Baltimore's Drug Problem

It's Costing Too Much
Not To Spend More On It

Published by
The Abell Foundation
210 North Charles Street
Baltimore, Maryland 21201
October, 1993

Baltimore's Drug Problem

It's Costing Too Much
Not To Spend More On It

Published by
The Abell Foundation
210 North Charles Street
Baltimore, Maryland 21201
October, 1993

EXECUTIVE SUMMARY

The most effective and cost-efficient means of confronting the drug problem, according to a vast number of national studies, is through treatment programs. Yet over the last several years, at a time when drug abuse has escalated in the city, treatment slots have been pared.

Baltimore City is beset by a significant drug abuse problem that is continuing to worsen. The State of Maryland estimates that more than 62,000 people in Baltimore City — approximately one in every 12 city residents — are in need of substance (including alcohol) abuse treatment. Cocaine and heroin abuse are increasing in the city at a pace far faster than national trends.

One indicator of the growing severity of Baltimore City's drug abuse problem is the recent dramatic increase in the number of hospital emergency room patients who are seeking medical attention because of drug use. According to a study of 21 major U.S. cities by the Drug Abuse Warning Network (DAWN), between 1990 and 1991, the number of heroin mentions by hospital emergency room patients increased by 134 percent in Baltimore, while the national average rose only eight percent. Cocaine mentions in hospital emergency rooms increased nationally at a rate of 28 percent, while soaring 121 percent in Baltimore. These statistics are somewhat misleading because it is not surprising that addiction rates are higher in a central city such as Baltimore than in the nation as a whole. But even if one only considers large, distressed cities, as of the third quarter of 1992, Baltimore's heroin, cocaine, and alcohol-in-combination with other drugs emergency room mentions, per 100,000 people, were higher than any other city in the country. In 1992, more patients visited emergency rooms because of heroin use in Baltimore than in any other major U.S. city, except New York.

According to the 1990 census, 15 percent of Maryland's population resides in Baltimore City, yet 27 percent of the state's substance abusers in treatment and 67 percent of the individuals injecting drugs live in the city. (Authorities believe the percentage of substance abusers in treatment in the city would be even higher were it not for the limited number of treatment slots.)

The impact of drug abuse on the city — both direct and indirect — is immense: rampant crime, over-populated jail cells (currently four out of every five residents of the city jail have been involved with drugs), homelessness, a severe diminution of personal safety, an increasing burden on the city's hard-strapped fiscal infrastructure, population flight to the suburbs, an overload on the city's social services network, and a frightening increase in cases of individuals testing positive for the HIV virus.

The most effective and cost-efficient means of confronting the drug problem, according to a vast number of national studies, is through treatment programs. Yet over the last several years, at a time when drug abuse has escalated in the city, treatment slots have been pared. While the city appropriates millions of dollars for fighting the drug problem through law enforcement and the judicial system, it spends barely $150,000 of city funds annually on treatment programs. Baltimore's capacity to offer quality treatment is diminishing just when it is most sorely needed.

Over the past three years the total amount of government funds available for drug treatment in Baltimore has declined from $16.349 million in 1991 to $15.218 million in 1992 to $14.756 million this year in spite of the fact that the addiction problem is worsening. For the 1993 fiscal year, the federal government contributed $11,479,096 to the city's drug treatment program, the state gave $3,122,073, and the city contributed $154,798.

The City of Baltimore contributes a significantly lower proportion of the public money going to drug treatment than do other jurisdictions in the state. Between 1992 and 1993, the city cut its funding for drug treatment by just over 25 percent. The city's share ($154,798) of total public funding ($14.756 million) is 1.05 percent. Other jurisdications in Maryland contribute 8.9 percent of the total allocation of federal, state and local dollars for drug treatment programs in Maryland. Across the country, according to the National Association of State Alcohol and Drug Abuse Directors, local communities contribute 11 percent of the public dollars going to drug treatment. Again, it is not completely fair to compare the contribution of a fiscally stressed city to that of more affluent jurisdictions. On the other hand, the addiction problem is more severe here than in almost any other political subdivision in the country.

The city is also ill-equipped to determine which programs work best and which are least effective. Within the drug abuse treatment network, to date there is no operating system to track clients as they go through one treatment modality or program to another. And once clients leave the system, there is no mechanism to assess the effectiveness of the treatment they received.

Furthermore, the city has no plan delineating what it thinks is necessary to provide adequate treatment and what it would cost to implement such a plan. This report provides a portrait of the city's drug abuse problem and the treatment services available to substance abusers. It also looks at the many obstacles — particularly funding constraints and inadequate evaluation systems — that stand in the way of a healthier drug treatment network in Baltimore City.

A promising approach is to improve and dramatically expand Baltimore's substance abuse treatment system. While some of the proposals may appear to be obvious, common-sense suggestions, to date they have not been implemented.

With substance abuse and its concommitant problems on the rise, Baltimoreans must decide how to fight drugs in their community. Some proposals were offered recently by the Mayor's Working Group on Drug Policy Reform. The traditional response of increasing law enforcement protection is failing. A more promising approach is to improve and dramatically expand Baltimore's substance abuse treatment system by implementing the following proposals. While some of the proposals may appear to be obvious, common-sense suggestions, to date they have not been implemented.

- Develop and utilize mechanisms to evaluate Baltimore's drug treatment system to determine which individual programs and types of programs work best for which specific types of clients. The federally-funded Target Cities' computerized network (see page 14) is a step in this direction. Initiate a program for tracking clients upon discharge so that a comprehensive assessment can be made of the long-term effects of various treatment programs and their treatment methods, known in the field as "modalities."
- Target available resources to the most promising and cost-effective programs. Reimburse providers based on the intensity of treatment, staff qualifications and performance, and the effectiveness of the programs. Standards should be strengthened to assure that program staff are well qualified.
- Develop a plan identifying what additional treatment resources are needed. Then secure resources for a dramatic increase in treatment by shifting funds within the city

budget, by obtaining increased state appropriations, by soliciting private contributions from businesses and foundations, and by ensuring that treatment funds are being utilized appropriately and efficiently. Currently, the city spends more than 50 times as much on law enforcement as a means of abating the drug abuse problem as it does on treatment. Perhaps the city should consider maintaining the current tax rate (rather than cutting by five cents as the city council recently proposed) or even increasing the rate by five cents in order to provide resources for additional treatment slots. Also, increase funding for programs designed to help recovering addicts maintain their sobriety over the long-term, particularly those that address housing and employment needs.

- Treat the war on drugs as a public health problem rather than a law enforcement problem by:
  - Increasing cooperation between the drug treatment community and the criminal justice system in Baltimore City. The recent effort to set up a drug treatment court within the judicial system in the city is a step in the right direction. Also, despite the fact that 80 percent of the inmates in the city jail have been involved with drugs, there has been little to no drug treatment available in recent years to those incarcerated. Clearly, the city needs to increase the number of treatment programs operating within the jail itself.
  - Improving the linkages between the drug treatment community and the city's health care network. Health care professionals should receive more intensive education and training in identifying, treating and referring drug addicts. Expand the practice of establishing primary health care units in drug treatment programs.
  - Establishing forums to set in motion genuine public dialogue on the concept of drug medicalization.
  - Developing programs for educating the public on the efficacy of drug abuse treatment as the most successful and cost-effective method for dealing with the city's drug problem.

Perhaps the city should consider maintaining the current tax rate (rather than cutting by five cents as the city council recently proposed) or even increasing the rate by five cents in order to provide resources for additional treatment slots.

I. THE PROBLEM:

A. A Look at Drug Use In Baltimore City

Drug abuse in Baltimore City, according to a 1979 report by the National Institute on Drug Abuse, once was largely confined to a small, closely knit group of non-violent, black male heroin addicts in the inner city. Over the last three decades, however, the abuse of drugs has escalated to where today it represents one of the community's most grievous social problems.

While black males still represent the largest demographic group of drug abusers in the city, one-third of all individuals seeking substance abuse treatment in the city today are female and almost one-fourth are white. (Blacks represent 59 percent of Baltimore's total population, while 47 percent of the city's residents are male.)

