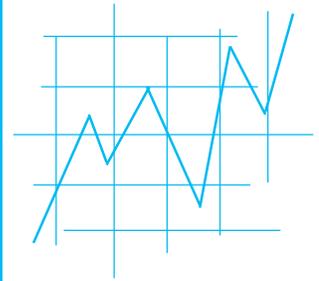


Outlook & Outcomes



2003 Annual Report

Maryland Alcohol and Drug Abuse Administration
Department of Health and Mental Hygiene



*Robert L. Ehrlich, Jr. , Governor
Michael S. Steele, Lt. Governor*

*S. Anthony McCann, Secretary
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TTY USERS CALL VIA MD RELAY

Dear Fellow Marylanders,

On the very first day of the Ehrlich-Steele Administration, I spoke about the devastating effect that substance abuse has on our society. Alcohol and drug addiction exact an enormous toll on the lives of thousands of Marylanders, affecting not only the abusers but their families and their communities as well. Our commitment to addressing this issue is shown by the inclusion of substance abuse prevention, intervention and treatment programs in two of the five pillars of this Administration – Healthier Maryland and Safer Neighborhoods. In 2004, we proposed and the General Assembly enacted a major drug and alcohol abuse initiative that provided for increased evaluations and assessments, alternatives to incarceration and a new planning system to coordinate delivery of State and local services. The new State Drug and Alcohol Abuse Council, created by my Executive Order and chaired by Judge Andrew Sonner, is providing a framework for this coordination process.

The Maryland Alcohol and Drug Abuse Administration has done an outstanding job collecting the data in this *2003 Annual Report - Outlooks and Outcomes* that will help state agencies and local governments develop strategies and priorities for prevention, intervention and treatment programs that will make a difference. We can use this information to ensure that programs funded with tax dollars are held accountable for helping our citizens recover from the scourge of addiction. This 2003 Annual Report also details information about substance abuse among our kids that will be especially important in promoting youth prevention and intervention programs that can stop substance abuse before its starts.

The Ehrlich-Steele Administration will continue to make substance abuse a priority issue for State government. We look forward to working with local governments, health officials and concerned citizens across the State to reduce addiction, promote recovery and improve the lives of our citizens.

Very truly yours,

A handwritten signature in black ink that reads "Robert L. Ehrlich, Jr." The signature is written in a cursive style with a large, looping "R" and "E".

Robert L. Ehrlich, Jr.
Governor

OUTLOOK AND OUTCOMES

*For Maryland Substance Abuse
Prevention, Intervention
and Treatment*

Fiscal Year 2003

*Robert L. Ehrlich, Jr., Governor
Michael S. Steele, Lt. Governor
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The services and facilities of the Maryland State Department of Health and Mental Hygiene (DHMH) are operated on a non-discriminatory basis. This policy prohibits discrimination on the granting of advantages, privileges and accommodations.

The Department, in compliance with the Americans With Disabilities Act, ensures that qualified individuals with disabilities are given an opportunity to participate in and benefit from DHMH services, programs, benefits and employment opportunities.

Outlook and Outcomes is the annual publication of the Maryland Alcohol and Drug Abuse Administration (ADAA). It presents data from the Substance Abuse Management Information System (SAMIS) to which all Maryland Department of Health and Mental Hygiene (DHMH) certified or Joint Committee on Accreditation of Healthcare Organization (JCAHO) accredited alcohol and drug abuse treatment programs are required to report.

The data in Outlook and Outcomes reflects the status of substance treatment, intervention, and prevention programs in Maryland, the services they deliver and the populations that they serve. Data collected through the tracking of patients who have entered the treatment system provides a rich repository of information on activity and treatment outcomes in the statewide treatment network. The data are an essential indicator of the trends and patterns of alcohol and drug abuse in the state. Through the identification of these trends and patterns sound long-term planning to meet the population needs can occur, and outcome measures that insure quality treatment and fiscal accountability are established and met.

ADAA wishes to recognize all those who contributed to the publication of Outlook and Outcomes 2003

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The second issue of "Outlook and Outcomes" continues to tell a good story. It's a story line shaped by these questions:

Where are we going? Who do we serve? What are we buying? Is it worth it?

This issue of "Outlook and Outcomes" examines prevention and treatment in detail. It is a data rich inquiry, but an inquiry in the past that was separate. The artificial split between the prevention and treatment functions of the continuum serves no good purpose. In fact, Maryland should get accustomed to reading about the substance abuse prevention, intervention and treatment system, not systems.

In this issue, treatment outcomes are reported separately for the first time for funded and non-funded programs. The outcomes used are the standard in the substance abuse field and are required reporting for the federal Substance Abuse Prevention and Treatment grant: reduction in substance use, decrease in criminal activity, increase in employment and establishing or maintaining a stable living situation. We also explore the relationship between time in treatment, treatment completion and treatment outcome. Additionally, selected outcome measures by jurisdiction are presented in the appendix, demonstrating the flexibility and utility of the information system. Finally, this issue inaugurates a new section highlighting adolescent treatment. Future issues of "Outlook and Outcomes" will include a section highlighting a treatment population, modality or special concern.

There is a good deal of information reported in "Outlook and Outcomes" with both straightforward and provocative interpretations. However, this information is of little value if it is neither useful, nor used. It is the ADAA's job to make sure that the information is useful. It is the ADAA's, the program's and the jurisdiction's job to make sure it is used. Program and jurisdiction level data is essential if the "Where are we going?" question is to be answered. Governor Ehrlich's substance abuse initiative provides some definition to "Where are we going?" Maryland is going to a proactive, rational, locally managed system of prevention, intervention and treatment services. A system that is intentional and planned. A system that uses data and outcomes to drive decisions and goes where the data leads.

Peter F. Luongo, Ph.D.

ALCOHOL AND DRUG ABUSE ADMINISTRATION LEADERSHIP 2004

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The Outlook

Where Are We Going, Who Do We Serve, What Are We Buying, and Is It Worth It?

To answer these questions the Alcohol and Drug Abuse Administration (ADAA) of Maryland continues to institutionalize a proactive agenda for the publicly-funded prevention, intervention and treatment system by emphasizing planning, information-based decision making, increased use of technology and business practice reforms. The benefits are noticeable and comprise the baseline processes for the ADAA Performance Management system.

Performance Management

To better understand the system we are funding and to better answer the question of "What are we buying?", ADAA has established performance measures for the 24 jurisdictions receiving grant dollars. Jurisdictions report program outcomes using data on the following performance measures:

- Retention in treatment
- Patients moving from one level of treatment and entering another level of treatment
- Decreases in patient substance use
- Increases in patient employment
- Decreases in patient arrest rates during treatment

These measures become the tool used for performance-based compensation introduced into the ADAA procurement process. Performance incentives are awarded when treatment program outcomes exceed predetermined objectives.

ADAA Technical Assistance Teams have been created, composed of a staff member from each of the four Divisional Units (Community Services, Quality Assurance, Management Services and Informa-

tion Services). These teams were developed to provide technical assistance to the jurisdictions in each region including performance measurement data validation, participation in grant and budget modification reviews, and to be a resource to the Compliance Section prior to investigations. This team approach will increase in prevalence throughout the course of interactions and communications between ADAA and our partners in the field in the years to come.

All certified treatment programs were mandated to use the ADAA approved data system by the end of Fiscal Year 2004. Substance Abuse Management Information System (SAMIS) data are collected over the Internet using HATS¹, a Web-enabled data system.

ADAA is an agency committed to providing all Maryland citizens access to quality substance abuse prevention and treatment services.

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*State of Maryland
Alcohol and Drug Abuse Administration
Printed September 2004*

¹ University of Maryland HIDTA Automated Tracking System

EXECUTIVE SUMMARY

The Alcohol and Drug Abuse Administration is the single state agency responsible for the provision, coordination, and regulation of the statewide network of substance abuse prevention, intervention and treatment services. It serves as the initial point of contact for technical assistance and regulatory interpretation for all DHMH certified prevention and treatment programs. Maryland is somewhat unique among states in that ADAA has the legal responsibility for the evaluation of treatment outcomes and for the certification and regulation of both publicly and privately funded programs.

In Outlook and Outcomes 2003, ADAA compares and contrasts the characteristics of funded and non-funded treatment programs for fiscal year 2003, the populations they serve and the treatment outcomes reported.

WHO DO WE SERVE?

Prevention Services

- Approximately 304,000 individuals received prevention services in Maryland.
- There were 15,367 individuals who actively participated in recurring prevention programs in Maryland.
- The total number of individuals attending single prevention services or activities was 100,696.
- A total of 10,446 individuals received prevention intervention services through the High Risk Preschool Initiative in Fiscal Year 2003.
- College Prevention Centers provided prevention services to 42,245 individuals statewide with a primary focus on peer education.

Treatment Services

- There were 30,749 individuals who received services from non-funded programs and 28,221 who received ADAA-funded treatment. Readmission rates were 30 percent and 23 percent respectively.
- Approximately two percent of the total admissions during FY 2000 - 2003 were high-risk youth or family members of primary patients, but were not necessarily substance abusers.

ADAA-Funded Patients

- As compared to patients participating in non-funded treatment programs, the data show that ADAA-funded patients tend to be less likely to have graduated from high school, and less likely to be full-time employed. Two-thirds of all ADAA-funded patients are uninsured.
- Over one-half of all patients admitted to funded programs had at least one prior treatment episode.
- Nearly half of all patients admitted to ADAA-funded programs were referred to treatment through the criminal justice system and two-thirds of funded patients had one or more arrests in the two years prior to admission. The majority of criminal justice referrals to ADAA-funded treatment came from parole and probation.

Type of Abuse: ADAA-Funded Treatment

- The leading substances of abuse in ADAA-funded treatment were alcohol (60%), marijuana (39%), heroin (33%), crack cocaine (23%) and other cocaine (20%).
- More than thirty percent of ADAA-funded individuals had primary heroin problems compared to 15.6 percent for the nation as a whole. Other opiates and synthetics were mentioned in three percent of all admissions to ADAA-funded programs.

Non-Funded Patients

- Patients participating in non-funded treatment programs are more likely to have graduated from high school and/or attended college; and are more likely to be full-time employed and have health care coverage.
- Over one-half of all patients admitted to non-funded programs had at least one prior treatment episode.
- Only one-third of all patients admitted to non-funded treatment programs were referred through the criminal justice system and slightly more than half of non-funded patients had one or more arrests in the two years prior to admission. The majority of criminal justice referrals to non-funded treatment were DWI/DUI referrals.

Type of Abuse: Non-Funded Treatment

- Substances that predominated among non-funded admissions were: Alcohol (55%), heroin (41%), marijuana (25%), crack cocaine (20%) and other cocaine (17%).
- More than forty percent of non-funded admissions had primary heroin problems compared to 15.6 percent for the nation as a whole. Other opiates and synthetics were mentioned in seven percent of all admissions to non-funded programs.

Adolescents

- Adolescent admissions made up 11.8 percent of the total admissions. Among adolescent admissions the highest substance use was marijuana (89.2%) and alcohol (69.1%) followed by heroin and other opiates (6.9%) and cocaine, including crack (6.8%).
- Eighty-two percent of both the ADAA-funded and non-funded populations admitted for alcohol and/or marijuana problems reported first substance use during adolescence.

- Since 2000, the numbers of adolescent patients reporting substance problems with inhalants have risen, this follows an emerging national trend.
- Overall heroin use among adolescents has decreased by slightly over two percent since 1999 but use of other opiates has increased nearly ten-fold in five years.
- Alcohol use by adolescents has remained fairly constant over the past five years comprising about two-thirds of the adolescent admissions. Marijuana has remained a consistent substance problem comprising from 85 to 90 percent of all adolescent admissions.
- Adolescent other drug use on the rise since 2000 includes over-the-counter medications and PCP.
- Adolescent drug use showed some decline in the past five years for steroids and crack.

WHAT WE ARE BUYING?

- In Fiscal Year 2003, the ADAA provided an additional \$600,000 to select jurisdictions to implement evidence-based programs.
- About 85 percent of patients who participated in ADAA-funded treatment received individual counseling services. Traditional outpatients averaged about two sessions per month, while intensive outpatients averaged 2.8. Over 80 percent of ADAA-funded patients received group counseling.

IS IT WORTH IT?

Outcome Measurement Use of Alcohol and Drugs

- For the top five reported drugs of abuse (alcohol, marijuana, crack, other cocaine and heroin) the FY 2003 data show that reported substance use from the time of admission was reduced from 65.5 percent to 44.8 percent, a drop of 20 percent by discharge.

Treatment Reduces Substance Use

- Staying in treatment more than 90 days was associated with a lower percentage of patients who continued using at discharge. Of patients retained in treatment at least 180 days, only 22 percent were using at discharge.
- Urinalysis testing was associated with higher percentages of success in every treatment type except Intermediate Care Facilities (ICF), where tested and non-tested patients were equally likely to complete treatment successfully.

Treatment Reduces Crime

- Arrest rates were reduced by over 80 percent for patients who completed treatment successfully and by about half among those who ended treatment unsuccessfully.

Treatment Increases Employment

- The data indicate that across all treatment types employment rates were improved by treatment. The employed were likely to stay in treatment longer, and the unemployed were more likely to become employed the longer they stayed in treatment.
- Overall, employment increased ten percent among non-completers and 30 percent among completers.

Treatment Decreases Homelessness

- The percentage of homeless patients declined during treatment of various types. In halfway houses, the percentage living independently doubled, corresponding to dramatic increases in employment.

Treatment of Co-occurring Disorders Increases Successful Completion

- Forty-nine percent of patients with identified mental health problems who received mental health treatment during a course of substance abuse treatment completed treatment successfully.



At the end of FY 2004, the Alcohol and Drug Abuse Administration moved to real time Internet-based data collection for both prevention and treatment services.

Prevention

- The Prevention Minimum Data Set (MDS) application was designed to collect basic process data about the services provided.
- The MDS serves as the main repository for prevention program data collection in Maryland.
- The MDS data collection is uniform across the state and implements extensive validations to ensure internal consistency.

Treatment

- The data for the ADAA SAMIS system is collected through the University of Maryland Bureau of Governmental Research HATS program.
- With the proper consents, multiple agencies using HATS can share treatment information over the Internet.
- HATS provides automated assessment tools, progress notes, treatment plan development, drug test and sanction tracking.
- HATS provides measurement tools to assess quality assurance and cost effectiveness among programs, as well as across agencies.

DATA COLLECTION AND REPORT METHODOLOGY

Prevention

The state Prevention System Management Information System (SPS-MIS) is a Center for Substance Abuse Prevention (CSAP) project to provide computer-based tools to the states in support of state substance abuse prevention activities. Included is a process evaluation tool called the Minimum Data Set (MDS). The MDS was developed by ORC Macro under contract to CSAP. The MDS is designed to work in concert with CSAP's Prevention Technology Platform (PrevTech) to support evaluation of prevention activities by states, communities, providers, and individuals. The MDS is a Web-based client-server data collection system that uses Internet technology and serves as the main repository for prevention program data collection in Maryland.

Treatment

The Substance Abuse Management Information System (SAMIS) is a vital component of the mission of the ADAA to administer available resources effectively and efficiently so that all of Maryland's citizens who need them will have access to quality treatment and prevention services. As a condition of state certification and funding, treatment programs in Maryland are required to report data through this process.

The parent agencies of the ADAA began collecting data on patients abusing drugs in 1976, followed by data collection on alcohol abusers two years later. In the beginning, there were fewer than 50 drug treatment programs and approximately 70 alcohol treatment centers submitting data. The present data collection system, with participation by 150 ADAA-funded and 230 non-funded substance abuse treatment clinics in FY 2003, is the result of numerous modifications based upon the needs of the Maryland ADAA and treatment providers as well as federal reporting requirements of the Office of Applied Studies of the Substance Abuse and Mental Health Services Administration (SAMHSA).

Information on patients in treatment is routinely gathered and analyzed by the ADAA Management Information Services section. Each occurrence of an admission to, or a discharge from, a treatment clinic is documented in a report submitted to the Management Information System (MIS).

Interpretation of the data reported to SAMIS is facilitated by an understanding of several concepts. The number of days a patient is in treatment refers to the time between admission and discharge. The number of treatment sessions that occurred during the treatment episode will differ by program type and patient need. However, a patient must be seen in a face-to-face treatment contact at least once in 30 days, or be discharged as of the date of last direct contact.

The number of programs reporting to SAMIS differs over the years due to the opening or closing of some programs. Table totals in this report may differ slightly due to missing data. Due to rounding, percentages may not always total 100. Since a patient may have more than one treatment episode, each admission does not necessarily represent a unique individual.

The 39,847 FY 2003 non-funded admissions reflect 30,749 unique individuals, for a ratio of 1.3 admissions per individual in the non-funded sector. The 34,852 FY 2003 ADAA-funded admissions reflect 28,221 unique individuals, for a ratio of 1.24 admissions per individual. Among non-funded admissions, 79 percent of the individuals had one admission during the year and 15 percent had two. The respective figures for ADAA-funded admissions were 82 and 14 percent.

Approximately two percent of the total admissions during FY 1999 - 2003 did not have substance abuse problems but underwent a treatment regimen. These were primarily high-risk youth or family members

of primary patients. They are included in all tables and figures except those involving substance mentions.

Maryland is somewhat unique among states in that its patient-based substance abuse treatment reporting system captures the entire treatment network. In this report, ADAA-funded and non-funded treatment admissions are compared and contrasted. Programs were classified as ADAA-funded if they received any ADAA dollars; every patient episode in those facilities was not necessarily paid for with ADAA funds. However, given the differences in the average patient in each sector, which will become apparent to the reader, it was appropriate to discuss treatment outcomes separately, and no attempt should be made to compare ADAA-funded and non-funded outcomes.

The primary discharge performance and outcome measures presented in this report are the following:

Continuum of Care

For discharges from non-hospital detoxification and from intensive outpatient (IOP) during FY 2003, the percentage of unique individuals completing treatment who were tracked to a subsequent admission to another treatment type during the year or within the first quarter of the subsequent year were calculated. Subsequent admissions were primarily to intermediate care (ICF) for detox discharges and to traditional outpatient for IOP discharges. This measure required matching discharges to subsequent admissions on the last four digits of the Social Security Number and complete birth date.

Services

The measures in this section can be classified as process rather than outcome measures, but they are used to assess performance of treatment programs. Analyses were conducted on the average individual, group and family counseling sessions delivered to participating patients per month. Also, the percentages of positive urinalysis results among total tests conducted were calculated. Finally, the percentages of discharges assessed as having mental health

problems at admission that received mental health treatment during the substance abuse treatment episodes were examined.

Use of Alcohol and Drugs

This is the difference between the individuals completing treatment during the year reporting any frequency of use of selected substances and the percentage reported as using the same substances at discharge, including those for whom frequency of use is reported as unknown. There are SAMIS reporting issues affecting the interpretation of this measure. Often at admission, patients are less than forthcoming about their levels of substance use. A SAMIS instruction to correct frequency of use levels reported at admission that are later determined to have been inaccurate is frequently overlooked. Also, it is often the case that admitted patients will be referred from a controlled environment such as detention or residential treatment. These factors tend to suppress levels of improvement on this measure.

Change in Arrest Rate

For discharges during FY 2003, this is the difference between the arrest rate during the two years preceding admission (total arrests/total years) and arrest rate during treatment (total arrests during treatment/total years of treatment). Total years of treatment equals total days of treatment delivered to discharges (summed days in treatment for all discharged patients) divided by 365.25.

Change in Employment Status

For discharges during the year, this was measured as the difference between the percentage employed full or part-time at admission and the percentage employed full or part-time at discharge.

Change in Living Situation

For discharges, this was measured as the change in percentage of homeless patients at discharge from the percentage at admission and the change in percentage of patients living independently.

WHERE ARE WE GOING?*

Governor Robert L. Ehrlich's "multi-front" approach to the impact of substance abuse on the state's citizens, its economy and its public safety seeks to provide a more effective and efficient fit between state and local substance abuse treatment programs, plan for the needs of both the criminal justice system and the general public, and provide re-entry support and services for newly released offenders.

The Governor's initiative includes:

- Comprehensive substance abuse treatment legislation proposed to the 2004 General Assembly and enacted with wide bipartisan support;
- The RESTART plan under the direction of the Department of Public Safety and Correctional Services to provide pre-release and post-release programming for offenders; and
- The new state Drug and Alcohol Abuse Council that is empowered to develop strategies and priorities for state substance abuse services and coordinate those efforts with local subdivisions.

The legislation proposed by Governor Ehrlich and enacted by the General Assembly (Chapters 237 and 238, Laws of Maryland 2004) had the support of 55 delegates and 29 senators. The law encompasses diversion from prosecution for low-level non-violent offenders and linkages to treatment systems for courts to use in sentencing decisions in non-violent cases. It also included improved procedures to promote compliance with treatment ordered as a condition of probation and creation of local planning councils to identify priorities and strategies in providing substance abuse prevention, intervention and treatment services.

The law's new diversion from prosecution structure was designed to ensure that prosecutors had access to substance abuse evaluations performed

under ADA A regulations prior to making diversion decisions for eligible non-violent offenders. The evaluations would include a determination of the offender's amenability to treatment and identification of an appropriate treatment program.

Data collection and evaluation of these programs will be facilitated by the recordation of these diversions in limited-access sections of the state's criminal justice information system. Successful completion of treatment directed as part of the diversion will allow offenders to expunge their records.

Unless indigent, the diverted offender will pay a \$150 court cost to the newly created Maryland Substance Abuse Fund. The Fund will be administered by ADA A and used to defray local government costs for their Councils and provide an additional source of money for treatment services.

With the cooperation of the Maryland Judicial Committee on Mental Health, Addictions and Alcoholism, Governor Ehrlich included in the legislation a revision of provisions in the Health-General Article dealing with access to evaluation and treatment services by the criminal justice system. Specifically, Sections 8-505 through 8-507 of that Article were amended to require that court-ordered evaluations of defendants be conducted under ADA A standards and recommendations for treatment include an identified appropriate program with estimated date of admission. Commitment for treatment of offenders already serving sentences in correctional facilities will occur only under supervision of probation authorities.

The procedures for drug and alcohol evaluations and court referral to treatment programs will now include specific directions regarding the contents of evaluations, transportation for defendants from correctional facilities and supervision of offenders

committed for treatment. Courts will retain their existing discretion to grant or refuse requests for treatment under these Sections.

The second part of the Governor's initiative focuses on the treatment and life skills needs of state prison inmates. The RESTART plan, led by Department of Public Safety and Correctional Services Secretary Mary Ann Saar, provides addiction treatment services, pre-release educational and vocational programming as well as post-release services. The plan includes local partnerships to provide housing, employment, substance abuse treatment, health care and life skills education to offenders returning to their communities.

We know that treatment works. ADAA reports that in some cases people completing ADAA-funded programs reduced their primary substance use by 93 percent. In Baltimore, completing an ADAA-funded program results in a 25 percent greater likelihood of becoming employed within one year with significantly higher wages than those who did not complete treatment. Arrest rates in the city for offenses including theft, burglary, and robbery were 55 percent lower for those completing treatment compared with those who did not complete treatment.

The data support the belief that unless changes are made in the current correctional system or the criminal justice system's current access to treatment services, there is little hope that recidivism rates can be lowered or that we can reduce the number of offenders incarcerated for drug law violations.

Governor Ehrlich's creation of the new Drug and Alcohol Abuse Council, the 2004 substance abuse treatment legislation, and the RESTART effort in the state's correctional system represent a coordinated effort to improve the health and welfare of Maryland's citizens and help make our communities safer places to live and work.

** Article contributed by Alan Friedman.
Mr. Friedman is the Policy Advisor in the Governor's Policy Office. He is also the Director of the state Drug and Alcohol Abuse Council.*



Created by Governor Robert L. Ehrlich, Jr. through an Executive Order, the new state Drug and Alcohol Abuse Council, chaired by former Montgomery County State's Attorney and retired Court of Special Appeals Judge Andrew Sonner, is composed of key state cabinet department secretaries, judges, legislators and citizens.

A major responsibility of the Council is preparing and annually updating a state two-year plan of strategies and priorities for delivery and funding of services. This plan will then be coordinated with similar plans submitted by each local subdivision. The state and local plans will help ensure the most effective and efficient system of prevention, intervention and treatment services.

The Council will work closely with the local Drug and Alcohol Abuse Councils established in each subdivision. These local Councils will develop priorities and strategies for their own jurisdictions' two-year substance abuse services plan that will include strategies and priorities for evaluation, treatment and prevention services for both the general public and the criminal justice system.

The Alcohol and Drug Abuse Administration will provide technical assistance to local Councils, including providing data to assist in needs assessments and outcome evaluations. Allocations from the Maryland Substance Abuse Fund, created under the Governor's legislation, will help defray the cost of local Council operations.

Excerpt from "Governor Ehrlich Establishes Drug and Alcohol Abuse Council", Friedman, Alan, ADAA Compass, Summer 2004.

PREVENTION SERVICES IN MARYLAND

What is Prevention?

Prevention's focus is the promotion of constructive lifestyles and norms that discourage drug use. A recent study by the National Institute on Drug Abuse (NIDA) estimated that every dollar spent on prevention saves from \$4 to \$5 on future substance use.² Prevention eliminates the need for future treatment. It is achieved through the application of multiple strategies.

ADAA funds the Model Program Initiative. Programs funded by this initiative reflect evidence-based principles, strategies, and practices which research has demonstrated as leading to effective outcomes.

Prevention Network

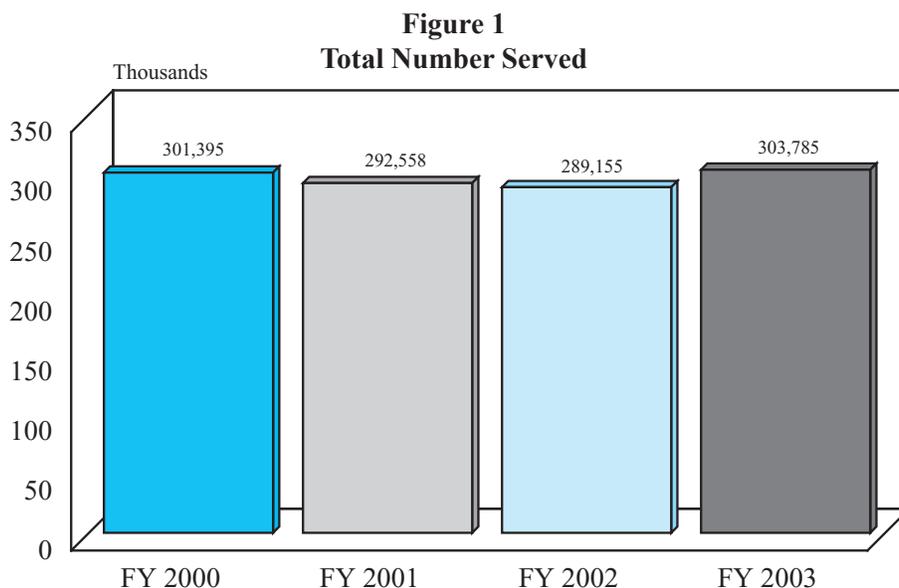
In support of evidence-based prevention, ADAA has initiated a county prevention coordinator networking system – an established, successful and recognized strategy to plan, deliver, coordinate, and monitor prevention services that meet the varying needs of local subdivisions.

