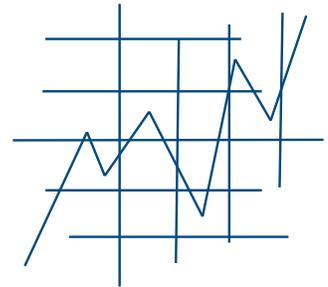


Outlook & Outcomes



2007 Annual Report

Maryland Alcohol and Drug Abuse Administration

Department of Health and Mental Hygiene



Martin O'Malley, Governor
Anthony G. Brown, Lt. Governor
John M. Colmers, Secretary
Kathleen Rebbert-Franklin, L.C.S.W., Acting Director

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 2007

Martin O'Malley, Governor

Anthony G. Brown, Lt. Governor

John M. Colmers, Secretary, DHMH

Arlene Stephenson, Acting Deputy Secretary, DHMH

Kathleen Rebbert-Franklin, LCSW, Acting 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 granting of advantages, privileges and accommodations.

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

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

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

ADAA wishes to recognize all those who contributed to the publication
of *Outlook and Outcomes* 2007

Acting Director
Kathleen Rebbert-Franklin LCSW
Research
William Rusinko

Data
Chad Basham
William Rusinko

Publication Layout
Lucinda Shupe
Deborah Green

Contributing Writers
William Rusinko
Deborah Green
Erik Gonder
Lucinda Shupe

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

TABLE OF CONTENTS

THE OUTLOOK	6
EXECUTIVE SUMMARY	8
DATA COLLECTION AND REPORT METHODOLOGY	10
PREVENTION SERVICES IN MARYLAND	12
What is Prevention?.....	12
Prevention Network.....	12
Total Numbers Served FY 2003-FY 2007.....	12
Numbers Served.....	12
Center for Substance Abuse Prevention (CSAP) Strategies	13
MODEL PROGRAM INITIATIVE	14
Evidence-Based Practice in the Context of NREPP	15
CSAP MODEL PROGRAMS	15
What is Evidence Based?.....	15
National Registry of Evidence Based Programs & Practices (NREPP)	15
Gender.....	16
Age.....	16
Race and Ethnicity	16
MARYLAND PREVENTION: WHO RECEIVED SERVICES?	16
INSTITUTE OF MEDICINE (IOM)	17
Single Prevention Services.....	18
Service Population	18
Recurring Prevention Services	18
PREVENTION: WHAT DID WE BUY?	18
Protecting Our Children.....	19
SPECIAL PREVENTION INITIATIVES	19
Promoting a Healthy Transition to Adulthood	19
WHO RECEIVED TREATMENT SERVICES?	20
Admissions to Treatment Programs by ASAM Level of Care.....	21
DEFINING TREATMENT “LEVELS OF CARE”	23
PREVIOUS TREATMENT EXPERIENCE	26
SOURCE OF REFERRALS	30
Criminal Justice Referrals.....	30
Voluntary Referrals.....	30
PRIMARY SUBSTANCE PROBLEMS	33
Mentions of Injected Substances Among Admissions to Treatment.....	36
Age of First Use	36
How Maryland Compares to the Nation	37
PATIENTS TREATED	38
Discharges from Treatment.....	38
Measuring Treatment Effectiveness	40
Length of Stay: Days In Treatment.....	40
Average Percentages of Positive Urinalysis Tests for Discharged Patients	41
WAS IT WORTH IT?	42
Treatment Outcomes	42

Treatment Reduces Substance Use.....	42
Length of Stay in Treatment Reduces Substance use	43
Treatment Increases Employment.....	44
Percent of Patients Receiving Mental Health Treatment	45
Treatment Correlates with Improved Living Situation	46
Treatment Reduces Crime.....	47

APPENDIX

Table A: Admissions to Treatment Programs by Substance Mentions	50
Table B: Alcohol Related Admissions to Treatment Programs by Residence.....	51
Table C: Marijuana Related Admissions to Treatment Programs by Residence.....	52
Table D: Heroin Related Admissions to Treatment Programs by Residence	53
Table E: Other Opiates Related Admissions to Treatment Programs by Residence	54
Table F: Crack Related Admissions to Treatment Programs by Residence	55
Table G: Other Cocaine Related Admissions to Treatment Programs by Residence.....	56
Table H: Adolescent Admissions to Treatment Programs by Residence.....	57

SUBSTANCE ABUSE TREATMENT: OUTCOME MEASUREMENT TABLES

Table I: Substance Use at Admission and Discharge by Jurisdiction	59
Table J: Employment Status at Admission and Discharge by Jurisdiction	60
Table K: Arrest In the Thirty Days Prior to Admission and Prior to Discharge Treatment by Jurisdiction	61
Table L: Level I (Outpatient Treatment) Retention Rates by Jurisdiction	62
Table M: Level III.1 (Halfway House) Retention Rates by Jurisdiction	63
Table N: Subsequent Admission to Another Treatment Level Completion/Transfer/Referral Discharges from Level II.1 (IOP) by Jurisdiction	64
Table O: Subsequent Admission to Another Treatment Level Completion/Transfer/Referral Discharges from Level III.7D (ICF Detox) by Jurisdiction	65

AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) PATIENT PLACEMENT CRITERIA

Acronyms and Abbreviations

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

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*State of Maryland
Alcohol and Drug Abuse Administration
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THE OUTLOOK

Strategic Planning for Prevention Services

With funding from Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP), Maryland embarked on a multi-year project to develop a state-of-the-art empirically based system for setting priorities for the state's substance abuse prevention activities. This project is coordinated by staff at the Maryland Alcohol and Drug Abuse Administration (ADAA) and at the University of Maryland's Center for Substance Abuse Research (CESAR). A statewide epidemiological outcomes workgroup (SEOW) and a core advisory group of key staff from relevant state and local agencies were formed to guide the work of this project.

CSAP has provided each state with a logic model to guide their planning activities, beginning with the delineation of measurable consequences of substance abuse in a state, followed by a ranking of these consequences to be targeted by prevention programs. To facilitate the ranking of the consequences, the SEOW produced an epidemiological profile that provides extensive statistical data about the scope and severity of each consequence and forms the basis of an assessment of the importance of each consequence for prevention programming in Maryland. The consequences identified for illegal drug use included drug dependence or abuse, drug-related arrests, HIV/AIDS cases, property crimes, drug-induced deaths, school suspensions, and school expulsions. For alcohol use, the consequences identified included alcohol dependence or abuse, violent crimes, alcohol-related crashes, school suspensions, alcohol induced deaths, and school expulsions.

During year one of this project, Maryland established its SEOW, produced an epidemiological profile, and designed an innovative process for ranking the priority of the consequences. Maryland

substance abuse professionals and policy makers used the epidemiological profile to scientifically rank the consequences on six dimensions: numbers directly affected, changes in size/magnitude over time, Maryland compared to the United States, numbers indirectly affected, potential economic and social costs, and potential for change through intervention.

Based on the rankings, the highest priorities in Maryland were alcohol and drug dependence and abuse, violent crime, and drug-related arrests.

Once Maryland had a priority list of consequences to address, we moved on to determine the consumption behaviors that are empirically linked to each consequence. The remaining steps of the logic model include identifying risk and protective factors for intervention and determining evidenced-based prevention programs that Maryland can support to reduce the adverse consequences of substance abuse. The SEOW's goal in year two of the project is to create a more detailed county level analysis of the consequences, such as demographic breakdowns to help local SEOW representatives identify target populations.¹

Pay for Performance

One of ADAA's long term goals is to enhance the treatment network by encouraging strategic planning at the local level. Each jurisdiction (the 23 counties and Baltimore City) has its Local Drug and Alcohol Abuse Council that submits a two year plan with goals, objectives and action plans for services within the jurisdiction. ADAA instituted a pay for performance pilot that was designed to reward local jurisdictions for proactively managing their system of care. An incentive was paid to

¹*Maryland Epidemiological Profile: Consequences of Illicit Drug Use, Alcohol Abuse, and Smoking* March 15, 2007. accessed July 15, 2008, www.maryland-adaa.org

The Outlook continued..

jurisdictions if their Level I (outpatient) programs achieved a successful discharge rate of 50% or better and/or had 65% of patients stay in treatment 90 days or more. These incentives were given to the jurisdiction to use in any manner they felt would enhance their service network. Several jurisdictions used the monies to reward the Level I programs and others chose to use the dollars to help close treatment gaps.

FY 2007 was the first full year of the pay for performance for Statewide Residential Contracts. These contracts for long term residential care were made available to agencies that satisfied the Code of Maryland (COMAR) program requirements for Level III.3 and Level III.5 with demonstrated ability to provide specialty services to pregnant and post partum women and women with dependent children, co-occurring disorders or therapeutic community. The agencies applied for the contracts to be paid on a per diem rate. At the end of the contract year agencies were evaluated based on two goals: fifty percent of the contracted patients had a successful treatment episode, and/or the length of stay was equal to or greater than 210 days. Agencies that achieved either goal were paid two and a half percent of the per diem for each patient that achieved one of the goals. If both goals were met a bonus five percent of the daily rate was paid.

2007 Management Conference

The 2007 Management Conference brought together more than 200 program managers, administrators and support staff from funded substance abuse programs in Maryland. Keeping in line with last year's theme "The Business of Addiction" this year the added focus was "The Workforce Connection". The Conference featured nationally recognized keynote speakers who shared their knowledge and expertise about the study, structure and dynamics of the

addiction services industry with specific attention to workforce development. Using the platform of the "National Action Plan" developed by the Annapolis Coalition on the Behavioral Health Workforce keynote speakers and workshop facilitators worked with participants to examine, inform and elicit conversation on the critical issues of recruitment, retention and training of the workforce.

The 2008 conference will continue to inform and engage the workforce through the examination of recovery oriented systems of care (ROSC). This growing movement to both transform treatment and enhance recovery support services is being closely examined in Maryland. The conference will provide opportunities to learn from our peers in other states who have already implemented ROSC. Workshops will be geared to equip program managers and administrators with tools and resources to begin looking at ways to incorporate ROSC into Maryland's care delivery system.

ALCOHOL AND DRUG ABUSE
ADMINISTRATION
LEADERSHIP

Office of the Director

Acting Director: Kathleen Rebbert-Franklin,
LCSW-C

Medical Director: Peter R. Cohen, M.D.

Research Director: 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.

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.

In Outlook and Outcomes 2007, ADAA focusses on the characteristics of funded treatment programs for fiscal year 2007, the populations they serve and the treatment outcomes reported.

WHO RECEIVED SERVICES?

Prevention Services

- Over 211,000 individuals received prevention services in Maryland.
- Over 191,000 (91%) individuals were served in a program with a universal strategy. Programs with a selective prevention strategy that target subsets of the population which are deemed to be at risk for substance abuse comprised 19,195, or nine percent.
- A total of 2,763 individuals received prevention intervention services through the High Risk Preschool Initiative in fiscal year 2007.
- The College Prevention Centers initiative provided prevention services, with a primary focus on peer education, to 31,006 students enrolled in four of Maryland's universities.
- In fiscal year 2007, 83 prevention programs were delivered using evidence-based Center for Substance Abuse Prevention (CSAP) Model Programs.

Treatment Services

- There were 47,122 patients admitted to ADAA-funded programs.
- Sixty-three percent of patients admitted during FY 2007 had at least one prior admission to treatment.

- Sixty-one percent of all patients had no health insurance. Nearly 20 percent were insured with public funds and the rest were privately insured.
- Just under half of all patients admitted were referred to treatment by components of the criminal justice system and 52.1 percent of patients had one or more arrests in the one year prior to admission. The majority of criminal justice referrals to treatment came from parole and probation services.
- Twenty-eight percent of patients had mental health problems in addition to substance abuse.
- Sixty-two percent smoked cigarettes, up three percent from FY 2006.

Type of Substance Abuse

- The leading substances of abuse were alcohol (59.4%), marijuana (37.6%), crack cocaine (29.7%) heroin (29.3%), and other cocaine (15.9%).
- Oxycodone and "other opiates" were mentioned in over seven percent of all admissions.
- Sixty-five percent of all patients were abusing multiple substances at admission.

Maryland and the Nation

- More than 25 percent of Maryland admissions had primary heroin problems compared to 13.7 percent for the nation as a whole.

Adolescents

- About 37 percent of alcohol and 49 percent of marijuana related admissions reported age of first use as prior to age 15.
- Forty-five percent of cocaine and heroin users first used those drugs between the ages of 18 to 25.
- Over 70 percent of the individuals admitted for alcohol problems reported first substance use during adolescence.

ASAM Levels of Care

- Nearly 46 percent of all admissions went to Level I (traditional outpatient) services and another 16.7 percent were admitted to Level II.1 and Level II.5 (intensive outpatient).
- More than four percent of funded admissions were to opioid maintenance therapy (OMT).
- Residential levels of care accounted for 28.3 percent of admissions.
- Admissions to level OMT-D continued to decline from five percent in 2006 and nearly disappearing in data reports in 2007.
- While admissions to Level I continued a 5 year decline, admissions to Level II.1 rose from nine percent to sixteen percent in the same period.

Was It Worth It? Outcome Measurement

Treatment Reduces Substance Use

- Among the discharges from Level I treatment, including both successful completers and non-successful completers, there was a 36 percent reduction in substance use.
- Decreases in substance use of 50 percent or more occurred in all 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 over 50 percent.

Treatment Reduces Crime

- Arrest rates were reduced by half or more during treatment in every level of care except Level OMT-D (Opioid Maintenance Therapy-Detoxification).

Treatment Promotes Mental Health Referrals

- Two-thirds of patients assessed as having mental health problems at admission to Levels III.1, III.3 and III.7 received mental health treatment during their substance abuse episode.

Treatment Increases Employment

- The data indicate that across all levels of care employment rates were improved by treatment. The employed were likely to stay in treatment longer, and the unemployed were more likely to become employed the longer they stayed in treatment.
- Employment increased 15 percent in Level I, and nearly five-fold in Level III.5 (long-term residential treatment).

Treatment Decreases Homelessness

- Between admission and discharge homelessness decreased by 73 percent in Level I, and 66 percent in Level II.



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

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 (Prev-Tech) 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 195 ADAA-funded and 250 non-funded substance abuse treatment clinics in FY 2006, 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. Programs were classified as ADAA-funded if they received any ADAA dollars; every patient episode in those facilities was not exclusively paid with ADAA funds.

In FY 2006 ADAA moved to a new Web-based electronic record and experienced a period of data adjustment. In previous years individuals entering any level of care were counted as an admission to

the system. If an individual left a level of care and entered a new level of care it was recorded as a new admission even if it occurred in the same agency. In the new electronic record individuals will be admitted to an agency and enrolled in programs representing levels of care. As the individual leaves a level of care he/she is disenrolled and then enrolled in the new level of care. The new method of documenting a patient's experience in the treatment system will provide a better picture of the total patient experience; however for FY 2006, orientation to the new system has resulted in admission numbers nearly the same as FY 2005. For data on the number of dis-enrollments see page 36, Figure 29.

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 2006, the percentage of unique individuals completing treatment who were tracked to a subsequent admission in 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

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

Change in Arrest Rate

For discharges during FY 2006, this is the difference between the arrest rate during the year preceding admission (total arrests/total years of treatment) and arrest rate during treatment (total arrests during treatment/total years of treatment). Total years of treatment equals total days of treatment delivered to discharges (summed days in treatment for all discharged patients) divided by 365.25.

Change in Employment Status

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

Change in Living Situation

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

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 research 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

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.

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 prevention projects, implement programs and obtain funding.

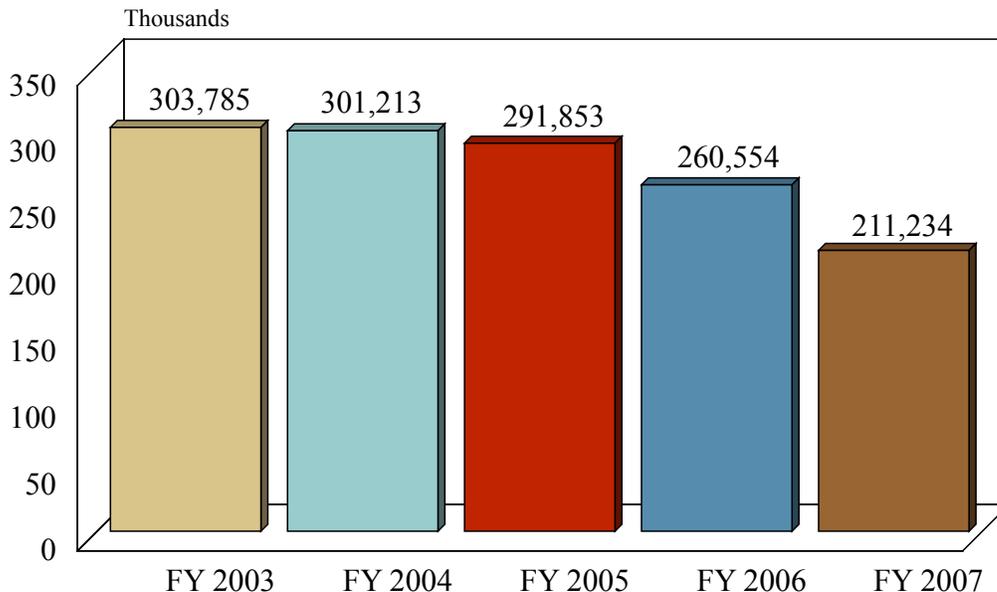
Numbers Served

During fiscal year 2007 over 211,000 individuals received prevention services in Maryland. Tight resources, staff vacancies and more sophisticated programming requirements have caused the total number of individuals served to dip during the past two years. Over the last four years there has been a shift from the "one time" single service activities to more intensive recurring service activities. Data have shown Maryland averaging approximately 266,000 individuals served annually through prevention services.

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

Total Numbers Served
FY 2003-FY2007

Figure 1



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 1 below shows the total number of individuals served during fiscal year 2007 by jurisdiction and CSAP strategy.

CSAP Strategies and Number of Participants Served Fiscal Year 2007

Table 1

County	Alternatives	Community Based Process	Education	Environmental	Information Dissemination	Problem ID And Referral	Total
Allegany	4904	631	443	102	3588	0	9668
Anne Arundel	116	89	431	0	4629	58	5323
Baltimore City	9651	514	1899	100	21885	9,069	43118
Baltimore	9379	26	1005	17264	14698	0	42372
Calvert	1,484	270	263	0	2727	0	4744
Caroline	2,473	197	46	12	3749	0	6477
Carroll	174	380	339	0	15064	0	15957
Cecil	0	0	219	0	73	0	292
Charles	30	497	0	0	1015	0	1542
Dorchester	225	75	241	151	1919	0	2611
Frederick	300	80	803	13	403	4	1603
Garrett	4409	1184	540	99	245	232	6709
Harford	2312	2337	747	150	5829	230	11605
Howard	0	409	147	246	4355	0	5157
Kent	0	103	52	120	916	0	1191
Montgomery	75	504	1507	0	3859	0	5945
Prince George's	2069	102	2318	414	4465	0	9368
Queen Anne's	1445	1300	75	0	963	178	3961
St. Mary's	0	1087	335	50	5701	0	7173
Somerset	27	52	96	9	3521	0	3705
Talbot	44	493	109	53	1100	0	1799
Washington	645	344	355	0	230	2090	3664
Wicomico	201	89	918	0	1050	0	2258
Worcester	13064	34	134	0	1760	0	14992
TOTAL	53027	10797	13022	18783	103744	11861	211234
PERCENTAGE	25%	5%	6%	9%	49%	6%	100%

Model Program Initiative

In an ongoing effort to prevent substance use in Maryland, the ADAA provided an additional \$600,000 to select jurisdictions (Tables 2 and 3) 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.