As the relative cost of illicit drugs has soared over the past four decades, criminal activity has become a way of life for most of those dependent on hard drugs. Almost one of every three persons entering drug treatment in the city is referred by the criminal justice system. In 1992, the Baltimore City Police Department had a total of 16,725 narcotic arrests, with 4,501 for heroin and 9,204 for cocaine. Underlining the connection between substance abuse and crime in Baltimore City is the fact that approximately four of every five residents of the city jail have been involved with drugs, while 23 percent were arrested directly on drug charges. Between May 1991 and May 1992, 21 percent of the males held in pretrial release in the city tested positive for heroin.

As the relative cost of illicit drugs has soared over the past four decades, criminal activity has become a way of life for most of those dependent on hard drugs. Almost one of every three persons entering drug treatment in the city is referred by the criminal justice system.

Heroin has continued since the early 1950s to be a major contributor to illicit drug abuse in the city. But it has been joined over the past several years by crack/cocaine as a drug of choice by substance abusers. Many now switch back and forth and use combinations of heroin, crack/cocaine, alcohol and marijuana.

The number of city drug abusers in the early 1950s amounted to several hundred people, according to a study of narcotic addiction in Baltimore between 1950 and 1977. Today, estimates vary from about 30,000 to close to 80,000. The Substance Abuse Management Information System (SAMIS), a division of Maryland's Alcohol and Drug Abuse Administration, estimated the number of people in Baltimore City in need of substance (including alcohol) abuse treatment in fiscal year 1993 to be 62,829.

Before the recent emergence of crack/cocaine in Baltimore, the city was known as a heroin — or "drug injection" — city. In fiscal year 1993, according to SAMIS, 63 percent of individuals entering drug treatment programs in the city reported using crack/cocaine and 55 percent mentioned heroin use. (Another 49 percent mentioned alcohol and 21 percent marijuana, indicating an increasing problem of multiple-substance abuse in the city.)

Across the country, the use of heroin has reportedly stabilized or decreased. Unfortunately, heroin use in Baltimore is going in the opposite direction. In 1992, more patients visited emergency rooms because of heroin use in Baltimore than in any other major U.S. city except New York. (See **Figure 1 in Appendix C**) According to a study of 21 major U.S. cities by the Drug Abuse Warning Network (DAWN), between 1990 and 1991, the number of heroin mentions by hospital emergency room patients seeking medical attention because of drug use increased by 134 percent in Baltimore, while the national average rose only 8 percent. Cocaine mentions in hospital emergency rooms increased nationally at a rate of 28 percent, while soaring 121 percent in Baltimore.

In 1991, the number of drug mentions in Baltimore emergency rooms ranked fourth per 100,000 population (behind San Francisco, Newark, and New Orleans), according to DAWN. By the third quarter of 1992, the Baltimore metropolitan area's rates per 100,000 population of heroin, cocaine, and alcohol-in-combination with other drugs emergency room mentions were the highest in the country. (See Figure 2 in Appendix C) The city's 101.8 cocaine-related emergency room mentions easily topped New York's rate of 70.1. In addition, Baltimore ranked third in PCP-related and fourth in marijuana-related emergency room episodes respectively. The DAWN survey demonstrates the relative severity of Baltimore's substance abuse problems.

Drug abuse treatment experts say anecdotal data validates the rapid and continuing abuse of heroin and crack/cocaine in the city.

B. Who Abuses Drugs in Baltimore City? The Demographics of Drug Use

Two-thirds, or 66 percent, of individuals entering drug treatment programs in fiscal year 1992 were male, 34 percent female. Seventy-seven percent were black and 22 percent white. Three-fourths of the clients were unemployed upon admission and 72.2 percent came from families earning less than $20,000 annually.

There is no way of drawing a precise demographic picture of drug abusers in the city, since most never surface publicly. But a portrait can be sketched based on those drug abusers who enter treatment programs. All individuals entering treatment programs are interviewed and asked to provide personal data upon admission. The information is compiled by SAMIS and turned into a composite profile. Authorities believe the profile generally offers an accurate reflection of the city's substance-abusing population.

Two-thirds, or 66 percent, of individuals entering drug treatment programs in fiscal year 1992 were male, 34 percent female. Seventy-seven percent were black and 22 percent white. Three-fourths of the clients were unemployed upon admission and 72.2 percent came from families earning less than $20,000 annually.

In fiscal year 1992, 36 percent of the clients enrolled in programs had their treatment paid for by Medicare, Medicaid, or other government programs. Another 27 percent paid from their own funds, while the fees of almost 10 percent were covered by Blue Cross/Blue Shield, HMO's or private insurance carriers. Twenty-eight percent were not charged a fee because of insufficient income.

Just over six percent of individuals entering drug treatment programs in fiscal year 1992 were under 18 years old. Another 18 percent were between the ages of 18 and 25, 20 percent were between 26 and 30 years old and 47 percent were from 31 to 44 years of age. Another eight percent were between 45 and 64 years old, and less than one percent were 65 years or older.

The demographic composite of drug abusers in Baltimore is quite different in many ways from that of the rest of the state. For example, while blacks represent three of every four drug abusers in the city, there are more white substance abusers in the rest of the state (57 percent) than blacks (42 percent). And while two-thirds of Baltimore's drug abusers are male, the proportion jumps to almost three-quarters statewide. When it comes to the substance being abused, three of every four Marylanders mention alcohol; in Baltimore, cocaine and heroin are mentioned more frequently than alcohol. In Baltimore, one in 10 individuals entering drug treatment programs is married, while 63.7 percent never have married; statewide, two in 10 are married and 55 percent have never married.

According to the 1990 census, 15 percent of Maryland's population resides in Baltimore City, yet 27 percent of the state's substance abusers in treatment and 67 percent of the individuals injecting drugs live in the city. Overall, just over 10 percent of the clients in the city's substance abuse treatment programs are non-residents. People in need of drug treatment often gravitate to the city because of its relative wealth of treatment programs. Approximately 80 percent of the methadone programs in the state, for example, are located in Baltimore City.

Almost one-third of substance abusers entering treatment programs in Baltimore City are referred to the programs by the criminal justice system. Another third seek treatment on their own or on the recommendation of their family, friends or employers. The remaining clients decided to enter treatment for unspecified reasons.

Three of four newly admitted clients in fiscal year 1992 entered substance abuse programs for the first time. The others were readmitted or changed the type of service they were receiving. More than half of the heroin abusers entering programs used the drug at least twice daily, with a full 30 percent using it at least three times a day.

Almost one of every three clients in treatment in fiscal year 1992 took two or more types of drugs prior to admission. Another 36 percent were using one drug and alcohol, 17 percent used one drug only and 16 percent were consuming alcohol only.

In general, the longer a client stays in a program, the better his/her chance of recovery. Although different programs have different objectives which affect the optimal length of stay, most counsellors prefer to keep clients in treatment as long as it takes to get them off drugs and bring some stability to their lives. But this task is often a difficult one. Drug abusers generally have a multitude of problems in their lives that extend beyond their addiction. It is difficult to get most substance abusers to enter programs, and it is not always easy to keep them in treatment once they have stepped through the door. The average stay in an outpatient treatment program in Baltimore City last year was three-and-one-half months. Yet some programs were more successful in keeping clients than others; the average stay ranged from a low of 18 days in one program to a high of almost two years in another.

In general, the longer a client stays in a program, the better his/her chance of recovery. Although different programs have different objectives which affect the optimal length of stay, most counsellors prefer to keep clients in treatment as long as it takes to get them off drugs and bring some stability to their lives.

Of those leaving treatment programs in fiscal year 1992, 38 percent departed before their treatment was completed and 15 percent were dropped for failure to comply with program regulations or requirements. Another 15 percent left after completing the program and halting their drug use. One percent completed a program but continued some drug use, and 14 percent completed one program and were referred to another. State officials contend the above rates of program completion compare favorably with national figures, although they have no statistics to verify the claim.

C. The Impact of Drug Abuse on the City's Social and Economic Fabric

"The problem of drug and alcohol abuse is a vast web that is intertwined with many social factors — violent crime, lack of education, unemployment, inadequate housing, and the breakdown of the family unit and of our value system." So wrote Gov. William Donald

Schaefer in Maryland's Drug and Alcohol Abuse Control Plan for 1992. That assessment by the governor only touches the tip of the iceberg when it comes to describing the impact substance abuse has had on life in Baltimore City.

