

Outlook and Outcomes

FY 2012

Maryland Alcohol and Drug Abuse
Administration

(ADAA)

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The data in this report reflect primary-patient admissions to and discharges from programs receiving state-funding reported to the Statewide Maryland Automated Record Tracking (SMART) system, a Web-based tool that provides a consent-driven patient-tracking system. Programs receiving any public funds are required to report data on all their patients regardless of source of payment for individual patients. Analysis of the accumulated data is a vital component of ADAA's mission to administer available resources effectively and efficiently so that Maryland citizens in need will have access to quality treatment and recovery services.

Figure 1
Individual Patients, Admissions and Enrollments in State-Supported Alcohol
and Drug Abuse Treatment Programs Reporting Data
FY 2008 to FY 2012

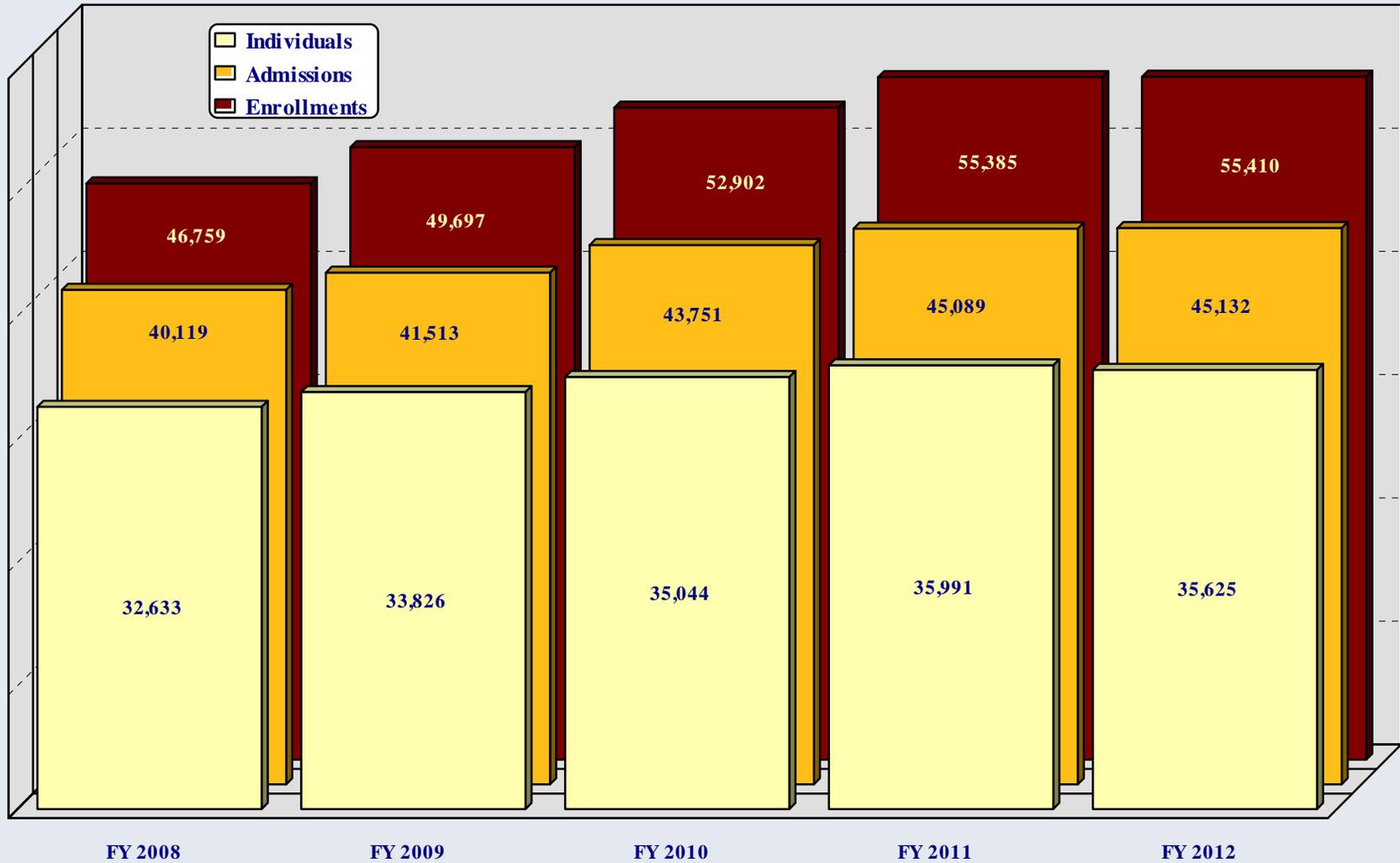
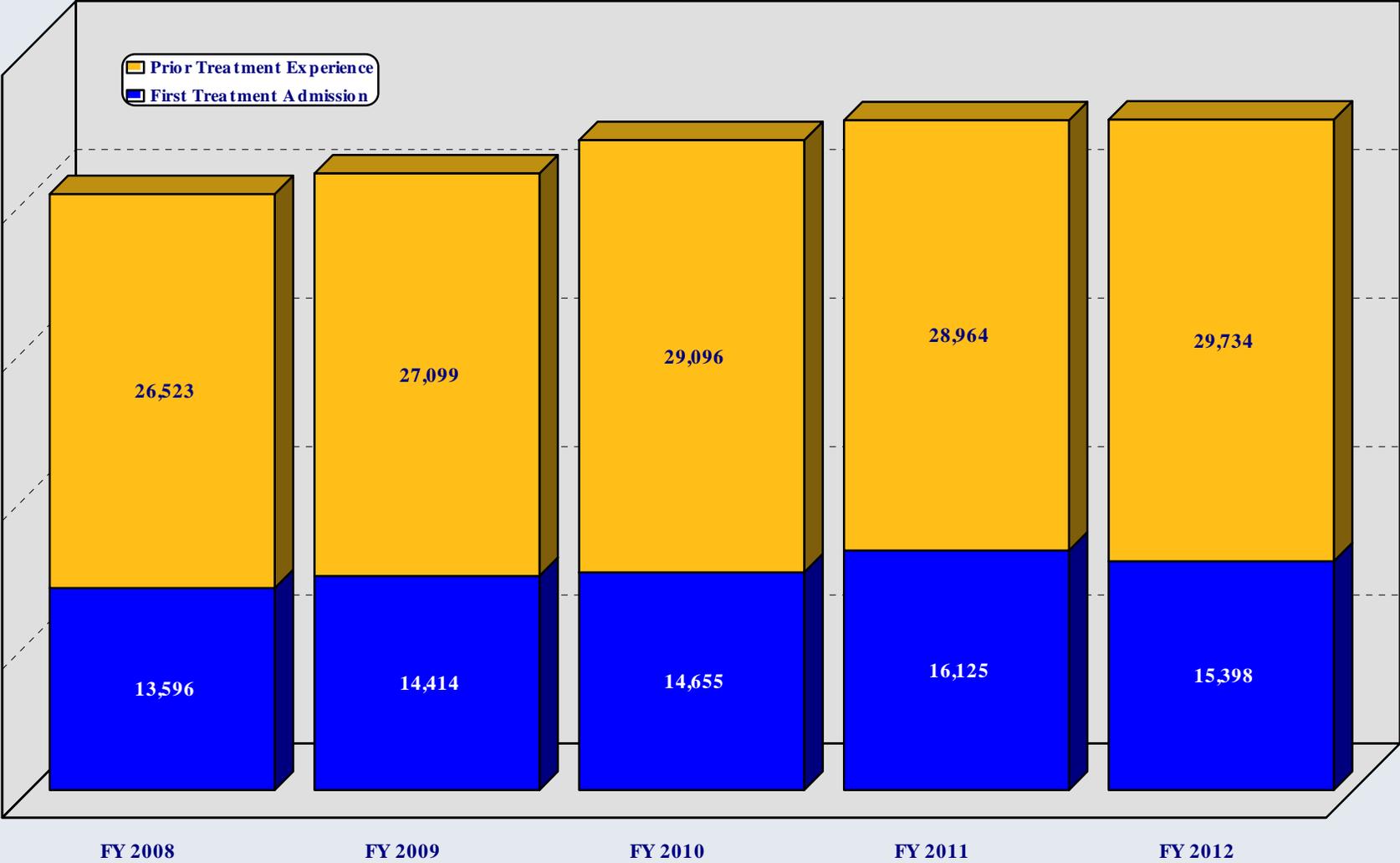


Figure 2
Admissions to State-Supported Alcohol and Drug Abuse
Treatment Programs Reporting Data
FY 2008 to FY 2012

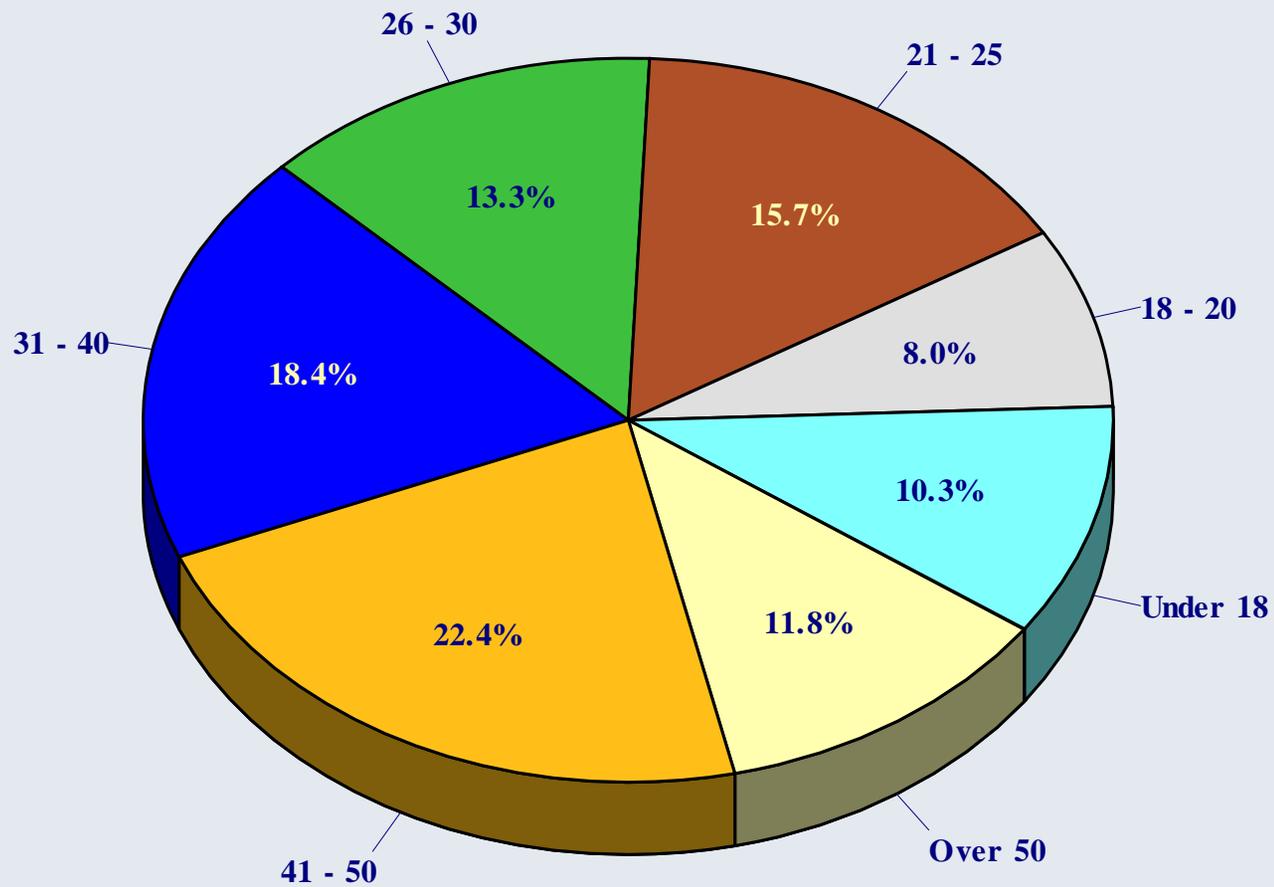


As shown in Figure 1, State-supported treatment admissions, individuals admitted and enrollments increased slightly in FY 2012, while the individuals involved declined. An admission coincides with an initial enrollment in a treatment program; subsequent enrollments may ensue as part of the same treatment episode.

The ratio of admissions to individuals increased each year from 1.23 in FY 2008 to 1.27 in FY 2012. The ratio of enrollments to admissions also increased each year from 1.17 in FY 2008 to 1.27 in FY 2012. These results are consistent with ADAA's promotion of an effective continuum of care throughout the State-supported treatment network.

Figure 2 shows the number of reported first-time treatment admissions increased by 19 percent from FY 2008 to 2011 but fell back by 5 percent in FY 2012. About two-thirds of FY 2012 admissions had at least one prior treatment admission.

Figure 3
Patient Age at Admission to State-Supported Alcohol and Drug Abuse
Treatment Programs Reporting Data
FY 2012

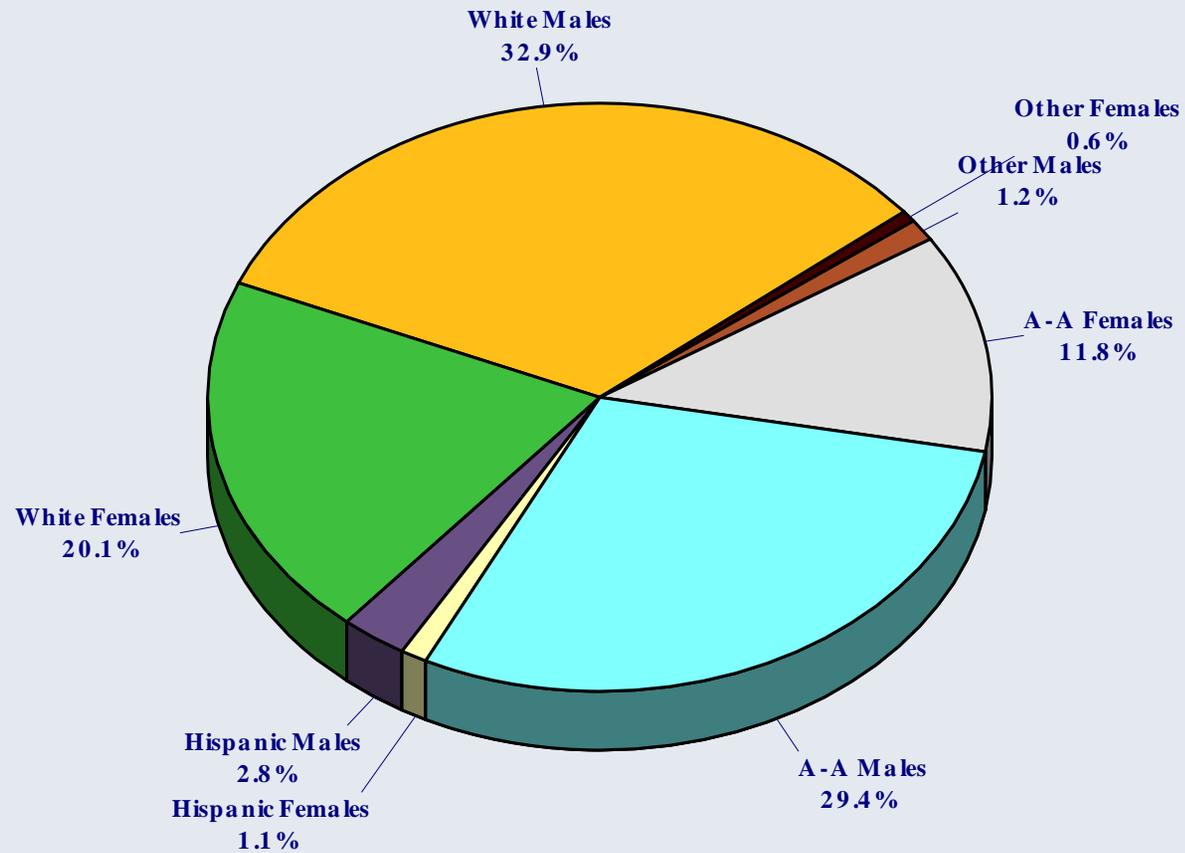


N = 45,129

Age at Admission

In FY 2012 10 percent of admissions involved adolescents and 12 percent involved persons over the age of 50. (Figure 3). In the past five years the categories of patients in their twenties and of those over 50 have undergone the greatest expansion. In FY 2012 eighteen percent of admissions were under 21 and 33 percent were over 40. Since FY 2008 the number of admissions over age 50 increased 37 percent, reflecting increasing problem drug and alcohol use by older adults.

Figure 4
Admissions by Race/Ethnicity/Gender to State-Supported Alcohol and Drug Abuse Treatment Programs Reporting Data
FY 2012

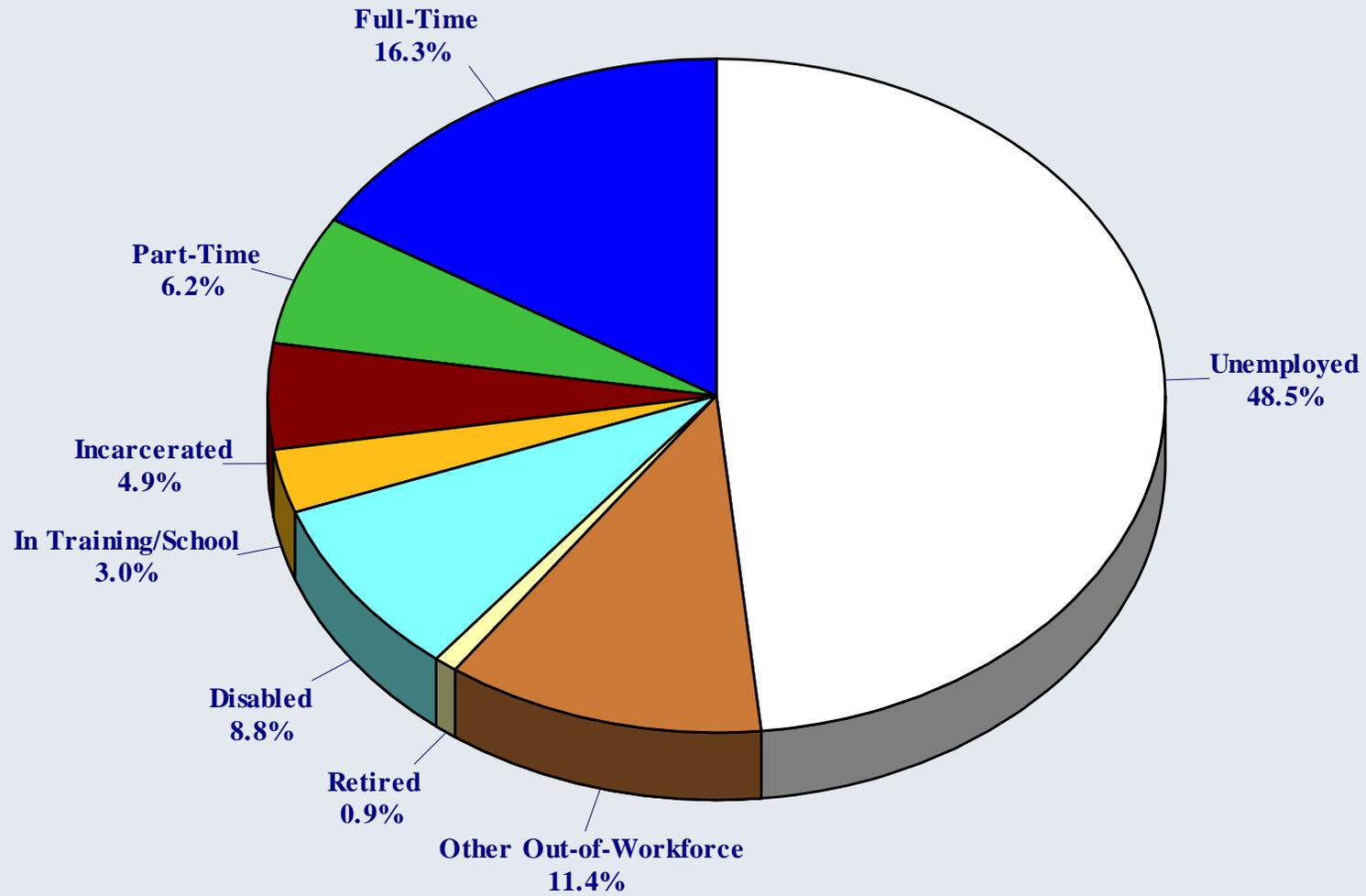


N = 45,132

Race/Ethnicity/Gender

The race/ethnicity/gender breakdown of admissions is shown in Figure 4. Just over a third of all admissions were female. About 52 percent of admissions were white; the percentage of admissions involving African-Americans fell from 46 percent in FY 2008 to 41 percent in FY 2012. While the male/female ratio was 1.64 for whites and 2.48 for African-Americans, it was 2.56 for Hispanics, a decline from about 3.0 in FY 2011, reflecting increased access by Hispanic females. While the number of Hispanic-male admissions increased 27 percent since FY 2008 Hispanic females increased by 78 percent.

