Maryland State Drug and Alcohol Abuse Council

AGENDA
September 24, 2008

1. **Opening Remarks** - Secretary Colmers, Chairperson

2. **Introductions**

   Brief comments from council members concerning substance abuse service issues that impact on their consumers, constituents, or communities.

3. **Review of Council Duties** – Secretary Colmers, Chairperson

4. **Substance Abuse in the State of Maryland** – Kathleen Rebbert-Franklin, ADAA

5. **Summary of Needs Assessment** – William McAuliffe, Harvard Medical School

6. **The Work Plan** – Suzan Swanton, State Drug and Alcohol Abuse Council

7. **Committees** - Suzan Swanton, State Drug and Alcohol Abuse Council

8. **Future Meetings** - Secretary Colmers, Chairperson

   All meetings are scheduled to be held at the ADAA Building, Spring Grove Hospital Center between 3:00 p.m. and 5:00 p.m.

   December 9, 2008
   March 18, 2009
   June 17, 2009
   September 16, 2008

9. **Comments from the Public** - Secretary Colmers, Chairperson

10. **Adjournment**

MARYLAND STATE DRUG AND ALCOHOL ABUSE COUNCIL

Minutes
September 24, 2008

In Attendance: Shannon Bowles (DJS), Teresa Chapa, John Colmers (Chair), Rebecca Hogamier, Bobby Houston, Kim Kennedy, John Kuo, George Lipman, Kristen Mahoney, Patrick McGee, Kevin McGuire, Patricia Miedusiewski, Kathleen O'Brien, Glen Plutschak, Catherine Pugh, Kathleen Rebbert-Franklin, Kirill Reznik, Richard Rosenblatt, Gale Saler, Joshua Sharfstein, Greg Shupe, Larry Simpson, Peter Singleton, Suzan Swanton (Executive Director), Chris Zwicker (DBM)

I. Call to Order: The meeting was called to order at 3:00 p.m.

II. Introductions

Chairmen Colmers opened the meeting with a few introductory remarks. He introduced himself and noted his background in health care and economics. He spoke of the important work of the council given the impact substance abuse has on the citizens of Maryland. He talked of the necessity to enhance coordination of the use of available funds in more effective ways, particularly in light of current financial challenges.

Each of the other council members present introduced themselves and spoke about the interface between substance abuse issues and their work and their stakeholders. Members represented substance abuse service providers, the Division of Parole and Probation, the Maryland General Assembly, the Judiciary, private citizens, former consumer, Department of Transportation, Baltimore City Health Commissioner, Department of Housing and Community Development, Mental Hygiene Administration, Governor's Office on Crime Control and Prevention, Department of Budget and Management, Department of Public Safety and Correctional Services, Governor's Office on Children, and Department of Human Resources.

Some specific issues mentioned were:

- The great need for recovery support services for individuals in the criminal justice system, including treatment services and other service needs of those re-entering the community, and recovery support service needs for those "behind the walls."
- The great need for recovery support services for individuals who are high utilizers of the criminal justice system, the substance abuse treatment system and the mental health treatment system.
- The need to have more residential, long term care in the State.
- The need to evaluate the location of treatment facilities in terms of accessibility and being sited in "recovery-friendly" areas.

- The need to address the recent increases of overdoses in the State.
- The need to ensure services are oriented towards individuals with co-occurring disorders and developmental disabilities.
- The need to focus on better integration of primary health care and behavioral health care.
- The great need for recovery support services for vulnerable children and families who are homeless and/or those involved in public assistance programs and the child welfare system.

III. Review of Council Duties: Chairman Colmers reviewed the duties of the Council as listed on Page 6 and 7 of Executive Order 01.01.2008.08 establishing the Maryland State Drug and Alcohol Abuse Council.

IV. Substance Abuse in the State of Maryland: Kathleen Rebbert-Franklin, Acting Director of the Alcohol and Drug Abuse Administration (ADAA), presented on the current state of substance abuse and substance abuse prevention and treatment services in Maryland. She noted that the field now has over 30 years of empirical evidence that support the view of addiction as a chronic illness. The data also demonstrates that certain methods of organizing services at a system level and interventions at a treatment provider level are more effective than others. She discussed ADAA's effort to improve and refine the electronic management of system, program and patient information to support informed decision-making at each of those levels. She noted that, in all jurisdictions except for Baltimore City, alcohol has the most mentions at treatment admission as a problem substance. For the City, heroin has the most mentions as the problem substance. She reported data that demonstrates that Maryland is one of the leaders in the country in meeting or exceeding federally mandated outcome measures. In addition, she

- discussed the various levels of care that are available to Marylanders seeking substance abuse treatment,
- reported various prevention services available to protect individuals from developing substance abuse problems, and
- informed the Council on funding sources and funding allocation for those services

V. Summary of Needs Assessment: Erin Artigiani**,** Deputy Director of Policy and Governmental Affairs for the Center for Substance Abuse Research (CESAR) at the University of Maryland, presented the results of a needs assessment conducted by CESAR and William E. McAuliffe from Department of Psychiatry, Harvard Medical School. In the 2007 Joint Chairmen's Report, the General Assembly allocated funds for the ADAA to conduct a substance abuse treatment needs assessment. ADAA contracted with CEASR to do so.

Ms. Artigiani presented the methodology and the results of the research. Many concerns and issues regarding both were raised by Council members:

- Does the data include juvenile arrest data?

- Were the best arrest data used to accurately determine substance abuse treatment need? For instance, why wasn't prostitution arrest data used?
- Should an alcohol arrest be weighed the same as heroin arrest?
- In general, was the methodology used the right approach to determine need in each of the vastly different jurisdictions of Maryland?

Because Dr. McAuliffe is the principle investigator on this study (he was unable to attend this meeting due to health problems), Ms. Artigiani made notes on the questions and said that she would submit them to him for his response.

Because of these questions and problems concerning the needs assessment, it was stressed that the results can help inform policy, but it, alone, cannot drive policy.

VI. **Work Plan:** Suzan Swanton presented a draft work plan that listed steps and timelines for accomplishing the duties of the Council as outlined in the Executive Order. The work plan was based on the Council accomplishing its tasks through workgroups organized around the five duties. There were some concerns expressed as to whether or not this was the best way for the Council to conduct its business. This led to a discussion about what the Council's workgroup structure should be.

VII. **Committees:** Chairman Colmers presented some ideas on workgroup formation. A general discussion ensued and several structures were posited: workgroups should be formed around the five duties; workgroups should be formed based on topic areas (criminal justice, prevention, etc.); and, the same workgroups the previous council used appear to be adequate and a good structure to complete the required tasks.

As time was getting short, it was decided to form an ad-hoc committee to consider the issue and make recommendations to the whole Council at the next meeting. John Colmers, Rebecca Hogamier, Kim Kennedy, George Lipman, Mark Luckner, Kevin McGuire, Kathleen O'Brien, Glen Plutschak, Richard Rosenblatt, and Gale Saler agreed to serve on the committee and participate on a conference call.

VIII. **Future Meetings:** The next SDAAC meeting will be on **12-9-08, 3:00 p.m. to 5:00 p.m**., at the ADAA Building on Spring Grove Hospital Center grounds. Future meetings will be on:

March 18, 2009
June 17, 2009
September 16, 2009

All meetings are scheduled to be held at the ADAA Building, Spring Grove Hospital Center between 3:00 p.m. and 5:00 p.m.

