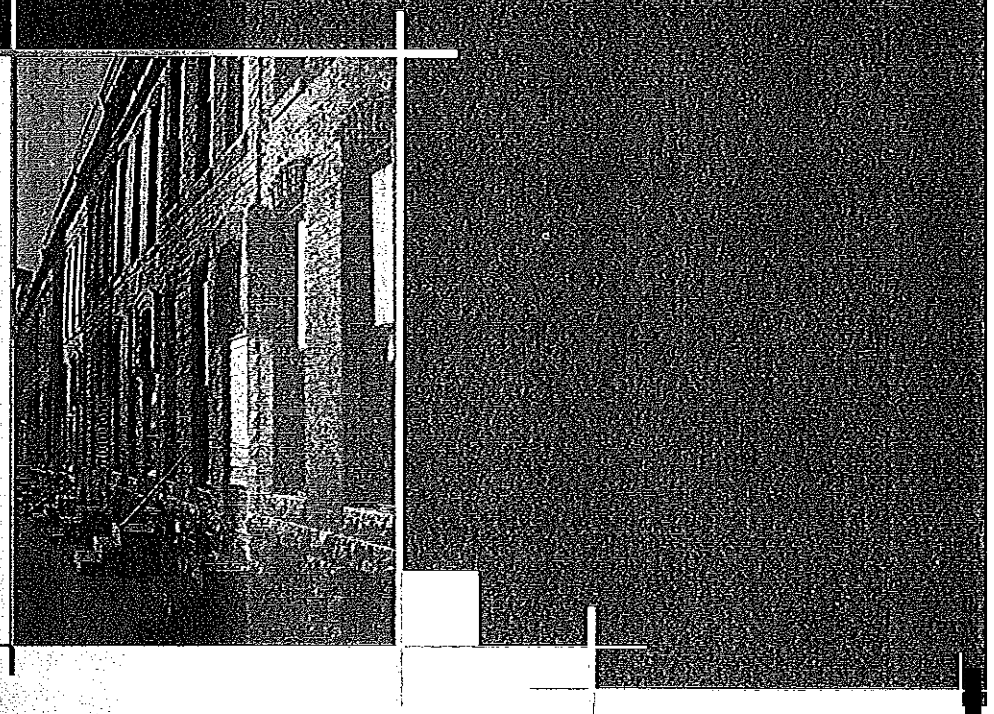
Smart Steps



Treating Baltimore's Drug Problem

Drug Strategies

possible by grants from the Abell Foundation and the Open Society Institute-Baltimore. *Smart Steps* is part of a series of Drug Strategies' reports on alcohol, tobacco and drug problems in cities and states across the country. Other cities profiled by Drug Strategies include Detroit, Michigan; Santa Barbara, California; and Washington, D.C. The states profiled include Arizona, California, rural Indiana, Kansas, Massachusetts, Ohio and South Carolina.

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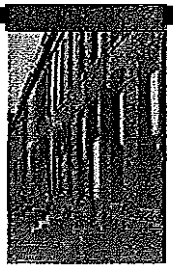
_*Smart Steps* is available at www.drugstrategies.org

I. Introduction



"The crisis that's killing our city" is how Baltimore[1] Mayor Martin O'Malley refers to drug addiction. Beyond the devastating consequences for the individuals who abuse alcohol and drugs, addiction contributes to the spread of infectious diseases and fuels crime. In Baltimore, injection drug use is the primary cause of AIDS, which is the leading killer of city residents between the ages of 25 and 44. Baltimore's crime rate is double the national average, and as many as three-quarters of the city's thefts, robberies and murders are associated with alcohol and illicit drugs. During the 1990s, the city's drug overdose death rate tripled. The economic costs of drug abuse and addiction in Baltimore exceed $2.5 billion a year.

In response to the drug crisis, Baltimore's leaders have embarked on an aggressive strategy to make high-quality treatment available "on request:' Research across the country demonstrates that treatment more than pays for itself by averting the much steeper health care and crime-related costs that addiction imposes when left unchecked. A 1994 California study, for example, found that state taxpayers saved $7 in future costs for every $1 invested in treatment. For policymakers ultimately concerned about the bottom line, the evidence is unambiguous: It costs less to treat addiction than it costs not to treat it.

In pursuing an ambitious treatment strategy, Baltimore's leaders are bolstered by strong political support from diverse constituencies across the city who favor a treatment approach-from religious congregations; neighborhood organizations; the legal, medical, business and philanthropic communities; as well as the media. Indeed, treatment on request has become a major item on the city's agenda for renewal.

Beginning in the mid-1990s, the city government launched a major treatment expansion, shifting funds into treatment services and transferring responsibility for treatment from the city health department to the quasi-governmental Baltimore Substance Abuse Systems, Inc. (BSAS). Even so, Baltimore's leaders have no illusions that the city can shoulder the burden on its own. Given the sharp limits on Baltimore's own budget-city revenues are essentially flat-outside help is crucial. The Maryland state government, drawing on federal funds, has historically contributed the bulk of Baltimore's treatment budget. Implementing the city's aggressive new plans will require unprecedented levels of funding from-and cooperation with-Annapolis.

At least 60,000 residents need treatment for alcohol and drug abuse-one in eight Baltimore **adults.**

Many of Maryland's leaders are coming to the conclusion already reached in Baltimore: Treatment deserves more support. Elected officials have become increasingly concerned about drug abuse throughout the state, especially over heroin's resurgence during the 1990s. In 1998, the Maryland General Assembly created a Task Force to Study Increasing the Availability of Substance Abuse Programs statewide. In its De.cember 1999 interim report, the Task Force concluded that insufficient treatment capacity throughout Maryland was primarily due to "insufficient funding for treatment by the State:' The Task Force recommended providing treatment on request for Maryland's uninsured and underinsured, 24 hours a day, seven days a week.

Baltimore and Maryland are in the early stages of a promising partnership to reduce drugaddiction and its related harms by investing more in treatment. Their success in doing so could provide a powerful model for other cities and states across the country.

[1] As used in this report, the word "Baltimore" appearing atone always signifies just the City of Baltimore, not the Baltimore metropolitan area or Baltimore County.

II. Alcohol and Drug Abuse m Baltimore

Alcohol and illicit drug abuse are among the most serious problems confronting Baltimore.!2l At least 60,000 city residents need alcohol and drug treatment. Even on the basis of conservative estimates, the proportion of Baltimore residents needing treatment is at /east double the national rate. Alcohol and drug abuse reaches deep into taxpayers' pockets, increasing the costs of health care, criminal justice and other services. Based on national calculations by the National institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA), Drug Strategies estimates that the economic costs of alcohol and drug abuse in Baltimore exceed $2.5 billion a year.

Extent of the Problem

For more than two decades, Baltimore has had an entrenched subculture of heroin addiction. Two-thirds of Baltimore residents with addictions are injection drug users. Crack cocaine's arrival in the early 1990s compounded the city's longstanding problems with heroin; crack drew a younger crowd of users and dealers, and violent crime associated with drug sales escalated. Many heroin addicts also began using crack. According *to* a July 2000 assessment by the U.S. Drug Enforcement Administration (DEA), Baltimore is the "most heroin-plagued area" in the nation and faces one of the most severe crack problems as well.

Alcohol and Drug Use Among Youth

During the past decade, crack cocaine, heroin and marijuana use among Baltimore 8th and 1Oth grade students has been consistently higher than the national averages. Drinking is much more prevalent among Baltimore students than illicit drug use, as is true nationwide. Student drinkers in Baltimore outnumber marijuana, crack and heroin users by a wide margin. Based on student self-reports as part ol the 1998 Maryland Department of Education's *Marylano Adolescent Survey,* 5,300 Baltimore 8th and 10th graders had at least one drink in the month prior *to* the survey, compared to 3,030 who used marijuana, 375 who used crack, and 275 who used heroin.

Heroin is Baltimore's primary drug of abuse. The proportion of city residents needing treatment for heroin abuse is **15 times** the national rate.

Underage Drinking and Maryland's Low Alcohol Tax Rates

Underage drinking in Baltimore, however, is Jess prevalent than among youth in the rest of Maryland. Indeed, rates of youth drinking in Maryland are higher than among youth nationwide. According to NIAAA, youth who begin drinking early {before age 15) are four times more likely to develop alcohol dependence than those who begin at age 21. Each year's delay in initiation of drinking greatly reduces the likelihood of later alcohol problems.

Research has shown that increasing the price of alcohol reduces drinking and alcohol-related problems, including accidents, violence and disease. Youth and young adults are especially sensitive to alcohol price increases. However, Maryland's alcohol excise taxes (based on alcohol content) are among the lowest in the nation. Maryland's beer excise tax rate ranks eighth lowest, while only a dozen states have a lower wine excise tax rate, and no state has a lower liquor excise tax rate. Because Maryland's excise taxes are not indexed for inflation, their value erodes over time. The current excise tax on liquor is worth only 16 percent of its value ". in 1955, when the tax rate. was last raised, and the beer and

[2] This report discusses alcohol as well as illicit drugs because alcohol, though legal for those 21 and older, is an intoxicant with high potential for abuse and addiction. Most drinkers are not problem drinkers, but the sheer prevalence of drinking-given alcohol's legal status and social 8.cceptability results in adverse consequences for health and safety exceeding the damage caused by illicit drugs. In Ba/limore, 36 percent of those who enter treatment have a drinking problem.

wine taxes are worth only 25 percent of their value in 1972, when they were last raised.

Drug·Related Hospital Emergencies

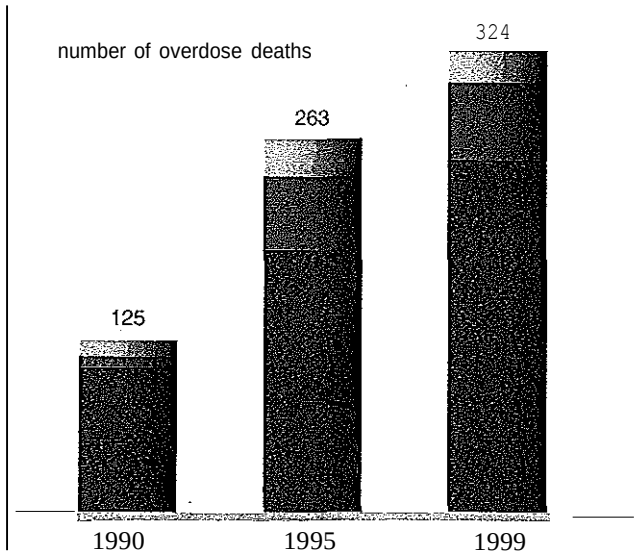
The U.S. Department of Health and Human Services' Drug Abuse Warning Network (DAWN) tracks hospital emergency room (ER) episodes related to drugs in metropolitan areas across the country. From 1994 to 1998, the rate in the Baltimore area was nearly triple the national rateJ31 The Baltimore area consistently reports the highest rates of cocaine- and heroin-related ER episodes in the nation. In 1998, half of Baltimore-area ER drug episodes involved heroin, compared to only 14 percent nationwide. Every year since 1992, the rate of ER cocaine mentions in the Baltimore area has been at least quadruple the national rate.

In 1999, for the **first** time ever, more Baltimore residents **died** of drug overdose (324) than by homicide (309).

Alcohoi·Related Deaths

Alcohol poisoning and alcohol-related diseases and accidents claim the lives of nearly 350 Baltimore residents each year, according to mortality data maintained by the National Center for Health Statistics. From 1993 through 1997 (the most recent five-year period for which data are available), Baltimore's alcohol-related mortality rate of 50 deaths per 100,000 residents was 60 percent higher than the rate in the rest of Maryland and 40 percent higher than the national rate. Deaths from cirrhosis and other chronic liver diseases related to heavy and prolonged use of alcohol occur in Baltimore at three times the rate in the rest of the state and at twice the national rate.

Drug Overdose Deaths Nearly Triple in Baltimore



Maryland Office of the Chief Medical Examiner, 2000

Illicit Drug Overdose Deaths

In 1999, Maryland's Chief Medical Examiner recorded 324 drug overdose deaths in Baltimore (excluding alcohol)-63 percent of all such deaths in Maryland. The city's 1999 overdose death rate (51 per 100,000 residents) was triple the 1990 rate, driven by a skyrocketing number of heroin deaths. This steep increase may reflect widespread experimentation by a new generation of younger users as well as a surge in low-cost, high-purity heroin. Heroin's price in the Baltimore metropolitan area-already 40 percent cheaper than the national average in 1998-fell by a third in 1999, to 33¢ per pure milligram. According to the DEA, heroin purity in Baltimore is 13 percent higher than the qational average.

[3] A high level of awareness of drug problems by health officials and hospital personnel in the greater Baltimore region arguably results in a fuller, more accurate accounting of drug-related emer encies than in many other metropolitan areas. DAWN statisticians acknowledge that uneven reporting practices make site-by-sile comparisons problematic. But even if the true level of ER drug episodes nationwide from 1994-1998 were double the rate of 222 episodes per 100,000 residents reported to DAWN, the Baltimore-area rate (656 per 100,000) would still have been nearly 50 percent higher.

Increasing drug overdose deaths in Ba'!timore may also be related to rising incarceration rates of city residents addicted to drugs. On average nationwide, prisoners serve about 2112 years behind bars before release. Injecting drug users (IDUs) who serve time in prison are especially vulnerable to overdose in the weeks immediately following their release. Enforced abstinence or greatly reduced drug use while incarcerated lowers physical tolerance for drugs, heightening susceptibility to overdose if drug use is resumed at the same level as prior to confinement. A possible link between release from incarceration and the rising rate of drug overdose deaths in Baltimore warrants close examination, especially given that at least 40 percent of the 10,200 Maryland state prison inmates sentenced from Baltimore had engaged in injection drug use prior to their incarceration.

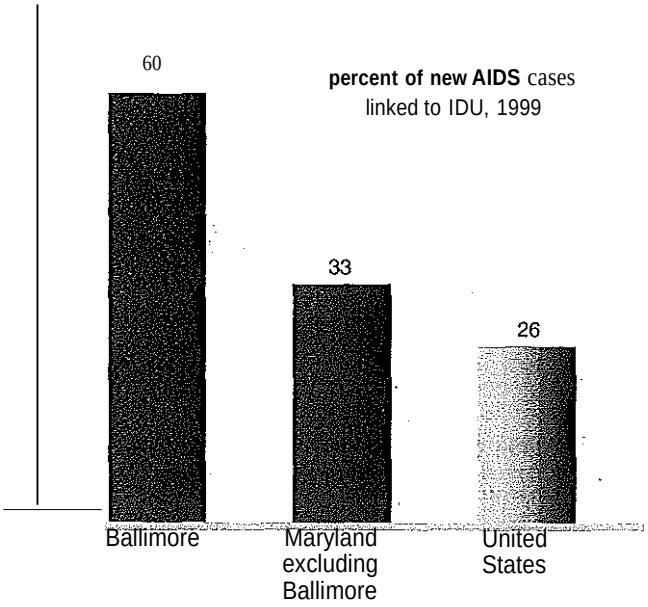
Infectious Diseases

Injection drug use (IOU) creates multiple health risks, including transmission of infectious diseases such as AIDS and hepatitis. Since 1979, more than half of the 11,250 AIDS deaths in Maryland have been in Baltimore, where AIDS is the leading killer of young adults (aged 25 to 44). IDU is the ieading cause of AIDS in Baltimore, accounting for 60 percent of new AIDS cases in the city in 1999, compared to 33 percent in the rest of Maryland and 26 percent nationally.

