Maryland Alcohol and Drug Abuse Administration

COMPASS

A Quarterly Newsletter For Maryland's Prevention, Intervention and Treatment Providers and Stakeholders

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The History of the ADAA - A New Administration Begins Its Journey

This is the final article in the year-long series on the history of the ADAA. The series was researched and written by Deborah Green and Iva Patel. Special thanks to Sunya Smith for her research assistance and to the countless others who have served the administrations and shared their stories.

The new 90's brought with it a host of challenges for the Alcohol and Drug Abuse Administration. Late in 1989 the administration unknowingly became embroiled in what was called the "Maryland State Games" scandal. "State Games" while not a function of the ADAA was a program of the Department of Health and Mental Hygiene designed to promote amateur athletics among the state's youth. The program, touted as a substance abuse prevention strategy, utilized monies designated for prevention activities. Unfortunately those appointed to head up the program were accused of mishandling the earmarked funds and several DHMH managers would resign.[1] While no one in the ADAA was directly connected with the scandal the investigation disrupted the new administration for much of that year.

The Budget Crisis

It wasn't all bad news. The budget appropriations for FY 1991 hit an all-time high of $66,537,560 and there were 76 funded positions.[2] The good news was not fated to last. According to the Baltimore Sun February 22, 1991, "The slumping economy and declining state tax receipts forced $75 million more in cuts to the 1991 budget, bolstering the likelihood of employee layoffs." Fiscal cuts, already being felt by state agencies, were now trickling deep into the pockets of both state and local government. ADAA was not to escape. The Baltimore Sun October 2, 1991 states, "Yesterday, Health Secretary Nelson J. Sabatini said grimly that the budget ax would force the closing of all adult residential treatment centers across Maryland that rely on state funds. These long-term treatment facilities included 10 programs like the Tuerk House. "More outpatient treatment, less institutional bureaucracy and better networking between public and private programs are needed to cope with the cutbacks," said ADAA Director H.R. "Rick" Sampson.[3]

Furloughs and More Closings

By December of that year, Governor William Donald Schaefer recommended, to the legislature, unpaid furloughs for state employees. It was the sixth round of budget cuts in 15 months. Having already trimmed $446 million from the state budget the Governor tasked the legislature with eliminating an additional $225 million. By January 1993, cuts had forced the closing of 16 state-funded or hospital-based centers, including three detox units in Baltimore, seven long-term care programs (Baltimore City, Anne Arundel, Carroll, Somerset and Worcester counties), three half-way houses, a residential center in southern Maryland, and an adolescent group home in Montgomery County. It also meant the close of the state Division of Correction's drug counseling program.[4]

At last, in early 1993 things began to get better. Secretary Sabatini said, " There are no further cuts planned through 1994. We're not increasing the addiction budget, but we are not cutting it either. Maybe we have turned the corner."[5] ADAA Director Rick Sampson summed up the damage to the treatment system by saying, "Outpatient services are practically everything we do now."[6] Overall, during the period between FY1991 and FY1993 the state's share of the overall substance abuse budget was dropped from $32.8 million to $22.2 million a loss of $10.6 million. Fortunately, increases in federal funds during the period made up nearly $6 million for the loss.[7]

Crack and Heroin Use on the Rise

While the capacity for treatment declined, the need for treatment was on the rise. *Trends and Patterns in Maryland's Alcohol and Drug Abuse Treatment* for FY 1993, states that "From FY 1989 to 1993 increases were seen in the percentages of clients smoking cocaine in the form of crack."

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Notes

[1] *The Sun, Baltimore MD; Dec., 19, 1990. Retrieved 11/20/2007 ; http://proquest.umi.com*

[2] *The Sun, Baltimore MD; November 13, 1991 Retrieved 11/20/2007; http://proquest.umi.com*

[3] *Archives of Maryland Online, Retrieved 11/15/ 2007; http://.msa.md.gov*

[4] *The Sun, Baltimore MD; Dec., 19, 1990. Retrieved 11/20/2007; http://proquest.umi.com*

[5, 6, 7] *The Sun, Baltimore MD; Jan., 25, 1993 Retrieved 11/20/2007; http://proquest.umi.com*

[8] *The Sun, Baltimore MD; Feb., 4, 2001 Retrieved 11/20/2007; http://proquest.umi.com*

The History of ADAA Data Collection...A Reminiscence

By ADAA Research Director, Bill Rusinko

Approaching my thirtieth year with ADAA/DAA, I wanted to reminisce about the history of data collection and analysis in the Administration. We may take for granted that we can sit at our desks, write a simple analysis program on the PC, submit it and have the output back on our screens in a matter of seconds.