IX. **Adjournment: The meeting was adjourned at 4:55 p.m.**

Alcohol and Drug Abuse Administration (ADAA) Overview

State Drug and Alcohol Abuse Council

September 24, 2008

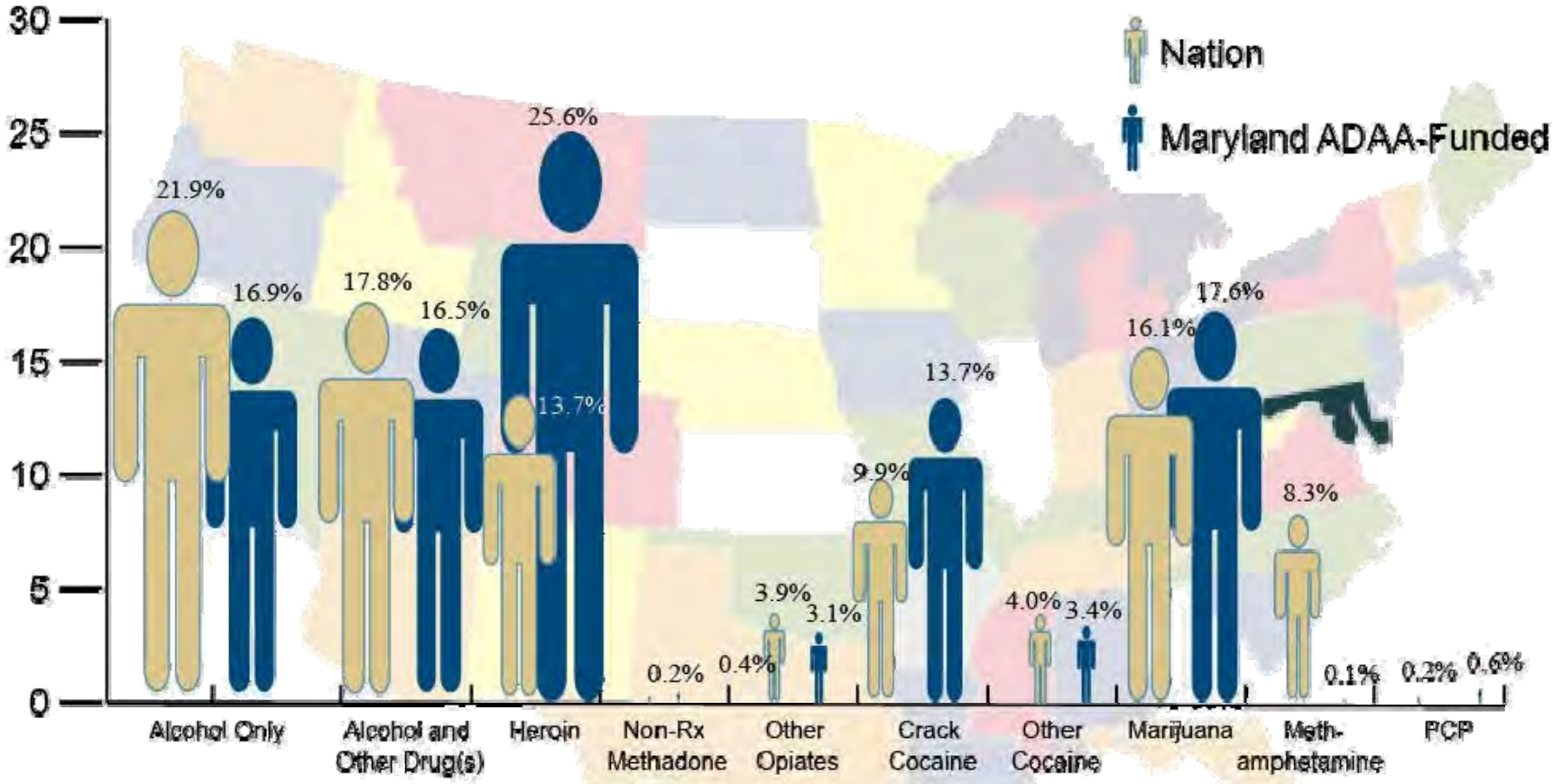
Kathleen Rebbert-Franklin, LCSW-C
Acting Director, ADAA

ADAA
Alcohol and Drug Abuse Administration

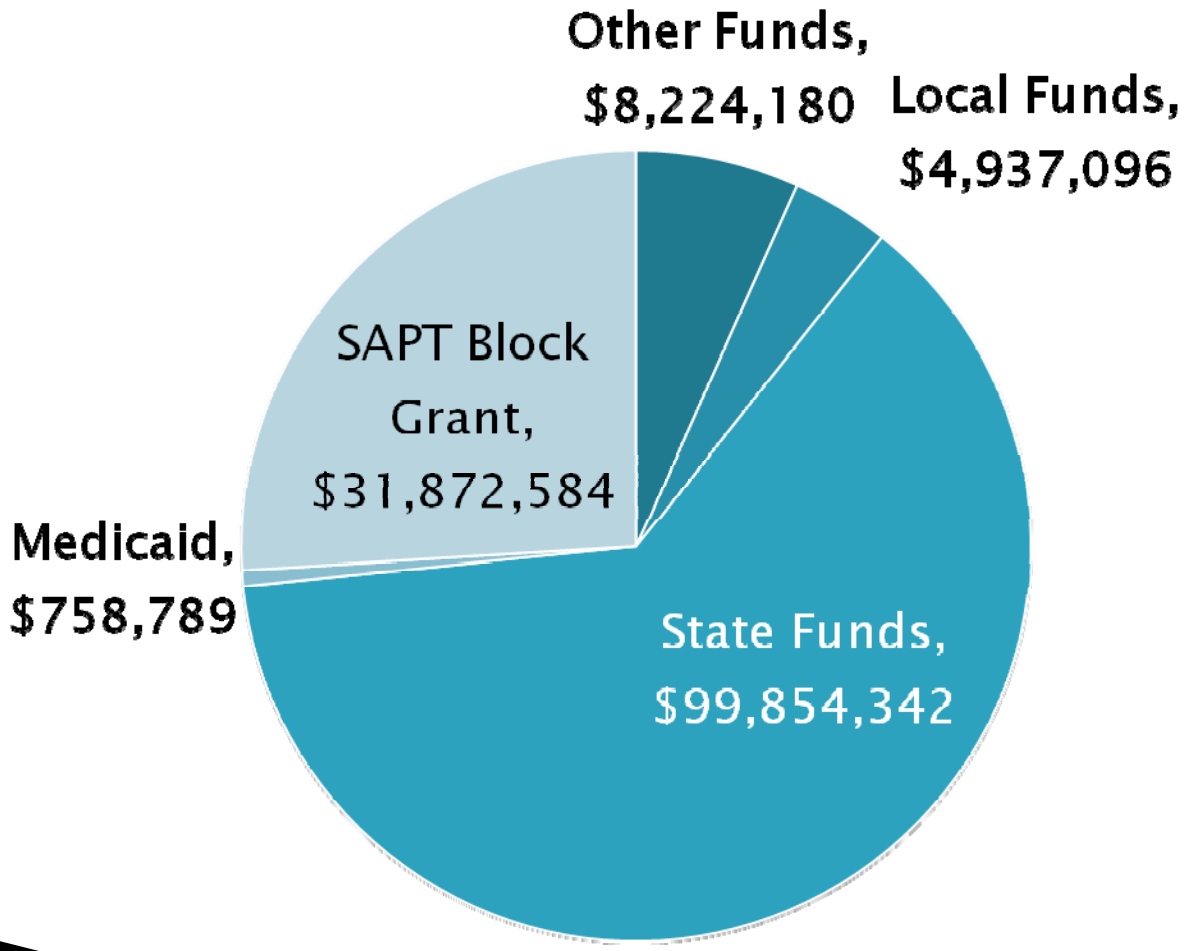
Research/Information Based Practice

- 30 Years of empirical evidence
- Addictions as a chronic not acute medical condition
- Support for **certain** prevention and treatment principles
- Support for a systems perspective
- Information management for patient, program, and system level decisions

