The University of Georgia

CLINICAL TRIALS NETWORK
SUMMARY & COMPARISON REPORT

National Treatment Center Study
Summary Report No. 10

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INSTITUTE FOR BEHAVIORAL RESEARCH
Center for Research on Behavioral Health and Human Services Delivery

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National Treatment Center Study Investigators

Principal Investigator:	Paul M. Roman, Ph.D. University of Georgia
Co-Investigators:	J. Aaron Johnson, Ph.D. Lori Ducharme, Ph.D. Hannah Knudsen, Ph.D. University of Georgia
Report Compiled by:	Meredith P. Huey, M.A. University of Georgia

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Additional copies of this report may be obtained free of charge by contacting the project office. The report is also available for download on the study's website.

National Treatment Center Study
Institute for Behavioral Research
101 Barrow Hall
University of Georgia
Athens, GA 30602-2401
Phone: (800) 742-0694
Fax: (706) 542-6436
Email: NTCS@uga.edu
Website: www.uga.edu/ntcs

Overview of the National Treatment Center Study

The National Treatment Center Study (NTCS) is a family of projects designed to document and track changes in the organization, structure, staffing, and service delivery patterns of substance abuse treatment programs throughout the U.S. The NTCS is headquartered at the University of Georgia's Institute for Behavioral Research.

The NTCS currently consists of 5 separate national samples of substance abuse treatment providers:

- NIDA Clinical Trials Network community treatment programs (CTPs)
- Publicly Funded Treatment Centers
- Privately Funded Treatment Centers
- Therapeutic Communities (TCs)
- Opioid Treatment Programs

This report is based on data from a sample of 240 community based treatment programs participating in NIDA's Clinical Trials Network (CTN). These data were collected via face-to-face interviews conducted in 2003-2004. Of particular interest are patterns of clinical service delivery, including the use of evidence-based practices, and the organizational structure of the CTPs.

It is important to note how CTPs were identified within the CTN for this study, as this may differ from definitions used by the CTN itself or by other researchers. At the time of data collection, there were 17 nodes in the CTN and all nodes were involved in the study. Each node consisted of a university-based RRTC (regional research and training center) and multiple community-based treatment organizations. The node coordinator of each RRTC was contacted and asked to verify the name and location of the CTPs within the node. Representatives from those CTPs were then contacted via telephone for a brief screening interview. The primary goal of this brief interview was to ascertain the basic structure of the CTP in terms of how many autonomous units were embedded within the organization. *For the purpose of the study, we defined a CTP as a treatment unit that had a separate administrator who possessed autonomy over that unit's budget.* It is important to note that this is not necessarily the same as a service delivery unit, a "site," or an organization. For example, some CTPs have separate administrative lines for each modality, or level of care, or physical location. Other CTPs operate an entire organization as a single administrative unit. Our definition reflected the realities of day-to-day business operations in each CTP.

Three other criteria determined eligibility for inclusion of CTPs in the NTCS. First, the administrative unit as defined by the CTP had to deliver some form of substance abuse detoxification or treatment services. Units that were

primarily organized around assessment, corrections, or prevention services were excluded from the study. In addition, the administrative unit had to have a realistic expectation of participating in a CTN trial at some point. Actual participation in a trial was *not* a requirement for the study, but occasionally units were identified that the CTP indicated had no realistic expectation of being involved in CTN activities, and they were excluded from the study to conserve project resources. Finally, the CTN itself is an evolving organizational structure. CTPs have joined and exited the CTN over time. Only CTPs that were formally affiliated with the original 17 nodes at the time of our interviews were eligible for study. This means that some recent additions to the original nodes, as well as all CTPs in the new Texas and Appalachia nodes, are not represented in this report.

Using our definition, we collected data from 240 administrative units affiliated with 104 CTN-affiliated organizations in the 17 nodes. In all, 61 of the 104 organizations were structured as a single administrative unit. The remaining 43 organizations were structured with a total of 179 administrative units. The unit of analysis was defined in this way so that valid comparisons could be made with our nationally representative samples of non-CTN facilities. (For simplicity, we refer to these 240 units as "CTPs" throughout this report.)

The 240 participating CTPs represented a 95.41% response rate to our on-site interviews. More detail on the data collection process is provided in the "Study and Sample Design" section at the end of this report (see pg. 51).

The purpose of this report is twofold. First, we report summary statistics on community-based treatment programs (CTPs) participating in NIDA's Clinical Trials Network, and consider variations in services delivered within the CTN by treatment modality. The second aim of this report is to compare these CTPs to nationally representative samples of publicly funded and privately funded treatment organizations. The purpose of these comparisons is to understand the ways in which treatment units affiliated with the CTN are significantly different or similar to treatment units outside the CTN. (Further detail regarding the design and procedures of the non-CTN samples are available at the end of this report in the section entitled, "Study and Sample Design.")

The project is continuing to collect longitudinal data from these CTPs, which will address an even larger research goal: to identify whether exposure to clinical trials and CTN activities significantly enhances a program's likelihood of adopting evidence-based practices. This latter goal will be addressed in a later report.

I. CTN SUMMARY REPORT

This section of the report summarizes findings about the organizational structure and clinical services of CTPs in the CTN (n=240) in 2003-2004. We describe overall clinical services in terms of levels of care offered and use of evidence-based practices and make comparisons between types of CTPs within the CTN.

A. Clinical Service Delivery

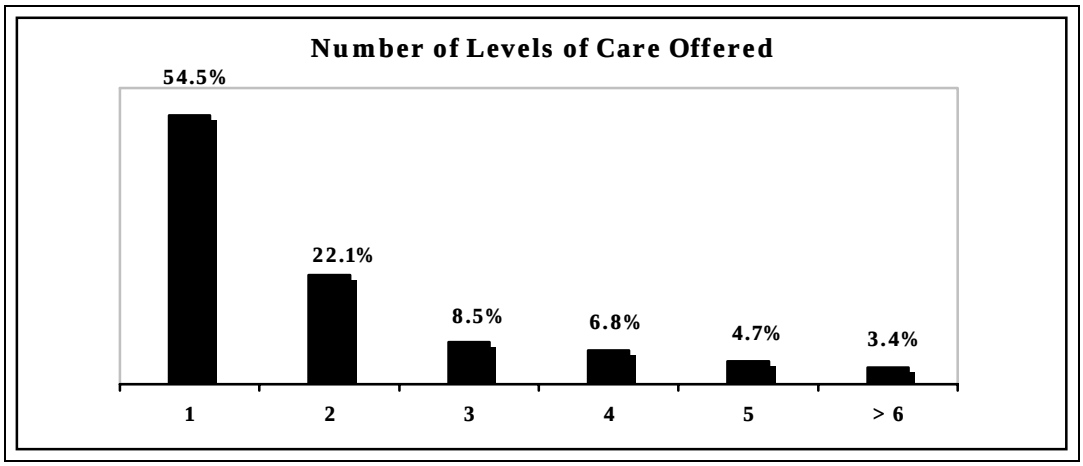
Levels of Care

Administrators reported the level(s) of care available in each participating CTP. The availability of detoxification, inpatient and residential, and various outpatient services were measured along with the availability of adult and adolescent inpatient psychiatric services.

Percentage of CTPs Offering Level of Care*	
Detoxification	
Inpatient Detoxification	18.6%
Outpatient Detoxification	10.6%
24-Hour Care	
Residential (>28 days)	31.8%
Inpatient Adult Chemical Dependency (<28 days)	12.3%
Inpatient Adolescent Chem. Dep. (<28 days)	1.3%
Adult Psychiatric (Inpatient)	3.4%
Adolescent Psychiatric (Inpatient)	1.7%
Outpatient Drug-Free (OPDF)**	
Partial Hospitalization (at least 20 hours/week)	7.7%
Intensive Outpatient (9 - 20 hours/week)	38.1%
Outpatient (<9 hours/week)	49.0%
Methadone Outpatient	24.5%
Aftercare	40.9%

*NOTE: Percentages do not add to 100% as CTPs may offer more than one level of care.
**NOTE: "Outpatient drug free" is used to denote outpatient units that are not primarily methadone maintenance or opioid treatment programs. It is not meant to imply that these facilities do not utilize other medications in the course of treatment.

The vast majority of CTPs provided one or two levels of care.



The following table presents the percentage of CTPs offering each level of care. CTPs are classified into one of five distinct categories based on the levels of care they offer. These data provide a context for comparisons in this section of the report.

Percentage of CTPs by Modality

Residential (n=49)	IP-Only (n=22)	OPDF-Only (n=76)	Mixed IP/OPDF (n=35)	Methadone (n=58)
20.3%	9.1%	31.5%	14.5%	24.5%

- CTPs in the residential category offer only non-hospital residential services (greater than 28 days). Included in this category are 31 CTPs whose services are based on a therapeutic community (TC) model.
- IP-only CTPs are defined as programs that only offered inpatient services (28 days or less) such as IP-detox, IP-chemical dependency services, and IP-psychiatric services.
- CTPs in the OPDF-only category are programs offering any of a range of drug-free outpatient levels of care including OP-detox, partial hospitalization, intensive outpatient, and outpatient. Some CTPs offered a single outpatient level of care while others had multiple outpatient programs. OPDF-only CTPs represented the largest modality in this sample.
- The Mixed IP/OPDF category includes CTPs offering a combination of OPDF with either residential or inpatient services.
- This sample of CTPs included 58 methadone units.

Evidence-Based Practices

Standardized Addiction Measures

Administrators were asked whether standardized addiction measures such as the American Society of Addiction Medicine's Patient Placement Criteria (ASAM PPC) and/or the Addiction Severity Index (ASI) were utilized at intake to assess the client's level of addiction and to match the client with the appropriate care.

A substantial proportion of the sampled CTPs reported using standardized addiction measures. There were no significant differences across modalities.

Percentage of CTPs Using Standardized Intake/Assessment Measures	
Use any Standardized Addiction Measures	86%
Use ASAM PPC	67%
Use ASI	61%

Medical and Psychiatric Assessments

Mean Percentage Of Clients Receiving Medical and Psychiatric Assessments at Intake

	Residential	IP-Only	OPDF-Only	Mixed IP/OPDF	Methadone	All CTPs
Psychiatric Assessments***	39.4%	26.8%	15.9%	23.9%	11.6%	21.6%
Physicals***	68.1%	81.2%	13.5%	42.6%	92.4%	53.8%

***Between-group differences significant at $p < .001$.

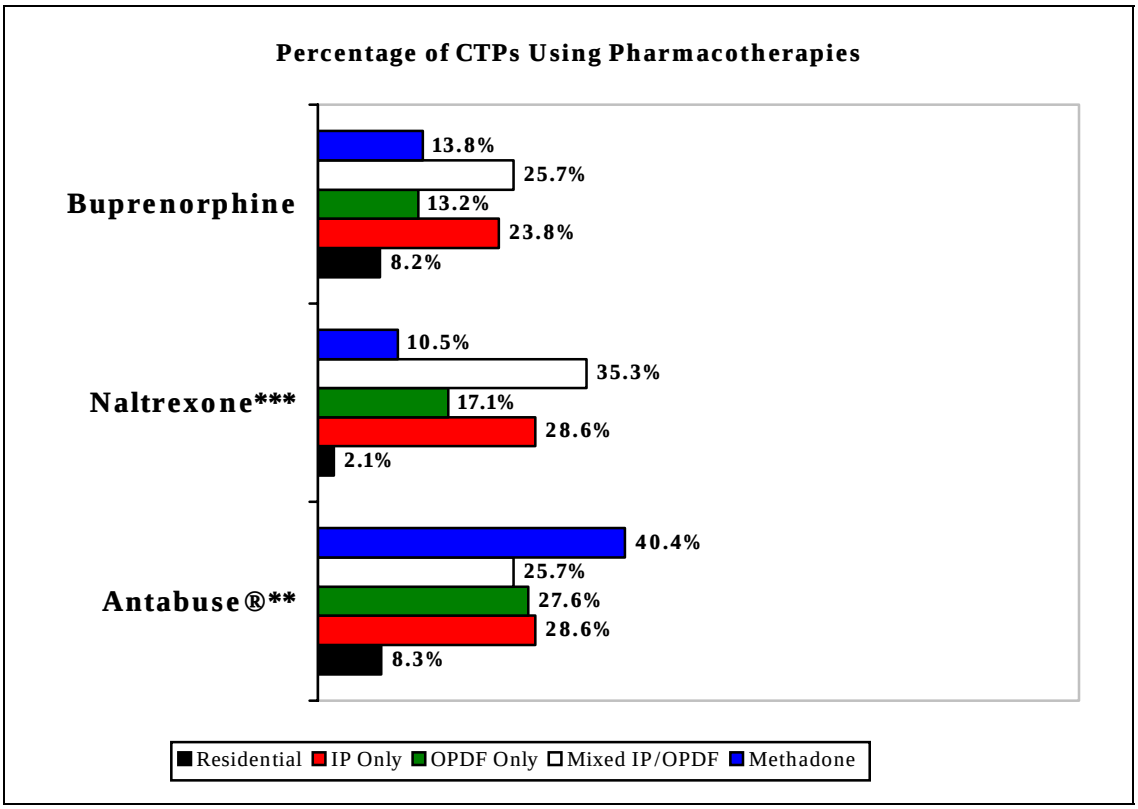
In addition to standardized addiction measures, CTPs were also asked if clients received psychiatric assessments and/or physical exams during the intake process. Residential CTPs were significantly more likely than OPDF-only units to conduct psychiatric assessments ($p < .01$).

