driven, which implies a partnership between researchers and practitioners. The San Francisco Injury Center for Research and Prevention and the San Francisco Department of Public Health continue their collaboration in producing this 5th Edition of the *Profile of Injury in San Francisco*. This document provides injury data drawn from death certificates and hospital discharge records for the year 2001, with specialized information spanning the years 2000-2002.

There are many people who work tirelessly for the prevention of injury and violence in San Francisco. This Profile is designed to assist them, by highlighting data in four areas of particular interest: 1) traffic-related injuries, with a focus on pedestrians, 2) falls, with a focus on our senior residents, 3) drugs and other poisons, and 4) violent injuries. An additional chapter provides contact information on agencies and organizations working to prevent injuries and violence in San Francisco.

The authors and staff of the San Francisco Injury Center and the SF Department of Public Health hope that this information will help to shape prevention programs, allocate scarce resources to solvable problems, and make life healthier and safer for all San Franciscans.

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Acknowledgements

This is the Fifth Edition of the *Profile of Injury in San Francisco*. As usual, it is the product of the hard work of many, many people. Major responsibility was shared by six people:

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Two additional people contributed data:

Jerry Robbins, Transportation Planner with the SF Department of Parking and Traffic, who contributed data on vehicles registered in and entering/leaving San Francisco for the motor vehicle chapter

Susan Shallow, of the SF Department of Public Health, who contributed data from Community Substance Abuse Services for the drug/poisoning chapter

The Profile depends entirely upon data sets collected primarily for other purposes but which are made available to us. Therefore, we would also like to recognize the many people contribute to these data sets: health care providers and the Medical Examiner who record useful patient information; data enterers and coders; quality assurers and agency directors.

Of course, we also recognize that each number in this Profile represents a real human being, who sustained an injury. It is to aid in the prevention of such suffering that we present this Profile.

The authors want to acknowledge the contribution of many individuals without whom this report could not have been produced, especially to those authors of previous editions of the Profile: Connie Heye, MPH; Gregory Nah, MA; Jennifer Balogh, MPH; and Mary Weitzel, JD, MPH. We are also extremely grateful to the directors of the two partner institutions that provided essential funding and support: Margaret Knudson, MD, SF Injury Center, and Mitchell Katz, MD at the SF Department of Public Health.

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Overview

Injury Facts at a Glance, San Francisco, Year 2001

Number of injury deaths: 542

Residents killed in San Francisco: 400

Residents killed elsewhere: 61

Visitors killed in San Francisco: 81

Because rates must be calculated using known populations, such as the resident population of the city of San Francisco, the following rates include San Francisco residents killed in San Francisco or elsewhere in 2001 but exclude visitors who were killed in San Francisco.

Age-adjusted injury mortality rate per 100,000 residents* for 461 residents:
55.1

Age-adjusted injury mortality rate per 100,000 residents for four leading injury mechanisms:

Drugs & other poisonings	16.9
Falls	7.5
MV Traffic	6.8
Firearms	6.5
All others	16.7

Age-adjusted injury mortality rate per 100,000 residents for “intent of injury” categories:

Unintentional	33.3
Suicide	12.1
Homicide	8.0

Injury mortality rate per 100,000 San Francisco residents by age group:

	Male	Female	Combined
0-4	**	**	**
5-14	**	**	11.2
15-24	78.2	15.7	47.0
25-34	57.6	18.8	39.4
35-44	93.4	41.7	70.3
45-54	108.7	48.5	79.8
55-64	109.1	39.2	73.5
65-74	48.8	34.0	40.8
75-84	174.9	102.2	131.8
85+	321.3	253.3	253.0

* Age-adjusted rates are standardized using the population of San Francisco from the year 2000 United States census data.

** In cells with fewer than 5 deaths, rates were not calculated. Numbers in these categories were: 0-4 Male (2), Female (0); 5-14 Male (4), Female (3).

Number of non-fatal injury-related hospital discharges: 8,037

Residents hospitalized in San Francisco: 5,047

Residents hospitalized elsewhere: 627

Visitors hospitalized in San Francisco: 2,363

Because rates must be calculated using known populations, such as the resident population of the city of San Francisco, the following rates include San Francisco residents hospitalized in San Francisco or elsewhere in 2001 but exclude visitors hospitalized in San Francisco.

Age-adjusted injury-related hospitalization rate per 100,000 residents* for 5,674 residents: 695.5

Age-adjusted injury-related hospitalization rate per 100,000 residents for eight leading injury mechanisms:

Falls	313.7
Drugs & other poisonings	81.0
MV Traffic	72.5
Cut/pierce	36.9
Struck by	34.5
Nature	14.9
Fire/burn	14.3
Over-exertion	10.9

Age-adjusted injury hospitalization rate per 100,000 residents for “intent of injury” categories:

Unintentional	575.1
Assault	61.2
Self-inflicted	54.5

Injury hospitalization rate per 100,000 San Francisco residents by age group:

	Male	Female	Combined
0-4	411.7	325.6	369.9
5-14	298.3	203.1	251.7
15-24	742.2	331.4	537.0
25-34	510.1	276.7	400.2
35-44	671.2	360.6	532.1
45-54	739.3	459.4	605.3
55-64	769.7	662.8	715.3
65-74	919.3	1041.6	981.2
75-84	2034.5	2925.1	2562.7
85+	5095.2	6575.5	6122.2

* Age-adjusted rates are standardized using the population of San Francisco from the year 2000 United States census data.

Mechanisms of Death by Injury

In 2001, 461 San Francisco residents died as a result of injury. This is 19 more than the 442 injury deaths in 1998 (the year highlighted in the 4th Edition of this Profile).

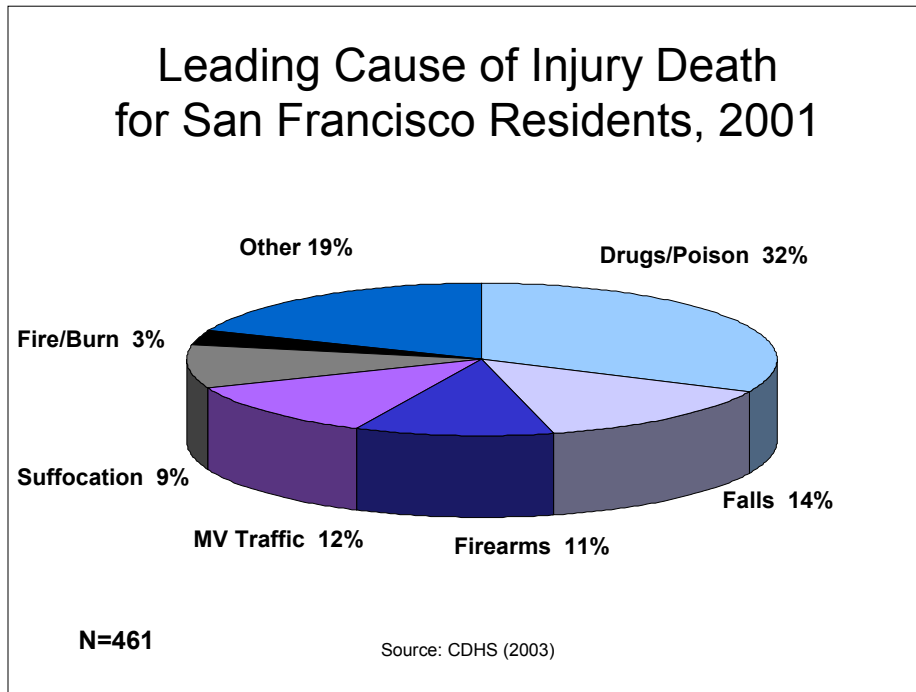


Figure 1. Drugs and other poisonings, primarily drug overdose, were the leading mechanism of injury deaths among San Franciscans in 2001.

Injuries are often classified by the object or mechanism that caused the injury. By order of magnitude, the leading causes of injury death in San Francisco in 2001 were drugs and other poisonings (149 deaths), motor vehicles (56 deaths), falls (64 deaths), firearms (51 deaths), suffocation (42 deaths), and fire/burns (15 deaths). The “other” category includes cut/pierce injuries (such as from a knife), drowning, natural and environmental causes, being struck by a blunt instrument, and “other and unspecified” causes as reported in the original death records.

Mechanism of Non-Fatal Injury Requiring Hospitalization

In 2001, there were 5,674 injury-related hospital discharges of San Francisco residents, 508 fewer than the 6,182 that occurred in 1998. This may represent changes in hospital admission policies or treatment protocols, rather than numbers of injuries sustained and treated.

It is important to recognize that these are hospital discharge records. Scheduled admissions, which suggest that the condition was not acute, accounted for 11% of the total in 2001. It is extremely difficult to determine if these discharges were for the same or different injury causing incidents. Therefore, we included all discharge records, a practice that we followed in previous editions of the Profile.

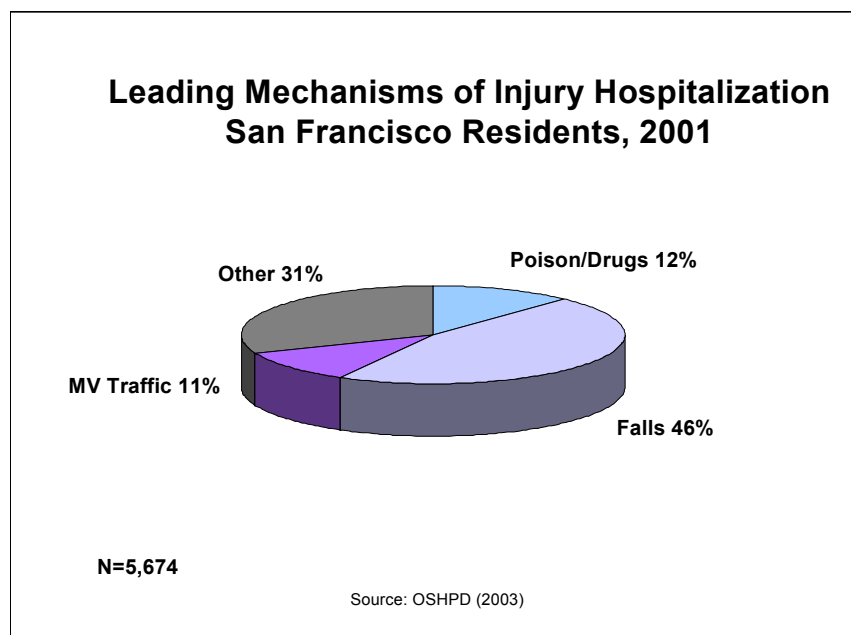


Figure 2.
Falls accounted for almost half of all injury related hospital discharges among San Francisco residents in 2001.

The leading causes of injury hospitalization differ from those of injury deaths. Falls accounted for almost half of all injury-related hospital discharges. Among all fall patients, 69% (1,781) were 65 years of age or older. Drugs & other poisonings were the second leading cause of hospitalization (n=665), and motor vehicle crashes were the third leading cause (n=597). None of the other mechanisms account for more than 10% of injury hospitalizations apiece.

Included in the “other/unspecified” category are hospitalizations resulting from cut/pierce injuries (such as from a knife), being struck by a blunt instrument, fire/burn, firearms, non-traffic bicycle or pedestrian injury, suffocation, drowning, natural or environmental causes, machinery and other unspecified causes.

Reported Intentionality in Fatal Injury

Injuries are classified by intentionality as well as by mechanism. Injuries that are determined to be purposefully inflicted are considered *intentional injuries*, while those traditionally called “accidents” are labeled *unintentional injuries*. Intentional injuries are either self-inflicted (suicides and suicide attempts) or inflicted by another (homicides and assaults). With regard to intent, injuries are classified as “other” when they are caused by legal intervention (such as a police action), war, or when, in the case of a death, the intent is judged “undetermined” by a medical examiner or coroner.

Determining intentionality of fatal injury can be problematic. The deceased is not able to reveal intent, and family and friends may be unwilling or unable to answer questions about the circumstances surrounding the event. This may lead to intentional injury deaths being misclassified as unintentional, but it is rare that unintentional injuries are coded as intentional.

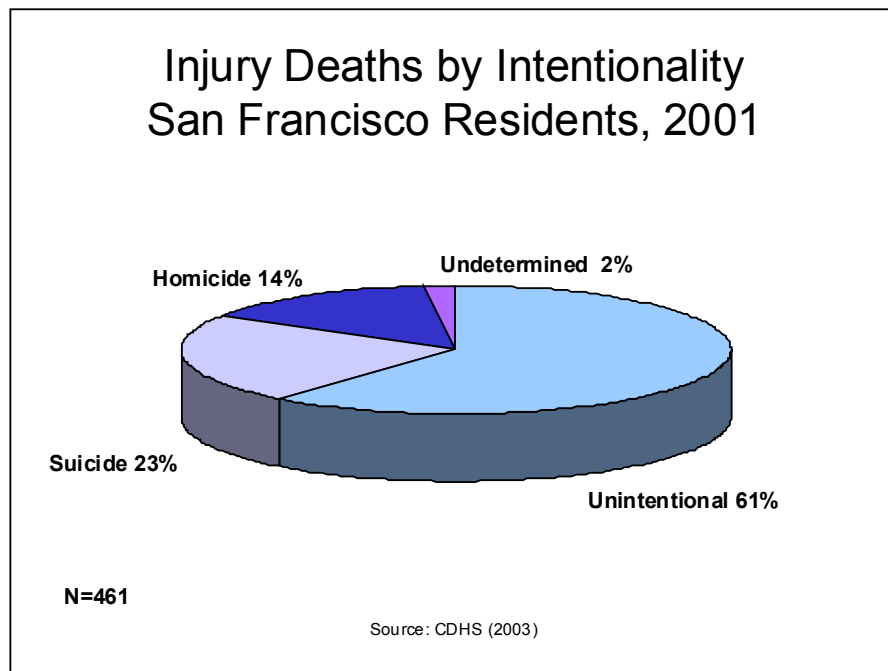


Figure 3.

In 2001, a smaller percentage of deaths was judged to be unintentional than in 1998 (61% vs. 66.8%), but a larger proportion was judged to be suicide (23% vs. 21%). This shift may be due to how the intentionality of drug overdose deaths is determined. Medical examiners make judgments about intent based on direct evidence left by the deceased, from interviews with family and friends, or police observations. Given the complexity of determining intent in drug overdose deaths, one should be cautious about identifying trends in intentionality of injury deaths in San Francisco.

Reported Intentionality in Non-Fatal Injury Requiring Hospitalization

As with fatal injuries, caution should be exercised in determining the intentionality of injuries requiring hospitalization. A health care provider treating a patient's injuries has limited time to collect a detailed history of the circumstances surrounding the injury event, and patients may not voluntarily disclose that an injury was intentional because of fears about the legal or personal consequences of telling a health care provider.

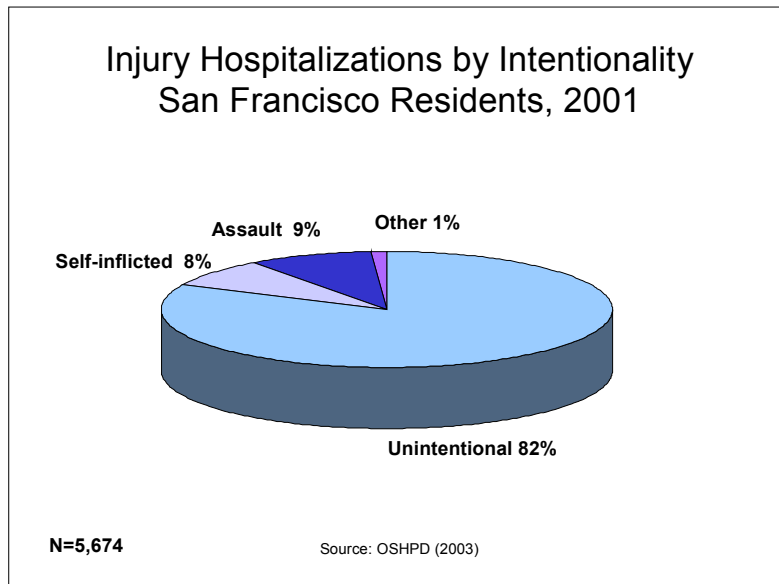


Figure 4. The vast majority of injuries requiring hospitalization were classified as unintentional, which is similar to the distribution in 1998.

Despite the difficulties in determining intent, it is of utmost importance that health care providers attempt to reliably identify and document injuries caused by the abuse of a child, intimate partner or elder. Training medical professionals to identify and document abuse will provide better services for abused patients and more accurate data to document the problem of intentional, non-fatal injuries.

Residency and San Francisco Injury Data: Deaths

San Francisco is a favorite tourist destination and an employment hub for the Bay Area. These characteristics complicate the injury profile because there are three distinct groups to consider: SF residents killed in San Francisco, visitors killed in San Francisco, and SF residents killed elsewhere. Below is the distribution of these three groups; one pie chart considers all residents, and the other represents all deaths that occurred in San Francisco.

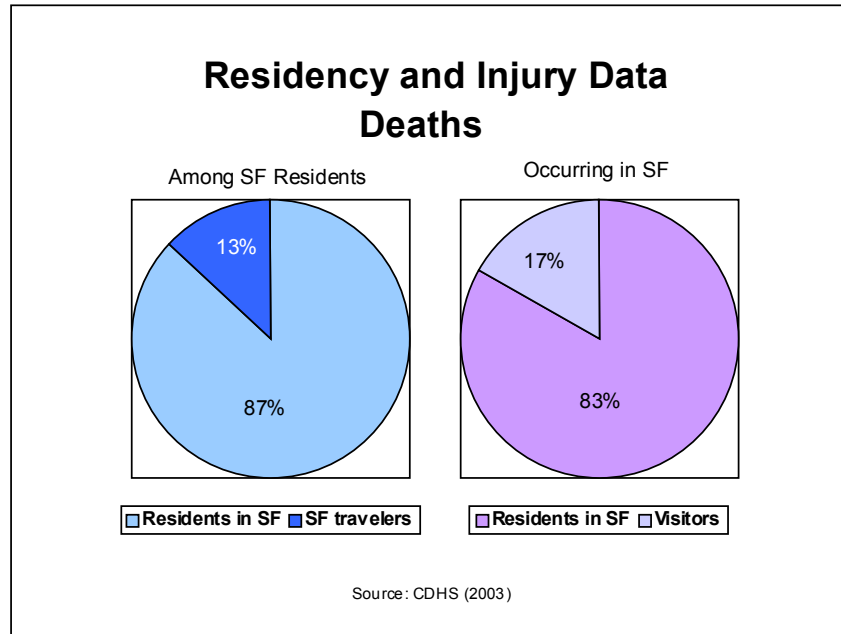


Figure 5.
Residents in SF: Residents who lived and died in San Francisco (n=400)
SF Travelers: Residents who lived in San Francisco but died outside San Francisco (n=61)
Visitors: Non-residents who died in San Francisco (n=81)

In 2001, a total of 542 people, who were residents of or visitors to San Francisco, died from injuries. Four hundred of those were SF residents who died of injury in San Francisco; 81 were visitors from other counties or states who were fatally injured in San Francisco, and 61 were SF residents who died while traveling outside of San Francisco. The following pages discuss the differences in injury events among these three groups.

When calculating rates, one must use a known denominator, such as the population of San Francisco. Therefore, all residents, regardless of where they were injured, must be included in rate calculations. On the other hand, many city services, including trauma centers, fire and police, are most interested in the injuries that occur in SF, regardless of residency. However, visitors cannot be included in rates because they are not San Francisco residents. Therefore, whenever rates are presented, they include all SF residents but not visitors.

Residency and San Francisco Injury Data: Hospitalizations

Residency complicates the profile of non-fatal injuries requiring hospitalization. Almost one-third of all injury patients in San Francisco hospitals are residents of other jurisdictions, while a much smaller percentage of SF residents are treated outside of San Francisco.

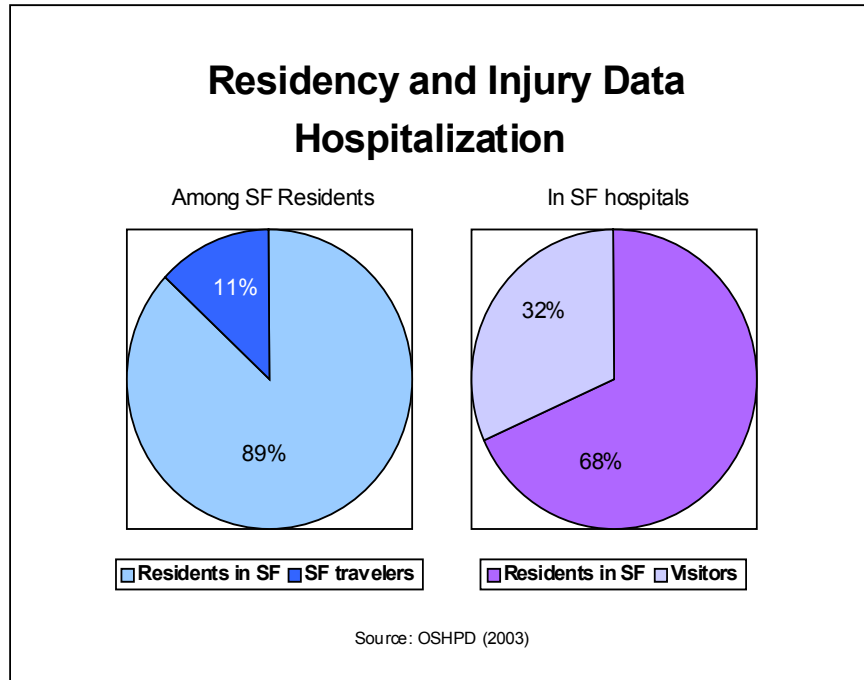


Figure 6.
Residents in SF: Residents hospitalized in San Francisco (n=5,047)
SF Travelers: Residents hospitalized outside San Francisco (n=627)
Visitors: Non-residents hospitalized in San Francisco (n=2,363)

In 2001, 8,037 people, who were residents of or visitors to San Francisco, were hospitalized for non-fatal injuries. Of those, 5,047 were San Francisco residents who were hospitalized in San Francisco; 2,363 were people from other jurisdictions but who were hospitalized in San Francisco (some may have been transferred into San Francisco after an injury), and 627 San Francisco residents were hospitalized elsewhere when traveling outside San Francisco.

When rates of hospitalization for injury are calculated, they do not reflect the injury burden of the visitors who were hospitalized in San Francisco. Remember that we can only calculate rates for SF residents because we do not have accurate numbers of visitors.

Residency and Mechanism of Injury: Deaths

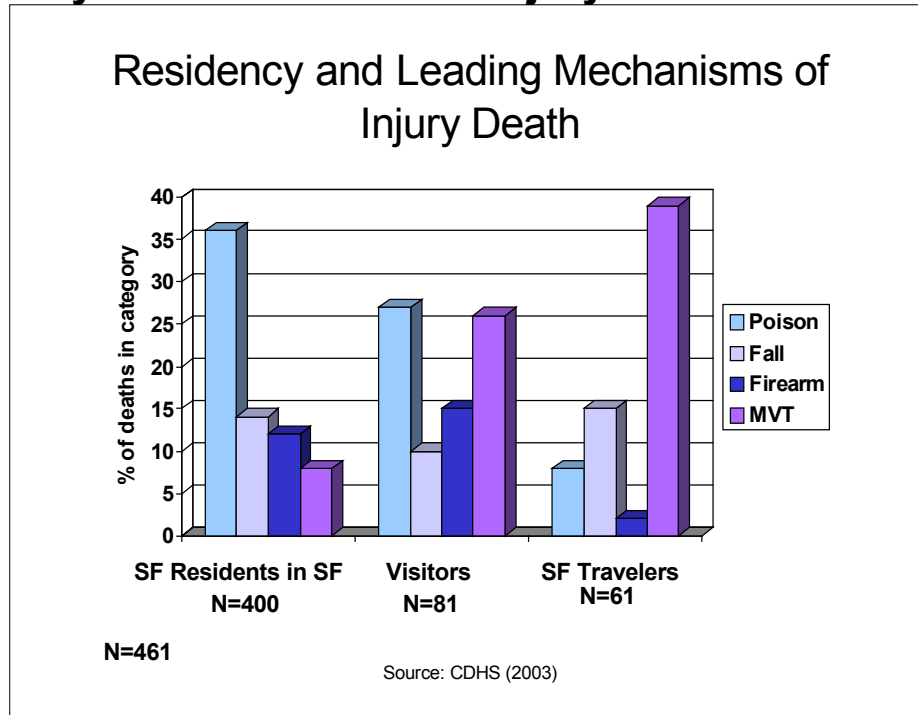


Figure 7.

Poisoning (primarily drug overdose) is the most common injury death for residents in San Francisco. Drug overdoses seem to be a lesser but still leading problem for visitors but are even less of a problem for SF travelers.

The reverse situation holds for residents and visitors in motor vehicle traffic (MVT) crashes. Proportionately, traffic-related death is the greatest injury risk for SF travelers. This makes sense since travelers tend to spend time in motor vehicles. It is less clear why MVT crashes kill a greater proportion of visitors than SF residents in San Francisco. One possible explanation is that visitors to SF, like SF travelers are more likely to be in motor vehicles and more likely to be pedestrians than SF residents. Also it may be due to the presence of the Trauma Center at San Francisco General Hospital (SFGH). Seven deaths of “visitors” injured in MVT crashes occurred at SFGH, but the data do not indicate whether the crash occurred in San Francisco or whether the crash occurred elsewhere, but the patient was transferred to SFGH. Police data (SWITRS) does not provide information on the residence of those killed in crashes in San Francisco.

Firearm injury does not appear to be a high risk for SF travelers. Proportionally, it is slightly higher for visitors than residents in SF.

The percentages of deaths due to falls range from 10% to 15% across the three categories. Residents in SF and SF travelers suffer from slightly more falls than do visitors.

Residency and Mechanism of Injury: Hospitalization

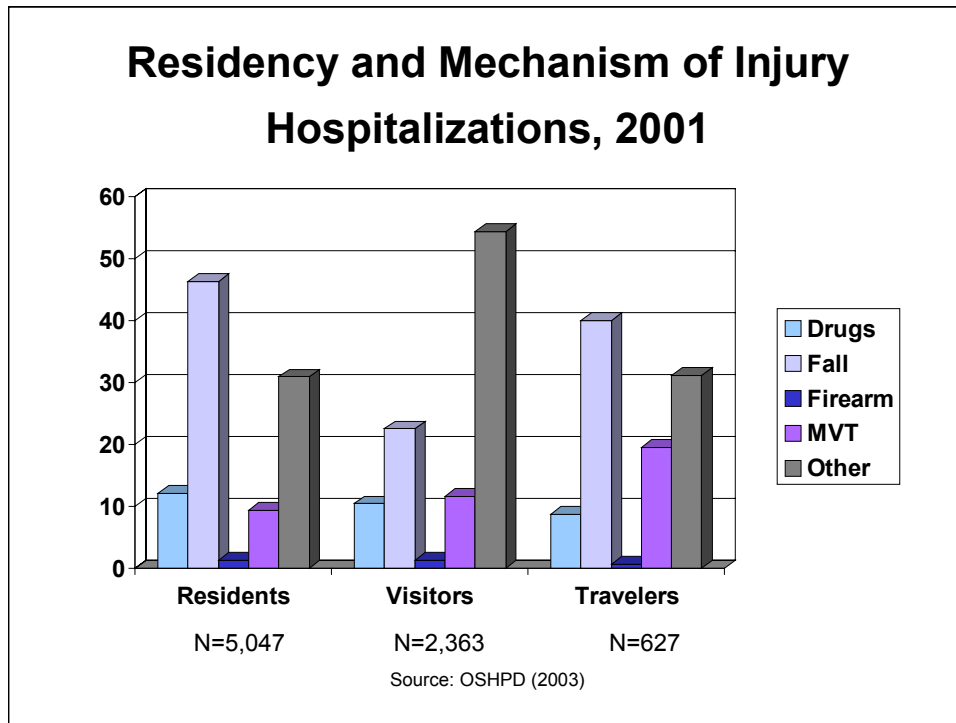


Figure 8.

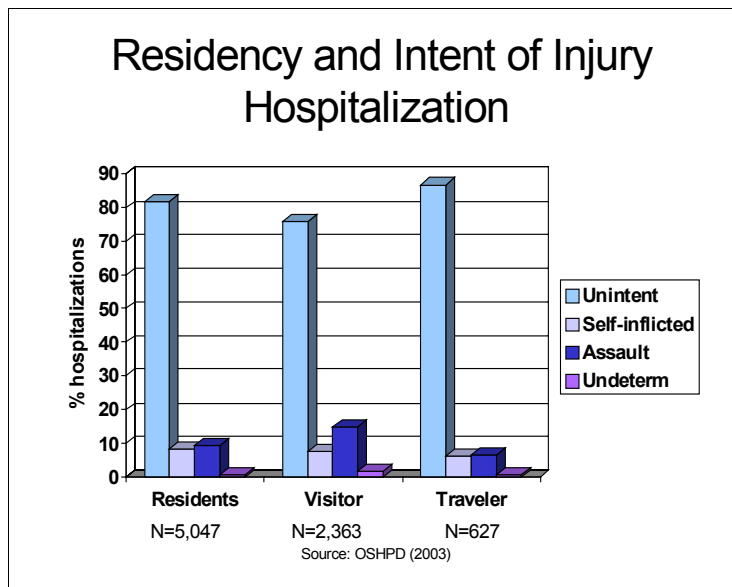
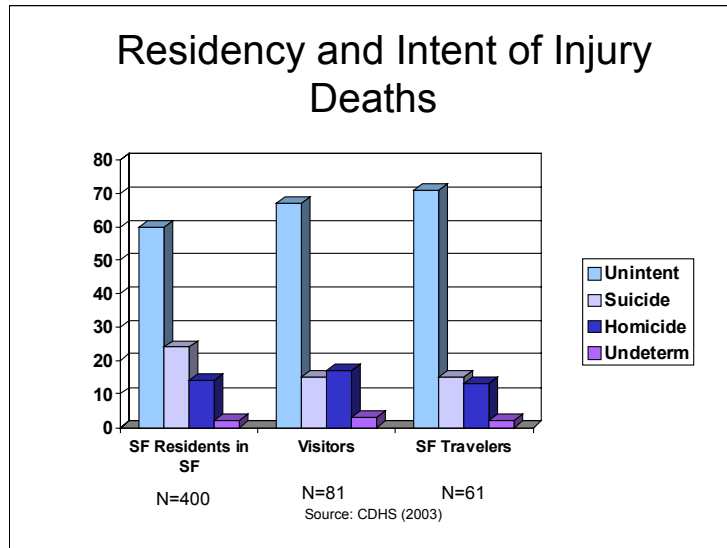
While falls account for almost half of all non-fatal hospitalizations of SF residents in San Francisco, they account for less than one quarter of hospitalizations among visitors. This could be due to age differences among the groups, such as if visitors are younger and thus less likely to fall, or the result from hospital transfer policies. In general, if taken as a group, SF travelers are probably older than visitors but younger than non-traveling residents.

MVT-related hospitalizations follow the same trend as for deaths. There are proportionally more for travelers, fewer for visitors and even fewer still for non-traveling residents.

The pattern of hospitalizations due to drugs is very different from that of drug-related deaths. Drugs account for about 10% of hospitalizations in each of the three groups.

Included in the “other/unspecified” category are hospitalizations that resulted from cutting/piercing, struck by a blunt instrument, natural and environmental causes, fire/burn, firearms, non-traffic bicycle and pedestrian, suffocation, drowning, machinery and other unspecified causes.