AIDS and hepatitis B and C spread quickly among injection drug users who share needles. Like AIDS, hepatitis B has no cure. The U.S. Centers for Disease Control and Prevention (CDC) and NIDA report that AIDS and hepatitis B are twice as common among young injection drug users (aged 15 to 30) in Baltimore than among those in New York City, Los Angeles, Chicago and New Orleans. Moreover, 90 percent of the Baltimore drug users studied who share needles are infected with hepatitis C, which leads to chronic liver disease for 70 percent of those infected.

Baltimore experienced a syphilis epidemic during the 1990s. Although syphilis is easily treated with penicillin, it can be caught again and again, and those with syphilitic lesions are more likely to contract HIV. By 1999, Baltimore's rate of new syphilis cases (38 per 100,00 residents) had fallen 63 percent since its 1997 peak, but remained 15 times higher than the national average. City health officials report that the practice of selling sex for drugs--Bspecially crack cocaine-contributes to the spread of syphilis.

Injection Drug Use the Leading Cause of AIDS in Baltimore



Maryland Department of Health and Mental Hygiene, 2000
U.S. Centers for Disease Control and Prevention, 2000

Impact on Crime

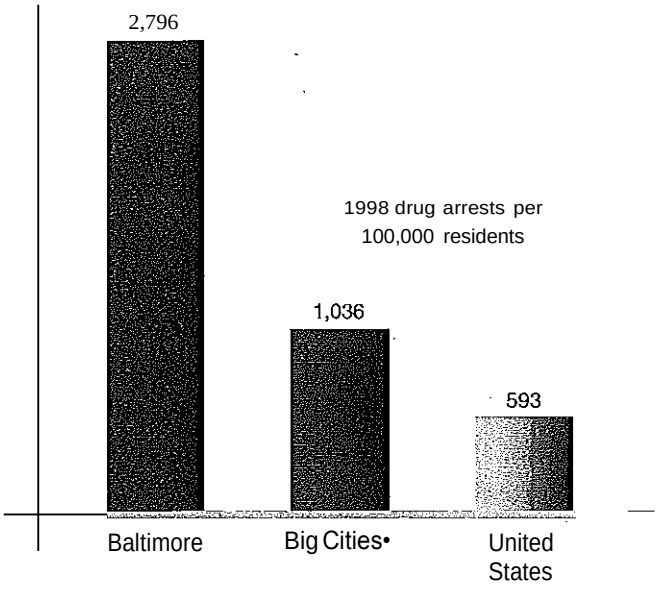
Baltimore is troubled by a persistently high crime rate, which in 1998 was double the national average. In 1998, Baltimore's overall crime rate was two-thirds higher than in other big U.S. cities; violent crimes occurred twice as frequently and Baltimore's murder rate was 3.5 times higher. Among the 26 largest U.S. cities, only Detroit recorded higher rates of overall crime and violent crime in 1998. Only Washington, D.C. had a higher murder rate.

Drinking, drug addiction and drug trafficking fuel both property crime and violent crime in Baltimore. Three-quarters of nonviolent property offenses in Baltimore are linked to alcohol and drug abuse, with unrecovered property losses totaling $46 million a year-more than $885,000 per week. Baltimore law enforcement officials estimate that 50 to 60 percent of the city's homicides are related to drug

dealing, including violent clashes among competing dealers and buyers and sellers.

Data on the number of alcohol-related homicides in Baltimore are not available, but 45 percent of imprisoned murderers nationwide report having been drinking heavily at the time of their offense.[4] Although significant overlap occurs between alcohol-related homicides and those linked to illicit drugs, as many as three-quarters of Baltimore's murders are associated with alcohol and illicit drugs.

Baltimore Drug Arrests Far Exceed National Rates



**54 U.S. cities with popufalions of 250,000 or more*

Uniform Crime Reports, Federal Bureau of Investigation, 1999
Uniform Crime Reports, Maryland State Police, 1999

Drug Arrests

Drug arrests climbed steadily in Baltimore from 1990 to 1995, peaking at 23,092 before falling to 15,706 in 1996 due to a shift in police priorities toward gun enforcement. Drug arrests have recently climbed again, reaching 18,052 in 1998 (10,334 for possession; 7,718 for sales). Juvenile arrests for drug distribution increased 40 percent from 1994 to 1998. Although still below the 1995 peak, Baltimore's 1998 drug arrest rate was nearly triple the rate for U.S. cities with populations of 250,000 or more, and nearly five times the national average. Heroin and cocaine arrests, which make up 80 percent of the city's drug arrests, occur at ten times the n'ational rate. On average, Baltimore police made 49 drug arrests per day in 1998, including 19 for heroin and cocaine sales and 21 for heroin and cocaine possession.

Drug Offenders in Prison, on Parole and Probation, and in the Juvenile Justice System

Drug offenses are the leading reason for incarceration of state prisoners convicted of crimes committed in Baltimore. As of September 2000, half of the 10,200 prisoners who had been sentenced in Baltimore committed drug offenses. Drug crimes were the most serious offense for 29 percent of Baltimore offenders sentenced to more than a year in state prison, compared to 11 percent of prisoners nationwide. Most of those imprisoned by the state for drug crimes committed in Baltimore are not violent offenders. Indeed, the vast majority (84 percent) of all non-violent Baltimore offenders in prison are drug offenders.

Drug crimes are also the most common offense among those on parole and probation in Baltimore. As of September 2000, nearly half of Baltimore's 30,150 parolees and probationers were under court supervision for drug offenses. Drug crimes are the most serious offense for almost half of Baltimore probationers, compared to one-quarter of probationers nationwide. Drug offenders comprise the majority (62 percent) of all non-violent offenders on parole or probation in Baltimore.

One in every 40 Baltimore adults is on **probation** for a drug offense, **seven** times the national rate.

Drug offenses are also the leading reason for which Baltimore youth enter the state's juvenile justice system. In 1998, nearly one-quarter of the 12,800 juvenile justice intake cases involving Baltimore youth were due to alcohol (128) and other drug offenses (1,128 for possession and 1,770 for distribution). Baltimore's rate of juvenile intake cases involving drug distribution offenses rose nearly 50 percent

[4] Research has shown that neighborhoods with a high density of liquor stores suffer increased health and social problems, including violent crime. In Baltimore, neighborhoods that are both low income and predominantly African American have substantially more liquor stores per capita than do other neighborhoods in the city.

between 1994 and 1998, and the city accfJ.unted for more than two-thirds of all such cases statewide in 1998. As of March 2000, Baltimore accounted for one-third of the 10,100 youths statewide assigned to probation, detention and residential programs within Maryland's juvenile justice system.

Drug Use and Treatment Need Among Offenders

Drug use is widespread among adults arrested in Baltimore. A 1995 study (the most recent data available) conducted by the Center for Substance Abuse Research {CESAR) at the University of Maryland found that two-thirds of men and three-quarters of women arrested by the Baltimore Police Department tested positive for at least one drug, not including alcohol. Baltimore arrestees recorded the highest rates of heroin use ever found in any U.S. city- 37 percent of men and 48 percent of women tested positive for opiates in 1995. These rates were five times higher than the averages found in 23 cities participating in the federal Arrestee Drug Abuse Monitoring (ADAM) program. (Baltimore has never been an ADAM program site, but CESAR's 1995 study was based on ADAM's methodology.)

The CESAR study concluded that almost half of those arrested over the course of the year needed treatment, and that nearly three-quarters of those who needed treatment were heroin users. In 1998 (the latest year for which comprehensive data are available), the Baltimore Police Department made 17 percent more total arrests than in 1995, suggesting that some 22,000 adult arrestees were in need of treatment. However, only 18,738 people (from all referral sources) actually received treatment in Baltimore in 1998, according to Maryland's Alcohol and Drug Abuse Administration (ADM). The need for treatment among adult arrestees alone outstripped the city's overall treatment capacity by 17 percent in 1998.

According to state criminal justice officials, four out of five convicted offenders in Baltimore need treatment. As of September 2000, at least 80 percent of the state prison inmates who were sentenced in Baltimore (8,160 out of 10,200) had substantial alcohol and drug abuse problems when they entered prison, regardless of offense; half of this group (more than 4,000 inmates) had engaged in injection drug use prior to their incarceration. In addition, at least 80 percent of Baltimore's 30,150 parolees and probationers also needed treatment, regardless of offense.

In recent years, many of Maryland's other counties have seen **rapid** increases in their own drug problems, particularly with regard to **heroin,** whose resurgence nationwide appears related to falling retail **pnces** {down 60 percent nationwide from 1990 to 1998) and increasing purity {up 128 percent).

According to the Maryland Department of Juvenile Justice (DJJ), data from nearly a decade of drug testing show that the more involved a youth is in the juvenile justice system, the greater the likelihood of a drug problem. Both in Baltimore and statewide, DJJ estimates the prevalence of drug abuse at 30 percent for youth on probation, 40 percent for youth in detention, and 50 to 60 percent for youth in residential programs. One-third of the 3,400 Baltimore youth involved in the juvenile justice system in early 2000 had drug problems.

Many people addicted to drugs come into frequent contact with the criminal justice system, which can be a key venue for treatment. Research has shown that treatment imposed through the coercion of the criminal justice system can effectively reduce drug use and crime. Too often, however, this opportunity is missed. Chapter IV describes the important role of court-mandated treatment in Baltimore, especially given the extensive need for treatment among offenders.

Impact on Greater Baltimore and the State of Maryland as a Whole

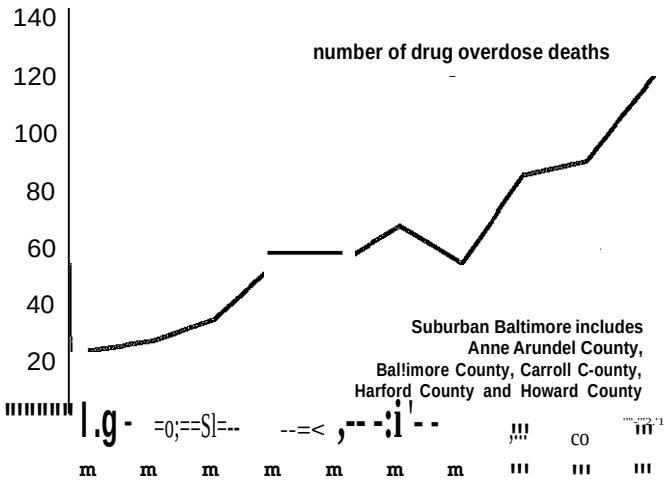
Drug abuse and trafficking harm Baltimore's quality of life, but the damage is not confined to Baltimore. Indeed, 70 percent of Maryland residents who need alcohol and drug treatment live outside Baltimore. Many of them come to Baltimore to buy drugs, helping to fuel the open-air drug markets that aHiict numerous neighborhoods. Because

Baltimore's problems are intertwined with those::Qf the rest of the state, progress in reducing drug · addiction in Baltimore-where the problem is most severe-will benefit all Maryland residents.

Problems with drug abuse elsewhere in the state still do not approach the magnitude of the problems in Baltimore. But because today's more potent heroin means that users can get high by snorting the drug-thereby removing the risk of exposure to HIV that might have deterred many new users-more people appear to be experimenting with and becoming addicted to heroin. This trend has compelled the state's other counties to look more closely at their own drug problems.

o0111 Based on interviews with 132 drug treatment, prevention, enforcement and medical personnel statewide, Maryland's summer 2000 Drug Scan reported heroin as a primary drug of abuse in Baltimore and seven counties (Baltimore, Calvert, Carroll, Cecil, Frederick, Prince George's and Wicomico) and as an emerging drug of abuse in eight of the state's other 16 counties.

Drug Overdose Deaths Rise Sharply in Suburban Baltimore



Maryland Office of the Chief Medical Examiner, 2000

o0111 In 1998, 34 percent of Baltimore County residents believed that heroin was being sold in their neighborhoods, up from 21 percent in 1992. Also in 1998, 35 percent of Anne Arundel and Howard County residents believed that heroin was being sold in their neighborhoods, up from 15 percent in 1992.

o1111 During the 1990s, heroin use was higher among 8th and 1Oth graders statewide than in Baltimore. In 1998, Baltimore 1Oth graders reported past month heroin use at more than double the national rate, while 1Oth graders statewide reported past month heroin use at more than triple the national rate (2.2 percent vs. 0.7 percent).

dill From 1990 to 1999, the number of heroin overdose deaths nearly tripled in Baltimore, and more than tripled in the rest of the state, led by a nearly five-fold increase-from 24 to 112 deaths-in Baltimore's five neighboring suburban counties (Baltimore County and Anne Arundel, Carroll, Harford and Howard counties).

Heroin's spread beyond Baltimore is not Maryland's only concern regarding substance abuse. For example:

o1111 Binge drinking (defined as five or more drinks at a time) was more prevalent among 1Oth graders statewide than in Baltimore throughout the 1990s. In 1998, 26 percent of 1Oth graders statewide reported binge drinking in the past month, coropared to 17 percent in the city.

o>11 The drug arrest rate in the rest of Maryland rose 19 percent from 1994 to 1998, led by a 41 percent increase in suburban Baltimore (from 368 to 520 arrests per 100,000 residents).

.o111 Baltimore's rate of juvenile drug arrests rose 17 percent from 1994 to 1998, compared to a 63 percent increase in the rest of Maryland. Suburban Baltimore had an 86 percent increase (from 316 to 587 arrests per 100,000 youth).

III. Baltimore's Commitment to Treatment

Baltimore's leaders are forging a consensus that treatment is key to reducing drug abuse and its attendant problems. Mayor Martin O'Malley, who took office in December 1999, has committed his administration to achieving '1reatment on request:' Since the mid-1990s, the city has significantly increased funding for treatment, with broad public support in advancing this cause. Baltimore's status as an independent city-it is not part of a larger county-means that its aggressive treatment strategy will require significant investment from the state government. Although tensions exist, key state officials support treatment expansion in Baltimore.

A New Commitment to Treatment

Although Baltimore has had severe drug problems for many years, the city's investment in treatment lagged badly until the mid-1990s. In 1995, the city government devoted only $350,000 of its own revenues to drug treatment. Early in his last term, then Mayor Kurt Schmoke launched a major treatment expansion, increasing Health Department funding for treatment and shifting federal grant funds from other city agencies into treatment services. By the time Schmoke left office in 1999, Baltimore was budgeting $2.5 million for treatment, seven times more than in 1995.

Rising Support for Treatment

Since the early 1990s, Baltimore's legal, business, medical and religious communities as well as grassroots political organizations, media, and philanthropic foundations have forcefully advocated improving the city's treatment system.

- In 1990, the Bar Association of Baltimore City published its landmark report, *The Drug Crisis and Underlunding of the Justice System in Baltimore,* which concluded that "effective drug abuse treatment is the only answer to reducing drug related criminal cases:·
- In its 1995 report *Smart on Crime,* the Greater Baltimore Committee (GBC)-a "who's who" of the region's business leaders-called drug treatment an underutilized, potentially powerful weapon against crime. For the 1999 mayoral and city council elections, the GBC urged all candidates to endorse its call 'to fully fund effective drug treatment on request." More state funding for treatment was one of the GBC's top priorities for the year 2000 session of the Maryland General Assembly.
- In their 1996 *Baltimore Oracles' Report,* leaders of the city's premier medical and health research institutions underscored the importance of drug treatment in addressing the public health and crime problems confronting Baltimore.
- Drug treatment on request topped the 1999 election agenda of the Greater Baltimore Interfaith Clergy Alliance (GBICA), which represents more than 200 congregations in the region. The GBICA has offered to work with Mayor O'Malley to strengthen community-based services in neighborhoods throughout the city.