Figure 5
Employment Status for Adults (18 and Older) at Admission to State-Supported
Alcohol and Drug Abuse Treatment Programs Reporting Data
FY 2012

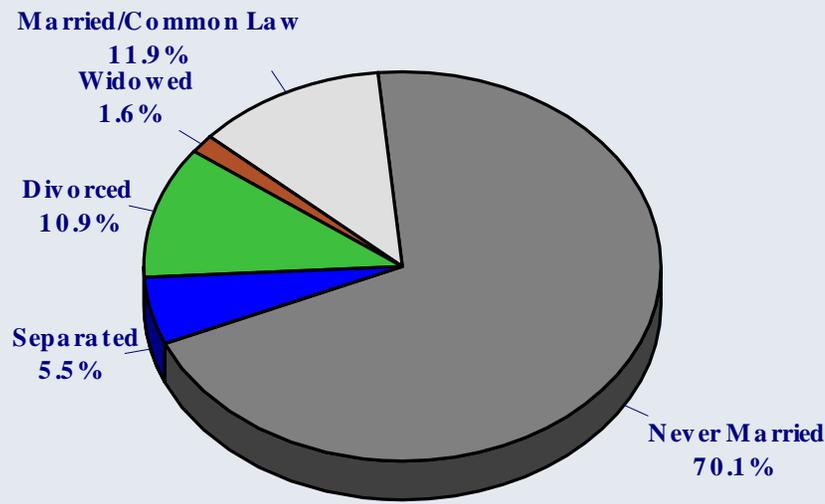


N = 40,475

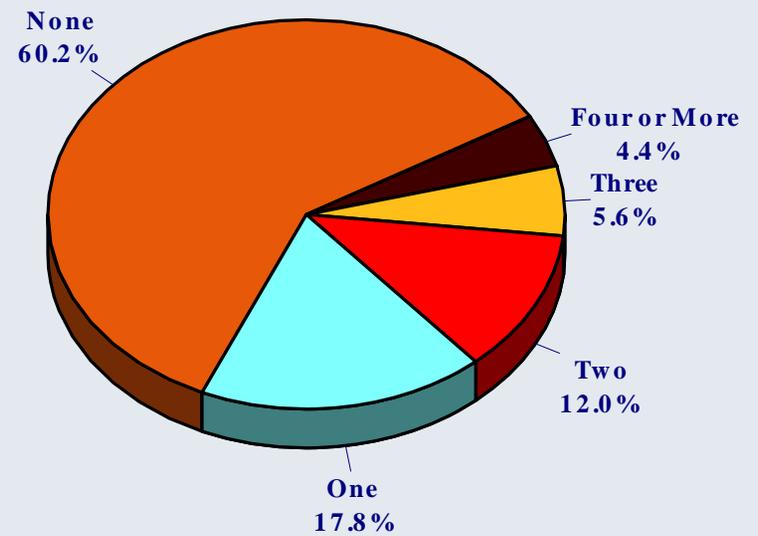
Employment Status

Figure 5 displays the distribution of FY 2012 adult admissions by employment status. Only 16 percent of adult admissions were employed full-time and 6 percent part-time as they entered treatment. Full-time employment among adult admissions has declined steadily from 22 percent in FY 2008, no doubt related to the economic difficulties facing the State and nation.

Figure 6
Marital Status and Numbers of Dependent Children of Admissions to State-Supported Alcohol and Drug Abuse Treatment Programs Reporting Data FY 2012



Marital Status
N = 45,012



Number of Dependent Children
N = 45,132

Marital Status & Dependent Children

Seventy percent of FY 2012 admissions had never been married and 12 percent were married or in a common-law relationship, as shown in Figure 6.

Forty percent of the admissions to treatment in FY 2012 reported having one or more dependent children. The 24,065 unduplicated males admitted during FY 2012 reported a total of 17,458 dependent children, while the 11,560 individual females reported 12,107 children.

Five percent of the 11,424 females of child-bearing age admitted during FY 2012 were pregnant at admission and two percent were uncertain about their pregnancy status.

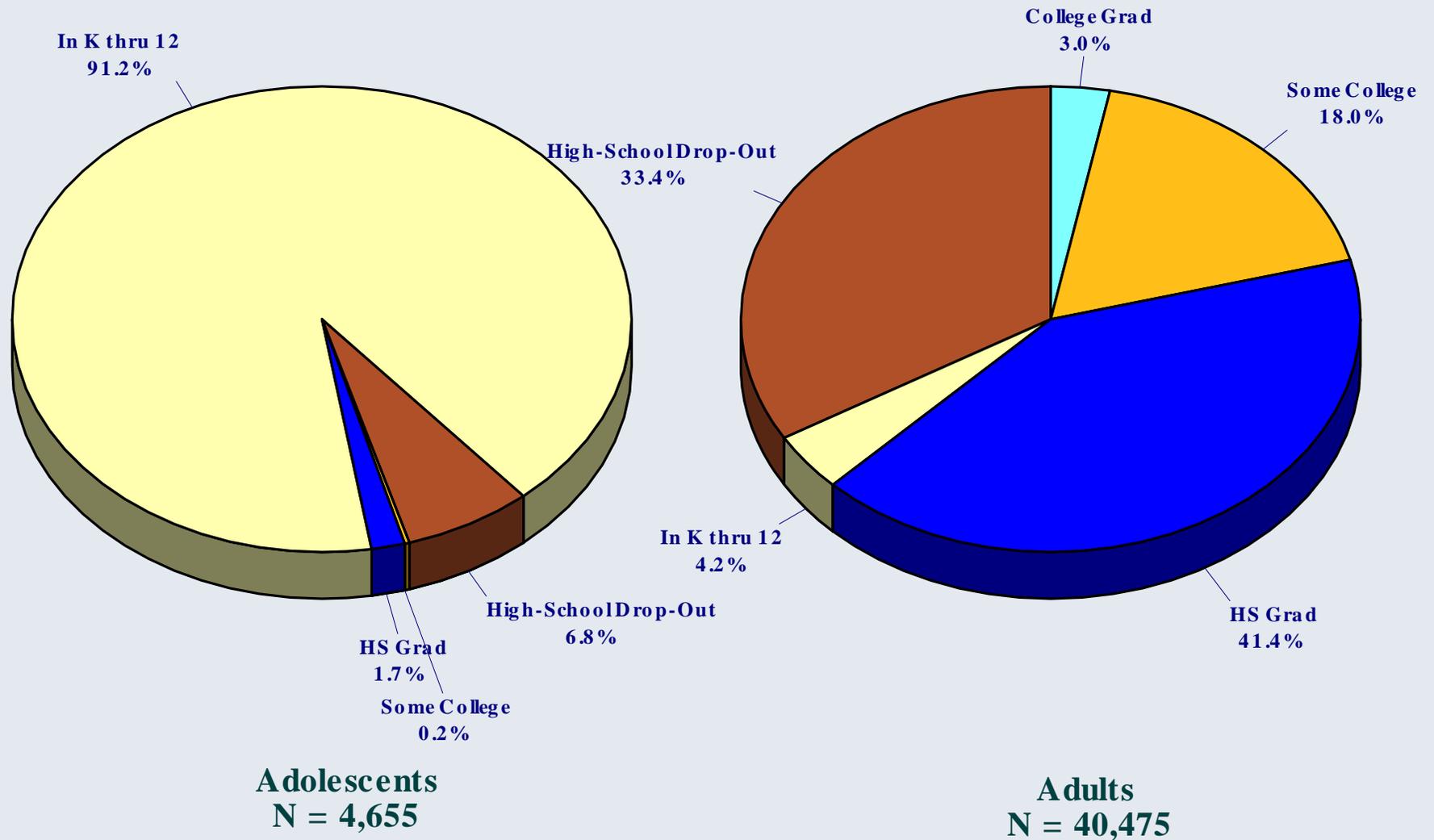
Table 1
Patient Residence for Admissions to State-Supported Alcohol
and Drug Abuse Treatment Programs Reporting Data
FY 2008 to FY 2012

Residence	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Allegany	929	851	848	728	687
Anne Arundel	2839	3050	3335	3770	4202
Baltimore City	12483	12510	12787	13328	13528
Baltimore County	3737	3838	4335	4610	4862
Calvert	1043	1182	1440	1573	1568
Caroline	361	463	473	455	452
Carroll	864	927	1135	1276	927
Cecil	798	777	807	1109	1368
Charles	1223	1195	1186	1095	1098
Dorchester	572	593	654	720	680
Frederick	1201	1255	1429	1419	1266
Garrett	302	354	346	367	378
Harford	1083	889	1091	1305	1372
Howard	597	699	889	934	919
Kent	420	395	354	365	297
Montgomery	2634	2759	2477	2280	2230
Prince George's	2499	2467	2521	2247	2041
Queen Anne's	594	680	791	601	710
St. Mary's	836	969	1147	1212	1123
Somerset	362	386	342	328	369
Talbot	452	493	526	496	410
Washington	1165	1245	1278	1195	1159
Wicomico	1147	1255	1284	1568	1475
Worcester	828	766	792	787	810
Out-of-State	1150	1515	1484	1321	1201
Total	40119	41513	43751	45089	45132

Patient Residence

Admissions are distributed by location of residence from FY 2008 to FY 2012 in Table 1. The largest five-year increases involved residents of Cecil, Howard, Calvert, Anne Arundel and St. Mary's counties. Largest declines were in Kent, Allegany, Prince George's and Montgomery counties. Out-of-State residents decreased by 21 percent from FY 2009 to 2012. The locations contributing the largest percentages of the FY 2012 out-of-state residents admitted were Delaware (38.6), Washington, D.C. (29.3) and Virginia (11.0).

Figure 7
Educational Attainment at Admission to State-Supported Alcohol and Drug Abuse Treatment Programs Reporting Data
FY 2012

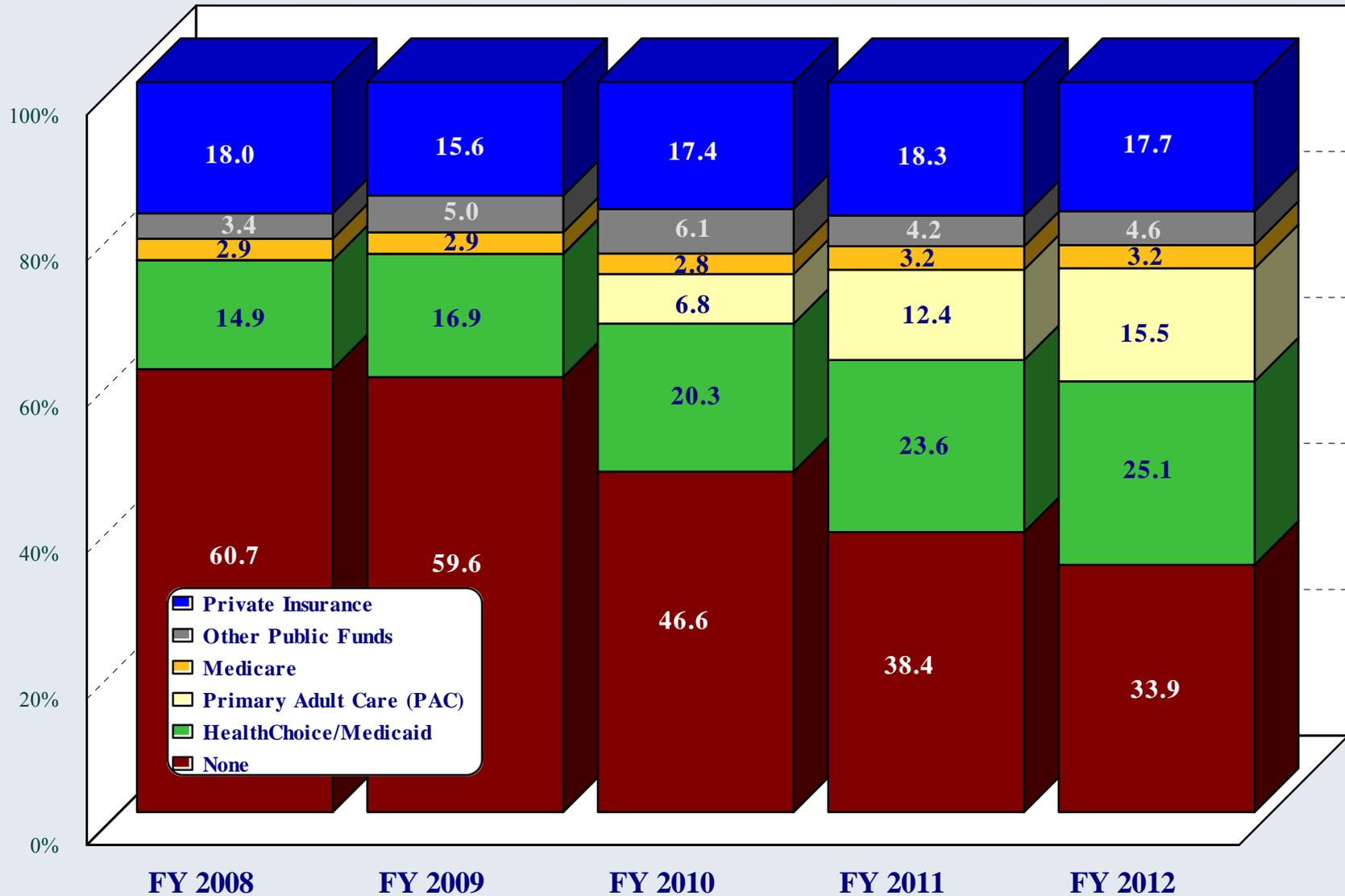


Educational Status

The educational attainment of adolescent and adult admissions is shown in Figure 7. Nine out of ten adolescents were attending school.

Only about 62 percent of adult FY 2012 treatment admissions had high-school diplomas. Considering jointly items on highest school grade completed, employment and attending grades K through 12 reveals 6 percent of adolescents and a third of adults admitted could be classified as high-school drop-outs.

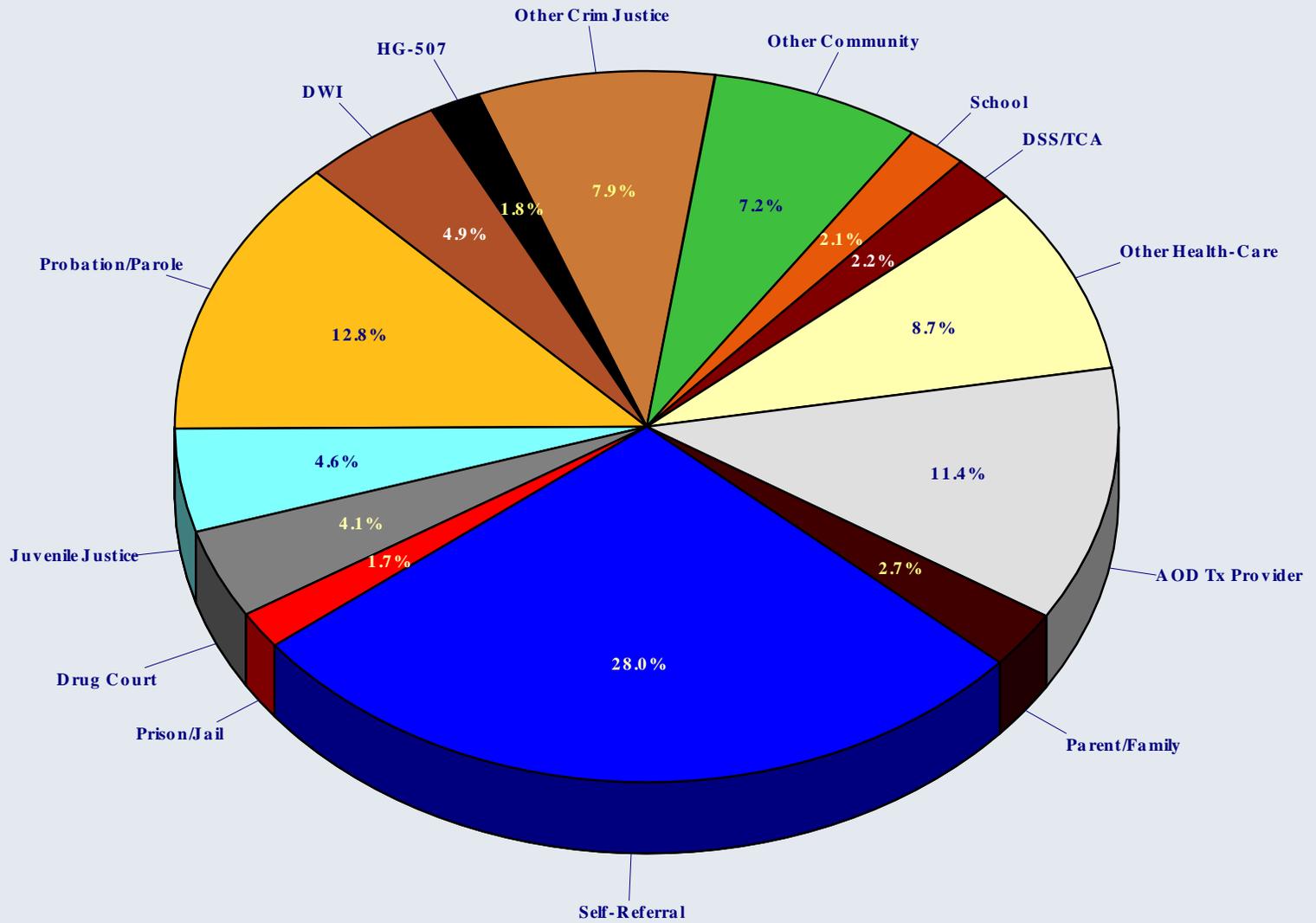
Figure 8
Health Coverage of Admissions to State-Supported Alcohol
and Drug Abuse Treatment Programs Reporting Data
FY 2008 to FY 2012



Health Coverage

Health coverage of admissions is shown in Figure 8. Admissions involving patients with no health coverage decreased steadily from 61 percent in FY 2008 to just over a third in FY 2012. Another 48 percent were under a public health-care plan. The number of admissions with Primary Adult Care (PAC) increased 135 percent from FY 2010 as ADAA and DHMH expanded efforts to maximize coverage by this funding source. Admissions with private insurance were relatively stable.