Table 2

County	Programs		Total Programs
	Recurring	Single	
Allegany	2	0	2
Anne Arundel	2	15	17
Calvert	2	0	2
Carroll	3	3	6
Charles	2	0	2
Dorchester	2	0	2
Garrett	4	0	4
Howard	1	12	13
Montgomery	1	0	1
Total	19	30	49

Table 3

County	Numbers Served		Total Served
	Recurring	Single	
Allegany	72	0	72
Anne Arundel	99	115	214
Calvert	145	0	145
Carroll	130	170	300
Charles	215	0	215
Dorchester	49	0	49
Garrett	24	0	24
Howard	40	150	190
Montgomery	465	0	465
Total	1239	435	1674

Figure 2
MPI Gender Distribution

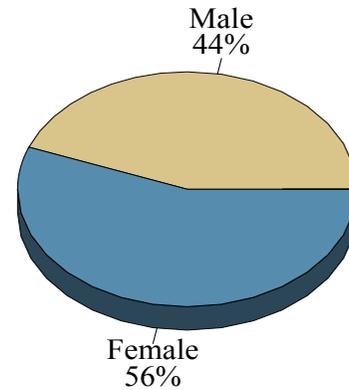


Figure 3
MPI Age Distribution

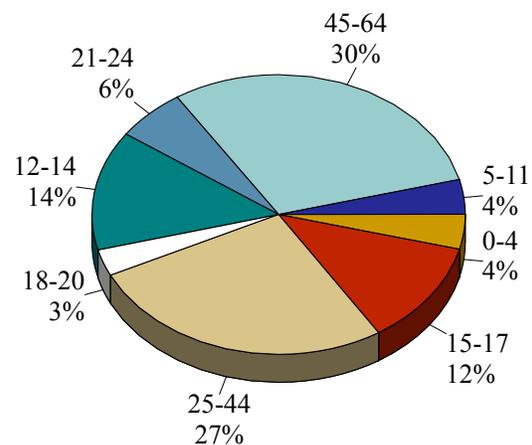
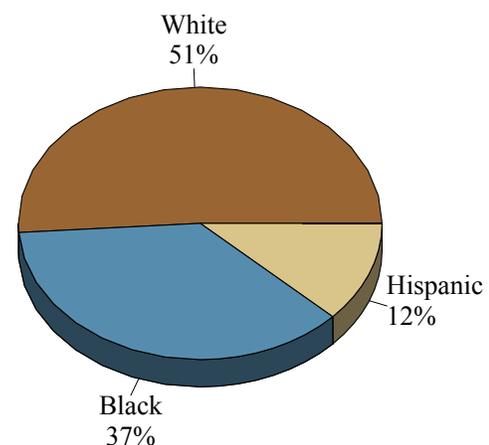


Figure 4
Race Distribution



CSAP Model Programs

Table 4
Numbers Served by Model Program
Fiscal Year 2007

Model Program	Number of Programs	Numbers Served
Across Ages	2	495
All Stars	8	465
Communities Mobilizing for Change on Alcohol (CMCA)	3	475
Creating Lasting Family Connections (CLFC)	3	477
Dare To Be You (DTBY)	18	1822
Guiding Good Choices (GGC)	8	779
Life Skills Training (LST)	6	611
Positive Action	1	215
Project Alert	8	2023
Project Towards No Drug Use (Project TND)	1	22
Second Step	15	4115
Strengthening Families Program (SFP)	10	1981
Total	83	13,480

What is Evidence Based?

In the health care field, evidence-based practice (or practices), also called EBP or EBPs, generally refers to approaches to prevention or treatment that are validated by some form of documented scientific evidence. What counts as "evidence" varies. Evidence often is defined as findings established through scientific research, such as controlled clinical studies. Evidence-based practice stands in contrast to approaches that are based on tradition, convention, belief or anecdotal evidence.²

²<http://nrepp.samhsa.gov/about-evidence.htm>

National Registry of Evidence Based Programs & Practices (NREPP)

The National Registry of Evidence-based Programs and Practices (NREPP), is a voluntary rating and classification system for mental health and substance abuse prevention and treatment interventions. All ADAA funded evidence-based prevention programs were selected from NREPP.

Evidence-Based Practice in the Context of NREPP

NREPP does not offer a single, authoritative definition of evidence-based practice. SAMHSA expects that people who use this system will come with their own perspectives and contexts for understanding the information that NREPP offers. By providing a range of objective information about the research that has been conducted on each particular intervention, SAMHSA hopes users will make their own judgements about which interventions are best suited to particular needs.³

³<http://nrepp.samhsa.gov/about-evidence.htm>.

Maryland Prevention Who Received Services?

Gender

Figure 5 shows the statewide distribution of gender for prevention program participants in fiscal year 2007. Approximately 56 percent of program participants were female while 44 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 2007, approximately half of the prevention program participants (56%) receiving services were adults over 18 years of age. Parents comprised 28 percent of those adults who attended prevention programs in fiscal year 2007. Youth under the age of 18 represented 44 percent of individuals participating in prevention programs. All age breakdowns for prevention programs are shown in Figure 6.

Race and Ethnicity

CSAP has defined five 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 three of the five racial groups into one standard category defined as "Other," namely Asian, American Indian and Native Hawaiian or Pacific Islander.

Caucasians made up approximately 52 percent of participants while African Americans comprised 41 percent of the individuals attending prevention programs in fiscal year 2007 (Figure 7). Hispanic individuals represented approximately four percent of the participants receiving prevention services in fiscal year 2007

Figure 5
Gender
Distribution

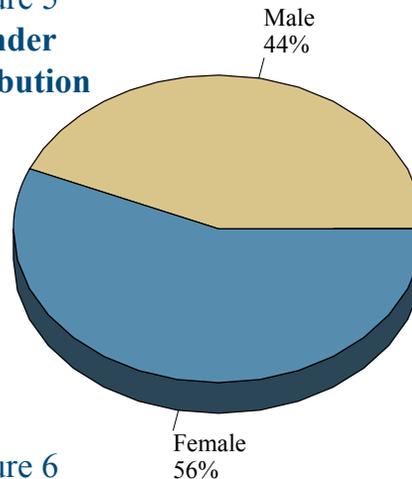


Figure 6
Age
Distribution

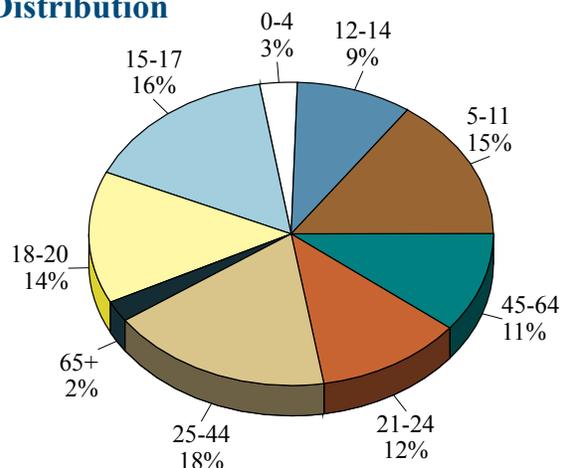
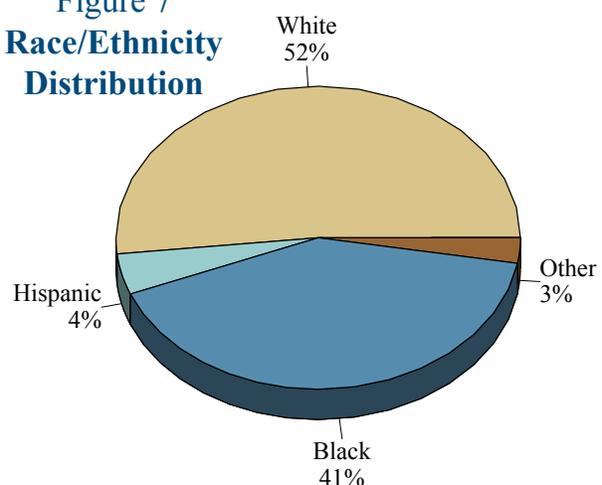


Figure 7
Race/Ethnicity
Distribution



Institute of Medicine (IOM)

Table 5
Numbers Served By Intervention Type (IOM Category)
Fiscal Year 2007

COUNTY	Universal	Selected	Indicated	Total
Allegany	8975	685	8	9668
Anne Arundel	4340	983	0	5323
Baltimore City	37727	5338	53	43118
Baltimore	38751	3394	227	42372
Calvert	4744	0	0	4744
Caroline	6362	113	2	6477
Carroll	14912	688	357	15957
Cecil	53	219	20	292
Charles	872	670	0	1542
Dorchester	2510	33	68	2611
Frederick	1596	7	0	1603
Garrett	6331	378	0	6709
Harford	11153	402	50	11605
Howard	4134	1023	0	5157
Kent	985	194	12	1191
Montgomery	5841	104	0	5945
Prince George's	5512	3856	0	9368
Queen Anne's	3961	0	0	3961
St. Mary's	7164	9	0	7173
Somerset	3654	51	0	3705
Talbot	1714	85	0	1799
Washington	3618	46	0	3664
Wicomico	1378	826	54	2258
Worcester	14901	91	0	14992
Total	191188	19195	851	211234
Percentage	91%	9%	>1%	100%

IOM Category Definitions

Universal - Universal prevention strategies address the entire population (national, local community, school, neighborhood), with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. The mission of universal prevention is to deter the onset of substance abuse by providing all individuals the information and skills necessary to prevent the problem. These programs are delivered to large groups without any prior screening for substance abuse risk.

Selected - Selected prevention strategies target subsets of the total population which are deemed to be at risk for substance abuse by virtue of their membership in a population segment -for example, children of adult alcoholics, drop out or students who are failing academically. The selected prevention program is presented to the entire subgroup because the subgroup as a whole is at higher risk for substance abuse than the general population.

Indicated - Indicated prevention strategies are designed to prevent the onset of substance abuse in individuals who do not meet DSM-IV criteria for addiction, but who are showing early danger signs, such as falling grades and consumption of alcohol and other gateway drugs. Indicated prevention approaches are used for individuals who may or may not be abusing substances, but exhibit risk factors that increase their chances of developing a drug abuse problem.

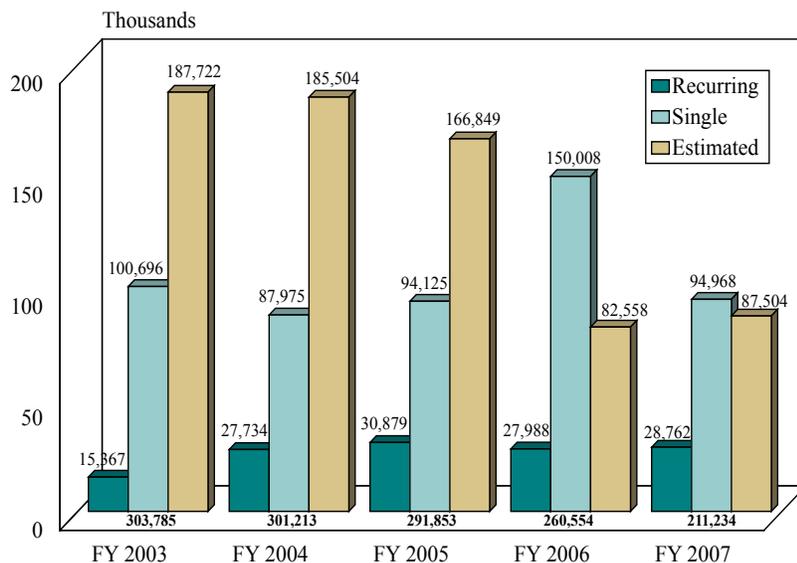
PREVENTION: WHAT DID WE BUY?

Recurring Prevention Services

Figure 8

Numbers Served FY 2003-2007

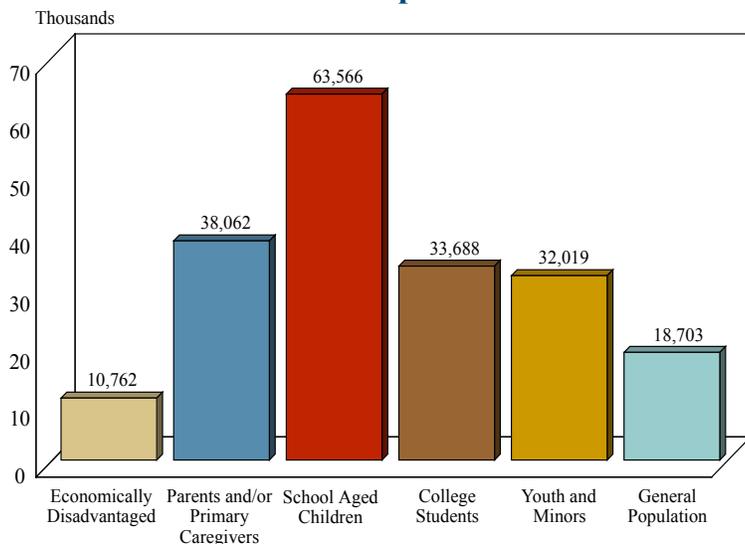
In fiscal year 2007 there were 28,762 individuals who actively participated in recurring prevention programs in Maryland. The state has mandated its funded prevention service providers to implement Substance Abuse and Mental Health Services Administration (SAMHSA) model programs. As a result, there has been an increase in the annual totals for participants in recurring programs (Figure 8). 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.



Single Prevention Services

The total number of individuals attending single prevention services or activities was 94,968 in fiscal year 2007. Annual totals for all prevention services are shown in Figure 8.

Figure 9
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 82,558 individuals who attended or received prevention services in fiscal year 2007.

Service Population

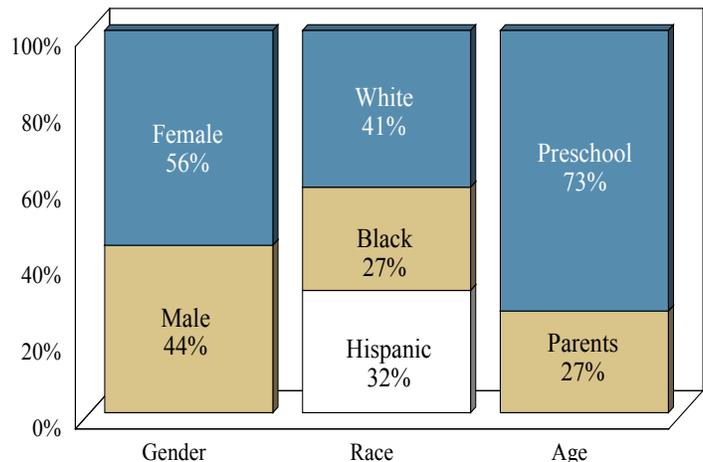
During fiscal year 2007, Maryland offered prevention services to 26 different service populations. The majority of individuals receiving services were parents and school-aged children (Figure 9).

SPECIAL PREVENTION INITIATIVES

Protecting Our Children

In fiscal year 1997, the ADAA began an initiative to focus on preschool children at high risk for alcohol, tobacco and other drug (ATOD) use and their families. ADAA's High-Risk Preschool Initiative now encompasses six subdivisions. The objective of these programs is to reduce the onset of alcohol, tobacco and other drug use among high risk preschool children by identifying and reducing community activities that place them at greater risk for ATOD use. Figure 10 shows characteristics of participants of the High-Risk Preschool Initiative.

Figure 10
Maryland Preschool Program Characteristics



FY 2007: A total of 2,763 individuals received prevention intervention services through the High Risk Preschool Initiative in fiscal year 2007.

Promoting a Healthy Transition to 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.

Figure 11
Individuals Served Statewide by College Centers Gender Distribution

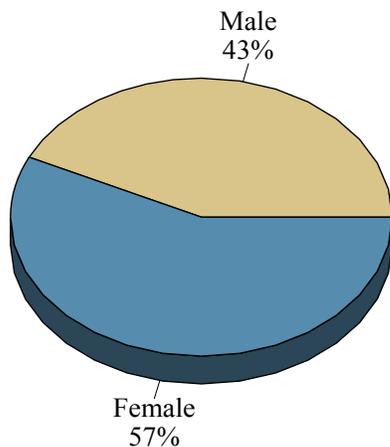
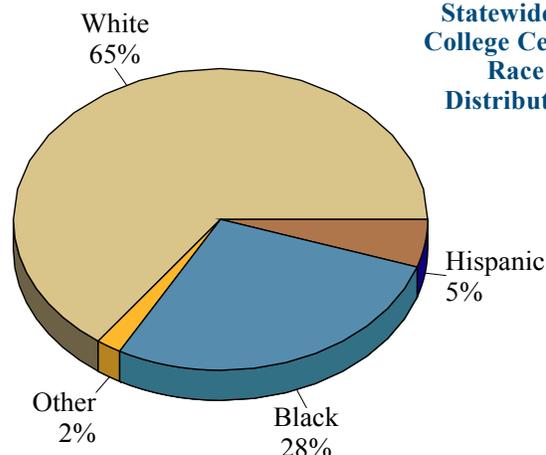


Figure 12
Individuals Served Statewide by College Centers Race Distribution

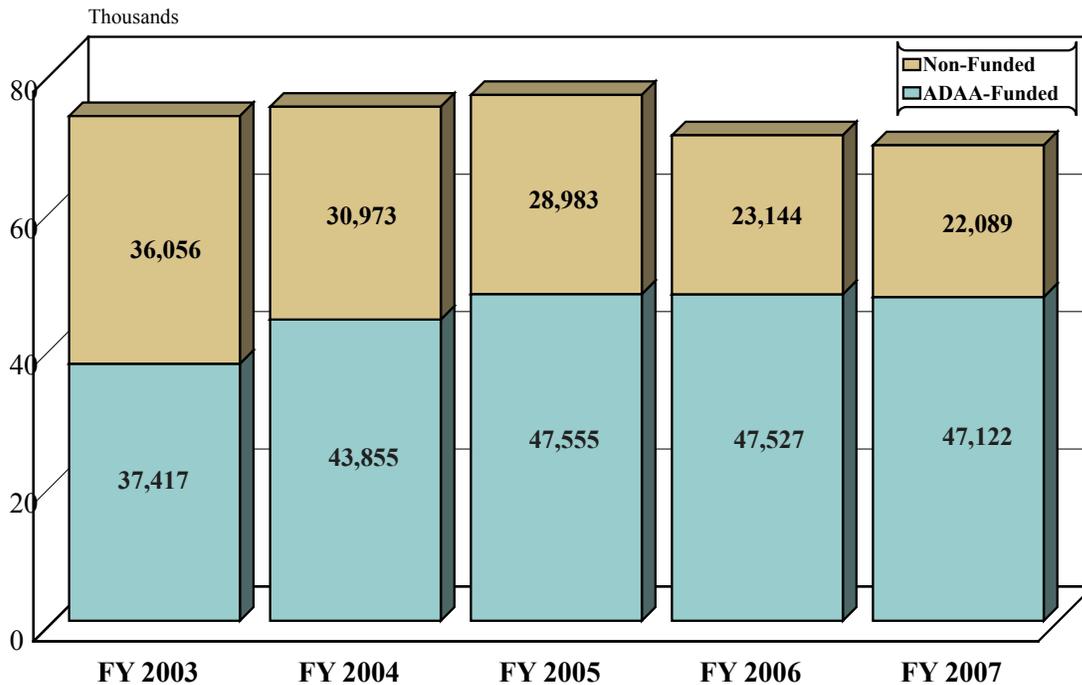


FY 2007: The college centers provided prevention services to 31,006 individuals statewide with a primary focus on peer education. Figures 11 and 12 show demographic characteristics for all four college prevention centers for fiscal year 2007.