Residential and IP-only units were significantly more likely to conduct physicals than OPDF-only ($p < .001$) and mixed IP/OPDF CTPs ($p < .05$). In addition, CTPs offering mixed IP/OPDF were significantly more likely to conduct physicals than OPDF-only units ($p < .001$). Availability of physical exams was greatest in methadone units.

Pharmacological and Behavioral Therapies

Administrators were asked whether or not specific pharmacological and/or behavioral therapies were currently used at their CTP. Most of the therapies included in the NTCS interview have been identified as "evidence-based practices" by the National Institute on Drug Abuse (*Principles of Drug Abuse Treatment* 2000). This list of practices was expanded to include other therapies for which there is some evidence of improved treatment outcomes.

Pharmacotherapies



**Between-group differences significant at $p < .01$.
***Between-group differences significant at $p < .001$.

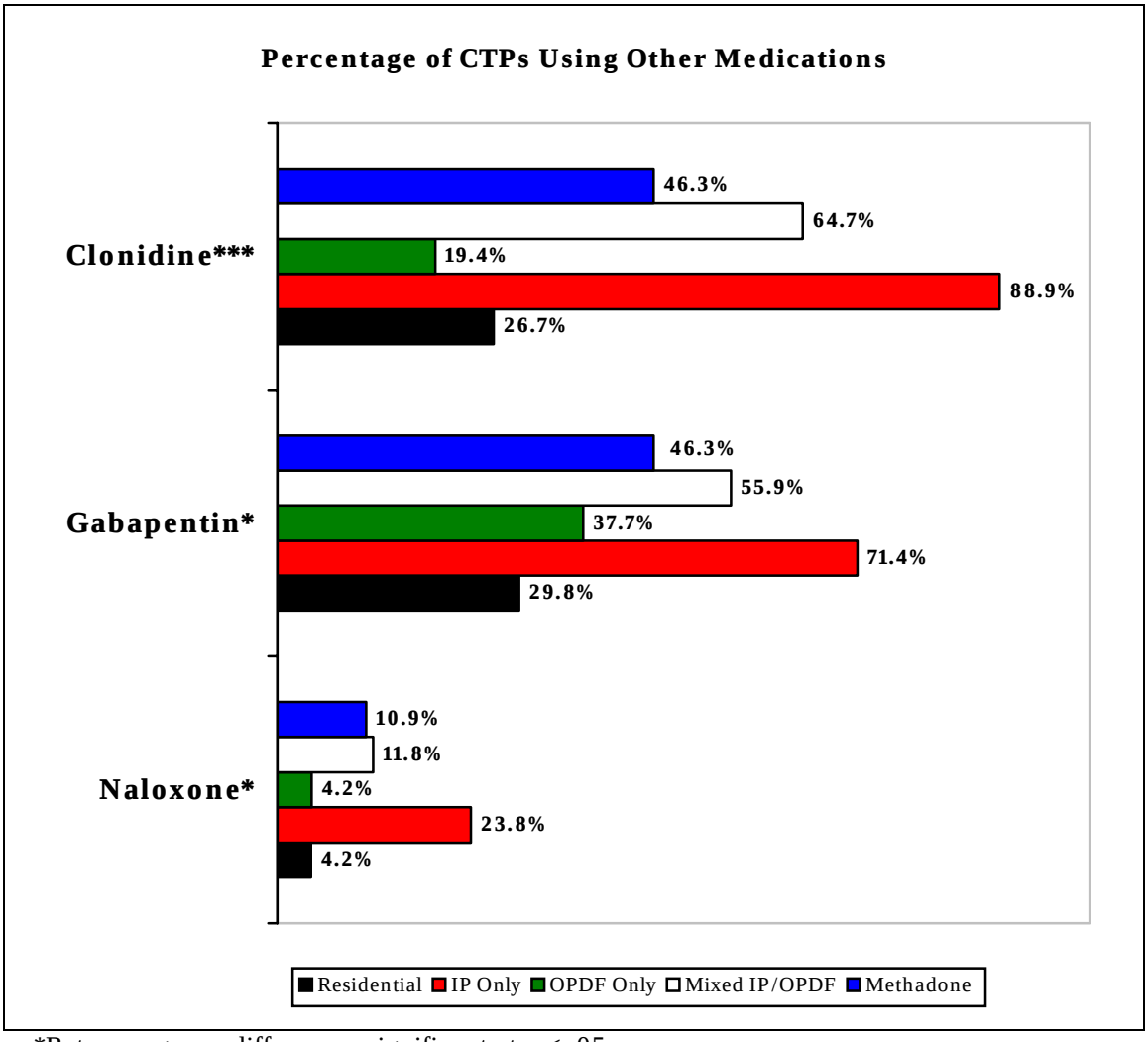
Overall, Antabuse® (26.6%) was the most commonly used pharmacotherapy followed by naltrexone (16.1%) and buprenorphine (15.1%).

Across modalities, residential CTPs were significantly less likely to use Antabuse® than methadone units ($p < .01$), and significantly less likely to use Naltrexone than in IP-only ($p < .05$) and mixed IP/OPDF units ($p < .001$). In addition, mixed IP/OPDF units were significantly more likely to use naltrexone than methadone units ($p < .05$).

CTPs were also asked about the use of a variety of other medications. According to administrators, clonidine, gabapentin, and naloxone were used in 39.9%, 44.0%, and 8.3% of CTPs respectively.

Comparisons across modalities revealed significant differences between IP-only and other units in the use of clonidine ($p < .001$), gabapentin ($p < .05$), and naloxone ($p < .05$), with IP-only CTPs significantly more likely to report using these medications.

In addition, mixed IP/OPDF CTPs were significantly more likely to use clonidine than both OPDF-only ($p < .001$) and residential units ($p < .01$).



*Between-group differences significant at $p < .05$.
**Between-group differences significant at $p < .01$.
***Between-group differences significant at $p < .001$.

Behavioral Therapies

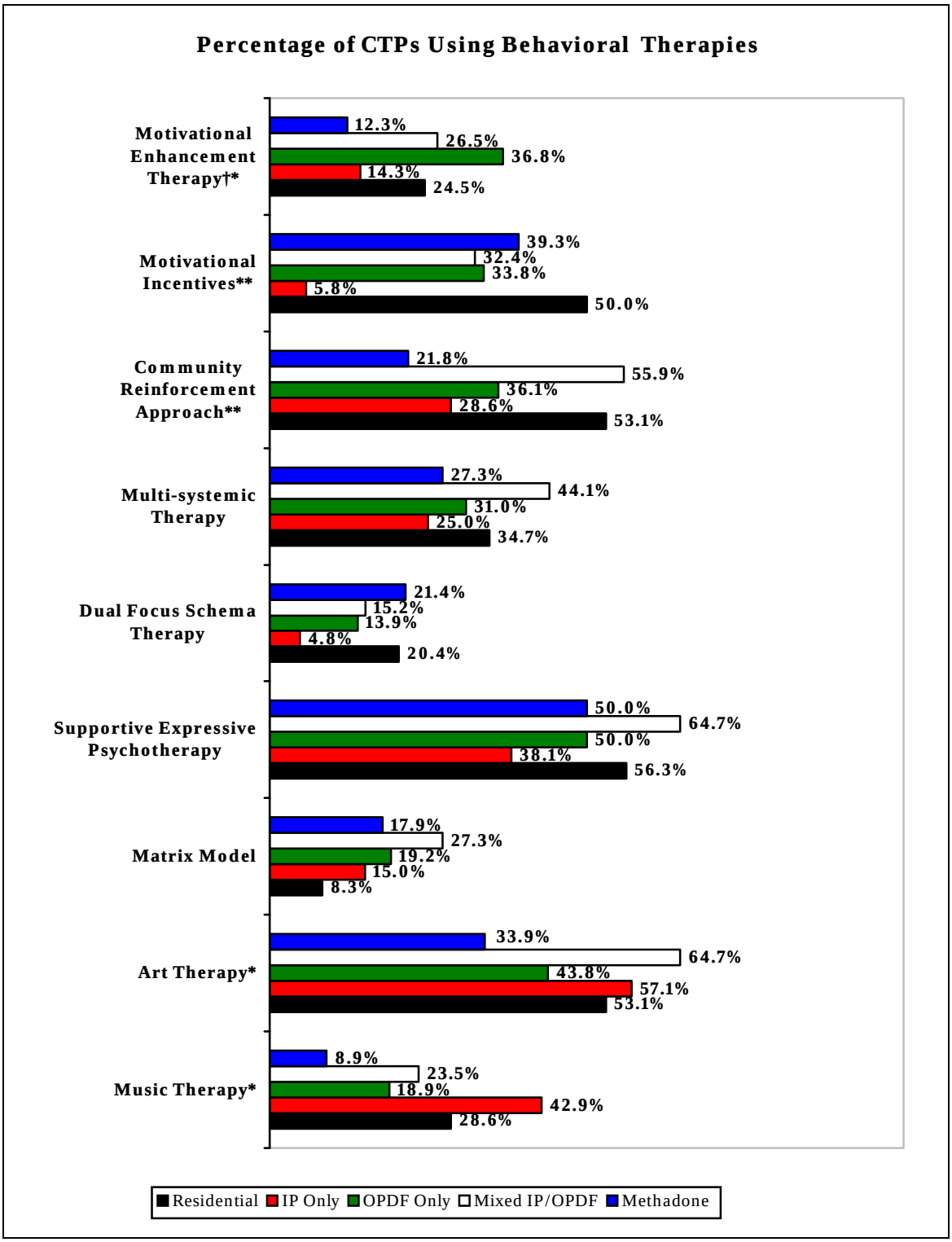
Among the list of evidence-based behavioral therapies, supportive expressive psychotherapy was the most commonly used (52.4% of CTPs). Dual focused schema therapy (16.5%) and the Matrix Model (17.4%) were the least common among those included in the surveys.

Percentage of CTPs Using Behavioral Therapies (Overall Means)	
Motivational Enhancement Therapy (manualized)	24.9%
Motivational Incentives	35.6%
Community Reinforcement Approach	38.5%
Multi-systemic Therapy	32.3%
Dual Focus Schema Therapy	16.5%
Supportive Expressive Psychotherapy	52.5%
Matrix Model	17.4%
Art Therapy	47.6%
Music Therapy	21.4%

There was significant variation in the use of behavioral therapies across the different types of programs (see following figure on p. 11).

While the use of pharmacotherapies was relatively high for IP-only units (see above), inpatient CTPs were less likely to report using these evidence-based behavioral therapies. Specifically, IP-only units were significantly less likely to use motivational incentives than residential units (5.8% versus 50.0%; $p < .01$).

Methadone units were significantly less likely than other modalities to use many of these evidence-based behavioral therapies (e.g. MET, community reinforcement approach, music and art therapies), which is not surprising given the structure of clinical services in these settings. However, methadone units were significantly more likely to use motivational incentives than IP-only units ($p < .01$).



†Refers to the use of manualized MET.
*Between-group differences significant at $p < .05$.
**Between-group differences significant at $p < .01$.

Therapeutic Orientation

CTP administrators were asked to what extent their CTP emphasizes the following types of counseling and therapies. Answers were reported on a scale of 0-to-5, where 0 is "no emphasis" and 5 is "very great emphasis." The table below shows the mean scores across the different types of programs.

