NATIONAL TREATMENT CENTER STUDY

SUMMARY REPORT

A comprehensive report detailing the findings of the first wave of on-site interviews with a nationally representative sample of publicly funded drug and alcohol treatment programs participating in the National Treatment Center Study conducted by the Institute for Behavioral Research, University of Georgia.

September 2004

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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 4 separate national samples of substance abuse treatment providers:

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

Refer to the section on "Study and Sample Design" at the end of this report for further details on the NTCS design and procedures.

This report is based on data from 362 publicly funded substance abuse treatment centers. The 362 centers are *nationally representative* – i.e., they are reflective of the distribution and characteristics of all publicly-funded treatment programs in the U.S. in 2003.

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 sample received 86% of its annual revenues from such sources. These centers include government-owned facilities, as well as privately owned non-profit programs relying heavily on federal, state and/or local government funds.

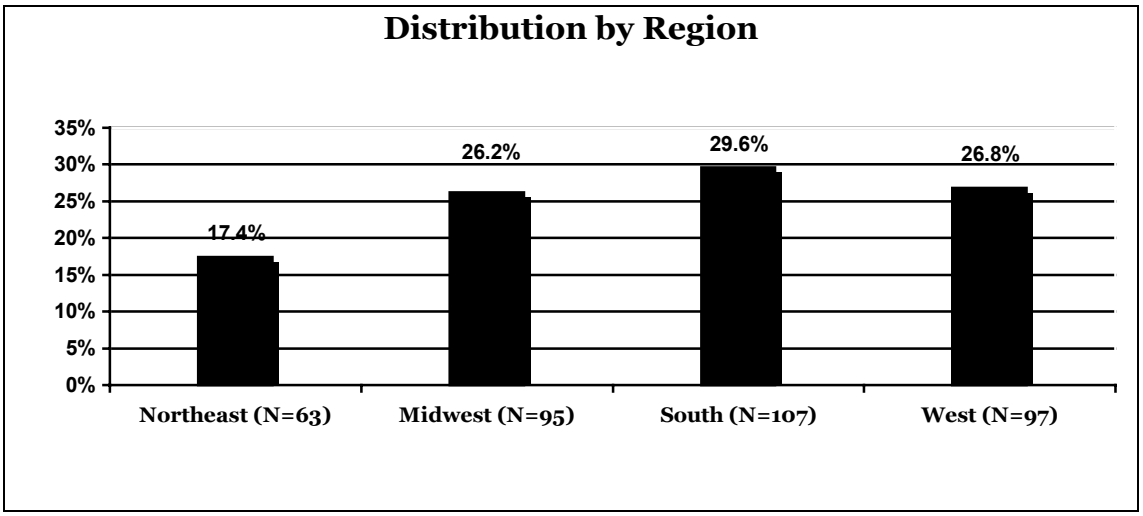
It is the investigators' policy that individual participating treatment facilities are not identified in any published reports. All NTCS data are reported in the aggregate. Separately, each participating center receives periodic individualized feedback reports comparing the center to the rest of the sample, and to aggregated data from other similar centers. Those individualized reports are not released to the general public.

Other findings from the NTCS may be found on our website, www.uga.edu/ntcs.

We welcome your comments and questions, and we thank you for your interest and participation in the National Treatment Center Study.

Sample Distribution (Public Centers)

Three hundred sixty-two publicly funded treatment centers from 40 states and the District of Columbia participated in this wave of the National Treatment Center Study.



Regions were defined as follows (parentheses show number of programs in each state):

Northeast: Connecticut (3); Maine (2); Massachusetts (11); New Hampshire (2); New Jersey (12); New York (22); Pennsylvania (11)

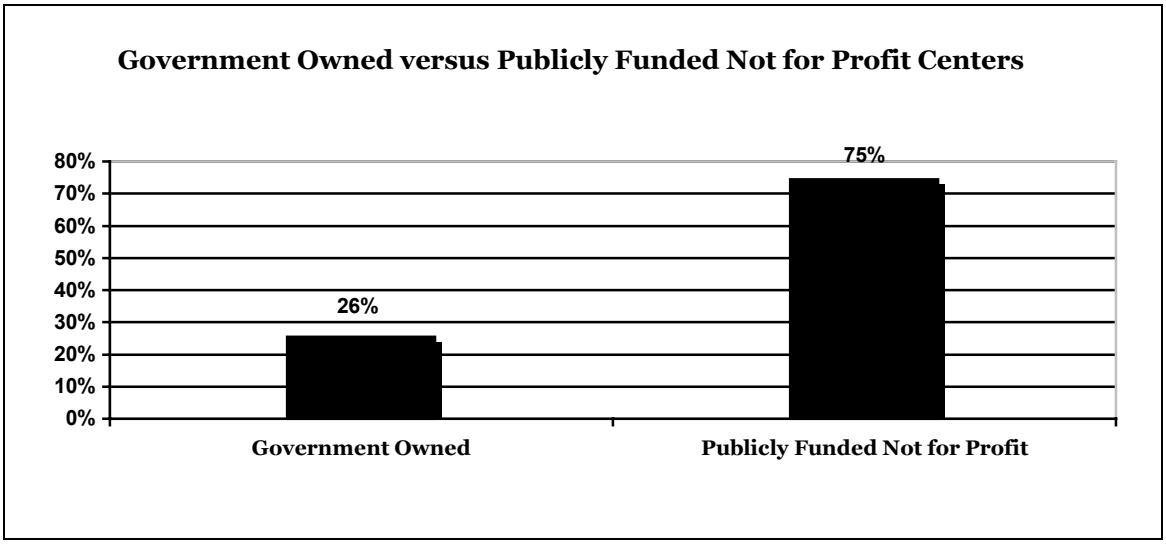
Midwest: Illinois (11); Indiana (3); Iowa (3); Kansas (3); Michigan (14); Minnesota (14); Missouri (7); Nebraska (2); Ohio (31); Wisconsin (7)

South: Alabama (3); Arkansas (1); Delaware (1); District of Columbia (3); Florida (9); Georgia (9); Louisiana (16); Maryland (12); Mississippi (2); North Carolina (3); Oklahoma (8); South Carolina (5); Tennessee (5); Texas (23); Virginia (6); West Virginia (1)