Barely a day goes by when a drug-related homicide does not occur. The city's health care system is burdened by — and ill-equipped to cope with — drug-related disease. Injection drug use is the fastest and most potent vehicle for transporting the HIV virus throughout the city's heterosexual population. **(See Figure 3 in Appendix C)**

According to a 1990 survey by Action for the Homeless, the major precipitating factor leading to homelessness in Baltimore City was chemical dependency. While 26 percent of homeless surveyed reported chemical dependency as the major factor precipitating their homelessness, only 12 percent reported drug/alcohol treatment as their major daytime activity.

Across the state, one in every ten babies is born drug-affected (*The Sun*, 4/29/90). Likewise in Baltimore, 10 percent of all babies born at Johns Hopkins Hospital in 1989 were born drug exposed (*The Evening Sun*, 9/29/89). In 1989, the Maryland State Task Force on Drug-Affected Newborns estimated that the state would spend $52,013 for each child born drug exposed by the time he/she reached 18 years of age.

Although there is no good data, anecdotal information reveals that substance abuse is involved in at least 85 to 90 percent of cases in the child protective services system.

A less tangible but equally debilitating impact of substance abuse is the psychological fear it spreads across Baltimore. Many individuals are loathe to enter the downtown area of the city because of the perception of crime related to drug abuse. The resultant impact on businesses in the city, as well as on the city's tax base, is immense.

A less tangible but equally debilitating impact of substance abuse is the psychological fear it spreads across Baltimore. Many individuals are loathe to enter the downtown area of the city because of the perception of crime related to drug abuse. The resultant impact on businesses in the city, as well as on the city's tax base, is immense.

In a "Quality of Life Survey" conducted in 1991 by the University of Baltimore's Schaefer Center for Public Policy and the Baltimore Regional Council of Governments, Baltimore City residents cited drugs as the major problem in their community. When asked what were "the two or three biggest problems facing your community today . . . on which you personally would like to see some action taken," 55.7 percent of the respondents listed drugs among the top three problems and 45.9 percent listed controlling crime. No other problem was cited by more than 25 percent of the respondents. Drug abuse was the first problem indicated by 32.8 percent.

During the 1980s, according to the Internal Revenue Service, net migration from Baltimore City to the surrounding five counties was just under 70,000. While no definitive studies have been conducted to explain the causes for this migration, it is commonly believed that drug abuse and related crime in the city are a major contributor.

The city's budget, already under duress because of the recession and federal budget limitations, is further burdened by being forced to react to drug abuse — particularly in the area of law enforcement and the criminal justice system.

The overall impact of substance abuse on life in the city is incalculable; certainly it touches every citizen in one way or another.

II. SUBSTANCE ABUSE TREATMENT: A PROMISING SOLUTION

A. Substance Abuse Treatment Works

Given the severity of Baltimore's drug problem and its negative impact on the economic and social fabric of the city, what can be done? Many contend that the city should improve and expand its network of drug treatment facilities. However, an imposing barrier to increasing and/or enhancing drug treatment programs is the lingering doubt in the minds of the public and politicians as to the efficacy of treatment. Does treatment actually work? Is it a viable weapon for combating drug abuse? Is it cost effective?

Research on the national level demonstrates conclusively that the answer to all these questions is 'yes.' "Virtually all studies conducted over the last 15 years show that substance abuse treatment is effective in reducing drug abuse, increasing employment, improving psychological adjustment, and decreasing crime, along with other negative behaviors," the National Association of State Alcohol and Drug Abuse Directors declared in a report published in 1990. "Indeed, the evidence to support greatly increased public expenditures for treatment is undeniable."

Does treatment actually work? Is it a viable weapon for combating drug abuse? Is it cost effective? Research on the national level demonstrates conclusively that the answer to all these questions is 'yes.'

In 1988 the National Institute on Drug Abuse issued a report, "Effectiveness of Drug Abuse Treatment," which concluded, among other things, the following about treatment:

— Illicit drug use among intravenous drug abusers is immediately reduced, with an average of 75 percent of those in treatment using no illicit drugs.

— The transmission of AIDS among intravenous drug abusers is significantly abated. Those in treatment the longest show the lowest rates of infection.

A study published in 1989 by the National Institute on Drug Abuse, based on the observation of 10,000 clients admitted to treatment beginning in 1979, reported the following:

— Three to five years following treatment less than 20 percent of clients in any modality were regular users of any drug, other than marijuana.

— Except with marijuana, abstinence rates averaged 40 to 50 percent. Improvement rates (for lessening drug use) were 70 to 80 percent, again with the exception of marijuana. And even with marijuana, the abstinence rate was about 20 percent and the improvement rate 40 percent.

—Three to five years after treatment, the proportion of clients involved in predatory crimes ranged from one-third to one-half of pre-treatment levels in all modalities.

— The percentage of clients employed full-time registered gains in all modalities following treatment.

"There is no question that treatment works," wrote the authors of the study. "The costs of drug abuse treatment are substantially recovered during the time a client is in treatment, and the savings to society after a client has left treatment represent further returns on investment. By serving as an alternative to incarceration, treatment can be particularly beneficial for drug abusers identified in jails or prisons, and it can play a central role in combatting the spread of AIDS by reducing the intravenous use of heroin and other drugs."

A national study of 44,000 admissions to treatment between 1969 and 1974, supported by the National Institute on Drug Abuse and known as Drug Abuse Report Program, found:

— In the third year following discharge, daily opiate use had declined in all modalities, from about 100 percent to approximately 25 percent.

— Following treatment, arrest rates dropped by 74 percent.

— Employment increased from 33 percent before treatment to 57 percent in the third year following discharge.

B. Substance Abuse Treatment Programs Are Cost-Effective

Officials with the state Alcohol and Drug Abuse Administration acknowledge that they lack the sophistication and assessment methodology, as well as the evaluation data, to determine whether individual treatment programs are cost-effective. While programs are monitored by the state, in conjunction with the city, cost-effectiveness is not one of the standards assessed.

"Treatment programs now, as in the past, are undervalued as weapons in the so-called 'drug war,' and funds for treatment services continue to be inadequate to serve many people who need and request help."

Instead, drug abuse officials point to the overall cost-effectiveness of treatment vis-a-vis the other alternatives facing drug abusers: incarceration or remaining on the street.

"Treatment programs now, as in the past, are undervalued as weapons in the so-called 'drug war,' and funds for treatment services continue to be inadequate to serve many people who need and request help," according to a report published by the National Association of State Alcohol and Drug Abuse Directors (NASADAD). "The inadequacy of funding for treatment has continued despite overwhelming scientific evidence and the irrefutable collective experience of NASADAD members in 50 states, the District of Columbia, Guam, Puerto Rico and the Virgin Islands that treatment works and is cost-effective."

The report goes on to state, "The benefit-cost ratio of drug treatment programs is 1-to-11.54: for every dollar of funds spent for a drug treatment service, $11.54 of social costs is saved." That assessment, which is generally in the range of the benefit-cost ratio suggested by drug abuse and treatment authorities in Baltimore, is based on the relative cost of treatment to the cost of the alternatives. Generally, outpatient treatment is estimated to cost $2,000 to $2,500 annually per slot; methadone maintenance costs about $3,000; and non-hospital residential treatment costs between $15,000 and $20,000.

Alternatively, the annual cost of incarceration is between $25,000 and $50,000 and AIDS treatment about $100,000. Allowing a drug addict to remain on the streets is estimated to cost from four to 10 times as much as treatment, taking into account social costs. The degree of the four-to-10 factor depends upon the level of crime being committed in a community.

III. THE REALITY: BALTIMORE'S DRUG TREATMENT SYSTEM IS UNDERFUNDED AND OVERLOADED

A. Drug Treatment Programs in Baltimore City

Clearly, the city has a significant and rapidly growing substance abuse problem. Its impact is devastating in both social and economic terms. If substance abuse treatment is indeed our most potent weapon in the war on drugs, as indicated in numerous national studies, is Baltimore City well-positioned for this battle? How many and what kind of treatment services are available in Baltimore City? Are the number and types of programs available sufficient to meet the demand for substance abuse treatment? How effective are the various treatment modalities and individual programs in combatting the drug abuse problem? Which modalities and programs work best for which types of clients? Are the city's resources being targeted towards those programs that are the most effective?

In an effort to answer these questions, this report provides an in-depth description and analysis of Baltimore City's drug treatment network, including a discussion of funding mechanisms, modalities, and program evaluation.