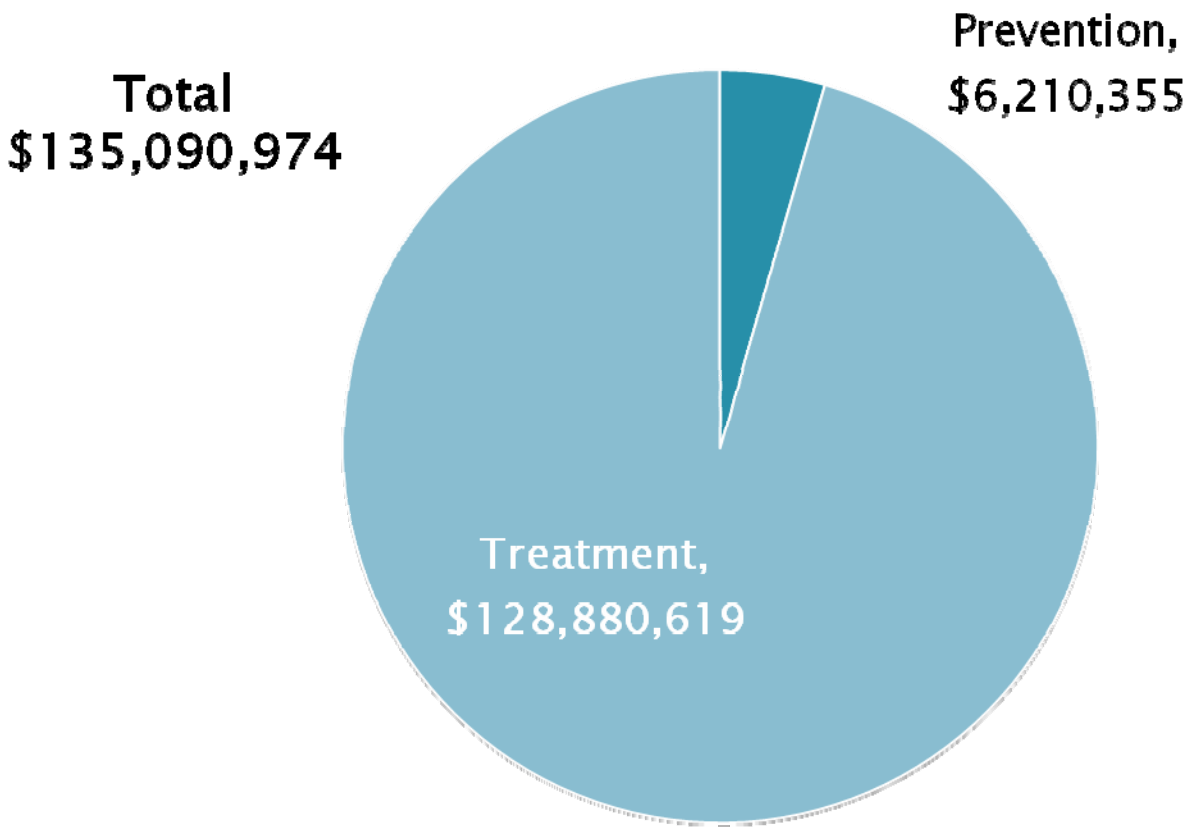
Primary Substance Problem
Calendar Year 2006



Funding Sources for Substance Abuse Prevention and Treatment FY 2007



FY 2008 Prevention and Treatment Services Allocation



Prevention Services

- Strategic Prevention Framework
- Evidence-Based Prevention Programs
- Primary Prevention Strategies – 211,234 participants in FY 2007
  - Alternatives
  - Community Based Process
  - Education
  - Environmental
  - Information Dissemination
  - Problem ID and Referral

Treatment Services

- Levels of Care Model
  - Ambulatory Care
    - Level 0.5 Early Intervention
    - Level I Outpatient
    - Level II.1 Intensive Outpatient
  - Residential Care
    - Level III.1 Halfway House
    - Level III.3 Long Term Residential
    - Level III.5 Long Term Residential – Therapeutic Community
    - Level III.7 Medically Monitored Short Term Residential

Treatment Funding

FY 2004 – FY 2008

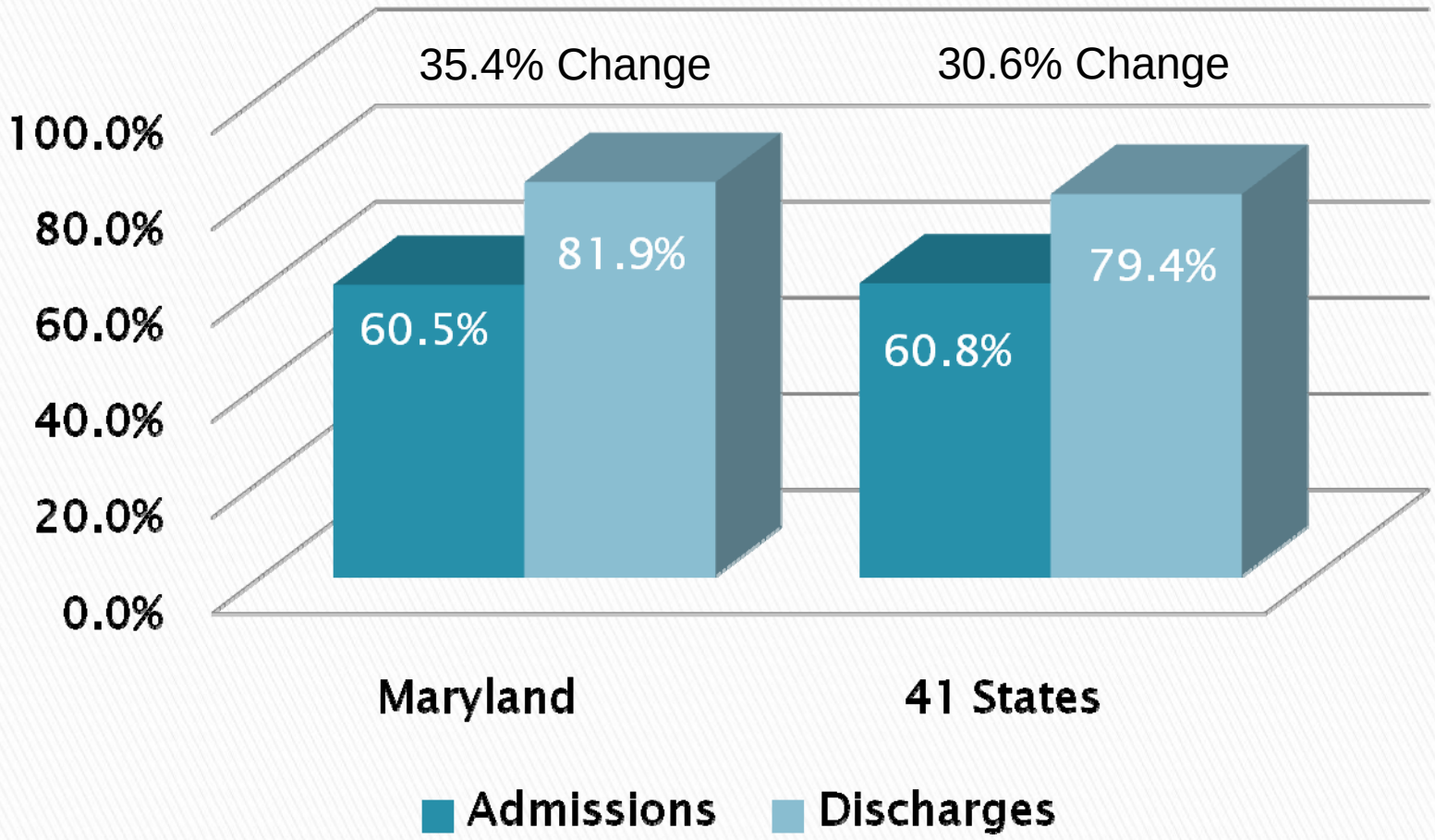
	2004	2008	% change
Appropriation	$120,035,927	$128,880,619	7.3%
Individuals Treated*	48,170	51,330**	6.6%