West: Arizona (4); California (63); Colorado (6); Nevada (3); New Mexico (4); Oregon (6); Utah (5); Washington State (6)

I. Organizational Structure

A) Ownership

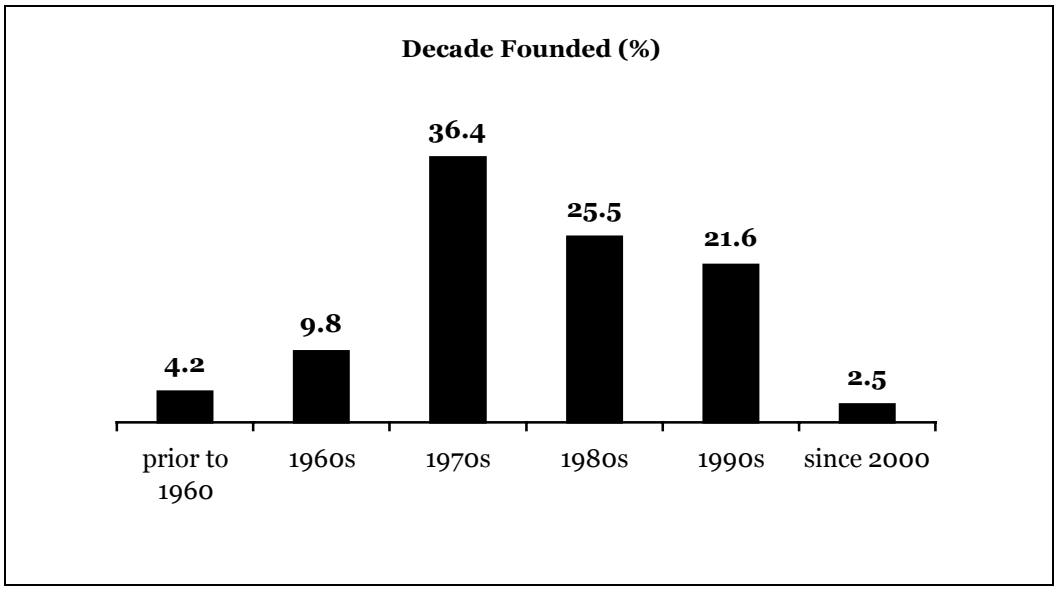


Because sample selection criteria were based on programs' funding sources, all treatment centers in this sample received more than 50% of their annual operating revenues from government grants and/or contracts. Those programs were owned by one of two types of organizations: government agencies (typically county-run facilities) and privately owned (but publicly funded) non-profits.

These data are shown to provide a context for comparisons depicted in subsequent sections of this report.

B) Center Age

The average public center was 23 years old. Center age ranged from 1 to 139 years.



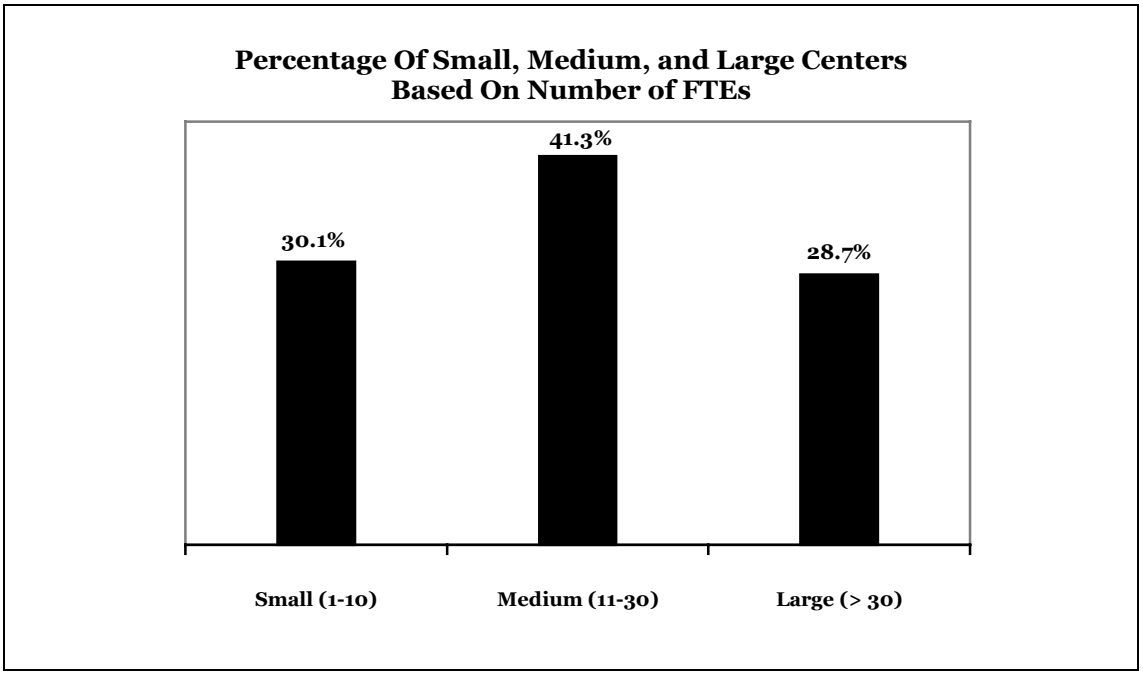
C) Accreditation

Thirteen percent of the public centers were accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO). Similarly, 15.6% of the public centers were accredited by the Rehabilitation Accreditation Commission (CARF). Nearly 2% of the public centers were accredited by both JCAHO and CARF. Seventy-two percent of the centers held neither JCAHO nor CARF accreditation.

While only a small proportion of the public centers were accredited by JCAHO or CARF, nearly all of the centers in this sample (98.9%) were state licensed.

D) Full-time Equivalents (FTEs) and Total Employees

	Mean	Range
FTEs	30.8	1 to 508
Total Employees	37.7	1 to 603



E) Counselor Characteristics

The average public center employed 13 counselors (range 0 to 290). Centers, on average, reported the following counselor characteristics.

	Mean %
Masters Degree or higher	36.3%
Certified	56.7%
Female	61.3%
Racial/Ethnic Minority	39.9%
Recovering	47.0%

On average, 36.3% of counselors held Masters Degrees or higher. However, 21.6% of centers employed no Masters level counselors. Conversely, in 8.5% of public centers, all counselors possessed at least a Masters Degree.