If substance abuse treatment is indeed our most potent weapon in the war on drugs, is Baltimore City well-positioned for this battle? In an effort to answer these questions, this report provides an in-depth description and analysis of Baltimore City's drug treatment network, including a discussion of funding mechanisms, modalities, and program evaluation.

In Baltimore City there are two general classifications of substance abuse treatment programs — publicly-funded and non-funded or private programs. Publicly-funded programs are required to offer treatment even to those unable to pay for the services rendered. The state determines a sliding fee scale based on a client's income to establish how much non-indigent clients must pay for services. Non-funded programs receive no federal or state monies and have discretion in rejecting indigent clients.

All official substance abuse treatment programs, both publicly-funded and non-funded, must be certified by the Department of Health and Mental Hygiene's Office of Licensing and Certification Programs. The programs are required to meet certain standards to be certified. While some programs principally serve a particular neighborhood, others offer services to a city-wide population. Among the non-funded programs, there are also some with non-traditional approaches to recovery, such as the Cathedral House Re-Entry Program. This report, however, will focus only on the status and impact of the city's certified drug treatment programs.

The number of programs offering substance abuse services often fluctuates. As of September 1993, according to the state Alcohol and Drug Abuse Administration, there were 42 publicly-funded programs and 31 non-funded programs in the city. Because of clients completing or dropping out of programs, the number receiving services during a year exceeds the available number of treatment slots. In fiscal year 1993, 16,195 clients were treated in publicly-funded programs and 5,864 in non-funded programs.

The programs offer a variety of services, or treatment "modalities," to substance abuse clients in Baltimore City. Among them are methadone maintenance, outpatient, intermediate care, halfway house, detoxification and long-term care. The most prevalent is methadone maintenance, which is offered to clients using opiates, principally heroin. Of the 5,456 publicly-funded slots available in Baltimore City last year, more than half — or 2,817 — were for methadone maintenance. Another 2,346 slots provided a variety of outpatient services. There were 108 intensive outpatient, 97 intermediate care, and 88 halfway house slots. Because of funding cuts, Baltimore's 20 long-term residential treatment and 20 non-hospital

detoxification slots were eliminated in fiscal year 1992. While long-term treatment is expensive and served a relatively small number of clients, substance abuse professionals believe the elimination of these slots creates a tremendous gap in the city's treatment continuum. (For a more detailed discussion of the various treatment modalities and specialized services for addicts in treatment, see Appendix A. See Appendix B for a listing of all publicly funded and non-funded substance abuse treatment programs in Baltimore City, as of September 1993.)

Another program recently defunded (as of September 30, 1993) was the Baltimore City Acupuncture Behavioral Substance Abuse Treatment Program (BCABSATP), a non-profit organization funded by the Baltimore City Health Department to provide a two-month detoxification program combining acupuncture with counseling services. But the program itself was plagued by a variety of administrative and financial problems that contributed to its demise. Still, the Health Department believes BCABSATP did prove acupuncture to be a worthwhile component of drug treatment and a useful means for clients to avoid withdrawal symptoms and gain access to other services. The Health Department plans to continue offering acupuncture as part of its treatment system. Acupuncture is an important component of a new substance abuse treatment program which began operating in the Women's Detention Center in September of 1993.

Baltimore City contributes a significantly lower proportion of the public money going to drug treatment than do other jurisdictions in the state.

Publicly funded substance abuse treatment programs are supported by block grants from the federal government and the state Alcohol and Drug Abuse Administration and by client fees. The city also contributes a minuscule amount. For the 1993 fiscal year, based on approved program grants, the combined federal and state awards amount to 61 percent of the programs' annual budgets, with client fees accounting for 39 percent.

Federal and state grant funds are funneled through the Baltimore City Health Department. Program directors submit their annual budgets to state and city drug abuse officials, who evaluate the program costs and budgetary items. They take into account how much each program can collect in client fees and the ratio between number of clients and number of counsellors in a program. Some programs receive their entire budgets from the combined state and federal grant, while others obtain more than 90 percent of their operating expenses through client fees.

For the 1993 fiscal year, the total cost of running publicly funded programs (including administrative costs for the Baltimore City Health Department's drug abuse office) was $23.976 million. Of that, $14.601 million was covered by the combined federal and state grants and $9.375 million by client fees.

Total governmental contributions for city drug treatment programs in fiscal year 1993 broke down in the following way: federal government, $11,479,096; state, $3,122,073; city, $154,798. Over the past three years the total amount of government funds available for drug treatment in Baltimore has declined from $16.349 million in 1991 to $15.218 million in 1992 to $14.756 this year in spite of the fact that the addiction problem is worsening.

Baltimore City contributes a significantly lower proportion of the public money going to drug treatment than do other jurisdictions in the state. The city's share ($154,798) of total public funding for fiscal year 1993 ($14.756 million) was 1.05 percent. Other jurisdications

contributed 8.9 percent of the total allocation of federal, state and local dollars for drug treatment programs in Maryland. The city reduced its funding for drug treatment by just over 25 percent from 1992 to 1993. Across the country, according to the National Association of State Alcohol and Drug Abuse Directors, local communities contribute 11 percent of the public dollars going to drug treatment. While it may not be completely fair to compare the contribution of a fiscally stressed city to that of more affluent jurisdictions, the addiction problem is more severe in Baltimore than in almost any other political subdivision in the country.

In addition, the state and federal governments awarded the city $776,095 for drug abuse prevention programs in fiscal year 1993. The city itself put no money into drug prevention. As a means of comparison, Montgomery County received $215,309 in prevention money from the state and federal governments and appropriated $1.9 million from its own budget for prevention programs.

The $154,798 Baltimore City spent on drug treatment programs is dwarfed by the money appropriated for combatting drugs through law enforcement, even though criminologists have found no relationship between the number of police officers and crime rates. Among the U.S.' 100 largest cities, Baltimore has the second highest number of police officers per 1,000 residents. The city police puts $5.5 million specifically into its drug enforcement units. That figure does not account, however, for the dollars spent on routine police work that often goes towards apprehending drug offenders.

Similarly, the state's attorney's office received $1.3 million this year earmarked specifically for drug prosecutions in Baltimore City. But budget and judiciary officials estimate that 75 percent or more of the prosecutions initiated by the state's attorney for Baltimore City are drug related. That office's overall budget for the current fiscal year is $12.9 million.

An instructive incident occurred recently when the Baltimore City Council voted to spend an additional $2 million to hire additional police officers. This was done despite the fact that, as mentioned above, Baltimore City already has more police officers per capita than any city in the country but one, and there is no indication that additional police officers will reduce crime. This decision was also made even though there is clear evidence that drug treatment programs do, in fact, cause a significant decrease in crime.

Despite the increasing severity of Baltimore's drug abuse problem, the number of publicly-funded treatment slots has declined and then plateaued over the past several years.

B. Too Many Addicts, Too Few Slots

Despite the increasing severity of Baltimore's drug abuse problem, the number of publicly-funded treatment slots has declined and then plateaued over the past several years. In fiscal year 1993, the publicly-funded substance abuse programs in Baltimore City had a total of 5,456 treatment slots available for clients, six slots fewer than were available in the previous year. During fiscal year 1991, the number of slots available — 5,762 — was five percent higher than in fiscal year 1992.

As it is, Thomas Davis, the director of Alcohol and Drug Abuse for Baltimore City and acting director of Baltimore Substance Abuse Systems, Inc., estimates the city is offering drug treatment to but one of every 10 substance abusers in need of help.

"People with drug abuse needs can't get into programs," laments Dr. David N. Nurco, a leading substance abuse researcher who is with the Department of Psychiatry at the University of Maryland's School of Medicine. "This is the price we've had to pay. The budgets are constantly being cut back."

The city's inability to increase its number of treatment slots in recent years has had a devastating impact on drug treatment services. Programs have waiting lists of substance abusers seeking access to treatment services. The wait can stretch into months. During the first ten months of fiscal year 1993, the city's publicly-funded drug treatment programs recorded an average daily number of 729 addicts on the waiting list seeking treatment.

Most treatment professionals in the city say the number of treatment slots needs to be tripled. Some believe that addicts should be able to receive treatment on demand, an ideal that is but a fantasy in Baltimore today. There is a growing concern that substance abusers with life-threatening problems are unable to receive treatment.

Most treatment professionals in the city say the number of treatment slots needs to be tripled.