**Unduplicated individuals treated* ***Estimate based on 10 month data*

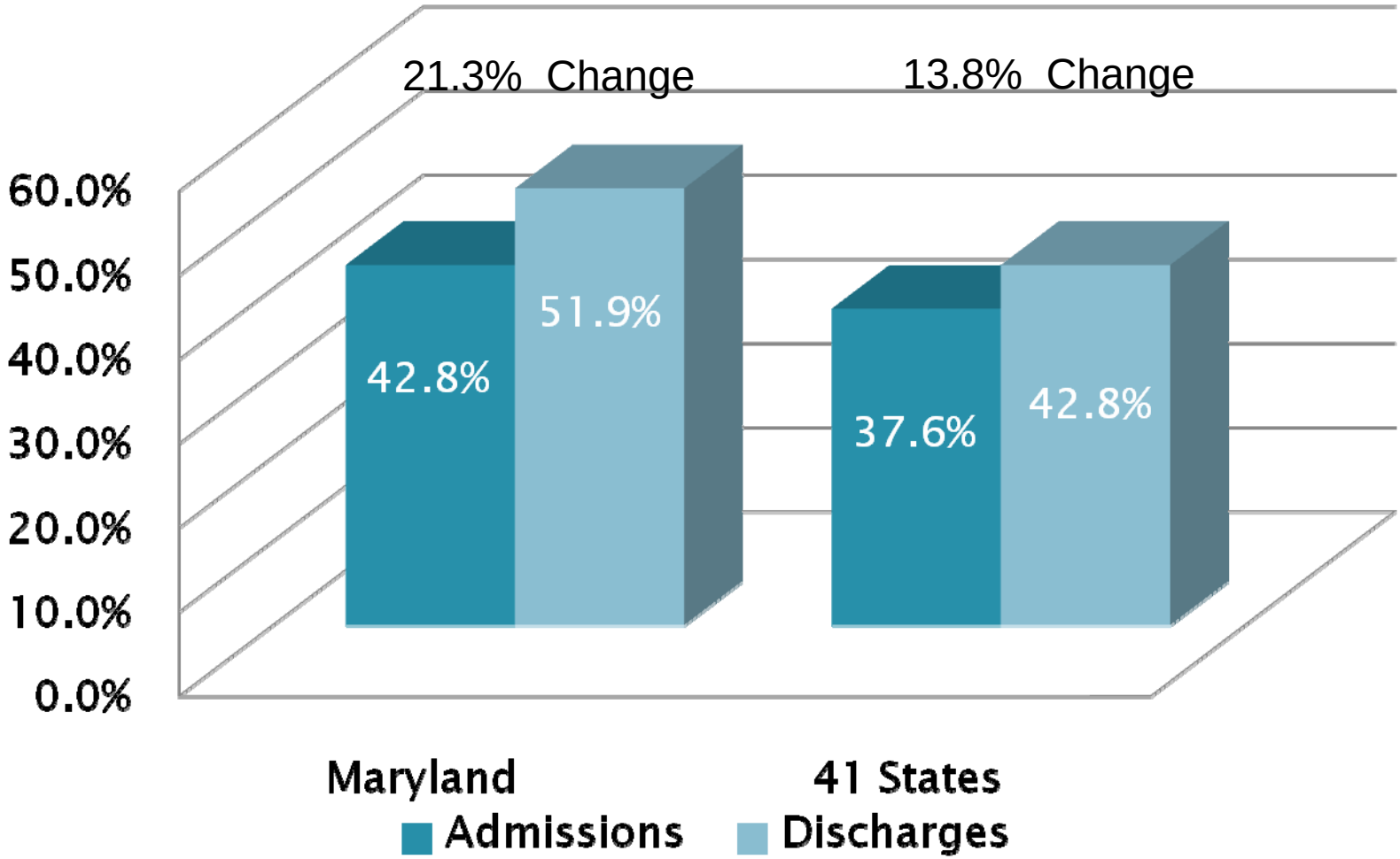
Treatment Effectiveness

- Alcohol and Drug dependent people who participate in drug treatment
  - Decrease substance use
  - Decrease criminal activity
  - Increase employment
  - Improve their social and intrapersonal functioning
  - Improve their physical health
- Drug use and criminal activity
  ⇓⇓ for virtually all who enter treatment ⇒
  ⇑⇑ results the longer they stay in treatment.

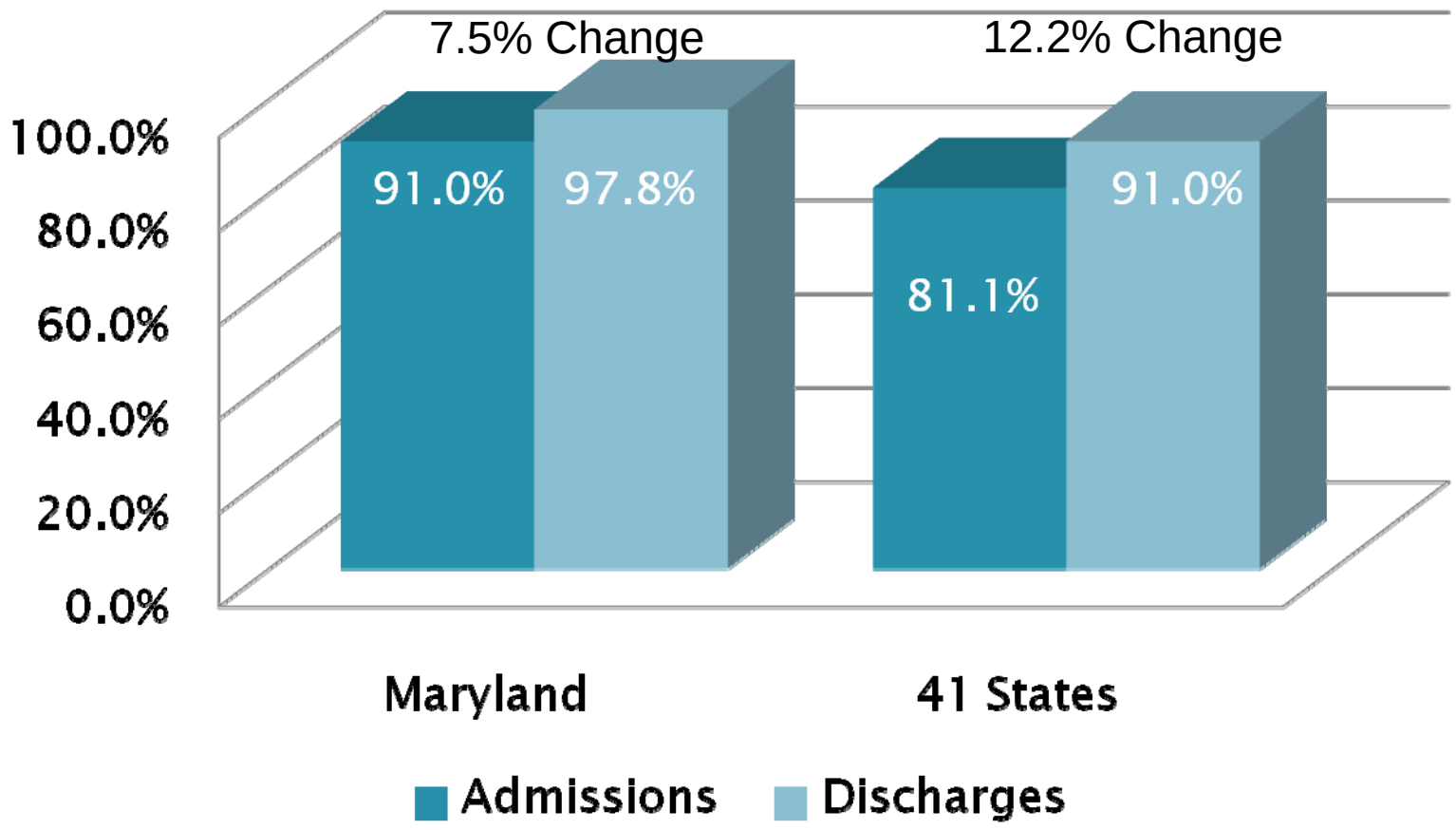
FY 2008 ADAA-Funded Data and National Outcome Measures (NOMS) Data for Reporting States
Abstinent from Drugs



