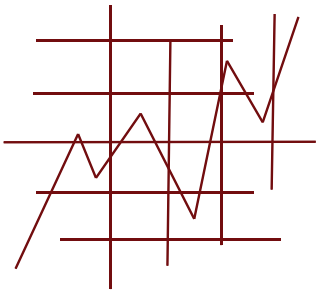
Outlook & Outcomes



2005 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
Peter F. Luongo, Ph.D., Director

STATE OF MARYLAND
OFFICE OF THE GOVERNOR

ROBERT L. EHRLICH, JR.
GOVERNOR

STATE HOUSE
100 STATE CIRCLE
ANNAPOLIS, MARYLAND 21401
(410) 974-3901
(TOLL FREE) 1-800-811-8336

TTY USERS CALL VIA MD RELAY

Dear Fellow Marylanders,

On behalf of all the citizens of Maryland, I am pleased to accept this *2005 Annual Report – Outlook and Outcomes* from the Alcohol and Drug Abuse Administration. The Ehrlich-Steele Administration has made the fight against substance abuse one of its top priorities. The information provided in the report helps ensure that our policy development and implementation continues to be based on reliable data and that our efforts have measurable outcomes.

Our comprehensive 2004 drug and alcohol abuse initiative has seen the creation of the Maryland State Drug and Alcohol Abuse Council and the presentation of the Council's first report. The State Council's work has been supported in every jurisdiction of the state through local Drug and Alcohol Abuse Councils and submission of local plans outlining substance abuse prevention, intervention, and treatment priorities and strategies. Our Fiscal Year 2007 budget includes over $136 million for the Alcohol and Drug Abuse Administration, with an additional $3 million provided to specifically address these local priorities.

The Ehrlich-Steele Administration has also supported local Drug Courts as an effective tool for helping adult and juvenile offenders remain drug-free and obtain support services that reduce recidivism. In the coming fiscal year, the Alcohol and Drug Abuse Administration will be able to provide these courts with an additional $1 million for treatment services for these offenders.

I am proud of the Alcohol and Drug Abuse Administration's long history of cooperation with local health departments, advocates, and treatment providers. This report will be another tool in our continuing efforts to improve prevention, intervention, and treatment programs throughout the state.

Very truly yours,

Robert L. Ehrlich, Jr.
Governor

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

Outlook and Outcomes

For Maryland Substance Abuse Prevention, Intervention and Treatment

Fiscal Year 2005

Robert L. Ehrlich, Jr., Governor
Michael S. Steele, Lt. Governor
S. Anthony McCann, Secretary, DHMH
Peter F. Luongo, Ph.D., Director

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 basis of race, color, sex, or national origin and applies to the provisions of employment and 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 essential indicators 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 2005

Director
Peter F. Luongo, Ph.D.

Research
William Rusinko

Publication Layout
Lucinda Shupe
Deborah Green

Contributing Writers
William Rusinko
Deborah Green
Erik Gonder
Susan Jenkins
Dave Ennis
Suzette Tucker
Bruce Meade
Peter Luongo, Ph.D.

Editorial Assistance
Peter Cohen, M.D.
Erik Gonder
Susan Jenkins

Table of Contents

The Outlook 6
Performance Management 6
Executive Summary 7
Maryland State Drug and Acohol Abuse Council 10
Regional Teams 12
Admission to Treatment by Residence 20
Data Collection and Report Methodology 21
Prevention Services in Maryland 23
Prevention: Who Received Services? 25
Prevention: What Did We Buy? 26
Recurring Prevention Services 26
Single Prevention Services 26
Service Population 26
Model Program Initiative 27
Gender 27
Age 27
Race and Ethnicity 27
Protecting our Children 28
Promoting a HealthyTransition into Adulthood 28
Defining "Levels of Care" 29
Treatment Services in Maryland 30
Who Received Services? 30
FY 2005 Admissions 29
ASAM Levels of Care 31
Race and Gender 32
Previous Treatment Experience 33
Employment 34
Educational Attainment 34
Tobacco Use 35
Health Care Coverage 35
Co-occurring Disorders 36
Criminal Justice Referrals 37
Voluntary Referrals 38
Severity of Selected Substances 39
Pattern of Substance Problems - Adults 40
Injection 41
How Maryland Compares to the Nation 42
Age at First Use 43
Was It Worth It? 44
Reason For Discharge 45
Length of Stay/Mean Days in Treatment 46
Measuring Treatment Effectiveness 47
Percentage of Discharged Patients Who Underwent Urinalysis During Treatment 47

Average Percentage of Positive Urinalysis Tests 48
Urinalysis Testing and Percentages Completing Treatment 49
Mental Health Treatment Received by Patients During Treatment 50
Treatment Outcomes 51
Treatment Reduces Substance Use 51
Treatment Reduces Crime 53
Treatment Increases Employment 54
Treatment Correlates with Improved Living Situation 55
Appendix 56
Table A: Admissions to Maryland Treatment Programs by ASAM Level of Care FY 2002 - FY 2005 57
Table B: Discharges from Maryland Treatment Programs by ASAM Levels of Care FY 2002 - FY 2005 58
Table C: Admissions to ADAA-Funded Treatment Programs by Substance Mentions FY 2002 - FY 2005 59
Table D: Admissions to Non-Funded Treatment Programs by Substance Mentions FY 2002 - FY 2005 60
Table E: Alcohol Related Admissions to Treatment Programs by Residence FY 2002 - FY 2005 61
Table F: Marijuana Related Admissions to Treatment Programs by Residence FY 2002 - FY 2005 62
Table G: Heroin Related Admissions to Treatment Programs by Residence FY 2002 - FY 2005 63
Table H: Crack Related Admissions to Treatment Programs by Residence FY 2002 - FY 2005 64
Table I: Other Cocaine Related Admissions to Treatment Programs by Residence FY 2002 - FY 2005 65
Table J: Adolescent Admissions to Maryland Treatment Programs by Residence FY 2005 66
Substance Abuse Treatment Outcome Measures Tables 67
Table K: Substance Use at Admission and Discharge by Jurisdiction FY 2005 68
Table L: Employment Status at Admission and Discharge by Jurisdiction FY 2005 69
Table M: Arrest Rate Prior to Admission and During Treatment by Jurisdiction FY 2005 70
Table N: Retention Rates by Jurisdiction Level I (Outpatient Treatment) FY 2005 71
Table O:Retention Rates by Jurisdiction ADAA-Funded by Jurisdiction Level III.1 (Halfway House) FY 2005 72
Table P: Subsequent Admission to Another Treatment Level Completion Discharges from Level II.1 (IOP) 73
Table Q: Subsequent Admission to Another Treatment Level Completion Discharges from Level II.1 (IOP) Non-Funded by Jurisdiction 74
Table R: Subsequent Admission of Level III.7 (Non-Hospital Detox) Completion by Jurisdiction FY 2005 75
Crosswalk from ADAA's Previous Treatment Type Categories to American Society of Addiction Medicine (ASAM) Patient Placement Criteria 76
Acronyms and Abbreviations 77

This is the fourth annual publication of the Maryland Alcohol and Drug Abuse Administration's *Outlook and Outcomes*.

The report, once again, demonstrates gains in Maryland that are consistent with those expected from the research literature. Treatment in Maryland reduces substance use, increases employment, decreases criminality and homelessness. The longer the individual remains in treatment the better the outcome; once again, reaffirming the importance of engaging and retaining individuals in treatment. In addition, more individuals were admitted for public treatment services statewide in FY 2005 than in the previous year (47,555 vs 43,852, an 8% increase).

Results vary by jurisdiction, however. There are differential retention and completion rates, differential decreases in substance use, criminality and homelessness, and differential increases in employment by jurisdiction. Why?

In some instances we can offer explanations that the differential findings are artifacts from collection methods, or suggest that an incomplete continuum of care distorts outcomes (e.g. placing individuals into what care is available as a substitute for what they need). In some instances though, individual program performances are so outside of the "average" that they pull down a jurisdiction's overall performance. What to do?

One thing to do is to provide each jurisdiction with the performance measures and outcomes for its public programs and get more people working on it. The 2005 data has been distributed and it is assuring (and gratifying) to watch it being put to use.

There is more that can happen, too. This edition of *Outlook and Outcomes* features a regional section. Here ADAA introduces the structure and functions of the Regional Technical Assistance Teams and presents a brief overview of each region, its service mix and identified strengths and needs. These multidisciplinary regional teams are the resource available to each jurisdiction for technical assistance on planning, implementing and redesigning services to maximize the local system's efficiency and effectiveness. And to help answer, Why?

Needless to say, there is more work to be done in Maryland. But there is also work that has been done.
Read about it.

Peter F. Luongo, Ph.D.

Alcohol and Drug Abuse Administration Leadership 2005

Office of the Director
Director: Peter F. Luongo, Ph.D.
Deputy Director:
C. Wayne Kempske, M.S.
Medical Director:
Peter R. Cohen, M.D.
Research: William Rusinko, M.A.

Community Services Division
Division Director:
Eugenia W. Conolly, M.Ed.

Information Services Division
Division Director:
Lucinda E. Shupe, B.S.

Management Services Division
Division Director:
Stephen A. Bocian, M.P.P.

Quality Assurance Division
Division Director:
Donald Hall, M.H.S.

The Outlook

Maryland continues to improve its public substance abuse prevention, intervention and treatment system while strengthening its basic supportive administrative and clinical infrastructure.

A significant milestone achieved in the past year was the completion of the initial local substance abuse plans. Jurisdictional and state wide data from the automated information system, data that included performance and outcome measures, was provided to each local drug and alcohol abuse council. The data provided jurisdictions a way to compare their performance, by level of care, to state wide averages and adjust their program plans accordingly. Additionally, jurisdictions received data on individual program performance, using the metrics established in the state's Managing for Results (MFR) program. This is information that is vital to the management of the local systems. The plans were subsequently used in crafting the FY 2007 Alcohol and Drug Abuse Administration (ADAA) budget request.

In FY 2005 the process of moving the automated information system from web enabled (HATS) to web based began. The Statewide Maryland Automated Record Tracking system (SMART) is being implemented in funded programs during FY 2006 (July 1, 2005 – June 30, 2006) and in non-funded programs through FY 2007 (July 1, 2006 – June 30, 2007). SMART includes an electronic patient record and access to patient level, program level and system level information to manage the public system to better performance. Information based decision making is now the expected standard at the patient, program and system levels.

An important part of the public's work in strengthening local systems of care is providing technical assistance to jurisdictions. ADAA's multidisciplinary regional teams have provided assistance to jurisdictions throughout the year and will be expanded to a new region in FY 2006. Prince George's and Montgomery counties will be joined in a Suburban Maryland region. Specific technical assistance consultations are anticipated in topic areas such as competitive procurement, system design, the use of data for decision making, the epidemiology of substance abuse and addiction, and the "business" of addiction.

Improving outcomes for Maryland citizens seeking public services is critical. Providing information to practitioners and managers so they can gauge their effectiveness consistently produces improved outcomes. Like-wise, technical assistance to improve the overall efficiency and effectiveness of a system has demonstrated benefits. Yet another, and potentially far reaching strategy, is to implement performance based compensation; i.e. incentives. Performance based compensation recently debuted in state-wide contracting for long-term residential care. This was feasible because of the establishment of empirically reliable and valid measures, and the implementation of SMART. Performance incentives are under development for jurisdictional grants and will be introduced for at least one level of care in FY 2007 grant awards. Economic incentives are relatively new in health care, and rewarding results is a promising development.

As the future continues to unfold, the outlook for Maryland is now shaped by factors that are accessible to study, and manipulation. Addressing differential outcomes in prevention, intervention and treatment services is no longer a wish. It is expected. This is the outlook for Maryland.

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

The material appearing in this report is public domain and may be reproduced or copied without permission from ADAA. The following citation is recommended:

***Outlook and Outcomes**: 2005 Annual Report. Catonsville, MD: Maryland Alcohol and Drug Abuse Administration.*

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*** *2005, ADAA compares and contrasts the characteristics of funded and non-funded treatment programs for Fiscal Year 2005, the populations they serve and the treatment outcomes reported.*

Who Received Services?

Prevention Services

- Approximately 292,000 individuals received prevention services in Maryland.
- There were 30,879 individuals who actively participated in recurring prevention programs offered throughout Maryland last year .
- During Fiscal Year 2005, Maryland offered prevention and intervention services to 26 different service populations comprised mostly of parents and school-aged children.
- A total of 2,325 individuals received prevention intervention services through the High Risk Preschool Initiative in Fiscal Year 2005.
- The College Prevention Centers initiative provided prevention services, with a primary focus on peer education, to 56,488 students enrolled in four of Maryland's universities.
- In Fiscal Year 2005, 32 prevention programs were delivered in nine jurisdictions through the new Model Program Initiative, assisting communities in identifying needs by implementing evidence-based programs.

Treatment Services

- There were 47,555 patients admitted to ADAA-funded programs and 28,983 who were admitted to non-funded treatment.
- Fifty-six percent of funded and 57 percent of non-funded patients admitted during FY 2005 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 are less likely to have college educations, and to be employed full-time. Sixty-two percent of all ADAA-funded patients were uninsured.
- About 47 percent of all patients admitted to ADAA-funded programs were referred to treatment through the criminal justice system, and two-thirds of funded patients had one or more arrests in the two years prior to admission. The majority of criminal justice referrals to ADAA-funded treatment came from parole and probation.
- Twenty-three percent of funded patients had mental health problems in addition to substance abuse and 60 percent smoked cigarettes.

Type of Abuse: ADAA-Funded Treatment

- The leading substances of abuse in ADAA-funded treatment were alcohol (58%), heroin (36%), marijuana (36%), crack cocaine (29%) and other cocaine (17%).

- Over 60 percent 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 attended college and obtained college degrees, to be full-time employed and to have health care coverage.

- Fifty-six percent of all patients admitted to non-funded programs had at least one previous treatment episode.

- Less than 30 percent of all patients admitted to non-funded treatment programs were referred through the criminal justice system and about 45 percent 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.

- Nearly 30 percent of non-funded patient admissions had mental health problems and 53 percent smoked cigarettes.

Type of Abuse: Non-Funded Treatment

- Substances that predominated among non-funded admissions were: alcohol (53%), heroin (42%), marijuana (22%), crack cocaine (22%) and other cocaine (15%).

- One in five non-funded admissions was abusing alcohol only.

Maryland and the Nation

- Thirty-two percent of Maryland admissions had primary heroin problems compared to 15 percent for the nation as a whole. Methamphetamines were a primary problem in 6.3 percent of nationwide admissions but less than half of one percent in Maryland.

Adolescents

- Adolescent admissions made up 11 percent of ADAA-funded patient admissions and only 3.4 percent of non-funded admissions, and most adolescent patients reported abusing alcohol and/or marijuana.

- About 70 percent of ADAA-funded and non-funded populations admitted for alcohol problems reported their first intoxication occurred during adolescence or before.

- Eighty-two percent of those with marijuana problems reported first use before they turned 18.

ASAM Levels of Care

- Nearly half of all ADAA-funded admissions went to Level I (traditional outpatient) services and another 16 percent were admitted to Level II.1 (intensive outpatient) or I.D (ambulatory detox). The respective figures for non-funded admissions were 32 and 36 percent.

- Six percent of funded and 13 percent of non-funded admissions were to opioid maintenance therapy (OMT).

- Residential levels of care accounted for 28 percent of ADAA-funded admissions and 18 percent of non-funded admissions.

- Thirteen percent of funded and 20 percent of non-funded patients admitted to treatment accessed detoxification services on an ambulatory, residential or hospital basis.

Urinalysis

- About 72 percent of patients who participated in funded Level I treatment and 63 percent of those in non-funded Level I treatment underwent urinalysis. Undergoing urinalysis was associated with higher rates of treatment completion in almost every level of care. Completers of treatment had lower percentages of positive urinalysis test results.

Was It Worth It?
Outcome Measurement

Treatment Reduces Substance Use

- Among the total discharges from ADAA-funded treatment, including both successful completers and non-successful completers, there was a 27 percent reduction in substance use. Decreases in substance use of 50 percent or more occurred in several residential levels of care.

- 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 45 percent.

Treatment Reduces Crime

- Arrest rates during both funded and non-funded treatment were about 75 percent lower than arrest rates during the two years preceding treatment. Arrest rates were reduced by half or more during treatment in most levels of care.

Treatment Increases Employment

- Overall, employment increased by 20 percent during ADAA-funded treatment and three percent during non-funded treatment. 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 14 percent in funded Level I and ten-fold in Level III.1 (halfway house).

Treatment Decreases Homelessness

- In general, homelessness declined by 37 percent in ADAA-funded treatment and 23 percent in non-funded treatment. 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.

ADAA Takes Steps to Improve its Electronic Clinical Record

The Maryland Alcohol and Drug Abuse Administration and the Bureau of Governmental Research have been involved in the development of a federally funded Web-based core case management system, which was developed by incorporating key concepts and functions from HATS, and two additional state-wide systems from Texas and Washington states.

To meet our goal of moving funded programs to a complete electronic record, we have adopted this core case management information system developed for the Center for Substance Abuse Treatment and are modifying it to meet the needs of Maryland providers.

The new application will provide treatment providers with the ability to monitor client progress electronically, review treatment plans, monitor and approve client services, and conduct quality assurance activities. The full electronic record will include but not be limited to the following items and functions:

- Client Profile
- Client Intake
- Screening Tools
- Assessment Tools
- Treatment Plans
- Drug Testing
- Treatment Encounters
- Treatment Teams
- Treatment Plan Reviews
- Progress Notes
- Pre-authorization
- Provider Billing
- Case Management
- Referrals
- And much more...

Maryland State Drug and Alcohol Abuse Council Report to Governor Robert L. Ehrlich, Jr. September 9, 2005

This is the Introduction to the "Maryland State Drug and Alcohol Abuse Council Report to Governor Robert L. Ehrlich, Jr."
The entire report can be downloaded from the ADAA Web site at
www.maryland-adaa.org

For over thirty five years, through a multitude of task forces, boards, commissions and councils, Maryland has striven to understand and respond to the impact of substance abuse on the political, social, and economic structures of the state. Over these decades, the focus has bounced from intensive law enforcement and punishment to prevention and early intervention to ad hoc efforts to increase treatment resources. Throughout this period, however, the general principles guiding the state's substance abuse policies were simple and unchanging – prevent the spread of substance abuse through early intervention, reduce the incidence of substance abuse related problems, and provide effective treatment for the abusers and their families.

We have reached the point where we no longer need to debate the virtues of early intervention and treatment over the old "lock them up and throw away the key" philosophy. The members of the State Council have hundreds of years of accumulated experience in the public health and criminal justice fields. The Council recognized that recommendations from past Commissions and Task Forces were never placed in the context of overall policy objectives and priorities with a standardized method of measuring existing outcomes and determining which policies or programs achieved the desired results.

We know that treatment works. Data collected and analyzed by the Alcohol and Drug Abuse Administration (ADAA) shows that in some cases people completing ADAA-funded programs reduced their primary substance use by 93 percent. In Baltimore, completing an ADAA-funded program results in a 25% greater likelihood of becoming employed within one year with significantly higher wages than those who did not complete treatment.

Arrest rates in the city for offenses including theft, burglary, and robbery were 55% lower for those completing treatment compared with those who did not complete treatment.[1]

Governor Robert L. Ehrlich, Jr. took the first steps towards developing a new approach in October 2003 when he asked senior Administration officials to meet and examine new approaches to these very old problems. Based on their work, Governor Ehrlich introduced and promoted enactment of landmark legislation in the 2004 session of the General Assembly. A key element of the new law established a locally-based coordinated structure for planning and implementing prevention, intervention, and treatment services. Recognizing that the overwhelming percentage of state general funds used for

these services flows from the Alcohol and Drug Abuse Administration to each of the state's political subdivisions, the legislation created a Drug and Alcohol Abuse Council in each jurisdiction.

A key part of this new approach was the statutory empowerment of a local group consisting of all the major players across the spectrum of substance abuse service demands, and providers in every county. As a matter of state law, the plans, strategies, and priorities of each county for meeting the services needs of the general public and the criminal justice system will be set out in a comprehensive county plan developed by the local Council. Equally important are the requirements that the plan include a survey of all federal, state, local, and private funds used for these services, and that applications from county agencies for state funds for evaluation, prevention, or treatment services must be considered by the local Council.

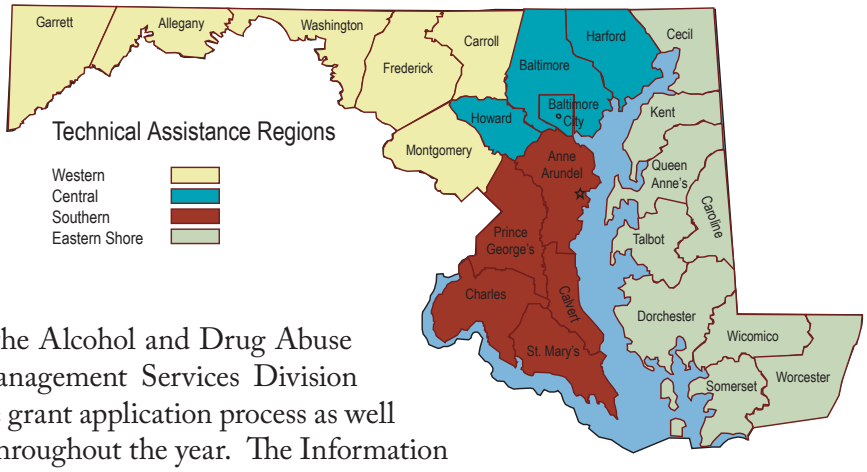
On July 20, 2005, Governor Ehrlich announced the formation of the Maryland State Drug and Alcohol Abuse Council. Establishing the Council was the next step in a comprehensive strategy to coordinate substance abuse prevention, intervention, and treatment services.

Maryland State Drug and Alcohol Abuse Council's "Next Steps"

From the "Maryland State Drug and Alcohol Abuse Council Report to Governor Robert L. Ehrlich, Jr."

- Complete the State Survey of Resources, utilizing ADAA and Department of Budget and Management technical assistance; Establish a baseline for the total state government effort dedicated to substance abuse services;
- Standardize the results of the state and local surveys of resources, identifying overlapping resources, under-served, or un-served populations;
- Identify priorities as determined by analysis of these standardized results, using all available data; determine if these priorities match existing policy and priorities for utilization of substance abuse resources; identify methods for implementing and standardizing outcome and accountability measurements;
- Examine the resources available for the assessment and treatment of drunk and drugged driving offenders and make appropriate recommendations to this complex and under-diagnosed challenge to public safety and health;
- Develop an integrated presentation of substance abuse prevention, intervention, and treatment resources as a foundation for a thematic substance abuse budget tied to clear, measurable policy goals;
- Create a comprehensive two-year Plan, using a framework of goals, objectives, and outcome measurements; and,
- Develop accountability standards that will allow state policy makers to evaluate strategies and program outcomes.

Regional Teams



ADAA's Regional Teams bring together a variety and depth of experience in order to provide support, technical assistance, and consultation to the funded substance abuse prevention, intervention and treatment programs in Maryland. Each team is led by a Regional Services Manager and team members represent the four divisions of the Alcohol and Drug Abuse Administration (ADAA). The Management Services Division lends fiscal expertise to help with the grant application process as well as overall fiscal management issues throughout the year. The Information Services Division offers expertise on data collection, research, and implementation of the new SMART electronic record and data collection system. The Quality Assurance Division supplies knowledge on training and compliance issues. The Community Services Division provides know-how on the implementation of special projects and program management.

The regional teams continue to evolve in their role. The team members function as primary conduits for information between the administration and the local jurisdictions responsible for the development and implementation of the addictions prevention, intervention and treatment systems. Additionally, the teams serve as a resource to the jurisdictional programs to provide technical assistance in all aspects of program planning and implementation, bringing new technologies to the field, and aiding in the continuous process of getting better at serving the citizens of Maryland who are struggling to cope with the symptoms and complications of addictive disease.

The regional reports that follow were developed by the regional team managers. Each report is a snapshot of the region highlighting the demographics and unique characteristics of the specific area. Included in each report are the "Needs, Challenges, and Service Gaps" identified by local treatment providers and /or the local Drug and Alcohol Abuse Council.

Table 1 Regions	Eastern	Central	Southern	Western
Jurisdictions	*Cecil, Talbot, Kent, Dorchester, Queen Anne's, Wicomico, Caroline, Worcester, Somerset Counties*	*Baltimore City, Baltimore, Harford, Howard Counties*	*Prince George's, Calvert, Charles, St. Mary's, Anne Arundel Counties*	*Allegany, Garrett, Washington, Carroll, Montgomery, Frederick Counties*
Team Manager	Bruce Meade	Sue Jenkins	Suzette Tucker	David Ennis
Community Services Division	Joyce Melvin	Sherri Cohen/ Dave Putsche	Janice Thompson/ J. Sue Henry	Michelle Strasnick
Information Services Divison	Siatta Massaquoi	Vicke Kaneko/ Jeff Allison	Bob Woods	Priscilla Marcoccio
Management Services Division	Mike Morgan	Allison Frank	Bonita Ciurca	Pamela Sexton
Quality Assurance Divison	Larry Stevens	Lorraine Sykes	Renee Howard	Leslie Woolford

Central Region

by Susan Jenkins

Regional Description: The Central Region is comprised of Baltimore City, and Baltimore, Harford and Howard counties. Approximately two million of Maryland's 5.5 million people live in the Central Region. Baltimore City, with an area of 80.3 square miles, is home to a population of 636,251 (2004). Baltimore County has a slightly larger population of 780,821 and covers a 600 square mile area surrounding the city. Both Harford County to the north and Howard County to the southwest of Baltimore are predominantly suburban, with populations of 235,594 and 266,738.

Median household income ranges from $34,000 in Baltimore City to a high of $84,200 in Howard County, one of the highest median income rates in the country. In Baltimore County the median household income average is about $57,000 ; and Harford County $68,150 .

Unemployment rates also follow this general pattern: Baltimore City has the highest unemployment rate in Maryland at 7.4 percent, and Howard County has a much lower rate of 3.1 percent. Comparatively, crime rates for the region show Baltimore City with the highest rate of crime and Harford County the lowest. (Table 2)

The most common substance use disorder reported by patients in treatment in Baltimore City programs is heroin, followed by alcohol. Baltimore County reports alcohol as the most common substance use disorder followed by heroin for its adults and marijuana is the substance of choice for adolescents with alcohol as the second most common. Patients in Harford and Howard counties' treatment programs present primarily with alcohol use disorders, followed by marijuana abuse or dependence.