	Mean Score				
	Residential	**IP-Only**	**OPDF-Only**	**Mixed IP/OPDF**	**Methadone**
Supportive Group Therapy***	4.8	4.4	4.4	4.7	3.5
Confrontational Group Therapy***	2.7	1.3	1.4	1.2	0.8
Supportive Individual Counseling***	4.5	4.0	4.1	3.9	4.7
Family Therapy***	3.4	2.0	2.9	3.1	2.1
Medical/Psychiatric Model	3.2	3.8	3.4	3.6	N/A
Use of Medications**	3.4	4.1	3.0	3.2	N/A
Spiritual***	3.3	3.9	2.9	3.8	2.4

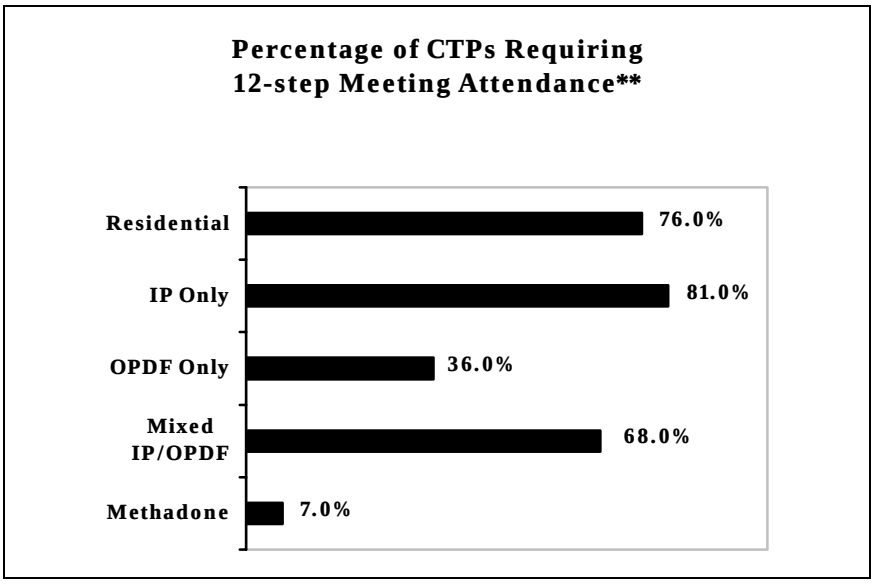
N/A indicates item not asked of these programs.
**Between-group differences significant at $p < .01$.
***Between-group differences significant at $p < .001$.

As shown by their high mean scores, CTPs generally reported a greater degree of emphasis on supportive group therapy and supportive individual counseling.

Relatively speaking, the least emphasis within these programs was on confrontational group therapy. Note that, as expected, Residential CTPs, which consist primarily of TCs (n=31), scored significantly higher on confrontational group therapy than all other modalities ($p < .001$). In addition, residential units scored significantly higher than IP-only units on emphasis on family therapy ($p < .05$). In comparison to OPDF-only CTPs, IP-only units scored significantly higher on the use of medications ($p < .05$).

Twelve-step Model

Emphasis on the 12-step model has been pervasive in addiction treatment for decades. Our research, however, has shown that the emphasis on the 12-step model has been declining over the past decade with increasingly smaller percentages of administrators or clinical directors reporting that their program is based on the 12-step model. In interviews with CTP administrators, we found that less than half (46.0%) reported that attendance at 12-step meetings during the course of treatment was "required." Again, there were variations across the different types of programs. OPDF-only units were significantly less likely to require 12-step attendance than inpatient, residential, and mixed IP/OPDF ($p < .01$).



**Between-group differences significant at $p < .01$.

Twelve step meetings were held on-site at 57.0% of the CTPs, with Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) representing the most common types of on-site twelve-step meetings. AA and NA meetings were significantly less likely to be held in OPDF-only than residential, IP-only, and mixed IP/OPDF units ($p < .001$).

Percentage of CTPs Offering 12-step Meetings

	Residential	IP-Only	OPDF-Only	Mixed IP/OPDF	Methadone
AA***	57.0%	90.0%	31.0%	80.0%	7.0%
NA***	65.0%	90.0%	28.0%	60.0%	14.0%
CA	8.0%	5.0%	4.0%	14.0%	4.0%
Al-Anon	2.0%	19.0%	7.0%	11.0%	2.0%

***Between-group differences significant at $p < .001$.

Treatment Tracks

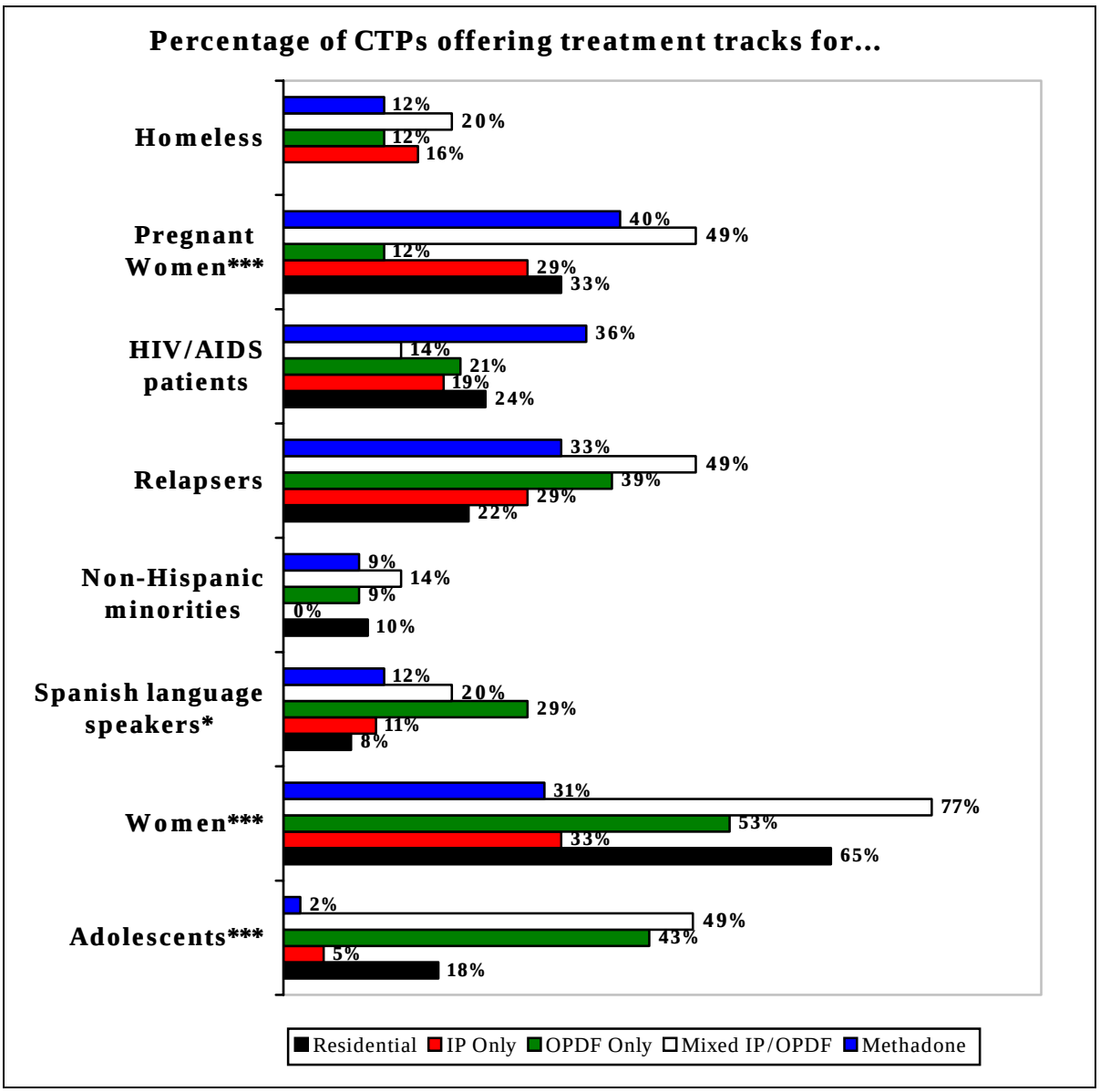
Nearly all CTPs (98%) provided at least one separate treatment track for a specific demographic group. Women were the most common group for whom a special treatment track had been created. In addition to special tracks in more general programs, more than one in five CTPs (21%) were specialty programs providing services exclusively for a specific demographic group (e.g., adolescents, women, pregnant women, etc.).

Percentage of CTPs Offering Treatment Tracks: (Overall Means)	
Adolescents	33.0%
Women	52.0%
Spanish language speakers	18.0%
Non-Hispanic Minorities	9.0%
Relapsing Clients	34.0%
HIV/AIDS patients	24.0%
Pregnant Women	30.0%
Homeless	14.0%

There were significant variations across the different treatment modalities. As shown in the following figure, mixed IP/OPDF CTPs were significantly more likely to offer tracks for:

- Adolescents (compared to IP-only and residential);
- Women (compared to IP-only)
- Pregnant women (compared to OPDF-only).

Outpatient drug-free units were significantly more likely than residential and IP-only CTPs to offer tracks for adolescents and Spanish language speakers ($p < .05$).



*Between-group differences significant at $p < .05$.
***Between-group differences significant at $p < .001$.

Comprehensive/Wraparound Services

Previous research has shown that addressing the "whole" client rather than focusing only on the client's addiction results in better treatment outcomes. For this reason, CTP administrators were asked to rate, on a 0 to 5 scale, how much effort their program made to provide the following services to clients who need them. Here, 0 represents "no efforts made" and 5 represents "extensive efforts made." As measured, "efforts" could refer to provision of services at the program itself, or via referrals to other providers. While not a direct measure of service delivery, these questions do reflect programs' propensity to link clients with needed services. The table below reflects the mean scores across the five different types of treatment programs.

	Mean Score				
	Residential	**IP-Only**	**OPDF-Only**	**Mixed IP/OPDF**	**Methadone**
Medical	4.5	4.4	3.9	4.2	4.3
Dental***	4.0	2.9	3.0	3.5	2.9
Employment***	3.5	1.8	3.4	3.1	3.6
Legal***	4.0	2.4	3.3	3.4	3.1
Family/Social**	4.2	3.3	4.2	4.3	3.9
Psychological/Emotional	4.7	4.2	4.5	4.4	4.4
Financial***	3.4	1.7	3.2	3.4	3.3

**Between-group differences significant at $p < .01$.
***Between-group differences significant at $p < .001$.

Compared to OPDF-only units, residential CTPs were significantly more likely to make provisions for clients with dental problems ($p < .01$).

Inpatient-only CTPs were significantly less likely than other modalities to report making provisions for clients with:

- Employment problems (residential, OPDF-only and mixed IP/OPDF)
- Legal problems (residential)
- Family/social problems (all modalities)
- Financial problems (all modalities)

Transportation and Childcare

CTP administrators were asked whether or not their treatment unit offered transportation assistance and childcare services for clients who need them. More than half of the CTPs (55.7%) offered transportation assistance, with inpatient (90.5%), residential (91.8%), and mixed IP/OPDF units (76.5%) significantly more likely to offer transportation than OPDF-only units (55.3%; $p < .001$).

One quarter of the CTPs (25.6%) offered childcare services. None of the CTPs categorized as IP-only offered childcare. Childcare was most common in residential CTPs (42.9%), followed by mixed IP/OPDF (40.0%), OPDF-only (22.4%), and lastly, methadone units (15.8%). There were no significant differences across modalities.

Dual Diagnosis

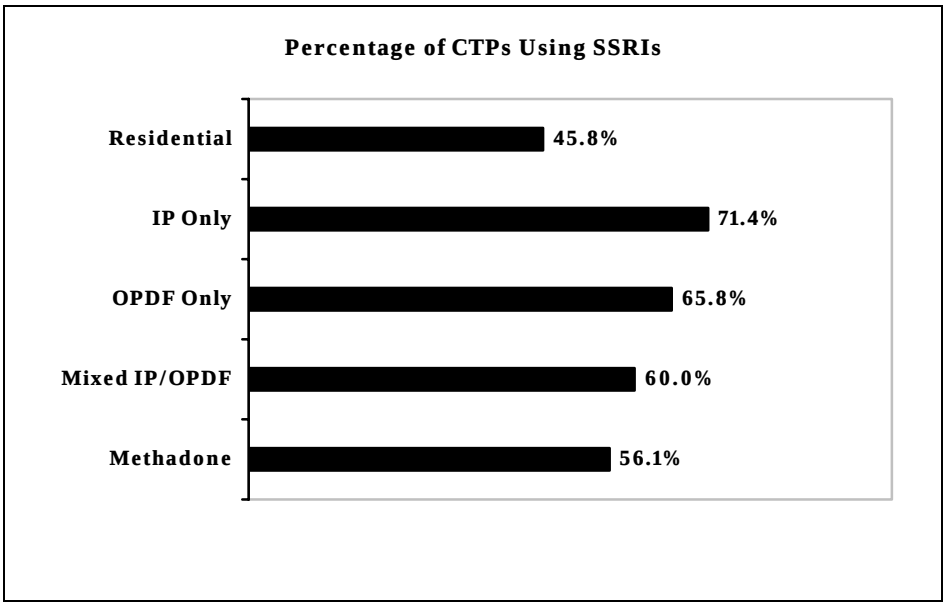
Sixty-nine percent of the CTPs reported having a program to treat dually diagnosed clients (co-occurring substance abuse and mental health conditions). Within these CTPs with dual diagnosis programs, about 55% of the clients, on average, were dually diagnosed. Of the dually diagnosed clients, an average of 63% received some type of psychiatric medication.

Research suggests that a "best practice" for clients with co-occurring substance abuse and psychiatric disorders is integrated care, where services for both conditions are delivered within the same organization by the same treatment team. In this sample, 63.2% of CTPs offered integrated care. There were no significant differences across modalities.

Percentage of CTPs Offering Integrated Care

Residential	IP-Only	OPDF-Only	Mixed IP/OPDF	Methadone
67.4%	57.1%	67.1%	65.7%	55.2%

CTPs were asked about the availability of selective serotonin reuptake inhibitors (SSRIs) within their programs. Overall, 59% of the CTPs reported currently using SSRIs, which are designed to treat some psychiatric problems. There were no significant differences across modalities.



