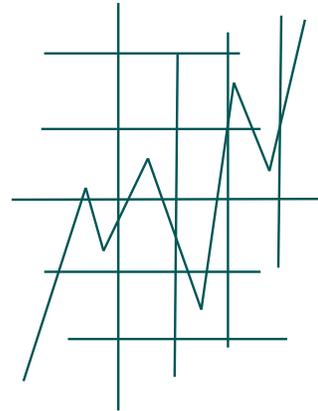


Outlook & Outcomes

At a Glance 2008



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
Thomas P. Cargiulo, Pharm.D., Director

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

OUTLOOK AND OUTCOMES

At a Glance

Fiscal Year 2008

Martin O'Malley, Governor
Anthony G. Brown, Lt. Governor
John M. Colmers, Secretary, DHMH
Renata Henry, Deputy Secretary, DHMH
Thomas Paul Cargiulo, Pharm. D., Director



The services and facilities of the Maryland State Department of Health and Mental Hygiene (DHMH) are operated on a non-discriminatory basis. This policy prohibits discrimination on the 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 at a Glance is a publication of the Maryland Alcohol and Drug Abuse Administration (ADAA). It presents data from the State of Maryland Automated Record Tracking (SMART) system 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 receiving public funds 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 at a Glance* reflect a brief look at the status of substance treatment, intervention, and prevention programs in Maryland, the services they deliver and the populations 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 which is more fully represented on the ADAA website, <http://maryland-adaa.org>. 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 2008*

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THE OUTLOOK

Gambling and Maryland



During the 2007 special session of the Maryland General Assembly, Senate Bill 3, entitled Maryland Education Trust Fund – Video Lottery Terminals, was enacted

relating to the legalization of video lottery terminals. This legislation was contingent on passage of a constitutional amendment to authorize video lottery gaming in Maryland. The amendment to Senate Bill 3 was ratified by the voters of Maryland at the general election on November 4, 2008. The resulting legislation was added to the Annotated Code of Maryland (Health-General Article § 19-804). The legislation requires the Department of Health and Mental Hygiene (DHMH) to conduct a prevalence study and replication prevalence studies to measure the rate of problem and pathological gambling in the State. Replication prevalence studies shall be conducted no less than every 5 years with measures taken to permit comparisons between the initial prevalence study and subsequent replication prevalence studies.

The DHMH, through the Alcohol and Drug Abuse Administration, has solicited proposals from qualified applicants to implement a comprehensive research project that addresses the issues identified in the regulation, including the impact and prevalence of problem gambling, consistent with the comparable efforts of other states. The Statewide Problem Gambling Prevalence Study will examine the baseline prevalence of problem and pathological gambling in Maryland as it relates to socio-demographic factors, gambling frequency, preferred gambling venues, amounts of money gambled and lost or won, debt accumulated, co-morbid mental health and addiction problems, as well as employment, financial and interpersonal problems. The study will generate information on attitudes, perceptions, and benefits of gambling. It will ascertain the public's knowledge of the availability of

treatment for problem and pathological gambling in Maryland and perceived barriers to treatment. Finally, the study will yield an estimate of the number of individuals in need of treatment for problem gambling.

Senate Bill 3 also requires DHMH to provide prevention and treatment services for problem and pathological gamblers. DHMH is currently in the planning phase of developing a network of services that ensure adequate access to treatment for pathological gambling. It is expected that treatment will be offered by substance abuse and mental health programs across Maryland. DHMH is dedicated to providing competent, quality services for problem and pathological gamblers in the State of Maryland.

Recovery Oriented Systems of Care (ROSC)

Maryland's Alcohol and Drug Abuse Administration (ADAA) is beginning the process of transforming the current system of addiction service delivery into a *recovery oriented system of care*. This model of service provision focuses on the development of a network of formal and informal services designed to sustain long term recovery for individuals and families impacted by severe substance use disorders.

In a recovery oriented system of care, more emphasis is placed on attracting and retaining patients in services so that earlier intervention in the disease process can mediate the severity of complications. The focus of treatment shifts from recovery initiation to support for long-term recovery through strategies such as providing continuing care recovery monitoring, assertively linking patients with services in the community, and lowering the threshold for re-engagement with treatment services when necessary. New types of services and roles, such as recovery

coaches and recovery community centers, are evolving that serve to embed recovery in the community and support the patient and family over the long term.

Maryland's plan to develop a recovery oriented system of care includes formation of a steering committee to guide the process of change, which will include engagement of stakeholder groups in the implementation process, providing training and technology transfer, defining standards for recovery oriented services, changing funding priorities, and measuring recovery outcomes of patients and their families.

Medical Assistance/Primary Adult Care Expansion

With economic problems curtailing grant funding, we are challenged by how to expand access to treatment services for substance use disorders. During the 2009 legislative session, legislation passed that required the transfer of funds from the Alcohol and Drug Abuse Administration to the Maryland Medical Assistance Program for the purpose of expanding and enhancing the substance abuse treatment benefit package. Currently, the only substance abuse benefit under the Primary Adult Care (PAC) program is coverage of Suboxone medication. Beginning January 1, 2010, the Primary Adult Care program will cover most of the substance abuse treatment services available under Medical Assistance. Additionally, the reimbursement rate for Medical Assistance (MA) services will increase.

The impact on the grant-funded substance abuse treatment system could be substantial both in terms of numbers of new patients seen and in adapting business practices. To make this effort a success, treatment programs will have to develop methods for managing a hybrid business – one that relies on fee-for-service collections through MA/PAC as well as grant funds. The business approach to these disparate funding sources emphasizes different elements. In

a grant-funded system, grant funds are received prior to the delivery of services and are not immediately and directly contingent on the program's ability to engage and maintain patients. Staffing is determined by caseload requirements and slots, and billing processes are not a main concern. In a fee for service arrangement, staffing is determined by collections needed to support the cost of the entire office. Engagement and retention of patients is critical, and fiscal processes must be precise to track billings, collections, and denials.

It is imperative the substance abuse treatment system expand its capacity so more individuals with substance use disorders can receive treatment. Although it presents challenges, this expansion of substance abuse treatment benefits is a positive public health approach that puts us one step closer to our goal of "treatment on request".

ADAA's Behavioral Health Electronic Record (BHER)

ADAA is continuing to enhance the State of Maryland Automated Record Tracking (SMART) application. The electronic data collection application has grown into a fledgling electronic health record. In the past year Maryland has added or enhanced several of its modules. ADAA and the University of Maryland Institute for Governmental Service and Research (IGSR) have enhanced SMART's medication tracking module to include the Buprenorphine Initiative information, added an adolescent assessment instrument, and incorporated an automated Drug Testing Management Service (DTMS). The DTMS module will allow labs providing drug test results to connect directly with the treatment agencies through SMART to electronically send test results to the patient record.

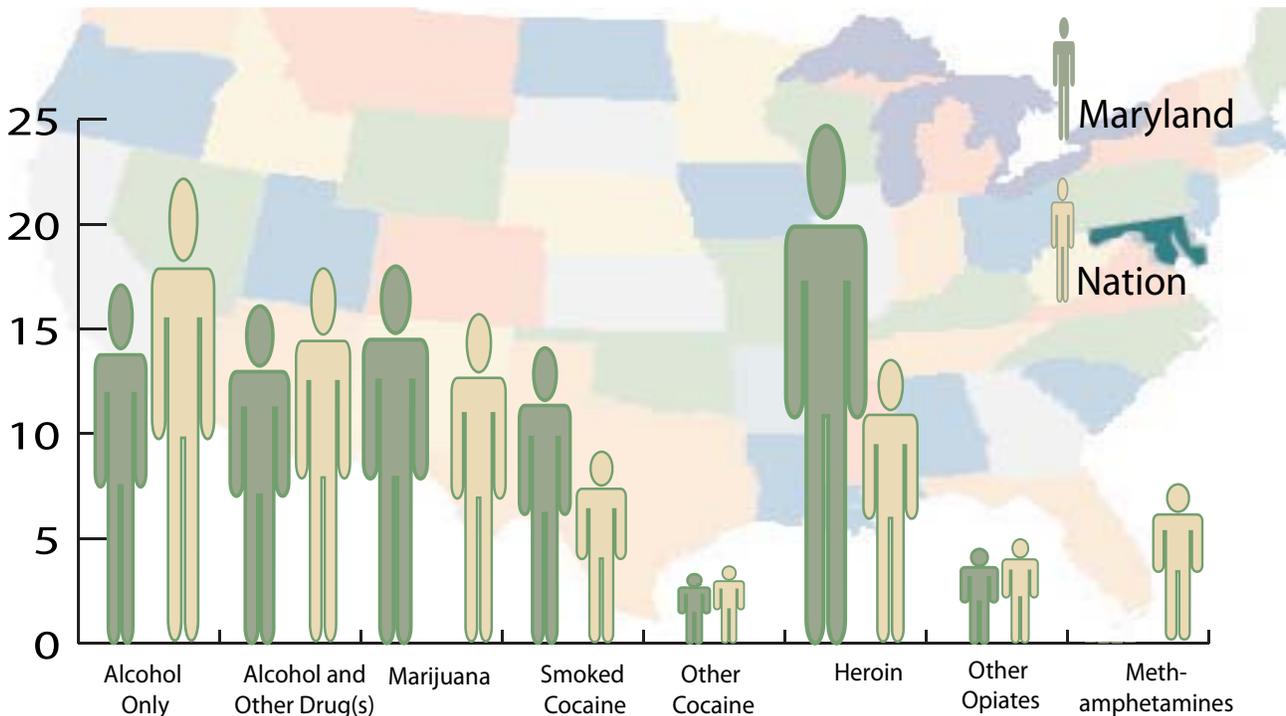
As resources permit, ADAA will begin to provide linkages to partner departments and agencies to promote communication between treatment agencies and the supports our patients use in the community.

