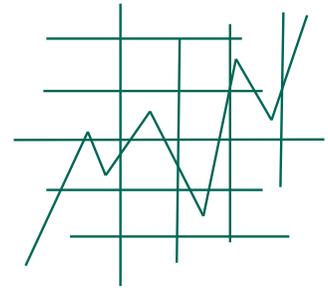


Outlook & Outcomes



2004 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 behalf of all the citizens of Maryland, I am pleased to accept this *2004 Annual Report – Outlooks and Outcomes* from the Alcohol and Drug Abuse Administration. As I travel around the State, I am constantly reminded of the tragic toll that substance abuse takes on our people and our communities.

The Ehrlich-Steele Administration's leadership and commitment to prevention, intervention and treatment was demonstrated by our comprehensive 2004 drug and alcohol abuse initiative. We look forward to continued collaboration and cooperation with the local Drug and Alcohol Abuse Councils established as part of that initiative. Our creation of the Maryland State Drug and Alcohol Abuse Council provides a strong structure for progress on the State level. The work undertaken by these Councils, the various departments of State government, and concerned citizens throughout the State has established an excellent foundation for efforts to reduce substance abuse in Maryland.

We all recognize that addressing the direct and indirect social and health costs of drug and alcohol abuse is a job that requires the State and its local governments to work hand in hand. Thus, I am especially pleased that this *2004 Annual Report* presents data in a format that will allow us to track the State's progress over time, increase accountability, and help jurisdictions develop and evaluate their local substance abuse treatment systems.

The Ehrlich-Steele Administration will continue to make reduction of substance abuse a top priority. We also look forward to working with local subdivisions to provide effective and comprehensive prevention, intervention and treatment services that will make our communities safer and healthier.

Very truly yours,

A handwritten signature in black ink that reads "Robert L. Ehrlich, Jr." in a cursive style.

Robert L. Ehrlich, Jr.
Governor

OUTLOOK AND OUTCOMES

*For Maryland Substance Abuse
Prevention, Intervention
and Treatment*

Fiscal Year 2004

*Robert L. Ehrlich, Jr., Governor
Michael S. Steele, Lt. Governor
S. Anthony McCann, Secretary, DHMH
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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. Prevention Program activity presented is derived from data reported to the Maryland State Prevention System Management Information System (SPS-MIS).

The data in Outlook and Outcomes reflect 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 2004*

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This issue of *Outlook and Outcomes* should have a familiar look and feel for the reader.

The structure and layout of the document closely track the design first introduced in the previous issue. There are several thoughts behind this. First, the editorial staff

wanted a layout that allowed the reader to go right to sections of interest in the issue and then be able to use prior issues for a sort of self-guided comparative analysis. Most recurring publications are designed with that convenience in mind. Second, deciding on a “core” layout as well as “core” content for the publication makes it easier for policy and decision makers to use the information in their work and importantly, makes it easier for the public to use the information to track the state’s progress over time. Third, ADAA is trying to develop the *Outlook and Outcomes* layout so that it can be used by jurisdictions to publish their own, local edition. A locally published, jurisdiction specific, *Outlook and Outcomes* will be a valuable tool for developing and evaluating a local substance abuse system. Finally, the editorial staff decided that an annual publication should be routine, relatively easy to organize and produce, and be part of the work of the agency. In other words, don’t re-invent the wheel every time out. Make it as painless as possible. We think this format does that.

This edition of *Outlook and Outcomes* reports on FY 2004 data. FY 2004 is the last year that data were reported to the ADAA through a combination of on-line and batched submissions from treatment programs. It also is the last year that the legacy mainframe (and software) had any part of the analysis. On the changeover from FY 2004 to FY 2005 all treatment data came to ADAA on-line. The immediate result was a combination of the expected and the unexpected. The expected was that the FY 2005 data would immediately reveal the “holes” inherent in the FY 2004 data as the mismatches between admission, discharge and carried-over patients were easy to spot after only one month of FY 2005 data for comparison. That happened. What was not expected was that the legacy system’s label for program type, and whether a program was funded vs. non-funded had not been matched and updated routinely to reflect the changes over the years in program status. Not good. It was a sharply delivered reminder of why the decision to get off the mainframe, leave batching behind, get

data on-line and not cede control of information to a third party so that changes couldn’t be made was the right thing to do. The FY 2004 data required labor intensive verification, including a review of each program’s level of care and funding status. In several instances, this produced a substantially different picture in a jurisdiction from that seen in prior years. This is a one time occurrence that does not carry forward into FY 2005 data.

The data improvements made in the conversion to on-line data reporting means the quicker availability of information for programs and jurisdictions, easier data verification and analysis, and a faster publication schedule. The next *Outlook and Outcomes* reporting on FY 2005 data will be published by the end of December, 2005.

Peter F. Luongo, Ph.D.

**ALCOHOL AND DRUG ABUSE
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The Outlook

A primary responsibility of the ADAA is to stimulate, guide and reinforce local health leadership to design, implement and direct a system of substance abuse prevention, intervention and treatment services. The objective of this prevention, intervention and treatment system is to: 1) reduce the number of individuals with substance use disorders, and (2) reduce the direct and indirect health and social costs of substance abuse to the individual and community. It is ADAA's responsibility to integrate these functions into a unified, purposeful system.

This year ADAA continued to make strides towards the goal of functional integration of the substance abuse treatment system through the continued improvement and streamlining of the grant and information processes.

The integration of these two processes is designed to answer the basic questions of what are we buying, with what funds, and for whom are we buying services.

In Fiscal Year 2004 ADAA used the following ingredients in the revamping of these two key processes:

- statewide implementation of the ADAA information system
- interdisciplinary grant reviews
- development of regional technical assistance teams,
- use of performance measures
- initiation of performance-based compensation

With baselines established and patient-level data available, the answers are increasingly accessible at the program, jurisdiction and state level.

This year, grant awards that consistently conveyed conditions that include both quality of care and outcomes have become a reality.

With this in mind, the next step toward system design and planning was the establishment of regional inter-disciplinary teams composed of staff from treatment, prevention, grants management, information services and quality assurance. Teams versed in knowledge about specific jurisdictions offer opportunities for discussion and ongoing technical assistance to enhance systems design, implementation and growth.

So, where does all this get us? We are now pointed in a direction that builds jurisdiction-based plans for prevention, intervention and treatment, specifies current capacities and competencies, and establishes the baseline for future initiative requests. It is outcome based. It uses numbers, data, and theory. It tells about a good story developing in Maryland.

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
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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 2004, ADAA compares and contrasts the characteristics of funded and non-funded treatment programs for Fiscal Year 2004, the populations they serve and the treatment outcomes reported.

WHO RECEIVED SERVICES?

Prevention Services

- Approximately 301,000 individuals received prevention services in Maryland.
 - There were over 540 recurring prevention programs offered throughout Maryland last year .
 - During Fiscal Year 2004, Maryland offered prevention and intervention services to 26 different service populations comprised mostly of parents and school-aged children.
 - A total of 4,020 individuals received prevention intervention services through the High Risk Preschool Initiative in Fiscal Year 2004.
 - The College Prevention Centers initiative provided prevention services, with a primary focus on peer education, to 39,345 students enrolled in four of Maryland's universities.
 - In Fiscal Year 2004, 34 prevention programs were delivered in nine jurisdictions through the new Model Program Initiative, assisting communities in identifying needs by implementing evidence-based programs.
- Fifty-eight percent of funded and 55 percent of non-funded patients admitted during FY 2004 had at least one prior admission to treatment.

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.
- Forty-two percent of patients admitted to funded programs had at least one dependent child.
- About 44 percent of all patients admitted to ADAA-funded programs were referred to treatment through the criminal justice system and 64 percent 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.
- Twenty-two percent of funded patients had mental health problems in addition to substance abuse and 64 percent smoked cigarettes.

Treatment Services

- There were 43,855 patients admitted to ADAA-funded programs and 30,973 who were admitted to non-funded treatment. Readmission rates were 20 percent and 18 percent respectively.
- **Type of Abuse: ADAA-Funded Treatment**
The leading substances of abuse in ADAA-funded treatment were alcohol (58%), heroin (38%), marijuana (36%), crack cocaine (29%) and other cocaine (17%).

- Nearly half of all funded patients were abusing multiple substances at admission.
- Over half of ADAA funded heroin-related admissions primarily inhaled the drug.

Non-Funded Patients

- Patients participating in non-funded treatment programs were more likely to have graduated from high school and/or attended college; and were more likely to be full-time employed and have health care coverage.
- Fifty-seven percent of all patients admitted to non-funded programs had at least one prior treatment episode; 18 percent were readmissions.
- Less than 40 percent 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.
- Over one-fourth of non-funded patient admissions had mental health problems and 64 percent smoked cigarettes.

Type of Abuse: Non-Funded Treatment

- Substances that predominated among non-funded admissions were: Alcohol (61%), heroin (35%), marijuana (29%), crack cocaine (20%) and other cocaine (14%).
- Over one-fourth of non funded admissions were abusing alcohol only.

Maryland and the Nation

- More than 30 percent of Maryland admissions had primary heroin problems compared to 15 percent for the nation as a whole. Methamphetamines were a primary problem in seven percent of nationwide admissions but less than half of one percent in Maryland.

Adolescents

- Adolescent admissions made up 10 percent of ADAA-funded patient admissions and seven percent of non-funded admissions, and most adolescent patients reported abusing alcohol and/or marijuana.
- Over 70 percent of both the ADAA-funded and non-funded populations admitted for alcohol problems reported first substance use during adolescence.
- Eighty-two percent of those with marijuana problems reported first use during adolescence.

ASAM Levels of Care

- Forty-five percent of all admissions went to Level I (traditional outpatient) services and another 15 percent were admitted to Level II.1 (intensive outpatient).
- Seven percent of funded and 12 percent of non-funded admissions were to opioid maintenance therapy (OMT).
- Residential levels of care accounted for 29 percent of ADAA-funded admissions and 19 percent of non-funded admissions.
- Thirteen percent of funded and 10 percent of non-funded patients admitted to treatment accessed detoxification services on an ambulatory, residential or hospital basis.

WHAT DID WE BUY?

- About 89 percent of patients who participated in ADAA-funded treatment received individual counseling services. Traditional outpatients averaged about two sessions per month. About 85 percent of ADAA-funded patients received group counseling.

WAS IT WORTH IT? Outcome Measurement

Use of Alcohol and Drugs

- Among the total discharges from ADAA-funded treatment, including both successful completers and non-successful completers, there was a 25% reduction in substance use. Decreases in substance use of 50 percent or more occurred in several residential levels of care.

Treatment Reduces Substance Use

- Staying in treatment more than 90 days was associated with a lower percentage of patients who continued using at discharge. For patients retained in treatment at least 180 days, the reduction in use was 50 percent.

Treatment Reduces Crime

- Arrest rates were reduced by half or more during treatment in every level of care except Level III.7 (ICF).

Treatment Increases Employment

- The data indicate that across all levels of care 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.
- Employment increased 13 percent in funded Level I and nearly nine-fold in Level III.1 (halfway house).

Treatment Decreases Homelessness

- The percentage of homeless patients declined during treatment of various types, especially in halfway houses.

Treatment of Co-occurring Disorders Increases Successful Completion

- Patients with identified mental health problems who received mental health treatment during a course of substance abuse treatment were significantly more likely to complete treatment successfully.



The Alcohol and Drug Abuse Administration moved to real time Internet-based data collection for treatment services in Fiscal Year 2004. ADAA upgraded its prevention online data collection to the fourth version of MDS.

Prevention

- The MDS-4 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.
- Additional data presented by jurisdictional subdivision can be found in the *Management Information System Prevention Activity Report FY 2004* on the ADAA Web site: <http://maryland-adaa.org>

Treatment

- In preparation to moving to electronic data collection, ADAA performed rigorous data reconciliation with each treatment program resulting in the elimination of data anomalies and a realigning of clinics according to new funding sources.
- Data collected by HATS is subject to validation from within the application and is validated again with onsite program visits from the ADAA MIS staff.

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 165 ADAA-funded and 201 non-funded substance abuse treatment clinics in FY 2004, 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.

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 Level III.7.D. (non-hospital detoxification) and from Level II.1 (intensive outpatient - IOP) during FY 2004, the percentage of unique individuals completing treatment who were tracked to a subsequent admission to another level of care during the six months after discharge was calculated. Subsequent admissions were primarily to Level III.7 (intermediate care - ICF) for detox discharges and to Level I (traditional outpatient) for Level II.1 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 discharged during the year reporting any use of substances and the percentage reported as using 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 2004, 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.



Look for all issues of Outlook and Outcomes and other publications on the recently revised ADAA website
<http://maryland-adaa.org>

PREVENTION SERVICES IN MARYLAND

What is Prevention?

Prevention's focus is the promotion of constructive lifestyles and norms that discourage drug use. Research-based prevention programs can be cost-effective. Similar to earlier research, recent data findings show that for each dollar invested in prevention, a savings of up to \$10 in treatment for alcohol or other substance abuse can be seen.¹

In Fiscal Year 2004, ADA A continued to fund the Model Program Initiative. Programs funded by this initiative reflect evidence-based principles, strategies, and practices that research has demonstrated as leading to effective outcomes.

Prevention Network

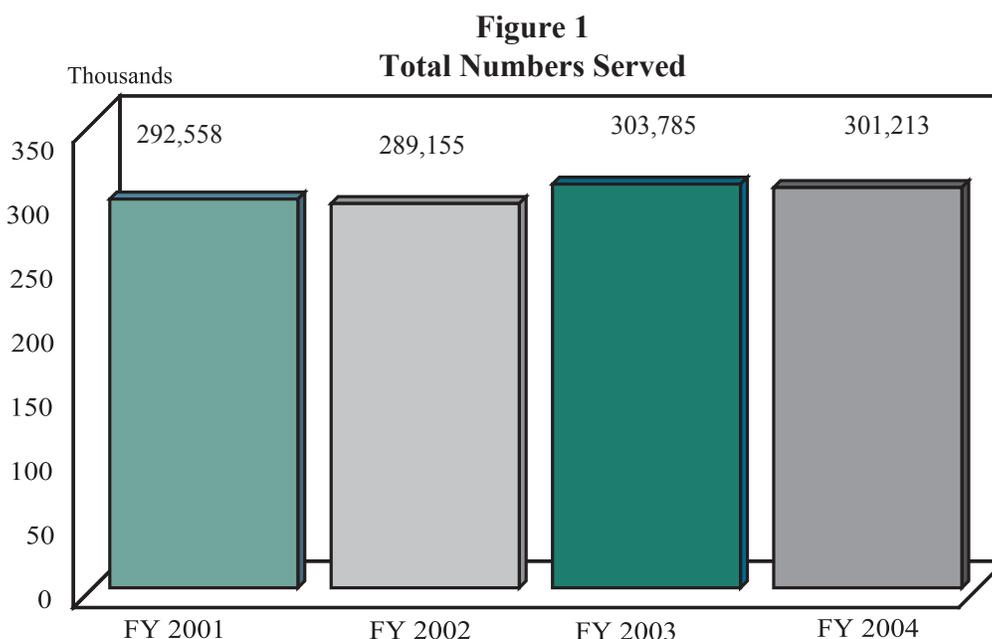
In support of evidence-based prevention, ADA A has initiated a county prevention coordinator networking system – an established, successful and recognized strategy to plan, deliver, coordinate, and monitor prevention services that meet the varying needs of local subdivisions.

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 2004 approximately 301,000 individuals received prevention services in Maryland. This reflects a slight decrease in the total numbers served from FY 2003 (Figure 1). In the last four years, data have shown Maryland averages approximately 300,000 individuals served annually through prevention intervention services.

¹ Aos, S.; Phipps, P.; Barnoski, R.; and Lieb, R. *The Comparative Costs and Benefits of Programs to Reduce Crime. Volume 4 (1-05-1201)*. Olympia, WA: Washington State Institute for Public Policy, May 2001.



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 2004, 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 sub-categories 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

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

Table 1

CSAP Strategies and Number of Participants Served - FY 2004							
Subdivision	Information Dissemination	Alternatives	Education	Problem ID And Referral	Community Based Process	Environmental	Total
Allegany	7,334	1,473	360	24	862	16	10,069
Anne Arundel	1,786	1,426	224	0	357	14	3,807
Baltimore City	45,104	7,805	2,068	7,361	569	4	62,911
Baltimore	18,764	37,354	5,411	3,286	9,023	8,034	81,872
Calvert	8,499	636	611	0	276	0	10,022
Caroline	4,283	12	33	0	47	0	4,375
Carroll	4,413	100	530	0	603	8	5,654
Cecil	727	135	115	22	177	0	1,176
Charles	1,244	293	1,031	120	20	0	2,708
Dorchester	9,279	2,268	297	0	173	829	12,846
Frederick	969	0	1,733	0	7	0	2,709
Garrett	594	3,567	544	0	737	20	5,462
Harford	16,678	2,885	648	75	939	1,127	22,352
Howard	5,907	1,077	984	46	80	0	8,094
Kent	1,249	67	0	18	17	90	1,441
Montgomery	515	307	132	0	61	0	1,015
Prince George's	8,433	1,560	692	0	0	89	10,774
Queen Anne's	500	0	83	0	0	0	583
St. Mary's	0	15,750	73	0	1,100	1,000	17,923
Somerset	5,032	1,102	94	0	15	123	6,366
Talbot	1,000	44	113	0	752	148	2,057
Washington	2,003	375	429	350	0	0	3,157
Wicomico	2,002	291	1,198	0	50	7	3,548
Worcester	4,042	15,469	582	20	179	0	20,292
TOTAL	150,357	93,996	17,985	11,322	16,044	11,509	301,213
Percentage	50%	31%	6%	4%	5%	4%	100%

MARYLAND PREVENTION

WHO RECEIVED SERVICES?

Gender

Figure 2 shows the statewide distribution of gender for prevention program participants in Fiscal Year 2004. Approximately 54 percent of program participants were female while 46 percent of the participants statewide were male. 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.

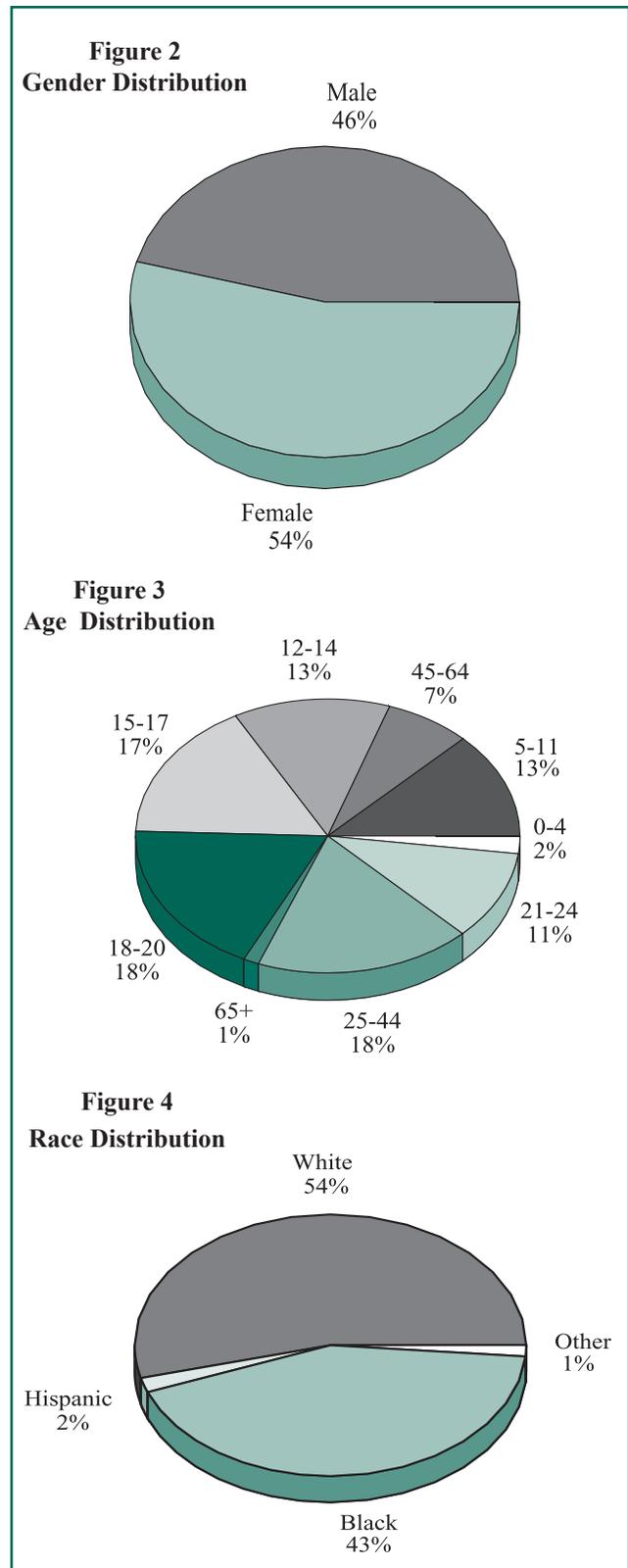
Age

During Fiscal Year 2004, approximately half of the prevention program participants (55 percent) receiving services were adults over 18 years of age. Parents comprised 35 percent of those adults who attended prevention programs in Fiscal Year 2004. Youth under the age of 18 represented 36 percent of individuals participating in prevention programs. All age breakdowns 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.

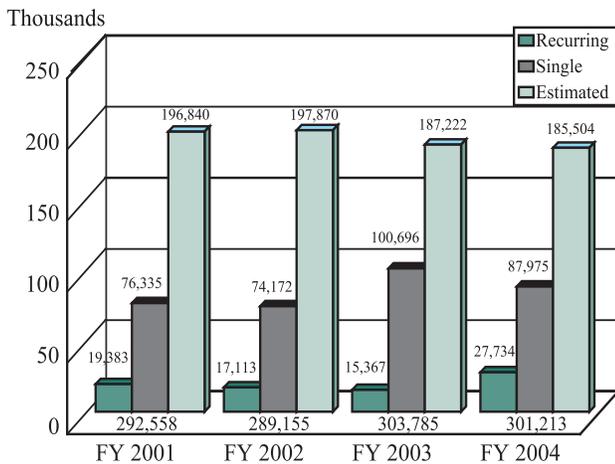
Caucasians made up approximately 54 percent of participants while African Americans comprised 43 percent of the individuals attending prevention programs in Fiscal Year 2004 (Figure 4). Hispanics represented approximately two percent of the participants receiving prevention services in Fiscal Year 2004.



PREVENTION: WHAT DID WE BUY?