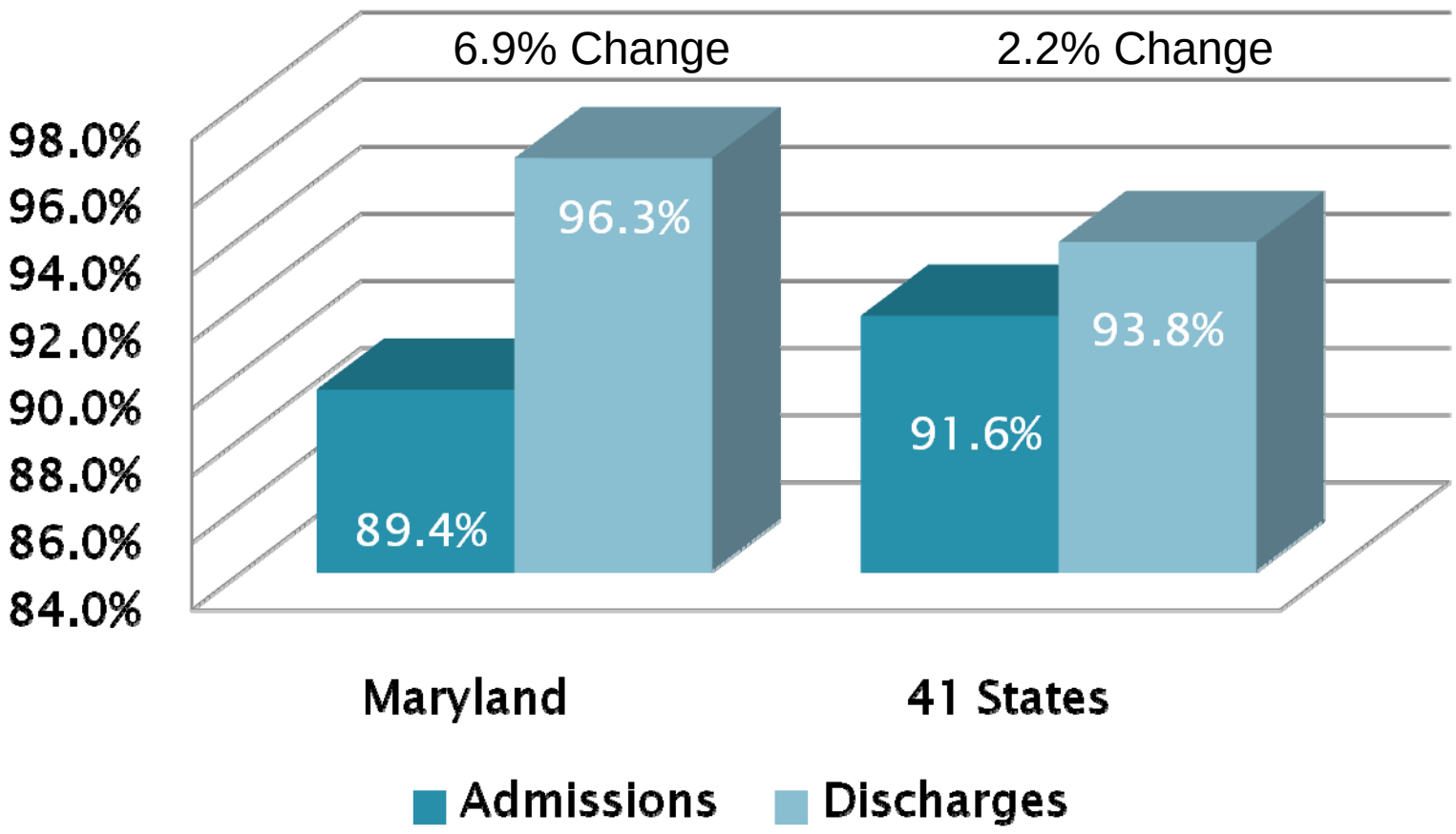
FY 2008 ADAA-Funded Data and National Outcome Measures (NOMS) Data for Reporting States
Employment



FY 2008 ADAA-Funded Data and National Outcome Measures (NOMS) Data for Reporting States
No Arrests During Prior 30 Days



FY 2008 ADAA-Funded Data and National Outcome Measures (NOMS) Data for Reporting States In Stable Housing Situation



Adult Outpatient Level I Treatment

Selected Outcomes
FY 2004 – FY 2008

	2004	2008	% change
Completed Treatment	51.2%	53.6%	4.7%
LOS ≥ 90 days	56.6%	60.1%	6.3%
Reduction in Substance Users	8.5%	48.3%	468.2%
Increase in Employment	11.9%	16.6%	40.1%

Level I Outpatient Incentive Award Standards

- $\geq$65% retained at least 90 days
- $\geq$50% successful completion

- Both standards = 100% performance payment
- One standard = 50% performance payment

Jurisdictions Receiving Incentive Awards FY 2007	
Partial – Completed > 50%	**Full—Completed >50% and LOS > = 90 days**
Allegany County	Caroline County
Baltimore County	Carroll County
Talbot County	Charles County
Partial – LOS > = 90 days	Somerset County
Cecil County	St. Mary's
Montgomery County	Washington County

ALCOHOL AND DRUG ABUSE ADMINISTRATION (ADAA)

www.maryland-adaa.org

55 Wade Avenue
Catonsville, MD 21228
410-402-8600

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

Outlook and Outcomes

For Maryland Substance Abuse Prevention, Intervention and Treatment

Fiscal Year 2007

Martin O'Malley, Governor
Anthony G. Brown, Lt. Governor
John M. Colmers, Secretary, DHMH
Arlene Stephenson, Acting Deputy Secretary, DHMH
Kathleen Rebbert-Franklin, LCSW-C, Acting Director

The services and facilities of the Maryland State Department of Health and Mental Hygiene (DHMH) are operated on a non-discriminatory basis. This policy prohibits discrimination on the granting of advantages, privileges and accommodations.

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

At a Glance

The Executive Summary

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

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Maryland Alcohol and Drug Abuse Administration. (2008). Outlook and Outcomes in Maryland Substance Abuse Prevention, Intervention and Treatment, 2007. Catonsville, MD: Department of Health and Mental Hygiene,

State of Maryland
Alcohol and Drug Abuse Administration

Executive Summary

The Alcohol and Drug Abuse Administration is the single state agency responsible for the provision, coordination, and regulation of the statewide network of substance abuse prevention, intervention and treatment services. It serves as the initial point of contact for technical assistance and regulatory interpretation for all DHMH certified prevention and treatment programs. Maryland is somewhat unique among states in that ADAA has the legal responsibility for the evaluation of treatment outcomes and for the certification and regulation of both publicly and privately funded programs.

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

Who Received Services?

Prevention Services

- Over 211,000 individuals received prevention services in Maryland.
- Over 191,000 (91%) individuals were served in a program with a universal strategy. Programs with a selective prevention strategy which target subsets of the population which are deemed to be at risk for substance abuse comprised 19,195 or 9%.
- A total of 2,763 individuals received prevention intervention services through the High Risk Preschool Initiative in fiscal year 2007
- The College Prevention Centers initiative provided prevention services, with a primary focus on peer education, to 31,006 students enrolled in four of Maryland's universities.
- In fiscal year 2007, 83 prevention programs were delivered using evidence-based Center for Substance Abuse Prevention (CSAP) Model Programs.

Treatment Services

- There were 47,122 patients admitted to ADAA-funded programs.
- Sixty-three percent of patients admitted during FY 2007 had at least one prior admission to treatment.
- Sixty-one percent of all patients had no health insurance. Nearly 20 percent were insured with public funds and the rest were privately insured.
- Just under half of all patients admitted were referred to treatment by components of the criminal justice system and 52.1 percent of patients had one or more arrests in the one year prior to admission. The majority of criminal justice referrals to treatment came from parole and probation services..
- Twenty-eight percent of patients had mental health problems in addition to substance abuse.
- Sixty-two percent smoked cigarettes, up three percent from FY 2006.