The lack of slots means that substance abusers often must compete for access to treatment. Such issues as pregnancy, severity of need and motivation on the part of the potential client are taken into account by some programs. Others simply admit clients on a first-come, first-serve basis. For substance abusers who are impatient or reluctant to seek treatment in the first place, being put on a waiting list often blunts their interest in entering a program.

The level of services offered under tight budget constraints is greatly diminished. Some say the client-counsellor ratio in programs is escalating to the point where only rudimentary services are available.

Another funding dilemma, according to some professionals, is that non-funded treatment clinics are attracting those clients who can afford to pay fees. That means less income for the public clinics and a further erosion of their ability to provide full services.

Although the number of treatment slots available to the general population has remained static, the city is actively seeking funds to offer more treatment services to individuals involved in the criminal justice system through the creation of a "Drug Court." This new program would give non-violent drug offenders the option to undergo substance abuse treatment in an effort to reduce recidivism among this population. Offenders would undergo full assessments to identify those most appropriate for treatment. Participants would be required to abide by agreed-upon conditions drawn up by physicians and treatment professionals.

C. An Un-evaluated Treatment System

Some treatment programs obviously operate more successfully than others. But authorities have great difficulty in evaluating programs and in agreeing on what constitutes successful treatment.

The most obvious barometer of assessing successful treatment is whether a client who entered a program as a drug abuser completes the program drug-free. But using this barometer to judge programs or clients is not as simple as it may seem.

Some programs are much more strict in admitting drug abusers than others; they may turn away all but the most highly motivated clients, or only take clients who already have

been through other programs along the treatment continuum. Such restrictive programs will be able to boast of turning out a higher rate of drug-free clients than a program that accepts all substance abusers, regardless of their status or the severity of their dependency.

Also, because many methadone programs keep clients for years, they may not be able to release as many drug-free clients from treatment as outpatient treatment clinics. That alone does not imply that clients in methadone programs are more debilitated by drugs than clients leaving outpatient clinics.

Furthermore, there are other yardsticks for judging success besides a client's becoming drug-free: Is a client able to complete the requirements of a treatment program successfully? Has he or she been able to obtain employment or a graduate equivalency degree since beginning treatment? Has the client's family situation stabilized? Has he or she been incarcerated? All these factors can be weighed in attempting to define successful treatment.

Some drug treatment professionals believe that if a substance abuser leaves a program and returns sometime later for treatment, it is a sign of success. Others disagree.

"There is no one answer for everyone," says Todd Rosendale of the state Alcohol and Drug Abuse Administration, adding that each individual substance abuser has a different set of problems and, ideally, should be treated and evaluated individually. Because of the tight financial vise gripping treatment programs, however, individualized treatment usually is more of an unmet goal than a reality.

Yet the greatest barrier to evaluating programs and the impact of treatment on clients is the drug treatment community's incapacity to collect meaningful data. This is a problem haunting researchers, program directors and governmental officials nationwide, not just in Baltimore.

Almost all data collected on clients in treatment programs come at the points of admission and discharge. Because of the expense and other significant obstacles, there has been very little tracking of clients following their discharge from individual treatment programs. That makes it difficult to assess the long-term effects of treatment.

Baltimore was the recipient of a three-year, $13 million pilot project grant from the federal government, known as the Target Cities program, aimed at improving existing services. The grant expired in September of 1993, and the city's two-year, $3.4 million renewal application was denied. Although the city will most likely be able to use $4.8 million in unspent funds from the original three-year grant over the next two years, it is unfortunate that the city was unable to maximize this opportunity for federal funding. Under Target Cities, three primary functions are being funded: intensive staff training, the provision of primary health care clinics in existing programs, and the establishment of a centralized computer data collection system.

The Target Cities data collection system, which is partially in place, will link all of the city's publicly-funded and some of the non-funded substance abuse programs by computer and is expected to enhance the compilation of information on clients while they are in treatment. The program will provide authorities with a faster and more comprehensive method of collecting data on clients and various programs as well as the means to make a more well considered assessment of what the city's needs are regarding treatment services. The com-

Because of the expense and other significant obstacles, there has been very little tracking of clients following their discharge from individual treatment programs. That makes it difficult to assess the long-term effects of treatment.

puter system is also expected to enable authorities to improve access for clients by allowing each program to determine where slots are available in the city for an abuser with a particular need. Substance abusers wishing to enter treatment will be matched as quickly as possible with the most appropriate program available. And professional staff will be able to track clients' progress throughout their treatment regimen.

Despite all of these benefits of the Target Cities data collection system, it will not be equipped to track clients once they leave programs, except to identify which clients reenter treatment and how they have changed as a result of their previous treatment experience. This is very unfortunate, particularly since there have been no comprehensive efforts in recent years to evaluate treatment in Baltimore City, according to researchers. Most professionals in the field of drug treatment see the absence of such evaluation as one of the most pressing needs in the community. "If you're going to change addict behavior, you should know what it is," says one prominent researcher.

and the effectiveness of the programs. Standards should be strengthened to assure that program staff are well qualified.

C. Develop a plan identifying what additional treatment resources are needed and then secure resources for a dramatic increase in treatment by shifting funds within the city budget, by obtaining increased state appropriations, by soliciting private contributions from businesses and foundations, and by ensuring that treatment funds are being utilized appropriately and efficiently. When the city council recently proposed a five cent cut in the city tax rate, the mayor advocated maintaining the current rate in order to enhance law enforcement in the city. Already the city ranks second among U.S.' 100 largest cities in the number of police officers per 1,000 residents and still the level of crime in the city continues to escalate. Currently, the city spends more than 50 times as much on law enforcement as a means of abating the drug abuse problem as it does on treatment. Perhaps the city should consider maintaining the current tax rate or even increasing the rate by five cents in order to provide resources for additional treatment slots. Also, increase funding for programs designed to help recovering addicts maintain sobriety over the long term, particularly those that address housing and employment needs.

When the city council recently proposed a five cent cut in the city tax rate, the mayor advocated maintaining the current rate in order to enhance law enforcement in the city. Already the city ranks second among the U.S.' 100 largest cities in the number of police officers per 1,000 residents and still the level of crime in the city continues to escalate.

D. Treat the war on drugs as a public health problem rather than a law enforcement problem by:

1. Increasing cooperation between the drug treatment community and the criminal justice system in Baltimore. The recent effort to set up a drug treatment court within the judicial system in the city is a step in the right direction. Also, despite the fact that 80 percent of the inmates in the city jail have been involved with drugs, there has been little or no drug treatment available in recent years to those incarcerated. Clearly, the city needs to increase the number of treatment programs operating within the jail itself.

2. Improving the linkages between the drug treatment community and the city's health care network. Health care professionals should receive more intensive education and training in identifying, treating and referring drug addicts. Expand the practice of establishing primary health care units in drug treatment programs.

3. Establishing forums to set in motion genuine public dialogue on the concept of drug medicalization.

4. Developing programs for educating the public on the efficacy of drug abuse treatment as the most successful and cost-effective method for dealing with the city's drug problem.

APPENDIX A
I. DRUG TREATMENT MODALITIES

A. Methadone Maintenance

The most common form of substance abuse treatment available in the city today is methadone maintenance, offered to clients using opiates, primarily heroin. Because of the high number of heroin abusers in the city, gaining admission to methadone programs is difficult. The number of addicts seeking treatment exceeds the number of available slots. Although most methadone treatment facilities operate at above capacity (serving more clients than they have slots for), it often takes heroin abusers a month or more to gain entry into a city methadone program because of the relative scarcity of slots.

One reason methadone treatment slots open so infrequently is that clients stay on methadone for long periods, often for years. The average stay for clients enrolled in city methadone maintenance programs last year was 456 days. Consequently, most methadone programs in the city have waiting lists of potential clients. Often a heroin abuser will change his or her mind about entering a methadone program by the time a slot opens up.

Although most methadone treatment facilities operate at above capacity (serving more clients than they have slots for), it often takes heroin abusers a month or more to gain entry into a city methadone program because of the relative scarcity of slots.

As of September, 1993, twelve publicly-funded and two non-funded programs offered methadone maintenance in Baltimore City, in addition to the federal Veterans Administration program. Clients generally visit the programs once a day to receive a liquid dose of methadone. Because methadone is a controlled substance, federal regulations regarding its dispensation are quite strict. A client in Baltimore programs must speak to a staff member immediately after taking the daily oral dosage to assure that he or sure has actually swallowed the drug. Urine testing is conducted, generally between once a week and once a month. Previously, urinalysis was more frequent at methadone programs but has been cut back as a cost-saving measure. The dispensation of methadone is regularly accompanied by various forms of counseling at treatment centers.