Resources/Strengths: Baltimore City's estimated need of treatment for substance abuse is more than double that of surrounding Baltimore County, and over six times greater than Harford or Howard counties. The city's ADAA funds are administered by Baltimore Substance Abuse Systems, Inc. BSAS contracts with approximately 70 treatment programs, representing all levels of care within the treatment continuum, and with 10 community based providers to implement three model prevention programs. In July 2005, BSAS received a grant from the Robert Wood Johnson Foundation's Local Initiatives Funding Partners program and matching funds from four local foundations for an innovative project called Threshold to Recovery. The project involves the collaboration of three existing sites in Baltimore that together offer 24 hour/7 day per week drop-in services for people transitioning from use and abuse to recovery. Services include screening and referral, acupuncture, Narcotics Anonymous meetings, traditional addiction counseling and peer support.

Table 2 Central Region By City/County	*Total Population 2004	*Unemployment Rate 2004	*Median Household Income	*Crime Rate *Number of crimes per 100,000 population*	*Land Area / Square Miles
Baltimore City	636,251	7.4%	$34,000	7,617.2	80.3
Baltimore County	780,821	4.4%	$57,000	4,218.4	597.6
Harford County	235,594	3.9%	$68,150	2,666.4	447.6
Howard County	266,738	3.1%	$84,200	2,799.8	251.0
Source	**Maryland Department of Planning 2004*	**Maryland Department of Labor, Licensing and Regulation 2004*	**Maryland Department of Planning 2004*	**Maryland State Police 2004*	**Maryland Geological Survey 2002*

Baltimore County Health Department Bureau of Substance Abuse directly operates Level I outpatient programs, and contracts with non-profit providers for Level I and Level II intensive outpatient services, residential programs at levels III.1, III.3, and III.7, as well as for Opioid Maintenance Therapy at Level I. Baltimore County's prevention programs include the provision of five model programs targeting both at risk youth and their families. To bridge a gap in services, Baltimore County purchases short-term mental health services for juvenile justice involved substance abusing adolescents, as a means of stabilizing adolescents with mental health problems who are unable to access the mental health system in a timely way. Services include initial psychiatric evaluation, medication monitoring, and purchasing of medications. These services are intended to be of limited duration, and act as a bridge for the adolescent to community based mental health services via procurement of insurance coverage.

Harford County Health Department Substance Abuse Services directly operates Level I and II outpatient programs, and provides Opioid Maintenance Therapy at Level I. The county contracts with *Mann House* for halfway house services. Harford County Office of Drug Control Policy implements prevention programs including two model programs serving at-risk youth. Harford County also has three drug courts in operation, and is beginning to implement a Suboxone detoxification protocol within its Opioid Maintenance Therapy program.

Howard County Health Department Substance Abuse Services directly operates Level I and II programs, and contracts with Vanguard, Inc. for halfway house services at *Howard House*. The county provides three model prevention programs, targeting both at-risk youth and their parents. Howard County's centralized evaluation unit provides a single point of entry into the treatment system for all potential patients, enhancing client access to appropriate levels of care. Howard County has also begun collaborating with the University of Maryland School of Pharmacy to design interventions that will identify and enhance access to treatment for older adults who are dependent on alcohol or prescription drugs, a typically underserved population.

Identified Needs/Challenges/Gaps: Needs identified by all jurisdictions within the Central Region include: 1) expanding prevention services, 2) expanding services to approach the goal of treatment on demand, 3) developing services to meet the needs of special populations — primarily adolescents and individuals with co-occurring disorders, and 4) investing in the prevention and treatment infrastructure, particularly with regard to attracting and retaining a competent workforce and making systemic improvements.

Baltimore City continues to be challenged by severe addiction that crosses over generations and is compounded by poverty, low education, violence and health problems. The City recognizes that strategies for prevention, treatment and long-term recovery cannot be limited to traditional addictions treatments but must include wrap-around services such as employment, housing, and family services.

Baltimore County identifies the lack of knowledge among citizens and service agencies regarding the availability and methods of accessing treatment services within the county as a challenge that needs to be addressed.

In Harford County, the lack of residential treatment levels of care, especially Level III.1 for women, is a major gap in the continuum of care available to citizens in need. In addition Harford County residents are experiencing approximately 100 days wait for outpatient treatment.

Howard County identifies a significant need to work with other agencies to enhance their capacity to follow best practices in the identification, referral for treatment, case management and ongoing support of patients in addiction treatment.

Eastern Region

by Bruce Meade

Regional Description: Maryland's Eastern Shore is comprised of nine counties on the Delmarva Peninsula, located between the Chesapeake Bay and the Atlantic Ocean. The total population of this region is over 380,000 spread over a 150 mile radius. The Eastern Region is primarily rural in nature with farming and poultry industries providing the major economic base for the region ,and Ocean City providing a tourist economy during the summer months.

The median population for the Eastern Region counties is 31,058. Kent County has the smallest population and Wicomico County the largest.(Table 3) The median household income for the nine counties is $40,412 with Somerset having the lowest median income at $28,309 and Queen Anne's County having the highest median income of $59,854. The average unemployment rate for the Eastern Region is 4.6 percent. Worcester and Somerset counties have the highest unemployment rates of 6.4 percent and 6.3 percent respectively. Queen Anne's county has the lowest rate of 3.4 percent.

The region has seven general hospitals with locations in Elkton, Chestertown, Easton, Cambridge, Salisbury, Berlin and Crisfield. The rural nature of the Eastern Region leaves population centers at a minimum of 15 miles and most often 30 miles from each other. Transportation to services in the population centers is a problem throughout the Eastern Region.

The predominant drugs of abuse are alcohol, marijuana and cocaine. Queen Anne's, Caroline, and Somerset counties show the highest percentage of use of alcohol. The counties with the highest percentage use of marijuana are Queen Anne's, Somerset and Caroline counties. Dorchester, Wicomico and Kent counties show the highest percentage use of cocaine.

Resources/Strengths: Substance abuse prevention services are offered in each of the Eastern Region counties under the direction of a county prevention coordinator. Center for Substance Abuse Prevention Model Programs (CSAP) are presented for citizen participation in each of the counties. Local Management Boards and citizen partnerships work well with prevention programming.

Substance abuse treatment services are available in each of the Eastern Region counties. ASAM Level I services are provided in each county. Level II.1 services are offered in Dorchester, Wicomico, Worcester and Somerset counties. Level III.7 services are offered in Kent, Dorchester and Wicomico counties. The *A.F. Whitsitt Center,* directly operated by Kent County, in Chestertown has a four bed Level III.7 detoxification unit. Detoxification services are also available when appropriate in III.7 certified programs, or contracted on

Table 3 Eastern Region By County	Total Population 2004	*Unemployment Rate 2004	*Median Household Income	*Crime Rate *Number of crimes per 100,000 population*	*Land Area / Square Miles
Caroline County	31,058	4.1%	$43,550	3,163.5	320.8
Cecil County	95,526	4.3%	$58,050	3,620.7	359.6
Dorchester County	30,912	5.6%	$39,200	4,173.5	593.2
Kent County	19,582	4.0%	$45,250	2,205.9	278.3
Queen Anne's County	45,078	3.4%	$66,800	2,141.5	371.9
Somerset County	25,863	6.3%	$34,100	3,147.2	338.4
Talbot County	35,017	3.5%	$49,400	2,907.5	258.6
Wicomico County	88,782	4.3%	$44,100	5,224.9	379.1
Worcester County	48,974	6.4%	$47,750	5,073.2	474.9
Source	**Maryland Department of Planning 2004*	**Maryland Department of Labor, Licensing and Regulation 2004*	**Maryland Department of Planning 2004*	**Maryland State Police 2004*	**Maryland Geological Survey 2002*

a bed day basis with private providers. Level III.1 halfway house services are offered at *Haven House* in Cecil County and *Second Wind* in Wicomico County. Level III.3 long-term care services are offered at *Warwick Manor* in Dorchester County.

Several counties share resources. For example, Talbot County discontinued Level II.1 services due to limited resources and entered into an agreement with Dorchester County to send appropriate referrals to a Level II.1 program in Dorchester County. Similarly, Dorchester County does not provide Level I services for its co-occurring disordered population and refers those patients to the co-occurring program in Talbot County. Caroline County has a Level I program that offers an Hispanic speaking treatment group that accepts appropriate referrals from adjacent counties.

Two innovative Level II.1 programs are offered by Worcester County for appropriate referrals in the four lower counties of the lower Eastern Shore. They are the *Center 4 Clean Start* offering Level II.1 women's services for pregnant and post-partum women and *The Hands Homeless Program* offering Level II.1 services for homeless individuals.

All Eastern Region counties with the exception of Kent County are planning for, or are implementing, drug courts. Cecil, Dorchester, and Worcester counties are involved in the planning and implementation of adult drug courts while Queen Anne's, Caroline, Talbot, Wicomico, Worcester and Somerset counties are involved in adolescent drug court planning and implementation.

Identified Needs/Challenges/Gaps: Needs identified by the region include establishing more Level II.1 programs, increasing access to detoxification treatment and Level III.5 treatment, increasing Level III.7 services, improving access to transportation services and improving the capability to serve non-English speaking patients.

A growing problem that all counties in the region are encountering is the recruitment and retention of qualified staff. The counseling and treatment staff are increasing in age and finding new staff to fill vacancies is becoming a problem.

Southern Region

by Suzette Tucker

Regional Description: The Southern Region consists of five counties. The region is a mixture of urban, suburban and rural communities, which account for its unique and diverse populations. Anne Arundel, Calvert, Charles, St. Mary's, and Prince George's counties are divided into three sub-groups for the purpose of description. The first sub-group, made up of Calvert, Charles and St. Mary's counties, is viewed as "traditional southern Maryland," having similar suburban and rural demographics. Within this sub-group there has been a recent increase in population. In the period between 2000 and 2004 the area experienced an average increase in population of 11.6 percent, adding 35,861 residents. (Table 4)

Anne Arundel County is located directly on the Chesapeake Bay. It is supported economically by private business, government and a strong maritime industry. The county has grown in population from 2000-2004 by 3.9 percent, an increase of 18,918 residents. It is the second largest jurisdiction by population in the southern region.

The largest county in southern Maryland by population is Prince George's County. The county is located in the Washington D.C corridor and has the second highest number of high-tech, defense and aerospace companies in the state. Prince George's population has increased 5.2 percent from 2000 to 2004, adding 41,452 people to the county population.

There are variations in southern Maryland by income. According to the *Bureau of Economic Analysis*, Anne Arundel County has the highest per capita personal income of $40,463 with the remaining counties averaging from $31,000 to $33,665 in per capita personal income. The crime rate for southern Maryland is wide-ranging, according to the Maryland State Police; based on crimes per 100,000 population Calvert County has the least crime and the highest crime rate is found in Prince George's County (Table 4).

The southern region reports similar drugs of abuse for patients entering the treatment system. Those entering treatment in Calvert, Charles, Prince George's, and St. Mary's counties report alcohol, marijuana and crack cocaine as the most problematic. In Anne Arundel County patients that enter treatment report alcohol, marijuana and heroin as the substances that are abused the most. Anne Arundel is the only county in the region that reports heroin as one of the top substances of abuse.

Resources/Strengths: The Southern Region has developed and implemented a complete system of substance abuse prevention, intervention and treatment based on the *ASAM Levels of Care.* Anne Arundel and Prince George's counties coordinate a full spectrum of services that include 0.5 Early Intervention, Level I, Opioid Maintenance Therapy (OMT), Levels II.1, and II.1D, Levels III.1 (halfway house), and III.3 (long-term care), Levels III.5, III.7 and III.7D

Prince George's County has the added resource of a drug court that provides assessments and referral to treatment for court-ordered populations. Bowie State University offers a unique blend of alcohol, tobacco and other drug prevention services through their on-campus *Alcohol/Drug Prevention Center.*

Calvert, Charles and St. Mary's counties share some of their resources. Additionally, there are treatment resources in the tri-county region that are available for patients referred statewide. For example, the *Calvert County Treatment Facility* has Level III.3 (long-term residential) and III.1 (halfway house) programs and Charles County's J*ude House* is a Level III.3 treatment facility. In St. Mary's County, under the umbrella of *Walden Sierra*, *Anchor* offers Level III.7 and III.7.D services, *Compass Halfway House* provides Level III.1 treatment for women and women with their children, and *Marcey House*, a Level III.1 halfway house, serves the co-occurring disordered population. All three counties provide prevention programs, Level I and Level II.1 services.

Charles and Calvert counties have jail-based treatment programs for incarcerated populations. Three counties in the Southern Region, Prince George's, Anne Arundel and St. Mary's, have dedicated residential services for women and women with children.

Anne Arundel County has successfully integrated an evidenced based prevention program into their jail-based treatment. *Strengthening Families* targets families impacted by addiction, by assisting high risk youth to make healthy decisions. Charles County has initiated the evidence-based program *Life Skills Training* at the *Alternative School.* Students from the 6th, 7th and 8th grades are taught skills to resist illegal drug activity. This program is designed to affect drug related knowledge, attitudes and norms.

In Calvert County, youth identified as having substance problems are a priority. The county is implementing a juvenile drug court to meet the demands created by this expanding population.

Table 4 Southern Region By County	*Total Population 2004	*Annual Average Unemployment Rate	*Median Household Income	*Crime Rate *Number of crimes per 100,000 population*	*Land Area / Square Miles
Anne Arundel County	508,572	4.2%	$73,150	3,972.3	418.4
Calvert County	86,474	3.3%	$79,600	1,820.6	213.2
Charles County	135, 807	3.4%	$74,000	3,680.8	451.6
Prince George's County	842,967	4.6%	$66.750	7,282.0	487.0
St. Mary's County	94,921	3.3%	$60,550	2,369.0	372.5
Source	**Maryland Department of Planning 2004*	**Maryland Department of Labor, Licensing and Regulation 2004*	**Maryland Department of Planning 2004*	**Maryland State Police 2004*	**Maryland Geological Survey 2002*

Buprenorphine detoxification services will soon be added to Calvert County's care continuum. The health department has a Memorandum of Understanding (MOU) with a local physician to initiate this service.

Identified Needs/Challenges/Gaps: All the counties in the Southern Region report a need to expand existing prevention. All counties are challenged with providing the full continuum of care to their residents with level funding. They are exploring various options to meet the need of residents and diversify funding. The counties are looking at meeting the needs of sub-groups within the population such as criminal justice and co-occurring populations. All counties are looking at workforce development problems as it has become problematic to recruit and retain competent clinical staff.

Prince George's County is challenged with providing more residential services for its residents, particularly in the criminal justice and homeless populations. Anne Arundel County is attempting to meet the needs of its residents that are involved in the criminal justice arena by increasing services to this population. Calvert County has the challenge of providing services to an expanding adolescent population because of a spike in enrollments within the middle and high schools. Charles County wants to meet the needs of its residents by developing a standardized method of screening and referral across the human service continuum, and St. Mary's is challenged with developing effective programming to an increasing co-occurring population.

Western Region

by David Ennis

Regional Description: The Western Region of ADAA includes Garrett, Allegany, Washington, Frederick, Carroll and Montgomery counties. This group of counties incorporates a significant amount of variation in demographics and needs, from the ethnically diverse and highly populated area of the Washington DC suburbs found in Montgomery County to the relatively isolated mountain communities of Garrett, Allegany and Washington counties.

Each jurisdiction creates unique demands on the human service delivery system. For example, Frederick and Carroll counties, historically thought of as rural communities, have experienced double digit increases in population between 2000 and 2004. Montgomery County remains the most populated of the Western Region with 1,762 people per square mile. On the other hand, population densities for Garrett County with 46 people per square mile, and Allegany County with 176 per square mile, have remained relatively stable. Washington County (288), located between Frederick and Allegany counties, reflects the status of a jurisdiction in transition. It is not experiencing the double-digit population growth but population numbers are more than half again that of its neighbor, Allegany. Montgomery County is among the most affluent jurisdictions in the country, with a median household income of almost $80,000. In contrast, the three rural counties have a median household income of about $40,000.

Resources/Strengths: The continuum for prevention, intervention, and treatment services was developed in response to the demographic realities of the various jurisdictions in the region. All jurisdictions provide traditional outpatient and intensive outpatient services. Montgomery County provides a range of services that encompasses the continuum from ASAM level 0.5 Early Intervention through Level III.7 - Medically Monitored Intensive Inpatient Treatment. Residential services are accomplished via contracts for Level III.7 and III.1 treatment. The county provides outpatient services to a diverse ethnic and language population in a dispersed geographic area through contracts with private outpatient providers. *Outpatient Adult Addiction Services* in Rockville is operated directly by the county and prioritizes services to the target populations with co-occurring disorders, pregnant and postpartum women, the homeless and patients who are HIV positive. In addition to its outpatient services, Montgomery County also provides Level III.5 long-term residential treatment services to patients with chronic co-occurring disorders.

The far western counties have maximized local resources by providing quality services that are utilized by the jurisdiction, the region, and statewide. Residential services are provided at Level III.7 in the *Massie* (adult) and *Jackson* (adolescent) Units at the *Finan Center* in Allegany County. Washington County provides long-term residential care for specialized populations at the *Cameo House* III.3 for women and children, and *Catoctin Summit* (III.3) for adolescents. Half-way house services (Level III.1) are provided in Washington County via contracts with *W House* and *Wells House,* and in Frederick County by way of contract at the *Gale* and *Olson Houses*. Allegany County provides this level of care through the local Health Department.

Frederick, Allegany, and Montgomery Counties provide methadone maintenance and all of the counties offer both traditional and intensive outpatient.

The Carroll County government has authorized funding for the construction of a new facility to provide long term care to augment its existing level III.7 services at *Shoemaker* and round out a complete continuum of residential services in the Western Region. The new building will be located on the grounds of Springfield Hospital Center, with groundbreaking to occur in May 2006.

Prevention efforts remain a high priority in the Western Region with four of the six counties (Allegany, Garrett, Carroll, and Montgomery) participating in the ADAA Model Program Initiative. The *Shoemaker* program, *Massie Unit, Jackson Unit,* and many jail-based programs have integrated prevention activities into the rehabilitation program. The prevention office at Frostburg State University provides evidence-based practices and social norming to successfully decrease the level of alcohol and drug use among the student population and correct the perception of use among the students and the surrounding community.

Identified Needs/Challenges/Gaps:

The challenges in the region indicate differences in population, diversity, and economics. The Washington suburban areas, primarily Montgomery County but increasingly Frederick and Carroll Counties, are challenged to provide the full range of levels of care to a population increasing in diversity. Language and cultural differences require modifications to traditional methods of delivering treatment for addictive disorders. The far western counties face the need to provide prevention, intervention, and treatment services to populations that are isolated and often without adequate transportation to treatment locations in the population centers.

All counties are planning or implementing services for individuals with an addictive disorder as well as other mental health disorders. The county mental health and addictions programs are increasing cooperation or integrating their services.

The challenge for counties maintaining adequate levels of service with several years of level funding is becoming increasingly difficult and is beginning to result in the reduction of services.

Table 5 Western Region By County	Total Population 2004	*Unemployment Rate 2004	Median Household Income	*Crime Rate *Number of crimes per 100,000 population*	*Land Area / Square Miles
Allegany County	73,871	6.4%	$36,450	3,160.4	472.6
Carroll County	166,159	3.3%	$72,750	1,761.2	452.0
Frederick County	217,653	3.2%	$73,500	2,139.5	662.7
Garrett County	30,124	4.9%	$37,050	1,619.6	656.8
Montgomery County	921,690	3.1%	$80,000	2,671.4	495.4
Washington County	139,624	4.4%	$47,050	2,639.5	455.0
Source	**Maryland Department of Planning 2004*	**Maryland Department of Labor, Licensing and Regulation 2004*	**Maryland Department of Planning 2004*	**Maryland State Police 2004*	**Maryland Geological Survey 2002*

Table 6

Admissions to Treatment by Residence

FY 2002 - FY 2005

	Location of Residence	Non-Funded				ADAA-Funded			
		FY 2002	FY 2003	FY 2004	FY 2005	FY 2002	FY 2003	FY 2004	FY 2005
Central	Baltimore City	11409	11154	8591	9875	10177	13155	15992	15311
	Baltimore County	4647	5061	3981	4095	2879	3090	3974	4452
	Harford	1294	1545	1488	1283	965	918	941	1110
	Howard	874	982	798	639	633	628	740	792
Eastern Shore	Caroline	82	75	90	76	417	453	516	466
	Cecil	401	394	459	459	912	1051	889	938
	Dorchester	76	92	151	157	557	608	615	480
	Kent	43	67	46	40	385	368	443	431
	Queen Anne's	158	142	102	101	409	444	485	554
	Somerset	77	61	50	53	399	424	423	504
	Talbot	134	158	158	158	516	542	523	522
	Wicomico	490	469	608	622	1283	1350	1307	1632
	Worcester	214	200	229	162	905	864	899	956
Southern	Anne Arundel	5046	4690	3475	1828	898	987	2230	4167
	Calvert	380	352	161	174	845	775	1145	1067
	Charles	363	287	229	254	1071	1195	1188	1208
	Prince George's	2212	2241	2426	1692	1886	1956	2071	2804
	St. Mary's	161	122	104	132	1110	977	1104	987
Western	Allegany	70	67	81	95	662	756	789	962
	Garrett	16	14	21	23	282	325	380	397
	Carroll	721	817	848	758	980	990	1069	1107
	Frederick	1107	1125	1091	1047	1069	1146	1050	1024
	Montgomery	2584	2927	2939	2341	2425	2696	3227	3661
	Washington	468	594	470	533	1352	1165	1102	1156
	Out-of-State	2712	2394	2374	2386	514	554	750	867
	Total	35739	36030	30970	28983	33531	37417	43852	47555

Table 6 presents the distribution of ADAA-funded and non-funded treatment admissions by subdivision of residence for FY 2002 to 2005, with subdivisions grouped by regions. Among Maryland residents, largest percentage increases in ADAA-funded admissions over the four years occurred in Baltimore (54.6) and Montgomery (51.0) counties, Baltimore City (50.5), Prince George's (48.7) and Allegany (45.3) counties. However, out-of-state residents increased by over two-thirds in the ADAA-funded sector. Anne Arundel County residents more than tripled among funded admissions, but this was largely due to funding adjustments. Despite a 19 percent decline in non-funded admissions over the four years, residents of Allegany, Carroll, Cecil, Dorchester, Garrett, Talbot, Washington, and Wicomico counties showed increasing trends of varying magnitude in non-funded admissions.

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), 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 192 ADAA-funded and 183 non-funded substance abuse treatment clinics in FY 2005, 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 2005, the percentage of unique individuals completing treatment who were tracked to a subsequent admission to another level of care during 30 days 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, complete birth date, gender and race.

Services

The percentages of positive urinalysis results among total tests conducted were calculated, as well as the treatment completion rates for patients who did and did not undergo urinalysis. Also, 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.

Arrest Rate

For discharges during FY 2005, 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.

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.

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 ADAA website*
http://www.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. Prevention programs developed from research, or evidence-based prevention programs, can be cost-effective. Similar to earlier research, recent data shows 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]

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

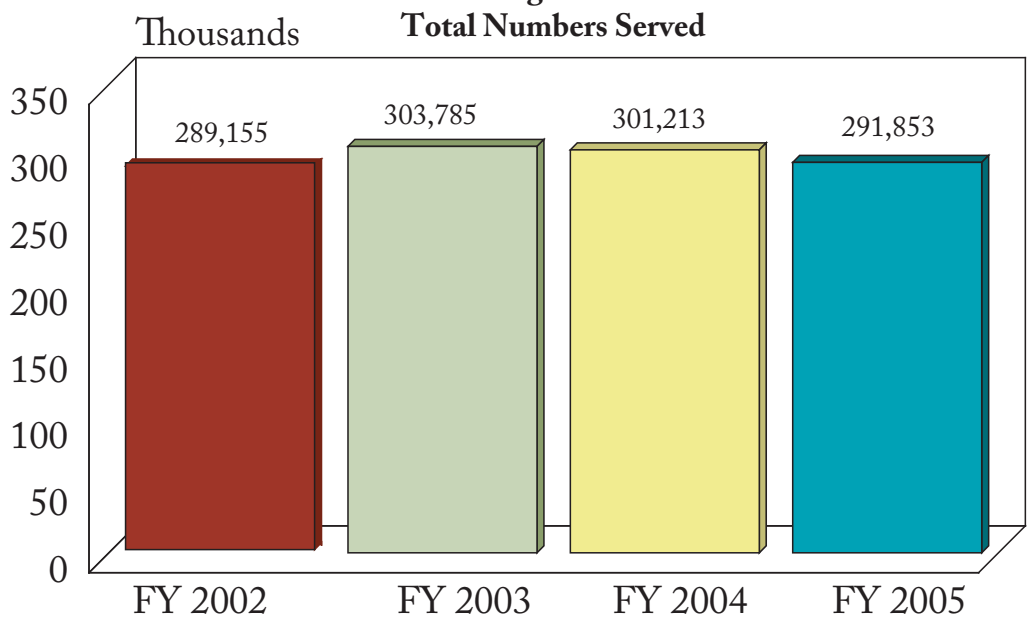
Prevention Coordinators communicate with and serve as resources for the community. There is a designated Prevention Coordinator in each of Maryland's 24 subdivisions. Prevention Coordinators work closely with all elements of the community to identify needs, develop substance abuse projects, implement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

Numbers Served

During Fiscal Year 2005 over 291,000 individuals received prevention services in Maryland. This reflects a slight decrease in the total numbers served from FY 2004 (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. Version 4.0 (1-05-1201). Olympia, WA: Washington State Institute for Public Policy, May 2001.

Figure 1
Total Numbers Served



Center for Substance Abuse Prevention (CSAP) Strategies

All strategies and service type codes reported 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. Table 7 below shows the total number of indivduals served during Fiscal Year 2005 by jurisdiction and CSAP strategy.