Prevention Coordinators communicate with and serve as resources for the community. There is a designated Prevention Coordinator in each of Maryland's 24 subdivisions. Prevention Coordinators work closely with all elements of the community to identify needs, develop substance abuse projects, implement programs and obtain funding.

Numbers Served

During Fiscal Year 2003 approximately 304,000 individuals received prevention services in Maryland. This reflects a five percent increase in the total numbers served from FY 2002 (Figure 1). Increased funding for prevention in Maryland from the Model Program Initiative has resulted in an overall increase in the total numbers served for Fiscal Year 2003. In the last four years, data have shown Maryland averages approximately 300,000 individuals served annually through prevention intervention services.

²NIDA. *Preventing drug use among children and adolescents: A research based guide.* 1997. Washington DC: NIDA Publication No. 97-4212.



Center for Substance Abuse Prevention (CSAP) Strategies

All strategies and service type codes reported in the MIS Prevention Program Activity Report by each individual program are based on CSAP's six primary prevention strategies. These six strategies provide a common framework for data collection on primary prevention services. During fiscal year 2003, ADAA promoted all of the following six CSAP strategies.

Information Dissemination - Information dissemination provides awareness and knowledge of the nature and extent of substance abuse and addiction and its effects on individuals, families, and communities. The strategy is also intended to increase knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.

Activities for this strategy:

1. Clearinghouse/Information Resource Center
2. Health Fairs
3. Health Promotion
4. Media Campaigns
5. Resource Directories
6. Speaking Engagements

Education - Substance abuse prevention education involves two-way communication and is distinguished from the information dissemination strategy by the fact that interaction between the educator and/or facilitator and the participants is the basis of the strategy. Services under this strategy aim to improve critical life and social skills, including decision-making, refusal skills, critical analysis, and systematic judgment abilities.

Activities for this strategy:

1. Children of Substance Abuse Groups
2. Education Programs for Youth
3. Parenting and Family Management
4. Preschool ATOD Prevention Programs
5. Peer Leader/Helper Programs
6. Ongoing Classroom and/or Small Group Sessions

Alternatives - The alternatives strategy provides for the participation of target populations in activities that exclude substance abuse. The assumption is

that constructive and healthy activities offset the attraction to or otherwise meet the needs usually filled by alcohol, tobacco, and other drugs and would therefore minimize or remove the need to use these substances.

Activities for this strategy:

1. Alcohol/Tobacco/Drug-Free Social/Recreational Events
2. Community Drop-In Centers
3. Community Service Activities
4. Youth/Adult Leadership Activities

Community-based Process - Community-based process strategies aim to enhance the ability of the community to more effectively provide substance abuse prevention and treatment. Services in this strategy include organizing, planning, and enhancing the efficiency and effectiveness of services implementation, interagency collaboration, coalition building and network building.

Activities for this strategy:

1. Assessing Services and Funding
2. Assessing Community Needs
3. Community and Volunteer Services
4. Formal Community Teams and Activities
5. Training Services and Technical Assistance
6. Systematic Planning

Environment - The environmental strategy establishes or changes written and unwritten community standards, codes and attitudes thereby influencing the incidence and prevalence of the abuse of alcohol, tobacco and other drugs by the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to service.

Activities for this strategy:

1. Public Policy Efforts
2. Changing Environmental Codes, Ordinances, Regulations and Legislation
3. Preventing Underage Alcohol Sales
4. Preventing Underage Sale of Tobacco and Tobacco Products (SYNAR)

Problem ID And Referral - Problem identification and referral aims to classify those who have indulged in illegal or age inappropriate use of tobacco or alcohol and those who have indulged

in the first use of illicit drugs and to assess whether their behavior can be reversed through education. It should be noted, however, that this strategy does not include any function designed to determine whether a person is in need of treatment.

Activities for this strategy:

1. Employee Assistance Programs
2. Student Assistance Programs
3. DUI/DWI Programs
4. Prevention Assessment and Referral Services

CSAP Strategies and Number of Participants Served FY 2003

Table 1

County	Info. Dis-semination	Alterna-tives	Educa-tion	Problem ID/Ref.	C. Based Process	Environ-mental	Total
Allegany	15,452	3471	1063	20	629	114	20,749
Anne Arundel	6481	467	1563	28	1596	0	10,135
Baltimore	29,278	26,246	19,174	416	2304	147	77,565
Calvert	7335	759	681	20	1454	36	10,285
Caroline	3877	7715	10	53	0	0	11,655
Carroll	2815	102	505	0	271	0	3,693
Cecil	853	426	64	64	156	0	1,563
Charles	1138	182	543	0	26	0	1,889
Dorchester	2727	183	20,221	0	1205	0	24,336
Frederick	804	95	1708	28	11	0	2,646
Garrett	0	723	772	0	51	0	1,546
Harford	19,071	217	6836	1327	226	404	28,081
Howard	862	0	969	0	5940	0	7,771
Kent	565	0	215	0	23	0	803
Montgomery	0	0	887	64	0	0	951
Prince George's	6614	2698	3020	0	405	12	12,749
Queen Anne's	560	35	237	0	82	0	914
St. Mary's	253	0	1055	0	0	0	1,308
Somerset	6130	25	1336	0	0	64	7,555
Talbot	72	159	271	0	1110	326	1,938
Washington	308	120	1849	0	198	0	2,475
Wicomico	77	786	1122	0	65	0	2,050
Worcester	603	15,656	2932	0	305	0	19,496
Baltimore City	31,610	9276	7817	51	2828	50	51,632
TOTAL	137,485	69,341	74,850	2,071	18,885	1,153	303,785
PERCENTAGE	45%	23%	25%	<1%	6%	<1%	100%

MARYLAND PREVENTION

WHO DO WE SERVE?

Gender

Figure 2 shows the statewide distribution of gender for prevention program participants in Fiscal Year 2003. Approximately 53 percent of program participants were female. A breakdown of jurisdictional data gathered in the last four years shows a trend of relatively equal distribution between males and females in most subdivisions.

Age

During Fiscal Year 2003, the majority of prevention program participants (61%) receiving services were adults over 18 years of age. Parents comprised approximately 57 percent of those adults who attended prevention programs in Fiscal Year 2003. Youth under the age of 18 represented 38 percent of individuals participating in prevention programs. All age categories for prevention programs are shown in Figure 3.

Race and Ethnicity

CSAP has defined eight racial categories for use by states to provide consistency in reporting data on a national level. For the purposes of this report, ADAA has combined five of the eight racial groups into one standard category defined as "Other". The "Other" category includes Asian and Pacific Islander, Native American, Multi-racial and Other.

Caucasians made up approximately 54 percent of participants while African Americans comprised 42 percent of the individuals attending prevention programs in Fiscal Year 2003 (Figure 4). Hispanics represented approximately two percent of the participants receiving prevention services in FY 2003.

Figure 2
Gender Distribution

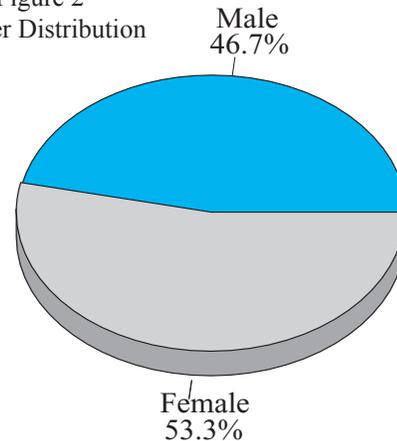


Figure 3
Age Distribution

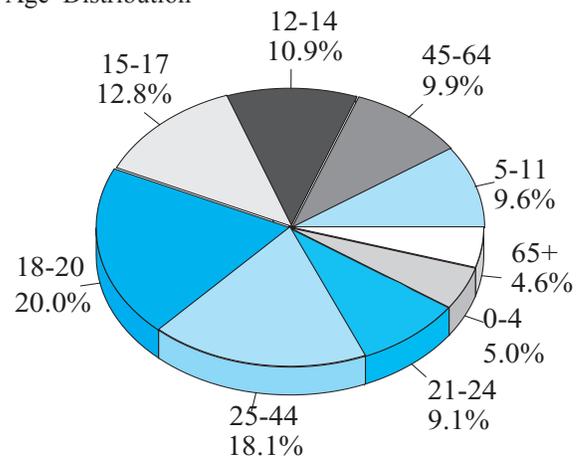
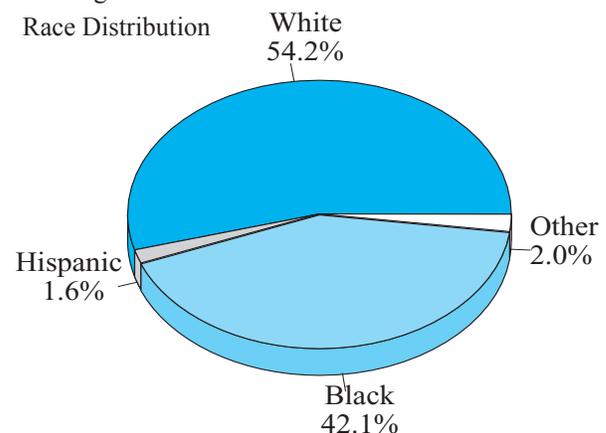


Figure 4
Race Distribution

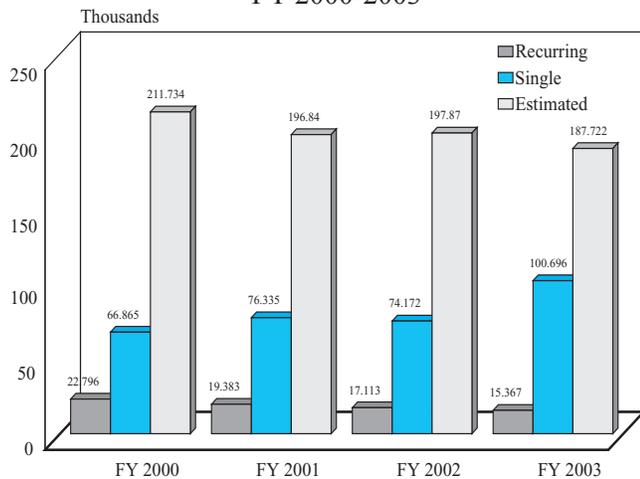


PREVENTION: WHAT ARE WE BUYING?

Increased funding for prevention in Maryland from the Model Program Initiative has resulted in an overall increase in the total numbers served for Fiscal Year 2003.

Recurring Prevention Services

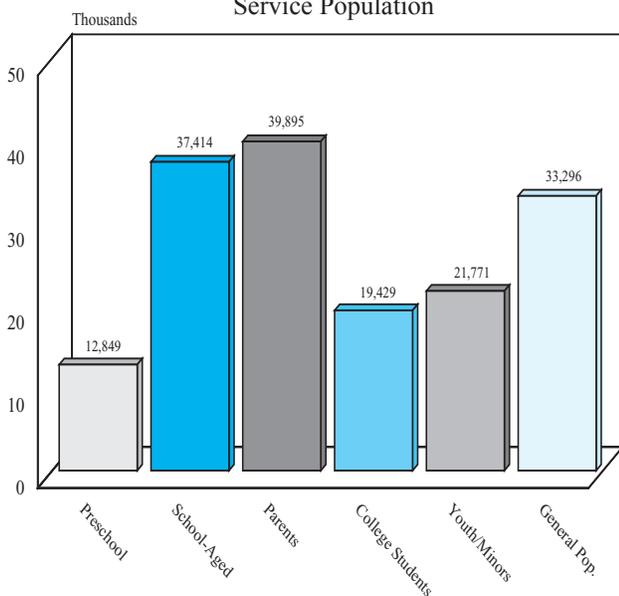
Figure 5
Numbers Served
FY 2000-2003



In Fiscal Year 2003 there were 15,367 individuals who actively participated in recurring prevention programs in Maryland. As a result of a two year transitioning period in which the state has mandated its funded prevention service providers to implement Substance Abuse and Mental Health Services Administration (SAMHSA) model programs, the state has seen a slight decrease in the annual totals for participants in recurring programs (Figure 5). As service providers begin to establish an infrastructure to implement their chosen SAMHSA model programs, it is anticipated that the number of individuals attending recurring prevention programs will increase.

Single Prevention Services

Figure 6
Service Population



The total number of individuals attending single prevention services or activities was 100,696 in Fiscal Year 2003. Annual totals for all prevention services are shown in Figure 6.

Based on information obtained from the MDS demographic estimate indicator (used only when the actual number of attendees at a specific event cannot be accurately counted) there were an additional 187,722 individuals who attended or received prevention services in Fiscal Year 2003.

Service Population

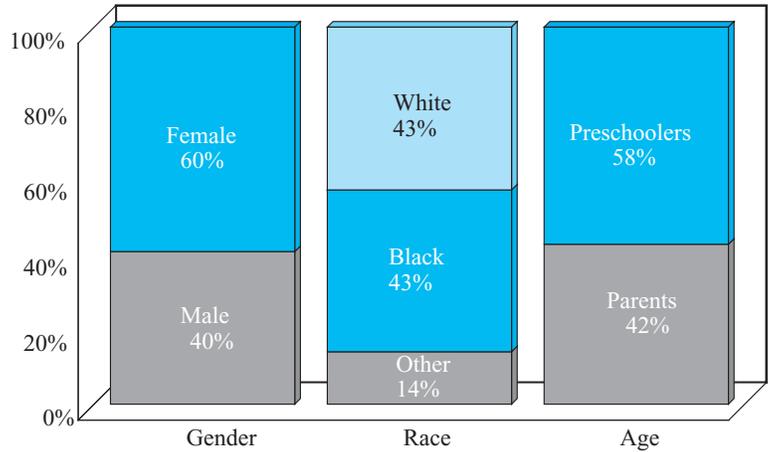
During Fiscal Year 2003, Maryland offered prevention intervention services to twenty-six different service populations. The majority of individuals receiving services were parents and school-aged children (Figure 6).

Special Prevention Initiatives

Protecting our Children

In Fiscal Year 1997, the ADAA began an initiative to focus on alcohol, tobacco and other drugs (ATOD) high risk preschool children and their families. ADAA's High-Risk Preschool Initiative now encompasses six subdivisions. The objective of these programs is to reduce the onset of alcohol, tobacco and other drug use among high risk preschool children by identifying and reducing community activities that place them at greater risk for ATOD use. Figure 7 shows characteristics of participants of the High-Risk Preschool Initiative.

Figure 7
Maryland Preschool Program Characteristics



FY 2003: A total of 10,446 individuals received prevention intervention services through the High Risk Preschool initiative in Fiscal Year 2003

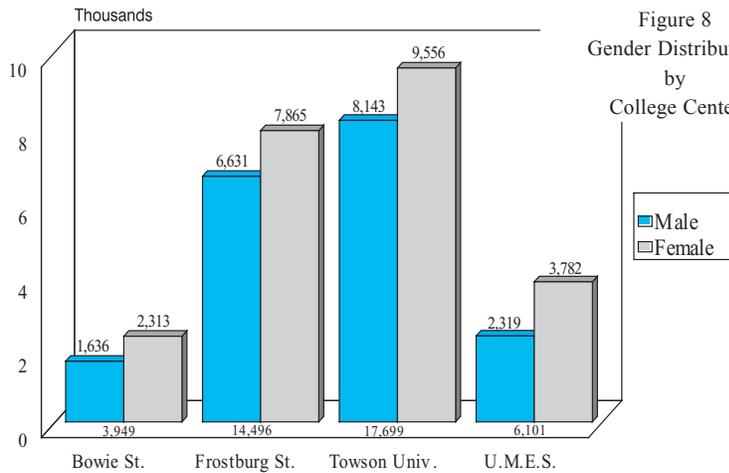


Figure 8
Gender Distribution
by
College Center

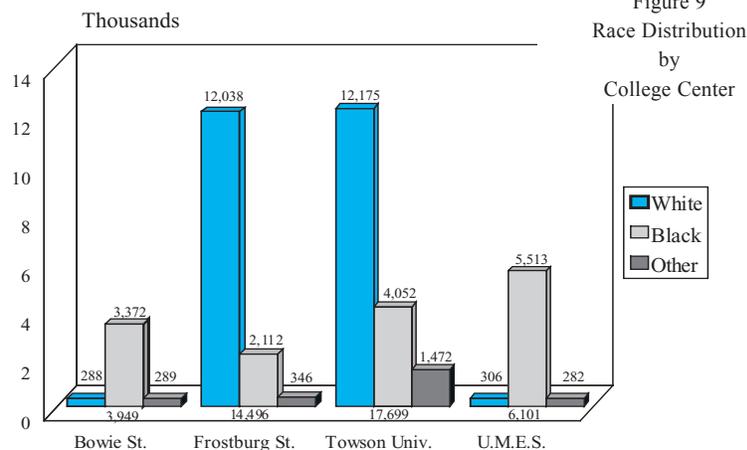


Figure 9
Race Distribution
by
College Center

Promoting a Healthy Transition into Adulthood

In Fiscal Year 1998, the ADAA began an initiative to prevent alcohol and drug abuse on college campuses. Four strategically located ATOD College Prevention Centers at Frostburg State University, Towson University, Bowie State University and the University of Maryland Eastern Shore receive funding to support ongoing ATOD efforts. A primary focus of these centers is to provide education and training for college students regarding ATOD prevention by creating and/or enhancing peer education networks.

FY 2003: The college centers provided prevention services to 42,245 individuals statewide with a primary focus on peer education. Figures 8 and 9 show demographic characteristics for all four college prevention centers for Fiscal Year 2003.

WHAT IS TREATMENT?

There are a variety of scientifically based approaches to drug addiction treatment. Treatment can include behavioral therapy (such as counseling, cognitive therapy, or psychotherapy), medications, or their combination. Case management and referral to other medical, psychological, and social services are crucial components of treatment for many patients. The best programs provide a combination of therapies and other services to meet the needs of the individual patient, which are shaped by such issues as age, race, culture, sexual orientation, gender, pregnancy, parenting, housing, and employment, as well as, in some cases, physical and sexual abuse.³

In Maryland, substance abuse treatment services are provided through a network of intervention and treatment providers that are publicly and/or privately funded. The network offers a continuum of care designed to provide Maryland's citizens with access to quality substance abuse treatment opportunities that match the clinically assessed needs of the patient, and utilize a variety of treatment types.

A "treatment type" is a primary treatment approach or modality. The categories of treatment types available in Maryland are shown below.⁴

Intermediate Care Facility (ICF) - A residential treatment facility that provides a short-term medically managed intensive regimen of individual and group therapy as well as other activities that promote physical, psychological and social recovery of patients.

Halfway House- (HWH) - A transitional residential care facility providing time-limited services to alcohol and drug abuse patients who have received prior evaluation or treatment for their addiction.

Non-Hospital Detox (NHDetox) - Treatment that provides 24 hour supervised medical care in a residential setting. The focus of this treatment is to systematically reduce toxins within the patient's body in an effort to reduce withdrawal symptoms and then to refer the patient to on-going treatment.

Other Residential (Other) or (RES) - Non-chemotherapeutic treatment in a residential environment for an extended period of time.

Hospital Detox (HOSP) – Detoxification in a hospital setting.

Outpatient (OP) - A non-residential program that requires less than nine hours of patient participa-

tion each week and provides assessment, diagnosis, treatment and rehabilitation to patients and their families or other designated support systems.

Intensive Outpatient (IOP) - A non-residential outpatient program that provides highly structured treatment services that require patient participation for nine or more hours per week.

Correctional (CORR)- A program located in a federal, state, or county prison or detention center for the patient who is incarcerated and in need of substance abuse treatment.

Medication Assisted Treatment (MAT)

Maintenance (MAIN) - Treatment including the on-going medically supervised administration of methadone for patients addicted to heroin or other opiates that is combined with a variety of outpatient treatment services.

Methadone Detox (MDetox) - Treatment including the short-term medically supervised administration of methadone or other medication for patients addicted to heroin or other opiates with the objective of systematically reducing the toxins and managing the withdrawal systems before referring to another treatment type.

³Principles of drug addiction treatment: A research-based guide, NIH Publication No. 99-4180, Printed October 1999

⁴In the FY 2004 Outlooks and Outcomes, "Treatment Type" will be replaced by ASAM Level of Care nomenclature.

ESTIMATING TREATMENT NEED

Table 2

Regional Estimates of Drug and Alcohol Abuse Treatment Need and Individuals Treated FY 2003					
	Population Over Age 14, CY 2000*	Estimated Treatment Need FY 2003	Percent of Population in Need	Individuals Treated FY 2003	Percent of Per- sons in Need Treated
Western MD	192,344	10,294	5.4%	3,066	29.8%
Eastern Shore	316,608	25,870	8.2%	7,892	30.5%
Southern MD	214,040	16,796	7.9%	4,435	26.4%
D.C. Metro	1,456,470	49,829	3.4%	13,792	27.7%
Central MD	1,464,521	87,454	6.0%	24,098	27.6%
Total	3,643,983	190,243	5.2%	53,283	28.0%
**FY 2002 Baltimore City	554,848	58,316	10.5%	NA	NA

The estimate of need is for both adolescents and adults.

*Western MD - Allegany, Garrett, Washington
Eastern Shore - Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, Worcester
Southern MD - Calvert, Charles, St. Mary's
D.C. Metro - Frederick, Montgomery, Prince George's
Central MD - Anne Arundel, Baltimore Co., Carroll, Harford, Howard*

** United States Census, Calendar Year 2000
**Most recent available data - Estimating the need for substance abuse treatment in Maryland: an update of Reuter et al, revised 2004,
<http://www.cesar.umd.edu/cesar/pubs/20020501.pdf>*

It is estimated about 6.5 percent of Maryland citizens over the age of 14 have substance abuse issues serious enough to require treatment.* Just under 30 percent of this population received treatment during FY 2003, according to the counts of unduplicated individuals reported to SAMIS.

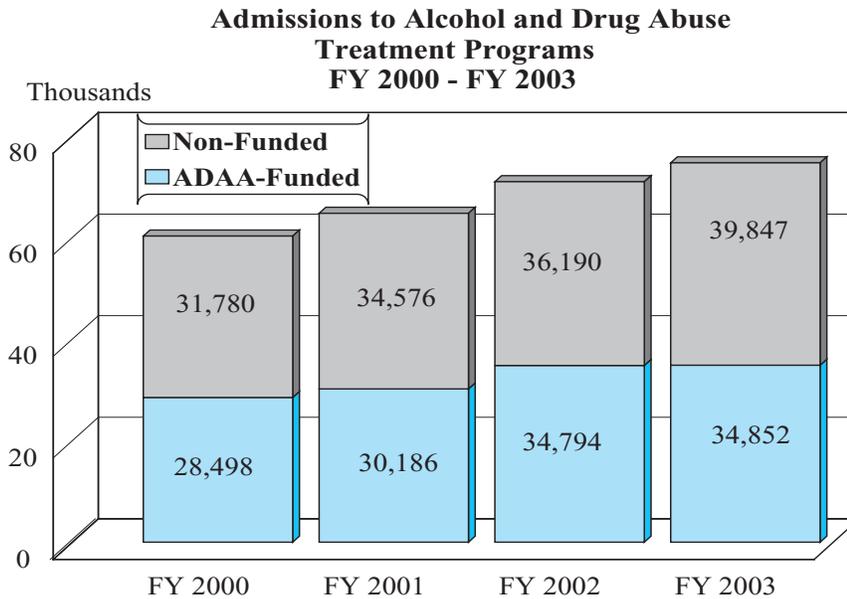
In a regional breakdown, the Eastern Shore (8.2%) and Southern Maryland (7.9%) had the highest percentage need estimates, and the latter had the lowest estimated percentage of need treated (26.4%). The treatment need in the D.C. Metro area had the lowest population percentage (3.4%).

** Estimates are based on application of the truncated Poisson probability distribution to SAMIS treatment data. The major drawback to this methodology is that biases built into the reasons people enter treatment in the various regions tend to be reflected in the estimates; however, it is an inexpensive and generally conservative way of estimating need, and results in past years have been fairly close to those developed through other more rigorous methodologies.*

WHO DO WE SERVE?

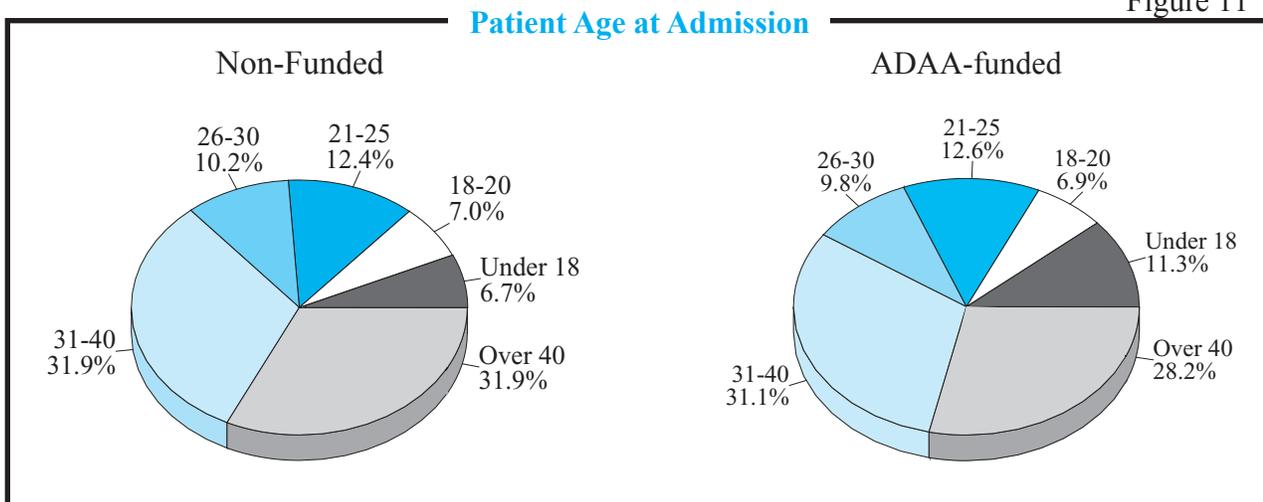
TREATMENT SERVICES

Figure 10



The increase in admissions over the past four fiscal years is shown clearly in Figure 10. While ADAA-funded admissions were essentially level during FY 2002 - FY 2003, total admissions shot up by nearly five percent. The biggest increase in ADAA-funded admissions occurred between FY 2000 and FY 2002 (22 percent), reflecting increased funding drawn from Cigarette Restitution funds and other sources.

Figure 11



There was little difference in the ages of ADAA-funded and non-funded patients – about 22 percent were in their twenties and 32 percent in their thirties (Figure 11). Overall, patients admitted to halfway houses, hospitals, detoxification in any setting and methadone maintenance tended to be older.

Race and Gender

Figure 12

ADAA-funded admissions tended to be about evenly split between black (49 percent) and white (48 percent) patients (Figure 12), while 56 percent of patients in non-funded programs were white (Figure 13). Non-funded patients admitted were slightly more likely to be female – 33.9 versus 32.7 percent (ADAA-funded). In general, 65 percent of ambulatory detox and 63 percent of long-term residential patients admitted were black; three-fourths of hospital inpatient admissions were white. Fifty percent of patients admitted to correctional programs were black males. For each of the past three years, "Other" patients, primarily Hispanic, made up three percent of total admissions.