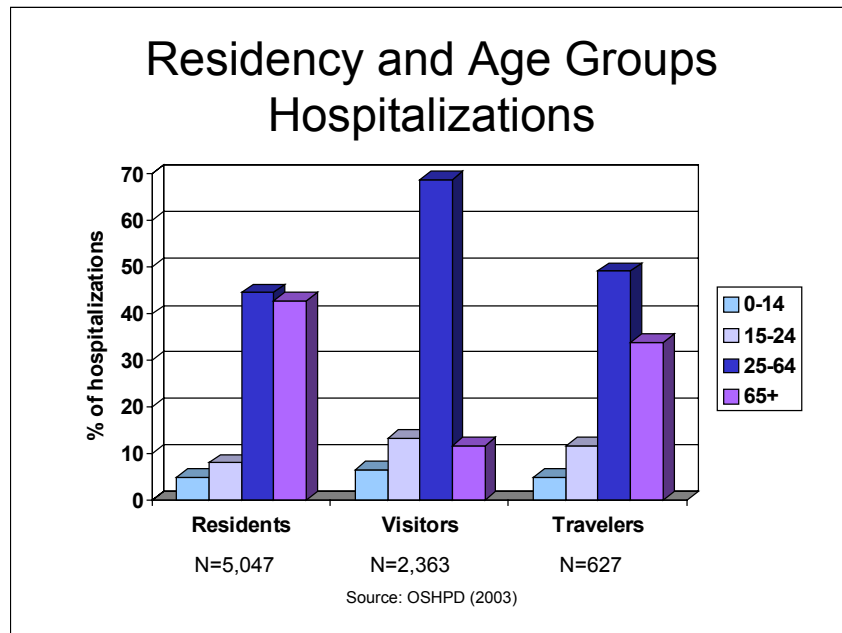
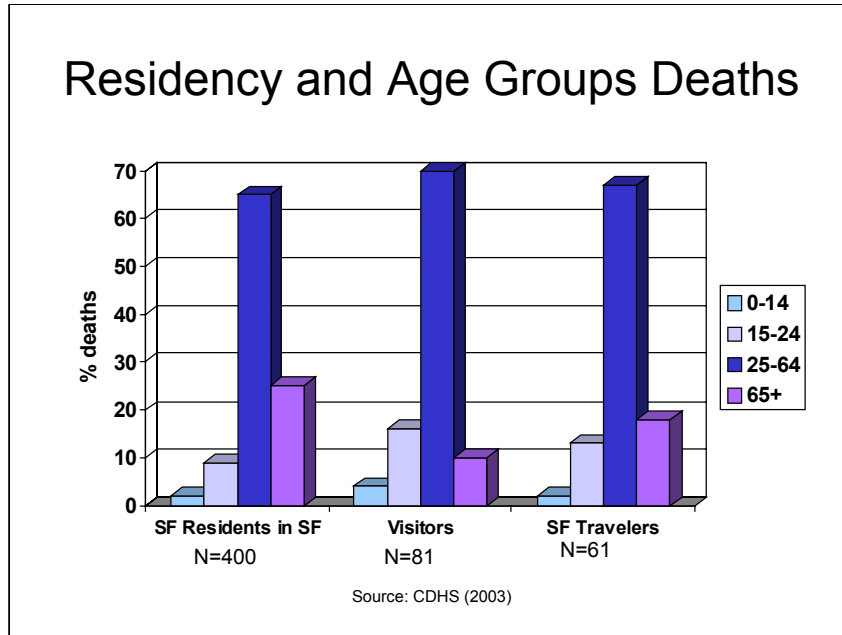
Residency and Intent of Injury



Figures 9 & 10.

The relationship between residency and the intentionality of an injury is not as striking as it is for the leading mechanisms of injury. However, there are two notable correlations. Both homicides and assaults are proportionally higher for visitors than for residents. On the other hand, suicide and self-inflicted injury are proportionally higher for residents than for visitors.

Residency and Age Groups



Figures 11 & 12.

Very few children under the age of 14 died of injury. Of the 12 who died of injury, 8 were SF residents in San Francisco, 3 were visitors and 1 was a SF traveler. Seniors have almost as many hospitalizations as adults aged 25-64 years, even though there are over three times more adults than seniors in the population.

Access to Medical Care: the Effect of Intent of Injury

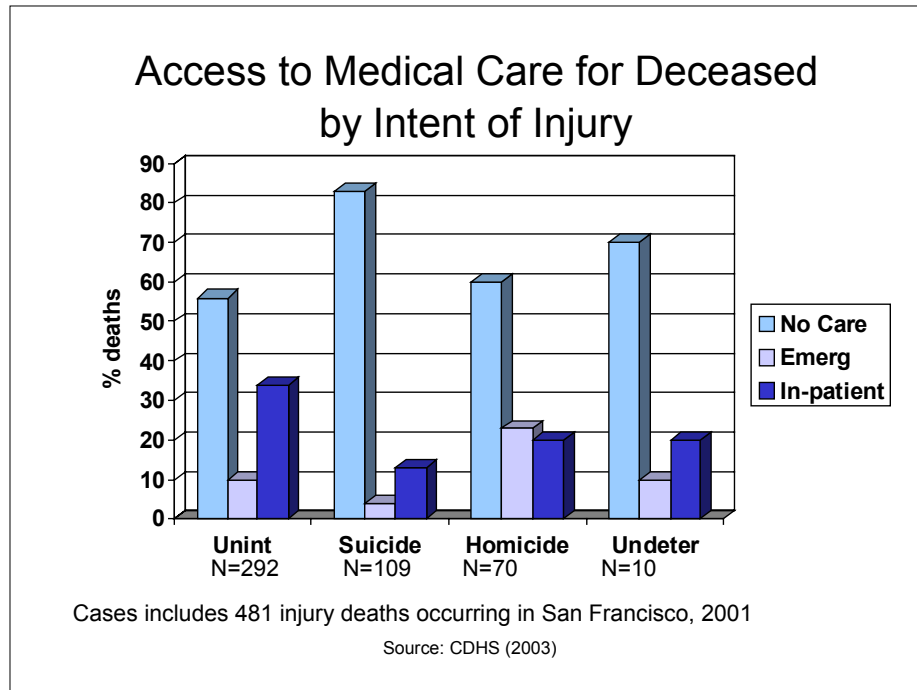


Figure 13.

For all intent categories, over half of the deceased never received any form of medical care. This is most pronounced for suicide, where over four-fifths of all suicides were completed before help could be summoned. Homicide victims more frequently reached an emergency department, but many died before admission. Those sustaining unintentional injuries were most likely to reach a hospital and be admitted, even though they did not survive their injuries. Therefore, this chart testifies most strongly to the importance of primary prevention, regardless of intent.

Access to Medical Care: the Effect of Injury Mechanism

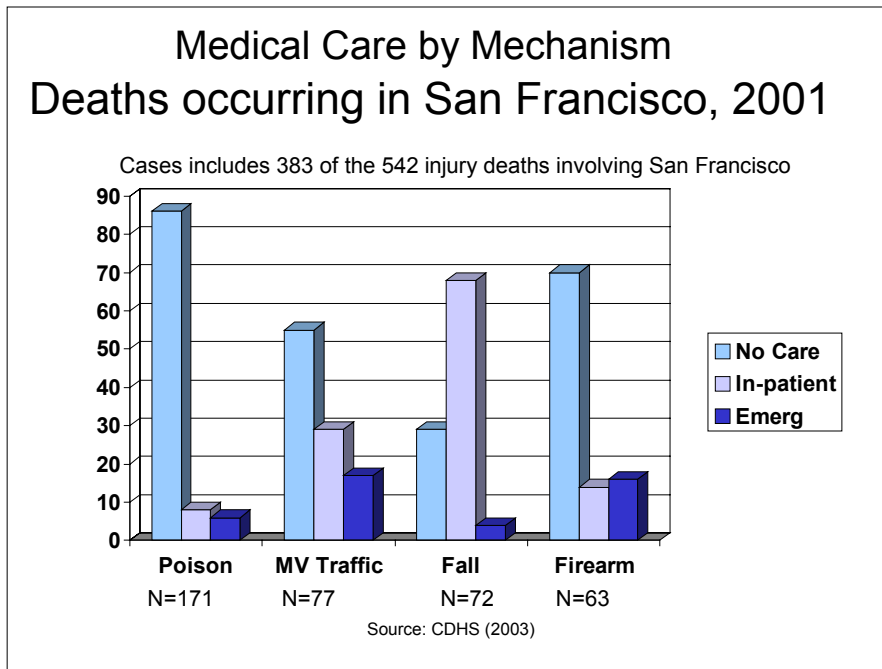


Figure 14.

Over 80% of those who died from a drug overdose or other poisoning never received any form of medical care. The same is true for about two-thirds of those who were shot with firearms. Again, these numbers testify to the importance of primary and secondary injury prevention, particularly in the areas of drugs and firearms.

In stark contrast, almost 70% of the people whose death resulted from a fall died after admission to a hospital. The swift response of Emergency Medical Services in San Francisco probably accounts for the percentage of victims of motor vehicle crashes who receive care, even though many do not survive their injuries.

Injury Deaths: Counts by Age and Sex

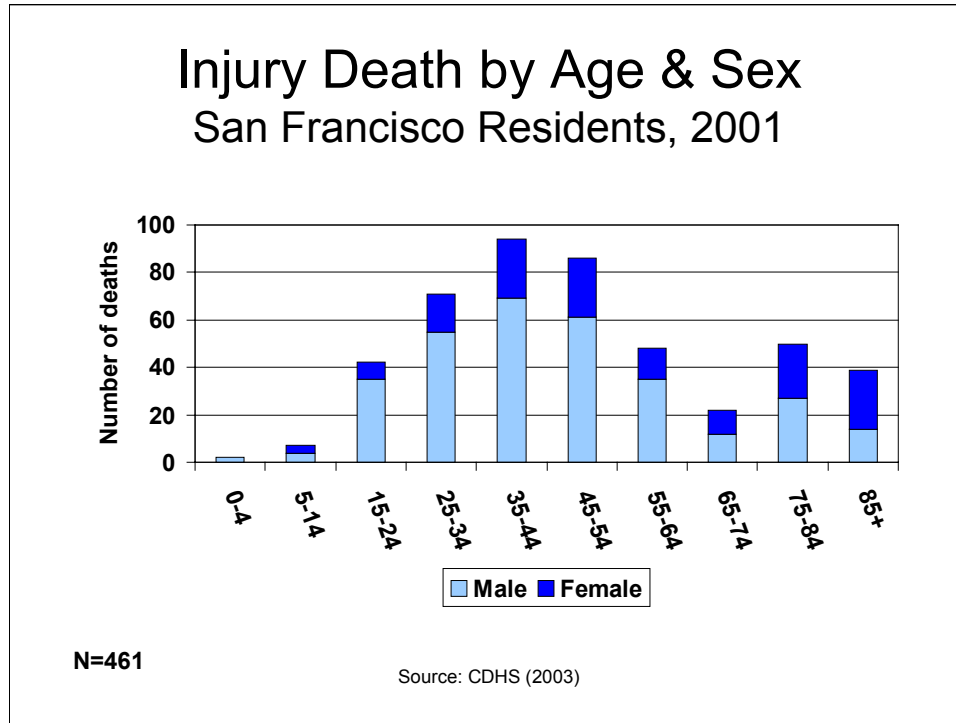


Figure 15.

Age	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Female	0	3	7	16	25	25	13	10	23	25
Male	2	4	35	55	69	61	35	12	27	14

Nine San Franciscan children under the age of 15 died from an injury in 2001. Overall, for most of the life span, deaths among males outnumber those among females 68% to 32%. Only after the age of 85 do deaths among females outnumber those among males, which may be due to the fact that the population of women outnumbers that of men at that age.

Injury Deaths: Rates by Age and Sex

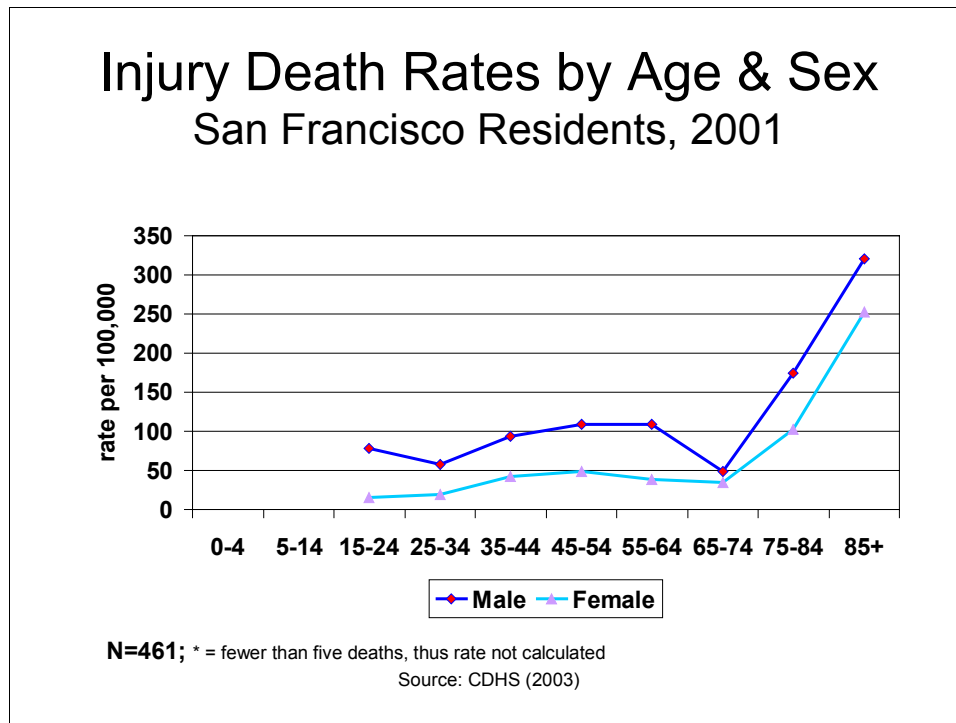


Figure 16.

Age	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Female	*	*	16	19	42	49	39	34	102	253
Male	*	*	78	58	93	109	109	49	175	321

Injury death rates are higher for males than females in all age groups. While more women than men aged 85+ die of injury, the injury rates for males are higher because there are far fewer males than females who live beyond the age of 85.

For both sexes, injury death rates spike for seniors. The rate for women 85+ years old is six times that for women aged 55-64. For men over the age of 85, the injury death rate is three times that for men aged 55-64.

Injury-related Hospitalizations: Counts by Age and Sex

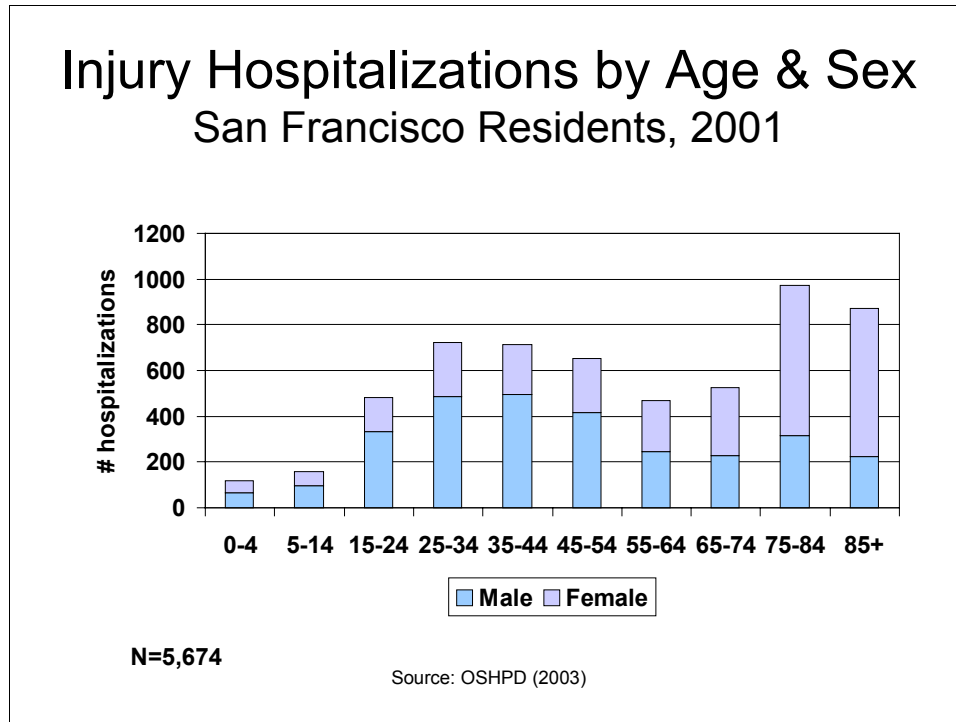


Figure 17.

Age	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Female	50	62	148	235	216	237	220	298	658	649
Male	67	95	332	487	496	415	247	226	314	222

Overall, injury-related hospitalizations among males outnumber those of females (51% versus 49%). However, the percentages vary dramatically between age groups. For example, up until age 64, males outnumber females. However, in the senior age groups, and most strikingly among older seniors, females outnumber males.

Injury-related Hospitalizations: Rates by Age and Sex

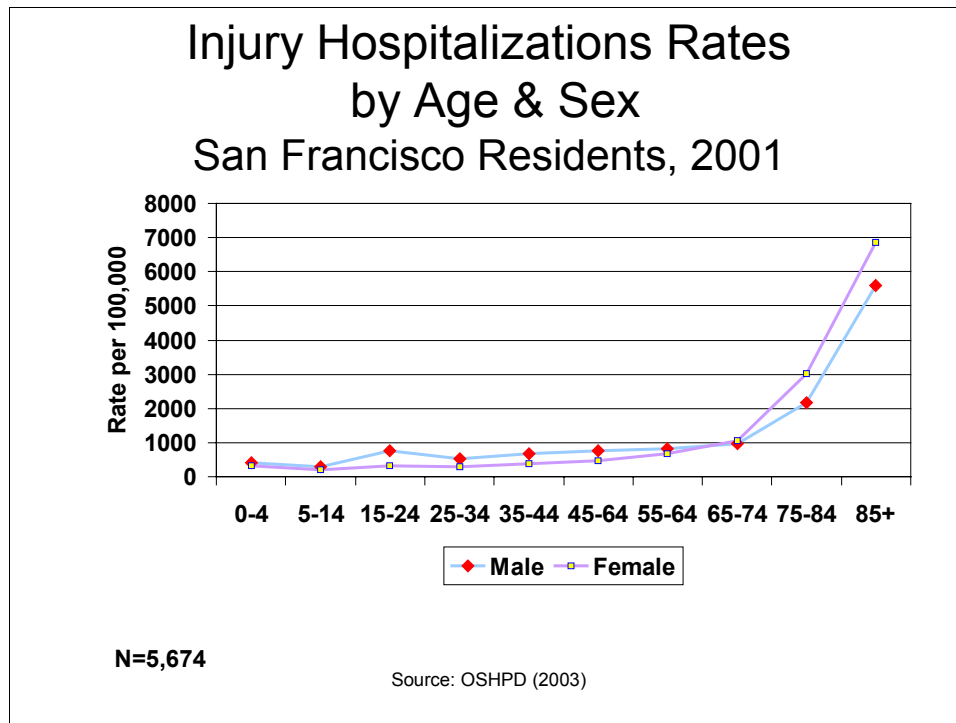


Figure 18.

Age	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Female	326	203	336	280	367	465	678	1042	3023	6869
Male	412	305	751	515	685	766	810	980	2164	5600

The graph of the rates of injuries requiring hospitalization reflects the same pattern as that for deaths regarding sex: males have higher rates of hospitalization than females through age 64. Then the rate lines cross, but the rates for both male and female seniors still rise precipitously. The rate for women over 85 years old is ten times that of women aged 55-64 years. For men over age 85, the rate of hospitalization due to injury is seven times that of men aged 55-64.

Motor Vehicle & Traffic-related Injuries Summary

San Francisco is a completely urban county; the county and city are one and the same. As is true in many large American cities, the predominant motor-vehicle-traffic-related (MVT) injury risk in San Francisco is to pedestrians.

In 2001, pedestrians accounted for one half (20 of 40) of the MVT deaths occurring in San Francisco, although not all were residents. Vehicle occupants accounted for 16 deaths, of which seven were on a motorcycle. Four deaths were sustained by bicyclists.

There were 748 hospital discharges coded as MVT injuries. Of these, 290 were occupants of vehicles, 264 were pedestrians, 121 involved motorcyclists, and 46 were bicyclists. The circumstances were unspecified in 27 other hospitalizations.

Police data from the Statewide Integrated Traffic Reporting System (SWITRS) shows that 6,535 persons were injured by MVT crashes in San Francisco. Among these persons, 4% were severely injured or killed, 23% had other visible injuries, and 73% complained of pain. Of the reported MVT crashes, 73% involved occupants of vehicles, and only 14% were pedestrians. These data indicate that, while the most frequent injuries in crashes are to vehicle occupants, it is the pedestrians who sustain the most serious injuries.

This Profile presents data on the MVT injury problem in a variety of ways:

- a social math exercise focusing on the number of vehicles in San Francisco;
- graphs drawing upon data from the Statewide Integrated Traffic Reporting System and hospital discharge record system;
- maps indicating where MVT injuries are occurring throughout the city.

Social Math: Vehicles in San Francisco

There were approximately 469,000 vehicles registered in San Francisco in 2003.¹ To put that into perspective, assume that the average vehicle is 15'2" (average length of 2003 model cars², not including trucks or 18-wheelers). If that many cars were bumper-to-bumper in a single file, the backup would stretch along highways from **San Francisco to Vail, Colorado**.³ The Department of Parking and Traffic has estimated that an additional 35,400 vehicles enter San Francisco and are present in the city at noon on an average business day. Then the backup would stretch from San Francisco to **Mount Rushmore, South Dakota**.³ CalTrans also has estimated that 435,000 vehicles drive into or through San Francisco on an average 24 hour weekday (although a similar number also leave the city daily).¹ If vehicles registered in San Francisco were added to the number of those coming into or through the city, the backup would stretch along highways from **San Francisco to Atlanta, Georgia**.³

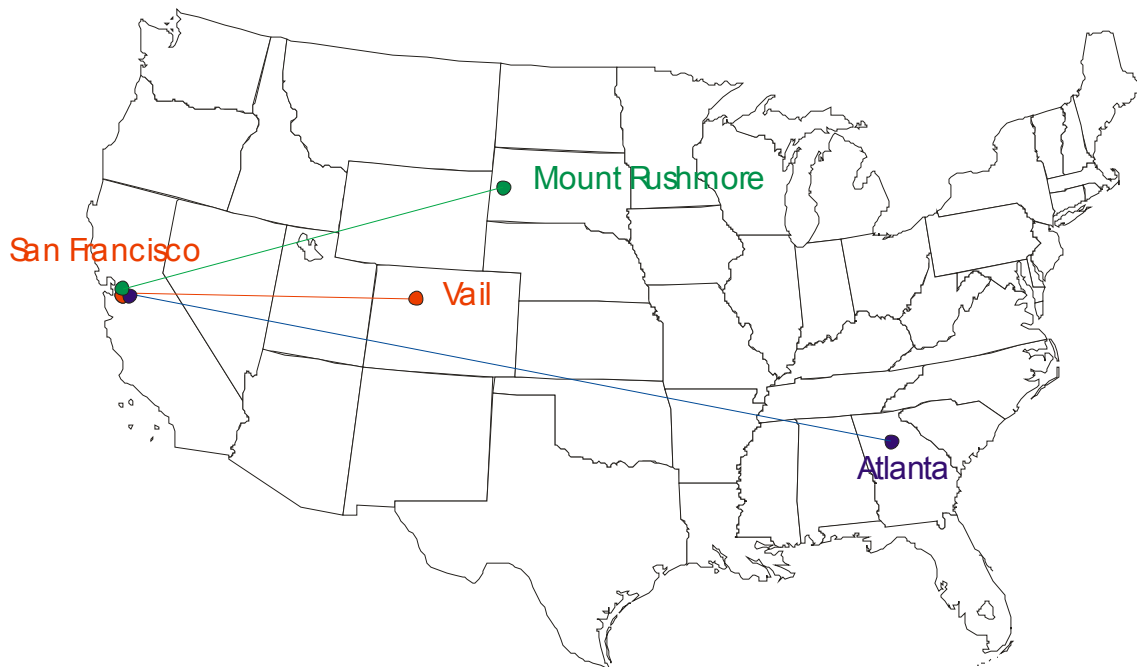


Figure 19.

Obviously, this would never happen in the real world. However, this exercise illustrates why San Francisco's pedestrians have difficulty competing with traffic as they attempt to cross streets and avenues.

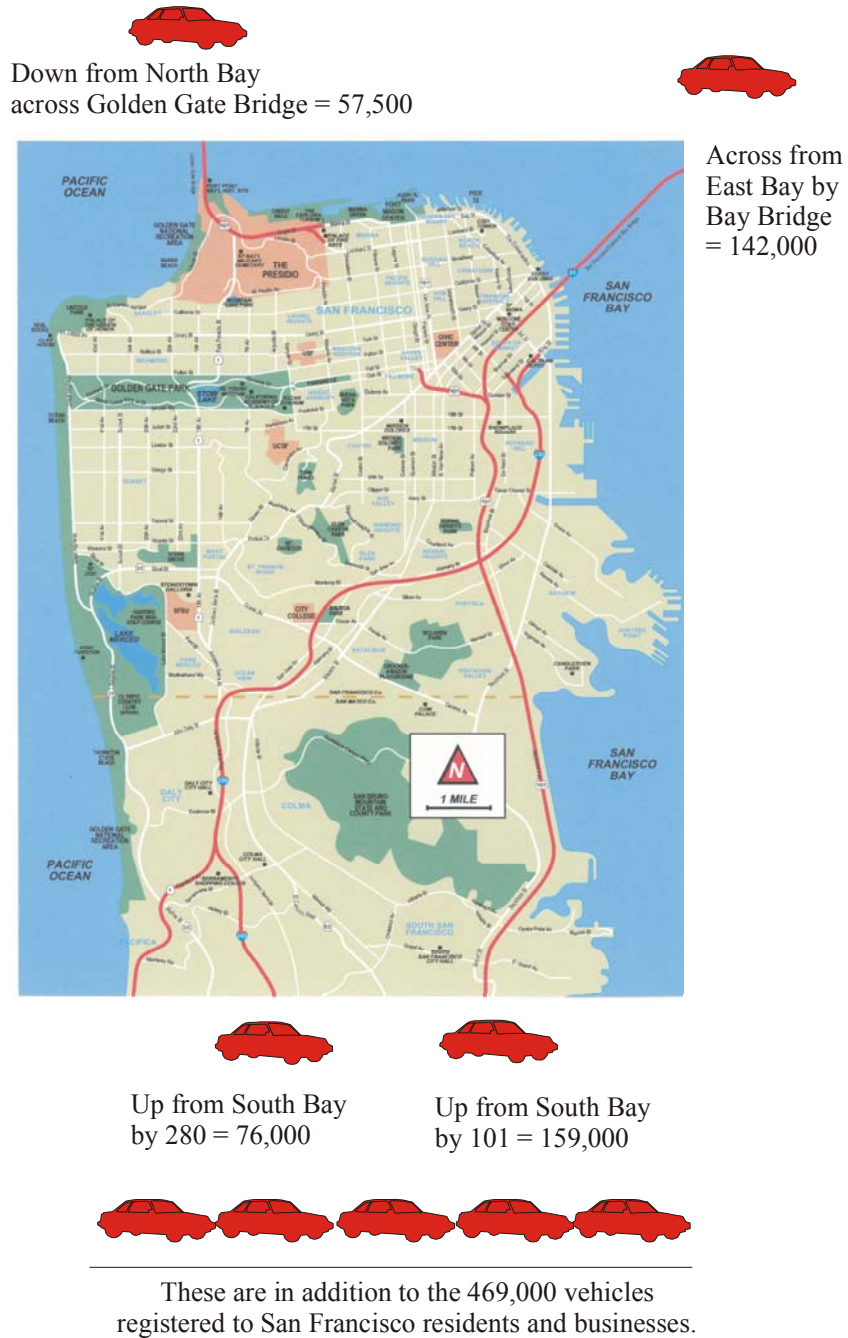
Information sources:

1. Personal communication, DPT
2. Consumer Reports, April, 2003
3. Mileage Chart, AAA Atlas, 2005



Figure 20.

Daily number of vehicles coming into San Francisco 24-hour period on weekdays



Motor Vehicle Traffic Deaths, 2001 Mode of Travel

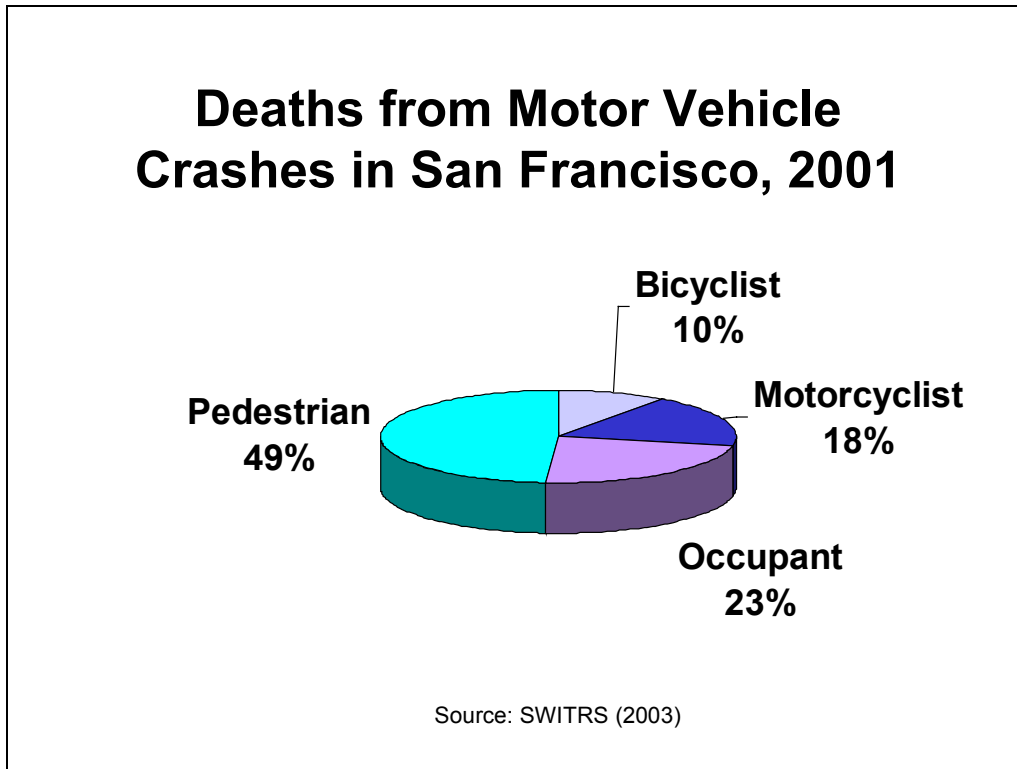


Figure 21.
Pedestrians account for half of the motor vehicle crash deaths in San Francisco.

In the United States, motor vehicle crashes are the leading cause of injury death. In San Francisco, they rate as the second leading cause of injury death in 2001 after drugs and other poisoning deaths. Of the 40 motor vehicle deaths in San Francisco in 2001, 20 were pedestrians, 7 motorcyclist, 9 vehicle occupants and 4 bicyclists.

Because vital statistics records are not specific about the mode of travel of the deceased, we obtain that information from the Statewide Integrated Traffic Reporting System (SWITRS). These data include any deaths that occurred within 30 days of a traffic crash that happened in San Francisco. Thus, these deaths include SF residents and visitors who were injured in San Francisco but exclude MVT deaths of SF residents who were injured while traveling outside the city.