Things were quite different when I came to the Drug Abuse Administration (DAA) in 1978. Doing any simple data analysis run involved creating and placing a stack of IBM punch cards in a card-reader in the bowels of the Health Department Death Star - 201 West Preston. Early on, all of the set-up information - formats, labels, recodes, etc. had to be submitted with the simplest job. The keypunch machine, card reader and printer for the whole Health Department were in an eight-by-twelve foot room. The cards for DAA jobs went into a queue with all of the other Health Department job cards – Medicaid, Kidney Disease, Vital Records, Personnel, etc., to be processed by the Annapolis Data Center (ADC) IBM mainframe. The output came back sporadically, eventually, in huge piles of green lined paper, and was separated into individual jobs by whoever happened to be there. You might say that confidentiality rules were a bit more lax back then. I don't know how the connections worked, but the printer couldn't print when the card reader was reading. At first we were able to stop the printer to read our cards, but this became a major annoyance for folks anxiously awaiting print jobs, so a rule was instituted that the printer took precedence – card decks had to be left stacked up in the reader awaiting a printing pause to be processed.

On days when Medicaid was printing reams of output it could take the entire day to find out you had a stupid little error in your program, a bad keypunch, or a card that had developed a torn chad. One of the dangers of leaving your card deck in the stack and returning to your office to do other work was sabotage - I never did this of course, but some practical jokers would make little changes in other administration's punch card programs without causing an error. It wasn't malicious, but it was always a good idea to review every page of your output before passing it on – you might have a title or a variable label in there a little more colorful than you intended.

The validity and utility of treatment data had always been a hallmark of DAA, and later ADAA. Much of the credit for this goes to the Federal Government and its support for the Client Oriented Data Acquisition Process (CODAP). CODAP is long gone, but its DNA can be easily traced through SAMIS, HATTS, HATS, SMART, and the current Federal TEDS. In fact, some of the non-surviving features of CODAP were well ahead of their time, but the technology didn't exist back then to support them. DAA implemented CODAP in 1976, but I recently came across what has to be the first CODAP manual, dated February, 1973, published by the National Institute of Mental Health. It was intended for "all Federal agencies directly financing drug abuse treatment and rehabilitation activities and all clinics and local administrations that receive Federal grants or contracts" for the delivery of drug treatment services. Rather than a population-based system, it featured a "Case Sample" intended to provide a "dynamic sensing mechanism, with longitudinal analysis characteristics." Far out. This ancestral CODAP also included a Census Report, Funding Summary, Progress Report, and since it was sample-based it could include 15 Client Relationship and Environment codes, 9 Approach codes, 9 Medication codes and 18 Disposition codes! Among the Approach categories was Abstinent Character Restructuring, which has a kind of Dr. Strangelove appeal. Only twelve substance problem codes were provided back then; we now have twenty.

In the mid eighties, it was the success of CODAP and DAA's emphasis on data editing and validation that enabled the agency to provide accurate data on trends, demographics, and the actual numbers of patients served. This led the Department to compel the data-poor Alcohol Control Administration (ACA) to use the system even before the two administrations were merged. The initial attempt to create a parallel CODAP system using the same forms for alcohol treatment but with different rules and meanings, a gesture to the fiercely independent ACA staff, was unsuccessful. Parenthetically, a similar attempt to adapt the CODAP forms to gambling treatment in the eighties was also a failure. It did, however, produce the memorable tongue-in-cheek replacement for the Discharge category, Completed Treatment, Some Drug Use - Still Gambling, but Winning.

In the early days of CODAP, every certified program's monthly paper Admission, Discharge and Client Flow reports were mailed to DAA, where a cursory edit verified counts and the forms were boxed up and hand-carried to the National Institute on Drug Abuse (NIDA) offices in Rockville. There they were data-entered and processed, and error reports were mailed to us for correction, along with ten-inch magnetic tapes that we could use for our analyses. In the late eighties Maryland was a pilot-state for mini-CODAP, a version of the processing software that was

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Director's Corner

Peter F. Luongo, PhD.

A Not So Distant Past

This year's final issue of the Compass concludes our history of the public substance abuse system in Maryland. Publishing this series presented some challenges.

Shortly after the editorial board decided to write the series, they began the research with a search for source documents. Documents were retrieved from the Maryland Archives and in some instances, from the dusty bookshelves of folks who had no idea anyone would be interested in this "old stuff." Making sense of it all and deciding what helped to tell the story and what did not, presented the writers and editor with an ongoing challenge.

The administrative and budget histories of the Alcoholism Control Administration (ACA), Drug Abuse Administration (DAA) and the ADAA were easy to track. Bureaucracies are good at that type of thing, so no problem there. It soon became apparent, however, if taken alone, the story that would have been produced from those documents would be a sterile, weirdly distorted picture of history.