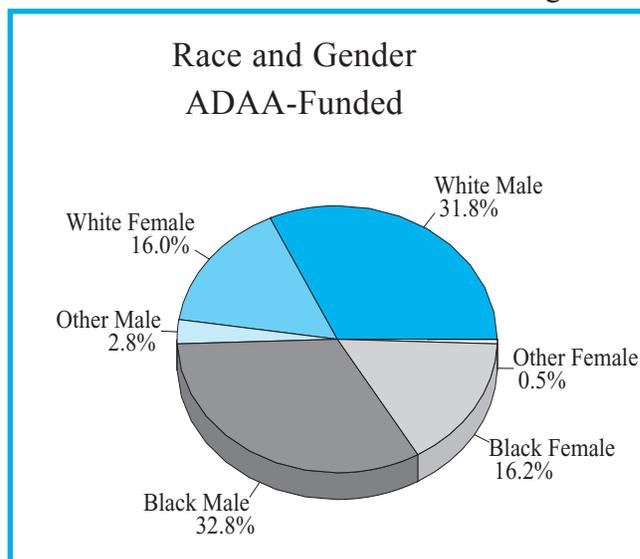
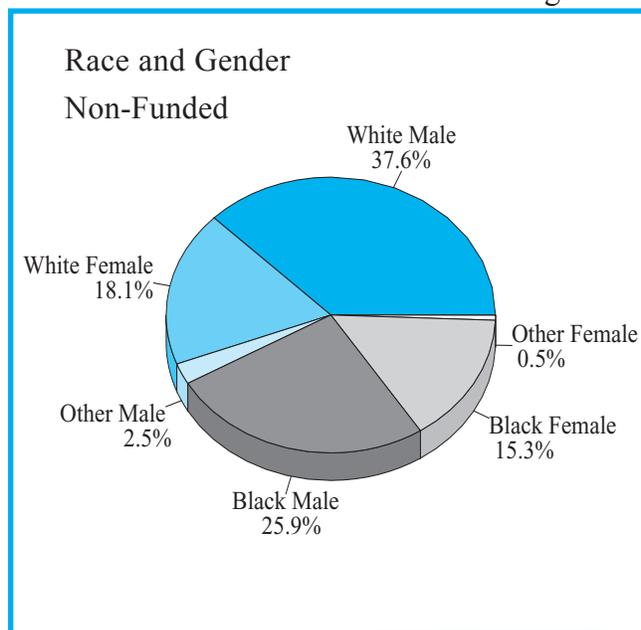


Figure 13



A recent article in the ADAA Compass Newsletter (July 2003) reviewed gender differences among Maryland treatment patients. Overall, about 33 percent of Maryland patient admissions were female, compared to 30 percent nationally, as reported by the federal Treatment Episode Data Set (TEDS). In general, female patients entering treatment in Maryland presented more problems and were more seriously addicted than the average male patient. Females were more likely to be poly-abusers, heroin and cocaine abusers, and daily users. Higher percentages of females than males had substance problems ranked at the highest level of severity, with the exception of marijuana. Females were also more likely than males to have mental health problems, smoke cigarettes, have dependent children, have state-funded or other Medicaid, and they were less likely to be employed.

One possible explanation for these findings is that much of the treatment network has been traditionally oriented to males, making women with less severe problems less likely to seek treatment. The pressure of family responsibilities may be another factor keeping women out of treatment until problems become unmanageable. In addition, it may be that males are more likely to act out and be identified by the community as having a problem and thus referred earlier to treatment than females. Certainly the criminal justice system is an avenue into the treatment network that is much more heavily traveled by men.

Treatment Type and Number of Prior Treatment Admissions

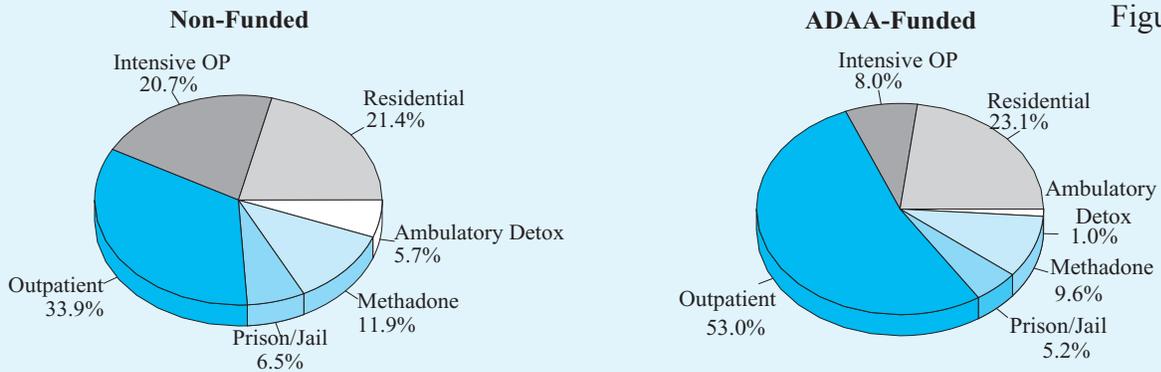


Figure 14

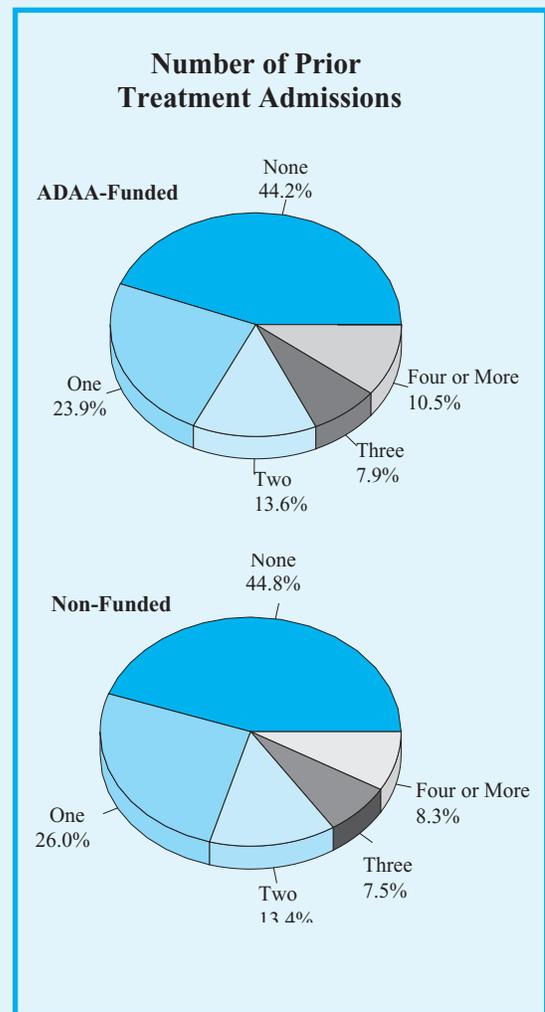
Note: Residential includes halfway house, ICF, non-hospital detox, hospital inpatient and detox, and other residential. Methadone includes maintenance and detox.

The major non-funded and funded treatment types for patients at admission during FY 2003 are shown above in figure 14. The major difference in the two distributions concerns intensive and traditional outpatient. Fifty-three percent of patients admitted to funded treatment entered the outpatient level of care compared to 34 percent of non-funded. On the other hand, only eight percent of ADAA-funded and over 20 percent of non-funded admissions entered intensive outpatient. Ambulatory detox was also significantly more utilized in non-funded programs.

Figure 15

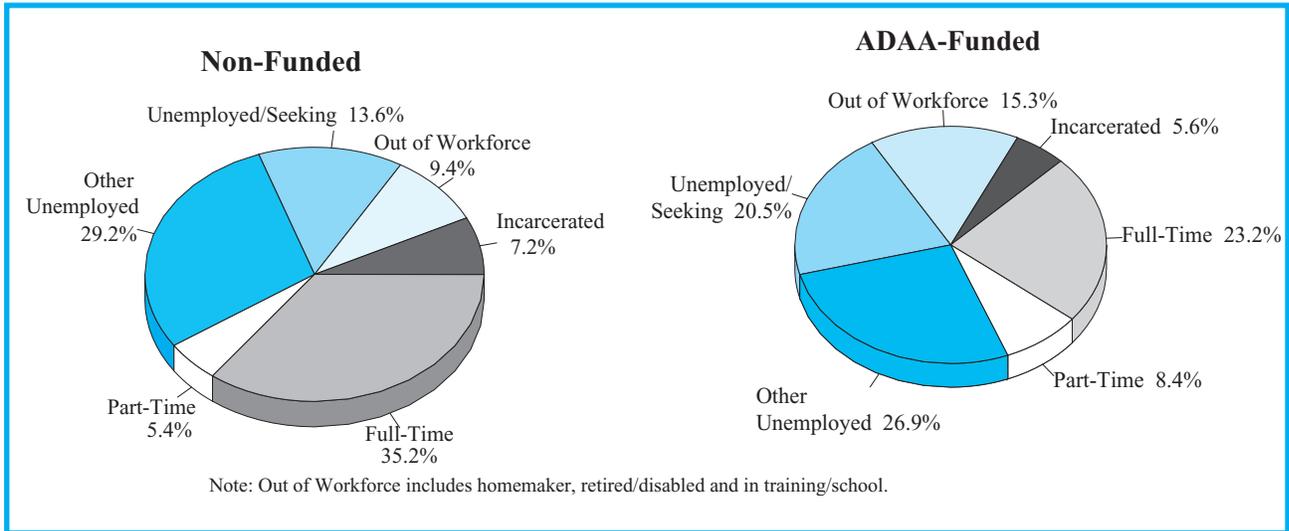
Table A in the appendix further distributes these categories and provides trend information for the past five fiscal years. Interestingly, the distributions for both funded and non-funded treatment have changed little over this time period. Most notably, non-hospital detox increased by 78 percent in non-funded and by 115 percent in funded treatment. Ambulatory detox increased nearly ten-fold among non-funded programs.

The numbers of prior treatment experiences of ADAA-funded and non-funded admissions are shown in Figure 15. Patients, in general, were more likely than not to have been in treatment before, with between 44 and 45 percent of funded and non-funded admissions having had no prior treatment. ADAA-funded admissions were more likely to have had two or more prior treatment episodes, 32 versus 29 percent, reflecting a slightly more recidivistic population. Overall, however, there was little difference between the two groups on this measure. However, halfway house admission data showed patients were most likely to have had prior treatment, almost half having had three or more prior experiences. Nearly 70 percent of ICF and long-term residential admissions had at least one prior admission. Half of all methadone maintenance patients admitted had two or more prior treatment episodes, illustrating the particularly chronic nature of opiate addiction.



Employment

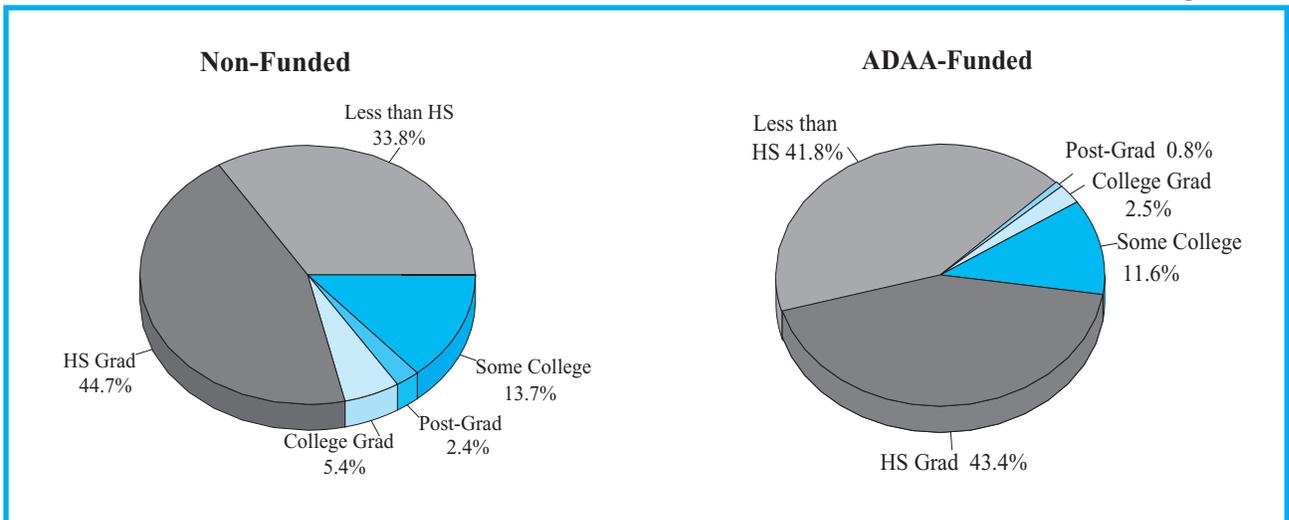
Figure 16



Not surprisingly, ADAA-funded admissions are significantly less likely to be full-time employed and more likely to be unemployed and seeking employment or out of the workforce, as shown in Figure 16. Non-funded programs admitted a slightly higher percentage of patients who are unemployed but not seeking employment, and the majority of these appear to be Medical Assistance cases.

Educational Attainment

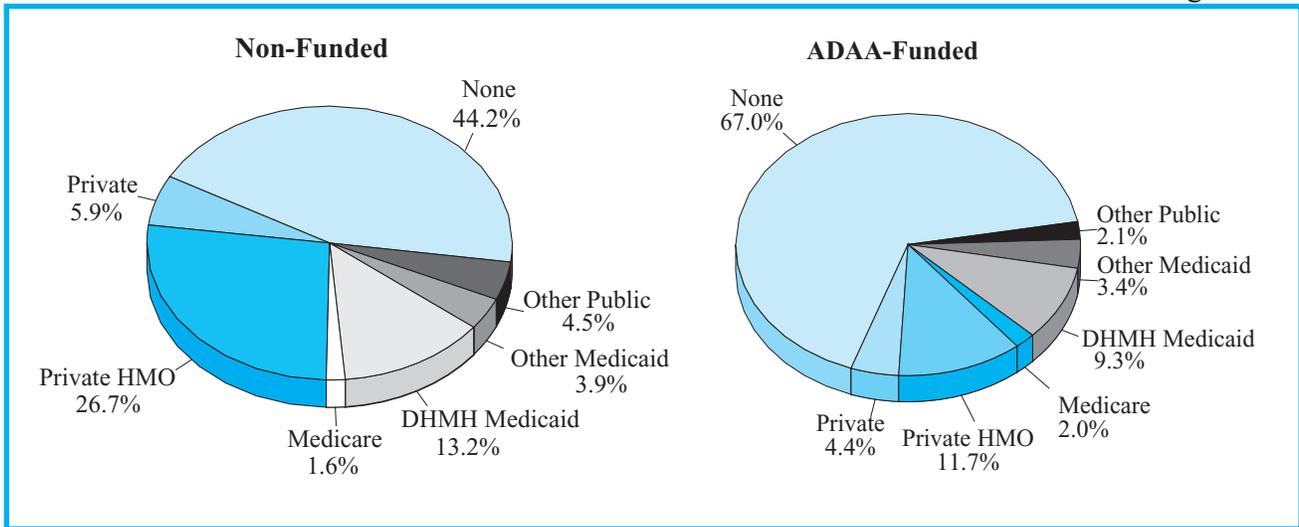
Figure 17



ADAA-funded admissions lag behind their non-funded counterparts educationally as well. Figure 17 shows that about a third of non-funded admissions had not attained at least a high school education; whereas 42 percent of admissions funded by ADAA were in that category. Non-funded patients were also more likely to have some college, have graduated from college, and to have obtained a college degree, and/or gone beyond college.

Health Care Coverage

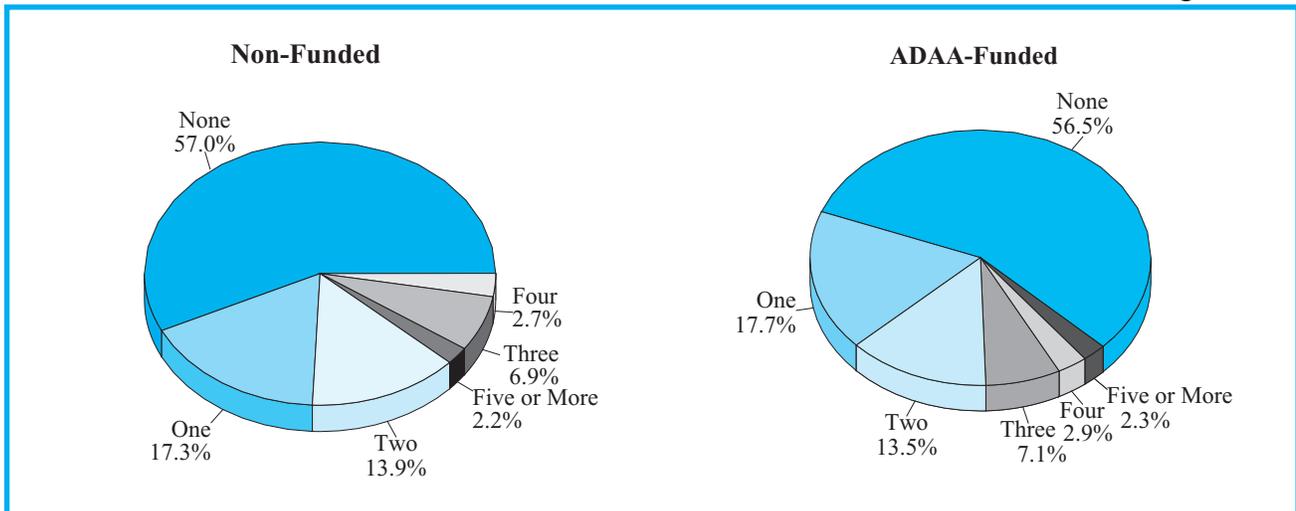
Figure 18



Two-thirds of the patients admitted to ADAA-funded programs lacked any form of health coverage, as shown in Figure 18. Only 44 percent of non-funded admissions were in that category. Just under one-third of the latter group had private insurance compared to about 16 percent of funded patients. A greater percentage of Medicaid admissions went to non-funded programs than funded because of the greater number of ICF programs in the private sector.

Number of Dependent Children

Figure 19



The distributions of number of dependent children among individuals admitted to funded and non-funded programs are remarkably similar (Figure 19). In both, 57 percent reported no dependent children and all other categories differed by less than 1 percentage point. Using these and other data and prevalence estimation methodology produces an estimate of about 245,000 Maryland children who are dependent on substance abusers receiving or in need of treatment.

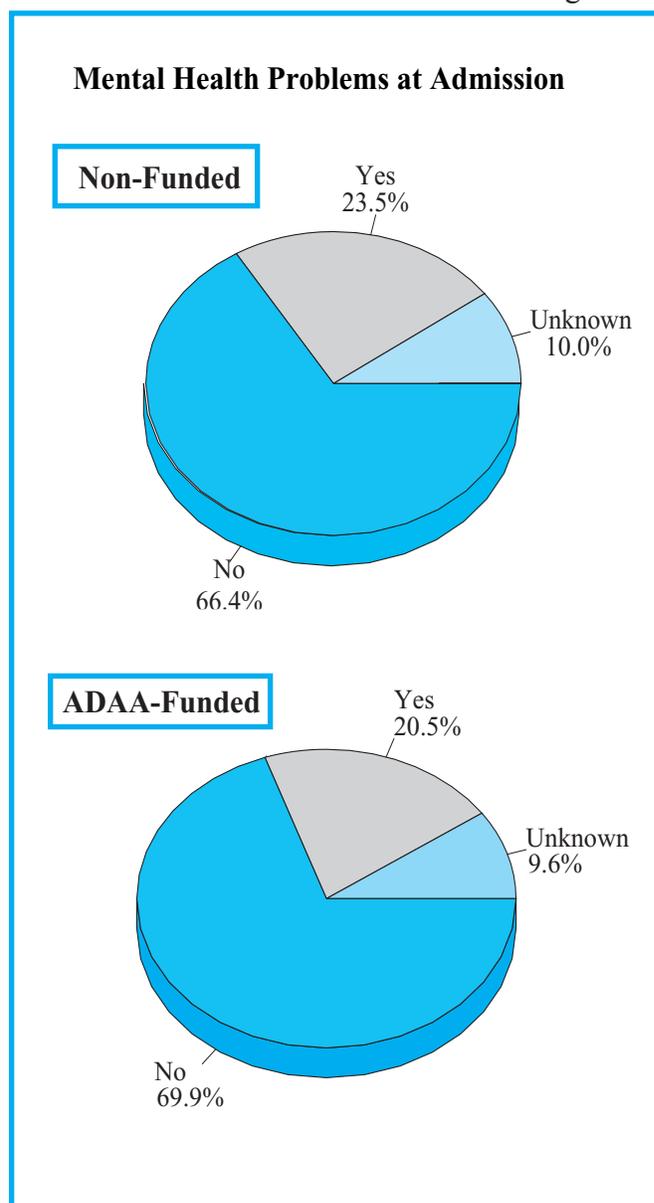
Co-occurring Disorders

Co-occurring disorders involve simultaneous abuse of substances or a substance abuse problem, and a psychiatric disorder or mental health problem. In SAMIS, an admission item is entitled Current Mental Health Problem, and the intake counselor is instructed to indicate whether such a problem exists according to documentation, or is suspected given the best clinical judgment of the counselor. Counselors are given the option of reporting “Unknown” for this item. Similar percentages of individuals with co-occurring disorders enter ADAA-funded and non-funded treatment, as shown in Figure 20.

"What the Data Say", in the April 2004 edition of the Compass Newsletter, examined the issue of patients admitted with mental health problems. The article discussed data supporting five critical factors related to this population. First, this population is increasing as a percentage of total admissions, either in number because intake counselors are better able to identify them. Second, they were found to be less likely than other patients to have opiate-related problems, but more likely to have issues with alcohol and other drugs. Third, females represent one-third of all substance abuse admissions, but one-half of admissions with co-occurring disorders. Fourth, these admissions were significantly more likely to be white. Fifth, individuals with co-occurring disorders were more likely to enter residential or intensive outpatient treatment and more likely to have multiple prior treatment experiences.

The SAMIS data support the accepted view that patients with co-occurring disorders are among the most difficult to treat effectively. Many of these patients undergo repeated referrals among substance abuse treatment programs and other health care entities, and their mental health issues frequently interact with multiple substance use to present extremely difficult challenges to recovery. In addition, this population is more likely to be homeless and less likely to be employed.

Figure 20



Criminal Justice Referrals

Figure 21

Figure 21 shows the distribution of the numbers of arrests in the two years preceding treatment for funded and non-funded patients. While just over half of non-funded patients admitted had been arrested at least once, over two-thirds of ADAA-funded patients had one or more arrests. Multiple arrests were also significantly more common among non-funded patients. This finding makes the distributions in Figure 22 hardly surprising. Half of ADAA-funded admissions were referred by components of the criminal justice system while 35 percent of non-funded admissions were criminal justice referrals.

In the ADAA Compass Newsletter, January 2004, devoted to treatment and criminal justice, data were examined to assess the difference between criminal justice and other referrals. During FY 2003, two-thirds of outpatient referrals were from criminal justice sources. Other than hospital inpatient, the treatment type least populated by patients referred by criminal justice programs was methadone maintenance. Referrals for both black and white males were evenly split between criminal justice and other sources while white females were significantly more likely than black females to come to treatment from the criminal

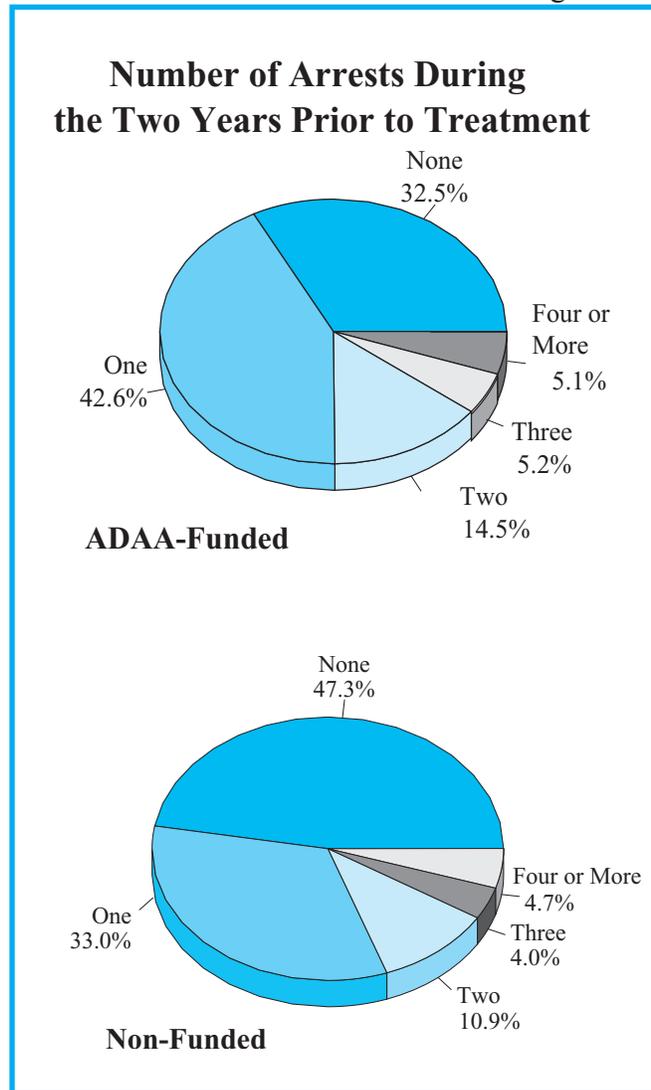
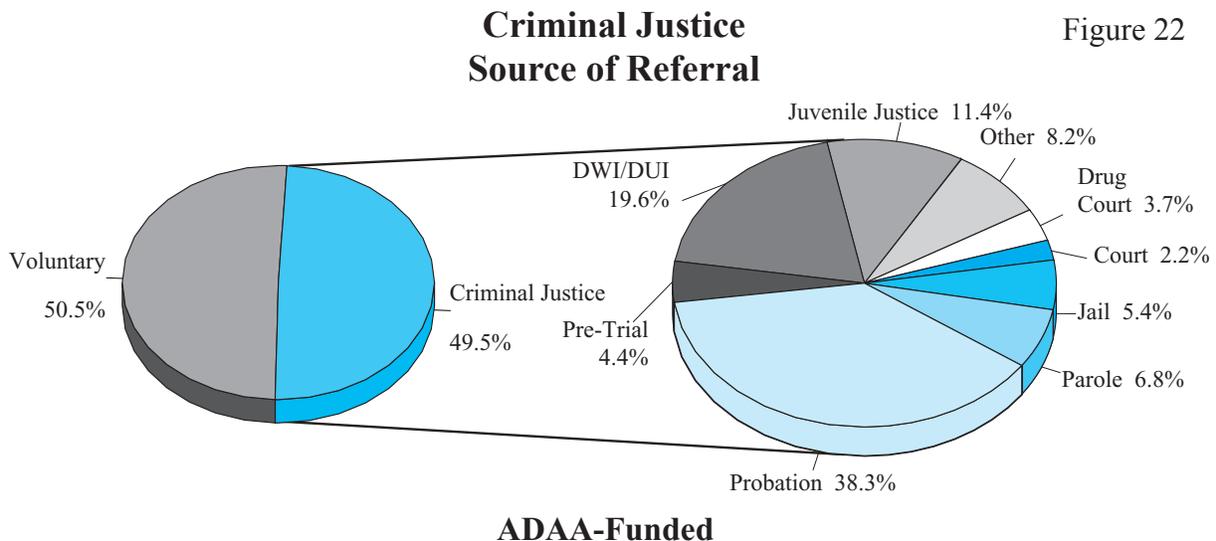


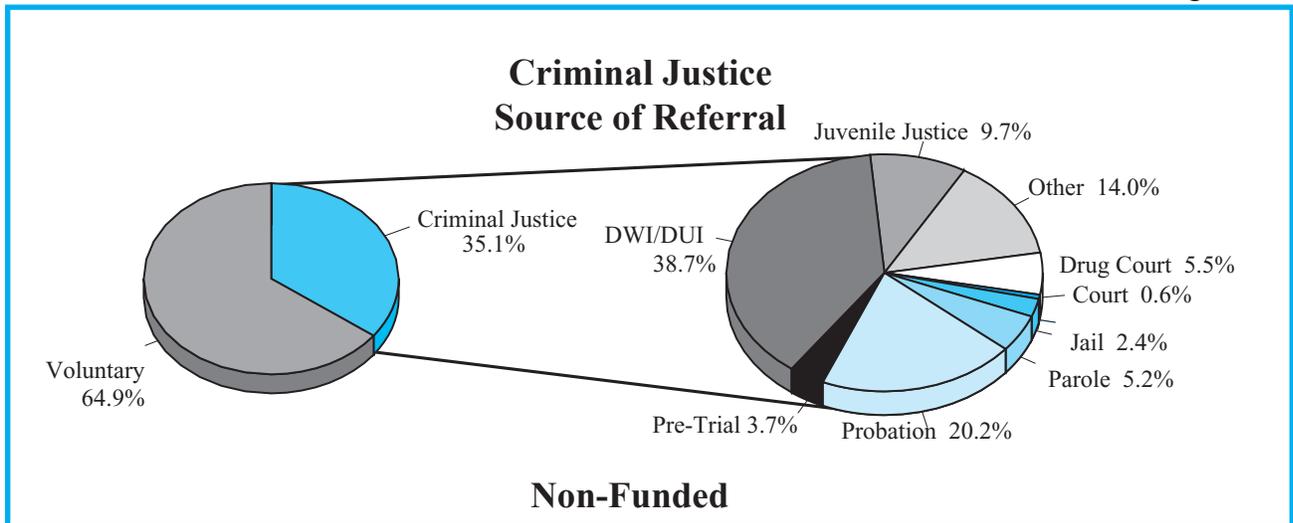
Figure 22



justice system. Not surprisingly, the age group between 18 and 25 produced the greatest percentage of criminal justice referrals.