Recurring Prevention Services

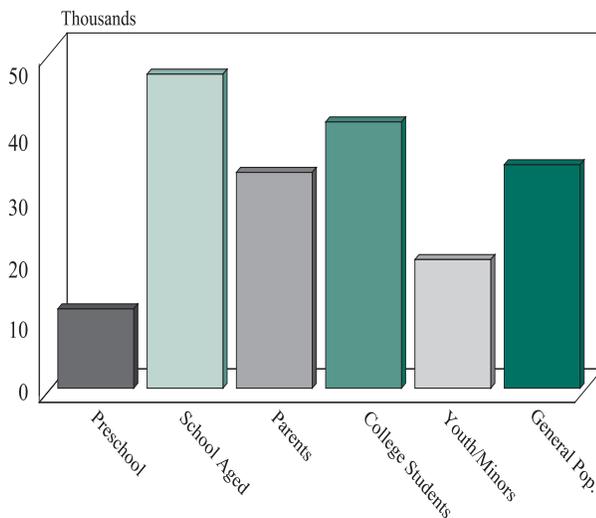
Figure 5
Numbers Served
FY 2001-2004



In Fiscal Year 2004 there were 27,734 individuals who actively participated in recurring prevention programs in Maryland. As a result of a two year transition 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 an increase 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 87,975 in Fiscal Year 2004. Annual totals for all prevention services are shown in Figure 5.

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 185,504 individuals who attended or received prevention services in Fiscal Year 2004.

Service Population

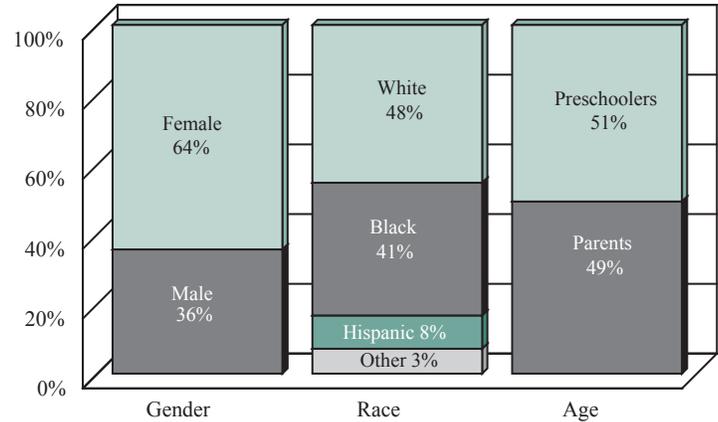
During Fiscal Year 2004, Maryland offered prevention intervention services to twenty-six different service populations. The majority of individuals receiving services were parents and school-aged children (Figure 6).

Special Prevention Initiatives

Protecting Our Children

In Fiscal Year 1997, the ADAA began an initiative to focus on preschool children at high risk for alcohol, tobacco and other drug (ATOD) use 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 2004: A total of 4,020 individuals received prevention intervention services through the High Risk Preschool Initiative in Fiscal Year 2004.

Promoting a Healthy Transition into Adulthood

Figure 8
Individuals Served
Statewide by
College Centers
Gender Distribution

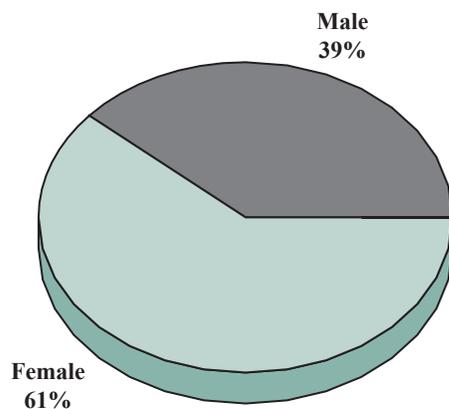
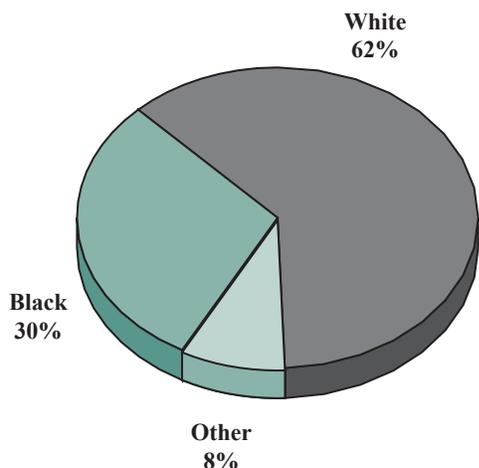


Figure 9
Individuals Served
Statewide by
College Centers
Race Distribution



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 2004: The college centers provided prevention services to 39,345 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 2004.

MODEL PROGRAM INITIATIVE

In Fiscal Year 2004 the ADAA provided \$600,000 to select jurisdictions (Tables 2 and 3) to implement evidence-based programs. The Model Program Initiative (MPI) required jurisdictions to use Substance Abuse Mental Health Services Administration (SAMHSA) Model Programs to respond to identified community needs.

Figures 10, 11 and 12 show the gender, age and race distributions of populations served by the MPI.

County	Number of Programs		Total Programs
	Recurring	Single	
Allegany	5	0	5
Anne Arundel	2	1	3
Calvert	4	5	9
Carroll	3	0	3
Charles	1	0	1
Dorchester	2	1	3
Garrett	4	0	4
Howard	5	0	5
Montgomery	0	1	1
Total	26	8	34

County	Numbers Served		Total Served
	Recurring	Single	
Allegany	61	0	61
Anne Arundel	59	12	71
Calvert	147	88	235
Carroll	66	0	66
Charles	67	0	67
Dorchester	46	67	113
Garrett	204	0	204
Howard	515	0	515
Montgomery	307	0	307
Total	1,472	167	1,639

Figure 10
Gender Distribution

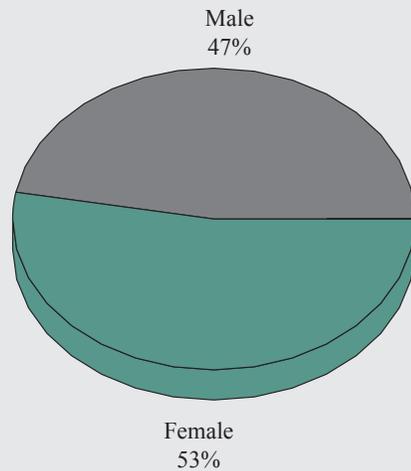


Figure 11
Age Distribution

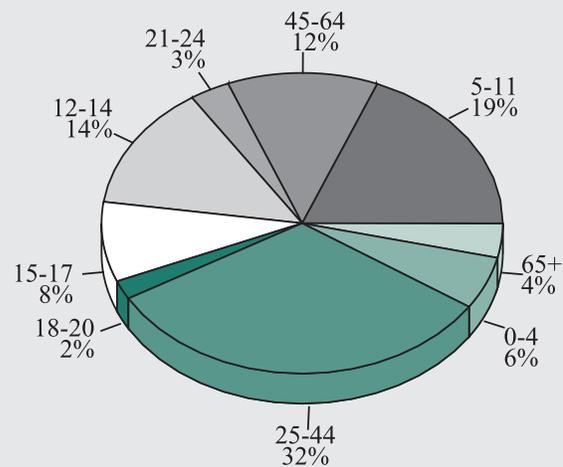
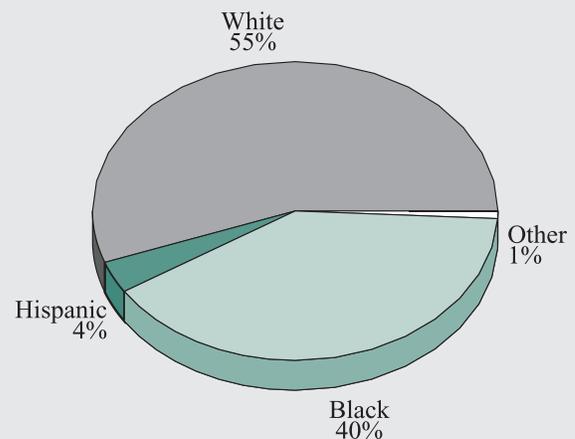


Figure 12
Race Distribution



DEFINING “LEVELS OF CARE”

In Maryland, substance abuse treatment is disseminated through a network of prevention, intervention and treatment services that are publicly and/or privately funded. This continuum of care network is defined through the standards set by the American Society of Addiction Medicine (ASAM) Patient Placement Criteria II-Revised (PPC II-R).¹ Such standards ensure increased uniformity of treatment and improved cost-effective allocation of resources.

A “level of care” is a primary treatment approach or modality. Programs must meet the standards defined by ASAM Criteria. License and certification procedures require programs to meet the established standards for the “level(s) of care” they deliver. A brief definition of each “level of care” available in Maryland is shown below.

Early Intervention (0.5) – Outpatient counseling for individuals who do not meet criteria for a substance use disorder, but who are at high risk for alcohol or other drug problems (e.g., DUI patients, school based early intervention).

Level I - Outpatient Treatment (I) – Nonresidential, structured treatment services for less than nine hours a week per patient. Examples might include office practice, health clinics, primary care clinics, mental health clinics, and “step down” programs that provide individual, group and family counseling services.

Opioid Maintenance Therapy (I-OMT) – Medication assisted treatment specific to opioid addiction. Patients are medically supervised and engaged in structured clinical protocols. Services are delivered under a defined set of policies, procedures and medical protocols. Methadone maintenance programs are an example of this level of care.

Level II - Intensive Outpatient (II.I) – A structured therapeutic milieu in an outpatient setting that delivers nine or more hours of structured treatment services per patient, per week.

Partial Hospitalization (II.5) - Provides each patient with 20 or more hours of clinically intensive programming per week based on individual treatment plans. Programs have pre-defined access to psychiatric, medical and laboratory services.

Level III - Clinically Managed Low Intensity Residential Treatment (III.1) - Provides Level I treatment services to patients in a residential setting such as a halfway house.

Clinically Managed Medium Intensity Residential Treatment (III.3)- Programs provide a structured recovery environment in combination with clinical services. For example, a therapeutic rehabilitation facility offering long-term care.

Clinically Managed High Intensity Residential Treatment (III.5)- A structured therapeutic community providing a recovery environment in combination with intense clinical services, such as a residential treatment center.

Medically-Monitored Intensive Inpatient Treatment (III.7)- Programs offering a planned regimen of 24 hour professionally directed evaluation, care and treatment for addicted patients in an inpatient setting, Level III.7 care is delivered by an interdisciplinary staff to patients whose sub-acute biomedical and emotional/behavioral problems are sufficiently severe to require inpatient care.

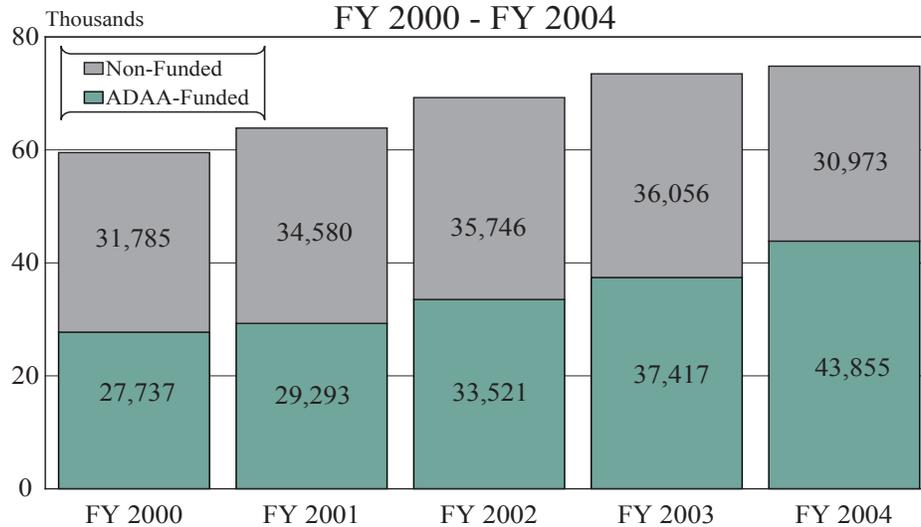
Level IV - Medically Managed Intensive Inpatient Services (IV) - Much like Level III.7 this level of care has an interdisciplinary staff that attend to patients whose acute biomedical, emotional or behavioral problems are severe enough to require primary medical and nursing services. The full resources of an acute general hospital or a medically managed inpatient treatment service system are required of this service level.

¹ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition -- Revised): (ASAM PPC-2R) April, 2001.

WHO RECEIVED SERVICES?

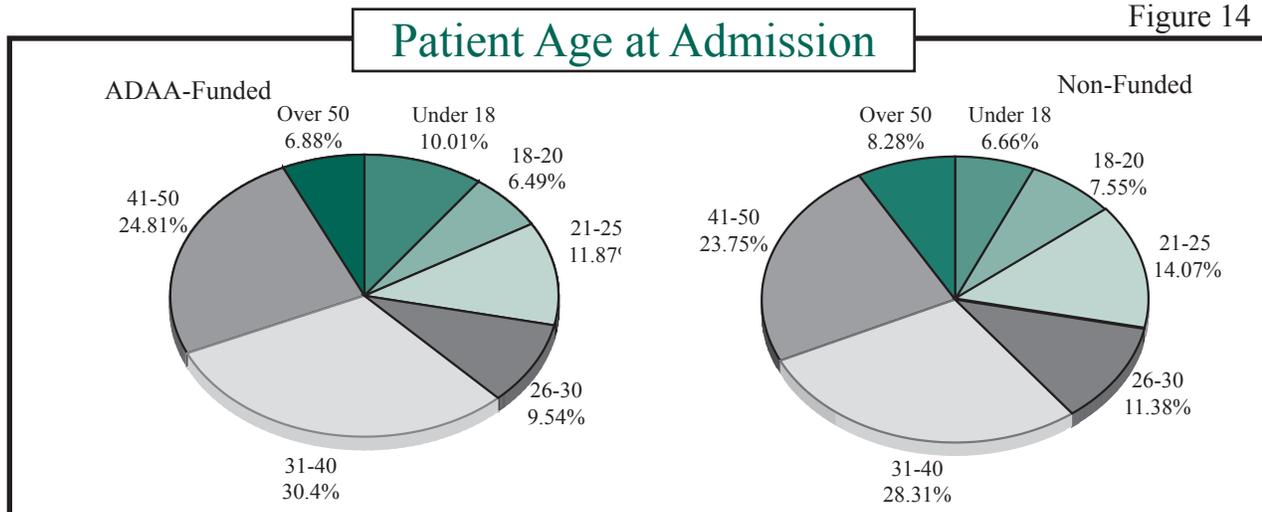
Figure 13

Admissions to Certified Alcohol and Drug Abuse Treatment Programs



Total admissions increased by 25 percent over the past four fiscal years. Whereas ADAA-funded admissions made up 46 percent of the total in FY 2001, they made up 59 percent in FY 2004. This shift is a result of reconciliation and realignment of funding sources in addition to the funding increases from Cigarette Restitution monies and other sources.

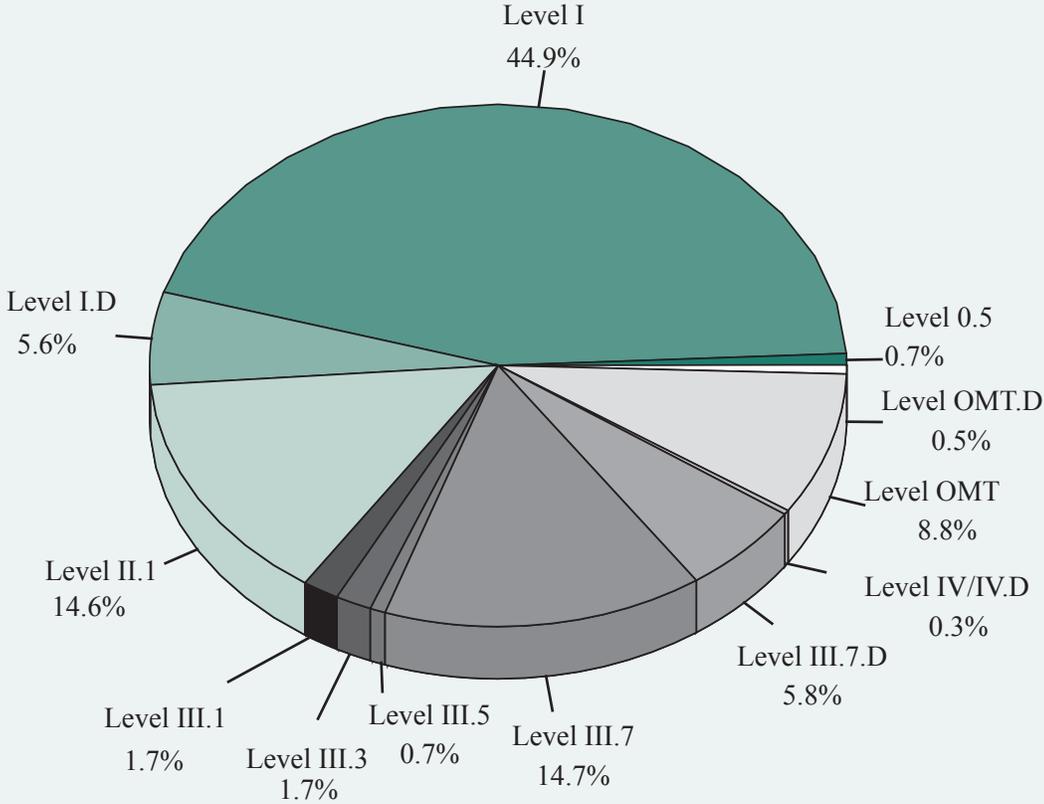
Figure 14



There were some differences in the distributions of age among funded and non-funded patient admissions. Patients admitted to ADAA-funded treatment were more likely to be under 18 or in their 30's and 40's. Over 35 percent of the patients in non-funded treatment were in their 20's. Patients admitted to levels of care with residential, detox or OMT services tended to be older; half of funded Level I patients admitted were under 30 whereas 70 percent or more of patients in Levels I.D, III.1, III.3, III.5, III.7 and III.7.D were older than 30. Eighty-six percent of OMT patients were over 30 and just over half were over 40.

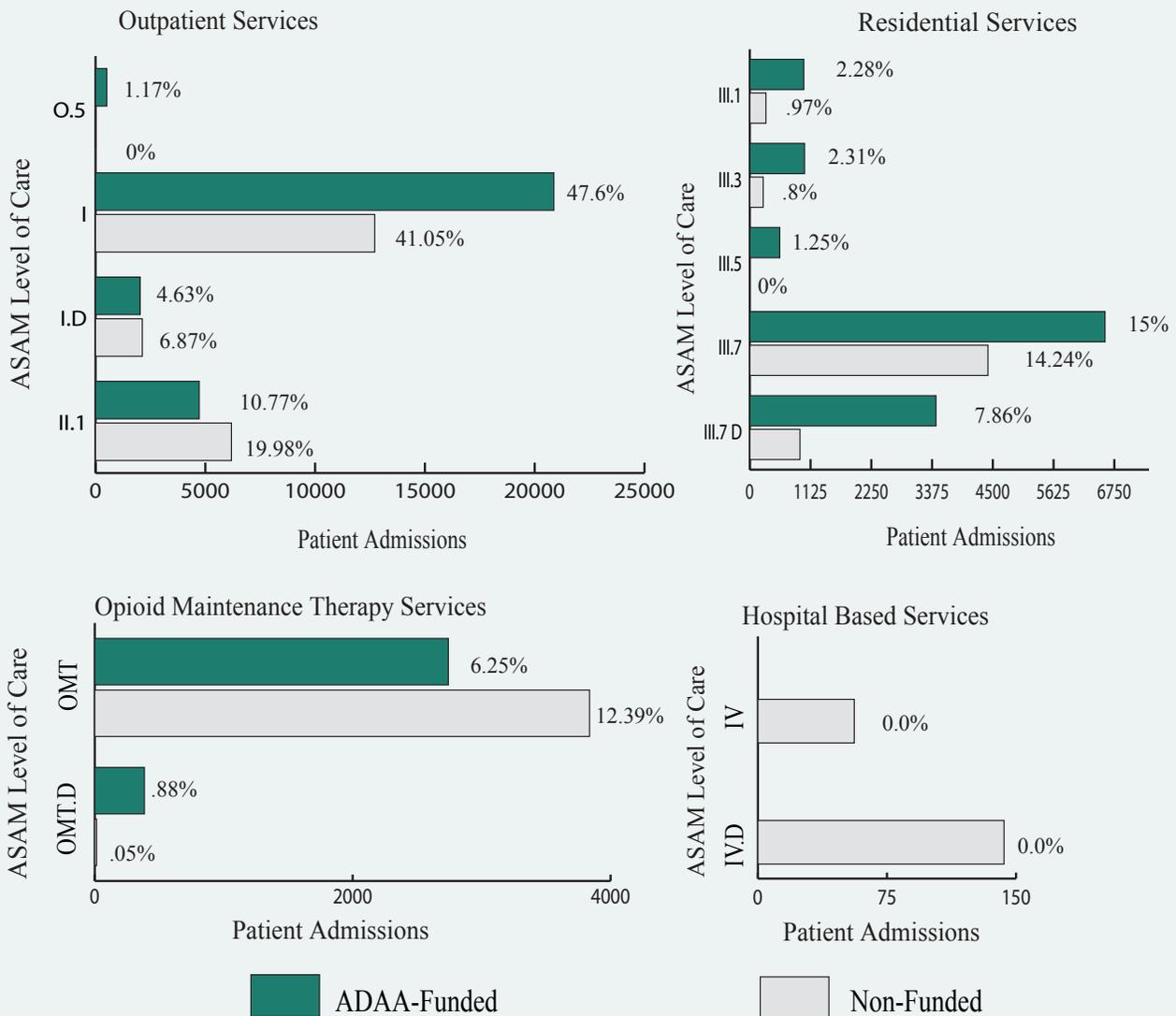
FY 2004 Admissions ASAM Levels of Care

Figure 15



Among the challenges facing ADAA is to ensure access to all levels of care throughout the state and strengthen the link between treatment program funding, certification and designated levels of care. It is anticipated this will significantly alter these distributions in future reports. Appendix Table A presents the raw data distribution of funded and non-funded levels of care over the past four years. Level II.1 has been expanded in both the public and private sectors but the increase is greater on the non-funded side. Methadone maintenance (OMT) admissions have declined slightly among ADAA-funded programs and increased slightly in non-funded programs. There has been a five-fold increase in funded admissions to Level I.D. Over the four years, total ADAA-funded admissions increased by half while non-funded admissions fell by ten percent. Part of this shift is a result of corrections applied to the funding designation of some programs.

Patient Admissions to ASAM Levels of Care by Funding Source



Note: Percentages represent level of care to the total population of patients within either the ADAA-funded or non-funded patient base.

Figure 16

The major funded and non-funded levels of care for patients at admission during FY 2004 are shown in Figure 16. There are some major differences in the distributions of funded and non funded levels of care. ADAA-funded patients were more than twice as likely to be admitted to Level III.7.D (residential detox) and half as likely to enter OMT. While approximately 60 percent of both funded and non-funded admissions consisted of Levels I and II.1 (outpatient and intensive outpatient), Level II.1 made up about a third of that total in non-funded treatment and less than 20 percent in funded. There were no ADAA-funded admissions to Level IV or IV.D (hospital treatment), and no non-funded admissions to Level III.5 (therapeutic community).