By 2000, **treatment** on request-defined as placing every person who seeks treatment (voluntarily or by court order) in a pro· gram within 48 hourS-had become a mainstream issue in Baltimore politics.

- Baltimore clergy have also joined forces with labor and neighborhood leaders in the influential 15,000-member coalition known as BUILD (Baltimoreans United in Leadership Development). BUILD's precinct-level organizing around Maryland's 1998 elections included a call for increased state funding for drug treatment.

..u In June 1999, more than 1,000 residents frortr 175 neighborhoods across the city convened a Neighborhood Congress to identify solutions to Baltimore's most pressing problems. Based on numerous neighborhood-level meetings organized by the Citizens Planning and Housing Association prior to the June convention, participants made "improving the quality and quantity of drug treatmenf' one of their major goals, and established a Crime and Drugs Solution Work Group to help build community and political support for treatment.

Baltimore's ambitiOUS plans to expand treatment will require substantial· assistance from the state government.

.o111 *The Baltimore* Sun-the city's major newspaper with a daily circulation of 327 ,000-has editorialized frequently since the early 1990s on the need to boost the city's investment in drug treatment. The *Sun* succinctly expressed its views in a 1996 editorial: "Successful treatment will dwindle the ranks of addicts, and the dealers who depend on their trade.... Drug crimes won't stop until Baltimore successfully treats the illness that is their genesis:' The *Sun's* editorial agenda for the year 2000 General Assembly session urged Governor Glendening and state legislators to . back Mayor O'Malley's treatment expansion plans with substantiai new funding.

.m11 Local foundations have advocated more public funding for treatment in Baltimore and have contributed their own dollars. In 1993, the Abell Foundation called attention to the city's meager spending on treatment in its report, *Baltimore's Drug Problem: It's Costing Too Much Not To Spend More On ft.* Since then, the Abell Foundation has pushed local policymakers toward a more energetic treatment response. Encouraged by city leaders' advocacy of treatment on request, philanthropist George Soros chose Baltimore as the site for his Open Society Institute's (OS!) first office to concentrate exclusively on the problems of a single city. OS!-Baltimore began work in 1998, with Soros pledging to spend $25 million over five years, with a focus on drug treatment and related needs, such as workforce development. The Abell Foundation and 081-Baltimore, together with the United Way of Central Maryland and the Harry and Jeanette Weinberg Foundation, have made more than $8.5 million in grants to improve the city's treatment system.

Treatment's New Political Prominence

During the 1990s, calls for the city to invest more in treatment-coming from groups representing a broad range of expertise and constituencies-reinforced Mayor Schmoke's outspoken leadership on the issue. During the 1999 mayoral election campaign, all the leading candidates promised to implement treatment on request. Since then, Mayor O'Malley has made securing substantial new state treatment funding the city's top priority in Annapolis.

From the outset of his term, O'Malley signaled his support for expanded treatment by reappointing health commissioner Peter L. Beilenson, who served as point-person on drug treatment in the previous administration. O'Malley won office on a platform focused on improving public safety. But neither the new mayor nor the new police commissioner, Edward T. Norris, expect police sweeps and arrests to curb the demand for drugs that drives much of the city's crime. For that, the O'Malley administration is counting on drug treatment. Beilenson has staked his job on the matter, pledging to resign if Baltimore's crime rate is not cut in half within three years of obtaining the new funding required to ensure ready access to high-quality drug treatment.

Partnership with the State

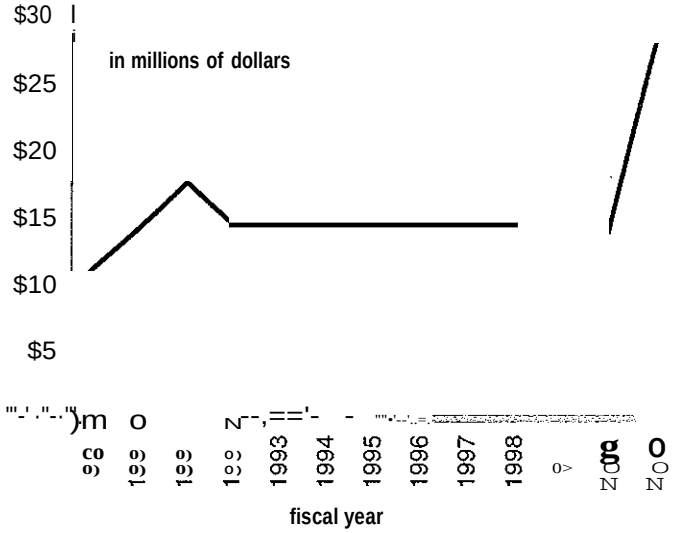
Unlike most other U.S. cities, Baltimore is not part of any county; it is the largest independent city in the nation. To varying degrees, the governments of the states and counties in which the nation's other big cities are located either perform or finance a range of government services-including health-related services such as alcohol and drug treatment.

The distinctive relationship between Baltimore and the state is reflected in the city's budget: 45 percent of Baltimore's general revenue comes from the state, more than double the average of 19 percent among the nation's other big cities {based on fiscal years 1993-1994, the most recent period for which comparative data are available). Independent of any county, Baltimore's reliance on Maryland is especially pronounced with respect to the state's funding for health care and hospitals-including support for alcohol and drug treatment-which amounts to 6.7 percent of the city's general revenue, more than five times the amount allocated by other states for health care and hospitals in the nation's other big cities. Given that Ballimore's own city-generated revenues are flat-projected to grow only 1 percent over the next year-much of the new investment required to upgrade the city's public treatment system will have to come from the state government.

Treatment Also a High Priority in Maryland's Other Counties

Baltimore is not alone in seeking greater state support; the state's other counties consider treatment funding a priority as well. The Maryland Association of Counties (MACo) made additional state funding for treatment one of its top four initiatives for the 2000 General Assembly session. Treatment officials in Maryland's other jurisdictions know that Baltimore is contending with more severe problems than elsewhere in the state, and applaud the city's treatment expansion. At the same time, Baltimore treatment officials know that the burdens on the city's treatment system will be eased to the extent that the state's other counties improve their own treatment capabilities.

Funding for Baltimore Treatment from Maryland's Alcohol and Drug Abuse Administration on the Rise



Baltimore Substance Abuse Systems, 2000

Disagreements between the city and the state often make headlines, but the growing convergence of city and state interests is the more significant story. For example, Mayor O'Malley's request for $25 million in additional treatment funding from the state was only partially fulfilled, with the General Assembly approving an additional $8 million in the FY 2001 budget. Although considerably less than requested, the $8 million represented Baltimore's largest single-year treatment funding increase from Maryland's Alcohol and Drug Abuse Administration (ADM) since ADM was created in 1989. Combined with the $18.97 million federal-state block grant allocation to Baltimore and $4.85 million from other state sources, Baltimore will receive 46 percent more state treatment funding in FY 2001 than in FY 2000. Moreover, several developments suggest that this funding increase may be the first step toward increased state support in the future.

Maryland's Treatment Task Force

In 1998, the General Assembly crea\ed a Task Force to Study Increasing the Availability of Substance Abuse Programs in Maryland, chaired by Lt. Governor Kathleen Kennedy Townsend and Baltimore County Delegate Dan Morhaim. The "Drug Treatment Task Force" is composed of

four other state delegates, two state senators, aDd numerous experts in addiction treatment, health services and criminal justice. In .December 1999, the Task Force issued an interim report, which found that insufficient treatment capacity throughout Maryland was primarily due to "insufficient funding for treatment by the State:' The Task Force recommended providing treatment on request for Maryland's uninsured and underinsured, 24 hours a day, seven days a week.

Maryland will receive $4.4 billion over the next 25 years as part of the national tobacco settlement. Governor Glendening and the General Assembly have agreed to earmark annually a portion of the tobacco money for alcohol and drug treatment, a step that few other states have taken. The $8 million in new treatment funds for Baltimore in FY 2001 were drawn from the tobacco settlement revenue.

The state government is also enjoying the benefits of a strong economy, which generated an $800 million budget surplus entering FY 2001. The nationwide economic recession in the early 1990s led to cuts in state funding for treatment in Baltimore, cuts that have only recently been overcome. The ADAA federal-state block grant fell from $16.9 million in FY 1991 to $14.8 million in FY 1992, and did not surpass the FY 1991 level until FY 2000. Maintaining a budget surplus should afford Annapolis the opportunity to address unmet needs, including drug treatment. Important one-time-only investments in treatment made possible by a budget surplus could include expenditures for staff development, evaluation and research infrastructure, and the purchase of property suitable for residential treatment.

Tapping Maryland's Alcohol Excise Tax Revenue to Invest in Treatment

The state's revenue from alcohol excise taxes is an additional, still untapped, source of funding fo(treatment. Maryland's alcohol excise tax revenue-which totaled $24 million in FY 2000-accrues to the state's general fund.f5J On a per capita basis, Maryland's alcohol excise tax revenue ($4.62 per resident) is lower than in. all but six other states, and amounts to only one third of the national average. Maryland's alcohol excise tax revenue is dwarfed by alcohol's annual economic cost to the state. Based on national economic cost estimates generated by NIDA and NIAAA, alcohol abuse costs Maryland residents about $5 billion per year in medical care, motor vehicle crashes and other accidents, criminal justice spending, and lost earnings due to illness and premature death.

The case for raising alcohol excise tax rates in Maryland is clear, both as a way to discourage underage drinking, as well as a way to raise new funds for treatment.

According to a 1998 national survey sponsored by the Robert Wood Johnson Foundation, four in five Americans favor increasing alcohol taxes by 5¢ per drink if the revenue is used to prevent underage drinking and to fund alcohol treatment programs. If Maryland increased its alcohol excise tax rates by as little as 1¢ per drink, the state could generate an additional $18 million annually, revenue which could be devoted to prevention and treatment.

More ambitiously, a phased implementation of a 5¢ per drink increase-a penny per year over five years-would magnify the preventive impact of higher alcohol prices, as well as generate substantially more revenue to invest in treatment By the fifth year, revenue could surpass $100 million-a projection that takes into account the modest decline in alcohol consumption likely in the event of a phased 5¢ per drink tax increase. Investing even half of this new revenue in treatment would provide an enormous boost in Baltimore and statewide.

[5} The revenue generated by the state's excise tax on cigarettes also accrues to the state's general fund. In 1999, Maryland raised the cigarette tax to 66¢ per pack of 20, t\velflh highest in the country and higher than any other jurisdiction in -the region. A fall 1997 statewide survey for Maryland Citizen Action found strong support for increasing alcohol taxes as well. Sixty-four percent of likely voters favored increasing alcohol taxes as a way to pay for a comprehensive array of programs for child well-being. By comparison, 68 percent of likely voters favored increasing the stale's tax on cigarettes, a preference eventually written iri.to law with passage of an 83 percent cigarette tax increase in 1999. The state has projected a 55 percent increase in cigarette tax revenue for FY 1999 and FY 2000, despite a 15 percent decline in the number of packs sold,

Any new attempt to raise alcohol excise tax rates must clear high political hurdles, given the influence of the alcohol industry in Mary\and.l6\ But even without raising excise tax rates, the state could dedicate the annual revenue to treatment rather than placing it in the state's general fund, where it amounts to Jess than three-tenths of one percent of total revenues ($9.3 billion in FY 2001).

Tensions Between City and State

Hopes in Baltimore for the infusion of state aid on the scale requested by Mayor O'Malley have been tempered by the comparatively modest amount approved by state law-. makers for FY 2001. *(The Ba/limore Sun's* editorial report card on the General Assembly's year 2000 session gave Governor Glendening and the legislature a grade of "D+" for their final treatment budget.) Although Baltimore is slated to receive nearly 50 percent more treatment funding from the state in FY 2001 than in FY 2000, city leaders and treatment proponents stress that the FY 2001 budget must be seen as only the first step toward larger, sustained increases in the state's support for treatment in the years ahead- a harbinger of more to come, not a high-water mark. They are also concerned that the shift in the state's Medicaid program from fee-for-service to managed care (which began three years ago) reduces revenue for treatment, and creates new obstacles for Medicaid clients who wish to obtain treatment.

Maryland's Drug Treatment Task Force has expressed concern about the impact of Medicaid managed care (known in Maryland as Hea\thChoice) on access to treatment, noting frequent complaints about the refusal of managed care organizations (MCOs) to authorize treatment and to reimburse treatment programs for appropriate services already provided. Since 80 percent of the 488,000 Maryland residents enrolled in Medicaid have joined HealthChoice (including 80 percent of Medicaid-enrolled Baltimore residents), the MCOs' questionable performance in providing treatment to those in need has become an important issue.

Critics argue that managed care-which saves money by **reducing services** and discouraging use of specialists-is a poor fit to the health needs of people with addictions;· to save money on the care of these patients, a health plan must make treatment more **accessible.**

The Maryland Department of Health and Mental Hygiene (DHMH) is analyzing data provided by HealthChoice MCOs, and preliminary findings suggest that concerns about managed care's impact on access to treatment are warranted. Among Medicaid-insured individuals eligible for Hea\thChoice, the total number of treatment services received fell by 66 percent between FY 1996 and FY 1999. Anecdotal evidence that it is particularly difficult to secure MCO authorization for methadone maintenance-typically a long-term treatment-is supported by DHMH's preliminary analysis, which shows a 72 percent drop in methadone services. (The MCOs' own figures show a less dramatic but still significant 29 percent decline in overall treatment services over the same period.)

On the Cutting Edge Nationwide

Baltimore's commitment to treatment on request has placed the city at the forefront of drug policy innovation. In 1998, treatment was available for only one in three of an estimated 5 million Americans with severe drug problems (not including alcohol). Alcohol and drug abuse cost all levels of government (federal, state and local) $125 billion in 1997; only $7.3 billion of this amount was spent on treatment. The neglect of publicly-supported treatment nationwide for the past 25 years has left programs swamped and unable to perform to potential. Scarce resources have meant that many people seeking help must be turned away, discouraging them from thinking of treatment as a real option. This is the historical context in which Baltimore is now seeking to improve its own treatment system.

[6) The alcohol industry is as firmly a bipartisan political donor in Maryland as it is in the rest of the country. Seven of the eight candidates elected from Maryland to the U.S. House of Representatives in 1998 accepted alcohol industry political action committee (PAC) money during the 1997-1998 campaign cycle, including all four Democrats and three of four Republicans.

Public-sector treatment has been especiallyJ>urdened in other big U.S. cities which, like Baltimore, were hit hard by crack cocaine in the late 1980s and high-potency heroin in the mid-1990s.I7J San Francisco, expressly committed to providing "treatment on demand," has significantly increased treatment funding in recent years and recorded a 10 percent increase in the number of patients in treatment between 1996 and 1999.

Differences in the scale of the drug problems facing Baltimore and San Francisco, as well as considerable differences in social and economic levels, portend a more arduous road ahead for Baltimore. The size of the population in need of treatment is greater in Baltimore, even though Baltimore has about 115,000 fewer residents than San Francisco. By many measures a wealthier, less distressed city than Baltimore, San Francisco has greater resources: The city's Department of Public Health has a treatment budget of $48 million compared to Baltimore Substance Abuse Systems' (BSAS) $27 million treatment budget.