Maryland and the Nation

Figure 1 compares the percentages of primary substance problems among Maryland treatment admissions to percentages for the nation reported by all or nearly all states to the Treatment Episode Data Set (TEDS). Maryland treats significantly higher percentages of patients with hard drug problems of heroin and crack cocaine than the nation as a whole. Nationally more patients are treated with alcohol problems, both alone and in combination with other substance problems, than in Maryland. Despite a national decline in methamphetamine primary problem cases, the nation had dramatically more than Maryland, where primary problems with methamphetamine accounted for less than a tenth of one percent of admissions.

Treatment Admissions by Selected Primary Substances of Abuse
Maryland and the Nation
2007

Figure 1



Data Collection and Report Methodology

In this Outlook and Outcomes issue, ADAA has departed from its previous annual report format and has presented a publication that reflects highlights of the treatment data for FY 2008. Charts and tables represented in previous publications have been updated with FY 2008 information and can be found on the ADAA Web site (Maryland-ADAA.org) as well as additional data reflecting trends. The analysis of these data can be found in the *Research* content area.

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

The parent agencies of the Maryland Alcohol and Drug Abuse Administration (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 131 ADAA-funded providers with 230 treatment sites, 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 by the ADAA Management Information Services Division and analyzed by the ADAA Research Division. Each occurrence of an admission to, or a discharge from, a treatment provider is documented, as well as each enrollment in and dis-enrollment from a treatment level of care.

In FY 2006 ADAA moved to a Web-based electronic record. In previous years individuals entering any level of care were counted as admissions; 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 within the same provider. In this report for the most part the term admission is used to reflect enrollment in a level of care; however, some outcome measures are collected only at discharge and not at dis-enrollment, so analyses of these were restricted to cases in which the dis-enrollment and discharge dates were the same.

The number of days a patient is in treatment refers to the time between admission and discharge, and the number of days spent in a particular level of care is the time between enrollment and dis-enrollment. 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.

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 and multiple enrollments, each admission and enrollment does not necessarily represent a unique individual. The 47,758 FY 2008 ADAA-funded admissions (enrollments) reflect 35,108 unique individuals for a ratio of 1.36 admissions per individual. Three quarters of individuals admitted had one admission during the year; 18 percent had two and seven percent had more than two.

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

Continuum of Care

For discharges (dis-enrollments) from Level III.7.D (non-hospital detox) and from Level II.1 (intensive outpatient) during FY 2008, the percentage of unique individuals completing, transferred or referred and tracked to a subsequent enrollment in another level of care in the same or another provider within 30 days of discharge was calculated. Subsequent enrollments were primarily to Level III.7 (intermediate care) for detox discharges and to Level I (traditional outpatient) for IOP discharges. This measure required matching discharges to subsequent enrollments on the last four digits of the Social Security Number and complete birth date.

Services

Analyses were conducted on the average individual, group and family counseling sessions per month. Also, the percentages of positive urinalysis results among total tests conducted were calculated. 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 individuals discharged this is the difference between the percentage of patients using substances at admission and the percentage using at discharge.

There are reporting issues affecting the interpretation of this measure. Often at admission, patients are less than forthcoming about their levels of substance use, and later corrections are not often made. 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 2008, this is the difference between the percentage of patients arrested in the 30 days before admission and the percentage arrested in the 30 days before discharge.

Change in Employment Status

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

Change in Living Situation

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

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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Maryland Prevention

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 seen¹

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

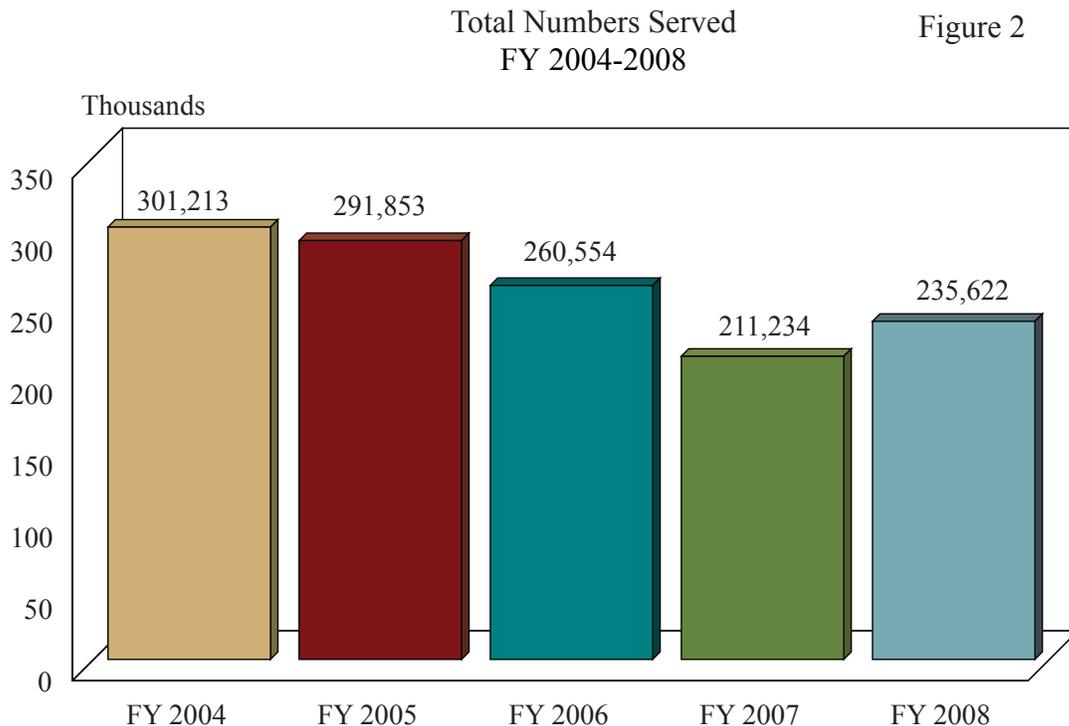
Prevention Network

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 2008 over 235,000 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 260,000 individuals served annually through prevention services. (Figure 2)



Institute of Medicine (IOM)

IOM Category Definitions

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.

Table 1
Numbers Served By Intervention Type (IOM Category)
Fiscal Year 2008

County	Universal	Selected	Indicated	Total
Allegany	15,490	1220	60	16,770
Anne Arundel	4352	1365	6	5,723
Baltimore City	35,864	10,823	338	47,025
Baltimore	31,539	1665	85	33,289
Calvert	5409	6	0	5,415
Caroline	2740	46	2	2,788
Carroll	8214	1662	328	10,204
Cecil	521	208	0	729
Charles	7925	199	0	8,124
Dorchester	3338	38	0	3,376
Frederick	1469	639	63	2,171
Garrett	8033	259	143	8,435
Harford	8077	4928	528	13,533
Howard	6504	21	0	6525
Kent	356	704	33	1,093
Montgomery	2827	48	32	2,907
Prince George's	5043	2577	0	7,620
Queen Anne's	14,957	413	0	15,370
St. Mary's	15,730	0	0	15,730
Somerset	2615	524	126	3,265
Talbot	2948	71	19	3,038
Washington	748	600	2647	3,995
Wicomico	1214	1242	11	2,467
Worcester	16,030	0	0	16,030
Total	201,943	29,258	4,421	235,622
Percentage	86%	12%	2%	100%