Hospitalizations for Motor Vehicle Injuries, 2001 Mode of Travel

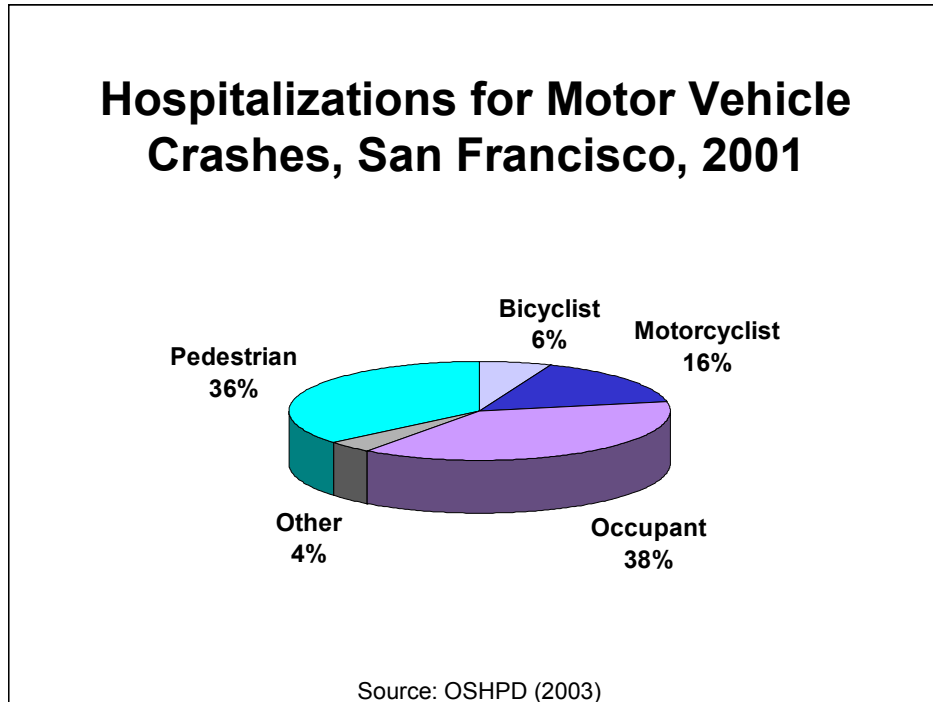


Figure 22. Hospitalizations due to injuries from motor vehicle crashes predominantly involve pedestrians and vehicle occupants.

In 2001, 748 hospital discharges were coded as non-fatal motor vehicle traffic injuries. Of those discharge records, 290 involved occupants of motor vehicles, 264 were pedestrians, 121 were motorcyclists and 46 involved bicyclists. Twenty-seven were coded to unspecified circumstances.

SWITRS indicates that 6,535 persons were injured in 4,542 MVT crashes. However, the majority of these persons were not hospitalized as a result of their injuries.

Burden of Motor Vehicle Injuries and Deaths San Francisco, 2000-2002

Vehicle collisions during the three-year data period (2000-2002) imposed a considerable injury burden on the city of San Francisco. SWITRS data reflects the extent of that burden, in terms of who was injured and the extent of their injuries.

Number of Injuries in Motor Vehicle Crashes, San Francisco

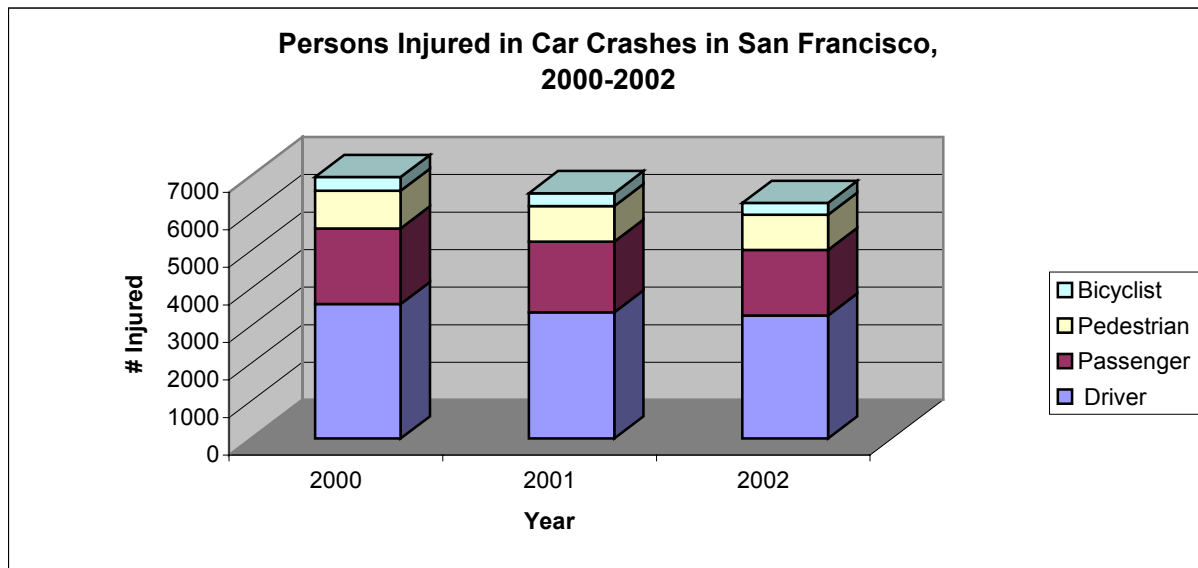


Figure 23.

Year	Driver	Passenger	Pedestrian	Bicyclist
2000	3,580	2,017	1,005	360
2001	3,358	1,886	942	349
2002	3,275	1,749	937	313

Source: *Annual Report of Fatal and Injury Motor Vehicle Traffic Collision (Years 2000, 2001, 2002)*; CHP, Statewide Integrated Traffic Records System.

The vast majority of people injured in collisions are the occupants of the vehicles involved. However, as is clear from the next graph, most of the injuries, such as “complaint of pain” or “other visible injury,” are not considered severe. Fatal or severe injuries occur in only a few collisions, but half of the fatal injuries are suffered by pedestrians.

Severity of Injury in Motor Vehicle Crashes, San Francisco

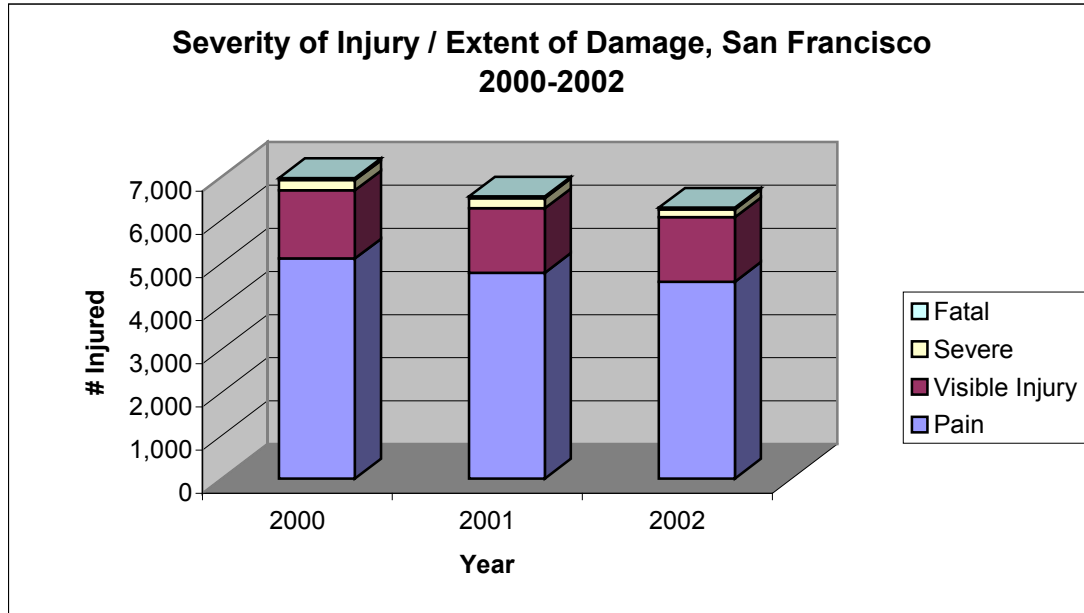


Figure 24.

Year	Fatal	Severe Injury	Other visible injury	Complaint of Pain
2000	49	236	1,578	5,099
2001	40	232	1,497	4,766
2002	40	183	1,492	4,561

Source: Annual Report of Fatal and Injury Motor Vehicle Traffic Collision (Years 2000, 2001, 2002); CHP, Statewide Integrated Traffic Records System.

Traveler Type

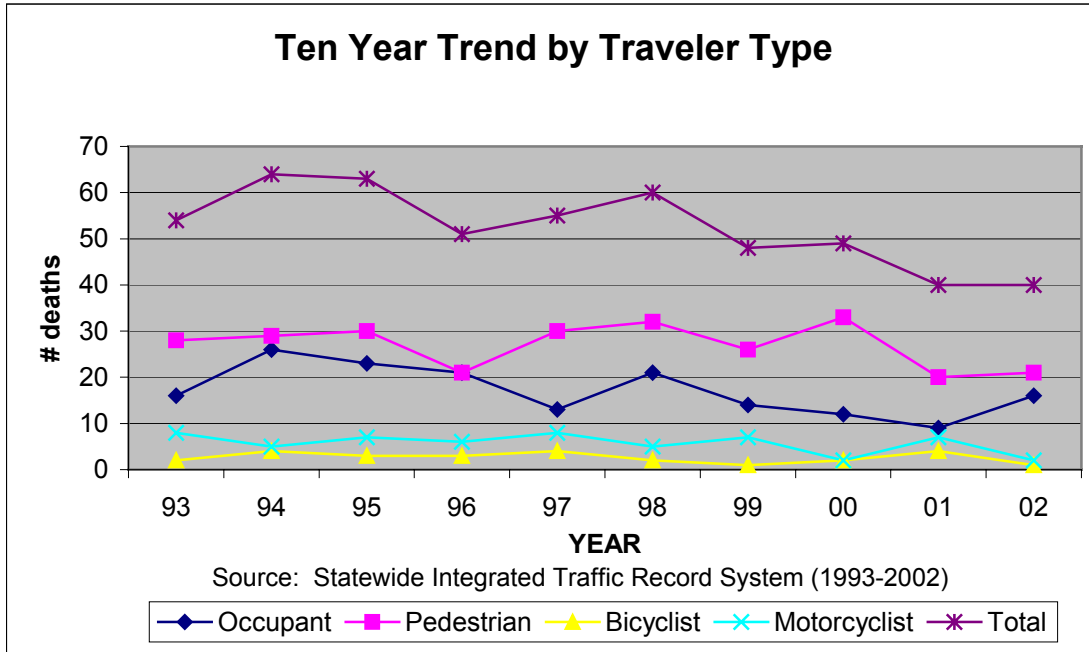


Figure 25.

Year	Occupant	Pedestrian	Bicyclist	Motorcyclist	Total
93	16	28	2	8	54
94	26	29	4	5	64
95	23	30	3	7	63
96	21	21	3	6	51
97	13	30	4	8	55
98	21	32	2	5	60
99	14	26	1	7	48
00	12	33	2	2	49
01	9	20	4	7	40
02	16	21	1	2	40

Over the past decade, there has been a downward trend in the total number of people killed in motor vehicle traffic crashes in San Francisco. While the average number of total MVT deaths per year in the '90s (1993-1999) was 56 deaths, the average for the '00 (00-02) was 42 deaths.

On the other hand, there is not a clear downward trend within each individual category of MVT injuries. Even when the numbers have declined, they have often increased again, indicating that there is still plenty of variability in the types of MVT injuries from year to year.

Costs Associated with Motor Vehicle Traffic Injury San Francisco, 2000-2002

It is impossible to assign a dollar value to the true burden of injury. As stated by the Centers for Disease Control,¹ the list of costs not included in most estimates include “loss of patient and caregiver time, non-medical expenditures (e.g., wheelchair ramps), insurance costs, property damage [*included in DOT estimates below*], litigation, decreased quality of life, and diminished functional capacity. Long-term – non-injury health consequences (e.g., mental health-care costs) are another important component...” However, policymakers must have some financial estimates of how costly a certain condition is as they allocate scarce resources to address it.

The 2001 SWITRS report, *Annual Report of Fatal and Injury Motor Vehicle Traffic Collisions*, provides a table that permits jurisdictions to estimate the costs of motor vehicle crashes that occur within their boundaries. The following table uses these SWITRS estimates to calculate a cost of motor vehicle crashes in San Francisco.

While the “costs per” estimates by the U.S. Department of Transportation include information on individual victims as well as collisions, data for the table below focus on collisions rather than individuals. Thus, the estimates are conservative, since they do not include multiple victims of a single collision. For example, in 2001, there were 39 fatal collisions that involved 40 deaths, and 6,535 persons were injured in 4,542 crashes. However, this table is calculated using collisions rather than injuries for 2001.

	# Collisions	Cost per	Totals
Fatal	125	\$2,709,000	\$338,625,000
Severe	599	\$188,000	\$112,612,000
Visible Injury	4024	\$38,000	\$152,912,000
Pain	9011	\$20,000	\$180,220,000
Property only	10131	\$2,000	\$20,262,000
Total			\$804,631,000

Source of SWITRS cost estimates: U.S. Department of Transportation, Federal Highway Administration, October 31, 1994, “Technical Advisory on Motor Vehicle Accident Costs. Costs have been updated to 2001 dollars using the Gross Domestic Product (GDP) figure provided by the U.S. Department of Commerce-Bureau of Economic Analysis.

Because of the high population density and the other unique characteristics of San Francisco, there is an extremely high rate of pedestrian death and injuries. For that reason, the remainder of this chapter will be devoted to pedestrian issues.

¹ *Morbidity and Mortality Weekly Report* on “Medical Expenditures Attributable to Injuries – United States, 2000”, (January 16, 2004/Vol.53/No.1)

Pedestrian Injuries and Deaths

San Francisco is considered the "air-conditioned city," with a range of average temperatures between 48° and 65°, relative humidity averaging between 84% in the morning and 62% in the afternoon and 20 inches annual rainfall — perfect weather for walking. It is organized informally into 15 neighborhoods, with stores within easy walking distance from the majority of residences. It has many parks where residents of all ages can play, walk or sit on the grass. Public transportation systems allow people to move around the city without using a car.

At the same time, San Francisco copes with about 900,000 vehicles: 435,000 come in and out daily and 469,000 are registered to San Francisco residents and businesses. These vehicles compete with pedestrians for space on San Francisco roads as they drive along city streets to get to work places, schools, shopping areas, sports complexes, restaurants, theaters, museums or hundreds of other destinations. The major corridors in the city have extremely high traffic volumes, and, not surprisingly, very high rates of pedestrian deaths and injuries. (See map and note on next page.)

The Department of Parking and Traffic reports yearly fluctuations in pedestrian injuries and deaths over the past decade, ranging from a high of 32 deaths in 1998 to a low of 16 deaths in 2001. The trend over these years peaked in the later-'90s and has decreased in recent years.

Several city departments are working to address pedestrian injury risk by collaborating on pedestrian safety programs, using the three "E"s: engineering, education and enforcement. These programs are listed in the section on community resources.

Severity of Pedestrian Injuries in San Francisco, 2000-2002

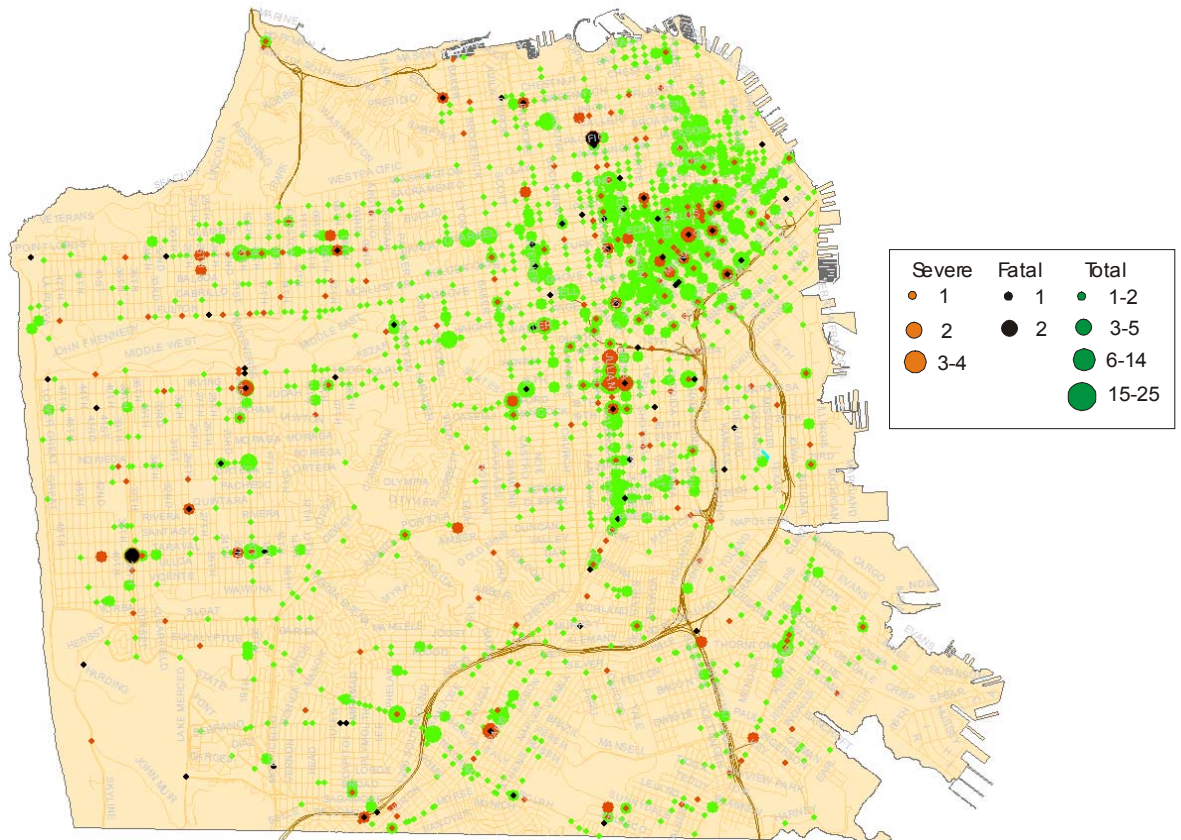


Figure 26.

This map displays where pedestrian injuries and deaths occurred in San Francisco over a three-year period (2000-2002). Clearly, the densest area of injury is the downtown, on both sides of Market Street. However, the city streets bearing traffic along commute routes are perilous as well. Commute traffic pours along the streets south of Market from and to the approaches to the Bay Bridge and Highways 280 and 101. Traffic from the Golden Gate Bridge goes downtown along Lombard Street and Van Ness Avenue. Between the Golden Gate Bridge and Highway 280, 19th Avenue is the connector route. Mission Street, Potrero Avenue, Bayshore Boulevard and 3rd Street also bring traffic from Highways 280 and 101 in and out of the city. Other routes with multiple pedestrian injuries are Geary Boulevard, Haight Street, Taraval Street, Ocean Avenue, and Geneva Avenue.

Map information: SWITRS traffic collision data. Map created by Stanley Sciortino, PhD, CHES, SFDPH, funded by a grant from the California Office of Traffic Safety through the Business, Transportation & Housing Agency.

Pedestrian Deaths by Age in San Francisco, 2000-2002

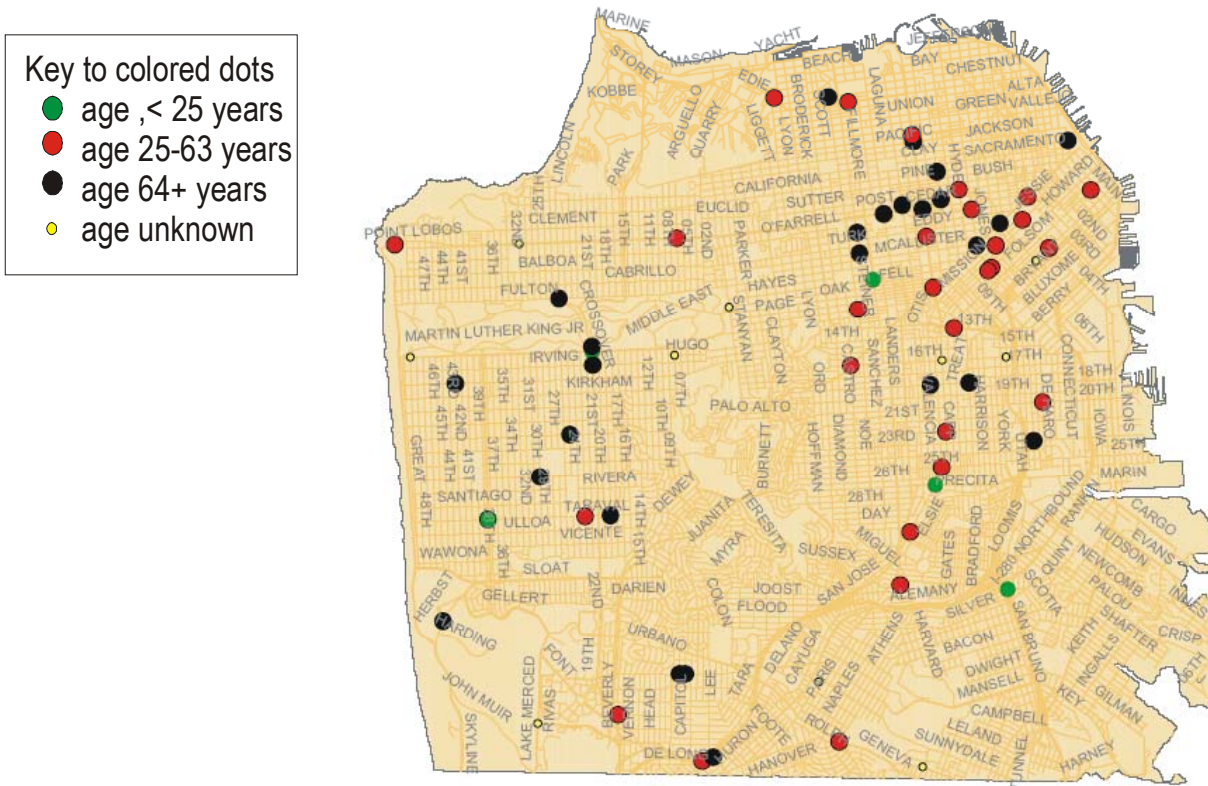


Figure 27. This map shows the location (to the nearest intersection) of the 71 pedestrian deaths that occurred in San Francisco during the years 2000-2002. Based on the neighborhood boundaries used throughout this Profile, the two neighborhoods with more than 10 pedestrian deaths are the Tenderloin (15 deaths) and the Sunset (14 deaths). The impact of pedestrian deaths and injuries on each neighborhood will be examined in later pages.

Another factor to note is the number of fatal pedestrian injury victims in each age group: <25 years (5 deaths), 25-64 years (28 deaths), 65+years (28 deaths); age was unreported for 10 deaths. However, just looking at the numbers of victims can be misleading. Instead, by comparing the rate of pedestrian deaths for adults aged 18-64 (approximately 5 per 100,000) with that for seniors (26.4 per 100,000), it is evident that seniors are at much greater risk of death from pedestrian injury. Therefore, the impact of pedestrian deaths on seniors will be examined further in later pages.

Map information: SWITRS traffic collision data. Map created by Stanley Sciortino, PhD, and Li Yu, CHES, SFDPH, funded by a grant from the California Office of Traffic Safety through the Business, Transportation & Housing Agency.

Pedestrian Injuries to Children <18 Years, 2000-2002 7:00 AM to 5:00 PM - Jan 2000 to Dec 2002

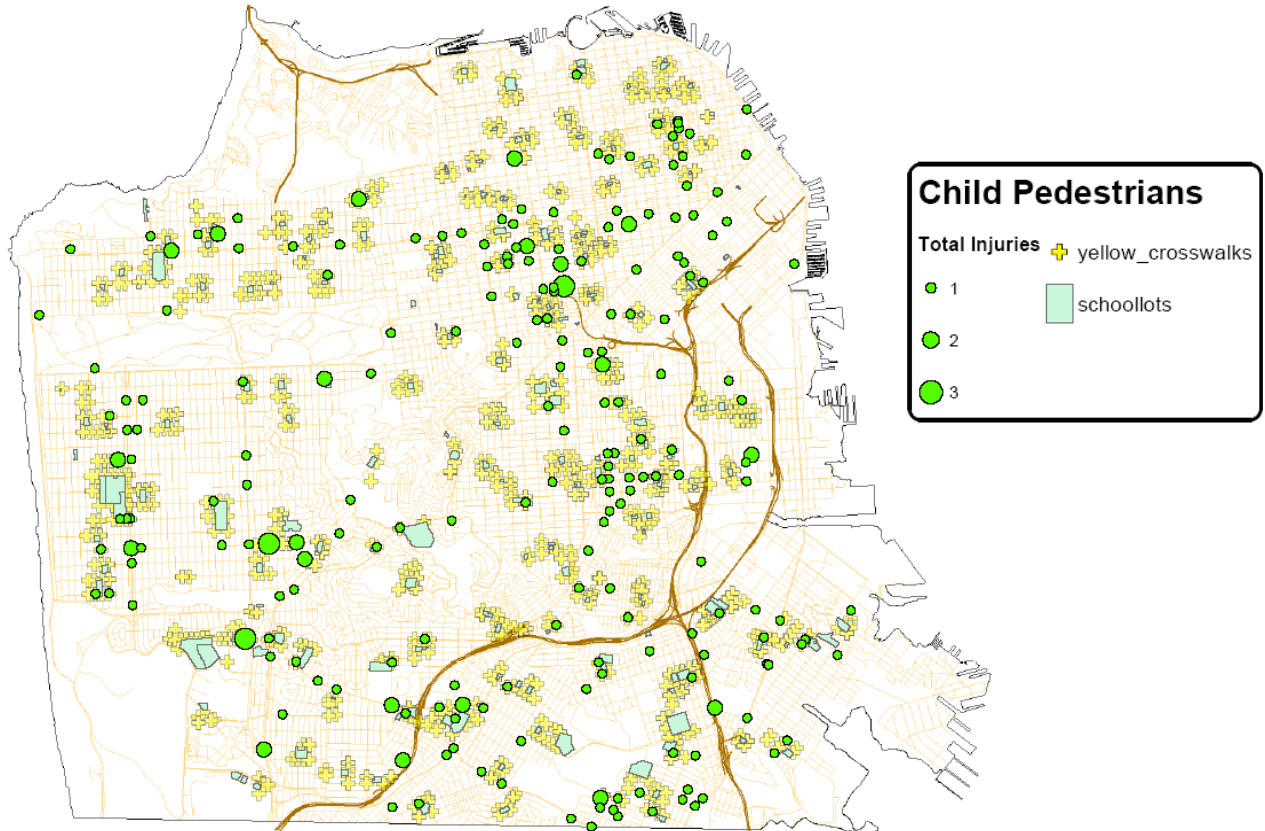


Figure 28.

During the three-year period of 2000-2002, three pedestrians under 18 years of age were killed. However, there was a significant number of children injured as motor vehicle occupants.

This map illustrates the relationship between the location of schools, yellow crosswalks and child pedestrian injuries. It is clear from the map that there are many school vicinities and yellow crosswalks without any child pedestrian injuries. However, there is some significant correlation between school areas and child pedestrian injuries in certain areas, particularly in the Western Addition, the Mission District, the Sunset (especially along Sunset Boulevard), the Excelsior (especially along Geneva Avenue) and at the southern end of 19th Avenue.

Map information: SWITRS traffic collision data. Map created by Stanley Sciortino, PhD, CHES, SFDPH, funded by a grant from the California Office of Traffic Safety through the Business, Transportation & Housing Agency.

Pedestrian Injuries to Seniors 65+ Years, 2000-2002

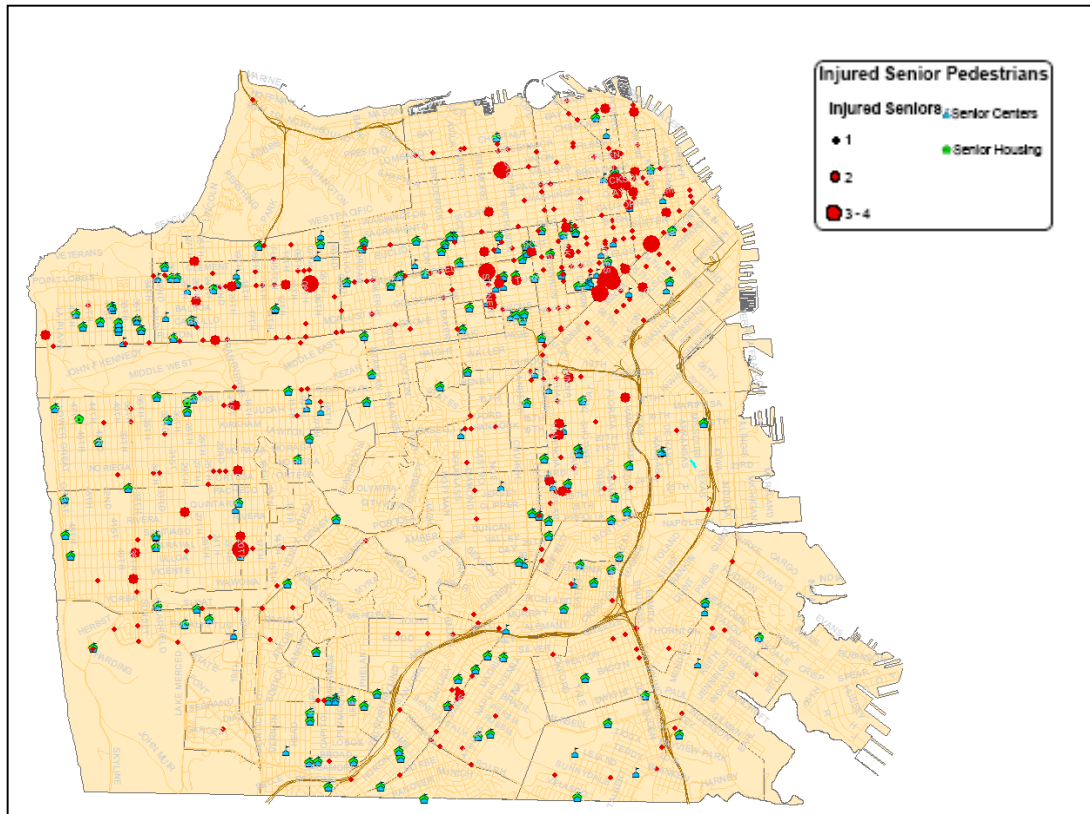


Figure 29.

The pedestrian injury death rate among seniors is the highest of any age group. For example, the rate of pedestrian deaths for seniors over 64 years of age is more than five times the rate for adults aged 18-64 years (approximately 26 per 100,000 versus 5 per 100,000, respectively). Walking is the way many mobile seniors get around the city.

This map illustrates the relationship between senior pedestrian injuries and the location of senior centers and senior housing. The correlation is not high. However, there are certain areas of the city that appear to have particularly high rate of senior pedestrian injury. The most notable of those areas are Market Street, Chinatown, the Mission District, the Western Addition (particularly Webster Street), along Geary Boulevard and Fulton Street in the Richmond, and the Sunset (particularly 19th Avenue and Sunset Boulevard).