Only in San Francisco has treatment gained public and **political support** comparable to that in Baltimore in recent years. However, San Francisco-like Baltimore-remains well short of its **treatment** goal. Each city provides treatment to less than a third of those considered to be in need.

Detroit and Washington, D.C. also face severe drug problems, with sochil and economic difficulties similar to Baltimore's. Under a 1993-1998 Target Cities grant from the federal Center for Substance Abuse Treatment (CSAT), Detroit prioritized coordinating its existing treatment services and strengthening linkages with other health and human service agencies through a case management system. Detroit's improved management of treatment increased the number of patients in treatment from 8,100 in 1995 to 11,900 in 1999. Even so, Detroit's public-sector treatment system serves only 10 percent of the 116,000 Detroit residents considered to be in need of treatment.

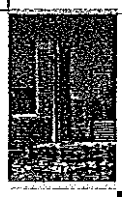
By comparison to Baltimore, Detroit and San Francisco, the treatment system in Washington, D.C. has languished. During tre mid-1990s, budget cuts and contracting problems reduced the District's publicly-funded treatment capacity by half. Fresh leadership-including a new mayor, an invigorated D.C. Council, a new health department director, and a new Addiction Prevention and Recovery Administration (APRA) administrator-has given the city's treatment efforts direction and energy lacking in recent years. Since i998, funding increases have allowed APRA to recover some of the capacity lost during the mid-1990s, but the number of slots in key modalities such as methadone maintenance and residential treatment remain below 1994 levels.

Public Opinion and Treatment: An Important Caveat for Baltimore

Support for treatment is strong in Baltimore compared to other places. According to a 1999 household survey conducted by the Center for Substance Abuse Research (CESAR) at the University of Maryland, one in five Baltimore residents believe that treatment "should receive the most money and effort in the fight against *drugs:'* This compares to only one.in 25 adults nationwide who think that "providing treatment programs for drug addicts" would "do the most to reduce the drug problem;' according to a 1995 Gallup poll. Nonetheless, Baltimore residents gave drug interdiction twice as much support as treatment; two in five believe that reducing the flow of drugs into the country should be the top priority. These findings suggest that sustained public support for greater investment in treatment cannot be taken for granted.

[?J The cities compared to Baltimore in this section-San Francisco, California; Detroit, Michigan; and Washington, D.C.-all have serious drug problems of their own. They are similar to Baltimore in. terms of size and {except for San Francisco) socioeconomic and demographic characteristics..

IV. The Case for Treatment



Baltimore's commitment to treatment is supported by three decades of scientific research and clinical practice demonstrating treatment's effectiveness. The most recent national, multi-site evaluation of clients in publicly-funded treatment found substantial reductions in drug use, arrests, alcohol- and drug-related medical care, and homelessness. These reductions saved more than $6,000 per client. In-prison treatment followed by aftercare in the community is also effective in creating significant, long-term reductions in drug use and recidivism. This is critical for Baltimore and for Maryland, where 80 percent of prisoners have alcohol and drug problems.

Drug Addiction Is a Chronic Disorder

Alcohol and drug addictions are similar to other chronic medical conditions, such as diabetes, hypertension and asthma, in that successful treatment often requires life-long behavioral change. Prolonged drug use produces changes in brain function that drive a compulsive craving for the drug, despite adverse consequences. Relapse occurs with all chronic illnesses, and drug addiction is no different. Once the intensive supervision of treatment ends, a patient's failure to adhere to behavioral changes and prescribed medication, if any, can lead to relapse. As with other chronic disorders, major contributors to relapse are low socioeconomic status, co-occurring psychiatric conditions, and lack of family or other social supports. The fact that 50 to 60 percent of hypertension patients relapse within a year because they fail to adhere to their medication and dietary regimens does not mean that hypertension treatment does not work. On the contrary, the abatement of hypertension's symptoms during periods of treatment compliance, and their recurrence due to lack of compliance, are evidence that the prescribed treatment works.

Reduced Drug Use Is the Measure of Success

The reductions in drug use and corresponding social damage accomplished through treatment confer real benefits, especially when compared to the ·alternative:_ non-treatment and unchecked drug abuse. The most recent national, multi-site evaluation-the National Treatment Improvement Evaluation Study (NTIES)-examined results for 4,411 patients in treatment between 1993 and 1995 (including patients in Baltimore) and found that the proportion of·patients using any drug dropped by 41 percent in the year after treatment. Significant reductions also occurred in the proportion of patients selling drugs (down 78 percent), arrested on any charge (down 64 percent), requiring medical care due to alcohol or other drug use (down 54 percent), and being homeless (down 42 percent).

Private compantes offering drug treatment services to their employees reap the benefits of reduced medical. claims, absenteeism, corporate liability, and disability costs.

Treatment Is Cost-Effective

The benefits of treatment far exceed the cost. A landmark 1994 study, *The California Drug and Alcohol Treatment Assessment (CALDATA),* found that every dollar invested in treatment saved taxpayers $7 in future costs. *CALDATA* researchers concluded that "each day of treatment paid for itself ... on the day it was received, primarily through an avoidance of crime:• In the NTIES treatment evaluation, treating low-income clients created a net savings of $6,236 per client-Due to reduced spending on health care, welfare and crime-related costs-with a three to one ratio of benefits to costs. Based on these findings, NTIES researchers estimate that public treatment services

supported by CSAT funds in 1994 generated a: net benefit to society of $1.7 billion.

In the private sector, Northrup Corporation saw productivity increase 43 percent among the first 100 employees to enter an alcohol treatment program; after three years, savings per rehabilitated employee approached $20,000. Blue Cross/Blue Shield has found that families' health care costs dropped by 87 percent after treatment-from $100 per month in the two years prior to treatment to $13 per month five years after treatment. Business leaders in the Baltimore area understand that treatment's benefits improve the business climate of the entire region by reducing crime, lowering health care costs and improving worker productivity.

Extensive research offers abundant evidence that providing treatment is less costly than not providing treatment. Calculations based on National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimates of the nationwide costs of alcohol and drug abuse suggest that investing in treatment makes very good economic sense in Baltimore. Conservatively estimated, each person addicted to drugs and not in treatment costs Baltimore $30,000 a year. By comparison, the average treatment cost per methadone maintenance patient in Baltimore is $3,500 a year, a funding level that permits only bare-bones services (methadone maintenance slots comprise more than half of all publicly-funded treatment slots in Baltimore). Even if the average treatment cost per patient in Baltimore were as high as $10,000 a year, the savings would outweigh the costs by a three to one margin.

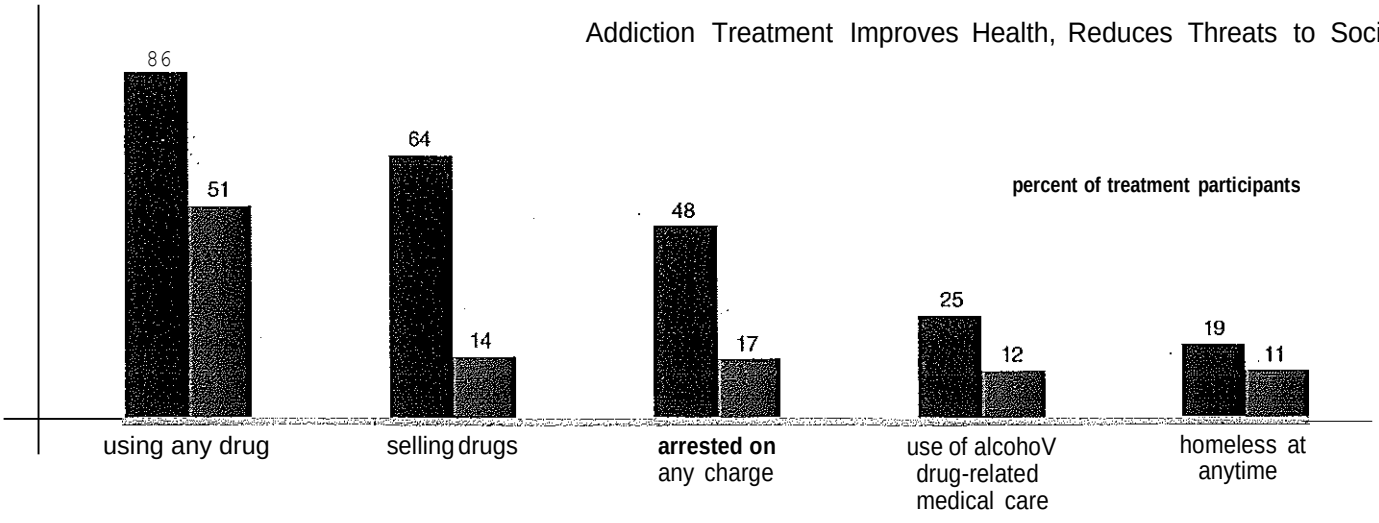
Treatment is also cost-effective compared to other drug control strategies that compete for public funds. The RAND Corporation has found that treatment for heavy.cocaine users is 23 times more effective than source-country programs, 11 times more effective than interdiction, and three times more effective than mandatory minimum sentencing in reducing cocaine consumption.

Treatment Works Whether Voluntary or Coerced

People typically enter treatment when the adverse consequences of drug use compel them to seek help. For many, this may be some personal calamity Oob loss, marriage breakup, legal difficulties) if they fail to rein in their drug use. Those arrested for criminal activity may be compelled to enter treatment by court order, or offered the chance to participate in treatment rather than face full criminal prosecution and the threat of incarceration.

Treatment can work whether a patient enters freely or under coercion from the criminal justice system. Most of the research on treatment outcomes has dealt with patients who entered treatment voluntarily, but several studies have demonstrated the effectiveness of coerced treatment as well. Indeed, involvement in the criminal justice system presents a

Addiction Treatment Improves Health, Reduces Threats to Society



Substance Abuse and Mental Health Services Administfation, 1996

prime opportunity to engage drug users in trea)ment. A 1998 study based on a large nationwide sample of heroin users found little history of involvement with treatment, but a high level of contact with the criminal justice system. While more than 70 percent of the sample of 38,561 heroin users had never been in methadone maintenance, 75 percent had been incarcerated within the previous five years, and 40 percent were either on probation or parole or had pending criminal charges at the time of the research interview. Among the nearly 30,000 heroin users who had been incarcerated within the previous five years, only 15 percent reported having received treatment while incarcerated.

Treatment interventions within the criminal justice system can work at several stages. Offenders who complete drug court programs-intensive court-supervised treatment in lieu of criminal prosecution or incarceration-are one-third as likely to be arrested for new drug offenses or felonies, and only one-fourth as likely to violate probation or parole. A 1998 study of 440 drug court participants in Multnomah County, Oregon found a two-year savings to the county of $10.2 million. Research in the Delaware correctional system underscores the importance of aftercare in the community for sustaining the benefits of prison treatment.

In FY 2000, Baltimore spent $263 million on **police protection** and the courts ($415 per resident), compared to $30 million on **treatment** ($47 per resident).

Given the expense of incarceration ($25,000 per inmate per year) and the high proportion of Maryland prisoners with alcohol and drug problems {80 percent), prison-based treatment followed by aftercare in the community is a critical means of reducing crime and spending on criminal justice. The 8,160 Baltimore offenders with drug problems in state prison as of September 2000 will cost Maryland over $200 million a year to keep behind bars, more than one-fourth of the state's entire annual corrections budget. Failure to provide adequate treatment, including aftercare in the community, increases the likelihood that many of these people will return to prison. According to the National Institute of Justice, between 65 and 70 percent of all untreated parolees with histories of cocaine or heroin use will return to drug use within just three months of release. By achieving even modest reductions in the rate at which former prisoners return to drugs, treatment can help prevent crime and avoid millions of dollars in spending on publiq safety and criminal justice.

Investing in drug treatment cannot substitute for competent policing and a functional courtsystem, but drug treatment can reduce the burden borne by public safety and criminal justice institutions. Given the exjent to which crime in Baltimore is associated with drug use and drug trafficking, the research suggests that increasing access to treatment-both in prison and in the community will help the police and the courts to do their jobs more effectively.

The Gap Between Research-Based Evidence and Public Perceptions of Treatment

By its nature, addiction cannot be fixed the way a broken leg can be set and healed. Once a broken leg is mended, we do not expect that the leg will break again. But because addiction is a chronic disorder, the ultimate goal of long-term abstinence often requires repeated treatment episodes. Much of the public's ambivalence toward treatment reflects unrealistic expectations for what treatment should achieve-expectations frequently dashed by the reality of addiction.

The gap between research and practice is illustrated clearly within the medical community itself. Physicians are often unschooled in modern addiction medicine and hold a low opinion of treatment's effectiveness. They often treat the acute medical conditions resulting from drug abuse without recognizing the underlying problem. According to a May 2000 survey by the National Center on Addiction and Substance Abuse (CASA) at Columbia University, most primary care physicians believe that treatment is "very effective" for chronic disorders such as hypertension (86 percent) and diabetes {69 percent), but very few consider treatment "very effective" for alcohol dependence (4 percent) and illicit drug dependence {2 percent). These findings underscore why treatment's growing support in Baltimore is so noteworthy.

V. Baltimore's Publicly-Funded Treatment System

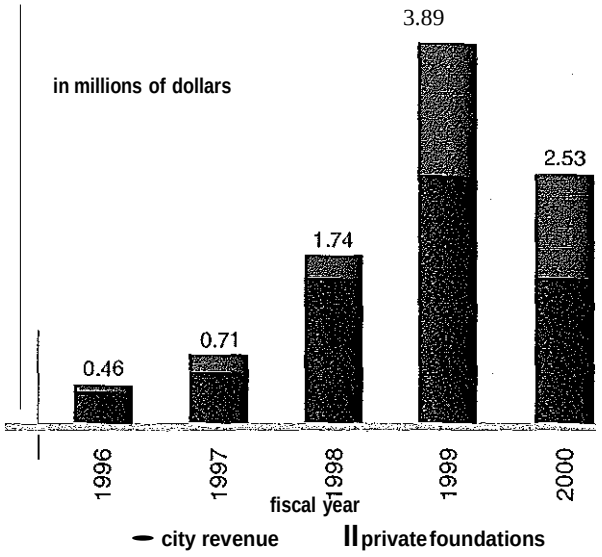
Baltimore is developing new approaches to manage its publicly-funded treatment system and to deliver treatment services. The Board of Directors of Baltimore Substance Abuse Systems, Inc. (BSAS), the city's substance abuse prevention and treatment agency, includes officials from city and state government agencies as well as representatives from private organizations. BSAS seeks advice on its operations from a Scientific Advisory Committee composed of treatment experts from across the country. Innovative treatment approaches have taken root in Baltimore, including outreach through the city's needle exchange program and a drug court for drug-involved offenders.

Baltimore Substance Abuse Systems

In 1990, the Baltimore City Health Department created BSAS-a quasi-public, non-profit corporation-to administer a Target Cities treatment improvement grant awarded to Baltimore by CSAT. The Target Cities project led to the creation of a Centralized Intake Referral and Management Information System (CIRMIS), which gave the city a much clearer picture of treatment needs than had been previously available. The Target Cities project also established primary health care centers at five drug treatment programs, developed an addiction education program for primary care physicians, created an acupuncture drug treatment program at the Baltimore City Detention Center, and coordinated Maryland's. "One Church-One Addicf' (a statewide effort to educate faith communities about addiction and support services for those in recovery).