A small number of methadone clients in the city are permitted to receive a monthly dosage and consume it at home on a daily basis. Those permitted to take methadone at home either on weekends (after showing no drug use, being employed and having been a regular client at a program) or for longer periods, must return to the center at a moment's notice and without warning to demonstrate they are properly using the methadone.

Ever since its development in the early 1960s as a means of breaking heroin addiction, methadone has been a controversial method of treatment. Critics contend that by substituting methadone usage for heroin abuse, one addiction is simply being traded for another. And the addiction to methadone is much more difficult to break than the addiction to heroin. Whereas the physical pain of heroin withdrawal lasts about three days, the pain accompanying methadone withdrawal can last a couple of weeks. As a result, only about 10 percent of methadone patients ever get off of their medication and become drug-free. In addition, critics claim that many individuals in methadone treatment continue using heroin and other drugs, relying on stealing, dealing and prostitution to support their habit. Those with take-home doses sometimes sell them to junkies looking for a drug to carry them over until they can find some heroin. The most cynical of methadone critics maintain that patients in for-profit clinics are often kept on methadone longer than necessary because the clinics have a vested interest in getting and keeping clients.

Proponents of methadone maintenance assert, however, that it is the most common and effective form of treatment for narcotics addiction both in Baltimore and across the United States. While methadone maintenance does not work for all heroin (or other opiate) addicts, many methadone clients are able lead normal lives as long as they continue on the drug. Consumers of methadone do not get high as do users of heroin. And unlike heroin, one's dependency on methadone does not escalate. Because methadone is legal, plentiful, and relatively cheap (about $50 week), proponents believe its use helps to reduce criminal activity. The fact that methadone is swallowed rather than injected also eliminates the threat of contact with the HIV virus.

"Methadone maintenance is a widely accepted and highly successful form of treatment for narcotic abusers," according to the Legal Action Center of New York. "Methadone, when taken orally in stable dosages as part of a medically supervised treatment plan, permits the patient to lead a normal and productive life without any of the narcotic effects of heroin addiction . . . All available medical and scientific evidence demonstrates, clearly and incontrovertibly, that a person who is successfully participating in a methadone maintenance program is in no way impaired by the administration of methadone."

Data from the New York City Department of Health have shown that within the first year of methadone treatment there is an 85 percent reduction in the number of patients using heroin. With patients in treatment at least three years, according to the data, 94 percent do not use heroin.

Many professionals would like to see funding increased so that the number of methadone slots can be expanded in the city. They believe the need for more treatment slots is particularly acute because of the AIDS threat and the level of crime accompanying heroin abuse. Many heroin addicts are involved in crime on a daily basis to support their habits. While authorities insist a need exists for more methadone treatment centers, communities have thwarted efforts to site new programs. A zoning exemption, as well as city council authorization, is required to establish a methadone program in Baltimore. According to Todd Rosendale of the state Alcohol and Drug Abuse Administration, no new publicly funded center has been approved in approximately 15 years, "The community says do something about the drug problem, but they won't let us," he explains.

Outpatient treatment, both at hospitals and non-hospital programs, is the most common service offered cocaine, crack/cocaine and alcohol abusers in the city.

B. Outpatient Treatment

Outpatient treatment, both at hospitals and non-hospital programs, is the most common service offered cocaine, crack/cocaine and alcohol abusers in the city. Various types of outpatient services are offered — drug-free, intensive and methadone (while methadone is an outpatient service, it is also generally classified separately from other outpatient programs).

Drug-free outpatient treatment enables clients to remain in their usual home environment while receiving diagnosis, treatment and rehabilitative services. Such services typically include individual, group and family therapy, educational and employment counselling, and support group activity. State substance abuse officials emphasize that family therapy is a vital component in almost all treatment programs.

Intensive outpatient treatment also is non-residential but entails more highly structured services and includes at least 20 hours of treatment a week. Again, individual, group and family therapy is provided, as well as drug and alcohol education, support groups and referrals to other pertinent programs.

Outpatient services, including methadone maintenance, are significantly less costly than residential programs, including intermediate care, halfway house and long-term residential.

As of September 1993, at least 30 publicly-funded programs in the city offered some form of outpatient services. Besides the methadone slots, there were 108 intensive outpatient slots in publicly-funded programs in Baltimore and 2,346 non-intensive hospital or non-hospital outpatient slots.

C. Intermediate Care

Three publicly-funded facilities offer intermediate care services in Baltimore City. Intermediate care is a residential service providing intensive group and individual therapy to drug addicts. The objective is to bring about the physical and psychological recovery, as well as the social adjustment, of the addict.

Intermediate care facilities generally offer 14- or 28-day programs. The length of these programs is not necessarily optimal, since longer treatment generally results in a greater chance of successful recovery. But insurance companies limit their coverage to those time periods, thereby effectively constraining the length of treatment. Adolescents entering intermediate care facilities can stay for up to 45 days. The city has 97 publicly funded intermediate care slots.

As of September 1993, there were 88 publicly-funded slots for drug abusers in halfway houses in Baltimore. City Health Department officials say that a large portion of the clients using halfway houses in the city are not Baltimore residents. Baltimore County has no halfway houses.

D. Halfway Houses

Seven publicly-funded halfway houses in the city offer substance abuse treatment. The halfway house is usually a link in the continuum of treatment for certain drug addicts. A typical route along the continuum involves a three- to seven-day hospital detoxification episode followed by treatment at an intermediate care facility and then a stay at a halfway house. Treatment is more intensive at intermediate care facilities than at halfway houses. The halfway house often is an alternative to returning to the home and outpatient treatment when that home environment is unstable. But because of the lack of halfway house slots, an increasing number of clients are forced to return home and into difficult situations that can aggravate, rather than abate, their drug dependency.

The halfway house is a transitional residential program. Clients are encouraged to find employment and work toward self-sufficiency. Services provided in the halfway house environment generally include case management, social and vocational skills development, supportive counselling, and assistance with daily living essentials.

As of September 1993, there were 88 publicly-funded slots for drug abusers in halfway houses in Baltimore. City Health Department officials say that a large portion of the clients using halfway houses in the city are not Baltimore residents. Baltimore County has no halfway houses.

E. Detoxification

Detoxification programs are intended to provide substance abusers with medically supervised detoxification, management of withdrawal symptoms, motivational counselling, referral to other treatment programs, and aftercare services. By definition, detoxification is not a treatment modality. Today, detoxification is offered only in hospitals in Baltimore. Twenty slots for non-hospital detoxification were eliminated two years ago due to funding cuts.

F. Long-term Care

As with non-hospital detoxification, all long-term care slots were dropped because of funding reductions. Long-term care facilities are geared toward chronically addicted substance abusers. The programs offer psycho-social programs in a therapeutic community and are based upon a highly regimented, encounter group approach. Group and individual counselling, educational and vocational skill development, case management and referral services are offered.

Long-term treatment initially was designed for alcoholics, but eventually other substance abusers also began entering long-term care facilities.

Chronic substance abusers who would have been enrolled in long-term residential programs now must seek treatment in outpatient clinics or other programs because of the elimination of long-term treatment slots. While substance abuse professionals acknowledge that long-term treatment is far more costly than other treatment modalities, they see the elimination of the 20 long-term slots in Baltimore as leaving a gaping hole in the city's treatment continuum. The scarcity of treatment slots — whether for outpatient services, methadone maintenance or a halfway house — also disrupts the capacity of the city's treatment system to offer clients the optimal length of continued service.

Chronic substance abusers who would have been enrolled in long-term residential programs now must seek treatment in outpatient clinics or other programs because of the elimination of long-term treatment slots.

II. SPECIAL PROGRAMS

In addition to the more traditional treatment services offered in Baltimore, several special services are available for substance abusers. Several programs provide specialized psychiatric help in addition to the regular counselling and psychological services avaliable at treatment programs. Other special services available to substance abusers include:

A. HIV Services

Programs report an alarming increase in the incidence of substance abusers infected with the HIV virus. A year ago just over 20 percent of methadone clients in the city tested positive for the HIV virus. Now, according to state officials, the percentage of new admissions testing positive exceeds 25 percent. Richard Lane, the director of Man Alive, a major methadone program in the city, reports that since January 1, 1993, 40 percent of new admissions entering his program who are tested for the virus test positive. Last year the rate in his program was 16 percent. He describes AIDS as the greatest enemy confronting injection drug abusers today.