Table 7

CSAP Strategies and Number of Participants Served - FY 2005

Subdivision	Information Dissemin-ation	Alternatives	Education	Problem ID And Referral	Community Based Process	Environ-mental	Total
Allegany	3,512	7,342	508	2	415	0	11,779
Anne Arundel	1,443	473	327	7	477	0	2,727
Baltimore City	44,108	912	1,956	9,250	240	0	56,466
Baltimore	34,239	24,751	858	3,318	208	15,448	78,822
Calvert	6,470	1,062	556	14	125	0	8,227
Caroline	4,584	4	24	0	131	15	4,758
Carroll	4,728	0	158	0	794	0	5,680
Cecil	1,200	0	174	5	1770	0	1,379
Charles	1,653	328	425	0	14	4	2,424
Dorchester	8,000	0	41	0	44	0	8,085
Frederick	843	400	580	0	0	0	1,823
Garrett	22	4,965	588	0	795	13	5,383
Harford	13,511	2,556	562	0	1,006	2,016	19,651
Howard	2,900	2,269	164	0	15,208	40	20,581
Kent	56	81	105	0	252	196	690
Montgomery	750	200	255	801	2,404	0	3,609
Prince George's	7,919	1475	692	0	903	317	12,398
Queen Anne's	500	0	110	0	0	0	410
St. Mary's	2,000	11,755	296	0	17	0	14,068
Somerset	4,686	131	93	0	54	45	5,009
Talbot	0	94	113	0	554	387	1,156
Washington	3,367	618	391	172	8	0	4,556
Wicomico	1,408	675	973	0	139	53	3,248
Worcester	3,701	12,843	923	10	447	0	17,924
TOTAL	151,400	72,934	11,171	13,579	24,235	13,579	291,853
Percentage	52%	25%	4%	5%	8%	5%	100%

A description of the Center for Substance Abuse Prevention's six primary prevention strategies can be found in the Prevention Annual Report in the Publications section of the ADAA website at: *www.maryland-adaa.org*

Maryland Prevention

Who Received Services?

Gender

Figure 2 shows the statewide distribution of gender for prevention program participants in Fiscal Year 2005. Approximately 53 percent of program participants were female while 47 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 2005, approximately half of the prevention program participants (48 percent) receiving services were adults over 18 years of age. Parents comprised 31 percent of those adults who atttended prevention programs in Fiscal Year 2005. Youth under the age of 18 represented 52 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 others.

Caucasians made up approximately 54 percent of participants while African Americans comprised 40 percent of the individuals attending prevention programs in Fiscal Year 2005 (Figure 4). Hispanic individuals represented approximately three percent of the participants receiving prevention services in Fiscal Year 2005.

Figure 2 Gender Distribution

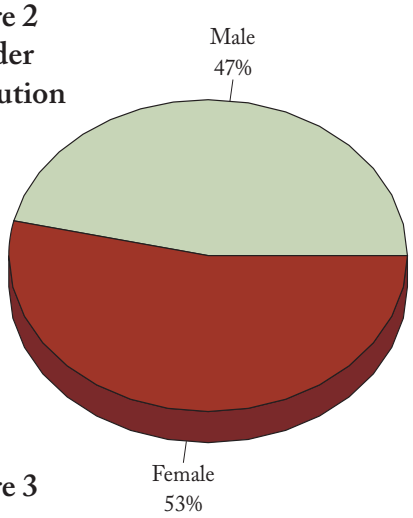


Figure 3 Age Distribution

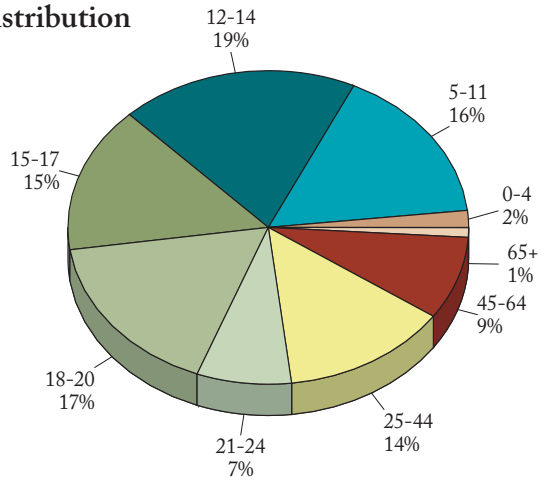
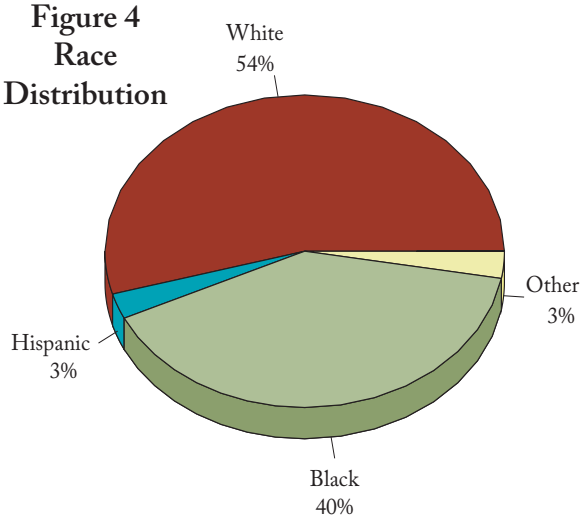


Figure 4 Race Distribution



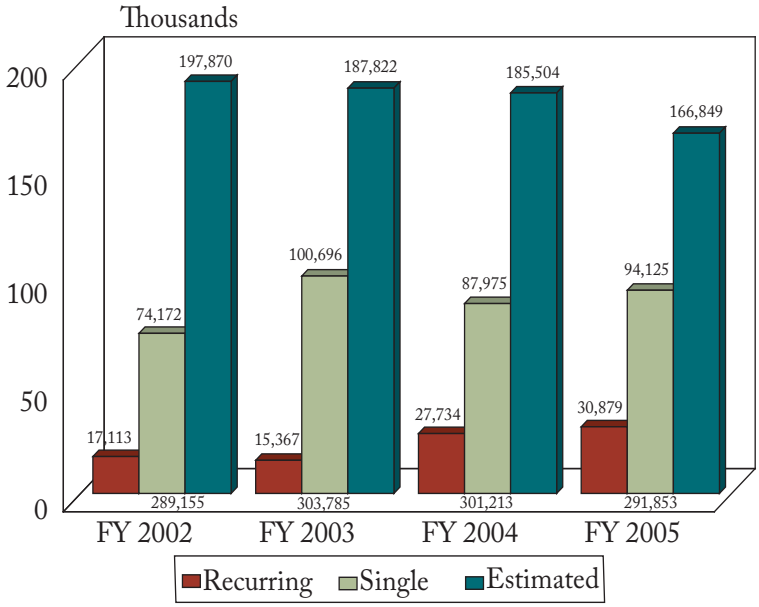
Prevention:

What Did We Buy?

Recurring Prevention Services

In Fiscal Year 2005 there were 30,879 individuals who actively participated in recurring prevention programs in Maryland. The state has mandated its funded prevention service providers to implement Substance Abuse and Mental Health Services Administration (SAMHSA) model programs. As a result, there has been 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 continue to increase.

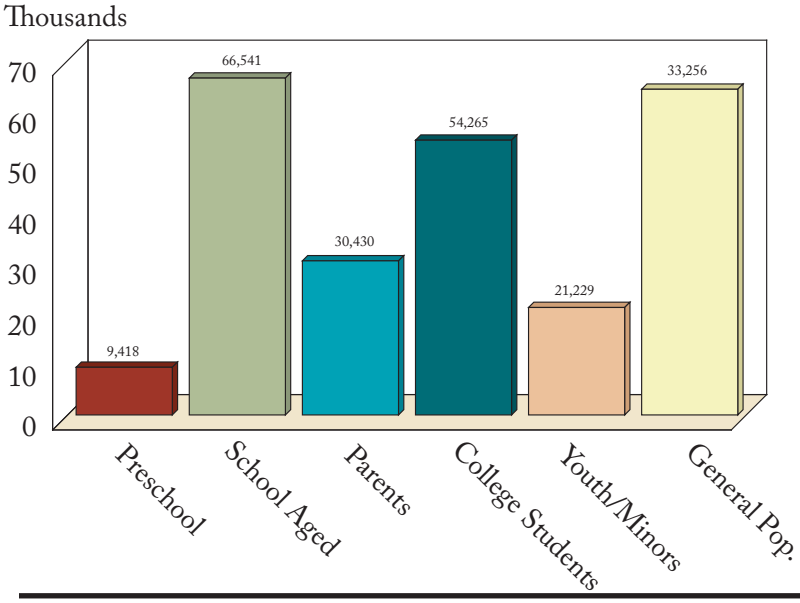
Figure 5
Numbers Served
FY 2001-2004



Single Prevention Services

The total number of individuals attending single prevention services or activities was 94,125 in Fiscal Year 2005. Annual totals for all prevention services are shown in Figure 5.

Figure 6
Service Population



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 166,849 individuals who attended or received prevention services in Fiscal Year 2005.

Service Population

During Fiscal Year 2005, Maryland offered prevention intervention services to 26 different service populations. The majority of individuals receiving services were parents and school-aged children (Figure 6).

Model Program Initiative

In Fiscal Year 2005 the ADAA provided $600,000 to select jurisdictions (Tables 8 and 9) to implement evidence-based programs. The Model Program Initiative (MPI) requires jurisdictions to use Substance Abuse and Mental Health Services Administration (SAMHSA) Model Programs to respond to identified community needs.

Figures 7, 8 and 9 show the gender, age and race distributions of populations served by the MPI.

Table 8

County	Number of Programs		Total Programs
	Recurring	Single	
Allegany	4	0	4
Anne Arundel	3	1	4
Calvert	6	2	8
Carroll	6	3	9
Charles	2	0	2
Dorchester	1	0	1
Garrett	4	0	4
Howard	3	0	3
Montgomery	3	2	5
Total	32	8	40

Table 9

County	Numbers Served		Total Served
	Recurring	Single	
Allegany	78	0	78
Anne Arundel	82	62	144
Calvert	250	14	264
Carroll	100	44	144
Charles	386	0	386
Dorchester	15	0	15
Garrett	106	0	106
Howard	146	0	146
Montgomery	289	84	273
Total	1,452	204	1,656

Figure 7
Gender Distribution

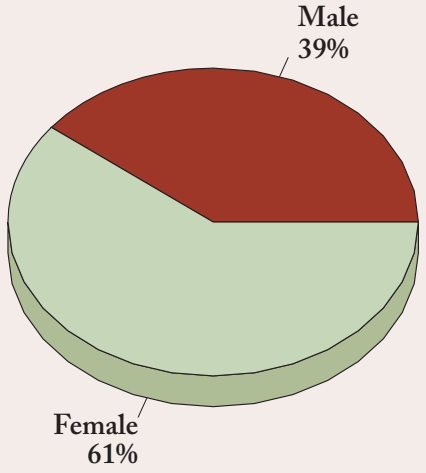


Figure 8
Age Distribution

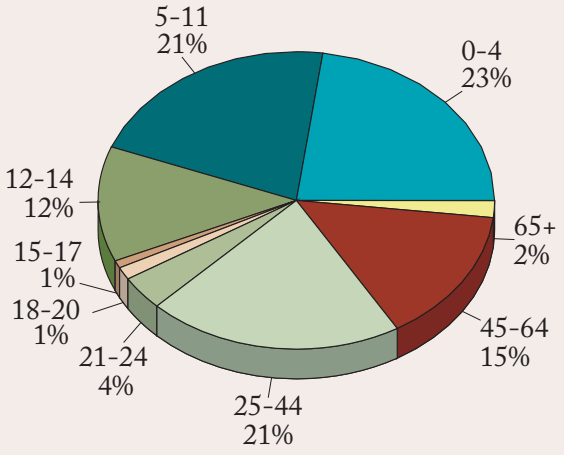
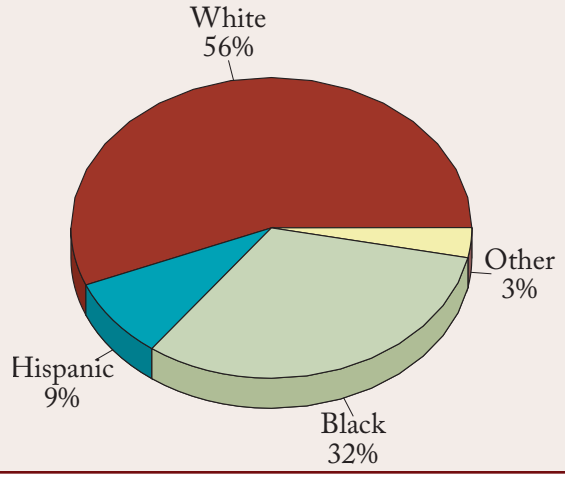


Figure 9
Race Distribution



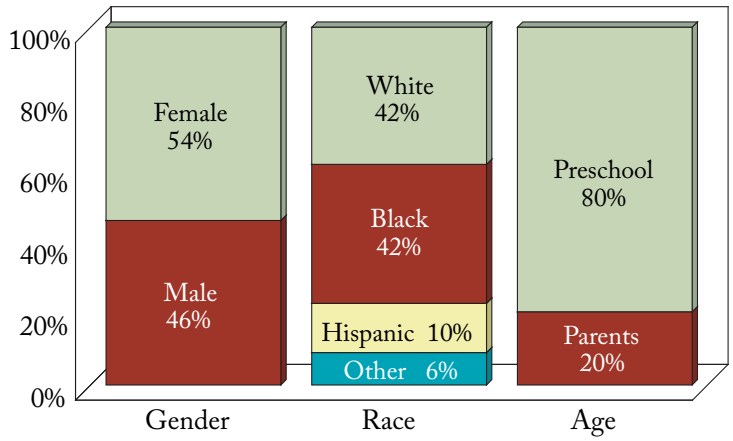
Special Prevention Initiatives

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. Characteristics of participants of the High-Risk Preschool Initiative is found in Figure 10.

FY 2005: A total of 2,325 individuals received prevention intervention services through the High Risk Preschool Initiative in Fiscal Year 2005.

Figure 10
Maryland Preschool Program Characteristics



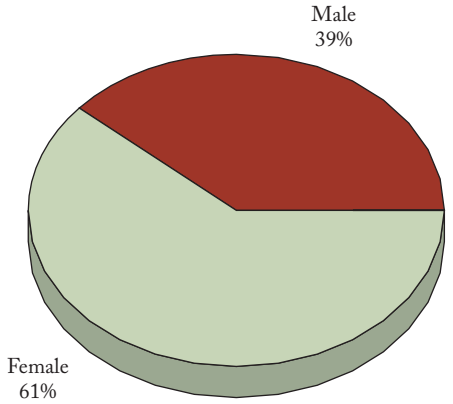


Figure 11 Individuals Served Statewide by College Centers Gender Distribution

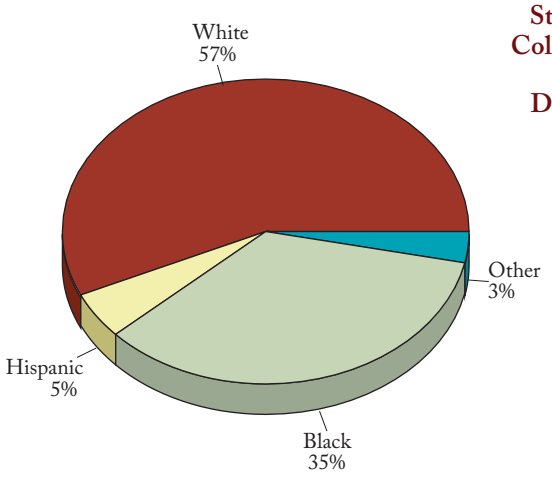


Figure 12 Individuals Served Statewide by College Centers Race Distribution

Promoting a Healthy Transition into Adulthood

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

FY 2005: The college centers provided prevention services to 56,488 individuals statewide with a primary focus on peer education. Figures 11 and 12 show demographic characteristics for all four college prevention centers for Fiscal Year 2005.

Defining Treatment "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 comprised of quantity and types of services offered. Programs must meet the standards defined by ASAM Criteria. 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.

Level I - 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.

Level II -Partial Hospitalization (II.5) - Twenty 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) - Level III treatment services are provided to patients in a residential setting such as a halfway house.

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

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

Level III - Medically-Monitored Intensive Inpatient Treatment (III.7)- Programs offer 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.

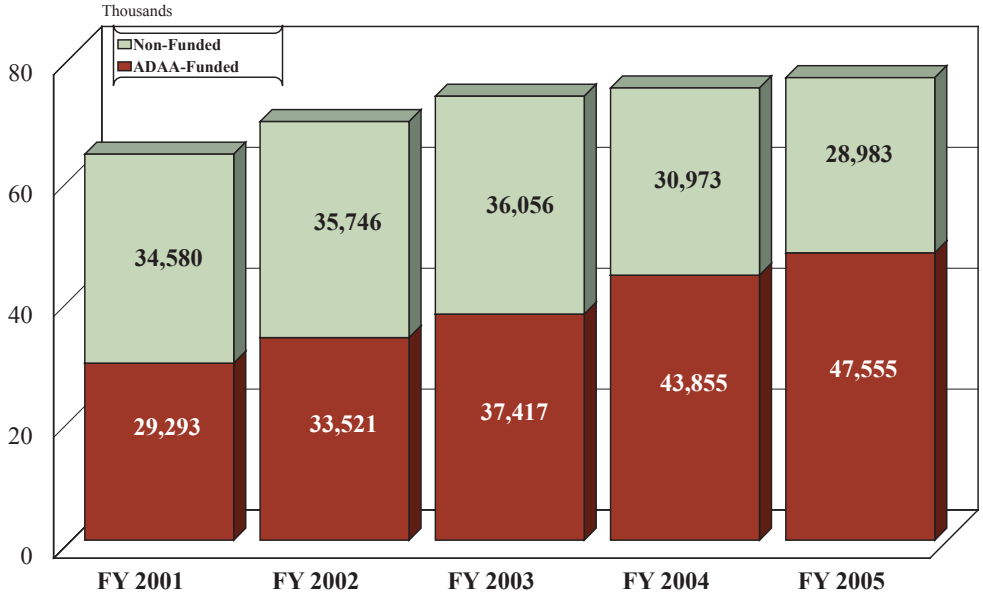
Level IV - Medically Managed Intensive Inpatient Services (IV) - Much like Level III.7 this level of care has an interdisciplinary staff that attend to patients whose acute biomedical, emotional or behavioral problems are severe enough to require primary medical and nursing services. The full resources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

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

Who Received Treatment Services?

Admissions to Certified Alcohol and Drug Abuse Treatment Programs
FY 2001 - FY 2005

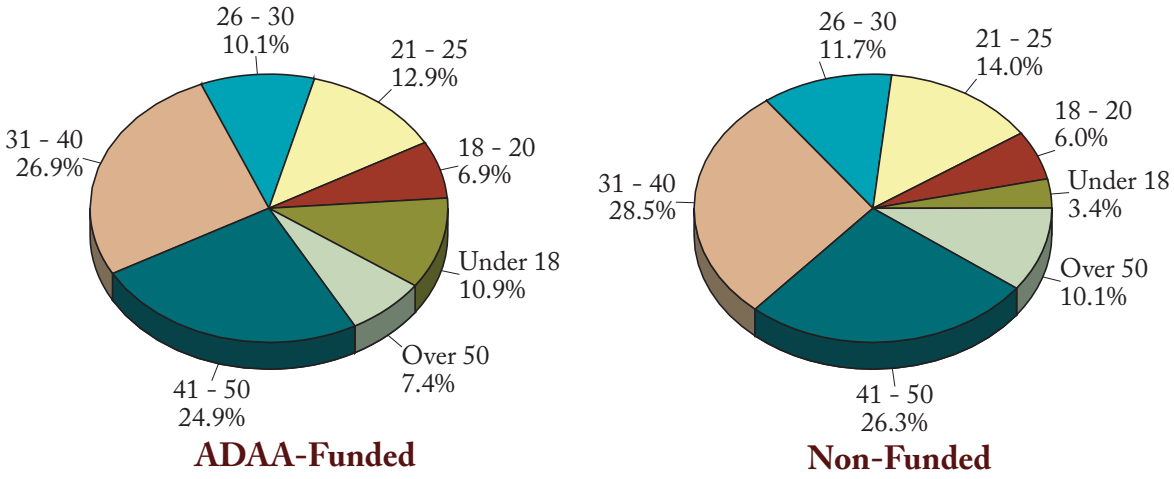
Figure 13



Total admissions increased by 20 percent since Fiscal Year 2001. Whereas ADAA-funded admissions made up 46 percent of the total in FY 2001, they made up 62 percent in FY 2005. 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.

Patient Age at Admission

Figure 14



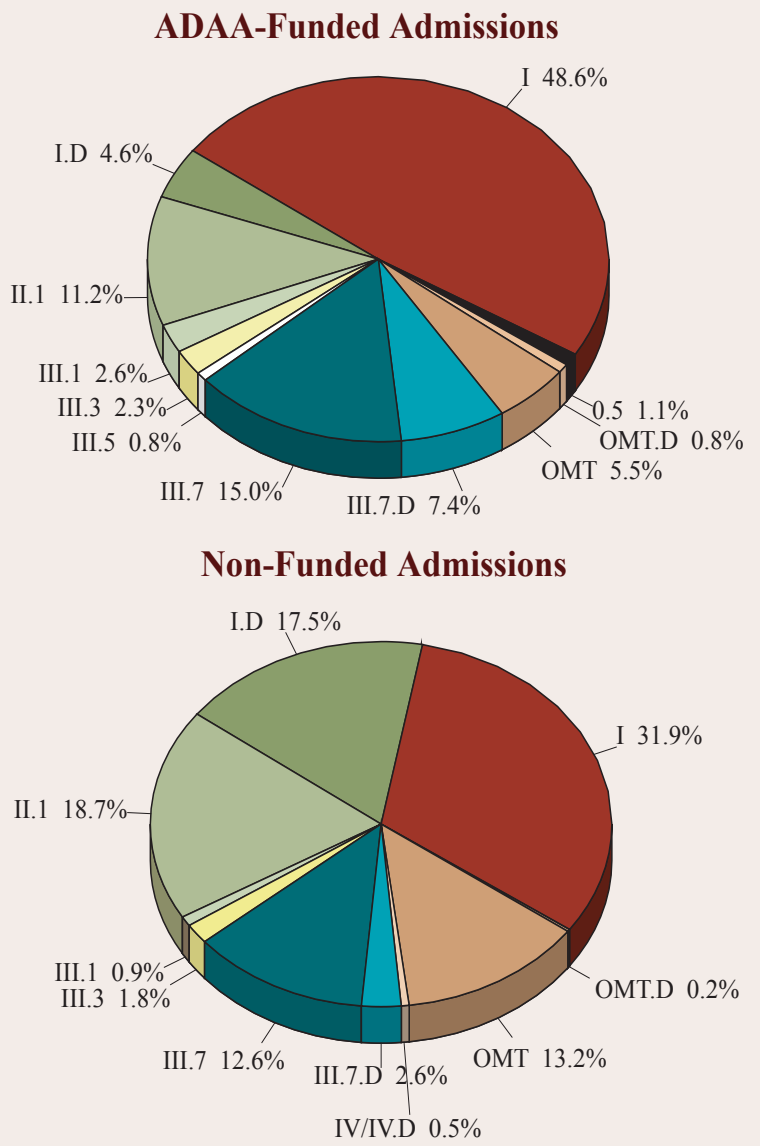
There were some differences in the distributions of age among funded and non-funded patient admissions. Patients admitted to ADAA-funded treatment were more likely to be under 21 and less likely to be over 50. Twenty-three percent of funded Level I patients were under 21, compared to 11 percent of patients in Level II.1. Over 70 percent of individuals in funded Level I.D were over 30; still, 18 percent were under 20. Just under three-fourths of patients admitted to funded Level III.1 and III.7.D programs, and two-thirds of III.3 were over 30. Twelve percent of funded III.7 admissions were under 18 compared to only one percent of non-funded. Over 40 percent of patients admitted to non-funded OMT programs were under 40 while only 16 percent of funded OMT admissions were that young.

FY 2005 ASAM Levels of Care

Figure 15 presents the FY 2005 distributions of ADAA-funded and non-funded admissions by ASAM levels of care. ADAA-funded admissions were much more likely than non-funded to be in Level I programs; nearly half were in that category. Non-funded program admissions were more likely to be to other ambulatory levels — I.D, II.1 and OMT. Twenty-eight percent of funded and 23 percent of non-funded patients were admitted to residential levels of care.