In 1995, BSAS became the single substance abuse authority for the city, administering public funds, monitoring prevention and treatment programs, collecting client data, and collaborating with other agencies to improve services. After the transfer of treatment oversight fro111 the Baltimore City Health Department to BSAS, Baltimore began to increase treatment funding with the goal of providing ready access to treatment for all who request it. The signature program of this effort-the Mayor's Initiative-was launched in FY 1998 and created new treatment slots with city revenues drawn from the Health Department budget and with federal grant dollars allocated to treatment by the Baltimore City Department of Housing and Community Development and the Housing Authority of Baltimore.

BSAS Treatment Funding from City Revenue and Private Foundations



Baltimore City Health Depaitment and Baltimore Substance Abuse Systems, 2000

Since 1996, funding from the Abell Foundation, the Robert Wood Johnson Foundation, the Open Society Institute-Baltimore, and the Harry and Jeanette Weinberg Foundation has allowed BSAS to invest additional funds in strategic planning, staff training, new staff positions for research and advocacy, and innovative clinical programs.

BSAS supports 38 alcohol and drug abuse treatment programs through a combination of federal, state and local grants. All programs funded by BSAS are certified by the Maryland Department of Health and Mental Hygiene's Office of Health Care Quality. To ensure that publicly-funded

programs are operating according to the ··reJevant federal, state and city regulations and are providing high-quality services, BSAS staff conduct monthly on-site monitoring. These visits include meetings with patients, staff and program directors and examination of patient recilrds to assess the appropriateness of treatment planning and care.

Patients in BSAS-Funded Treatment, FY 1999

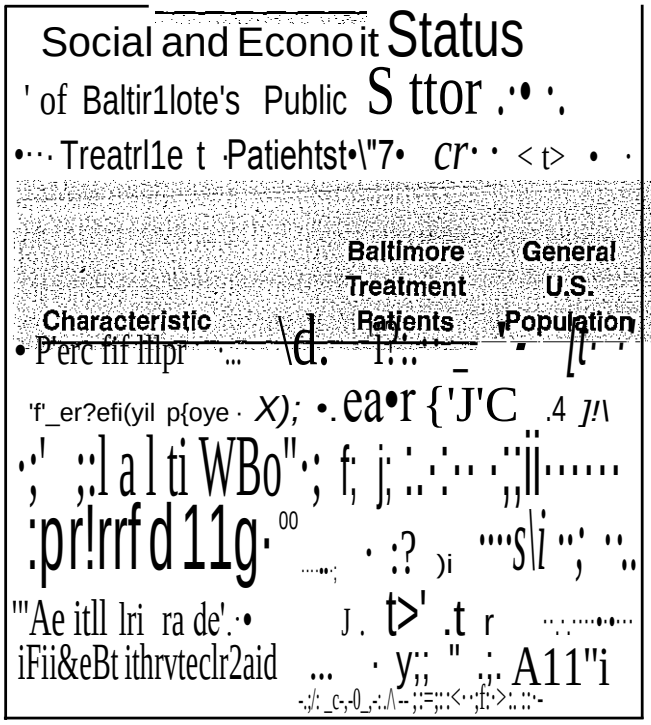
Modality	Episodes of Care	Percent of Total
Outpatient	**13,995**	**77.8**
Intensive/Standard Outpatient	6,093	33.9
Methadone (Detoxification & Maintenance)	5,457	30.3
Youth Outpatient	1,275	7.1
Outpatient Detoxification	1,170	6.5
Inpatient	**3,991**	**22.2**
Intermediate Care Facility	2,538	14.1
Inpatient Detoxification	850	4.7
Intensive Transitional Living	333	1.9
Halfway House	216	1.2
Residential Women & Children	33	0.2
Therapeutic Community	21	0.1
Total	**17,986**	**100.0**

Of the 6,500 slots funded by BSAS in FY 2000, the great majority were for methadone maintenance (56 percent) or outpatient drug-free treatment (31 percent), which are the least expensive modalities. By comparison, there are very few slots for residential treatment of any kind {5 percent), and even fewer residential slots with an average stay as long as six months (3 percent). One methadone maintenance slot, serving one patient for 12 months, costs BSAS about $3,500 (a level of funding that supports only the bare minimum of services). Residential slots for women with children, with an average stay of six months; cost BSAS about $22,500 per patient.

In addition to Baltimore's BSAS-funded treatment programs, some 20 other treatment providers in the city only take patients who are able to pay for the services themselves or through their health insurance (including HealthChoice, Maryland's Medicaid managed care system). BSAS programs serve about 70 percent of those who receive treatment in Baltimore. In general, BSAS patients face a greater array of problems than those who can access private programs. For example, only 19 percent of the 19,000 patients active in BSAS-funded programs during FY 2000 were employed full time, 54 percent had been arrested at least once within the previous two years, and 29 percent were placed in treatment via the criminal justice system.

The BSAS Board of Directors

The 24-member BSAS Board of Directors includes officials from a range of city and state government agencies, as well as numerous representatives from private organizations with expertise in local treatment issues. In addition to Baltimore's health commissioner, the BSAS Board includes officials from the city council, the police, the departments of social services and housing and community development, the state's attorney for Baltimore, and Baltimore Mental Health Systems, Inc. (the city's mental health equivalent of BSAS). The state government is represented on the Board by the Lt. Governor and by the directors of the departments of human resources, health and mental hygiene, and public safety and correctional services. (See page 38 for a list of the members of the BSAS Board of Directors.)



The BSAS Board's Allocations Committee is responsible for recommending which treatment modalities and particular programs should be funded. Beginning with the FY 2001 round of funding decisions, the Allocations Committee was placed in charge of BSAS' request for proposals (RFP) process. The Committee reviews each applicanfs internal operations and financial data as well as measures of treatmenl performance, including retention and utilization rates and drug test results. The performance measures, which are the responsibility of the Board's Performance Evaluation Committee, are based on data generated by CIRMIS. The Performance Evaluation Committee is also responsible for developing performance criteria to assess results achieved by the BSAS treatment system as a whole.

Baltimore's Treatment Innovations

Baltimore's recent efforts are noteworthy both for the city's explicit commitment to treatment on request and for the extensive involvement on the part of private organizations, including local foundations, business leaders, the religious community and university researchers. Baltimore has been particularly creative in attempting to extend treatment to hard-to-reach populations, increasing the intensity of treatment counseling services, maximizing available methadone maintenance slots, and including treatment in criminal justice settings. Illustrative initiatives are described below:

..,. Outreach. Improving outreach efforts to people addicted to drugs but distrustful of or lacking confidence in treatment is crucial to reaping the benelils of an upgraded treatment system. If most people who are addicted to drugs never enroll in treatment, or at least not until many years into their addiction, then·even a system that performs well for those who do enter is only beginning to address the true scope of the problem. A 1998 study based on a nationwide sample of more than 38,561 heroin users (obtained through the National AIDS Demonstration Research Program) found very low levels of involvement with treatment: 58 percent reported never having been in detoxification, more than 70 per-. cent were never in methadone maintenance, and more than 80 percent were never in any form of outpatient treatment. Even among the minority who reported some form of treatment experience, most had been in treatment only one or two times.

The BSAS Scientific Advisory Committee

In addition to the colfective expertise of its Board, BSAS has assembled a Scientific Advisory Committee of 14 nationalfy recognized treatment researchers and practitioners tasked with identifying gaps in the city's treatment system and suggesting strategies for improving services and for adopting state-of-the art practices being implemented elsewhere. No other city in the country has calfed upon such an expert group to examine its treatment efforts on an ongoing basis.In October 1999, the Scientific Advisory Committee submitted its first set of recommendations for how the city should go about expanding, evaluating and improving its treatment system. (See page 38 *tor* a list of the BSAS Scientific Advisory Committee members.)

Social and Economic Status of Baltimore's Public Sector Treatment Patients

Characteristic	Baltimore Treatment Patients	General U.S. Population
Percent Single	76	44
Percent Unemployed	68	4
Annual Family Income		
Percent under $5,000	52	3
Percent under $10,000	74	6
Percent with No Health Insurance	63	18
Percent with Medicaid	21	11

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Baltimore's Needle Exchange Program as a Bridge to Treatment

Needle exchange programs curb the spread of HIV among injection drug users (IDUs) by decreasing needle 'sharing and other HIV risk behaviors. Needle exchange can also be an effective bridge to treatment. The National Institutes of Health, the National Academy of Sciences, the Centers for Disease Control and Prevention, and researchers at the Johns Hopkins University have found that needle exchange effectively reduces the spread of HIV and hepatitis-B without increasing drug use or other public safety risks.

The rate of new HIV infections among Baltimore IDUs has fallen by 35 per· cent since the Baltimore Needle Exchange Program began; each HIV infection prevented saves at least $150,000 in direct medical costs.

Baltimore's Needle Exchange Program (BNEP) has become an integral part of the city's public health system. Since the program began in 1994, 12,000 people have participated in needle exchange through mobile vans and pharmacies. BNEP makes referrals to 390 treatment slots (primarily methadone maintenance) set aside for needle exchange participants in five Baltimore treatment programs. The city spends about $300,000 a year on BNEP, and another $250,000 on drug treatment for participants.

In a 1998 Johns Hopkins University study, methadone maintenance patients referred by BNEP showed reductions in drug use and criminal activity comparable to those of other methadone patients, even though BNEP referrals had more severe drug habits, less treatment experience and more medical problems.

In light of the strong results for needle exchange participants who enter treatment, Baltimore has won NIDA funding to evaluate the impact of a motivational interview designed to enhance treatment interest and participation by BNEP clients. Based on 150 .participants through June 2000, the study has found a high level of interest in treatment reported by new BNEP registrants: Close to 90 percent say they are interested in treatment, and half are interested in methadone maintenance in particular. As study participants are followed over the next two years, the strength of their interest in treatment as initially reported will be compared to their actual treatment participation and length of stay in treatment. The high level of interest in treatment that the study has· already found underscores the great potential of the needle exchange program as a bridge to treatment, and also highlights the need to expand treatment capacity so that slots are readily available when drug users say they want treatment.

Mobile Treatment Partnerships

Methadone and LAAM (levo-alpha-acetyl-methadol) suppress opiate withdrawal symptoms and cravings, thus reducing drug use and improving treatment retention. LAAM, which is long-acting, can be administered three times a week rather than daily, as is the case with methadone. In early 1999, Baltimore launched the nation's first program to distribute LAAM through a mobile treatment van in combination with outpatient counseling. A van operated by REACH Mobile Health Services stops three times a week at the University of Maryland's Harambee outpatient program to provide methadone and LAAM to patients referred from Baltimore's Needle Exchange Program.

Johns Hopkins University researchers have found that the mobile LAAM program successfully engages and retains needle exchange participants in treatment. Between February 1999 and January 2000, ?o percent of the 121 needle exchange participants referred to the LAAM program enrolled, and over three-quarters of enrollees remained active in the program for at least six months. Even more importantly, nearly three-quarters of enrollees (average age of 42) had never entered a treatment program before. These findings confirm the effectiveness of Baltimore's Needle Exchange Program as a bridge to treatment and suggest

that mobile LAAM and methadone programs may engage greater numbers of drug users in treatment than would be possible through fixed-site clinics alone. The National Institute on Drug Abuse (NIDA) and the Center for Substance Abuse Treatment (CSAT) funded thEl mobile LAAM-counseling partnership through June 2000, when the program was discontinued until new funding can be found.

' Recovery in the Community and AID First

In 1999, the Abell Foundation began funding a new community treatment program targeting Baltimore neighborhoods where many residents have been addicts for as long as 10 to 15 years with little, if any, experience with treatment. Recovery in the Community combines street outreach, treatment readiness services, case management, and placement in treatment with transitional housing services and strong links to key community organizations, which expand the program's service referral network. With funding from OSI-Baltimore, the Johns Hopkins University School of Hygiene and Public Health has launched AID First, another community:oriented effort, which trains family and community members to recognize the early signs of serious drug involvement and to provide support and referral when an individual seeks help. A triage a ent receives referrals from AID First volunteers in the community and, where warranted, helps the individuals who have been referred to prepare to enter treatment.

- **Intensive Services.** More frequent contact with counselors early in the treatment process has been shown to increase the length of time that patients remain in treatment, which is a major factor in successful treatment outcomes. By comparison with methadone maintenance programs, "drug-free" outpatient programs (which for the most part do not involve the use of medications) typically retain a lower proportion of their patients in treatment.

To address this problem, in FY 1997 BSAS began the phased implementation of intensive front-end services at all BSAS-funded outpatient programs. Instead of the standard minimum counseling schedule of one to three hours per week, all BSAS-funded programs now provide a minimum of nine hours per week during the first month of treatment. The frequency of counseling sessions Is gradually reduced in subsequent months(outpatient services are typically meant to last six months), with the pace of transition depending on each patient's progress.

- **Maximizing Resources.** Baltimore treatment providers and researchers are conducting demonstration projects which show that medical methadone maintenance for stabilized, well-functioning patients is a safe, effective way to free up standard methadone maintenance treatment slots for new patients.

Methadone maintenance is unavailable to many who would benefit, due both to inadequate funding and to regulations that restrict prescribing practices; even highly stable patients must attend a methadone clinic one or more times per week to receive medication. Medical maintenance reduces this reporting schedule to once per month, with medication dispensed and counseling provided by medical staff either at a traditional methadone clinic or in a physician's office.

Researchers in Baltimore have obtained exemptions from existing regulations to evaluate the safety and effectiveness of medical maintenance for patients who have done well in standard methadone maintenance. A demonstration project following 21 medical maintenance patients in Baltimore for 12 years reports high retention in treatment, very low rates of illicit drug use--only 0.5 percent of the 2,290 urine specimens collected tested positive-and no evidence that medication was diverted to others in the community. Research based on a larger sample of 78 patients at three different Baltimore clinics has shown similar results at the six-month follow-up.

These findings reinforce earlier research done in New York City and suggest that Baltimore should be permitted to implement medical maintenance on a larger scale. Maryland's Alcohol and Drug Abuse Administration (ADAA) estimates that 10 percent of Baltimore's methadone maintenance patients might qualify for medical maintenance.

o<11 Criminal Justice. The criminal justice s)'$lem is a critical venue for integrating treatment-from the pre-trial stage, to prison-based programs, to community-based treatment for parolees and probationers.

Drug Court

The Baltimore City Drug Court opened in March 1994 and includes separate programs for misdemeanor offenders (District Court) and felony offenders (Circuit Court). As of August 2000, more than 500 people had graduated from the Drug Court. Only 7 percent of graduates have had new criminal convictions within three years of graduation, compared to 37 percent for all probationers in Baltimore. The University of Maryland is currently conducting a randomized, controlled evaluation of treatment outcomes for drug court participants. The drug court receives $2.3 million annually in state funding, of which $1.5 million is spent on treatment. The program, which was filled beyond capacity in December 2000, will be expanded in FY 2001. An additional $900,000 in treatment funding has been obtained from the state, allowing the drug court to increase the number of participants from 600 to 900.