Map information: *SWITRS traffic collision data. Map created by Stanley Sciortino, PhD, CHES, SFDPH, funded by a grant from the California Office of Traffic Safety through the Business, Transportation & Housing Agency.*

San Francisco Neighborhood Map: Vicinity of the Tenderloin and South of Market Pedestrian Injuries in 2000-2002

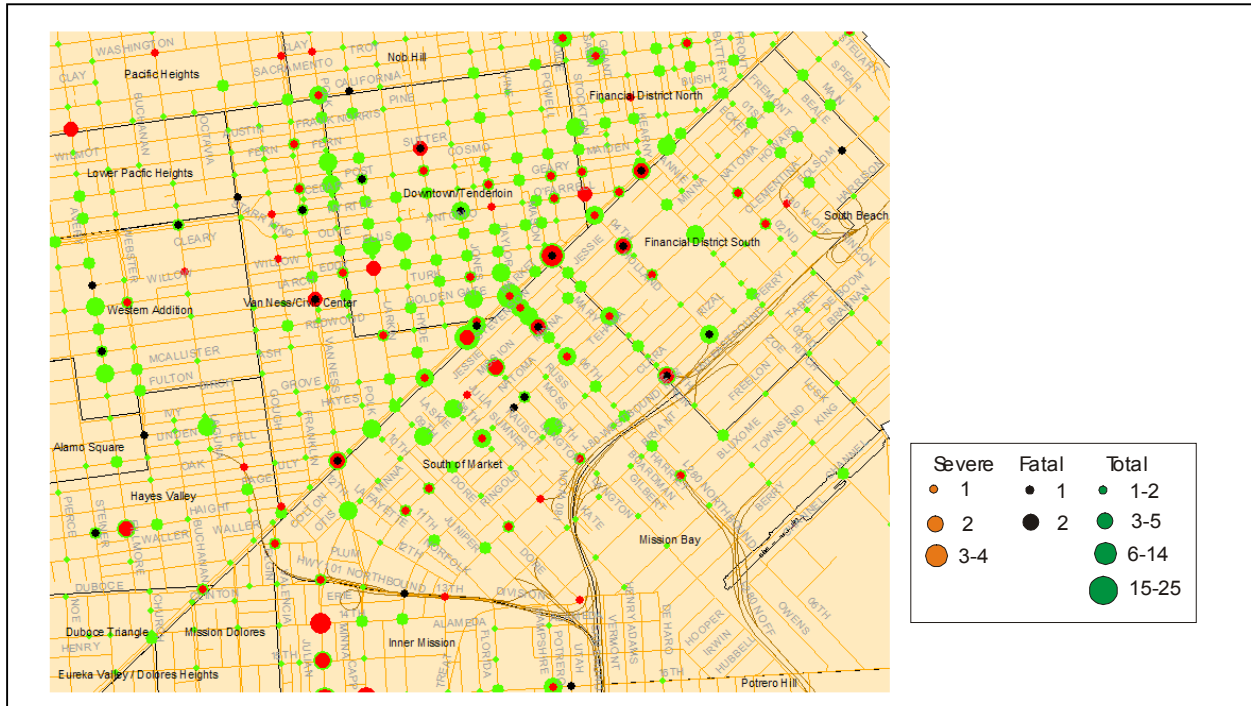


Figure 30.

The neighborhoods included in this map are among the poorest in the city, with the majority of residents living well below the poverty level. The Tenderloin is also densely populated, as are parts of the South of Market area.

Market Street, one of San Francisco’s most heavily traveled pedestrian thoroughfares and a major nexus and transfer point for public transportation, is high in injuries to pedestrians. There were pedestrians injured at almost every intersection including four fatalities and many severe injuries.

The approach routes to the Bay Bridge ramps have many pedestrian injuries and/or deaths, as do Franklin, Van Ness, Polk and Larkin Streets, which carry commute traffic north. Other routes with fatalities include: three on Van Ness Avenue, two on Mission, two on Larkin Street and two on Fourth Street.

Map information: *SWITRS traffic collision data. Map created by Stanley Sciortino, PhD, CHES, SFDPH, funded by a grant from the California Office of Traffic Safety through the Business, Transportation & Housing Agency.*

San Francisco Neighborhood Map: Vicinity of the Inner Mission & Potrero Hill Pedestrian Injuries in 2000-2002

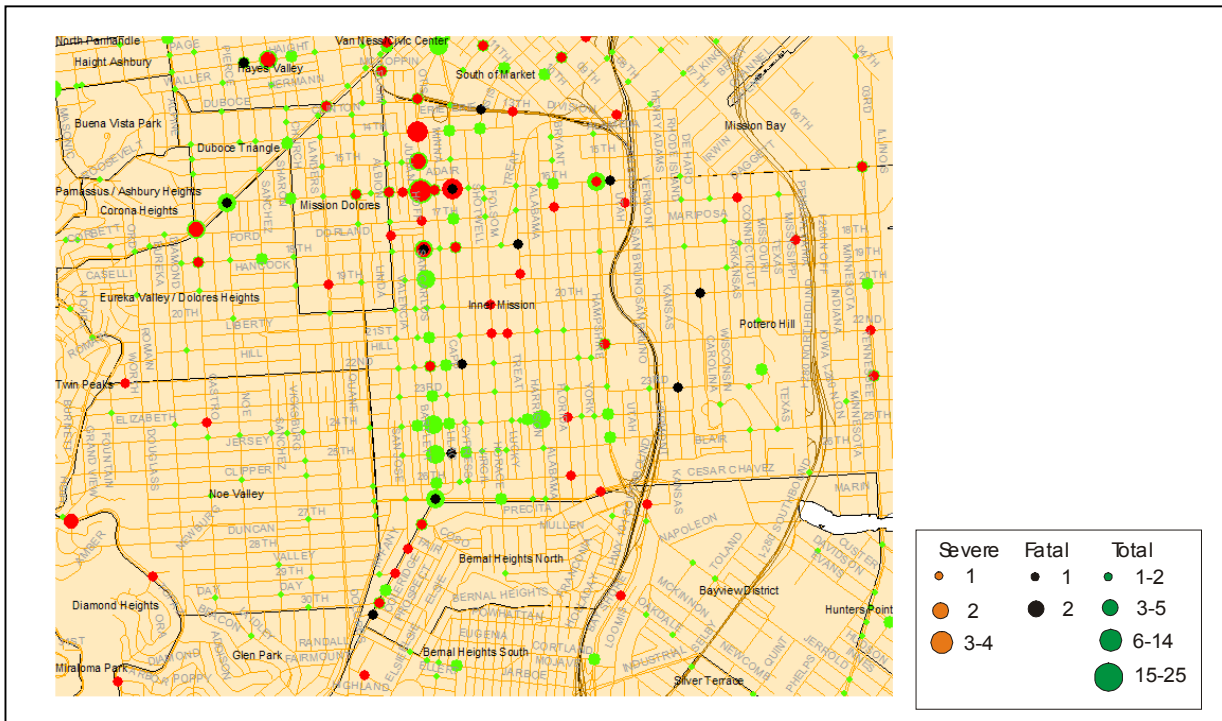


Figure 31. The Mission District is densely populated, with the majority of residents earning very low incomes. These two demographic realities are high risk factors for pedestrian injuries, and there were twelve pedestrian fatalities in this area of the city during these three years.

The length of Mission Street had pedestrian injuries at almost every intersection. The routes extending out from the intersection of Mission and 16th Streets show where many pedestrians sustained severe and even fatal injury. A comparable stretch of Mission Street extends from Cesar Chavez southwest to the merge of Mission Street and San Jose Avenue. South Van Ness and Potrero Avenues are other north-south routes with many pedestrian injuries. Other east-west routes with multiple pedestrian injuries are Cesar Chavez, 24th, 22nd, 21st & 18th Streets.

Map information: *SWITRS traffic collision data. Map created by Stanley Sciortino, PhD, CHES, SFDPH, funded by a grant from the California Office of Traffic Safety through the Business, Transportation & Housing Agency.*

San Francisco Neighborhood Map: Vicinity of Bayview, Ingleside & Excelsior Pedestrian Injuries in 2000-2002

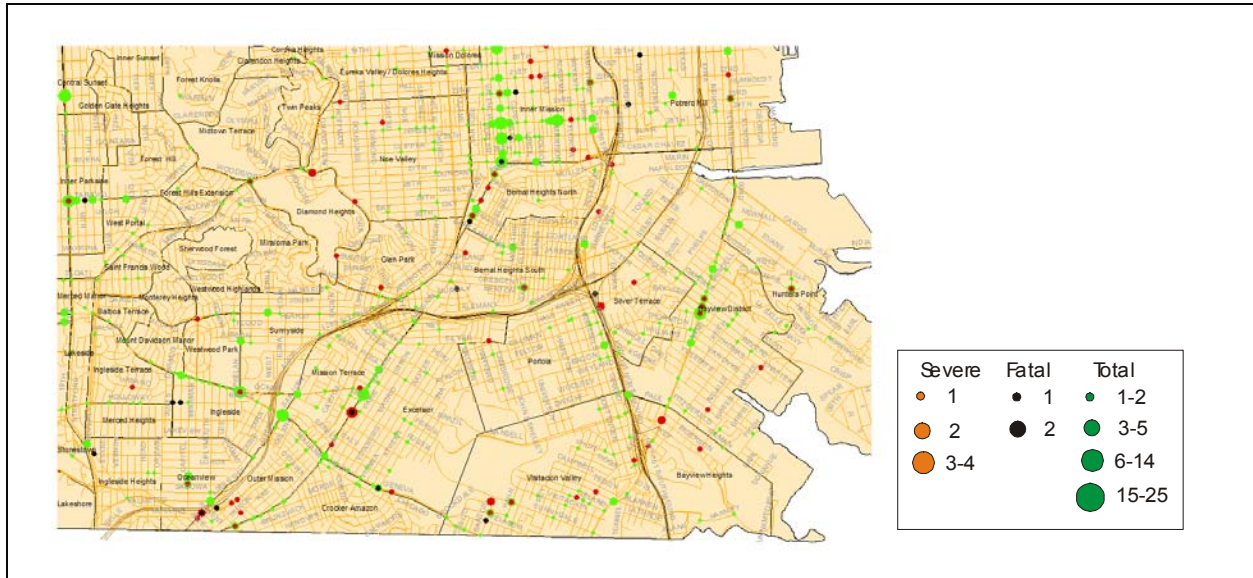


Figure 32.

The neighborhoods depicted in this map represent the southeast quadrant of the city. While the earnings of populations of some sections (such as Bernal Heights, Twin Peaks and the Castro) exceed the median household income, other sections (such as Bayview and Excelsior) are densely populated with mostly very low-income residents.

The locations of multiple and severe pedestrian injuries are consistent with what is known about risk factors: heavily traveled routes carrying commuters and other high traffic volume through poorer neighborhoods. These include 3rd Street, Mission Street, and Bayshore and Geneva Avenues. In addition, there are clusters of severe pedestrian injuries in Visitación Valley and in the Outer Mission.

Map information: *SWITRS traffic collision data. Map created by Stanley Sciortino, PhD, CHES, SFDPH, funded by a grant from the California Office of Traffic Safety through the Business, Transportation & Housing Agency.*

San Francisco Neighborhood Map: Vicinity of Haight-Ashbury & Western Addition Pedestrian Injuries in 2000-2002

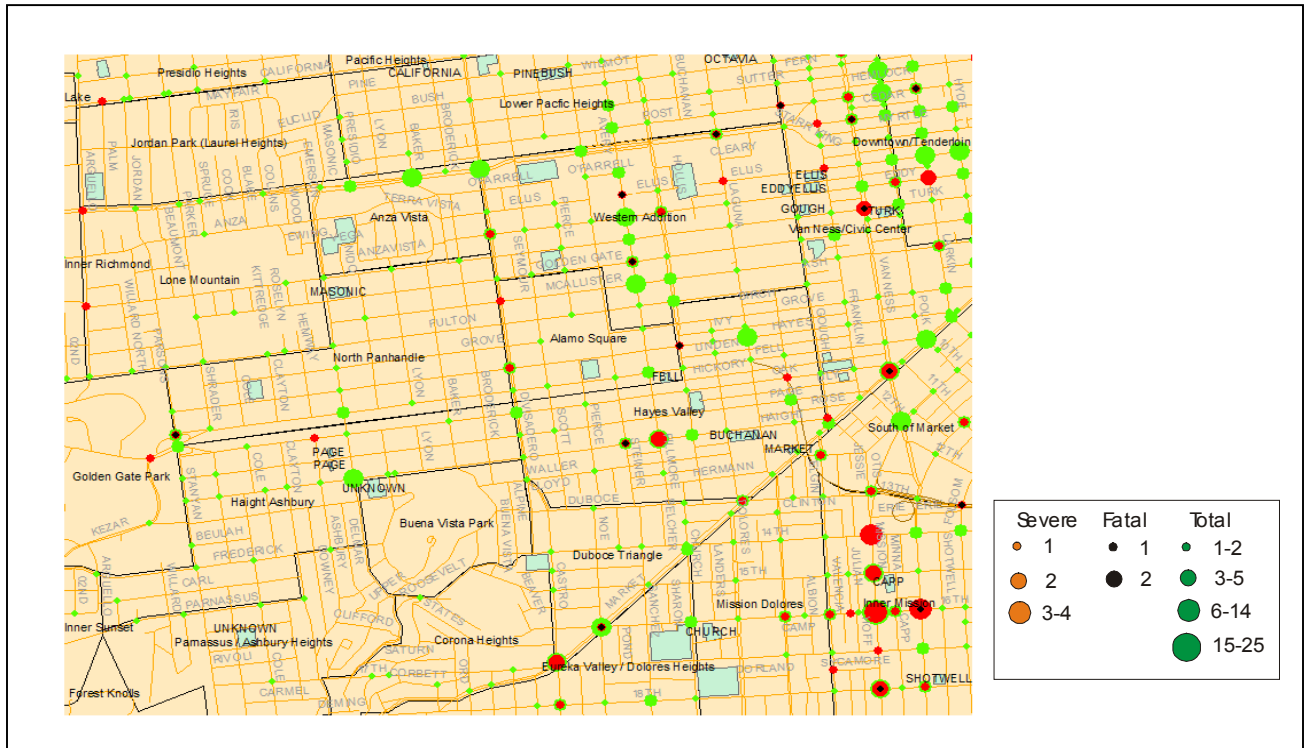


Figure 33.
The light blue areas in the map indicate school lots.

The neighborhoods included in this map are densely populated, with the majority of the residents earning less than the 1999 estimated median income of \$45,400. There were three pedestrian fatalities in the Western Addition, two of them on Fillmore Street, which is a route with many non-fatal injuries as well. Divisadero Street had serious pedestrian injuries at Eddy, Hayes and McAllister Streets. There was a fatality at Hayes and Webster. Geary Boulevard had two pedestrian fatalities and had injuries at almost half of its intersections. In Haight-Ashbury, there was a fatal crash at Fell and Stanyan Streets and injuries at many of the intersections throughout the neighborhood.

Map information: *SWITRS traffic collision data. Map created by Stanley Sciortino, PhD, CHES, SFDPH, funded by a grant from the California Office of Traffic Safety through the Business, Transportation & Housing Agency.*

San Francisco Neighborhood Map: Vicinity of Richmond District Pedestrian Injuries in 2000-2002

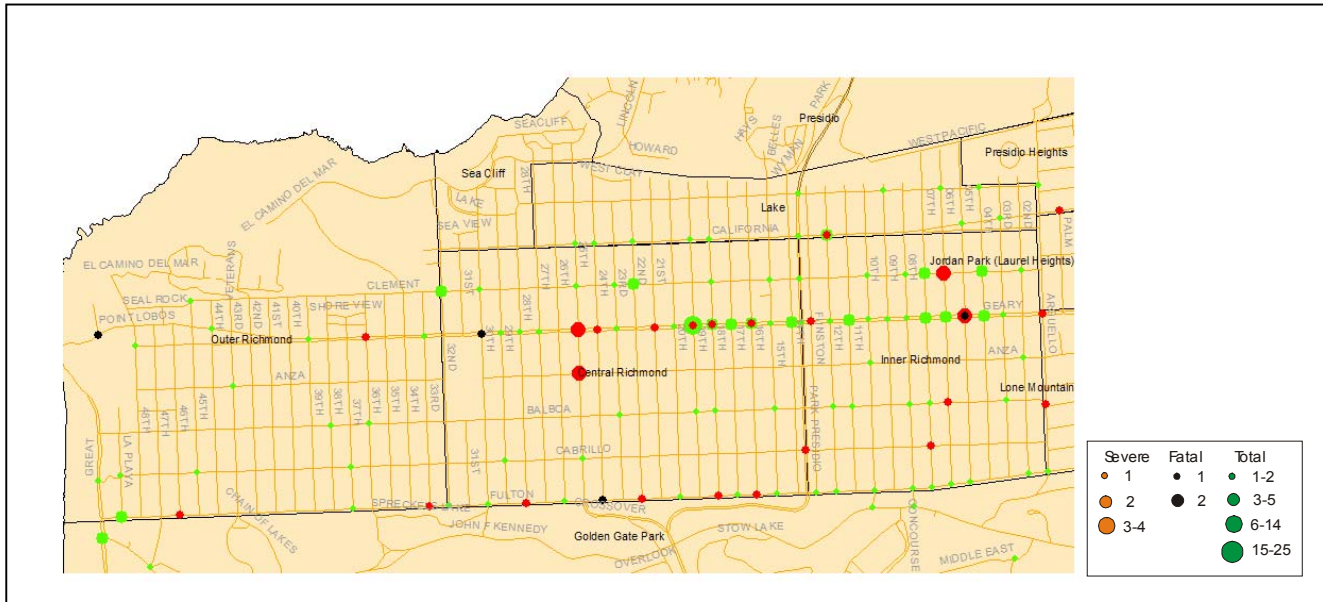


Figure 34.

The neighborhoods depicted in this map represent the northwest quadrant of the city, where some of the wealthiest sections of the city (such as Sea Cliff), as well as some relatively poorer sections in central and inner Richmond, are located. There are three east-west routes with multiple pedestrian injuries: California Street, Geary Boulevard and Fulton Street. Geary is a major commute route for public transportation, and its buses carry more passengers than any other line. It also has many pedestrian destinations, such as shops and restaurants. Park Presidio (which is also Route 1) and Arguello Boulevard are the major north-south routes with multiple pedestrian injuries

Map information: *SWITRS traffic collision data. Map created by Stanley Sciortino, PhD, CHES, SFDPH, funded by a grant from the California Office of Traffic Safety through the Business, Transportation & Housing Agency.*

San Francisco Neighborhood Map: Vicinity of the Sunset District Pedestrian Injuries in 2000-2002

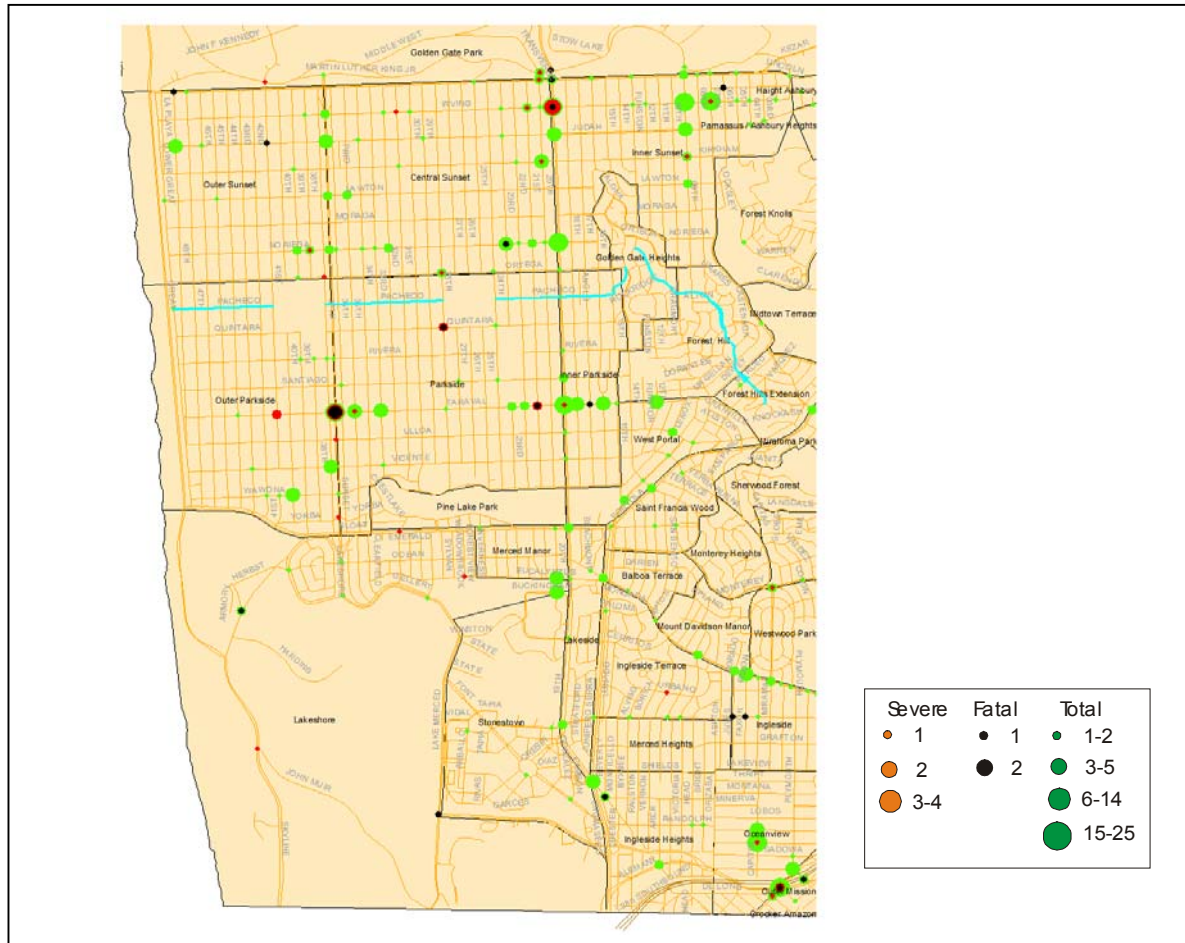


Figure 35.

The neighborhoods depicted in this map represent the southwestern quadrant of the city. This is a moderately affluent section of the city, which hosts a major north-south highway (Route 1, also known as 19th Avenue). Two other major north-south routes are Sunset Boulevard and 9th Avenue, with Taraval, Noriega, Irving and Lincoln Avenues being the east-west routes with the most injury collisions. A particularly high collision zone is where cross-Golden Gate Park traffic exits onto 19th Avenue.

Map information: *SWITRS traffic collision data. Map created by Stanley Sciortino, PhD, CHES, SFDPH, funded by a grant from the California Office of Traffic Safety through the Business, Transportation & Housing Agency.*

Pedestrian Deaths by Location, 2000-2002 (Table 1.)

Year	Neighborhood	Intersection	Age	Sex
2000	Bayview	AUGUSTA ST & BAY SHORE BLVD	18	F
2000	Bernal Heights	KINGSTON ST & MISSION ST	39	M
2000	Bernal Heights	COLLEGE AVE & JUSTIN DR	61	F
2000	Castro	16TH ST & MARKET ST	31	M
2000	Downtown	BEALE ST & FOLSOM ST	51	F
2000	Downtown	CLAY ST & DRUMM ST	73	F
2000	Downtown	BROADWAY & VAN NESS AVE	80	M
2001	Downtown	03RD ST & MARKET ST	48	M
2001	Downtown	BROADWAY & VAN NESS AVE	49	M
2000	Excelsior	GENEVA AVE & MOSCOW ST	37	F
2001	Excelsior	ALEMANY BLVD & SICKLES AVE	80	M
2002	Excelsior	MISSION ST & ONONDAGA AVE	?	F
2002	Excelsior	SANTOS ST & VELASCO AVE	?	M
2000	Haight-Ashbury	FELL ST & STANYAN ST	?	M
2002	Haight-Ashbury	HAIGHT ST & STEINER ST	36	M
2002	Haight-Ashbury	06TH AVE & HUGO ST	?	M
2002	Ingleside	FAXON AVE & HOLLOWAY AVE	65	F
2002	Ingleside	HOLLOWAY AVE & JULES AVE	67	M
2000	Mission	CESAR CHAVEZ ST & MISSION ST	3	F
2000	Mission	25TH ST & CAPP ST	59	M
2000	Mission	16TH ST & UTAH ST	?	M
2001	Mission	22ND ST & SOUTHVAN NESS AVE	42	M
2001	Mission	18TH ST & MISSION ST	72	M
2001	Mission	16TH ST & SOUTHVAN NESS AVE	?	M
2002	Mission	18TH ST & HARRISON ST	72	M
2000	Pacific Heights	FRANCISCO ST & RICHARDSON AVE	60	F
2000	Pacific Heights	CHESTNUT ST & STEINER ST	75	F
2001	Pacific Heights	PACIFIC AVE & VAN NESS AVE	87	M
2002	Pacific Heights	LOMBARD ST & WEBSTER ST	27	F
2000	Potrero Hill	20TH ST & CAROLINA ST	50	M
2000	Potrero Hill	23RD ST & RHODE ISLAND ST	82	M
2000	Richmond	05TH AVE & GEARY BLVD	32	M
2001	Richmond	MERRIE WAY & POINT LOBOS AVE	61	M
2001	Richmond	CROSSOVER DR & MARTIN LUTHER KING	72	F
2002	Richmond	24TH AVE & FULTON ST	86	M
2000	Sunset	HERBST RD & SKYLINE BLVD	74	M
2000	Sunset	SUNSET BLVD & TARAVAL ST	74	M
2000	Sunset	17TH AVE & TARAVAL ST	85	F
2000	Sunset	41ST AVE & JUDAH ST	91	M
2001	Sunset	SUNSET BLVD & TARAVAL ST	13	M
2001	Sunset	28TH AVE & QUINTARA ST	67	F
2001	Sunset	19TH AVE & IRVING ST	86	M
2001	Sunset	30TH AVE & GEARY BLVD	?	M
2001	Sunset	BROTHERHOOD WAY & LAKE MERCED BLVD	?	M
2002	Sunset	19TH AVE & LINCOLN WAY	24	M
2002	Sunset	19TH AVE & RANDOLPH ST	41	M
2002	Sunset	21ST ST & TARAVAL ST	44	M
2002	Sunset	23RD AVE & NORIEGA ST	82	F
2002	Sunset	48TH AVE & LINCOLN WAY	?	F
2000	Tenderloin	HOWARD ST & LANGTON ST	44	M
2000	Tenderloin	13TH ST & FOLSOM ST	51	F
2000	Tenderloin	JONES ST & O'FARRELL ST	55	F
2000	Tenderloin	04TH ST & MISSION ST	58	M
2000	Tenderloin	JONES ST & MARKET ST	71	F
2001	Tenderloin	LEAVENWORTH ST & SUTTER ST	36	M
2001	Tenderloin	TURK ST & VAN NESS AVE	54	M
2001	Tenderloin	LARKIN ST & POST ST	73	M
2001	Tenderloin	05TH ST & MARKET ST	75	M
2001	Tenderloin	CALIFORNIA ST & LARKIN ST	76	F
2002	Tenderloin	07TH ST & HOWARD ST	29	F
2002	Tenderloin	04TH ST & HARRISON ST	37	M
2002	Tenderloin	MARKET ST & VAN NESS AVE	47	M
2002	Tenderloin	06TH ST & MISSION ST	55	M
2002	Tenderloin	05TH ST & HARRISON ST	?	M
2000	Twin Peaks	ALEMANY BLVD OC & RT 280	37	F
2000	Western Addition	HAYES ST & WEBSTER ST	10	F
2000	Western Addition	FILLMORE ST & GOLDEN GATE AVE	83	F
2000	Western Addition	GEARY BLVD & VAN NESS AVE	85	M
2000	Western Addition	GOUGH ST & POST ST	89	F
2000	Western Addition	ELLIS ST & FILLMORE ST	90	M
2002	Western Addition	GEARY BLVD & LAGUNA ST	82	M

Alcohol-Related Pedestrian Injuries, 2000-2002

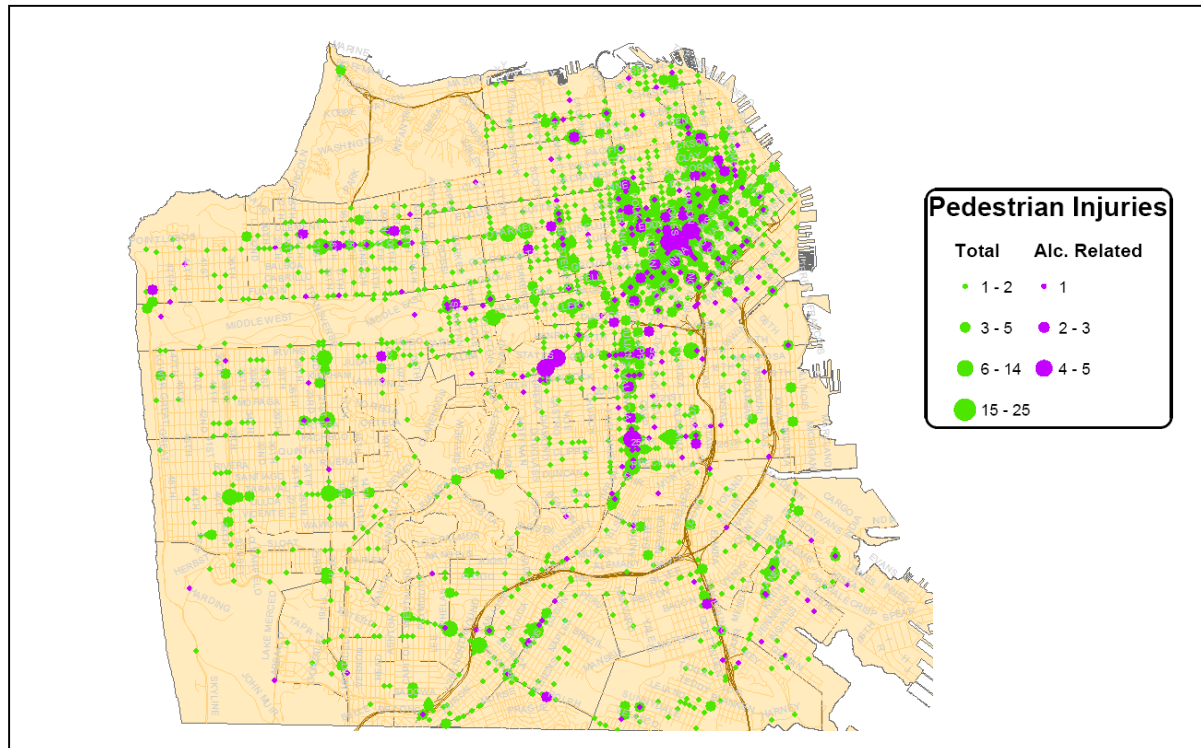


Figure 36.

An injury is considered “alcohol-related” when the reporting police officer records that either the driver or the pedestrian had been drinking. This is not usually confirmed by a blood alcohol concentration test, unless there is a fatality and the test is done by the Medical Examiner.

It is not a coincidence that where there is a concentration of alcohol outlets, there is a cluster of alcohol-related pedestrian injuries. Market and Mission Streets are the routes with the greatest number of alcohol-related pedestrian injuries, followed by Columbus Avenue, Van Ness Avenue and Geary Boulevard. The area around the intersection of Market and Castro Street, Market between 3rd and 6th Streets, and Mission Street and 24th Street are particularly at high risk.

Map information: *SWITRS traffic collision data. Map created by Stanley Sciortino, PhD, CHES, SFDPH, funded by a grant from the California Office of Traffic Safety through the Business, Transportation & Housing Agency.*

Location of Alcohol Outlets (Non-Restaurant), 2001

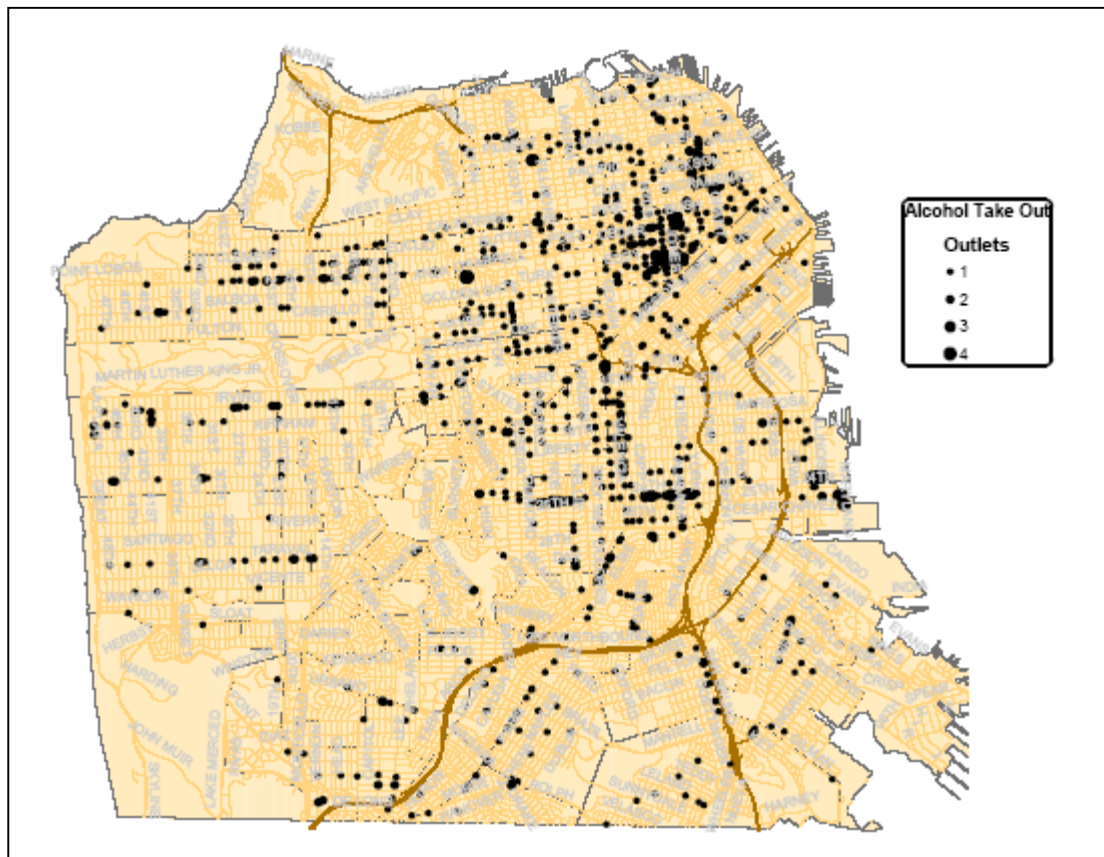


Figure 37.