Race and Gender

Figure 17

ADAA-funded admissions tended to be about evenly split between black (49 percent) and white (47 percent) patients (Figure 17), while 60 percent of patients in non-funded programs were white (Figure 18). ADAA-funded patients admitted were slightly more likely to be female – 33.8 versus 32.5 percent (non-funded). With regard to funded treatment, black patients were most prevalent among Level I.D (71 percent), Level III.5 (80 percent) and OMT (71 percent) admissions. Over 36 percent of Level III.5 and OMT patients admitted were black females. In non-funded treatment programs nearly 90 percent of Level III.7 and three-quarters of OMT patients admitted were white.

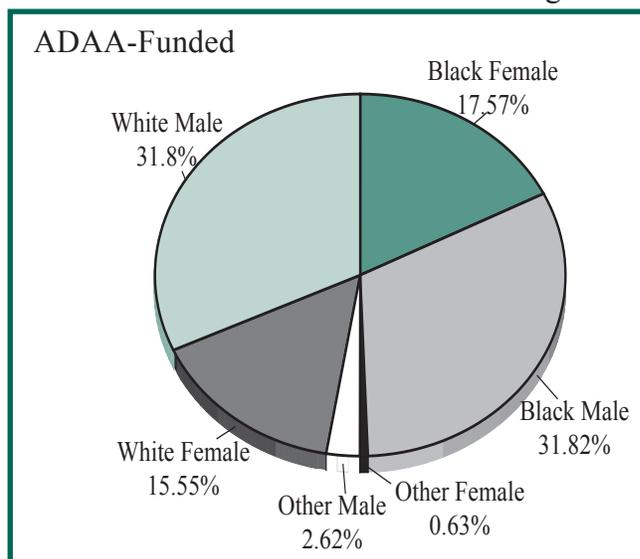
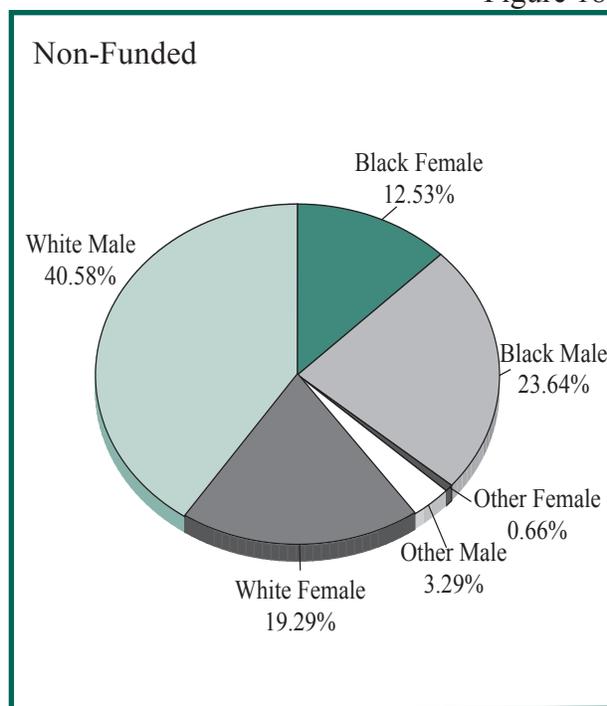


Figure 18



A July 2003 article in the ADAA Compass Newsletter 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.

Previous Treatment Experience

The numbers of prior treatment experiences of ADAA-funded and non-funded admissions are shown in Figure 19. Patients, in general, were more likely than not to have been in treatment before, with between 43 and 45 percent of funded and non-funded admissions having had no prior treatment. About 32 percent of both funded and non-funded individuals entering treatment had two or more prior treatment experiences. It is important to note that prior treatment may, in some cases, reflect an antecedent level of care. Among funded admissions prior treatment experience was most associated with Levels III.1, III.7, and OMT. Least likely to have been in treatment before were admissions to Levels I, I.D, III.5 and of course, Level 0.5 (Early Intervention). Forty-three percent of Level III.1, 32 percent of OMT and 30 percent of III.3 had three or more prior treatment episodes. Findings were similar in the non-funded sector except patients in Level I.D were among the most likely to have been in treatment before.

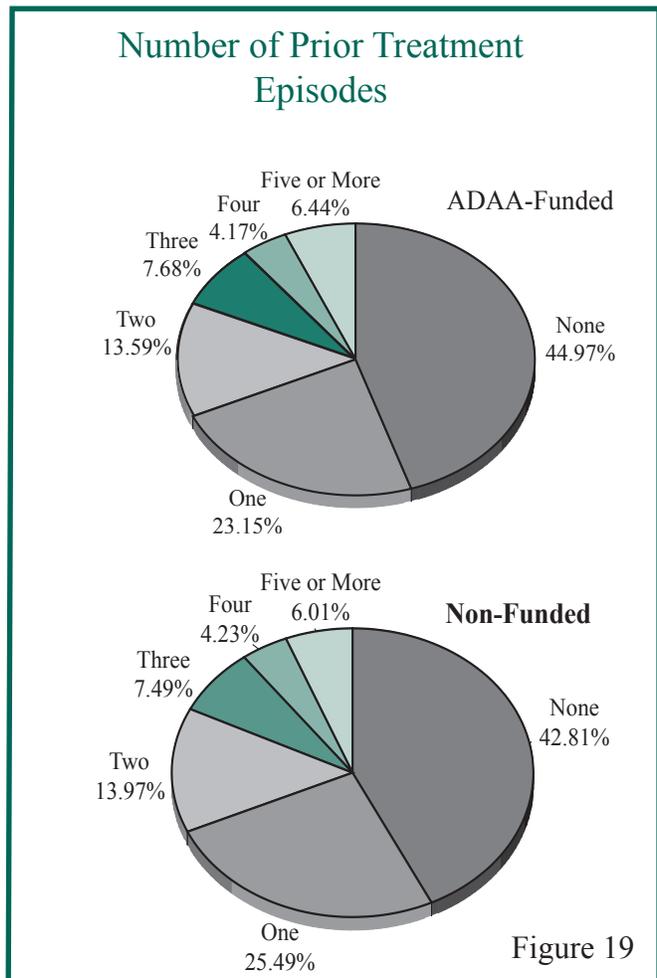
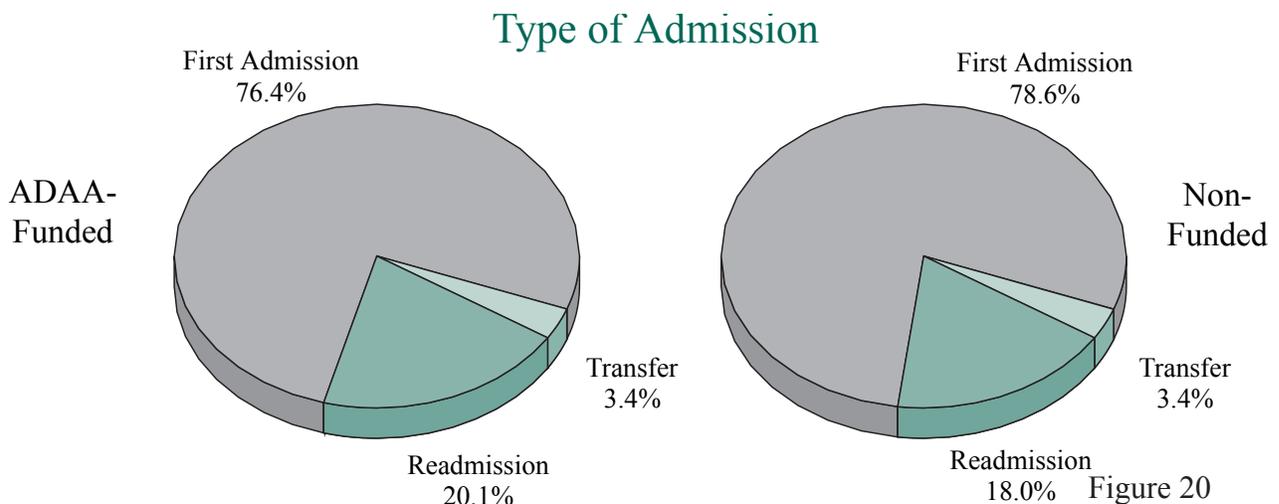
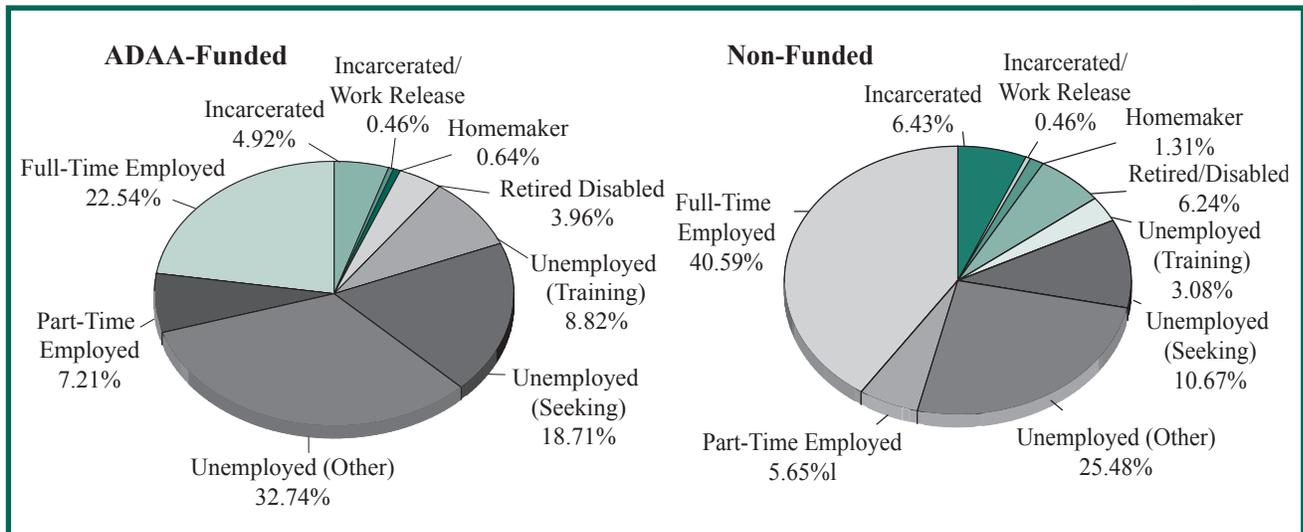


Figure 20 distributes types of admission for funded and non-funded patients. Patients were slightly more likely to be readmissions in the ADAA-funded sector. Readmissions were most prevalent in Levels I and II.1; transfer or change in service within episode was most common among admissions to Levels III.3, II.1 and III.7. In non-funded treatment readmissions reached their highest levels among admissions to Level I.D and the hospital services, Levels IV and IV.D.



Employment

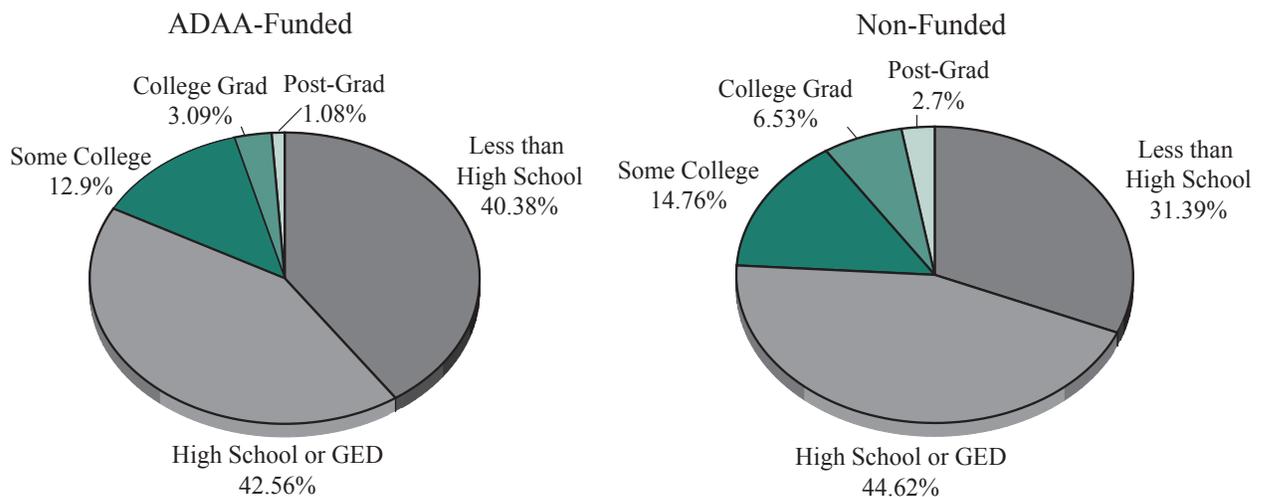
Figure 21



Clearly, ADAA-funded patients admitted in 2004 are less likely to be employed than their non-funded counterparts, as shown in Figure 21. Over 40 percent of non-funded patients at admission were full or part-time employed, whereas less than a third of patients admitted to funded treatment indicated they were working. Much of the difference was made up of individuals who were out of the workforce. Level I outpatients were most likely to be employed - 62 percent of non-funded and 43 percent of funded outpatients had full or part-time jobs at admission.

Educational Attainment

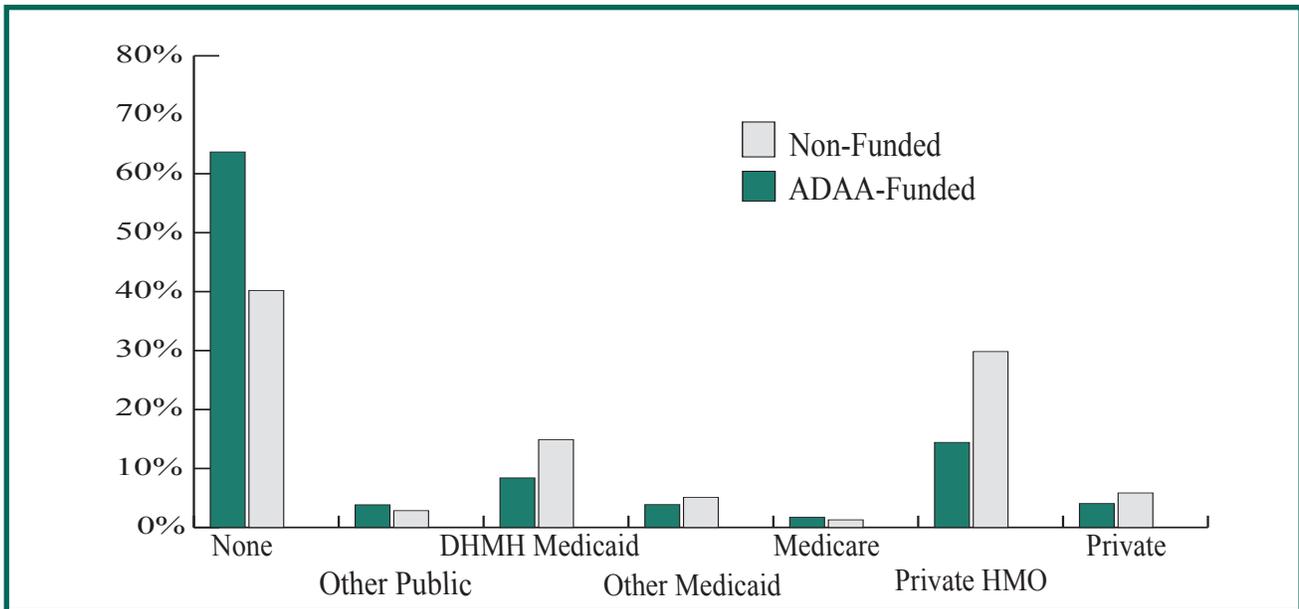
Figure 22



ADAA-funded admissions lag behind their non-funded counterparts educationally as well, although part of that gap is associated with the higher percentage of adolescents in ADAA-funded programs. Figure 22 shows that less than a third of non-funded admissions had not completed high school and over 40 percent of patient admissions funded by ADAA were in that category. Non-funded patients were also more likely to have had some college, graduated from college, and gone beyond college.

Health Care Coverage

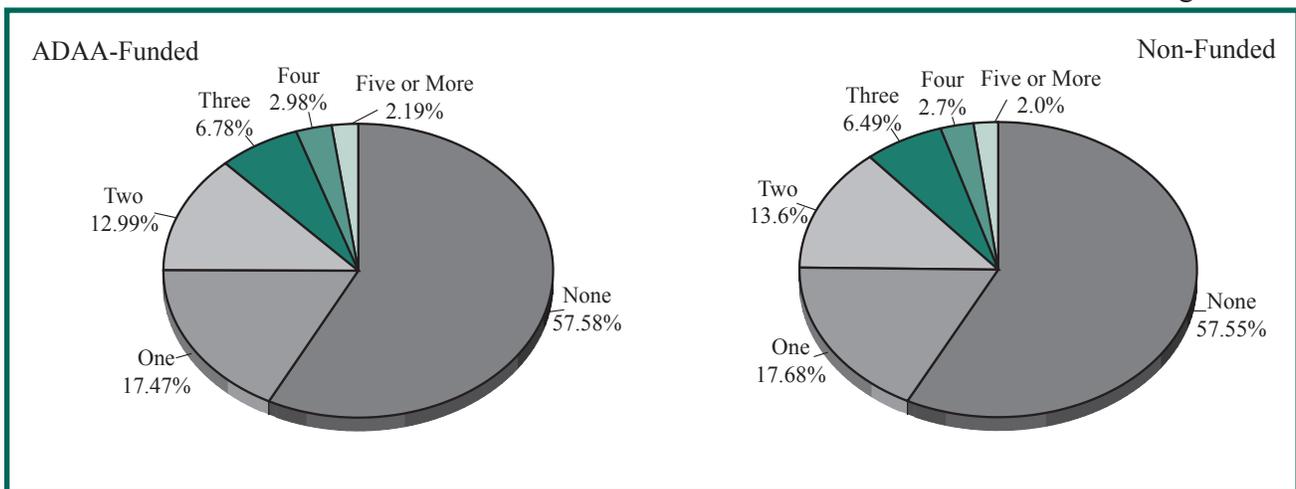
Figure 23



Nearly two-thirds of the patients admitted to ADAA-funded programs lacked any form of health coverage, as shown in Figure 23. Only 40 percent of non-funded admissions were in that category. About 36 percent of the latter group had private insurance compared to about 18 percent of funded patients. A greater percentage of Medicaid admissions went to non-funded programs than funded. This item does not necessarily indicate the reported health coverage paid for the treatment episode.

Number of Dependent Children

Figure 24



The distributions of number of dependent children among individuals admitted to funded and non-funded programs are remarkably similar (Figure 24). In both, 58 percent reported no dependent children and all other categories differed by less than 1 percentage point. Two-thirds of patient admitted to Level III.5 reported dependent children. 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.

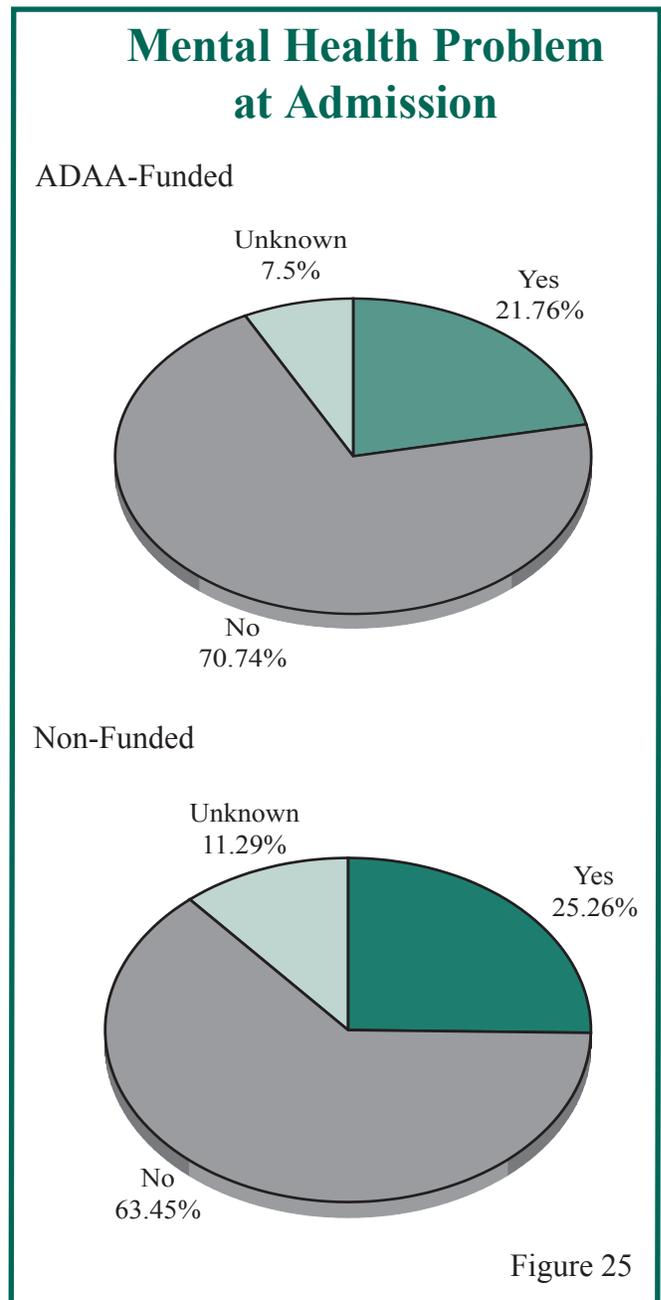
Co-occurring Disorders

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 labeled 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. A lower percentage of individuals with co-occurring disorders enter ADAA-funded than non-funded treatment, as shown in Figure 25.

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 or 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, except for Level III.5, 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.

Cigarette smoking is also a co-occurring problem among most substance abusers; about 64 percent of funded and non-funded patients admitted to treatment were smokers during FY 2004. Three fourths or more patients at admission reported smoking cigarettes in funded Levels III.3, III.7, III.7.D and OMT, and in non-funded Levels I.D, III.7 and OMT.



Criminal Justice Referrals

Figure 26

Figure 26 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 ADAA-funded patients. This finding makes the distributions in Figure 27 hardly surprising. Forty-four percent of ADAA-funded admissions were referred by components of the criminal justice system while 39 percent of non-funded admissions were criminal justice referrals.

In the January 2004 ADAA Compass Newsletter, devoted to treatment and criminal justice, data were examined to assess the difference between criminal justice and other referrals. As indicated in the article during FY 2003, two-thirds of outpatient referrals were from criminal justice sources. Other than hospital inpatient, the level of care 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 justice system. Not surprisingly, the age group between 18 and 25 produced the greatest percentage of criminal justice referrals.