WHO RECEIVED TREATMENT SERVICES?

Admissions to Certified Alcohol and Drug Abuse Treatment Programs FY 2003 - FY 2007

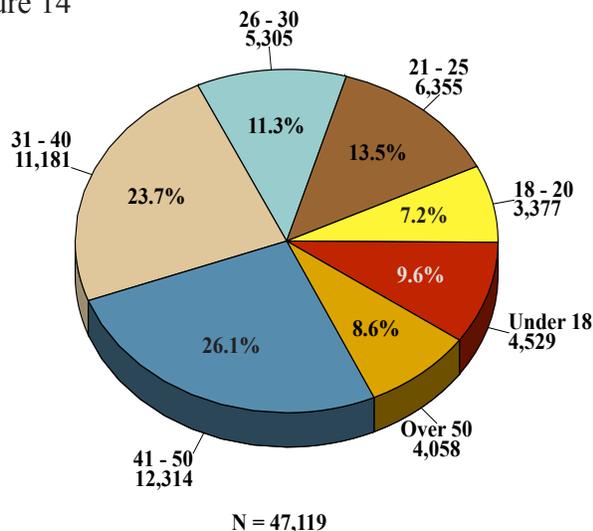
Figure 13



Total admissions decreased by 5.8 percent from Fiscal Year 2003 to 2007, but ADAA-funded admissions increased 26 percent during that time period. Whereas ADAA-funded admissions made up about half of the total in FY 2003, they made up two-thirds in FY 2006 and 2007. 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



The treatment admission population is aging. The distribution of age at admission is shown in Figure 14, which reveals that 35 percent of ADAA-funded admissions were over age 40 as compared to 32 percent in FY 2005. While 20 percent of FY 2005 admissions were under 21, only 17 percent were under 21 in FY 2007. This finding reflects a gradual nationwide trend toward more drug and alcohol use by older adults and decrease in youth drug use.

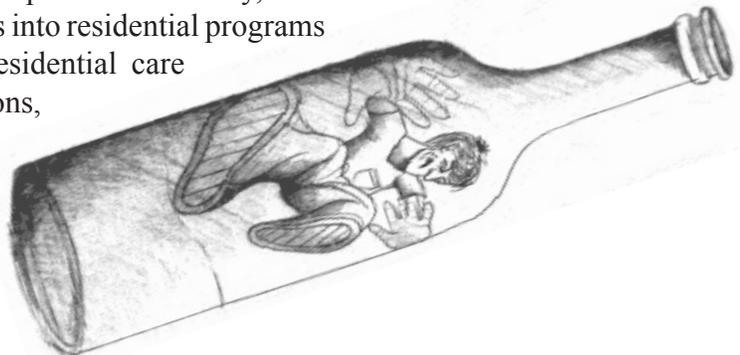
Admissions to Treatment Programs by ASAM Level of Care FY 2003 - FY 2007*

Table 6

ASAM Level of Care	FY 2003		FY 2004		FY 2005		FY 2006		FY 2007	
	#	%	#	%	#	%	#	%	#	%
Level 0.5	516	1.4	513	1.2	516	1.1	745	1.6	679	1.5
Level I	20231	54.1	20873	47.6	23091	48.6	21084	44.4	21159	45.6
Level I.D	1613	4.3	2032	4.6	2193	4.6	511	1.1	70	0.2
Level II.1	3239	8.7	4722	10.8	5326	11.2	7812	16.4	7468	16.1
Level II.5	-	-	-	-	12	0.0	87	0.2	347	0.7
Level II.D	-	-	-	-	16	0.0	313	0.7	408	0.9
Level III.1	809	2.2	1000	2.3	1232	2.6	1742	3.7	1772	3.8
Level III.3	444	1.2	1014	2.3	1108	2.3	713	1.5	752	1.6
Level III.5	374	1.0	550	1.3	389	0.8	529	1.1	1087	2.3
Level III.7	5075	13.6	6577	15.0	7150	15.0	8576	18.0	7425	16.0
Level III.7.D	2011	5.4	3447	7.9	3525	7.4	1969	4.1	3046	6.6
OMT	2760	7.4	2742	6.3	2609	5.5	3381	7.1	2192	4.7
OMT.D	345	0.9	385	0.9	388	0.8	65	0.1	10	0.0
Total	37417	100.0	43855	100.0	47555	100.0	47527	100.0	46415	100.0

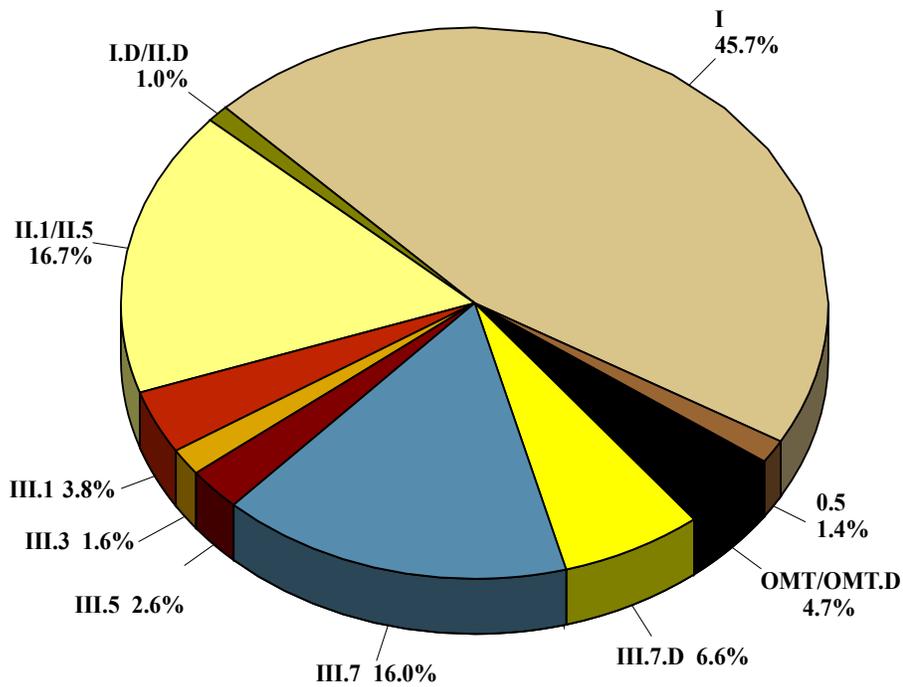
* It is important to note that late FY 2007 admissions and discharges continue to be submitted, so the final totals, at least for treatment, are likely to show modest increases.

Table 6 presents the distributions of funded levels of care over the past five years. The proportion of Level I admissions has been on the decline, going from 54 percent of FY 2002 admissions to 46 percent of FY 2007. Most of that difference was made up by Level II.1 (intensive outpatient), which went from 9 to 16 percent over the time period. Admissions to Level I.D dropped back considerably in FY 2006 and 2007, going from 5 percent to about one percent in 2006 and almost disappearing in 2007. A doubling of admissions to Level III.5, therapeutic community, is related to expanded use of ADAA's placement of patients into residential programs participating in contracts for long term residential care across the state. OMT and OMT.D admissions, which had been declining through FY 2005, increased by 15 percent in raw numbers during FY 2006, but fell again by 13 percent in FY 2007. This is related to a decline in heroin-related admissions, chiefly in Baltimore City, to be discussed later in this report.



Admissions by ASAM Levels of Care

Figure 15



N = 47,122

- 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 — Clinically Managed High Intensity Residential Treatment
- Level III.7 — Medically Monitored Intensive Inpatient Treatment
- Level III.7.D — Medically Monitored Intensive Inpatient Detox

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 2-Revised (PPC 2-R).¹ Such standards ensure increased uniformity of treatment and improved cost-effective allocation of resources.

A “level of care” is a primary treatment approach or modality. Programs must meet the standards defined by ASAM Criteria. 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 include office practice, health clinics, primary care clinics, mental health clinics, and “step down” programs that provide individual, group and family counseling services.

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

Level II - Intensive Outpatient (II.1) – A structured therapeutic milieu in an outpatient setting that delivers nine or more hours of structured treatment services per patient, per week.

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

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

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

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

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

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

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

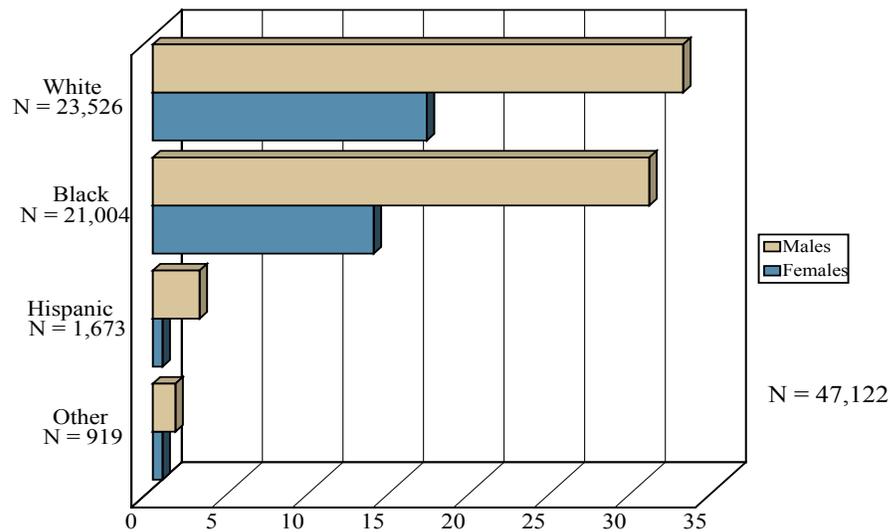
Table 7

A D M I S S I O N S B Y R E S I D E N C E	FY 2003 - FY 2007					
	Location of Residence	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
	Allegany	756	789	962	842	954
	Anne Arundel	987	2230	4167	4040	4563
	Baltimore City	13155	15992	15311	15687	14034
	Baltimore County	3090	3974	4452	4567	4215
	Calvert	775	1145	1067	1189	1452
	Caroline	453	516	466	463	405
	Carroll	990	1069	1107	1074	1089
	Cecil	1051	889	938	853	904
	Charles	1195	1188	1208	1418	1488
	Dorchester	608	615	480	505	471
	Frederick	1146	1050	1024	1098	1336
	Garrett	325	380	397	438	392
	Harford	918	941	1110	955	1124
	Howard	628	740	792	703	758
	Kent	368	443	431	392	487
	Montgomery	2696	3227	3661	2873	3357
	Prince George's	1956	2071	2804	3077	2698
	Queen Anne's	444	485	554	562	610
	St. Mary's	977	1104	987	1141	969
	Somerset	424	423	504	515	467
	Talbot	542	523	522	422	486
	Washington	1165	1102	1156	1333	1406
	Wicomico	1350	1307	1632	1314	1297
	Worcester	864	899	956	941	883
	Out-of-State	554	750	867	1125	1277
	Total	37417	43852	47555	47527	47122

Table 7 presents the distribution of treatment admissions by residence for FY 2003 to FY 2007. While total admissions were stable in the past year, there were significant increases in selected categories. The largest one-year increases were in Kent (24 %), Calvert (22 %) and Frederick (22 %) counties. The largest declines were in St. Mary's (15 %) and Caroline (13 %) counties. Prince George's County dropped by 12 percent in FY 2007 while Montgomery increased 17 percent. This was a reversal of the previous year, when Prince George's increased 10 percent and Montgomery fell by 22 percent. Over the five-year period the largest increases were in Anne Arundel County and admissions from states other than Maryland. The largest contributor to the out-of-state total was Washington, D.C. with 41 percent; Delaware had 18 percent, Virginia had 13, Pennsylvania had 11 percent and West Virginia had 6. Another 12 percent came from other states and countries.

Race and Gender Percentages of ADAA-Funded FY 2007 Admissions

Figure 16



Half of admissions were white and about 45 percent were black (Figure 16). There was a continuing shift toward lower percentages of black females; with 17.6 percent of admissions black females in FY 2004, only 15.2 percent in that category the following two years and only 13.7 percent were black females in FY 2007. This is related to the aforementioned decline in heroin related admissions, which was significantly greater among females. The admissions ratio of males to females was slightly above two-to-one, except among Hispanics where the ratio was nearly five-to-one. A small part of this difference was due to demographic factors – there are approximately 11 percent more males than females in the Maryland Hispanic population. However, social and cultural factors may contribute – two-thirds of Hispanic males entered treatment through the criminal justice system, especially DWI-related, and the great majority of all criminal justice-related admissions involved males. Among voluntary referrals, the ratio of male to female Hispanics was about 2.3 to one.

Female patients entering treatment in Maryland presented more problems and were more seriously addicted than male patients who had on average, more criminal justice issues. Females were more likely to be poly-abusers (65 vs. 60 %), heroin (36 vs. 26 %), crack cocaine (41 vs. 25 %) and other opiate (12 vs. 7 %) abusers. In general females used alcohol, marijuana, crack, other cocaine, heroin and other opiates on a more frequent basis than did males, and percentages of females having those substance problems that were ranked at the highest level of severity tended to be higher than for males. Only with respect to marijuana did males have a higher percentage with severe problems. Females were also more likely than males to have mental health problems (42 vs. 22 %), smoke cigarettes (67 vs. 60 %), and have dependent children (50 vs. 37 %). They were also less likely to be employed (21 vs. 34 %). Note that 3.4 percent of females admitted were pregnant.

One possible explanation for these male-female differences 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.

PREVIOUS TREATMENT EXPERIENCE

The numbers of past treatment admissions are shown in Table 8. Patients, in general, were more likely than not to have been in treatment before, with about 63 percent of funded admissions having had prior treatment experience. About 38 percent of individuals entering treatment had two or more prior treatment experiences. It is important to note that previous treatment may, in some cases, reflect an antecedent level of care. It appears the increase in those treatment admissions over the past two years is in part a function of greater reliance on a continuum of care with emphasis on progression from one level of care to another. Among funded admissions prior treatment experience was most associated with Levels III.1 and OMT. Forty-one percent of Level III.1 and 43 percent of OMT had three or more prior treatment episodes. Forty-four percent (down from 47 % in FY 2006 and 52 % the previous year) of funded Level I admissions had never been in treatment.

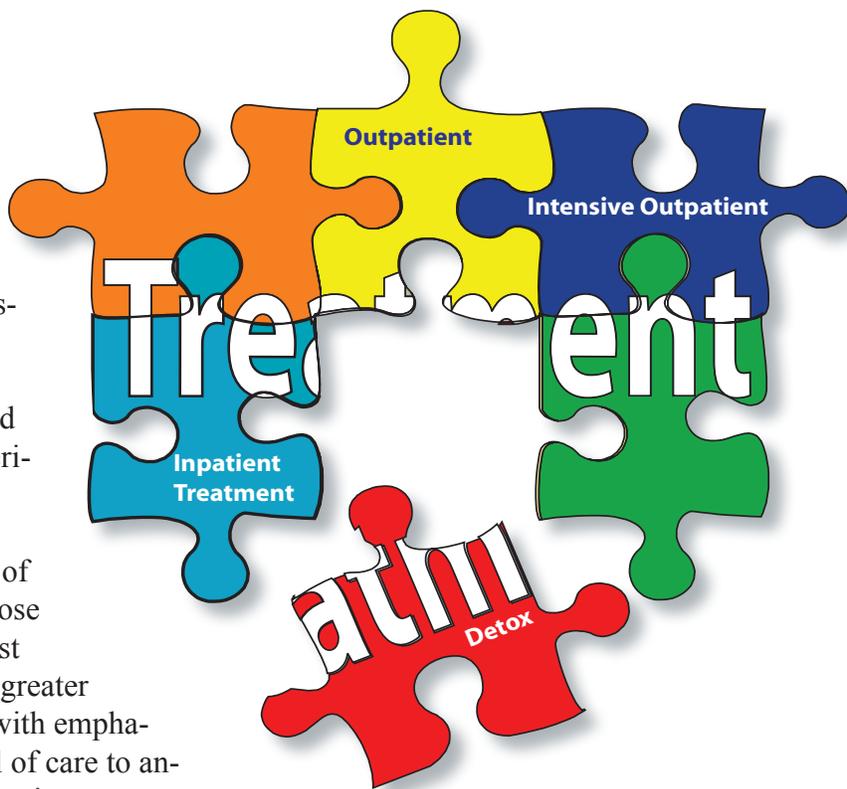
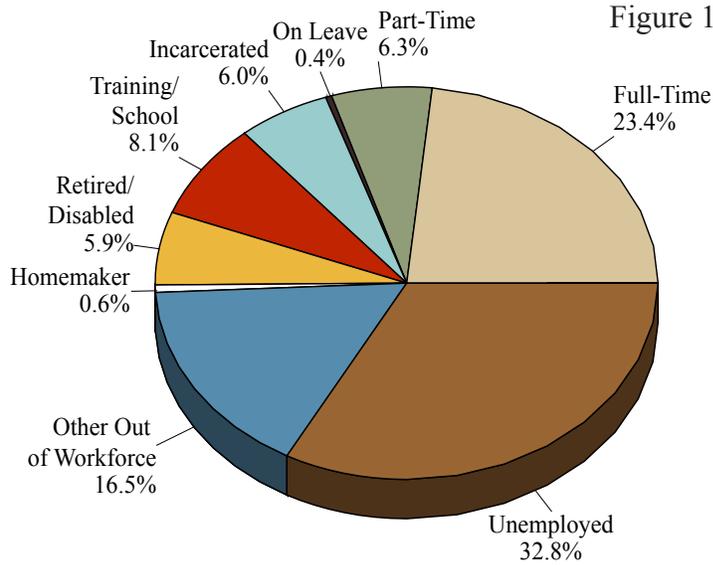


Table 8

Number of Prior Admissions to Treatment FY 2007		
Prior Admissions	#	%
None	17353	36.8
One	11854	25.2
Two	7241	15.4
Three	4411	9.4
Four	2509	5.3
Five or More	3754	8.0
Total	47122	100.0



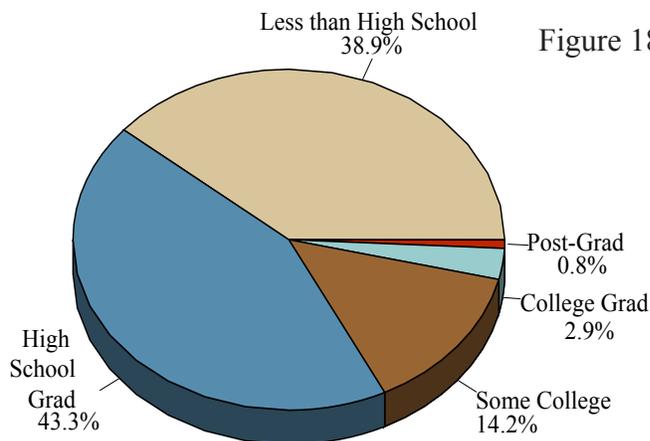
Employment at Admission



N = 47,122

Least likely to be employed among funded admissions were those in Levels III.3 (6 percent) and III.5 (3 percent). About 13 percent of OMT admissions had full-time employment (down from 16 percent) and seven percent part-time. Notably, 15 percent of OMT admissions were categorized as disabled, compared to about four percent of admissions to other levels of care.

Education at Admission



N = 47,121

Figure 18

Over the last two fiscal years there has been a slight decline in patients employed at admission. In addition there has been an increase in patients that are out of the workforce due to disability, retirement, or other out of the workforce categories. As shown in Figure 17, about 37 percent of patients at admission were outside the workforce (up from 25 percent in FY 2006) and 33 percent were otherwise unemployed (down from 44 percent). Level I outpatients were most likely to be employed - 34 percent of funded outpatients had full-time jobs at admission (down from 38 percent in FY 2006) and 10 percent were working part-time.