The challenge was how to bring it to print while retaining the vibrancy and character of the time and people. One way to capture it was to talk to people who lived the history. A special feature of the series presents the memories of people who have been a part of the last 30 years of what is now the Alcohol and Drug Abuse Administration. Their reflections add a personal touch to the story that we wanted to tell. Each one serves as reminder that the story is always a personal one.

One take away lesson from the series maybe something like this; if you want to look to the future, be mindful, and respectful, of the past. Bill Rusinko's piece (p. 2, The History of ADAA Data Collection…A Reminiscence) reminds us that the push for data driven decision-making and actionable information is not new. He provides us with the remarkable progression of technology from collecting data on forms for central keypunching onto IBM punch cards and processing on mainframe computers, to today's web based electronic health record, SMART. But it is also the story of a tradition that uses the technology to assist in managing the information and to use the information to guide decisions. While that part has not always been so apparent through our history, it is important to acknowledge that the current focus on data driven decisions did not spring from the ether. There is a history here. Bill's reminiscence does the job of reminding us that we are not plowing new ground.

Two old hands still working with us from their days in the Alcoholism Control Administration, Bruce Meade and John Soffe provide some perspective for the youngsters. Bruce's early days at ACA in 1982 were as the DWI coordinator. That time marked the "discovery" of drunk driving and an impressive surge in arrest activity that shortly overwhelmed both the courts and alcoholism treatment programs. We still live with the results of the response. But, get ready we are about to "discover" impaired driving again. (See, Study of the DWI Treatment and Assessment Process in Maryland, @ *www.maryland-adaa.org)*. You would hope we learned something. Time will tell. John's piece will certainly bring smiles to old timers as he recounts some of the real characters who provided the original, "you can't make this up," stories.

There certainly is more history to write and make. We hope you look as much forward to being a part of it as we do here at ADAA.

Editor's note: The series, which ran in four editions of the Compass, will be published as a separate pamphlet in 2008 and posted to the ADAA website as a PDF.

ADAA is pleased to welcome its new Deputy Director Kathleen Rebbert-Franklin, LCSW-C. You can reach Kathy by email at Krebbert-Franklin@dhmh.state.md.us or by telephone at 410-402-8615.

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With the growing prevalence of HIV/AIDS the routes of administration of heroin were also changing. As injection decreased, inhalation of heroin significantly increased. Finally, with heightened media attention and stepped up prevention campaigns, crack use began declining across the country. Maryland was no exception.

Heroin mentions, however, continued to increase and would continue to rise for the remainder of the decade.[8] Now the dwindling attention to the HIV epidemic led to opioid users return to injection of the substance. *Trends and Patterns* 1999-2000 reports, "after a decline of heroin injectors for several years the trend towards IV administration is on the increase. With the reduction of residential treatment beds and community resistance to allow methadone treatment programs to open, treatment for heroin addicts was increasingly hard to find. "If you are a heroin addict who needs methadone or residential care, the wait could be months and months," said ADAA Director Rick Sampson.[9]

Methadone Controversy

Things would get worse. In early 1997 the state would cut-off funding to a large methadone clinic in mid-town Baltimore over discrepancies in billing Medicaid. This created an urgent rush to find slots for the more than 200 patients in treatment at the clinic. ADAA Director Thomas Davis said, "ADAA has obtained alternate placements for 105 of the patients in other methadone programs, another 80 will be placed in other programs within the next several weeks and the rest are staying in the original treatment at a cost of $7.50 per day.[10] Methadone treatment while historically showing positive results as a recovery method, was met with increased opposition both in the addiction field and most notably the community. "Not in my backyard," was the cry of communities who, fearing that the onslaught of addicts to their community would wreak havoc, fought tooth and nail to keep them away. "This kind of program has a tendency to bring people in from all over the place. It is very destabilizing," said the director of one community coalition, when asked about their response to a proposal to open a clinic in the area. Todd Rosendale, the ADAA policy chief, defended methadone treatment by saying, "It (methadone) is proven to be the most effective form of opioid treatment that exists."[11] ADAA would continue to support medication assisted treatment and push to fund and expand, when plausible, this treatment throughout the reminder of the decade.