Type of Substance Abuse

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

Maryland and the Nation

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

- Non-prescription methadone was mentioned by one percent of admissions.

Adolescents

- About 37 percent of alcohol and 49 percent of marijuana related admissions reported age of first use as prior to age 15.

- Forty-five percent of cocaine and heroin users first used of those drugs between the ages of 18 to 25.

- Over 70 percent of the individuals admitted for alcohol provlems reported first substance use during adolescence.

ASAM Levels of Care

- Nearly 46 percent of all admissions went to Level I (traditional outpatient) services and another 16.7 percent were admitted to Level II.1 and Level II.5 (intensive outpatient).

- More than four percent of funded admissions were to opioid maintenance therapy (OMT).

- Residential levels of care accounted for 28.3 percent of admissions .

- Admissions to level OMT-D continued to decline from five percent in 2006 and nearly disappearing in data reports in 2007.

- While admissions to Level I continued a 5 year decline, admissions to Level II.1 rose from nine percent to sixteen percent in the same period.

Was It Worth It?
Outcome Measurement

Treatment Reduces Substance Use

- Among the discharges from Level I treatment, including both successful completers and non-successful completers, there was a 36% reduction in substance use.

- Decreases in substance use of 50 percent or more occurred in all residential levels of care.

Length of Stay in Treatment Reduces Substance Use

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

Treatment Reduces Crime

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

Treatment Promotes Mental Health Referrals

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

Treatment Increases Employment

- The data indicate that across all levels of care employment rates were improved by treatment. The employed were likely to stay in treatment longer, and the unemployed were more likely to become employed the longer they stayed in treatment.

- Employment increased 15 percent in Level I, and nearly five-fold in Level III.5 (Long-term Residential treatment).

Treatment Decreases Homelessness

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

Table 7

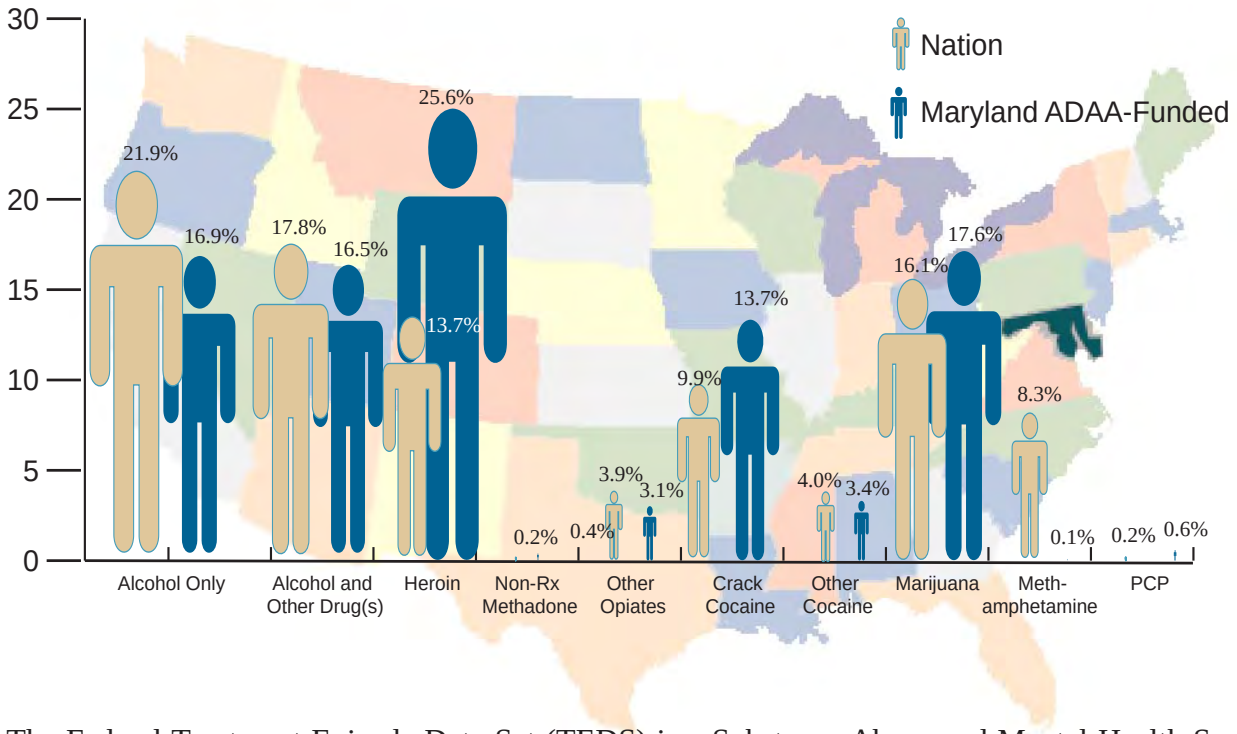
ADMISSIONS BY RESIDENCE

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

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

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

Figure 30



The Federal Treatment Episode Data Set (TEDS) is a Substance Abuse and Mental Health Services (SAMHSA) reporting system on substance abuse treatment admissions in which all 50 states participate. It allows for comparison of Maryland data with national and other states' data; the most recently available national data are for calendar year 2005.

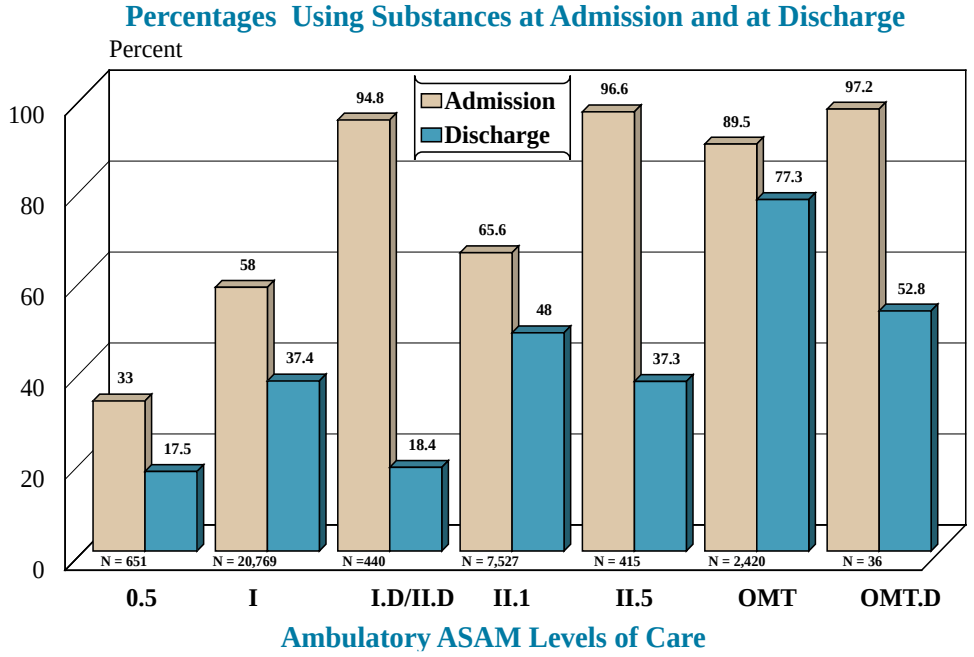
Maryland patients present with primary substance abuse problems in proportions similar to the rest of the nation, with three notable exceptions. 1) Maryland treatment admissions are less likely than national admissions to involve alcohol either alone or with other drugs as secondary problems. 2) Nationally,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

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

Was It Worth It?
Treatment Outcomes

The ADAA Performance Management system is based on the ability to measure treatment outcomes and to use that information to improve the quality of treatment outcomes for patients entering care. Measures reported in this section include retention in treatment, patient movement through the continuum of care, changes in substance use, employment, arrest rate and living situation.