Most commonly, counselors held Masters Degrees in psychology or social work, but other degree categories were mentioned. The following table shows the types of degrees held by Masters level counselors employed in public centers.

DEGREE CATEGORY FOR MASTERS LEVEL COUNSELORS	
Counseling:	
Psychology/Mental Health	36.8%
Education	6.3%
Marriage and Family	4.5%
Addiction	5.0%
Social Work	27.7%
Community/Human Services (including law, criminal justice, and corrections)	4.7%
Religion/Alternative Treatments	4.2%
Medical	1.7%
Other	8.9%

Over half (56.8%) of counselors, on average, were certified alcohol/drug abuse counselors. In one-quarter of centers (23.9%) all employed counselors were certified, while 6.8% of centers employed no certified substance abuse counselors.

F) Medical Staff

CENTERS EMPLOYING PHYSICIANS AND NURSES

	% On Payroll or Contract	% Neither Payroll nor Contract
Physicians	65.4%	34.6%
Nurses	39.5%	61.5%

Government owned centers were significantly more likely to employ physicians (73.0% versus 62.6%; $p < .01$) and nurses (53.3% versus 32.7%; $p < .001$) than other public centers.

II. Caseload Characteristics

A) Demographics

CLIENT DEMOGRAPHICS

	Mean % of Caseload
Women	39.7%
Adolescents	13.6%
Minorities	49.3%
Relapsers	61.7%
Parolees/Probationers	52.1%

Most centers' caseloads comprised a mix of gender, age, and racial/ethnic groups. Of note, 6% of the centers did not treat women, while 10% of the centers served only women.

Over half of the centers (52.6%) did not serve adolescents, while about 5% of the centers served only adolescents. Of the centers that served adolescents, patients under age 18 comprised an average of 28.8% of their caseloads.

Regional Variation in Caseloads

Centers in the West served a significantly greater mean percentage of women than those in the Midwest (44.6% versus 35.0%; $p < .10$).

Centers in the Northeast region served a significantly greater mean percentage of relapsers than those in the South (72.3% versus 53.6%; $p < .001$) or the West (72.3% versus 59.8%; $p < .05$). In addition, centers in the Midwest served a significantly greater percentage of relapsers than those in the South (65.7% versus 53.6%; $p < .01$).

B) Primary Diagnosis

CLINICAL DIAGNOSTIC SUBGROUPS: Primary Diagnosis	Mean %
Alcohol Dependence or Abuse	38.7%
Cocaine Dependence or Abuse	25.6%
Opiate Dependence or Abuse	14.5%
Marijuana Dependence or Abuse	19.4%
Methamphetamine Dependence or Abuse	12.4%
Club Drugs Dependence or Abuse	1.4%

Among diagnostic groups, alcohol dependence and cocaine dependence accounted for the greatest proportion of centers' caseloads, although a variety of primary and secondary conditions were reported.

Ten percent of public centers did not serve clients with a primary diagnosis of opiate dependence or abuse. Over half of centers have not encountered persons with a primary diagnosis of club drugs dependence or abuse.

Regional Variation in Primary Diagnosis

Centers in the Midwest treated a significantly greater percentage of clients with a primary diagnosis of alcohol dependence or abuse than in the South (44.6% versus 34.7%; $p < .05$).

Centers in the West treated a significantly smaller percentage of clients with a primary diagnosis of cocaine dependence or abuse than in the Northeast, the South and the Midwest (16.5% versus 29.9%; $p < .05$ and 16.5% versus 30.0%; $p < .001$; 16.5% versus 29.2%; $p < .001$).

Centers in the Northeast treated a significantly greater percentage of clients with a primary diagnosis of opiate dependence or abuse than in the Midwest or the South (21.6% versus 10.4%; $p < .001$; 21.6% versus 14.0%; $p < .01$).

Centers in the West treated a significantly greater percentage of clients with a primary diagnosis of methamphetamine dependence or abuse than those in the Northeast, Midwest, or South (33.9% versus 1.4%, 5.3% and 5.7% respectively; $p < .000$).

C) Referral Sources

AVERAGE PERCENTAGE OF CLIENTS REFERRED FROM SOURCE

	Government Owned	Publicly Funded Not for Profit
	Mean %	**Mean %**
Self-referrals	24.6%	21.3%
Program alumni	7.5%	8.3%
Employee Assistance Programs*	2.0%	3.1%
Direct non-EAP workplace referrals**	2.3%	4.6%
Legal system	38.6%	39.9%
Drug court	12.6%	12.6%
Social services	21.4%	22.7%
Within Hospital/Treatment System*	14.8%	6.4%
Physicians	1.8%	2.2%
Other Health Care	11.5%	14.1%
Clergy	1.9%	1.2%
Schools	9.6%	12.0%

*p<.10; **p<.05

Centers received client referrals from a variety of sources. The most common referral sources were the legal system, social services agencies, and client self-referrals. (Note that percentages in the table above do not sum to 100% because patients are often referred from multiple sources.)

Within the NTCS sample, some significant differences in referral sources were found between government-owned programs and other publicly-funded treatment centers. Notably, government-owned programs received significantly more referrals from the hospital or treatment system in which they may have been located (14.8% vs. 6.4%, p< .10). Government-owned programs received fewer referrals from workplaces; however, the absolute number of referrals received from any of these sources was quite low.