Non-restaurant alcohol outlets include bars, liquor stores and mini-marts, i.e., all places where one can purchase alcohol by the glass or bottle that does not serve food. Although one can purchase alcohol throughout the city, alcohol outlets are most densely concentrated in the Tenderloin, the Mission, Haight-Ashbury, the Richmond, the Outer Sunset, the Marina, and along several major traffic routes (Mission Street, Bayshore Boulevard, 24th Street, Geary Boulevard, Irving Street, Taraval Street).

Map information: California Department of Alcohol Beverage Control (ABC) data. Map created by Stanley Sciortino, PhD, CHES, SFDPH, funded by a grant from the California Office of Traffic Safety through the Business, Transportation & Housing Agency.

Falls Summary

Injuries from falls account for 14% (n=64) of the deaths and 46% (n=2,587) of the hospitalizations due to injuries among San Francisco residents in 2001.

Unfortunately, the “External Causes of Injury & Poisoning” codes do not capture the multiple and complex circumstances surrounding falls. Very often, death certificates and medical records lack specific details on the circumstances of a fall. For example, over half of the falls-related hospital discharges have non-specific fall cause codes.

Codes are also used to describe the nature of the injury sustained. Among those patients hospitalized for a fall-related injury, 56% of the discharges were coded as musculoskeletal and connective tissue disorders (fractures, sprains and strains), 11% as nervous system disorders (primarily brain injury), 7% as circulatory disorders, and the remaining 26% as all other “major diagnostic categories.”

Falls are a particularly significant injury problem among older San Francisco residents. Seniors aged 65+ account for 24% (n=111) of all injury deaths; of these, 35% (n=39) are due to falls. For hospitalizations, seniors and falls predominate even more. Seniors aged 65+ comprised 14% of the population in 2001, yet accounted for 42% (n=2,367) of all injury hospitalizations; of these, 75% (n=1,783) were due to falls.

This Profile presents data on falls, with a specific focus on older adults, through:

- graphs drawing upon vital statistics and hospital discharge records
- national data collected by the Centers for Disease Control

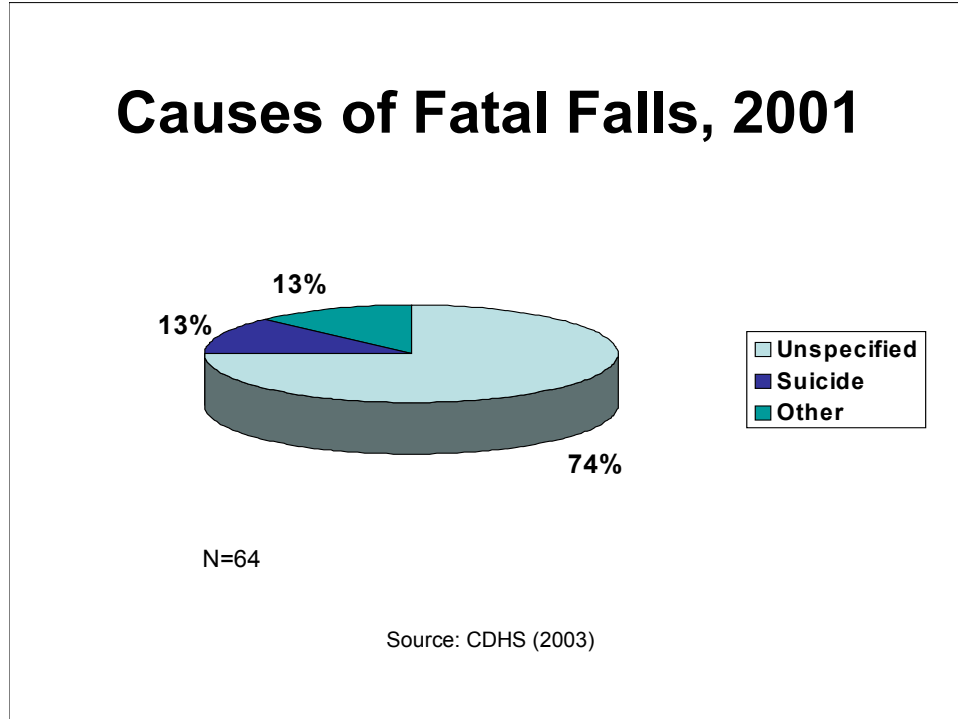


Figure 38.

The coding of circumstances surrounding fatal falls is not especially informative. While there are 19 codes in the International Classification of Diseases (ICD-10) for use in classifying unintentional deaths resulting from a fall, 74% of the deaths (n=48) were attributed to a single code titled "Unspecified fall." Eight deaths had the code for "Intentional self-harm by jumping from high place." There was one homicide, one "intent undetermined," and six specific codes for unintentional falls: 1 "slip," 2 involving steps, 1 involving a fall from a building, and 2 resulting from an "other fall on same level."

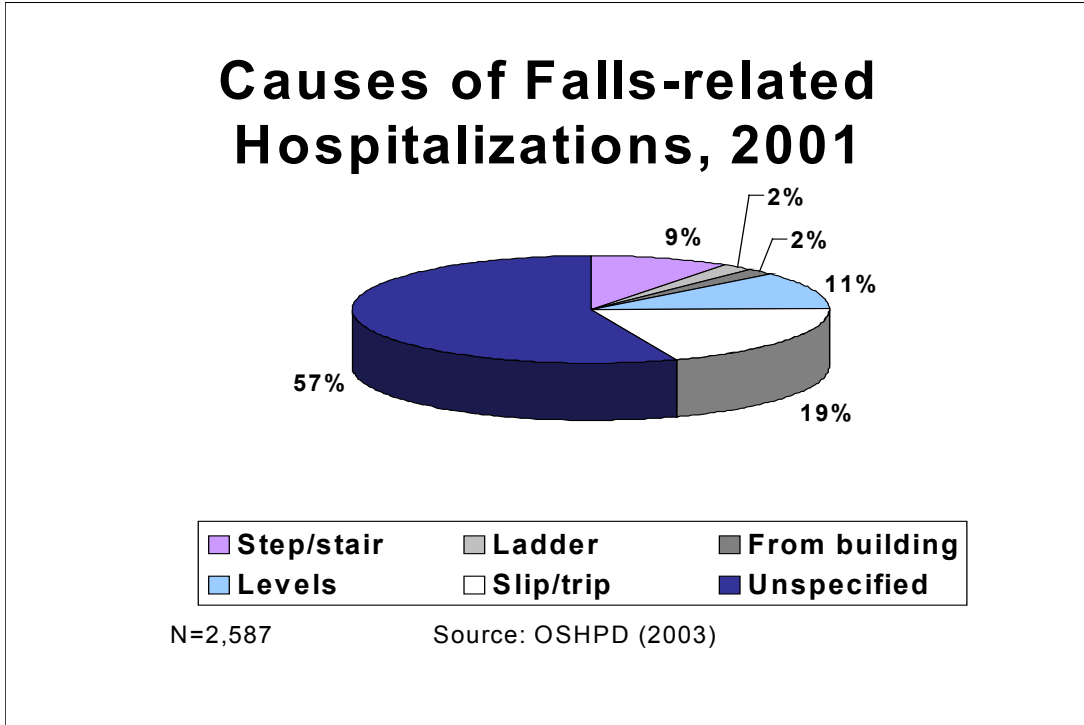


Figure 39.

Falls accounted for 46% of all hospitalizations for non-fatal injuries in 2001. While the cause coding for fall-related hospital discharges were somewhat more informative than those for fatal falls, more than half were coded with non-specific codes. Of those that were specifically coded, there were 92 hospitalizations for falls from a bed, 45 for falls from a chair, 34 for falls from a wheelchair, 21 for falls from a commode, and 12 for falls on playground equipment. However, given that the causal circumstances of the majority of hospitalizations for fall injuries are unspecified, it is difficult to tailor prevention programs based solely upon hospitalization data.

Falls Injuries by Age Group

Falls are, by far, the leading injury mechanism in San Francisco that results in hospitalization because they account for nearly half of all injury hospitalizations. By comparison, motor vehicle traffic collisions, the next leading mechanism, account for less than one eighth of injury hospitalizations.

Almost 2,600 San Franciscans were hospitalized as the result of a non-fatal fall in 2001. Young children (aged 0-14) have slightly more hospitalizations for fall injuries than do adolescents and young adults, but falls are a special problem for older San Franciscans. Sixty-nine percent of all hospitalizations and 61% of all deaths due to fall injuries occur to those over age 65. The rate graph below shows how dramatic this risk is for seniors.

From infancy until middle adulthood (around age 55), men outnumber women as falls patients. However, after that, the trend reverses, and women predominate with each successive decade. In fact, in the over 95-year old age group (not shown), 85% of the patients are women.

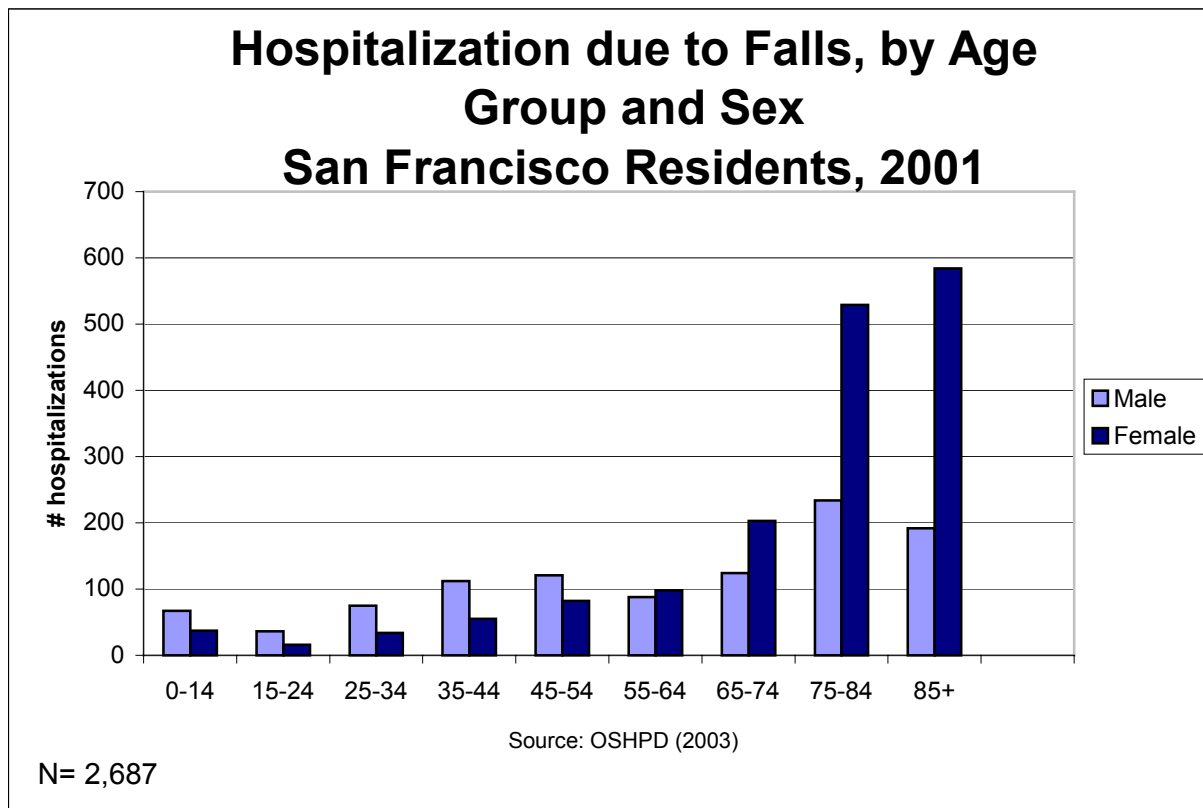


Figure 40.

In the younger age groups, men outnumber women because they tend to take more risks that lead to a fall. However, as women age, their bone fragility makes them more susceptible to fall injuries than are men of the same age. Though not shown here, men continue to have substantially greater rates of fatal falls, even in extreme old age, where the numbers of men and men who suffer fatal falls is less than the number of women. This may indicate that male risk taking behaviors continue.

The table below gives the raw data used for the chart above. Over the age of 75, there are two to three times more women than men hospitalized due to falls.

**Hospitalizations due to Falls, by Age Group and Sex
San Francisco Residents, 2001 (n=2,687)**

	0-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Female	37	16	34	55	82	98	203	529	584
Male	67	36	75	112	121	88	124	234	192

Similarly, the rate of hospitalization for injuries from a fall increases dramatically after age 55. In the older years of life, the rate rises to almost 30 times that of 45 to 54 year olds. While falls account for four times as many hospitalizations as the next leading mechanism of injury in the general population, they account for 15 times as many among the population over age 65.

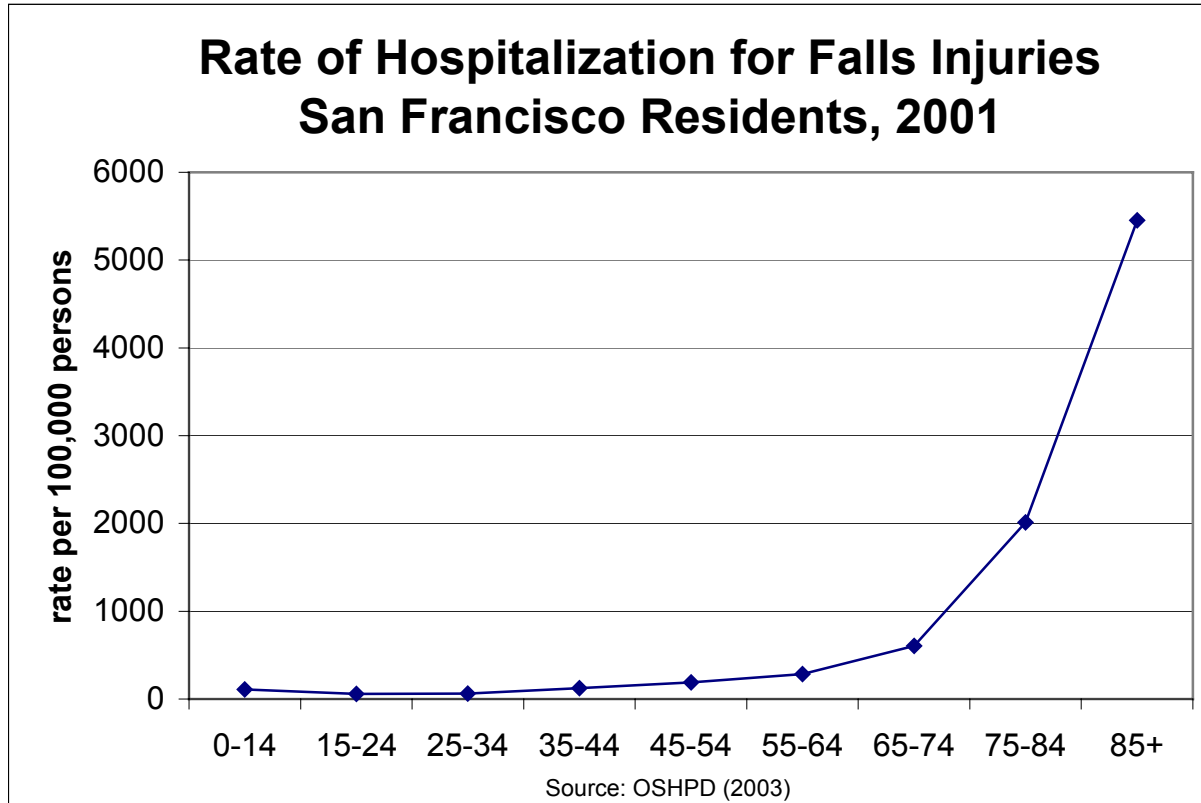


Figure 41.

Zip code of Residence of Patients Hospitalized for Falls By Age Group, 2001

Zip	0-14	15-24	25-64	65+	Total	Zip	0-14	15-24	25-64	65+	Total
"94101"			2		2	"94122"	9	5	39	159	212
"94102"	2	3	49	59	113	"94123"	1		14	81	96
"94103"	3	2	40	52	97	"94124"	11	3	52	26	92
"94104"				4	4	"94125"			1		1
"94105"			3	1	4	"94127"	4	1	9	74	88
"94107"	3		10	26	39	"94129"	1			1	2
"94108"			8	40	48	"94130"			1		1
"94109"	3	3	59	210	275	"94131"	3	1	18	63	85
"94110"	14	6	81	128	229	"94132"	1	6	17	88	112
"94111"		1	4	18	23	"94133"	2	2	10	88	102
"94112"	19	3	53	133	208	"94134"	14	4	25	59	102
"94114"	4	2	28	56	90	"94142"			4	2	6
"94115"	2	2	39	87	130	"94143"			1	2	3
"94116"	2	2	31	135	170	"94146"				1	1
"94117"	2	3	29	49	83	"94159"			1		1
"94118"	3	1	19	103	126	"94166"				1	1
"94119"			2	2	4	"94188"		1			1
"94121"	1	1	16	118	136						

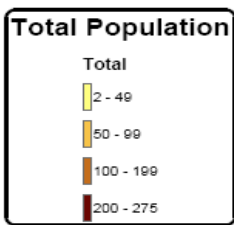
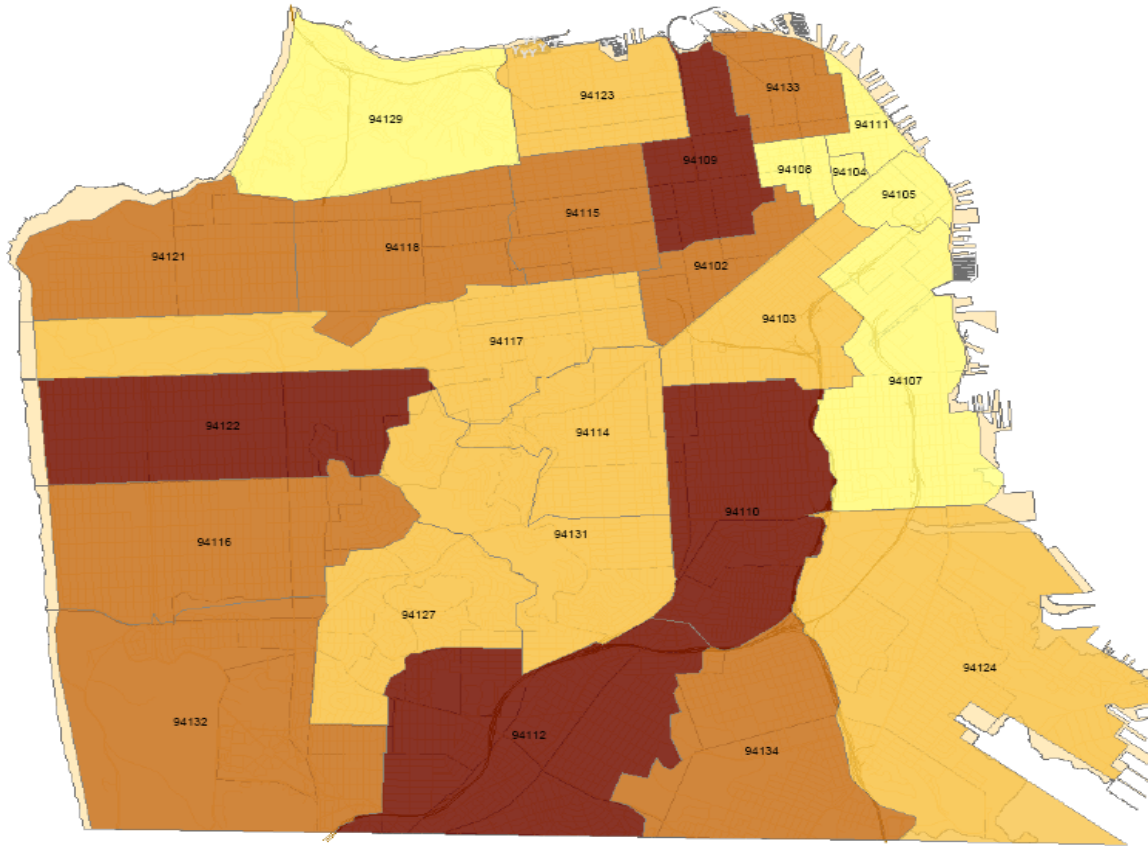
Key to colors of zip code data chart (# hospitalizations)

>200
 100-199
 50-99
 <50

Table 2.

The areas with the greatest numbers of patients hospitalized for falls are zip codes 94109, 94110, 94122 and 94112, which roughly correspond to the neighborhoods of Nob Hill/Russian Hill, Mission, Bernal Heights, Sunset, Excelsior, Ingleside and Ocean View. The areas with the next highest incidence of hospitalizations for falls are zip codes 94116, 94121, 94115, 94118, 94102, 94132, 94133, and 94134. The neighborhoods encompassed by these zip codes are: Parkside, Richmond, Western Addition, Pacific Heights, Presidio Heights, Laurel Heights, Hayes Valley, Park Merced, Telegraph Hill, North Beach, Portola and Visitacion Valley.

Zipcode of Residence of Patients Hospitalized for Falls 2001



San Francisco
Dept. of Public Health
CHES
Stan Sciortino, PhD

Figure 42.

Map Information: City of San Francisco zip code map. Created by Stanley Sciortino, PhD, CHES, SFDPH.

Causes of Injury Death for Older San Franciscans

One hundred and eleven senior San Francisco residents died as the result of an injury in 2001. Eight other seniors visiting from elsewhere died in San Francisco following an injury. Among these seniors ages 65 years old and older, falls were the leading cause of injury-related death.

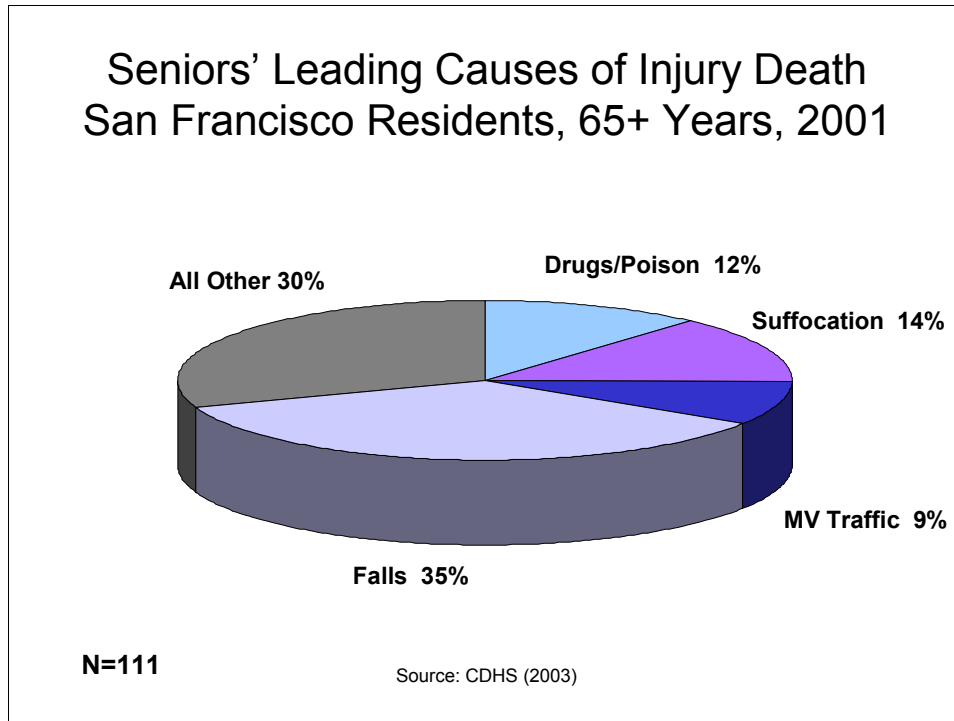


Figure 43.

Falls accounted for 35% of the injury deaths among seniors. None of the mechanisms of injury included in the “other” category accounted for more than 10 deaths.

Despite the high percentage of falls among seniors, the actual number of fatal falls in the elderly may be understated. For example, an older person may be hospitalized for a fall and, during a long hospital stay, could develop complications (such as pneumonia), which then lead to death. Depending upon the circumstances, the coding practices of hospitals, and the judgments of medical examiners and coroners, that death may or may not be coded as a fatal fall.

In 2001, more than 11,600 people aged 65 or older in the USA died from fall-related injuries. More than 60% of people who die from falls are 75 or older.

Causes of Injury-related Hospitalizations for Seniors

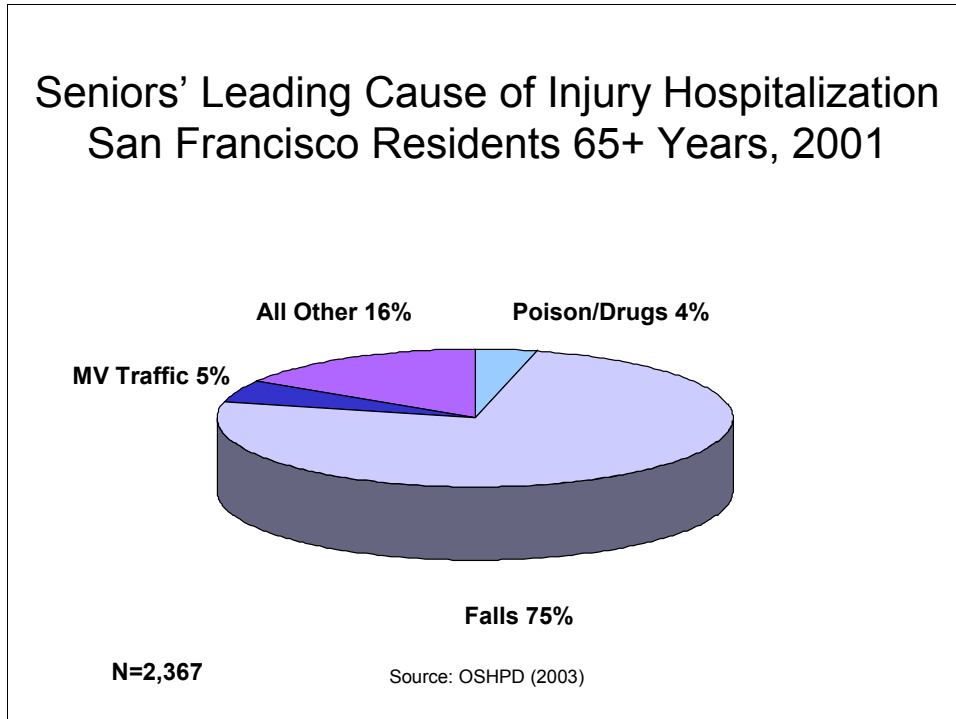


Figure 44.

Falls accounted for three quarters of all injury-related hospital discharges for older San Franciscans. There were very few other mechanisms, such as MVT and Poison/Drugs, that accounted for a significant proportion of discharges.

The CDC reports that, in 2001, more than 1.6 million seniors nationally were treated in emergency departments for fall-related injuries. Nearly 388,000 were hospitalized.

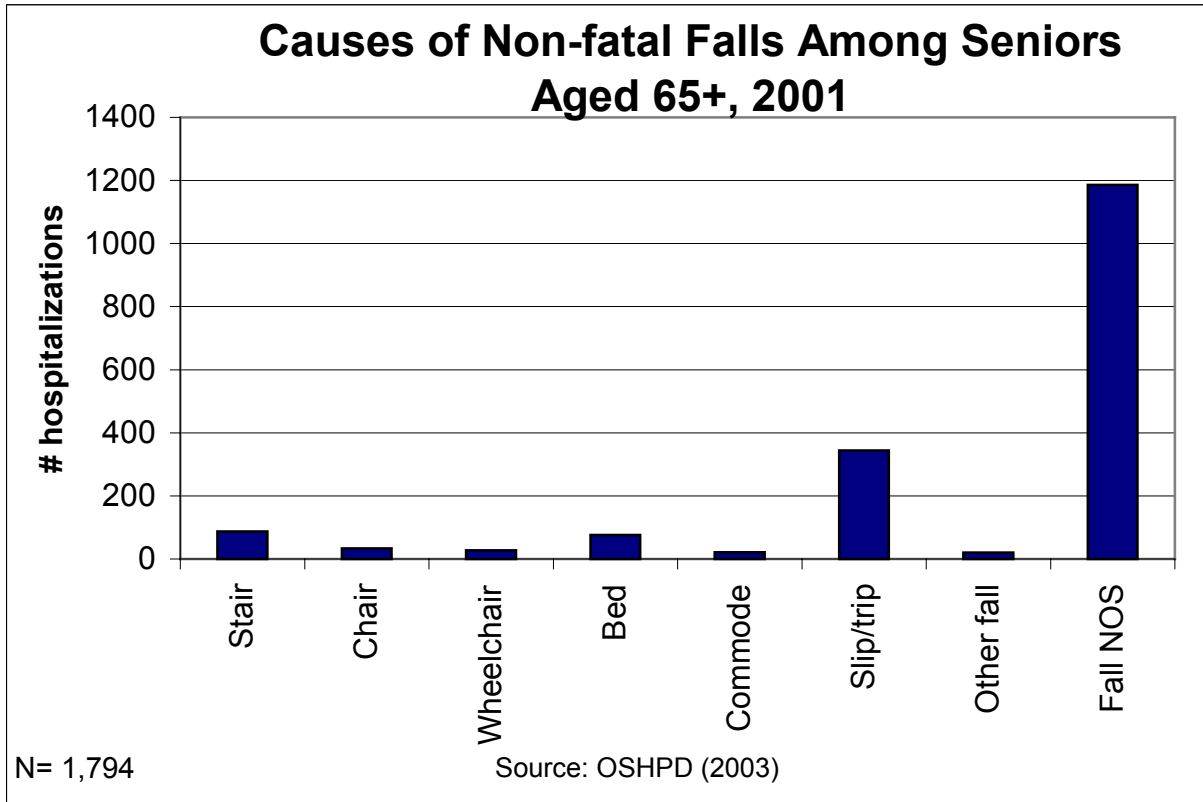


Figure 45. NOS= Not otherwise specified

Documentation of the specific circumstances surrounding falls is often absent from the medical record; therefore, over 65% of these falls were coded simply as an “other and unspecified fall.” Of those that were noted, slip/trips (18.7%), falls from stairs (6.8%), beds (4.1%), chairs (1.8%), wheelchairs (1.5%) and commodes (1.1%) were the most common. More accurate coding of falls would significantly help injury prevention efforts, especially among the older age groups.