The Sanctuary Project

The highly publicized Sanctuary Project was also an issue at the forefront of the ADAA in 1998. That year a group called Project Life filed a suit in Baltimore circuit court against Governor Parris Glendening and other state officials including the Alcohol and Drug Abuse Administration. The Sanctuary was a former Navy Hospital ship purchased by Project Life who intended to turn the vessel into a treatment program for women. The idea, a seemingly good one, ran aground when the Port Authority was not able to locate a safe berthing location that met the approval of all the parties involved. Several years of court decisions did not support the state's request to drop the suit but also did not force a decision on where the Sanctuary would berth. The idea of housing a treatment program on an decommissioned ship would die a slow death and along with it over a million dollars in state funds. [12]

TOPPS

In the late nineties ADAA collaborated with CSAT and CESAR to conduct the first Treatment Outcomes Performance Pilot Studies (TOPPS-I). Its purpose was to measure the performance of the publicly supported drug free outpatient treatment system. Programs were rated on specific performance measures which eventually became the criteria for State Substance Abuse Prevention and Treatment Block Grant Applications. The study created quite a stir when specific program ratings became public and programs with lower ratings feared they would be closed. While that did not occur, the TOPPS II study which that treatment improves employment and arrest outcomes, that were not ignored by the legislature.

The following year, under the direction of Lt. Governor Kathleen Kennedy Towsend, a task force to study Maryland's treatment system is convened. In 2001 they published their final report, *Blueprint for Change: Expanding Access to and Increasing the Effectiveness of Maryland's Drug and Alcohol Treatment System.* Shortly after the report was released ADAA Director Tom Davis was enlisted to head up a newly reconvened State Drug and Alcohol Abuse Council, vacating his position at the ADAA. Not long before this change, ADAA moved its headquarters from Preston Street to the Spring Grove Campus. The new space met growing needs, accommodating both administrative and OETAS training requirements.

The Last Five Years

Peter F. Luongo, Ph.D., joined the Administration as Director in 2001 and resurrected the annual ADAA Management Conference. A casualty of the budget crisis of the nineties the annual event brings together the leaders in the funded treatment community and noted experts throughout the country. Under his leadership, the next five years are focusing on the *Business of Addiction.* We move from HATTS, a web-enabled system, to SMART a web-based platform. (see; *The History of ADAA Data Collection...A Reminiscence* page 2). Accountability through data tracking makes its way from private industry to government. The ADAA is once again, like its DAA ancestor, among the first in the state to take up this challenge.

"What are we buying?" and "Is it worth it?" These have become the questions of the day. In ADAA's *Compass Newsletter - Fall 2005*, Dr. Luongo said, "Data, used by clinicians to improve patient care, data used by program managers to improve program outcomes, data used to improve system design and outcomes, and data to evaluate whether we just don't do enough or have enough of what we should do."

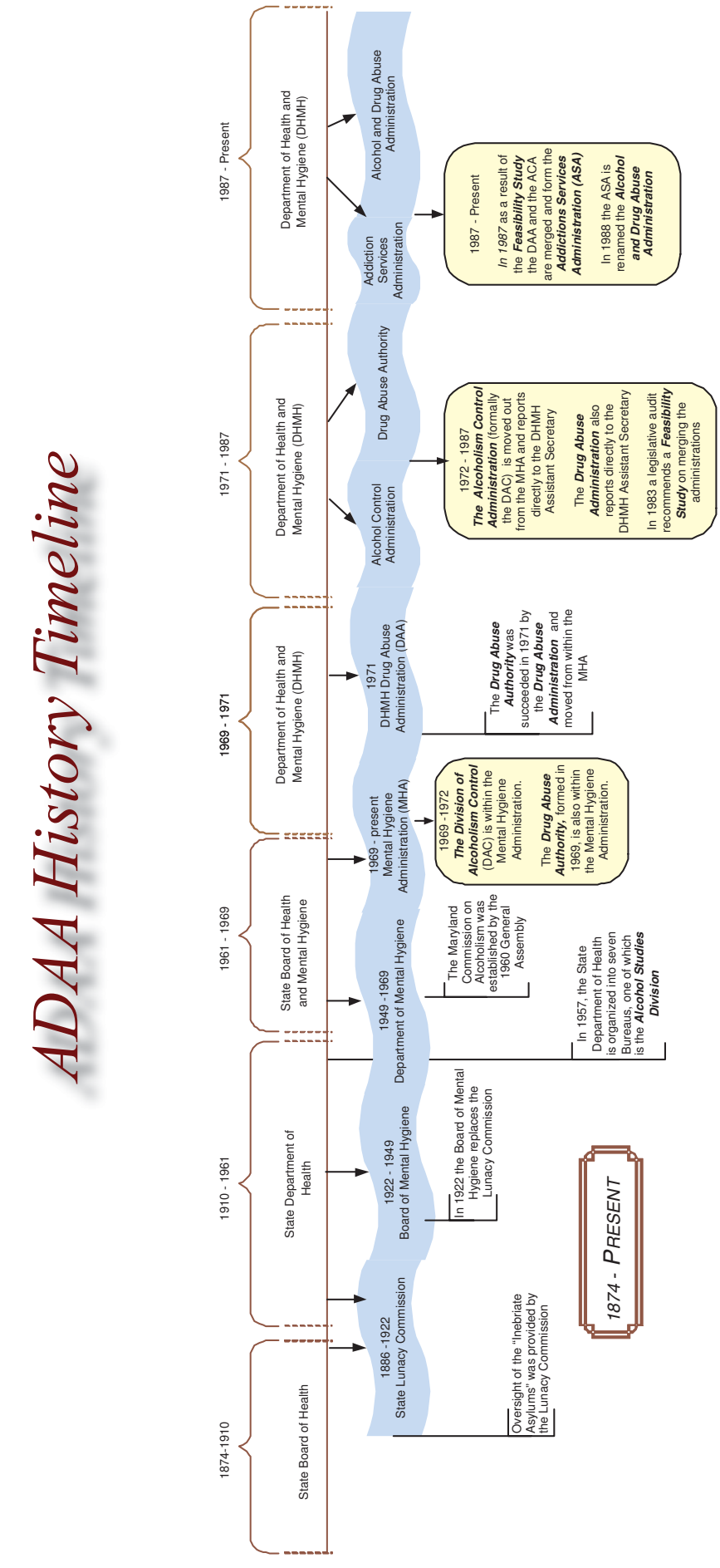
A fitting summary of where the Administration is today, and where we are headed.