Figure 35

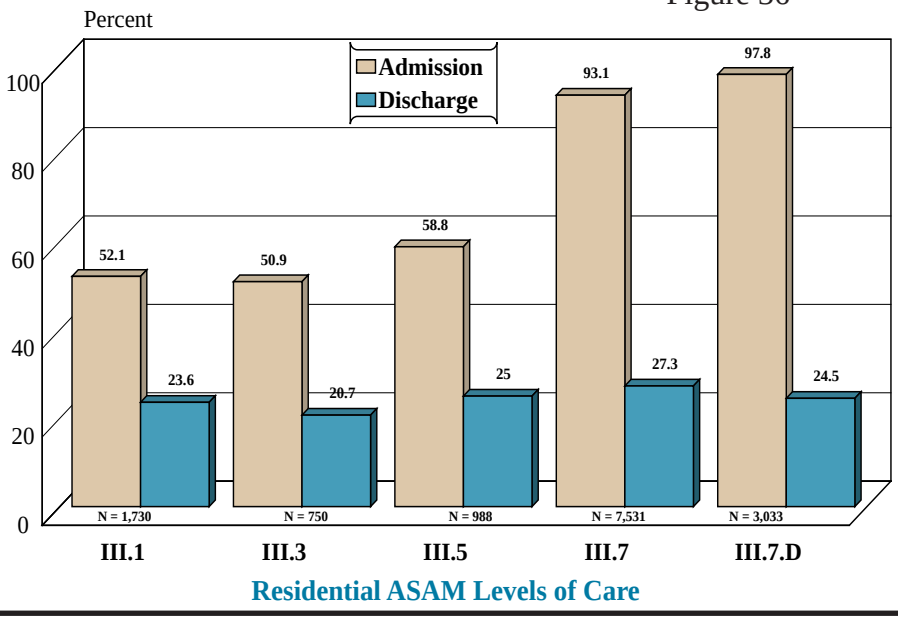


Treatment Reduces Substance Use

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

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

Figure 36



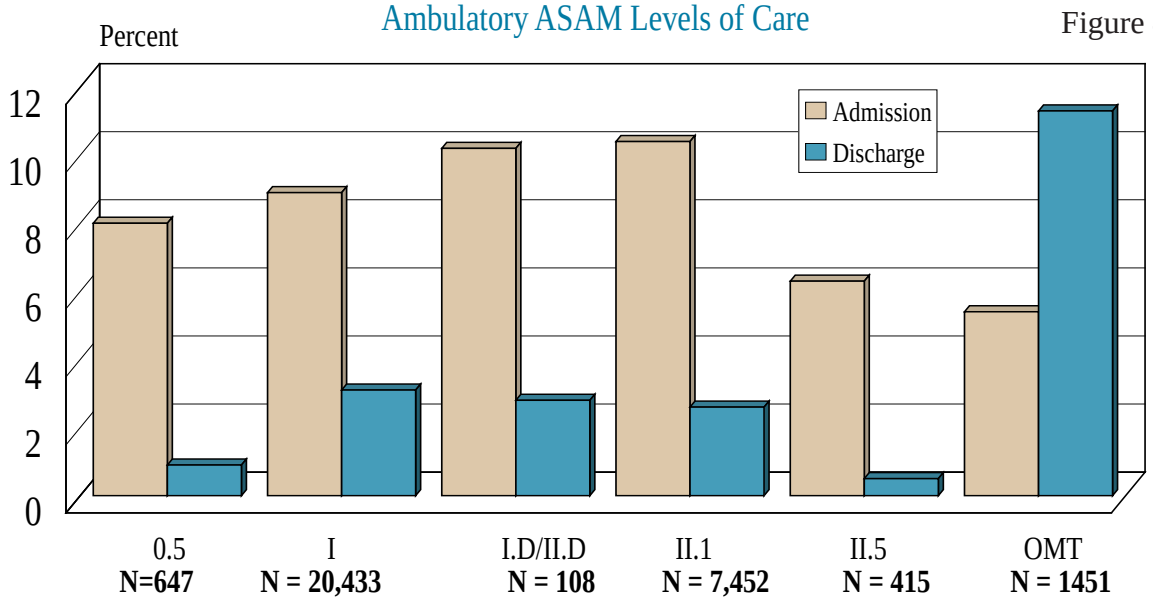
Treatment Reduces Crime

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

Percentages Arrested in the 30 Days Preceding Admission and Discharge

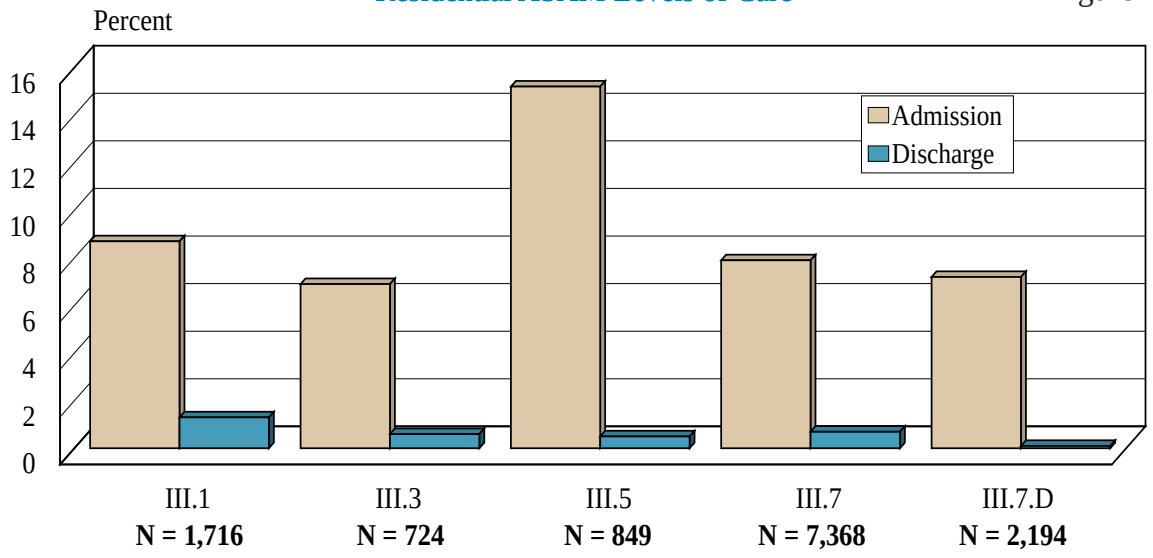
Ambulatory ASAM Levels of Care

Figure 43



Residential ASAM Levels of Care

Figure 44



Substance Abuse Treatment Outcome Measurement Tables

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

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

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

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

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

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

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

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

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

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

ADAA wishes to recognize all those who contributed to the publication
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State of Maryland FY05 Survey of Resources for Prevention, Intervention and Treatment of Tobacco and other Drugs

State Agency/Dept.		Category of Service	Funding Source	Adjusted Totals
DHMH	ADAA	Prevention	Federal SAPT Block Grant	4,985,017
		Intervention	State General Funds	2,322,384
		Intervention & Treatment	State Special Funds (CRF)	17,015,181
		Intervention & Treatment	Federal SAPT Block Grant	20,729,771
		Intervention & Treatment	State General funds	72,417,131
		Treatment	State General funds	6,410,000
			Total	123,879,484
DHMH	AIDS	Prevention & Intervention	Federal Funds (SAMHSA)	292,356
		Treatment	Federal Funds (SAMHSA)	630,625
			Total	922,981
DHMH	Family Health/CRF	Prevention	Federal funds (CRF) Total	1,863,000
DHMH	OHS/MA	Intervention & Treatment	Federal & State (see Note #1)	pending
DHMH	MHA	Intervention	State Funds	100,000
		Intervention & Treatment	State Funds	27,331,580
		Treatment	State & Federal Funds	3,948,966
		P, I, T	State Funds	64,545,912
			Total	95,926,458
DJS		Prevention & Intervention	State Funds	18,650
		Intervention	State & Federal Funds	1,479,914
		Intervention & Treatment	State Funds	85,556
		Treatment	State & Federal Funds	6,238,662
			Total	7,822,782
DHR		Intervention	Federal (SAMHSA)	3,363,095
GOCCP		Prevention	State & Federal Funds	937,235
		Prevention & Intervention	Federal Funds	23,000
		Intervention	Federal Funds	14,252
		Intervention & Treatment	Federal Funds	200,218
		Treatment	State & Federal Funds	1,336,584
		P, I, & T		127,973
			Total	2,639,262
DPSCS		Intervention	State Funds	4,181,753
		Treatment	State Funds	3,567,085
		Treatment	Federal-HIDTA, State Funds	1,995,178
			Total	9,744,016
MSDE		Intervention & Treatment	Federal (See Note #2) Total	4,940,260
DOT	MHSA	Prevention & Intervention	Federal (See Note #3) Total	1,351,116
VA Affairs		Intervention & Treatment	State Funds Total	18,000
			Total	**$ 252,470,454.00**