Figure 9
Source of Referral to State-Supported Alcohol and Drug Abuse Treatment Programs
Reporting Data
FY 2012



N = 43,852

Source of Referral

Figure 9 shows that 28 percent of admissions were self or family referrals and 20 percent were from substance-use-disorder or other health-care providers. Criminal-justice sources accounted for 38 percent of admissions in FY 2012, down slightly from the previous fiscal year.

Defining Treatment Levels of Care

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. Detoxification services are delivered in Level I.D.

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. Detoxification services are delivered in Level OMT.D.

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. Detoxification services are delivered in Level II.D.

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, Care is delivered by an interdisciplinary staff to patients whose sub-acute biomedical and emotional/behavioral problems are sufficiently severe to require inpatient care. Detoxification services are delivered in Level III.7.D.

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

Table 2
Admissions and Enrollments by ASAM Level of Care in State-Supported Alcohol and Drug Abuse Treatment Programs Reporting Data
FY 2008 to FY 2012

ASAM Level of Care	FY 2008			FY 2009			FY 2010			FY 2011			FY 2012		
	Adm	Enr	E/A Ratio												
Level 0.5	295	302	1.02	687	703	1.02	1026	1068	1.04	2125	2201	1.04	1852	1938	1.05
Level I	17203	19796	1.15	17264	20452	1.18	17164	20397	1.19	16946	20872	1.23	16041	19907	1.24
Level I.D	259	309	1.19	323	414	1.28	225	278	1.24	45	49	1.09	65	75	1.15
Level II.1	6448	7500	1.16	7025	8295	1.18	7080	8326	1.18	7717	9257	1.20	8125	9745	1.20
Level II.5	423	855	2.02	444	1071	2.41	792	1517	1.92	971	1797	1.85	838	1693	2.02
Level II.D	191	225	1.18	89	99	1.11	102	120	1.18	105	126	1.20	53	62	1.17
Level III.1	1807	1919	1.06	1687	1765	1.05	1539	1678	1.09	1363	1518	1.11	1216	1367	1.12
Level III.3	730	815	1.12	749	852	1.14	1488	1622	1.09	1618	1726	1.07	1470	1552	1.06
Level III.5	854	913	1.07	1115	1362	1.22	1163	1313	1.13	1074	1202	1.12	1229	1360	1.11
Level III.7	5491	7469	1.36	4583	6773	1.48	5028	8040	1.60	5042	8097	1.61	5130	8147	1.59
Level III.7.D	4170	4237	1.02	4676	4768	1.02	5280	5381	1.02	5089	5176	1.02	5270	5369	1.02
OMT	2247	2418	1.08	2865	3136	1.09	2853	3150	1.10	2902	3253	1.12	3791	4139	1.09
OMT.D	1	1	1.00	6	7	1.17	11	12	1.09	92	111	1.21	52	56	1.08
Total	40119	46759	1.17	41513	49697	1.20	43751	52902	1.21	45089	55385	1.23	45132	55410	1.23

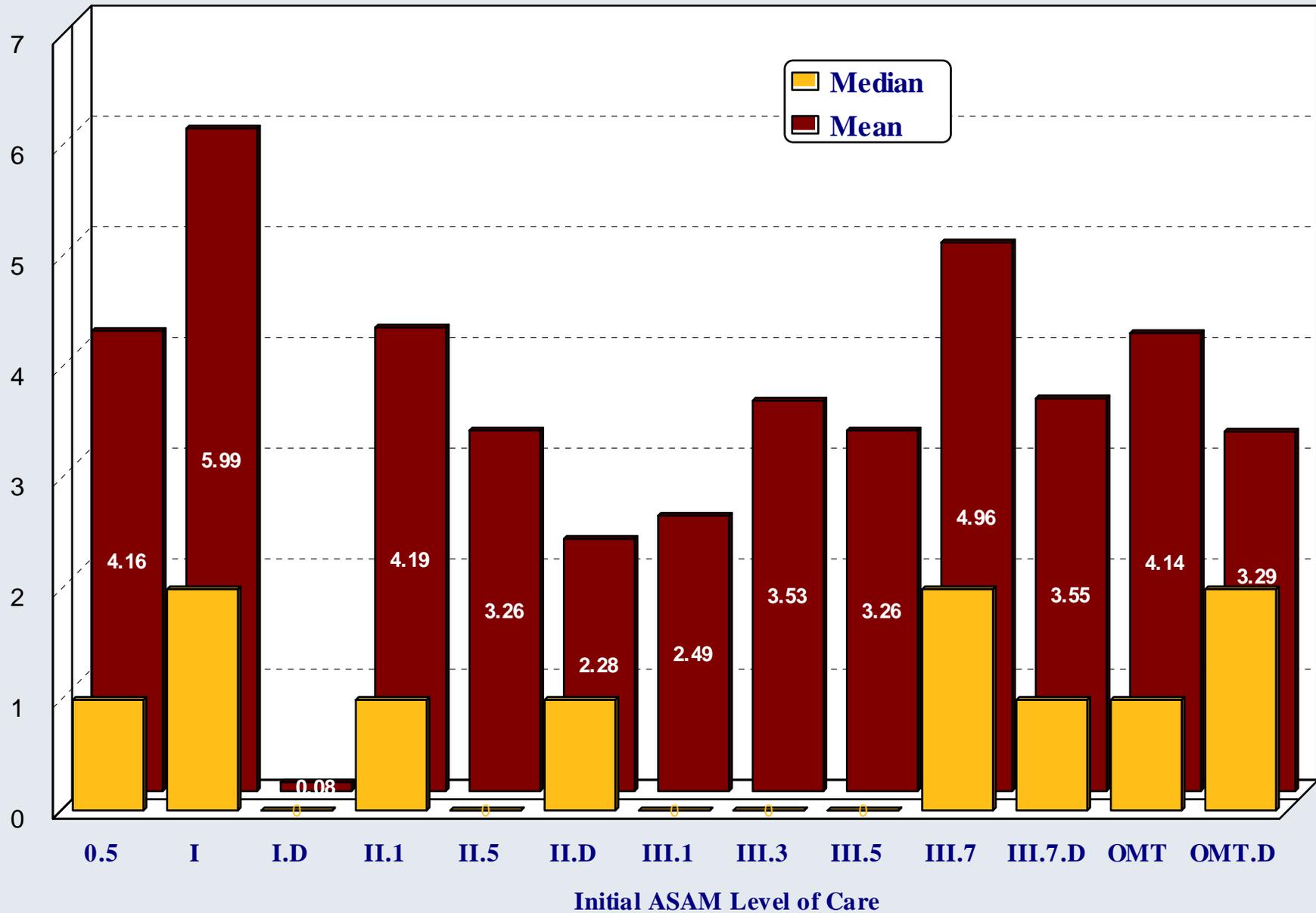
ASAM Levels

Table 2 presents the distributions of state-supported admissions and enrollments by level of care over the past five years. Admissions reflect the initial enrollments in treatment episodes; subsequent enrollments during the episodes (transfers to other levels of care) are not counted as admissions.

The overall ratio of enrollments to admissions was 1.23 in FY 2011 and 2012 compared to 1.17 in FY 2008, reflecting increased reliance on the continuum of care to promote patient recovery. Not surprisingly the highest enrollment/admission ratios were in levels of care to which patients are typically transferred or referred from more intensive levels.

Largest increases from FY 2008 to 2012 were in Levels 0.5 (Early Intervention), III.3, II.5, OMT and III.5. Largest declines were in the Levels I.D and II.D. Consistently just over two-thirds of admissions entered ambulatory levels of care.

Figure 10
Median and Mean Days Waiting for Admission to State-Supported Alcohol and Drug Abuse Treatment
Programs Reporting Data
FY 2012

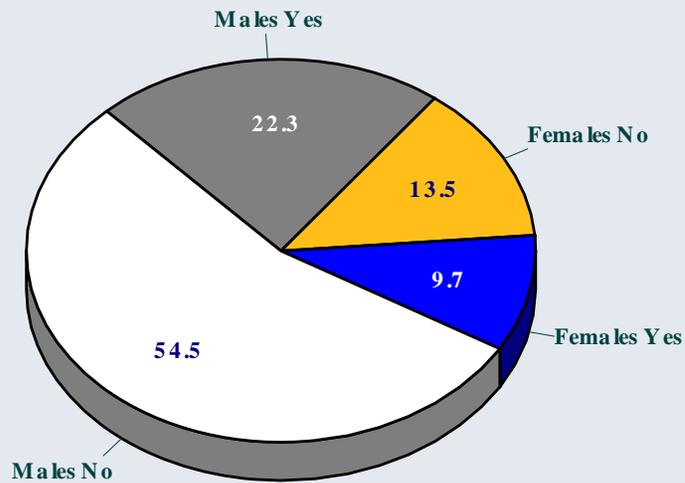


Waiting Time to Enter Treatment

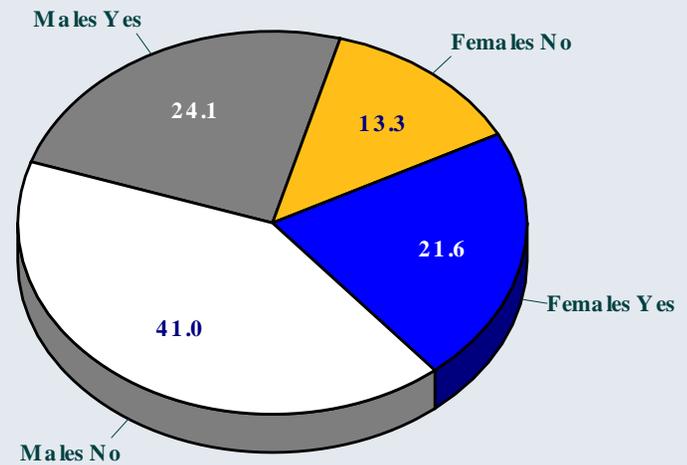
Figure 10 shows those seeking State-supported treatment in Maryland had less than six days on average between their initial request for treatment and the admission date to any level of care. For Levels II.5, III.1, III.3 and III.5 the median wait to enter treatment was zero days, indicating more than half the admissions to those levels involved same-day entry.

The overall average days patients wait to enter State-supported treatment has gone down each year from 7.6 in FY 2008 to 4.7 in FY 2012.

Figure 11
Mental-Health Problem(s) and Gender at Admission to State-Supported Alcohol and Drug Abuse Treatment Programs Reporting Data
FY 2012



Adolescents
N = 4,655



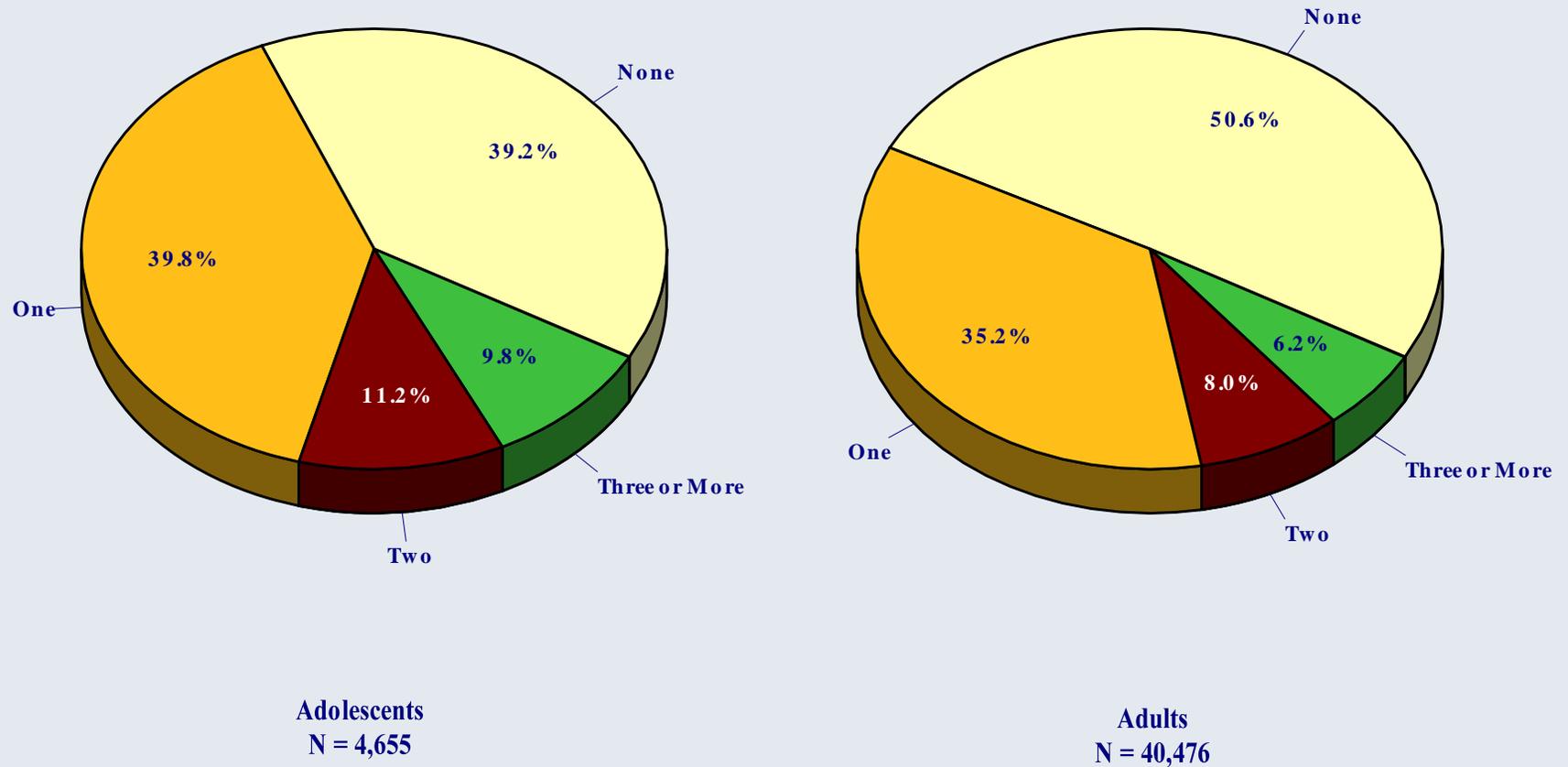
Adults
N = 40,476

Mental-Health Problems

There was a steady increase in the number and percentage of admissions identified as involving mental-health problems in addition to substance-use-disorders in each year from FY 2008 to 2012. Figure 11 shows 32 percent of adolescents and 46 percent of adults had mental-health issues at admission to State-supported alcohol and drug-abuse treatment. In both groups, but especially among adults, females were significantly more likely to be reported as having mental-health problems than males.

Figure 12

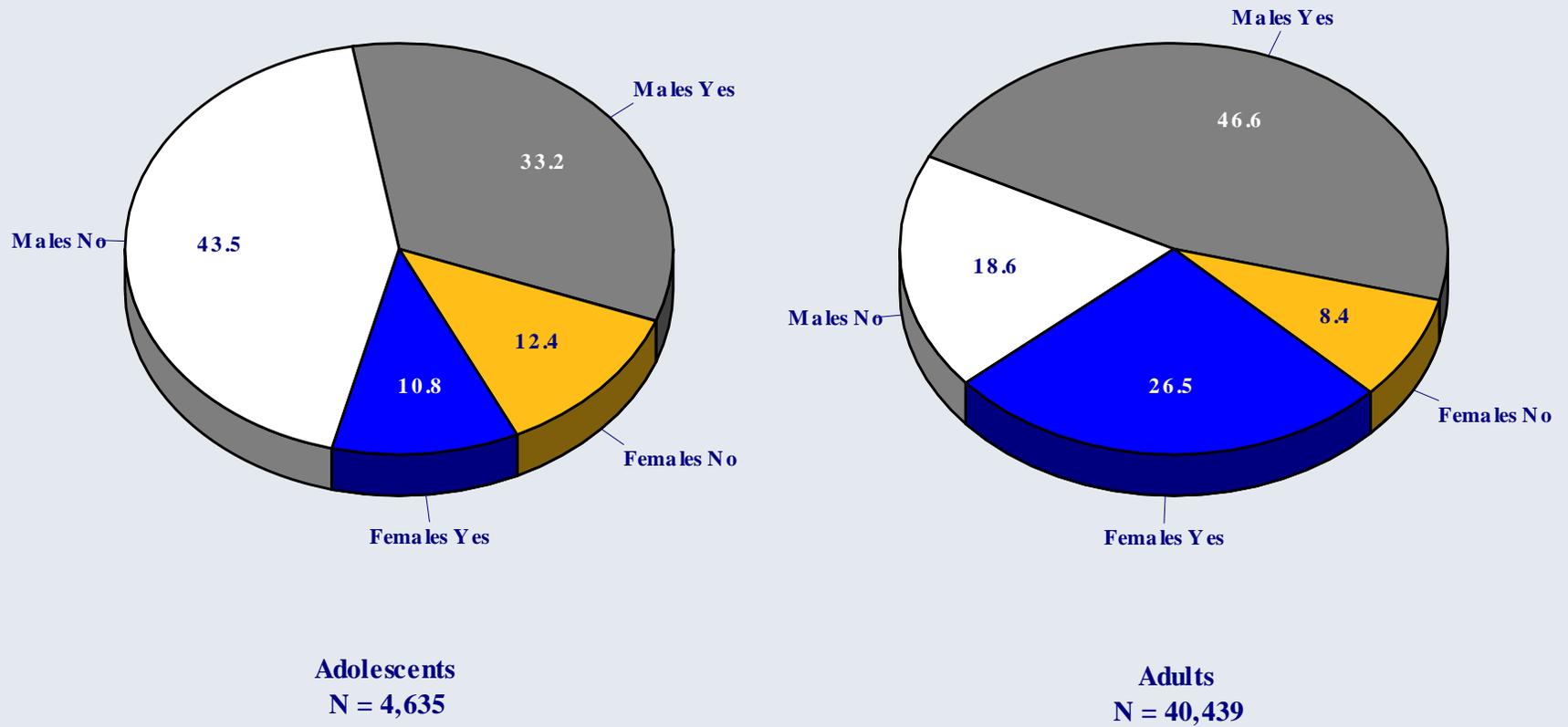
**Number of Arrests in the 12 Months before Admission to State-Supported Alcohol and Drug Abuse Treatment Programs Reporting Data
FY 2012**



Arrests

Half of adult and 60 percent of adolescent treatment patients had been arrested in the year preceding admission to treatment (Figure 12). The higher percentage for adolescents is related to the finding that 48 percent of adolescents and only 37 percent of adults were referred by components of the criminal-justice system in FY 2012.