Smoking Cessation

Just over one third (35.2%) of CTPs reported offering programs for nicotine addiction. In 16.6% of the CTPs, clients could be admitted solely for nicotine addiction. There were no significant differences across modalities.

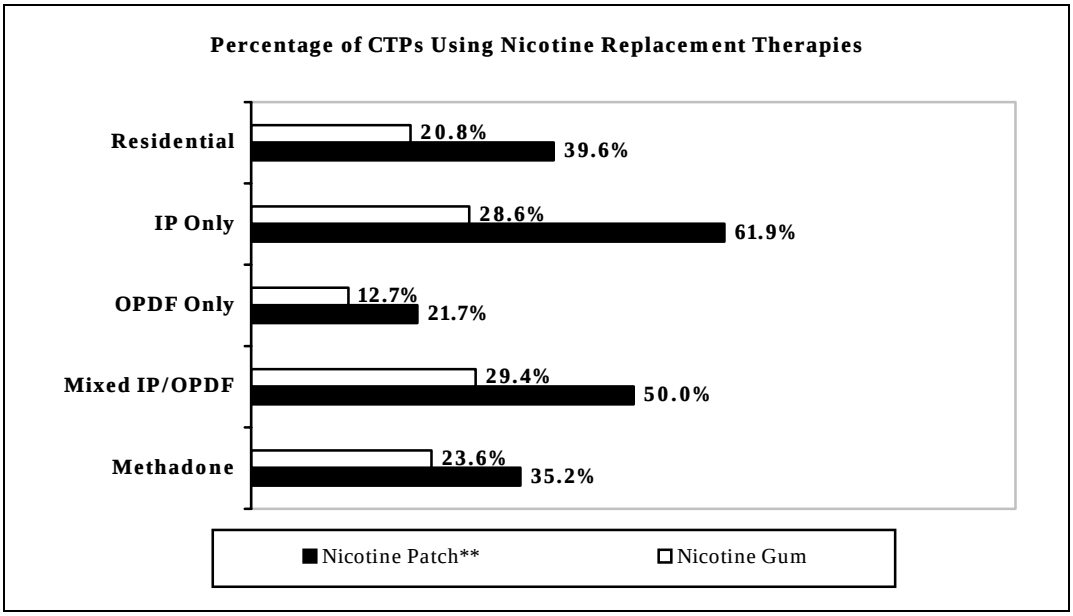
Percentage of CTPs Offering Nicotine Addiction Programs

Residential	IP-Only	OPDF-Only	Mixed IP/OPDF	Methadone
50.0%	19.0%	33.0%	46.0%	26.0%

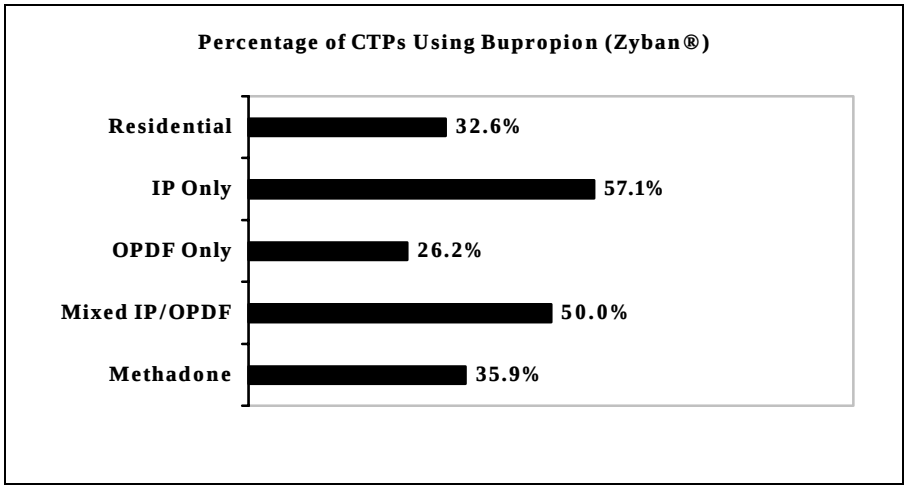
When compared to the use of medications for alcohol and other drug dependence, the use of smoking cessation-related pharmacotherapies (e.g., nicotine patch, gum) was considerably higher. This was especially true in residential programs, where there was little use of medications for alcohol and other drug use. Over 20% of the CTPs reported using nicotine gum, and 36.7% reported the use of the nicotine patch. It may be that over-the-counter

availability of nicotine replacement therapies has facilitated the adoption of these medications.

Despite such general use, significant differences in the use of nicotine replacement therapies were evident across modalities. OPDF-only units were significantly less likely to report using the nicotine patch than IP-only ($p < .01$) and mixed IP/OPDF ($p < .05$).



Administrators were also asked whether or not their CTP prescribed bupropion (Zyban®) for the treatment of nicotine addiction. Overall, 36.5% of CTPs reported using bupropion. There were no statistically significant differences across modalities.



Other Behavioral Health Programs

In addition to offering programs for nicotine dependence and the dually diagnosed, many CTPs also offer programs for other behavioral health problems. The table below shows the percentage of CTPs offering these programs across the five modalities.

Percentage of CTPs Offering Other Behavioral Health Programs

	Residential	IP Only	OPDF-Only	Mixed IP/OPDF	Methadone
Eating Disorders**	23.0%	19.0%	8.0%	14.0%	2.0%
Sex Addiction*	14.0%	5.0%	15.0%	11.0%	0.0%
Internet Addiction	5.0%	5.0%	5.0%	0.0%	0.0%
Gambling Addiction***	14.0%	10.0%	28.0%	14.0%	0.0%

*Between-group differences significant at $p < .05$.
**Between-group differences significant at $p < .01$.
***Between-group differences significant at $p < .001$.

Comparing data across the five modalities, we found, not surprisingly, that methadone units were significantly less likely to offer these behavioral health services than other modalities. However, despite the seemingly large differences across the remaining modalities, none of the other between-group differences reached statistical significance.

B. Caseload Characteristics

There are several different ways to describe the types of clients CTPs are treating. Clients may be categorized by their principal drug of choice (primary diagnosis), demographic characteristics, or the route by which they entered treatment (referral source). Each of these is considered in this section. A fourth way of categorizing clients, their source of payment, is considered in a later section on program funding.

Primary Diagnosis

Clinical Diagnostic Subgroups: Primary Diagnosis†

	Mean % of Caseload			
	Residential	IP Only	OPDF-Only	Mixed IP/OPDF
Alcohol Dependence or Abuse*	29.6%	40.0%	40.1%	44.2%
Cocaine Dependence or Abuse***	38.4%	16.2%	22.5%	14.6%
Opiate Dependence or Abuse***	24.7%	37.6%	17.7%	17.2%
Marijuana Dependence or Abuse***	18.2%	3.2%	23.9%	18.7%
Methamphetamine Dependence or Abuse*	13.7%	1.8%	14.8%	11.3%
Club Drugs Dependence or Abuse	3.2%	< 1%	1.8%	1.5%

†Methadone programs omitted from this comparison.
*Between-group differences significant at $p < .05$.
***Between-group differences significant at $p < .001$.

In terms of primary drugs of abuse, alcohol (38.0%), cocaine (24.4%), and opiates (22.3%) accounted for the greatest proportion of CTPs' caseloads. (However, it should be noted that "polydrug abuse" is commonly described as the primary problem in many cases.) Overall, primary problems with marijuana, methamphetamine, and club drugs accounted for 18.8%, 12.2%, and 2.0% of CTPs' caseloads respectively. Over half (52.1%) of CTPs have not encountered persons with a primary diagnosis of club drugs dependence/abuse.

Residential units, on average, served a significantly smaller percentage of clients with primary alcohol dependence/abuse than mixed IP/OPDF CTPs ($p < .05$). Conversely, residential units, on average, served a significantly greater percentage of clients with primary cocaine abuse/dependence compared to all other modalities ($p < .001$).

On average, IP-only units served a significantly greater percentage of clients with primary opiate dependence/abuse than both OPDF-only units ($p < .001$) and CTPs offering mixed IP/OPDF ($p < .01$).

The proportions of clients with primary diagnoses of marijuana ($p < .001$) and methamphetamine dependence/abuse ($p < .05$), on average, were significantly greater in OPDF-only than IP-only units.

Demographics

Client Demographics

	Mean % of Caseload				
	Residential	**IP-only**	**OPDF-only**	**Mixed IP/OPDF**	**Methadone**
Women***	51.4%	30.1%	36.5%	44.1%	42.9%
Adolescents (<21)**	14.5%	< 1%	16.5%	13.9%	3.6%
Racial/Ethnic Minorities***	65.5%	48.7%	50.3%	38.1%	47.3%
Probationers***	50.4%	38.5%	41.7%	40.0%	18.7%

******Between-group differences significant at $p < .01$.
***Between-group differences significant at $p < .001$.

In the average CTP, women made up 41% of the clients. Slightly more than 3% of CTPs did not admit women into treatment, while almost 9% of CTPs were female-only programs.

Across all CTPs, approximately 13% of clients are adolescents. More than half (59.5%) of the CTPs, however, did not admit adolescent clients. Among CTPs treating adolescents, the average percentage of clients under the age of 21 was 23.6%. Seven percent of the CTPs were adolescent only programs.

Residential CTPs, on average, served a significantly greater percentage of:

- Women (compared to IP-only and OPDF-only)
- Racial/ethnic minorities (compared to OPDF-only and mixed IP/OPDF)

The average proportion of probationers served was significantly lower in methadone units than all other modalities ($p < .001$).

Referral Sources

Mean Percentage of Clients Referred From Source

	Mean %				
	Residential	**IP-only**	**OPDF-only**	**Mixed IP/OPDF**	**Methadone**
Self-referrals***	27.8%	43.7%	25.0%	23.7%	64.2%
Program alumni	12.0%	12.2%	8.6%	8.2%	15.4%
Employee Assistance Pgms**	2.8%	2.9%	4.7%	3.2%	1.0%
Non-EAP workplace referrals	6.5%	4.6%	5.4%	3.0%	2.6%
Drug court	19.8%	5.0%	24.9%	10.3%	3.9%
Other Legal system***	37.5%	18.2%	33.8%	31.5%	9.9%
Social services**	21.7%	32.1%	21.2%	18.9%	13.1%
Within hospital/tx system*	14.3%	21.8%	25.3%	7.6%	11.0%
Physicians	2.3%	4.0%	5.3%	7.1%	2.6%
Other health care***	17.1%	31.1%	14.2%	14.9%	8.8%
Clergy	1.8%	1.3%	1.7%	1.4%	.7%
Schools**	2.0%	0.0%	14.5%	7.2%	3.5%

*Between-group differences significant at $p < .05$.
**Between-group differences significant at $p < .01$.
***Between-group differences significant at $p < .001$.

Among the many referral sources listed, CTP administrators reported self-referrals as the most prevalent source, followed by the legal system, social services, and health care providers.

IP-only and methadone CTPs reported receiving a significantly greater percentage of self-referrals, on average, than OPDF-only units ($p < .05$).

In contrast, IP-only ($p < .05$) and methadone units ($p < .001$) reported a significantly smaller percentage of referrals from the legal system, than residential, OPDF-only, and mixed IP/OPDF CTPs.

Referrals from health care providers, on average, were significantly greater for IP-only units compared to all other modalities ($p < .05$).

C. Staffing and Accreditation

There are wide variations in staffing across the five different types of programs including differences in overall numbers of staff, availability of medical staff (physicians and nurses), and background and training of clinical staff.

FTEs and Total Employees

Mean Number of Employees

	Residential	IP-Only	OPDF-Only	Mixed IP/OPDF	Methadone
FTEs*** *(Range 1 to 310)*	33.5	39.3	14.3	78.9	29.2
Total Employees*** *(Range 1 to 357)*	38.3	45.8	18.5	97.6	34.2

***Between-group differences significant at $p < .001$.

As expected, the CTPs offering mixed IP/OPDF levels of care tend to be larger than programs in other categories at least in terms of the number of FTEs and total employees working in these settings ($p < .001$). The smallest category is the OPDF-only, which is not unexpected since a larger number of clients can be treated in an outpatient group setting with proportionately fewer employees.

Medical Staff

As expected, there is a wide variation in the availability of medical staff across the five treatment modalities. Because OPDF-only settings rely primarily on a group treatment model with limited medical services, fewer than 19% of OPDF-only units employed nurses compared with 50% - 98% of other CTPs ($p < .001$). By contrast, physicians and nurses were universally available in methadone units. A significantly greater percentage of methadone units employed physicians and nurses than other CTPs ($p < .001$).