Appendix Table A presents the distributions of funded and non-funded levels of care over the past four years. The proportion of all Level I admissions has been on the decline, going from 58 percent of funded and 42 percent of non-funded in FY 2002 to 49 and 32 percent respectively in FY 2005. Funded OMT admissions have also been declining but have been slowly increasing among non-funded OMT programs. The largest proportionate increases over the five years among both funded and non-funded admissions were in Level I.D

Figure 15

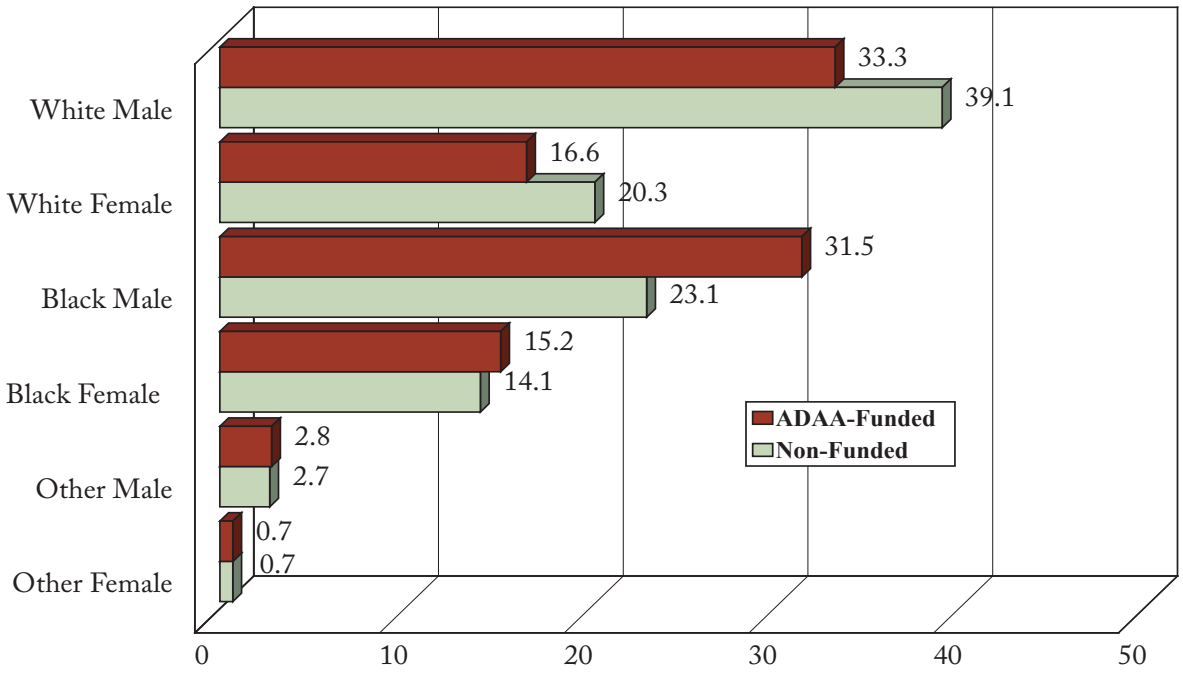


Level 0.5 Early Intervention
Level I Outpatient
Level I.D Outpatient Ambulatory Detox
Level I OMT Outpatient Opioid Maintenance Therapy
Level I.OMT.D Opioid Maintenance Detox
Level II.1 Intensive Outpatient
Level III.1 Clinically Managed Low intensity Residential Treatment
Level III.3 Clinically Managed Medium Intensity Residential Treatment
Level III.5 Clincally Managed High Intensity Residential Treatment
Level III.7 Medically Monitored High Intensity Residental Treatment
Level III.7.D Medically Monitored Intensive Inpatient Detox
Level IV/IVD Medically Managed Intensive inpatient Treatment

Race and Gender

Figure 16

Pecentages of ADAA-Funded and Non-Funded Totals

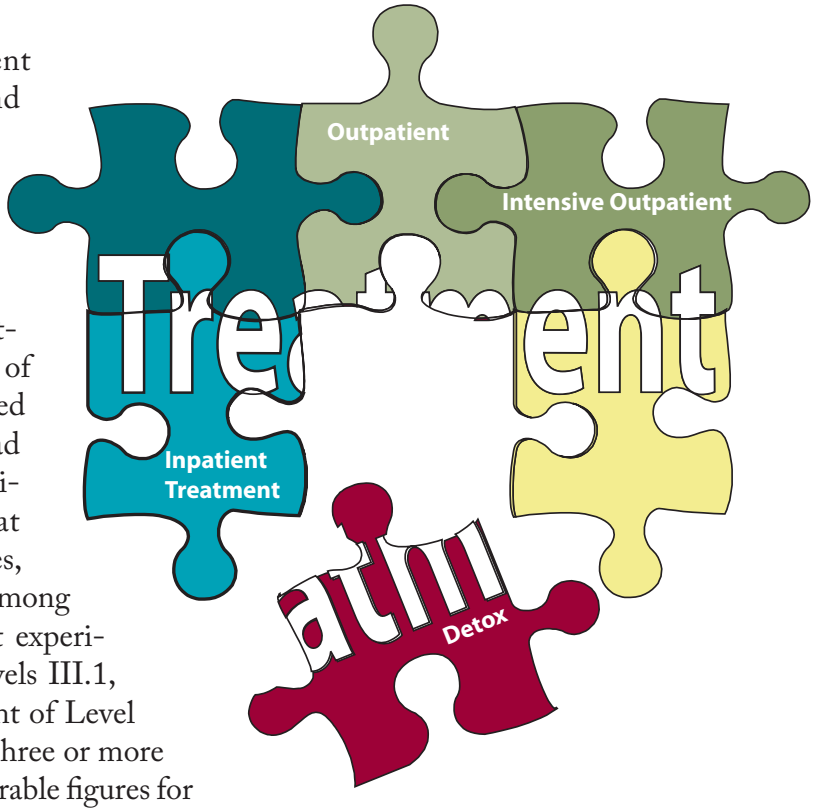


ADAA-funded admissions tended to be evenly split between white (49 percent) and black (47 percent) patients (Figure 16), while 60 percent of patients in non-funded programs were white. There was a small but distinct shift among funded admissions toward greater percentages of white patients from FY 2004 – in that year, the percentages were exactly the reverse, with 49 percent black and 47 percent white. Whereas 17.6 percent of funded admissions were black females in FY 2004, only 15.2 percent were in that category the next year. Non-funded patients admitted were slightly more likely to be female – 35.1 versus 32.5 percent (ADAA-funded). This also reflects a shift – there were relatively more females among funded admissions in FY 2004. With regard to funded treatment, about two-thirds of the admissions to Levels I.D, III.5 and OMT were black, although each of these reflects a decline from the previous year. In non-funded treatment programs over 90 percent of admissions to Level III.7.D and 72 percent of OMT patients admitted were white.

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 the above 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 previous treatment experiences of ADAA-funded and non-funded admissions are shown in Table 10. Patients, in general, were more likely than not to have been in treatment before, with about 56 percent of funded and non-funded admissions having had prior treatment experience. About 32 percent of funded and 34 percent of 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. Forty-four percent of Level III.1 and 35 percent of OMT had three or more prior treatment episodes; the comparable figures for non-funded programs were 19 and 22 percent. 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). Sixty-four percent of non-funded Level I admissions and 52 percent of funded had never been in treatment before. Conversely, patients in non-funded Level I.D were much more likely to have been in treatment before than those in the ADAA-funded sector.

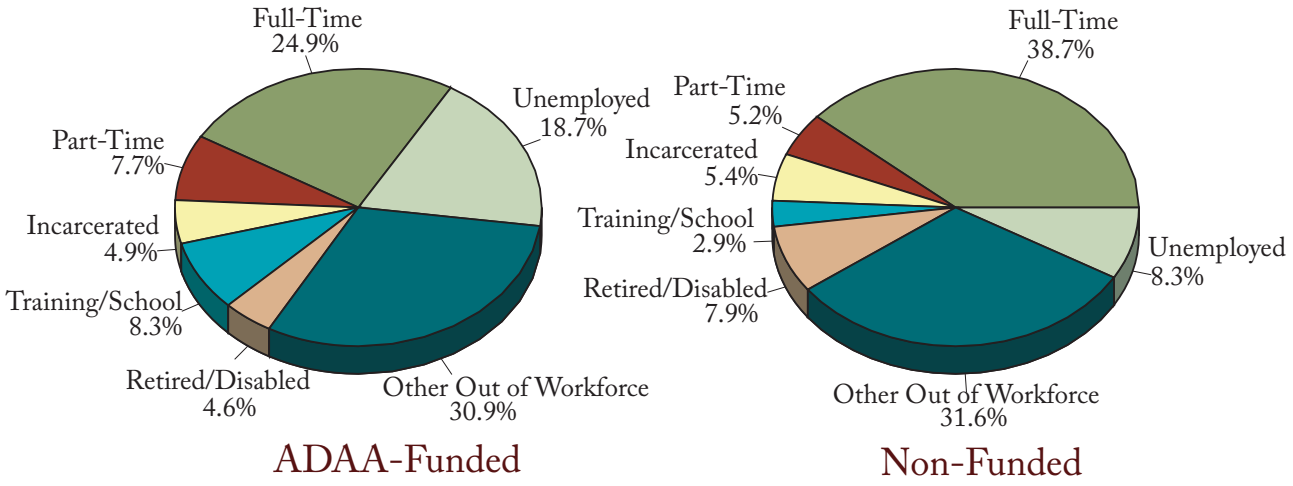
Table 10

Number of Prior Admissions to Substance Abuse Treatment Programs FY 2005

Previous Treatment Episodes	Non-Funded		ADAA-Funded	
	#	%	#	%
None	12649	43.6	20904	44.0
One	6508	22.5	11600	24.4
Two	3890	13.4	6118	12.9
Three	2219	7.7	3612	7.6
Four	1380	4.8	1986	4.2
Five or More	2337	8.1	3335	7.0
Total	28983	100.0	47555	100.0

Employment

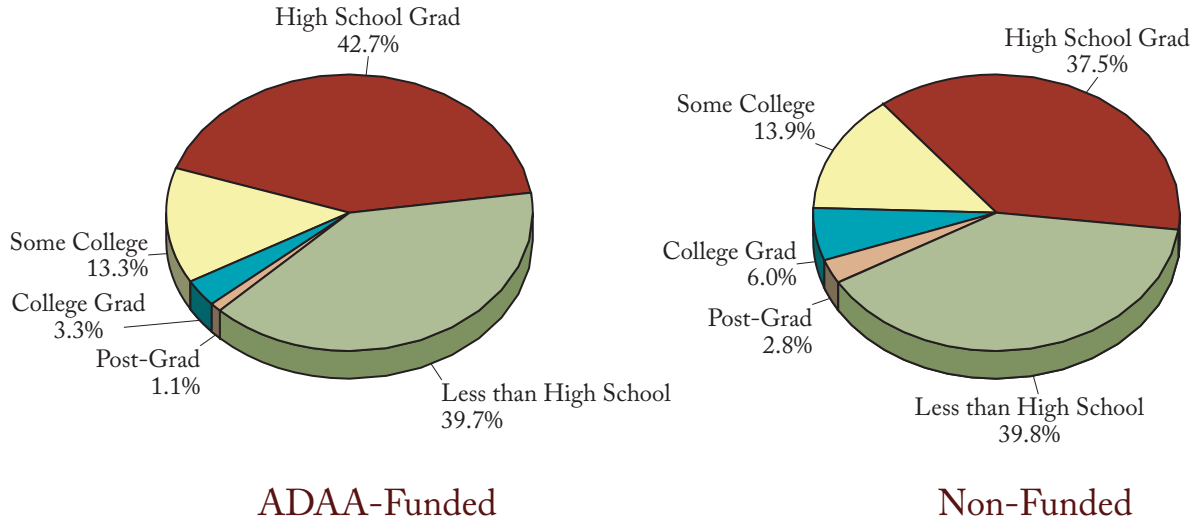
Figure 17



Clearly, ADAA-funded patients admitted in FY 2005 are less likely to be employed than their non-funded counterparts, as shown in Figure 17. Nearly 40 percent of non-funded patients at admission were full-time employed, compared to a quarter of patients admitted to funded treatment. Some of the difference was made up of individuals who were out of the workforce – 49 percent of funded and 42 percent of non-funded admissions. Level I outpatients were most likely to be full-time employed – 55 percent of non-funded and 36 percent of funded outpatients had full-time jobs at admission. Least likely to be full-time employed among funded admissions were those to Levels III.1and III.5 (4 percent). About 16 percent of funded Level OMT admissions had full-time employment, compared to 39 percent of non-funded OMT.

Figure 18

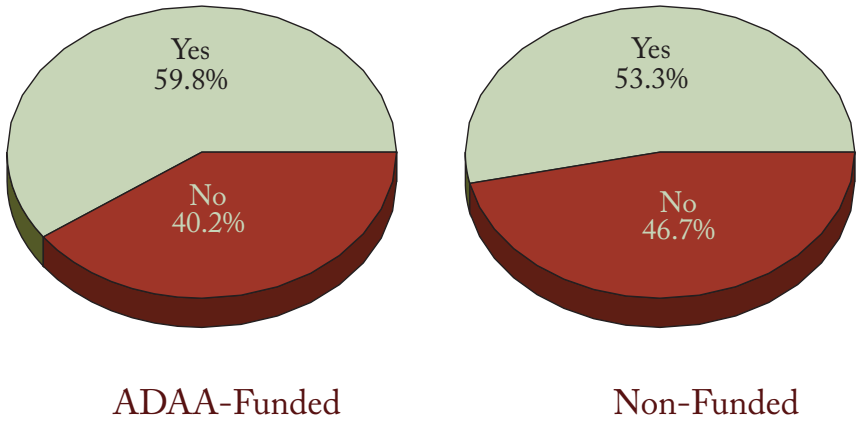
Educational Attainment



ADAA-funded admissions lag behind their non-funded counterparts educationally as well; however, unlike previous years, the largest gap was at the college and post-college levels. As shown in Figure 18, about four percent of funded admissions had college degrees compared to nine percent of non-funded. The difference was made up among high school graduates; about 40 percent of both funded and non-funded patients presented at admission having not completing high school.

Tobacco Use

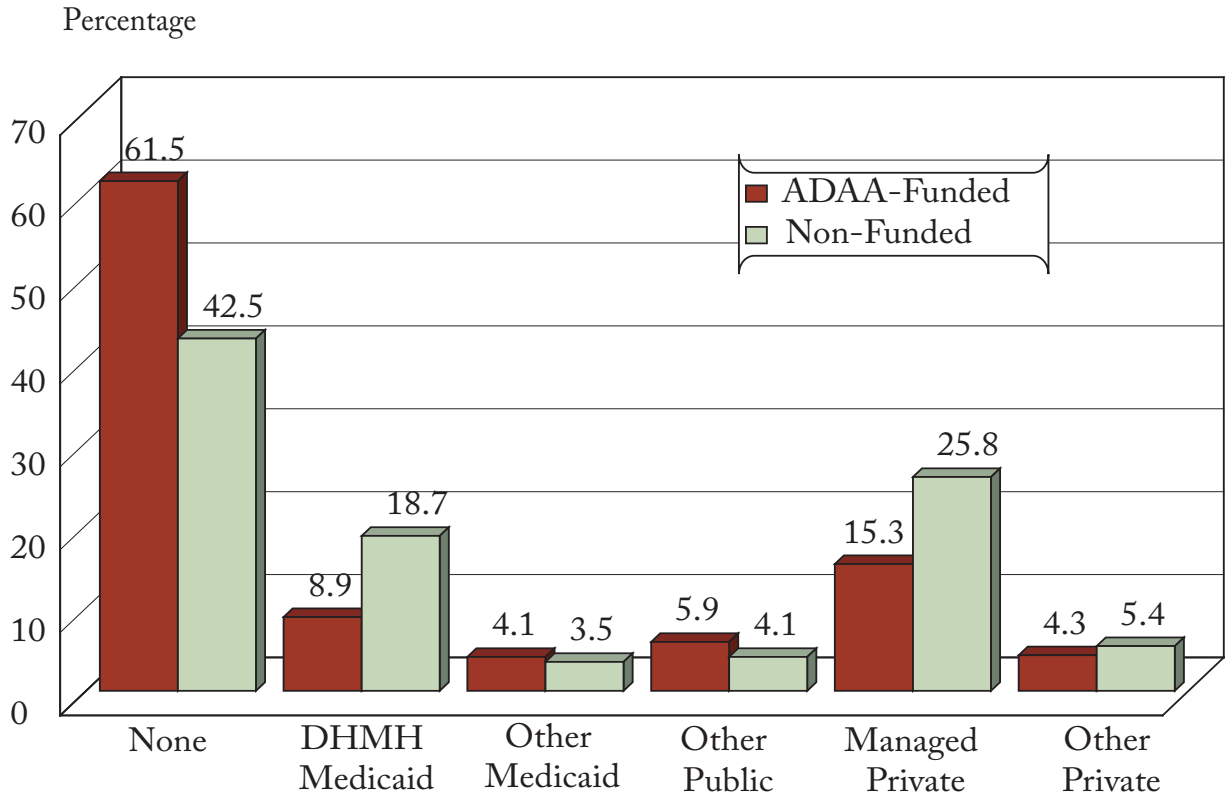
Figure 19



Cigarette smoking is considered a co-occurring problem among most substance abusers; Figure 19 shows that 60 percent of ADAA-funded and 53 percent of non-funded admissions were smokers during FY 2005, well above the general population percentages for this addiction. Further analysis revealed that non-smokers were significantly more likely than smokers to complete treatment. Smoking was most prevalent among admissions to residential and methadone levels of care.

Health Care Coverage

Figure 20



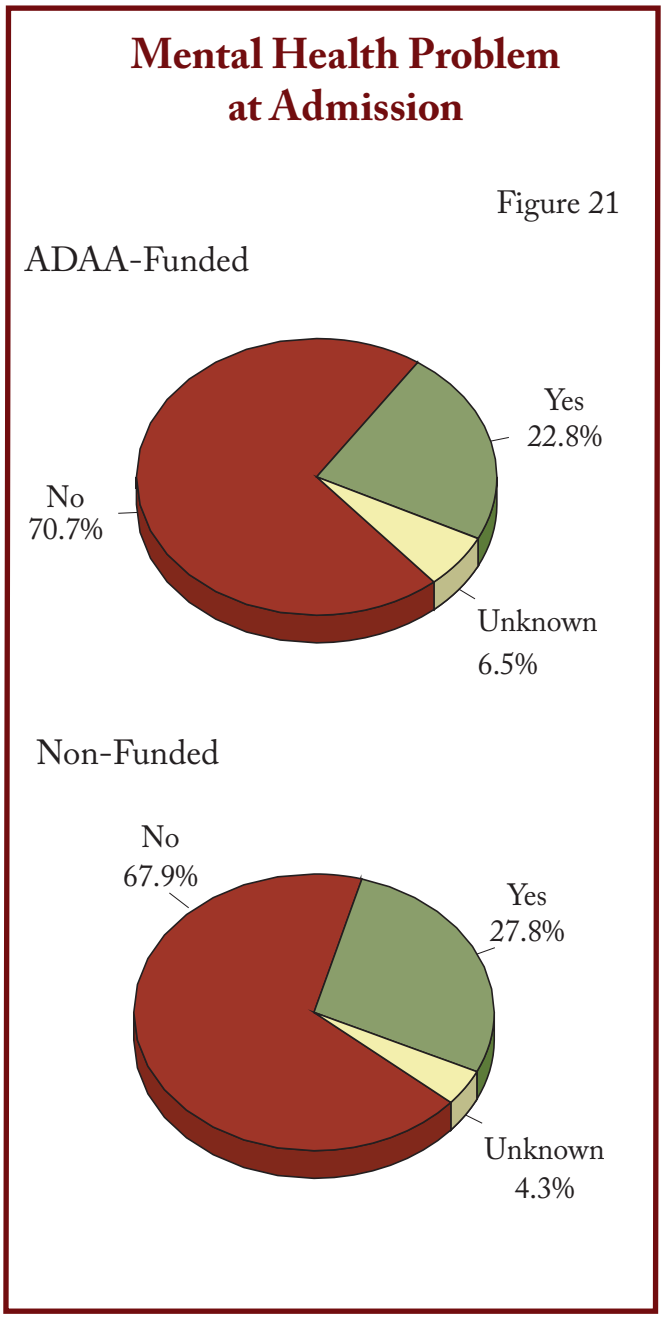
Over 60 percent of the patients admitted to ADAA-funded programs lacked any form of health coverage, as shown in Figure 20. About 43 percent of non-funded admissions were in that category. About 31 percent of non-funded had private insurance compared to about 20 percent of funded patients. A greater percentage of Medicaid admissions went to non-funded programs than funded. This item does not necessarily mean that the reported health coverage paid for the immediate treatment episode.

Co-occurring Disorders

Co-occurring disorders involve simultaneous abuse of substances or a substance abuse problem, and a psychiatric disorder or mental health problem. 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 21.

The co-occurring substance abuse and mental health population has increased each year since FY 2000 as a percentage of total admissions, either in number or because intake counselors are better able to identify them. They were less likely than other patients to have opiate-related problems, but more likely to have issues with alcohol and other drugs. Females represent about one-third of all substance abuse admissions, but one-half of admissions with co-occurring disorders. Also, these admissions were significantly more likely to be white, to enter residential or intensive outpatient treatment, and to have multiple prior treatment experiences.

The ADAA 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. 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.

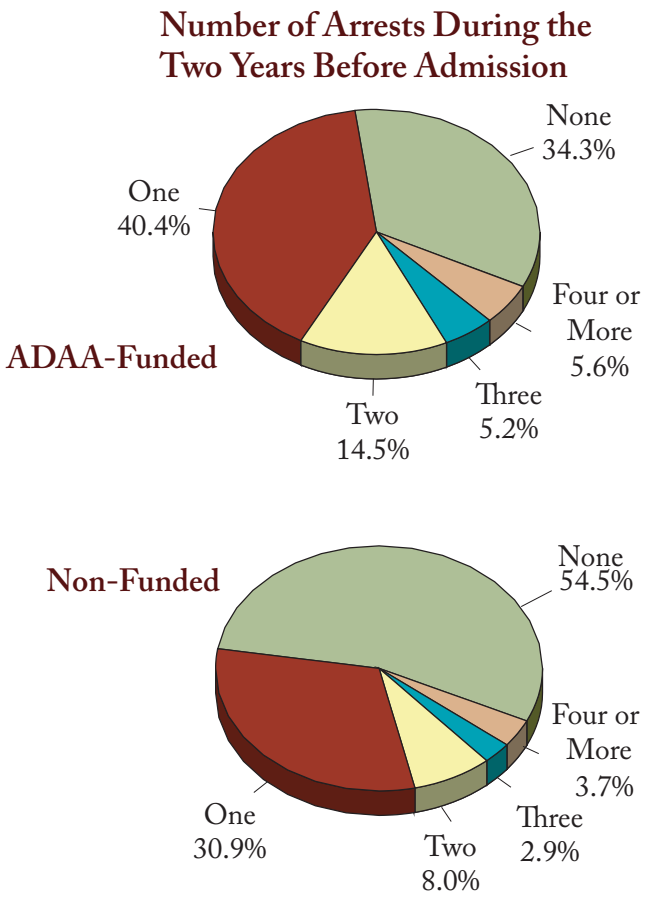


Criminal Justice Referrals

Figure 22

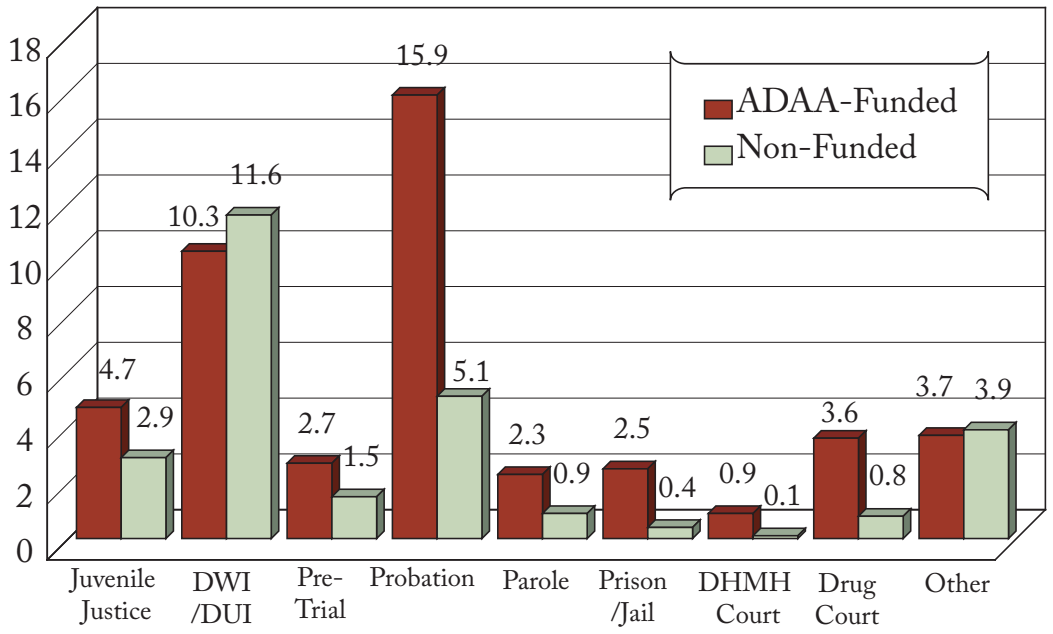
Figure 22 shows the distribution of the numbers of arrests in the two years preceding treatment for funded and non-funded patients. While 45 percent of non-funded patients admitted had been arrested at least once, about two-thirds of ADAA-funded patients had one or more arrests. Multiple arrests were also significantly more common among ADAA-funded patients. This finding makes the distributions in Figure 22 hardly surprising. Nearly half of ADAA-funded admissions were referred by components of the criminal justice system while only 27 percent of non-funded admissions were criminal justice referrals.

Most of the ADAA-funded and non-funded criminal justice referrals received treatment in the community rather than a correctional facility, although non-funded admissions were much more likely than funded to be treated in state Department of Corrections facilities and funded admissions were more likely to be treated in local detention centers. Figure 23 compares funded and non-funded criminal justice referral sources



Percentage Distribution of Criminal Justice Referrals*

Figure 23

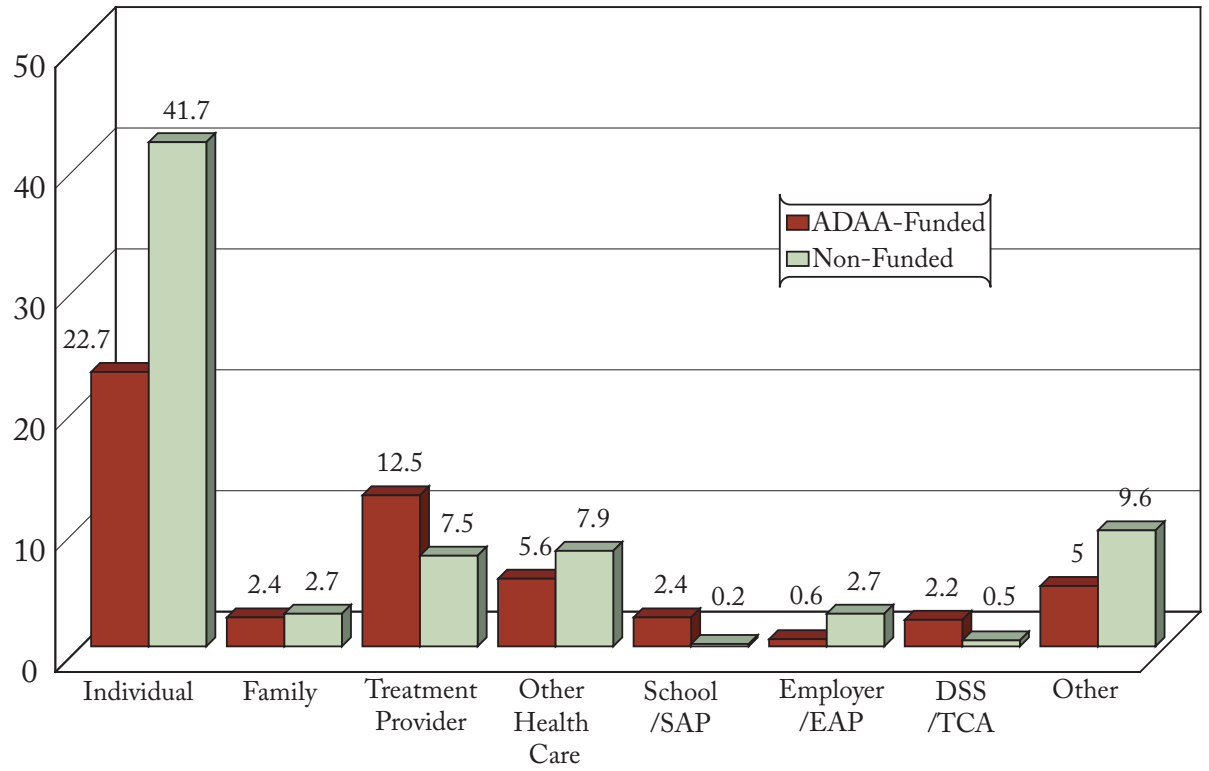


*Percentages are based on total ADAA-Funded or total Non-Funded criminal justice and voluntary referrals.

according to their overall percentages among admissions. DWI is the only criminal justice category in which its contribution to non-funded admissions exceeds its contribution to funded admissions.