III. Clinical Service Delivery

A) Level of Care

PERCENTAGE OF CENTERS OFFERING LEVEL OF CARE

	Government Owned	Publicly Funded Not for Profit
Inpatient Detox	16.3%	12.3%
Inpatient Adult Chemical Dependency (<28 days)*	25.0%	10.8%
Inpatient Adolescent Chem. Dep. (<28 days)	2.2%	4.1%
Residential (>29 days)*	28.6%	43.4%
Adult Psychiatric (Inpatient)	3.3%	2.6%
Adolescent Psychiatric (Inpatient)	2.2%	1.1%
Outpatient Detox	6.5%	7.5%
Partial Hospitalization (at least 20 hours/week)	10.9%	13.9%
Intensive Outpatient (9 - 20 hours/week)	56.5%	56.0%
Outpatient (<9 hours/week)	68.5%	66.4%
Aftercare	57.6%	57.3%

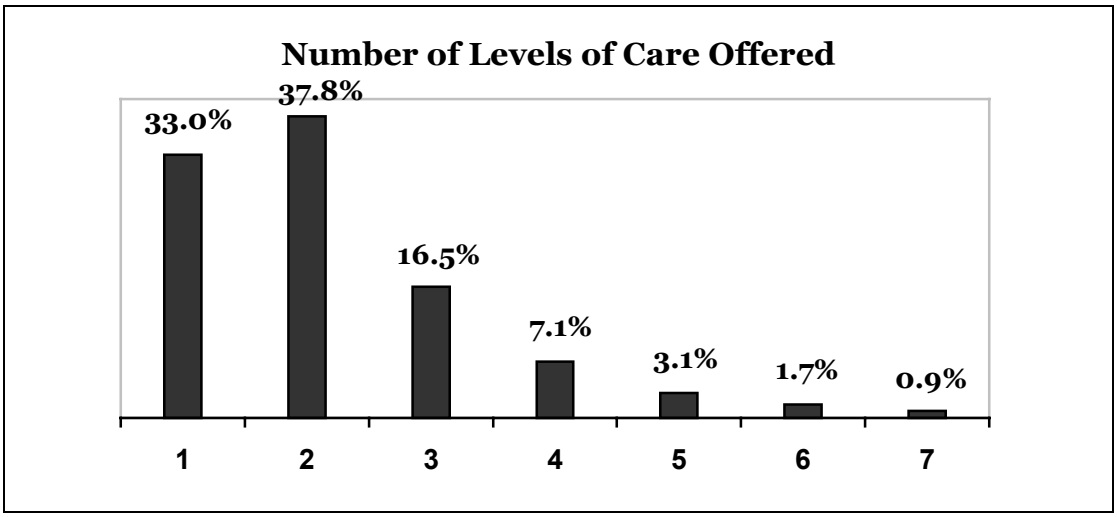
*p< .05;

Among this sample of publicly funded treatment centers, 11.7% of government-owned facilities were based in hospitals, while 6% of the other publicly funded non-profit units were based in hospitals. Many centers had formal arrangements in place with other facilities to provide medically managed services such as detoxification.

Government owned centers were significantly more likely to offer inpatient chemical dependency services and residential care than other public centers. For example, 25.0% of government owned centers provided adult inpatient chemical dependency services compared to 10.8% of other public centers (p< .05).

No significant differences based on ownership were identified for outpatient, partial hospitalization, intensive outpatient, or aftercare.

B) Continuum of Care



PERCENTAGE OF CENTERS OFFERING INPATIENT ONLY, OUTPATIENT ONLY, AND MIXED LEVELS OF CARE

IP ONLY		OP ONLY		MIXED*	
Government Owned	Publicly Funded Not for Profit	Government Owned	Publicly Funded Not for Profit	Government Owned	Publicly Funded Not for Profit
25.0%	21.0%	53.3%	46.4%	21.7%	32.6%

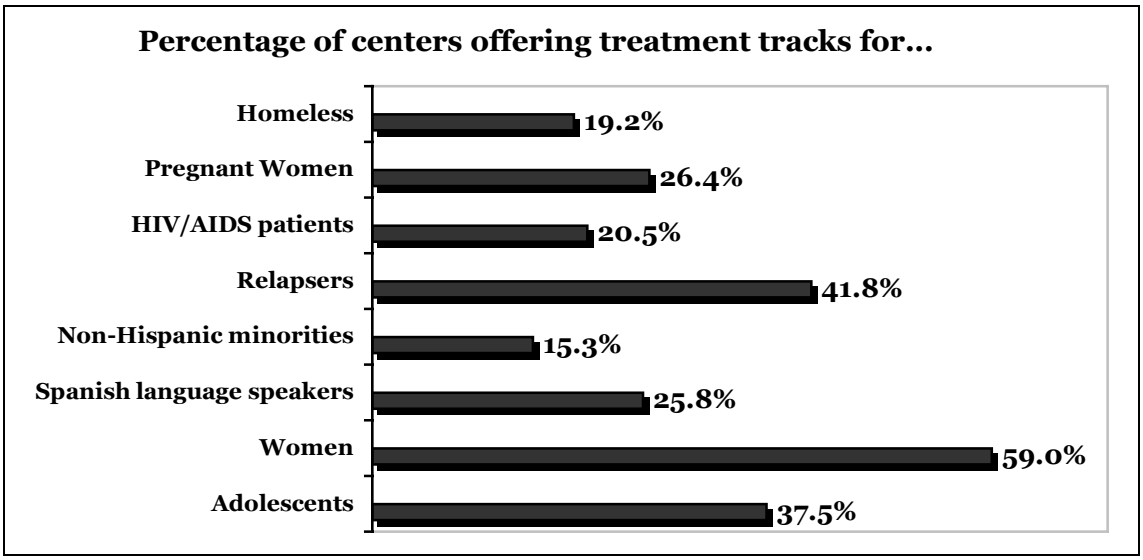
*p< .05

The majority of centers (70.8%) offered one or two distinct levels of care (see graph above).

Government owned centers were more likely to offer either inpatient only or outpatient only services than other public centers (N.S.), but they were significantly less likely to offer mixed levels of care (both inpatient and outpatient treatment) than other public centers (21.7% versus 32.6%; p< .05).

B) Treatment Tracks

Almost 83% of the centers provided at least one separate treatment track for specific demographic groups.



Government owned centers were significantly more likely to offer separate treatment tracks for pregnant women (37.4% versus 22.7%; $p < .01$) than other public centers.

C) Innovation and Evidence-Based Practices

Intake/Assessment

Medical and Psychiatric Assessments

At intake, an average 19.5% of clients received psychiatric assessments that were conducted by a psychiatric nurse or psychiatrist and an average 38.5% of clients received physicals that were conducted by a nurse practitioner or physician. These percentages differ significantly, however, for government owned versus other public centers, with a significantly greater percentage of clients receiving psychiatric assessments (26.5% versus 16.8%; $p < .05$) in government owned centers.