Notes

[9] The Sun, Baltimore MD; Jan., 25, 1993 Retrieved 11/20/2007; http://proquest.umi.com.

[10, 11] The Sun, Baltimore MD; Apr., 3, 1997 Retrieved 11/20/2007; http://proquest.umi.com.

[12] The Sun, Baltimore MD; June., 10, 1997 Retrieved 11/20/2007; http://proquest.umi.com.


ADAA History Timeline
1874-1910
State Board of Health
1910 - 1961
State Department of Health
1886 -1922
State Lunacy Commission
Oversight of the "inebriate Asylums" was provided by the Lunacy Commission
1922 - 1949
Board of Mental Hygiene
In 1922 the Board of Mental Hygiene replaces the Lunacy Commission
1874 - PRESENT
1961 - 1969
State Board of Health and Mental Hygiene
1949 -1969
Department of Mental Hygiene
The Maryland Commission on Alcoholism was established by the 1960 General Assembly
In 1957, the State Department of Health is organized into seven Bureaus, one of which is the Alcohol Studies Division
1969 - 1971
Department of Health and Mental Hygiene (DHMH)
1969 - present
Mental Hygiene Administration (MHA)
1969 -1972
The Division of Alcoholism Control (DAC) is within the Mental Hygiene Administration.
The Drug Abuse Authority, formed in 1969, is also within the Mental Hygiene Administration.
1971
DHMH Drug Abuse Administration (DAA)
The Drug Abuse Authority was succeeded in 1971 by the Drug Abuse Administration and moved from within the MHA
1971 - 1987
Department of Health and Mental Hygiene (DHMH)
Alcohol Control Administration
Drug Abuse Authority
1972 - 1987
The Alcoholism Control Administration (formally the DAC) is moved out from the MHA and reports directly to the DHMH Assistant Secretary
The Drug Abuse Administration also reports directly to the DHMH Assistant Secretary
In 1983 a legislative audit recommends a Feasibility Study on merging the administrations
1987 - Present
Department of Health and Mental Hygiene (DHMH)
Addiction Services Administration
Alcohol and Drug Abuse Administration
1987 - Present
In 1987 as a result of the Feasibility Study the DAA and the ACA are merged and form the Addictions Services Administration (ASA)
In 1988 the ASA is renamed the Alcohol and Drug Abuse Administration

ADAA Memories

The Year is 1982...

By Bruce Meade
ADAA Eastern Shore Regional Services

The year is 1982, budget reductions are looming at the federal level, the state has a task force on drunk driving and I am considering transferring from a position as director of the health department's alcoholism program in Prince George's County to work at the state level for the Alcoholism Control Administration (ACA). I accept the position as the DWI coordinator for ACA in February of 1982, John Bland is the Director of ACA, Shirley Cooke is the Deputy Director and my immediate supervisor is Paul Gunning. Paul is an Assistant Director and is in charge of special programs such as DWI, women and adolescents.

The state legislature increased state funding to focus on DWI programming in 1982. In-court assessors and new counselor positions to handle the projected increase in DWI referrals for treatment in local health departments were put into place. The Division of Parole and Probation also received funding to hire drinking driver monitors. With the merger of the Alcoholism Control Administration, I became a member of the field services unit under the supervision initially of Brenda Gilliam-Jones and eventually Lil Berdit. Other supervisors in field services included John Soffe and Ray Miller. Since 1988, I have had the pleasure of being assigned to Maryland's nine counties first as a field representative and currently as regional services manager in the community services division under the direction of assistant director Eugenia Conolly.