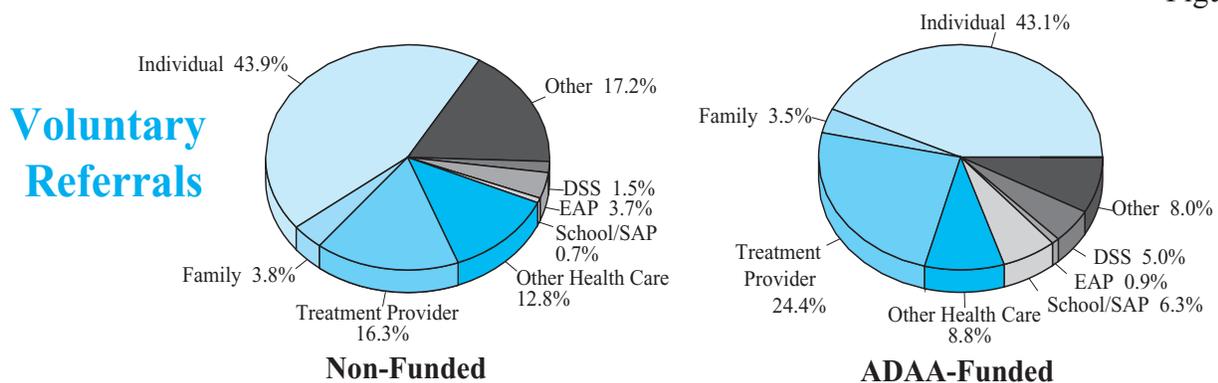
Compared to other referrals, criminal justice treatment cases were more likely to involve alcohol, (70% vs 48%), and marijuana, (43% vs 23%). Naturally, DWI referrals account for many of the alcohol problems among criminal justice cases and here non-funded programs had twice as many DWI referrals as ADAA-funded programs (38% vs 19%). Criminal justice cases were more likely to involve urinalysis, and the tests among criminal justice cases were less frequently positive (21% vs 40%).

Figure 23



Figures 22 and 23 reveal some dramatic differences in the categories of criminal justice referrals to ADAA-funded and non-funded treatment. Non-funded patients referred by criminal justice were nearly twice as likely to involve DWI/DUI offenses, whereas ADAA-funded patients referred by criminal justice were nearly twice as likely to be probationers. Funded criminal justice patients were more than twice as likely to come from jail or prison sources and court, although the percentages in these categories are small. At 20 percent, DWI/DUI was still the second largest category of criminal justice referrals for ADAA-funded admissions.

Figure 24



Voluntary referrals are distributed by source in Figure 24. In both the funded and non-funded programs the proportion of individual and family referrals was the same, about 48 percent. ADAA-funded referrals were significantly more likely to come from other treatment providers, schools and Department of Social Services (DSS). Non-funded referrals were more likely to come from other health care providers, Employee Assistance Programs (EAP), and the “other” category.

WHERE DO PATIENTS LIVE?

Admissions to Certified Non-Funded Maryland Alcohol and Drug Abuse Treatment Programs FY 2000 - FY 2003				
Location of Residence	FY 2000	FY 2001	FY 2002	FY 2003
Allegany	86	90	71	75
Anne Arundel	4,017	4,929	5,024	4,788
Baltimore City	10,879	10,929	11,596	14,345
Baltimore County	3,911	4,091	4,672	5,229
Calvert	277	339	379	352
Caroline	80	86	85	75
Carroll	686	728	729	832
Cecil	352	431	402	388
Charles	392	359	361	287
Dorchester	87	103	77	95
Frederick	1,062	1,075	1,118	1,140
Garrett	12	14	17	14
Harford	1,074	1,000	1,302	1,573
Howard	946	905	888	1,011
Kent	24	47	43	68
Montgomery	2,377	3,029	2,615	2,984
Prince George's	1,901	2,310	2,321	2,309
Queen Anne's	104	138	155	149
St. Mary's	186	159	162	122
Somerset	54	86	75	63
Talbot	83	101	132	167
Washington	536	616	469	659
Wicomico	524	548	488	479
Worcester	176	190	212	208
Out-of-State	1,914	2,248	2,778	2,406
Total	31,740	34,551	36,171	39,818

Table 3

Admissions to Certified ADAA-Funded Maryland Alcohol and Drug Abuse Treatment Programs FY 2000 - FY 2003				
Location of Residence	FY 2000	FY 2001	FY 2002	FY 2003
Allegany	663	604	664	759
Anne Arundel	834	911	1,063	1,012
Baltimore City	8,005	8,704	10,512	10,561
Baltimore County	2,928	2,916	2,989	3,074
Calvert	649	632	858	785
Caroline	348	386	423	457
Carroll	973	972	1,005	999
Cecil	603	700	923	1,076
Charles	783	911	1,084	1,204
Dorchester	479	528	563	614
Frederick	942	1,082	1,112	1,138
Garrett	297	258	281	326
Harford	863	889	973	924
Howard	681	683	649	628
Kent	324	344	392	370
Montgomery	1,988	1,909	2,527	2,404
Prince George's	1,750	1,820	2,018	2,069
Queen Anne's	501	417	423	447
St. Mary's	684	993	1,286	1,050
Somerset	413	530	404	427
Talbot	614	531	522	538
Washington	975	1,089	1,356	1,130
Wicomico	1,066	1,112	1,311	1,367
Worcester	732	831	917	868
Out-of-State	388	433	535	623
Total	28,483	30,185	34,790	34,850

Table 4

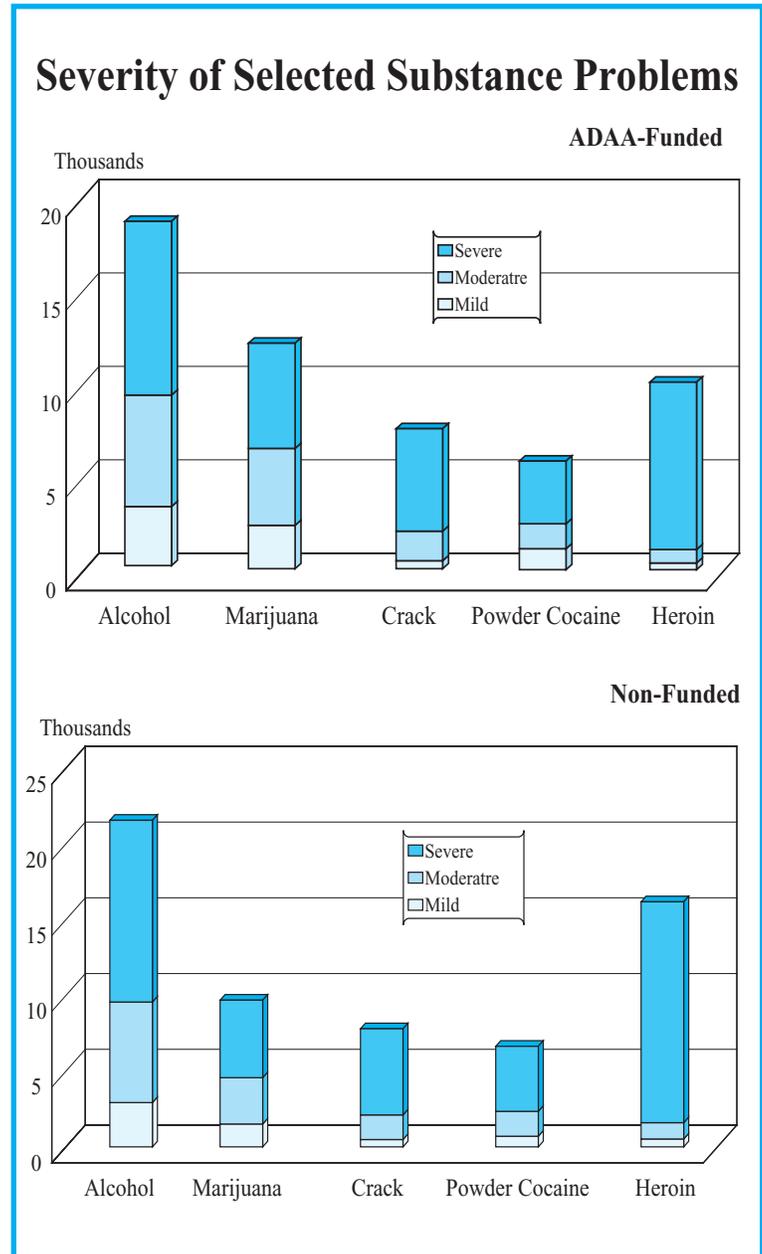
Reported subdivision of residence of non-funded and ADAA-funded admissions is shown in Tables 3 and 4. From FY 2002 to 2003, Baltimore City residents admitted to non-funded treatment increased by 24 percent. Among ADAA-funded admissions, City resident admissions have been stable at about 30 percent for 2002 and 2003. Over the past five years, while total funded admissions increased 20 percent, the subdivisions showing the greatest increases were exurban: Cecil, Charles, Frederick, and St. Mary's. In non-funded treatment, the 29 percent five-year statewide increase was more evenly distributed, with the exceptions of greater increases in Baltimore City and Montgomery County.

Drug Use Trends

Reports of heroin problems increased 23 percent in non-funded programs during FY 2003 while remaining relatively stable in ADAA-funded treatment (Appendix Tables B and C). Over the five years, however, heroin increased by 40 percent in funded treatment and other opiates and synthetics increased by 156 percent. Other dramatic five-year jumps occurred among hallucinogen (137%), PCP (187%), benzodiazepine (85%), methamphetamine and other amphetamine (112%), other sedative (59%) and other or powdered cocaine (53%) abusers. Still, the leading substances of abuse in Maryland's ADAA-funded treatment were alcohol (60%), marijuana (39%), heroin (33%), crack cocaine (23%) and other cocaine (20%). No other substance mentions exceeded four percent of funded admissions (Figure 25).

The same five substances predominate among non-funded admissions, but the order differs: alcohol (55%), heroin (41%), marijuana (25%), crack cocaine (20%) and other cocaine (17%). Here, other opiates and synthetics increased 212 percent in five years, and were mentioned in about 7 percent of admissions. Again, PCP (382%), hallucinogens (129%), benzodiazepines (70%), methamphetamine and other amphetamines and stimulants (177%) and other sedatives (332%) showed large five year gains. In addition, marijuana (48%), and heroin (47%) well exceeded the overall increase for non-funded admissions.

Figure 25

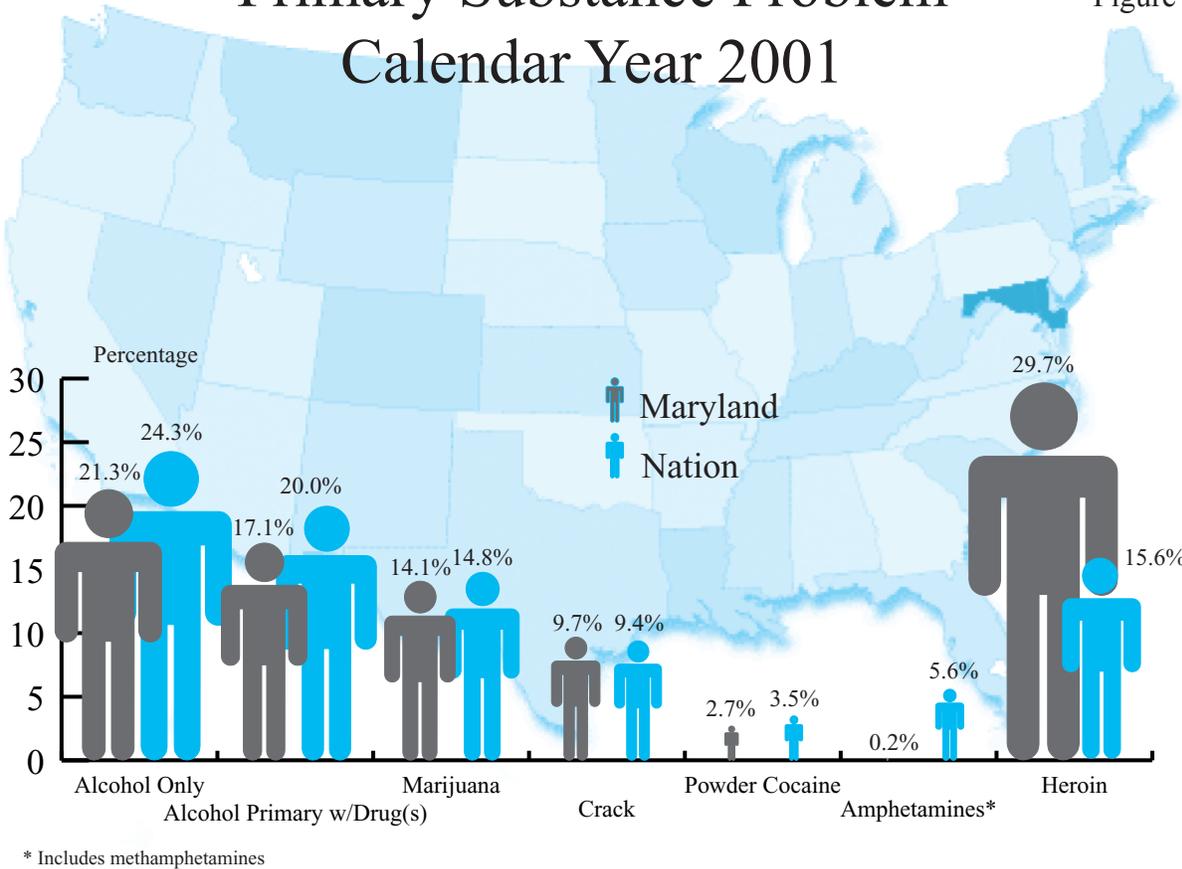


How Maryland Compares to the Nation

Primary Substance Problem

Calendar Year 2001

Figure 26



The Federal Treatment Episode Data Set (TEDS) is a reporting system on substance abuse treatment admission in which all fifty states participate. It allows for comparison of Maryland data with national and other states' data, but the most recently available national data is for calendar year 2001.

Maryland patients present with primary substance abuse problems in proportions similar to the rest of the nation, with a couple of notable exceptions. Maryland treatment admissions are somewhat less likely than national admissions to involve alcohol either alone or with other drugs as secondary problems. The major differences, however, concern amphetamines and heroin.

For 2001, the states with the highest rates of admission for primary methamphetamine abuse were all west of the Mississippi River with the exception of Alabama. Data for the last ten years show the trend gradually moving eastward, although the Mississippi continues to represent a kind of barrier.

Eight contiguous states in the North Atlantic region, including Maryland, had the highest admission rates for primary problems with heroin. Thirty percent of Maryland patients admitted had primary heroin problems compared to 15.6 percent for the nation as a whole.

Age at First Use

The distributions of reported age at first use of the five major substances of abuse are shown below in Tables 5 and 6. Not surprisingly, the distributions are similar for ADAA-funded and non-funded treatment for alcohol-related admissions experiencing their first intoxication before turning 18 and first using a drug before turning 15.

Age of First Use
ADAA-Funded

	Alcohol		Marijuana		Crack		Powder Cocaine		Heroin	
	#	%	#	%	#	%	#	%	#	%
Under 15	7568	37.2%	6135	47.0%	347	4.4%	469	6.9%	712	6.4%
15-17	7077	34.8%	4574	35.1%	1178	14.9%	1428	20.9%	2282	20.5%
18-25	4809	23.7%	2026	15.5%	3571	45.3%	3224	47.3%	4958	44.5%
26-30	419	2.1%	171	1.3%	1311	16.6%	864	12.7%	1465	13.2%
Over 30	446	2.2%	136	1.0%	1475	18.7%	838	12.3%	1720	15.4%

Table 5

The picture is quite different for cocaine and heroin. About 81 percent of crack abusers first used the drug after age 17; nearly 70 percent of abusers of other forms of cocaine first used between 15 and 25. Only about 27 percent of heroin-related cases first became involved with the drug in adolescence; about 30 percent first used heroin after turning 26.

Age of First Use
Non-Funded

	Alcohol		Marijuana		Crack		Powder Cocaine		Heroin	
	#	%	#	%	#	%	#	%	#	%
Under 15	7227	34.1%	4892	49.6%	369	4.7%	499	7.5%	1087	6.7%
15-17	7513	35.5%	3254	33.0%	1079	13.9%	1579	23.6%	3247	20.1%
18-25	5485	25.9%	1453	14.7%	3437	44.2%	3025	45.2%	6885	42.6%
26-30	470	2.2%	123	1.2%	1328	17.1%	764	11.4%	2166	13.4%
Over 30	470	2.2%	150	1.5%	1560	20.1%	823	12.3%	2777	17.2%

Table 6

* For alcohol the item pertains to the age at first intoxication

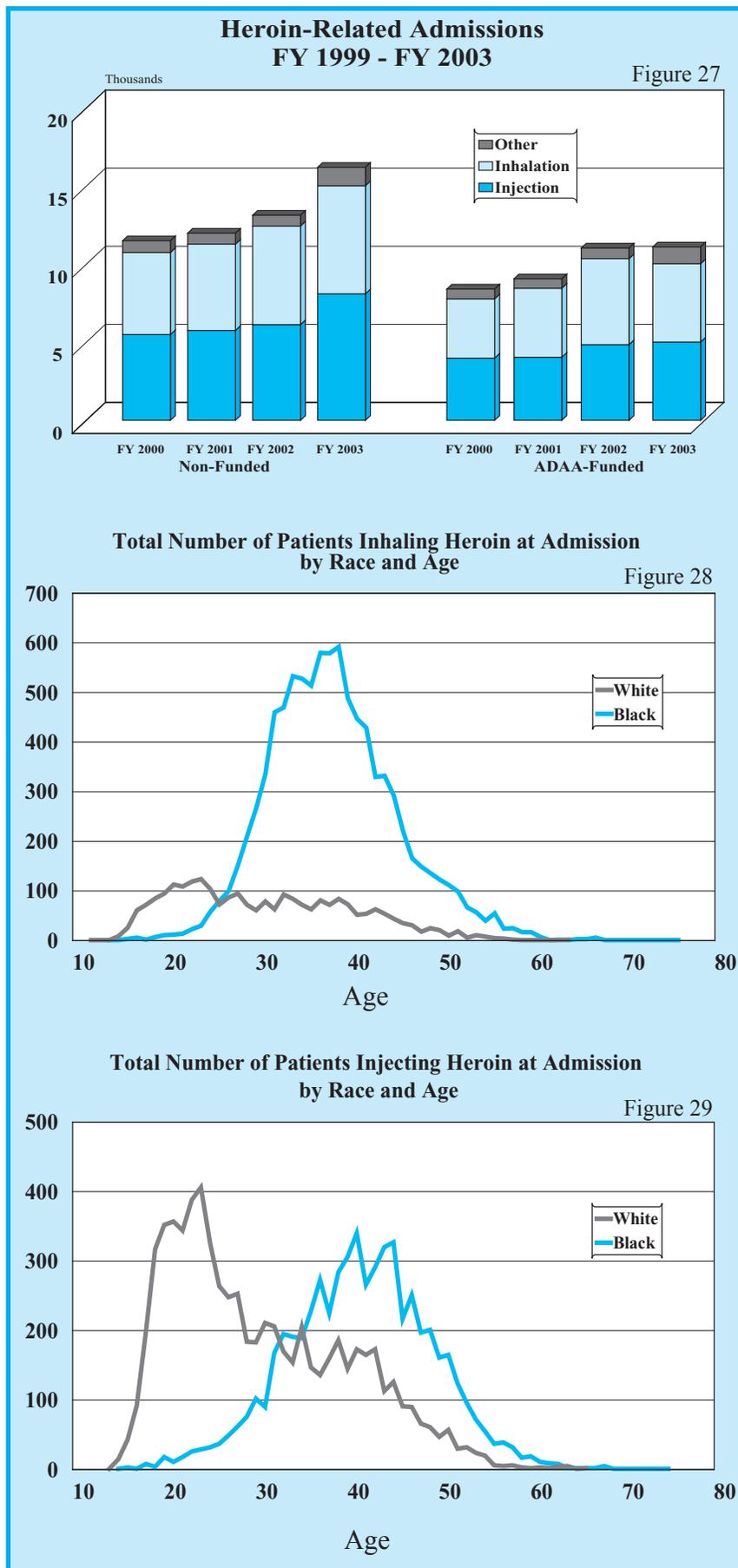
"Eighty-two percent of individuals admitted to treatment with alcohol or marijuana problems reported first substance use during adolescence."



Routes of Administration

Figure 27 displays the primary route of administration for heroin admissions over the four years. Among non-funded admissions, injection increased 45 percent (32% during FY 2003), and inhalation increased 48 percent. Among ADAA-funded admissions, the increase in injection was 26 percent and in inhalation, 50 percent. This surge in inhaled heroin is related to a number of factors, including the increasing availability of pure heroin and the association of needles with HIV infection.

Further analysis shows that heroin inhalation is particularly popular among black users from about age 30 to 50 (Figure 28). More white patients inhaling were admitted up to about age 26, but from that point on admissions of black patients inhaling make up the majority of admissions. Figure 29 shows a similar pattern for admissions of black patients injecting heroin, peaking at about age 40, but white patients in their late teens and twenties are the predominant injectors, and their numbers decline gradually through age 60. These patterns have existed for at least the past three years.



Changes in Routes of Administration for Heroin: An ADAA Research Study

Do opiate inhalers eventually progress to injection as tolerance grows? While this may have been a common occurrence in the past, recent research by ADAA suggests it is no longer a typical progression. Using a unique identifier in SAMIS, all records of heroin-involved patients who had both their first treatment admission and at least one subsequent admission during the five-year period from FY 1999 to FY 2003 were analyzed. What became apparent was that patients were more likely to move from injecting heroin to inhaling than the other way around, and that most patients with multiple heroin-related admissions during the five years were consistently either injectors or inhalers.

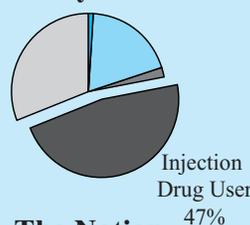
During FY 1999 through FY 2003 there were nearly 24,000 heroin-related cases involving a first-time heroin admission and one or more subsequent admissions. Forty-three percent involved inhalation only and 28 percent involved injection only. Sixteen percent were primarily injecting in their first admissions and subsequently inhaling, while only 13 percent showed the reverse pattern. Incidentally, 83 percent of the consistent inhalers were black, while the remaining cases were split fairly evenly between blacks and whites.

It is possible that progressing from inhalation of heroin to injection was common at one time, but the great influx of high-purity heroin and spread of HIV infection attributable to injecting drug use have created a new dynamic. The August 2002 Maryland Drug Threat Assessment by the National Drug Intelligence Center reports that heroin purity levels reached 96 percent in Baltimore in late 2000. According to the Maryland AIDS Administration injection drug use is the predominant mode of HIV transmission in the state. Changing circumstances and following heroin users for a longer time period may produce different results.

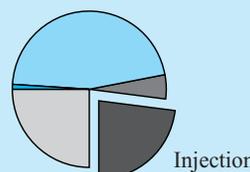
Injection Drug Users and HIV/AIDS



Maryland



The Nation



- Heterosexual contact with a partner who has or is at risk for HIV
- Injecting Drug User
- Men who have sex with men / Injecting Drug User
- Men who have sex with men
- Other

Maryland had the third highest annual AIDS case report of any state in 2002 (34 cases per 100,000 population).