National Statistics

In 2006, admissions for alcohol only were the most likely to be employed (43%). The proportion employed was lowest (16 %) among admissions for smoked cocaine. The proportion not in the labor force was highest (49%) among admissions for heroin and lowest (29%) among admissions for abuse of alcohol only.
oas.samhsa.gov/2k6/highlights/2k6highWeb.pdf.

As shown in Figure 18, 39 percent of funded adult admissions lacked high school or GED diplomas while 17 percent had either some college or college degrees.

Co-Occurring Disorders

Co-occurring disorders commonly involve a simultaneous 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. As shown in Figure 19, 28 percent of individual admissions were deemed to have mental health problems, increasing from 25 percent in FY 2006.

Mental Health Problem At Admission

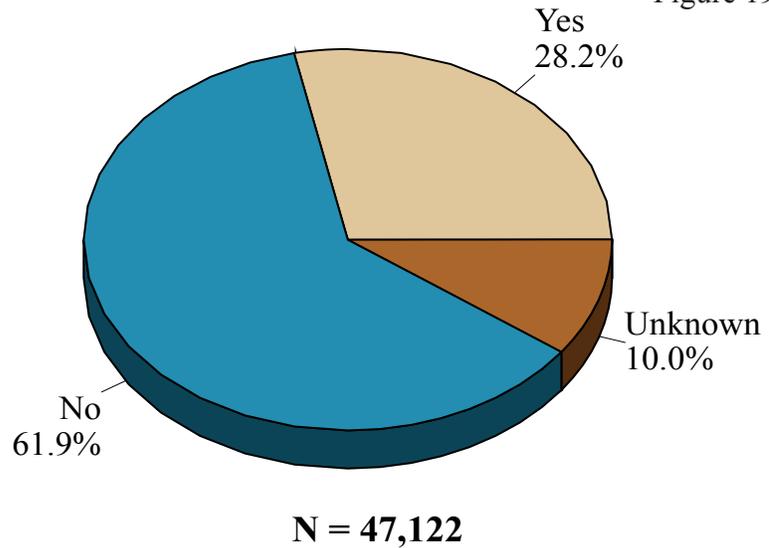


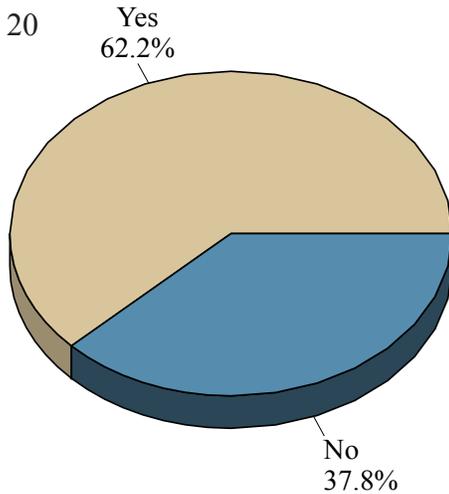
Figure 19

The co-occurring substance abuse and mental health population has been increasing as a percentage of admissions for several years, either in number or because intake counselors are better able to identify them. In FY 2007 these individuals were more likely to have other opiate rather than heroin-related primary problems and more likely to have crack cocaine primary problems than alcohol, marijuana or other cocaine. Sixty-nine percent of patients with primary problems of over-the-counter drugs and 62 percent of those with benzodiazepines also had mental health problems. In addition, these patients were significantly more likely to be tobacco users. Overall, females were about twice as likely as males to have mental health issues. Particularly susceptible were white females – 48 percent had mental health problems according to intake counselors. White males were nearly twice as likely as black males to have mental health problems, but were less likely than black females to have them. Hispanic females were about three times more likely than Hispanic males to have mental health problems. Also, mental health problem admissions were significantly more likely to enter residential or intensive outpatient treatment. Finally, there was a direct linear relationship between the number of prior treatment experiences and the likelihood of having mental health problems.

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

Tobacco Use

Figure 20



Cigarette smoking is considered a co-occurring problem affecting many substance abusers; Figure 20 shows that 62 percent of admissions were smokers during FY 2007, well above the general population percentages for this addiction and representing a three percentage point increase from FY 2006. Further analysis revealed that smokers were less likely than non-smokers to complete treatment, and the more prior treatment experiences the greater the likelihood of smoking. As noted above, females were more likely than males to smoke and smoking was most prevalent among admissions to residential and OMT levels of care. Over three-quarters of OMT admissions were smokers. The substances most associated with smoking tobacco were non-prescription methadone, heroin, crack cocaine, other opiates and over-the-counter drugs.

Figure 21

Healthcare Coverage

Over 61 percent of the patients admitted to programs lacked any form of health coverage, as shown in Figure 21. Nearly 20 percent had private insurance and the remainder had Medicaid, Medicare or other public coverage. Notably, this item does not necessarily indicate the immediate treatment episode was paid for by the reported health coverage.

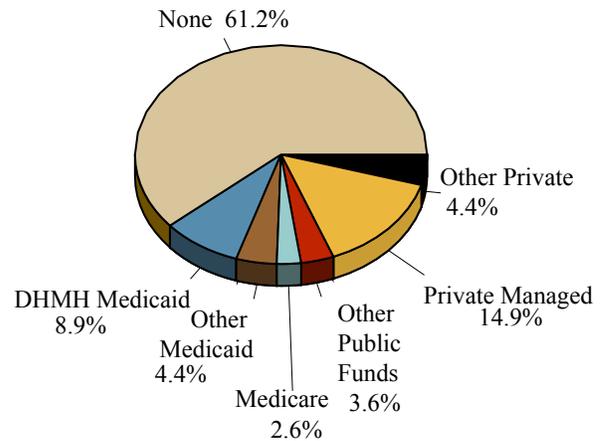
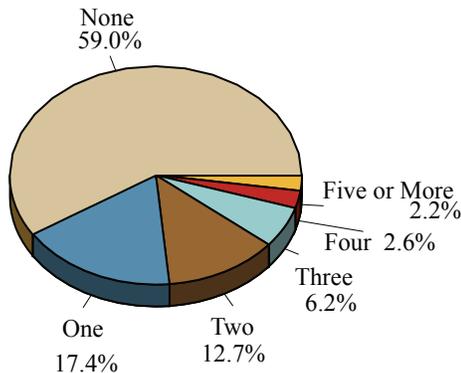


Figure 22

Dependent Children



N = 47,122

Nearly one-fourth of admissions claimed two or more dependent children. The 35,428 unique individuals admitted to treatment in FY 2007 reported a total of 30,847 dependent children directly affected by the substance abuse problems and the outcomes of treatment.

Source of Referrals

Figure 23

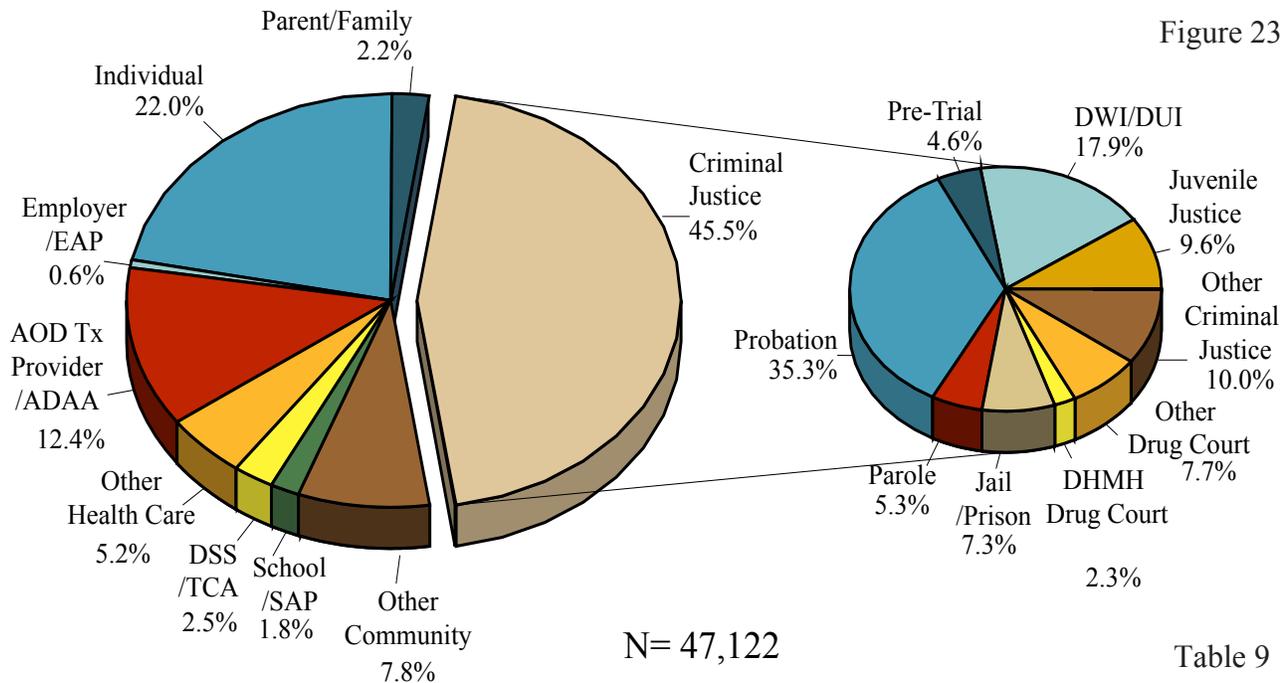


Table 9

Criminal Justice Referrals

Just under half of all admissions were referred by components of the criminal justice system, most often from probation and DWI-related sources, which are also frequently probation agencies. Most of the criminal justice referrals (90 percent) received treatment in the community rather than a correctional facility. About 85 percent were in outpatient or intensive outpatient levels of care, and two-thirds of all Level I (outpatient) admissions were from criminal justice sources.

The age group between 18 and 25 was about 56 percent criminal justice related. Black males were more likely than white males to be criminal justice referrals; however, a higher percentage of white females (34 %) than black females (29 %) came from the criminal justice system. The race/gender category with the highest percentages of criminal justice referrals was Hispanic males – 66 percent were criminal justice-related, although this is a substantial drop from the 85 percent in FY 2006. This is largely a result of the disproportionate occurrence of DWI referrals among Hispanic males. Hispanics were twice as likely as white males and nearly seven times as likely as black males to be DWI referrals.

Referral Source	#
Individual	10265
Parent/Family	1014
Employer/EAP	287
AOD Tx Provider	5275
Other Health Care	2897
DSS/TCA	1173
School/SAP	838
Other Community	3639
Juvenile Justice	2041
DWI/DUI	3904
Pre-Trial	974
Probation	7582
Parole	1133
Jail/Prison	1553
DHMH Drug Court	476
Other Drug Court	1627
Other Criminal Justice	2427

Voluntary Referrals

Voluntary or community referrals are also distributed by their relative contribution to total admissions in Figure 23. Individual or self-referrals made up 40 percent of voluntary referrals, which is 22 percent of total referrals; treatment and other health care providers made up 32 percent of voluntary and 17 percent of total referrals.

Number of Arrests Prior to Admission

Figure 24

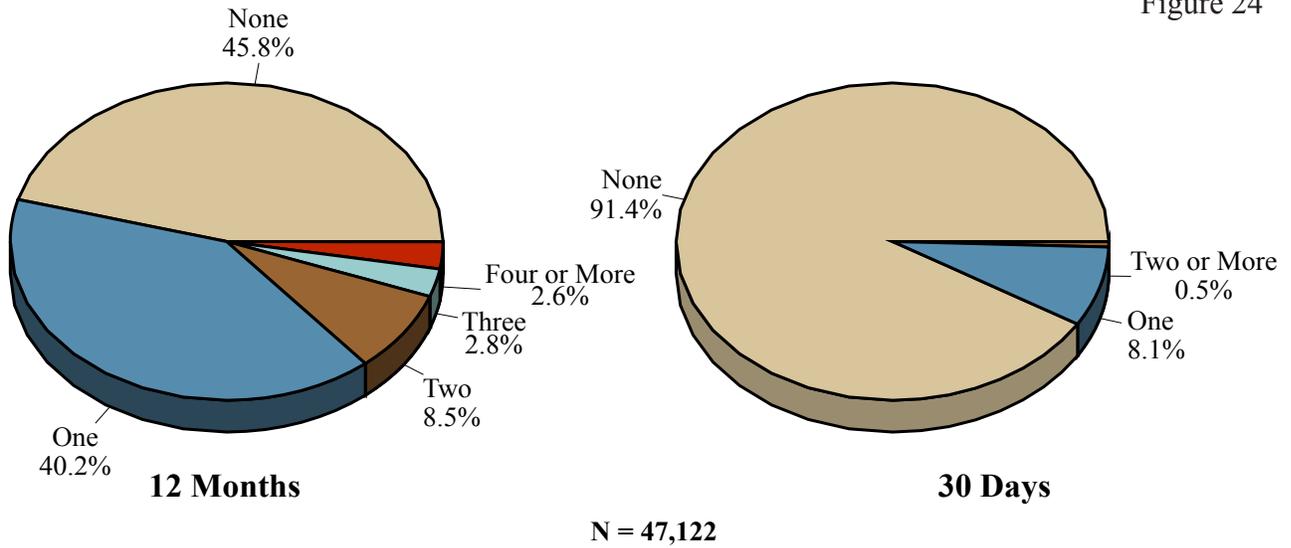
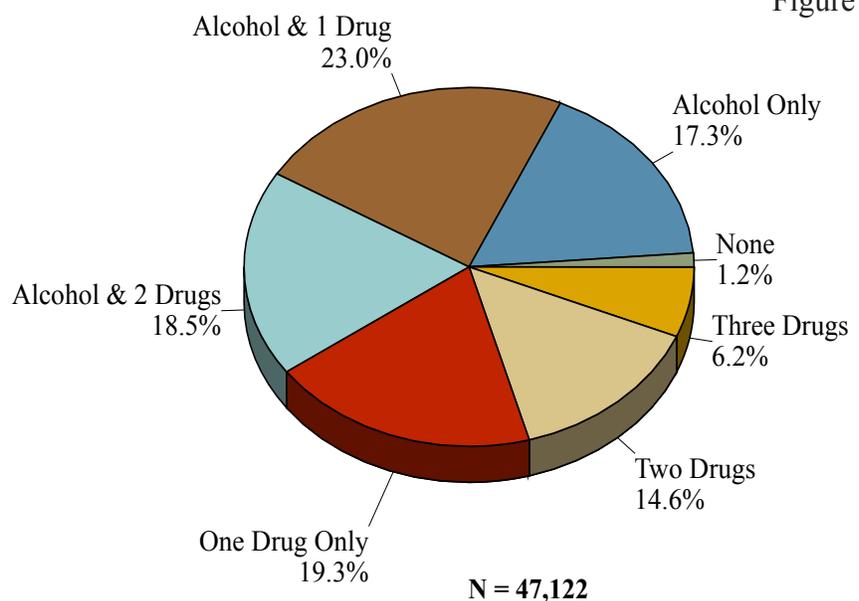


Figure 24 shows the distribution of the numbers of arrests in the twelve months preceding treatment and the 30 days before admission. Just over half of admissions had at least one arrest during the year before treatment and 14 percent had two or more. However, only about 9 percent had experienced an arrest during the thirty days before admission.

Pattern of Substance Problem(s)

Figure 25

Figure 25 presents the patterns of substance abuse problems among admissions. Sixty-three percent of funded admissions had multiple substance problems. Alcohol was a factor in nearly 60 percent of treatment admissions. Alcohol and marijuana appeared jointly in 54 percent of the cases involving alcohol and another substance and 23 percent of all admissions. Heroin and cocaine were co-abused in 18 percent of all cases.



Substance Mentions Among Admissions to Treatment FY 2003 to FY 2007

Table 10

Substance Mentions	FY 2003		FY 2004		FY 2005		FY 2006		FY 2007	
	#	%	#	%	#	%	#	%	#	%
Alcohol	20504	60.3	25041	58.2	27986	59.9	27963	59.7	27674	59.4
Crack	7896	23.2	12326	28.6	12997	27.8	13747	29.3	13816	29.7
Other Cocaine	6835	20.1	7382	17.2	7589	16.3	7834	16.7	7394	15.9
Marijuana/Hashish	13077	38.5	15440	35.9	17350	37.2	17966	38.3	17503	37.6
Heroin	11162	32.8	16136	37.5	15803	33.8	15714	33.5	13652	29.3
Non-Rx Methadone	103	0.3	228	0.5	315	0.7	380	0.8	450	1.0
Oxycodone	—	—	—	—	—	—	1996	4.3	2278	4.9
Other Opiates	1115	3.3	2005	4.7	2680	5.7	1071	2.3	1297	2.8
PCP	490	1.4	551	1.3	483	1.0	779	1.7	770	1.7
Hallucinogens	458	1.3	493	1.1	491	1.1	341	0.7	302	0.6
Methamphetamines	136	0.4	175	0.4	183	0.4	129	0.3	156	0.3
Other Amphetamines	144	0.4	140	0.3	176	0.4	468	1.0	462	1.0
Stimulants	35	0.1	254	0.6	176	0.4	33	0.1	47	0.1
Benzodiazepines	300	0.9	567	1.3	576	1.2	1160	2.5	1151	2.5
Other Tranquilizers	30	0.1	25	0.1	40	0.1	10	0.0	22	0.0
Barbiturates	77	0.2	106	0.2	115	0.2	67	0.1	48	0.1
Other Sedatives or Hypnotics	202	0.6	307	0.7	393	0.8	116	0.2	99	0.2
Inhalants	66	0.2	70	0.2	63	0.1	60	0.1	35	0.1
Over the Counter	25	0.1	60	0.1	66	0.1	81	0.2	97	0.2
Other	90	0.3	114	0.3	317	0.7	378	0.8	272	0.6
Total Respondents	34001	—	43023	—	46692	—	46870	—	46559	—

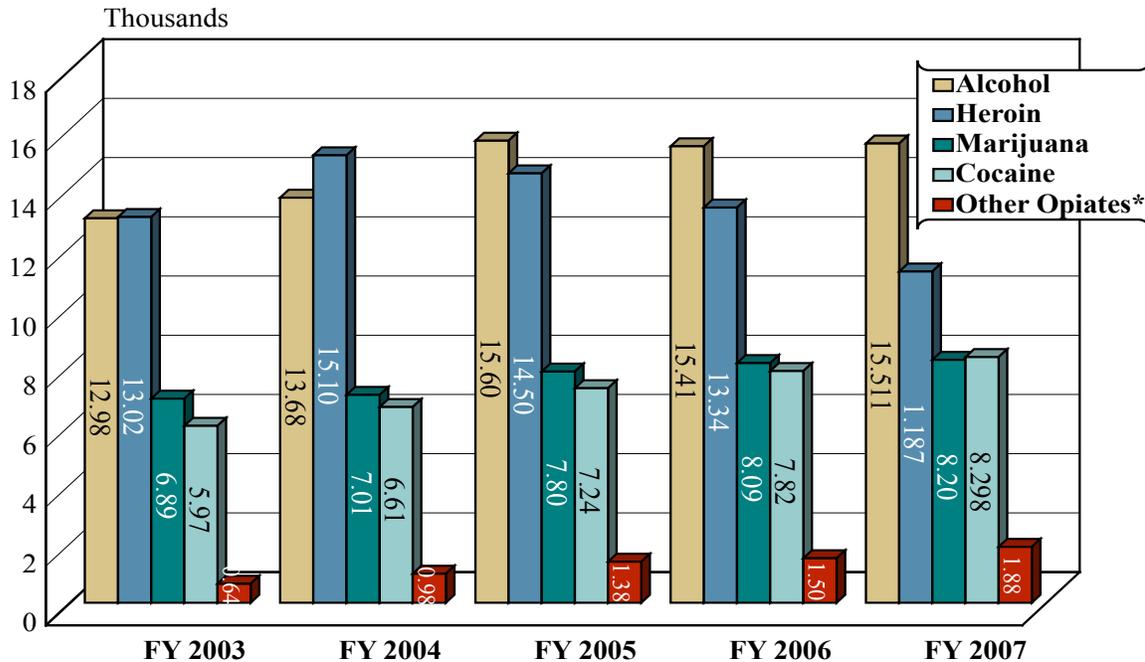
*Up to three substance problems can be reported for each admission. A mention is a report of a particular substance problem as either primary, secondary or tertiary, with any of three levels of severity.