Among funded admissions, the level of care least populated by patients referred by criminal justice programs was OMT (14 percent). Three quarters of Level III.5 admissions were referred by the criminal justice system, reflecting the influence of the House Bill §8-507 court commitment process. Black males were slightly more likely than white males to be criminal justice referrals, but the race/gender category with the highest percentages of criminal justice referrals was other males — two-thirds of ADAA-funded and 62 percent of non-funded. This is largely a result of disproportionate occurrence of DWI referrals among Hispanic males. Hispanics were three times as likely as Non-Hispanics to be DWI referrals. The age group between 18 and 25 produced the greatest percentage of criminal justice referrals, except that among non-funded admissions, 80 percent of adolescent admissions came from juvenile justice.

Percentage Distribution of Voluntary Referrals* Figure 24

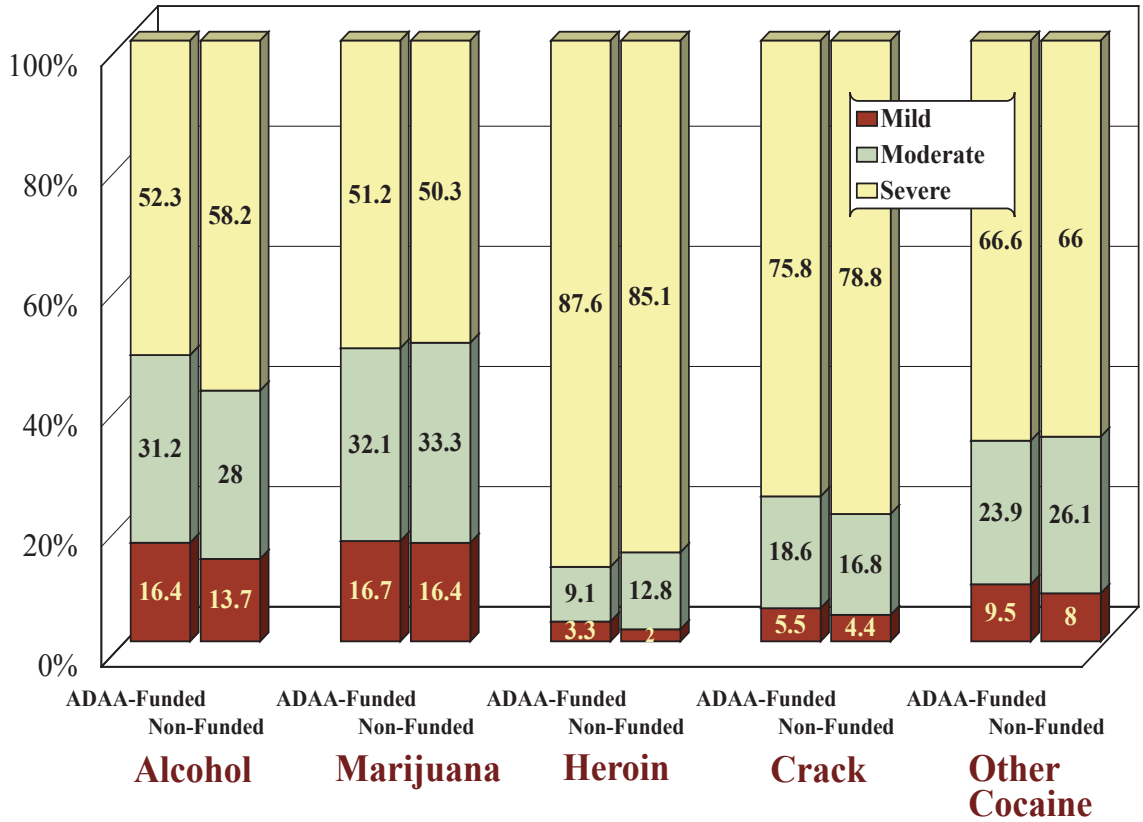


*Percentages are based on total ADAA-Funded or total Non-Funded criminal justice and voluntary referrals.

Voluntary or community referrals are distributed by their relative contribution to funded and non-funded admissions totals in Figure 24. In non-funded programs, admissions were nearly twice as likely to have been categorized as individual or family referrals. 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.

Severity of Substance Problems

Figure 25



Appendix Tables C and D on pages 59-60 show what substances patients report using for funded and non-funded admissions during FY 2002 to FY 2005.* Alcohol has consistently appeared as a substance problem among about 60 percent of ADAA-funded admissions, marijuana among about 37 percent, and heroin has consistently been reported for about a third. Just over two-thirds of cocaine-related admissions involved crack, or smoking the drug, and the total cocaine contribution was about 45 percent. The next most prevalent substance problem was other opiates at about six percent, and no other substance problem mentions exceeded two percent of funded admissions. Other opiate mentions increased by nearly 35 percent from FY 2004 to 2005.

For non-funded admissions, alcohol mentions declined from 60 to 53 percent from FY 2004 to 2005, and marijuana from 29 to 22. Conversely, heroin increased from 35 to 42 percent and cocaine from about 34 percent to 36. About 60 percent of non-funded cocaine-related admissions involved crack. As with funded admissions, other opiates was the next most prevalent substance problem, but their percentage was about double the funded percentage, and they increased by a fourth from FY 2004 to 2005.

Figure 25 shows the percentage distribution of severity of the five major substance problems reported for FY 2005 admissions. Over 85 percent of funded and non-funded heroin problems, over three-fourths 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. Alcohol problems among non-funded admissions were more likely to be severe – 58 vs. 52 percent – but for the most part, severity distributions in funded and non-funded treatment were remarkably similar.

*Up to three substance problems can be reported for each admission. A mention is a report of a particular substance problem as either primary, secondary or tertiary, with any of three levels of severity.

Pattern of Substance Problems

Figure 26

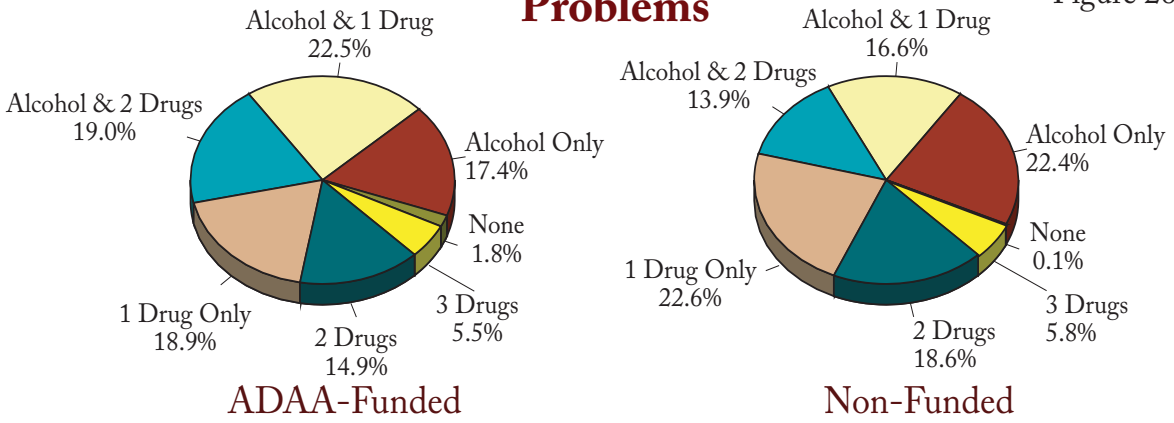


Figure 26 presents the patterns of substance abuse problems among funded and non-funded admissions. Non-funded admissions were substantially more likely than funded to involve alcohol only; 43 percent of non-funded alcohol-related admissions involved no other drugs, compared to 27 percent of funded. Multiple substance problems occurred among 62 percent of funded and 55 percent of non-funded admissions.

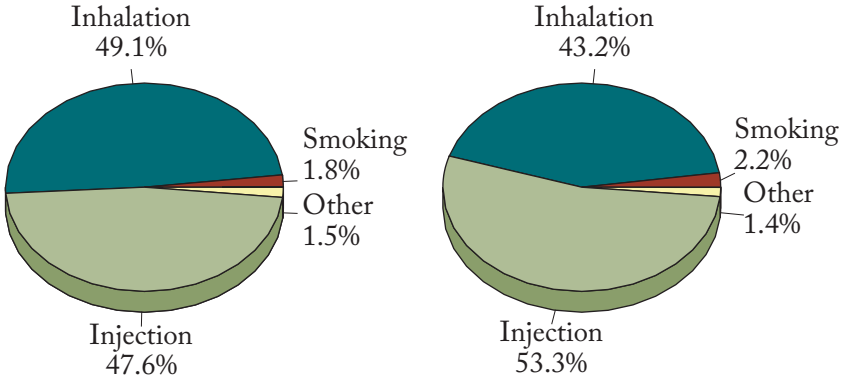
Table 11 distributes the major substance combinations by age category at admission. Excluded are cases with no substance problems at admission, which constituted 11 percent of funded admissions under 18 and about two percent of funded admissions over 50, but less than one percent of every other category. The combination of alcohol and marijuana occurred in 55 percent of funded and 64 percent of non-funded adolescent admissions. Alcohol and marijuana together and apart, were involved in about 90 percent of adolescent admissions. Alcohol only and heroin only were the largest categories for non-funded admissions 18 years and above, but for funded admissions the heroin and cocaine category surpassed heroin only among those aged 18 years and above.

Table 11

Percentages of Admissions with Selected Substance Problem Combinations						
Substance Problem Combinations	Age at Admission					
	Under 18		18 - 50		Over 50	
	Funded	Non-Funded	Funded	Non-Funded	Funded	Non-Funded
Alcohol & Marijuana Only	40.8	48.5	11.1	6.4	3.2	2.4
Alcohol, Marijuana & Cocaine	4.9	5.2	7.8	4.1	3.6	2.3
Alcohol, Marijuana & Other Drug	9.0	10.1	1.7	1.5	0.4	0.7
Alcohol & Other Drug(s)	0.9	0.5	1.2	2.4	1.7	5.9
Heroin & Alcohol Only	0.0	0.0	2.2	1.9	3.6	3.6
Heroin, Marijuana & Alcohol	0.4	0.2	1.2	0.8	0.6	0.4
Heroin & Cocaine Only	0.2	0.7	12.0	13.3	11.1	9.1
Heroin, Cocaine & Alcohol	0.1	0.1	8.2	5.2	7.7	5.2
Heroin, Cocaine & Marijuana	0.7	0.3	3.0	1.9	1.2	1.0
Heroin & Other Drug(s)	0.2	0.5	1.2	3.1	1.0	1.8
Heroin, Cocaine & Other Drug	0.2	0.2	1.7	1.7	1.0	1.0
Other Drug(s) Only	1.0	0.7	1.9	4.7	2.4	5.4

Heroin - Primary Route of Administration

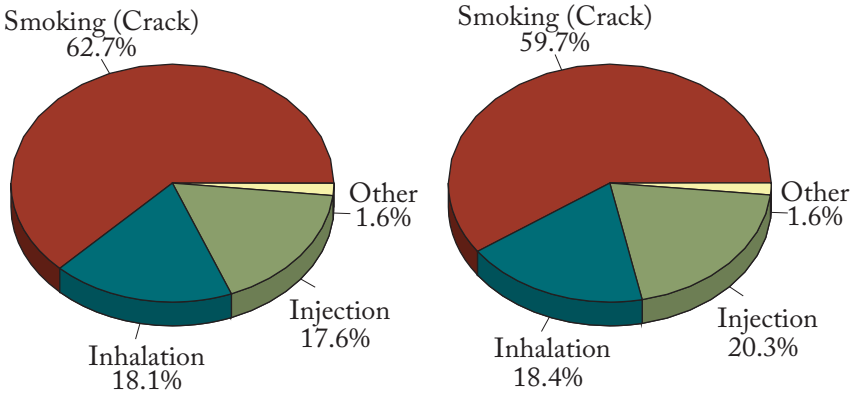
Figure 27



ADAA-Funded Non-Funded

Figures 27 and 28 show the primary routes of administration of heroin and cocaine for admissions involving those drugs. Funded cocaine abusers were slightly more likely than non-funded to smoke the drug, and slightly less likely to inject. Funded heroin abusers were also less likely than their non-funded counterparts to be injectors and more likely to inhale that drug. The greater likelihood for ADAA-funded admissions to be cocaine smokers and heroin inhalers rather than injectors is probably a function of the greater proportion of blacks among funded admissions. Blacks predominate among cocaine smokers and heroin inhalers, and whites who abuse these drugs are more likely to be injectors. Nearly a third of funded and 29 percent of non-funded crack-related admissions were black females, compared to 10 percent of cocaine inhalers and 17 percent of injectors. Blacks were significantly more likely than whites to inhale rather than inject heroin; over 80 percent of funded heroin inhalers and two-thirds of non-funded were black, compared to 44 percent of funded and 32 percent of non-funded heroin injectors.

Cocaine - Primary Route of Administration



ADAA-Funded Non-Funded

Figure 28

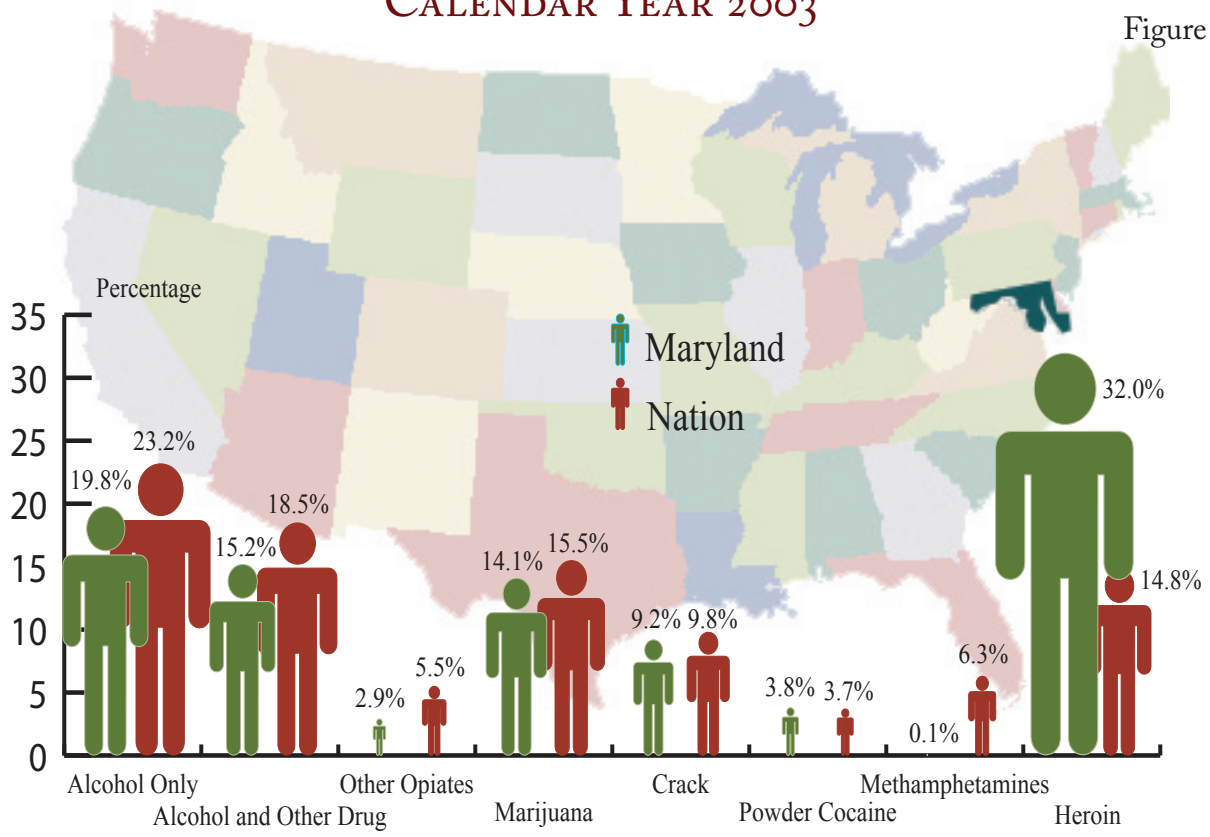
Table 12 shows the major categories of substances injected among FY 2005 admissions. Admissions involving injection made up about 17 percent of ADAA-funded and 23 percent of non-funded admissions. It was rare that an injector of cocaine was not also an injector of heroin, while half or more of heroin injectors did not inject any other drugs. Ninety-two percent of funded cocaine injectors were also heroin injectors, while 44 percent of funded heroin injectors also injected cocaine. The respective figures for non-funded admissions were 93 and 31 percent.

Mentions of Injected Substances Table 12

Injected Substances	ADAA-Funded		Non-Funded	
	#	%	#	%
Heroin	7526	94.2	6478	96.0
Cocaine	3614	45.2	2150	31.9
Other Opiates	170	2.1	170	2.5
Methamphetamines	36	0.5	23	0.3
Injecting Respondents	7992	—	6746	—

How Maryland Compares to the Nation
Primary Substance Problem
Calendar Year 2003

Figure 29



The Federal Treatment Episode Data Set (TEDS) is a Substance Abuse and Mental Health Services (SAMHSA) 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 2003.

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 methamphetamines and heroin. Nationally, over 6 percent of admissions involved methamphetamines while less than one-half of one percent of Maryland admissions involved that drug. Heroin, on the other hand, was a factor in 32 percent of Maryland admissions and only about 15 percent of national admissions.

For 2003, the states with the rates of admission for primary methamphetamine abuse exceeding five percent were all west of the Mississippi River with the exceptions of Alabama (7.4) and Mississippi (6.1). Highest were Hawaii (41.5), California (30.7), Nevada (27.8), Idaho (26.2) and Utah (25.9). Data for the last ten years show the trend gradually moving eastward, but Maryland, Washington, D. C. and thirteen other central and northeastern states had rates of primary methamphetamine abuse at less than one percent of admissions. States or jurisdictions with the highest rates of primary heroin-related admissions were Puerto Rico (57.8), Massachusetts (48.5), New Jersey (47.0), Washington, D.C. (41.9), Connecticut (38.5) and Maryland (32.2).

Age at First Use

The distributions of reported age at first use of the five major substances of abuse are shown in Tables 13 and 14. Higher percentages of ADAA-funded than non-funded alcohol and marijuana-related admissions experienced their first alcohol intoxication before turning 15 (34 to 30 percent) and first used marijuana before turning 15 (45 to 39 percent).

Table 13

Age of First Use
ADAA-Funded

	Alcohol		Marijuana		Crack		Powder Cocaine		Heroin	
	#	%	#	%	#	%	#	%	#	%
Under 15	10532	37.8%	8518	49.2%	659	5.1%	634	8.4%	1130	7.2%
15-17	9645	34.6%	5883	34.0%	2045	15.8%	1848	24.4%	3298	20.9%
18-25	6603	23.7%	2512	14.5%	5656	43.6%	3334	44.0%	6835	43.3%
26-30	526	1.9%	198	1.1%	2096	16.1%	883	11.6%	2063	13.1%
Over 30	591	2.1%	209	1.2%	2523	19.4%	882	11.6%	2458	15.6%

The picture is quite different for cocaine and heroin. About three-fourths of crack abusers and nearly two-thirds of those involved with other forms of cocaine first used the drug in adulthood (over 17). Only about 28 percent of heroin-related cases first became involved with the drug in adolescence; and another 28 percent first used heroin after turning 26.

Table 14

Age of First Use
Non-Funded

	Alcohol		Marijuana		Crack		Powder Cocaine		Heroin	
	#	%	#	%	#	%	#	%	#	%
Under 15	4511	29.6%	2482	39.1%	473	7.5%	440	10.4%	894	7.4%
15-17	5361	35.2%	2111	33.2%	1012	16.0%	1009	23.9%	2437	20.1%
18-25	4376	28.7%	1369	21.5%	2683	42.5%	1883	44.5%	5233	43.1%
26-30	447	2.9%	187	2.9%	982	15.5%	413	9.8%	1541	12.7%
Over 30	554	3.6%	206	3.2%	1167	18.5%	484	11.4%	2026	16.7%

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

"Seventy-eight percent of individuals admitted to funded treatment with marijuana problems reported first substance use during adolescence."

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.

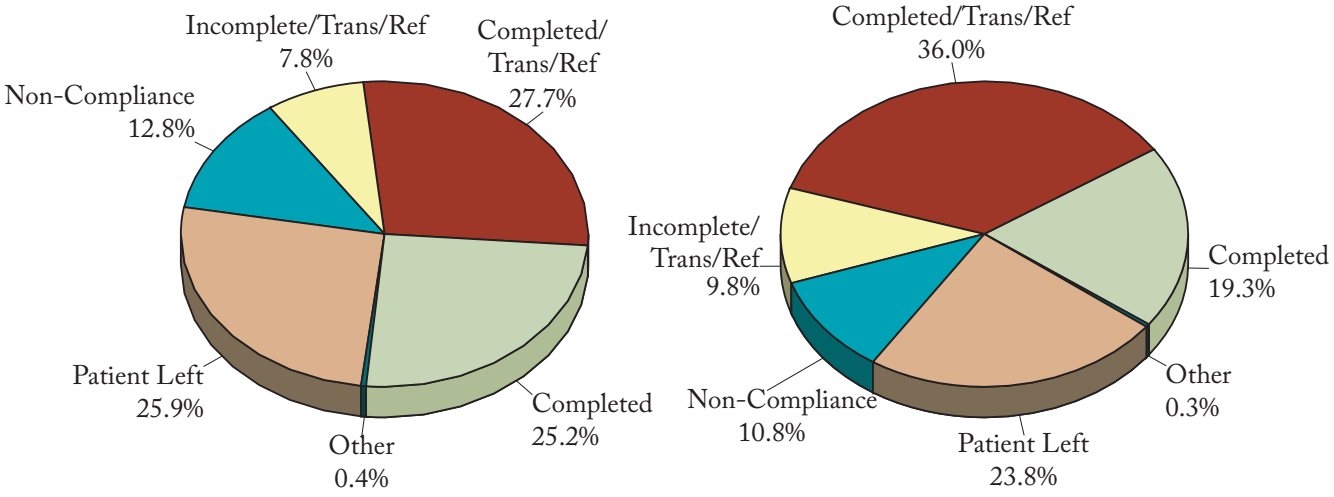
Table 15 presents major treatment plan components and their status at discharge. Employment objectives were included in about 43 percent of funded and non-funded treatment plans, education objectives in about 37 percent, and family relationship objectives in about half. Employment objectives were improved or achieved among 34 percent of applicable funded discharges; educational objectives were improved or achieved among 30 percent; and family objectives among 42 percent. Most significantly, substance abuse objectives were achieved or improved among 64 percent of funded discharges and 62 percent of non-funded.

Table 15

Treatment Plan Progress at Discharge								
Treatment Plan Progress	Employment				Education			
	ADAA-Funded		Non-Funded		ADAA-Funded		Non-Funded	
	#	%	#	%	#	%	#	%
Not Applicable	26896	—	15653	—	28832	—	17732	—
Worse	441	2.3	375	3.1	255	1.5	97	1.0
Unchanged	12237	63.9	9458	77.8	11826	68.6	8284	82.2
Improvement	2812	14.7	1432	11.8	3040	17.6	1054	10.5
Achieved	3674	19.2	886	7.3	2107	12.2	637	6.3
ApplicableTotal	19164	100.0	12151	100.0	17228	100.0	10072	100.0
Treatment Plan Progress	Family Relationships				Substance Abuse			
	ADAA-Funded		Non-Funded		ADAA-Funded		Non-Funded	
	#	%	#	%	#	%	#	%
Not Applicable	23716	—	13842	—	1045	—	586	—
Worse	702	3.1	424	3.0	2345	5.2	978	3.6
Unchanged	12249	54.8	9108	65.2	14017	31.1	9286	34.1
Improvement	6490	29.0	3439	24.6	10946	24.3	8287	30.4
Achieved	2903	13.0	991	7.1	17707	39.3	8667	31.8
ApplicableTotal	22344	100.0	13962	100.0	45015	100.0	27218	100.0

Reason for Discharge

Figure 30



ADAA-Funded **Non-Funded**

As shown in Figure 30, funded discharges were more likely to complete treatment with no indicated need for further treatment, while non-funded discharges were more likely to be completions with transfers or referral to other levels of care. In total, 53 percent of funded and 55 percent of non-funded patients completed their treatment plans in the various levels of care.

Reason for Discharge: Definitions

Completed Treatment Plan
The patient has completed his/her prescribed treatment plan and is found no longer to have a substance problem.

Completed Treatment Plan/Referred
The patient has completed his/her prescribed treatment plan, but requires additional treatment at another facility.

Completed Treatment Plan/Transferred
The patient moves from one level of care to another or one physical location to another within the same treatment episode as prescribed in his/her treatment plan.

Incomplete Treatment/Client Left Before Completing Treatment
The patient has been discharged because of his/her decision to leave the clinic before the treatment plan has been completed.

Incomplete Treatment/Death
The patient was discharged because of his/her death.