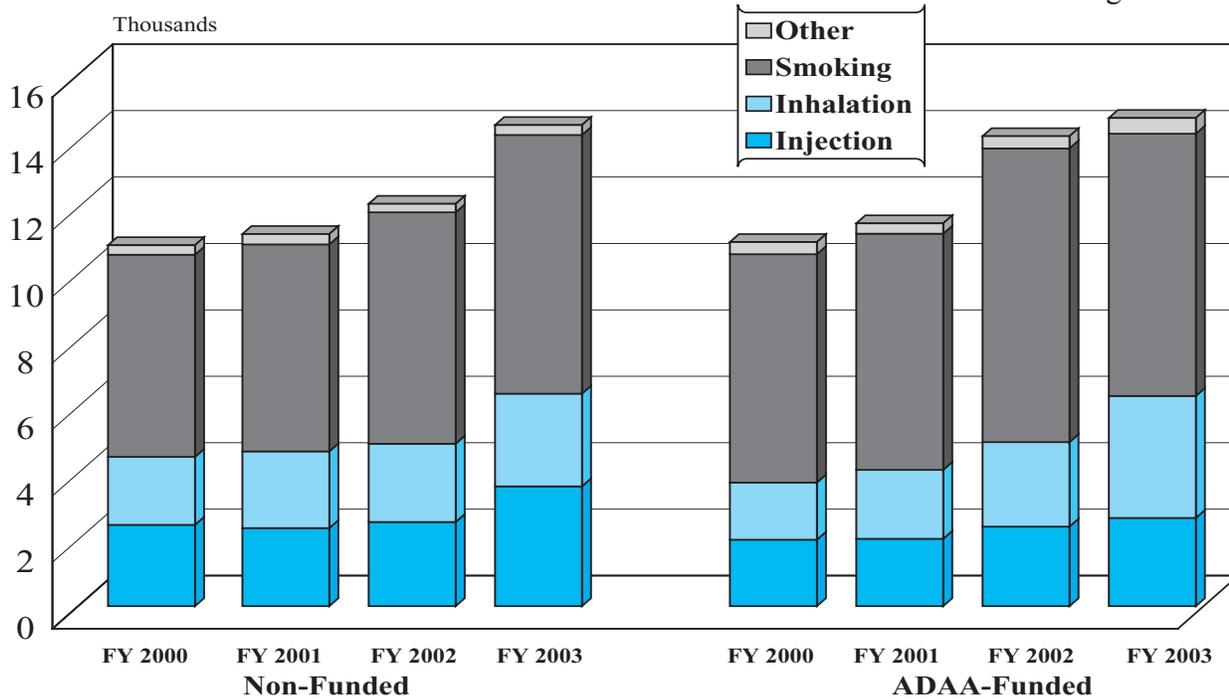
Baltimore had the fourth highest rate of any major metropolitan area (48.7 cases per 100,000 population).

The national rate in 2002 was 15.0 cases per 100,000 population.

Maryland HIV/AIDS Epidemiological Profile - March 31, 2004.

Cocaine-Related Admissions FY 1999 - FY 2003

Figure 30



Cocaine-related admissions are distributed by the primary route of administration in Figure 30. Clearly, smoking (crack) is the predominant mode of administration; however, there were significant increases in both injection and inhalation cases during FY 2003. Crack made up 54 percent of the cocaine-related funded and non-funded FY 2003 admissions. While crack has increased about ten percent among ADAA-funded admissions the last four years, it has increased each year among non-funded admissions, for a total of 38 percent. While injection increased by 42 percent among non-funded admissions in FY 2003, inhalation increased 44 percent among their funded counterparts.

About two-thirds of all crack related admissions were black patients. Notably, females constituted 53 percent of the black patients admitted with crack problems in non-funded programs. In the ADAA-funded programs black female patients only represented 47 percent of admissions of crack related cases.

Overall, females made up 47 percent of crack, 35 percent of other cocaine and 43 percent of heroin admissions, far exceeding their representation in the total treatment admission population. As noted earlier, females entering treatment tend to be more severely addicted in terms of the nature and quantity of their substance abuse problems.

IS IT WORTH IT?

TREATMENT OUTCOMES

The ADA A Performance Management system is based on the ability to measure treatment outcomes and to use that information to improve the quality of treatment outcomes for patients entering care. Measures reported in this section include retention in treatment, patient movement through continuum of care, changes in substance use, employment, arrest rate and living situation.

Discharges

Discharges from treatment from FY 2000 to FY 2003 are distributed by treatment type in Tables 7 and 8. During the four years, discharges for both ADA A-funded and non-funded treatment increased by 16 percent. The largest increases were in non-hospital and ambulatory detox, and prison/jail treatment. Discharges from methadone detox fell by about half in ADA A-funded programs, while almost tripling in non-funded programs.

Tables 7 & 8

Discharges from ADA A-Funded Maryland Alcohol and Drug Abuse Treatment Programs FY 2000 - FY 2003								
Treatment Type	FY 2000		FY 2001		FY 2002		FY 2003	
	#	%	#	%	#	%	#	%
Halfway House	580	2.1	551	2.0	658	2.0	628	1.9
Intermediate Care	4127	14.9	4558	16.2	4903	14.7	4644	14.4
Non-Hospital Detox	850	3.1	1140	4.0	1994	6.0	1848	5.7
Other Residential	614	2.2	759	2.7	713	2.1	806	2.5
Outpatient	15385	55.6	15412	54.6	18058	54.3	17177	53.3
Intensive Outpatient	1974	7.1	1834	6.5	2139	6.4	2328	7.2
Prison/Jail	1173	4.2	1183	4.2	1780	5.4	1817	5.6
Methadone Detox	665	2.4	499	1.8	395	1.2	319	1.0
Methadone Maint.	2147	7.8	1953	6.9	2358	7.1	2444	7.6
Ambulatory Detox	140	0.5	323	1.1	247	0.7	199	0.6
Total	27655	100.0	28212	100.0	33245	100.0	32210	100.0

Discharges from Non-Funded Maryland Alcohol and Drug Abuse Treatment Programs FY 2000 - FY 2003								
Treatment Type	FY 2000		FY 2001		FY 2002		FY 2003	
	#	%	#	%	#	%	#	%
Halfway House	141	0.5	153	0.5	114	0.3	201	0.6
Intermediate Care	4463	14.8	4659	14.7	5287	15.9	5562	15.8
Non-Hospital Detox	986	3.3	1094	3.5	1350	4.1	1742	5.0
Hospital Detox	11	0.0	201	0.6	304	0.9	148	0.4
Hospital Inpatient	292	1.0	271	0.9	251	0.8	237	0.7
Other Residential	664	2.2	599	1.9	313	0.9	165	0.5
Outpatient	11208	37.1	12143	38.4	11935	35.8	11613	33.1
Intensive Outpatient	6269	20.8	5603	17.7	6565	19.7	7138	20.3
Prison/Jail	2802	9.3	2645	8.4	2633	7.9	2447	7.0
Methadone Detox	124	0.4	58	0.2	16	0.0	359	1.0
Methadone Maint.	2517	8.3	2611	8.2	3047	9.1	3564	10.1
Ambulatory Detox	703	2.3	1626	5.1	1490	4.5	1959	5.6
Total	30180	100.0	31663	100.0	33305	100.0	35135	100.0

Source: Alcohol and Drug Abuse Administration Substance Abuse Management Information System

Reason for Discharge

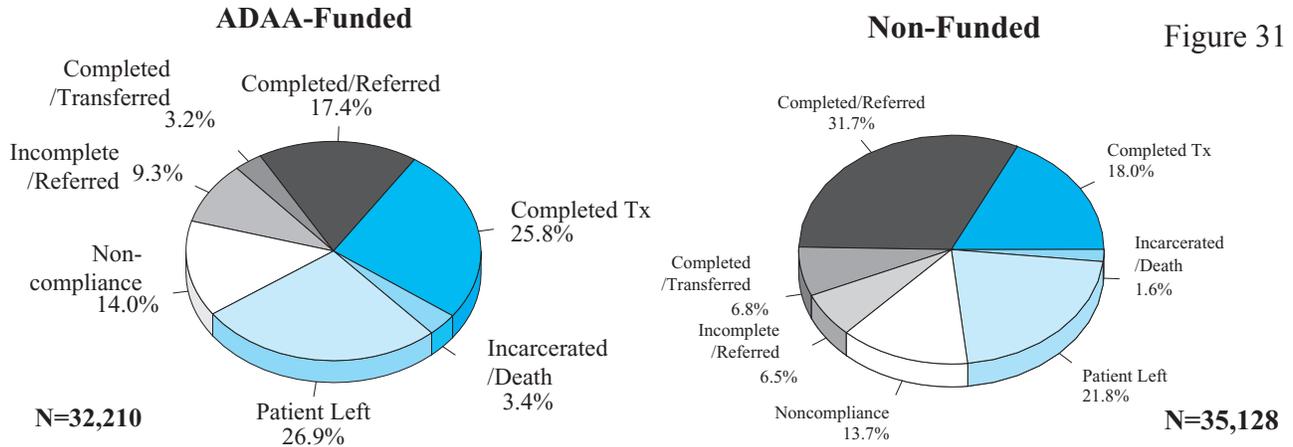


Figure 31

Both funded and non-funded treatment saw the largest number of discharges, roughly 55 percent, in the completed treatment categories. Twenty-six percent of ADAA-funded discharges completed treatment with no need for further care indicated, and another 21 percent completed the immediate episode with a referral or transfer for further care (Figure 31). Non-funded treatment programs had a smaller percentage (18%) complete treatment without need for further care with almost twice the number completing treatment with a referral or transfer for further care.

Average Length of Stay by Treatment Type

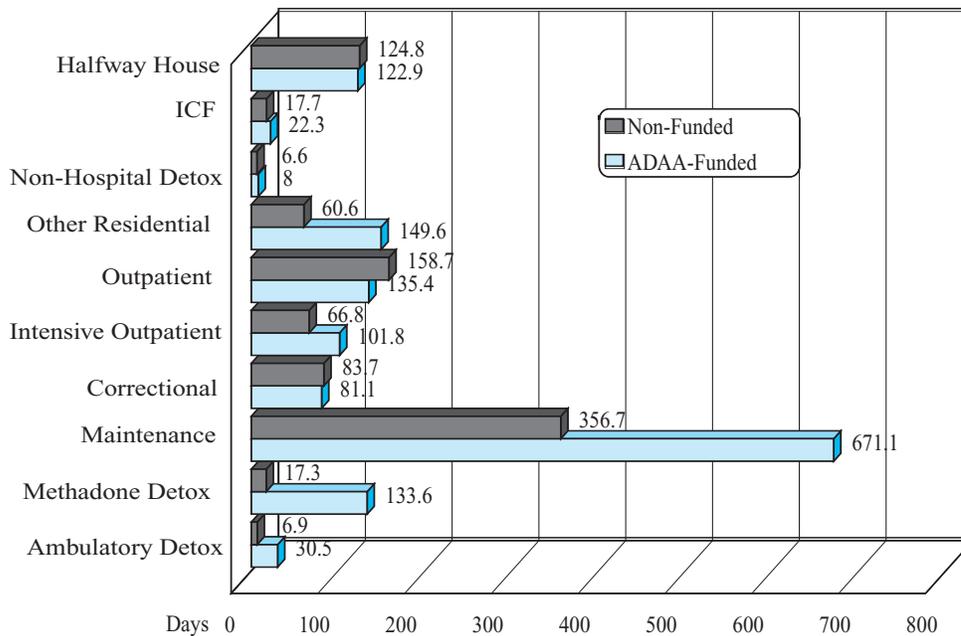


Figure 32

Figure 32 above shows the average length of stay in various categories of treatment during FY 2003. The average outpatient spent about four and one-half to five months in treatment while the average methadone maintained patient stayed one year in non-funded treatment and two years in ADAA-funded treatment.

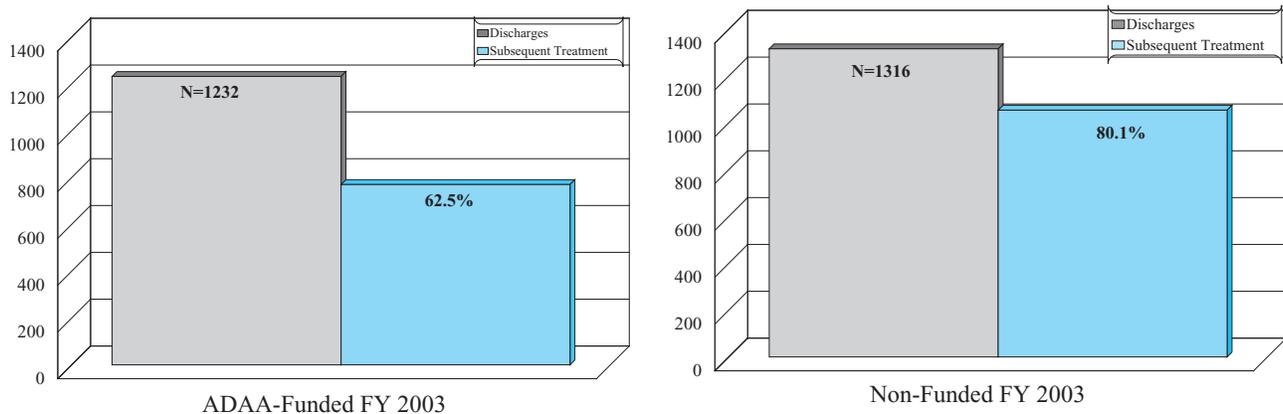
Continuum of Care

Similarly to retention in treatment, discussed previously, ensuring that patients move through a continuum of care encompassing different levels of services is an important ADAA objective for treatment providers. The treatment types most applicable to transfer or referral to subsequent treatment are non-hospital detox, from which patients usually move to ICF, and intensive outpatient, from which most patients are expected to move to traditional outpatient.

Figure 33 shows patients who were successfully discharged from non-hospital detox treatment during FY 2003, of which 63 and 80 percent were tracked to a subsequent treatment type through the first quarter of FY 2004. The great majority of these patients went on to intermediate care (ICF).

Subsequent Treatment in Another Modality for Successful Discharges from Non-Hospital Detox Treatment

Figure 33



Treatment Services

Certain information collected at discharge can be employed to describe some aspects of the content of treatment, beyond the treatment type. Data are collected on the number and type of counseling services delivered during the treatment episode. About 85 percent of patients from ADAA-funded treatment and about 73 percent of non-funded patients discharged during FY 2003 received individual counseling services. Traditional outpatients averaged about two sessions per month, while intensive outpatients averaged 2.8 for ADAA-funded and 5.2 for non-funded treatment. This unexpectedly low average for intensive outpatient suggests this category is inconsistently reported with regard to treatment type.

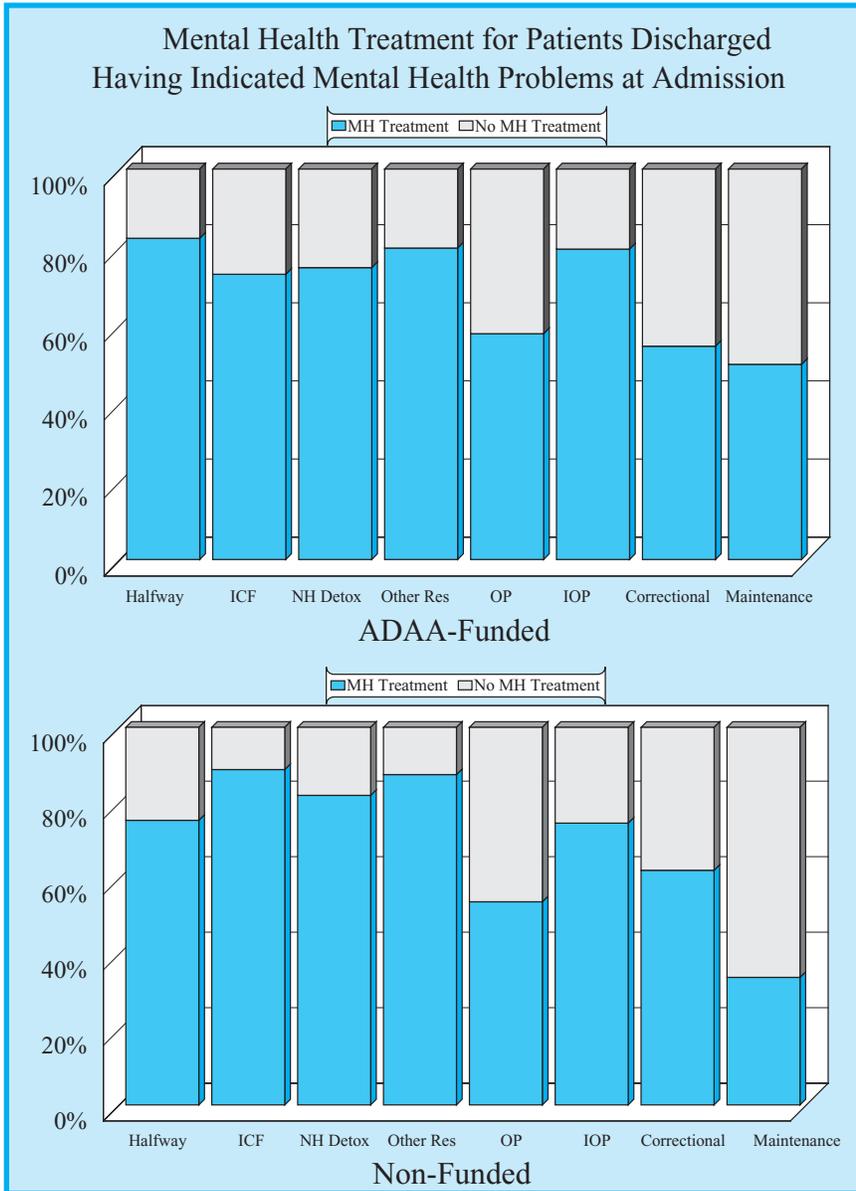
The majority of patients in both funded and non-funded treatment received group counseling. All treatment types provided both individual and group counseling with residential treatment providing the highest number of group sessions per patient. Only about 11 percent of patients in all treatment systems received family counseling, averaging 2.5 sessions a month.

Co-occurring Disorders

Figure 34

As shown in Figure 34, the great majority of patients assessed as having mental health problems at admission to any type of residential or intensive outpatient treatment received mental health treatment during their substance abuse treatment episodes. Half or more of ADAA-funded outpatient, prison/jail and maintenance patients with problems received treatment with non-funded programs only lagging behind in the area of mental health services to maintenance patients. This treatment may or may not have occurred within the substance abuse program. Studies have suggested that the co-occurrence of psychiatric and substance abuse problems often results in treatment failure if issues are not addressed in a coordinated and comprehensive manner.

In general patients in halfway house and other residential treatment types are more likely to receive mental health counseling for mental health problems identified at admission.



Co-occurring Disorder Facts

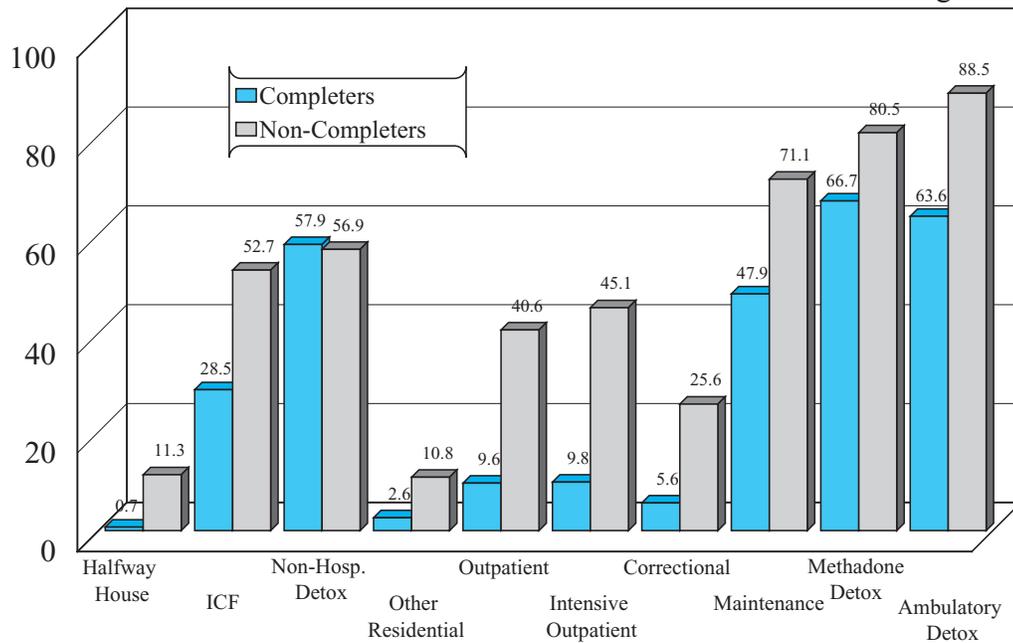


Seven to ten million individuals in the United States have at least one mental health disorder as well as an alcohol or drug use disorder (U.S. DHHS, 1999; SAMHSA National Advisory Council, 1998)

About 10 million adults each year enter U.S. jails. About 700,000 of these individuals have co-occurring disorders (From Co-occurring Mental and Substance Abuse Disorders: A Guide for Mental Health Planning and Advisory Councils (Adobe Acrobat PDF, 550 KB)

Average Percentage of Positive Urinalysis Tests by Treatment Type for ADAA-Funded Programs

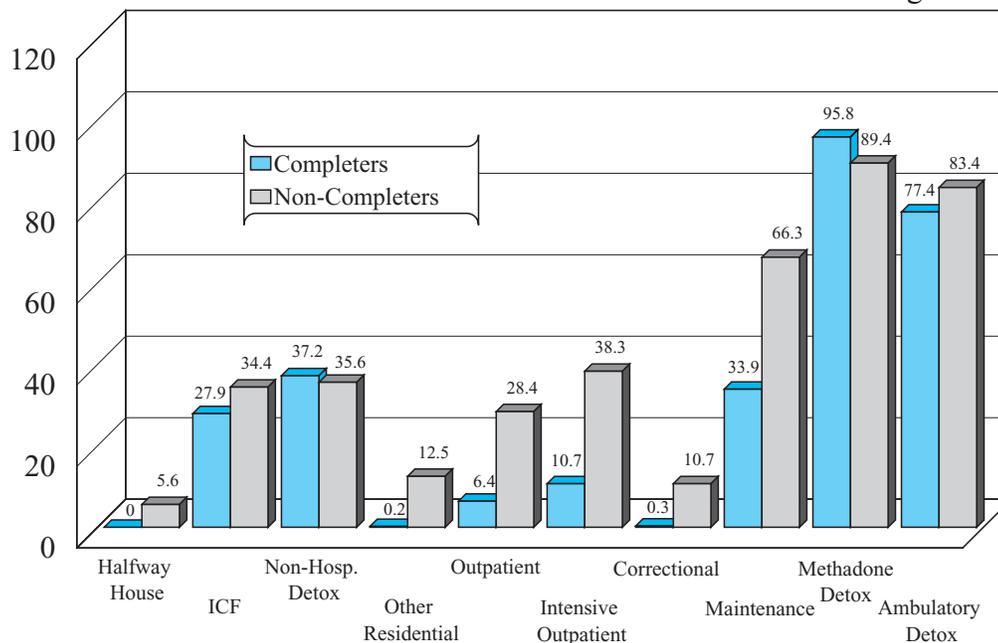
Figure 35



Figures 35 and 36 compare the average percentages of positive urinalysis tests for completers and non-completers of treatment. For all treatment types except non-hospital detox, higher levels of positive urinalysis results were associated with failure to complete treatment successfully.

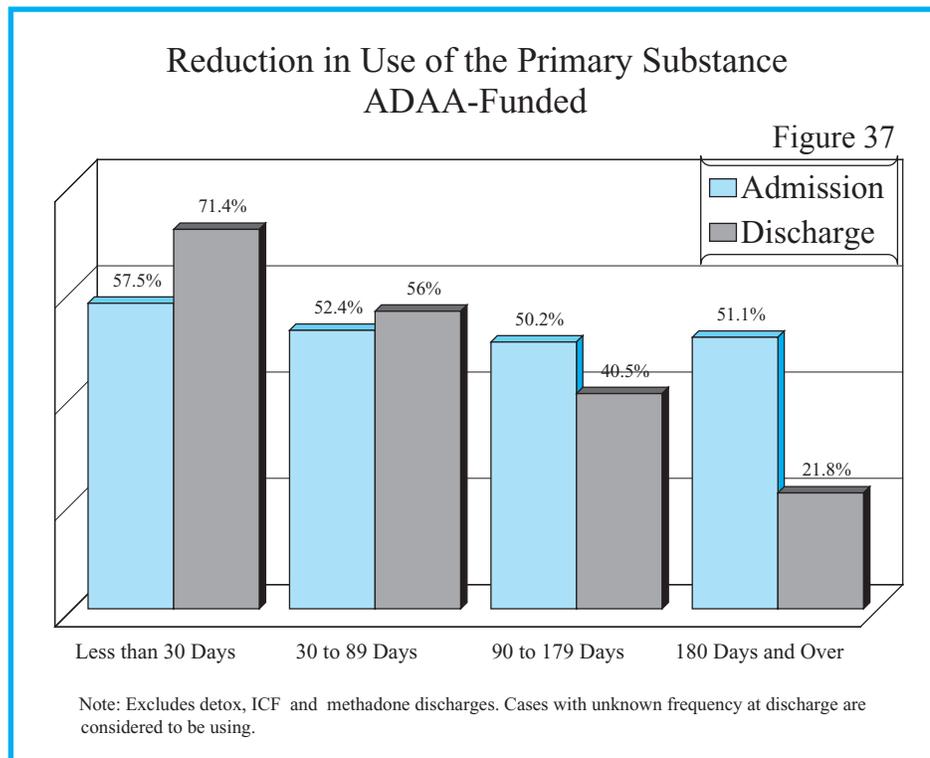
Average Percentage of Positive Urinalysis Tests by Treatment Type for Non-Funded Programs

Figure 36



Treatment Reduces Substance Use

Figure 37 shows that staying in ADAA-funded treatment less than 90 days was associated with increases in the percentage using at discharge. At 90 to 179 days the discharge percentage was ten points lower and at 180 days or more it was 30 points lower than the percentage at admission. Of those staying in treatment at least 180 days, only 22 percent were using the primary substance at discharge.

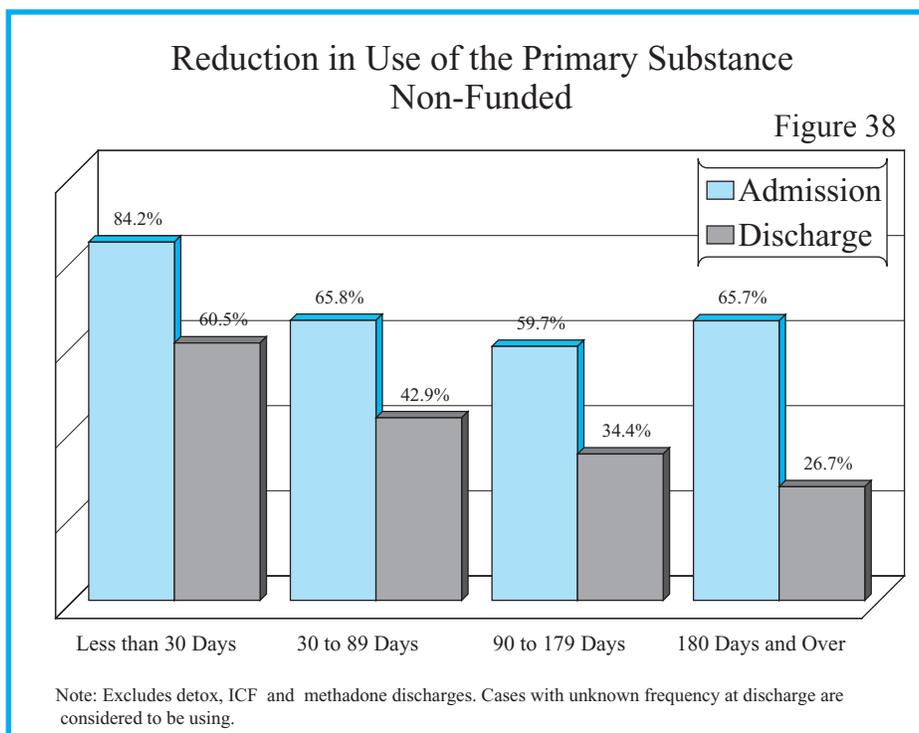


Strongly associated with time in treatment is completion of treatment; it follows that completion is associated with substantial reduction in frequency of use. Overall the reduction in days of use is 87 percent for treatment completers and 46 percent even for those who fail to complete treatment.