Figure 13
Tobacco Use and Gender at Admission to State-Supported Alcohol and Drug Abuse Treatment Programs
Reporting Data
FY 2012

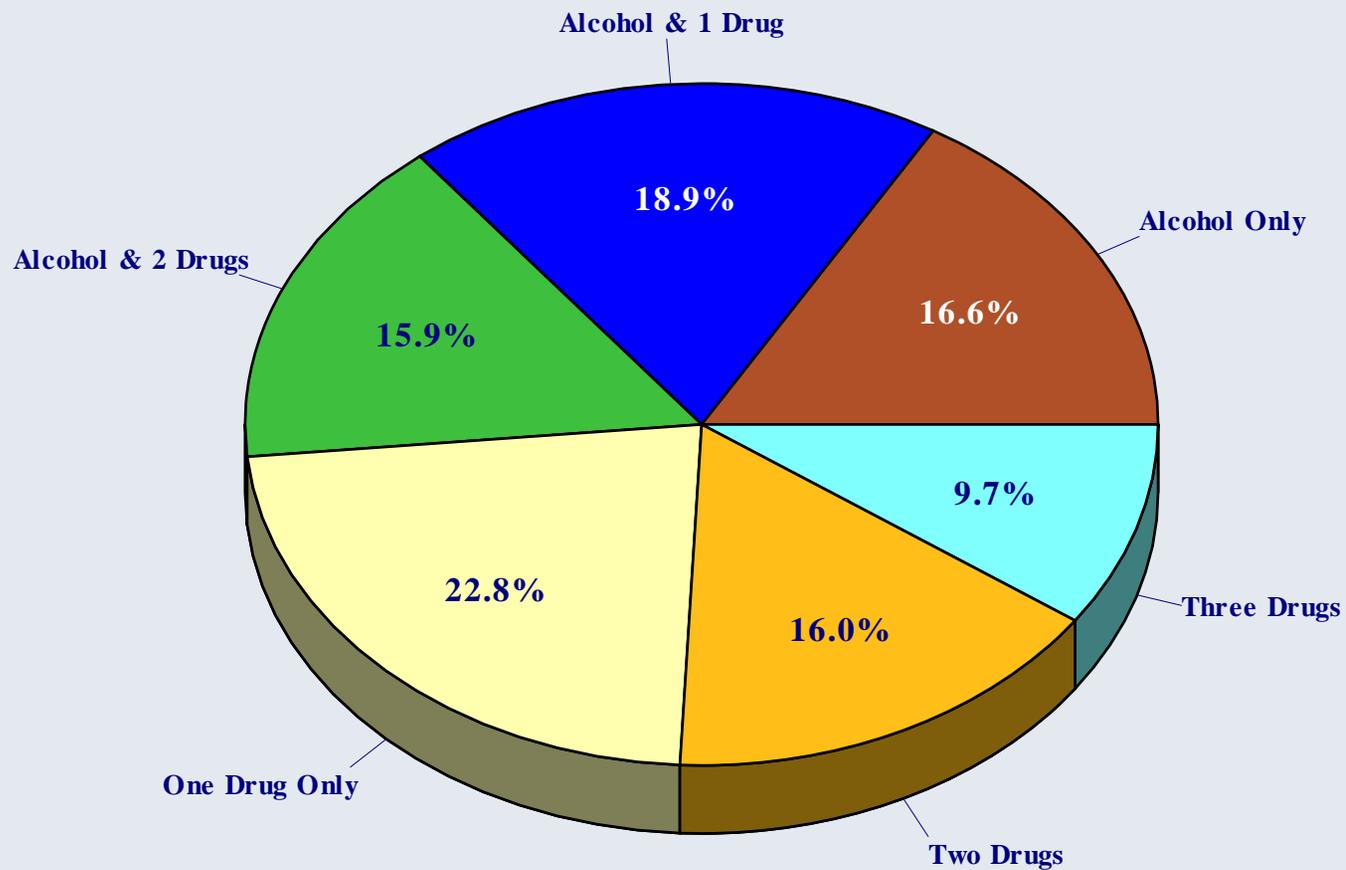


Tobacco Use

Figure 13 shows the percentages of adolescent and adult admissions using tobacco by gender in the month preceding admission. Forty-four percent of the adolescents and 73 percent of adult admissions were smokers, far exceeding the percentages in the general population. As in the case of mental-health problems, females were more likely than males to be smokers in each age group. In Maryland, cigarette smoking has been shown to be associated with failure to complete substance-use-disorder treatment.

State-supported treatment programs are required to include smoking cessation in the treatment plans of tobacco-using patients who can be encouraged to quit.

Figure 14
Pattern of Substance Abuse Problems among Admissions to State-Supported Alcohol and Drug Abuse Treatment Programs Reporting Data FY 2012



N = 45,132

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

Substance Abuse

The patterns of substance problems among admissions are shown in Figure 14. Alcohol was involved in 52 percent of all admissions; 35 percent involved both alcohol and other drugs. Sixty percent of admissions involved multiple substance problems.

Ninety-three percent of adolescent admissions involved marijuana; 44 percent involved alcohol and 39 percent involved both substances.

Table 3
Substance Problems among Admissions to State-Supported Alcohol and Drug Abuse
Treatment Programs Reporting Data
FY 2008 to FY 2012

Substance Problems	FY 2008		FY 2009		FY 2010		FY 2011		FY 2012	
	#	%	#	%	#	%	#	%	#	%
Alcohol	22725	56.6	22958	55.3	23571	53.9	23958	53.1	23210	51.4
Crack	11732	29.2	9970	24.0	9211	21.1	8861	19.7	8756	19.4
Other Cocaine	5756	14.3	5048	12.2	4994	11.4	5186	11.5	5313	11.8
Marijuana/Hashish	14792	36.9	16260	39.2	17195	39.3	18542	41.1	18343	40.6
Heroin	12468	31.1	12575	30.3	13613	31.1	12936	28.7	13486	29.9
Non-Rx Methadone	458	1.1	521	1.3	523	1.2	558	1.2	539	1.2
Oxycodone	2096	5.2	2990	7.2	4244	9.7	5220	11.6	6075	13.5
Other Opioids	1402	3.5	1786	4.3	2284	5.2	2735	6.1	2877	6.4
PCP	697	1.7	861	2.1	916	2.1	945	2.1	960	2.1
Hallucinogens	232	0.6	277	0.7	224	0.5	324	0.7	312	0.7
Methamphetamines	110	0.3	123	0.3	136	0.3	110	0.2	139	0.3
Other Amphetamines	341	0.9	302	0.7	294	0.7	317	0.7	328	0.7
Stimulants	30	0.1	29	0.1	36	0.1	44	0.1	49	0.1
Benzodiazepines	1319	3.3	1498	3.6	2111	4.8	2661	5.9	3031	6.7
Other Tranquilizers	11	0.0	6	0.0	6	0.0	10	0.0	5	0.0
Barbiturates	30	0.1	31	0.1	19	0.0	22	0.0	17	0.0
Other Sedatives or Hypnotics	83	0.2	63	0.2	70	0.2	85	0.2	96	0.2
Inhalants	28	0.1	40	0.1	30	0.1	59	0.1	48	0.1
Over the Counter	88	0.2	59	0.1	59	0.1	91	0.2	68	0.2
Other	251	0.6	270	0.7	302	0.7	382	0.8	348	0.8
Total Respondents	40116	—	41513	—	43751	—	45089	—	45125	—

Table 3 presents detail on the substance problems reported for admissions from FY 2008 to FY 2012. The most significant increases over the four years involved:

- Oxycodone (190 percent);
- Other Opioids (105 percent);
- Benzodiazepines (130 percent);
- PCP (38 percent); and,
- Hallucinogens (34 percent).

Inhalants and stimulants also increased significantly but with relatively small numbers. Marijuana-related admissions increased by 24 percent and heroin by 8 percent.

The largest decrease occurred among crack-cocaine-related admissions (25 percent), and with small totals - tranquilizers, barbiturates and over-the-counter drugs.

Figure 15
Leading Primary-Substance Problems for Admissions to State-Supported Alcohol and
Drug Abuse Treatment Programs Reporting Data
FY 2008 to FY 2012

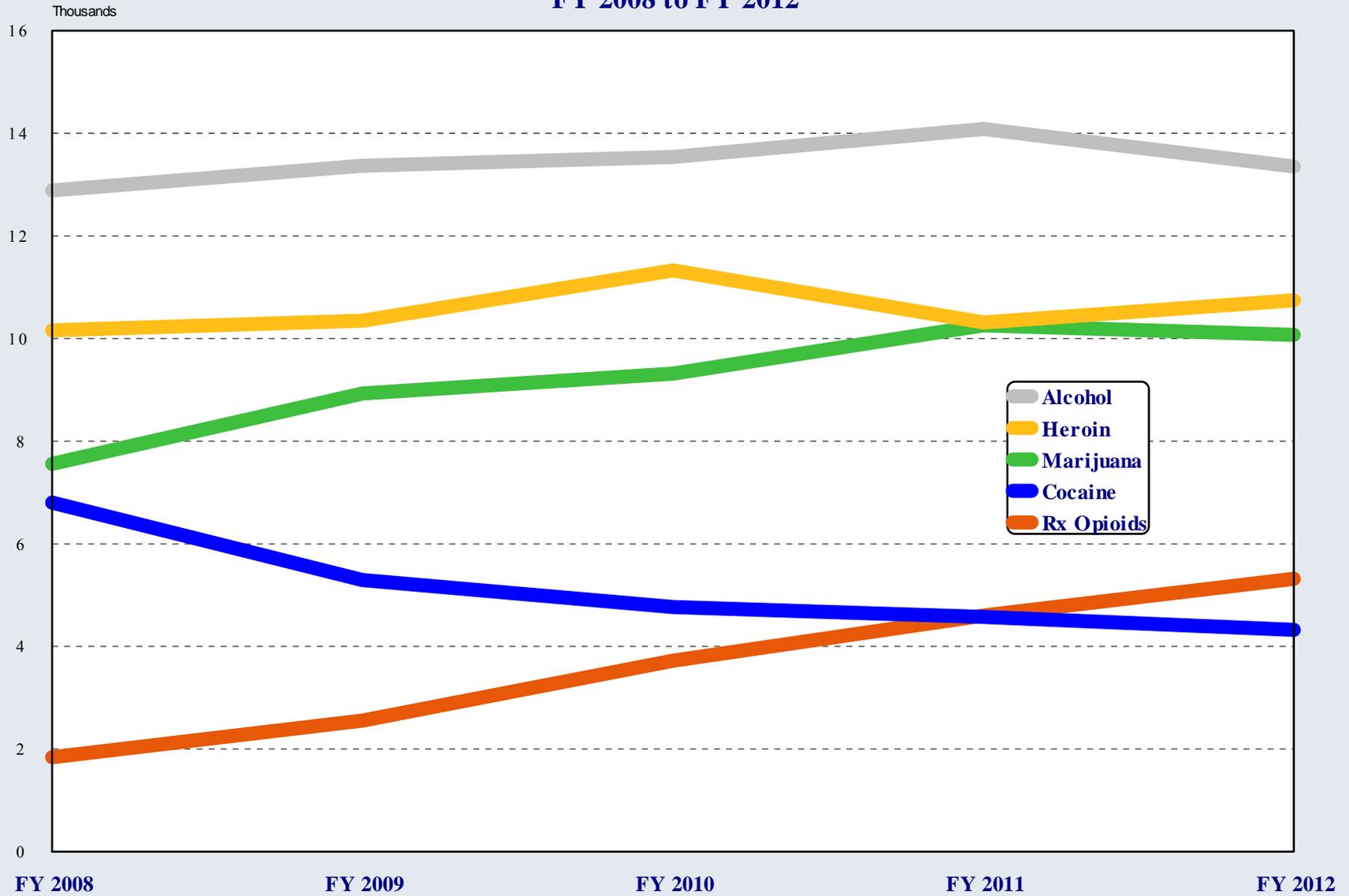
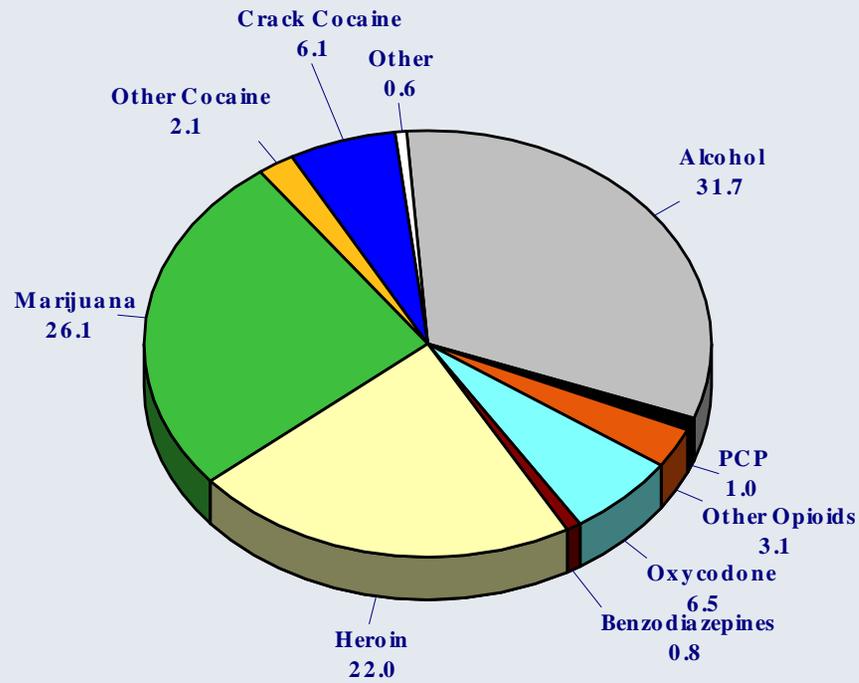
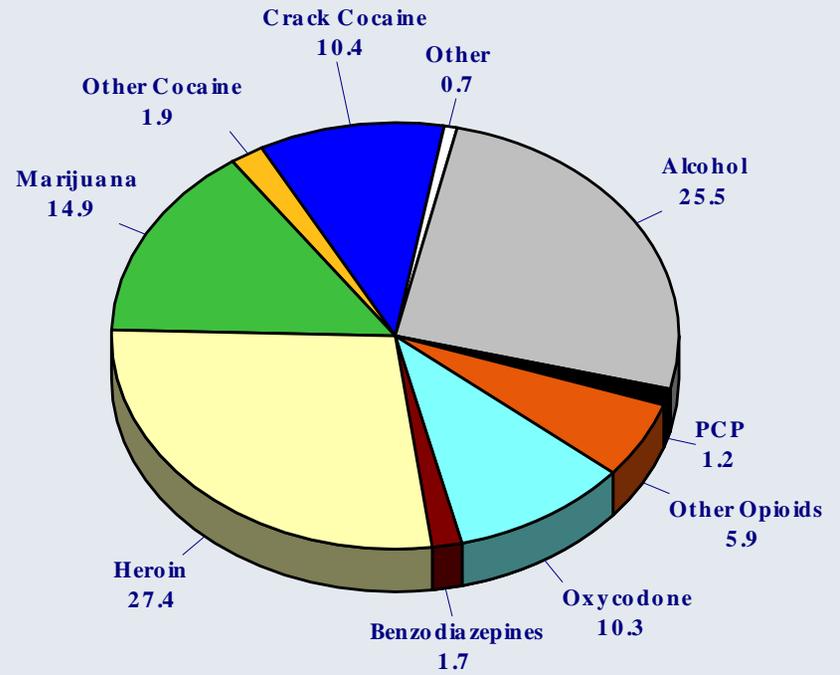


Figure 16
Primary-Substance Problem at Admission to State-Supported Alcohol and Drug Abuse
Treatment Programs Reporting Data
FY 2012



Males
N = 29,920



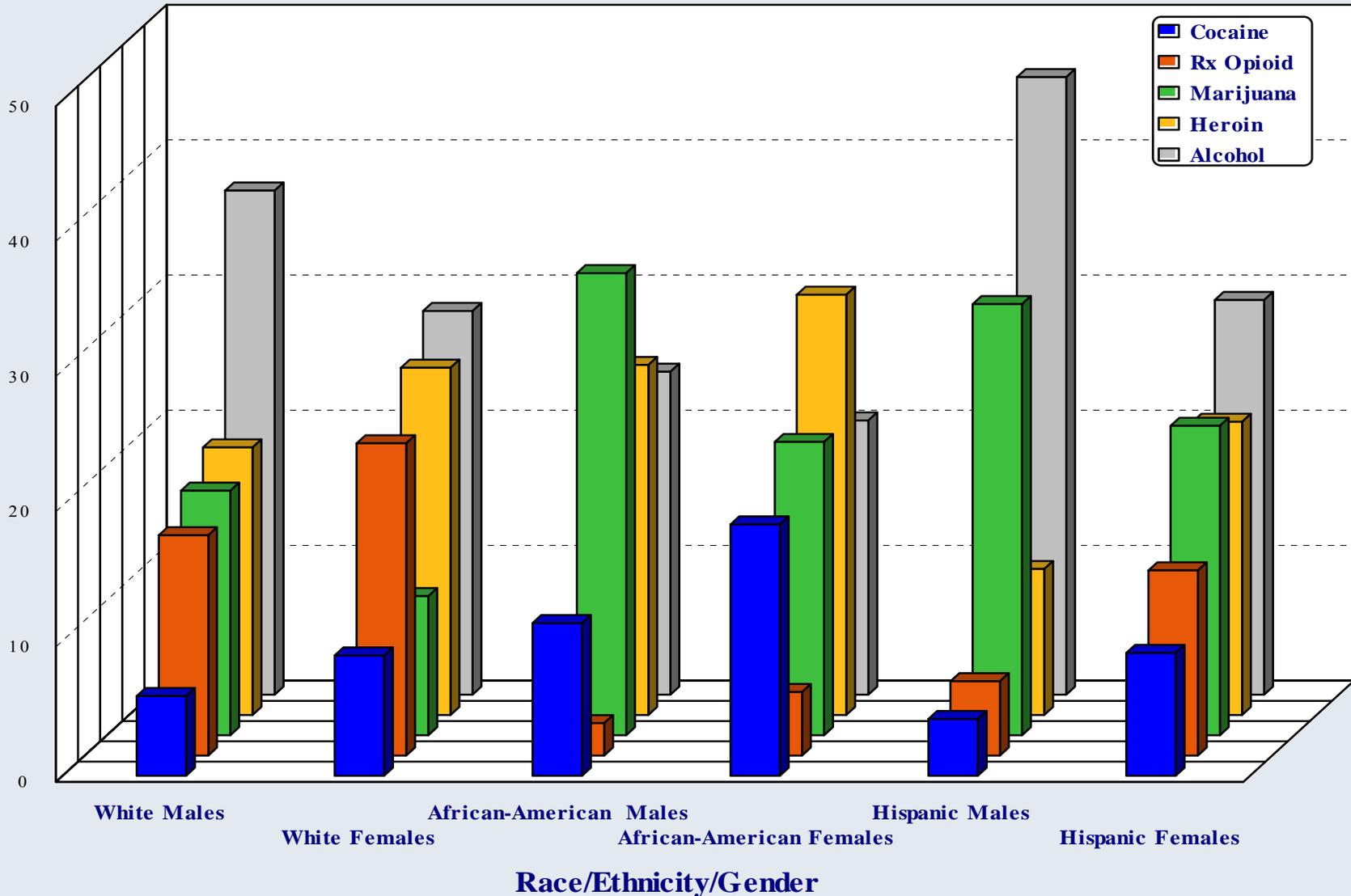
Females
N = 15,178

Figure 15 shows the five-year trends in the five leading categories of primary-substance problems. While alcohol and marijuana had been trending upward through FY 2011 FY 2012 saw each decline. Prescription opioids increased 189 percent over the five years while cocaine fell 36 percent. After a 9 percent drop in FY 2011 heroin increased 4 percent in FY 2012.

Figure 16 distributes the FY 2012 percentages of leading primary-substance problems for males and females. Higher percentages of females than males had primary substance problems of crack cocaine, heroin, oxycodone, other opioids, PCP and benzodiazepines. The highest percentage of females (27) had heroin as the primary problem, whereas heroin trailed alcohol and marijuana among males.

Eighty-four percent of adolescents admitted had primary problems with marijuana and 11 percent with alcohol.

Figure 17
Percentages of Race/Ethnic/Gender Groups with Selected Primary-Substance Problems
Admissions to State-Supported Alcohol and Drug Abuse Treatment Programs Reporting Data
FY 2012



Note: Less than two percent of cases reported in other categories of race are excluded.