Costs associated with Falls Among Older Adults

Hospital discharge data provides “total charges” for patients who have been treated as the result of a fall. There were 1,783 hospital discharges resulting from falls among older San Franciscans in 2001.

For older adults hospitalized due to a fall:

- the median charge was \$23,335.
- the average charge was \$32,199.
- hospital charges totaled \$57.4 million.

Several things should be noted.

- 1) The average charge is always higher than the median charge, because it factors in the “outliers,” or patients with very long hospital stays and very high bills. The highest hospital bill in this data series was over \$1 million.
- 2) Charges include, but are not limited to: daily hospital services, ancillary services and any patient care services. Hospital-based physician fees are excluded.
- 3) Charges, costs and actual reimbursement are three very different numbers. What is reported here is what was charged, not necessarily what is reimbursed.
- 4) There were 198 discharges with no charge associated with them because the charges were not reported by the hospital. For example, Kaiser Foundation Hospitals are exempted from reporting charges, since they charge patients a monthly capitation fee, regardless of what health care services are provided. Thus, these cost numbers underestimate the charges associated with hospitalization due to falls.

The National Center for Injury Prevention and Control of the CDC published a report: *The Costs of Fall Injuries Among Older Adults*. “The total cost of all fall injuries for people age 65 or older in 1994 was \$27.3 billion (in current dollars). By 2020, the cost of fall injuries is expected to reach \$43.8 billion (in current dollars).” This estimate is drawn from Englander F, Hodson TJ, Terregrossa RA. Economic dimensions of slip and fall injuries. *Journal of Forensic Science* 1996;41(5): 733-46.

Injury Intent: Unintentional, Assaultive, and Self-Inflicted Deaths

While many seniors may be fearful of being intentionally harmed by someone else, it is very rare for a senior to die from intentional injuries, other than from suicide. Over three-quarters of the senior injury deaths were coded as unintentional, while 19% were suicide. Only four seniors were victims of homicide. Again, falls are the most common cause of injury death for San Franciscans over the age of 65.

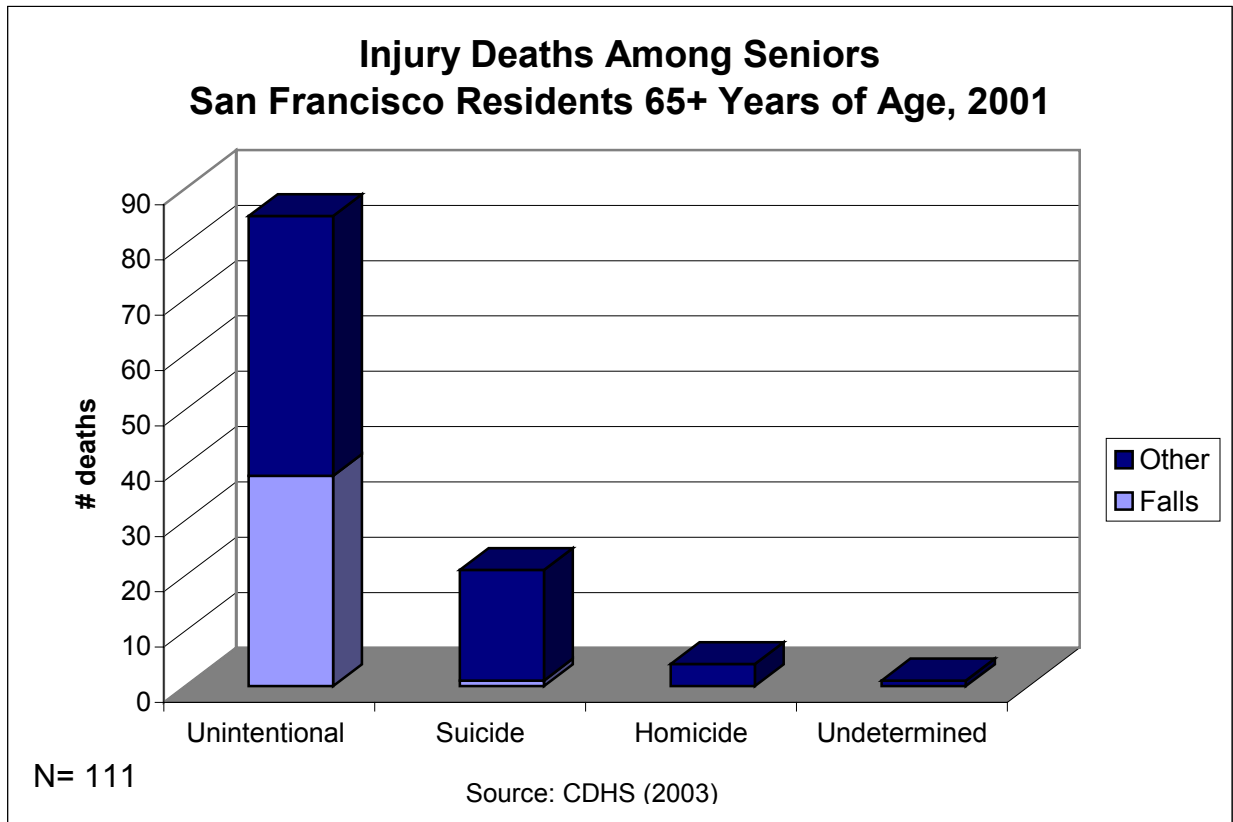


Figure 46.

Injury Intent: Unintentional, Assaultive, and Self-Inflicted Hospitalizations

Older persons in San Francisco are overwhelmingly more likely to be hospitalized for unintentional injuries, such as falls, than for assaults or even self-inflicted intentional injuries. All of the 1,866 hospitalizations for patients 65 and older who had fallen in 2001 were coded as unintentional. While suicides accounted for 19% of injury deaths, only 1% of the hospitalizations were coded as self-inflicted and 1% as assaults.

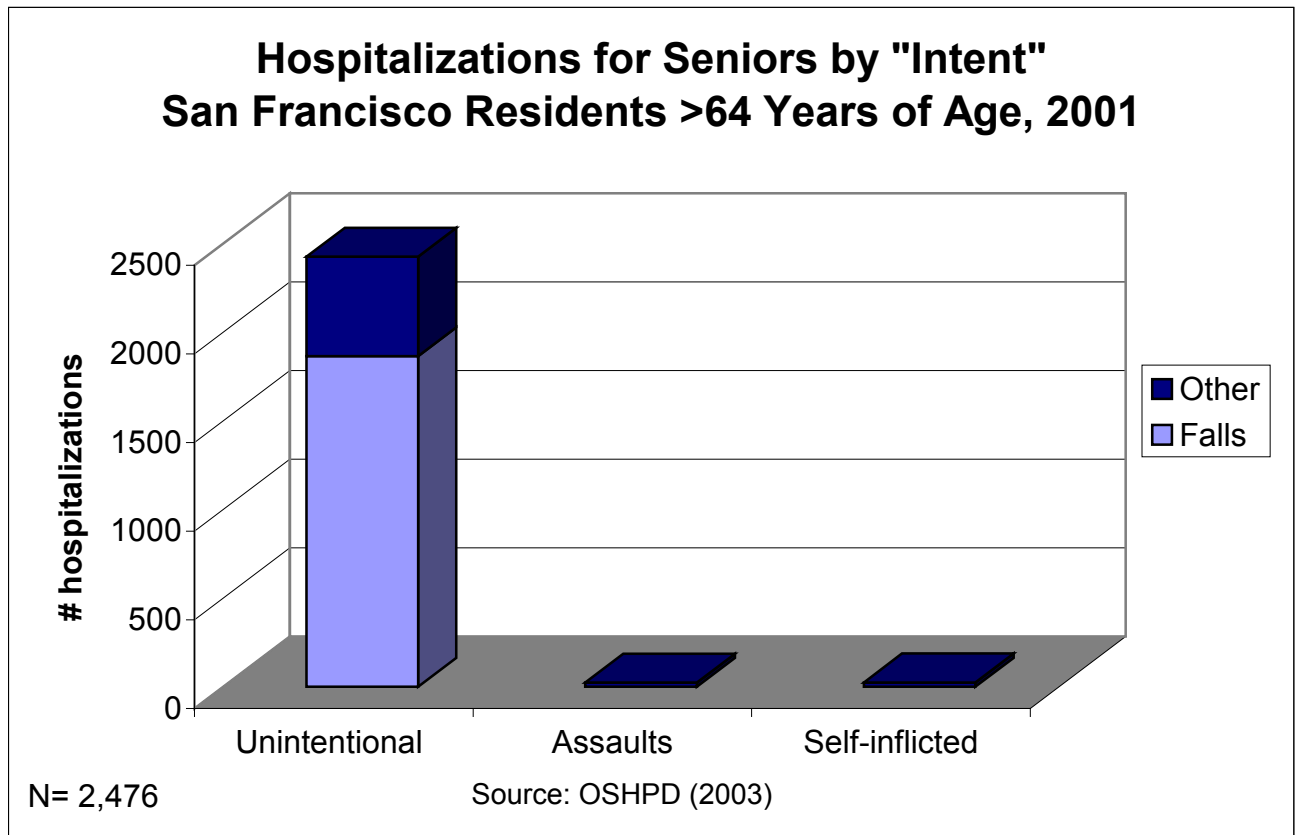


Figure 47.

Consequences of a Fall for Older San Franciscans

As people get older, they gradually lose their resilience and ability to heal quickly from an injury. One measure of this ability to heal is the number of days in an average hospital stay. For those 65 years or older, the median stay is 5 days, compared to 3 days for younger San Franciscans. Even among seniors, the median length of stay for those who fell was 5 days, compared to 4 days for those suffering other injuries. When we calculate the mean stay, which takes into account the very long stays of many seniors, it is 15 days, compared to 9 days for younger San Franciscans.

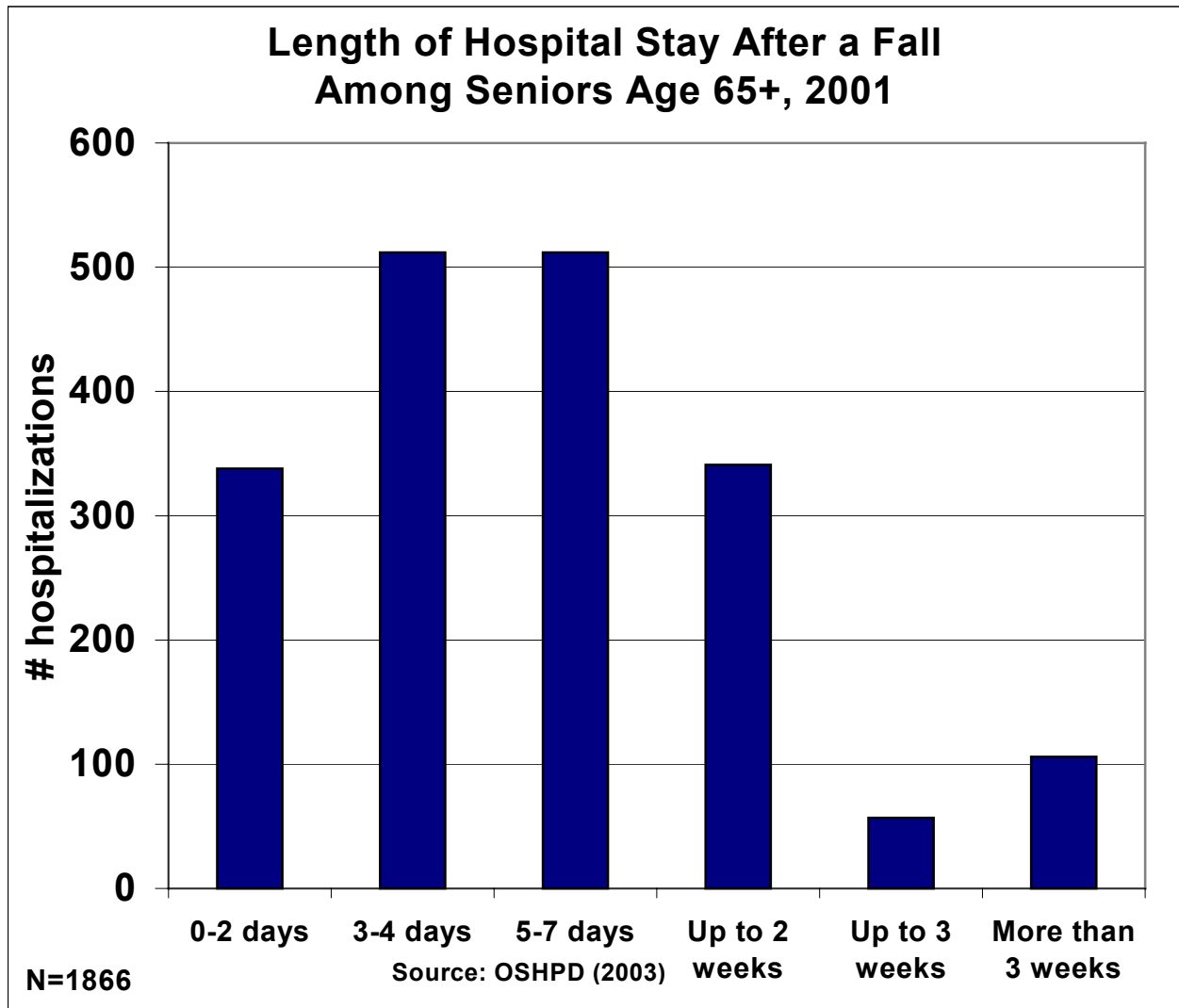


Figure 48.

Older adults who suffer from a fall have an exceptionally high rate of discharge to institutional settings and long term care, which can mark an end to their independence. For people over age 65, 45% of all admissions to long-term care are due to a fall.

Overall, 62% of those over 65 who were hospitalized after a fall in San Francisco in 2001 were discharged to a long-term care or other care facility. The likelihood of being admitted to a long-term care facility after a fall continues to increase with age.

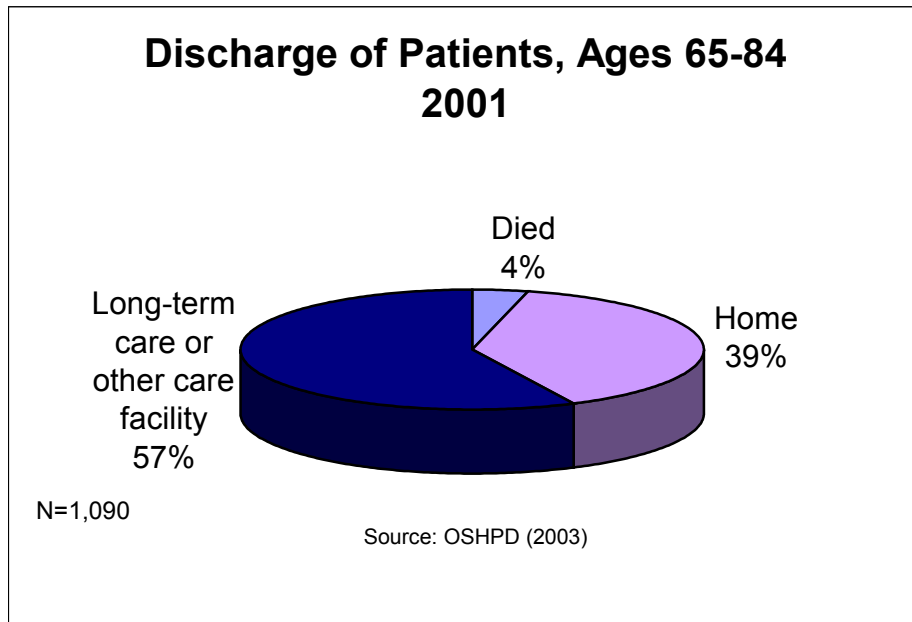


Figure 49.

With age, the proportion of patients who are admitted to another care facility after leaving the hospital increases while the percentage of those who return home decreases.

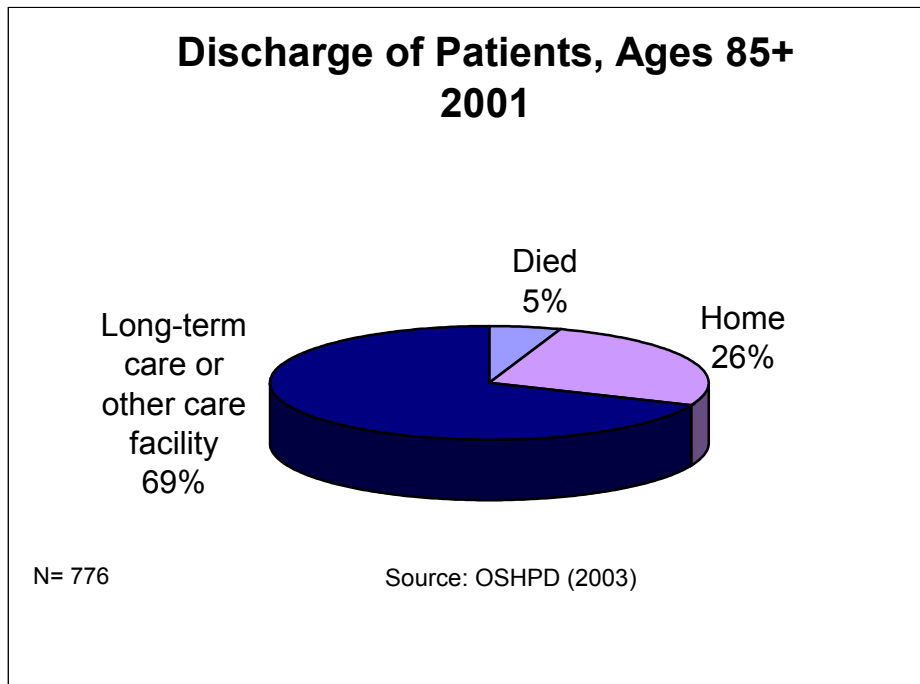


Figure 50.

Drug/Poisoning-related Injuries Summary

Drugs and other poisons account for the greatest number of injury deaths in San Francisco. In 2001, there were 149 drug or poisoning-related deaths. The majority (74%) of these deaths were coded as unintentional, which should be noted is the default code when there is no specific evidence that the deceased intended to die.

Drug/poisoning-related non-fatal injuries were second to falls as the leading cause of injury hospitalizations. In 2001, these injuries accounted for 665 hospitalizations. The majority of cases were coded as self-inflicted (52%), but 45% were coded as unintentional. Almost one-third of the drugs involved in these non-fatal injuries were tranquilizers and other psychotropic agents.

The Profile includes data from the San Francisco Department of Public Health's Community Substance Abuse Services and from a report by the Drug Abuse Warning Network (DAWN) on substances that were detected during emergency department care provided in San Francisco, Marin and San Mateo counties.

Drug/Poisoning-related Deaths

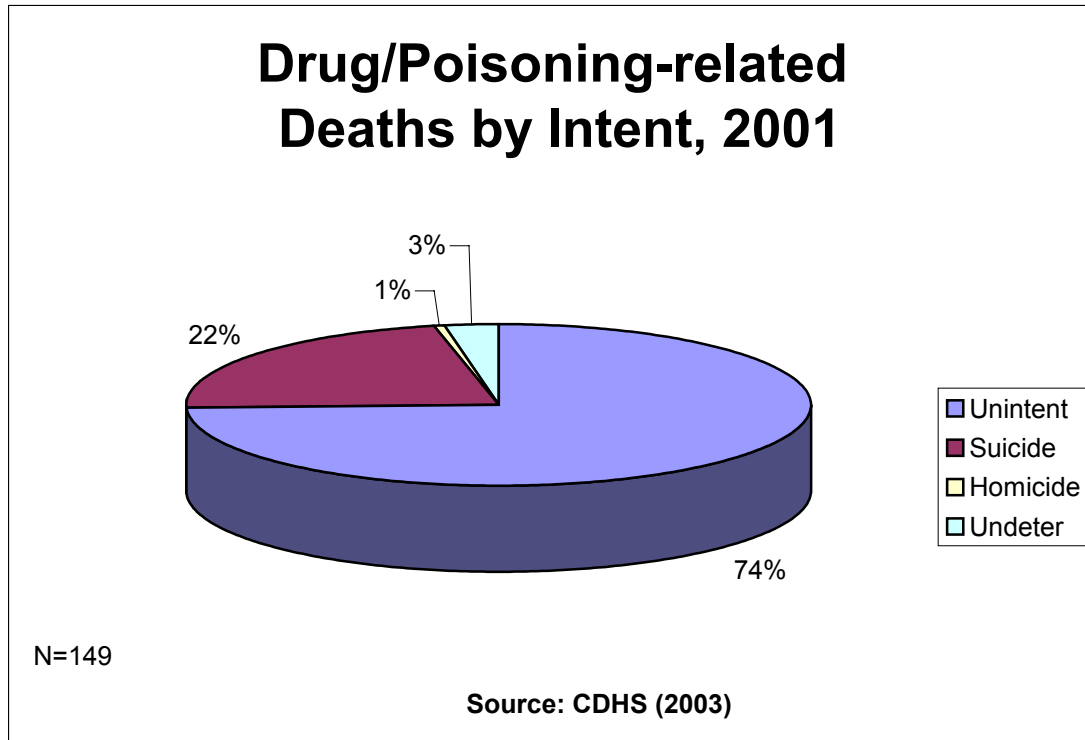


Figure 51.

Three-quarters of the drug/poisoning-related deaths in 2001 were coded as unintentional. However, it must be noted that determining the intentionality of drug/poisoning-related deaths is problematic. It is extremely difficult to judge after death whether someone actually intended to overdose.

Throughout the early to mid 1990s, about three-quarters of the deaths were coded as unintentional. Then, in 1998, the percentage coded as unintentional rose to 87%. The 2001 distribution is comparable to that of the early 1990s. This fluctuation may be due to changes in coding practices at the Medical Examiner's office.

Drug/Poisoning-related Hospitalizations

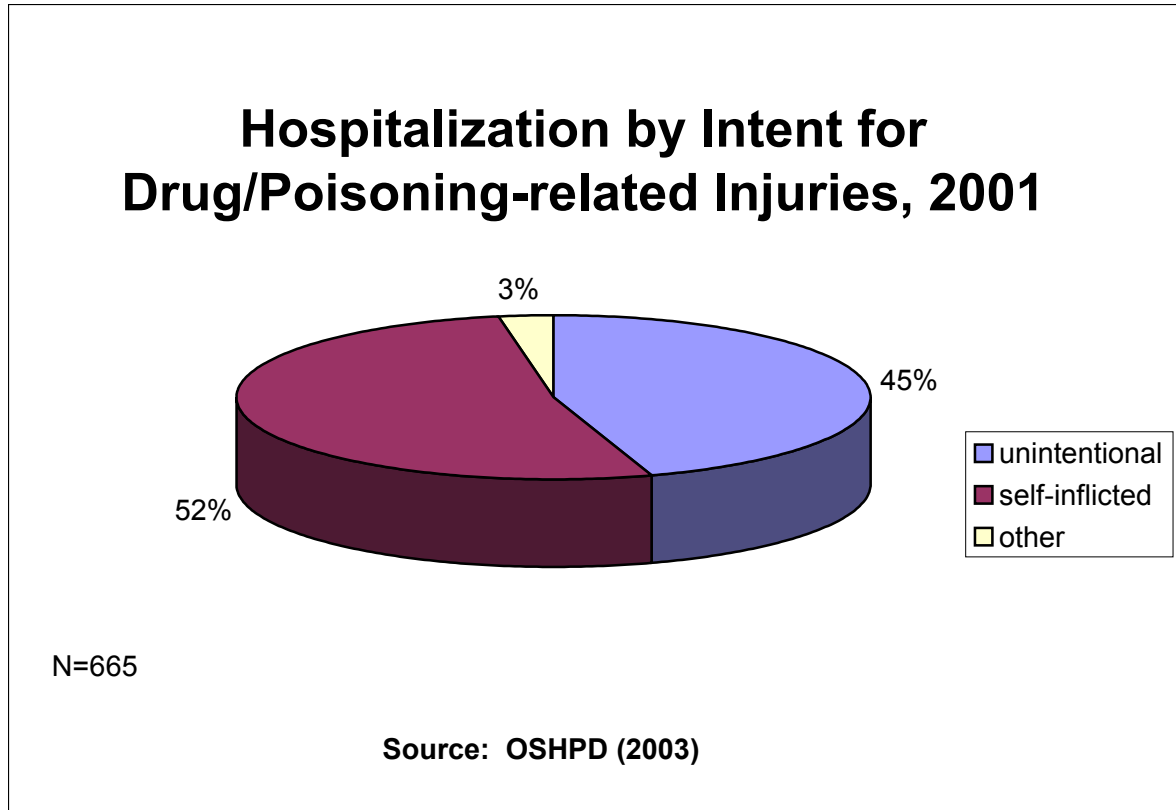


Figure 52.

In 2001, 665 San Francisco residents were hospitalized for non-fatal drug-related injuries. The pattern of intentionality of non-fatal drug/poisoning-related injuries is opposite that of drug-related deaths. Hospitalizations for injuries coded as self-inflicted outnumbered those coded as unintentional. In Table 3 on page 64, the substances associated with these hospitalizations are identified.

As with drug/poisoning-related deaths, it is difficult to identify the intent of a non-fatal injury with great certainty. For example, if someone intentionally takes several tranquilizers, seeking temporary oblivion but not seeking to injure himself, but is not completely aware of the potential complications caused by having other drugs and alcohol in his body, is this a “self-inflicted” injury? This question could be answered differently among health care providers. Thus, the distinction between unintentional and self-inflicted harm is not as clear as might appear in graphs and data tables.

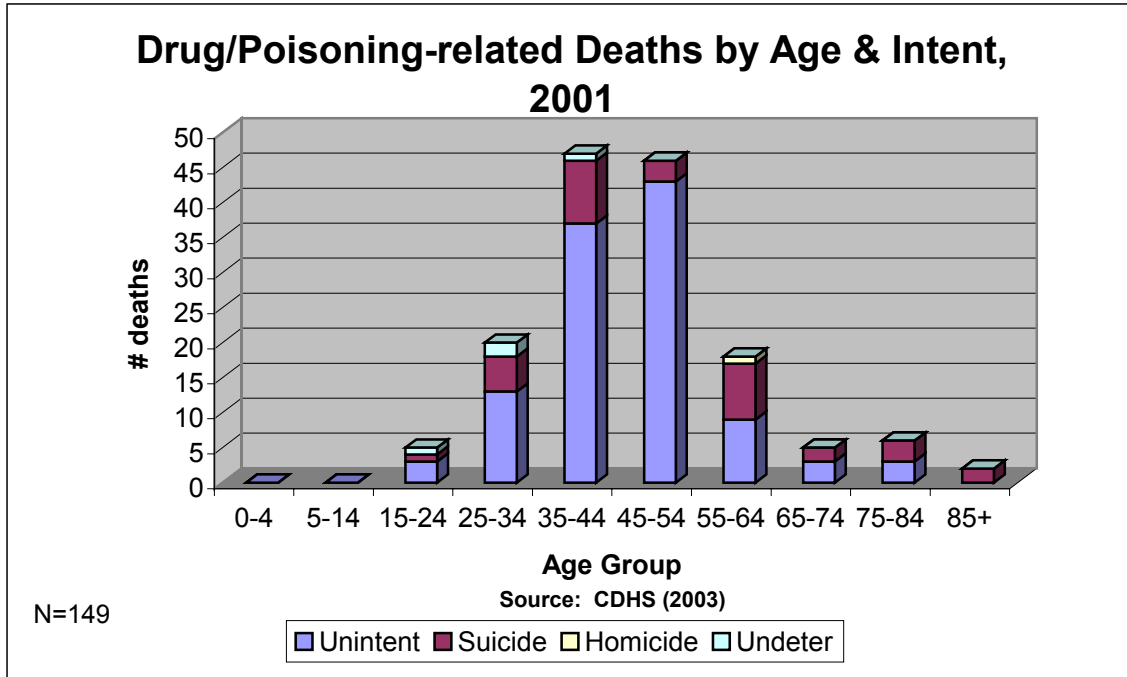


Figure 53.

Age Groups	Unintent	Suicide	Homicide	Undeter	Total	Rate per 100000
0-4	0	0	0	0	0	*
5-14	0	0	0	0	0	*
15-24	3	1	0	1	5	5.6
25-34	13	5	0	2	20	11.1
35-44	37	9	0	1	47	35.1
45-54	43	3	0	0	46	42.7
55-64	9	8	1	0	18	27.6
65-74	3	2	0	0	5	9.3
75-84	3	3	0	0	6	15.8
85+	0	2	0	0	2	*
Total	111	33	1	4	149	19.2

* = too few deaths for rate calculation

There were no drug/poisoning-related deaths among San Francisco children under 15 years of age, which could be testimony to the effectiveness of preventive interventions (such as bubble-packs and child-proof caps on medicine containers). Rates of drug/poisoning-related injuries range from a low of 5.6 (deaths per 100,000 population) for 15-24 year olds to a high of 42.7 among 45-54 year olds. The highest rates of drug/poisoning-related deaths are found among adults aged 35 to 64 years. In that age range, very few of the deaths were coded as suicide. Only among the oldest seniors (aged 85+) do suicides outnumber unintentional drug deaths (although there were only 2 suicides in this group).

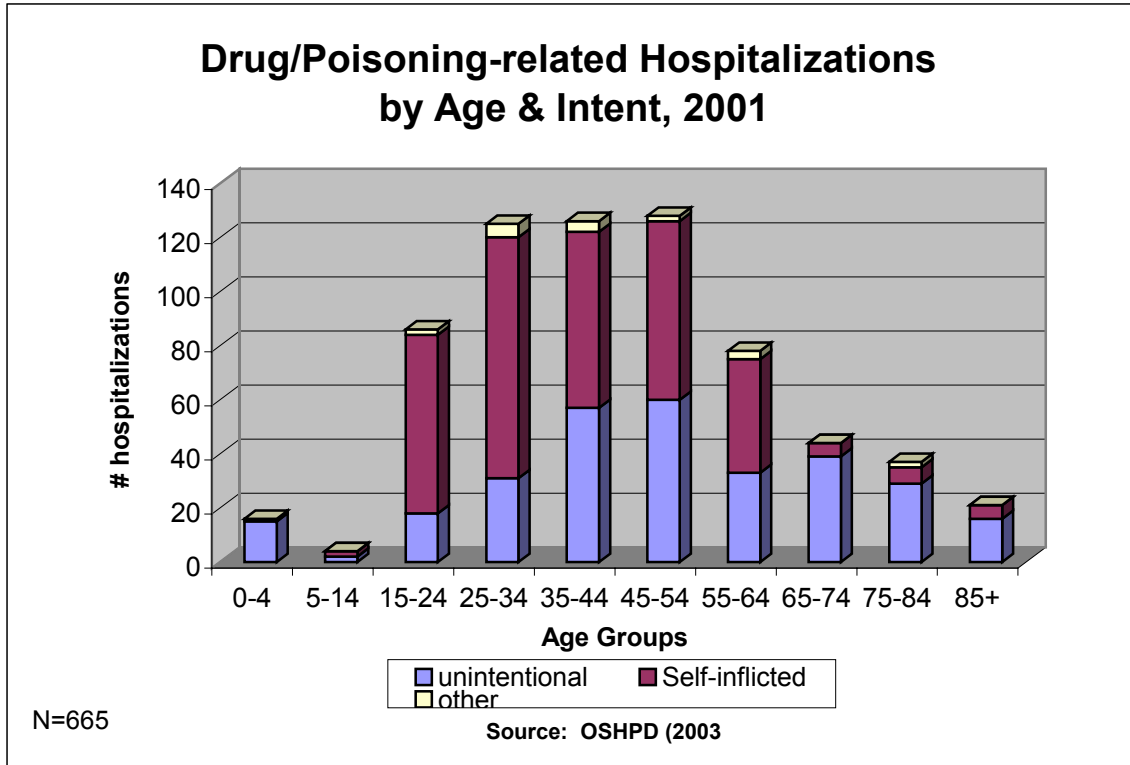


Figure 54.