With the progression of directors since 1982 we have moved from a paper data collection system to a computer data based collection system. Data collection has gone from NAPIS, CODAP, SAMIS and now SMART.

Probably the biggest change has been in the way we communicate among staff and programs. Written phone messages have been replaced by voice mail and e-mail. It has forced someone who has never had typing lessons to learn to be a novice typist.

ACA + DAA = ADAA

***by** Sunya L. Smith, ADAA Webmaster*
Information Services Division

I have worked for the Alcohol and Drug Abuse Administration (ADAA) since January 10, 1979. Working at ADAA has been an experience. I survived the freezes, the merger (ACA + DAA = ADAA), state games, budget cuts and the furloughs.

ADAA in 1979 was the Drug Abuse Administration (DAA) and dealt specifically with drug abuse issues. My employment began under the directorship of Richard L. Hamilton. I worked in the Prevention Division with James A. Dorsey, Chief, Plato Theophilus, Richard Burkhardt and Anthony Donadio. At that time, there was an annual prevention conference for junior and senior high school students to encourage them to stay away from drugs. There was also a Kool Kat Drug Abuse Prevention Program geared towards elementary school children. The Kool Kat Program was performed by Richard Burkhardt and Anthony Donadio with hand puppets. It was a great tool for deterring children from using drugs.

I also remember the Client Oriented Data Acquisition Process (CODAP) system. The CODAP forms had to be hand stamped. They were in triplicate,so the stamp had to be made deep enough to imprint all of the copies. The first copy was the admission form, the second was the discharge, and the third copy was kept by the program for their records. Data collection has come a long way. CODAP, SAMIS, HATS, and now SMART .

THE GOOD OLD DAYS

by Angela Chaffin
Management Services Division

My memories of the good old days at the Drug Abuse Administration are gratifying. Back then, Drug Abuse and Alcoholism Control were two separate administrations. In the 1987, they merged and became the Alcohol and Drug Abuse Administration. We were like a family. We worked together, played together and prayed together.

Long before computers the good old typewriter was the thing. When we got electric typewriters we thought we were on the cutting-edge of technology. It was a friendly place to work and I think everyone knew one another in the main building at 201 W. Preston Street.

Yes, how wonderful it was and how blessed I am to have been associated with the old timers of the Alcohol and Drug Abuse Administration.

Angela Chafin started working for the Drug Abuse Administration in 1974 and has thirty -three years of service to the administration

.....More ADAA Memories

My Stay at ADAA

By Vickie Kaneko
ADAA Chief of Information Services

When I came to ADAA in February of 1982 the then Alcohol Control Administration (ACA) and Drug Abuse Administration (DAA) were starting the process of combining the two administrations. I was hired by Richard Proctor to monitor the programs that were receiving Title 20 monies. Mr. Joseph Myers and I would do on-site visits to programs to review the client records.

After about a year or so the Title 20 monies were running out. The Administration found us other jobs in the DAA. I was placed in the Management Information Services (MIS) Unit (MIS) under the leadership of Eugene Farrell. The MIS Unit was one of the first units to merge ACA and DAA functions. At the time we were collecting data under CODAP (the federal Client Oriented Data Acquisition Process). We went through many revisions of the form to accommodate the admission/discharge reporting requirements of the certified alcohol programs. Back then, data once received into the MIS unit was processed by hand stamping with a sequential number. Each form was reviewed for errors, batched and sent to the DHMH data entry department. The DHMH programmers had to revise the screens and the programming each and every time we changed the form.

In about 1998 we took a big leap into the future by revising the form and developing an electronic version of the Substance Abuse Management Information System (SAMIS), called SAMIS PC. When we first promoted it we had many grumblings from the field. Eventually the programs started to really like it when they realized they could conduct their own data analysis. It was also during this time the Baltimore City Substance Abuse System (BSAS) initiated their own electronic data collection called CIRMIS.

In 2000 we moved from SAMIS PC to the University of Maryland's Automated Tracking System (HATS). This was an integrated management information system that functioned at the client (services), management (efficiency) and system (effectiveness) levels. Once again there were many complaints about the new system but once everyone got on board it started to be everyone's friend. This time the data was collected electronically and reports could still be generated. This partnership with the University of Maryland brought together, for the first time, trainers from both the software side and the data collection side.