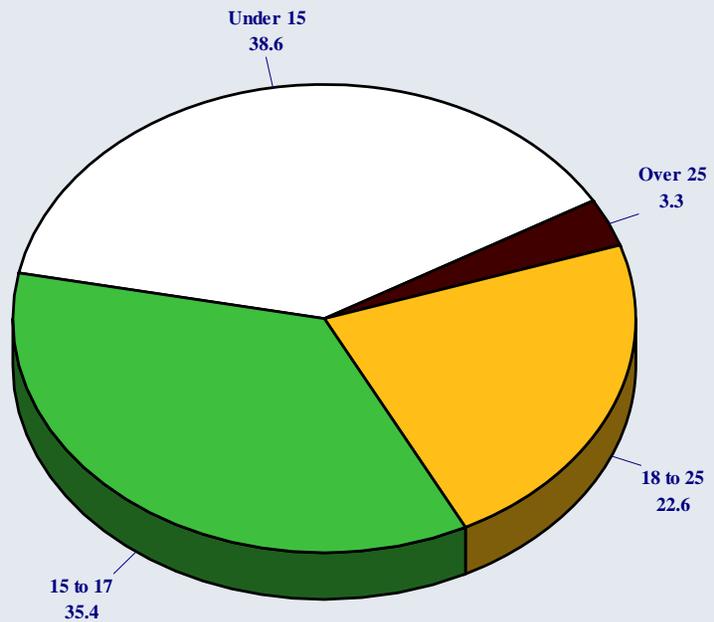
Figure 17 distributes the percentages of leading primary-substance problems for each of six race/ethnic/gender groups.

At 23 percent, white females had the highest percentage of primary problems of prescription opioids while African-American females had the highest percentages with cocaine primary at 19 and heroin primary at 31. Nearly half of the Hispanic males admitted had primary problems of alcohol.

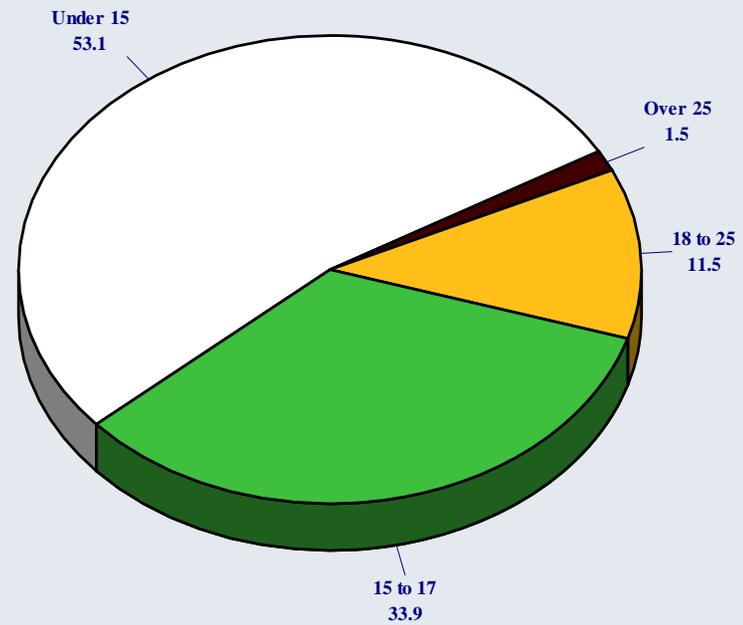
Percentages of females exceeded their male counterparts with respect to prescription opioids, cocaine and heroin primary problems among whites, African-Americans and Hispanics.

The opposite pattern occurred for marijuana and alcohol. Females entering the treatment system tend to have greater percentages of opioid and cocaine problems and mental-health issues than do males.

Figure 18
Age at First Use of Alcohol* and Marijuana
Admissions to State-Supported Alcohol and Drug Abuse
Treatment Programs Reporting Data
FY 2012



Alcohol
N = 23,045

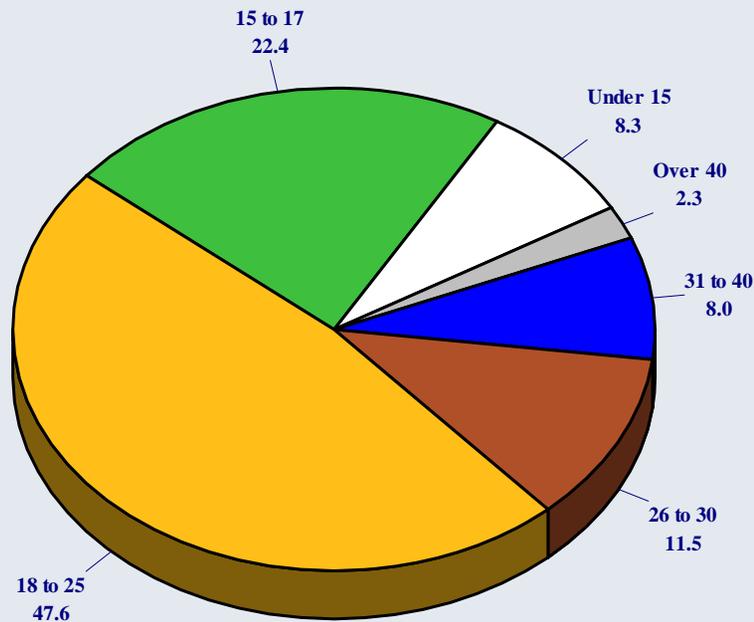


Marijuana
N = 18,228

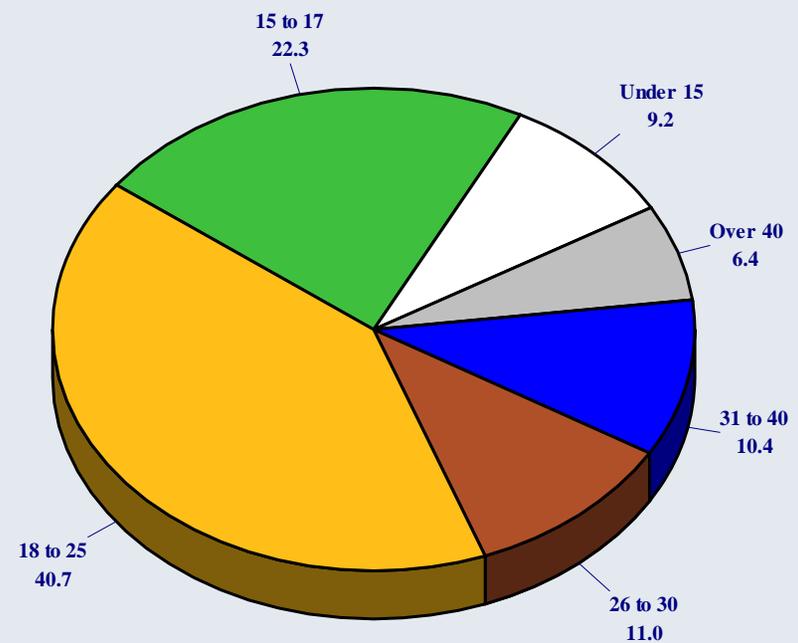
*For alcohol the age of first use is defined as the age of first intoxication.

Figure 18 shows the distributions of alcohol and marijuana-related admissions by reported age of first intoxication for alcohol and age of first use of marijuana. Over half of admissions with marijuana problems first used the drug before turning 15, and nearly forty percent of those with alcohol problems experienced their first intoxication at an earlier age than 15. Just under three-quarters of alcohol-related admissions experienced their first intoxication before turning 18 and 87 percent of marijuana-related admissions first used the drug as adolescents.

Figure 19
Age at First Use of Heroin and Other Opioids
Admissions to State-Supported Alcohol and Drug Abuse Treatment Programs Reporting Data
FY 2012



Heroin
N = 13,366

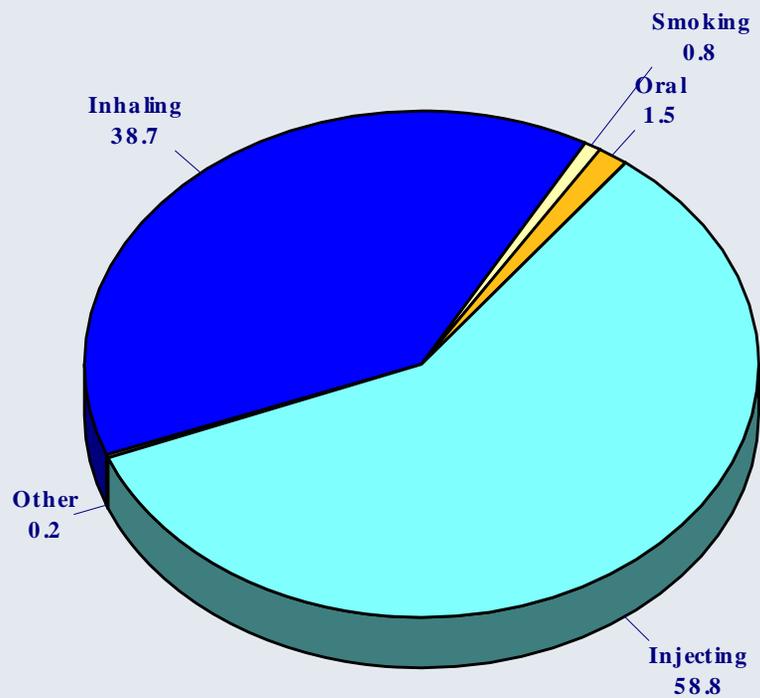


Other Opioids
N = 8,827

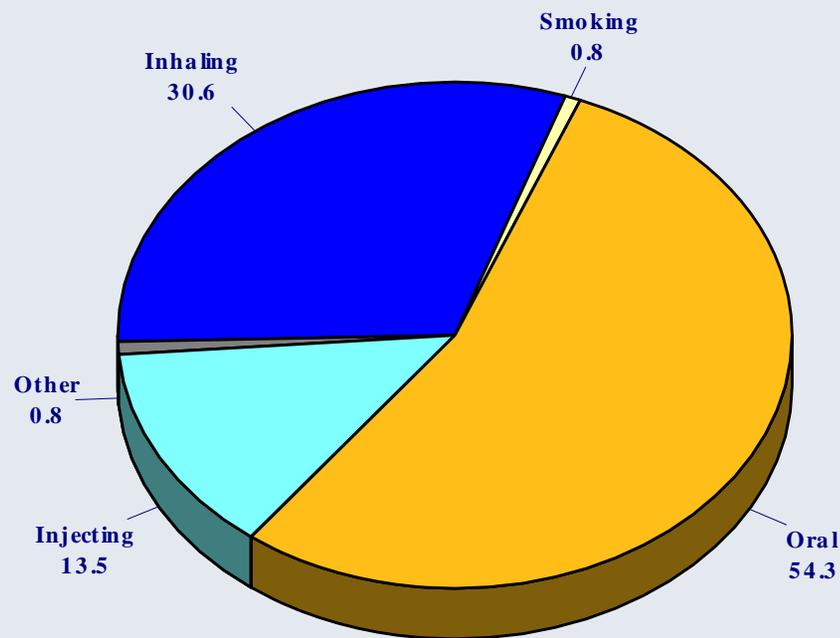
Distributions of age at first use of heroin and other opioids are shown in Figure 19. The distributions are similar, with 31 percent of each first using those drugs in adolescence. There was, however, a greater likelihood of first use of other opioids occurring after age 40.

From FY 2008 to FY 2012 the ages of first use of both heroin and other opioids have been trending downward. In FY 2012 78 percent of heroin and 72 percent of other-opioid-related admissions first used the drugs before turning 26.

Figure 20
Primary Route of Administration of Heroin and Other Opioids
Admissions to State-Supported Alcohol and Drug Abuse
Treatment Programs Reporting Data
FY 2012



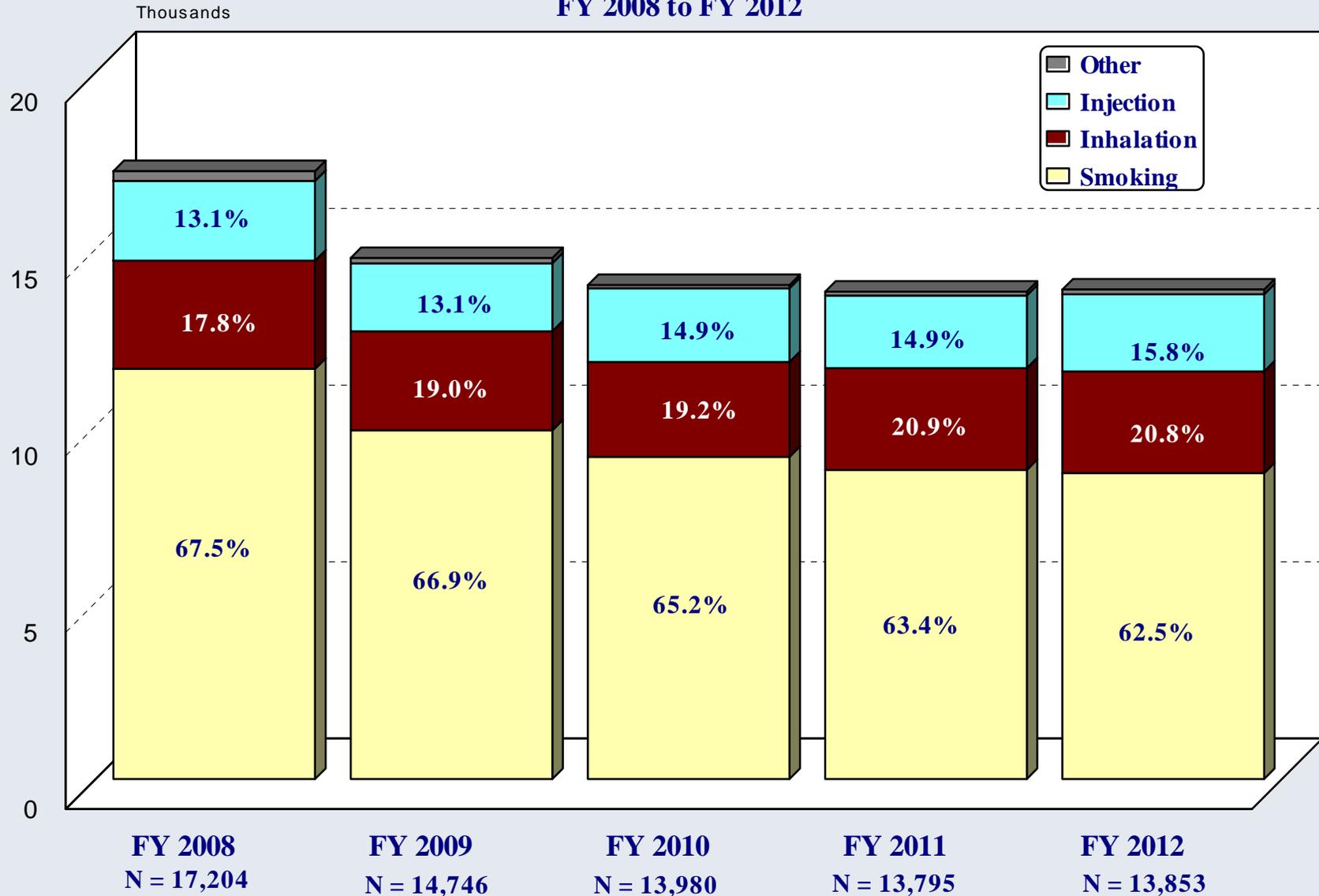
Heroin
N = 13,477



Other Opioids
N = 8,915

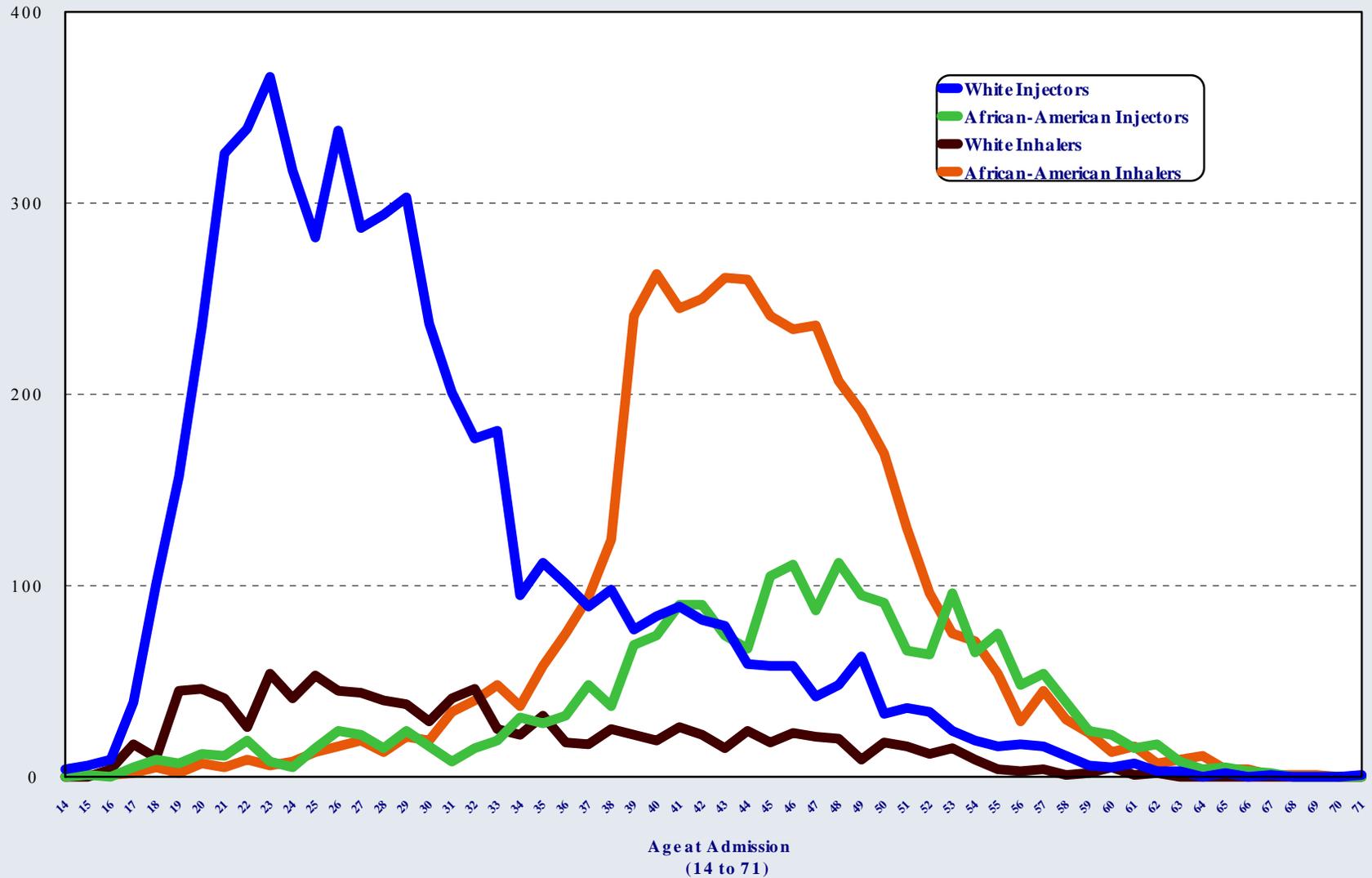
Figure 20 displays the primary routes of administration of heroin and other opioids among FY 2012 admissions. In FY 2008 heroin-related admissions were evenly split between injectors and inhalers; since then the balance has shifted toward injection, with 59 percent taking heroin by syringe in FY 2012. This trend correlates with a shift toward more white and Hispanic and fewer African-American heroin-related admissions. Whites rose from 38 percent of heroin cases in FY 2008 to 51 in FY 2012, while African-Americans went from 59 to 47 percent. During the five years oral ingestion of other-opioids decreased from 76 to 54 percent while inhalation rose from 17 to 31 percent and injection from 6 to 14 percent. This may be related to the development of abuse-resistant pharmaceutical opioid formulations.