Percentage of CTPs Employing Physicians or Nurses					
	Residential	IP-Only	OPDF-Only	Mixed IP/OPDF	Methadone
Physicians (on payroll)***	39.6%	68.2%	50.7%	55.9%	79.3%
Physicians (on contract)	16.7%	9.1%	12.0%	20.6%	20.7%
Nurses***	50.0%	86.4%	18.7%	73.5%	98.3%

***Between-group differences significant at $p < .001$.

Counselors

CTPs employed an average of 14 counselors, although the range was quite wide (0 to 150). The characteristics of the counselors employed in these settings were varied widely across the different types of programs.

Counselor Characteristics (Mean %)					
	Residential	IP-Only	OPDF-Only	Mixed IP/OPDF	Methadone
Master's Degree or higher***	36.8%	35.5%	61.5%	41.4%	33.3%
Certified in Addictions	46.3%	44.0%	39.4%	53.4%	37.4%
Female	66.0%	59.3%	62.5%	59.7%	61.6%
Racial/Ethnic Minority***	43.2%	37.5%	23.4%	45.0%	34.3%
Recovering***	55.8%	53.9%	39.1%	42.2%	31.2%

***Between-group differences significant at $p < .001$.

The largest percentage of counselors with Master's degrees or higher can be found in OPDF-only settings (61.5%) This percentage is significantly greater than all other modalities ($p<.05$). Regardless of modality, women comprise approximately 60% of the counselor workforce. More than one third of CTP counselors (34.3%) are racial/ethnic minorities. Compared to residential

CTPs, OPDF-only units employed a significantly lower percentage of minority counselors ($p < .001$). The percentage of counselors in recovery has been declining over the past two decades. On average, counselors in recovery now represent just over 40% of counselors employed in the CTPs. The highest percentage of recovering counselors is found in the residential units, primarily because of the large number of Therapeutic Communities represented in this category.

Accreditation

Thirty-three percent of the CTPs were accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). Similarly, 35% of the CTPs were accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). There were no significant differences in accreditation across modalities.

Funding Sources

For the CTPs, Medicaid and state and federal government monies represent the largest funding sources in terms of the percentage of total annual revenues, though there are significant variations across the different types of programs. For instance, methadone units receive a significantly larger percentage of their revenues from Medicaid and self-paying clients when compared to the other modalities ($p < .05$) while the largest source of revenue for IP-only units in the CTN is state funds. Although not their largest source of revenue, residential units rely much more heavily on criminal justice sources than do the other modalities ($p<.01$).

It should be noted that these percentages represent the proportion of annual revenues obtained from each of the sources listed; these data do not represent the proportion of patients paying for their care with each of these sources.

Mean Percentage of Total Revenues Received From Source						
	Residential	**IP-Only**	**OPDF-Only**	**Mixed IP/OPDF**	**Methadone**	**All CTPs**
Medicaid***	18.3%	14.3%	13.2%	17.9%	35.2%	20.4%
Medicare	< 1%	< 1%	1.4%	2.9%	5.1%	2.3%
Private (Indemnity) Insurance**	< 1%	< 1%	2.1%	6.1%	< 1%	2.0%
HMO, PPO, and POS***	1.5%	1.2%	6.4%	12.8%	2.3%	4.9%
Self Pay**	4.6%	< 1%	10.7%	8.5%	13.7%	9.0%
Criminal Justice System***	9.4%	< 1%	1.9%	1.0%	< 1%	2.8%
SAPT Block Grants	19.4%	10.9%	12.8%	11.9%	15.4%	14.4%
Other Federal	8.1	2.0%	8.9%	3.0%	2.1%	5.5%
Other State***	20.6%	45.3%	13.7%	18.1%	11.3%	18.0%
Other County, City, Local	7.0%	12.9%	12.9%	9.2%	4.9%	9.3%
Charity	1.3%	< 1%	< 1%	1.2%	< 1%	< 1%
Endowments	< 1%	< 1%	< 1%	1.1%	< 1%	< 1%
Other	2.7%	5.9%	5.7%	2.4%	1.6%	3.6%

**Between-group differences significant at $p < .01$.
***Between-group differences significant at $p < .001$.

II. CTN COMPARISON REPORT

This section of the report presents data comparing the structure and services of CTPs in the CTN to nationally representative samples of treatment programs outside the CTN. Because no comparison sample is available at this time, methadone units are excluded from these comparisons.* The remaining non-methadone CTPs (n=182) are compared to 749 treatment programs outside the CTN. These 749 non-CTN programs are drawn from nationally representative samples of publicly funded and privately funded addiction treatment organizations. (Please refer to the section, "Study and Sample Design" at the end of this report for further details on the non-CTN samples.)

Funding Sources

The U.S. addiction treatment system consists of both public-sector and private-sector organizations. We differentiate these two sectors by measuring the types of revenue received by the organization. For the purposes of this section of the report, public programs are those that received greater than 50% of their annual operating revenues from federal, state, and local government grants and contracts, while private programs are defined as those receiving less than 50% of revenue from such sources. In practice, publicly funded centers received more than 80% of their operating revenues from government grants (including Block Grants, other state grants, and criminal justice contracts), while privately funded centers received less than 18% of their annual revenues from these sources. In the private sector, revenue sources were predominantly from commercial insurance reimbursements and client payments (self-pay and co-pay). Although both sectors receive reimbursements from Medicaid, these do not make up a substantial portion of revenues in either sector.

For the purpose of comparison, we re-classified CTPs into "public" and "private" sectors based on these revenue sources. The following table shows the distribution of publicly and privately funded programs within and outside the CTN.

* A new NIDA grant awarded to the University of Georgia in October 2005 is collecting data from a matched sample of methadone units outside the CTN to provide comparative data on program structure and adoption of evidence-based practices. These data will be available in late 2006.

Number of Publicly and Privately Funded Programs Inside and Outside the CTN			
CTN		Non-CTN	
Public	**Private**	**Public**	**Private**
122	60	355	394

Note: "Public" and "Private" refer to a centers' principle funding source, not ownership.

These categorizations provide the context for comparisons in the remainder of this report. For this section of the report, we are primarily interested in the significant differences between CTN and non-CTN programs rather than public/private differences. Therefore, for each comparison we highlight only the significant CTN/non-CTN differences in organizational structure and clinical services, although differences may be evident between public and private programs.

A. Clinical Service Delivery

Levels of Care

Percentage of Units Offering Level of Care				
	CTN Public	**Non-CTN Public**	**CTN Private**	**Non-CTN Private**
Detoxification				
Inpatient Detox*	20.7%	12.7%	27.6%	43.7%
Outpatient Detox	7.4%	7.1%	15.3%	12.2%
24-Hour Care				
Residential (>28 days)	43.0%	39.1%	32.8%	20.4%
Inpatient Adult Chemical Dependency (<28 days)**	15.7%	13.5%	15.5%	36.0%
IP Adolescent Chemical Dependency (<28 days)	0.0%	3.4%	5.2%	10.7%
Adult Psychiatric (Inpatient)**	2.5%	2.5%	6.9%	2.1%
Adolescent Psychiatric (Inpatient)	< 1%	1.4%	3.5%	10.7%
Outpatient Drug-Free				
Partial Hospitalization (20+ hours/week)***	7.4%	13.0%	10.5%	42.5%
Intensive Outpatient (9 – 20 hours/week)**	37.2%	55.5%	60.3%	73.4%
Outpatient (<9 hours/week)	54.6%	66.5%	59.3%	64.2%
Aftercare* **	30.6%	57.1%	36.2%	63.5%

NOTE: Percentages do not add to 100% as centers may offer more than one level of care.
*Between-group differences significant at $p < .05$.
**Between-group differences significant at $p < .01$.
***Between-group differences significant at $p < .001$.

The most common levels of care across all program types are outpatient and intensive outpatient. There were, however, several significant CTN/non-CTN differences.

- Private CTN programs were significantly less likely to report offering inpatient services (detoxification, adult CD and psychiatric services) and partial hospitalization than private programs outside the CTN ($p < .05$).

- Public CTN programs were significantly less likely to provide intensive outpatient than non-CTN public programs ($p < .01$).
- Public and private CTN programs were significantly less likely to provide aftercare than non-CTN public and private programs ($p < .001$).

Percentage of Units Offering Modality

	CTN Public	Non-CTN Public	CTN Private	Non-CTN Private
IP-only*	11.6%	4.2%	11.9%	7.6%
Residential**	30.6%	17.8%	18.6%	3.8%
OPDF-only	40.5%	48.9%	45.8%	38.6%
Mixed IP/OPDF***	17.4%	29.1%	23.7%	50.0%

*Between-group differences significant at $p < .05$.
**Between-group differences significant at $p < .01$.
***Between-group differences significant at $p < .001$.

- CTN public programs were significantly more likely to offer inpatient ($p < .05$) and residential ($p < .01$) services than non-CTN public programs.
- Private programs affiliated with the CTN were significantly less likely to offer mixed IP/OPDF compared to private programs outside the CTN ($p < .001$).

Evidence-Based Practices

Standardized Addiction Measures

Administrators were asked whether standardized addiction measures such as the American Society of Addiction Medicine's Patient Placement Criteria (ASAM PPC) and/or the Addiction Severity Index (ASI) were utilized at intake to assess the client's level of addiction and to match the client with the appropriate level of care.

Percentage of Units Using Standardized Intake/Assessment Measures

	CTN Public	Non-CTN Public	CTN Private	Non-CTN Private
Use any Standardized Addiction Measures	90.0%	85.0%	75.0%	81.0%
ASAM PPC	69.0%	68.0%	70.0%	77.0%
ASI	58.0%	59.0%	54.0%	37.0%

There were no significant differences based on CTN affiliation.

Medical and Psychiatric Assessments

Mean Percentage of Clients Receiving Medical and Psychiatric Assessments At Intake

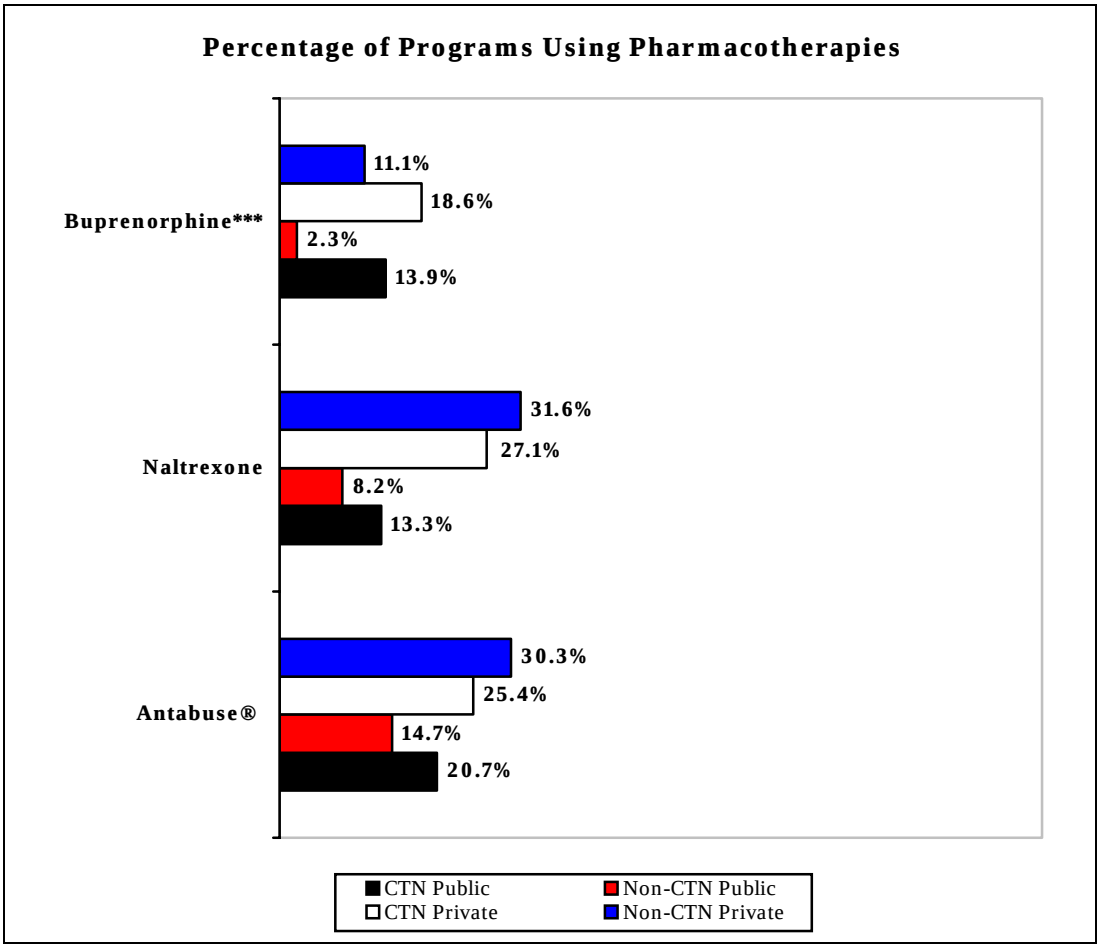
	CTN Public	Non-CTN Public	CTN Private	Non-CTN Private
Psychiatric Assessments	21.2%	19.7%	31.6%	36.0%
Physicals	36.8%	38.3%	49.8%	55.1%

There were no significant CTN/non-CTN differences in the percentage of clients receiving psychiatric assessments or physicals at intake.