Treatment for Heroin-Dependent Prisoners Nearing Release

In February 2000, Baltimore's Friends Research Institute (FRI) began evaluating the effectiveness of providing LAAM maintenance treatment to heroin-dependent inmates at the Metropolitan Transitional Center, a pre-release facility in Baltimore. Over the course of the study, 60 male inmates will be randomly assigned to 12 months of LAAM maintenance treatment, including three months of treatment while incarcerated and nine months while on parole; another 60 inmates will be randomly assigned to the control group and will not receive LAAM treatment. Both groups will receive standard correctional and parole supervision. To prevent relapse, FRI's project combines prison-based treatment (medication and counseling) and continued treatment in the community. In prison and in the community, treatment will be provided by the same program (Man Alive, one of Baltimore's oldest and largest methadone and LAAM maintenance programs). FRI researchers anticipate that the LAAM treatment participants will be more s ccessful in avoiding a return to heroin use, other criminal activity, HIV risk behaviors and reincarceration.

Demand for treatment of Criminal offenders is expected to grow in coming years, raising concerns that voluntary treatment applicants will be pushed further back on program waiting lists . unless treatment capacity expands at the same time.

Break the Cycle

Break the Cycle (BTC), championed by Maryland Lt. Governor Kathleen Kennedy Townsend, is the state's first systematic effort to address drug use among offenders on probation and parole. The goals of BTC are to reduce drug use and criminal recidivism among offenders by using regular drug tests and graduated sanctions and incentives to keep drug-abusing offenders in treatment. BTC eventually will be instituted statewide, but the strategy was initiated in Fall 1998 in Baltimore and six counties. A January 2000 process evaluation found uneven implementation of BTC across the participating jurisdictions and recommended conducting- an outcome study when all of the strategy's components-drug testing, sanctions and rewards, and treatment-are in place.

Since 1997, Maryland's ADAA has required BSAS to reserve 35 percent of block grant funding for treatment slots for clients referred by criminal justice agencies. Full implementation of BTC will include closer monitoring and sanctions for Baltimore offenders who fail to attend treatment, which should improve treatment compliance among probationers and parolees.

VI. Assessing Baltim-ore's Treatment System

Baltimore's current treatment capacity serves only one in three city residents addicted to alcohol and drugs. Wrap-around services, which increase treatment success, are lacking in Baltimore: Of 20 programs surveyed in the city, *only* four offer on-site primary health care, two offer job training and one offers childcare. Despite these challenges, the city, with guidance from the Scientific Advisory Committee, is working to address shortcomings in its treatment system. Increasing treatment availability while ensuring quality core treatment services is a top priority for city leaders. Plans are underway to provide wrap-around services that address the myriad problems faced by people with addictions. The city has also been expanding data collection within and across treatment programs to evaluate performance.

The Ingredients of Treatment Success

This chapter assesses the city's treatment system according to three major criteria: progress toward ready availability of high-quality treatment; progress toward providing a comprehensive continuum of treatment services; and capacity to evaluate program performance and ensure high standards. These assessment criteria have been chosen based on research identifying the "active ingredients" of successful treatment.

The National Institute on Drug Abuse (NIDA) recently compiled a list of 13 factors that research has identified as crucial to successful treatment outcomes. Two factors in NIDA's 1999 *Principles of Drug Addiction Treatment* stand out for assessing the performance of a treatment system as a whole: "treatment needs to be readily available;' and "effective treatment attends to multiple needs of the individual, not just his or her drug *use:'*

System-wide treatment success depends on making progress toward these two goals. The window of opportunity during which a person addicted to drugs is ready to enter treatment may open infrequently and briefly, and the opportunity is wasted if treatment is not immediately available. But success also depends on the comprehensiveness of the services <; ctually provided. Research shows that treatment outcomes improve when comprehensive services-varying intensities of weekly counseling and provision of a wide array of medications-are supplemented by "wrap-around" services that address the patient's other needs, ranging from primary health care, psychiatric care and family services to education, employment and housing assistance. Failure to address such problems in conjunction with treatment leaves patients especially vulnerable to relapse.

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high-quality treatment readily available, and to wrap comprehensive services that address a patient's multiple needs around solid core treatment services.

Although NIDA's *Principles* leave it implied, a treatment system's core services-addiction counseling and, in many cases, medication-must be adequate to reap the full benefits of ready availability and comprehensive wrap-around services. If drug users have rapid access to treatment, but the core services are limited or of poor quality, then treatment's ready availability will accomplish far less than it should. Similarly, if services are provided to address a patienfs problems beyond addiction, but the core treatment services are themselves flawed, then the results will be less than anticipated. The importance of adequate core services ties "ready availability" and "comprehensive wrap-around services" to the third criterion for assessing Baltimore's treatment system: the capacity to evaluate program performance.

The Historical Context: Facing the Legacy of Treatment's Neglect

Decades of inadequate support for public treatment mean that NIDA's research-based *principles* of effective

treatment are far from being achieved in *practice* system-wide anywhere in the country. Scarce funding has left the field hard-pressed to attract and retain qualified counselors. Salaries are not commensurate with the education and interpersonal skills required to be an effective counselor. As a result, many talented people who enter the field soon leave for other opportunities. High staff turnover disrupts counselor-patient relationships, which take time to develop. Maryland's Treatment Task Force reports a shortage of qualified addictions counselors statewide, resulting in vacancies at treatment programs, including those in Baltimore.

In FY 2000, BSAS invested nearly $775,000 in salary enhancements to bring BSAS-funded program staff in line with the state's pay scale. Still, the $27,500 average annual salary in the BSAS system for front-line counselors (whose work does not include supervising other counselors) falls $10,000 short of the average salary for all jobs in Baltimore; the vast majority {88 percent) of BSAS-funded counselors, including those with supervisory responsibilities, earn less than the average Baltimore worker. (To keep pace with state-level salary increases, BSAS plans to devote a portion of the FY 2001 funding increase from the state to a 4.6 percent pay increase for staff at BSAS-funded programs.)

Cities like Baltimore that are now firmly committed to rmprovrng treatment confront the difficult legacy of years of inadequate investment.

Ready Availability of High-Quality Treatment

People addicted to drugs are often uncertain about entering treatment. More than half of applicants on treatment waiting lists are less interested in entering treatment at the end of the waiting period than when they first enlisted. The length of time applicants spend on a waiting list is also associated with greater likelihood that a person addicted to drugs will resort to criminal activity to continue obtaining drugs.

At least one in eight adults in Baltimore needs treatment. Current treatment capacity is adequate for only about one-third of them. Although there is no wait for intensive outpatient treatment, the wait for admission ranges from one week to one month for methadone maintenance, detoxification and residential care. With the exception of transitional living, no publicly-funded long-term residential treatment (beyond 30 days) is available in Baltimore.

A survey of ten of the city's methadone maintenance programs found. that, on average, they receive over 50 telephone calls a week from people seeking to enter treatment, but are able to admit only about five new patients per week.

It is difficult to determine specific capacity shortfalls for each treatment modality; BSAS records the treatment needs of the 950 to 1,200 treatment inquiries it receives directly each month, but the calls drop off once word gets out around the city that treatment slots are filled. As part of the city's intensified enforcement efforts against ten open-air drug markets during the first half of 2000, health officials identified 612 people addicted to drugs near the designated areas. Eighty-four of the 236 people identified as addicted to drugs who subsequently tried to enroll in treatment had to be turned away due to lack of space.

Baltimore's Approach

Baltimore's leaders know the city needs the state's assistance in order to add treatment capacity, and in FY 2001 Baltimore will receive 46 percent more treatment funding from the state than the prior year. Despite this considerable increase, the city's overall treatment budget for FY 2001 will only be half of the $70 million in annual spending needed to add enough new capacity-about 4,000 slots-to provide treatment on request. BSAS has also estimated that some 1,900 new slots could be funded with an additional $15 million in spending per year, with the new capacity divided equally between court-ordered and voluntary

slots, and emphasizing methadone maintenance (1,150 slots), the area of greatest need.IBI

In October 1999, the BSAS Scientific Advisory Committee submitted its first set of recommendations on how Baltimore should pursue its capacity expansion. Many of these recommendations are reflected in BSAS's FY 2000-FY 2002 Operating Plan and are already underway:

- The Committee recommended integrating detoxification services into all adult outpatient programs, since detoxification increases patients' ability to make good use of outpatient treatment. In FY 2000, BSAS awarded grants creating 16 outpatient detoxification slots integrated into existing outpatient treatment programs, enough to serve 400 patients a year. In FY 2001, BSAS plans to fund an additional 80 such slots (40 for court-ordered patients and 40 for voluntary entrants), projected to serve 2,000 patients.

Baltimore's health commissioner estimates that **achieving** treatment on request will require serving about 40,000 people per year-double the current number.

- The Committee recommended introducing LAAM into opiate treatment programs, allowing the programs to *serve* more patients without requiring more space, and providing another option for patients who do not respond to methadone. In FY 2000, the city added 70 new LAAM slots as part of the REACH Mobile Health Services project. BSAS has also won funding through a CSAT capacity expansion grant that would partner mobile services with a fixed-site facility and expand LAAM slots by 100.
- The Committee recommended the creation of an interim methadone maintenance program to increase the number of people receiving treatment. For people on methadone program waiting lists, federal regulations now allow "interim" treatment consisting of medical assessment and daily, supervised administration of medication while the patient waits for entry in full-service programs, which add counseling services. BSAS and Maryland's Alcohol and Drug Abuse Administration (ADAA) have collaborated with the Friends Research Institute in submitting a proposal to NIDA to fund a pilot interim methadone maintenance program.
- The Committee considered that *every* citywide treatment system must have at least one long-term residential program, which is essential to providing services to a young, difficult group of patients who do not respond well in outpatient settings. A committee of the BSAS Board has been tasked with identifying the barriers to creating new residential programs in the city and formulating a strategy to overcome those barriers.
- The Committee recommended that BSAS engage in public education to deepen understanding of what makes an effective treatment system and sustain support for the level of investment necessary to achieve treatment on request. In March 2000, BSAS hired an Advocacy and Public Information Coordinator to design and implement a public education strategy.

In addition to these initiatives, in FY 2000 BSAS funded 145 new methadone maintenance slots through a supplemental grant from ADAA. Also beginning in FY 2000, capacity expansion funds were used to expand the early morning and evening hours of operation of certain programs to accommodate patients' work schedules. With the increased state funding provided for FY 2001, BSAS also plans to create an additional 945 methadone and LAAM maintenance slots.

Comprehensive Wrap-Around Services

Improved outcomes from wrap-around services outweigh the costs associated with providing these services. A study of publicly-funded treatment in Philadelphia found that the economic benefits of outpatient treatment enhanced by wrap-around services outweighed the costs by a ratio of

[8] Securing the funding to add capacity is merely the first step in what is necessarily a painstaking process. Before even one additional patient can receive treatment, proposals must be requested and reviewed, contracts awarded, space secured, and staff hired and trained. So even when new funding can be devoted to expansion, adding new capacity takes time.

nearly seven to one. For methadone maintenance, the benefits were even more pronounced: Every dollar spent on treatment enhanced with comprehensive wrap-around services saved $18 in avoided costs, largely due to reductions in crime and psychiatric problems.

A treatment system's progress toward providing a comprehensive continuum of services will affect progress in related areas highlighted in NIDA's *Principles.* For example, research has demonstrated that providing treatment services appropriate to each patient's particular needs (' reatment matching") and ensuring that patients remain in treatment long enough to reap the benefits ("adequate length of stay") are critical for treatment effectiveness. The longer patients remain in treatment, the greater their reductions in drug use and their improvement over time. For most patients, significant improvement begins after three months in treatment, and benefits increase beyond the three-month threshold.

The existence of a comprehensive continuum of servi.ces may persuade many people addicted to drugs that treatment has something to offer. Even when drug use has become compulsive, an addicted person may see other problems-such as lack of education, unemployment or depression-as the real causes for concern, and view drugs as a way to cope with, if not solve, these problems.

Treatment Matching

Once enrolled, whether patients stay in treatment long enough to reap the benefits depends in good measure on whether they are matched to services appropriate to their needs. A patient who feels that the particular services being provided (including core treatment counseling and wrap-around services) are not helping him address his problems is not apt to remain in the program for long.

Matching patients to the appropriate services is a two-step process. One step entails the accurate assessment of each patient's particular needs. Baltimore's publicly-funded programs use two instruments designed for this purpose—the Addiction Severity Index (ASI) and the American Society of Addiction Medicine's Patient Placement Criteria (ASAM-PPC-2).

The second step in matching depends on the necessary range of services being available. The ability to accurately assess patients' needs is moot if the proper services do not exist or are in too short supply. This applies both to core treatment service modalities (for example, intensive counseling, alcohol and drug detoxification, and methadone maintenance) and wrap-around services (for example, psychiatric care and job training).

Patients receiving **Wrap-around** services are more likely to remain in treatment, stay **abstinent** for longer periods of time, and demonstrate **improvements** in psychiatric, vocational and personal functioning.

Despite the evidence that wrap-around services improve treatment outcomes, research has shown a sharp decline in the availability of such services. In Baltimore, research from 1989-1994 involving more than 700 heroin addicts in treatment found that nearly 50 percent suffered co-occurring psychiatric problems, with antisocial personality disorder and major depression the most common diagnoses. During NIDA's 1991-1993 Drug Abuse Treatment Outcome Study (DATOS), 54 percent of methadone maintenance patients who needed psychological services did not receive them. Medical, family and employment services were also significantly less available for methadone patients in DATOS than they were a decade earlier. The same trends prevail in long-term residential and outpatient drug-free programs. Wrap-around services are rarely offered in public treatment settings.

A December 1999 BSAS survey of 20 Baltimore treatment providers found that 90 percent have enough space at their facilities to expand or add wrap-around services if fund-

ing were available. The survey also found that Ba imore's treatment providers consider their patients to be most in need of medical, vocational and housing services. Currently, however, few programs offer these services. Only four programs offer on-site primary health care, two programs offer on'site job training and six programs offer on-site housing assessment. In addition, only one of the 20 programs reported providing on-site childcare. A greater number of programs offer referrals to other services, but often with no assurances that their patient will receive these services promptly. In the case of housing assessment, only seven of the 20 programs even provide referrals.

Baltimore's Approach

In October 1999, the BSAS Scientific Advisory Committee recommended that BSAS tighten linkages between drug treatment and ancillary services. The Committee noted that the leadership of the agencies that provide these services is represented on the BSAS Board, which should facilitate close cooperation. The Board's Operating Committee has identified five important ancillary services for patients in the BSAS system: medical, mental health, educational/vocational, housing and childcare. The city's Department of Social Services will fund childcare for the children of patients in treatment. In FY 2001, BSAS will test the feasibility of system-wide implementation of the other services through pilot programs at three sites:

- Nurse practitioners will provide on-site medical services, including HIV, tuberculosis and sexually transmitted disease (STD) testing; HIV risk assessment and education; physical examinations; family planning education; and referral to specialty care (primary and urgent care, gynecology and specialized HIV care) at community-based health organizations. In addition, the Johns Hopkins University School of Hygiene and Public Health will provide HIV and hepatitis screening for patients enrolled in methadone maintenance.
- The mental health services pilot programs will include on-site psychiatric assessment and services. BSAS and its mental health counterpart, Baltimore Mental Health Services (BMHS), also plan to provide training in the identification and treatment of dual-diagnosed patients for counselors in both systems. (The possibility of merging BSAS and BMHS to create a single behavioral health entity has come under consideration in Baltimore. Regardless of the ultimate organizational structure chosen by city leaders, success in treating addictions and other mental health problems will require that the responsible entities be adequately funded and well managed.)
- Vocational assessment, job readiness training and job placement services will be made available on-site. BSAS is developing referral linkages to workforce development providers and agencies such as the city's Office of Employment Development (OED).
- The services of community-based agencies specializing in housing will be made available to patients at each pilot program. BSAS is also exploring the possibility of placing treatment counselors on-site at all city shelters and transitional living facilities.