Incomplete Treatment/Non-compliance with Program Rules
The patient was discharged for not following program rules.

Incomplete Treatment/Health Problems
The patient was unable to complete his/her substance abuse treatment plan because of either a physical or mental health problem.

Incomplete Treatment/ Incarcerated
The patient has been incarcerated and is therefore unable to participate in treatment at the program. The treatment plan has not been completed, and further treatment is indicated.

Incomplete Treatment/Referred
The patient did not complete his/her treatment plan. As a result, the patient was referred to another substance abuse treatment program.

Incomplete Treatment/Transferred
This category is used when the patient did not complete his/her treatment plan. As a result, the patient was transferred to a more intensive level of care.

Length of Stay: Mean Days In Treatment

Figure 31

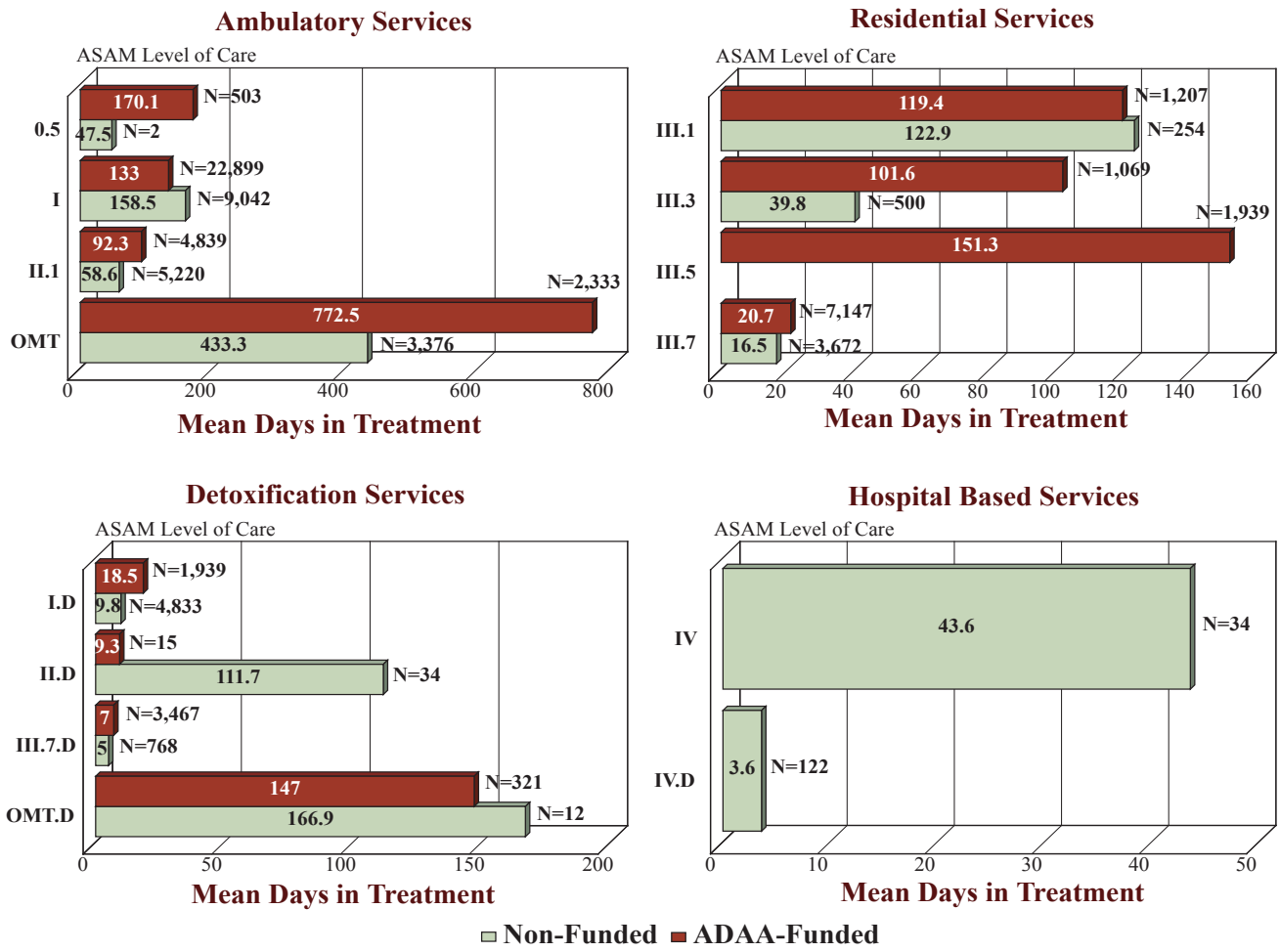


Figure 31 shows the average length of stay in funded and non-funded ASAM levels of care during FY 2005. On average, non-funded Level I discharges stayed in treatment nearly a month longer than funded, while funded Level II.1 discharges stayed over a month longer than non-funded. OMT discharges remained in funded and non-funded treatment well over a year, but the average in funded treatment was well over two years.

There was a substantial difference between funded and non-funded discharges in Level III.3, suggesting that some of the non-funded reporting in that category is in error. Reporting by ASAM levels of care is still a relatively recent requirement. On average, patients stayed four months in halfway houses (Level III.1) and five months in therapeutic communities (Level III.5).

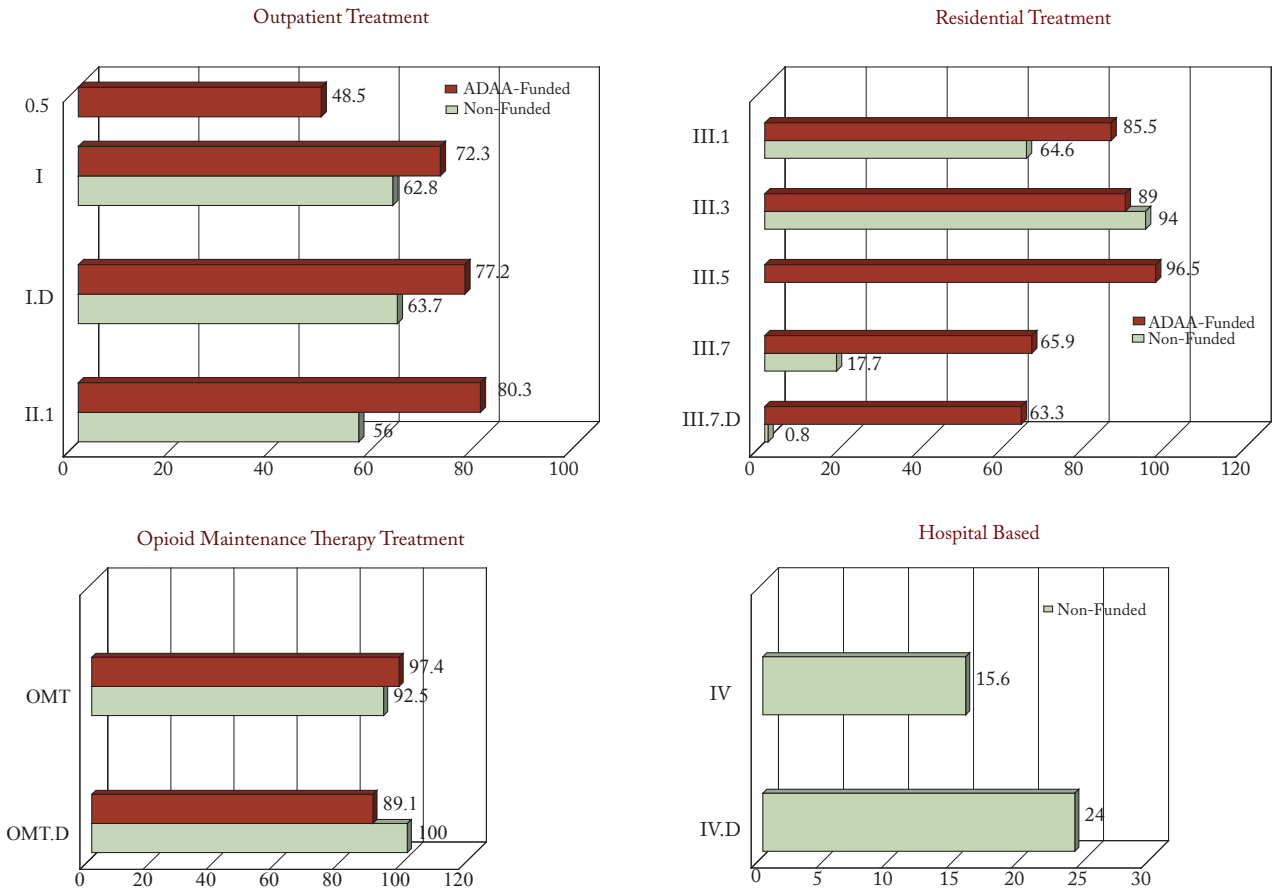
OMT detox tends to last over five months in funded and non-funded programs; the average length of stay in non-funded II.D suggests the possibility of error, although relatively few cases are involved. On average, patients stayed about twice as long in funded ambulatory detox (Level I.D) as in non-funded.

Measuring Treatment Effectiveness

Information is collected on urinalysis tests undergone by patients discharged, and the number that were positive. Figure 32 shows the percentage of patients in each level of care who underwent urinalysis during treatment

Figure 32

Percentage of Discharged Patients Who Underwent Urinalysis During Treatment



Figures 33 and 34 show the average percentages of positive tests for funded and non-funded patients completing treatment and not completing treatment by level of care. Not surprisingly, highest positive test results occurred in detox services, and non-completers had significantly higher positive test percentages at every level except I.D and III.7.D, where incomplete treatment was associated with only slightly higher positive test results. Lowest positive test results occurred in the longer term residential levels of care, except for non-funded discharges from Level III.3 who failed to complete treatment.

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 Fiscal Year 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.

Figure 33

Average Percentage of Positive Urinalysis Tests in ADAA-Funded Treatment

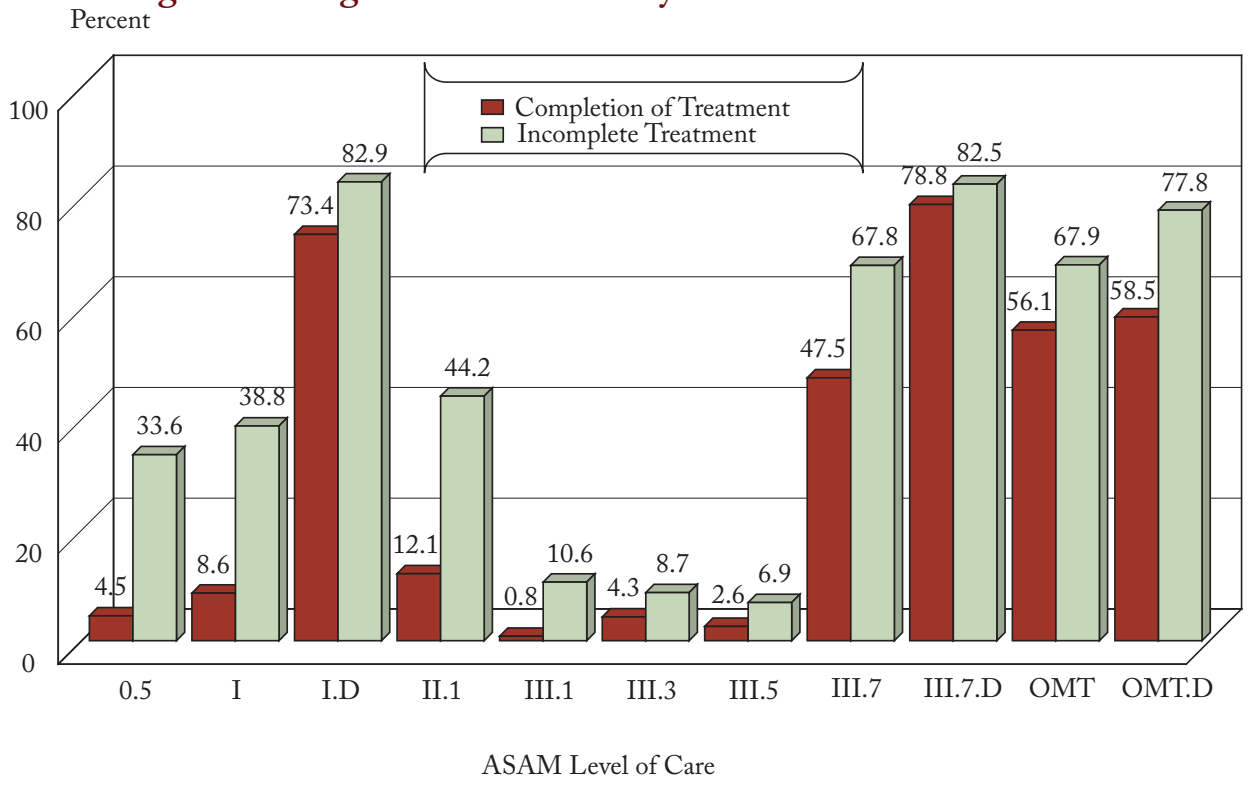
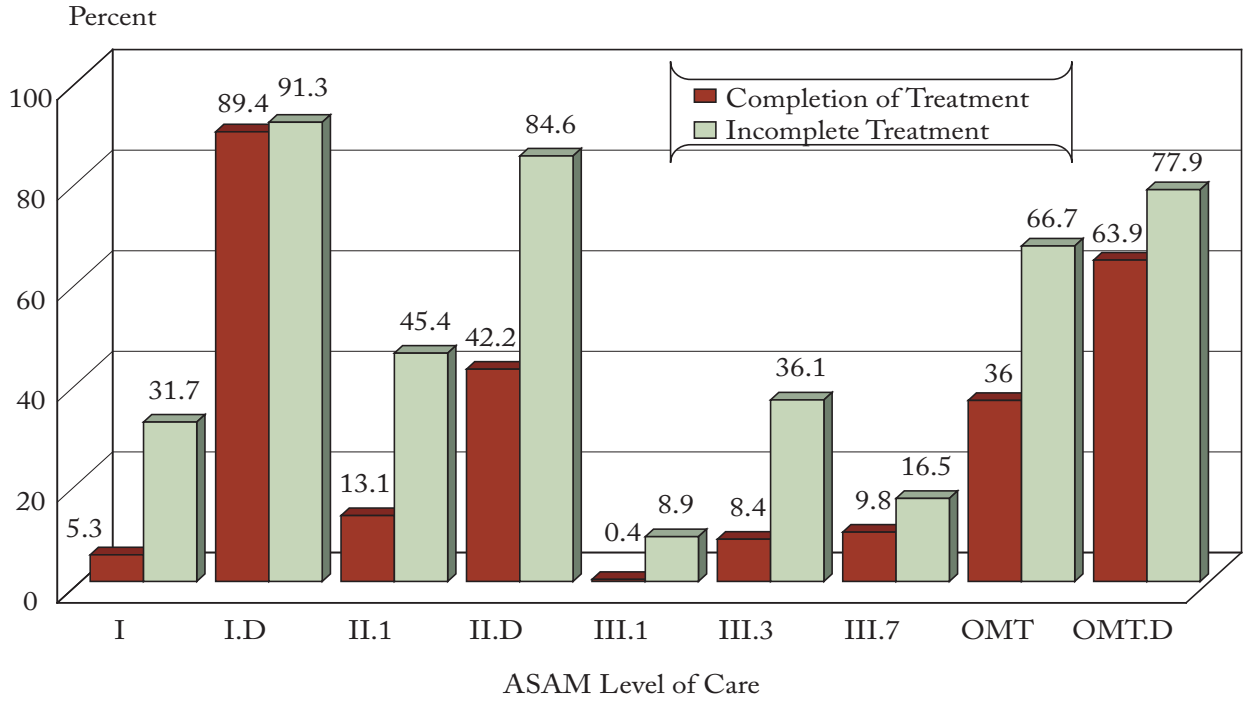


Figure 34

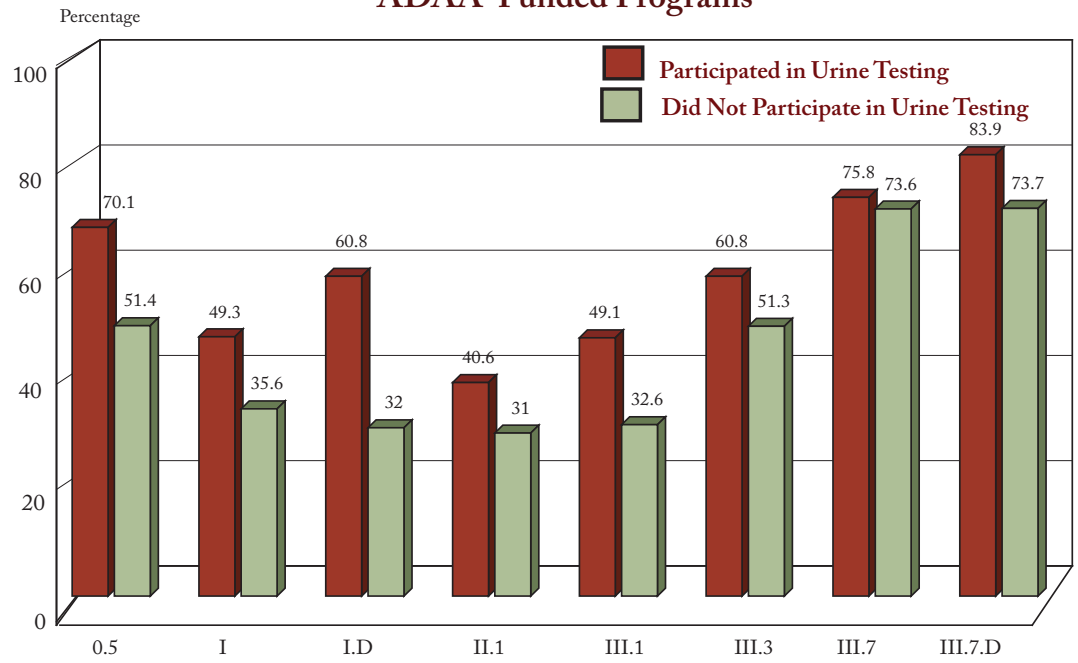
Average Percentage of Positive Urinalysis Tests in Non-Funded Treatment



Figures 35 and 36 present, for funded and non-funded programs, the percentage distribution of treatment completion by level of care, and by whether or not the discharged patients underwent urinalysis during treatment. At every level of care except non-funded OMT, undergoing urinalysis testing was associated with higher treatment completion percentages.

Urinalysis Testing and Percentages Completing Treatment by ASAM Level of Care ADAA-Funded Programs

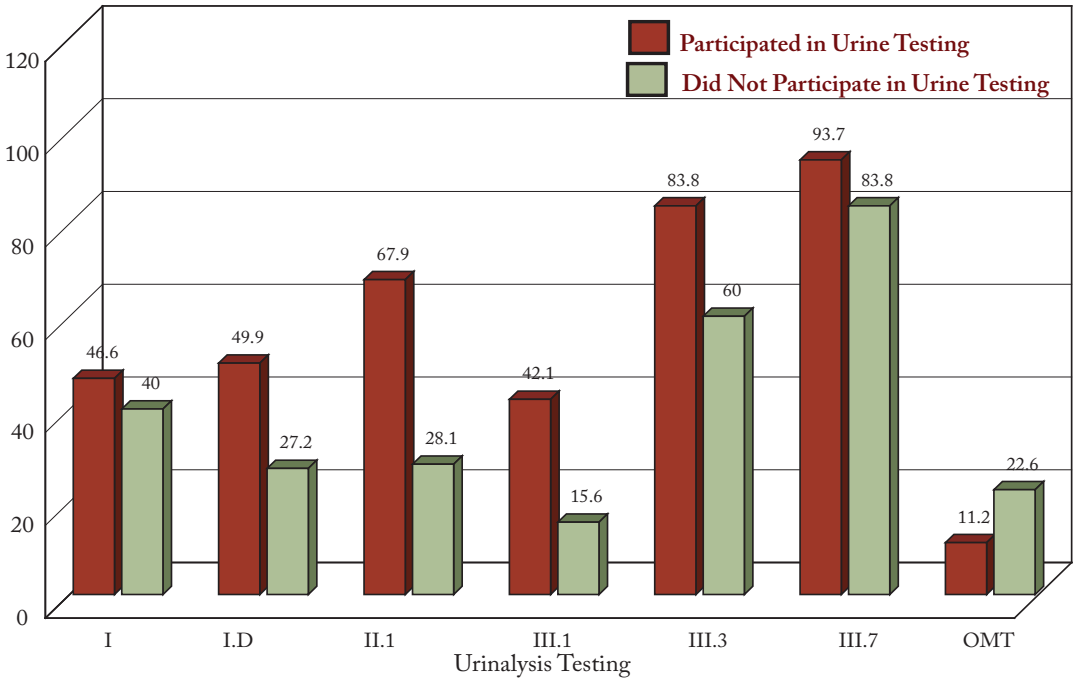
Figure 35



Note: Levels III.5, OMT and OMT.D were excluded because the vast majority of patients in those levels of care underwent urinalysis.

Urinalysis Testing and Percentages Completing Treatment by ASAM Level of Care Non-Funded Programs

Figure 36



Note: Level III.7.D was excluded because the vast majority of patients in that level of care did not undergo urinalysis.

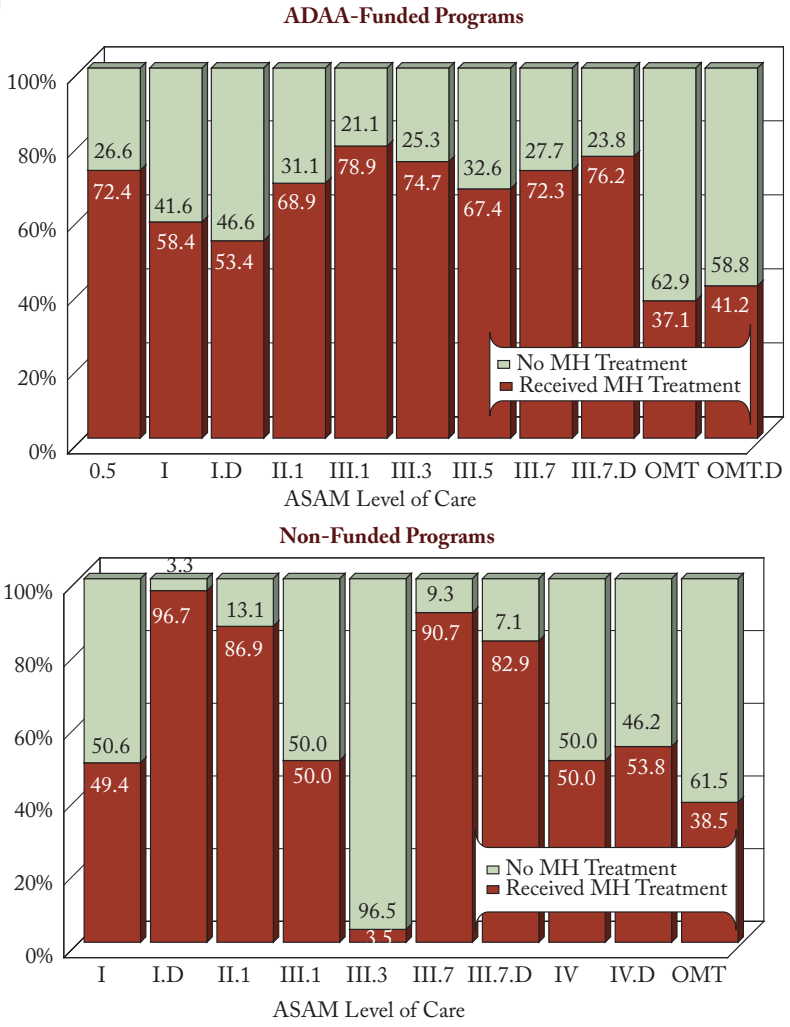
Mental Health Treatment Received by Patients with Co-occuring Disorders

As shown in Figure 37, two-thirds or more 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 exceptions of non-funded Levels III.1 and III.3. Again, the discharges in non-funded Level III.3 are probably in fact short-term residential. About half of non-funded and 58 percent of funded Level I patients with problems received treatment and nearly 40 percent of those in funded and non-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.

Of those individuals discharged who had mental health problems at admission, successful completion rates were 19 percent higher for ADAA-funded patients who received mental health services and 24 percent higher for those in non-funded treatment.

Figure 37

Mental Health Treatment for Patients with Mental Health Problems at Admission



Note: Overall, 79.8 percent of 7,858 non-funded discharges with mental health problems at admission received mental health treatment during the episode.