Pharmaco- and Behavioral Therapies

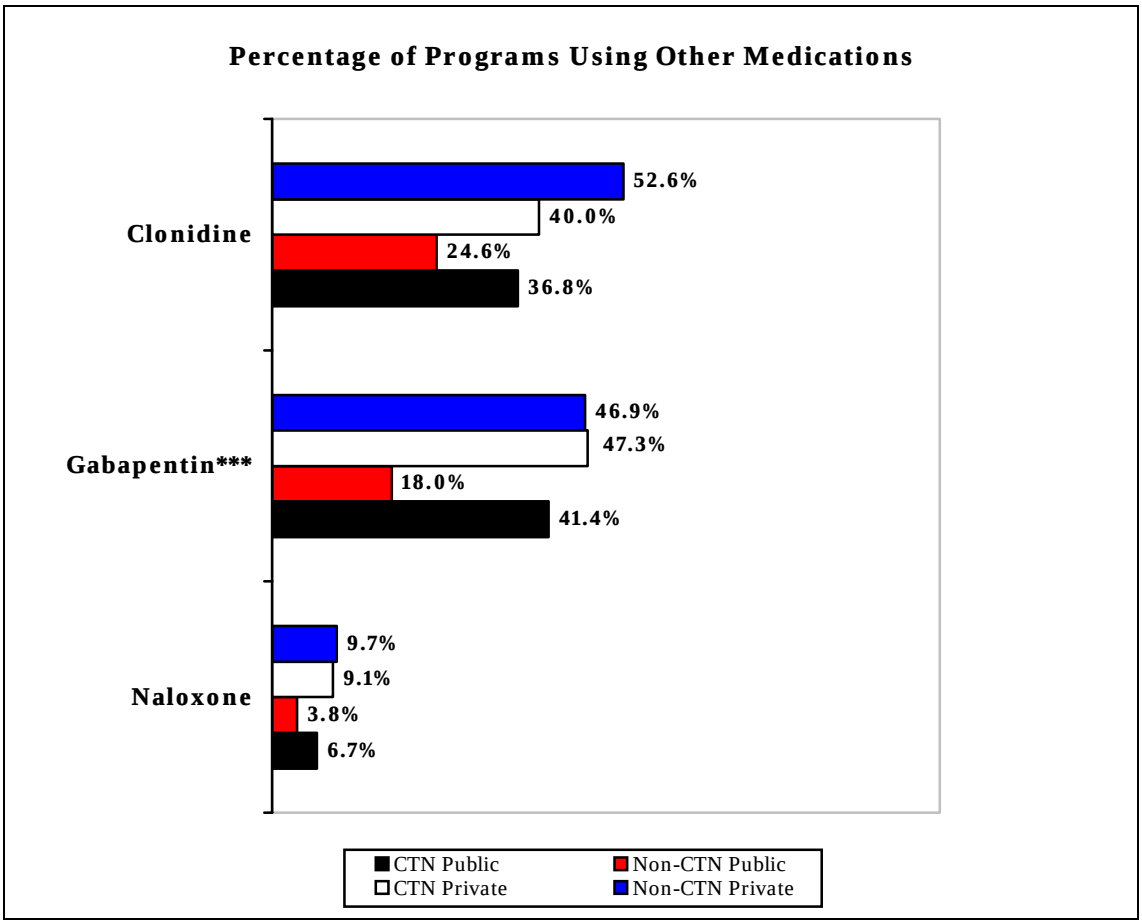
Pharmacotherapies

Administrators were asked whether or not their program currently used specific pharmaceutical and/or behavioral therapies. Most of the therapies included in the NTCS on-site interview have been identified as "evidence-based practices" by the National Institute on Drug Abuse (*Principles of Drug Abuse Treatment* 2000). This list of practices was expanded to include other therapies for which there is some evidence of improved treatment outcomes.



***Between-group differences significant at $p < .001$.

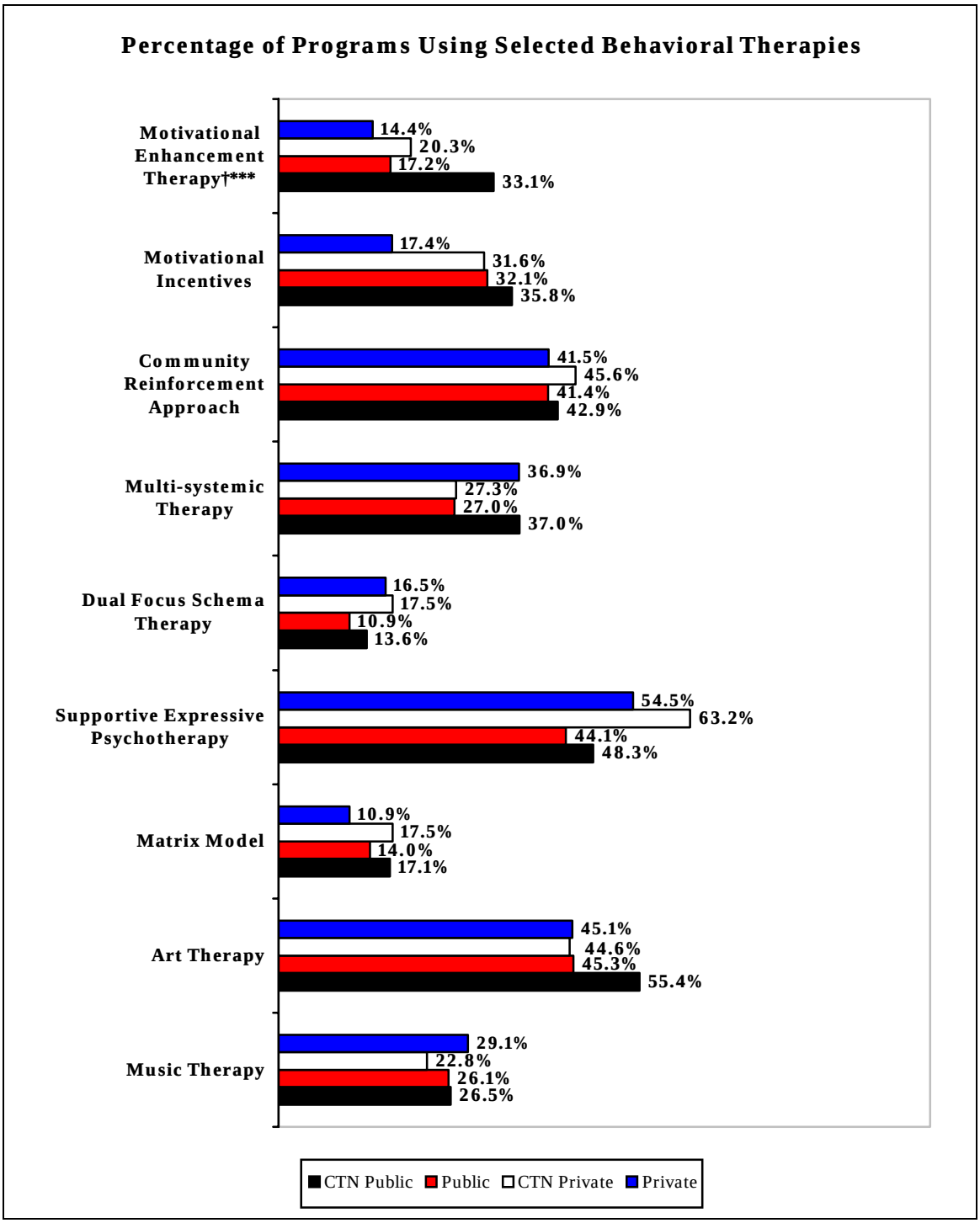
Public units in the CTN were significantly more likely to use buprenorphine than non-CTN public programs (13.9% versus 2.3%; $p < .001$). Private CTN/non-CTN differences were not statistically significant.



***Between-group differences significant at p < .001.

A large percentage of both CTN private and non-CTN private programs report using Clonidine and Gabapentin. Public units in the CTN were significantly more likely to use gabapentin than non-CTN public units (41.4% versus 18.0%; p < .001). Private CTN/non-CTN differences were not statistically significant.

Behavioral Therapies



†Refers to the use of manualized MET.
***Between-group differences significant at $p < .001$.

Public CTN units were significantly more likely to use manualized MET than non-CTN units (33.1% versus 17.2%; $p < .001$). There were no statistically significant CTN/non-CTN differences among the other behavioral therapies.

Therapeutic Orientation

Administrators were asked to what extent their treatment unit emphasizes the following types of counseling and therapies. Answers were reported on a 0-to-5 scale, where 0 is "no emphasis" and 5 is "very great emphasis."

	Mean Score			
	CTN Public	Non-CTN Public	CTN Private	Non-CTN Private
Supportive Group Therapy	4.6	4.7	4.5	4.7
Confrontational Group Therapy*	1.7	2.2	1.8	2.2
Supportive Individual Counseling	4.2	4.5	4.2	4.2
Family Therapy	2.9	3.0	3.1	3.7
Medical/Psychiatric Model	3.4	3.1	3.5	3.5
Use of Medications***	3.2	2.5	3.5	3.1
Spiritual	3.3	3.4	3.2	3.7

*Between-group differences significant at $p < .05$.
***Between-group differences significant at $p < .001$.

As reflected in their high mean scores, the strongest emphasis across all program types is on supportive group and supportive individual therapies (possible scores ranged from 0 to 5). Confrontational group therapy received the least emphasis.

CTN public units, on average, placed significantly less emphasis on confrontational group therapy ($p < .05$), but significantly more emphasis on the use of medications than non-CTN public units ($p < .001$). None of the private CTN/non-CTN comparisons were statistically significant.

Twelve-step Model

Administrators were asked whether the unit's treatment program was based on a 12-step model. CTN public units were significantly less likely to be based on a 12-step model than non-CTN public units (43% versus 60%; $p < .01$). Private CTN/non-CTN comparisons were not statistically significant.

Among the programs offering 12-step meetings on-site, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) were the most common. There were no statistically significant CTN/ non-CTN differences.

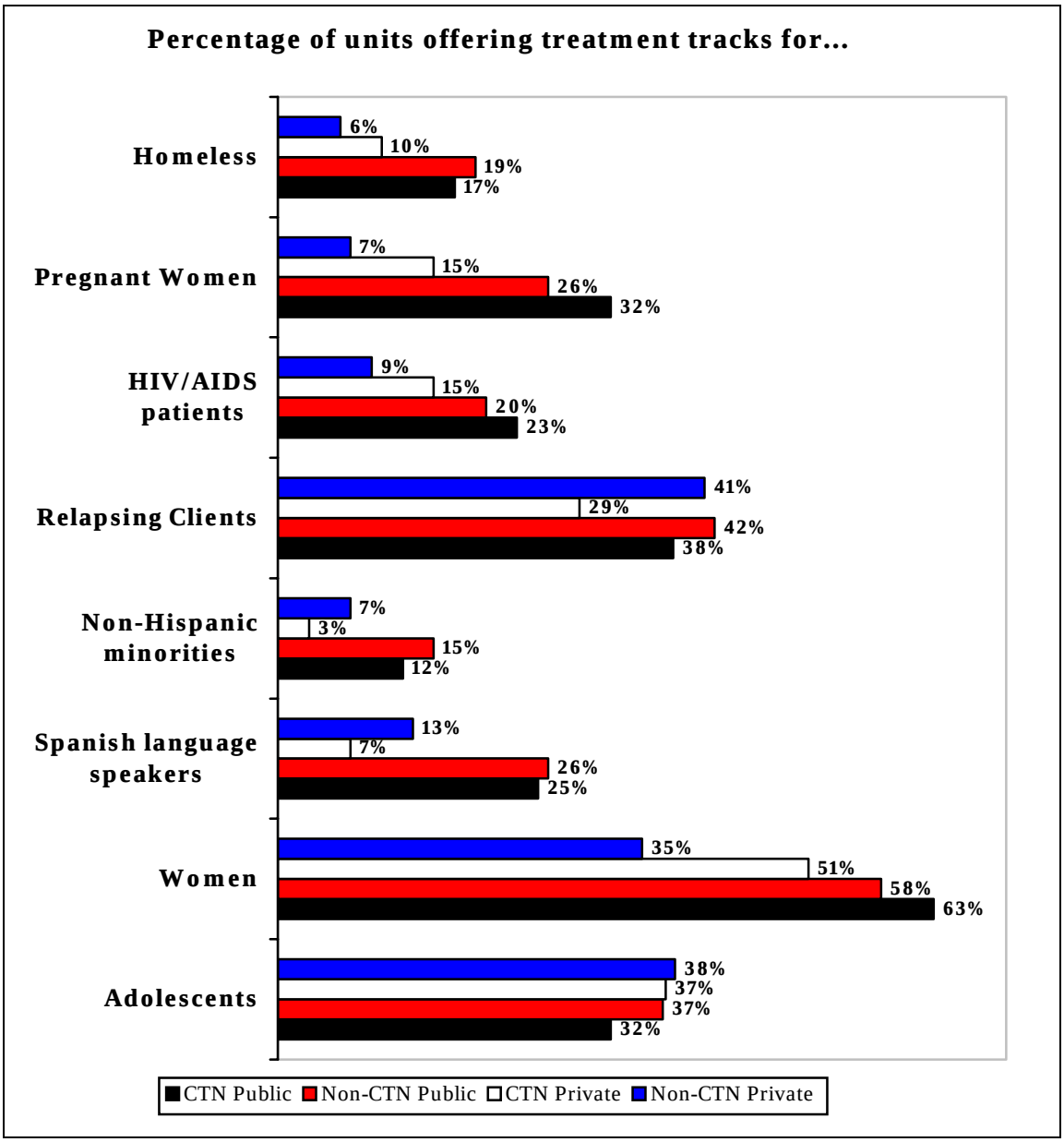
Percentage of Units Offering 12-step Meetings

	CTN Public	Non-CTN Public	CTN Private	Non-CTN Private
AA	54.0%	48.0%	53.0%	61.0%
NA	50.0%	46.0%	53.0%	48.0%
CA	7.0%	10.0%	7.0%	11.0%
Al-Anon	7.0%	19.0%	9.0%	12.0%

Treatment Tracks

Separate treatment tracks for specific demographic groups are common across all types of programs. The most prevalent treatment tracks are for women, adolescents and relapsers.