Figure 38 shows clearly that the longer an individual stays in non-funded treatment the less likely they are to be using the primary substance at discharge and the greater the reduction in use. Among those who stayed in treatment

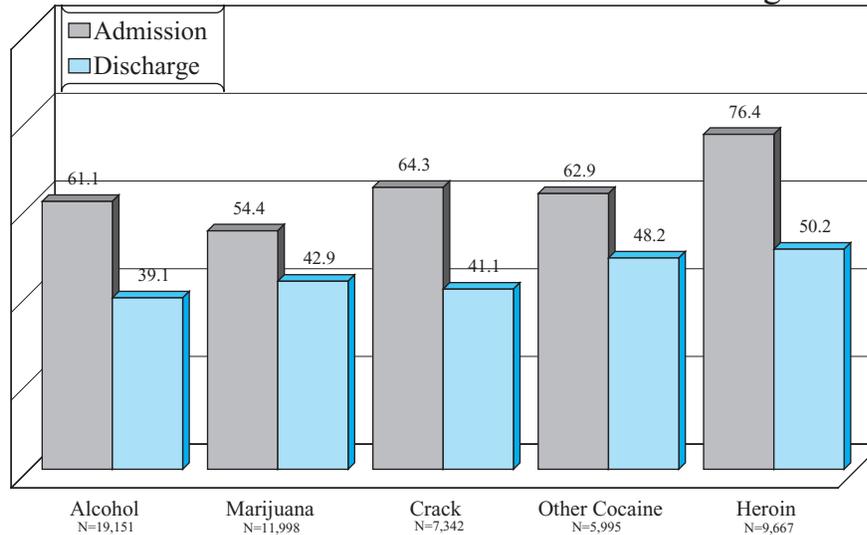
180 days or more, nearly two-thirds were using the primary substance at admission and only 27 percent were using during the month preceding discharge.

Cases where the frequency of use at discharge was reported as "unknown" are included with the cases where substance use at discharge was reported. This occurs because patients who leave treatment against clinical advice are typically reported as "substance use unknown."



Reduction in Use of Selected Substances ADAA Funded

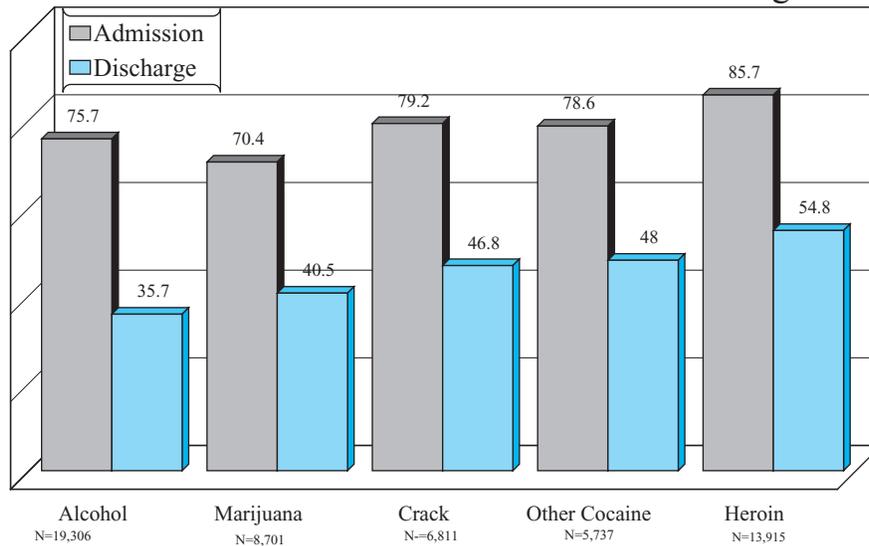
Figure 39



Note: Cases with unknown frequency at discharge are considered to be using.

Reduction in Use of Selected Substances Non-Funded

Figure 40



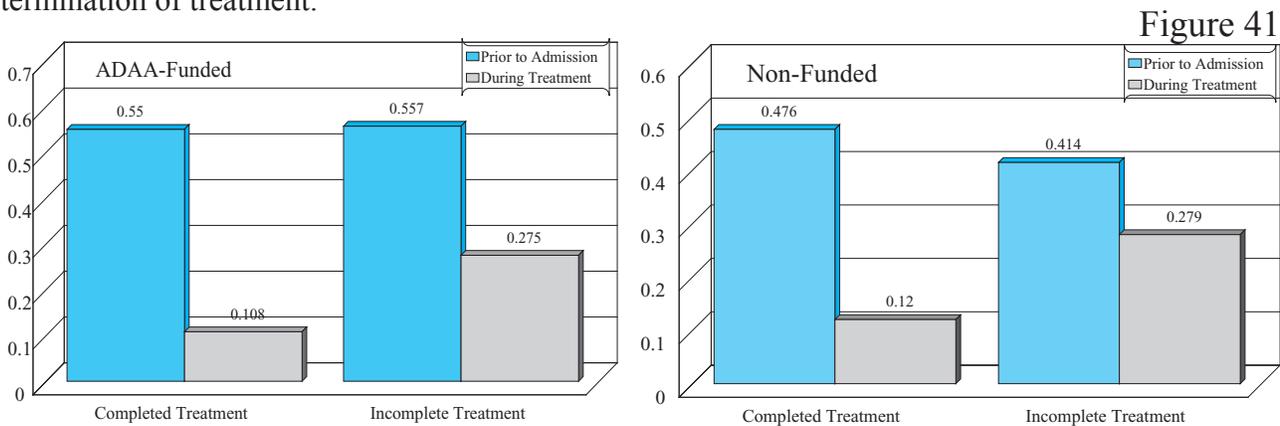
Note: Cases with unknown frequency at discharge are considered to be using.

The overall reductions in the numbers of discharged patients using selected substances at admission and at discharge are shown in Figures 39 and 40. The substance most likely to have been used at admission by problem cases during the month preceding admission was heroin (76.4 percent). Only 54.4 percent of marijuana-related admissions were reported to be using at admission, partly a reflection of the high proportion of criminal justice referrals among marijuana-related admissions. Also the higher percentage of younger patients probably contributes to less openness about use at admission. The largest reductions in percentages using occurred among crack and heroin cases, which had the highest levels of use at admission.

Treatment Reduces Crime

Aggregate arrest rates for the two years preceding treatment are compared to arrest rates during treatment for various types of treatment. Not surprisingly, the highest arrest rate before entry occurred in prison/jail treatment (1.08 funded and .831 non-funded). Non-funded residential treatment arrest rates were nearly as high (.733). With the exception of methadone maintenance, which had the lowest arrest rate at admission, ADAA-funded treatment types had rates ranging from .518 to .571. The residential treatment types had the sharpest reductions in arrest rates during treatment, but the rates for maintenance, outpatient and intensive outpatient fell 62, 56 and 47 percent respectively during treatment.

Completion of treatment further reduces crime. As Figure 41 shows, arrest rates were reduced by over 80 percent during treatment ending in completion and by about half in treatment ending unsuccessfully. Of course, arrests during treatment, like substance use, could be a direct contributor to administrative termination of treatment.

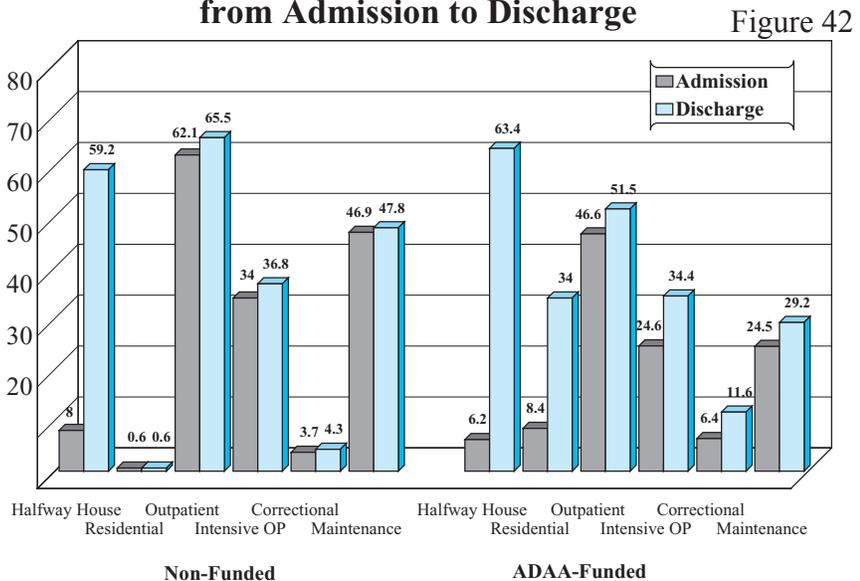


Treatment Increases Employment

Halfway houses are particularly effective in getting patients employed, as shown in Figure 42. The percentage employed increased ten-fold during halfway house treatment. Employment also increased in funded programs by 90 percent in other residential, over ten percent in outpatient, 40 percent in intensive outpatient and 19 percent in methadone maintenance.

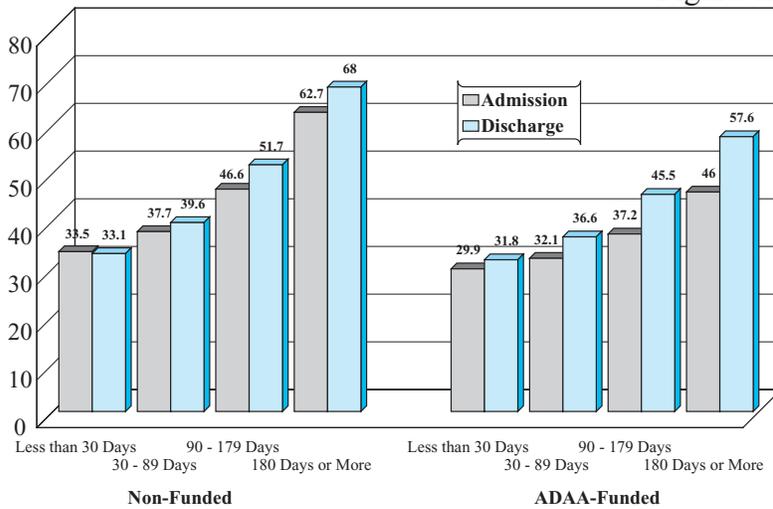
**Changes in Percentage Employed
from Admission to Discharge**

Length of stay in treatment is associated with both employment at admission and becoming employed during treatment. The employed are likely to stay in treatment longer, and the unemployed are more likely to become employed the longer they stay. Employment at admission ranges from about 30 percent of those who stayed less than 30 days to 46 percent of those who stayed over



Changes in Percentage Employed from Admission to Discharge

Figure 43



180 days or more. Increases in employment ranged from 6 percent for the former group to one-fourth for the latter.

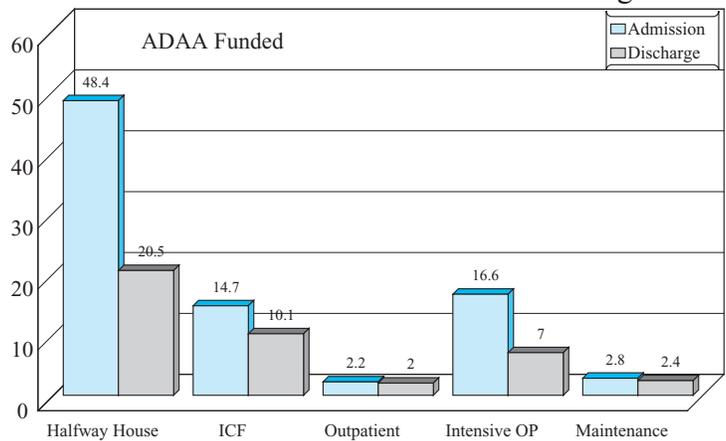
A similar phenomenon exists with respect to completion of treatment and employment. The percent employed at admission was higher for treatment completers, yet the increase in percentage employed during treatment was greater for them as well. Employment increased ten percent among non-completers and 30 percent among completers (Figure 43).

Treatment Correlates with Improved Living Situation

Figures 44 and 45 show that the percentages of homeless patients tend to drop during treatment of various types, and the percentages of patients living independently increase. In funded halfway houses and intensive outpatient treatment, the homeless percentages were more than halved. In outpatient and maintenance there were very small decreases from already small percentages.

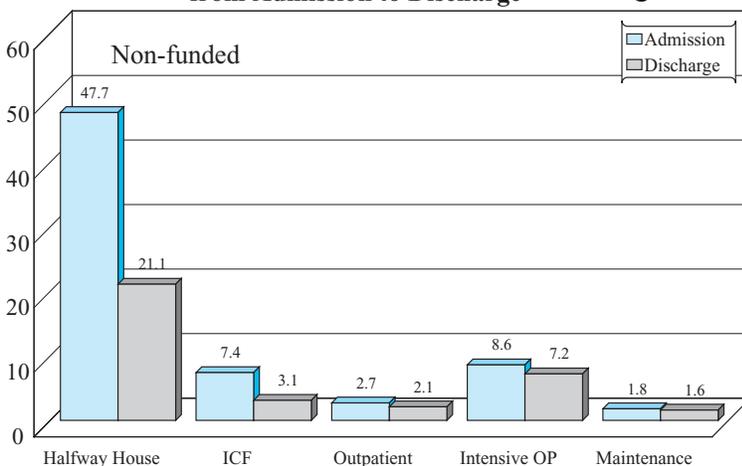
Changes in Percentage Homeless from Admission to Discharge

Figure 44



Changes in Percentage Homeless from Admission to Discharge

Figure 45



In halfway houses, the percentage living independently doubled, corresponding to the dramatic increases in employment observed above.

WHO DO WE SERVE?

ADOLESCENTS IN TREATMENT

Monitoring the Future National Results On Adolescent Drug Use⁴

Overview of Key Findings, 2003

More than half (54%) of students have tried cigarettes by the 12th grade.

Nearly four out of five students (77%) have consumed more than a few sips of alcohol by the end of high school, with half (46%) having used alcohol by 8th grade.

Fifty-eight percent of 12th graders and 20 percent of 8th graders have been drunk at least once in their life.

Fifty-one percent of students have used an illicit drug by the time they finish high school, with 30 percent having done so by 8th grade.

In 2003, the consistent decline in use of illicit substances other than marijuana by 8th graders over the past several years was halted.

Inhalant use by 8th graders significantly increased.

Reported use of both OxyContin and Vicodin increased slightly for all grade levels in 2003.

Overview of ADAA's Key Findings on Adolescent Substance Use

Below are key findings from FY 2003 ADAA SAMIS data related to treatment of adolescent substance use in Maryland:

- Eleven percent of ADAA-funded and 7 percent of non-funded patients admitted were under 18 at the time of admission.
- Over 80 percent of marijuana-related patients admitted to treatment in Maryland first used the drug during adolescence; nearly half first used when they were younger than 15.
- About 70 percent of patients admitted experienced their first alcohol intoxication before reaching the age of 18.
- Nearly 20 percent of all crack cocaine abusers and 27 percent of heroin abusers admitted to treatment during FY 2003 first became involved with those drugs before reaching the age of 18.
- Forty-four percent of all adolescents admitted to treatment had problems with alcohol and one drug, and in the vast majority of cases that drug was marijuana. In fact, the alcohol/marijuana combination appeared in 56 percent of all non-funded and 52 percent of all funded adolescent admissions.
- From FY 1999 to 2003 increases were observed in admissions related to other opiates and synthetics, marijuana, PCP, benzodiazepines and over-the counter drugs. Marijuana was involved in 89 percent of the FY 2003 admissions and alcohol in two-thirds.

⁴Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2004). Monitoring the future national results on adolescent drug use: Overview of key findings, 2003. (NIH Publication No. [04-5506].) Bethesda MD: National Institute on Drug Abuse.

Characteristics of Adolescent Admissions

Age

- ADAA-funded adolescent admissions tend to be younger than their non-funded counterparts; 21 percent of the former were under 15 compared with 12 percent of the latter (Figure 46)
- Over two-thirds of the non-funded admissions and 58 percent of the funded were 16 or 17 years of age.

Figure 46

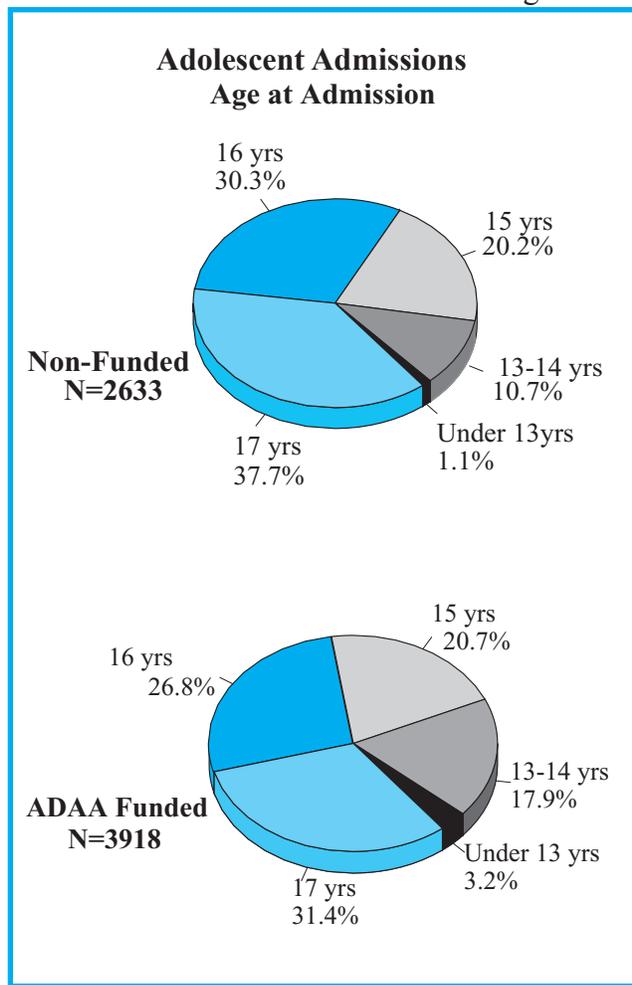
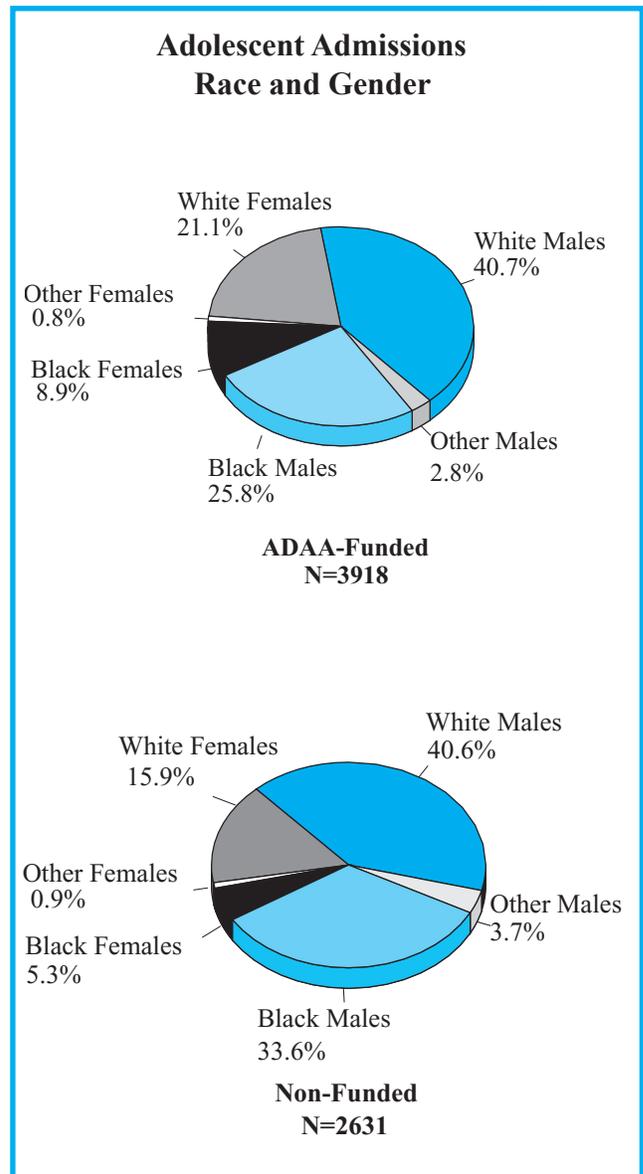


Figure 47



Gender and Race

- ADAA-funded adolescent admissions were more likely to be females and less likely to be black males (Figure 47).
- One-third of non-funded adolescents admitted were black males. White males comprised 41 percent of both funded and non-funded admissions.

Health and Education Issues

- Thirty percent of non-funded adolescents admitted were assessed as having mental health problems compared to 27 percent of funded admissions.
- Fifty-nine percent of non-funded adolescent patients admitted were tobacco users versus nearly 50 percent of funded admissions.
- ADAA-funded adolescent patients admitted were more than twice as likely to have no health coverage.
- Both sectors have considerable proportions of school drop-outs.

Source of Referral to Treatment

- Nearly 45 percent of adolescents of both funded and non-funded programs were referred to treatment through the juvenile justice system, as shown in Figure 48.
- Funded admissions were considerably more likely to come through school referral and less likely to come from other treatment or health care providers. This, in large part, may be due to the number of funded programs that collaborate with the Maryland Department of Education in Student Assistance Programs (MSAP). MSAP counselors are provided by local funded treatment programs to assist schools with assessment and referral services for youth identified by the school for suspected substance use problems.

County of Residence

- The reported residence locations of adolescent admissions are shown in appendix Table D. The subdivisions in which non-funded admissions predominated were Anne Arundel, Howard, Montgomery and Prince George's counties.
- ADAA-funded admissions were 80 percent or more of the total adolescent admissions in Allegany, Caroline, Cecil, Dorchester, Garrett, Kent, Queen Anne's, St. Mary's, Somerset, Talbot and Worcester counties.

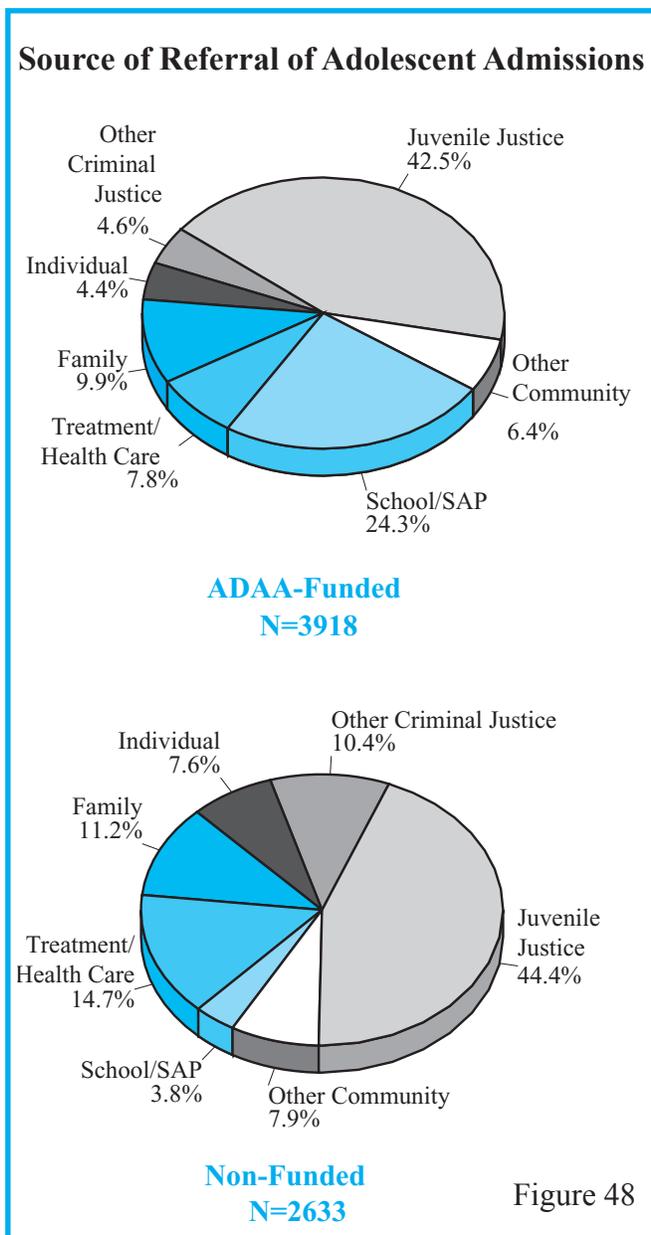


Figure 48

Patterns of Adolescent Substance Abuse Problems

- From FY 2000 to 2003 increases were observed in admissions of adolescents with problems related to other opiates and synthetics (nearly ten-fold), PCP (nearly six-fold), benzodiazepines (five-fold) and over-the-counter drugs (ten-fold), with marijuana staying relatively consistent.
 - Nearly 14 percent of funded adolescent admissions involved no drugs, and these are primarily cases of adolescents at high risk of developing substance abuse problems due to one or more parent abusing substances.
- These adolescents may be admitted to treatment despite having no current dysfunction related to substance abuse.
- Inhalant mentions have increased over the past two years from 0.6 percent in 2001 to one percent in 2003. This might support an emerging trend identified in the Monitoring the Future Report (Johnson et al, 2004).

Table 9 below shows the four year data (FY 2000-2003) on substance use mentions among ADAA-funded and non-funded adolescent admissions.

Table 9

Substance Problem Mentions for Adolescent Admissions - FY 2000 - FY 2003								
Substance Problem Mentions	FY 2000		FY 2001		FY 2002		FY 2003	
	#	%	#	%	#	%	#	%
Heroin	309	6	254	4	267	4	306	5
Non-Rx Methadone	3	0	6	0	6	0	7	0
Other Opiates	23	0	84	1	149	2	227	4
Alcohol	3847	72	4169	71	4137	69	3970	67
Barbiturates	6	0	5	0	8	0	11	0
Other Sedatives	16	0	21	0	23	0	21	0
Hallucinogens	197	4	324	6	302	5	248	4
Crack	115	2	91	2	114	2	113	2
Other Cocaine	171	3	165	3	206	3	290	5
Marijuana	4707	88	5158	88	5359	89	5323	89
Methamphetamines	18	0	19	0	46	1	31	1
Other Amphetamines	30	1	41	1	58	1	69	1
Inhalants	34	1	37	1	47	1	62	1
PCP	17	0	31	1	57	1	93	2
Other Stimulants	16	0	20	0	35	1	31	1
Benzodiazepines	8	0	14	0	32	1	42	1
Other Tranquilizers	6	0	4	0	8	0	7	0
Over the Counter	3	0	10	0	19	0	32	1
Steroids	11	0	2	0	8	0	11	0
Other	10	0	15	0	30	0	51	1

Note: Up to three substance problems may be reported for each respondent.