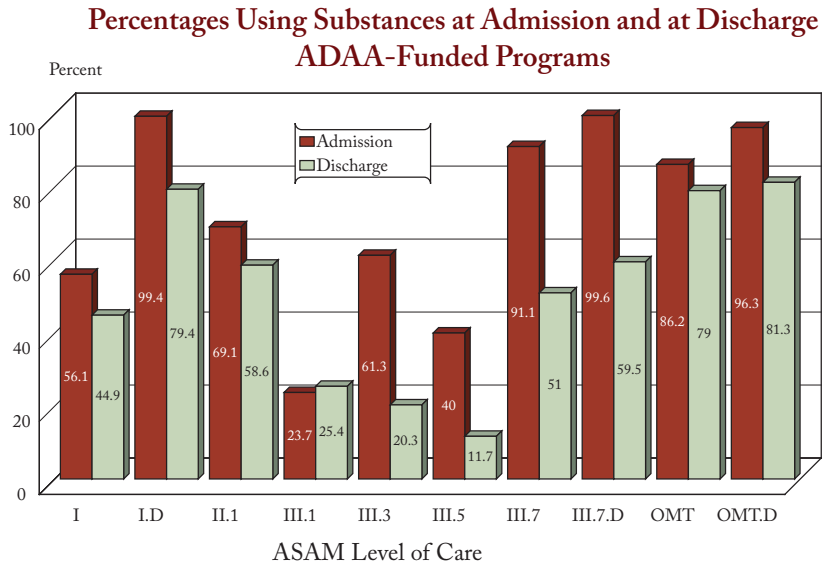
Co-occurring Disorder Facts

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

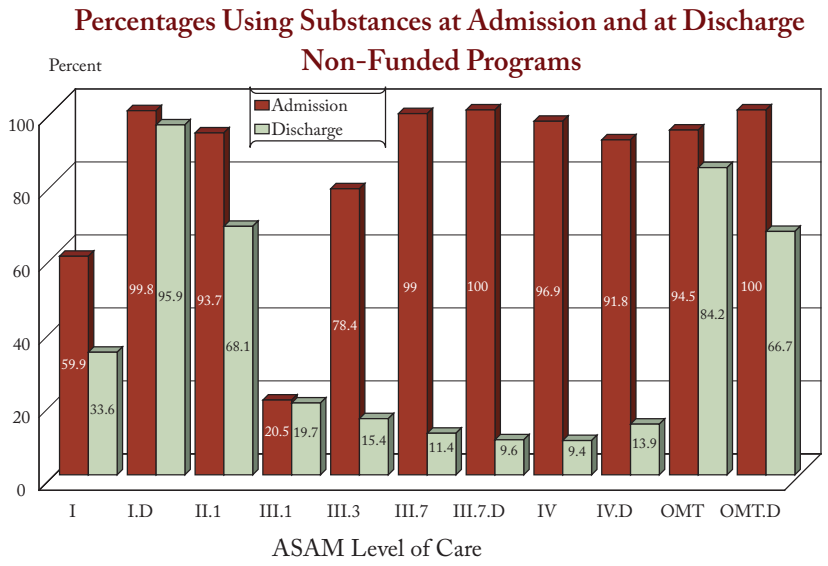
Figures 38 and 39 illustrate the reductions in use of substances that occur in ADAA-funded and non-funded treatment from the 30 days preceding admission to the 30 days preceding discharge for all discharges, whether successful or not. In funded Level I, use was reduced by 20 percent and by 15 percent in II.1; in non-funded Level I, the reduction was a dramatic 44 percent and in Level II.1 it was 27 percent. As pointed out earlier, these results are not truly comparable. The patients treated in ADAA-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. Also, funded discharges are more likely than non-funded to have originated in the criminal justice system, where levels of use at admission tend to be suppressed.

Figure 38



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. Admissions to Level III.1 usually come from a controlled environment, so use of substances at admission is low, making improvement at discharge difficult. The reductions in percentage of users during treatment in Level OMT were relatively small, eight percent in funded and 11 percent in non-funded treatment; however, as pointed out above, discharges from opiate maintenance therapy tend to be skewed by unsuccessful patients.

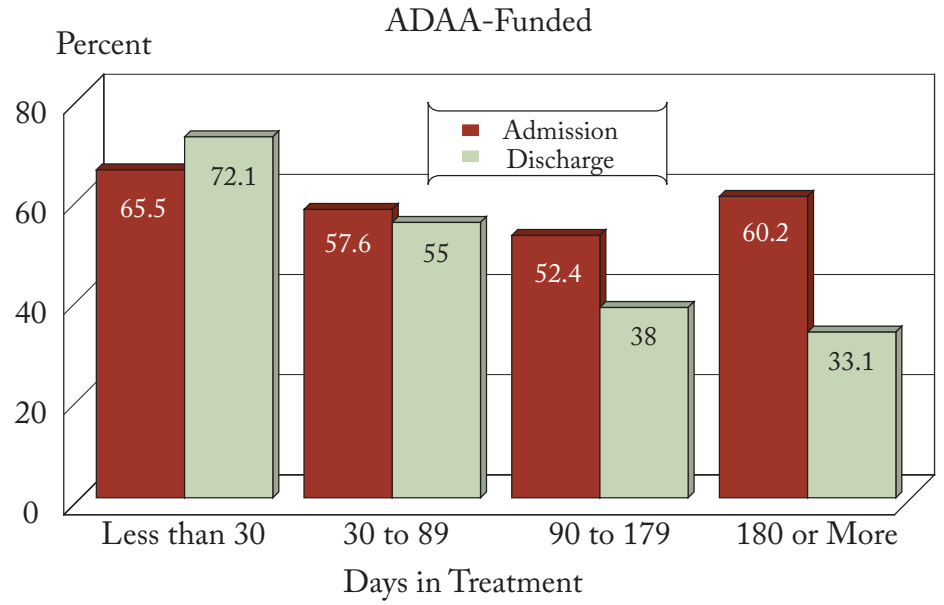
Figure 39



Further analysis, illustrated in Figures 40 and 41, revealed that for most levels of care, the longer the time patients spent in treatment, the greater the reduction in percentage using. Among funded patients who spent less than 30 days in treatment, substance users increased by 10 percent; staying up to 89 days produced a 5 percent reduction; 90 to 179 days yielded a 28 percent reduction; and remaining in treatment at least 180 days was associated with a 45 percent reduction in percentage of discharged patients using substances. Results for non-funded treatment showed a similar pattern, with less than 30 days in treatment associated with a ten percent reduction in users, 30 to 89 days associated with 26 percent fewer, 90 to 179 days 39 percent, and 180 or more days associated with halving the percentage using.

Figure 40

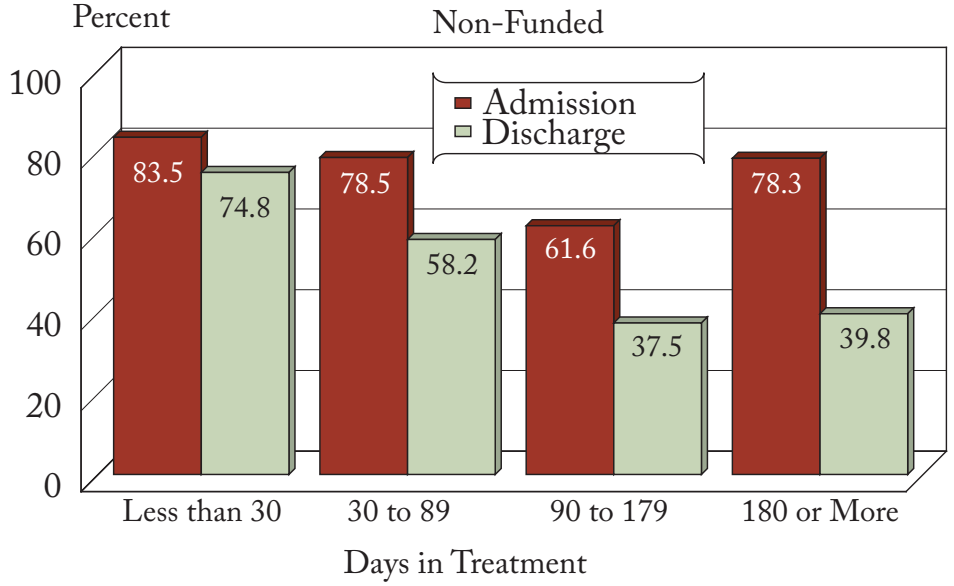
Percentages of Patients Using Substances at Admission and at Discharge by Length of Stay



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

Figure 41

Percentages of Patients Using Substances at Admission and at Discharge by Length of Stay



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

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 42

Arrest Rates for the Two Years Preceding and During Treatment

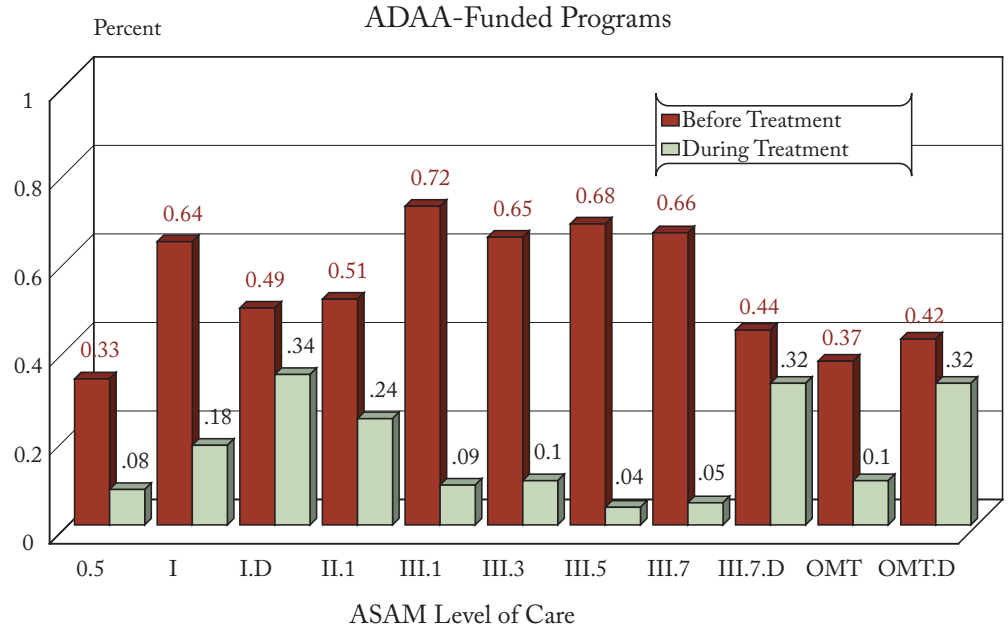
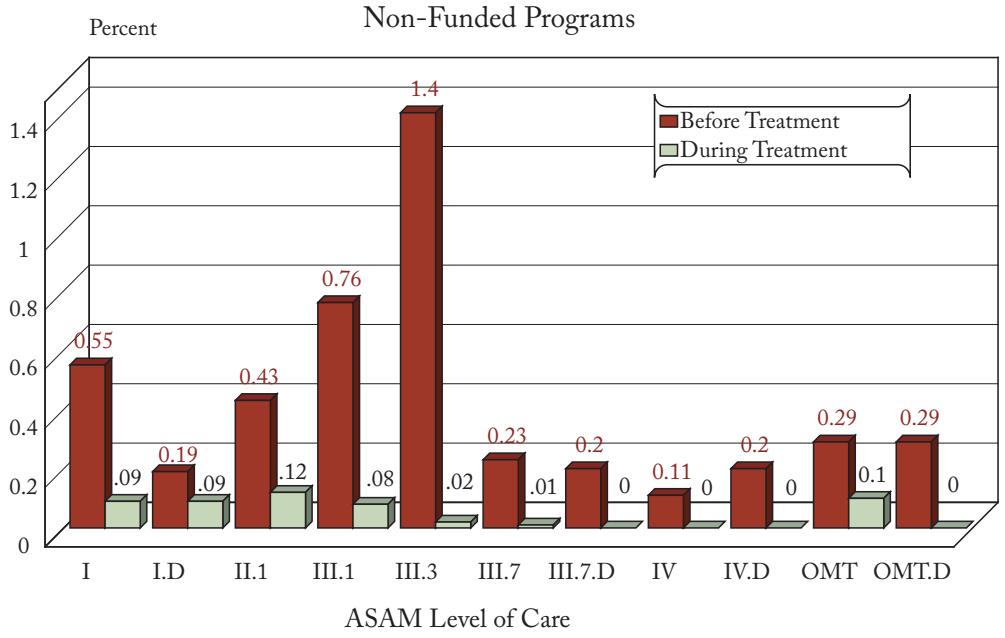


Figure 43

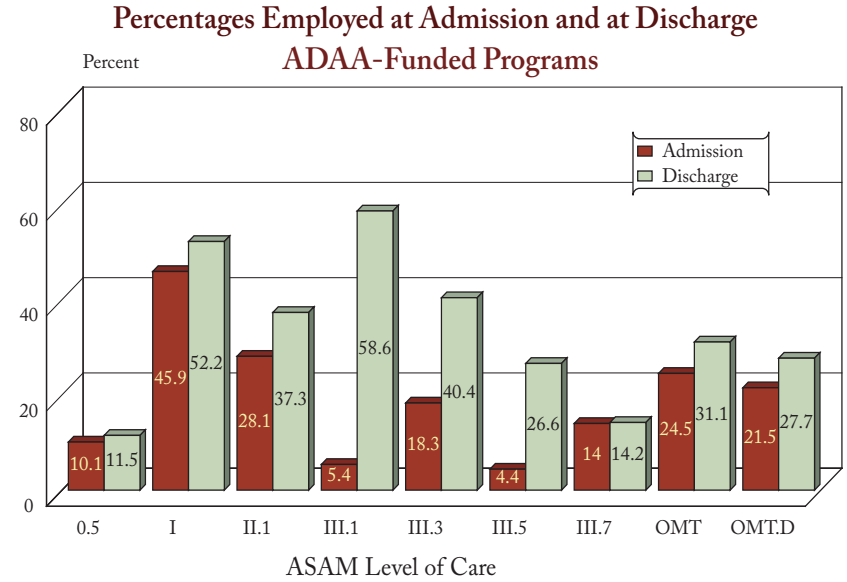


Aggregate arrest rates for the two years preceding treatment are compared to arrest rates during treatment for ASAM levels of care in Figures 42 and 43. The highest entry arrest rates among ADAA-funded patients were in residential levels of care and Level I, all exceeding 0.60. Reductions during treatment were dramatic, especially in residential treatment. The lowest pre-treatment arrest rates occurred among Level 0.5 (0.33) and OMT (0.37) discharges. In funded OMT treatment, the arrest rate was reduced by over 70 percent during treatment.

With the exceptions of Level III.1 and 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 over 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

Figure 44

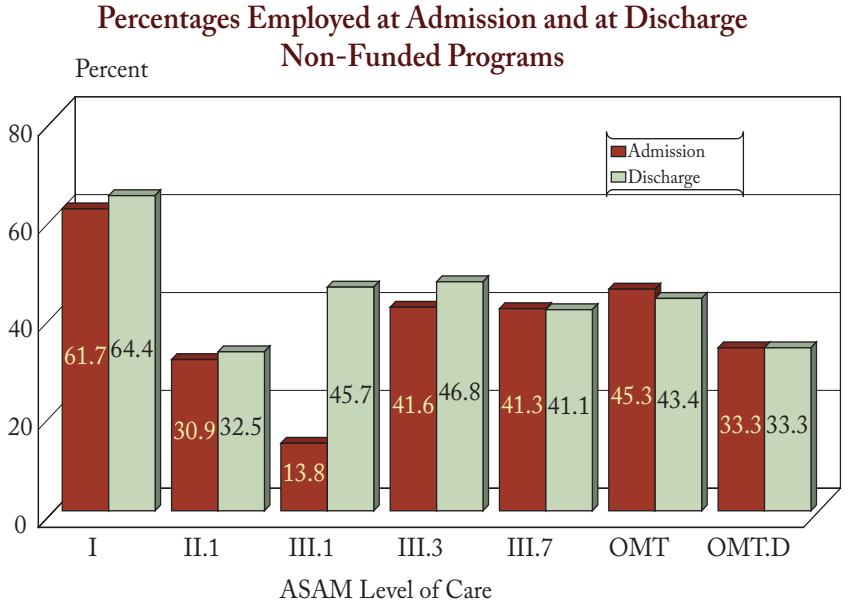


Note: ASAM Levels I.D and III.7.D are excluded.

Halfway houses (Level III.1) were particularly effective in getting patients employed, as shown in Figures 44 and 45. The percentage employed increased ten-fold during funded halfway house treatment and more than tripled in non-funded. Employment also increased six-fold in funded Level III.5 and more than doubled 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 14 percent from an already relatively high 46 percent; in Level II.1 the increase was a third. Employment increased by 27 percent in funded OMT treatment. Except for Level III.1, employment increases in non-funded levels of care were modest or nonexistent, but admission employment levels tended to be significantly higher.

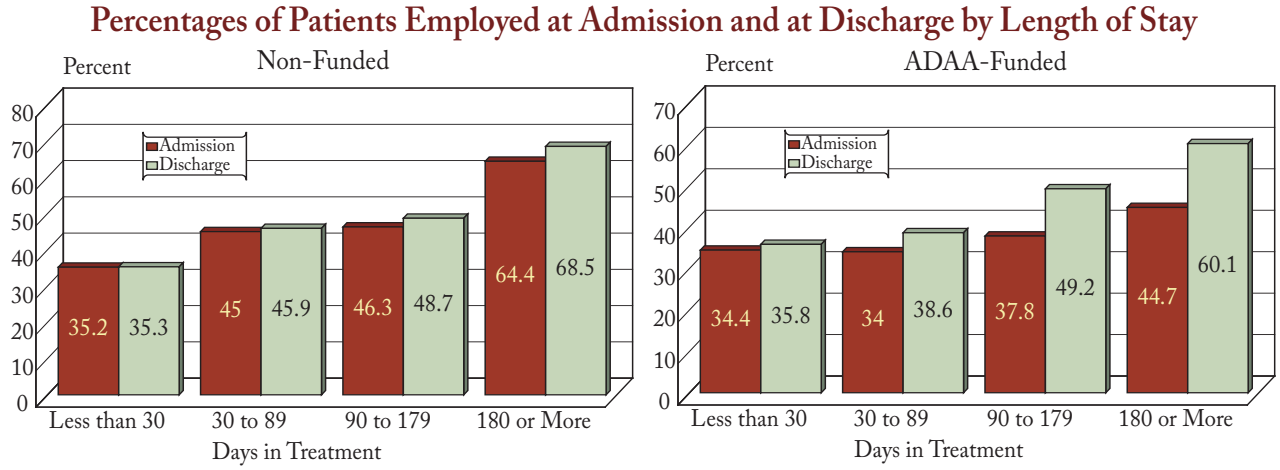
Length of stay in treatment was associated with both employment at admission and becoming employed during treatment, as shown in Figure 46. Employed patients stay in treatment longer, and unemployed patients are more likely to become employed the longer they stay. In ADAA-funded treatment (excluding short-term detox and residential), there was very little change in employment status for patients who stayed less than 30 days; staying up to 89 days was associated with a 14 percent increase; patients staying 90 to 179 days had a 30 percent increase; and, those who remained in treatment at least 180 days increased by 35 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 admission employment rates are generally higher and improvement rates lower. Given the strong relationship between

Figure 45



Note: ASAM levels I.D, III.7.D, IV and IV.D are excluded.

Figure 46



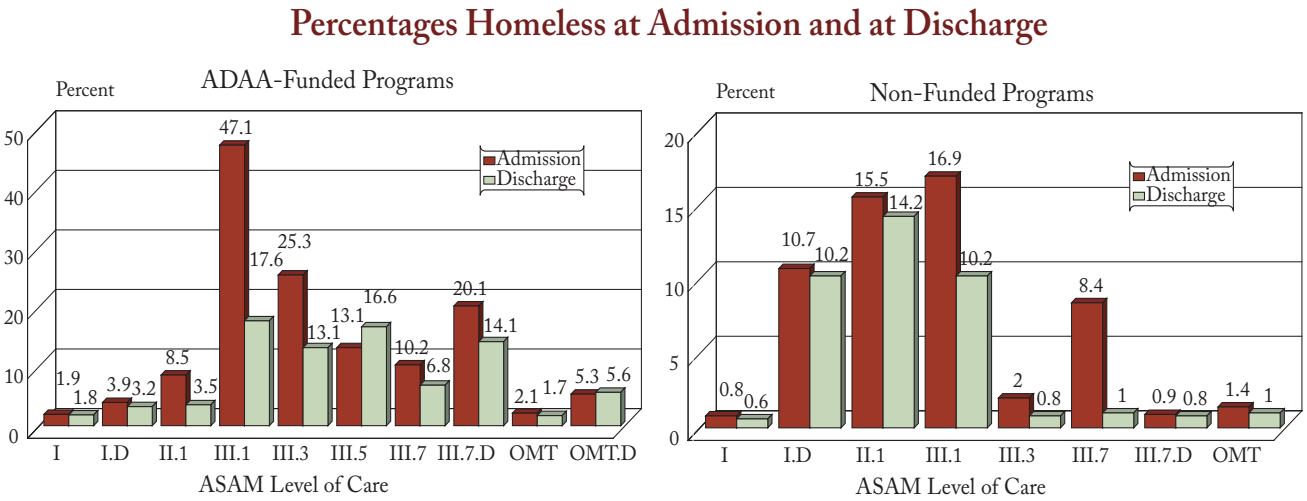
Note: ASAM Levels I.D, IV.D, III.7 and III.7.D are excluded.

length of stay and treatment completion, it is not surprising that a similar 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.

Treatment Correlates with Improved Living Situation

Figure 47 shows that the percentage of homeless patients at admission was reduced in various levels of care, especially those that are residential. It is important to note that treatment was also associated with patients moving from dependent to independent living situations.

Figure 47



Note: ASAM levels IV, IV.D and OMT.D are excluded.

Appendix

Table A: Admissions to Maryland Treatment Programs by ASAM Level of Care
FY 2002 - FY 2005

ASAM Level of Care	FY 2002		FY 2003		FY 2004		FY 2005	
	#	%	#	%	#	%	#	%
	ADAA-Funded							
Level 0.5	508	1.4	530	1.3	551	1.2	516	1.1
Level I	20307	55.6	20899	51.6	21127	47.9	23091	48.6
Level I.D	355	1.0	1611	4.0	2043	4.6	2209	4.6
Level II.1	2651	7.3	3680	9.1	4666	10.6	5338	11.2
Level III.1	716	2.0	791	2.0	1001	2.3	1232	2.6
Level III.3	339	0.9	444	1.1	1018	2.3	1108	2.3
Level III.5	0	0.0	374	0.9	551	1.2	389	0.8
Level III.7	6143	16.8	6373	15.8	6588	14.9	7150	15.0
Level III.7.D	2379	6.5	2650	6.6	3455	7.8	3525	7.4
OMT	2706	7.4	2768	6.8	2743	6.2	2609	5.5
OMT.D	422	1.2	344	0.9	390	0.9	388	0.8
Total	36526	100.0	40464	100.0	44133	100.0	47555	100.0
	Non-Funded							
Level 0.5	50	0.2	51	0.2	4	0.0	14	0.0
Level I	14344	43.7	13183	39.8	12991	41.4	9241	31.9
Level I.D	2230	6.8	2449	7.4	2150	6.8	5078	17.5
Level II.1	5915	18.0	6546	19.8	6276	20.0	5414	18.7
Level III.1	125	0.4	141	0.4	301	1.0	261	0.9
Level III.3	552	1.7	508	1.5	247	0.8	527	1.8
Level III.5	349	1.1	0	0.0	0	0.0	0	0.0
Level III.7	4274	13.0	4145	12.5	4427	14.1	3651	12.6
Level III.7.D	1038	3.2	1559	4.7	930	3.0	763	2.6
Level IV	262	0.8	242	0.7	56	0.2	33	0.1
Level IV.D	2	0.0	31	0.1	142	0.5	122	0.4
OMT	3646	11.1	4215	12.7	3859	12.3	3826	13.2
OMT.D	12	0.0	39	0.1	14	0.0	53	0.2
Total	32799	100.0	33109	100.0	31397	100.0	28983	100.0

Table B: Discharges from Maryland Treatment Programs by ASAM Level of Care
FY 2002 - FY 2005

ASAM Level of Care	FY 2002		FY 2003		FY 2004		FY 2005	
	#	%	#	%	#	%	#	%
	ADAA Funded							
Level 0.5	0.0	0.0	530	1.3	522	1.2	503	1.1
Level I	19838	59.7	18994	59.0	20425	47.9	22899	49.6
Level I.D	247	0.7	199	0.6	1914	4.5	1954	4.2
Level II.1	2139	6.4	2328	7.2	4513	10.6	4842	10.5
Level III.1	658	2.0	628	2.0	885	2.1	1207	2.6
Level III.3	713	2.1	806	2.5	993	2.3	1069	2.3
Level III.5	_	_	_	_	517	1.2	428	0.9
Level III.7	4903	14.7	4644	14.4	6498	15.2	7147	15.5
Level III.7.D	1994	6.0	1848	5.7	3390	8.0	3467	7.5
OMT	2358	7.1	2444	7.6	2685	6.3	2333	5.1
OMT.D	395	1.2	319	1.0	302	0.7	321	0.7
Total	33245	100.0	32740	101.6	42644	100.0	46170	100.0
	Non-Funded							
Level 0.5	_	_	_	_	7	0.0	2	0.0
Level I	14568	43.7	14050	40.0	12099	40.9	9042	32.4
Level I.D	1490	4.5	1959	5.6	1984	6.7	4867	17.5
Level II.1	6565	19.7	7138	20.3	6067	20.5	5220	18.7
Level III.1	114	0.3	201	0.6	235	0.8	254	0.9
Level III.3	313	0.9	165	0.5	239	0.8	500	1.8
Level III.5	_	_	_	_	_	_	_	_
Level III.7	5287	15.9	5562	15.8	4386	14.8	3672	13.2
Level III.7.D	1350	4.1	1742	5.0	939	3.2	768	2.8
Level IV	251	0.8	237	0.7	42	0.1	32	0.1
Level IV.D	304	0.9	148	0.4	107	0.4	122	0.4
OMT	3047	9.1	3564	10.1	3477	11.7	3376	12.1
OMT.D	16	0.0	359	1.0	17	0.1	12	0.0
Total	33305	100.0	35125	100.0	29599	100.0	27867	100.0

Table C: Admissions to ADAA-Funded Treatment Programs by Substance Mentions
FY 2002 - FY 2005

Substance Mentions	FY 2002		FY 2003		FY 2004		FY 2005	
	#	%	#	%	#	%	#	%
Alcohol	20683	61.0	20504	60.3	25041	58.2	27986	59.9
Crack	8853	26.1	7896	23.2	12326	28.7	12997	27.8
Other Cocaine	5312	15.7	6835	20.1	7382	17.2	7589	16.3
Marijuana/Hashish	12495	36.8	13077	38.5	15440	35.9	17350	37.2
Heroin	11045	32.6	11162	32.8	16136	37.5	15803	33.8
Non-Rx Methadone	106	0.3	103	0.3	228	0.5	315	0.7
Other Opiates	1019	3.0	1115	3.3	2005	4.7	2680	5.7
PCP	340	1.0	490	1.4	551	1.3	483	1.0
Hallucinogens	445	1.3	458	1.3	493	1.1	491	1.1
Methamphetamines	123	0.4	136	0.4	175	0.4	183	0.4
Other Amphetamines	125	0.4	144	0.4	140	0.3	176	0.4
Stimulants	28	0.1	35	0.1	254	0.6	176	0.4
Benzodiazepines	356	1.1	300	0.9	567	1.3	576	1.2
Other Tranquilizers	17	0.1	30	0.1	25	0.1	40	0.1
Barbiturates	75	0.2	77	0.2	106	0.2	115	0.2
Other Sedatives or Hypnotics	167	0.5	202	0.6	307	0.7	393	0.8
Inhalants	37	0.1	66	0.2	70	0.2	63	0.1
Over the Counter	20	0.1	25	0.1	60	0.1	66	0.1
Other	62	0.2	90	0.3	114	0.3	317	0.7
Total Respondents	33922	—	34001	—	43023	—	46692	—