Although some of the differences in the table below appear large, none of the CTN/ non-CTN differences are statistically significant.



Comprehensive/Wraparound Services

Administrators were asked to rate, on a 0 to 5 scale, how much effort their treatment program made to provide the following services to clients who need them. Here, 0 represents "no efforts made" and 5 is "extensive efforts made." As measured, "efforts" could refer to provision of services at the program itself, or via referrals to other providers. While not a direct measure of service delivery, these questions do reflect programs' propensity to link clients with needed services. The table below reflects the mean scores across the four groups of treatment programs.

	Mean Score			
	CTN Public	**Non-CTN Public**	**CTN Private**	**Non-CTN Private**
Medical	4.3	4.1	3.9	4.1
Dental	3.4	3.3	3.3	2.9
Employment	3.2	3.6	3.1	2.9
Legal	3.5	3.6	3.3	3.0
Family/Social	4.2	4.4	4.1	4.3
Psychological/Emotional	4.5	4.4	4.6	4.5
Financial	3.2	3.4	3.0	2.9

As reflected by the high mean scores, all treatment programs tend to place the strongest emphasis on addressing medical, family/social, and psychological/emotional problems. There were no statistically significant differences between CTN and non-CTN units on any of these measures.

Transportation and Childcare

In addition to these services, many programs also provide childcare and transportation assistance to clients who need these services. Privately-funded units in the CTN were significantly more likely to offer childcare programs than non-CTN private units (28% versus 7%; $p < .001$). The differences between CTN public and non-CTN public units were not statistically significant (31% versus 27%).

Transportation assistance for clients was available in 77% of the CTN public units, 71% of the non-CTN public units, 64% of the CTN private units, and 53% of non-CTN private units. There were no significant CTN/non-CTN differences.

Dual Diagnosis

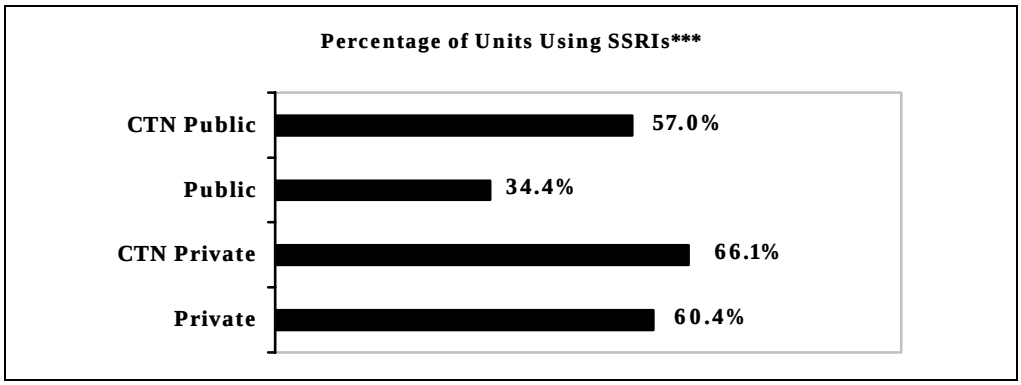
The following table compares the availability of services for dually diagnosed clients in public and private units inside and outside the CTN. Overall, about two-thirds of centers offered integrated care (i.e., treatment for both substance abuse and psychiatric conditions). Publicly funded units in the CTN were also significantly more likely to offer integrated care than public units outside the CTN ($p < .05$). Comparisons between Privately funded units within and outside the CTN were not statistically significant. Within the subset of units treating dually diagnosed clients, proportionately more clients in CTN public units had these problems than clients in non-CTN public units ($p < .01$).

Percentage of Units Offering Treatment for Dually Diagnosed Clients

	CTN Public	Non-CTN Public	CTN Private	Non-CTN Private
Provides Integrated Care* (Center treats both substance abuse and psychiatric problems)	64.8%	50.0%	67.8%	65.3%
% of clients who are dually diagnosed ** (n=669)	54.2%	42.8%	56.8%	48.0%
% of dually diagnosed clients receiving psychiatric medications (n=635)	62.9%	61.1%	71.9%	73.1%

*Between-group differences significant at $p < .05$.
**Between-group differences significant at $p < .01$.

Administrators were also asked about the use of selective serotonin reuptake inhibitors (SSRIs) as one method of addressing co-occurring psychiatric conditions. CTN public units were significantly more likely than non-CTN public units to report using SSRIs (57.0% versus 34.4%; $p < .001$). Private CTN/non-CTN comparisons were not significant.



***Between-group differences significant at $p < .001$.

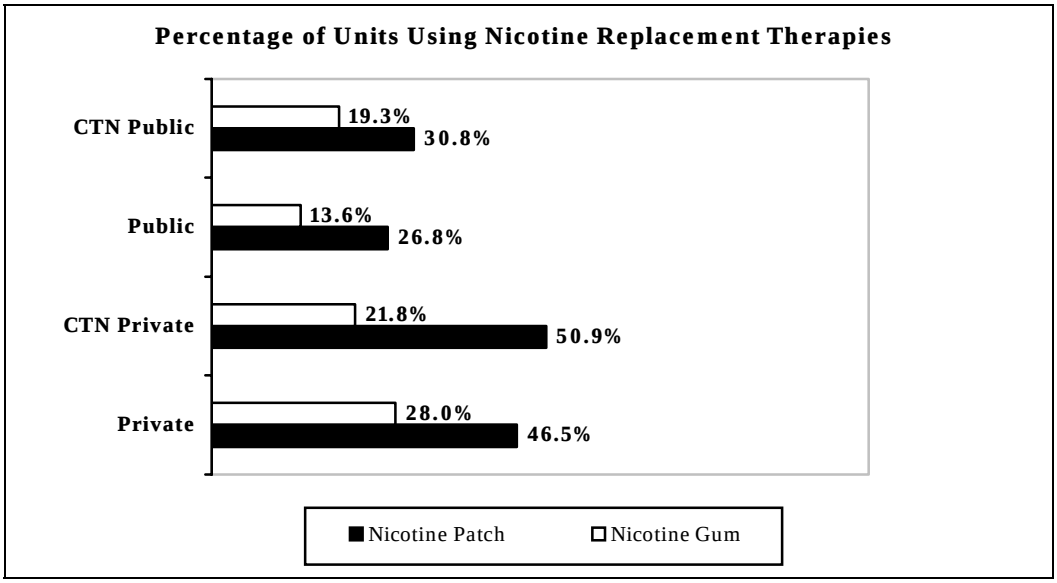
Smoking Cessation

Administrators were asked if their treatment unit offered programs for nicotine addiction, and whether clients could be admitted for the sole purpose of treating nicotine addiction. The availability of these programs ranged from a low of 32% in non-CTN private units to a high of 50% in CTN public units. However, there were no statistically significant differences between CTN and non-CTN units.

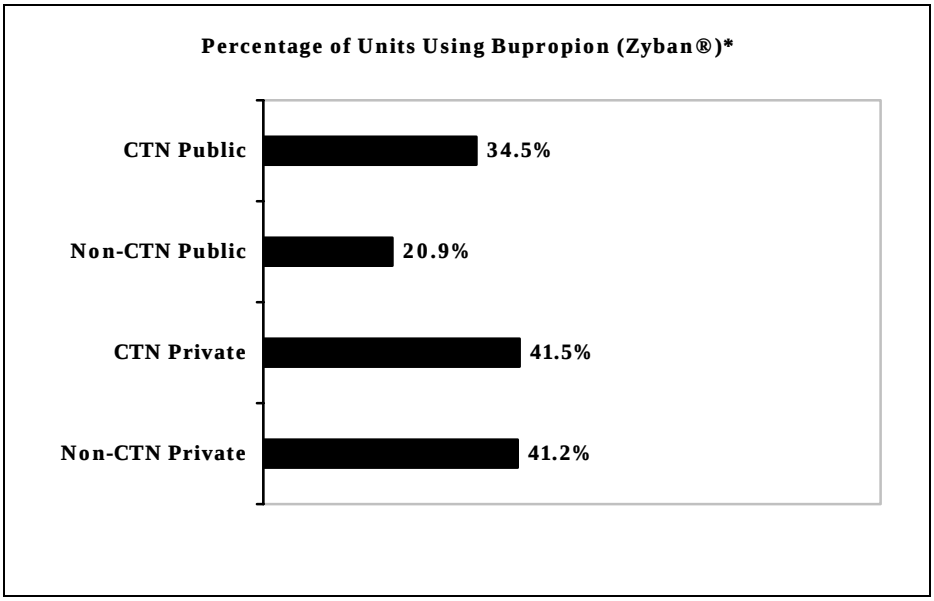
Percentage of Units Offering Treatment for Nicotine Addiction

	CTN Public	Non-CTN Public	CTN Private	Non-CTN Private
Nicotine Addiction Program	50.0%	41.0%	41.0%	32.0%
Admits Clients for Nicotine Addiction	19.6%	15.8%	10.3%	14.5%

Compared to the use of treatment-related medications, the use of nicotine replacement therapies (e.g., patch, gum) was considerably higher. However, there were no significant CTN/ non-CTN differences.



Finally, administrators were asked if their center used bupropion (Zyban®) for smoking cessation. Public units in the CTN were significantly more likely to report using bupropion for the treatment of nicotine addiction than non-CTN public units (34.5% versus 20.9%; $p < .05$).



*Between-group differences significant at $p < .05$.

Other Behavioral Health Programs

In addition to offering programs for nicotine dependence and the dually diagnosed, many CTPs also offer programs for other behavioral health problems. The table below shows the percentage of CTN and non-CTN units offering these programs. Though some of the CTN/ non-CTN differences appear large, none of these differences were statistically significant.

Percentage of Units Offering Other Behavioral Health Programs

	CTN Public	Non-CTN Public	CTN Private	Non-CTN Private
Eating Disorders	15.0%	12.0%	14.0%	21.0%
Sex Addiction	15.0%	17.0%	9.0%	20.0%
Internet Addiction	5.0%	7.0%	2.0%	10.0%
Gambling Addiction	22.0%	21.0%	14.0%	25.0%
Co-dependency	32.0%	43.0%	29.0%	41.0%

B. Caseload Characteristics

There are several ways to categorize clients in addiction treatment programs. Clients may be categorized by their principal drug of choice (primary diagnosis), demographic characteristics, or the route in which they entered treatment (referral source). Each of these categorizations is considered in this section along with the differences across the four types of units.

Primary Diagnoses

Clinical Diagnostic Subgroups: Primary Diagnosis

	Mean % of Caseload			
	CTN Public	Non-CTN Public	CTN Private	Non-CTN Private
Alcohol Dependence or Abuse***	39.4%	38.9%	35.4%	50.2%
Cocaine Dependence or Abuse	24.6%	25.7%	24.2%	18.4%
Opiate Dependence or Abuse**	19.4%	14.1%	27.1%	17.6%
Marijuana Dependence or Abuse	19.8%	19.6%	17.1%	14.4%
Methamphetamine Dependence or Abuse	12.6%	12.4%	11.3%	7.5%
Club Drugs Dependence or Abuse	1.8%	1.4%	2.4%	2.3%

**Between-group differences significant at $p < .01$.
***Between-group differences significant at $p < .001$.

On average, private units outside the CTN treated a significantly higher percentage of clients with primary diagnosis of alcohol dependence/abuse than private units within the CTN ($p < .001$). By contrast, private units in the CTN treated a significantly greater percentage of opioid dependent clients than private units outside the CTN ($p < .01$). None of the remaining CTN/ non-CTN comparisons were significantly different.