Standardized Addiction Measures

Administrators were asked about the extent to which standardized addiction measures such as American Society of Addiction Medicine (ASAM) criteria and 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.

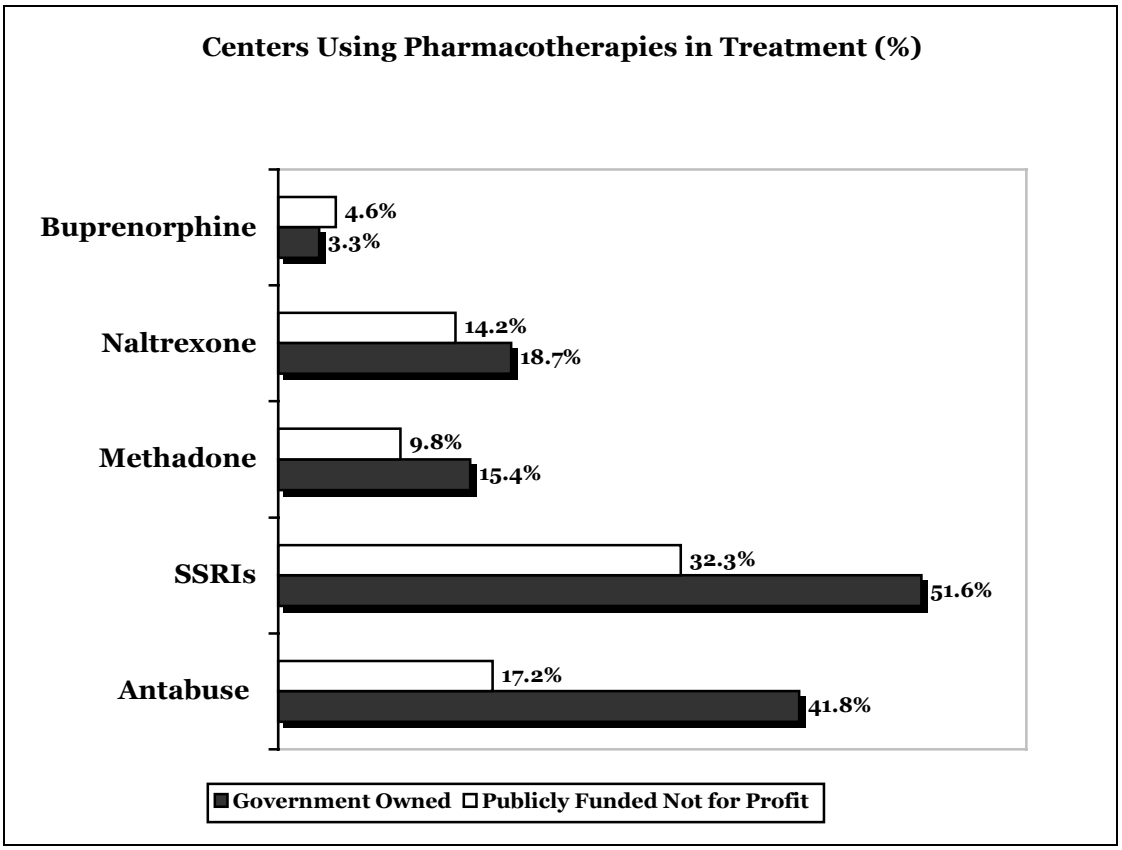
PERCENTAGE OF CENTERS USING STANDARDIZED INTAKE/ASSESSMENT MEASURES

	Government Owned	Publicly Funded Not for Profit
Use any Standardized Addiction Measures*	91.3%	83.2%
ASAM (Level of Care)	69.6%	68.0%
ASI*	66.3%	57.1%

*$p < .10$

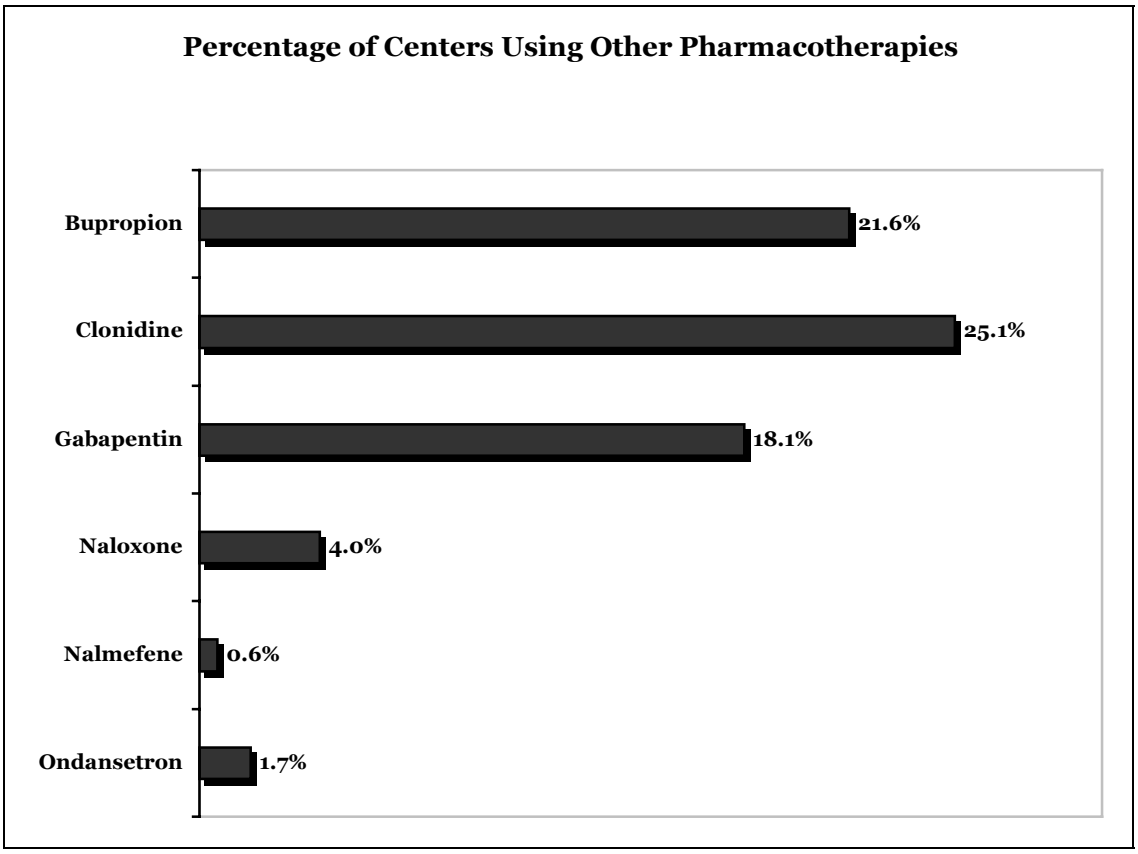
Government owned centers were significantly more likely to use standardized intake/assessment measures than other public centers.