In February of 2006, we once again changed our electronic data collection to a web-based system called SMART (State of Maryland Automated Record Tracking). Part of a federal system called (WITS), his system has a comprehensive clinical data collection system. Counselors can enter their treatment plans, their progress notes and track their urinalysis results. It also has a billing component. As of today we have most of our funded programs reporting on this system. Now the system is being used by the Drug Courts, Parole and Probation, treatment programs, TCA, the assessors all who are engaged in providing a seamless system for the alcohol and drug clients.

DOWN MEMORY LANE

by John Soffe, LCPC, LCADC
Community Services Division

When asked to write an article about the "old days", my mind started to reminisce about the personalities we have come to know and admire and people like Dr. Max Wismen. I can still see him in the lobby of the Ocean City hotel at the annual conference, pipe in hand, with his disciples hanging on every word of his worldwide escapades. And who could forget "Chip" Silverman and his office replete with the rogues gallery of dead rock and roll stars. Not only was he the Director of DAA but held the honor of being the initial Director of the combined Drug and Alcohol Administration. Surely John Bland and Shirley Cooke will not be forgotten for their pioneering work with the Alcoholism Control Administration.

Let us not forget our first two colleagues sent by the Secretary to work with the courts, Everett Wilson and Sandra Yorke. They would be the first of many to spend their days with the Criminal Justice System. When we think of "personalities" could we ever forget Bill Lowery, truly a man for all seasons. For me, he held a special place since it was Bill who hired me.

Then there were the other characters like Lil Berdit with her field mice; Jo Riley Kauer and the sweet melodious tones; Todd Rosendale for his never to be forgotten work on COMAR; Shane Dennis and his creative budgets; Gloria Merriam and Sheila Litzky for the spark they gave to services to women in addiction; and Burt D'Lugoff for the "humor" he spread on the old fourth floor. For me, this is the start of the ADAA Hall of Fame.

The ADAA Old Timers

By Bonita Ciurca
ADAA Tobacco Compliance Chief

Being a part of the "old timers" of ADAA is an honor. I knew when I came to the Drug Abuse Administration prior to the merger with the Alcohol Control Administration in 1983 that I was going to be a part of a family, have many opportunities for personal growth and above all be a part of an organization that really cares about people with addictions. Through all of the changes ADAA has moved forward in the fields of research, technology and social policy to find better ways to serve the addicted populations.One thing that remains constant is ADAA's dedication to the health of the citizens of Maryland.

An ADAA/DAA Memory

By Steve Goldklang, Former ADAA Assistant Director

REMEMBER WHEN

Steve Goldklang began working for the Drug Abuse Administration in 1975. He retired from state service in 2001 and presently works in the private sector.

In the late summer of 1989 (or 1990---sorry I forgot which year) Second Genesis had opened its expanded treatment facility at Crownsville. To celebrate this important happening, the program decided to have a Grand Opening celebration with a variety of dignities and addiction treatment professionals in attendance. The Grand Opening also coincided with the national September celebration of Addiction Treatment Month.

One of the Second Genesis Board members was Mrs. Elliot Richardson, whose husband was a prominent member of both the Nixon and Ford cabinets. Mrs. Richardson used her political pull to get her good friend, then First Lady Barbara Bush to attend the event. Of course, ADAA's Director, Rick Sampson was invited as was I. DHMH Secretary, Adele Wilzack also made it a point to show her support for ADAA-funded programs like Second Genesis by attending as well.

The ceremony was held outdoors, outside of the Second Genesis building. A podium and row of chairs for dignitaries was set up, as were several rows of chairs for the audience in attendance. Seated next to each other in the front row were Mrs. Bush (with a contingent of Secret Service men nearby) and Secretary Wilzack. Because of Mrs. Bush's presence there was also a contingent of TV, radio and other press present. One of the concluding speakers was a graduate of Second Genesis, who was obviously scared to death to be speaking before the First Lady, the Secretary of Health & Mental Hygiene, and all of the other big shots who were present.

Despite his nervousness, the young man gave a powerful and heartfelt speech about how the program saved his life. Although throughout the years I had heard similar "testimony" from recovering addicts, this young man's talk was so moving that I, along with the rest of the audience and the dignitaries in the front row were, felt my eyes starting to tear up. When he was done, the entire audience erupted in huge applause and cheers, as he was seated in between Mrs. Bush and Adele, who each grabbed a hand of his and held it tightly throughout the rest of the ceremony.

Needless to say, this event got tremendous press coverage for Second Genesis and ADAA. Later that day, when I returned to our office on Preston Street, I got a message that WMAR TV wanted someone to come down to the station ASAP to do an interview as part of their story on Treatment Works Month and the Second Genesis event. Rick was not back in Baltimore to do this, so I dashed over to meet with (I think it was) Sally Thorner to do the interview, which was broadcast that evening.

All in all, that was a very memorable day for me, particularly because the message was really getting out that our addiction treatment network and programs were making a positive impact on the lives of a lot of people throughout the State.