Demographics

Client Demographics

	Mean % of Caseload			
	CTN Public	Non-CTN Public	CTN Private	Non-CTN Private
Women	40.9%	39.3%	42.3%	38.2%
Adolescents	14.4%	13.5%	12.0%	11.4%
Racial/Ethnic Minorities***	53.2%	49.2%	48.2%	30.6%
Relapsers	60.4%	62.3%	63.3%	54.3%
Probationers***	41.9%	52.8%	46.2%	34.4%

***Between-group differences significant at $p < .001$.

Women comprise approximately 40% of client caseload across all four types of programs. Likewise, all four types of programs treatment similar percentages of adolescent clients. However, on average, privately funded units within the CTN treated a significantly greater percentage of racial/ethnic minorities and a significantly greater percentage of probationers/parolees than non-CTN private units ($p < .001$). CTN public units treated a significantly lower percentage of probationers/parolees than non-CTN public units ($p < .001$).

Referral Sources

Average Percentage of Clients Referred From Source				
	Mean %			
	CTN Public	Non-CTN Public	CTN Private	Non-CTN Private
Self-referrals	26.6%	21.4%	29.6%	22.5%
Program alumni	10.4%	7.9%	9.0%	12.7%
Employee Assistance Programs*	3.2%	2.5%	4.7%	7.6%
Direct non-EAP workplace referrals	4.7%	3.5%	6.3%	6.1%
Drug court**	11.0%	12.6%	16.7%	8.7%
Other Legal system	35.6%	39.4%	26.2%	23.3%
Social services	22.9%	22.8%	20.8%	15.9%
Within hospital/treatment system*** (n=480)	22.2%	8.2%	13.9%	19.4%
Physicians	3.1%	2.0%	7.8%	7.9%
Other health care	15.5%	13.2%	20.6%	15.3%
Clergy	1.7%	1.4%	1.5%	2.4%
Schools (n=546)	9.0%	11.5%	10.7%	7.5%

*****Between-group differences significant at $p < .05$.
******Between-group differences significant at $p < .01$.
*******Between-group differences significant at $p < .001$.

Among the many referral sources listed, the most common referral sources were client self-referrals, the legal system, and social services. (Note that percentages in the columns above do not sum to 100% because patients are often referred from multiple sources.)

- Private units in the CTN received significantly fewer referrals, on average, from employee assistance programs than non-CTN private units ($p < .001$).
- CTN private units received significantly more referrals from drug courts than private units outside the CTN ($p < .01$).
- CTN public units received significantly more referrals, on average, from the hospital/treatment system in which the CTP is located than did non-CTN public units ($p < .001$).

C. Staffing and Accreditation

In terms of total FTEs and total employees, CTN units and non-CTN units are very similar. There were no significant differences in the number of FTEs or total employees based on CTN affiliation.

FTEs and Total Employees

	Mean Number of Employees			
	CTN Public	Non-CTN Public	CTN Private	Non-CTN Private
FTEs *(Range: 1 to 508)*	31.1	29.8	43.3	37.5
Total Employees *(Range: 1 to 603)*	35.6	36.4	55.6	47.8

Medical Staff

Percentage of Units Employing Physicians and Nurses				
	CTN Public	Non-CTN Public	CTN Private	Non-CTN Private
Physicians (on payroll)*	42.5%	28.2%	67.8%	50.9%
Physicians (on contract)***	15.8%	36.8%	11.9%	25.6%
Nurses	40.0%	37.7%	57.6%	61.4%

*Between-group differences significant at $p < .05$.
*** Between-group differences significant at $p < .001$.

Public units in the CTN were significantly more likely to employ physicians than non-CTN public units ($p < .001$).

Contracting for physician services is also a common practice in addiction treatment programs. Although public units outside the CTN were significantly less likely to employ physicians, these units were significantly more likely to contract physicians compared to CTN public units ($p < .001$).

Counselors

	Mean %			
	CTN Public	Non-CTN Public	CTN Private	Non-CTN Private
Master's Degree or higher	45.4%	36.1%	53.5%	52.2%
Certified in Addictions***	46.2%	56.3%	40.9%	59.5%
Female	63.5%	61.1%	60.3%	59.6%
Racial/Ethnic Minority	33.2%	39.8%	26.8%	19.0%
Recovering	45.5%	46.9%	46.8%	44.2%

***Between-group differences significant at $p < .001$.

The demographics of the counselors working in these settings were very similar. The only statistically significant CTN/ non-CTN differences were in the percentage of certified counselors. Both public and private units affiliated with the CTN employed, on average, a significantly smaller percentage of certified addictions counselors than non-CTN units ($p < .001$).

Accreditation

Thirty-six percent of the centers were accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). There were significant differences in accreditation among public and private units as well as centers inside and outside the CTN. Specifically, private CTN units were significantly less likely to hold JCAHO accreditation than non-CTN private units (41% versus 60%; $p < .001$).

Thirty five percent of the centers were accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). CARF accreditation was significantly more common in both types of CTN units than in their non-CTN counterparts (31% CTN public, 24% CTN private, 15% public, and 12% private; $p < .001$).

APPENDIX:

Study and Sample Design

The National Treatment Center Study (NTCS) is a family of projects designed to document and track changes in the organization, structure, staffing, and service delivery patterns of substance abuse treatment programs throughout the U.S. The NTCS is headquartered at the University of Georgia's Institute for Behavioral Research.

As of November 2005, the NTCS consists of five components, each of which are described briefly here. The value of collecting longitudinal data from multiple sectors of the treatment system is that it permits statistical comparisons across sectors, allowing us to better understand the influence of organizational structure on clinical services, particularly the use of evidence-based practices.

Clinical Trials Network Treatment Programs

In 2001, NIDA awarded the University of Georgia a grant to study the impact of CTN participation on innovation adoption. The CTN is designed as a national network of treatment programs that implement structured trials of emerging pharmacological and behavioral treatment techniques in real-world treatment settings. CTN programs include government owned, public, private non-profit, and private for-profit facilities offering a broad spectrum of treatment services. The study offers a basis for comparison with other non-CTN treatment providers, particularly in terms of programs' familiarity with, and use of, various emerging treatment techniques. A total of 240 administrative units within 104 CTPs were interviewed for this study in 2003-'04.

Representatives from each participating unit provided data in face-to-face interviews with UGA staff. Interviews focused on organizational structure, management practices, personnel (number and type), case mix, services offered, and CTN protocols in which the CTP was involved. A particular focus was the centers' adoption and use of various evidence-based treatment techniques, particularly those examined in CTN protocols. All administrative respondents were subsequently asked to provide a list of their counselors, to whom anonymous questionnaires were later distributed. Findings from the questionnaire data (which focused on the counselor's caseload characteristics, services delivered, training received, and attitudes toward various treatment techniques) will be reported separately.

During 2003-2004, there were 109 community treatment programs participating in the CTN. Together, these 109 CTPs operated 262 autonomous units that were participating or expecting to participate in a CTN clinical trial. Of these, 240 agreed to participate in the NTCS face-to-face interview. The following table presents a breakdown of the node-by-node response and participation rates.

Node-By-Node Response and Participation

Nodes	Organizations		Administrative Units	
	CTN Population (2003-2004)	NTCS Participants	Eligible CTPs	CTPs Interviewed
1. California/Arizona	7	7	20	20
2. Delaware Valley	12	11	27	26
3. Florida	4	4	21	21
4. Great Lakes	5	5	5	5
5. Long Island Regional	5	3	22	12
6. Mid-Atlantic	8	8	11	11
7. New England	5	5	12	12
8. New York	8	7	24	14
9. North Carolina	7	6	7	6
10. Northern New England	5	5	18	18
11. Ohio Valley	6	6	15	15
12. Oregon	7	7	18	18
13. Pacific Region	5	5	23	23
14. Rocky Mountain	5	5	10	10
15. South Carolina	6	6	9	9
16. Southwest	7	7	10	10
17. Washington	7	7	10	10
TOTAL	N=109	n=104	N=262	n=240
(Response Rate)	(95.41%)		(91.60%)	

Public Treatment Centers

In 2003-2004, we interviewed the administrators of 362 publicly funded treatment centers throughout the U.S. Unique to this study, "public" centers are defined as those receiving more than 50% of their annual operating revenues from government grants or contracts (including block grant funds). The average center participating in this study received 86% of its annual revenues from such sources.

These centers were selected using a two-stage statistical sampling process to ensure representation across geographic regions and inclusion of a wide range of treatment facilities. First, all counties in the U.S. were assigned to one of 10 geographic strata of equivalent size, based on population. Next, counties within strata were randomly sampled. All public treatment centers in those sampled counties were then enumerated using federal and state treatment directories and other available sources. Centers were then sampled proportionately across strata. Centers declining to participate in the study were replaced by random selection of alternate units within the same geographic strata. The 362 participating centers reflect a response rate of 80%.

A second round of interviews with this panel of centers began in December 2004 and will conclude in early 2006.

Eligible centers for this study offer treatment for alcohol and drug problems, at a level of care at least equivalent to structured outpatient programming as defined by the American Society of Addiction Medicine's Patient Placement Criteria. Counselors in private practice, DUI / driver education programs, halfway houses, and programs offering exclusively methadone maintenance services were not eligible. Programs with methadone units were eligible if other addiction treatment services meeting ASAM level of care criteria were available. Additionally, because the research design focused on treatment services available to the general public, treatment units based in correctional facilities and those operated by the Veteran's Administration were not eligible.

Private Treatment Centers

A companion study of privately funded treatment centers began in 1995, initially with support from NIAAA (R01AA10130) and most recently with support from NIDA (R01DA13110). In this study, "private" centers are those that receive less than 50% of their annual operating revenues from government grants or contracts. The average center in this component of the NTCS receives only 17% of its funding from such sources. Sampling and eligibility rules were identical to the public center sample just described.

Using panel data from four waves of interviews (1995-'96, 1997-'98, 2000-'01, 2003-'04), we have been able to identify significant patterns of change within the private sector, including changes in service availability, the adoption of new medications and behavioral therapies, and trends in program closure.

Funding for a fifth and sixth wave of interviews with this panel of private-sector treatment facilities (to extend through 2010) is currently pending award. This would be the longest-running panel study of private-sector addiction treatment services in the U.S.

Therapeutic Communities

In 2000, UGA was awarded an additional grant from NIDA to study the structure, staffing, and service provision of a nationally representative sample of therapeutic communities (TCs) across the US. The central criterion for inclusion in this study was that the program self-identified as a therapeutic community. By using self-identified TCs as the sample, we were better able to capture the diversity of TCs in the U.S. The two-stage sampling design again parallels the studies described above, resulting in a sample of 380 TCs located in 42 states. On-site interviews were conducted in late 2002-early 2004, with a response rate exceeding 85%. Of particular interest in that study is the extent to which modern TCs have adapted or diverged from the "essential elements" of the traditional therapeutic community model described by George DeLeon and colleagues. The TC interviews also ask about the program's clinical services and the availability of specialized treatment services.

Opioid Treatment (Methadone) Programs

In 2005, UGA was awarded an exploratory/developmental grant from NIDA (R21DA20028) to study the adoption of buprenorphine and contingency management (motivational incentives) in a small sample of opioid treatment programs. The design of this study will essentially provide a "reference group" for the 59 methadone units interviewed as part of the CTN study described above. By pooling data from both samples of OTPs, we will be able to address (a) whether OTPs in the CTN are representative of the general population of OTPs; and (b) how direct exposure to clinical trials involving buprenorphine or contingency management techniques enhances programs' propensity to adopt those practices. Data are expected to be available for analysis in late 2006.

Publications in the Series

Report No. 1 – Private Treatment Centers: Wave 1 On-site Interview Results (1996)
Report No. 2 – Private Treatment Centers: 6- and 12-month Follow-up Data (1997)
Report No. 3 – Private Treatment Centers: Wave 2 On-site Interview Results (1998)
Report No. 4 – Private Treatment Centers: Results of Staff Questionnaires (1999)
Report No. 5 – Private Treatment Centers: Wave 3 On-site Interview Results (2002)
Report No. 6 – Private Treatment Centers: Longitudinal Results, 1995-2001 (2003)
Report No. 7 – Public Treatment Centers: On-site Interview Results (2005)
Report No. 8 – Private Treatment Centers: Wave 4 On-Site Interview Results (2005)
Report No. 9 – Therapeutic Communities: On-site Interview Results (2005)
Report No. 10 – Clinical Trials Network: Summary and Comparison Report (2005)

For More Information

Summary reports from all components of the National Treatment Center Study are posted on the project's website, www.uga.edu/NTCS, or may be obtained by requesting copies from the project's main office.

Abstracts of all peer-reviewed publications, and slides from all conference presentations, are posted on the website as soon as they become available. Hard copies of these materials may be ordered free of charge from a link on the site.

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The National Treatment Center Study
Institute for Behavioral Research
101 Barrow Hall
The University of Georgia
Athens, GA
1-800-742-0694
www.UGA.edu/ntcs