Pharmacotherapies



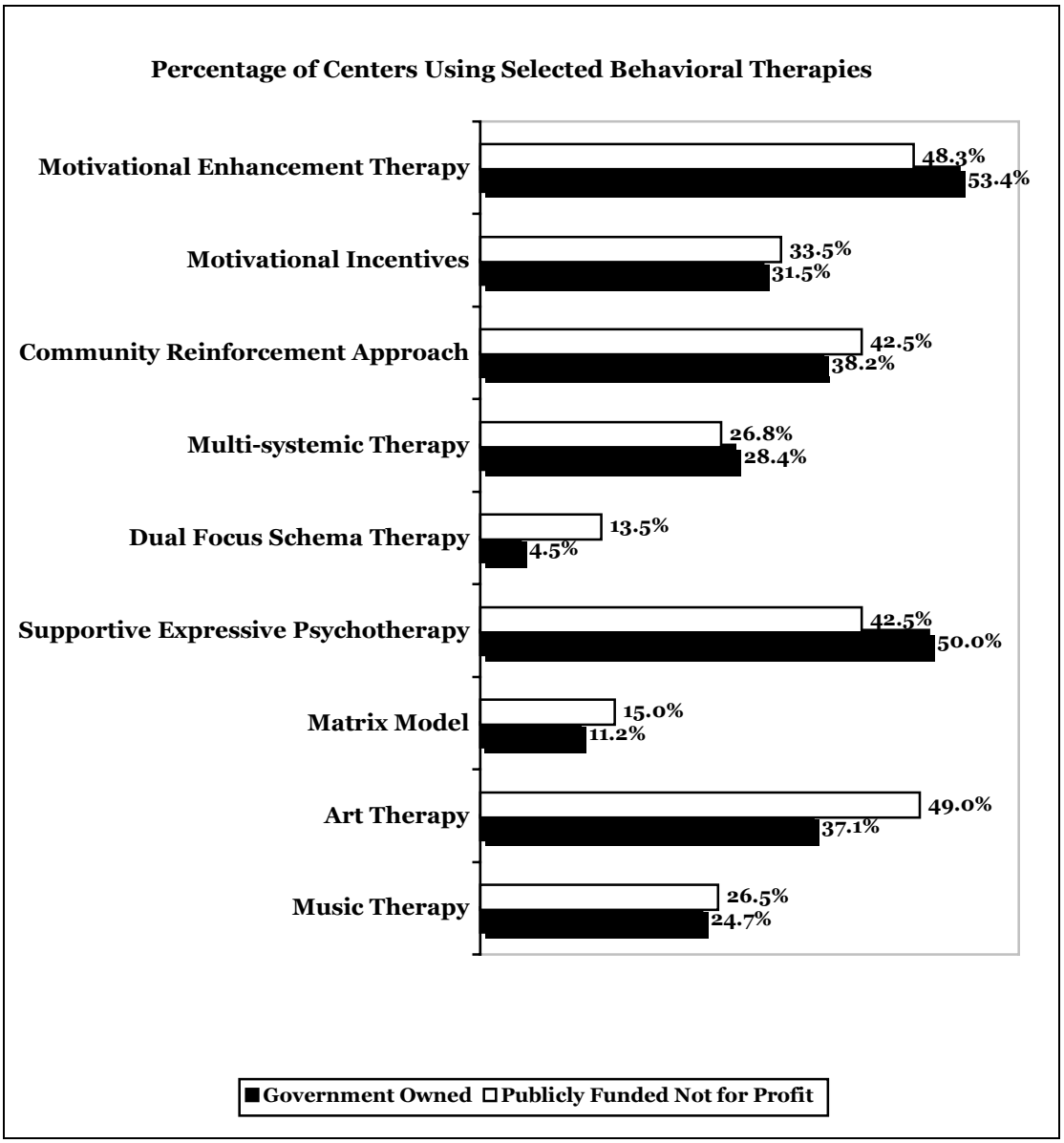
Government owned centers were significantly more likely to use Antabuse than other public centers (41.8% versus 17.2%; p< .001). In addition, government owned centers were significantly more likely to use SSRIs (selective serotonin reuptake inhibitors) than other public centers (51.6% versus 32.3%; p< .01).

Other Pharmacotherapies



Government owned centers were significantly more likely to use clonidine (35.2% versus 21.8%; p< .05), which may be partly a function of there being more inpatient detoxification services offered in government-owned centers, as reported earlier. Government-owned centers were significantly more likely to use bupropion (29.5% versus 18.9%; p< .05).

Behavioral Therapies



Centers utilize a diverse array of treatment techniques. Among them, government owned centers were significantly less likely to use dual focused schema therapy than other public centers (4.5% versus 13.5%; $p < .05$), and they were also less likely to use art therapy than other public centers (37.1% versus 49.0%; $p < .10$).

D) Therapeutic Orientation

Centers were asked to what extent they emphasized each of the following types of counseling and therapy. Answers were reported on a 0-to-5 scale, where 0 is "no emphasis" and 5 is "very great emphasis."

	Government Owned	Publicly Funded Not for Profit
	Mean Score	**Mean Score**
Supportive Group Therapy	4.8	4.7
Confrontational Group Therapy	2.0	2.2
Family Therapy	2.9	3.0
Supportive Individual Counseling*	4.2	4.5
Individual Behavioral Therapy	3.3	3.6
Medical/Psychiatric Model	3.2	3.0
Use of Medications	2.7	2.4
Spiritual	3.1	3.4

*p< .05

As shown, centers tended to report the greatest degree of emphasis on supportive group therapy and supportive individual counseling, reflected in the highest mean scores. (Possible scores ranged from 0 to 5.) Relatively speaking, the areas receiving the least amount of emphasis were confrontational group therapy and the use of medications. The latter is reflected in overall low rates of pharmacotherapy use shown in earlier tables.