All Agencies	Prevention	7,785,252
All Agencies	Prevention & Intervention	6,625,382
All Agencies	Intervention	11,461,398
All Agencies	Intervention& Treatment	137,797,437
All Agencies	Treatment	24,127,100
All Agencies	P, I, & T combined	64,673,885
		$ 252,470,454.00

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Note 1 Healthchoice dollars were not available as budgeted expenditures, will request audit of actual expenses

Note 2 Dollars to be used at the discretion of the jurisdiction for safe and/or drug free schools

Note 3 Includes some enforcement dollars that were not able to be differentiated from Prevention dollars

MHA

State	P,I, T	50,775,642
State	I, T	27,331,580
State	P, I, T	13,697,762
State	P, I, T	72508
Fed Block Grant	indirect	0
PGHD	I&T	0
State	Treatment	3,663,869
State	Treatment	31,000
BSAS/OSI	indirect?	0
FedFunds	Treatment	57,006
State	Treatment	197,091
GOCCP	intervention, TAMAR	0
State to BC	CM (TAMAR)	50,000
State	RRP, PRP	
State	Indirect & mixed MH & DD	
State to PG	intervention, TAMAR	50,000
		95,926,458

Intervention	100,000
Intervention & Tx	27,331,580
P, I, T	64,545,912
Treatment	3,948,966

State PIT	
50,775,642	50,775,642
13,697,762	13,697,762
72,508	72,508
64,545,912	64,545,912

State IT	
27,331,580	27,331,580

State Tx	
3,663,869	3,663,869
31,000	31,000
197,091	197,091
3,891,960	3,891,960

Fed Tx	
57,006	57,006

State I	
50,000	50,000
50,000	50,000
100,000	100,000

Fed block Ind-	
210,130	0

PGHD I,T	
13,335	0

GOCCP I	
59,749	0

State Ind & mixed
72,000 ?

BSAS/OSI Ind	
149,095	0

DJS

Source	category	amount
ADAA (Fed)	Treatment	34,664
ADAA (Fed)	Treatment	51,695
State	Treatment	30,596
ADAA (Fed)	Treatment	173,977
State DJS	Treatment	190,166
ADAA (Fed)	Treatment	173,797
ADAA (Fed)	Treatment	125,000
State DJS	Treatment	647,815
ADAA (Fed)	Intervention	55,896
State DJS	Intervention	38,748
ADAA (Fed)	Intervention	51,742
State DJS	Intervention	32,005
State DJS	Intervention	44,051
ADAA (Fed)	Intervention	33,413
State DJS	Intervention	44,888
ADAA (Fed)	Intervention	112,586
State DJS	Intervention	249,542
ADAA (Fed)	Intervention	44,051
State DJS	Treatment via Drug Cou	176,672
State DJS	Treatment	3,038,640
State DJS	Intervention	2,712
State DJS	P & I	1,500
State DJS	Intervention	13,250
State DJS	Intervention	675,152
State DJS	P & I	7,750
State DJS	P & I	9,400
State DJS	Intervention	49,000
State DJS	Treatment	1,150,240
State DJS	Treatment	445,400
State DJS	Intervention & Treatmer	85,556
State DJS	Intervention	18,078
State DJS	Intervention	8,600
State DJS	Intervention	6,200
		7,822,782

Prevention & Intervention		18,650
Intervention		1,479,914
Intervention & Treatment		85,556
Treatment	State & Fed	6,238,662
		7,822,782

ADAA Treatment	State Treatment
34,664	
51,695	
	30,596
173,977	
	190,166
173,797	
125,000	
559,133 total	647,815
	445,400
	1,150,240
559,133	3,038,640
5,679,529	176,672
6,238,662 Total	5679529 total

ADAA Intervention	State Intervention
55,896	38,748
51,742	32,005
33,413	44,051
112,586	44,888
44,051	249,542
297,688 total	2,712
	13,250
297,688	675,152
1,182,226	49,000
1,479,914	18,078
	8,600
	6,200
	1,182,226 total

State DJS Intervention & Treatment	
85,556	
85,556	**Intervention & treatment**

1,500	State DJS
7,750	
9,400	
18,650	**Prevention & Intervention**

DPSCS	Source	Category	Amount	Treatment	Intervention
	DPSCS	Treatment, SA & referral	247,274	247,274	.
	DPSCS	Treatment, SA & referral	183,256	183,256	.
	DPSCS	Treatment, SA & referral	1,186,285	1,186,285	.
	DPSCS	Treatment, SA & referral	1,500,000	1,500,000	.
	DPP	Intervention, SA assess& placement	4,094,479		4,094,479 .
	DPSCS	Treatment, SA & referral	313,768	313,768	.
	DPSCS	Treatment, SA & referral	33,610	33,610	.
	DPSCS	Treatment, SA & referral	102,892	102,892	.
	DPSCS	Intervention, SA assess& placement	87,274		87,274 .
			7,748,838	3,567,085	4181753
	GOCCP	Treatment, SA & referral	1,255,414	1,255,414	.
	GOCCP	Treatment, SA & referral	575,193	575,193	.
	HIDTA	Treatment, SA & referral	164,571	164,571	.
			1,995,178	1,995,178	
		total state and Federal	9,744,016		

H&CD	Shelter	599,866
	Group Homes	2,708,000
	Transitional/Shelter	1,000,000
		4,307,866

GOCCP	Source	Category	Amount	Prevention	P/I	I	P/T	T	PIT	I/T
	Federal	Treatment	214,889					214,889		
	State	P, T.	168,000				168,000			
	State	Prevention	191,123	191,123						
	Federal	Prevention	49,173	49,173						
	State	Prevention	21,220	21,220						
	Federal	Treatment	112,161					112,161		
	Federal	Treatment	65,000					65,000		
	Federal	Treatment	57,548					57,548		
	Federal	Treatment	296,449					296,449		
	Federal	Treatment	49,796					49,796		
	Federal	PIT	38,743						38,743	
	Federal	Prevention	26,654	26,654						
	Federal	Prevention	81,000	81,000						
	State	Prevention	30,000	30,000						
	Federal	Prevention	99,883	99,883						
	Federal	Prevention	25,638	25,638						
	Federal	PI	23,000		23000					
	State	Treatment	35,200					35,200		
	Federal	Prevention	29,160	29,160						
	Federal	Prevention	30,553	30,553						
	Federal	I,T	50,155							50,155
	Federal	Treatment	14,063					14,063		
	Federal	Prevention	109,590	109,590						
	Federal	I,T	136,000							136000
	Federal	I,T	89,230							89,230
	Federal	Treatment	57,000					57,000		
	Federal	Prevention	17,966	17,966						
	Federal	Treatment	28,291					28,291		
	State	Treatment	151,000					151,000		
	Federal	Prevention	6,682	6682						
	Federal	Treatment	101,250					101,250		
	Federal	Prevention	58,700	58,700						
	State	Prevention	50,000	50,000						
	Federal	Prevention	3,401	3401						
	Federal	I	14,252			14,252				
	Federal	Prevention	63,069	63069						
	Federal	Prevention	33,696	33,696						
	Federal	Prevention	9,727	9727						
			2,639,262	**937235**	**23,000**	**14,252**	**168,000**	**1,182,647**	**38,743**	**275,385**