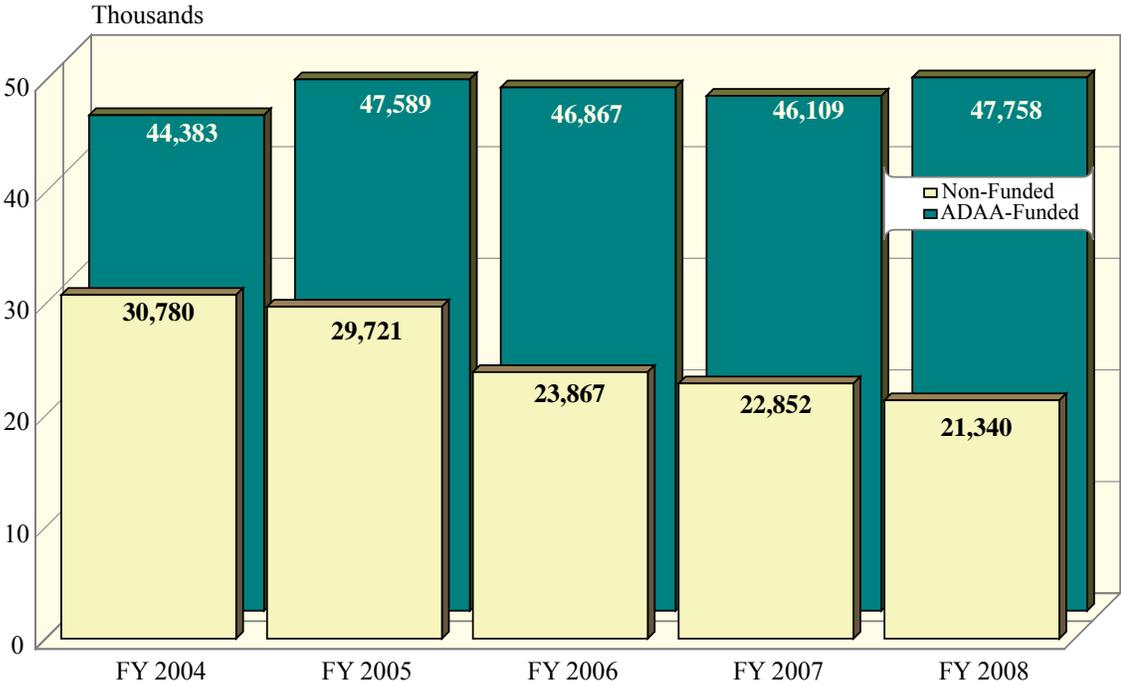
Selected prevention strategies target subsets of the total population that are deemed to be at risk for substance abuse by virtue of their membership in a particular population segment - for example, children of adult alcoholics, dropouts, or students who are failing academically. The selected prevention 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 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 substance abuse problem.

Treatment Admissions

FY 2004 - FY 2008 Admissions to Certified Alcohol and Drug Abuse Treatment Programs

Figure 3



As shown in Figure 3, total admissions decreased by 8.1 percent from Fiscal Year 2004 to 2008, but ADA A-funded admissions increased 7.6 percent during that time period. Whereas ADA A-funded admissions made up about 59 percent of the total in FY 2004, they made up 69 percent in FY 2008. This shift is a result of reconciliation and realignment of funding sources in addition to funding increases from Cigarette Restitution monies and other sources. Also, there has likely been some erosion of reporting by programs that receive no public funding, as the knowledge of the possibility of their release from the reporting requirement has become widespread. The 47,758 funded admissions were accounted for by 35,108 unique individuals (73.5 percent).

Primary substance abuse patients made up over 98 percent of admissions from FY 2004 to FY 2007, but their percentage fell to 96 percent in FY 2008 as more non-primary patients (family members and significant others) were admitted. Numbers and percentages of non-primary patients increased each year, nearly doubling in FY 2008. This reflects the beginning stages of developing a recovery-oriented system of care that puts greater emphasis on patients' overall improved health, wellness and quality of life.

Source of Referral

Table 2 shows that the bulk of referrals over the five years have been from voluntary or community sources. Criminal justice referrals were at their highest percentage in FY 2006, dropping to their lowest percentage in FY 2008.

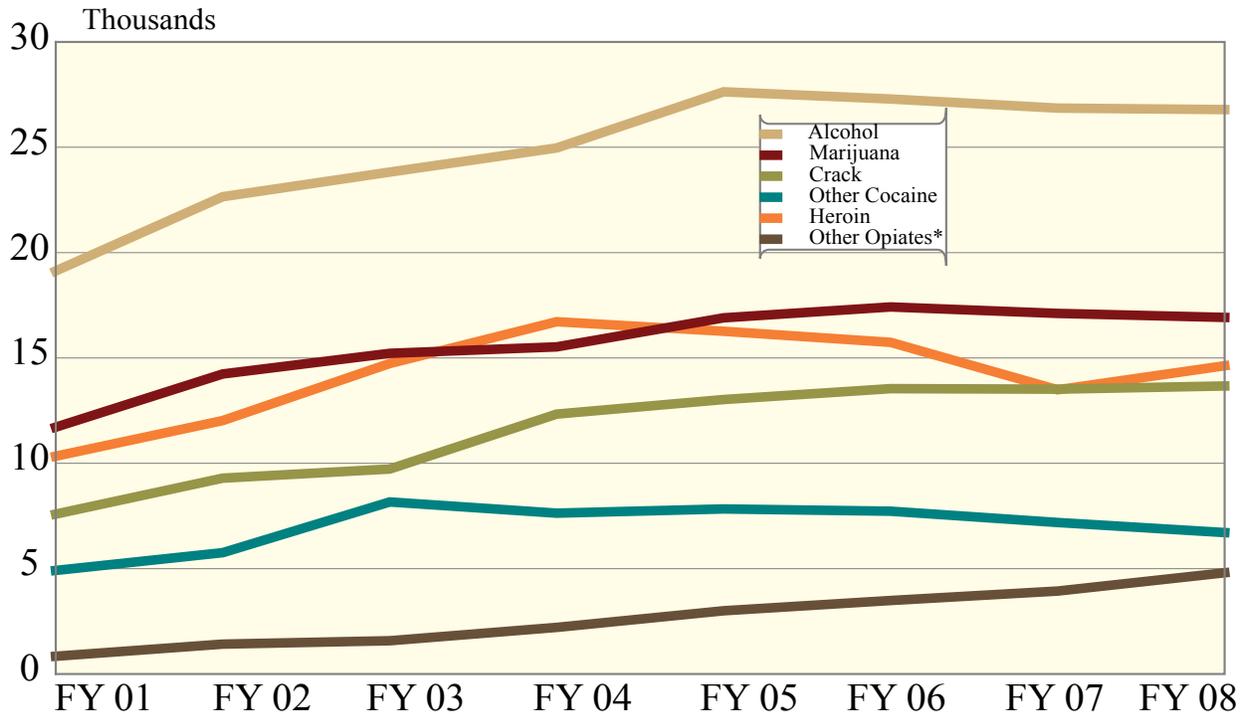
Table 2

Admissions to ADAF-Funded Treatment by Source of Referral FY 2004 - FY 2008

Source of Referral	FY 2004		FY 2005		FY 2006		FY 2007		FY 2008	
	#	%	#	%	#	%	#	%	#	%
Juvenile Justice	1901	4.3	2184	4.6	2144	4.6	2034	4.4	2098	4.4
TASC	461	1.0	211	0.4	253	0.5	276	0.6	255	0.5
DWI/DUI Related	3605	8.1	4790	10.1	4160	8.9	3660	7.9	2989	6.3
Pre-Trial	1094	2.5	1283	2.7	1239	2.6	960	2.1	737	1.5
Probation	6912	15.6	7485	15.7	7651	16.3	7425	16.1	6957	14.6
Parole	1009	2.3	1100	2.3	1142	2.4	1113	2.4	688	1.4
State Prison	18	0.0	42	0.1	56	0.1	48	0.1	49	0.1
Local Detention	762	1.7	1008	2.1	1171	2.5	1375	3.0	1225	2.6
DHMH Court Commitment (HG-507)	362	0.8	401	0.8	596	1.3	485	1.1	591	1.2
Drug Court	1545	3.5	1736	3.6	1653	3.5	1634	3.5	2671	5.6
Other Criminal Justice	1474	3.3	1556	3.3	1778	3.8	2115	4.6	2205	4.6
Individual/Self Referral	11021	24.8	11236	23.6	10501	22.4	10189	22.1	11076	23.2
Parent/Gaurdian/Family	888	2.0	1028	2.2	1015	2.2	963	2.1	877	1.8
Alcohol/Drug Abuse Provider	6080	13.7	6041	12.7	5512	11.8	5147	11.2	5023	10.5
Other Health Care Provider	2565	5.8	2649	5.6	2880	6.1	2273	4.9	3182	6.7
School	945	2.1	888	1.9	642	1.4	672	1.5	823	1.7
Student Assistance Program	198	0.4	239	0.5	208	0.4	160	0.3	88	0.2
Employer/EAP	248	0.6	311	0.7	358	0.8	283	0.6	252	0.5
DSS/TCA	1041	2.3	995	2.1	1159	2.5	1171	2.5	1090	2.3
Other Community Referral	2254	5.1	2381	5.0	2655	5.7	3611	7.8	3984	8.4
AIDS Administration	0	—	23	0.0	59	0.1	36	0.1	15	0.0
Alcohol and Drug Abuse Administration	0	—	2	0.0	35	0.1	475	1.0	827	1.7
Poison Control Agency	0	—	0	—	0	—	3	0.0	7	0.0
Total	44383	100.0	47589	100.0	46867	100.0	46108	100.0	47709	100.0

Substance Problems Admissions to
ADAA-Funded Treatment
FY 2001 - FY 2008

Figure 4



Note: Up to three substance problems may be reported for each admission.
*Includes Non-Rx Methadone, Oxycodone and Other Opiates.

Figure 4 presents the eight-year trend in reports of substance problems. Heroin problems fell by 19 percent from FY 2004 to FY 2007, after increasing 62 percent from FY 2001. Heroin was back up by eight percent in FY 2008; whether this is the start of another cycle of increase remains to be seen, but incidence of first use analysis and preliminary FY 2009 data suggest otherwise.