Programs report an alarming increase in the incidence of substance abusers infected with the HIV virus.

HIV counselling, therefore, is offered at all treatment programs in the city. The state mandates HIV risk reduction counselling for all clients within 30 days of entering treatment programs. And all methadone programs in Baltimore have special HIV coordinators who provide counselling and testing. Under state law, HIV testing cannot be mandated. Therefore, testing in the programs is voluntary. Counselling generally includes information on dirty needles and safe sex. Also, drugs such as AZT are prescribed and condoms are handed out. One program in the city has received a special grant to do HIV work.

Methadone treatment is seen as a major combatant to the spread of the AIDS virus, since it takes abusers off needles and offers them AIDS counselling. Also, a recent trend in the city toward the inhalation, rather than the injection, of heroin has helped keep the AIDS virus from spreading even more rapidly within the drug community.

B. Health Care Services

Another major concern of substance abuse specialists in the city is the paucity of good health care for drug abusers. Most addicts have health problems that extend beyond their drug addiction, but they often neglect their physical well being and are reluctant to seek health care services. Last year, 28 percent of clients enrolled in treatment programs were uninsured. Besides AIDS, tuberculosis has emerged as a major scourge among drug abusers. Drug counsellors often are frustrated that substance abusers will not even cross the street to nearby health clinics to obtain needed services.

To help alleviate these problems, five substance abuse treatment programs in the city have added primary health care clinics to their array of services: Man Alive, Sinai Hospital, Glenwood Life Counseling Center, Daybreak Rehabilitation, and Baltimore Recovery Center. Officials hope the on-site clinics also will serve as early prevention programs to ward off illness.

State officials have raised concern that traditional health care providers in the city, including hospitals, often are ill-equipped and inadequately trained to deal with drug abuse and its related plethora of health problems. By locating primary health care clinics within treatment programs, they are attempting to partially circumvent that problem.

C. Women's Services

State alcohol and drug abuse policy requires that pregnant women be given top priority for admission into publicly funded treatment programs. Three facilities in the city have programs designed specifically to offer specialized treatment to women, particularly pregnant drug abusers: the Center for Addiction in Pregnancy, the Johns Hopkins Comprehensive Women's Center, and the University of Maryland Methadone Center. According to the state Alcohol and Drug Abuse Administration, 783 pregnant women were in substance abuse treatment in Baltimore City in fiscal year 1993. The Center for Addiction and Pregnancy estimates that approximately $5 million in neonatal intensive care costs were saved through the care of 116 patients during its first full year of operation.

The Center for Addiction and Pregnancy estimates that approximately $5 million in neonatal intensive care costs were saved through the care of 116 patients during its first full year of operation.

In addition, about one of every four substance abuse treatment programs in Baltimore has protocols addressing the unique situation facing female drug abusers. These programs target services toward women clients when the need is present. Typically, women who come into drug programs have not had experience bonding with other women. Special women's groups are set up to enable women to share experiences and thoughts with one another. According to state drug abuse officials, the success of special women's programs and protocols generally depends on the commitment of the program director and the capability of the staff.

October, 1993

APPENDIX B

Maryland Alcohol and Drug Abuse Adminstration Funded Programs in Baltimore City (As of September 1993)

Program	Address	Phone	Modality	Number of Slots
Adapt Cares (Project Adapt)	3101 Towanda Avenue, Baltimore 21215	383-4900	methadone	410
Addict Referral & Counseling	21 W. 25th Street, Baltimore 21218	366-1717	outpatient	205
Baltimore City Acupuncture Program	2518 North Charles Street, Baltimore 21228	235-6891	outpatient	20
Baltimore City Health Department	4 S. Frederick Street, Room A-300, Baltimore 21202	396-5950	health department outpatient	451
Baltimore Recovery Center	16 S. Poppieton Street, Baltimore 21202	685-2811	intermediate care facility	18
Bridge House	1516 Madison Avenue, Baltimore 21217	523-6351	halfway	18
Counseling Center (Formerly Jones Falls)	5900 York Road, Suite 201, Baltimore 21212	532-1770	outpatient	130
Daybreak Rehabilitation	2490 Giles Road, Baltimore 21225	396-1646	methadone	220
East Baltimore Drug Abuse Program	707 Constitution Street, Baltimore 21202	727-7400	methadone	395
Echo House	1705 West Fayette Street, Baltimore 21223	947-1700	outpatient	192
Fayette House	1846-1850 W. Baltimore Street, Baltimore 21223	556-0550	halfway	14
Friendship House - Halfway	1435 South Hanover Street, Baltimore 21230	752-2475	halfway	9
FSK - Arc House	4940 Eastern Avenue, Baltimore 21224	955-0053	intermediate care facility	16
FSK - Arc House Outpatient	4940 Eastern Avenue, Baltimore 21224	550-0053	intensive outpatient	8
FSK - Outpatient Alcohol	4940 Eastern Avenue, Baltimore 21224	550-0032	outpatient	194
FSK Behavioral Pharmacology Research Unit	5510 Nathan Shock Drive, Baltimore 21224	550-0043	methadone	75
Glenwood Life Counseling Center	516 Glenwood Avenue, Baltimore 21212	323-9811	methadone	230
Harbel Substance Abuse Services	5807 Harford Road, Baltimore 21214	444-2100	outpatient	75
Harbel Youth Services	5807 Harford Road, Baltimore 21214	444-2100	outpatient	100
Institute For Behavioral Resources, Inc.	333 Cassell Drive, Suite 2400, Baltimore 21224	550-2460	methadone	60
Johns Hopkins - Women's Intensive Outpatient	911 N. Broadway, Baltimore 21205	955-9534	intensive outpatient	35
Johns Hopkins - Women's Outpatient	911 N. Broadway, Baltimore 21205	955-9534	methadone	35
Johns Hopkins Hospital	911 N. Broadway, Baltimore 21205	955-5654	outpatient	93
Johns Hopkins Hospital	911 N. Broadway, Baltimore 21205	955-5654	intensive outpatient	65
Man Alive	2100 N. Charles Street, Baltimore 21218	837-4292	methadone	282
New Hope Treatment Center	2401 West Baltimore Street, Baltimore 21223	945-7706	methadone	210
Next Passage (Liberty Medical Center)	730 Ashburton Street, Baltimore 21216	362-7983	outpatient	160
North Baltimore Center	2225 N. Charles Street, Baltimore 21218	366-4360	outpatient	120
Northwest Baltimore Youth Service	3319 W. Belvedere Avenue, Baltimore 21215	578-8100	outpatient	95
Overcome (Liberty Towanda)	3101 Towanda Avenue, Baltimore 21215	578-3518	outpatient	90
Quarterway Inc. Nilsson House	5665 Purdue Avenue, Baltimore 21239	323-5328	halfway	11
Quarterway Inc. Weisman/Kaplan	2523 Maryland Avenue, Baltimore 21218	669-9509	halfway	17
Safe House	7 West Randall Street, Baltimore 21230	385-1466	halfway	9
Sinai Hospital Alcoholism Program	2401 W. Belvedere Avenue, Baltimore 21215	578-5457	outpatient	150
Sinai Hospital Drug Dependency	Greenspring & Belvedere Avenues, Baltimore 21215	578-5355	methadone	310
Southeast Baltimore Drug Treatment Program (FSK)	5510 Nathan Shock Drive Bldg. G-1, Baltimore 21224	550-0132	outpatient	81
Southeastern DPM (FSK)	5510 Nathan Shock Drive Bldg. G-1, Baltimore 21224	550-0028	methadone	300
Total Health Care	1609 Druid Hill Avenue, Baltimore 21217	728-5300	outpatient	120
Treatment Resources For Youth	2517 N. Charles Street, Baltimore 21218	366-2123	outpatient	70
Tuerk House	P.O. Box 31419, Baltimore 21216	233-0684	intermediate care facility	63
University of Maryland Drug Treatment	630 West Fayette Street, Baltimore 21201	706-5154	methadone	290
Valley House	28 South Broadway, Baltimore 21231	675-7765	halfway	10

APPENDIX B (cont'd)