Table 10 lists substance problems reported at admission during FY 2003 to FY 2007. Alcohol has consistently appeared as a substance problem among about 60 percent of admissions and marijuana among about 38 percent. The most notable FY 2007 change is in heroin-related cases – whereas heroin was a reported problem in about a third of FY 2006 cases it was mentioned in only 29 percent of FY 2007 cases, a decline of over 2000 individuals. About 65 percent of cocaine-related admissions involved crack (smoking the drug), and the total cocaine contribution was 46 percent, second only to alcohol in prevalence in the treatment population. Other opiates (including oxycodone and non-prescription methadone) reached about nine percent, increasing by 231 percent from FY 2003 and 34 percent from FY 2005. The only other substances that exceeded two percent of admissions were benzodiazepines, which doubled in frequency from FY 2005 to 2006 but leveled off in FY 2007.

Methamphetamines continued as an insignificant problem in Maryland with less than a half percent of patients reporting the drug as a problem.

Primary Substance Problems FY 2003 - FY 2007

Figure 26



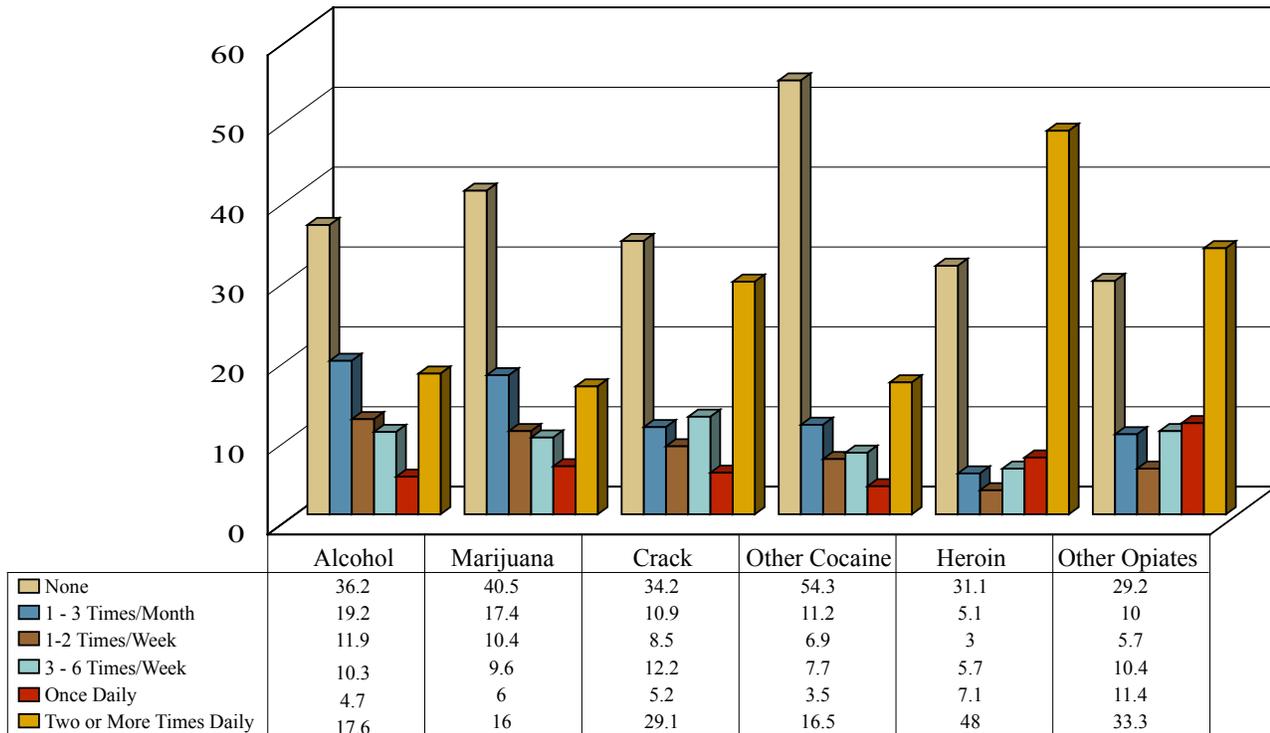
*Includes non-Rx methadone, Oxycodone and other opiates.

Figure 26 reveals that as a primary problem heroin has been declining in numbers of affected admissions since FY 2004 while all other major substance categories have been gradually increasing. The decrease in cases with heroin reported as the primary substance problem was 26 percent. Part of this decline is likely a result of restructuring of methadone treatment services in Baltimore to increase efficiency and retention; however, there is clearly a decline in the overall demand for services for heroin abuse as well. Preliminary data for FY 2008 suggest this decline will continue. Also, the percentage of first-time heroin-related admissions has been decreasing – prior to 2005 about 32 percent had consistently been entering treatment for the first time; from 2005 on it has been about 21 percent.

A recent report on "Intoxication Deaths Associated with Drugs of Abuse or Alcohol" by the Baltimore City Health Department (Jan. 2007, www.baltimorehealth.org/dataresearch.html) showed a decrease of about a third in heroin involved deaths of Baltimore City residents from 2002 to 2006.

Frequency of Use of Selected Substances During the 30 Days Prior to Admission

Figure 27



The distributions of frequencies of the leading substances of abuse during the 30 days preceding admission are shown in Figure 27. Thirty-six percent of alcohol and 41 percent of marijuana related admissions claimed no use of those substances in the 30 days preceding admission. Many of these cases came from controlled environments, correctional or residential, and therefore were unable to use substances in the month before admission. Others were referred or transferred from other levels of care where their use was reduced to zero. Finally, some of these admissions with no reported recent use involved individuals who concealed their true level of use, at least initially, until a level of trust was established with counselors. Daily use was reported among about 22 percent of admissions for both alcohol and marijuana.

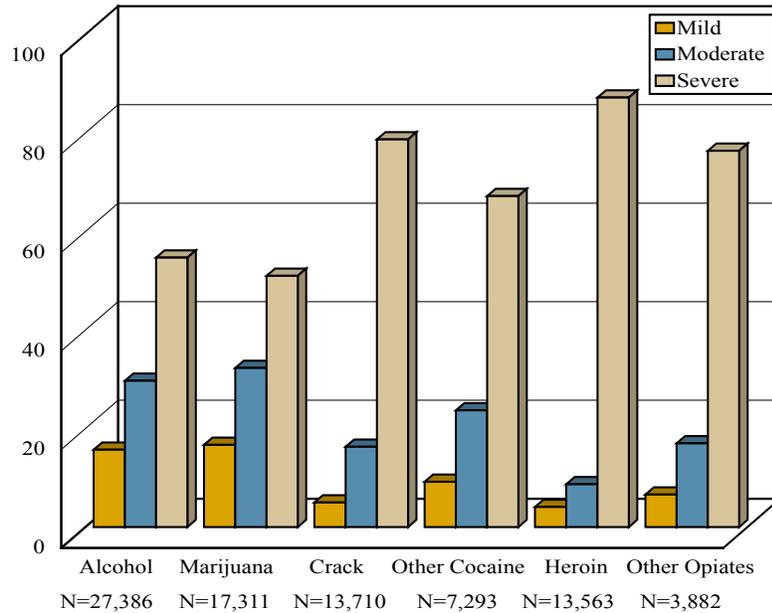
Over a third of crack-related admissions and 20 percent of other cocaine-related admissions used the drug on a daily basis. Nearly half of heroin-related admissions used the drug two or more times a day in the month before admission; seven percent used daily and nine percent used from one to six times a week. Other opiates were used one or more times daily by 45 percent of those admissions.

Appendix Tables B through H distribute admissions with the leading substance problems by residence.

Severity of Substance Problems

Figure 28

Figure 28 shows the percentage distribution of severity of the six major substance problems reported for FY 2007 admissions. Eighty-seven percent of heroin problems, over three-fourths of other opiate and crack problems and about two-thirds of other cocaine problems were rated severe. Just over half of alcohol and marijuana problems were rated at that level.



Primary Routes of Administration Involving Heroin and Cocaine

Figure 29

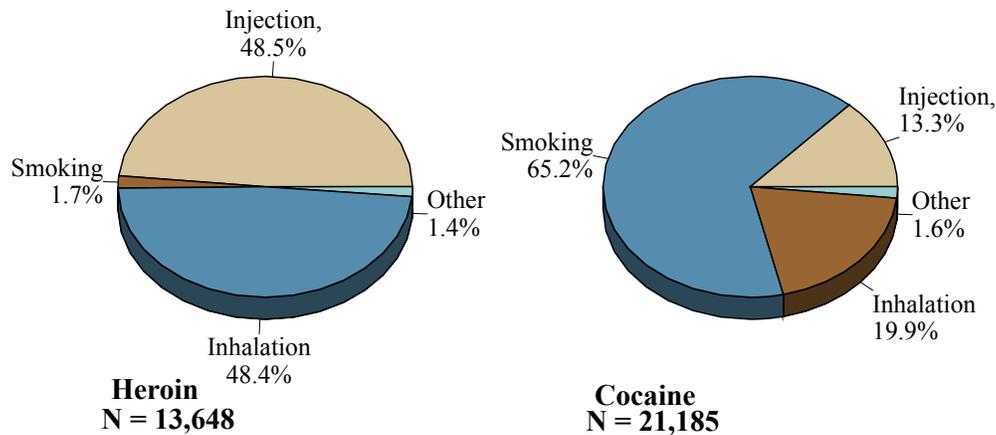


Figure 29 shows the primary routes of administration for admissions involving heroin and cocaine. Heroin admissions were evenly split between primary injectors and primary inhalers of the drug. Over 81 percent of inhalers of heroin were black, compared to about 41 percent of injectors. Two-thirds of black female and 63 percent of black male heroin admissions primarily inhaled the drug, compared to 21 percent of white females and 23 percent of white males. About three-fourths of white heroin admissions, both male and female, injected the drug primarily. Heroin injection was associated with younger users. About 73 percent of heroin admissions in the 21 to 25 age range were injectors, as were 70 percent of those 18 to 20, contrasted with 48 percent overall. Eighty-eight percent of heroin inhalers were over the age of thirty. Injection of heroin as opposed to inhalation was significantly associated with mental health problems. Heroin injectors were more likely than inhalers to enter OMT treatment, but they were equally likely to enter Level I.

Mentions of Injected Substances Among Admissions to Treatment

Table 11

Substance	FY 2003		FY 2004		FY 2005		FY 2006		FY 2007	
	#	%	#	%	#	%	#	%	#	%
Cocaine	3358	47.4	3545	45.3	3614	45.2	3199	41.0	2824	39.7
Heroin	6328	89.3	7380	94.3	7526	94.2	7323	93.8	6616	92.9
Other Opiates	107	1.5	162	2.1	170	2.1	261	3.3	278	3.9
Methamphetamine	19	0.3	27	0.3	36	0.5	21	0.3	22	0.3
Injecting Respondents	7084	—	7825	—	7992	—	7806	—	7125	—

Table 11 shows the mentions of injected substances for FY 2003 to FY 2007. Injection cases made up about 15 percent of all admissions, down from 17 percent the previous year. Consistently, 90 to 95 percent of injection-related admissions have involved heroin. In FY 2007, 40 percent also involved cocaine. Clearly, cocaine injection rarely occurs as an abuse problem that does not also involve heroin injection. More than half of heroin injectors reported no other injected substances.

Age of First Use

Table 12

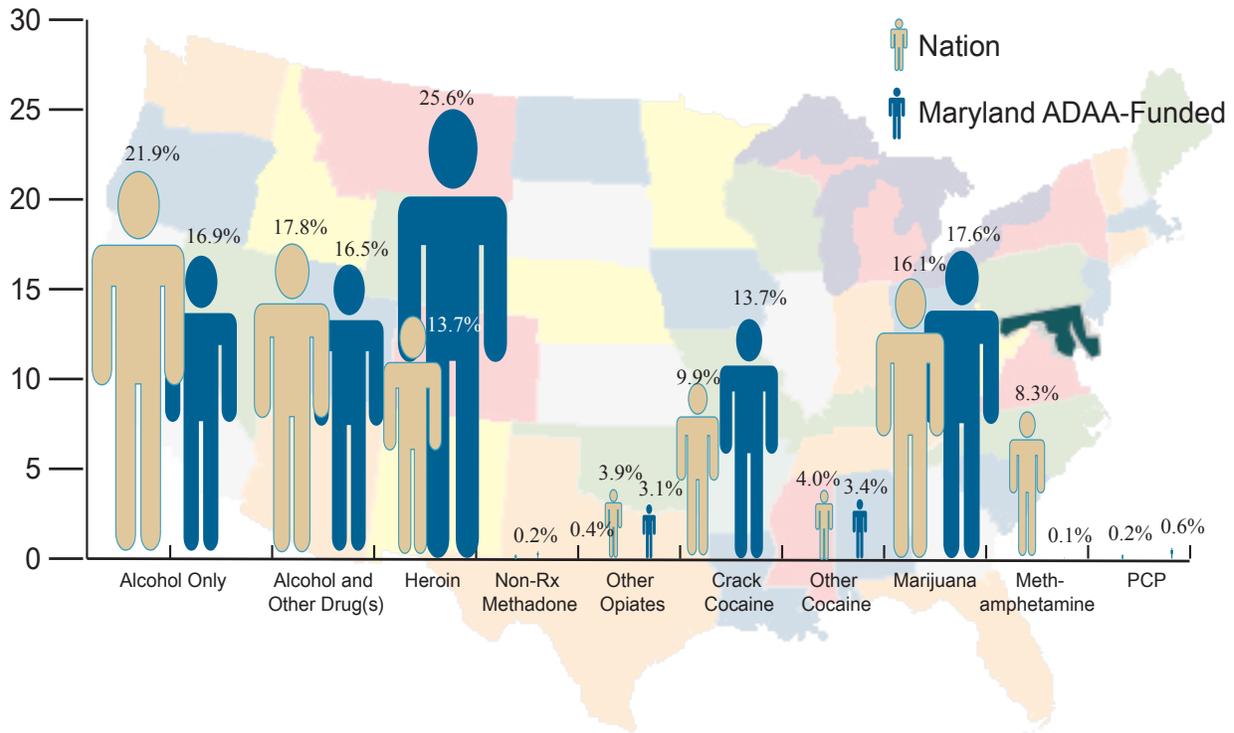
Substance	Under 15	15 to 17	18 to 25	26 to 30	Over 30
Alcohol*	37.4	34.8	24.1	1.8	1.9
Marijuana	48.9	34.3	14.8	1.1	0.9
Crack	5.1	15.9	43.7	15.6	19.6
Other Cocaine	8.5	24.3	45.7	11	10.6
Heroin	8.1	21.3	44.9	12.3	13.3
Other Opiates	7.3	18.4	38	12.5	23.7

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

The distributions of reported age at first use of the six major substances of abuse are shown in Table 12. About 37 percent of alcohol and 49 percent of marijuana-related admissions experienced their first alcohol intoxication and/or marijuana use before turning 15. Eighty-three percent of marijuana-related admissions first used the drug before the age of 18. About 45 percent of cocaine and heroin users first used those drugs in the 18 to 25 age range.

How Maryland Compares to the Nation Primary Substance Problem Calendar Year 2006

Figure 30



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; the most recently available national data are for calendar year 2005.

Maryland patients present with primary substance abuse problems in proportions similar to the rest of the nation, with three notable exceptions. 1) Maryland treatment admissions are less likely than national admissions to involve alcohol either alone or with other drugs as secondary problems. 2) Nationally, over eight percent of admissions involved methamphetamines while a tenth of one percent of Maryland admissions involved that drug. 3) Heroin, on the other hand, was a factor in 26 percent of Maryland admissions (down from 30 percent in 2006) and only about 14 percent of national admissions.

PATIENTS TREATED

Discharges from Treatment

National Statistics

Discharges from treatment during FY 2003 to 2007 are distributed by ASAM level of care in Table 13. The number of FY 2007 discharges is about three percent higher than the FY 2006 number and just slightly higher than the FY 2005 total. Largest changes in funded discharges from FY 2006 to 2007 were in Level II.5 (+ 502 percent from FY 2006 to FY 2007), Level I.D (-90 percent), Level III.5 (+ 89 percent) and OMT.D (- 84 percent).



SOURCE: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 10.03.06

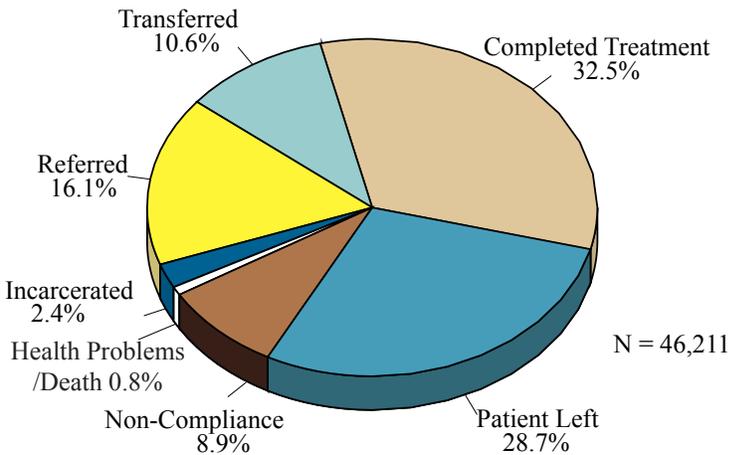
Discharges from Treatment by ASAM Level of Care FY 2003 - FY 2007

Table 13

ASAM Level of Care	FY 2003		FY 2004		FY 2005		FY 2006		FY 2007	
	#	%	#	%	#	%	#	%	#	%
Level 0.5	530	1.6	522	1.2	503	1.1	675	1.5	651	1.4
Level I	18994	58.0	20425	47.9	22899	49.6	20067	44.5	20769	44.9
Level I.D	199	0.6	1914	4.5	1954	4.2	569	1.3	53	0.1
Level II.1	2328	7.1	4513	10.6	4842	10.5	7224	16.0	7527	16.3
Level II.5	—	—	—	—	—	—	74	0.2	415	0.9
Level II.D	—	—	—	—	—	—	298	0.7	387	0.8
Level III.1	628	1.9	885	2.1	1207	2.6	1621	3.6	1730	3.7
Level III.3	806	2.5	993	2.3	1069	2.3	660	1.5	750	1.6
Level III.5	—	—	517	1.2	428	0.9	304	0.7	988	2.1
Level III.7	4644	14.2	6498	15.2	7147	15.5	8355	18.5	7531	16.3
Level III.7.D	1848	5.6	3390	7.9	3467	7.5	1997	4.4	3033	6.6
Level OMT	2444	7.5	2685	6.3	2333	5.1	3044	6.8	2420	5.2
Level OMT.D	319	1.0	302	0.7	321	0.7	187	0.4	36	0.1
Total	32740	100.0	42644	100.0	46170	100.0	45075	100.0	46290	100.0

Reason for Discharge

Figure 31



As shown in Figure 31, nearly a third of discharged patients completed treatment with no indicated need for further treatment, up from a fourth in FY 2006. About 27 percent were transferred or referred. As was the case in FY 2006, about 38 percent could be considered failures – either leaving against clinical advice or terminated for violating program rules.