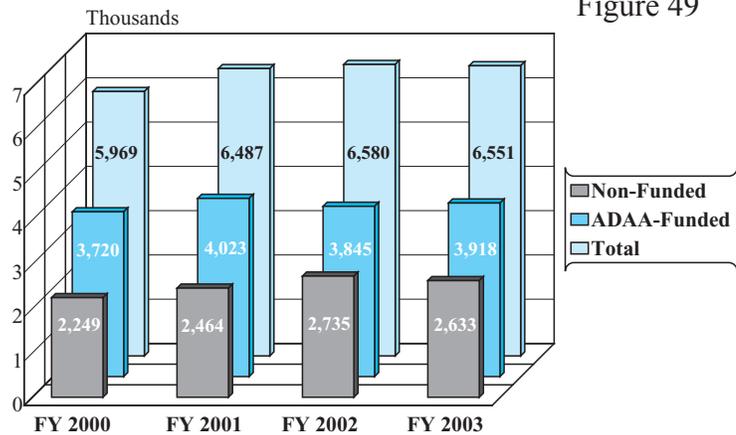
Characteristics of Adolescent Treatment

Admissions Increase

Figure 49 demonstrates there has been an increase in adolescent admissions over the past four years. Non-funded admissions show a cyclical trend, dipping in FY 2000, expanding in FY 2001 and 2002, declining again in FY 2003, culminating in a nine percent increase over the four years. The pattern for ADAA-funded admissions is similar; increases occur in FY 2001 and 2003 for a four percent increase overall.

**Adolescent Admissions:
FY 1999 - FY 2003**

Figure 49



Distributions by Treatment Type

It is difficult to compare funded to non-funded treatment of adolescents in terms of treatment type because of the disparities in the availability of treatment levels in the funded and non-funded treatment systems. For example, over 90 percent of the ADAA-funded admissions in FY 2003 were to outpatient services compared to 30 percent of non-funded admissions. However, non-funded admissions double (60 percent) when you factor in intensive outpatient treatment, a level of treatment rarely offered for adolescents by funded programs. In addition, both methadone and non-hospital detox treatment services for adolescents are available through non-funded programs but are generally not offered in any funded programs.

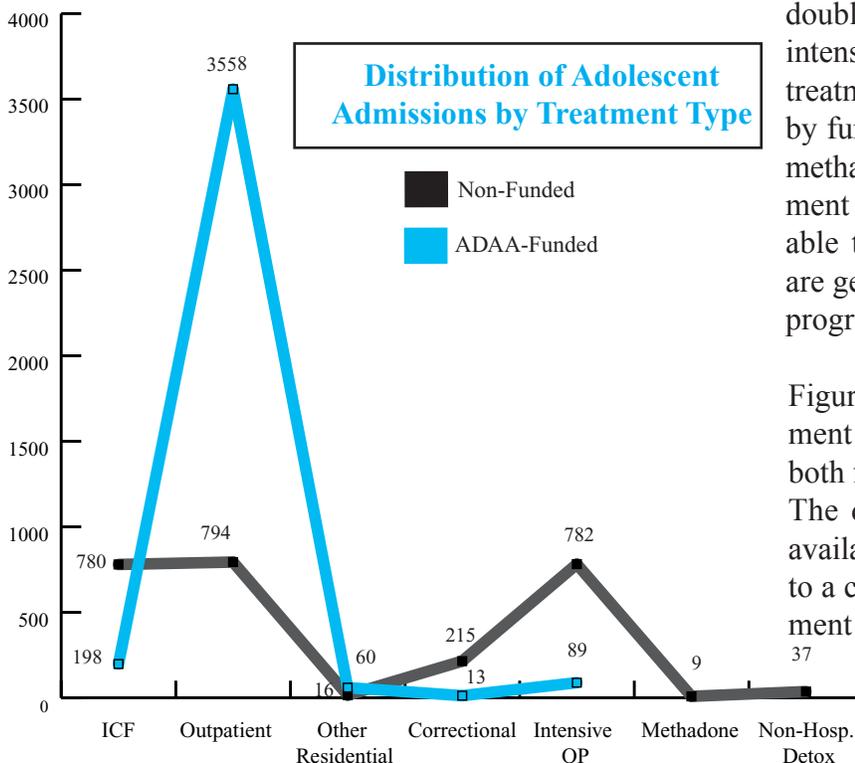


Figure 50 compares the types of treatment available for adolescents through both funded and non-funded providers. The data clearly show that increased availability of treatment types correlates to a consistent distribution of the treatment population.

Figure 50

Adolescent Treatment Outcomes

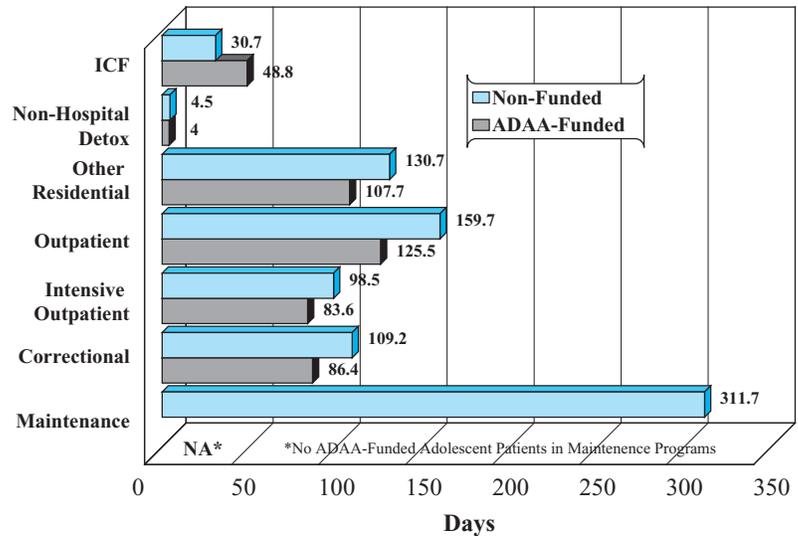
Length of Stay in Treatment

On average, non-funded adolescent patients stayed longer in treatment, with the exception of intermediate care facilities. In this case average lengths of stay in Other Residential and Outpatient treatment were a month longer for non-funded patients.

For the most populated treatment type, outpatient, non-funded patients averaged 160 days compared to funded treatment stays of 126 days. Treatment types IOP, Non-Hospital Detox, and Other Residential had longer average stays, however disparities in availability of treatment type or level across funded and non-funded networks may account for some of the length of stay variance (Figure 51).

Adolescent Average Length of Stay by Treatment Type

Figure 51



Discharge Characteristics

Approximately 40 percent of ADAA-funded adolescent patients discharged completed treatment successfully without need for further treatment and 6 percent completed treatment with referral or transfer for further treatment (Figure 52). In the non-funded network only 18 percent completed successfully while 41 percent completed a phase of treatment with referral or transfer to another treatment type. This reflects the difference in treatment categories noted above: over 90 percent of funded adolescent treatment involved traditional outpatient counseling whereas over 60 percent of non-funded adolescent treatment was intensive outpatient or residential. Also, funded patients were nearly twice as likely to leave treatment against clinical advice.

Figure 52

Adolescent Discharges: Reason for Discharge

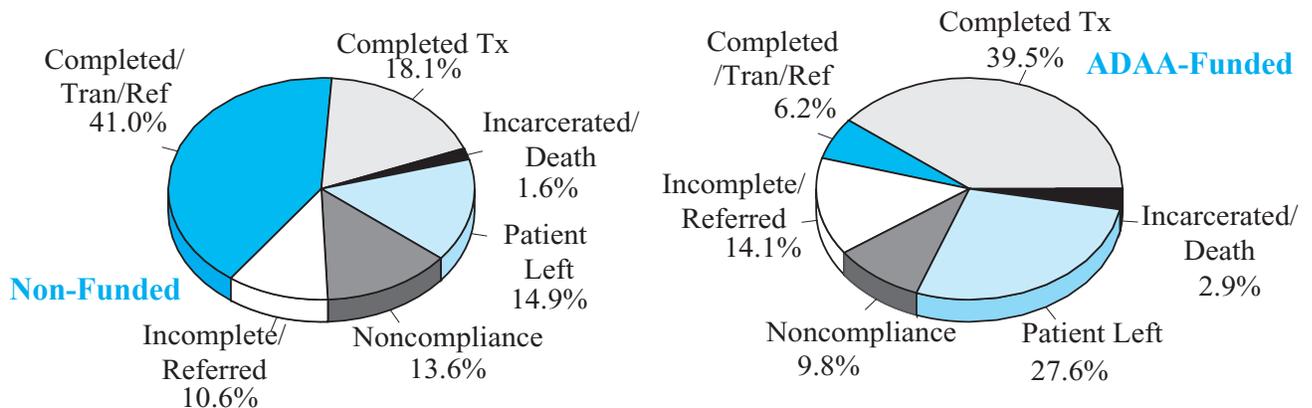
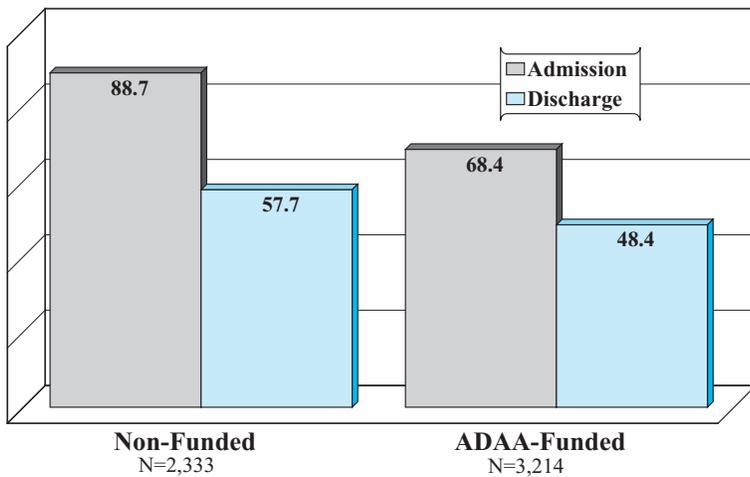


Figure 53

Reduction in Use of the Primary Substance



Note: Cases with unknown frequency at discharge are considered to be using. High-risk youth and family members are excluded.

Substance Use One Month Prior To Discharge Vs. One Month Prior To Admission

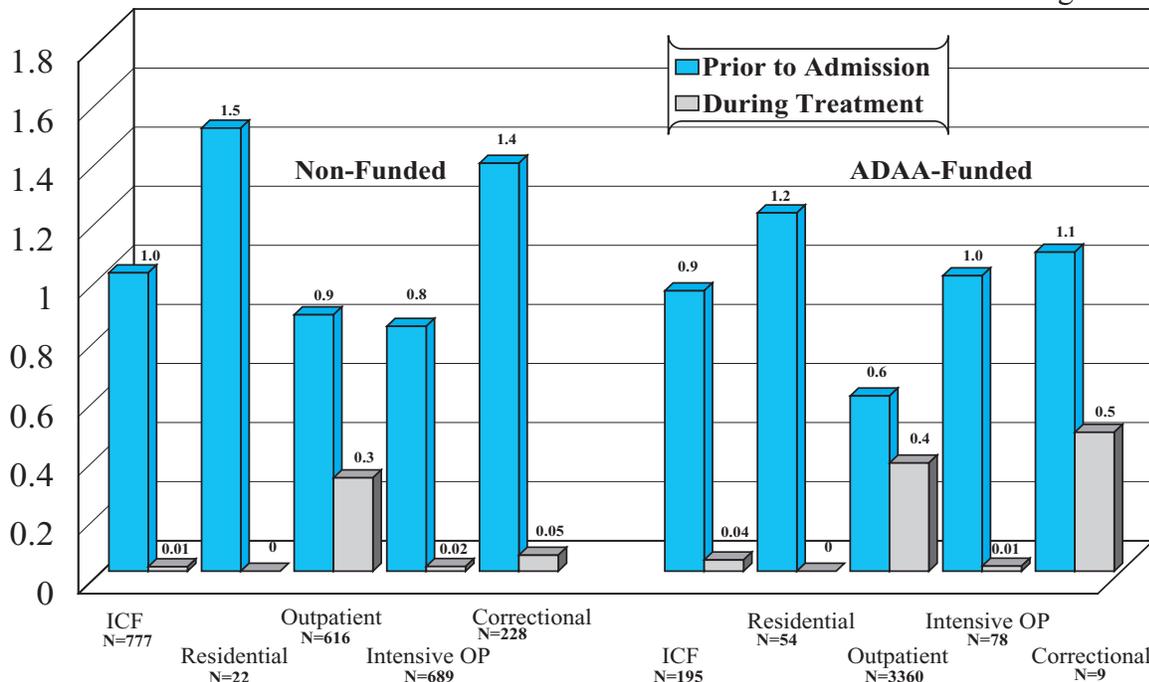
Nearly 90 percent of non-funded discharged patients were using the primary substance in the month preceding admission, and 58 percent were using in the month prior to discharge, reflecting a 35 percent improvement. The respective figures for ADAA-funded patients were 68 and 43 percent, and an improvement of 29 percent.

Arrest Rates Two Years Prior To Admission vs. Arrest Rates During Treatment

Figure 54 compares arrest rates during the two years preceding treatment to arrest rates during treatment for the major categories of non-funded and ADAA-funded treatment. Pre-treatment arrest rates were close to or exceeded 1.0 in most types of adolescent treatment. Rates were sharply reduced almost across the board during adolescent treatment.

Adolescent Arrest Rates Prior to and During Treatment

Figure 54



Appendix

**Table A: Admissions to Maryland Treatment Programs
by Treatment Type
FY 2000 - FY 2003**

Non-Funded								
Treatment Type	FY 2000		FY 2001		FY 2002		FY 2003	
	#	%	#	%	#	%	#	%
Halfway House	139	0	160	0	127	0	213	1
Intermediate Care	4461	14	4749	14	5382	15	5753	14
Non-Hospital Detox	995	3	1178	3	1427	4	1855	5
Hospital Detox	7	0	223	1	305	1	265	1
Hospital Inpatient	294	1	272	1	263	1	241	1
Other Residential	614	2	604	2	338	1	185	0
Outpatient	12003	38	13720	40	13357	37	13491	34
Intensive Outpatient	5921	19	5941	17	7150	20	8258	21
Prison/Jail	3195	10	2742	8	2598	7	2575	6
Methadone Detox	133	0	59	0	15	0	435	1
Methadone Maint.	3289	10	3264	9	3640	10	4321	11
Ambulatory Detox	729	2	1664	5	1588	4	2255	6
Total	31780	100	34576	100	36190	100	39847	100
ADAA-Funded								
Treatment Type	FY 2000		FY 2001		FY 2002		FY 2003	
	#	%	#	%	#	%	#	%
Halfway House	586	2	571	2	673	2	659	2
Intermediate Care	4170	15	4574	15	4971	14	4658	13
Non-Hospital Detox	856	3	1156	4	2120	6	1948	6
Other Residential	767	3	739	2	725	2	879	3
Outpatient	15362	54	16310	54	18528	53	18428	53
Intensive Outpatient	1911	7	2067	7	2249	6	2765	8
Prison/Jail	1183	4	1239	4	1812	5	1822	5
Methadone Detox	724	3	455	2	457	1	447	1
Methadone Maint.	2789	10	2741	9	2951	8	2883	8
Ambulatory Detox	150	1	334	1	308	1	363	1
Total	28498	100	30186	100	34794	100	34852	100

**Table B: Admissions to ADAA-Funded
Treatment Programs by Substance Mentions
FY 2000 - FY 2003**

Substance Mentions	FY 2000		FY 2001		FY 2002		FY 2003	
	#	%	#	%	#	%	#	%
Heroin	8427	31	9075	31	11045	33	11162	33
Non-Rx Methadone	105	0	75	0	106	0	103	0
Other Opiates & Synthetics	400	1	566	2	1019	3	1115	3
Alcohol	16532	60	17241	59	20683	61	20504	60
Barbiturates	59	0	51	0	75	0	77	0
Other Sedatives & Hypnotics	115	0	146	0	167	0	202	1
Other Tranquilizers	14	0	24	0	17	0	30	0
Hallucinogens	245	1	416	1	445	1	458	1
Crack	6878	25	7115	24	8853	26	7896	23
Other Cocaine	4108	15	4438	15	5312	16	6835	20
Marijuana/Hashish	9293	34	10445	36	12495	37	13077	38
Methamphetamines	61	0	76	0	123	0	136	0
Other Amphetamines	73	0	84	0	125	0	144	0
Other Stimulants	30	0	24	0	28	0	35	0
Inhalants	49	0	36	0	37	0	66	0
PCP	169	1	206	1	340	1	490	1
Benzodiazepines	127	0	191	1	356	1	300	1
Over the Counter	11	0	16	0	20	0	25	0
Steroids	21	0	13	0	14	0	21	0
Other	22	0	21	0	48	0	69	0
Total Respondents	27503		29270		33922		34001	

**Table C: Admissions to Non-Funded
Treatment Programs by Substance Mentions
FY 2000 - FY 2003**

Substance Mentions	FY 2000		FY 2001		FY 2002		FY 2003	
	#	%	#	%	#	%	#	%
Heroin	11537	37	12021	35	13171	37	16238	41
Non-Rx Methadone	132	0	108	0	176	0	202	1
Other Opiates & Synthetics	1047	3	1660	5	2288	6	2638	7
Alcohol	18314	58	20127	58	20831	58	21667	55
Barbiturates	87	0	70	0	66	0	94	0
Other Sedatives & Hypnotics	107	0	133	0	266	1	402	1
Other Tranquilizers	27	0	55	0	26	0	26	0
Hallucinogens	218	1	362	1	327	1	353	1
Crack	6100	19	6240	18	6979	19	7798	20
Other Cocaine	4814	15	4990	14	5167	14	6717	17
Marijuana/Hashish	7650	24	9187	27	9400	26	9903	25
Methamphetamines	43	0	59	0	83	0	112	0
Other Amphetamines	61	0	75	0	99	0	102	0
Other Stimulants	16	0	19	0	50	0	70	0
Inhalants	35	0	41	0	46	0	49	0
PCP	193	1	324	1	423	1	540	1
Benzodiazepines	505	2	543	2	655	2	729	2
Over the Counter	11	0	11	0	27	0	36	0
Steroids	18	0	12	0	11	0	55	0
Other	32	0	52	0	70	0	112	0
Total Respondents	31568		34422		36069		39711	

**Table D: Adolescent Admissions to Maryland Treatment Programs by Residence
FY 2000 - FY 2003**

Location of Residence	Non-Funded		ADAA-Funded		Total	
	#	%	#	%	#	%
Allegany	13	6	204	94	217	100
Anne Arundel	369	79	99	21	468	100
Baltimore City	578	46	684	54	1,262	100
Baltimore County	415	44	521	56	936	100
Calvert	27	21	100	79	127	100
Caroline	10	11	79	89	89	100
Carroll	60	29	146	71	206	100
Cecil	14	7	175	93	189	100
Charles	59	27	160	73	219	100
Dorchester	12	12	90	88	102	100
Frederick	94	33	189	67	283	100
Garrett	3	6	48	94	51	100
Harford	75	24	237	76	312	100
Howard	119	54	100	46	219	100
Kent	1	2	61	98	62	100
Montgomery	360	68	173	32	533	100
Prince George's	141	58	103	42	244	100
Queen Anne's	14	16	74	84	88	100
St. Mary's	16	8	175	92	191	100
Somerset	3	6	49	94	52	100
Talbot	8	8	96	92	104	100
Washington	45	22	157	78	202	100
Wicomico	62	43	81	57	143	100
Worcester	16	14	97	86	113	100
Out-of-State	119	86	20	14	139	100
Total	2,633	40	3,918	60	6,551	100

**Table E: Admissions to Maryland
Treatment Programs by Residence
FY 2000 - FY 2003**

Non-Funded

Location of Residence	FY 2000	FY 2001	FY 2002	FY 2003
Allegany	86	90	71	75
Anne Arundel	4,017	4,929	5,024	4,788
Baltimore City	10,879	10,929	11,596	14,345
Baltimore County	3,911	4,091	4,672	5,229
Calvert	277	339	379	352
Caroline	80	86	85	75
Carroll	686	728	729	832
Cecil	352	431	402	388
Charles	392	359	361	287
Dorchester	87	103	77	95
Frederick	1,062	1,075	1,118	1,140
Garrett	12	14	17	14
Harford	1,074	1,000	1,302	1,573
Howard	946	905	888	1,011
Kent	24	47	43	68
Montgomery	2,377	3,029	2,615	2,984
Prince George's	1,901	2,310	2,321	2,309
Queen Anne's	104	138	155	149
St. Mary's	186	159	162	122
Somerset	54	86	75	63
Talbot	83	101	132	167
Washington	536	616	469	659
Wicomico	524	548	488	479
Worcester	176	190	212	208
Out-of-State	1,914	2,248	2,778	2,406
Total	31,740	34,551	36,171	39,818

ADAA-Funded

Location of Residence	FY 2000	FY 2001	FY 2002	FY 2003
Allegany	663	604	664	759
Anne Arundel	834	911	1,063	1,012
Baltimore City	8,005	8,704	10,512	10,561
Baltimore County	2,928	2,916	2,989	3,074
Calvert	649	632	858	785
Caroline	348	386	423	457
Carroll	973	972	1,005	999
Cecil	603	700	923	1,076
Charles	783	911	1,084	1,204
Dorchester	479	528	563	614
Frederick	942	1,082	1,112	1,138
Garrett	297	258	281	326
Harford	863	889	973	924
Howard	681	683	649	628
Kent	324	344	392	370
Montgomery	1,988	1,909	2,527	2,404
Prince George's	1,750	1,820	2,018	2,069
Queen Anne's	501	417	423	447
St. Mary's	684	993	1,286	1,050
Somerset	413	530	404	427
Talbot	614	531	522	538
Washington	975	1,089	1,356	1,130
Wicomico	1,066	1,112	1,311	1,367
Worcester	732	831	917	868
Out-of-State	388	433	535	623
Total	28,483	30,185	34,790	34,850

**Table F: Heroin Related Admissions
to Treatment Programs by Residence
FY 2000 - FY 2003**

Non-Funded

Location of Residence	FY 2000	FY 2001	FY 2002	FY 2003
Allegany	19	22	22	26
Anne Arundel	755	934	1,036	1,154
Baltimore City	7,265	7,357	7,743	10,053
Baltimore County	1,538	1,558	1,887	2,276
Calvert	20	16	36	27
Caroline	8	24	16	7
Carroll	194	201	207	269
Cecil	119	125	167	147
Charles	38	28	42	36
Dorchester	9	8	10	11
Frederick	88	92	136	137
Garrett	2	3	0	2
Harford	292	257	365	459
Howard	254	233	210	254
Kent	3	6	8	25
Montgomery	263	266	252	280
Prince George's	211	267	238	275
Queen Anne's	9	12	22	26
St. Mary's	12	14	12	9
Somerset	5	9	6	11
Talbot	10	13	13	31
Washington	61	67	40	70
Wicomico	17	24	19	20
Worcester	8	9	10	11
Out-of-State	308	443	640	585
Total	11,508	11,988	13,137	16,201

ADAA-Funded

Location of Residence	FY 2000	FY 2001	FY 2002	FY 2003
Allegany	31	36	68	72
Anne Arundel	354	446	492	475
Baltimore City	5,711	6,063	7,435	7,194
Baltimore County	791	846	919	970
Calvert	13	18	40	37
Caroline	10	13	14	21
Carroll	238	228	290	248
Cecil	84	69	119	217
Charles	26	24	32	38
Dorchester	16	15	16	24
Frederick	66	99	140	162
Garrett	6	6	6	5
Harford	88	128	209	191
Howard	168	170	158	131
Kent	17	11	18	17
Montgomery	275	285	283	270
Prince George's	266	249	296	376
Queen Anne's	14	32	43	90
St. Mary's	10	28	50	53
Somerset	30	54	55	74
Talbot	29	32	46	40
Washington	38	35	84	68
Wicomico	60	82	97	176
Worcester	35	46	47	81
Out-of-State	41	57	80	126
Total	8,417	9,072	11,037	11,156

**Table G: Alcohol Admissions
to Treatment Programs by Residence
FY 2000 - FY 2003**

Non-Funded

Location of Residence	FY 2000	FY 2001	FY 2002	FY 2003
Allegany	58	55	39	45
Anne Arundel	2,818	3,394	3,379	3,114
Baltimore City	3,833	3,792	4,386	5,016
Baltimore County	2,197	2,300	2,620	2,746
Calvert	232	264	311	294
Caroline	61	54	60	58
Carroll	440	465	453	531
Cecil	213	240	188	167
Charles	286	270	236	187
Dorchester	64	80	52	69
Frederick	875	874	871	862
Garrett	9	8	13	9
Harford	728	679	870	1,022
Howard	593	586	558	622
Kent	15	29	24	24
Montgomery	1,803	2,399	2,000	2,276
Prince George's	1,417	1,655	1,664	1,640
Queen Anne's	77	113	113	98
St. Mary's	152	130	132	99
Somerset	44	62	58	46
Talbot	65	74	99	119
Washington	405	461	371	487
Wicomico	428	436	386	371
Worcester	146	162	180	179
Out-of-State	1,321	1,525	1,751	1,571
Total	18,280	20,107	20,814	21,652

ADAA-Funded

Location of Residence	FY 2000	FY 2001	FY 2002	FY 2003
Allegany	502	440	480	543
Anne Arundel	355	391	514	476
Baltimore City	2,213	2,562	3,456	3,643
Baltimore County	1,697	1,645	1,693	1,730
Calvert	539	529	702	634
Caroline	289	287	326	352
Carroll	564	550	568	566
Cecil	400	471	645	737
Charles	675	781	965	1,060
Dorchester	324	331	412	442
Frederick	741	797	833	833
Garrett	234	222	253	269
Harford	681	614	629	652
Howard	432	419	417	432
Kent	231	260	268	272
Montgomery	1,371	1,188	1,842	1,766
Prince George's	1,111	1,145	1,336	1,302
Queen Anne's	375	338	321	308
St. Mary's	498	745	1,052	827
Somerset	340	407	322	316
Talbot	446	408	368	370
Washington	765	868	1,102	874
Wicomico	805	830	990	1,012
Worcester	615	684	766	687
Out-of-State	316	318	409	397
Total	16,519	17,230	20,669	20,500