Maryland Alcohol and Drug Abuse Adminstration Non-Funded Programs in Baltimore City (As of September 1993)

Program	Address	Phone	Modality	Average Number of Clients Per Month
Action Counseling Services	611 Park Avenue Suite 2, Baltimore 21201	539-5368	outpatient	98
Baltimore Recovery Center - OP/Aftercare	16 S. Poppleton Street, Baltimore 21201	685-2811	outpatient	*
Baltimore Recovery Center - Intensive Outpatient	16 S. Poppleton Street, Baltimore 21201	685-2811	intensive outpatient	*
Bright Hope House	1611 Baker Street, Baltimore 21217	462-5510	outpatient	60
C P Health Services Inc.	4808 Harford Road, Baltimore 21214	444-0400	outpatient	50
Carter Center ADAP	630 W. Fayette Street, Baltimore 21201	328-2335	outpatient	0
Connor Associates	2309 Chelsea Terrace, Baltimore 21216	566-3682	outpatient	0
Contemporary Counseling Services Inc.	723 South Charles Street, Baltimore 21230	528-9333	outpatient	48
Crossroads Centers	2 W. Madison Street, Baltimore 21201	752-6505	outpatient	96
FSK Center For Addiction & Pregnancy	4940 Eastern Avenue, Baltimore 21224	550-3033	intensive outpatient	101
Glass Substance Abuse Program	821 N. Eutaw Street, Suite 101, Baltimore 21201	225-0594	methadone	328
Greenspring Mental Health Services Inc.	5100 Falls Road, Baltimore 21210	964-6050	outpatient	0
Harbor Mental Health	6310 Harford Road, Baltimore 21214	426-6380	outpatient	8
Harbour Center	924 East Baltimore, Baltimore 21202	332-1111	outpatient	14
Institute For Behavioral Resources Inc.	333 Cassell Drive, Suite 2400, Baltimore 21224	550-2460	methadone	118
JADAS	5750 Park Heights Avenue, Baltimore 21215	542-6300	outpatient	19
Loyola College Alcohol & Drug Education	4501 N. Charles Street, Baltimore 21218	617-2928	outpatient	0
Mountain Manor	3800 Frederick Avenue, Baltimore 21229	233-1400	intermediate care facility	37
Mountain Manor Treatment Center	3800 Frederick Avenue, Baltimore 21229	233-1400	outpatient	0
New Beginnings Family Center	1035 N. Calvert Street, Baltimore 21202	837-7272	outpatient	98
New Outlook	821 N. Eutaw Street, Suite 201, Baltimore 21201	225-9185	outpatient	104
Operation Recovery Mercy Hospital	333 St. Paul Street, Suite B, Baltimore 21202	547-6695	outpatient	54
Park Circle Counseling Center	3000 Druid Park Drive, Baltimore 21215	448-4280	outpatient	9
Quarterway Outpatient Clinic	730 Ashburton Clinic, Baltimore 21216	233-0684	outpatient	65
St. Agnes Hospital Dept.-Psychology	900 S. Caton Avenue, Baltimore 21229	368-2845	outpatient	18
University Of Maryland - Outpatient	405 W. Redwood Street, Baltimore 21201	328-6600	outpatient	133
Universal Counseling Services	101 W. Read Street, Suite 222, Baltimore 21201	752-5525	outpatient	78
VA Alcohol Dependence Treatment Program	3900 Loch Raven Blvd., Unit 116A, Baltimore 21218	467-9932	military only	*
VA Substance Abuse Treatment	Federal Bldg., 31 Hopkins Plaza, Baltimore 21201	962-3300	military only	*
Veterans Administration Medical Center	Fort Howard, 21052	687-8223	military only	*
William Donald Schaefer House	907 Druid Lake Drive, Baltimore 21217	333-7152	residential	29

** number not reported to ADAA*

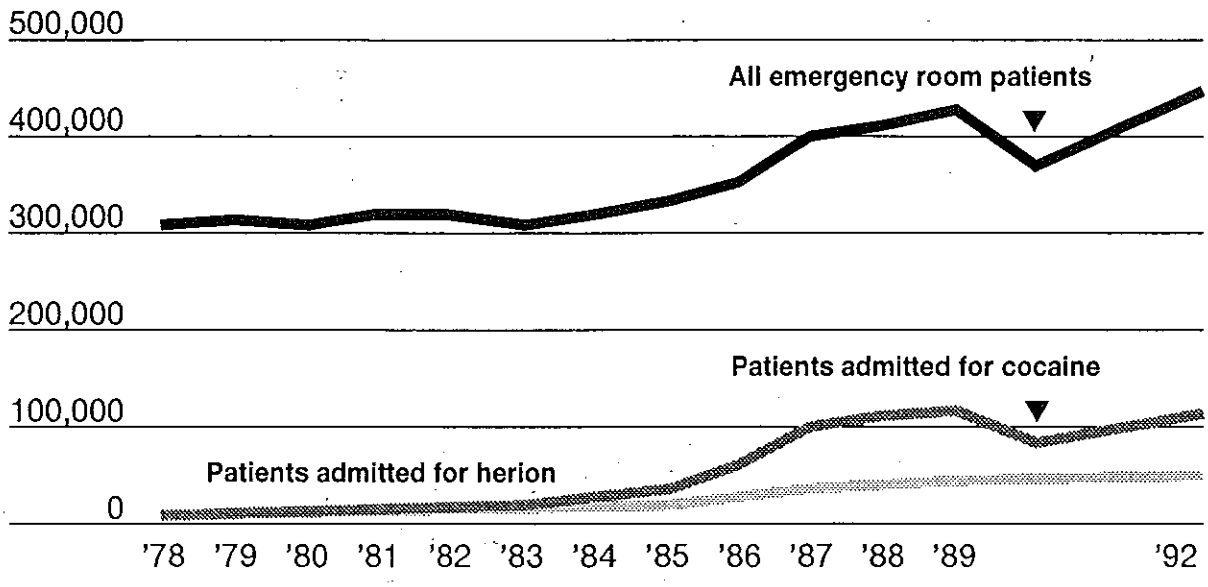
Appendix C – Figure 1

Drugs and Emergency Room Visits

THE NUMBER OF PATIENTS HAS RISEN . . .

	Marijuana Hashish	Heroin Morphine	Cocaine
	'91 / '92	'91 / '92	'91 / '92
Atlanta	610 / 957	157 / 232	3,266 / 5,118
Baltimore	355 / 672	3,892 / 5,106	6,687 / 8,078
Boston	616 / 1,006	1,165 / 2,061	2,992 / 4,266
Chicago	808 / 1,488	2,262 / 2,958	5,575 / 8,214
Detroit	807 / 1,487	1,828 / 1,843	5,919 / 6,939
Los Angeles	1,055 / 1,331	1,674 / 2,944	4,901 / 5,337
New York	1,195 / 2,004	6,019 / 8,382	16,099 / 20,414
Philadelphia	692 / 1,684	2,424 / 2,364	8,769 / 10,986
Washington	959 / 1,259	1,480 / 1,152	4,572 / 4,236

. . . AND HAS BECOME A LARGER PERCENTAGE OF ALL EMERGENCY ROOM PATIENTS



Sources: Drug Abuse Warning Network

Appendix C – Figure 2

EMERGENCY ROOM VISITS, THIRD QUARTER OF 1992

Baltimore leads all cities in patients who arrive in hospital emergency rooms with evidence of using cocaine, heroin or alcohol in combination with drugs. Ranking is based on rates of drug-related episodes per 100,000 population.

	COCAINE		HEROIN		DRUGS AND ALCOHOL		MARIJUANA		PCP	
1	**Baltimore**	**101**	**Baltimore**	**67.2**	**Baltimore**	**56**	New Orleans	11.5	New York	4.9
2	New York	70.1	San Francisco	56.8	Newark	54.7	Philadelphia	10.2	Washington	4.4
3	Newark	62.1	Newark	52.3	Atlanta	54.2	Washington	8.8	**Baltimore**	**4.2**
4	Philadelphia	61.9	New York	27.7	New Orleans	51.9	**Baltimore**	**8.7**	San Francisco	3.8
5	New Orleans	55.7	Seattle	20.5	Philadelphia	47.1	Detroit	8.6	Los Angeles	3.1

SOURCE: Federal Drug Abuse Warning Network

Appendix C – Figure 3