E) Twelve-step Model

Administrators were asked whether the center's treatment program was based on a 12-step model. More than half (59.7%) indicated that the 12-step model best characterized their program. Other centers tended to emphasize cognitive behavioral therapies, or an eclectic mix of approaches which generally incorporated 12-step as one component.

Regional Variation in 12-step orientation

Centers evidenced significant regional variations in 12-step orientation, with those in the Midwest (73.0%) and South (64.0%) significantly more likely than those in the West (47.0%) to base their treatment models on a 12-step approach ($p < .05$).

More than 64% of the centers reported that attendance at 12-step meetings during the course of treatment is a "requirement."

Twelve step meetings were held on-site at 59.7% of the centers. Alcoholics Anonymous (AA) and Narcotics Anonymous were the most commonly held twelve-step meetings followed by Cocaine Anonymous (CA) and Al-Anon.

PERCENTAGE OF CENTERS OFFERING 12-STEP MEETINGS

AA	48.3%
NA	47.0%
CA	10.5%
Al-Anon	6.9%

E) Comprehensive/Wraparound Services

Centers were asked to what extent they make efforts to provide each of the following services to clients who need them. Answers were reported on a 0-to-5 scale, where 0 is "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.

	Government Owned	Publicly Funded Not for Profit
	Mean Score	Mean Score
Medical	4.2	4.1
Dental	3.3	3.2
Employment*	3.3	3.8
Legal	3.6	3.7
Family/Social*	4.2	4.4
Psychological/Emotional	4.4	4.5
Financial	3.1	3.4

*p< .05

In addition, center administrators reported on the availability of child care and transportation services for clients who need them. Just over one-quarter (27.8%) of the centers offer a child care program for substance abuse patients with children. Just over two-thirds (71.0%) of centers provide clients with transportation assistance if needed.

F) Other Behavioral Health Services

PERCENTAGE OF CENTERS OFFERING SPECIFIC PROGRAMS

Eating Disorders	12.4%
Pathological Gambling	20.8%
Internet Addiction	6.2%
Sex Addiction	17.1%
Smoking/Nicotine Addiction	41.3%
Dual Diagnosis (Treats both substance abuse and psychiatric problems)	50.3%

Government owned centers were significantly more likely to offer programs for eating disorders (17.8% versus 10.6%; $p < .10$) and smoking cessation or nicotine addiction than other public centers (54.4% versus 37.0%; $p < .01$). Government owned centers were also significantly more likely to offer integrated care for the treatment of dually diagnosed clients than other public centers (40.4% versus 53.0%; $p < .05$).

G) Outcomes

Centers reported that on average 60.2% of substance abusing clients complete their prescribed treatment program or plan.

Government owned and other public centers did not differ significantly in the average percentage of substance abusing clients completing their prescribed treatment program or plan.

Half (50.4%) of the centers collect data on patient outcomes after discharge.

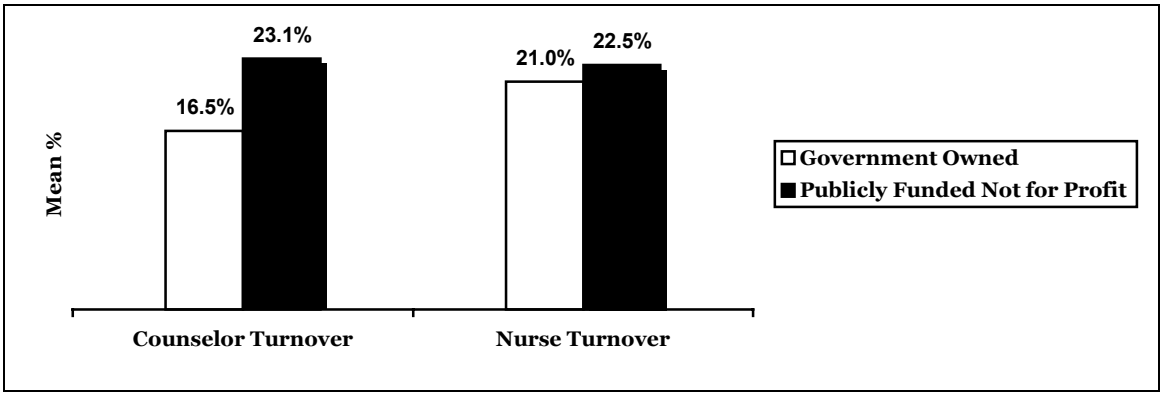
IV. Organizational Performance

A) Voluntary Turnover

Counselors and Nurses

On average, centers lost 21.4% of counseling staff over the past year due to voluntary turnover. However, approximately 28% of centers reported no counselor turnover.

A total of 137 centers employed nurses. On average, 21.9% of the nurses at these centers left voluntarily over the past year. As was the case with counselor turnover, a portion of the centers (55.5%) experienced no turnover among nurses, while other centers reported high turnover.



Government owned centers experienced significantly lower voluntary counselor turnover than other public centers ($p < .05$).

On average, administrators reported that it typically takes 8.5 weeks to fill a counseling position and 9.8 weeks to fill a nursing position (range 0 to 60 weeks).

Government owned centers reported a significantly greater number of weeks, on average, to fill a counselor position than other public centers (10.1 weeks versus 7.9 weeks; $p < .05$).

B) Layoffs

In addition to voluntary turnover, 12.6% of the centers reported counselor layoffs during the past year. Less than six percent of the centers reported nurse layoffs during the past year.