Under 18 and Over 50 Comparison

During FY 2008 the number of admissions over the age of 50 (seniors) was about 13 percent higher than the number under the age of 18 (adolescents). The two admission populations have been moving in opposite directions since FY 2005, adolescents decreasing by 17 percent and seniors increasing by an astonishing 52 percent. Some of the characteristics of these two populations are discussed in this section.

An interesting contrast exists with respect to race and gender (Figure 5). Adolescents admitted were disproportionately white males, coming in at 39 percent versus 33 percent for all admissions, while African American females were underrepresented at 6 percent compared to 14. In the over 50 age group it was African American males that were overrepresented – 42 versus 31 percent in the full population, while white females were only 11 percent as opposed to 17. Females in general were underrepresented at about 26 percent in both groups.

Race and Gender Comparison of Under 18 and Over 50 Admissions to ADAA-Funded Treatment

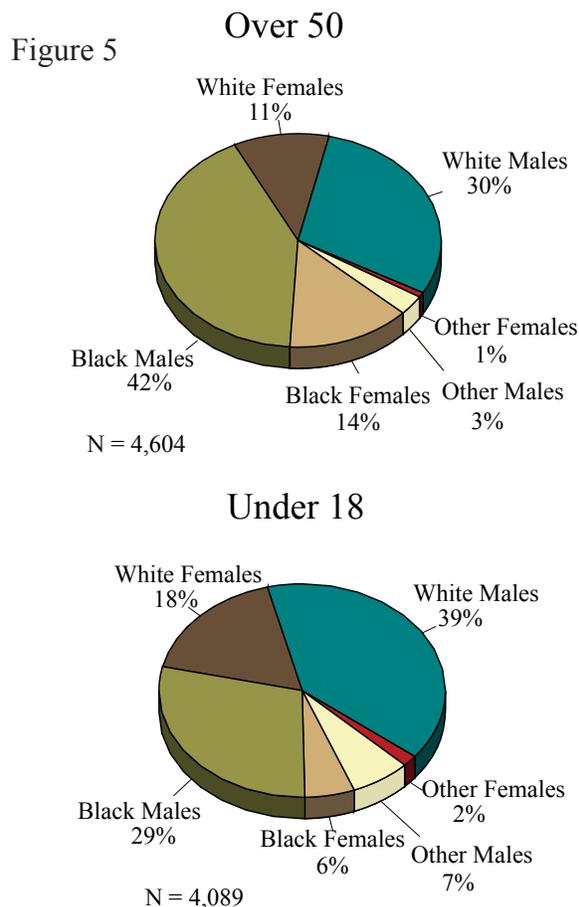


Figure 6 presents the distribution of health coverage for the two age groups. Senior admissions were more likely than the total to have coverage of some type, and adolescents were substantially more likely than the total population to be covered. Both groups were more likely to have private insurance, 41 percent of adolescents and 23 percent of seniors, compared to 19 percent for the total. Adolescents were also more likely than total admissions to have DHMH and other Medicaid.

Health Coverage Comparison of Under 18 and Over 50 Admissions to ADAA-Funded Treatment

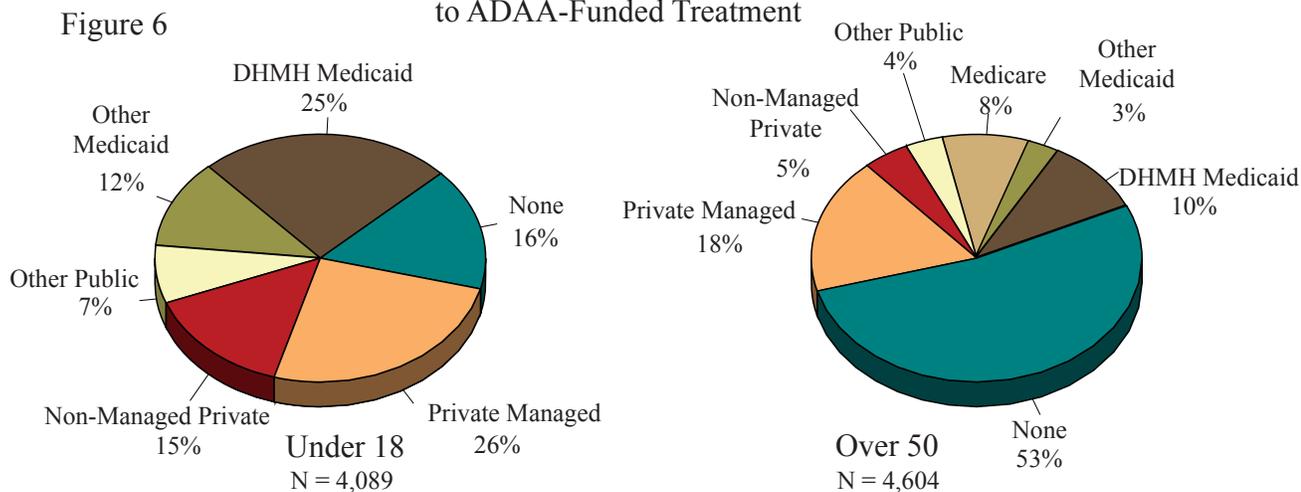


Table 3 compares adolescents and over 50 seniors on source of referral to treatment. Fifty-two percent of adolescent treatment cases originated in the criminal justice system, the bulk from juvenile justice (Department of Juvenile Justice). Only 36 percent of seniors were referred by justice system sources. Over 90 percent of adolescents entered ambulatory treatment compared to two-thirds of seniors.

Table 3

Source of Referral Comparison of Under 18 and Over 50 Admissions to ADAA-Funded Treatment
FY 2008

Source of Referral	Under 18		Over 50	
	#	%	#	%
Juvenile Justice	1757	43.0	18	0.4
TASC	11	0.3	8	0.2
DWI/DUI Related	8	0.2	388	8.4
Pre-Trial	12	0.3	89	1.9
Probation	55	1.3	626	13.6
Parole	8	0.2	62	1.3
State Prison	0	0.0	5	0.1
Local Detention	78	1.9	64	1.4
DHMH Court Commitment (HG-507)	1	0.0	41	0.9
Drug Court	109	2.7	202	4.4
Other Criminal Justice	72	1.8	157	3.4
Individual (Include Self-Referral)	136	3.3	1354	29.4
Parent/Guardian/Family	469	11.5	41	0.9
Alcohol/Drug Abuse Care Provider	273	6.7	473	10.3
Other Health Care Provider	110	2.7	459	10.0
School	728	17.8	8	0.2
Student Assistance Program	67	1.6	4	0.1
Employer/EAP	1	0.0	38	0.8
DSS/TCA	46	1.1	40	0.9
Other Community Referral	141	3.5	417	9.1
AIDS Administration	0	0.0	3	0.1
Alcohol and Drug Abuse Administration	3	0.1	100	2.2
Poison Control Agency	1	0.0	1	0.0
Total	4086	100.0	4598	100.0



A national survey of juvenile detainees in 2000 found that about 56 percent of the boys and 40 percent of the girls tested positive for drug use at the time of their arrest

(National Institute of Justice, 2003; U.S. Department of Health and Human Services, 2006).

Patients Treated

Reason for Discharge

Discharges from ADAA-funded treatment during FY 2004 to FY 2008 are distributed by ASAM level of care in Table 4. The FY 2008 total reflects a slight increase from the previous year, but is lower than the FY 2005 and 2006 totals. The ratio of admissions to discharges for FY 2004 to FY 2007 is about 1.0, and for FY 2008 about .98. This reflects completeness of reporting and stability in the ADAA data system.

Discharges from ADAA-Funded Treatment by ASAM Level of Care
FY 2004 - FY 2008

Table 4

ASAM Level of Care	FY 2004		FY 2005		FY 2006		FY 2007		FY 2008	
	#	%	#	%	#	%	#	%	#	%
Level 0.5	529	1.2	539	1.1	695	1.5	669	1.5	824	1.8
Level I	21121	48.0	23572	49.5	21248	45.1	20769	45.1	20210	43.3
Level I.D	1878	4.3	1651	3.5	549	1.2	56	0.1	332	0.7
Level II.1	4867	11.1	5374	11.3	7630	16.2	7486	16.3	6793	14.6
Level II.5	3	0.0	0	0.0	69	0.1	419	0.9	861	1.8
Level II.D	6	0.0	7	0.0	300	0.6	389	0.8	258	0.6
Level III.1	939	2.1	1253	2.6	1304	2.8	1361	3.0	1421	3.0
Level III.3	500	1.1	592	1.2	665	1.4	726	1.6	787	1.7
Level III.5	593	1.3	488	1.0	529	1.1	1025	2.2	969	2.1
Level III.7	6540	14.9	7242	15.2	8471	18.0	7587	16.5	7484	16.0
Level III.7.D	3373	7.7	3369	7.1	2035	4.3	3061	6.6	4248	9.1
Level OMT	3269	7.4	3026	6.4	3433	7.3	2449	5.3	2380	5.1
Level OMT.D	406	0.9	491	1.0	221	0.5	36	0.1	117	0.3
Total	44024	100.0	47604	100.0	47149	100.0	46033	100.0	46684	100.0



According to TEDS Data on type of service at discharge in 2006

- 41 percent were discharged from outpatient treatment
- 23 percent were discharged from detoxification
- 11 percent were discharged from intensive outpatient treatment
- 10 percent were discharged from short-term residential treatment
- 8 percent were discharged from long-term residential treatment
- 5 percent were discharged from medication-assisted (i.e., using methadone or buprenorphine) opioid therapy or detoxification
- Less than 1 percent were discharged from hospital residential treatment

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Treatment Episode Data Set (TEDS): 2006 Discharges from Substance Abuse Treatment Services, DASIS Series: S-46, DHHS Publication No. (SMA) 09-4378, Rockville, MD, 2009.