Evaluation and Quality Assurance

Because research has shown that apparently similar treatment programs can actually vary widely in the range and quality of services provided as well as patient outcomes, the continual monitoring of program pertormance is crucial to building a strong treatment system. Pertormance evaluation has direct clinical value by offering insights into why certain programs excel while others may lag. By providing objective information about the treatment outcomes achieved by individual programs within the system, evaluation results can guide funding decisions. If weaker programs cannot improve their pertormance, then changes in funding or program management are in order.I9J Perhaps most importantly, evaluation can provide evidence of treatment success in reducing drug use and other drug-related problems.

[9) In evaluating performance, it is essential to take into account differences in the severity of patients' problems across programs. Failure to control for patient differences exaggerates the effecliveness of programs treating less impaired patients and understates the effectiveness of programs treating patients with more severe problems.

Evaluation and quality assurance. require putting two distinct systems in place. First, there must be a management information system (MIS) with the capacity to support program-specific and system-wide perforq< nce monitoring and evaluation. The MIS must incorporate data for key performance measures, and procedures must be established to ensure that programs can provide the data on a routine basis. Funding must be available to support evaluation research and retain personnel with the expertise to use the MIS to its full potential. Second, formal decision-making processes must be in place to ensure that the information derived from performance evaluation guides program funding decisions.

Sustaining **public support** for an aggressive treatment strategy will require that BSAS can provide scientifically valid **evidence** that treatment **WOrkS** in Baltimore.

Baltimore's Approach

Baltimore began developing its Centralized Intake Referral and Management Information System (CIRMIS) in 1990 as part of the federally-funded Target Cities project. CIRMIS now links more than 60 treatment programs, other social service providers and criminal justice agencies. CIAMIS performs two major functions, monitoring slot availability and collecting demographic and treatment data as the basis for performance evaluation.

To improve performance monitoring of individual programs and the treatment system as a whole, the Scientific Advisory Committee recommended in its October 1999 report that BSAS track data for five key outcome measures: treatment retention rates; reductions in alcohol and drug use (verified by frequent, random drug testing); kept appointment rates; program utilization rates; and repeated measurement of a subset of patients' Addiction Severity Index (ASI) scores.

...u Although research has demonstrated the validity of patient self-reports in measuring alcohol and drug use, breathalyzer readings and urinalysis have become standard practice in measuring treatment outcome; Negative urine or breath results support the success c treatment, while positive results indicate some dru! use. Drug tests are also clinically valuable for man' patients, for whom the prospect of a drug test provide; additional motivation to sustain recovery. The Scientific Advisory Committee recommended random weekly drug testing for patients in outpatient programs during the first three months of treatment, and twice monthly afterwards (depending on a patienfs. progress). The Committee's recommendation represented a significant increase in testing by BSAS programs, and would therefore increase costs.

...u The rate of kept appointments is a crucial measure of treatment participation. If counseling has been shown to work, but patients miss counseling sessions and are not adequately motivated to participate by program staff, then successful outcomes should not be expected.

4 Program utilization rates provide a measure of the treatment system's efficiency. For example, if a significant proportion of funded capacity in a certain modality is consistently unused, then funding should probably be switched to treatment modalities that are operating at full capacity but still unable to meet demand.

4 Repeating the administration of a subset of ASI questions at regular intervals in the treatment process will provide a fine-grain picture of patients' progress in treatment over time. The Committee recommended that questions be asked of all patients monthly for the first three months of treatment, and every other month for the first year of treatment, if applicable. The information derived should help counselors assess the effectiveness of treatment services, and determine whether midcourse modifications are needed. ASI data will also constitute an important source of information on the benefits of treatment as it occurs. Outcome evaluations typically study a patient's behavior after treatment, and therefore fail to capture the benefits to society generated during treatment. For example, one of the ASI questions recommended for repeat administration

by the Scientific Advisory Committee asks how many days in the past month a patient has engaged in illegal activities for profit.

Steep **reductions** in illegal activities and other measures compared to a patient's Addiction Severity Index scores at admission to treatment would indicate that the patient's participation in treatment is of tangible **benefit to society,** apart from any consideration of how the patient does after leaving treatment.

CIRMIS is already capable of tracking retention rates, drug test results and program utilization rates. The subset of ASI questions recommended by the Scientific Advisory Committee was piloted at one of the city's treatment programs. The clinical and performance evaluation benefits of regularly administering the ASI subset will likely be significant. Like any new data-gathering task, though, it will take staff time and training to be done properly, which will add to the cost of treatment.

The ASI subset provides a good illustration of the fact that improving performance evaluation capabilities carries a price, and cannot be done well on the cheap. Tracking kept appointment rates presents a similar issue. While tracking kept appointments rates is a straightforward task in terms of CIRMIS' software, the data collection and reporting burden would currently be too heavy for many BSAS-funded programs unless a specific allowance is made in the BSAS budget to hire and train staff responsible for collecting and reporting data to BSAS.

BSAS is standardizing the administration of urinalysis and the recording of the results across all of the system's programs. Since July 2000, a single laboratory conducts all of the tests for BSAS programs and electronically posts the results to BSAS. This relieves program staff of the significant burden of urine test data entry, and makes the results available more quickly in a form suitable for CIRMIS. BSAS plans to devote more than $500,000 of the increased state funding for FY 2001 to increase the frequency of drug testing across the system, with the minimum goal of randomly administering drug tests to every patient twice a month for the first three months in treatment, and once a month thereafter, with more frequent testing indicated where relapse appears likely. This schedule does not yet meet the Scientific Advisory Committee's recommended level of ,testing-once per week for the first three months of treatment, and twice per month thereafter. Increasing the volume of tests again will require another increase in funding.

In pursuing the Scientific Advisory Committee's recommendations, BSAS is building a management information system with considerable capacity to support ongoing program evaluation and research. To take advantage of the system, BSAS created the new staff position of Director of Research and Evaluation, and filled the position in February 2000. Beginning with the FY 2001 round of funding decisions, which took place in February 2000, the BSAS Board incorporated retention rates, utilization rates and drug test results in its grant review process.

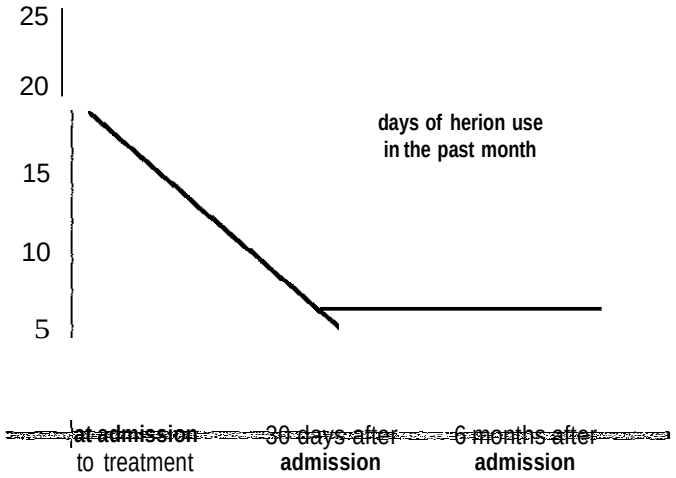
In addition to enhancing its own evaluation capabilities, BSAS and its component programs have been involved in several major treatment outcome studies. When the city's treatment expansion was launched, funding for evaluation was incorporated into the budget for city-funded slots known as the Mayor's Initiative. The results of a three-year evaluation of the Mayor's Initiative are due in Spring 2001. BSAS and individual treatment providers in the city are also participating in two important statewide studies of treatment effectiveness, known as the Treatment Outcome Performance Pilot Studies (TOPPS), and a federal network of clinical trials designed to test the effectiveness of innovative treatment techniques.

Mayor's Initiative Evaluation

Established under Mayor Schmoke, the Mayor's Initiative funds 860 treatment slots in detoxification, methadone and outpatient programs. The University of Maryland, the Johns Hopkins University and Morgan State University are conducting a three-year evaluation of the Mayor's Initiative, including the impact of the treatment expansion on program operations, treatment retention, service utHization, and drug use during and after treatment. Although final results are not due until Spring 2001, preliminary findings-based on ASI scores for 806 study partici-

pants in outpatient and methadone maintenance programs-underscore the effectiveness of treatment and its benefits for Baltimore. Compared to their behavior in the period before treatment, six months a(ier entering treatment, participants (on average) had reduced the number of days in which they used heroin from 21 out of the previous 30 to 6 of 30. Participants also reduced the number of days in which they engaged in illegal activity for profit from 41 out of the previous '180 to 17 of 180, while cutling their past-month spending on illicit drugs from $714 to $220.

Heroin Use Declines Among Baltimore Treatment Participants



Johns Hopkins University, University of Maryland and Morgan State University, 2000

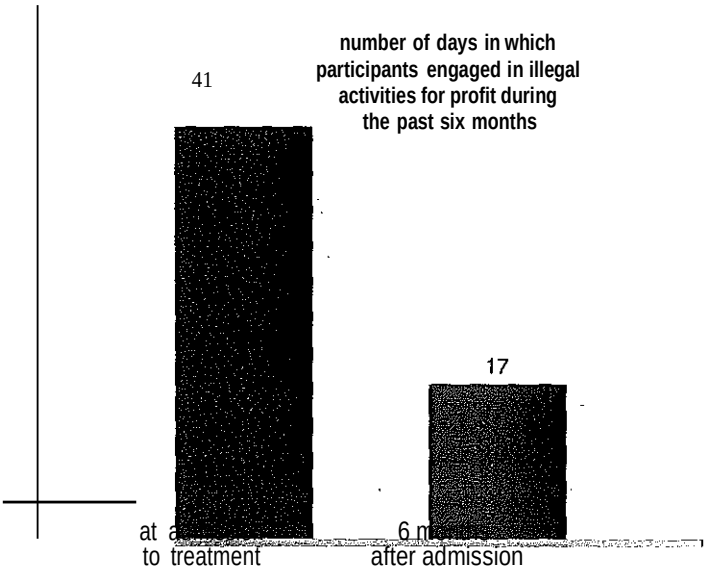
Mayor's Initiative researchers will also be testing the feasibility of conducting outcome research by linking to other public systems' databases for information that will allow for objective follow-up research on the behavior of patients after they leave treatment. For example, patient information in CJRMIS is being linked to criminal justice information in state databases. The Scientific Advisory Committee endorsed this line of research for its potential to cost-effectively expand the scope of the city's treatment outcome research.

Treatment Outcomes and Performance Pilot Studies

Conducted by ADAA and CESAR with funding from CSAT, the TOPPS-1 study piloted a methodology to assess the performance of outpatient treatment programs statewide based on information collected through ADAA's Substance Abuse Management Information System (SAMIS). TOPS-1 ranked 58 programs in the state among five tiers (quintiles) according to their performance along seven measures at discharge, based on SAMIS data for FY 1997. ADAA stressed that the study was only the first step in exploring the feasibility of using SAMJS (an administrative database) to conduct program evaluation research, and that the results cannot be interpreted as conclusive evidence about the performance of the participating programs.

Although TOPPS-1 controlled for the severity of client problems across programs (as measured by the ASI), it could not take into account the varied neighborhoods in which treatment participants lived. A treatment client returning to a Baltimore neighborhood characterized by poverty and open-air drug markets, for example, might find less support for staying in treatment than a client who goes home to a more stable neighborhood. Despite this potential disadvantage, several Baltimore programs were ranked among the best performing programs in the state; others were ranked in the middle, and some near the bottom. However, given the exploratory nature of the research and the limited value of the TOPPS-1 rankings themselves, ADAA and CESAR are following-up TOPPS-1 with a more in-depth study of the

Illegal Activity for Profit Declines Among Baltimore Treatment Participants



Johns Hopkins University, University of Maryland and Morgan State University, 2000

Baltimore programs that participated in the .-uriginal research. Known as Community Research on Effective Substance Abuse Treatment (CREST), the study will interview program administrators, staff and clients to \l.scertain which particular program characteristics are most associated with the strongest treatment outcomes and which are ,associated with weaker results.

TOPPS-2 is exploring on a statewide basis the feasibility of linking SAMIS treatment data to data in other public databases. SAMIS, the state's treatment information system, only records the last four digits of each patient's Social Security number. Baltimore's CIRMIS-which collects full Social Security numbers-will be used to help test whether the state's four-digit Social Security number and date of birth records will be adequate to make the linkages to other databases.

Clinical Trials Network

Bridging the gap between research and practice is crucial to achieving the full benefits of treatment. In 1998, the Institute of Medicine recommended that NIDA create a Clinical Trials Network (CTN) that would link community-based providers with researchers to test the effectiveness of promising new treatment techniques in real-world settings with diverse patient populations.

NIDA envisions a network consisting of 20 to 30 regional research centers; the first six regional centers were established in 1999, including a Mid-Atlantic Node anchored by Baltimore's Johns Hopkins University and by Virginia Commonwealth University. Six of the nine treatment programs participating in the Mid-Atlantic Node are located in Baltimore.

Within each CTN node, researchers team with treatment program directors to propose which promising techniques should be tested among community-based programs throughout the network. By spanning multiple sites, populations and geographic regions, CTN research findings will be more generalizable than is typically the case for research carried out in only one location and in a limited set of circumstances. Among the research concepts already approved for implementation is a test of the effectiveness of buprenorphene/naloxone as an alternative to other medication for short-term opioid detoxification. Successful detoxification in short-term outpatient settings and through mobile services would represent a major step forward, especially for cities such as Baltimore, where heroin is a major drug of abuse.

> Participation in NIOA's Clinical Trials Network by members of the BSAS Scientific Advisory Committee and local treatment programs ensures that the most **promiSing** treatment techniques from across the country will be **infused** into Baltimore's public system.

All Things Considered: Assessing Baltimore's Priorities and Progress

BSAS has described its top priorities to Maryland's Treatment Task Force as supporting the current treatment system, expanding treatment system capacity, and improving treatment outcomes through enhancement of treatment services. In light of the research that underscores adequate core services and performance evaluation, ready availability of treatment and comprehensive wrap-around services as keys to successful treatment, BSAS's priorities are in good order.

Baltimore, however, does not have the luxury of resources to fully address all of these priorities at the same time. Nor can BSAS afford to focus all of its resources in one area before moving on to the next. The scope and urgency of the city's drug problems require that BSAS move on all fronts at once, and BSAS has been doing so. Given the city's unmet demand for treatment services, capacity expansion cannot be delayed. Yet simply expanding capacity without shoring up the foundations of existing programs would be of limited benefit, as would enhancing treatment with wrap-around services without being able to evaluate whether such enhancements improve treatment outcomes.

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Despite the urgent need for greater **capacity,** BSAS has in practice adopted a more deliberate pace-so as not to neglect shoring up the existing system, and in order to begin the process of providing patients with the **comprehensive** range of high·quality services they need. This more deliberate pace of expansion, with close attention to the **quality** and comprehensiveness of services offered, should serve Baltimore well.

VII. looking to the Future

The persistence of America's drug problems, despite years of costly efforts, is persuading more and more people that new approaches are needed. One of the most promising approaches places fresh emphasis on treatment *for* individuals addicted to alcohol and drugs-and less reliance on the criminal justice system to provide solutions.