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 2002 - FY 2005

Substance Mentions	FY 2002		FY 2003		FY 2004		FY 2005	
	#	%	#	%	#	%	#	%
Alcohol	20831	57.8	21667	54.6	18722	60.5	15323	52.9
Crack	6979	19.4	7798	19.6	6059	19.6	6323	21.8
Other Cocaine	5167	14.3	6717	16.9	4285	13.9	4236	14.6
Marijuana/Hashish	9400	26.1	9903	24.9	8870	28.7	6368	22.0
Heroin	13171	36.5	16238	40.9	10662	34.5	12144	41.9
Non-Rx Methadone	176	0.5	202	0.5	260	0.8	436	1.5
Other Opiates & Synthetics	2288	6.3	2638	6.6	2608	8.4	3153	10.9
PCP	423	1.2	540	1.4	523	1.7	362	1.3
Hallucinogens	327	0.9	353	0.9	388	1.3	198	0.7
Methamphetamines	83	0.2	112	0.3	122	0.4	161	0.6
Other Amphetamines	99	0.3	102	0.3	66	0.2	66	0.2
Stimulants	50	0.1	70	0.2	46	0.1	23	0.1
Benzodiazepines	655	1.8	729	1.8	587	1.9	1105	3.8
Other Tranquilizers	26	0.1	26	0.1	21	0.1	20	0.1
Barbiturates	66	0.2	94	0.2	68	0.2	60	0.2
Other Sedatives & Hypnotics	266	0.7	402	1.0	542	1.8	318	1.1
Inhalants	46	0.1	49	0.1	28	0.1	12	0.0
Over the Counter	27	0.1	36	0.1	50	0.2	32	0.1
Other	81	0.2	167	0.4	291	0.9	238	0.8
Total Respondents	36069	—	39711	—	30927	—	28953	—

Table E: Alcohol Related Admissions to Treatment Programs by Residence
FY 2002 - FY 2005

Location of Residence	Non-Funded				ADAA-Funded			
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2002	FY 2003	FY 2004	FY 2005
Allegany	39	45	45	47	490	548	549	664
Anne Arundel	3408	3103	2197	736	463	470	1188	2687
Baltimore City	4601	4796	3598	3283	3710	4881	6182	5951
Baltimore County	2672	2780	2362	2087	1681	1787	2317	2540
Calvert	316	296	128	126	708	637	904	849
Caroline	61	59	67	54	325	359	390	374
Carroll	453	526	603	503	570	571	647	688
Cecil	188	169	203	171	647	737	579	638
Charles	241	190	151	179	958	1055	1018	1000
Dorchester	51	67	111	118	407	439	385	352
Frederick	865	860	856	784	807	844	793	729
Garrett	12	9	12	17	255	275	283	284
Harford	885	1019	960	829	633	677	670	755
Howard	553	614	530	394	411	431	509	527
Kent	24	24	25	29	269	276	317	322
Montgomery	1980	2258	2194	1821	1820	1964	2148	2539
Prince George's	1620	1616	1792	1179	1319	1299	1376	2022
Queen Anne's	114	96	72	57	319	321	357	444
St. Mary's	132	101	69	99	905	770	806	655
Somerset	59	45	35	34	327	315	304	323
Talbot	103	119	112	113	380	394	366	380
Washington	377	454	351	374	1102	900	864	881
Wicomico	391	364	469	468	986	1001	889	1068
Worcester	182	172	187	140	757	683	716	739
Out-of-State	1757	1581	1589	1680	396	374	482	569
Total	21084	21363	18718	15322	20645	22008	25039	27980

Table F: Marijuana Related Admissions to Treatment Programs by Residence
FY 2002 - FY 2005

Location of Residence	Non-Funded				ADAA-Funded			
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2002	FY 2003	FY 2004	FY 2005
Allegany	19	26	24	29	314	394	408	472
Anne Arundel	1869	1609	1155	339	239	280	722	1521
Baltimore City	2063	2076	1548	1156	2188	2858	3222	3399
Baltimore County	1213	1313	1105	774	1107	1194	1354	1657
Calvert	131	138	64	60	422	397	595	557
Caroline	31	29	36	29	227	275	282	244
Carroll	183	231	264	192	482	436	509	496
Cecil	70	77	84	107	396	477	418	384
Charles	134	118	81	100	494	591	568	603
Dorchester	28	26	61	71	344	343	400	306
Frederick	374	344	355	305	542	547	517	469
Garrett	9	7	6	3	150	148	164	150
Harford	312	441	474	351	504	486	489	554
Howard	227	284	211	125	290	287	339	357
Kent	18	8	12	15	220	189	227	222
Montgomery	862	880	1036	604	869	1027	1171	1291
Prince George's	843	905	1078	777	759	839	984	1299
Queen Anne's	55	36	30	22	200	217	259	282
St. Mary's	61	51	43	52	533	409	457	406
Somerset	28	16	21	19	220	222	191	227
Talbot	38	48	65	59	234	259	251	240
Washington	182	233	143	210	681	623	572	616
Wicomico	249	221	286	302	628	676	663	813
Worcester	68	71	85	58	411	397	387	423
Out-of-State	629	667	598	608	199	248	290	358
Total	9696	9855	8865	6367	12653	13819	15439	17346

Table G: Heroin Related Admissions to Treatment Programs by Residence
FY 2002 - FY 2005

Location of Residence	Non-Funded				ADAA-Funded			
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2002	FY 2003	FY 2004	FY 2005
Allegany	23	21	27	45	67	82	106	147
Anne Arundel	1069	1125	977	873	436	491	727	942
Baltimore City	7757	7644	5625	6994	7193	9441	11376	10441
Baltimore County	1910	2238	1459	1800	889	1020	1346	1451
Calvert	37	27	14	25	41	35	56	81
Caroline	16	8	7	15	12	21	37	28
Carroll	209	273	213	216	281	249	229	316
Cecil	169	151	184	223	120	212	259	278
Charles	42	36	45	35	33	37	57	62
Dorchester	10	15	13	20	16	23	21	16
Frederick	138	137	130	135	136	159	135	147
Garrett	0	2	6	6	8	5	19	21
Harford	372	458	430	368	204	202	190	235
Howard	213	254	173	178	151	133	147	151
Kent	8	26	8	2	19	18	51	35
Montgomery	245	270	263	220	269	312	359	374
Prince George's	241	284	268	214	268	334	201	289
Queen Anne's	22	24	26	25	44	93	92	76
St. Mary's	12	9	14	5	43	49	64	50
Somerset	7	11	15	15	52	75	49	45
Talbot	15	25	24	29	45	46	49	59
Washington	41	62	66	92	81	80	120	103
Wicomico	20	22	77	78	96	172	179	207
Worcester	14	13	19	11	43	80	97	83
Out-of-State	619	579	553	512	82	112	170	158
Total	13209	13714	10636	12136	10629	13481	16136	15795

Table H: Crack Related Admissions to Treatment Programs by Residence
FY 2002 - FY 2005

Location of Residence	Non-Funded				ADAA-Funded			
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2002	FY 2003	FY 2004	FY 2005
Allegany	8	12	4	13	61	66	76	107
Anne Arundel	724	718	531	242	262	252	489	761
Baltimore City	3352	3376	2791	3432	3004	4320	5667	5436
Baltimore County	692	728	651	693	516	526	737	878
Calvert	58	32	19	26	66	125	246	275
Caroline	21	11	19	15	63	54	88	81
Carroll	58	64	67	89	186	121	164	169
Cecil	27	28	39	31	158	136	174	200
Charles	65	43	40	52	218	210	275	319
Dorchester	24	25	59	68	179	139	183	168
Frederick	131	136	98	106	252	215	271	276
Garrett	1	1	1	0	12	18	24	28
Harford	154	139	138	154	114	101	113	160
Howard	88	85	67	63	152	89	141	145
Kent	7	8	10	7	110	103	139	110
Montgomery	409	371	327	217	738	653	1083	1205
Prince George's	602	478	638	516	743	580	832	961
Queen Anne's	19	18	7	23	87	57	89	120
St. Mary's	18	15	7	17	216	186	262	222
Somerset	13	8	7	11	89	80	106	110
Talbot	28	49	37	22	107	121	101	96
Washington	89	114	79	71	320	266	248	250
Wicomico	89	73	96	99	420	339	407	501
Worcester	25	21	21	11	240	193	163	188
Out-of-State	350	292	305	345	179	148	247	230
Total	7052	6845	6058	6323	8492	9098	12325	12996

Table I: Other Cocaine Related Admissions to Treatment Programs by Residence
FY 2002 - FY 2005

Location of Residence	Non-Funded				ADAA-Funded			
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2002	FY 2003	FY 2004	FY 2005
Allegany	4	6	8	14	37	59	69	115
Anne Arundel	531	597	385	224	168	228	329	559
Baltimore City	2663	2741	1859	1925	2559	3336	3597	3314
Baltimore County	788	1023	598	639	483	552	717	843
Calvert	32	48	12	32	110	129	159	148
Caroline	10	11	10	10	48	87	88	63
Carroll	86	130	96	93	123	198	150	210
Cecil	38	44	28	61	95	204	168	164
Charles	34	28	23	27	104	160	127	120
Dorchester	15	20	15	20	90	147	101	74
Frederick	92	106	104	108	121	207	148	127
Garrett	0	4	2	4	11	34	36	28
Harford	142	255	206	186	107	135	128	158
Howard	85	100	73	53	83	106	73	92
Kent	5	6	3	11	20	27	45	44
Montgomery	163	247	200	175	255	418	332	320
Prince George's	150	217	163	121	149	370	147	185
Queen Anne's	16	18	6	17	41	87	81	94
St. Mary's	16	19	17	16	123	167	136	121
Somerset	6	12	10	9	52	92	69	95
Talbot	14	16	24	25	64	80	74	82
Washington	46	65	36	44	108	151	107	132
Wicomico	52	61	88	99	156	352	252	245
Worcester	26	22	28	32	102	143	140	146
Out-of-State	278	290	288	290	58	105	108	107
Total	5292	6086	4282	4235	5267	7574	7381	7586

Table J: Adolescent Admissions to Maryland
Treatment Programs by Residence
FY 2004 -2005

Location of Residence	Non-Funded		ADAA-Funded	
	FY 2004	FY 2005	FY 2004	FY 2005
Allegany	8	3	192	213
Anne Arundel	167	58	354	338
Baltimore City	455	174	660	996
Baltimore County	269	84	577	655
Calvert	20	7	170	118
Caroline	17	3	111	98
Carroll	40	26	158	158
Cecil	15	11	150	166
Charles	33	20	119	151
Dorchester	10	12	83	68
Frederick	106	49	169	229
Garrett	3	1	68	77
Harford	41	16	234	229
Howard	72	15	152	137
Kent	4	5	67	58
Montgomery	436	236	113	208
Prince George's	85	57	177	271
Queen Anne's	9	13	68	67
St. Mary's	20	25	212	236
Somerset	7	5	44	92
Talbot	19	13	106	103
Washington	18	30	175	167
Wicomico	91	95	57	104
Worcester	16	13	114	118
Out-of-State	99	19	42	118
Total	2060	990	4372	5175

Substance Abuse Treatment Outcome Measurement Tables

Table K: Substance Use at Admission and Discharge by Jurisdiction
FY 2005

	ADAA-Funded Treatment Programs				Non-Funded Treatment Programs			
Subdivision	Discharges	Use at Admission	Use at Discharge	% Change	Discharges	Use at Admission	Use at Discharge	% Change
Allegany	1390	58.6	11.3	-80.7	98	99.0	2.0	-98.0
Anne Arundel	4112	83.8	63.3	-24.5	996	86.9	62.3	-28.3
Baltimore City	14941	77.1	61.2	-20.6	9892	94.3	86.6	-8.2
Baltimore County	3795	69.0	54.8	-20.6	2152	73.2	30.7	-58.1
Calvert	1177	64.5	40.4	-37.4	75	73.3	40.0	-45.4
Caroline	329	72.0	47.1	-34.6	—	—	—	—
Carroll	1218	54.8	32.7	-40.3	1184	45.8	26.5	-42.1
Cecil	687	58.1	45.0	-22.5	429	83.7	72.7	-13.1
Charles	1162	53.1	37.4	-29.6	217	84.8	74.7	-11.9
Dorchester	503	58.4	52.3	-10.4	1624	99.6	1.3	-98.7
Frederick	1003	35.9	25.3	-29.5	1877	86.0	46.6	-45.8
Garrett	378	47.4	60.1	26.8	146	95.9	2.7	-97.2
Harford	868	55.6	43.4	-21.9	2908	91.5	19.2	-79.0
Howard	523	65.4	53.2	-18.7	678	47.3	32.7	-30.9
Kent	866	84.4	21.5	-74.5	—	—	—	—
Montgomery	3945	66.7	44.9	-32.7	2386	82.1	43.2	-47.4
Prince George's	1675	72.2	55.8	-22.7	1747	47.5	37.1	-21.9
Queen Anne's	308	44.2	44.8	1.4	—	—	—	—
St. Mary's	1155	50.6	30.5	-39.7	40	72.5	12.5	-82.8
Somerset	445	58.9	43.1	-26.8	14	85.7	35.7	-58.3
Talbot	400	67.2	45.0	-33.0	181	76.8	53.6	-30.2
Washington	1020	31.6	20.9	-33.9	466	82.2	52.1	-36.6
Wicomico	1945	63.5	50.6	-20.3	736	84.1	49.7	-40.9
Worcester	1002	57.4	33.0	-42.5	21	85.7	71.4	-16.7
Statewide	1323	62.8	46.5	-26.0	—	—	—	—
Total	46170	68.3	49.9	-26.9	27867	83.8	53.0	-36.8

Table L: Employment Status at Admission and Discharge by Jurisdiction
FY 2005

	ADAA-Funded Treatment Programs				Non-Funded Treatment Programs			
Subdivision	Discharges	Employed at Admission	Employed at Discharge	% Change	Discharges	Employed at Admission	Employed at Discharge	% Change
Allegany	1390	20.9	25.6	22.5	98	4.1	2.0	-51.2
Anne Arundel	4112	57.5	62.6	8.9	996	67.5	64.7	-4.1
Baltimore City	14941	15.7	21.9	39.5	9892	22.5	23.8	5.8
Baltimore County	3795	44.2	47.6	7.7	2152	65.1	72.1	10.8
Calvert	1177	58.7	62.0	5.6	75	89.3	82.7	-7.4
Caroline	329	49.5	56.5	14.1	—	—	—	—
Carroll	1218	36.9	39.4	6.8	1184	39.4	38.9	-1.3
Cecil	687	35.5	40.6	14.4	429	61.1	59.4	-2.8
Charles	1162	48.5	60.1	23.9	217	71.0	62.2	-12.4
Dorchester	503	30.2	40.6	34.4	1624	29.9	30.0	0.3
Frederick	1003	23.4	41.1	75.6	1877	56.8	57.1	0.5
Garrett	378	39.7	42.1	6.0	146	13.7	11.6	-15.3
Harford	868	47.4	54.0	13.9	2908	62.0	62.9	1.5
Howard	523	42.1	54.1	28.5	678	45.7	45.9	0.4
Kent	866	32.2	39.1	21.4	—	—	—	—
Montgomery	3945	35.4	40.7	15.0	2386	69.5	72.1	3.7
Prince George's	1675	36.7	44.8	22.1	1747	45.7	48.0	5.0
Queen Anne's	308	62.3	63.3	1.6	—	—	—	—
St. Mary's	1155	37.6	45.7	21.5	40	87.5	87.5	0.0
Somerset	445	33.3	36.6	9.9	14	92.9	92.9	0.0
Talbot	400	47.0	57.2	21.7	181	50.8	54.7	7.7
Washington	1020	39.1	53.4	36.6	466	68.0	63.5	-6.6
Wicomico	1945	32.4	37.5	15.7	736	60.5	62.8	3.8
Worcester	1002	36.2	47.0	29.8	21	90.5	85.7	-5.3
Statewide	1323	17.3	27.3	57.8	—	—	—	—
Total	46170	32.1	38.6	20.3	27867	44.2	45.5	2.9

Table M: Arrest Rate Prior to Admission and During Treatment by Jurisdiction
FY 2005

	ADAA-Funded Treatment Programs				Non-Funded Treatment Programs			
Subdivision	Discharges	Arrest Rate Prior to Admission	Arrest Rate During Treatment	% Change	Discharges	Arrest Rate Prior to Admission	Arrest Rate During Treatment	% Change
Allegany	1390	0.806	0.203	-74.8	98	3.026	0.023	-99.2
Anne Arundel	4112	0.531	0.135	-74.6	996	0.325	0.074	-77.2
Baltimore City	14941	0.643	0.140	-78.2	9892	0.323	0.118	-63.5
Baltimore County	3795	0.459	0.163	-64.5	2152	0.846	0.052	-93.9
Calvert	1177	0.677	0.231	-65.9	75	0.447	0.071	-84.1
Caroline	329	0.473	0.142	-70.0	—	—	—	—
Carroll	1218	0.743	0.194	-73.9	1184	0.313	0.067	-78.6
Cecil	687	0.736	0.212	-71.2	429	0.340	0.097	-71.5
Charles	1162	0.615	0.135	-78.0	217	0.304	0.064	-78.9
Dorchester	503	0.588	0.350	-40.5	1624	0.273	0.308	12.8
Frederick	1003	0.786	0.173	-78.0	1877	0.339	0.115	-66.1
Garrett	378	0.612	0.277	-54.7	146	2.031	0.041	-98.0
Harford	868	0.491	0.270	-45.0	2908	0.273	0.081	-70.3
Howard	523	0.641	0.256	-60.1	678	0.398	0.084	-78.9
Kent	866	0.458	0.266	-41.9	—	—	—	—
Montgomery	3945	0.539	0.070	-87.0	2386	0.326	0.069	-78.8
Prince George's	1675	0.392	0.105	-73.2	1747	0.542	0.125	-76.9
Queen Anne's	308	0.568	0.188	-66.9	—	—	—	—
St. Mary's	1155	0.548	0.087	-84.1	40	0.700	0.000	-100.0
Somerset	445	0.627	0.295	-53.0	14	0.571	0.000	-100.0
Talbot	400	0.564	0.198	-64.9	181	0.323	0.141	-56.3
Washington	1020	0.720	0.174	-75.8	466	0.368	0.214	-41.8
Wicomico	1945	0.466	0.155	-66.7	736	0.409	0.124	-69.7
Worcester	1002	0.525	0.310	-41.0	21	0.524	0.144	-72.5
Statewide	1323	0.590	0.113	-80.8	—	—	—	—
Total	46170	0.590	0.156	-73.6	27867	0.395	0.095	-76.0

Table N: Retention Rates by Jurisdiction
FY 2005
Level I (Outpatient Treatment)

	ADAA-Funded Treatment Programs				Non-Funded Treatment Programs			
Subdivision	Discharges	Less than 90 Days	90 Days or More	% Retained 90 Days or More	Discharges	Less than 90 Days	90 Days or More	% Retained 90 Days or More
Allegany	627	211	416	66.3	98	15	83	84.7
Anne Arundel	1992	806	1186	59.5	388	141	247	63.7
Baltimore City	4429	2248	2181	49.2	747	317	430	57.6
Baltimore County	2237	960	1277	57.1	1344	432	912	67.9
Calvert	805	298	507	63.0	75	13	62	82.7
Caroline	328	129	199	60.7	—-	—	—	—
Carroll	751	342	409	54.5	860	144	716	83.3
Cecil	667	322	345	51.7	104	33	71	68.3
Charles	939	271	668	71.1	122	66	56	45.9
Dorchester	251	107	144	57.4	61	5	56	91.8
Frederick	690	265	425	61.6	568	163	405	71.3
Garrett	347	185	162	46.7	65	10	55	84.6
Harford	685	213	472	68.9	578	174	404	69.9
Howard	459	161	298	64.9	426	37	389	91.3
Kent	337	115	222	65.9	—	—	—	—
Montgomery	1776	675	1101	62.0	1304	456	848	65.0
Prince George's	1056	434	622	58.9	1584	800	784	49.5
Queen Anne's	308	97	211	68.5	—-	—	—	—
St. Mary's	576	224	352	61.1	40	6	34	85.0
Somerset	419	184	235	56.1	14	4	10	71.4
Talbot	392	185	207	52.8	124	57	67	54.0
Washington	815	273	542	66.5	239	57	182	76.2
Wicomico	861	558	303	35.2	282	139	143	50.7
Worcester	740	352	388	52.4	19	9	10	52.6
Statewide	412	193	219	53.2	—-	—	—	—
Total	22,899	9,808	13,091	57.2	9,042	3,078	5,964	66.0

Table O: Retention Rates by Jurisdiction
FY 2005
Level III.1 (Halfway House)

ADAA-Funded Treatment Programs				
Subdivision	Discharges	Less than 90 Days	90 Days or More	% Retained 90 Days or More
Allegany	23	6	17	73.9
Anne Arundel	152	76	76	50.0
Baltimore City	429	137	294	68.5
Baltimore County	27	16	11	40.7
Cecil	20	9	11	55.0
Frederick	138	79	59	42.8
Harford	35	16	19	54.3
Howard	37	18	19	51.4
Montgomery	90	34	56	62.2
Prince George's	42	15	27	64.3
St. Mary's	56	17	39	69.6
Washington	127	70	57	44.9
Wicomico	27	16	11	40.7
Total	1,203	509	696	57.9

Non-Funded Treatment Programs				
Subdivision	Discharges	Less than 90 Days	90 Days or More	% Retained 90 Days or More
Baltimore City	156	76	80	51.3
Baltimore County	70	36	34	48.6
Harford	28	14	14	50.0
Total	254	126	128	50.4

Table P: Subsequent Admission to Another Treatment Level
Completion Discharges from Level II.1 (IOP)
ADAA-Funded by Jurisdiction
FY 2005

Subdivision	Unduplicated Level II.1 Completion Discharges	Subsequent Admission Level of Care					
		Level I		Other		Total	
		#	%	#	%	#	%
Allegany	57	24	42.1	6	10.5	30	52.6
Anne Arundel	227	1	0.4	23	10.1	24	10.6
Baltimore City	653	235	36.0	93	14.2	328	50.2
Baltimore Co.	223	35	15.7	13	5.8	48	21.5
Calvert	21	17	81.0	2	9.5	19	90.5
Carroll	14	6	42.9	1	7.1	7	50.0
Charles	34	14	41.2	9	26.5	23	67.6
Dorchester	66	1	1.5	2	3.0	3	4.5
Frederick	15	3	20.0	9	60.0	12	80.0
Harford	13	1	7.7	3	23.1	4	30.8
Montgomery	54	25	46.3	6	11.1	31	57.4
Prince George's	34	3	8.8	1	2.9	4	11.8
St. Mary's	17	6	35.3	0	0.0	6	35.3
Somerset	7	6	85.7	0	0.0	6	85.7
Washington	34	17	50.0	4	11.8	21	61.8
Wicomico	131	92	70.2	4	3.1	96	73.3
Worcester	102	69	67.6	9	8.8	78	76.5
Total	1702	555	32.6	185	10.9	740	43.5

Table Q: Subsequent Admission to Another Treatment Level
Completion Discharges from Level II.1 (IOP)
Non-Funded by Jurisdiction
FY 2005

Subdivision	Unduplicated Level II.1 Completion Discharges	Subsequent Admission Level of Care					
		Level I		Other		Total	
		#	%	#	%	#	%
Baltimore City	851	112	13.2	123	14.5	235	27.6
Baltimore Co.	52	6	11.5	0	0.0	6	11.5
Carroll	83	0	0.0	0	0.0	0	0.0
Dorchester	12	4	33.3	0	0.0	4	33.3
Frederick	89	23	25.8	5	5.6	28	31.5
Garrett	70	10	14.3	0	0.0	10	14.3
Harford	104	2	1.9	5	4.8	7	6.7
Montgomery	347	121	34.9	3	0.9	124	35.7
Prince George's	35	2	5.7	1	2.9	3	8.6
Talbot	20	0	0.0	1	5.0	1	5.0
Washington	14	0	0.0	0	0.0	0	0.0
Wicomico	146	0	0.0	3	2.1	3	2.1
Total	1823	280	15.4	141	7.7	421	23.1

Table R: Subsequent Admission of Completion Discharges from Level III.7.D (Non-Hospital Detox) by Jurisdiction
FY 2005

ADAA-Funded Treatment Programs							
Subdivision	Unduplicated Level III.7.D Completion Discharges	Subsequent Admission Level of Care					
		Level III.7		Other		Total	
		#	%	#	%	#	%
Anne Arundel	326	256	78.5	29	8.9	285	87.4
Baltimore City	889	345	38.8	117	13.2	462	52.0
Baltimore Co.	175	49	28.0	33	18.9	82	46.9
Carroll	43	14	32.6	3	7.0	17	39.5
Kent	179	152	84.9	8	4.5	160	89.4
Montgomery	723	693	95.9	11	1.5	704	97.4
Wicomico	230	2	0.9	39	17.0	41	17.8
Total	2565	1511	58.9	240	9.4	1751	68.3

Non-Funded Treatment Programs FY 2005							
Subdivision	Unduplicated Level III.7.D Completion Discharges	Subsequent Admission Level of Care					
		Level III.7		Other		Total	
		#	%	#	%	#	%
Frederick	56	0	0.0	17	30.4	17	30.4
Harford	631	628	99.5	0	0.0	628	99.5
Total	687	628	91.4	17	2.5	645	93.9

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
IV	Medically Managed Intensive Inpatient Services	Acute Hospitals, Acute Psychiatric Hospitals.	Acute Care General Hospital, Acute Psychiatric Hospital or Unit within a general hospital, Licensed Chemical Dependence Specialty Hospital with Acute Care Medical and Nursing Staff

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

www.maryland-adaa.org

Maryland Alcohol and Drug Abuse Administration
55 Wade Avenue
Catonsville, MD 21228
Phone: 410-402-8600
Fax: 410-402-8601
e-mail: adaainfo@dhmh.state.md.us

ADAA
Maryland Alcohol and Drug Abuse Administration
Working toward drug-free communities

ADAA Publication No. 06-3-001
Published April 2006