Figure 21
Primary Route of Administration of Cocaine
Admissions to State-Supported Alcohol and Drug Abuse
Treatment Programs Reporting Data
FY 2008 to FY 2012



The pattern of cocaine administration from FY 2008 to 2012 is shown in Figure 21. While the numbers of primary inhalers and injectors of cocaine have remained relatively stable or increased slightly, smokers, or users of crack cocaine, have declined by 25 percent among admissions over the five years.

Figure 22
Heroin-Related Admissions to State-Supported Alcohol and Drug Abuse Treatment Programs
Reporting Data, by Primary Route of Administration, Race and Age
FY 2012

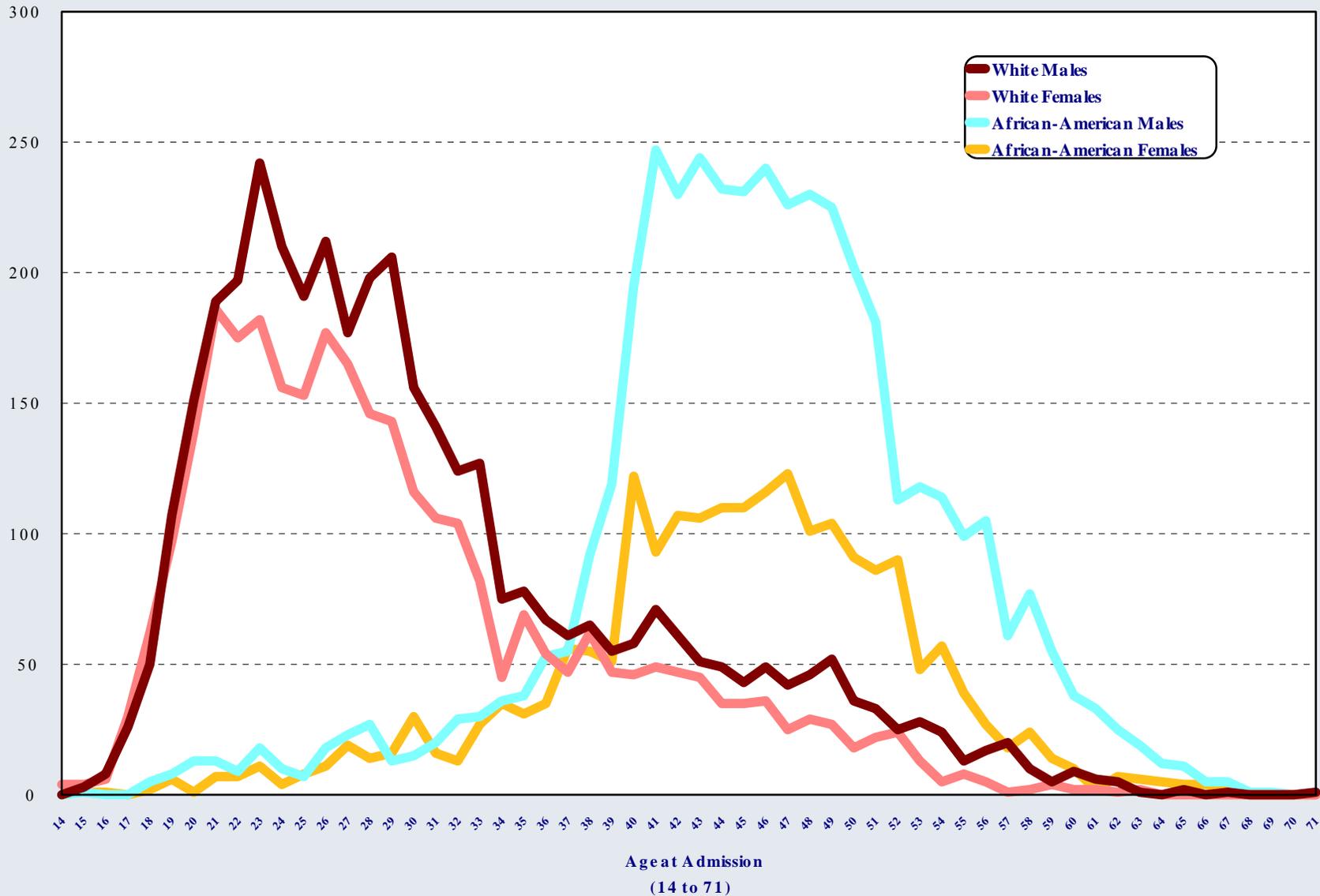


Note: Less than two percent of cases reported in other race categories are excluded.

Analysis of the interaction of age, race and route of administration of heroin, shown in Figure 21, revealed the two large components of FY 2012 heroin-related cases were white injectors in the age range of 18 to 33 and African-American inhalers from 38 to 52. This general pattern has been consistent in Maryland for more than ten years.

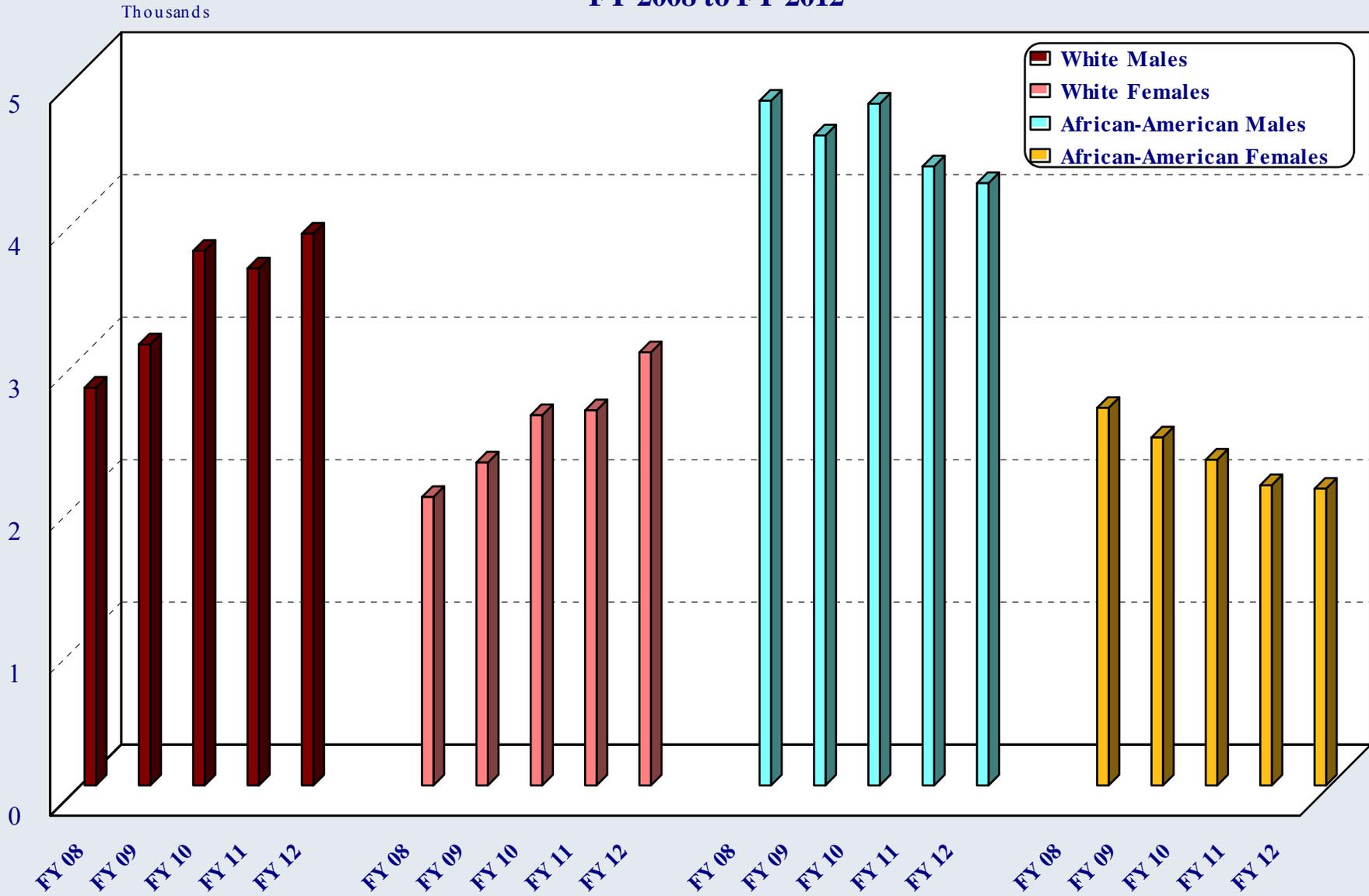
From FY 2008 to FY 2012, white males and females with heroin problems were about equally likely to enter OMT, at 16 and 20 percent respectively. African-Americans with heroin problems, however, went from 12 percent among males and 19 percent among females entering OMT in FY 2008 to 24 and 33 percent in FY 2012.

Figure 23
Heroin-Related Admissions to State-Supported Alcohol and Drug Abuse Treatment Programs
Reporting Data, by Race, Gender and Age
FY 2012



Note: Less than two percent of cases reported in other race categories are excluded.

Figure 24
Heroin-Related Admissions to State-Supported Alcohol and Drug Abuse Treatment Programs
Reporting Data, by Race and Gender
FY 2008 to FY 2012



Note: Less than two percent of cases reported in other race categories are excluded.

Figure 23 displays the distribution of race and gender by age for heroin-related admissions during FY 2012.

Although the number of African-American males exceeded white males among these cases, there were substantially more white females than African-American females.

As shown in Figure 24, over the five years white-male-heroin cases increased by 39 percent and white females by 50 percent, while African-American males dropped 12 percent and African-American females declined by 21 percent. For both genders whites were predominantly younger injectors and African-Americans were predominantly older inhalers. Notably, Hispanic males increased by a third and females by 93 percent among heroin-related admissions since FY 2008.

Table 4

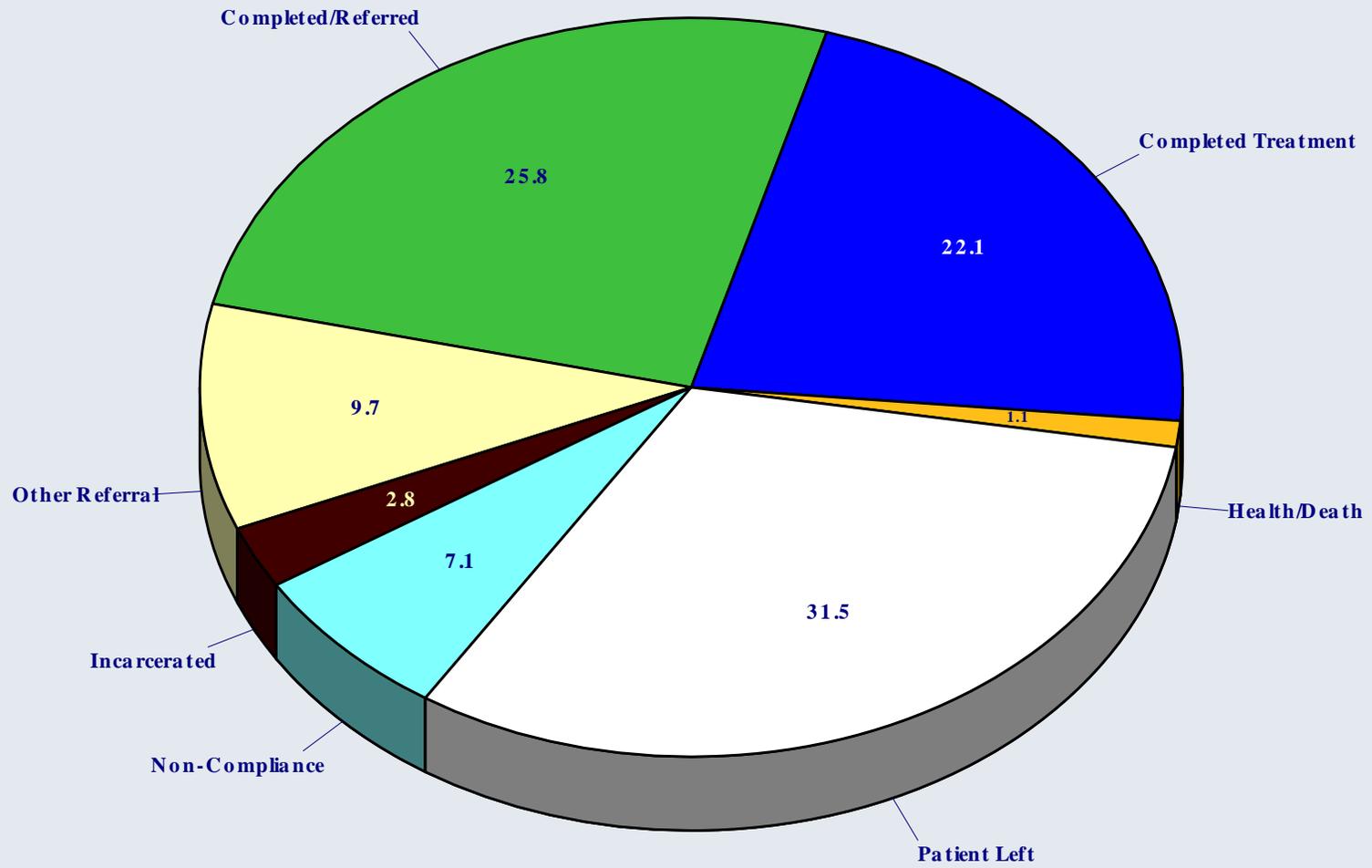
**Discharges from State-Supported Alcohol and Drug Abuse Treatment Programs
Reporting Data, by ASAM Level of Care at Discharge
FY 2008 to FY 2012**

ASAM Level of Care	FY 2008		FY 2009		FY 2010		FY 2011		FY 2012	
	#	%	#	%	#	%	#	%	#	%
Level 0.5	286	0.7	532	1.3	988	2.3	1881	4.3	1821	4.3
Level I	18485	45.9	19002	46.2	19528	44.6	18590	42.6	17262	40.6
Level I.D	116	0.3	118	0.3	96	0.2	26	0.1	32	0.1
Level II.1	5516	13.7	5803	14.1	5604	12.8	6166	14.1	6164	14.5
Level II.5	695	1.7	899	2.2	1113	2.5	1468	3.4	1448	3.4
Level II.D	164	0.4	52	0.1	63	0.1	53	0.1	16	0.0
Level III.1	1815	4.5	1702	4.1	1627	3.7	1463	3.3	1245	2.9
Level III.3	721	1.8	756	1.8	1394	3.2	1362	3.1	1358	3.2
Level III.5	898	2.2	1131	2.7	1206	2.8	982	2.2	1091	2.6
Level III.7	7191	17.9	6590	16.0	7765	17.7	7620	17.4	7420	17.5
Level III.7.D	1856	4.6	2008	4.9	1904	4.4	1564	3.6	1426	3.4
Level OMT	2507	6.2	2530	6.2	2453	5.6	2446	5.6	3177	7.5
Level OMT.D	27	0.1	9	0.0	24	0.1	63	0.1	52	0.1
Total	40277	100.0	41132	100.0	43765	100.0	43684	100.0	42512	100.0

Discharges

Discharges from State-supported treatment during FY 2008 to FY 2012 are distributed by ASAM level of care in Table 4. Discharges increased by 9 percent from FY 2008 to FY 2010 but decreased by 3 percent from that point to FY 2012. The ratio of admissions to discharges for FY 2008 to FY 2010 was about 1.00, reflecting completeness of reporting and stability in the SMART data system. The FY 2011 ratio was 1.03 and FY 2012 stands at 1.06, but with late-submitted discharges the eventual ratios will likely be close to 1.00.

Figure 25
Reason for Discharge from State-Supported Alcohol and Drug Abuse Treatment Programs Reporting Data
FY 2012

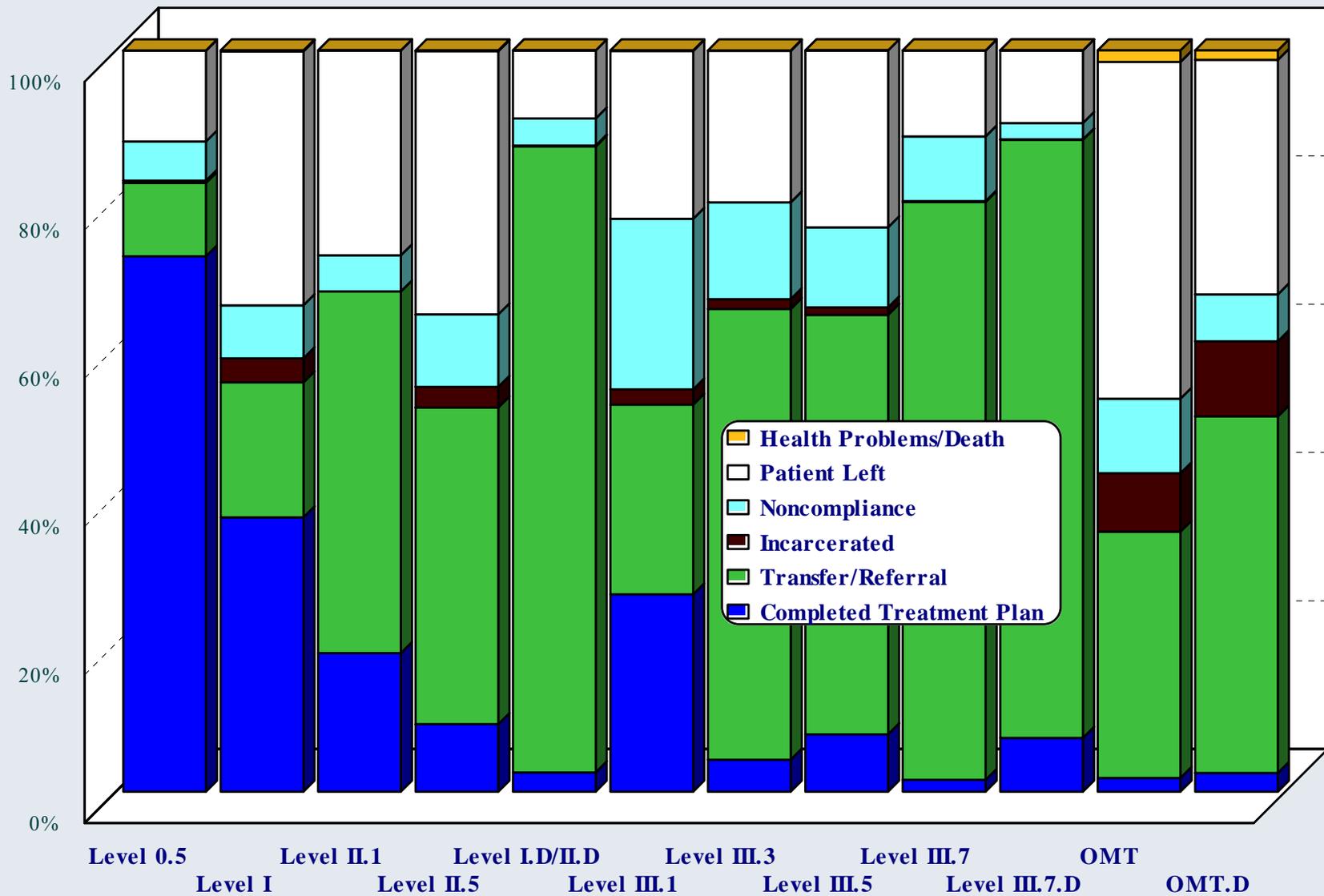


N = 42,512

Reason for Discharge

Figure 25 breaks out reasons for discharge from treatment during FY 2012. Just under half of discharges involved successful completion of the treatment plan, with 26 percent transferred or referred after completion of the immediate treatment plan. Thirty-two percent left against clinical advice before completing treatment and 7 percent were discharged for non-compliance with program rules.