Age Groups	Unintentional	Self-inflicted	Other	Total	Rate per 100,000
0-4	15	0	1	16	50.6
5-14	2	2	0	4	*
15-24	18	66	2	86	96.2
25-34	31	89	5	125	69.3
35-44	57	65	4	126	94.2
5-54	60	66	2	128	118.8
55-64	33	42	3	78	119.5
65-74	39	5	0	44	81.5
75-84	29	6	2	37	97.6
85+	16	5	0	20	140.6
Total	300	346	19	665	85.6

There were 16 drug/poisoning-related hospitalizations among young children 0-4 years, and 4 among children aged 5-14 years. These two age groups had the lowest drug/poisoning-related hospitalization rates in the population. Seniors aged 85+ had the highest rates, and adolescents aged 15-24 had rates comparable to adults aged 35-64 years. From age 15-64, there were more hospitalizations coded as self-inflicted than as unintentional. This is reversed among seniors aged 65+, whose drug/poisoning-related injuries were more often coded as unintentional.

Drug/Poisoning-related Deaths

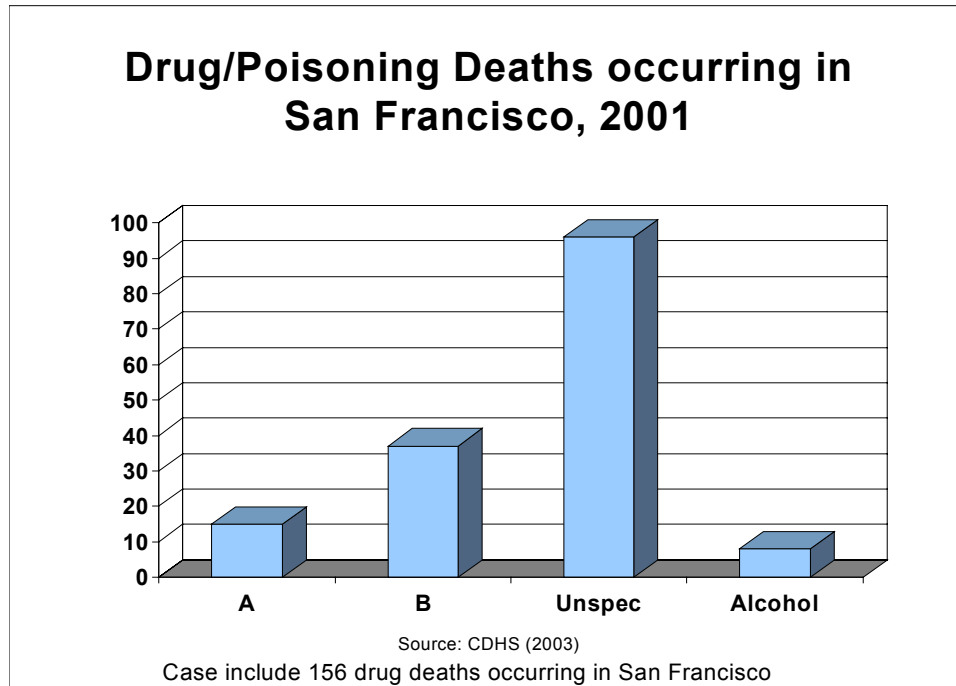


Figure 55.

‘A’ drugs— ICD-10 labels them as: antiepileptic, sedative-hypnotic, antiparkinsonism, psychotropic, and specifically includes antidepressants, barbiturates, hydantoin derivatives, iminostilbenes, methaqualone compounds, neuroleptics, psychostimulants, succinimides & oxazolidinediones, and tranquilizers.

‘B’ drugs— ICD-10 labels them as: narcotics & psychodysleptics [hallucinogens], and specifically includes: cannabis (derivatives), cocaine, heroin, LSD, mescaline, methadone, morphine, and opium (alkaloids).

‘Unspecified’— ICD-10 labels them as: other and unspecified drugs, medicaments & biological substances, and specifically includes agents that work on the muscle and respiratory systems, anaesthetics, drugs affecting the cardio & gastro systems, hormones & synthetic substances, systemic & haematological agents, therapeutic gases, topical preparations, vaccines, and agents affecting metabolism. It is speculated that “multi-drug” cases are classified under this category. Previous work suggests that the vast majority of overdose cases involve more than one substance, which is frequently alcohol and another drug or drugs.

Drug/Poisoning-related Hospitalizations: Involvement of Specific Substances

There were 855 discharges from San Francisco-based hospitals for drug/poisoning-related incidents in 1998 (which was the most updated information available on the involvement of specific substances). The table below lists the percentage distribution of the various drugs among these cases, regardless of whether the patients were SF residents or visitors. Listing the drugs or poisons involved in all drug/poisoning-related cases best represents the drugs and other poisons available in San Francisco.

When visitors were included, the drug/poisoning-related injuries were evenly split between unintentional and self-inflicted. Among the 655 San Francisco residents hospitalized for drugs, a slightly larger percentage were coded as having self-inflicted injury. Tranquilizers were the most commonly identified drug used in suicide attempts by both men and women.

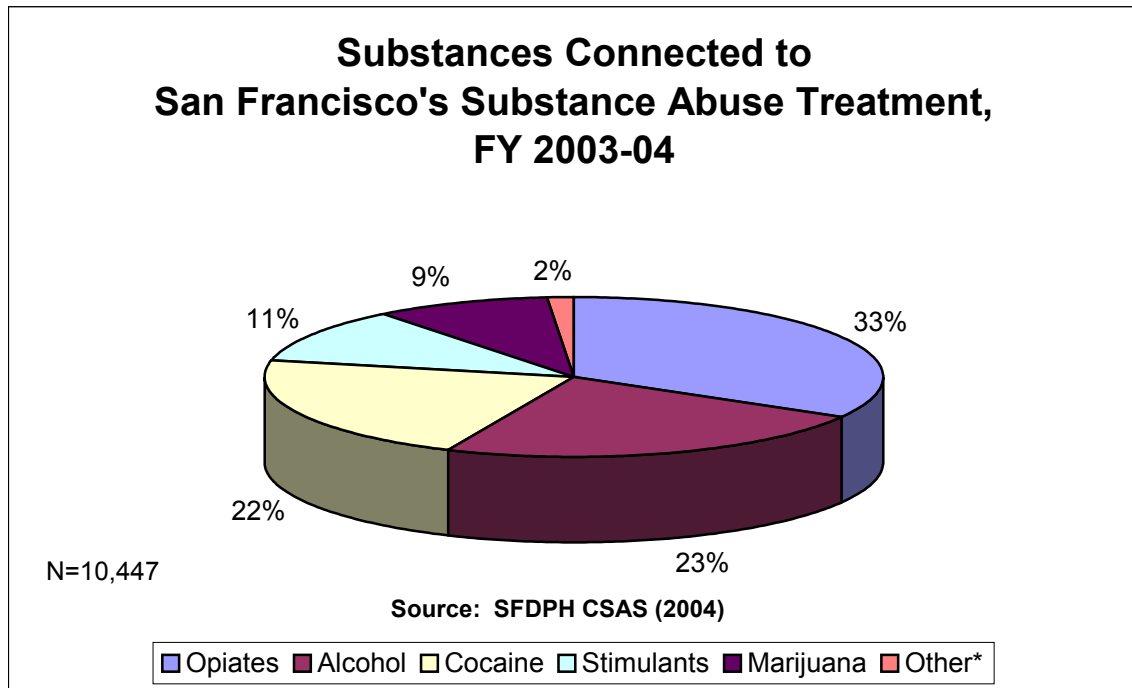
HOSPITALIZATIONS FOR DRUG OVERDOSE/POISONING, SAN FRANCISCO, 1998					
Intentionality:	Unintentional	Self	?*	Total	%
DRUGS, MEDICATIONS AND BIOLOGICAL SUBSTANCES					
Tranquilizers and other Psychotropic Agents (including caffeine, benzodiazepines & amphetamines)	95	176	8	279	32.6%
Analgesics, Antipyretics, and Antirheumatics (includes heroin, aspirin and acetaminophen)	67	116	5	188	22.0%
Central Nervous System (includes cocaine)	85	N/A	N/A	85	9.9%
Sedatives/Hypnotics	3	9	0	12	1.4%
Barbiturates	6	7	1	14	1.6%
Other drugs/medications	98	79	6	183	21.4%
Unspecified drugs/medications	7	2	2	11	1.3%
Total drugs, medications & biological substances	361	389	22	772	90.2%
SOLIDS, LIQUIDS, GASES AND VAPORS					
Carbon Monoxide	4	6	1	11	1.3%
Corrosives/Caustics	2	2	1	5	0.6%
Other and Unspecified Solids, Liquids and Gases (including alcohol)	44	23	0	67	7.8%
Total solids, liquids, gases & vapors	50	31	2	83	9.7%
TOTAL POISONING/DRUG OVERDOSE DEATHS	411	420	24	855	100%
	48%	49%	3%	100%	

* = intent undetermined.

Table 3.

Substance Abuse Services: Substances Involved

The San Francisco Department of Public Health contracts with community-based substance abuse programs to provide treatment to residents with drug-related problems. Between July 1, 2003 and June 30, 2004, the city financed direct treatment services for 10,447 residents through these programs.



* = This portion represents the last three categories in the table below.
Figure 56.

Substance Category	Frequency	Percent
Heroin/non-Rx methadone/other opiate	3,487	33.38
Alcohol	2,427	23.23
Cocaine	2,264	21.67
Methamphetamine/amphetamine/stimulant	1,177	11.26
Marijuana	934	8.94
PCP/hallucinogen/hypnotic	54	0.52
Downer	31	0.3
Other	73	0.7
TOTAL	10,447	100.00

Drug Abuse Warning Network (DAWN) Emergency Department Data

Drug Category ¹	Total 2000	Total 2001	Total 2002	% Change 2000 - 2002	% Change ² 2001 - 2002
MAJOR SUBSTANCES OF ABUSE	8,675	10,033	9,402		
Alcohol in combination	1,804	2,155	1,926		-10.6
Cocaine	2,054	2,482	2,353	14.6	
Heroin	2,756	2,790	2,672		
Marijuana	627	704	607		-13.8
Amphetamines	371	786	700	88.7	-10.9
Methamphetamine	591	611	727	23.0	19.0
MDMA (Ecstasy)	107	152	129	20.6	-15.1
Ketamine	14	111	10	-28.6	
LSD	67	46	17	-74.6	-63.0
PCP	70	76	50	-28.6	-34.2
Miscellaneous hallucinogens	33	42	37		
Flunitrazepam (Rohypnol)	0	0	0		
GHB	151	158	133		-15.8
Inhalants	4	5	15	275.0	200.0
Combinations NTA	25	17	24		41.2
OTHER SUBSTANCES OF ABUSE	3,496	3,710	3,683		
PSYCHOTHERAPEUTIC AGENTS	1,301	1,580	1,402		
Antidepressants	284	328	375	32.0	
MAO inhibitors	0	0	0		
SSRI antidepressants	102	124	155	52.0	25.0
Tricyclic antidepressants	52	56	48		
Miscellaneous antidepressants	130	149	172	32.3	
Antipsychotics	117	145	151	29.1	
Phenothiazine antipsychotics	25	23	17	-32.0	
Psychotherapeutic combinations	0	0	...		
Thioxanthenes	3	1	...		
Miscellaneous antipsychotic agents	89	121	130	46.1	
Anxiolytics, sedatives, and hypnotics	885	1,096	862		-21.4
Barbiturates	78	115	57	-26.9	-50.4
Benzodiazepines	664	825	657		-20.4
Misc. anxiolytics, sedatives & hypnotics	143	157	148		
CNS stimulants	14	10	14		
CNS AGENTS	1,389	1,589	1,550	11.6	
Analgesics	1,194	1,353	1,319		
Antimigraine agents	3	2	...		
Cox-2 inhibitors	0	4	9		125.0
Narcotics analgesics/combinations	696	839	813	16.8	
Nonsteroidal anti-inflammatory agents	130	155	151		
Salicylates/combinations	103	65	90		38.5
Miscellaneous analgesics/combinations	263	288	254		
Analgesic combination NTA	0	0	0		
Anorexiant	10	7	10		
Anticonvulsants	111	112	119		
Antiemetic/antivertigo agents	3	4	0	-100.0	-100.0
Antiparkinson agents	8	5	13	62.5	160.0
General anesthetics	0	0	0		
Muscle relaxants	61	109	90	47.5	-17.4
Miscellaneous CNS agents	0	0	0		
RESPIRATORY AGENTS	68	82	90	32.4	
CARDIOVASCULAR AGENTS	43	71	67	55.8	
OTHER SUBSTANCES	695	387	574		48.3
TOTAL DRUG ABUSE EPISODES	7,857	8,575	8,571		
TOTAL DRUG ABUSE MENTIONS	12,171	13,743	13,085		
TOTAL ED VISITS (in 1,000s)	503	545	589	17.2	8.2

Table 4.

This table reports data from the San Francisco Metropolitan Area, which includes three counties: Marin, San Francisco, and San Mateo

¹ This classification of drugs is derived from the Multum Lexicon, Copyright © 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements.

(2003) The Multum Licensing Agreement governing use of the Lexicon is provided in an appendix to this report and can be found on the Internet at <http://www.multum.com>.

² This column denotes statistically significant ($p < 0.05$) increases and decreases between estimates for the periods noted. See Relative Standard Error (RSE tables for p-values).

Note: These estimates are based on a representative sample of non-Federal short-stay hospitals with 24-hour emergency departments in the contiguous United States. Dots (...) indicate that an estimate with an RSE greater than 50% has been suppressed. Dashes (---) indicate that an estimate has been suppressed due to incomplete data.

Abbreviations:

CNS = center nervous system; ED = emergency department; GHB = gamma hydroxy butyrate; LSD = lysergic acid diethylamide; MAO = monoamine oxidase; MDMA = methylenedioxyamphetamine; NTA = not tabulated above; PCP = phencyclidine; SSRI = selective serotonin reuptake inhibitor.

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 2002 (updated 03/2003).

The preceding table is a truncated version of Table 2.2.19 from "Emergency Department Trends From the Drug Abuse Warning Network, Final Estimates 1995–2002" published by Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies (OAS).

The full table and report are available at:

http://dawninfo.samhsa.gov/pubs_94_02/edpubs/2002final/files/EDTrendFinal02AllText.pdf

Violence-related Injuries Summary

Violence can be interpersonal, which is called homicide when fatal and assault when non-fatal. Violence can also be directed against the self, which is called suicide when fatal and self-inflicted injury when non-fatal.

The Profile is based primarily upon death certificate and hospital discharge data. In 2001, there were 106 suicides and 65 homicides among San Francisco residents. An additional 9 deaths were coded as “undetermined” because the Medical Examiner was unable to conclude if the death was homicide, suicide or unintentional. In 2001, there were 459 hospital discharges related to self-inflicted injury, 503 hospitalizations resulting from assault, and 40 hospitalizations coded as other (undetermined intent and legal intervention).

Since 1999, San Francisco has been participating in a national fatal violent injury reporting project – the National Violent Injury Statistics System (NVISS, www.nviss.org). The Profile is able to draw upon this comprehensive database in order to present a more complete picture of every single homicide, suicide, and unintentional firearm death that occurs in the city. The local reporting system, the San Francisco Violent Injury Reporting System (SFVIRS), systematically collects all information regarding each homicide, suicide and unintentional firearm death. One of the key features of SFVIRS is that the Police Department, Medical Examiner and the Department of Public Health have been working together to find a public health approach to reduce the number of violent deaths. Information from death certificates, Medical examiner case and autopsy records, police incident reports, criminal records, and supplemental homicide reports (SHR) are collected and merged to form a unique record for each violent incident. The SFVIRS is able to answer the who, what, where and why these violent incidents occur.

On pages 74-80 of this chapter, the SFVIRS data will be presented. However, because the SFVIRS does not use the California hospital discharge database and is heavily weighted toward surgically-repaired, non-fatal injury, the Profile relies less upon information from SFVIRS to describe incidents of self-inflicted non-fatal injury.

Violence in San Francisco: Deaths

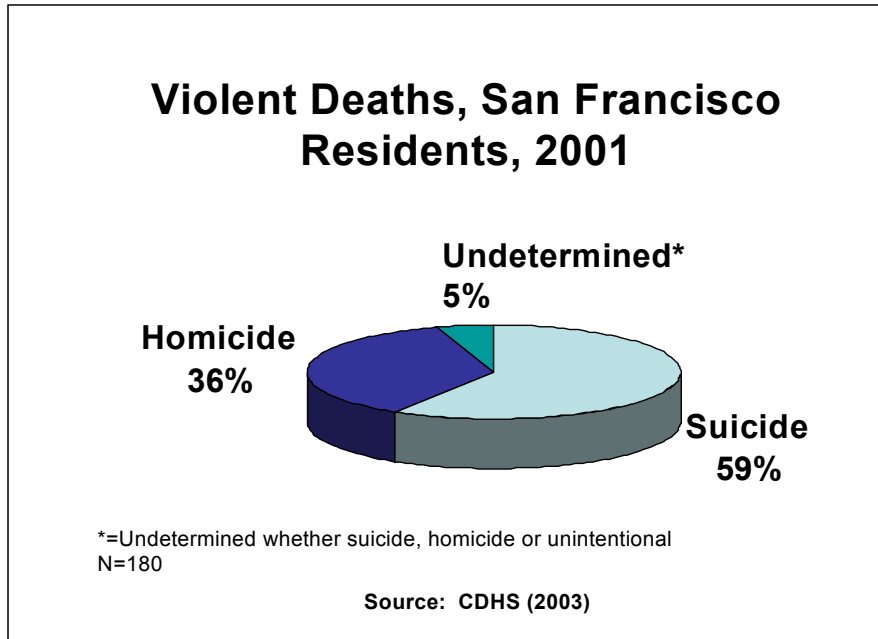


Figure 57.

		Intent			Total
		Suicide	Homicide	Undeter	
Mechanism	Cut pierce	3	7	0	10
	Drowning	4	1	1	6
	Jump	8	1	1	10
	Fire flame	2	0	0	2
	Firearm	17	33	0	50
	Other land trans	0	1	0	1
	Poisoning	33	1	4	38
	Struck	0	1	0	1
	Hanging	28	1	0	29
	Other spec	2	1	1	4
	NEC	3	6	0	9
	Not spec	6	12	2	20
Total		106	65	9	180

Table 5. Mechanisms of violent death

Violent deaths have two major categories: suicide and homicide. This chapter also includes nine deaths coded as “intent undetermined” because the Medical Examiner could not establish whether or not the death resulted from violence.

As in most cities, there were more suicides than homicides. Overall, 28% (50) of violent deaths were committed with a firearm, but 51% (33) homicide victims were killed with a firearm. Thirty-one percent (33) of suicides involved some type of drug/poison.

Violence in San Francisco: Hospitalizations

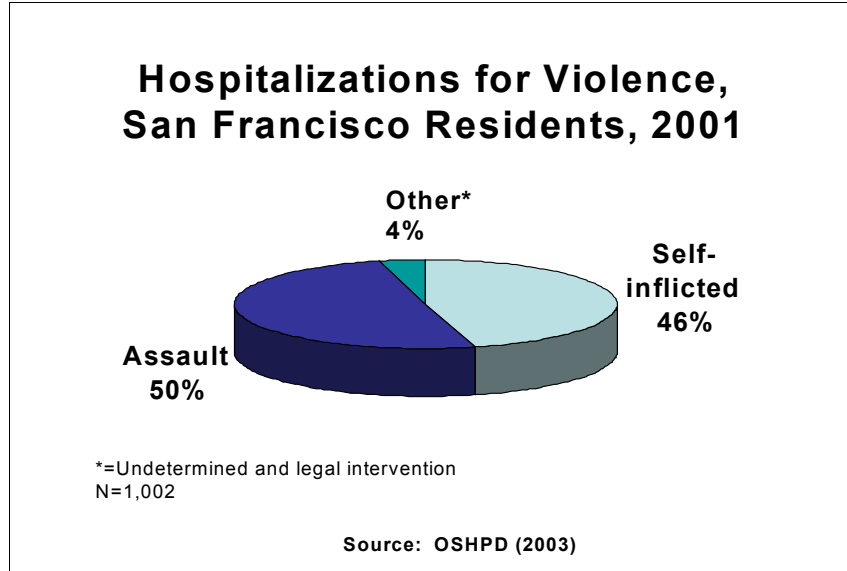


Figure 58.

		Intent			Total
		Self-inflicted	Assault	Other	
Summary	Cut/pierce	80	121	2	203
	Drowning	0	1	0	1
	Falls	11	1	2	14
	Fire/burn	4	1	0	5
	Firearms	1	65	0	66
	Poisonings	346	0	19	365
	Struck by	0	181	6	187
	Suffocation	2	1	0	3
	Other/unspecified	15	132	11	158
Total		459	503	40	1002

Table 6. Mechanisms of non-fatal violent injury resulting in hospitalization

San Francisco residents suffered more non-fatal interpersonal injuries (assaults) than self-inflicted injuries, which is opposite the breakdown for violent deaths. Poisonings, including drugs, accounted for 75% of the self-inflicted non-fatal injuries. Cutting with sharp objects such as knives, cutters, razors, and picks, and beatings with blunt objects such as fists, bats and tire irons account for 60% of the assaults.

While this table presents the data coded by intent, the 300 hospitalizations for drugs and other poisons that were coded as unintentional should not be ignored (under 'Drug/Poisoning-related Hospitalization' on page 60). This serves as a reminder that judgment about intent can vary significantly among health providers.

Violent Death by Age Groups

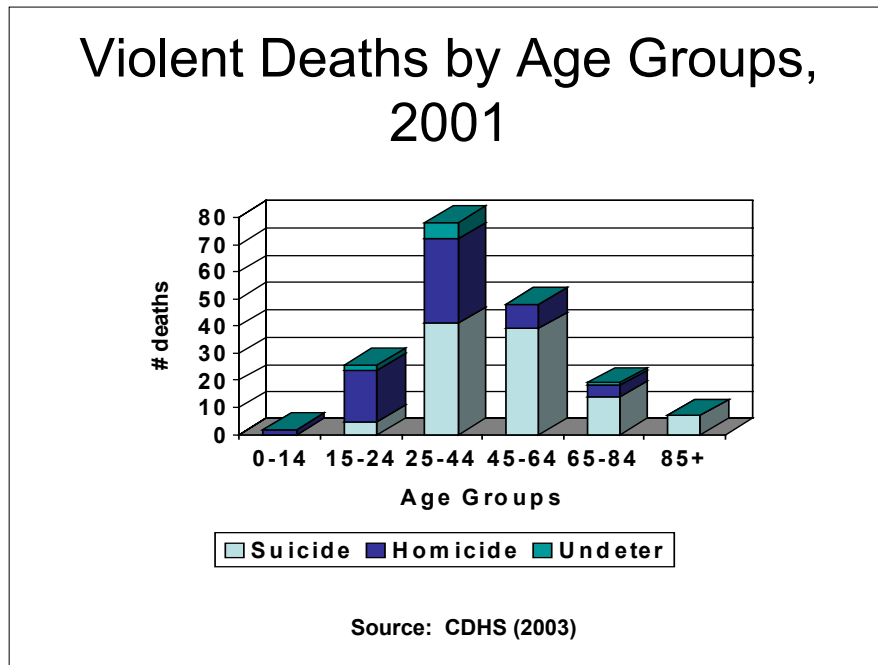


Figure 59.

Category (ages included)	Intent			Total	Overall rate per 100,000
	Suicide	Homicide	Undeter		
Child (0-14)	0	2	0	2	*
Adolescent (15-24)	5	19	2	26	29.1
Younger adult (25-44)	41	31	6	78	43.2
Older adult (45-64)	39	9	0	48	27.7
Young old (65-84)	14	4	1	19	20.7
Old old (85+)	7	0	0	7	*
Total	106	65	65	180	23.2

(* = too few deaths to calculate rate)

Table 7. Age Groups for violent deaths

The patterns in violent deaths differ by age group, especially as shown by the overall rates in the table above. In adolescence, homicides predominate. There are more suicides than homicides among younger adults, who have the highest overall rate of violent deaths (43.2 per 100,000). For all older age groups, suicides predominate. Violent deaths among the oldest age group are attributable solely to suicide.

Hospitalized Non-fatal Violent Injuries by Age Groups

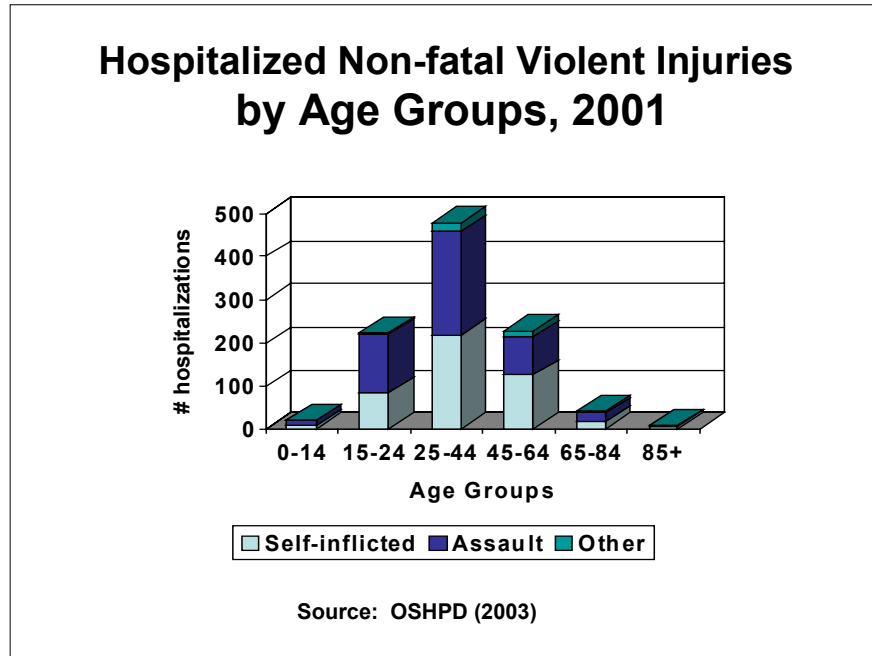


Figure 60.

	Intent			Total	Overall rate per 100,000
	Self-inflicted	Assault	Other		
Child (0-14)	8	13	1	22	23.4
Adolescent (15-24)	84	137	3	224	250.6
Younger adult (25-44)	218	241	20	479	152.4
Older adult (45-64)	125	90	12	227	131.2
Young old (65-84)	18	19	4	41	44.6
Old old (85+)	6	3	0	9	63.3
Total	459	503	40	1002	129.0

Table 8. Age groups for violent non-fatal injury resulting in hospitalization

Adolescents (ages 15-24) have the highest rates of non-fatal violent injury, primarily involving assaults. Children under 15 years have the lowest rates of non-fatal violent injury. Young adults have high numbers of both self-inflicted and assaultive injuries, but although they had the highest rates of fatal violent injuries, their rates of non-fatal violent injuries are significantly lower than the rate for adolescents.

The San Francisco Violent Injury Reporting System (SFVIRS)

San Francisco is privileged to be one of thirteen sites of the National Violent Injury Statistics System (NVISS), coordinated by the Harvard School of Public Health. The local effort, named the San Francisco Violent Injury Reporting System (SFVIRS), is led by the San Francisco Department of Public Health with support from the San Francisco Injury Center. The SFVIRS involves active data sharing by the San Francisco Police Department, the San Francisco Medical Examiner and Marin Coroner’s Office and San Francisco General Hospital (SFGH) trauma unit.

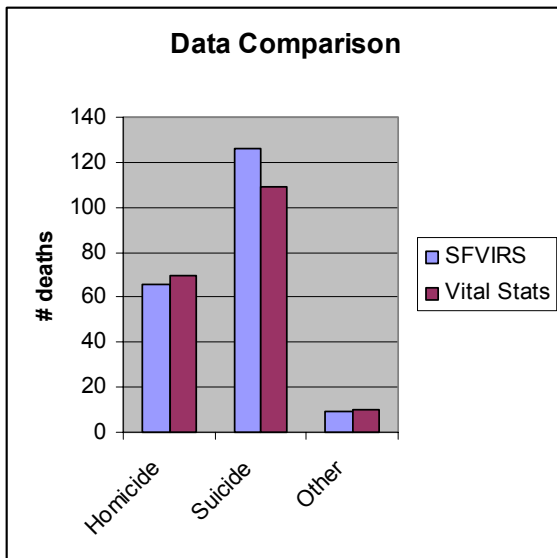


Figure 61. The presence of this project helps to fine-tune the Vital Statistics data used as the basis of the *Profile of Injury*. As can be seen in the adjacent chart, the numbers from the two data systems do not match exactly. Some of the differences can be traced to peculiarities of this city. For example, because the Coast Guard has a landing dock on the Marin side of the Golden Gate, suicides from the bridge are counted by the state as happening in Marin. Other differences derive from case inclusion criteria or from revisions in coding following examination of the linked data sets. Because of their accuracy, SFVIRS data are used to present information on homicides, suicides, non-fatal assaults that required hospitalization, unintentional firearm deaths, and all non-fatal firearm injuries that were treated at the SFGH Emergency Department.

The NVISS serves as the pilot project of the National Violent Death Reporting System (NVDRS), a new initiative of the National Center for Injury Prevention and Control of the CDC. California has just received a grant from CDC to become part of this reporting system. A state-based violent death reporting system, NVDRS will provide accurate and timely information to:

- make informed decisions about local policies and programs geared toward keeping citizens safe
- help decision makers answer questions about the magnitude, trends, and characteristics of violent deaths
- evaluate and continue to improve state-based violence prevention policies and programs.

Violent Injuries and Deaths in 2001 included in the SFVIRS

Number of Violent Incidents and Fatal and Nonfatal Violent Injuries, San Francisco, 2001				
	Number of Incidents N=648	Overall Number of people Injured N=735	Fatal n=201	Nonfatal n=534
Homicide	62	66	66	--
Assault	425	500	--	500
Suicide	125	126	126	--
Attempted Suicide	26	26	--	26
Legal Intervention	3	8	2	6
Accident-other person	1	1	1	0
Accident-self-inflicted	2	2	1	1
Other	1	2	2	0
Could not be determined	3	4	3	1

Table 9. Source: San Francisco Department of Public Health, San Francisco Violent Injury Reporting System (SFVIRS): Violent Injuries and Deaths in 2001 and Firearm Trend Data from 1999 to 2001. Local Data for Local Violence Prevention Tracking Violent Injuries and Deaths in San Francisco County. Spring 2004.

In 2001, the SFVIRS identified 648 violent incidents in San Francisco. Those involved approximately 1,548 people—735 victims and approximately 813 suspects. Over a quarter of these injuries resulted in death.

The major difference in the numbers presented by the SFVIRS and the Profile is the source of the data used. The Profile is based primarily upon vital statistics and California hospital discharge data. The SFVIRS draws upon SF Medical Examiner and Marin Coroner reports, San Francisco police reports, death certificates, and the SFGH trauma registries and emergency department records.

For non-fatal violent injuries, SFVIRS only collects data on those victims who were hospitalized due to a violent injury they incurred or those who were treated at SFGH for a gun shot injury. The SFVIRS originally intended to match a police report for each violent incident. However, it was more likely that a violent injury where a victim was hospitalized or was shot would be reported to the police than every violent brawl where someone was treated and released from the hospital. Information for the Profile was also collected from the hospital discharge data system, which includes all hospitals in San Francisco, and therefore includes data on more patients.

For homicides and non-fatal assaults, the respective numbers for the Profile and the SFVIRS are quite comparable: 65 vs. 66 homicides and 503 vs. 500 non-fatal assaults. However, for suicides and non-fatal self-inflicted injury, they differ considerably: 106 vs. 126 suicides and 459 vs. 26 non-fatal self-inflicted injuries. According to the hospital discharge data, 346 (75%) of these self-inflicted injuries were due to drugs or other poisons, injuries that do not require surgery and are therefore not included in the Trauma Registry. Because of these differences, this section of the Profile that uses SFVIRS data will focus primarily on the descriptions of homicides, assaults and suicides.