For many years, Drug Strategies has been conducting science-based, independent assessments of initiatives trying to reduce substance abuse. We have objectively examined dozens of policies and programs at the federal, state and local levels and produced comprehensive studies of drug abuse trends and policies in three cities and seven states In Baltimore-a city with one of the most serious drug problems in the United States-we have found the most comprehensive and committed effort yet to provide ready access to high-quality treatment for all who need it, regardless of ability to pay.

Baltimore has already made great strides toward this goal, but still has a considerable distance to go. Currently, the city can serve only a third of the estimated 60,000 residents who need treatment, and year after year of scarce resources has weakened many of the services that do exist. Ancillary "wrap-around" services (such as psychiatric care, childcare, job training and housing assistance) are seldom available, even though they enhance treatment success.

The challenge is daunting, but given the political support already mounted and the intellectual capital being invested, Drug Strategies believes that success in Baltimore is achievable--but only if the commitment to treatment demonstrated in recent years can be sustained.

Resources and Accountability

In recent years, Baltimore has markedly increased its investment in treatment and developed a sophisticated management information system capable of informing the city's funding decisions with data on treatment needs and program performance.

Building on Baltimore's recent progress will require a substantially greater commitment of resources by both the city and state governments. Close collaboration among city and state officials can provide the stability necessary to consolidate the gains already made and chart a long-term course to close the remaining. gaps in the city's publicly-funded treatment system. An important vehicle for deepening city-state collaboration already exists: A range of key city and state officials are ex-officio members of the Baltimore Substance Abuse Systems (BSAS) Board of Directors, including Baltimore's health commissioner and Maryland's lieutenant governor.

Treatment cannot achiev its **potential** in Baltimore without a significant, sustained **InCrease** in resources allocated to treatment programs that deliver the greatest **benefits.**

Increasing Treatment Funding

Treatment is now a fixture on Baltimore's political landscape, with wide and diverse citizen support. This support should be clearly reflected in the city's budget. Additional treatment funding from the Maryland state government will be more forthcoming if Baltimore is recognized to be making utmost use of its own resources. Increased support from the state is essential. In its December 1999 interim report, Maryland's Task Force to Study Increasing the Availability of Substance Abuse Programs (created by the General Assembly) found that insufficient treatment capacity throughout Maryland was primarily due to "insufficient funding for treatment by the State:' Planning and implementing substantial, predictable funding increases should be central to the city-state treatment collaboration.

The Task Force has been charged with proposing ways to increase treatment availability throughout the state.

Annapolis has already dedicated a portion of Maryland's tobacco settlement revenue to treatment, and should now tap the state's alcohol excise tax revenue for the same purpose. Maryland's alcohol excise tax rates are among the lowest in the nation; raising them would help discourage underage drinking *and* help the state government strengthen its funding support for treatment. Maryland's politically potent alcohol and hospitality industries can be expected to oppose any move to raise the state's excise taxes, so-as a first step-state lawmakers should earmark for treatment the $24 million in annual revenue generated by the beer, wine and liquor taxes at their current levels. Most importantly, new treatment resources should come directly from Maryland's general fund revenue, projected at $9.3 billion for fiscal year 2001. Research provides abundant evidence that investing in treatment makes good fiscal sense, because spending on treatment can be more than offset by reductions in government expenditures on health care and criminal justice.

Performance Evaluation and Accountability

Research and information systems are critical tools for targeting treatment funds most effectively, and Baltimore's management information system can help guide these critical decisions. Baltimore's Centralized Intake and Referral Management Information System (CIRMIS) and other data systems maintained by BSAS have already played a key role in significant city- and state-sponsored research projects. Preliminary findings from the Mayor's Initiative evaluation show steep drops among Baltimore treatment patients in drug use, illegal activity, and spending on drugs.

Baltimore has also invited ongoing external review of the city's treatment system by a prestigious group of treatment experts from around the country. In soliciting the suggestions of the Scientific Advisory Committee, BSAS is constantly measuring its own operations against high standards. In December 1999, the Committee submitted its first set of recommendations on how to improve BSAS treatment services and performance evaluation; BSAS has moved to incorporate the proposals in its operational plan for fiscal years 2000-2002.

Another significant asset for Baltimore is the involvement of Scientific Advisory Committee members and BSAS treatment programs in the Clinical Trials Network (CTN), a project run by the National Institute on Drug Abuse (NIDA) in which researchers and practitioners team up to test promising new treatment techniques in the demands of real-life settings. Involvement of some of Baltimore's leading researchers and treatment programs in the CTN will help Baltimore to adopt the most promising approaches to meet the city's pressing needs.

Pursuing Baltimore's Treatment Priorities

Baltimore is already pursing the priorities described below, and should continue to do so, as part of an ambitious, all-fronts treatmeni strategy. Implementing this strategy will require the city and the state to substantially increase funding for treatment services and for evaluation research.

dllll Fortify the current treatment system. Although expanding capacity to enable "treatment on requesf has become Baltimore's rallying cry, the city's leaders know that the quality of existing services must be enriched at the same time. Shoring up the current system will reinforce the foundation upon which the other priorities must be built.

dllll Expand the capacity of the treatment system. Treatment cannot work if those who need it cannot gain access in the first place. Baltimore's health commissioner estimates that achieving treatment on request will require serving about 40,000 people per year-double the current number.

dllll Enhance treatment through comprehensive wrap-around services. Patients receiving wrap-around services are more likely to remain in treatment, stay abstinent longer and improve personal functioning. Moreover, these improved outcomes outweigh the costs of providing wrap-around services. The BSAS Scientific Advisory Committee has recommended that Baltimore tighten the links between drug treatment and other services. BSAS has launched pilot programs to test the

feasibility of system-wide implementation of medical, mental health, vocational, housing and child'Care services for patients in BSAS programs,

oO!l Strengthen outreach to drug users with little or no history of participation in treatment. Baltimore will have only limited success if, despite improved services and expanded capacity, the treatment system fails to attract drug users who have had little experience with treatment. The Baltimore Needle Exchange Program (BNEP) is an effective bridge to treatment. New BNEP registrants have a high level of interest in entering treatment and, although BNEP referrals have more severe problems, they do as well in treatment as other patients. Other innovative outreach initiatives, such as Recovery in the Community and AID First, strengthen community support for addicts to enter and remain in treatment. Baltimore's_ plans to enhance treatment with comprehensive wrap-around services may also increase treatment's attraction for drug users who previously felt that treatment did not address their own primary concerns.

dill Educate the public about the benefits of an aggressive treatment strategy. Baltimore is forging a consensus about the importance of treatment in addressing the city's drug problems, but sustained support for investing in treatment cannot be taken for granted. The BSAS Scientific Advisory Committee recommended that BSAS engage in public education about treatment, and BSAS has hired an Advocacy and Public Information Coordinator to design and implement a public education strategy. This campaign should involve the mayor and other top city officials, and build on local research findings. The public education campaign should help Baltimore avoid falling into the trap of overselling treatment. If expectations are raised unrealistically high, then treatment's achievements will be greeted with disappointment rather than with continued support. For example, treatment can significantly reduce crime, but not eradicate it. And while a more effective treatment system is bound to save money and improve Baltimore's quality of life, the payoff will not appear overnight.

For decades, treatment has been underfunded, as policymakers at all levels have emphasized enforcement and incarceration rather than treatment and rehabilitation. Backed by research and bolstered by public support, Baltimore's efforts place it at the forefront of a growing movement to elevate treatment to a prominent role in the effort to reduce alcohol and drug addiction.

Every American has a stake in the outcome in Baltimore, If the city's efforts succeed, they can serve as models for the rest of the country, helping to reduce crime and the size of the U.S. prison population, contributing to urban revitalization, and enhancing the quality of life for all citizens.

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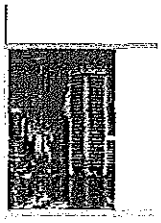
Appendix A



Baltimore's Social and Economic Indicators

Indicator	Baltimore	Maryland	United States
Per Capita Personal Income (1998)	$24,750	$30,557	$27,203
Unemployment Rate (1999)	7.1	3.5	4.2
Percentage of Residents in Poverty (1995)			
All Ages	24.0	9.2	13.8
Under Age 18	36.3	13.2	20.8
Percent Low Birth Weight Babies (1997)	14.1	8.7	7.6
Percent of Teens Who Are High School Dropouts (Ages 16-19) (19901	21.3	7.0	10.0
Crimes per 100,000 Residents (1998)			
Property Crime Rate	8,527	4,569	4,049
Violent Crime Rate	2,420	797	556
Percent Population Change, 1990-1999	-14.0	+8.2	+9.7

Socioeconomic and Drug-Related Indicators for Baltimore and Comparison Cities

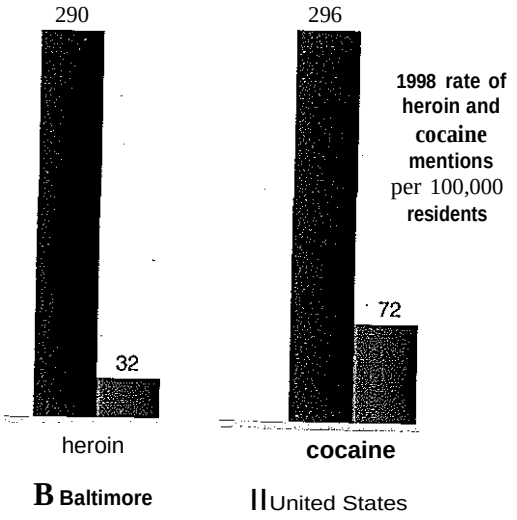
Indicator	Baltimore	Detrolt1	San Francisco	Washington, D.C.
Median Household Income (1995)	$25,918	$32,382	. $37,854	$33,682
Unemployment Rate (19991	7.1	7.0	3.0	6.3
Percent of Residents in Poverty (1995)				
All Ages	24.0	20.6	12.3	20.8
Under Age 18	36.3	34.8	20.6	36.8
Percent Low Birth Weight Babies (1997)	14.1	12.6	6.6	13.4
Percent of Teens Who Are High School Dropouts (Ages 16-19) (1990)	21.3	15.0	8.9	13.9
Crimes per 100,000 Residents (1998)				
Property Crime Rate	8,527	9,349	5,234	7,110
Violent Crime Rate	2,420	2,443	990	1,719
Socioeconomic Rankings2 {1996)				
Deprivation Index (1=best, 98=worst)	88	96	27	49
Child Welfare Index (1=best, 100=worst)	95	100	15	90
Population, 1999	632,681	965,084	746,777	519,000
Percent Population Change, 1990-1999	-14.0	-6.1	+3.2	-14.5
Emergency Room Drug Episodes per 100,000 Residents (1998)	592	409	569	303
Percent of Adult Arrestei>S Testing Positive for Illicit Drugs3 (1999)				
Males	69	65	n.a.	69
Females	75	69	n.a.	65
Number of Injection Drug Use-Related AIDS Cases Diagnosed, 1990-1998	5,691	1,400	3,274	3,100

1 For Detroit, data for all of Wayne County rather than the city itself are presented for the income, poverty and dropout indicators, and Detroit's number of IDU·related AIDS cases is an estimate based on the total number of AIDS cases in the city and the proportion of AIDS cases in the metropolitan area considered to be lOU-related.

2 The Deprivation Index ranks the largest U.S. cities based on poverty rate, educational attainment, unemployment rate, percent population that are non-English speakers, per capita income and crime rate. The Child Welfare Index ranks the same cities based on child poverty rate, births to teenage mothers, low birth weight babies, female headed households and infant mortality rates.

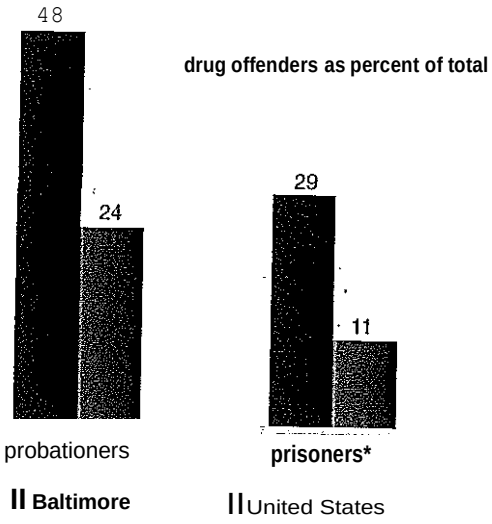
3 For Baltimore, data on arrestee drug test positives are from 1995; for Washington, D.C., data on female arrestees are from 1998.

Baltimore Leads the Nation in Emergency Room Heroin and Cocaine Mentions



Drug Abuse Warning Network, 1999

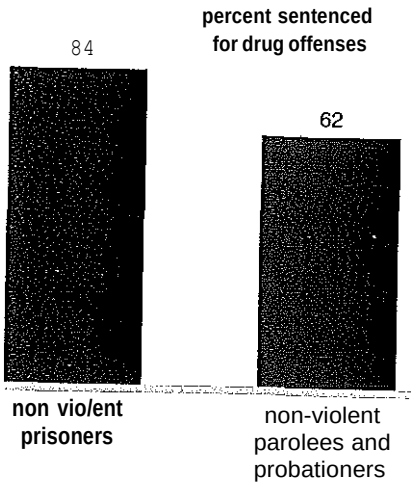
Baltimore Offenders More Likely to Comrnit Drug Crimes



sentenced to more than one year in state prison

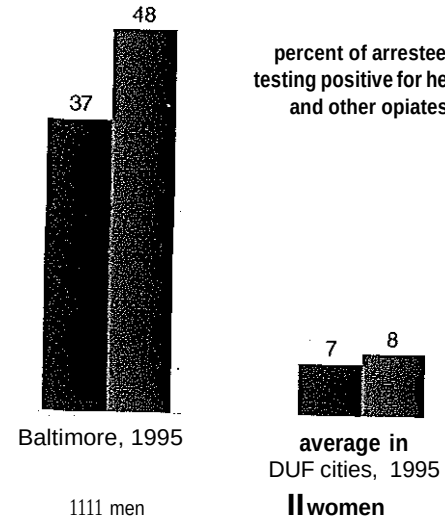
M&yland Department of Public Safety and Correctional Services, 2000
Federal Bureau of Justice Statistics, 1999

Drug Offenders Comprise the Majority of Baltimore's Non-Violent Prisoners, Parolees and Probationers



Maryland Department of Public Safety and Correctional Services, 2000

Baltimore Leads the Nation in Heroin Use Among Arrestees



1995 figures most recent available for Baltimore

Drug Use Forecasting Program, 1996
Center for Substance Abuse Research, 1998

Appendix B

Baltimore Substance Abuse Systems, Inc. (BSAS) Board of Directors

Steve Baron, .C.S.W.-C.
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Eric Wish, Ph.D.
Professor and Director, Center tor Substance Abuse Research, University of Maryland at College Park

George Woody, M.D.
Professor of Psychiatry, University of Pennsylvania School of Medicine

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Drug Strategies

Drug Strategies, a nonprofit research institute, promotes more effective approaches to the nation's drug problems and supports private and public initiatives that reduce the demand for drugs through prevention, education, treatment and law enforcement.

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Miriam & Peter Haas Fund

Horizon Foundation

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Henry J. Kaiser Family Foundation

Kansas Health Foundation

Joseph P. Kennedy, Jr. Foundation

John S. and James L. Knight Foundation

John D. and Catherine T. MacArthur Foundation

Open Society Institute

Spencer Foundation

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