Figure 26
Reason for Dis-enrollment from Levels of Care in State-Supported Alcohol
and Drug Abuse Treatment Programs Reporting Data
FY 2012



FY 2012 reasons for dis-enrollment are broken out by levels of care in Figure 26. Successful completion without need for further treatment was most common in Levels 0.5 (72 percent), I (37 percent) and III.1 (27 percent). Transfer/Referrals made up 80 percent or more of dis-enrollments from ambulatory non-OMT and residential detox and 78 percent from III.7. The level of care with the greatest percentage of dis-enrollments for non-compliance with program rules was III.1 at 23 percent. In OMT, 45 percent of the dis-enrollments involved patients leaving treatment early, which was also fairly common in Levels I and II.1 at about 35 percent.

Importantly, OMT dis-enrollments tend to be weighted with less successful cases, as those achieving stability tend to stay in treatment for extended time periods.

Table 5
Length of Stay for Dis-enrollments from Levels
of Care in State-Supported Alcohol and Drug
Abuse Treatment Programs Reporting Data
FY 2012

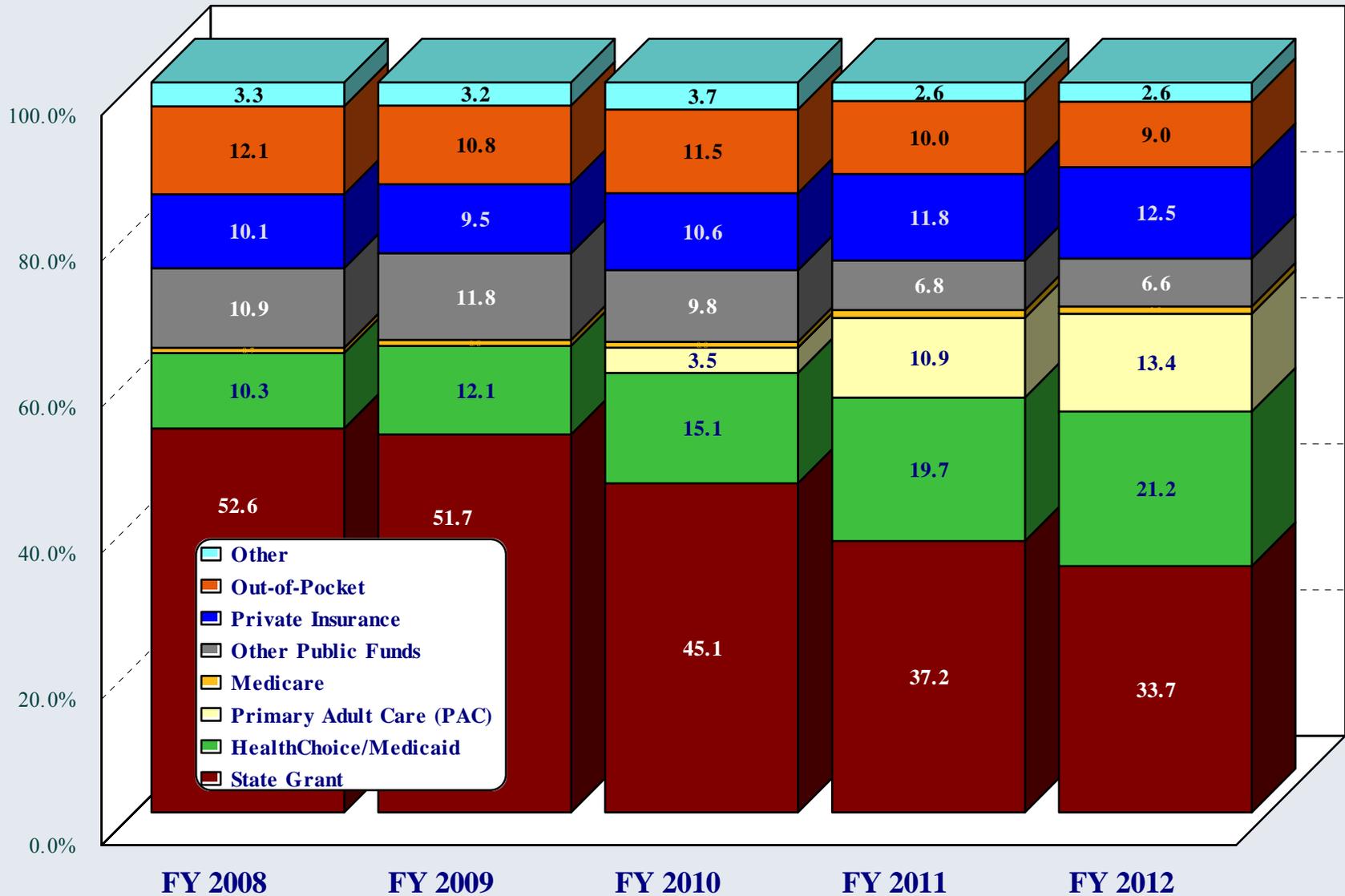
ASAM Level of Care	N	Length of Enrollment	
		Mean	Median
Level 0.5	1975	64.46	50.0
Level I	19835	128.91	103.0
Level I.D	58	40.12	5.0
Level II.1	9131	68.84	50.0
Level II.5	1622	26.90	13.0
Level II.D	66	24.33	6.0
Level III.1	1359	108.11	94.0
Level III.3	1573	92.13	59.0
Level III.5	1278	95.65	92.0
Level III.7	7918	18.38	16.0
Level III.7.D	5217	6.65	6.0
OMT	3181	377.72	178.0
OMT.D	79	135.65	59.0

Length of Stay

Table 5 shows the mean and median lengths of stay by level of care for enrollments ending in FY 2012. On average, Level I treatment lasted over four months while residential levels III.1, III.3 and III.5 averaged over 90 days.

The average OMT dis-enrolled patient spent more than a year in his/her program. Notably, OMT patients who were active in treatment on the last day of FY 2012 averaged 5.2 years in treatment with a median stay of 3.4 years.

Figure 27
Primary Source of Payment for Discharges from State-Supported Alcohol
and Drug Abuse Treatment Programs Reporting Data
FY 2008 to FY 2012

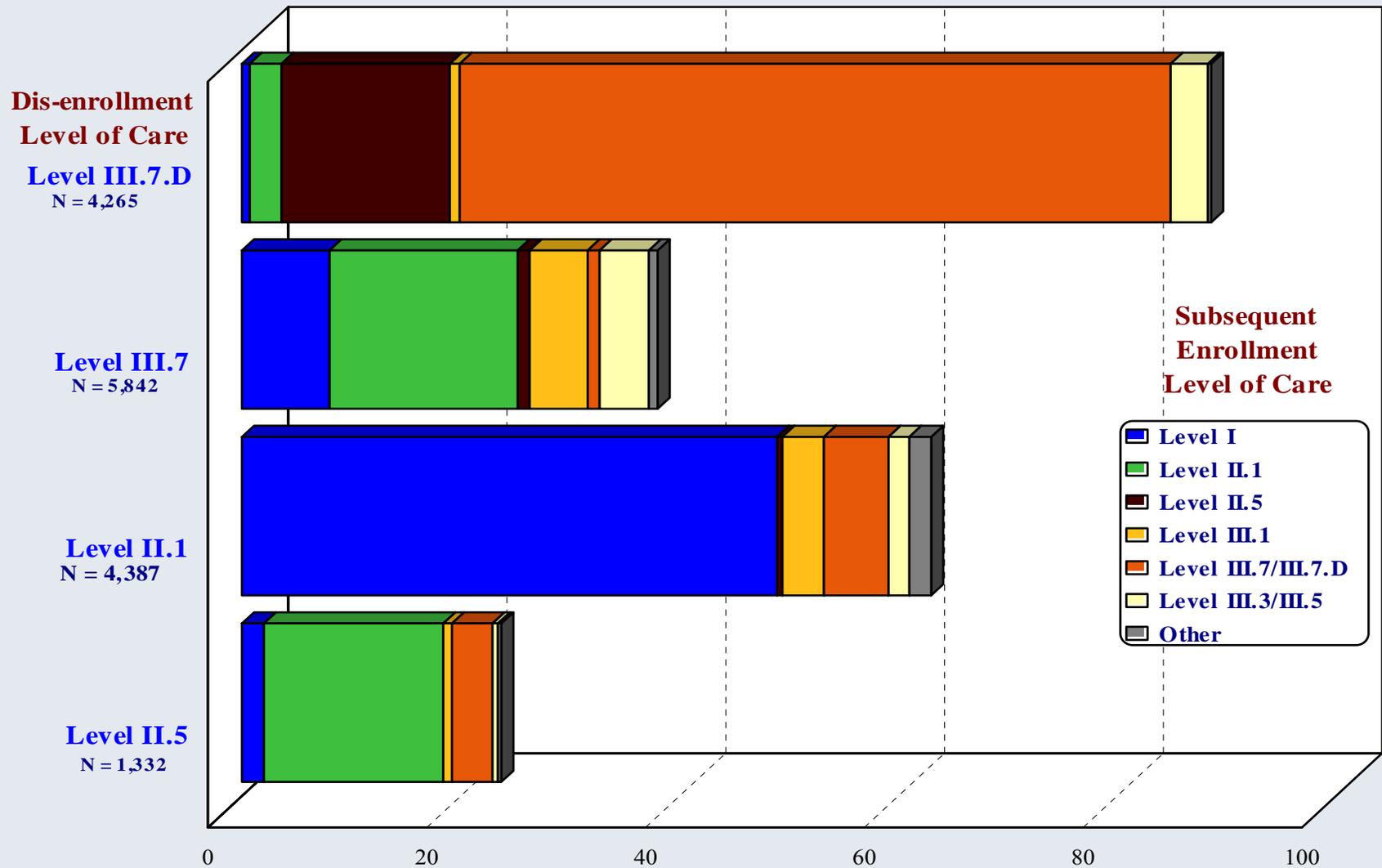


Primary Source of Payment

Figure 27 shows that while public funding has remained in the range of 74 to 77 percent of the primary payment source at discharge from State-supported treatment programs from FY 2008 to 2012, the distribution by source of public dollars has changed dramatically.

Discharges primarily supported by state-grant dollars declined from 53 to 34 percent over the five years while those paid primarily by Medicaid more than doubled and Primary Adult Care (PAC) payment went from zero to 13 percent.

Figure 28
Percentages of Unduplicated Dis-enrollments from State-Supported Alcohol and Drug Abuse Treatment Programs Reporting Data, Subsequently Enrolled in a Different Level of Care within 30 Days of Completion/Transfer/Referral FY 2012

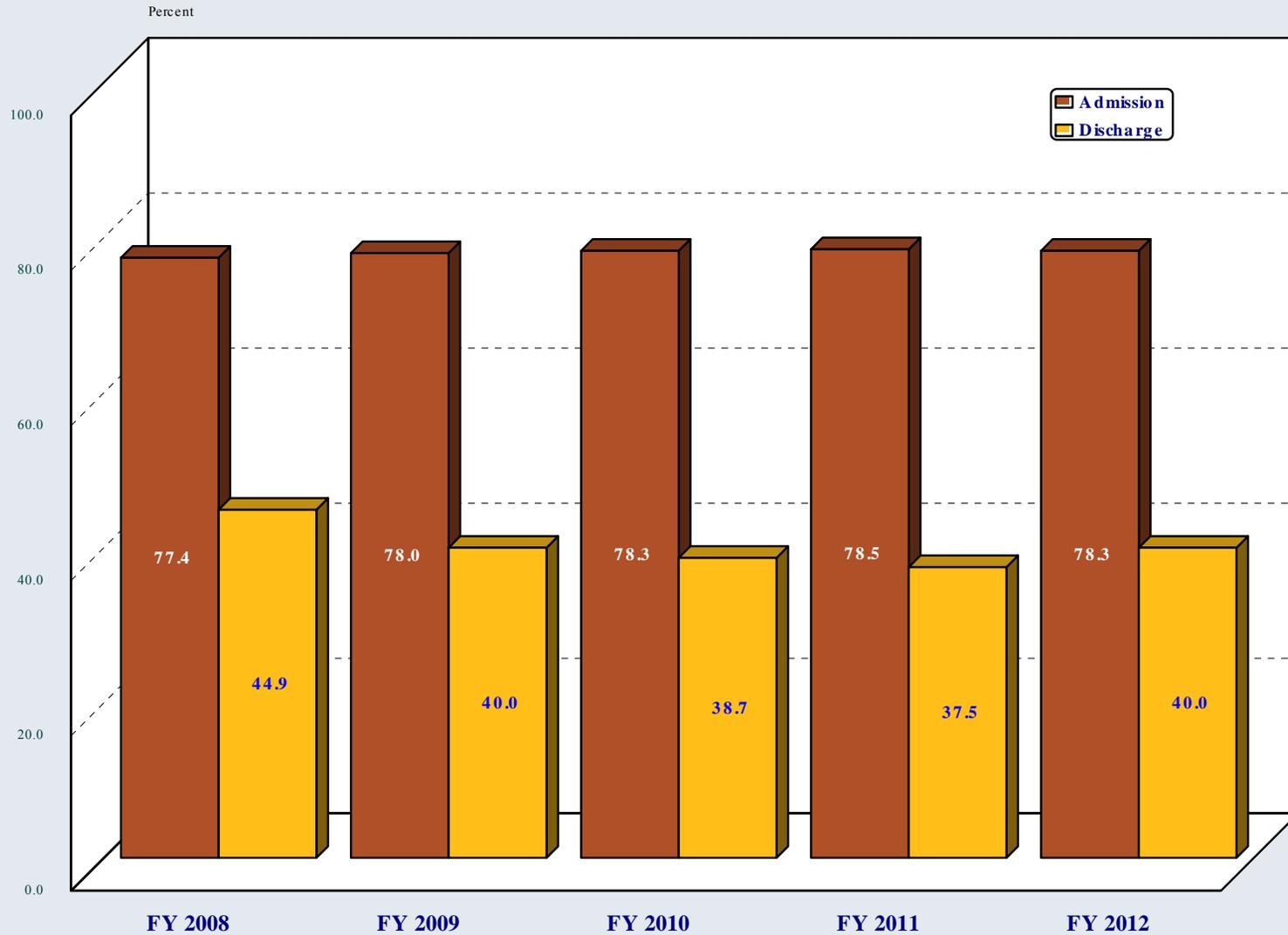


Continuation in Treatment

Successful management of patient flow to the level of care required at various points in the disease progression and recovery process is critical to sustaining the gains made in arresting the progression of the disease and reducing co-morbidity.

Figure 28 shows the percentages of completion/referral dis-enrollments from selected levels of care that entered other levels within thirty days. Sixty-five percent of those patients referred from Level III.7.D during FY 2012 entered Level III.7 within 30 days, and another 24 percent entered intensive outpatient or some other type of service. Referrals from III.7 were most likely to enter intensive outpatient (17 percent) and Level I outpatient (8 percent) or another residential level (10 percent). About half of dis-enrollments from Level II.1 entered Level I within 30 days; about 12 percent entered residential care. Sixteen percent of patients leaving Level II.5 entered II.1.

Figure 29
Percentages Using Substances at Admission to and at Discharge from State-Supported Alcohol and Drug Abuse Treatment Programs Reporting Data FY 2008 to FY 2012



Note: Patients reported as having been in a controlled environment during the 30 days before a admission and detoxification patients are excluded.

Substance-Use Outcome

Figure 29 presents the percentages of FY 2008 to 2012 discharged patients who were using substances in the 30 days preceding admission and the percentages using in the 30 days preceding discharge, excluding patients reported as having been in a controlled environment during the 30 days before admission. The reduction in patients using substances increased from 42 percent in FY 2008 to 52 percent in FY 2011, then fell back slightly to 49 percent in FY 2012. The percentage using at admission hovered around 78 percent in each of the years.

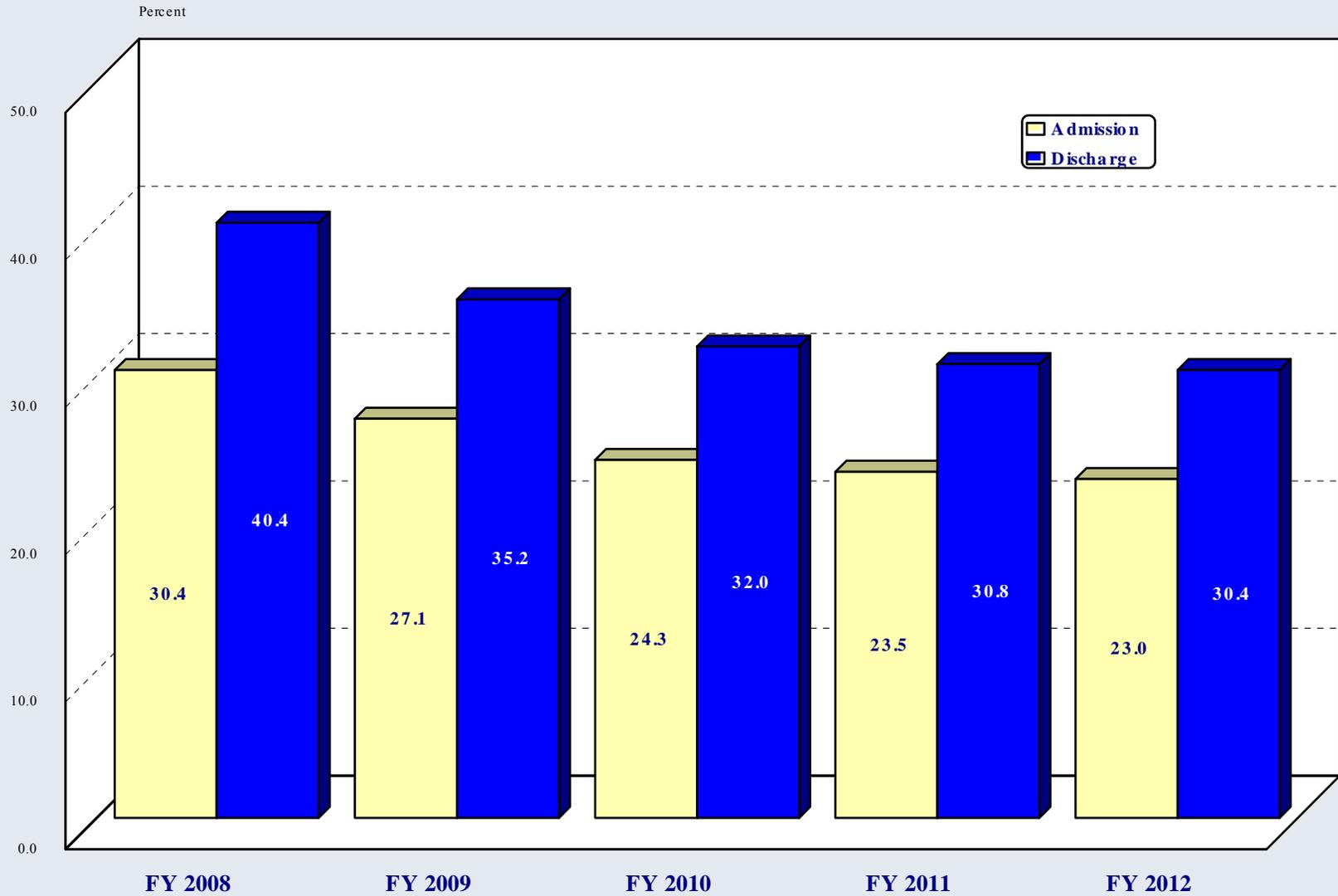
Table 6 presents the substance-use outcome results by program subdivision for FY 2012. The jurisdictions range from 28 percent in Harford to 83 percent in Frederick County in reduction in patients using substances from admission to discharge.