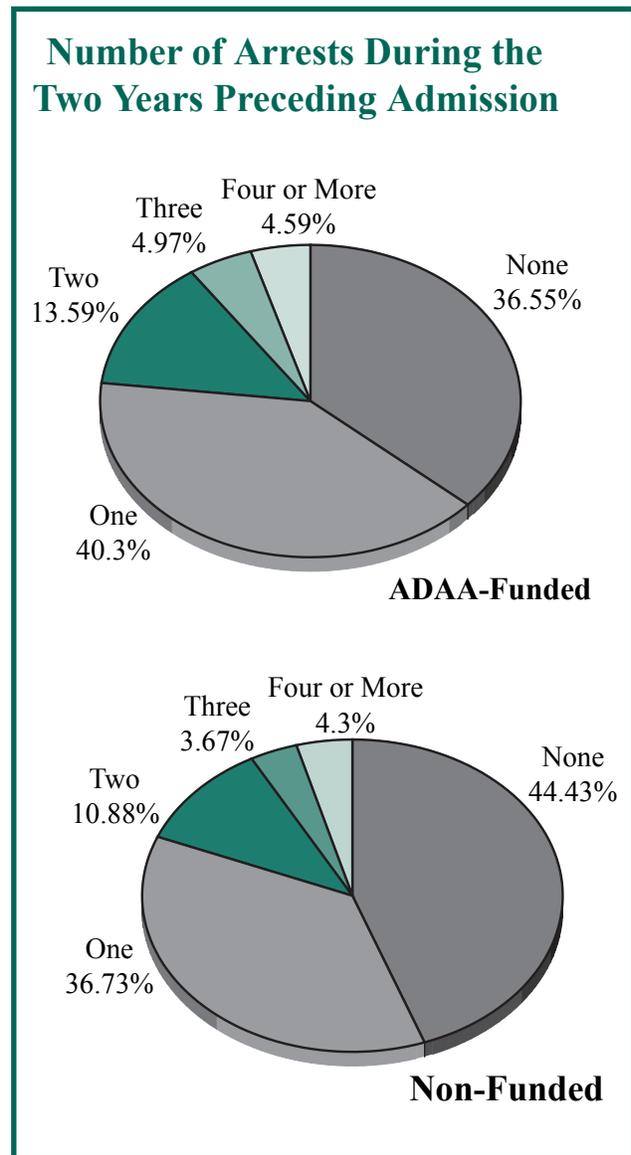
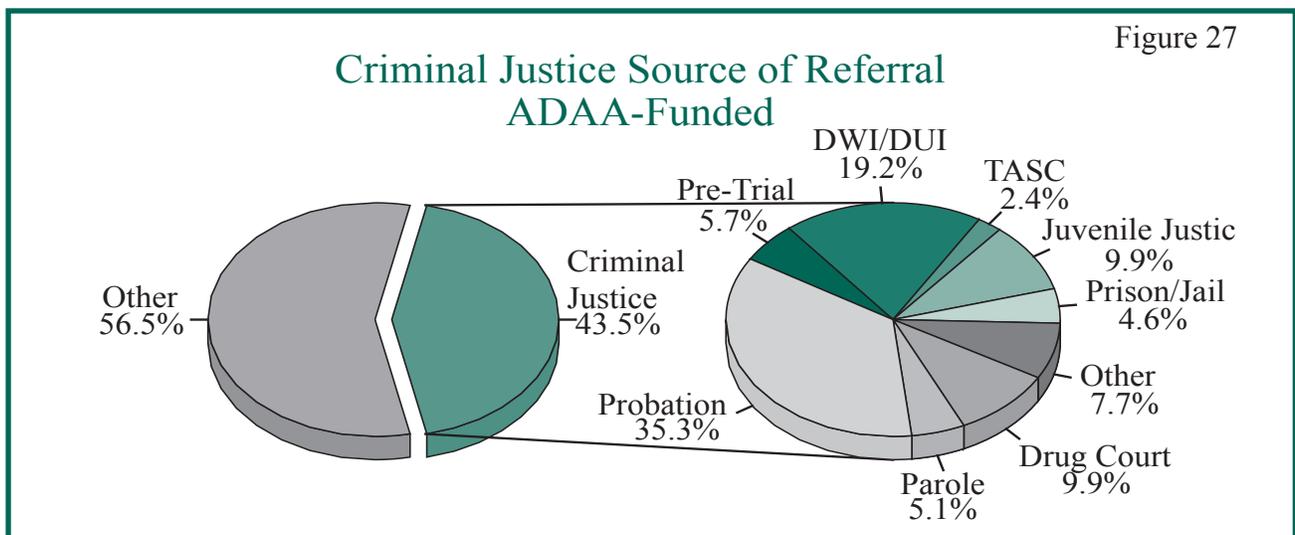
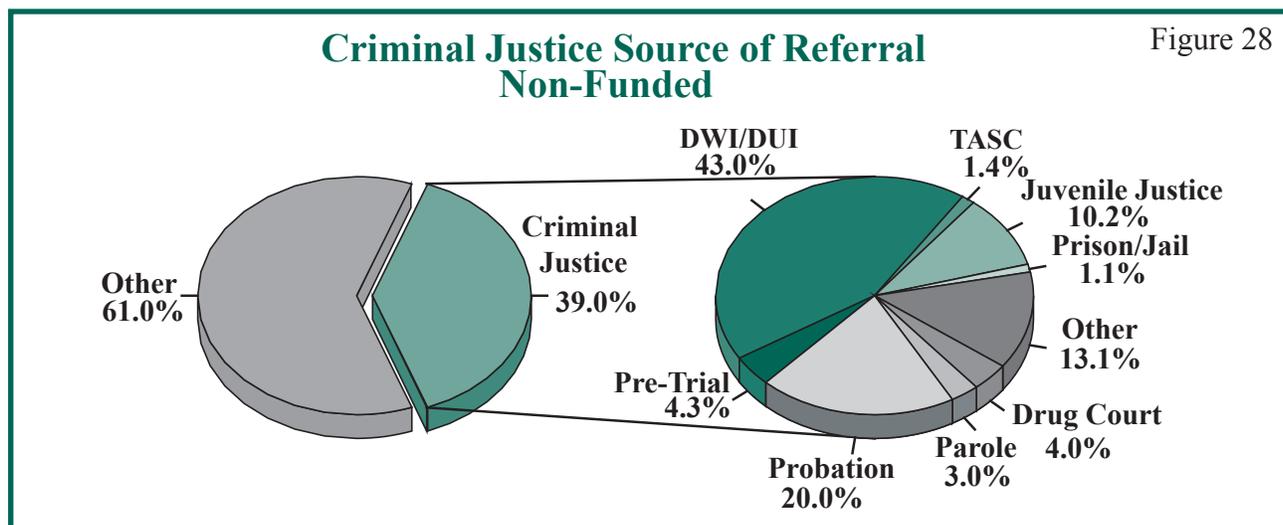


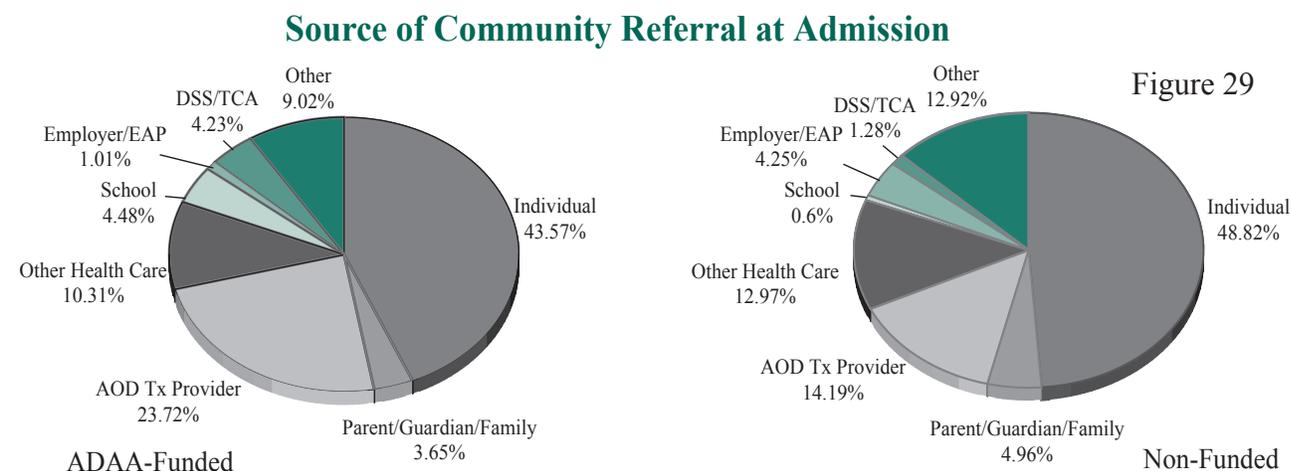
Figure 27



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%).



Figures 27 and 28 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 or parolees. 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 19 percent, DWI/DUI was still the second largest category of criminal justice referrals for ADAA-funded admissions.



Voluntary or community referrals are distributed by source in Figure 29. In non-funded programs, admissions were somewhat more likely to have been categorized as individual or family referrals - 54 vs. 47 percent. ADAA-funded patients were more likely to come from other treatment providers, schools and the Department of Social Services (DSS). Non-funded referrals were more likely to come from other health care providers and employers.

WHERE DO PATIENTS LIVE?

Admissions to Treatment by Residence²
FY 2001 - FY 2004

Table 4

Location of Residence	ADAA-Funded				Non-Funded			
	FY 2001	FY 2002	FY 2003	FY 2004	FY 2001	FY 2002	FY 2003	FY 2004
Allegany	599	662	756	789	92	70	67	81
Anne Arundel	815	898	987	2230	4958	5046	4690	3475
Baltimore City	8546	10177	13155	15992	10917	11409	11154	8591
Baltimore County	2829	2879	3090	3974	4080	4647	5061	3981
Calvert	627	845	775	1145	340	380	352	161
Caroline	381	417	453	516	88	82	75	90
Carroll	957	980	990	1069	718	721	817	848
Cecil	695	912	1051	889	428	401	394	459
Charles	899	1071	1195	1188	365	363	287	229
Dorchester	522	557	608	615	105	76	92	151
Frederick	1020	1069	1146	1050	1080	1107	1125	1091
Garrett	258	282	325	380	14	16	14	21
Harford	880	965	918	941	995	1294	1545	1488
Howard	672	633	628	740	889	874	982	798
Kent	343	385	368	443	46	43	67	46
Montgomery	1848	2425	2696	3227	3028	2584	2927	2939
Prince George's	1631	1886	1956	2071	2324	2212	2241	2426
Queen Anne's	411	409	444	485	138	158	142	102
St. Mary's	951	1110	977	1104	161	161	122	104
Somerset	508	399	424	423	95	77	61	50
Talbot	527	516	542	523	103	134	158	158
Washington	1081	1352	1165	1102	614	468	594	470
Wicomico	1107	1283	1350	1307	558	490	469	608
Worcester	801	905	864	899	192	214	200	229
Out-of-State	396	514	554	750	2231	2712	2394	2374
Total	29304	33531	37417	43852	34559	35739	36030	30970

Reported subdivision of residence of non-funded and ADAA-funded admissions during FY 2001 to 2004 is shown in Table 4. While total funded admissions increased by half during the four years, those residing in Baltimore City increased by 87 percent. Other areas that outpaced the overall funded admission increase were Anne Arundel (174 percent), Calvert (83 percent), Montgomery (75 percent) and out-of-state (89 percent).

² Multi-year trend data will show an adjustment in data between FY 2003 and FY 2004 due to data reconciliation and realignment of clinics by funding sources (see comments in Directors Column page 5)

Severity of Selected Substances ADAA-Funded Treatment Programs

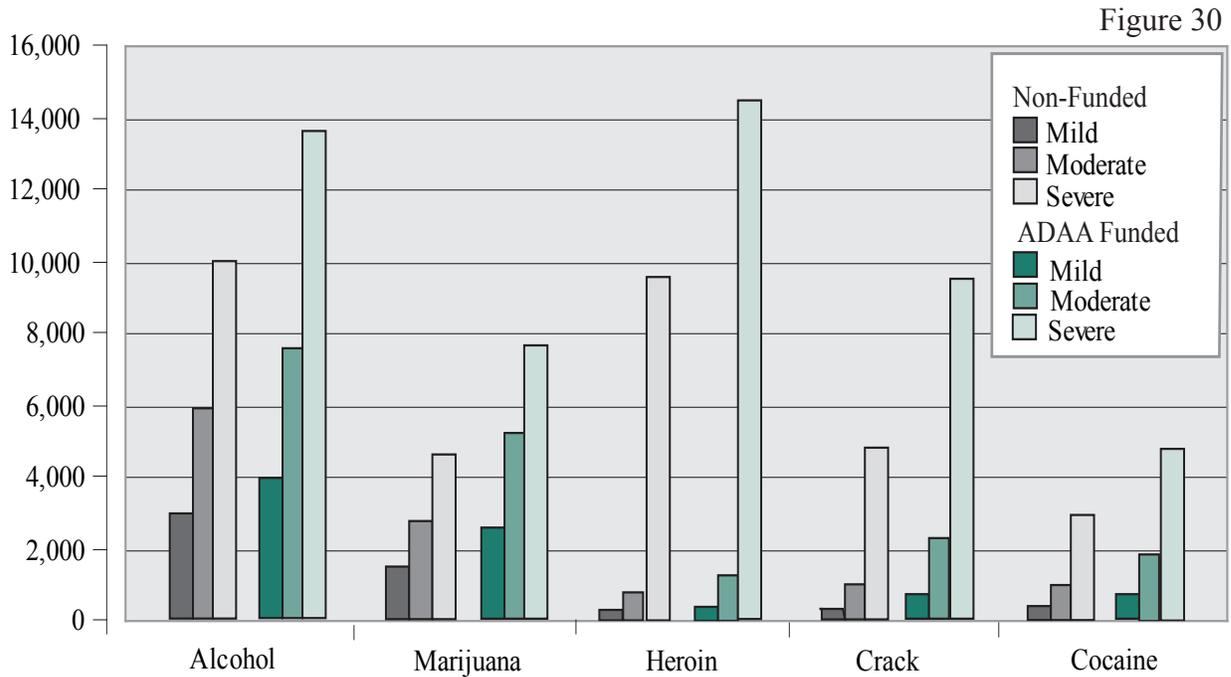
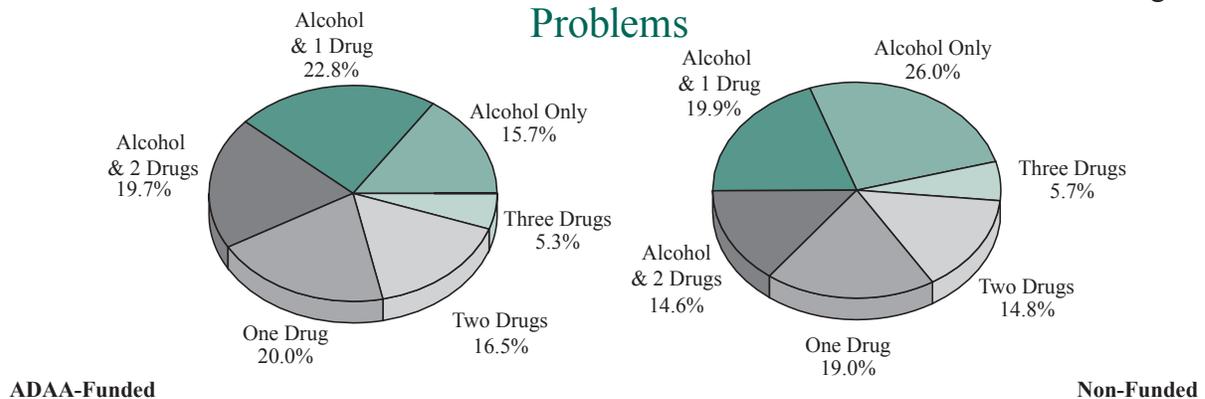


Figure 30 shows the relative distribution of the five major substance problems reported for FY 2004 admissions, further distributed by reported problem severity. Ninety percent of funded and non-funded heroin problems, 78 percent of crack problems and about two-thirds of other cocaine problems were rated severe; just over half of alcohol and marijuana problems were rated that serious. Non-funded admissions were slightly more likely to have alcohol problems - 60 vs. 57 percent, but every other major substance appeared in higher proportions among the ADAA-funded admissions. For funded and non-funded admissions the percentages for heroin were 37 and 34 percent, for marijuana 35 and 29 percent, for crack 28 and 20 percent, and for other cocaine 17 and 14 percent respectively. This is consistent with the finding that funded admissions are more likely than non-funded to report multiple substance problems. A fourth of funded admissions had three or more substance abuse problems and 39 percent had two; the respective figures for non-funded admissions were 20 and 35 percent. Over one-fourth of non-funded admissions had alcohol problems only. Figure 31 distributes FY 2004 funded and non-funded admissions by the pattern of substance problems.

Pattern of Substance Problems

Figure 31

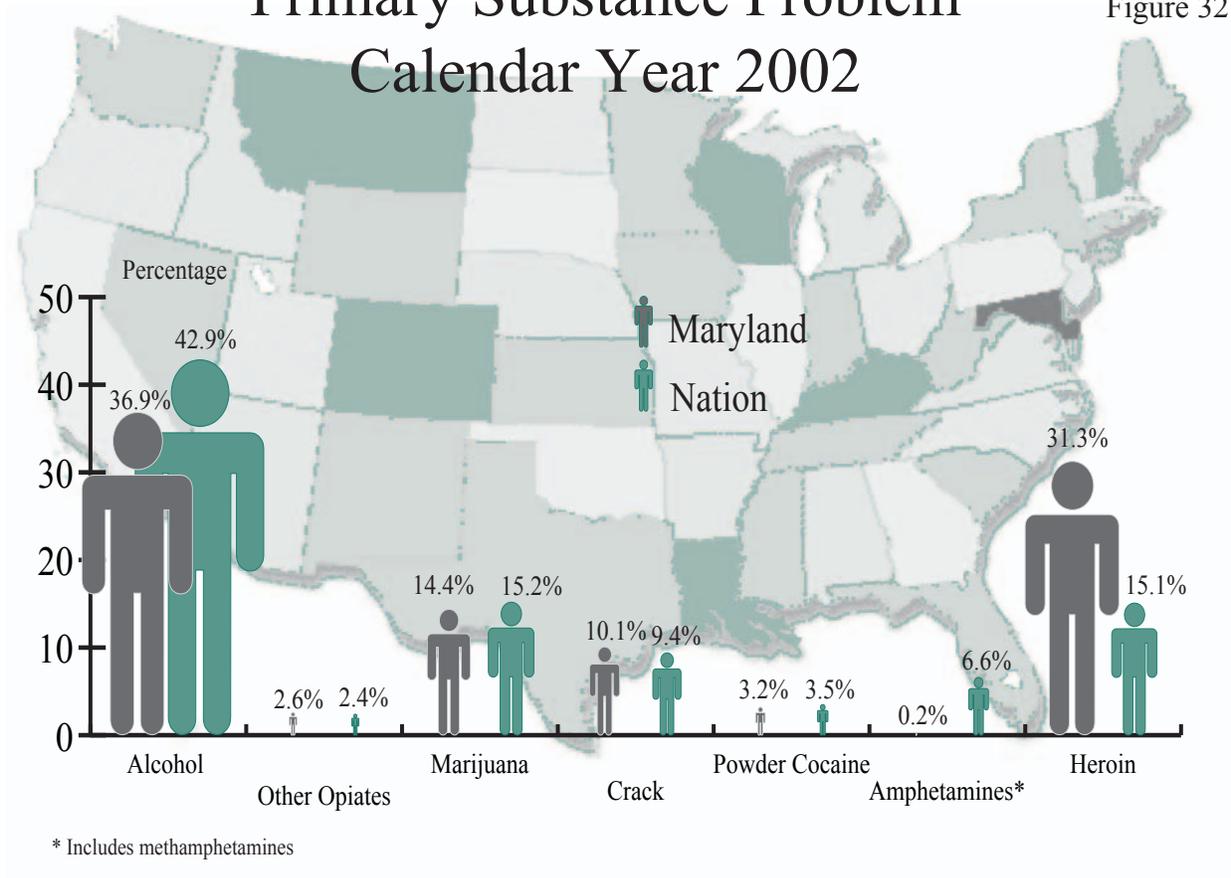


How Maryland Compares to the Nation

Primary Substance Problem

Calendar Year 2002

Figure 32



The Federal Treatment Episode Data Set (TEDS) is a reporting system on substance abuse treatment admissions in which all 50 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 2002.

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 2002, 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 Maryland and other Eastern states continue to show very low levels of methamphetamine abuse.

Eight contiguous states in the North Atlantic region, including Maryland, had the highest admission rates for primary problems with heroin. The Maryland treatment system had double the percentage of primary heroin abuse problems as 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 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 (35-38 percent) and first using marijuana before turning 15 (47-49 percent).

Table 5 **Age of First Use**
ADAA-Funded

	Alcohol		Marijuana		Crack		Powder Cocaine		Heroin	
	#	%	#	%	#	%	#	%	#	%
Under 15	9390	37.50%	7300	47.28%	565	4.58%	554	7.51%	1034	6.41%
15-17	8637	34.49%	5372	34.79%	1759	14.27%	1676	22.71%	3202	19.84%
18-25	5954	23.78%	2343	15.18%	5502	44.64%	3320	44.98%	7009	43.44%
26-30	503	2.01%	212	1.37%	2052	16.65%	890	12.06%	2275	14.10%
Over 30	556	2.22%	212	1.37%	2448	19.86%	941	12.75%	2616	16.21%

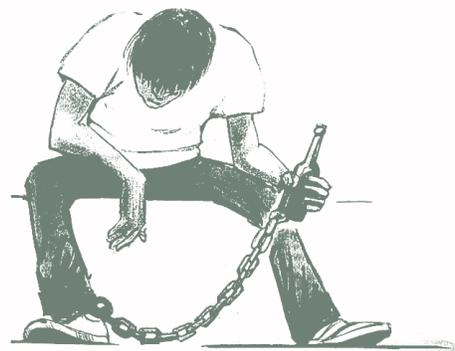
The picture is quite different for cocaine and heroin. About 80 percent of crack abusers first used the drug after age 17; nearly 70 percent of abusers of other forms of cocaine first used between 15 and 25. Only about 27 percent of heroin-related cases first became involved with the drug in adolescence; about 30 percent first used heroin after turning 26.