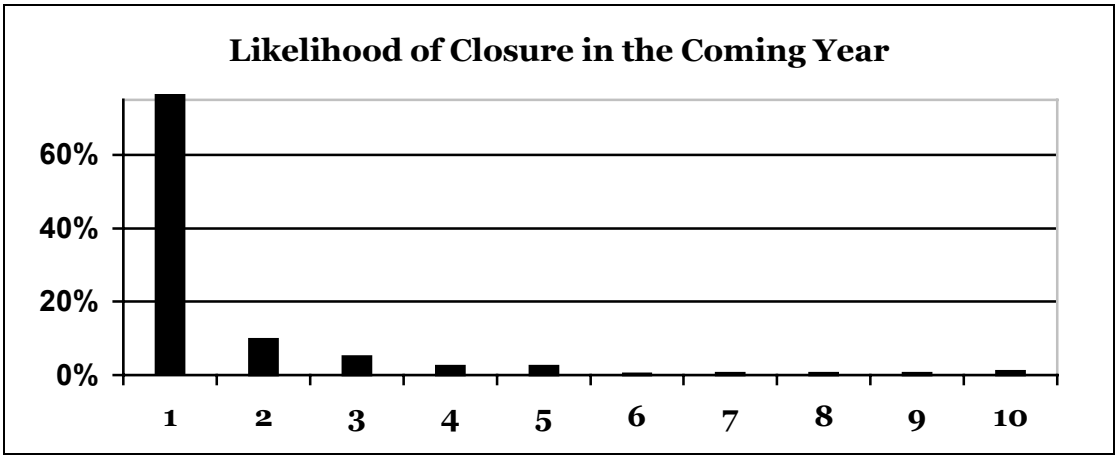
C) Expansion, Reduction, and Threat of Closure

Over one-third of the 362 public centers in the NTCS reported no change in the number of clients, programs, or staff in the preceding two years. Nearly half of the centers reported expansions in at least one of these three areas, whereas 8% to 12% reported reductions in these areas in the preceding two years. By and large, patterns of expansion and reduction did not co-occur within the same treatment center. However, between 5% and 8% of centers reported that both some expansion and reduction had occurred.

	% Reporting change in # of Clients	% Reporting change in # of Programs	% Reporting change in # of Staff
Expansion only	50.4%	46.2%	43.7%
Reduction only	8.6%	7.3%	12.3%
Both	5.3%	7.5%	8.6%
No Changes	35.7%	39.0%	35.4%
	100%	100%	100%

D) Likelihood of Closure

On a scale from 1 (not at all likely) to 10 (very likely), administrators were asked to report the likelihood of the center's closure in the coming year. On average centers reported a very low (1.60) likelihood of closure. Three-quarters of the centers reported that closure in the coming year was not at all likely.



A comparison of centers that experienced a reduction in the number of clients, programs, or services showed significant mean differences in the likelihood of closure. As expected, centers with recent reductions scored significantly higher on the closure scale than centers without recent reductions.

	MEAN LIKELIHOOD OF CLOSURE	
OVERALL	1.60	
	Reduced	**Did Not Reduce**
# Clients*	2.27	1.49
# Programs*	2.20	1.50
# Staff**	2.14	1.46

*p< .05; **p < .01

E) Counselor Salaries

AVERAGE COUNSELOR SALARY	
Minimum	$25,602.38
Maximum	$38,569.57
Average	$31,124.01

Government owned centers reported on average significantly higher maximum counselor salaries than other public centers ($43,936.63 versus $36,696.59; p< .05)

F) Revenue Sources

AVERAGE PERCENTAGE OF TOTAL REVENUES RECEIVED FROM SOURCE	
Medicaid	4.4%
Medicare	<1%
Private (Indemnity) Insurance	1.1%
HMO, PPO, and POS	1.4%
Self Pay	5.7%
Criminal Justice System	6.9%
Federal Block Grants Administered by State	25.7%
Other Federal	8.0%
Other State	21.5%
Other County, City, Local	16.1%
Charity	3.0%
Endowments	<1%
Other	2.7%

PERCENTAGE OF CENTERS RECEIVING NO REVENUES FROM SOURCE

Medicaid	56.6%
Medicare	91.5%
Private (Indemnity) Insurance	73.8%
HMO, PPO, and POS	78.7%
Self Pay	26.1%
Criminal Justice System	59.0%
Federal Block Grants Administered by State	41.0%
Other Federal	64.2%
Other State	40.5%
Other County, City, Local	41.8%
Charity	53.8%
Endowments	89.4%
Other	65.9%

Additional Data from the National Treatment Center Study

Participating centers with specific data needs are invited to submit requests for analyses to us at NTCS@UGA.edu. We will respond to all requests for data so long as the needed measures are available, and the request does not pose a risk to the confidentiality of any individual treatment center. We are unable to make data files directly available.

Additional summary reports for the public treatment center component of the NTCS will be forthcoming in late 2004.

Earlier reports produced for other components of the NTCS are available on the project's website (www.uga.edu/ntcs).

In addition, we frequently publish research articles in peer-reviewed scientific journals, and present findings from the NTCS at national conferences. Abstracts of all publications, and slides from all presentations, are available on the project's website. Full copies of papers can be ordered free of charge from a link on the website.

Study and Sample Design

The National Treatment Center Study 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.

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%.

Eligible centers were those offering 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.

Administrators of each participating treatment center provided data in face-to-face interviews that were conducted between late 2002 and early 2004. The majority of participating centers were interviewed in 2003. Interviews focused on organizational structure, management practices, personnel (number and type), case mix, and services offered. A particular focus was the centers' adoption and use of various evidence-based treatment techniques,

including pharmacotherapies and psychosocial therapies for addiction treatment. All administrators 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.

Other National Treatment Center Study Components:

The NTCS features three additional components, each of which provides a basis of comparison for findings obtained in the Public Treatment Center sample. Each uses sampling and data collection techniques similar to those described above.

Private Treatment Centers
A companion study of privately funded treatment centers began in 1995. 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. 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. Summary reports from the private center study are available on the NTCS website at www.uga.edu/ntcs. A future report will provide comparisons across the public and private sectors.

Therapeutic Communities
In 2000, UGA was awarded an additional grant from NIDA to study the structure, staffing, and service provision of N=400 therapeutic communities (TCs) across the US. The sampling design again parallels the studies described above; 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 DeLeon. The TC interviews also ask about the program's clinical services and the availability of specialized treatment services.

Clinical Trials Network Treatment Programs
Also underway is a study of all community treatment programs affiliated with NIDA's Clinical Trials Network. 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. Approximately 300 treatment units are affiliated with the CTN, and response rates for that study currently exceed 90%.

Findings from all components of the National Treatment Center Study are posted on the project's website, www.uga.edu/NTCS.

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