Homicide

San Francisco County had the third highest homicide rate (8.7 per 100,000¹) among counties in California with populations greater than 500,000. Los Angeles County (11.2) had the highest rate, followed by San Joaquin County (8.9) with the second highest rate. One factor that must be taken into account is that San Francisco is solely an urban area. Therefore, it can be misleading to directly compare the homicide rate in San Francisco with that of other less urban counties.

In San Francisco County from 1942 to 2002, there were 4,926 homicide victims. The most recent spike occurred in 1993 with 133 homicide victims, and the most recent low (of 59) occurred in 2000. In 2001, there were 66 homicide victims, which was a 12% increase from 2000.²

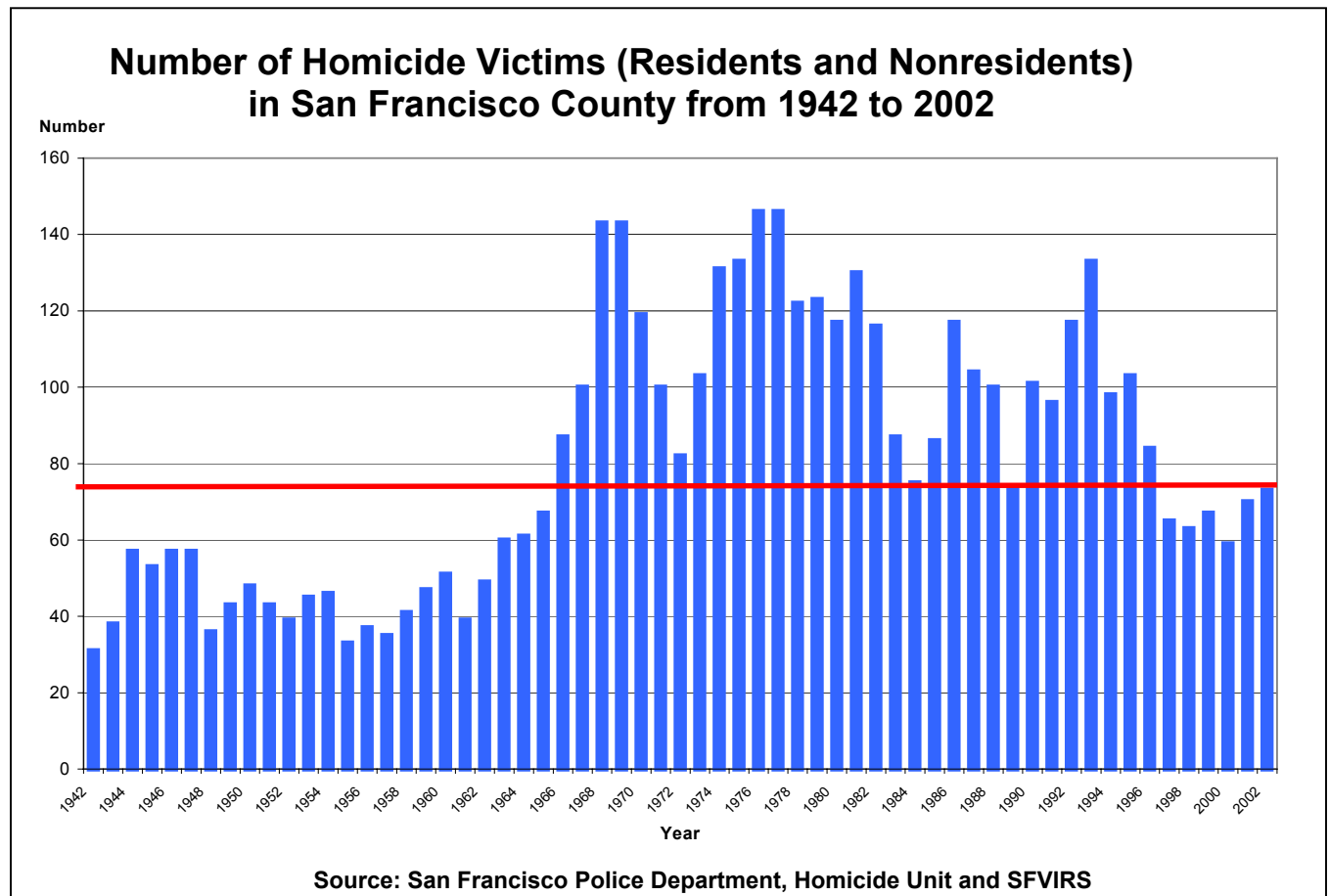


Figure 62.

¹ All rates are standardized to the 2000 U.S. million population and all are expressed per 100,000 persons.

² In 2002, there were 73 homicides, and in 2003 there were 70 homicides (preliminary data).

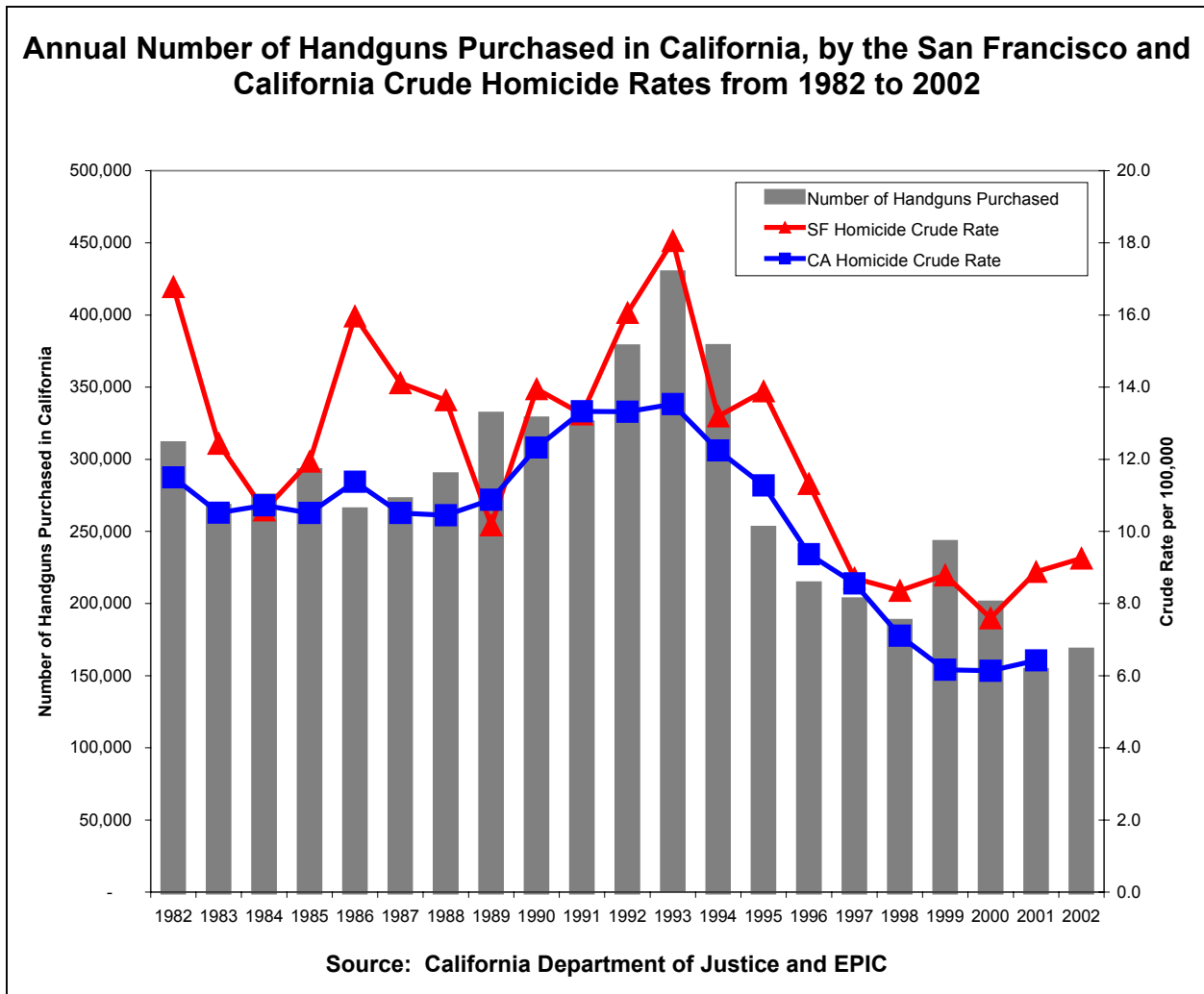


Figure 63. Source: San Francisco Department of Public Health, San Francisco Violent Injury Reporting System (SFVIRS): Violent Injuries and Deaths in 2001 and Firearm Trend Data from 1999 to 2001. Local Data for Local Violence Prevention Tracking Violent Injuries and Deaths in San Francisco County. Spring 2004.

For the past 15 years, firearms have been the primary mechanism used in homicides. In the graph above, the number of annual handgun sales is overlaid with the homicide rate (by all mechanisms, including firearms, knives, blunt objects, etc.) in San Francisco and in California. These data suggest a relationship between handgun sales and the crude rates of homicide, i.e., when handgun sales increase the homicide rate follows.

In 2001, homicides represented 12% of all violent interpersonal incidents. Sixty percent of the homicide victims were killed by a firearm. Non-fatal victims of an assault, on the other hand, were more likely to be injured by a sharp instrument (39%) rather than by a firearm (24%).

Interpersonal violence (including intimate partner violence) was the precipitating circumstance in 58% of the homicides, with 44% of these homicide victims knowing the suspect. Many homicides were identified to have been precipitated by another crime, such as a drug or robbery incident. Drug and gang-related circumstances for homicides each occurred 19% of the time.

Assault

Of the assault incidents for which a location was identified, 17% of victims were injured in their home. A total of 40% of the victims lived at or within one mile of the assault location.

The majority of assault victims were injured on the streets in the Inner Mission (48), South of Market (47) and Bayview/Hunter's Point (31) neighborhoods. The Rincon/Embarcadero (10) and the South of Market (9) neighborhoods experienced the greatest number of violent injuries that occurred in a bar.

When a suspect was identified, it was determined that 55% of the suspects lived at or within one mile of the incident location. In these cases, 26% of the victims identified the suspect as someone they knew.

Nearly 14% of the assault victims were not residents of San Francisco, and nearly 14% of the assault victims were identified as being homeless. Twenty-eight percent of assaults occurred between July and September. When time was known, 47% of the assaults occurred between the hours of 9:00 p.m. and 3:00 a.m.

Medical Services and Hospitalization

Of the 66 homicide victims, 55% (36) were dead at the scene. Thirty-eight percent (25) of these victims died as an inpatient at SFGH, one died in the SFGH Emergency Department, and 4 died at other facilities. Sixty-eight percent (17) of the homicide victims were hospitalized for less than a day, while 31% (125) of the assault victims were hospitalized for between 4 and 7 days

Of the 500 assault victims, 67% (337) were transported by ambulance to SFGH. Twenty-five percent (124) of the assault victims were brought to the hospital by other means—themselves (77), family or friends (35), police (2), strangers (2), or unknown (8). 21 assault victims either refused treatment or were treated at the scene.

Days	Overall		Homicide		Assault	
	n=432	%	n=25	%	n=407	%
<1	42	9.7	17	68.0	25	6.1
1	101	23.4	4	16.0	97	23.8
2-3	89	20.6	1	4.0	88	21.6
4-7	126	29.2	1	4.0	125	30.7
8-28	60	13.9	0	--	60	14.7
> 28	14	3.2	2	8.0	12	2.9

Table 10. Source: San Francisco Department of Public Health, San Francisco Violent Injury Reporting System (SFVIRS): Violent Injuries and Deaths in 2001 and Firearm Trend Data from 1999 to 2001. Local Data for Local Violence Prevention Tracking Violent Injuries and Deaths in San Francisco County. Spring 2004.

Forty-two percent (169) of assault hospitalizations were of victims who were injured by a knife, followed by 28% (116) who were injured of fist or foot, 20% (81) by firearms, and 9% (36) by blunt instruments. Assault victims who were injured by firearms had the greatest median hospitalization stay (5 days).

	Mean	Median	Range
Firearm n=81	8.7	5	Less than a day – 73
Knife n=169	3.4	2	Less than a day – 22
Personal n=116	7.7	4	Less than a day – 100
Blunt n=36	4.4	3	Less than a day – 27

There were 120 victims who were injured by firearms; 95 hospitalized (81 nonfatal, 14 fatal)
 There were 194 victims who were injured by a knife; 175 hospitalized (169 nonfatal, 6 fatal).
 There were 132 victims who were injured by fist or foot; 119 hospitalized (116 nonfatal, 3 fatal).
 There were 49 victims who were injured from a blunt object; 38 hospitalized (36 nonfatal, 2 fatal).
 There were six other hospitalizations (1 nonfatal strangulation; 1 nonfatal fall, 3 by unknown cause).

Table 11. Source: San Francisco Department of Public Health, San Francisco Violent Injury Reporting System (SFVIRS): Violent Injuries and Deaths in 2001 and Firearm Trend Data from 1999 to 2001. Local Data for Local Violence Prevention Tracking Violent Injuries and Deaths in San Francisco County. Spring 2004.

When the 407 assault victims with non-fatal injuries were discharged from the SFGH, 92% (375) went home, 12 went to rehabilitation, 11 went to skilled nursing, 5 went to another hospital, 3 went to other facilities, and a single victim went to acute care.

Suicide

In 2001, 126 suicides occurred in San Francisco. The preferred mechanism used in suicides in San Francisco was by drugs/poisoning (31%-street drugs, gases, prescriptions and over-the-counter medications), followed by hanging (26%). In fact, San Francisco leads the state in the proportion of suicides that are committed with poison. In San Francisco, only 15% of the suicides were committed with a firearm, compared with 47% of suicides in California and 55% of suicides nationally.

Of those who committed suicide, 53% had greater than a 12th grade education. Half were never married, and 22% were married at the time. Two victims were homeless, and 11% were veterans. Of the suicide victims, 29% were foreign born and over half of those foreign-born victims came from Asia.

Twenty-six patients who attempted suicides in 2001 were treated at SFGH. Half of those victims were males and 58% were White. The ages ranged from 17 to 77 years of age, with a mean and median of 37 and 34 years, respectively.

Nearly 60% (75) of the suicide victims had a reportable mental health disorder. Of those, 64% (48) were in treatment at the time of their suicide. Almost 32% (40) of all suicide victims had prior attempts. This underscores the suicide risk associated with mental health disorders, even among those undergoing treatment. This is a reminder that San Francisco needs to address how to better serve this population (See Table 12).

Location and Time

Fifteen percent of the suicide victims were not San Francisco residents. Death certificates were obtained for 114 of the victims. Of those victims who were residents and were not living under supervised care, 74% committed suicide in their residence. Of all suicide victims, 10% occurred at the Golden Gate Bridge, 10% occurred in residential or low-income hotels or in hotels, and 8% were living under supervised care (7 in care facilities and 3 in jail) at the time of their suicide, and 3 occurred in other areas.

Suicide by Mental Health Status, Intent and Circumstances, by Gender and Age Group: San Francisco, 2001														
Mental Health	Overall		Male		Female		Ages <=25		Ages 26-38		Ages 39-58		Age 58+	
	n=126	%	n=88	%	n=38	%	n=12	%	n=24	%	n=54	%	n=36	%
Depressed at the time	48	38.1	31	35.2	17	44.7	4	33.3	7	29.2	17	31.5	20	55.6
Mental Health Problem	75	59.5	49	55.7	26	68.4	5	41.7	14	58.3	41	75.9	15	41.7
If a mental health problem, then type...														
Depression	44	58.7	28	57.1	16	61.5	2	40.0	9	64.3	22	53.7	11	73.3
Bipolar	7	9.3	5	10.2	2	7.7	1	20.0	2	14.3	4	9.8	0	--
Schizophrenia	7	9.3	6	12.2	1	3.8	0	--	1	7.1	5	12.2	1	6.7
Anxiety disorder	1	1.3	1	2.0	0	--	0	--	0	--	1	2.4	0	--
Other	14	18.7	8	16.3	6	23.1	1	20.0	2	14.3	8	19.5	3	20.0
Unknown	2	2.7	1	2.0	1	3.8	1	20.0	0	--	1	2.4	0	--
In treatment for mental disorder at the time	48	64.0	30	61.2	18	69.2	3	60.0	8	57.1	28	68.3	9	60.0
Ever been in treatment for mental disorder	65	86.7	43	87.8	22	84.6	5	100.0	14	100.0	36	87.8	10	66.7
Any alcohol dependence or abuse	17	13.5	15	17.0	2	5.3	1	8.3	1	4.2	11	20.4	4	11.1
Any substance abuse	30	23.8	24	27.3	6	15.8	5	41.7	5	20.8	15	27.8	5	13.9
Any alcohol and/or substance abuse	47	37.3	39	44.3	8	21.1	6	50.0	6	25.0	26	48.1	9	25.0
Substance abuse treatment ever	4	3.2	4	4.5	0	--	0	--	0	--	4	7.4	0	--
Intent														
Suicide note left	47	37.3	30	34.1	17	44.7	5	41.7	8	33.3	16	29.6	18	50.0
Stated intent	32	25.4	18	20.5	14	36.8	3	25.0	6	25.0	15	27.8	8	22.2
Previous suicide attempt	40	31.7	25	28.4	15	39.5	3	25.0	10	41.7	20	37.0	7	19.4
Circumstances														
Crisis	25	19.8	16	18.2	9	23.7	2	16.7	4	16.7	12	22.2	7	19.4
Health problem	32	25.4	19	21.6	13	34.2	0	--	1	4.2	11	20.4	20	55.6
Intimate partner, other relationship	17	13.5	10	11.4	7	18.4	3	25.0	4	16.7	9	16.7	1	2.8
Job and or financial problem	6	4.8	3	3.4	3	7.9	1	8.3	3	12.5	2	3.7	0	--
Recent suicide or death of someone they knew	9	7.1	5	5.7	4	10.5	0	--	1	4.2	6	11.1	2	5.6
Criminal problem, perpetrator of violence	10	7.9	10	11.4	0	--	0	--	4	16.7	6	11.1	0	--
Victim of interpersonal violence	1	0.8	1	1.1	0	--	0	--	0	--	0	--	1	2.8
Other	10	7.9	5	5.7	5	13.2	1	8.3	1	4.2	5	9.3	3	8.3

Note: 28 of the 75 victims who had a mental health problem had multiple mental health conditions

Table 12. Source: San Francisco Department of Public Health, San Francisco Violent Injury Reporting System (SFVIRS): Violent Injuries and Deaths in 2001 and Firearm Trend Data from 1999 to 2001. Local Data for Local Violence Prevention Tracking Violent Injuries and Deaths in San Francisco County. Spring 2004.

Hospital Charges Associated with Violent Injuries

Hospital discharge data provides “total charges” for the treatment of injury victims. In the Profile, charges associated with all 1,487 violent injury discharges from San Francisco hospitals in 2001 are presented. Because health care costs are borne by local hospitals, regardless of the patient’s residence, it is important to discuss all charges and not just those for San Francisco residents. Among the violent injury patients, 919 or 62% were San Francisco residents. Of the total, 599 (40%) sustained self-inflicted injuries, 813 (55%) were assaulted, and 75 (5%) sustained other violent injuries.

For all these patients (n=1,487):

- the median charge was \$12,655.
- the average charge was \$24,790.
- total hospital charges for non-fatal violent injuries totaled \$36.9 million.

For all self-inflicted injuries (n=599):

- the median charge was \$10,320.
- the average charge was \$18,661.
- total hospital charges for non-fatal violent injuries totaled \$11.2 million.

For assaults (n=813):

- the median charge was \$15,175.
- the average charge was \$28,449.
- total hospital charges for non-fatal violent injuries totaled \$23.1 million.

For the “other” violent injuries (n=75), total charges summed to \$2.6 million.

Several factors should be noted:

- 1) The average charge is always higher than the median charge, because it factors in the “outliers,” or patients with very long hospital stays and very high bills. The highest hospital bill in this data series was over \$1.1 million.
- 2) Charges include, but are not limited to: daily hospital services, ancillary services and any patient care services. Hospital-based physician fees are excluded.
- 3) Charges, costs and actual reimbursement are three very different numbers. What is reported here is what was charged, not necessarily what was reimbursed.
- 4) There were 7 discharges with no charges associated with them because the charges were not reported by the hospital. For example, Kaiser Foundation Hospitals are exempted from reporting charges, since they charge patients a monthly capitation fee, regardless of what health care services are provided. Thus, these numbers slightly undercount charges associated with hospitalization due to violent injuries.

Selected Injury Prevention Program Resources in San Francisco

This chapter is intended to provide a listing of some of the injury prevention programs and resources in San Francisco that are addressing the injury issues highlighted in this edition of the Profile. Therefore, only resources that have a focus on the prevention (and not merely treatment) of **traffic-related injury, falls, violent injury and poisoning** are included in this section.

The objectives for providing this list are two-fold. One reason is to give readers of this report some resources for more information on how to address these issues. The other is to encourage organizations interested in working on these topics to contact existing programs and try to partner on creating solutions together.

Because available resources continuously change, it is difficult to know about all of the current programs in existence. Therefore, this list only was meant to be a summary and focuses particularly on broad-based or public organizations and programs in the four topic areas.

Overall Injury Prevention:

San Francisco Injury Center

Dr. Peggy Knudson and Dr. Geoffrey T. Manley, Co-Center Directors
SFGH Department of Surgery
1001 Potrero Avenue, Box 0807
San Francisco, CA 94110
(415) 206-4623
<http://www.surgery.ucsf.edu/sfic/>

Department of Public Health

Michael Radetsky, MPH, MA, Injury Prevention Planning Coordinator
Community Health Education Section
SF Department of Public Health
30 Van Ness Avenue, Suite 2300
San Francisco, CA 94102
(415) 581-2418
michael.radetsky@sfdph.org
<http://www.dph.sf.ca.us/CHPP/injury.htm>

Trauma Foundation

Andrew McGuire, Executive Director
San Francisco General Hospital
1001 Potrero Ave, Bldg 1 Room 300
San Francisco, CA 94110
(415) 821-8209
tf@tf.org
<http://www.tf.org/>

Traffic Related Injury Prevention:

Department of Public Health

Community Health Education Section
SF Department of Public Health
30 Van Ness Avenue, Suite 2300
San Francisco, CA 94102

http://www.dph.sf.ca.us/traffic_safety/

Pedestrian Safety Project

Ana Validzic, MPH, Pedestrian Safety Project Coordinator

(415) 581-2478

ana.validzic@sfdph.org

DUI Prevention Project

Nicamer Tolentino, Drunk Driving Prevention Project Coordinator

(415) 581-2420

nicamer.tolentino@sfdph.org

Traffic Injury Research

Stanley Sciortino, PhD, Epidemiologist

(415) 581-2419

stanley.sciortino@sfdph.org

Department of Parking and Traffic

DPT Traffic Engineering
25 Van Ness Avenue, Suite 345
San Francisco, CA 94102

Livable Streets Program

Bridget Smith, Program Manager

Livable Streets Hotline: (415) 554-2398

livable.streets@sfgov.org

http://sfgov.org/site/dpt_index.asp?id=14439#tc

Pedestrian Program

Frank Markowitz, Program Manager

(415) 252-4696

Frank.Markowitz@sfgov.org

Bicycle Program

(415) 585-BIKE

bicycle@sfgov.org

San Francisco Injury Center

Anna Zacher, MPH, Injury Prevention Coordinator
SFGH Department of Surgery
1001 Potrero Avenue, Box 0807
San Francisco, CA 94110
(415) 206-5952
azacher@sfghsurg.ucsf.edu
<http://www.surgery.ucsf.edu/sfic/>

Walk San Francisco

Peggy da Silva, Executive Director
1095 Market Street #502
San Francisco, CA 94103
(415) 431-WALK
director@walkSF.org
<http://www.walksf.org/>

San Francisco Bicycle Coalition

Leah Shahum, Executive Director
1095 Market St Ste 215
San Francisco CA 94103
(415) 431-BIKE
info@sfbike.org
<http://www.sfbike.org/>

Pedestrian Safety Advisory Committee

Pi Ra, Chair
srira@walksf.org
http://sfgov.org/site/dpt_index.asp?id=19509

Bicycle Advisory Committee

Andrew Thornley, Chair
apt@scootdesign.com
http://www.sfgov.org/site/bac_index.asp

Senior Action Network Pedestrian Safety Committee

Bruce Livingston, Executive Director, Pedestrian Safety Organizer
965 Mission Street, Suite 705
San Francisco, CA 94103
(415) 546-1334
Bruce@SeniorActionNetwork.org
www.senioractionnetwork.org

San Francisco Police Department, Traffic Company

Capt. Edgar Springer, Commanding Officer

850 Bryant Street #154

San Francisco, CA 94103

(415) 553-9601

edgar_springer@ci.sf.ca.us

http://www.sfgov.org/site/police_index.asp?id=20309

National Highway Traffic Safety Administration (NHTSA), Region 9

201 Mission Street, Room 2210

San Francisco, CA 94105

(415) 744-3133

region9@nhtsa.dot.gov

<http://www.nhtsa.dot.gov/nhtsa/whatis/regions/Region09/Index.html>

Fall Prevention:

Community and Home Injury Prevention Project for Seniors (CHIPPS)

Department of Public Health

Community Health Education Section

SF Department of Public Health

30 Van Ness Avenue, Suite 2300

San Francisco, CA 94102

(415) 581-2418

<http://www.dph.sf.ca.us/PHP/CHIPPS.htm>

Public Safety/Violence Prevention:

San Francisco S.A.F.E.

850 Bryant Street, #135

San Francisco, CA 94103

(415) 673-SAFE

info@sfsafe.org

<http://www.sfsafe.org/index.htm>

San Francisco Neighborhood Safety Partnership

Amy Peltier, Program Coordinator

850 Bryant Street, #135

San Francisco, CA 94103

(415) 553-1962

amy@sfensp.org

<http://www.sfensp.org/>

Community United Against Violence (CUAV)

160 14th Street
San Francisco, CA 94103
(415) 777-5500
24 Hr. Support Line: (415) 333-HELP
<http://www.cuav.org/>

Trauma Foundation

Andrew McGuire, Executive Director
San Francisco General Hospital
1001 Potrero Ave, Bldg 1 Room 300
San Francisco, CA 94110
(415) 821-8209
tf@tf.org
<http://www.tf.org/>

Department of Public Health

Community Health Education Section
SF Department of Public Health
30 Van Ness Avenue, Suite 2300
San Francisco, CA 94102

Violence Prevention Network

Dionne Carter, VP Specialist
(415) 581-2442
Dionne.Carter@sfdph.org
<http://www.dph.sf.ca.us/CHPP/vpn.htm>

Youth Power

Ana Validzic, MPH
(415) 581-2478
ana.validzic@sfdph.org
<http://www.dph.sf.ca.us/CHPP/YouthPower.htm>

Community Boards

3130 24th Street
San Francisco, CA 94110
Rebecca Araiz Iverson, Executive Director
(415) 920.3820, ext 105
riverson@communityboards.org
<http://www.communityboards.org/>

Safety Network

Chris Castillo, Program Director
2012 Pine Street, 2nd Floor
San Francisco, CA 94115
(415) 202-7940
cccastillo@safetynetwork.org
www.safetynetwork.org

Gang-Free Communities Initiative

David Mauroff
Department of Children, Youth and Their Families
1390 Market Street, Suite 900
San Francisco, CA 94102
(415) 753-7850
david.mauroff@sfgov.org

Physicians for Social Responsibility/San Francisco Bay Area

Marj Plumb – Administrator; Robert Gould – Executive Director
2288 Fulton St., #307
Berkeley, CA 94704
(510) 845-8395
info@sfbaypsr.org

Peaceful Streets

PO Box 460251
San Francisco, CA 94146
(415) 821-2309
info@meltguns.com
<http://www.meltguns.com/pages/home.html>

San Francisco Women Against Rape

Nina Jusuf, Executive Director
3543 18th Street, #7
San Francisco, CA 94110
(415) 861-2024
info@sffwar.org
<http://www.sffwar.org/>

Domestic Violence Prevention

Asian & Pacific Islander Institute on Domestic Violence

450 Sutter Street Suite 600
San Francisco California 94108
(415) 954-9988 ext. 315
apidvinstitute@apiahf.org
<http://www.apiahf.org/apidvinstitute/default.htm>

Asian Domestic Violence Prevention Collaborative

API Legal Outreach
1188 Franklin Street, Suite 202
San Francisco, CA 94109
info@youngaznlife.org
<http://www.youngaznlife.org/index.html>

Children and Youth DV Free

Community Health Education Section
SF Department of Public Health
30 Van Ness Avenue, Suite 2300
San Francisco, CA 94102 (415) 581-2400
ginger.smyly@sfdph.org
<http://www.dph.sf.ca.us/CHPP/dvfree.htm>

San Francisco Consortium for Elder Abuse Prevention

Institute on Aging
3330 Geary Boulevard
San Francisco, CA 94118
(415) 447-1989, ext 513
elderabuse@ioaging.org
<http://www.elderabusecenter.org/default.cfm?p=ioa.cfm>

Department of Children, Youth and Their Families

1390 Market Street, Suite 900
San Francisco, CA 94102

SafeStart Initiative

Andrea Lee, SafeStart Outreach Coordinator and Trainer
(415) 565-0698
alee@dcyf.org
<http://www.dcyf.org/safestart/>

Domestic Violence Consortium

contact@dvcpartners.org
<http://www.dvcpartners.org/home.html>

Family Violence Prevention Fund

383 Rhode Island St. Suite #304
San Francisco, CA 94103-5133
Phone: (415) 252-8900
info@endabuse.org
<http://endabuse.org/>

WOMAN, Inc.

333 Valencia Street, Suite 450
San Francisco, CA 94103
(415) 864-4777
info@womaninc.org
<http://www.womaninc.org/>

Asian Women's Shelter

3543 18th Street, Box 19
San Francisco, CA 94110
(415) 751-7110
<http://www.sfaws.org/home.html>

La Casa de las Madres

1850 Mission Street, Suite B
San Francisco, CA 94103
415-503-0500
info@lacasa.org
<http://www.lacasa.org/index.html>

Manalive

3338 17th St. Suite 202
San Francisco, CA 94110
(415) 861-8614
mmanalive@sbcglobal.net
www.manaliveinternational.org

Suicide Prevention

San Francisco Suicide Prevention (SFSP)

P0 Box 191350
San Francisco, CA 94119
(415) 984-1900
(415) 781-0500 24-hour crisis line
info@sfsuicide.org
<http://www.sfsuicide.org/index2.html>

Center for Elderly Suicide Prevention

Kelly Glazer Baldwin, M.S.
(415) 750-4180 x231
1-800-971-0016 Friendship Line
kbaldwin@ioaging.org
<http://www.ioaging.org/programs/cesp/cesp.html>

Poisoning Prevention/Control:

California Poison Control System

University of California, San Francisco
Box 1262

San Francisco, CA 94143-1262

Administration, (415) 502-6000

Poison Emergencies & Information Hotline, 800-876-4766

TTY Emergencies & Information Hotline, 800-972-3323

Public Education (stickers & pamphlets), 800-582-3387

<http://www.calpoison.org/>

Childhood Lead Prevention Program

Department of Public Health

Children's Environmental Health Promotion

1390 Market Street, Suite 230

San Francisco, CA 94102

(415) 554-8930

<http://www.dph.sf.ca.us/cehp/Lead/lead.htm>

Consumer Action - Healthy Children Organizing Project

(Lead Poisoning Prevention Project)

717 Market Street Suite 310

San Francisco, CA 94103

(415) 777-9648

katie.sternfels@consumer-action.org

<http://www.consumer-action.org/English/hcop/index.php>

Substance Abuse

Community Substance Abuse Services

1380 Howard St

San Francisco, CA 94103

(415) 255-3500

1-800-750-2727 Hotline

San Francisco Needle Exchange and Harm Reduction Services

(415) 565-1946

sfne666@yahoo.com

<http://www.sfne.org/>