Table 76 **Age of First Use**
Non-Funded

	Alcohol		Marijuana		Crack		Powder Cocaine		Heroin	
	#	%	#	%	#	%	#	%	#	%
Under 15	6545	34.97%	4361	49.19%	343	5.66%	355	8.28%	767	7.21%
15-17	6581	35.16%	2971	33.51%	1028	16.97%	1021	23.84%	2185	20.54%
18-25	4729	25.26%	1347	15.19%	2628	43.38%	1919	44.81%	4568	42.94%
26-30	305	1.95%	91	1.03%	921	15.20%	490	11.44%	1350	12.69%
Over 30	498	2.66%	96	1.08%	1138	18.79%	498	11.63%	1768	16.62%

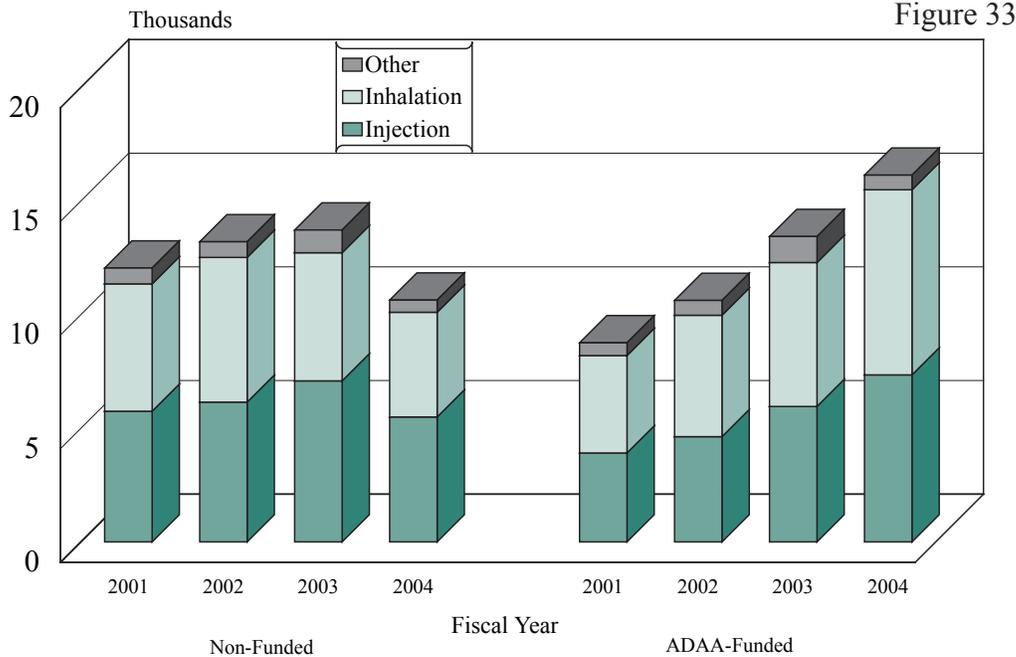
* For alcohol the item pertains to the age at first intoxication

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



Trend Changes in Routes of Administration for Heroin: A Continuing ADAA Research Study

Route of Administration of Heroin Related Admissions
FY 2001 - FY 2004



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 with unique identifiers who had both their first treatment admission and at least one subsequent admission during the five-year period from FY 2000 to FY 2004 were analyzed. What became apparent was that patients were about equally likely to move from injecting heroin to inhaling as 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 2000 through 2004 there were 24,001 unique heroin-related cases involving inhalation and/or injection, a first-time admission and one or more subsequent treatment admissions. Forty-two percent involved injection only and 36 percent inhalation only. The remaining 22 percent was about evenly split between those who started out inhaling primarily and subsequently were reported as primary injectors, and those that followed the reverse pattern.

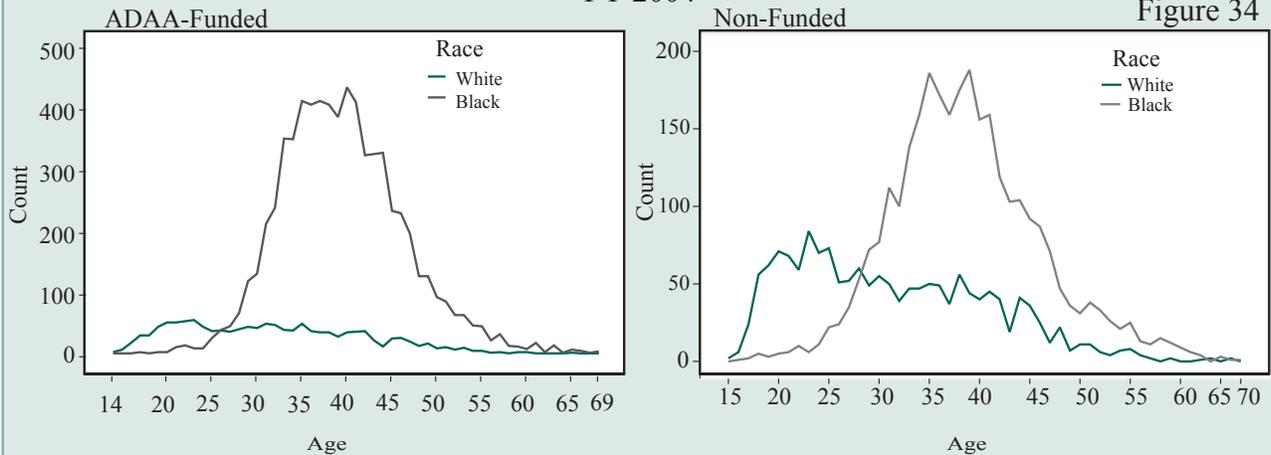
It is possible that progressing from inhalation of heroin to injection was common at one time, but the great influx of high-purity heroin and spread of HIV infection attributable to injecting drug use have created a new dynamic. The August 2002 Maryland Drug Threat Assessment by the National Drug Intelligence 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 exposure category for AIDS cases in the state, although heterosexual HIV transmission is rapidly gaining. Changing circumstances and following heroin users for a longer time period may produce different results.

Routes of Administration

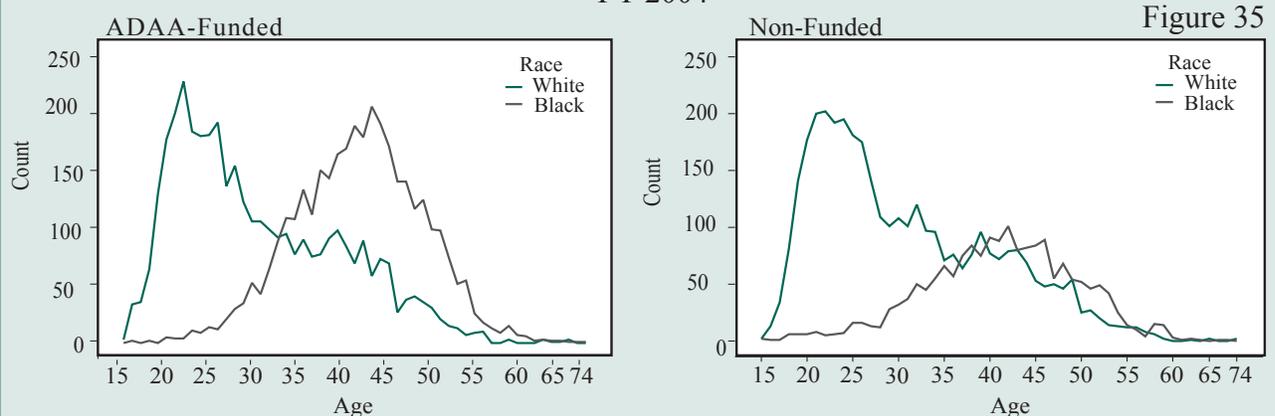
Among ADAA-funded admissions, as shown in Figure 33, mentions of heroin increased 84 percent from FY 2001 to FY 2004. The distribution of route of administration changed little over that period, with just over half of FY 2004 admissions primarily inhaling and about 46 percent injecting. Non-funded heroin-related admissions went up by 14 percent through FY 2003, but fell by 23 percent in FY 2004. In FY 2004, 52 percent injected primarily and 43 percent inhaled. The high rate of inhalation, especially among ADAA-funded patients, is related to high purity levels of available heroin, as well as avoidance of needles and potential HIV infection.

Further analysis in Figures 34 and 35 shows that heroin inhalation was particularly popular among black users from about age 30 to 50. In non-funded programs, more white patients inhaling were admitted up to about age 27, but black inhalers dominate at older ages in non-funded and funded programs. Injection was the preferred mode of use for whites in their late teens to early 40's and for blacks in their early 30's to early 50's. For all four route and funding combinations, heroin users in their late teens and 20's were predominantly white. Overall, 66 percent of funded and 47 percent of non-funded heroin-related admissions were black. These proportions jump to 84 and 64 percent when cases are restricted to primary inhalation.

Patients Inhaling Heroin as the Main Route of Administration
FY 2004

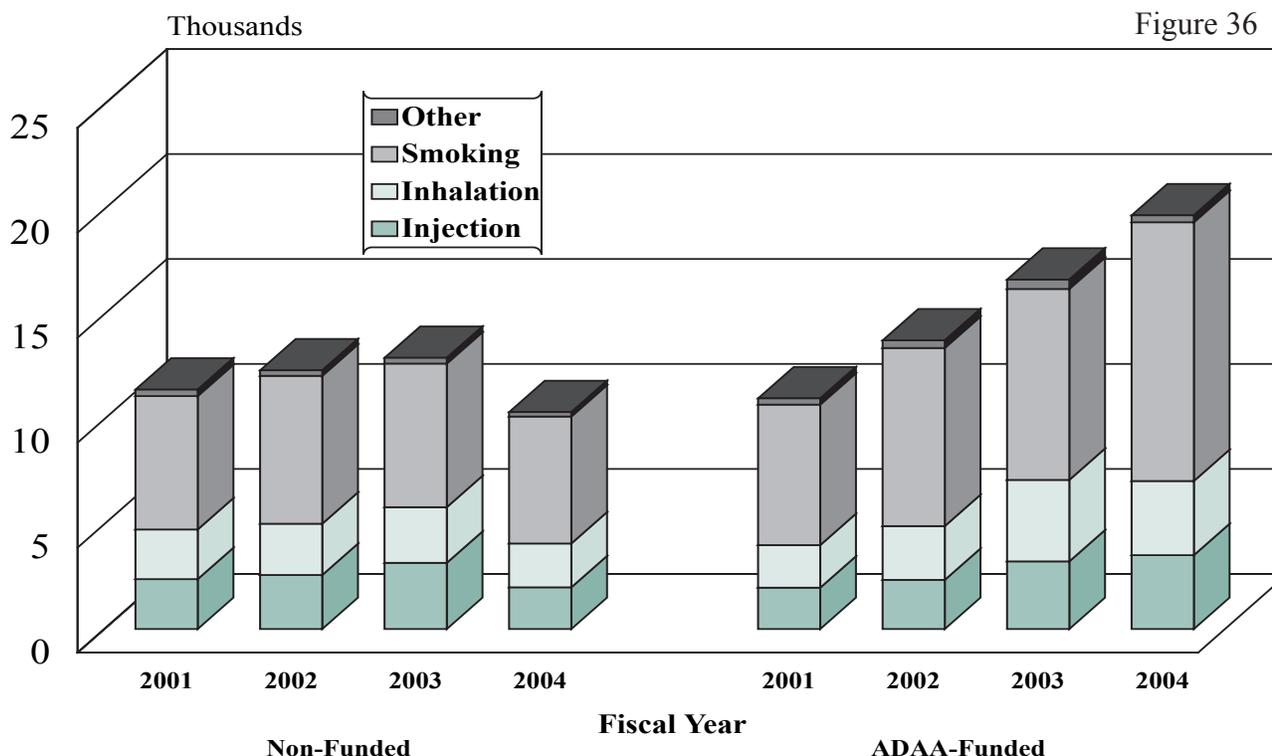


Patients Injecting Heroin as the Main Route of Administration
FY 2004



Cocaine Related Admissions FY 2001 - FY 2004

Figure 36



Cocaine-related admissions are distributed by the primary route of administration in Figure 36. Clearly, smoking (crack) is the predominant mode of administration, making up 63 percent of FY 2004 ADAA-funded cases and 59 percent of non-funded. Most of the remaining cases were fairly evenly split between inhalation and injection. While cocaine has increased by 79 percent among funded admissions and decreased 9 percent among non-funded, the distribution of route of administration has not changed substantially.

While 61 percent of funded FY 2004 cocaine-related admissions and 52 percent of non-funded were black, 67 and 60 percent respectively of those involving crack were black. Over 40 percent of cocaine admissions were female, well above the overall female percentage for admissions. While 23 percent of funded and 28 percent of non-funded cocaine admissions were white males, 34 and 43 percent respectively of cocaine inhalers were white males.

Overall, females made up 46 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.

WAS IT WORTH IT?

TREATMENT OUTCOMES

The ADAA 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 the continuum of care, changes in substance use, employment, arrest rate and living situation.

Discharges

Discharges from treatment from FY 2001 to FY 2004 are distributed by ASAM level of care in Table 8. During the four years, discharges from ADAA-funded treatment increased by half while non-funded discharges fell by seven percent. Largest increases in funded discharges were in Level I.D, which went up nearly five-fold, Level II.1 (146 percent) and Level III.7.D (197 percent). Non-funded discharges increased in Level I.D (22 percent), Level II.1 (8 percent) and Level OMT, which went up by a third.

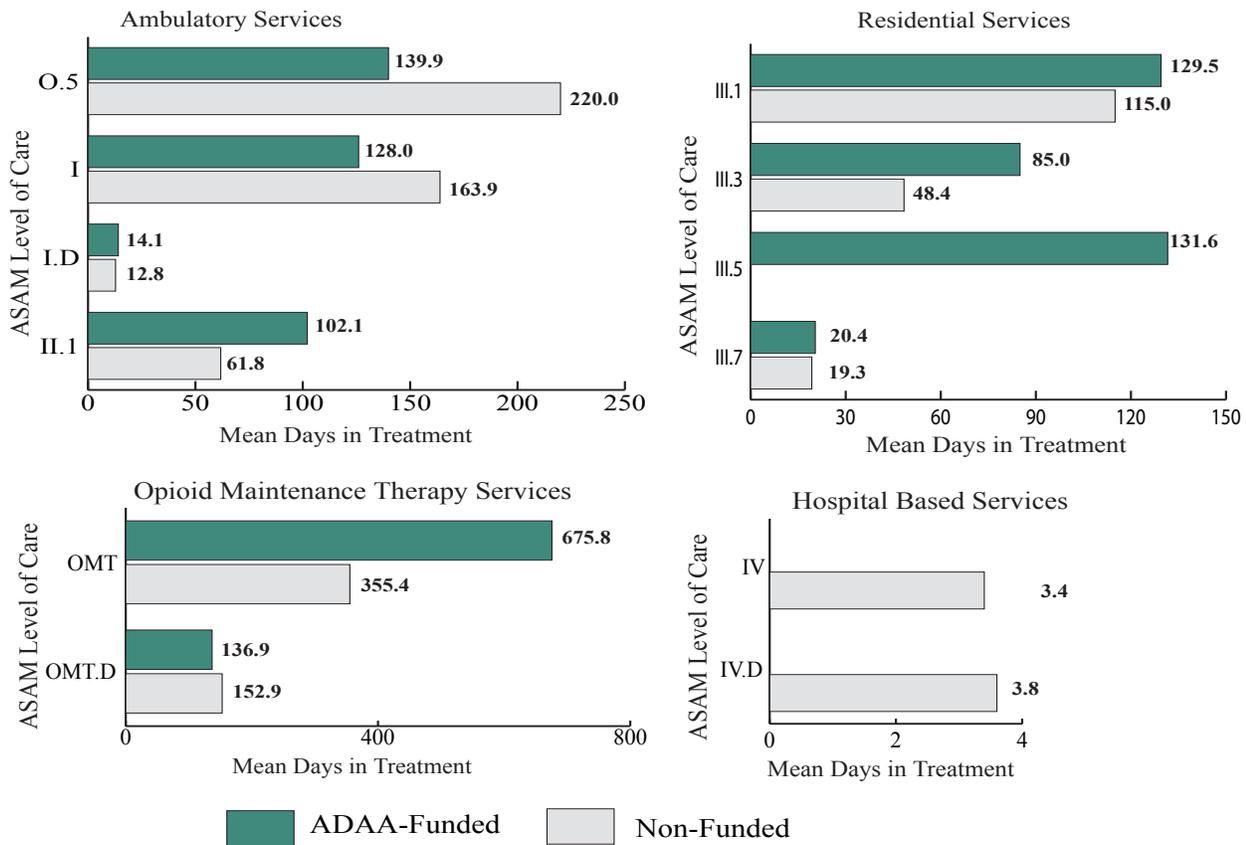
Figure 37 shows the average length of stay in ASAM levels of care during FY 2004. There were significant differences between funded and non-funded treatment in time spent in Levels 0.5 and Level I, with non-funded patients staying on average 80 days longer in the former case and 36 days longer in the latter. Funded patients stayed longer in Level II.1 (40 days), Level III.1 (15 days), Level III.3 (37 days) and OMT (321 days), on average.

Table 7

Discharges From Maryland Treatment Programs by ASAM Level of Care - FY 2001 - FY 2004								
ASAM Level of Care	FY 2001		FY 2002		FY 2003		FY 2004	
	ADAA-Funded	Non-Funded	ADAA-Funded	Non-Funded	ADAA-Funded	Non-Funded	ADAA-Funded	Non-Funded
Level 0.5	-	-	-	-	-	-	522	7
Level I	16595	14788	19838	14568	18994	14050	20425	12099
Level I.D	323	1626	247	1490	199	1959	1914	1984
Level II.1	1834	5603	2139	6565	2328	7138	4513	6067
Level III.1	551	153	658	114	628	201	885	235
Level III.3	769	599	713	313	806	165	993	239
Level III.5	-	-	-	-	-	-	517	-
Level III.7	4558	4659	4903	5287	4644	5562	6498	4386
Level III.7.D	1140	1094	1994	1250	1848	1742	3390	939
Level IV	-	271	-	251	-	237	-	42
Level IV.D	-	201	-	304	-	148	-	107
Level OMT	1953	2611	2358	3047	2444	3564	2685	3477
Level OMT.D	499	58	395	16	319	359	302	17
Total	28212	31663	33245	33305	32210	35125	42644	29599

Figure 37

Mean Days in Treatment by ASAM Level of Care



There was little difference between funded and non-funded discharges in the categories of treatment completion, except for Completed/Transferred in which eight percent of non-funded discharges were reported vs. five percent of funded. About 21 percent in both sectors completed treatment with no indicated need for further care. In total, half of funded and 55 percent of non-funded completed their treatment plans in the various levels of care.

Reason for Discharge

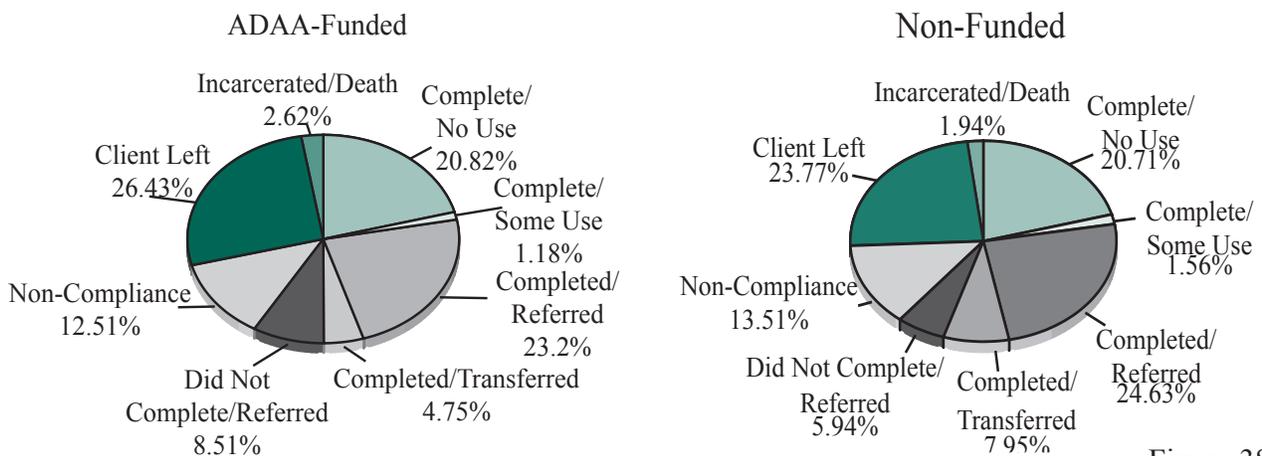


Figure 38

Continuum of Care

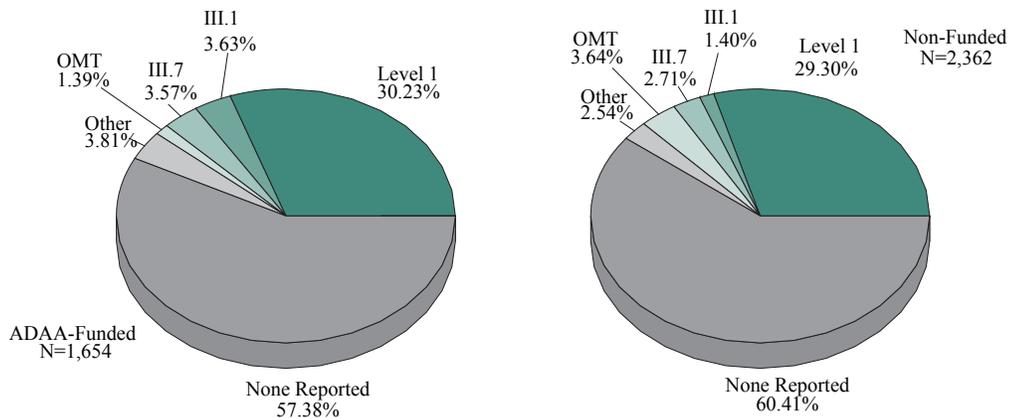
One of ADAA's most important objectives is to promote development of a complete continuum of care in various regions of the state so that all citizens in need will have access to appropriate levels of care. To assess current performance in this area, FY 2004 completion discharges from Levels II.1 and III.7.D were tracked for six months post-discharge to determine whether they were subsequently admitted to another level of care. The commonly expected progression is that patients who complete Level II.1 will be transferred or referred to Level I, and patients completing residential detox will move on to Level III.7.

Figure 39 presents the results of this analysis. It is apparent much work remains to be done, as only about 30 percent of patients completing Level II.1 in both funded and non-funded programs went on to Level I. Another 12 percent of funded and 10 percent of non-funded entered other levels of care in the six months post-discharge. Investigation has shown that faulty reporting contributes to these poor results – oftentimes the reduction in intensity or hours of treatment services per week does not result in a reported transfer or referral, so the discharge from Level II.1 is in fact a Level I discharge. ADAA is currently making system changes that should facilitate the reporting of this important link.

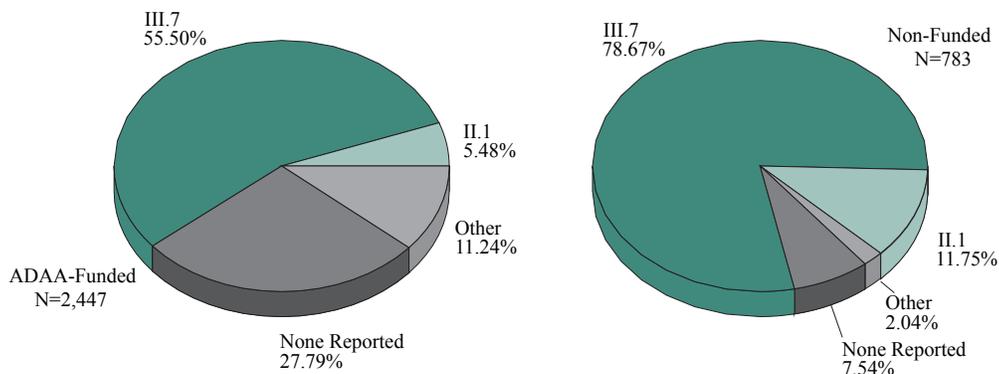
Program performance was substantially better with respect to Level III.7.D, especially with regard to non-funded treatment. Fifty-five percent of funded and 79 percent of non-funded Level III.7.D completion discharges subsequently entered Level III.7, and another 14 to 17 percent entered other treatment levels.