Continuation in Treatment

Figure 7 provides the percentages of unduplicated dis-enrollments from selected levels of care that entered different levels of care within thirty days. Nearly 60 percent of those patients leaving short-term residential detox due to completion, transfer or referral during FY 2008 entered Level III.7 within 30 days, and another 19 percent entered intensive outpatient or something else. Half of completers, transfers and referrals from intensive outpatient entered another level of care within 30 days, mostly Level I. A

fourth of applicable Level III.1 departures, 18 percent of III.3, 17 percent of III.5 and 22 percent of III.7 entered intensive or traditional outpatient treatment within 30 days. Appendix Tables F and G (Level II.1 Continuation and Level III.7.D Continuation) present the provider subdivision breakdown of Level II.1 and III.7.D dis-enrollments by the percentages entering another level of care within 30 days.

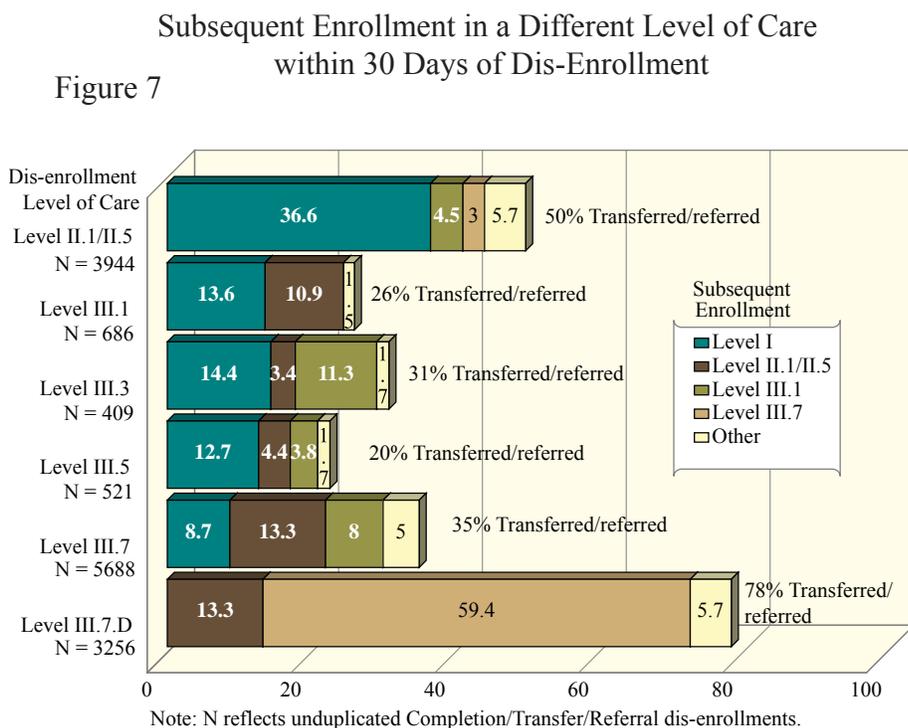
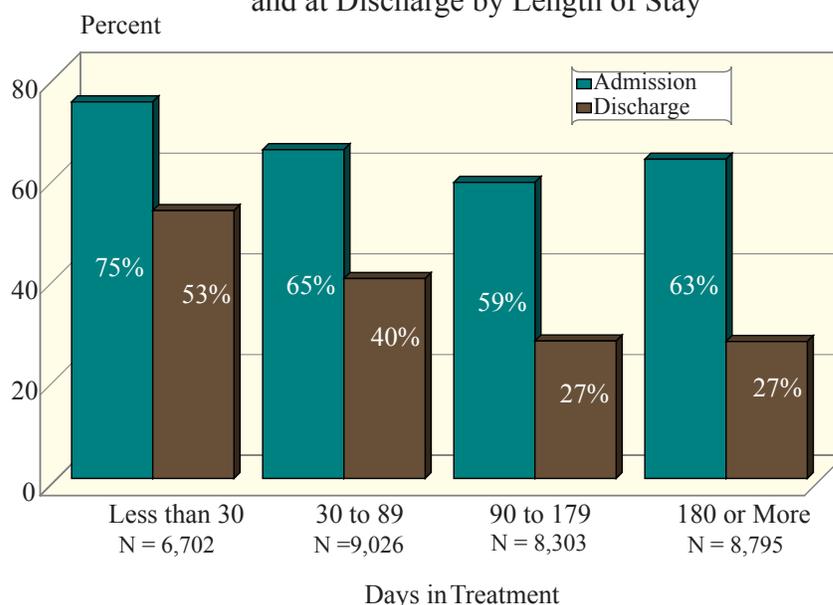


Figure 8 Percentages of Patients Using Substances at Admission and at Discharge by Length of Stay

Figure 8 shows clearly that the longer patients remain in treatment the greater likelihood they will be abstinent at discharge. For those who spent less than 30 days in treatment the reduction in substance users was 29 percent; the reduction among patients staying 30 to 89 days was 39 percent, 54 percent from 90 to 179 days and 57 percent for those staying 180 days or more.

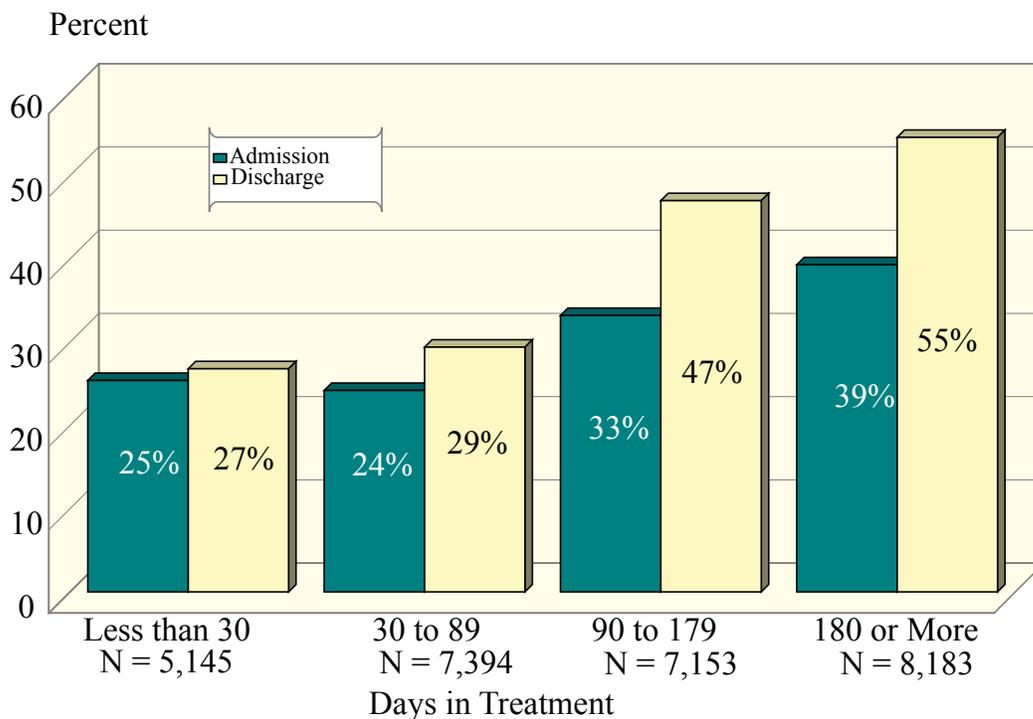


Note: Detoxification, short-term residential levels of care and non-primary patients were excluded.

Employment

Length of stay in treatment was associated with both employment at admission and becoming employed during treatment, as shown in Figure 9. Patients who remained in treatment at least 90 days were significantly more likely to be employed at admission, and at each time interval higher percentages of patients were employed at discharge. Staying in treatment 90 to 179 days was associated with a 42 percent increase in employment and staying 180 days or more was associated with a 39 percent increase.

Figure 9 Percentages of Patients Employed at Admission and at Discharge by Length of Stay
FY 2008 ADAA-Funded Discharges



Note: In order to distribute the data by level of care the analysis was restricted to discharges with single enrollments - employment information is collected at discharge and not at dis-enrollment from levels of care. Detoxification and short-term residential levels of care were excluded.