When looking at the major categories of Reason for Discharge by ASAM Level of Care, the data show 41 percent of discharges from Level I completed treatment with no indicated need for further

treatment. About 35 percent of Level II.1 patients went on for additional treatment while 16 percent completed. Transfer/referrals were most common from the detoxification levels. Only five percent of OMT discharges completed successfully; however, as has often been noted, the bulk of OMT successes are patients who remain in treatment indefinitely, while a substantial segment of OMT patients cycle through multiple episodes in different programs. About 50 percent of halfway house discharges completed treatment and 12 percent were transferred or referred.

Reason for Discharge:/Dis-enrollment 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. (Dis-enroll=Referred)

Completed Treatment Plan/Transferred

The patient moves from one level of care to another or one physical location to another within the same treatment agency as prescribed in his/her treatment plan. (Dis-enroll=Transferred)

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. (Dis-enroll=Left before Completing Treatment)

Incomplete Treatment/Death

The patient was discharged because of his/her death. (Dis-enroll=Deceased)

Incomplete Treatment/Non-compliance with Program Rules (Dis-enroll=Disciplinary violation)

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. (Dis-enroll=Incarcerated)

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. (Dis-enroll=Referred)

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. (Dis-enroll=Transferred)

Length of Stay: Days In Treatment

Table 14

Table 14 shows the average and median lengths of stay in funded ASAM levels of care during FY 2007. On average, patients spent 80 days in Level II.1 and 133 days in Level I. Halfway house treatment (Level III.1) lasted 93 days on average. OMT discharges remained in treatment over two years, with a median of 392 days.

Length of Enrollment FY 2007			
ASAM Level of Care	Mean	Median	N
Level 0.5	106.2	87	651
Level I	133.2	108	20769
Level I.D	90.4	5	53
Level II.1	80.2	57	7527
Level II.5	17.8	10	415
Level II.D	26.1	5	387
Level III.1	93.1	60	1730
Level III.3	104.3	92	750
Level III.5	99.4	56.5	988
Level III.7	21.1	21	7522
Level III.7.D	6.1	5	3033
OMT	782.3	391.5	2420
OMT.D	653.4	529.5	36
Total	127.3	57	46290

Measuring Treatment Effectiveness

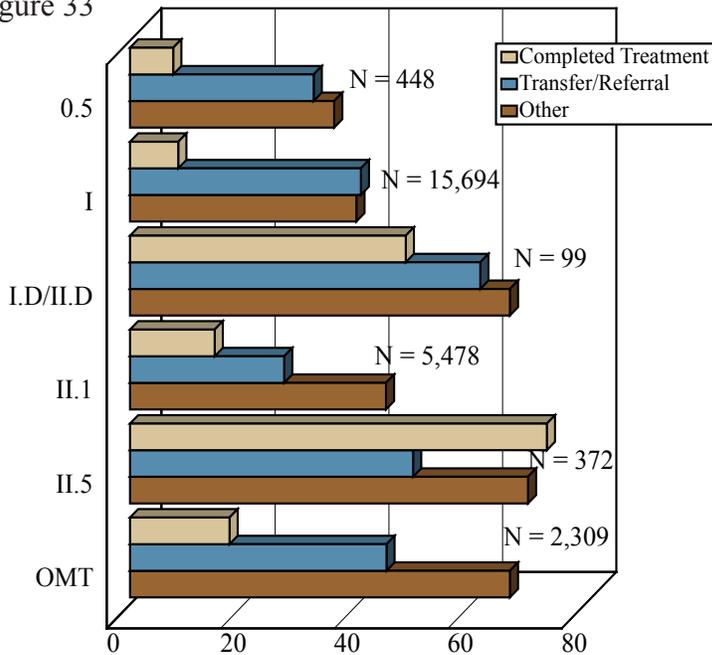
Information is collected on urinalysis tests undergone by patients discharged, and the number that were positive. Figure 32 shows the percentage of patients in each level of care who underwent urinalysis during the enrollment. Urinalysis was most common in OMT, Level III.3, II.5, I.D/II.D and III.1. Seventy-six percent of Level I patients had their urines tested at least once during treatment.



Average Percentages of Positive Urinalysis Tests for Discharged Patients During FY 2007

Ambulatory Levels of Care

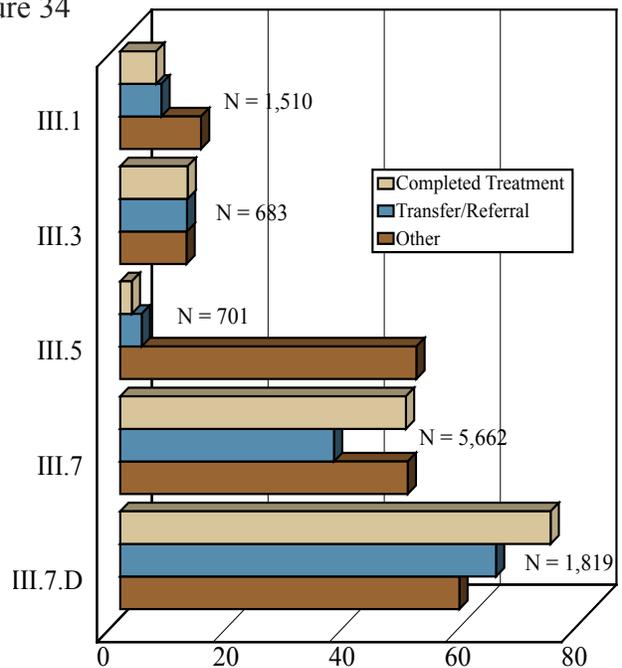
Figure 33



Figures 33 and 34 show the average percentages of positive urinalysis tests by reason for discharge from the various levels of care. About nine percent of the urinalysis tests of completers of Level I were positive, compared to 41 percent of transfer/referrals and 40 percent of others*. It should be noted that positive tests are more common early in treatment, so short-term treatment such as detoxification and treatment that is cut short due to referral, noncompliance or patients leaving against medical advice, will naturally show higher positive urinalysis results.

Residential Levels of Care

Figure 34



The positive urinalysis rates in OMT are not an indicator of ineffective treatment. As noted above, 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.

* others: Administrative discharges or otherwise left without completing treatment

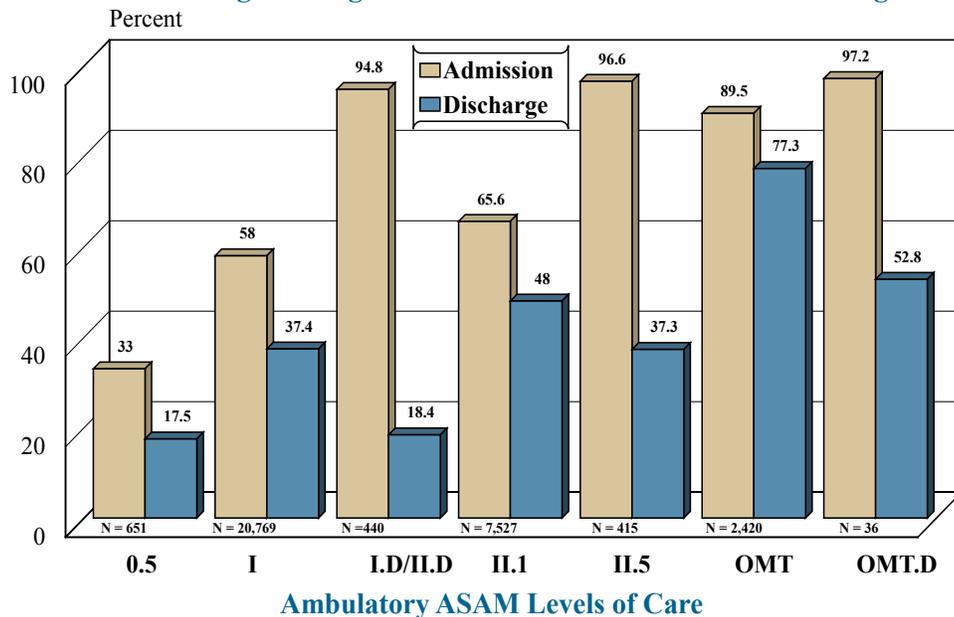
WAS IT WORTH IT?

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.

Figure 35

Percentages Using Substances at Admission and at Discharge



Treatment Reduces Substance Use

Figures 35 and 36 illustrate the reductions in use of substances that occur in treatment from the 30 days preceding admission to the 30 days preceding discharge for all discharges, whether successful or not. In Level I use was reduced by 36 percent and by 27 percent in II.1. These results reflect substantial improvement from FY 2006, when the reductions in use were 26 and 22 percent respectively, and from FY 2005, when the reductions in use were 20 and 15 percent. Reductions in Levels I.D/II.D and III.7.D were significant, but it should be noted that use levels at discharge were based on the typically brief length of stay only.

All of the residential levels of care had reductions in use that exceeded 50 percent, including Level III.1 where admissions usually come from a controlled environment. The reduction in percentage of users during treatment in Level OMT was 14 percent, an improvement from nine percent the previous year.

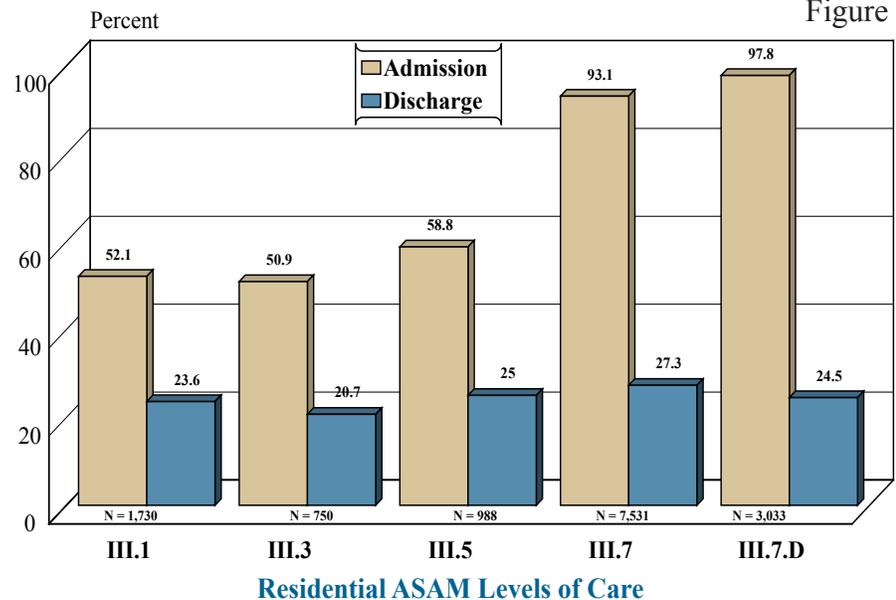
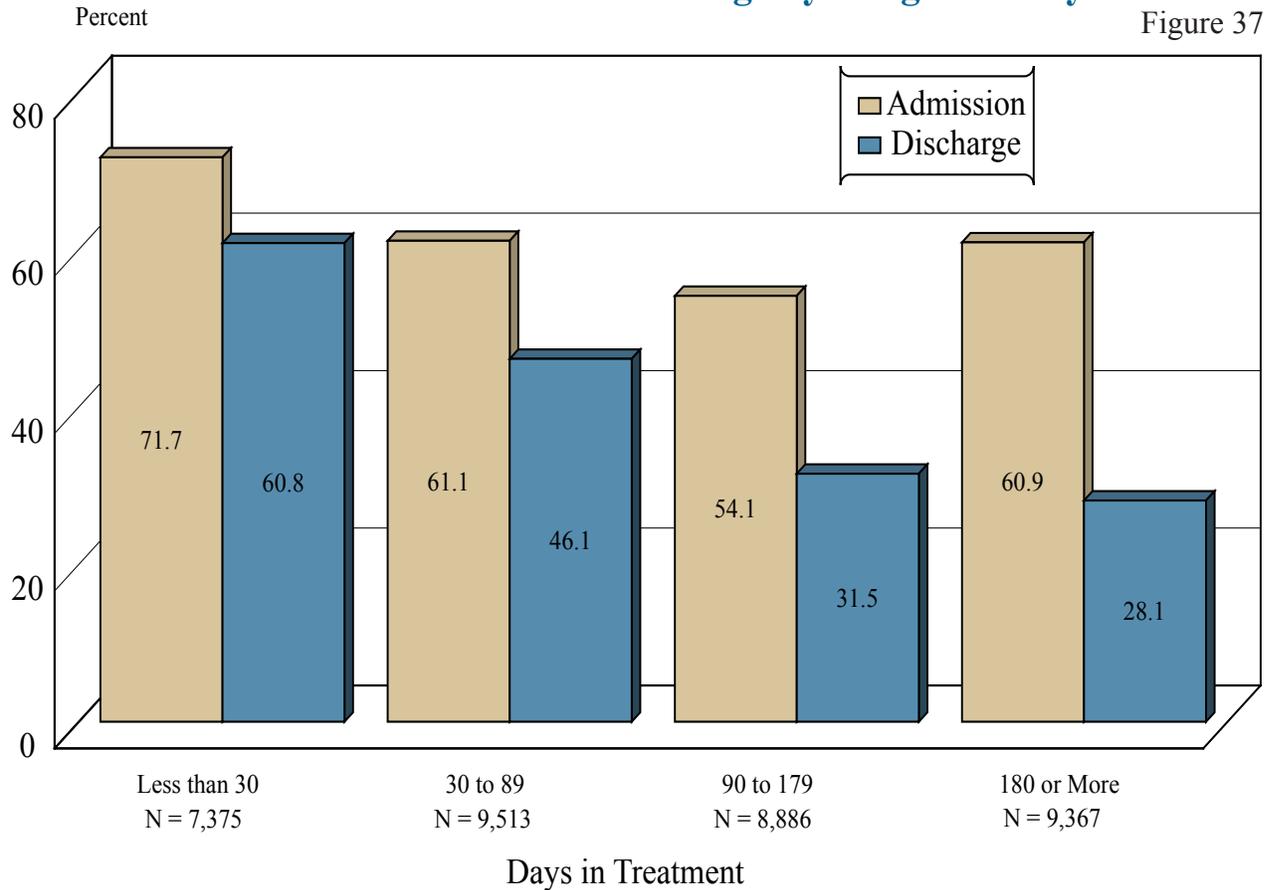


Figure 36

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



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

Further analysis illustrated in Figure 37 revealed that for most levels of care, the longer the patients spent in treatment, the greater the reduction in percentage using substances. Among funded patients who spent less than 30 days in treatment, substance users decreased by 15 percent; staying up to 89 days produced a 24 percent reduction; 90 to 179 days yielded a 42 percent reduction; and remaining in treatment at least 180 days was associated with a 54 percent drop in the percentage of discharged patients using substances.

Among discharges not receiving opioid replacement therapy, the median LOS in treatment was longest (117 days) among discharges who completed outpatient treatment. This was followed by 90 days among discharges completing long-term residential treatment, intensive outpatient treatment (59 days), short-term residential treatment (25 days), hospital residential treatment (19 days), and detoxification (4 days) [www.dasis.samhsa.gov/teds05/TEDSD2k5Hi.htm].

Treatment Increases Employment

Figure 38

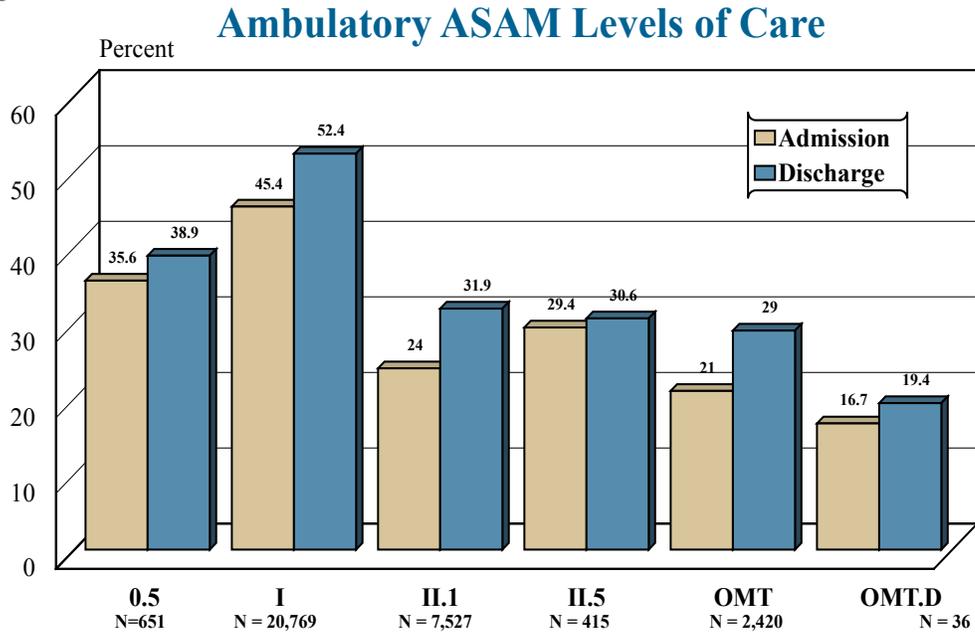
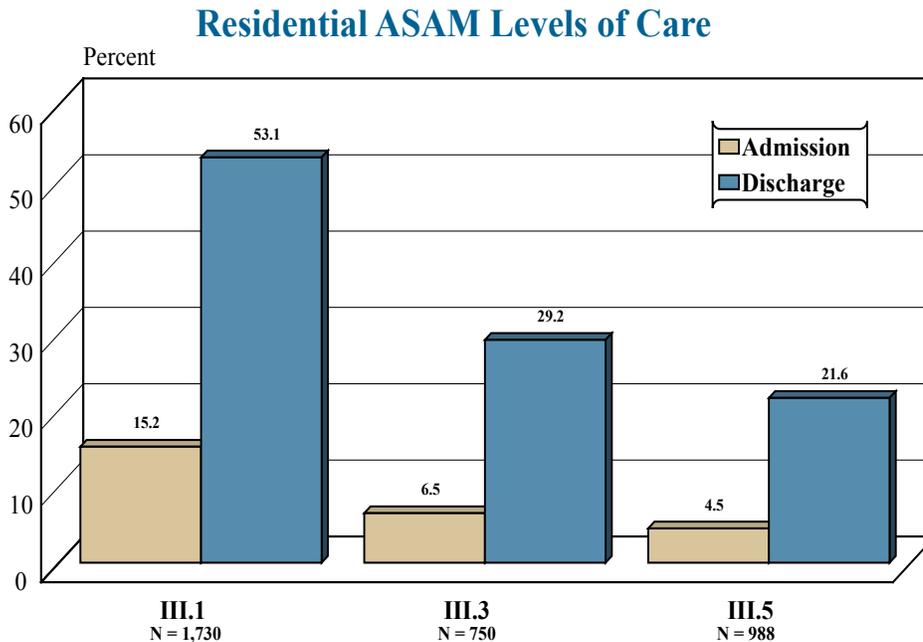
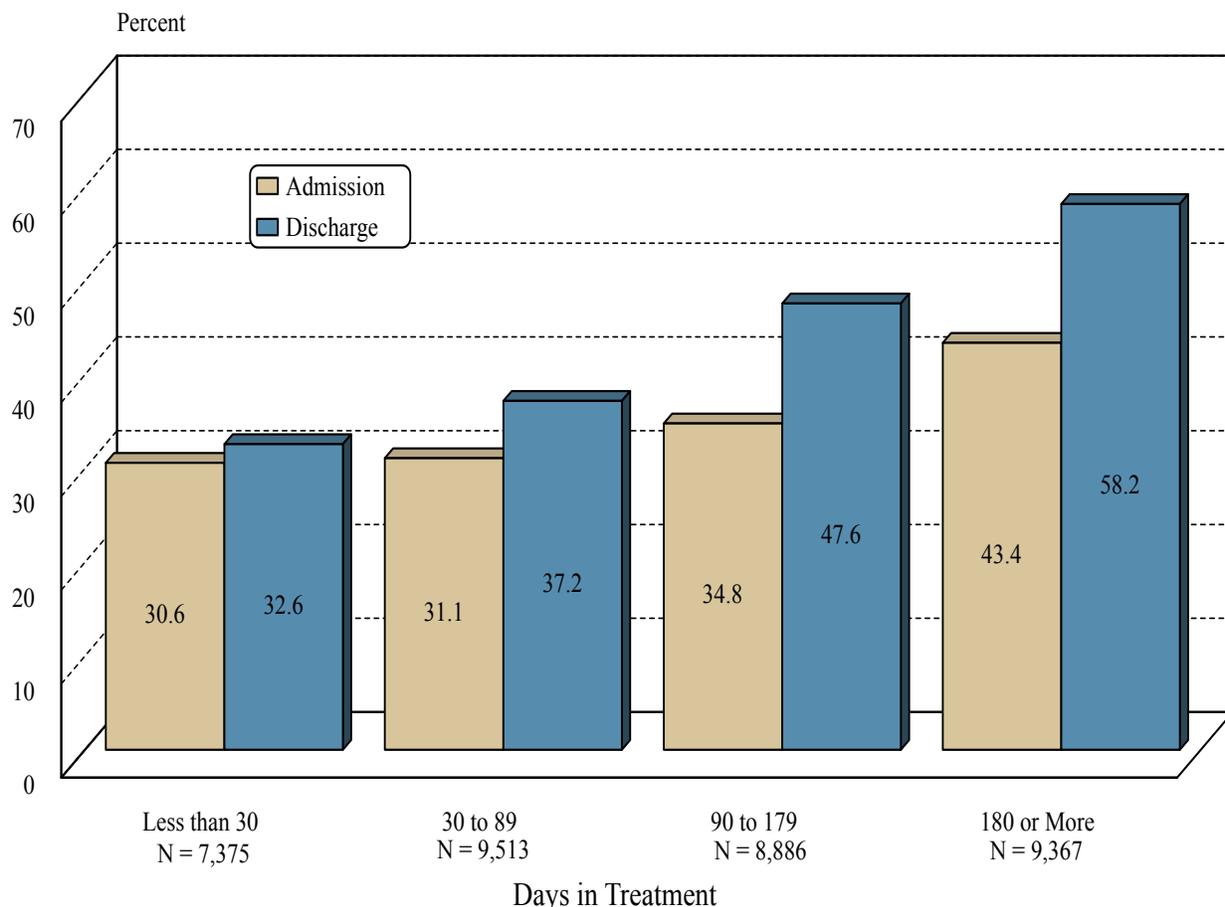