Level II.1 Treatment Completion Discharges - FY 2004

Figure 39



Level III.7.D Treatment Completion Discharges - FY 2004



Treatment Services

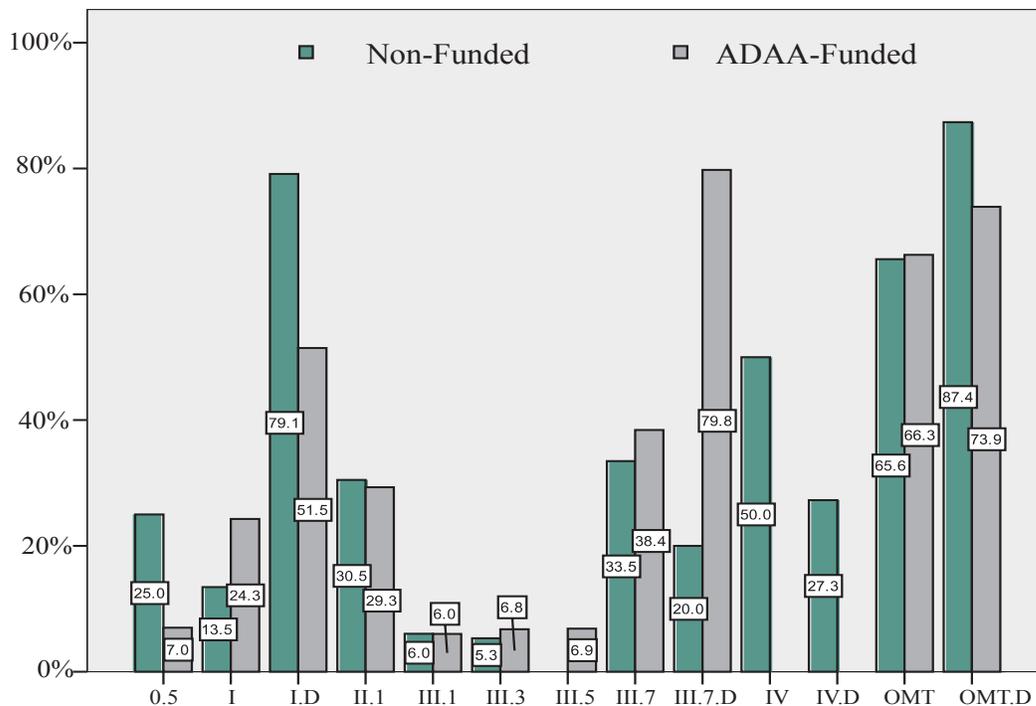
Certain information collected at discharge can be used to describe aspects of the treatment experience beyond the ASAM level of care. Data are collected on the number and type of counseling services delivered during the treatment episode. About 89 percent of patients discharged from ADAA-funded treatment and 73 percent of those from non-funded treatment received individual counseling during FY 2004. Level I patients averaged just over 2 sessions per month in funded programs and 1.6 in non-funded.

Eighty-five percent of funded patients and 82 percent of non-funded patients received group counseling, averaging 5.5 and 6.8 sessions per month respectively in Level I. Only 13 percent of funded and 11 percent of non-funded patients received family counseling.

Information is also collected on urinalysis tests undergone by patients discharged, and the number that were positive. Figure 40 shows the average percentages of positive tests for funded and non-funded patients by level of care. Not surprisingly, highest positive test results occurred in detox services; however, almost two-thirds of the urinalysis tests conducted in both funded and non-funded Level OMT were positive.

The positive urinalysis rates in OMT are not an indicator of ineffective treatment. Opiate maintenance therapy must be considered in a different light when discussing outcomes. Discharges are usually dominated by treatment failures; most of the successful cases in OMT are those that remain in treatment, usually employed, law-abiding and abstinent from illicit drugs. When ADAA-funded OMT patients who spent the entire FY 2004 active in treatment are added to the successful discharges from OMT during the year, positive outcomes for OMT are more in the range of 66 percent rather than 10 to 15 percent.

Average Percentages of Positive Urinalysis Tests During Treatment Figure 40



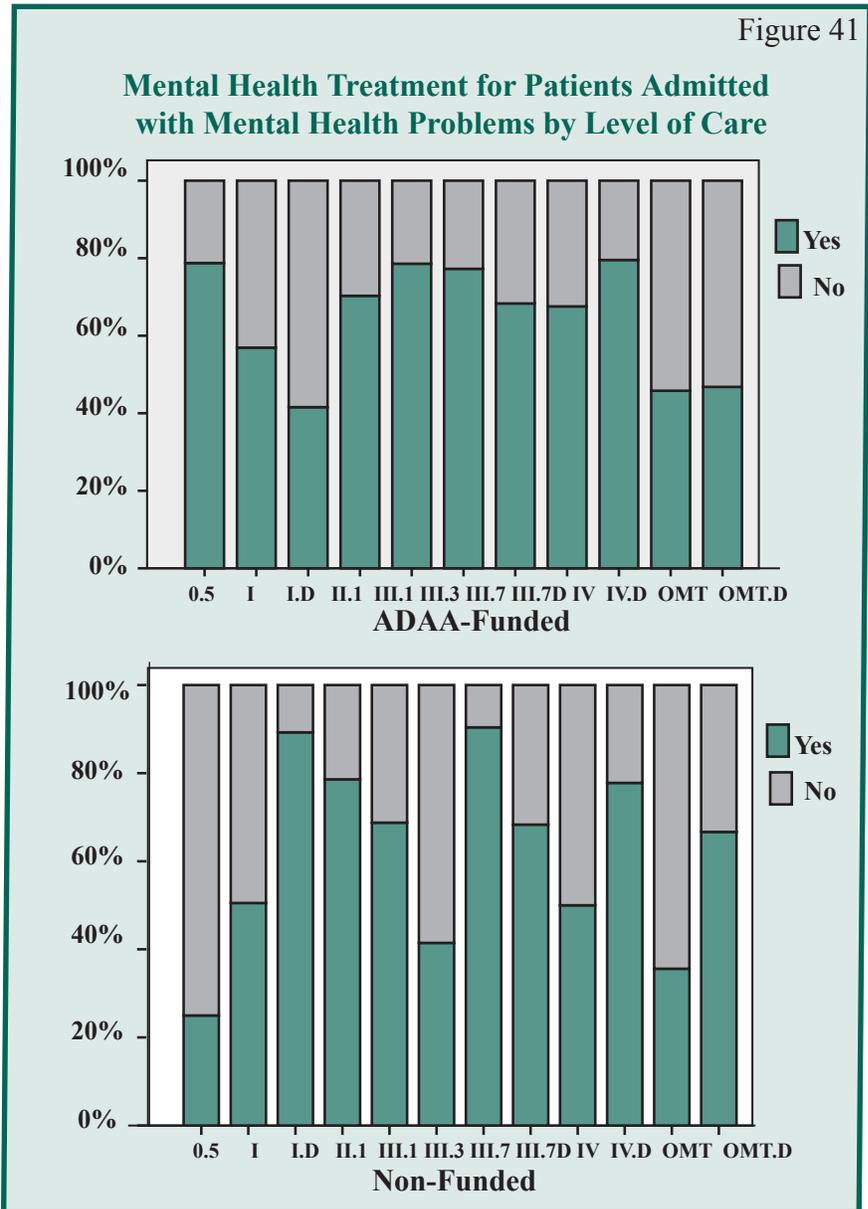
Mental Health Treatment Received by Patients with Co-occurring Disorders

As shown in Figure 41, the great majority of patients assessed as having mental health problems at admission to residential and intensive outpatient levels of care received mental health treatment during their substance abuse treatment episodes, with the exception of non-funded Level III.3. About half of ADAA-funded and non-funded Level I patients with problems received treatment, and just under half of those in funded OMT received mental health services. 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 Level III.7 and other residential levels of care are more likely to receive mental health counseling for mental health problems identified at admission.

Of those individuals discharged who had mental health problems at admission, successful completion rates were 16 percent higher for ADAA-funded patients who received mental health services and 34 percent higher for those in non-funded treatment.

Figure 41



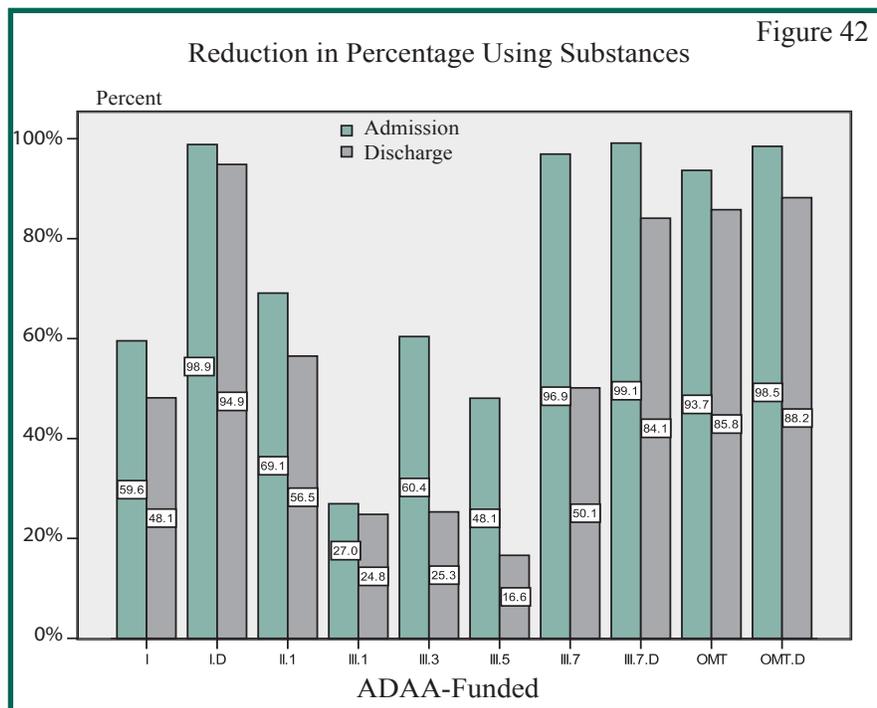
Co-occurring Disorder Facts



Among adults with serious mental illness in 2003, 21.3% were dependent on or abused alcohol or illicit drugs and among adults with substance dependence or abuse, 21.6% had serious mental illness.* (2003 National Survey on Drug Use and Health, SAMHSA)

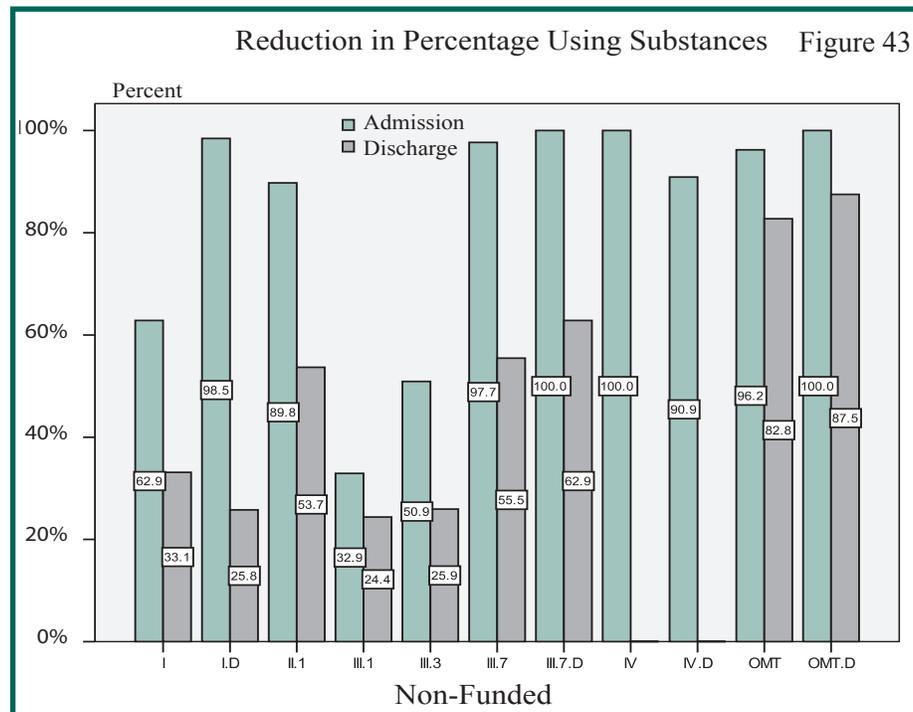
Treatment Reduces Substance Use

Figures 42 and 43 illustrate the reductions in use of substances that occur in ADAF-funded and non-funded treatment from the 30 days preceding admission to the 30 days preceding discharge for all discharges, whether successful or not. In funded Levels I and II.1, use was reduced by about 19 percent; in non-funded Level I, the reduction was a dramatic 47 percent and in Level II.1 it was 40 percent. As pointed out earlier, these results are not truly comparable. The patients treated in ADAF-funded programs tended to have more severe problems, higher rates of multiple substance abuse, higher arrest rates, more use of heroin and cocaine, and lower levels of social support than their non-funded counterparts. While reductions in Level III.1 were modest, Levels III.3, III.5 and III.7 had reductions in use that approached or exceeded 50 percent in both the funded and non-funded sectors. The reductions in percentage of users during treatment in Level OMT are relatively small; however, as pointed out above, discharges from opiate maintenance therapy tend to be skewed by unsuccessful patients.



Further analysis revealed that for most levels of care, the longer the time patients spent in treatment, the greater the reduction in use. Among funded patients in Levels I, II.1, III.1 and III.3 who spent less than 30 days in treatment, use of the primary substance was reduced by 10 percent; staying up to 89 days produced a 14 percent reduction; 90 to 179 days yielded double that; and remaining in treatment at least 180 days was associated with a 50 percent reduction in the percentage of discharged patients using the primary substance. Results for non-funded treatment showed the same pattern, with percentage reductions ranging from 36 to 58.

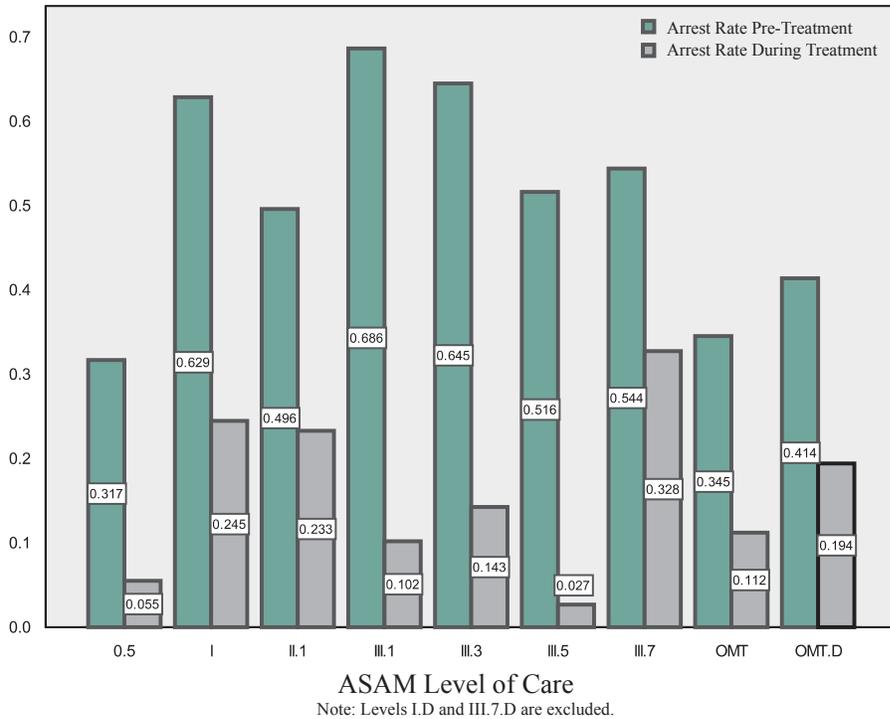
Cases where the frequency of use at discharge was reported as "unknown" are included with the cases where substance use at discharge was reported. This occurs because patients who leave treatment against clinical advice are often reported as "substance use unknown."



Treatment Reduces Crime

Figure 44

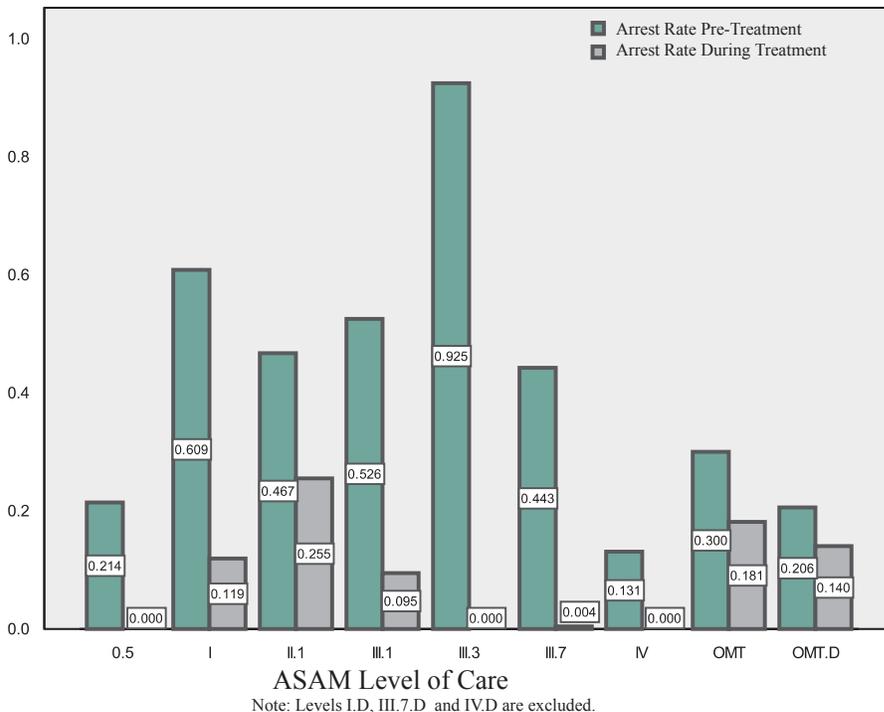
Arrest Rates for the Two Years Preceding and During Treatment
ADAA-Funded



Aggregate arrest rates for the two years preceding treatment are compared to arrest rates during treatment for ASAM levels of care in Figures 44 and 45. The highest entry arrest rates among ADAA-funded patients were in Level III.1 (.686), Level III.3 (.645) and Level I (.629), where reductions during treatment were 85, 78 and 61 percent respectively. The lowest pre-treatment arrest rates occurred among Level 0.5 (.317) and OMT (.345) discharges. In funded OMT treatment, the arrest rate was reduced by over two-thirds during treatment.

Figure 45

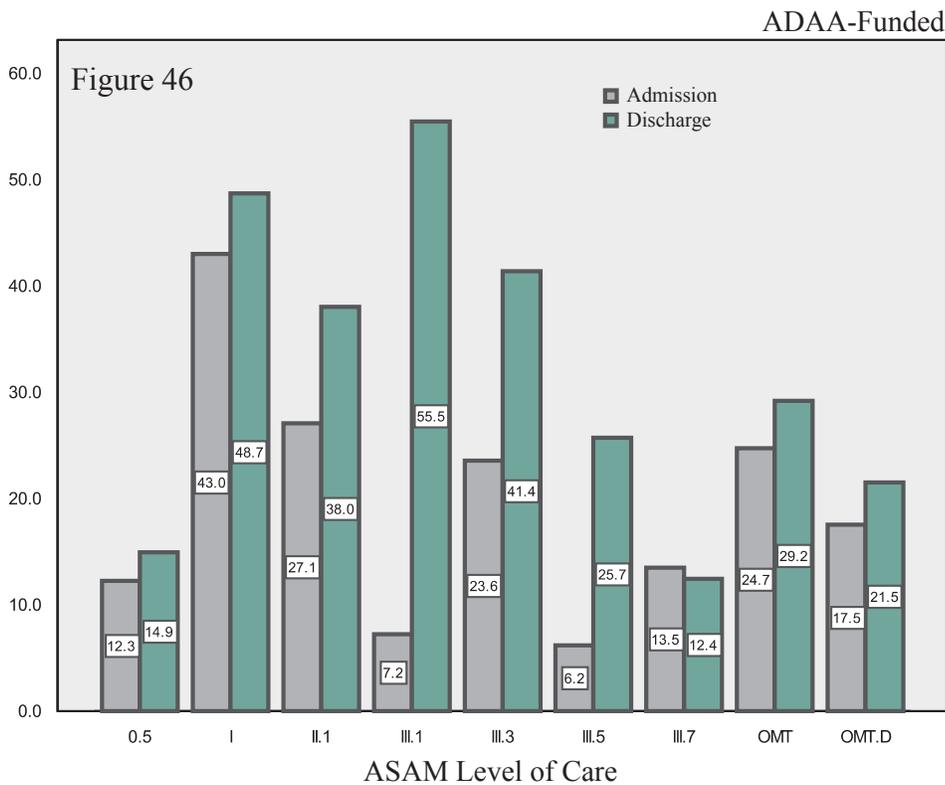
Arrest Rates for the Two Years Preceding and During Treatment
Non-Funded



With the exception of Level III.3, non-funded discharges had lower arrest rates at admission at every level of care, as well as substantial reductions during treatment. Among discharges from non-funded Level I, arrest rates during treatment were reduced by 80 percent. Not surprisingly, residential levels of care had the sharpest reductions in arrest rates, reflecting the various degrees of control or custody exerted.