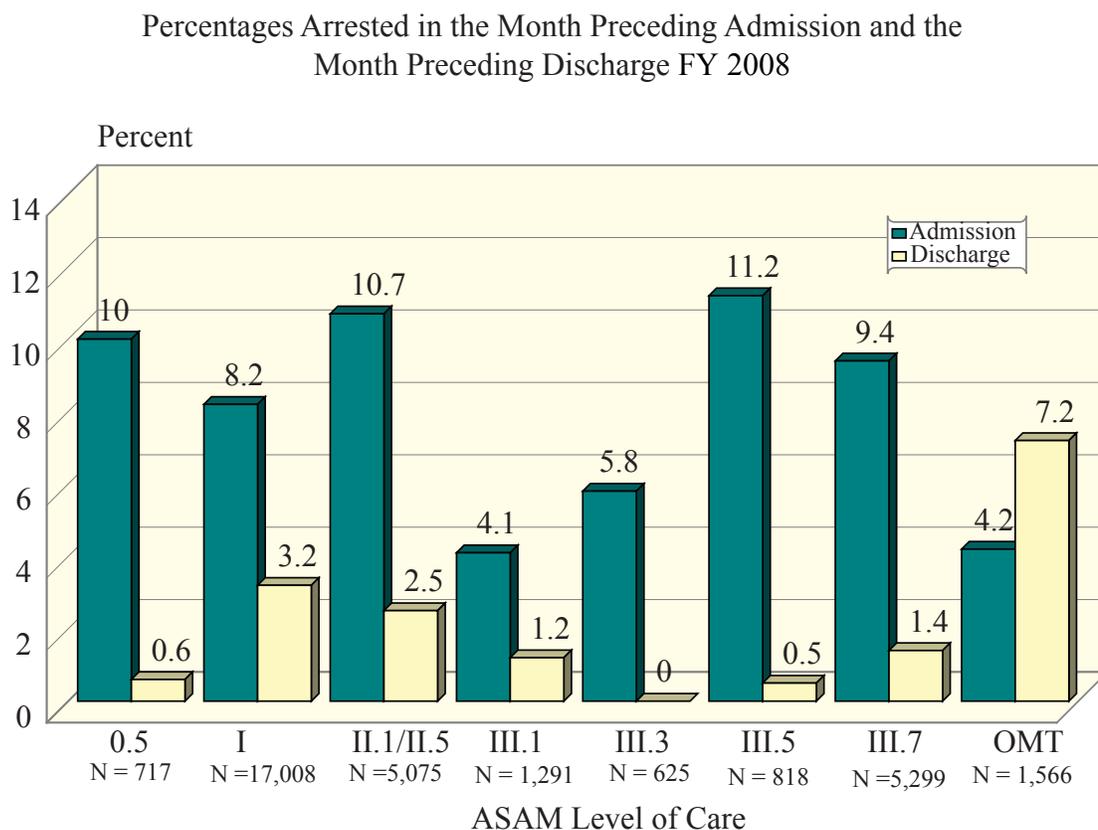


Maryland's overall increase in employed patients from admission to discharge (21.1 percent), presented in the SAPT Block Grant analysis, was third highest among northeastern states, slightly below the regional average but well above the national rate of 15.3 percent. Maryland's employment rate at admission (41.1 percent) was sixth highest in the northeast region

Arrests

Comparisons of percentages of those arrested in the thirty days before admission and the percentages arrested in the thirty days before discharge are presented by level of care in Figure 10. Reductions in percentages arrested were substantial in every level except OMT, where the percentage at discharge was higher than at admission. This reflects the above-noted finding that OMT discharges tend to be biased toward treatment failure. Appendix Table J provides 30-day arrest performance measures by provider subdivision.

Figure 10



Note: In order to distribute the data by level of care the analysis was restricted to discharges with single enrollments - arrest information is collected at discharge and not at dis-enrollment from levels of care. Detoxification levels of care were excluded.



Regarding the "arrest-free" status item in the Block Grant data analysis, Maryland at 7.6 percent, was again fourth highest among eleven northeastern states in increasing arrest-free status during treatment. Its rate of increase was, by necessity, below the regional rate of 15 percent and the national rate of 14.3 because Maryland's starting point was 91 percent "arrest-free" at admission.

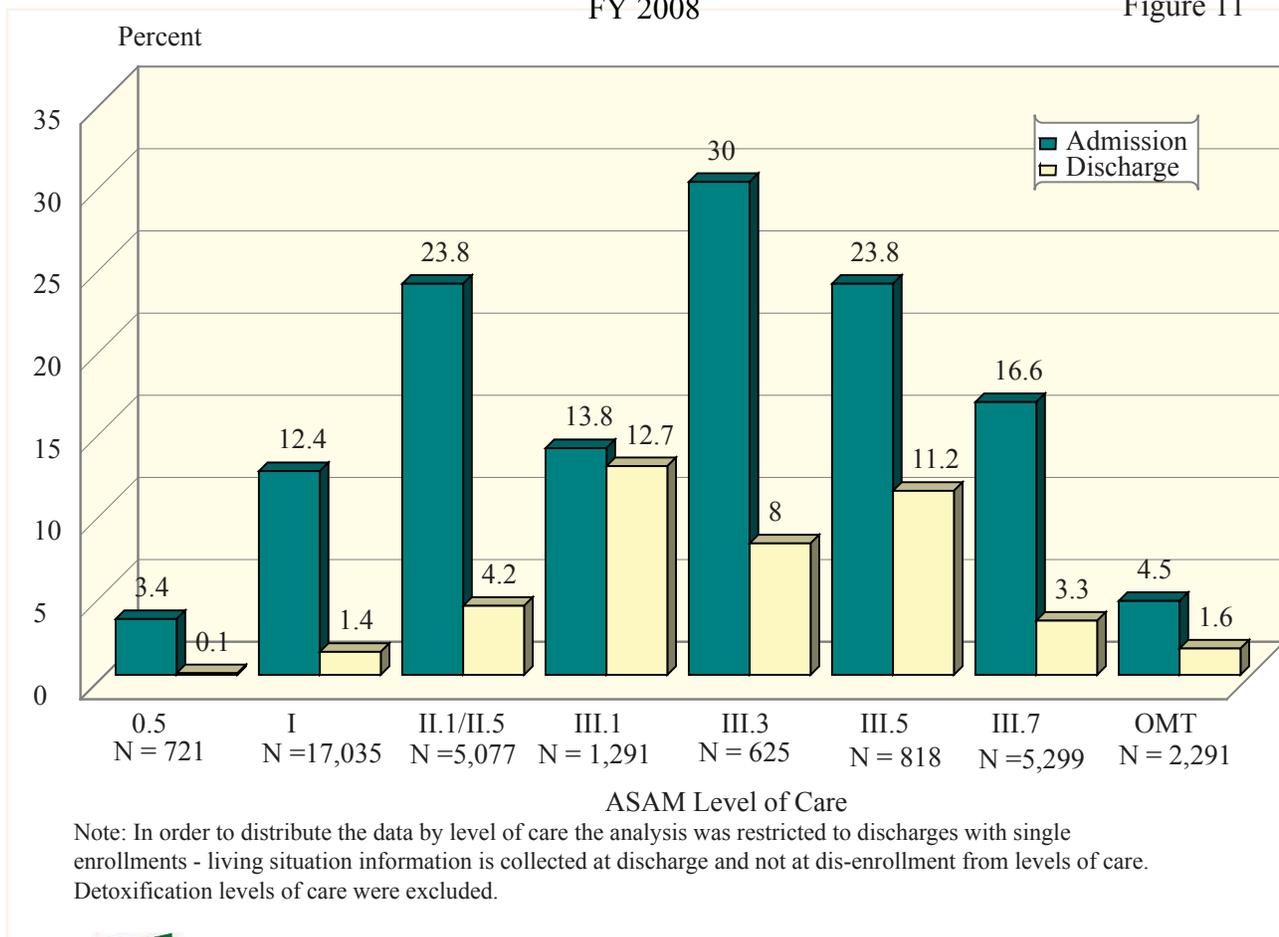
Homelessness

Figure 11 presents the percentages of discharged patients who were homeless at admission compared to the percentages of homeless at discharge. Reductions in homelessness were substantial in every level of care except III.1, where the drop was only 8 percent. However, all of the long-term residential care levels had discharge homeless percentages ranging from 8 to 13 percent. The levels of care with the highest percentages of homeless patients at admission were III.3 where the reduction was 73 percent, III.5 where the reduction was 53 percent, and intensive outpatient where the reduction was a dramatic 82 percent.