**Table H: Powder Cocaine Related Admissions to Treatment Programs by Residence
FY 2000 - FY 2003**

Non-Funded

Location of Residence	FY 2000	FY 2001	FY 2002	FY 2003
Allegany	23	22	10	19
Anne Arundel	979	1,129	1,192	1,300
Baltimore City	5,421	5,214	5,958	7,716
Baltimore County	1,191	1,182	1,420	1,745
Calvert	74	71	81	72
Caroline	20	27	29	21
Carroll	161	156	139	190
Cecil	72	53	63	69
Charles	97	83	91	68
Dorchester	36	55	38	45
Frederick	174	180	205	237
Garrett	2	3	1	5
Harford	260	192	291	376
Howard	185	168	167	181
Kent	12	15	13	15
Montgomery	560	743	574	651
Prince George's	578	783	760	694
Queen Anne's	32	29	34	37
St. Mary's	34	31	32	32
Somerset	18	34	17	20
Talbot	28	43	39	69
Washington	220	242	130	195
Wicomico	178	147	135	134
Worcester	44	46	48	44
Out-of-State	492	551	654	555
Total	10,891	11,199	12,121	14,490

ADAA-Funded

Location of Residence	FY 2000	FY 2001	FY 2002	FY 2003
Allegany	66	58	89	108
Anne Arundel	399	434	530	511
Baltimore City	4,105	4,412	5,633	5,851
Baltimore County	889	876	1,043	1,048
Calvert	114	111	171	250
Caroline	75	129	113	141
Carroll	225	228	306	315
Cecil	169	187	255	340
Charles	206	243	330	371
Dorchester	230	237	272	286
Frederick	344	380	397	424
Garrett	17	13	16	43
Harford	169	196	214	219
Howard	223	212	245	197
Kent	122	102	113	123
Montgomery	1,065	1,011	1,025	924
Prince George's	771	813	977	1,013
Queen Anne's	124	122	128	139
St. Mary's	132	247	391	388
Somerset	139	189	135	170
Talbot	215	162	168	163
Washington	278	299	430	391
Wicomico	476	450	579	696
Worcester	242	246	349	336
Out-of-State	174	184	244	279
Total	10,969	11,541	14,153	14,726

**Table I: Marijuana Related Admissions
to Treatment Programs by Residence
FY 2000 - FY 2003**

Non-Funded

Location of Residence	FY 2000	FY 2001	FY 2002	FY 2003
Allegany	24	35	18	26
Anne Arundel	1,444	1,799	1,836	1,578
Baltimore City	1,792	1,848	1,902	2,168
Baltimore County	798	1,036	1,152	1,257
Calvert	70	126	125	136
Caroline	25	27	29	28
Carroll	170	189	177	229
Cecil	66	106	64	73
Charles	119	113	133	118
Dorchester	30	38	24	27
Frederick	357	366	374	348
Garrett	4	6	10	6
Harford	257	231	289	429
Howard	238	197	227	293
Kent	8	13	16	8
Montgomery	716	1,004	865	913
Prince George's	639	828	873	918
Queen Anne's	26	45	51	37
St. Mary's	63	45	57	47
Somerset	25	42	28	15
Talbot	23	23	38	43
Washington	193	275	180	267
Wicomico	190	242	241	219
Worcester	74	65	68	73
Out-of-State	291	475	618	639
Total	7,642	9,174	9,395	9,895

ADAA-Funded

Location of Residence	FY 2000	FY 2001	FY 2002	FY 2003
Allegany	322	308	302	384
Anne Arundel	192	220	257	284
Baltimore City	1,266	1,604	2,051	2,335
Baltimore County	1,065	1,070	1,127	1,181
Calvert	310	290	412	390
Caroline	154	200	220	268
Carroll	441	484	471	428
Cecil	239	256	391	469
Charles	299	353	496	591
Dorchester	207	267	343	336
Frederick	443	528	560	537
Garrett	130	154	145	146
Harford	504	462	493	445
Howard	278	286	287	289
Kent	138	152	205	177
Montgomery	585	549	849	910
Prince George's	572	672	758	853
Queen Anne's	254	188	201	211
St. Mary's	218	396	591	423
Somerset	147	206	210	221
Talbot	241	208	224	240
Washington	470	593	682	601
Wicomico	423	473	594	679
Worcester	277	358	416	400
Out-of-State	110	165	205	275
Total	9,285	10,442	12,490	13,073

**Table J: Crack Related Admissions to
Treatment Programs by Residence
FY 2000 - FY 2003**

Non-Funded

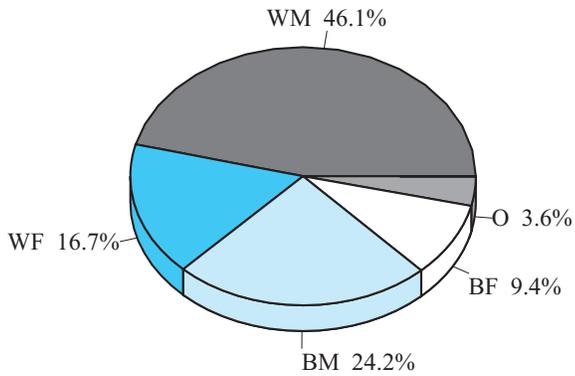
Location of Residence	FY 2000	FY 2001	FY 2002	FY 2003
Allegany	9	14	7	10
Anne Arundel	636	686	679	717
Baltimore City	2,701	2,655	3,338	4,321
Baltimore County	540	542	671	719
Calvert	57	50	53	28
Caroline	11	15	20	10
Carroll	70	52	56	61
Cecil	34	20	28	29
Charles	70	60	61	40
Dorchester	27	39	24	26
Frederick	115	107	119	134
Garrett	0	1	1	1
Harford	146	98	149	136
Howard	99	83	85	78
Kent	11	8	8	8
Montgomery	389	502	411	404
Prince George's	456	604	613	482
Queen Anne's	17	17	18	18
St. Mary's	21	20	18	14
Somerset	13	23	12	8
Talbot	19	28	26	53
Washington	170	177	87	122
Wicomico	130	70	86	74
Worcester	29	23	24	22
Out-of-State	325	339	382	276
Total	6,095	6,233	6,976	7,791

ADAA-Funded

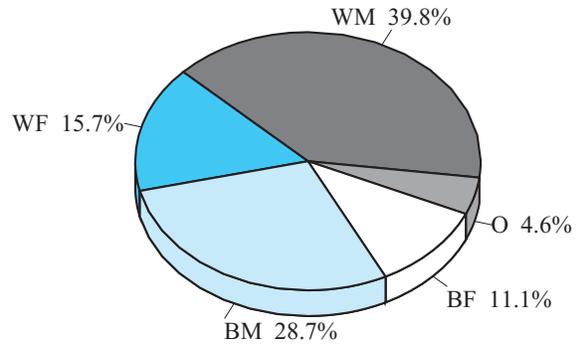
Location of Residence	FY 2000	FY 2001	FY 2002	FY 2003
Allegany	48	38	54	59
Anne Arundel	268	253	343	254
Baltimore City	1,922	2,193	3,041	3,256
Baltimore County	471	417	544	508
Calvert	36	44	63	125
Caroline	51	75	64	55
Carroll	144	120	190	119
Cecil	107	129	160	136
Charles	155	151	226	210
Dorchester	173	199	181	141
Frederick	225	271	273	209
Garrett	5	3	9	14
Harford	89	111	116	97
Howard	160	139	160	89
Kent	101	89	96	100
Montgomery	942	889	785	531
Prince George's	666	698	826	605
Queen Anne's	84	79	89	60
St. Mary's	98	145	257	204
Somerset	98	124	87	79
Talbot	156	109	111	104
Washington	220	221	322	252
Wicomico	361	315	427	338
Worcester	170	161	244	192
Out-of-State	123	141	183	157
Total	6,873	7,114	8,851	7,894

Figure A: Race and Gender of Patient Admissions Alcohol and Marijuana Problems

Alcohol

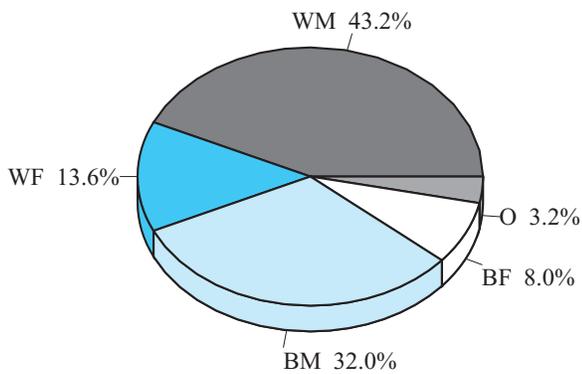


Non-Funded

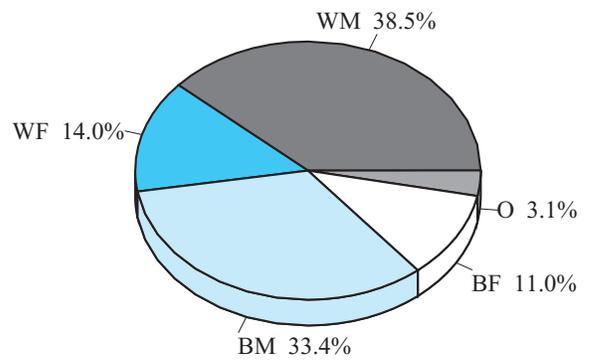


ADA-Funded

Marijuana



Non-Funded

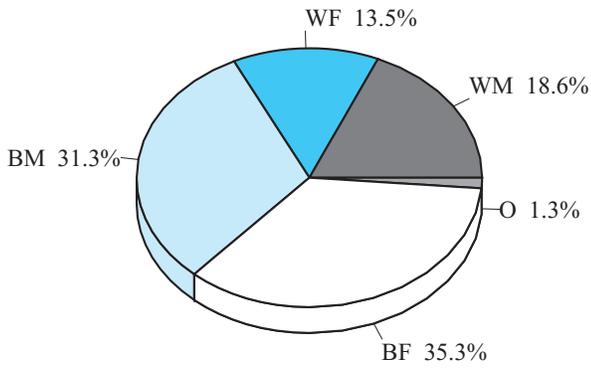


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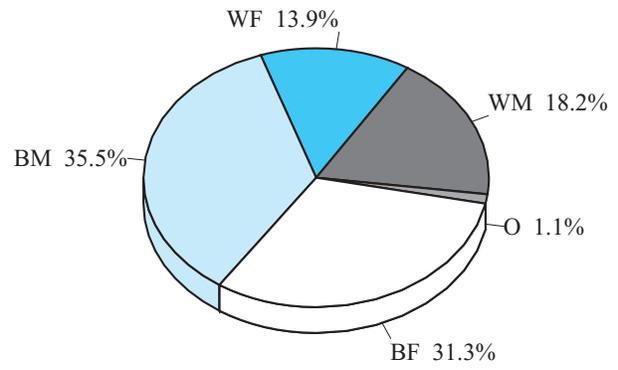
W - White	B - Black	M - Male
F - Female	O - Other Males & Females	

Figure B: Race and Gender of Patient Admissions Cocaine Related Problems

Crack Cocaine

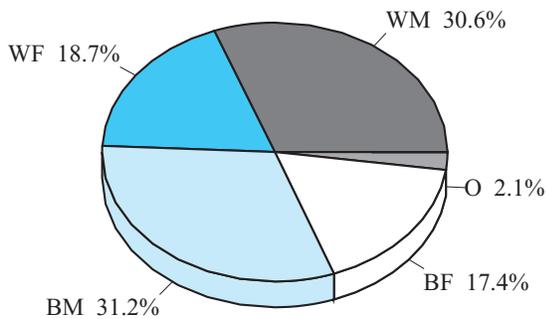


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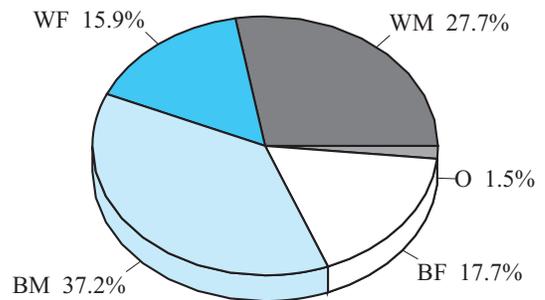


ADAA-Funded

Other Cocaine



Non-Funded

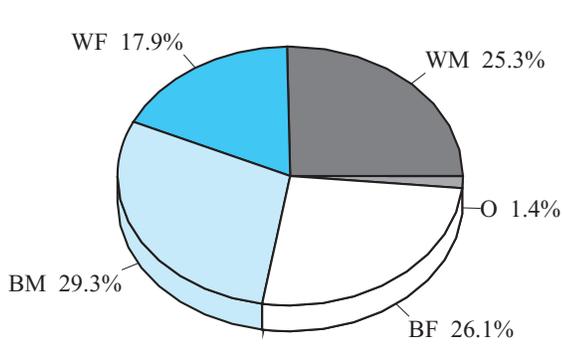


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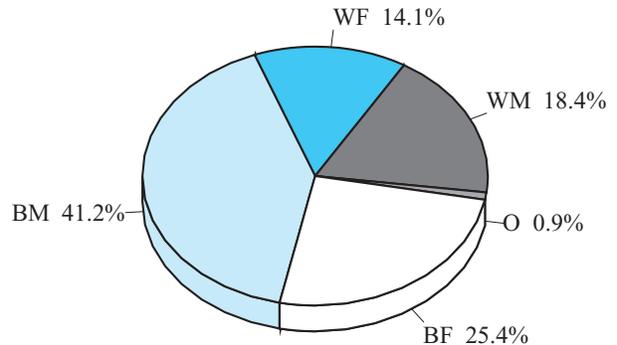
W - White	B - Black	M - Male
F - Female	O - Other Males & Females	

Figure C: Race and Gender of Patient Admissions Heroin and Other Opiate Related Problems

Heroin

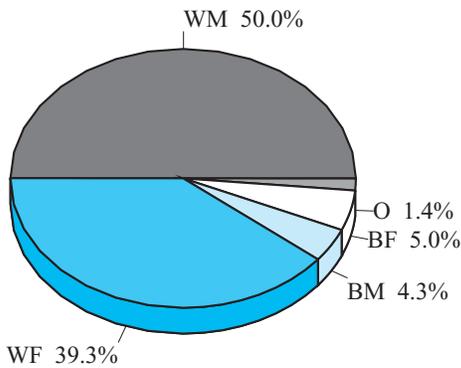


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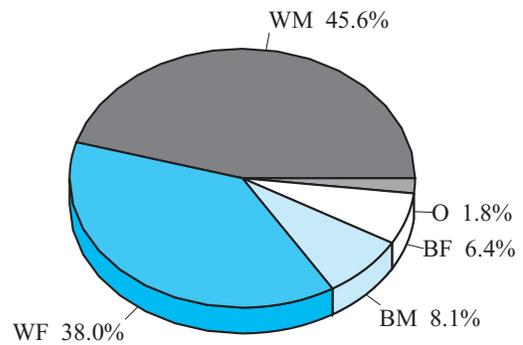


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Other Opiates



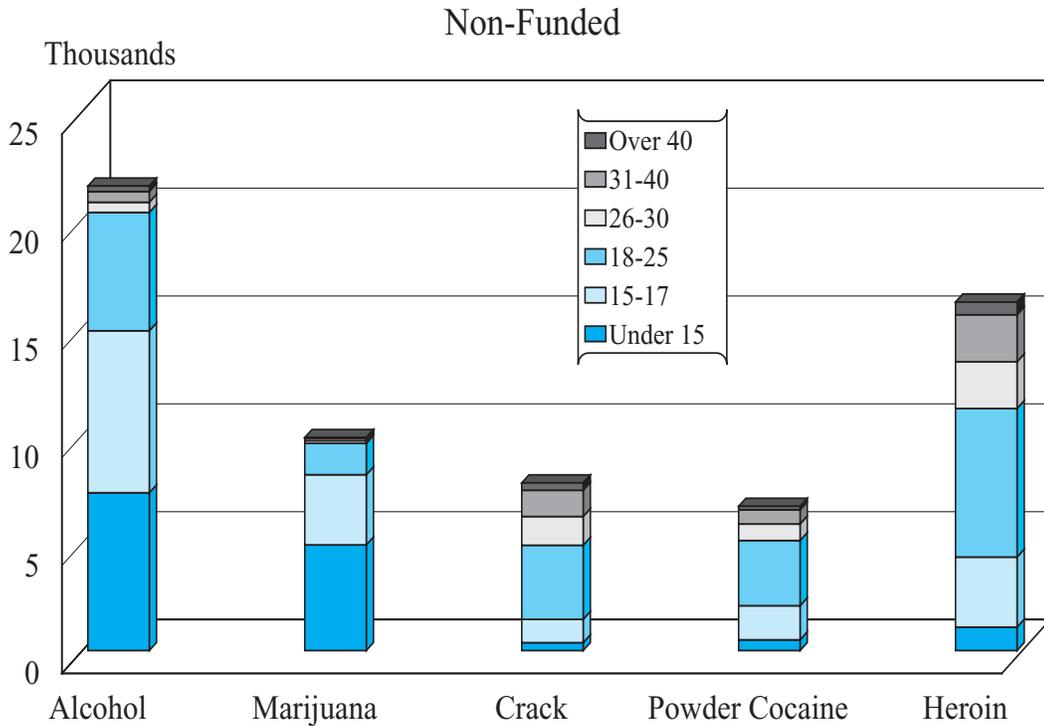
Non-Funded



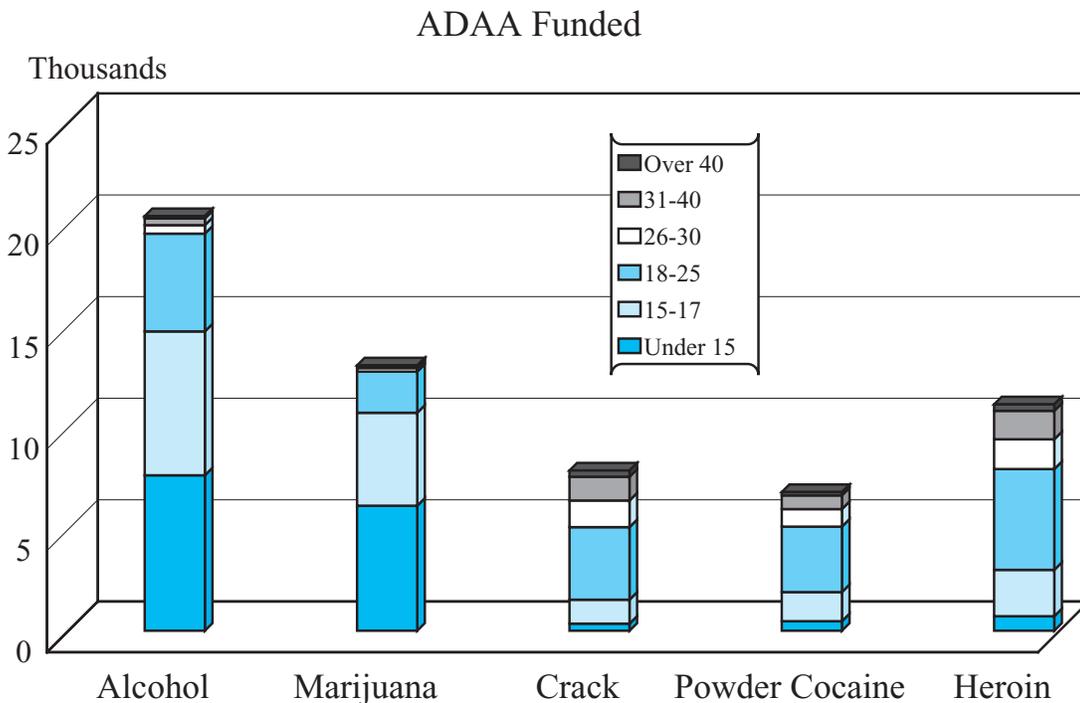
ADAA-Funded

W - White B - Black M - Male
F - Female O - Other Males & Females

Figure D: Age of First Use* of Selected Substances



*Reported as age of first intoxication for alcohol problems



Substance Abuse Treatment Outcome Measurement Tables

Table K: Use of Substances at Admission and Discharge Among Primary Patients at Discharges by Jurisdiction - FY 2003

Subdivision	Discharges	Percentage Using at Admission	Percentage Using at Discharge	Percent Change
Allegany	1,319	69	9	-86
Anne Arundel	4,657	77	55	-28
Baltimore City	18,712	86	61	-28
Baltimore Co.	7,423	78	54	-31
Calvert	1,203	59	32	-45
Caroline	320	71	60	-17
Carroll	2,275	59	37	-36
Cecil	1,351	72	52	-27
Charles	1,261	58	44	-24
Dorchester	2,353	92	11	-88
Frederick	2,790	68	53	-22
Garrett	321	74	41	-45
Harford	3,930	83	20	-75
Howard	2,077	53	44	-16
Kent	680	83	24	-71
Montgomery	5,303	79	46	-42
Prince George's	4,641	68	48	-29
Queen Anne's	253	36	55	53
St. Mary's	1,357	59	45	-24
Somerset	322	66	49	-26
Talbot	543	70	45	-36
Washington	1,642	44	33	-24
Wicomico	2,462	73	36	-50
Worcester	996	62	42	-32
Statewide	765	73	55	-25
Total	68,956	75	47	-37

**Table L: Employment Status
at Admission and Discharge
by Jurisdiction - FY 2003**

Subdivision	Discharges	Percentage Employed at Admission	Percentage Employed at Discharge	Percent Change
Allegany	1,382	22	27	22
Anne Arundel	4,686	53	56	6
Baltimore City	18,848	18	21	20
Baltimore Co.	7,701	43	46	7
Calvert	1,219	57	59	4
Caroline	320	52	60	14
Carroll	2,344	32	33	3
Cecil	1,387	51	53	3
Charles	1,261	48	56	16
Dorchester	2,370	36	37	3
Frederick	2,804	43	47	9
Garrett	342	19	20	2
Harford	3,957	60	60	2
Howard	2,087	39	42	8
Kent	680	34	36	7
Montgomery	5,311	50	53	5
Prince George's	4,656	39	47	20
Queen Anne's	253	56	58	5
St. Mary's	1,416	39	46	18
Somerset	327	36	40	13
Talbot	564	50	57	14
Washington	1,646	42	47	11
Wicomico	2,476	39	43	8
Worcester	1,010	47	56	18
Statewide	771	9	18	102
Total	69,818	37	40	10

**Table M: Arrest Rate Prior to
Admission and During Treatment
by Jurisdiction - FY 2003**

Subdivision	Discharges	Arrest Rate Prior to Admission	Arrest Rate During Treatment	Percent Change
Allegany	1,382	0.879	0.192	-78.2
Anne Arundel	4,686	0.575	0.165	-71.3
Baltimore City	18,848	0.510	0.195	-61.8
Baltimore Co.	7,701	0.656	0.292	-55.5
Calvert	1,219	0.655	0.200	-69.5
Caroline	320	0.600	0.237	-60.5
Carroll	2,344	0.516	0.117	-77.3
Cecil	1,387	0.619	0.230	-62.8
Charles	1,261	0.646	0.217	-66.4
Dorchester	2,370	0.326	0.268	-17.8
Frederick	2,804	0.536	0.171	-68.1
Garrett	342	1.265	0.236	-81.3
Harford	3,957	0.288	0.184	-36.1
Howard	2,087	0.558	0.220	-60.6
Kent	680	0.476	0.491	3.2
Montgomery	5,311	0.447	0.112	-74.9
Prince George's	4,656	0.476	0.108	-77.3
Queen Anne's	253	0.532	0.053	-90.0
St. Mary's	1,416	0.517	0.138	-73.3
Somerset	327	0.683	0.206	-69.8
Talbot	564	0.633	0.335	-47.1
Washington	1,646	0.702	0.364	-48.1
Wicomico	2,476	0.434	0.233	-46.3
Worcester	1,010	0.437	0.284	-35.0
Statewide	771	0.645	0.129	-80.0
Total	69,818	0.530	0.194	-63.4

**Table N: Subsequent Admission of
Non-Hospital Detox Completions
by Jurisdiction - FY 2003**

Subdivision	Completed Detox	Subsequent ICF Admission	Subsequent Other Residential Admission	Subsequent Other Admission	Percent Subsequently Admitted
Anne Arundel	275	171	5	34	76
Baltimore City	565	205	18	126	62
Baltimore Co.	160	42	3	35	50
Frederick	60	9	1	17	45
Harford	564	556	0	0	99
Kent	131	114	0	6	92
Montgomery	634	227	57	95	60
Wicomico	248	75	9	68	61
Total	2,637	1,399	93	381	71

**Table O: Halfway House Treatment
Retention Rates by Jurisdiction
FY 2003**

Subdivision	Admissions	Retained Less than 90 Days	Retained 90 Days or More	Percent Retained 90 Days or More
Allegany	23	6	17	74
Anne Arundel	141	63	78	55
Baltimore City	283	88	195	69
Cecil	24	12	12	50
Frederick	123	72	51	41
Harford	39	23	16	41
Montgomery	87	39	48	55
Prince George's	31	9	22	71
St. Mary's	46	17	29	63
Washington	78	30	48	62
Wicomico	26	17	9	35
Total	901	376	525	58

**Table P: Outpatient Treatment
Retention Rates by Jurisdiction
FY 2003**

Subdivision	Admissions	Retained Less than 90 Days	Retained 90 Days or More	Percent Retained 90 Days or More
Allegany	533	101	432	81
Anne Arundel	2,337	859	1,478	63
Baltimore City	6,277	2,947	3,330	53
Baltimore Co.	3,796	1,574	2,222	59
Calvert	704	169	535	76
Caroline	316	113	203	64
Carroll	885	318	567	64
Cecil	918	402	516	56
Charles	890	280	610	69
Dorchester	291	87	204	70
Frederick	1,284	478	806	63
Garrett	299	78	221	74
Harford	1,296	330	966	75
Howard	677	224	453	67
Kent	317	121	196	62
Montgomery	2,607	825	1,782	68
Prince George's	2,877	993	1,884	65
Queen Anne's	250	92	158	63
St. Mary's	735	297	438	60
Somerset	227	70	157	69
Talbot	356	157	199	56
Washington	907	360	547	60
Wicomico	918	459	459	50
Worcester	702	277	425	61
Statewide	98	25	73	74
Total	30,497	11,636	18,861	62

Acronyms and Abbreviations

ADAA	Alcohol and Drug Abuse Administration
ATOD	Alcohol, Tobacco and Other Drugs
BGR	University of Maryland Bureau of Governmental Research
COMAR	Code of Maryland Regulations
CSAP	Center For Substance Abuse Prevention
CSAT	National Center for Substance Abuse Treatment
CY	Calendar Year
DHMH	Maryland Department of Health and Mental Hygiene
DUI	Driving Under the Influence
DWI	Driving While Impaired
FY	Fiscal Year
HATS	University of Maryland Automated Tracking System
MDS	Minimum Data Set
MIS	Management Information Systems
MPI	Model Program Initiative
NIDA	National Institute on Drug Abuse
OETAS	Office of Education and Training for Addiction Services
PrevTech	Prevention Technology Platform
SAMIS	Maryland Substance Abuse Management Information System
SAMHSA	Substance Abuse and Mental Health Services Administration
TEDS	Federal Treatment Episode Data Set

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