Treatment Increases Employment

Percentages Employed at Admission and at Discharge

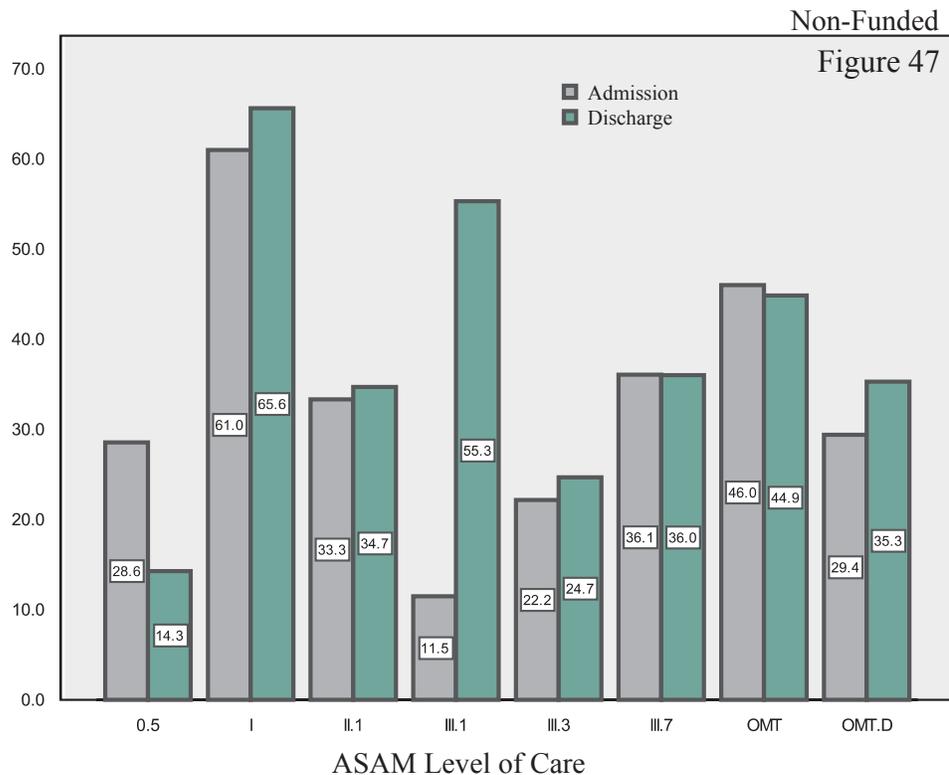


Halfway houses (Level III.1) were particularly effective in getting patients employed, as shown in Figures 46 and 47. The percentage employed increased eight-fold during funded half-way house treatment and five-fold in non-funded. Employment also increased three-fold in funded Level III.5 and by three-quarters in Level III.3. In outpatient levels of care increases were less dramatic, but employment rates at admission were substantially higher. In funded Level I treatment,

employment increased by 13 percent; in Level II.1 the jump was 40 percent.

An interesting phenomenon exists with respect to treatment completion and employment. The percentage employed at admission was higher for those who completed treatment successfully, yet the increase in employment during treatment was greater for them as well. The same phenomenon exists with respect to length of stay (Figure 48).

Percentages Employed at Admission and at Discharge



Changes in Percentages of Patients Employed at Admission and at Discharge

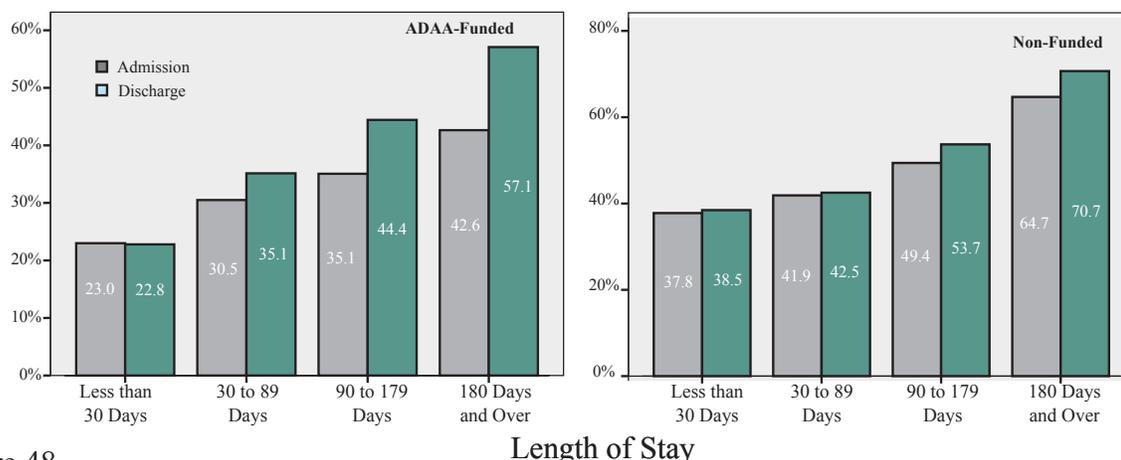


Figure 48

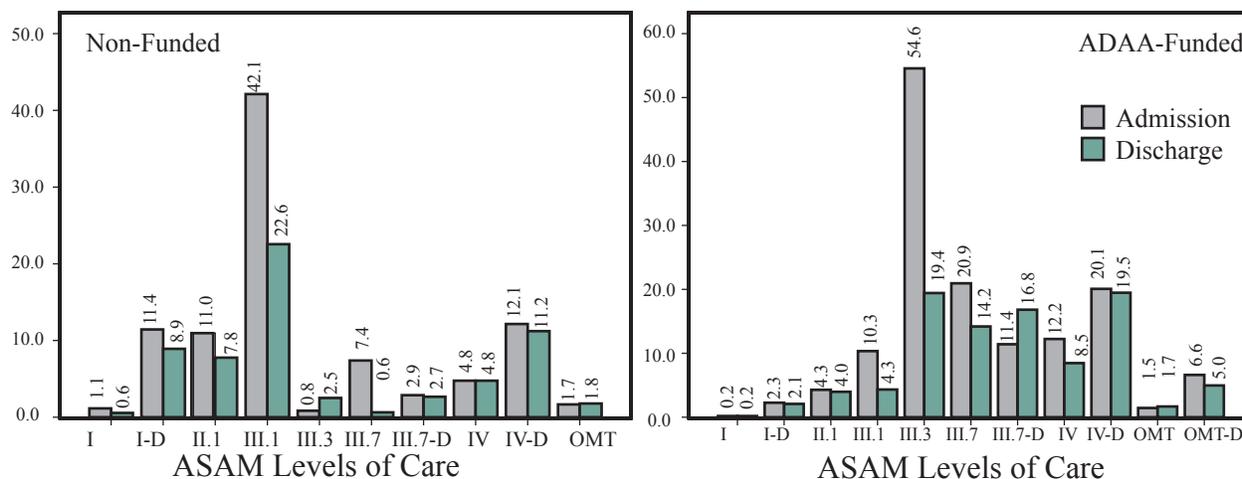
Note: Levels I-D, and III.7-D are excluded

Length of stay in treatment was associated with both employment at admission and becoming employed during treatment, as shown in Figure 48. Employed patients stay in treatment longer, and unemployed patients are more likely to become employed the longer they stay. In ADAA-funded treatment (excluding short-term detox), there was virtually no change in employment status for patients who stayed less than 30 days; staying up to 89 days was associated with a 15 percent increase; patients staying up to 179 days had a 25 percent increase; and, those who remained in treatment at least 180 days increased by 34 percent in employment. Significantly, at each length of stay interval, patients are increasingly more likely to be employed at admission and have an even greater likelihood of employment at discharge. The same pattern exists with non-funded treatment except that employment rates are generally higher and improvement rates lower.

Treatment Correlates with Improved Living Situation

Figure 49 shows that the percentage of homeless patients at admission is reduced in various levels of care, especially those that are residential. It is important to note that treatment was associated with patients moving from dependent to independent living situations.

Percentages of Patients Homeless at Admission and at Discharge



Note: Levels 0.5 and OMT.D had no reported homeless admissions or discharges

Figure 49

Appendix

**Table A: Admissions to Maryland Treatment Programs by ASAM Level of Care
FY 2001 - FY 2004**

ADAA-Funded Treatment Programs								
Level of Care	FY 2001		FY 2002		FY 2003		FY 2004	
	#	%	#	%	#	%	#	%
Level 0.5	611	2.1	501	1.5	516	1.4	513	1.2
Level I	16794	57.3	19616	58.5	20228	54.1	20873	47.6
Level I.D	332	1.1	355	1.1	1611	4.3	2032	4.6
Level II.1	1,893	6.5	2,052	6.1	3,245	8.7	4722	10.8
Level III.1	642	2.2	715	2.1	806	2.2	1000	2.3
Level III.3	208	0.7	339	1.0	444	1.2	1014	2.3
Level III.5	0	0.0	0	0.0	374	1.0	550	1.3
Level III.7	4,573	15.6	4,883	14.6	5,073	13.6	6577	15.0
Level III.7.D	1149	3.9	1940	5.8	2015	5.4	3447	7.9
OMT	2654	9.1	2705	8.1	2760	7.4	2742	6.3
OMT.D	449	1.5	428	1.3	347	0.9	385	0.9
Total	29,305	100.0	33,534	100.0	37,419	100.0	43855	100.0

Non-Funded Treatment Programs								
Level of Care	FY 2001		FY 2002		FY 2003		FY 2004	
	#	%	#	%	#	%	#	%
Level 0.5	77	0.2	53	0.1	51	0.1	4	0.0
Level I	16,233	46.9	15,045	42.1	13,788	38.2	12715	41.1
Level I.D	2,096	6.1	2,228	6.2	2,469	6.8	2129	6.9
Level II.1	5,213	15.1	6,535	18.3	6,997	19.4	6189	20.0
Level III.1	148	0.4	125	0.4	138	0.4	299	1.0
Level III.3	815	2.4	552	1.5	509	1.4	248	0.8
Level III.5	386	1.1	350	1.0	0	0.0	0	0.0
Level III.7	4,74	14.1	5,501	15.4	5,426	15.0	4410	14.2
Level III.7.D	1179	3.4	1452	4.1	2184	6.1	929	3.0
Level IV	273	0.8	262	0.7	241	0.7	56	0.2
Level IV.D	4	0.0	2	0.0	31	0.1	143	0.5
MAT	3,227	9.3	3,636	10.2	4,184	11.6	3837	12.4
MAT.D	58	0.2	12	0.0	39	0.1	14	0.0
Total	34,583	100.0	35,753	100.0	36,057	100.0	30973	100.0

**Table B: Discharges from Maryland
Treatment Programs by ASAM Levels of Care
FY 2001 - FY 2004**

ADAA-Funded Treatment Programs								
Level of Care	FY 2001		FY 2002		FY 2003		FY 2004	
	#	%	#	%	#	%	#	%
Level 0.5	*	*	*	*	*	*	522	1.2
Level I	16,595	58.8	19,838	59.7	18,994	59.0	20,425	47.9
Level I.D	323	1.1	247	0.7	199	0.6	1,914	4.5
Level II.1	1,834	6.5	2,139	6.4	2,328	7.2	4,513	10.6
Level III.1	551	2.0	658	2.0	628	2.0	885	2.1
Level III.3	759	2.7	713	2.1	806	2.5	993	2.3
Level III.5	*	*	*	*	*	*	517	1.2
Level III.7	4,558	16.2	4,903	14.7	4,644	14.4	6,498	15.2
Level III.7.D	1,140	4.0	1,994	6.0	1,848	5.7	3,390	8.0
Level OMT	1,953	6.9	2,358	7.1	2,444	7.6	2,685	6.3
Level OMT.D	499	1.8	395	1.2	319	1.0	302	0.7
Total	28,212	100.0	33,245	100.0	32,210	100.0	42,644	100.0

Non-Funded Treatment Programs								
Level of Care	FY 2001		FY 2002		FY 2003		FY 2004	
	#	%	#	%	#	%	#	%
Level 0.5	*	*	*	*	*	*	7	0.0
Level I	14,788	46.7	14,568	43.7	14,050	40.0	12,099	40.9
Level I.D	1,626	5.1	1,490	4.5	1,959	5.6	1,984	6.7
Level II.1	5,603	17.7	6,565	19.7	7,138	20.3	6,067	20.5
Level III.1	153	0.5	114	0.3	201	0.6	235	0.8
Level III.3	599	1.9	313	0.9	165	0.5	239	0.8
Level III.7	4,659	14.7	5,287	15.9	5,562	15.8	4,386	14.8
Level III.7.D	1,094	3.5	1,350	4.1	1,742	5.0	939	3.2
Level IV	271	0.9	251	0.8	237	0.7	42	0.1
Level IV.D	201	0.6	304	0.9	148	0.4	107	0.4
Level OMT	2611	8.2	3047	9.1	3564	10.1	3,477	11.7
Level OMT.D	58	0.2	16	0.0	359	1.0	17	0.1
Total	31,663	100.0	33,305	100.0	35,125	100.0	29,599	100.0

* Data not available prior to FY 2004

**Table C: Admissions to ADAA-Funded
Treatment Programs by Substance Mentions
FY 2001 - FY 2004**

ADAA-Funded Treatment Programs								
Substance Mentions	FY 2001		FY 2002		FY 2003		FY 2004	
	#	%	#	%	#	%	#	%
Heroin	9075	33.0	11045	32.6	11162	32.8	16136	37.5
Non-Rx Methadone	75	0.3	106	0.3	103	0.3	228	0.5
Other Opiates & Synthetics	566	2.1	1019	3.0	1115	3.3	2005	4.7
Alcohol	17241	62.7	20683	61.0	20504	60.3	25041	58.2
Barbiturates	51	0.2	75	0.2	77	0.2	106	0.2
Other Sedatives & Hypnotics	146	0.5	167	0.5	202	0.6	307	0.7
Other Tranquilizers	24	0.1	17	0.1	30	0.1	25	0.1
Hallucinogens	416	1.5	445	1.3	458	1.3	493	1.1
Crack	7115	25.9	8853	26.1	7896	23.2	12326	28.7
Other Cocaine	4438	16.1	5312	15.7	6835	20.1	7382	17.2
Marijuana/Hashish	10445	38.0	12495	36.8	13077	38.5	15440	35.9
Methamphetamines	76	0.3	123	0.4	136	0.4	175	0.4
Other Amphetamines	84	0.3	125	0.4	144	0.4	140	0.3
Other Stimulants	24	0.1	28	0.1	35	0.1	254	0.6
Inhalants	36	0.1	37	0.1	66	0.2	70	0.2
PCP	206	0.8	340	1.0	490	1.4	551	1.3
Benzodiazepines	191	0.7	356	1.1	300	0.9	567	1.3
Over the Counter	16	0.1	20	0.1	25	0.1	60	0.1
Steroids	13	0.0	14	0.0	21	0.1	15	0.0
Other	21	0.1	48	0.1	69	0.2	99	0.2
Total Respondents	27503	-	33922	-	34001	-	43023	-

Note: Up to three substances may be reported for each respondent, so percentages will not add up to 100.

**Table D: Admissions to Non-Funded
Treatment Programs by Substance Mentions
FY 2001 - FY 2004**

Non-Funded Maryland Treatment Programs								
Substance Mentions	FY 2001		FY 2002		FY 2003		FY 2004	
	#	%	#	%	#	%	#	%
Heroin	12021	34.9	13171	36.5	16238	40.9	10662	34.5
Non-Rx Methadone	108	0.3	176	0.5	202	0.5	260	0.8
Other Opiates & Synthetics	1660	4.8	2288	6.3	2638	6.6	2608	8.4
Alcohol	20127	58.5	20831	57.8	21667	54.6	18722	60.5
Barbiturates	70	0.2	66	0.2	94	0.2	68	0.2
Other Sedatives & Hypnotics	133	0.4	266	0.7	402	1.0	542	1.8
Other Tranquilizers	55	0.2	26	0.1	26	0.1	21	0.1
Hallucinogens	362	1.1	327	0.9	353	0.9	388	1.3
Crack	6240	18.1	6979	19.4	7798	19.6	6059	19.6
Other Cocaine	4990	14.5	5167	14.3	6717	16.9	4285	13.9
Marijuana/Hashish	9187	26.7	9400	26.1	9903	24.9	8870	28.7
Methamphetamines	59	0.2	83	0.2	112	0.3	122	0.4
Other Amphetamines	75	0.2	99	0.3	102	0.3	66	0.2
Other Stimulants	19	0.1	50	0.1	70	0.2	46	0.1
Inhalants	41	0.1	46	0.1	49	0.1	28	0.1
PCP	324	0.9	423	1.2	540	1.4	523	1.7
Benzodiazepines	543	1.6	655	1.8	729	1.8	587	1.9
Over the Counter	11	0.0	27	0.1	36	0.1	50	0.2
Steroids	12	0.0	11	0.0	55	0.1	219	0.7
Other	52	0.2	70	0.2	112	0.3	72	0.2
Total Respondents	34422	-	36069	-	39711	-	30927	-

Note: Up to three substances may be reported for each respondent, so percentages will not add up to 100.

**Table E: Alcohol Related Admissions to
Treatment Programs by Residence
FY 2001 - FY 2004**

Location of Residence	ADAA-Funded				Non-Funded			
	FY 2001	FY 2002	FY 2003	FY 2004	FY 2001	FY 2002	FY 2003	FY 2004
Allegany	438	490	548	549	55	39	45	45
Anne Arundel	351	463	470	1188	3407	3408	3103	2197
Baltimore City	2519	3710	4881	6182	3874	4601	4796	3598
Baltimore Co.	1612	1681	1787	2317	2292	2672	2780	2362
Calvert	528	708	637	904	264	316	296	128
Caroline	286	325	359	390	54	61	59	67
Carroll	554	570	571	647	457	453	526	603
Cecil	469	647	737	579	236	188	169	203
Charles	776	958	1055	1018	276	241	190	151
Dorchester	329	407	439	385	80	51	67	111
Frederick	766	807	844	793	867	865	860	856
Garrett	222	255	275	283	8	12	9	12
Harford	608	633	677	670	675	885	1019	960
Howard	415	411	431	509	573	553	614	530
Kent	258	269	276	317	29	24	24	25
Montgomery	1201	1820	1964	2148	2387	1980	2258	2194
Prince George's	1064	1319	1299	1376	1655	1620	1616	1792
Queen Anne's	336	319	321	357	112	114	96	72
St. Mary's	713	905	770	806	130	132	101	69
Somerset	397	327	315	304	67	59	45	35
Talbot	407	380	394	366	76	103	119	112
Washington	864	1102	900	864	460	377	454	351
Wicomico	829	986	1001	889	446	391	364	469
Worcester	664	757	683	716	163	182	172	187
Out-of-State	302	396	374	482	1539	1757	1581	1589
Total	16908	20645	22008	25039	20182	21084	21363	18718

**Table F: Marijuana Related Admissions
to Treatment Programs by Residence
FY 2001 - FY 2004**

Location of Residence	ADAA-Funded				Non-Funded			
	FY 2001	FY 2002	FY 2003	FY 2004	FY 2001	FY 2002	FY 2003	FY 2004
Allegany	306	314	394	408	36	19	26	24
Anne Arundel	187	239	280	722	1814	1869	1609	1155
Baltimore City	1582	2188	2858	3222	1962	2063	2076	1548
Baltimore Co.	1050	1107	1194	1354	1056	1213	1313	1105
Calvert	288	422	397	595	126	131	138	64
Caroline	198	227	275	282	28	31	29	36
Carroll	487	482	436	509	188	183	231	264
Cecil	256	396	477	418	104	70	77	84
Charles	350	494	591	568	116	134	118	81
Dorchester	267	344	343	400	37	28	26	61
Frederick	503	542	547	517	371	374	344	355
Garrett	154	150	148	164	6	9	7	6
Harford	456	504	486	489	238	312	441	474
Howard	282	290	287	339	194	227	284	211
Kent	151	220	189	227	12	18	8	12
Montgomery	541	869	1027	1171	997	862	880	1036
Prince George's	628	759	839	984	821	843	905	1078
Queen Anne's	184	200	217	259	46	55	36	30
St. Mary's	384	533	409	457	46	61	51	43
Somerset	204	220	222	191	43	28	16	21
Talbot	204	234	259	251	25	38	48	65
Washington	590	681	623	572	274	182	233	143
Wicomico	473	628	676	663	252	249	221	286
Worcester	341	411	397	387	64	68	71	85
Out-of-State	151	199	248	290	447	629	667	598
Total	10217	12653	13819	15439	9303	9696	9855	8865

**Table G: Heroin Related Admissions
to Treatment Programs by Residence
FY 2001 - FY 2004**

Location of Residence	ADAA-Funded				Non-Funded			
	FY 2001	FY 2002	FY 2003	FY 2004	FY 2001	FY 2002	FY 2003	FY 2004
Allegany	35	67	82	106	23	23	21	27
Anne Arundel	418	436	491	727	946	1069	1125	977
Baltimore City	5942	7193	9441	11376	7370	7757	7644	5625
Baltimore Co.	798	889	1020	1346	1572	1910	2238	1459
Calvert	18	41	35	56	16	37	27	14
Caroline	12	12	21	37	24	16	8	7
Carroll	226	281	249	229	201	209	273	213
Cecil	69	120	212	259	126	169	151	184
Charles	22	33	37	57	30	42	36	45
Dorchester	13	16	23	21	9	10	15	13
Frederick	95	136	159	135	93	138	137	130
Garrett	6	8	5	19	3	0	2	6
Harford	127	204	202	190	256	372	458	430
Howard	163	151	133	147	233	213	254	173
Kent	11	19	18	51	6	8	26	8
Montgomery	256	269	312	359	273	245	270	263
Prince George's	219	268	334	201	268	241	284	268
Queen Anne's	30	44	93	92	13	22	24	26
St. Mary's	25	43	49	64	15	12	9	14
Somerset	40	52	75	49	15	7	11	15
Talbot	32	45	46	49	12	15	25	24
Washington	34	81	80	120	67	41	62	66
Wicomico	82	96	172	179	25	20	22	77
Worcester	45	43	80	97	9	14	13	19
Out-of-State	49	82	112	170	440	619	579	553
Total	8767	10629	13481	16136	12045	13209	13714	10636

**Table H: Crack Related Admissions to
Treatment Programs by Residence
FY 2001 - FY 2004**

Location of Residence	ADAA-Funded				Non-Funded			
	FY 2001	FY 2002	FY 2003	FY 2004	FY 2001	FY 2002	FY 2003	FY 2004
Allegany	36	61	66	76	15	8	12	4
Anne Arundel	206	262	252	489	707	724	718	531
Baltimore City	2142	3004	4320	5667	2663	3352	3376	2791
Baltimore Co.	395	516	526	737	546	692	728	651
Calvert	40	66	125	246	52	58	32	19
Caroline	74	63	54	88	15	21	11	19
Carroll	121	186	121	164	52	58	64	67
Cecil	128	158	136	174	20	27	28	39
Charles	149	218	210	275	64	65	43	40
Dorchester	193	179	139	183	42	24	25	59
Frederick	239	252	215	271	122	131	136	98
Garrett	3	12	18	24	1	1	1	1
Harford	110	114	101	113	98	154	139	138
Howard	134	152	89	141	85	88	85	67
Kent	88	110	103	139	7	7	8	10
Montgomery	845	738	653	1083	517	409	371	327
Prince George's	559	743	580	832	651	602	478	638
Queen Anne's	77	87	57	89	18	19	18	7
St. Mary's	136	216	186	262	21	18	15	7
Somerset	114	89	80	106	28	13	8	7
Talbot	107	107	121	101	28	28	49	37
Washington	220	320	266	248	176	89	114	79
Wicomico	313	420	339	407	74	89	73	96
Worcester	159	240	193	163	24	25	21	21
Out-of-State	112	179	148	247	330	350	292	305
Total	6700	8492	9098	12325	6356	7052	6845	6058