Table 6
Use of Substances at Admission and at Discharge from State-Supported
Alcohol and Drug Abuse Treatment Programs Reporting Data, by Provider
Location
FY 2012

Provider Subdivision	Discharges	Use at Admission		Use at Discharge		Percentage Change
		N	%	N	%	
Allegany	685	577	84.2	179	26.1	-69.0
Anne Arundel	3365	2651	78.8	1261	37.5	-52.4
Baltimore City	7490	6676	89.1	4343	58.0	-34.9
Baltimore County	3913	2867	73.3	1118	28.6	-61.0
Calvert	1282	980	76.4	442	34.5	-54.9
Caroline	234	125	53.4	45	19.2	-64.0
Carroll	247	113	45.7	59	23.9	-47.8
Cecil	562	325	57.8	181	32.2	-44.3
Charles	767	501	65.3	204	26.6	-59.3
Dorchester	559	391	69.9	235	42.0	-39.9
Frederick	1487	1262	84.9	213	14.3	-83.1
Garrett	280	183	65.4	64	22.9	-65.0
Harford	765	509	66.5	369	48.2	-27.5
Howard	540	381	70.6	138	25.6	-63.8
Kent	640	579	90.5	240	37.5	-58.5
Montgomery	1114	972	87.3	532	47.8	-45.3
Prince George's	1466	1121	76.5	757	51.6	-32.5
Queen Anne's	267	192	71.9	123	46.1	-35.9
St. Mary's	862	624	72.4	370	42.9	-40.7
Somerset	164	119	72.6	72	43.9	-39.5
Talbot	256	162	63.3	79	30.9	-51.2
Washington	821	404	49.2	140	17.1	-65.3
Wicomico	746	511	68.5	328	44.0	-35.8
Worcester	1240	1063	85.7	423	34.1	-60.2
Total	29752	23288	78.3	11915	40.0	-48.8

Note: Patients reported as having been in a controlled environment during the 30 days before admission and detoxification patients are excluded.

Figure 30
Percentages Employed at Admission to and at Discharge from State-Supported
Alcohol and Drug Abuse Treatment Programs Reporting Data
FY 2008 to FY 2012



Note: Detoxification and short-term residential patients are excluded.

Employment Outcome

Employment at admission and employment at discharge are presented for FY 2008 through 2012 in Figure 30. Patients who were employed when they entered treatment declined each year, from about 30 percent in FY 2008 to 23 percent in FY 2012. In each year, however, the percentage of patients employed at discharge represented an increase from admission of from 30 to 33 percent.

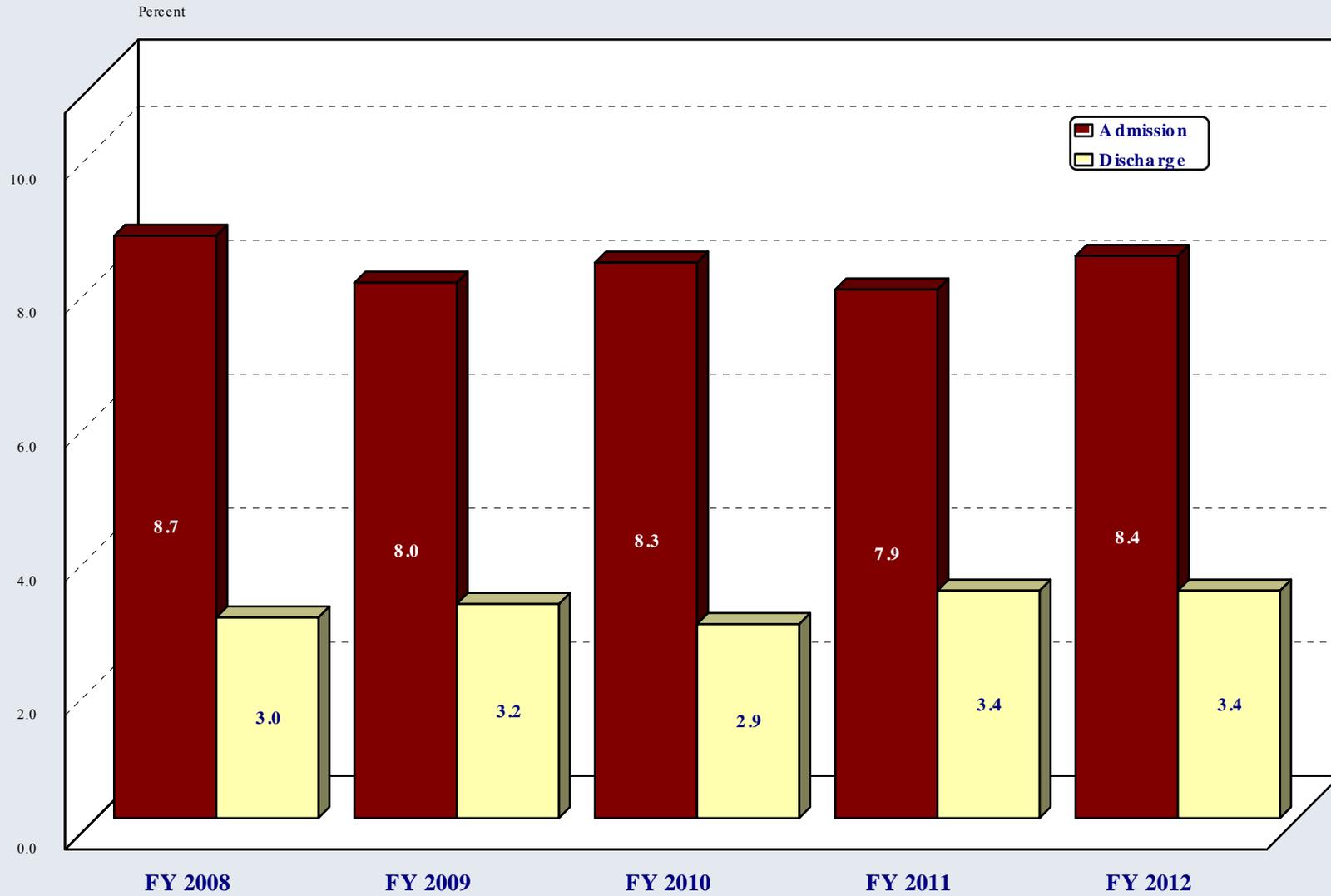
Table 7 presents the employment outcome by program location for FY 2012. The jurisdictions range from 12 (Calvert) to 100 percent (Frederick) in increase in employed patients from admission to discharge.

Table 7
Employment at Admission and at Discharge from State-Supported
Alcohol and Drug Abuse Treatment Programs Reporting Data, by
Provider Location
FY 2012

Subdivision	Discharges	Employed at Admission		Employed at Discharge		Percentage Change
		N	%	N	%	
Allegany	658	107	16.3	136	20.7	27.1
Anne Arundel	3937	1471	37.4	1678	42.6	14.1
Baltimore City	9834	861	8.8	1523	15.5	76.9
Baltimore County	3489	1232	35.3	1501	43.0	21.8
Calvert	1590	596	37.5	669	42.1	12.2
Caroline	244	95	38.9	108	44.3	13.7
Carroll	434	90	20.7	154	35.5	71.1
Cecil	630	255	40.5	296	47.0	16.1
Charles	987	290	29.4	430	43.6	48.3
Dorchester	741	135	18.2	207	27.9	53.3
Frederick	1007	140	13.9	280	27.8	100.0
Garrett	347	129	37.2	160	46.1	24.0
Harford	853	200	23.4	259	30.4	29.5
Howard	694	217	31.3	304	43.8	40.1
Kent	219	77	35.2	105	47.9	36.4
Montgomery	1178	159	13.5	238	20.2	49.7
Prince George's	1646	305	18.5	400	24.3	31.1
Queen Anne's	319	92	28.8	121	37.9	31.5
St. Mary's	783	254	32.4	323	41.3	27.2
Somerset	194	44	22.7	65	33.5	47.7
Talbot	307	136	44.3	165	53.7	21.3
Washington	1323	337	25.5	488	36.9	44.8
Wicomico	891	180	20.2	240	26.9	33.3
Worcester	1259	311	24.7	369	29.3	18.6
Total	33564	7713	23.0	10219	30.4	32.5

Note: Detoxification and short-term residential patients are excluded.

Figure 31
Percentages Arrested in the 30 Days Preceding Admission and Preceding Discharge from State-Supported Alcohol and Drug Abuse Treatment Programs Reporting Data
FY 2008 to FY 2012



Note: Detoxification and short-term residential patients are excluded.

Arrest Outcome

Comparisons of percentages arrested in the thirty days before admission and the percentages arrested in the thirty days before discharge are presented by Fiscal Year in Figure 31.

Reductions in percentages arrested approached or exceeded sixty percent in every year.

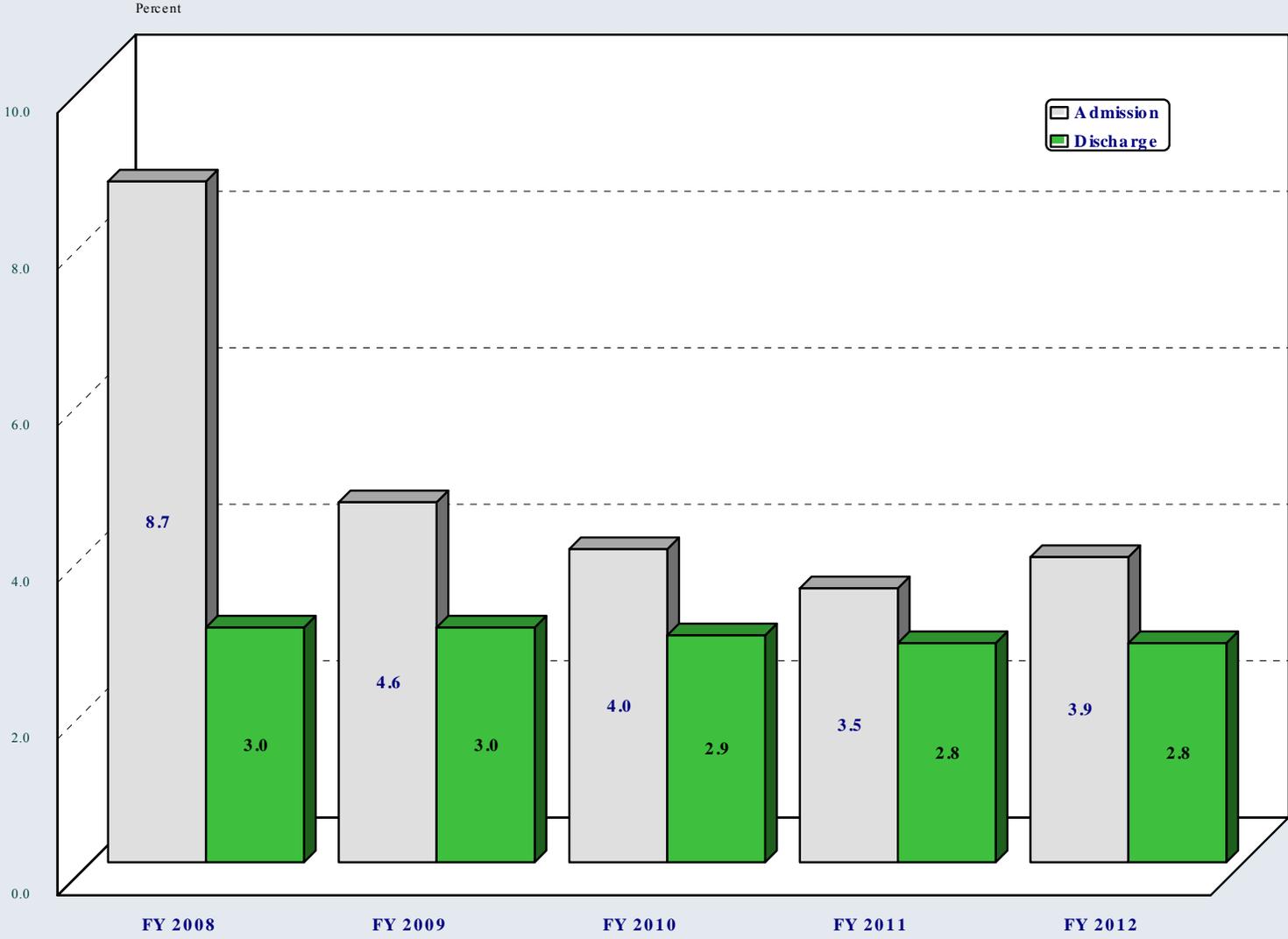
Table 8 presents the arrest outcome distributed by program location for FY 2012. The jurisdictions range from 15 in Somerset to 93 percent in Charles in reduction of patients arrested from admission to discharge.

Table 8
Arrested in the 30 Days before Admission and before Discharge from State-Supported Alcohol and Drug Abuse Treatment Programs Reporting Data, by Provider Location
FY 2012

Subdivision	Discharges with Admission Data	Arrested before Admission		Total Discharges	Arrested before Discharge		Percentage Change
		N	%		N	%	
Allegany	651	81	12.4	658	20	3.1	-75.3
Anne Arundel	3918	378	9.6	3937	49	1.3	-87.0
Baltimore City	9617	817	8.5	9834	557	5.8	-31.8
Baltimore County	2555	197	7.7	3489	27	1.1	-86.3
Calvert	1590	263	16.5	1590	49	3.1	-81.4
Caroline	240	10	4.2	244	4	1.7	-60.0
Carroll	434	35	8.1	434	12	2.8	-65.7
Cecil	614	49	8.0	630	12	2.0	-75.5
Charles	976	70	7.2	987	5	0.5	-92.9
Dorchester	741	68	9.2	741	25	3.4	-63.2
Frederick	996	63	6.3	1007	30	3.0	-52.4
Garrett	347	40	11.5	347	10	2.9	-75.0
Harford	849	47	5.5	853	30	3.5	-36.2
Howard	692	64	9.2	694	25	3.6	-60.9
Kent	219	15	6.8	219	18	8.2	20.0
Montgomery	1174	116	9.9	1178	37	3.2	-68.1
Prince George's	1641	80	4.9	1646	45	2.7	-43.8
Queen Anne's	319	22	6.9	319	15	4.7	-31.8
St. Mary's	783	70	8.9	783	9	1.1	-87.1
Somerset	194	13	6.7	194	15	7.7	15.4
Talbot	306	55	18.0	307	21	6.9	-61.8
Washington	1314	107	8.1	1323	26	2.0	-75.7
Wicomico	1424	71	5.0	891	56	3.9	-21.1
Worcester	684	85	12.4	1259	26	3.8	-69.4
Total	32278	2816	8.7	33564	1123	3.5	-60.1

Note: Detoxification and short-term residential patients are excluded.

Figure 32
Percentages Homeless at Admission to and at Discharge from State-Supported Alcohol
and Drug Abuse Treatment Programs Reporting Data
FY 2008 to FY 2012

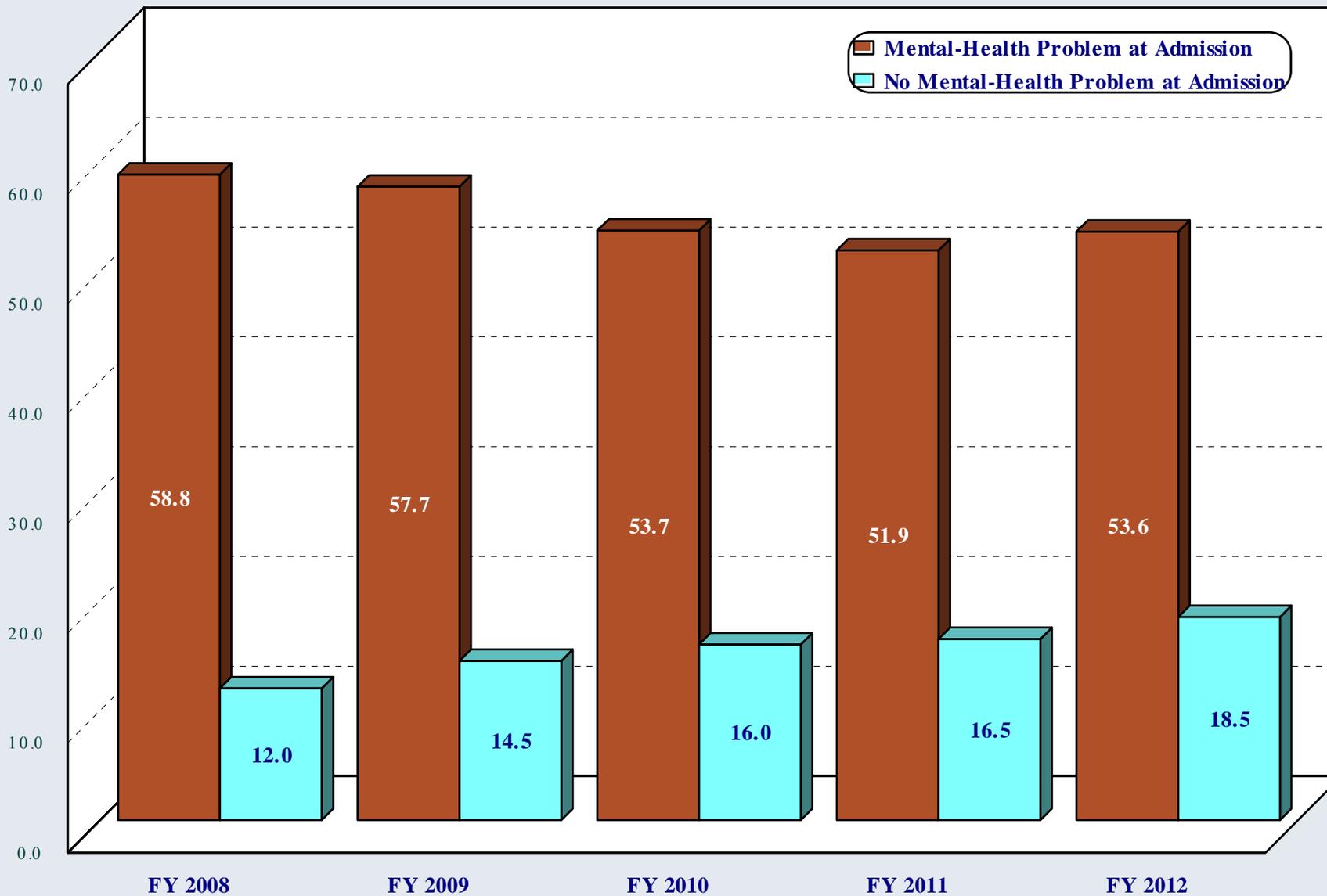


Note: Detoxification and short-term residential are excluded.

Homelessness Outcome

Figure 32 presents the percentages of discharged patients who were homeless at admission compared to the percentages homeless at discharge for the five fiscal years. The percentage of homeless patients entering treatment was cut in half from 9 in FY 2008 to 3.5 in 2011, then increased slightly in FY 2012. The percentage of homeless patients at discharge ranged from 2.8 to 3 percent during the five years.

Figure 33
Percentages Receiving Mental-Health Treatment in State-Supported Alcohol
and Drug Abuse Treatment Programs Reporting Data,
by Mental-Health Status at Admission
FY 2008 to FY 2012



Mental-Health Treatment

Figure 33 presents the percentages of discharges that received mental-health treatment either within or outside the program during the substance-use-disorder treatment episode, distributed by the assessment of a mental-health problem at admission and fiscal year of discharge. While the percentage of those judged by counselors to have mental-health problems at admission who received mental-health treatment declined slightly from FY 2008 to 2011, the FY 2012 level was back up. Among those patients not assessed as having mental-health problems at admission the percentage receiving mental-health treatment increased steadily from 12 to 19.

The overall percentage of discharged patients receiving mental-health treatment in State-supported substance-use-disorder treatment programs increased from 28 percent in FY 2008 to 34 percent in FY 2012.