Figure 39



Halfway houses (Level III.1) were particularly effective in getting patients employed, as shown in Figures 38 and 39. The percentage employed more than tripled during funded halfway house and long-term residential treatment and increased nearly five-fold in III.5. 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 15 percent from an already relatively high 45 percent; in Level II.1 the increase was 30 percent. Employment increased by 38 percent in funded OMT treatment, up from 13 percent in FY 2006.

Percent of Patients Employed at Admission and at Discharge by Length of Stay



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

Length of stay in treatment was associated with both employment at admission and becoming employed during treatment, as shown in Figure 40. Employed patients stay in treatment longer, and unemployed patients are more likely to become employed when they stay in treatment at least 90 days. In 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 20 percent increase and patients staying 90 to 179 days had a 36 percent increase. Staying in treatment 180 days or longer was associated with a slightly lower 34 percent reduction. Given the strong relationship between length of stay and treatment completion, it is not surprising that the same holds for 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

Figures 41 and 42 show that the percentage of homeless patients at admission was reduced in various levels of care. Homelessness decreased by 73 percent in Level I, 66 percent in Level II, 63 percent in Level III.1, by two-thirds in III.3, 26 percent in III.5 and 56 percent in III.7. Treatment was also associated with patients moving from dependent to independent living status

Figure 41

Percentages Homeless at Admission and at Discharge

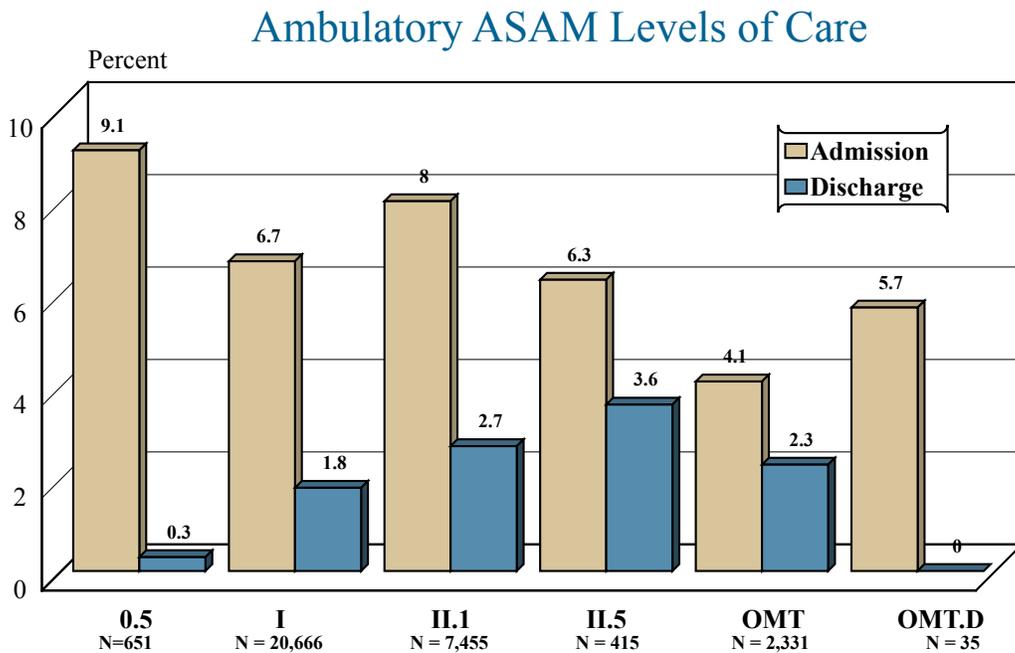
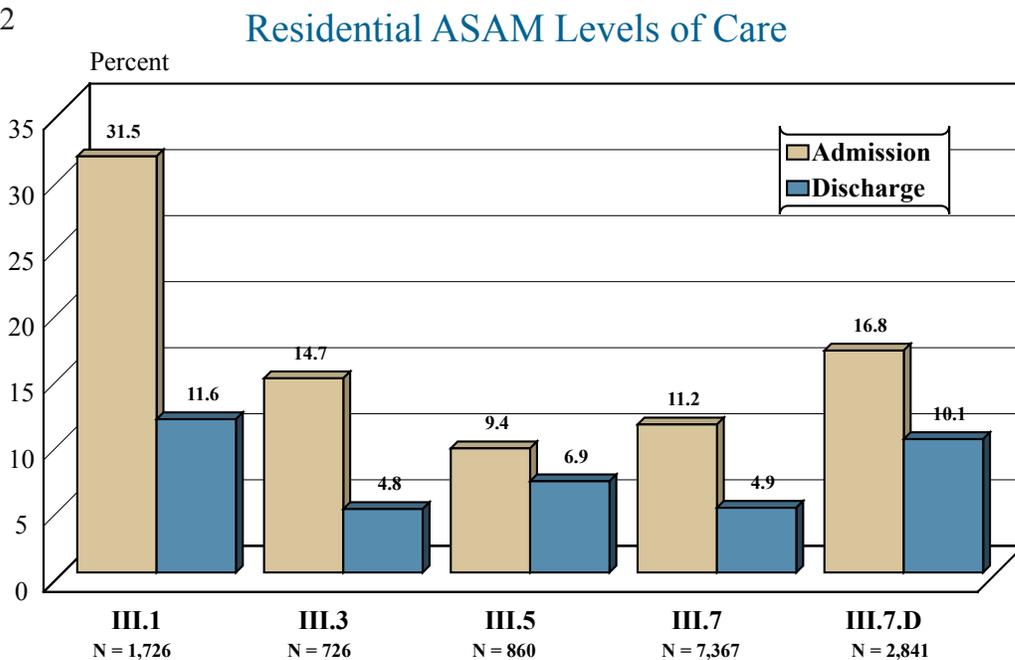


Figure 42



Treatment Reduces Crime

Patients were substantially less likely to be arrested during the 30 days before discharge than the 30 days before admission in every level of care except OMT, as shown in Figures 43 and 44. The highest entry arrest percentage among patients was in residential Level III.5, related to frequency of court committed referrals to therapeutic community treatment, and reductions during treatment were dramatic. The 11 percent arrested in the month before discharge from OMT were predominantly drop-outs.

Percentages Arrested in the 30 Days Preceding Admission and Discharge

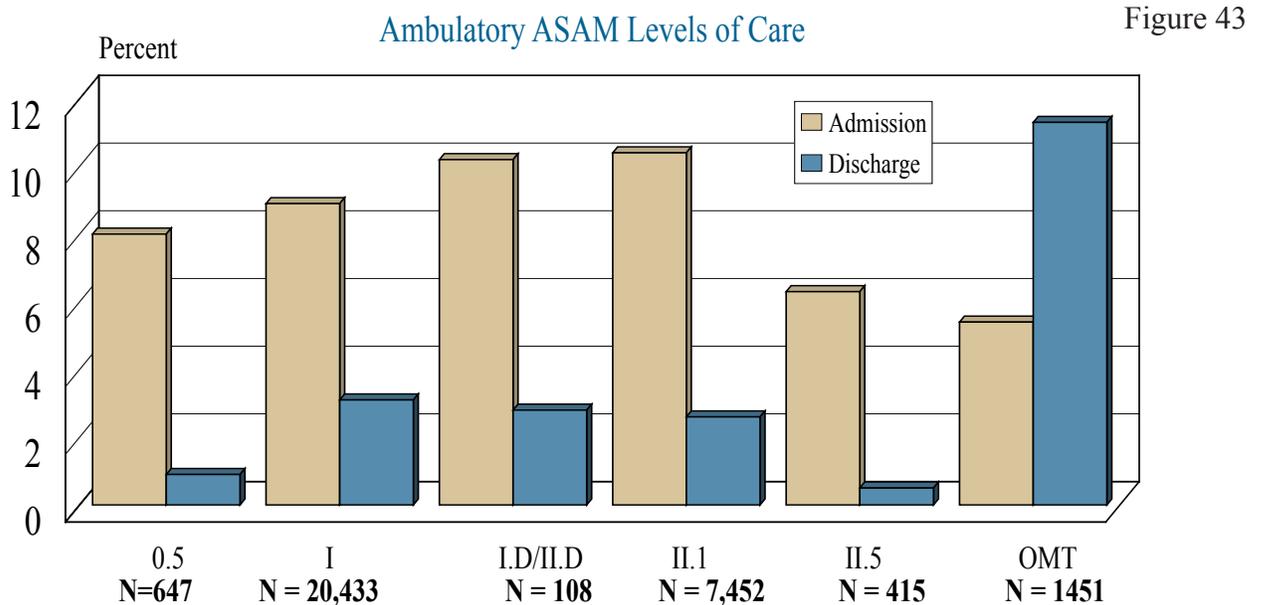
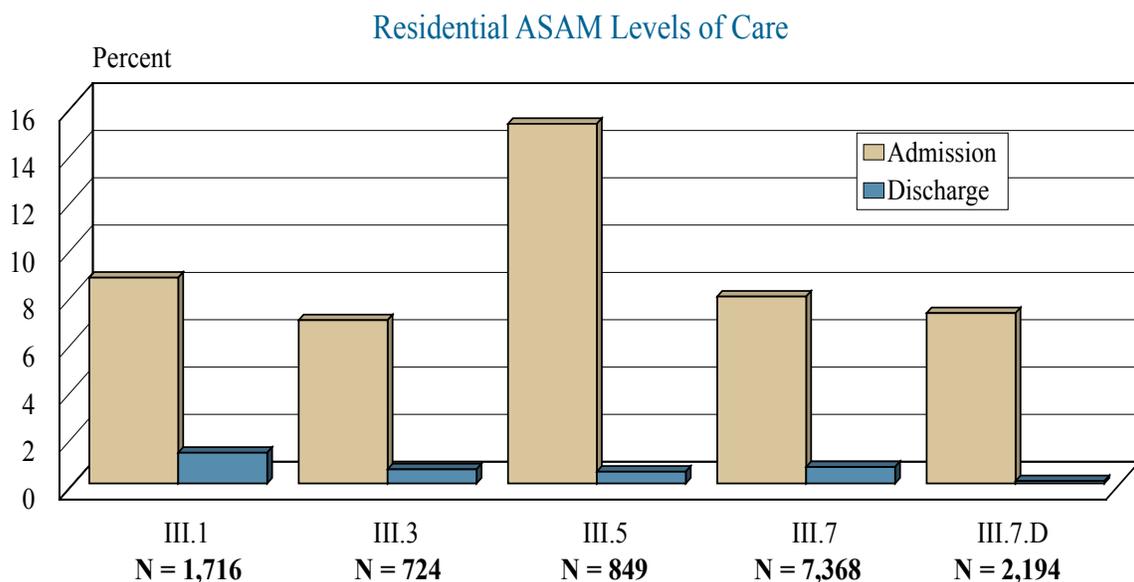
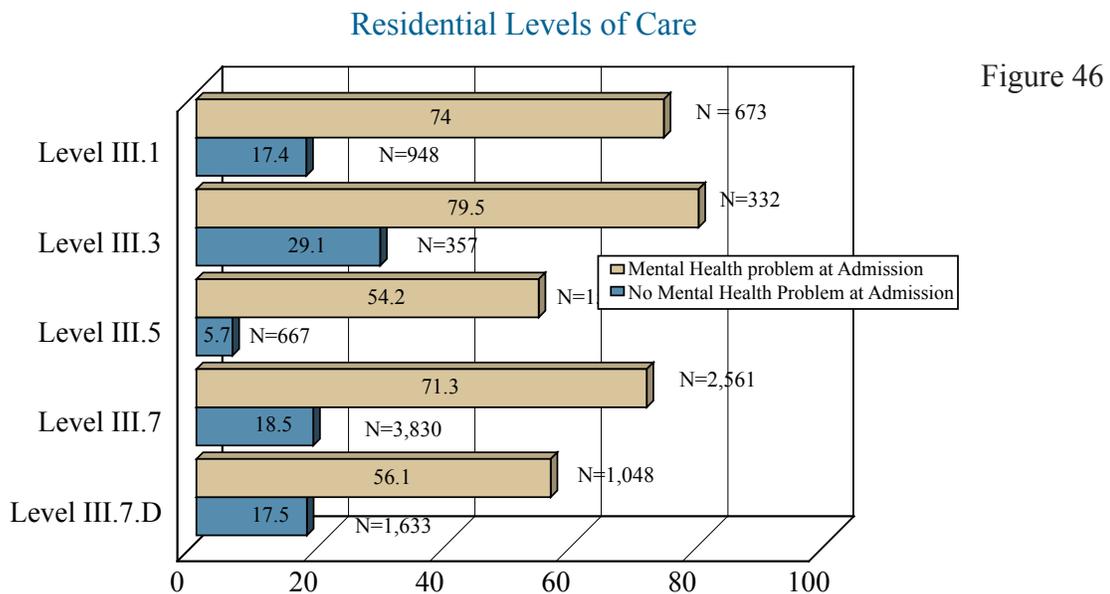
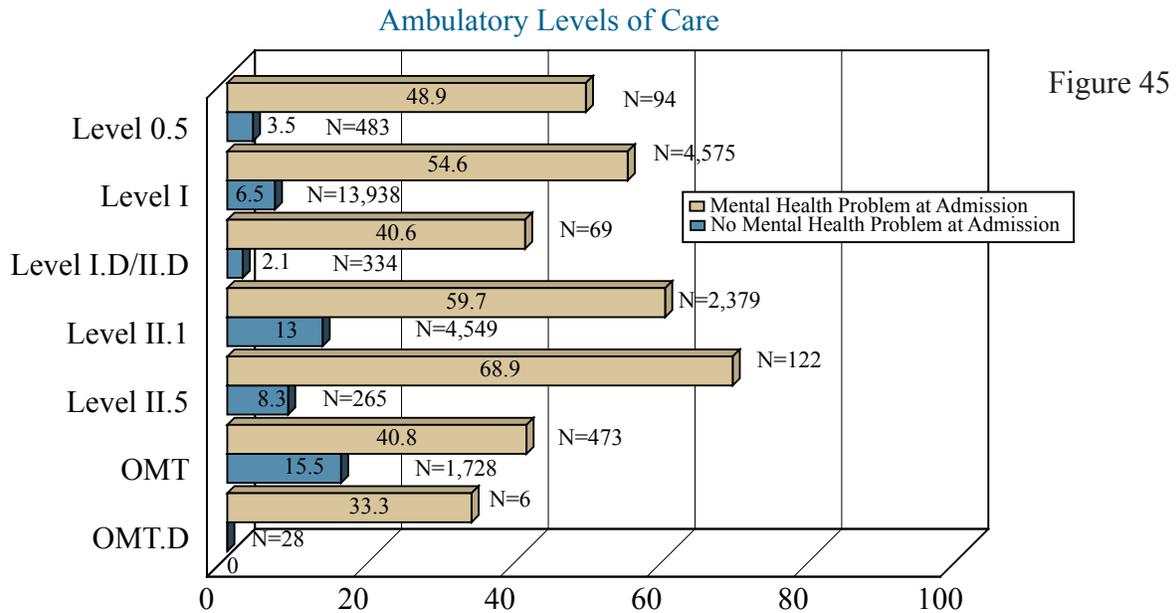


Figure 44



Percentages of Patients with and without Mental Health Problems at Admission Who Received Mental Health Treatment



As shown in Figures 45 and 46, two-thirds or more of patients assessed as having mental health problems at admission to Levels II.5, III.1, III.3 and III.7 received mental health treatment during their substance abuse treatment episodes. Levels III.3 and 5 also had the highest percentages of patients who received mental health treatment despite not having been assessed with mental health problems at admission. About 55 percent of Level I, 60 percent of II.1 and 41 percent of OMT patients with problems received treatment. 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.