Percentages Homeless at Admission and at Discharge

FY 2008

Figure 11

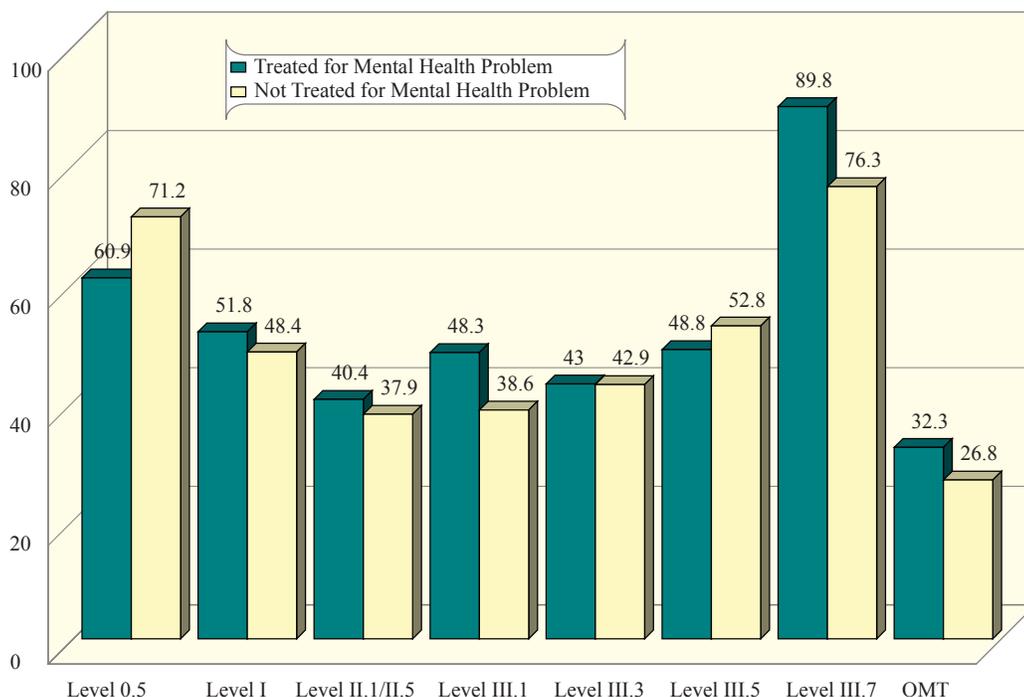


Among northeastern states, Maryland's 2007 increase in percentage of patients housed (not homeless) was 4.0, fifth of eleven states, below the regional increase of 5.3 but above the national rate of 2.8. Again, however, a ceiling effect prevails as Maryland's starting point was 93 percent housed; the regional starting point was 89 percent and national non-homeless admission percentage was 90.

In most levels of care, mental health problems at admission were associated with lower treatment completion/transfer/referral rates than no mental health problems, as shown in Figure 12. Only in III.7 and OMT did discharged patients with mental health problems do better than those without. For those who had a mental health problem at admission, receiving mental health treatment was associated with higher levels of treatment completion/transfer/referral in all levels of care except early intervention and III.5, although differences are statistically significant only for Levels I, III.1, and III.7.

Percentages Completing Treatment, Transferred or Referred by Treatment for a Mental Health Problem
 FY 2008

Figure 12



Note: In order to distribute the data by level of care the analysis was restricted to discharges with single enrollments - mental health treatment information is collected at discharge and not at dis-enrollment from levels of care. Detoxification levels of care were excluded.

In 2002 and 2003, approximately 340,000 male veterans had co-occurring severe mental illness (SMI) and a substance use disorder. The rate of co-occurring SMI and a substance use disorder was lower for male veterans than male nonveterans overall (1.3 percent vs. 2.3 percent), in part because of the older age of veterans. Comparisons within age groups indicate higher rates among veterans, although these were not statistically significant differences. However, veterans reported different rates of co-occurring SMI and a substance use disorder within age categories. Younger male veterans aged 18 to 25 (6.4 percent) were more likely than male veterans aged 26 to 54 (2.5 percent) or male veterans aged 55 or older (0.6 percent) to have had co-occurring SMI and a substance use disorder. Similarly, male veterans aged 26 to 54 were more likely than male veterans aged 55 or older to have had co-occurring SMI and a substance use disorder



Source: SAMHSA, 2002 NSDUH and 2003 NSDUH.
www.oas.samhsa.gov/2k4/vetsDualDX/vetsDualDX.htm

SUBSTANCE ABUSE TREATMENT OUTCOME MEASUREMENT TABLES

Table A

Discharges from ADAA-Funded Treatment by ASAM Level of Care
FY 2004 - FY 2008

ASAM Level of Care	FY 2004		FY 2005		FY 2006		FY 2007		FY 2008	
	#	%	#	%	#	%	#	%	#	%
Level 0.5	529	1.2	539	1.1	695	1.5	669	1.5	824	1.8
Level I	21121	48.0	23572	49.5	21248	45.1	20769	45.1	20210	43.3
Level I.D	1878	4.3	1651	3.5	549	1.2	56	0.1	332	0.7
Level II.1	4867	11.1	5374	11.3	7630	16.2	7486	16.3	6793	14.6
Level II.5	3	0.0	0	0.0	69	0.1	419	0.9	861	1.8
Level II.D	6	0.0	7	0.0	300	0.6	389	0.8	258	0.6
Level III.1	939	2.1	1253	2.6	1304	2.8	1361	3.0	1421	3.0
Level III.3	500	1.1	592	1.2	665	1.4	726	1.6	787	1.7
Level III.5	593	1.3	488	1.0	529	1.1	1025	2.2	969	2.1
Level III.7	6540	14.9	7242	15.2	8471	18.0	7587	16.5	7484	16.0
Level III.7.D	3373	7.7	3369	7.1	2035	4.3	3061	6.6	4248	9.1
Level OMT	3269	7.4	3026	6.4	3433	7.3	2449	5.3	2380	5.1
Level OMT.D	406	0.9	491	1.0	221	0.5	36	0.1	117	0.3
Total	44024	100.0	47604	100.0	47149	100.0	46033	100.0	46684	100.0

Table B

Discharges from ADAA-Funded Treatment
by Length of Stay and
ASAM Level of Care
FY 2008

ASAM Level of Care	N	Mean	Median
Level 0.5	824	94.2	80.5
Level I	20210	132.2	110.0
Level I.D	332	24.7	4.0
Level II.1	6793	70.3	49.0
Level II.5	861	10.2	9.0
Level II.D	258	37.9	22.0
Level III.1	1421	117.9	104.0
Level III.3	787	102.5	92.0
Level III.5	969	116.9	115.0
Level III.7	7484	17.8	16.0
Level III.7.D	4248	5.8	5.0
OMT	2380	937.9	543.5
OMT.D	117	360.3	81.0
Total	46684	129.5	52.0

Table C

Level I Retention Rates for ADAA-Funded Treatment Programs by Provider Location FY 2008

Subdivision	Discharges	Less than 90 Days	90 Days or More	Percentage Retained 90 Days or More
Allegany	543	232	311	57.3
Anne Arundel	1365	603	762	55.8
Baltimore City	3753	1834	1919	51.1
Baltimore County	1923	714	1209	62.9
Calvert	978	401	577	59.0
Caroline	190	67	123	64.7
Carroll	543	130	413	76.1
Cecil	543	216	327	60.2
Charles	988	326	662	67.0
Dorchester	295	142	153	51.9
Frederick	582	250	332	57.0
Garrett	263	118	145	55.1
Harford	821	310	511	62.2
Howard	332	114	218	65.7
Kent	364	156	208	57.1
Montgomery	1278	487	791	61.9
Prince George's	1612	846	766	47.5
Queen Anne's	423	185	238	56.3
St. Mary's	461	189	272	59.0
Somerset	300	74	226	75.3
Talbot	375	115	260	69.3
Washington	943	256	687	72.9
Wicomico	646	251	395	61.1
Worcester	683	317	366	53.6
Statewide	6	2	4	66.7
Total	20210	8335	11875	58.8

Table D

Level III.1 Retention Rates for ADAA-Funded Treatment Programs by Provider Location FY 2008

Subdivision	Discharges	Less than 90 Days	90 Days or More	Percentage Retained 90 Days or More
Allegany	22	7	15	68.2
Anne Arundel	186	118	68	36.6
Baltimore City	602	233	369	61.3
Baltimore Co.	103	60	43	41.7
Cecil	17	8	9	52.9
Frederick	126	67	59	46.8
Harford	27	11	16	59.3
Howard	32	13	19	59.4
Montgomery	70	35	35	50.0
Prince George's	42	18	24	57.1
St. Mary's	53	12	41	77.4
Washington	112	47	65	58.0
Wicomico	17	5	12	70.6
Worcester	12	6	6	50.0
Total	1421	640	781	55.0

Table E

Participation in Individual, Group and Family Counseling by Patients Discharged from ADAA-Funded Treatment FY 2008

ASAM Level of Care	Single Enrollment Discharges*	Individual Counseling			
		Received Individual Counseling	%	Mean Sessions per Month	Median Sessions per Month
Level 0.5	721	439	60.9	1.5	1.1
Level I	17039	14457	84.8	1.7	1.0
Level II.1/II.5	5078	4309	84.9	4.3	2.6
Level III.1	1292	1273	98.5	3.3	2.8
Level III.3	625	614	98.2	5.6	4.4
Level III.5	818	784	95.8	6.1	4.3
Level III.7	5299	5190	97.9	12.6	8.6
OMT	2302	2012	87.4	1.8	1.3
Total	33174	29078	87.7	4.3	2.0
ASAM Level of Care	Single Enrollment Discharges*	Group Counseling			
		Received Group Counseling	%	Mean Sessions per Month	Median Sessions per Month
Level 0.5	721	541	75.0	3.8	3.1
Level I	17039	14079	82.6	4.5	3.3
Level II.1/II.5	5078	4582	90.2	21.4	11.8
Level III.1	1292	1267	98.1	12.1	8.8
Level III.3	625	603	96.5	42.7	34.6
Level III.5	818	777	95.0	37.8	30.0
Level III.7	5299	5201	98.2	109.8	93.5
OMT	2302	1498	65.1	1.5	0.7
Total	33174	28548	86.1	28.3	5.1
ASAM Level of Care	Single Enrollment Discharges*	Family Counseling			
		Received Family Counseling	%	Mean Sessions per Month	Median Sessions per Month
Level 0.5	721	64	8.9	1.1	0.5
Level I	17039	1330	7.8	0.9	0.4
Level II.1/II.5	5078	456	9.0	2.4	1.8
Level III.1	1292	59	4.6	1.0	0.4
Level III.3	625	269	43.0	2.0	0.8
Level III.5	818	234	28.6	1.2	0.5
Level III.7	5299	1719	32.4	4.5	3.5
OMT	2302	165	7.2	0.3	0.1
Total	33174	4296	12.9	2.6	1.3