**Table I: Other Cocaine Related Admissions to
Treatment Programs by Residence
FY 2001 - FY 2004**

Location of Residence	ADAA-Funded				Non-Funded			
	FY 2001	FY 2002	FY 2003	FY 2004	FY 2001	FY 2002	FY 2003	FY 2004
Allegany	18	37	59	69	9	4	6	8
Anne Arundel	171	168	228	329	450	531	597	385
Baltimore City	2183	2559	3336	3597	2594	2663	2741	1859
Baltimore Co.	440	483	552	717	657	788	1023	598
Calvert	67	110	129	159	21	32	48	12
Caroline	50	48	87	88	14	10	11	10
Carroll	114	123	198	150	103	86	130	96
Cecil	57	95	204	168	32	38	44	28
Charles	90	104	160	127	24	34	28	23
Dorchester	45	90	147	101	16	15	20	15
Frederick	101	121	207	148	75	92	106	104
Garrett	10	11	34	36	2	0	4	2
Harford	83	107	135	128	99	142	255	206
Howard	68	83	106	73	88	85	100	73
Kent	13	20	27	45	7	5	6	3
Montgomery	109	255	418	332	257	163	247	200
Prince George's	108	149	370	147	177	150	217	163
Queen Anne's	41	41	87	81	14	16	18	6
St. Mary's	98	123	167	136	11	16	19	17
Somerset	62	52	92	69	13	6	12	10
Talbot	51	64	80	74	16	14	16	24
Washington	75	108	151	107	67	46	65	36
Wicomico	132	156	352	252	80	52	61	88
Worcester	84	102	143	140	23	26	22	28
Out-of-State	41	58	105	108	214	278	290	288
Total	4311	5267	7574	7381	5063	5292	6086	4282

**Table J: Adolescent Admissions to Maryland Treatment Programs by Residence
FY 2004**

Location of Residence	ADAA-Funded		Non-Funded	
	#	%	#	%
Allegany	192	4.4	8	0.4
Anne Arundel	354	8.1	167	8.1
Baltimore City	660	15.1	455	22.1
Baltimore County	577	13.2	269	13.1
Calvert	170	3.9	20	1.0
Caroline	111	2.5	17	0.8
Carroll	158	3.6	40	1.9
Cecil	150	3.4	15	0.7
Charles	119	2.7	33	1.6
Dorchester	83	1.9	10	0.5
Frederick	169	3.9	106	5.1
Garrett	68	1.6	3	0.1
Harford	234	5.4	41	2.0
Howard	152	3.5	72	3.5
Kent	67	1.5	4	0.2
Montgomery	113	2.6	436	21.2
Prince George's	177	4.0	85	4.1
Queen Anne's	68	1.6	9	0.4
St. Mary's	212	4.9	20	1.0
Somerset	44	1.0	7	0.3
Talbot	106	2.4	19	0.9
Washington	175	4.0	18	0.9
Wicomico	57	1.3	91	4.4
Worcester	114	2.6	16	0.8
Out-of-State	42	1.0	99	4.8
Total	4372	100.0	2060	100.0

Substance Abuse Treatment Outcome Measurement Tables

**Table K: Substance Use at Admission and Discharge by Jurisdiction
FY 2004**

ADAA-Funded Treatment Programs					Non-Funded Treatment Programs				
Subdivision	Discharges	Use at Admission	Use at Discharge	% Change	Subdivision	Discharges	Use at Admission	Use at Discharge	% Change
Allegany	1,212	62.4	10.6	-83.0	Allegany	88	98.9	0.0	-100.0
Anne Arundel	333	69.4	58.3	-16.0	Anne Arundel	4,675	82.2	47.4	-42.3
Baltimore City	13,113	79.6	61.6	-22.6	Baltimore City	8,953	92.7	67.2	-27.5
Baltimore Co.	2,480	60.5	53.7	-11.2	Baltimore Co.	4,069	83.6	53.0	-36.6
Calvert	863	54.3	42.9	-21.0	Calvert	456	67.8	25.9	-61.8
Caroline	357	72.3	64.7	-10.5	Carroll	1,212	45.4	31.1	-31.5
Carroll	1,282	56.5	32.7	-42.1	Cecil	468	87.8	67.7	-22.9
Cecil	791	59.9	43.5	-27.4	Charles	112	99.1	76.8	-22.5
Charles	1,197	47.2	34.4	-27.1	Dorchester	1,815	99.7	1.5	-98.5
Dorchester	537	64.1	60.5	-5.6	Frederick	1,766	85.3	69.3	-18.8
Frederick	979	38.5	39.7	3.1	Garrett	131	94.7	6.1	-93.6
Garrett	347	50.1	54.5	8.8	Harford	3,219	88.4	19.9	-77.5
Harford	795	55.3	42.8	-22.6	Howard	1,169	42.1	29.7	-29.5
Howard	516	71.3	50.4	-29.3	Montgomery	3,374	71.1	37.8	-46.8
Kent	806	81.3	20.8	-74.4	Prince George's	1,875	64.7	38.8	-40.0
Montgomery	3,175	93.8	76.0	-19.0	St. Mary's	41	73.2	19.5	-73.4
Prince George's	1,453	73.4	58.2	-20.7	Somerset	147	81.0	39.5	-51.2
Queen Anne's	259	37.5	57.5	53.3	Talbot	116	75.9	64.7	-14.8
St. Mary's	1,165	53.8	29.5	-45.2	Washington	471	74.1	54.8	-26.0
Somerset	351	55.8	49.6	-11.1	Wicomico	670	78.8	51.8	-34.3
Talbot	486	61.3	46.7	-23.8	Worcester	29	82.8	34.5	-58.3
Washington	938	29.5	23.8	-19.3	Total	34,856	81.9	46.8	-42.9
Wicomico	1,612	64.2	39.0	-39.3					
Worcester	807	59.5	38.7	-35.0					
Statewide	1,387	64.0	48.2	-24.7					
Total	37,241	69.0	51.5	-25.4					

**Table L: Employment Status at Admission and Discharge by Jurisdiction
FY 2004**

ADAA-Funded Treatment Programs					Non-Funded Treatment Programs				
Subdivision	Discharges	Employed Admission	Employed Discharge	% Change	Subdivision	Discharges	Employed Admission	Employed Discharge	% Change
Allegany	1,212	20.5	25.2	22.9	Allegany*	88	1.1	56.8	5063.6
Anne Arundel	333	25.8	55.0	113.2	Anne Arundel	4,675	57.9	61.1	5.5
Baltimore City	13,113	17.8	23.3	30.9	Baltimore City	8,953	18.2	19.5	7.1
Baltimore Co.	2,480	42.9	47.0	9.6	Baltimore Co.	4,069	52.9	58.5	10.6
Calvert	863	62.0	59.4	-4.2	Calvert	456	57.7	64.0	10.9
Caroline	357	53.5	59.4	11.0	Carroll	1,212	38.0	39.2	3.2
Carroll	1,282	39.1	39.9	2.0	Cecil	468	60.9	62.8	3.1
Cecil	791	39.3	47.2	20.1	Charles	112	72.3	64.3	-11.1
Charles	1,197	48.6	61.7	27.0	Dorchester	1,815	32.1	32.8	2.2
Dorchester	537	32.2	39.7	23.3	Frederick	1,766	54.9	53.8	-2.0
Frederick	979	23.6	40.7	72.5	Garrett	131	6.9	8.4	21.7
Garrett	347	35.4	38.3	8.2	Harford	3,219	60.2	59.8	-0.7
Harford	795	51.1	58.5	14.5	Howard	1,169	36.4	38.3	5.2
Howard	516	44.0	50.6	15.0	Montgomery	3,374	58.6	63.6	8.5
Kent	806	33.9	37.2	9.7	Prince George's	1,875	47.3	53.0	12.1
Montgomery	3,175	33.4	35.9	7.5	St. Mary's	41	87.8	87.8	0.0
Prince George's	1,453	24.5	34.3	40.0	Somerset	147	85.0	86.4	1.6
Queen Anne's	259	56.8	62.9	10.7	Talbot	116	60.3	54.3	-10.0
St. Mary's	1,165	41.8	50.0	19.6	Washington	471	63.3	59.2	-6.5
Somerset	351	33.9	39.0	15.0	Wicomico	670	57.5	59.7	3.8
Talbot	486	49.0	53.5	9.2	Worcester	29	79.3	89.7	13.1
Washington	938	38.0	47.4	24.7	Total	34,856	43.9	46.4	5.7
Wicomico	1,612	33.7	40.3	19.6					
Worcester	807	41.1	49.4	20.2					
Statewide	1,387	16.0	24.6	53.8					
Total	37,241	29.9	36.1	20.7					

* Low employment numbers at admission represent the two non-funded programs, Savage Mountain Youth and Green Ridge Youth, in Allegany County. Adolescents served in these programs tend to be unemployed at admission and have part-time employment at discharge.

**Table M: Arrest Rate Prior to Admission and
During Treatment by Jurisdiction
FY 2004**

ADAA-Funded Treatment Programs					Non-Funded Treatment Programs				
Subdivision	Discharges	Arrest Rate Prior to Admission	Arrest Rate During Treatment	% Change	Subdivision	Discharges	Arrest Rate Prior to Admission	Arrest Rate During Treatment	% Change
Allegany	1,212	0.804	0.210	-73.9	Allegany	88	3.153	0.023	-99.3
Anne Arundel	333	0.551	0.153	-72.2	Anne Arundel	4,675	0.495	0.145	-70.7
Baltimore City	13,113	0.528	0.135	-74.4	Baltimore City	8,953	0.467	0.140	-70.0
Baltimore Co.	2,480	0.523	0.173	-66.9	Baltimore Co.	4,069	0.641	0.143	-77.7
Calvert	863	0.659	0.275	-58.3	Calvert	456	0.652	0.149	-77.1
Caroline	357	0.520	0.120	-76.9	Carroll	1,212	0.363	0.075	-79.3
Carroll	1,282	0.654	0.239	-63.5	Cecil	468	0.386	0.171	-55.7
Cecil	791	0.774	0.162	-79.1	Charles	112	0.272	0.096	-64.7
Charles	1,197	0.672	0.132	-80.4	Dorchester	1,815	0.246	0.092	-62.6
Dorchester	537	0.461	0.381	-17.4	Frederick	1,766	0.370	0.241	-34.9
Frederick	979	0.756	0.245	-67.6	Garrett	131	2.011	0.037	-98.2
Garrett	347	0.651	0.222	-65.9	Harford	3,219	0.296	0.133	-55.1
Harford	795	0.496	0.211	-57.5	Howard	1,169	0.461	0.127	-72.5
Howard	516	0.666	0.201	-69.8	Montgomery	3,374	0.416	0.114	-72.6
Kent	806	0.514	0.410	-20.2	Prince George's	1,875	0.523	0.142	-72.8
Montgomery	3,175	0.540	0.072	-86.7	St. Mary's	41	0.659	0.159	-75.9
Prince George's	1,453	0.376	0.101	-73.1	Somerset	147	0.588	0.105	-82.1
Queen Anne's	259	0.504	0.216	-57.1	Talbot	116	0.418	0.194	-53.6
St. Mary's	1,165	0.505	0.116	-77.0	Washington	471	0.431	0.302	-29.9
Somerset	351	0.604	0.262	-56.6	Wicomico	670	0.404	0.149	-63.1
Talbot	486	0.655	0.429	-34.5	Worcester	29	0.345	0.092	-73.3
Washington	938	0.705	0.199	-71.8	Total	34,856	0.465	0.140	-69.9
Wicomico	1,612	0.422	0.113	-73.2					
Worcester	807	0.437	0.395	-9.6					
Statewide	1,387	0.579	0.068	-88.3					
Total	37,241	0.558	0.160	-71.3					

**Table N: Level I (Outpatient Treatment)
Retention Rates by Jurisdiction
FY 2004**

ADAA-Funded Treatment Programs					Non-Funded Treatment Programs				
Subdivision	Admissions	Less than 90 Days	90 Days or More	% Retained 90 Days or More	Subdivision	Admissions	Less than 90 Days	90 Days or More	% Retained 90 Days or More
Allegany	553	156	397	71.8	Allegany	85	7	78	91.8
Anne Arundel	60	32	28	46.7	Anne Arundel	2,522	897	1625	64.4
Baltimore City	4,695	2,286	2,409	51.3	Baltimore City	1,124	522	602	53.6
Baltimore Co.	1,839	826	1,013	55.1	Baltimore Co.	2,257	807	1,450	64.2
Calvert	784	288	496	63.3	Calvert	91	14	77	84.6
Caroline	367	172	195	53.1	Carroll	852	138	714	83.8
Carroll	799	333	466	58.3	Cecil	123	24	99	80.5
Cecil	639	309	330	51.6	Charles	52	18	34	65.4
Charles	930	269	661	71.1	Dorchester	58	7	51	87.9
Dorchester	302	122	180	59.6	Frederick	564	160	404	71.6
Frederick	766	330	436	56.9	Garrett	54	5	49	90.7
Garrett	326	149	177	54.3	Harford	621	198	423	68.1
Harford	660	209	451	68.3	Howard	781	461	320	41.0
Howard	519	168	351	67.6	Montgomery	2,231	741	1,490	66.8
Kent	357	116	241	67.5	Prince George's	1,966	832	1134	57.7
Montgomery	1,181	457	724	61.3	St. Mary's	36	4	32	88.9
Prince George's	626	302	324	51.8	Somerset	129	40	89	69.0
Queen Anne's	258	104	154	59.7	Talbot	87	33	54	62.1
St. Mary's	680	249	431	63.4	Washington	224	42	182	81.3
Somerset	322	124	198	61.5	Wicomico	177	79	98	55.4
Talbot	354	179	175	49.4	Worcester	28	6	22	78.6
Washington	841	315	526	62.5	Total	14,062	5,035	9,027	64.2
Wicomico	773	455	318	41.1					
Worcester	694	287	407	58.6					
Statewide	365	177	188	51.5					
Total	19,690	8,414	11,276	57.3					

**Table O: Level III.1 (Halfway House)
Retention Rates by Jurisdiction
FY 2004**

ADAA-Funded Treatment Programs				
Subdivision	Admissions	Less than 90 Days	90 Days or More	% Retained 90 Days or More
Allegany	24	4	20	83.3
Anne Arundel	142	61	81	57.0
Baltimore City	267	79	188	70.4
Cecil	19	7	12	63.2
Frederick	126	68	58	46.0
Harford	27	12	15	55.6
Howard	18	9	9	50.0
Montgomery	18	5	13	72.2
St. Mary's	60	20	40	66.7
Washington	96	45	51	53.1
Wicomico	27	16	11	40.7
Total	824	326	498	60.4

Non-Funded Treatment Programs				
Subdivision	Admissions	Less than 90 Days	90 Days or More	% Retained 90 Days or More
Baltimore City	154	76	78	50.7
Baltimore Co.	42	27	15	35.7
Harford	10	4	6	60.0
Montgomery	78	43	35	44.9
Prince George's	35	9	26	74.3
Total	319	159	160	50.2

Table P: Subsequent Admission to Another Treatment Level
Completion Discharges from Level II.1 (IOP)
ADAA-Funded by Jurisdiction

ADAA-Funded Treatment Programs													
Subdivision	Total Level II.1 Discharges	Unduplicated Level II.1 Completion Discharges		Completion Discharges Subsequently Admitted to Level I		Days Between Completed Discharge from Level II.1 and Subsequent Admission to Another Level of Care							
						Same Day		30 or Fewer		31 to 90		91 to 180	
		#	%	#	%	#	%	#	%	#	%	#	%
Allegany	53	34	64.2	22	64.7	13	38.2	10	29.4	1	2.9	0	0.0
Baltimore City	1515	417	27.5	95	22.8	70	16.8	53	12.7	18	4.3	11	2.6
Baltimore Co.	99	80	80.8	45	56.3	6	7.5	41	51.3	3	3.8	4	5.0
Calvert	115	66	57.4	54	81.8	53	80.3	4	6.1	0	0.0	0	0.0
Carroll	36	19	52.8	7	36.8	1	5.3	5	26.3	2	10.5	1	5.3
Charles	96	40	41.7	24	60.0	3	7.5	25	62.5	0	0.0	0	0.0
Dorchester	221	47	21.3	2	4.3	2	4.3	0	0.0	0	0.0	1	2.1
Frederick	2	2	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Harford	62	3	4.8	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Montgomery	34	3	8.8	0	0.0	1	33.3	2	66.7	0	0.0	0	0.0
Prince George's	467	124	26.6	39	31.5	35	28.2	0	0.0	3	2.4	4	3.2
St. Mary's	55	20	36.4	7	35.0	1	5.0	6	30.0	1	5.0	0	0.0
Somerset	32	5	15.6	1	20.0	0	0.0	1	20.0	0	0.0	0	0.0
Talbot	142	61	43.0	46	75.4	40	65.6	11	18.0	0	0.0	0	0.0
Washington	50	10	20.0	2	20.0	5	50.0	2	20.0	0	0.0	0	0.0
Wicomico	232	79	34.1	23	29.1	16	20.3	12	15.2	0	0.0	1	1.3
Worcester	157	101	64.3	66	65.4	8	7.9	63	62.4	2	2.0	2	2.0
Total	3,368	1,111	33.0	433	39.0	254	22.9	235	21.2	30	2.7	24	2.2

Table Q: Subsequent Admission to Another Treatment Level
Completion Discharges from Level II.1 (IOP)
Non-Funded by Jurisdiction

Non-Funded Treatment Programs													
Subdivision	Total Level II.1 Discharges	Unduplicated Level II.1 Completion Discharges		Completion Discharges Subsequently Admitted to Level I		Days Between Completed Discharge from Level II.1 and Subsequent Admission to Another Level of Care							
		#	%	#	%	Same Day		30 or Fewer		31 to 90		91 to 180	
						#	%	#	%	#	%	#	%
Anne Arundel	619	257	41.5	5	1.9	7	2.7	13	5.1	5.0	1.9	5	1.9
Baltimore City	3,279	953	29.1	202	21.2	150	15.7	166	17.4	35	3.7	40	4.2
Baltimore Co.	1,100	629	57.2	333	52.9	323	51.4	22	3.5	15	2.4	12	1.9
Carroll	236	124	52.5	1	0.8	1	0.8	0	0.0	3	2.4	4	3.2
Dorchester	69	58	84.1	4	6.9	1	1.7	1	1.7	2	3.4	3	5.2
Frederick	273	96	35.2	23	24.0	5	5.2	22	22.9	2	2.1	0	0.0
Garrett	79	73	92.4	24	32.9	0	0.0	18	24.7	4	5.5	4	5.5
Harford	254	154	60.6	18	11.7	3	1.9	15	9.7	9	5.8	6	3.9
Howard	34	13	38.2	0	0.0	2	15.4	0	0.0	0	0.0	0	0.0
Montgomery	673	356	52.9	177	49.7	148	41.6	29	8.1	3	0.8	1	0.3
Prince George's	29	22	75.9	6	27.3	0	0.0	5	22.7	1	4.5	1	4.5
Somerset	2	1	50.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Talbot	44	10	22.7	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Washington	93	15	16.1	1	6.7	10	66.7	0	0.0	0	0.0	0	0.0
Wicomico	429	166	38.7	3	1.8	2	1.2	3	1.8	0	0.0	1	0.6
Total	7,213	2,927	40.6	797	27.2	652	22.3	294	10.0	79	2.7	77	2.6

**Table R: Subsequent Admission of Level III.7
(Non-Hospital Detox)
Completion by Jurisdiction
FY 2004**

ADAA-Funded Treatment Programs													
Subdivision	Total Level III.7.D Discharges	Unduplicated Level III.7.D Completion Discharges		Completion Discharges Subsequently Admitted to Level III.7		Days Between Completed Discharge from Level III.7.D and Subsequent Admission to Another Level of Care							
						Same Day		30 or Fewer		31 to 90		91 to 180	
						#	%	#	%	#	%	#	%
Baltimore City	684	452	66.1	49	10.8	34	7.5	66	14.6	39	8.6	42	9.3
Baltimore Co.	181	102	56.4	15	14.7	20	19.6	13	12.7	7	6.9	6	5.9
Carroll	7	6	85.7	1	16.7	0	0.0	2	33.3	1	16.7	0	0.0
Kent	205	172	83.9	157	91.3	4	2.3	156	90.7	0	0.0	1	0.6
Montgomery	1,075	803	74.7	674	83.9	662	82.4	34	4.2	11	1.4	9	1.1
Wicomico	236	146	61.9	46	31.5	10	6.9	59	40.4	8	5.5	10	6.9
Total	2,388	1,681	70.4	942	56.0	730	43.4	330	19.6	66	3.9	68	4.0

Non-Funded Treatment Programs													
Subdivision	Total Level III.7.D Discharges	Unduplicated Level III.7.D Completion Discharges		Completion Discharges Subsequently Admitted to Level III.7		Days Between Completed Discharge from Level III.7.D and Subsequent Admission to Another Level of Care							
						Same Day		30 or Fewer		31 to 90		91 to 180	
						#	%	#	%	#	%	#	%
Anne Arundel	369	287	77.8	190	66.2	198	69.0	24	8.4	3	1.0	9	3.1
Baltimore City	630	507	80.5	234	46.2	287	56.6	24	4.7	18.0	3.6	26	5.1
Baltimore Co.	138	90	65.2	0	0.0	72	80.0	1	1.1	1	1.1	0	0.0
Frederick	145	93	64.1	8	8.6	3	3.2	22	23.7	10	10.8	6	6.5
Harford	666	614	92.2	608	99.0	608	99.0	1	0.2	0	0.0	1	0.2
Total	1,948	1,591	81.7	1,040	65.4	1,168	73.4	72	4.5	32	2.0	42	2.6

Crosswalk from ADAA’s Previous Treatment Type Categories to American Society of Addiction Medicine (ASAM) Patient Placement Criteria

CODES	ASAM LEVELS OF CARE	DEFINITIONS	EXAMPLES
0	Early Intervention	Patients in the early stages of alcohol and drug abuse or dependence	Counseling with at-risk individuals and DUI programs
I	Outpatient Treatment	Patients who require services for less than 9 hours weekly	Office practice, health clinics, primary care clinics, mental health clinics, “Step down” programs
I OMT	Opioid Maintenance Therapy	Patients receive pharmacological interventions including but not limited to methadone, LAMM	Methadone Maintenance Programs
II	Intensive Outpatient Treatment	Patients who receive 9 or more hours weekly	Day or evening outpatient programs
II.5	Partial Hospitalization	Day treatment 9 or more hours weekly	
III.1	Clinically Managed Low-Intensity Residential Treatment	Residential care and at least 4 hours a week of treatment	Day treatment programs Halfway Houses with “Recovery” Services or “Discovery” Services; Sober Houses, boarding houses, or group homes with in-house Level I intensity services and a structured recovery environment
III.3	Clinically Managed Medium-Intensity Residential Treatment	Residential care for long term care with structured environment and treatment	Therapeutic Rehabilitation Facility for extended or long-term care
III.5	Clinically Managed High-Intensity Residential Treatment	Residential care with highly structured with high intensity treatment and ancillary services	Therapeutic Community or Residential Treatment Center and Step-down from III.7
III.7	Medically Monitored Intensive Inpatient Services	Medically monitored inpatient treatment program	Inpatient Treatment Center, ICF

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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