Buprenorphine Information

The ADAA Web site (*www.maryland-adaa.org*) is adding a Buprenorphine information and resource page. The site will contain links to valuable resources such as SAMHSA's Tip 40 - *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction* and Tip 43 M*edication Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* ADAA guidelines for diversion control plans and considerations for establishing a Buprenorphine project will be posted for view and download. A *Powerpoint* presentation titled "Buprenorphine Treatment & Delivery of Care," addresses basic information regarding the history of Buprenorphine, its chemical principles, the treatment demand and specifics about establishing safe and effective treatment protocols. Links to resources such as physician locators, counselor education, consumer education, and research will be added and updated weekly.

In addition a *Frequently Asked Questions* page, specific to Buprenorphine, will be posted. The ADAA *Forums* feature on the Web will be available for virtual discussion of the critical issues and challenges involved in incorporating Buprenorphine treatment into established care delivery systems. You can post a discussion topic or participate in a discussion thread by accessing *ADAA Forums* in the *Site Utilities* menu. *Forum* participation requires a web log-in. If you do not have a log-in or have forgotten your user name and password send an e-mail to *adaainfo@dhmh.state.md.us* and request the information.

A Reminiscence Continued from page 2

installed on the ADC mainframe. This had the advantage of bringing most of the process under our control, and we were able to add some data elements of our own, such as Client Residence. But there was a major drawback – somebody had to keypunch all those Admissions, Discharges and Client Flows. This task fell to the Health Department Data Entry squadron in the basement. Sometimes we wished we could do it ourselves when we fell into a backlog with other administrations and never knew when our reports might get keyed. But a visit to the Data Entry room would disabuse us of any notion of that – thirty people chained to their consoles – eyes glued to the documents -complete silence but for the ceaseless tapping of computer keys melding into a collective hum – like a scene from a science fiction horror movie.

Actually, there was a period of time when one particular keypuncher was assigned to doing our forms, and she became adept at catching errors before they even hit the software! Maryland was a pilot state for an early Federal attempt at optically scanning CODAP forms, and we later tried our own character-reading system, but we could never achieve an acceptable level of precision to replace data keying.

The Substance Abuse Management Information System (SAMIS) was implemented in the late eighties, correcting everything that was wrong with CODAP. Not really. But, some of the changes were long overdue. We were still on paper, but admissions and discharges were put on a single sheet with a unique serial number – no more unmatched discharges! A unique client identifier was added, and the story of that is too long for this piece. Many of the elements and the basic structure of CODAP were retained, which proved prescient when the Feds decided to get back into mandating state data collection with the Treatment Episode Data Set (TEDS).

Maryland was well ahead of the game, and was recognized as one of the states with the most accurate and complete data, a result of the hard work by the reporting counselors and other program staff and the ADAA MIS. Based on the quality of its data Maryland was again selected as a pilot state, this time for TEDS discharge reporting. Eventually we developed a PC-based SAMIS software that providers could use to submit data electronically, and began

REMEMBER WHEN

OETAS

by Linda Oney
OETAS Director

In 1978, I interviewed for and was offered a position with the Office of Education and Training for Addiction Services (OETAS). After the fact, I learned that the director, Ludwig (Lud to his friends) Lankford had first offered the position to another candidate who decided against taking the job. It seems unreal now but at that time there were two separate administrations that dealt with substance abuse and addictions. There was the Alcohol Control Administration for alcohol treatment and prevention and then there was the Drug Abuse Administration for all other drug related substance abuse issues.

The Drug Abuse Administration was created in response to the increased drug use and abuse of the '70's'. In those days there were no requirements for becoming a counselor. Many people entered the field as a result of their own recovery and a desire to help others. The role of OETAS was to turn them into competent professional counselors. Many of the counselors of that period have become the managers of today. It was an exciting time.

The Office of Education and Training was the first unit to deal with both alcohol and drug addiction as a single entity. We brought counselors from both disciplines together in a classroom setting to discuss "substance abuse counseling." To say the least, there were some lively discussions occurring as a result of the different perspectives and treatment philosophies.

Now, with the certification and licensing requirements for addiction counselors in place, OETAS' role has changed. We provide more advanced courses, building upon the skills and knowledge already acquired in academic settings.

I have witnessed many advances in our field and I'm proud to be associated with the many counselors who make a real difference in the lives of their patients. I will always be grateful to that unknown person who refused the position with OETAS. Their refusal has allowed me the opportunity to work with great people and to have a rewarding career.

Look for the Spring 2008
OETAS Catalog
Coming to the ADAA Web Site
in January
www.maryland-adaa.org
For More Information Contact
OETAS at
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