Tables F and G

Subsequent Admission to Another Treatment Level within 30 Days of Completion/
Transfer/Referral from Level3 II.1 and III.7 for ADA A-Funded Treatment Programs
FY 2008

Subdivision	Unduplicated Level II.1 Completion/ Referrals	Subsequent Admission Level of Care					
		Level I		Other		Total	
		#	%	#	%	#	%
Allegany	193	40	20.7	9	4.7	49	25.4
Anne Arundel	745	151	20.3	67	9.0	218	29.3
Baltimore City	1378	655	47.5	238	17.3	893	64.8
Baltimore Co.	206	26	12.6	10	4.9	36	17.5
Calvert	55	41	74.5	4	7.3	45	81.8
Carroll	89	8	9.0	10	11.2	18	20.2
Charles	102	62	60.8	20	19.6	82	80.4
Dorchester	64	16	25.0	13	20.3	29	45.3
Frederick	145	32	22.1	17	11.7	49	33.8
Garrett	11	5	45.5	5	45.5	10	90.9
Harford	12	3	25.0	7	58.3	10	83.3
Howard	31	22	71.0	7	22.6	29	93.5
Montgomery	127	52	40.9	23	18.1	75	59.1
Prince George's	172	109	63.4	20	11.6	129	75.0
St. Mary's	46	13	28.3	8	17.4	21	45.7
Somerset	19	13	68.4	3	15.8	16	84.2
Talbot	32	21	65.6	7	21.9	28	87.5
Washington	77	52	67.5	13	16.9	65	84.4
Wicomico	85	59	69.4	5	5.9	64	75.3
Worcester	379	64	16.9	34	9.0	98	25.9
Total	3968	1444	36.4	520	13.1	1964	49.5

Subdivision	Unduplicated Level III.7.D Completion/ Referrals	Subsequent Admission Level of Care					
		Level III.7		Other		Total	
		#	%	#	%	#	%
Anne Arundel	619	303	48.9	281	45.4	584	94.3
Baltimore City	743	255	34.3	112	15.1	367	49.4
Baltimore Co.	389	242	62.2	69	17.7	311	79.9
Carroll	94	92	97.9	1	1.1	93	98.9
Frederick	53	4	7.5	4	7.5	8	15.1
Kent	165	157	95.2	0	0.0	157	95.2
Montgomery	838	730	87.1	21	2.5	751	89.6
St. Mary's	109	92	84.4	10	9.2	102	93.6
Worcester	262	92	35.1	108	41.2	200	76.3
Total	3272	1967	60.1	606	18.5	2573	78.6

Table H

Use of Substances at Admission and at Discharge from ADAA-Funded Treatment
Programs by Provider Location
FY 2008

Subdivision	Discharges	Use at Admission		Use at Discharge		Percentage Change
		N	%	N	%	
Allegany	1549	1107	71.5	287	18.5	-74.1
Anne Arundel	3605	2652	73.6	1187	32.9	-55.2
Baltimore City	11013	8281	75.2	5173	47.0	-37.5
Baltimore County	2999	2003	66.8	894	29.8	-55.4
Calvert	1088	672	61.8	330	30.3	-50.9
Caroline	186	165	88.7	92	49.5	-44.2
Carroll	951	658	69.2	275	28.9	-58.2
Cecil	561	338	60.2	163	29.1	-51.8
Charles	1286	658	51.2	247	19.2	-62.5
Dorchester	1956	1825	93.3	176	9.0	-90.4
Frederick	1902	1361	71.6	295	15.5	-78.3
Garrett	285	165	57.9	70	24.6	-57.6
Harford	951	665	69.9	346	36.4	-48.0
Howard	459	325	70.8	141	30.7	-56.6
Kent	649	501	77.2	122	18.8	-75.6
Montgomery	2449	1640	67.0	787	32.1	-52.0
Prince George's	2242	1519	67.8	997	44.5	-34.4
Queen Anne's	420	299	71.2	149	35.5	-50.2
St. Mary's	928	594	64.0	177	19.1	-70.2
Somerset	345	241	69.9	91	26.4	-62.2
Talbot	427	321	75.2	126	29.5	-60.7
Washington	1228	539	43.9	188	15.3	-65.1
Wicomico	882	465	52.7	251	28.5	-46.0
Worcester	1433	1065	74.3	473	33.0	-55.6
Statewide	486	226	46.5	251	51.6	11.1
Total	40280	28285	70.2	13288	33.0	-53.0

Table I

Employment at Admission and at Discharge from ADAA-Funded Treatment Programs by Provider Location FY 2008

Subdivision	Discharges	Employed at Admission		Employed at Discharge		Percentage Change
		N	%	N	%	
Allegany	1597	288	18.0	338	21.2	17.4
Anne Arundel	3882	1776	45.7	2030	52.3	14.3
Baltimore City	11267	1719	15.3	2839	25.2	65.2
Baltimore County	3082	1181	38.3	1428	46.3	20.9
Calvert	1095	587	53.6	642	58.6	9.4
Caroline	190	84	44.2	87	45.8	3.6
Carroll	1091	375	34.4	420	38.5	12.0
Cecil	563	209	37.1	255	45.3	22.0
Charles	1287	525	40.8	697	54.2	32.8
Dorchester	1958	497	25.4	518	26.5	4.2
Frederick	1956	566	28.9	705	36.0	24.6
Garrett	315	88	27.9	128	40.6	45.5
Harford	970	410	42.3	534	55.1	30.2
Howard	468	138	29.5	236	50.4	71.0
Kent	665	229	34.4	251	37.7	9.6
Montgomery	2544	673	26.5	780	30.7	15.9
Prince George's	2335	651	27.9	870	37.3	33.6
Queen Anne's	423	188	44.4	216	51.1	14.9
St. Mary's	1093	385	35.2	442	40.4	14.8
Somerset	426	144	33.8	190	44.6	31.9
Talbot	433	200	46.2	242	55.9	21.0
Washington	1265	415	32.8	583	46.1	40.5
Wicomico	887	345	38.9	437	49.3	26.7
Worcester	1449	480	33.1	546	37.7	13.8
Statewide	488	9	1.8	95	19.5	955.6
Total	41729	12162	29.1	15509	37.2	27.5

Table J

Arrested in the 30 Days before Admission and before Discharge from ADAA-Funded Treatment Programs by Provider Location FY 2008

Subdivision	Discharges	Arrested before Admission		Arrested before Discharge		Percentage Change
		N	%	N	%	
Allegany	1592	195	12.2	45	2.8	-76.9
Anne Arundel	3843	406	10.5	44	1.1	-89.2
Baltimore City	3076	737	7.0	54	1.8	-92.7
Baltimore County	1083	200	6.5	57	5.3	-71.5
Calvert	188	148	13.5	8	4.3	-94.6
Caroline	1090	16	8.4	22	2.0	37.5
Carroll	563	100	9.2	19	3.4	-81.0
Cecil	1280	35	6.2	28	2.2	-20.0
Charles	1953	89	6.9	102	5.2	14.6
Dorchester	1945	196	10.0	59	3.0	-69.9
Frederick	313	243	12.5	7	2.2	-97.1
Garrett	969	49	15.6	32	3.3	-34.7
Harford	460	60	6.2	17	3.7	-71.7
Howard	664	46	9.9	34	5.1	-26.1
Kent	2493	66	9.9	27	1.1	-59.1
Montgomery	2322	295	11.6	70	3.0	-76.3
Prince George's	415	151	6.6	26	6.3	-82.8
Queen Anne's	1085	42	10.0	5	0.5	-88.1
St. Mary's	424	42	3.8	19	4.5	-54.8
Somerset	432	52	12.2	28	6.5	-46.2
Talbot	1260	65	15.0	38	3.0	-41.5
Washington	875	95	7.5	32	3.7	-66.3
Wicomico	1432	57	6.4	49	3.4	-14.0
Worcester	10985	140	9.7	318	2.9	127.1
Statewide	485	43	8.8	2	0.4	-95.3
Total	41227	3568	8.7	1142	2.8	-68.0

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
MDS	Minimum Data Set
MIS	Management Information Systems
NIDA	National Institute on Drug Abuse
OETAS	Office of Education and Training for Addiction Services
PrevTech	Prevention Technology Platform
SAMHSA	Substance Abuse and Mental Health Services Administration
SMART	State of Maryland Automated Record Tracking
TEDS	Federal Treatment Episode Data Set

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