APPENDIX

**Table A: Admissions to
Treatment Programs by Substance Mentions
FY 2003 - FY 2007**

Substance Mentions	FY 2003		FY 2004		FY 2005		FY 2006		FY 2007	
	#	%	#	%	#	%	#	%	#	%
Alcohol	20504	60.3	25041	58.2	27986	59.9	27963	59.7	27674	59.4
Crack	7896	23.2	12326	28.6	12997	27.8	13747	29.3	13816	29.7
Other Cocaine	6835	20.1	7382	17.2	7589	16.3	7834	16.7	7394	15.9
Marijuana/Hashish	13077	38.5	15440	35.9	17350	37.2	17966	38.3	17503	37.6
Heroin	11162	32.8	16136	37.5	15803	33.8	15714	33.5	13652	29.3
Non-Rx Methadone	103	0.3	228	0.5	315	0.7	380	0.8	450	1.0
Oxycodone	—	—	—	—	—	—	1996	4.3	2278	4.9
Other Opiates	1115	3.3	2005	4.7	2680	5.7	1071	2.3	1297	2.8
PCP	490	1.4	551	1.3	483	1.0	779	1.7	770	1.7
Hallucinogens	458	1.3	493	1.1	491	1.1	341	0.7	302	0.6
Methamphetamines	136	0.4	175	0.4	183	0.4	129	0.3	156	0.3
Other Amphetamines	144	0.4	140	0.3	176	0.4	468	1.0	462	1.0
Stimulants	35	0.1	254	0.6	176	0.4	33	0.1	47	0.1
Benzodiazepines	300	0.9	567	1.3	576	1.2	1160	2.5	1151	2.5
Other Tranquilizers	30	0.1	25	0.1	40	0.1	10	0.0	22	0.0
Barbiturates	77	0.2	106	0.2	115	0.2	67	0.1	48	0.1
Other Sedatives or Hypnotics	202	0.6	307	0.7	393	0.8	116	0.2	99	0.2
Inhalants	66	0.2	70	0.2	63	0.1	60	0.1	35	0.1
Over the Counter	25	0.1	60	0.1	66	0.1	81	0.2	97	0.2
Other	90	0.3	114	0.3	317	0.7	378	0.8	272	0.6
Total Respondents	34001	—	43023	—	46692	—	46870	—	46559	—

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

**Table B: Alcohol Related Admissions to
Treatment Programs by Residence
FY 2003 - FY 2007**

Location of Provider	2003	2004	2005	2006	2007
Allegany	554	545	661	613	661
Anne Arundel	1030	1157	2623	2874	2889
Baltimore City	5181	6236	5930	5868	5317
Baltimore County	1936	2497	2659	2773	2453
Calvert	663	907	846	973	1084
Caroline	363	390	375	329	299
Carroll	606	643	689	637	634
Cecil	824	673	700	600	639
Charles	1085	1017	1001	1154	1216
Dorchester	446	384	353	344	335
Frederick	861	791	721	777	926
Garrett	275	283	285	311	274
Harford	703	667	755	708	497
Howard	469	512	528	485	469
Kent	276	320	321	311	339
Montgomery	2267	2145	2534	2031	2373
Prince George's	1479	1536	2004	1897	1768
Queen Anne's	349	350	441	454	479
St. Mary's	779	807	661	810	652
Somerset	308	302	324	378	291
Talbot	400	366	377	296	370
Washington	898	833	879	962	1020
Wicomico	1002	879	1074	864	927
Worcester	684	712	746	722	733
Statewide Contract	481	493	567	754	761
Total	23919	25445	28054	27925	27406

**Table C: Marijuana Related Admissions
to Treatment Programs by Residence
FY 2003 - FY 2007**

Location of Residence	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Allegany	398	404	469	436	485
Anne Arundel	621	718	1478	1587	1581
Baltimore City	3056	3282	3287	3384	3302
Baltimore County	1346	1524	1672	1857	1543
Calvert	413	594	556	647	723
Caroline	277	282	245	241	210
Carroll	471	506	493	421	454
Cecil	496	432	393	374	361
Charles	628	567	601	657	675
Dorchester	348	399	307	318	283
Frederick	566	515	461	537	593
Garrett	148	164	150	179	168
Harford	516	485	549	481	402
Howard	327	341	358	315	335
Kent	191	227	222	187	222
Montgomery	1261	1157	1279	1189	1310
Prince George's	975	1098	1279	1437	1340
Queen Anne's	229	256	279	295	295
St. Mary's	420	465	411	453	314
Somerset	218	189	228	248	220
Talbot	265	251	240	194	241
Washington	614	542	611	684	717
Wicomico	677	656	812	712	595
Worcester	400	382	426	440	432
Out-of-State	372	289	344	494	554
Total	15233	15725	17150	17767	17355

**Table D: Heroin Related Admissions
to Treatment Programs by Residence
FY 2003 - FY 2007**

Location of Residence	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Allegany	83	106	144	96	102
Anne Arundel	737	728	948	893	967
Baltimore City	10162	11939	10989	10964	8927
Baltimore County	1121	1420	1486	1360	1103
Calvert	43	54	80	85	91
Caroline	21	38	28	48	22
Carroll	271	227	319	295	237
Cecil	213	265	278	179	192
Charles	43	57	62	83	63
Dorchester	24	20	16	21	13
Frederick	160	132	146	148	179
Garrett	5	19	21	28	28
Harford	224	190	234	220	155
Howard	151	149	153	153	171
Kent	20	52	34	25	32
Montgomery	351	358	376	243	337
Prince George's	365	232	292	285	238
Queen Anne's	96	92	75	55	73
St. Mary's	51	65	50	49	48
Somerset	74	49	47	54	53
Talbot	46	49	58	35	40
Washington	83	122	102	130	126
Wicomico	174	174	209	144	146
Worcester	81	95	85	77	70
Out-of-State	128	171	159	192	224
Total	14727	16803	15795	15862	13637

**Table E: Other Opiates Related Admissions
to Treatment Programs by Residence
FY 2003 - FY 2007**

Location of Residence	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Allegany	64	81	144	127	203
Anne Arundel	176	281	460	466	521
Baltimore City	221	374	478	617	517
Baltimore County	178	302	430	487	486
Calvert	50	83	98	131	222
Caroline	12	32	19	29	34
Carroll	58	62	106	114	123
Cecil	85	109	126	109	151
Charles	60	69	91	104	106
Dorchester	6	15	13	17	26
Frederick	71	60	59	98	97
Garrett	20	19	27	43	48
Harford	45	57	96	104	105
Howard	30	36	51	63	72
Kent	29	40	50	54	74
Montgomery	107	152	176	182	220
Prince George's	67	67	81	75	98
Queen Anne's	44	49	50	41	60
St. Mary's	65	72	82	87	136
Somerset	9	15	18	24	33
Talbot	22	34	26	17	33
Washington	46	50	79	102	108
Wicomico	32	79	94	69	81
Worcester	36	46	50	56	38
Out-of-State	34	35	74	83	116
Total	1567	2219	2978	3299	3708

**Table F: Crack Related Admissions to
Treatment Programs by Residence
FY 2003 - FY 2007**

Location of Residence	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Allegany	67	76	107	120	162
Anne Arundel	383	479	772	810	918
Baltimore City	4572	5772	5580	5915	5507
Baltimore County	556	761	921	1024	878
Calvert	125	245	274	316	332
Caroline	54	88	80	82	68
Carroll	133	156	171	214	240
Cecil	144	178	195	199	233
Charles	215	276	313	340	321
Dorchester	139	182	169	156	143
Frederick	216	264	268	312	404
Garrett	18	24	28	32	48
Harford	104	115	156	187	157
Howard	101	145	146	181	183
Kent	102	137	106	99	135
Montgomery	753	1081	1208	958	1169
Prince George's	649	930	954	972	981
Queen Anne's	61	87	122	103	122
St. Mary's	189	262	222	255	262
Somerset	80	105	110	133	116
Talbot	117	101	94	85	83
Washington	265	245	241	344	320
Wicomico	339	398	506	411	414
Worcester	198	161	189	223	199
Out-of-State	159	248	228	273	367
Total	9739	12516	12996	13744	13762

**Table G: Other Cocaine Related Admissions to
Treatment Programs by Residence
FY 2003 - FY 2007**

Location of Residence	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Allegany	59	69	114	86	99
Anne Arundel	325	319	551	543	555
Baltimore City	3616	3833	3574	3363	2823
Baltimore County	595	770	873	802	662
Calvert	134	158	149	208	227
Caroline	87	88	64	93	63
Carroll	206	146	212	213	157
Cecil	207	170	171	108	167
Charles	162	127	125	153	135
Dorchester	151	100	74	83	67
Frederick	207	145	124	157	198
Garrett	34	36	28	29	43
Harford	150	132	161	166	117
Howard	111	70	91	112	119
Kent	28	45	47	56	77
Montgomery	497	332	327	310	410
Prince George's	395	173	193	249	192
Queen Anne's	91	80	96	86	102
St. Mary's	169	137	122	177	155
Somerset	90	69	93	88	98
Talbot	82	74	82	63	84
Washington	155	108	138	141	201
Wicomico	352	248	249	264	249
Worcester	140	138	148	152	162
Out-of-State	127	109	104	126	167
Total	8170	7676	7910	7828	7329

**Table H: Adolescent Admissions to
Treatment Programs by Residence
FY 2003 - FY 2007**

Location of Residence	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Allegany	206	191	213	200	181
Anne Arundel	337	341	318	316	317
Baltimore City	826	680	882	768	844
Baltimore County	635	659	579	573	505
Calvert	111	169	120	129	157
Caroline	79	111	99	98	82
Carroll	169	158	155	148	168
Cecil	171	150	164	139	91
Charles	187	119	151	111	159
Dorchester	96	83	68	87	74
Frederick	211	171	227	231	212
Garrett	49	69	77	82	80
Harford	262	235	226	186	165
Howard	130	154	135	109	122
Kent	62	67	58	47	62
Montgomery	294	112	196	160	133
Prince George's	165	175	259	362	278
Queen Anne's	82	68	65	73	101
St. Mary's	182	212	236	198	117
Somerset	47	44	92	80	90
Talbot	99	106	103	80	87
Washington	159	154	164	158	154
Wicomico	85	57	102	81	76
Worcester	100	113	120	134	113
Out-of-State	110	42	104	109	144
Total	4854	4440	4913	4659	4512

SUBSTANCE ABUSE TREATMENT OUTCOME MEASUREMENT TABLES

**Table I: Substance Use at Admission and Discharge by Jurisdiction
FY 2007**

Subdivision	Discharges	Use at Admission		Use at Discharge		Percentage Change
		N	%	N	%	
Allegany	1486	989	66.6	227	15.3	-77.0
Anne Arundel	4004	3058	76.4	1970	49.2	-35.6
Baltimore City	13962	10146	72.7	6876	49.2	-32.2
Baltimore County	3985	2944	73.9	1408	35.3	-52.2
Calvert	1617	1167	72.2	499	30.9	-57.2
Caroline	318	238	74.8	112	35.2	-52.9
Carroll	1254	781	62.3	294	23.4	-62.4
Cecil	678	420	61.9	193	28.5	-54.0
Charles	1300	724	55.7	288	22.2	-60.2
Dorchester	424	334	78.8	190	44.8	-43.1
Frederick	2070	1485	71.7	340	16.4	-77.1
Garrett	352	195	55.4	96	27.3	-50.8
Harford	760	475	62.5	274	36.1	-42.3
Howard	468	343	73.3	183	39.1	-46.6
Kent	873	724	82.9	187	21.4	-74.2
Montgomery	3379	2319	68.6	880	26.0	-62.1
Prince George's	1879	1080	57.5	810	43.1	-25.0
Queen Anne's	369	269	72.9	146	39.6	-45.7
St. Mary's	1193	742	62.2	245	20.5	-67.0
Somerset	408	268	65.7	117	28.7	-56.3
Talbot	361	248	68.7	125	34.6	-49.6
Washington	1314	477	36.3	185	14.1	-61.2
Wicomico	810	413	51.0	260	32.1	-37.0
Worcester	1627	1166	71.7	570	35.0	-51.1
Statewide	1399	1061	75.8	752	53.8	-29.1
Total	46290	32066	69.3	17227	37.2	-46.3

**Table J: Employment Status at Admission and Discharge by Jurisdiction
FY 2007**

Subdivision	Discharges	Employed at Admission		Employed at Discharge		Percentage Change
		N	%	N	%	
Allegany	1486	273	18.4	330	22.2	20.9
Anne Arundel	4004	2250	56.2	2522	63.0	12.1
Baltimore City	13962	2091	15.0	3246	23.2	55.2
Baltimore County	3985	1879	47.2	2105	52.8	12.0
Calvert	1617	773	47.8	869	53.7	12.4
Caroline	318	150	47.2	180	56.6	20.0
Carroll	1254	412	32.9	447	35.6	8.5
Cecil	678	283	41.7	306	45.1	8.1
Charles	1300	577	44.4	740	56.9	28.2
Dorchester	424	118	27.8	121	28.5	2.5
Frederick	2070	610	29.5	747	36.1	22.5
Garrett	352	108	30.7	126	35.8	16.7
Harford	760	351	46.2	401	52.8	14.2
Howard	468	155	33.1	235	50.2	51.6
Kent	873	281	32.2	302	34.6	7.5
Montgomery	3379	946	28.0	1057	31.3	11.7
Prince George's	1879	499	26.6	643	34.2	28.9
Queen Anne's	369	204	55.3	225	61.0	10.3
St. Mary's	1193	445	37.3	504	42.2	13.3
Somerset	408	140	34.3	170	41.7	21.4
Talbot	361	168	46.5	188	52.1	11.9
Washington	1314	393	29.9	571	43.5	45.3
Wicomico	810	364	44.9	434	53.6	19.2
Worcester	1627	513	31.5	618	38.0	20.5
Statewide	1399	208	14.9	326	23.3	56.7
Total	46290	14191	30.7	17413	37.6	22.7

**Table K: Arrest In the Thirty Days Prior to Admission and
Prior to Discharge Treatment by Jurisdiction
FY 2007**

Subdivision	Discharges	Arrests 30 days prior to Admission		Arrest 30 days Prior to Discharge		Percentage Change
		N	%	N	%	
Allegany	1482	183	12.3	43	2.9	-76.5
Anne Arundel	3889	428	11.0	66	1.7	-84.6
Baltimore City	11862	889	7.5	340	2.9	-61.8
Baltimore County	3905	303	7.8	34	0.9	-88.8
Calvert	1600	270	16.9	59	3.7	-78.1
Caroline	317	22	6.9	6	1.9	-72.7
Carroll	1190	108	9.1	33	2.8	-69.4
Cecil	678	69	10.2	22	3.2	-68.1
Charles	1298	136	10.5	34	2.6	-75.0
Dorchester	422	68	16.1	25	5.9	-63.2
Frederick	1967	203	10.3	75	3.8	-63.1
Garrett	343	42	12.2	7	2.0	-83.3
Harford	755	63	8.3	29	3.8	-54.0
Howard	454	27	5.9	14	3.1	-48.1
Kent	865	92	10.6	22	2.5	-76.1
Montgomery	3325	349	10.5	26	0.8	-92.6
Prince George's	1864	122	6.5	35	1.9	-71.3
Queen Anne's	366	20	5.5	19	5.2	-5.0
St. Mary's	1191	91	7.6	20	1.7	-78.0
Somerset	406	54	13.3	46	11.3	-14.8
Talbot	361	65	18.0	17	4.7	-73.8
Washington	1310	81	6.2	40	3.1	-50.6
Wicomico	788	36	4.6	45	5.7	25.0
Worcester	1603	86	5.4	37	2.3	-57.0
Statewide	1397	99	7.1	4	0.3	-96.0
Total	43638	3906	9.0	1098	2.5	-71.9

**Table L: Level I (Outpatient Treatment)
Retention Rates by Jurisdiction
FY 2007**

Subdivision	Discharges	Less than 90 Days	90 Days or More	Percentage Retained 90 Days or More
Allegany	488	171	317	65.0
Anne Arundel	2007	801	1206	60.1
Baltimore City	3900	1861	2039	52.3
Baltimore County	1754	756	998	56.9
Calvert	893	423	470	52.6
Caroline	314	105	209	66.6
Carroll	576	175	401	69.6
Cecil	533	156	377	70.7
Charles	874	252	622	71.2
Dorchester	179	68	111	62.0
Frederick	482	217	265	55.0
Garrett	264	161	103	39.0
Harford	582	218	364	62.5
Howard	239	97	142	59.4
Kent	396	200	196	49.5
Montgomery	992	353	639	64.4
Prince George's	1006	465	541	53.8
Queen Anne's	343	142	201	58.6
St. Mary's	344	78	266	77.3
Somerset	281	92	189	67.3
Talbot	312	124	188	60.3
Washington	661	173	488	73.8
Wicomico	502	215	287	57.2
Worcester	612	270	342	55.9
Statewide	113	54	59	52.2
Total	18647	7627	11020	59.1

**Table M: Level III.1 (Halfway House)
Retention Rates by Jurisdiction
FY 2007**

Subdivision	Discharges	Less than 90 Days	90 Days or More	Percentage Retained 90 Days or More
Allegany	30	7	23	76.7
Anne Arundel	155	92	63	40.6
Baltimore City	584	247	337	57.7
Cecil	10	1	9	90.0
Frederick	112	62	50	44.6
Harford	26	9	17	65.4
Howard	26	17	9	34.6
Montgomery	77	39	38	49.4
Prince George's	34	16	18	52.9
St. Mary's	70	20	50	71.4
Washington	138	44	94	68.1
Wicomico	17	8	9	52.9
Worcester	5	2	3	60.0
Total	1284	564	720	56.1

**Table N: Subsequent Admission to Another Treatment Level
Completion/Transfer/Referral Discharges
from Level II.1 (IOP) by Jurisdiction
FY 2007**

Subdivision	Unduplicated Level II.1 Completion/Referrals	Subsequent Admission Level of Care					
		Level I		Other		Total	
		#	%	#	%	#	%
Allegany	177	44	24.9	8	4.5	52	29.4
Anne Arundel	489	92	18.8	15	3.1	107	21.9
Baltimore City	1272	593	46.6	114	9.0	707	55.6
Baltimore Co.	565	97	17.2	5	0.9	102	18.1
Calvert	73	56	76.7	3	4.1	59	80.8
Carroll	89	7	7.9	11	12.4	18	20.2
Charles	97	41	42.3	10	10.3	51	52.6
Dorchester	51	1	2.0	0	0.0	1	2.0
Frederick	135	15	11.1	19	14.1	34	25.2
Garrett	7	5	71.4	0	0.0	5	71.4
Harford	5	1	20.0	2	40.0	3	60.0
Howard	51	21	41.2	0	0.0	21	41.2
Montgomery	139	26	18.7	6	4.3	32	23.0
Prince George's	91	60	65.9	2	2.2	62	68.1
St. Mary's	40	7	17.5	3	7.5	10	25.0
Somerset	19	14	73.7	0	0.0	14	73.7
Washington	170	112	65.9	27	15.9	139	81.8
Wicomico	94	62	66.0	2	2.1	64	68.1
Worcester	297	56	18.9	3	1.0	59	19.9
Total	3861	1310	33.9	230	6.0	1540	39.9

**Table O: Subsequent Admission to Another Treatment Level
Completion/Transfer/Referral Discharges
from Level III.7D (ICF Detox) by Jurisdiction
FY 2007**

Subdivision	Unduplicated Level III.7.D Completion/Referrals	Subsequent Admission Level of Care					
		Level III.7		Other		Total	
		#	%	#	%	#	%
Anne Arundel	21	1	4.8	6	28.6	7	33.3
Baltimore City	776	261	33.6	111	14.3	372	47.9
Baltimore Co.	221	150	67.9	32	14.5	182	82.4
Carroll	85	82	96.5	1	1.2	83	97.6
Frederick	38	2	5.3	1	2.6	3	7.9
Kent	168	155	92.3	2	1.2	157	93.5
Montgomery	659	576	87.4	8	1.2	584	88.6
St. Mary's	46	29	63.0	3	6.5	32	69.6
Worcester	101	42	41.6	27	26.7	69	68.3
Statewide	209	189	90.4	4	1.9	193	92.3
Total	2324	1487	64.0	195	8.4	1682	72.4

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	Day treatment programs
III.1	Clinically Managed Low-Intensity Residential Treatment	Residential care and at least 4 hours a week of treatment	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
COMAR	Code of Maryland Regulations
CSAP	Center For Substance Abuse Prevention
CSAT	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
IGSR	University of Maryland Institute of Governmental Service and Research
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
SMART	State of Maryland Automated Record Tracking
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



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