

NATIONAL TREATMENT CENTER STUDY

SUMMARY REPORT (No. 8)

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

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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:

- Privately Funded Treatment Centers
- Publicly 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 401 privately funded substance abuse treatment centers. The 401 centers are *nationally representative* – i.e., they are reflective of the distribution and characteristics of all privately -funded treatment programs in the U.S. in 2003.

Unique to this study, “private” centers are defined as those receiving less than 50% of their annual operating revenues from government grants or contracts (including block grant funds and criminal justice contracts). The average center in this sample received only 10% of its annual revenues from such sources. The majority of operating revenues for these “private” centers comes from insurance reimbursements and out-of-pocket payments, with a small percentage coming from Medicare and/or Medicaid.

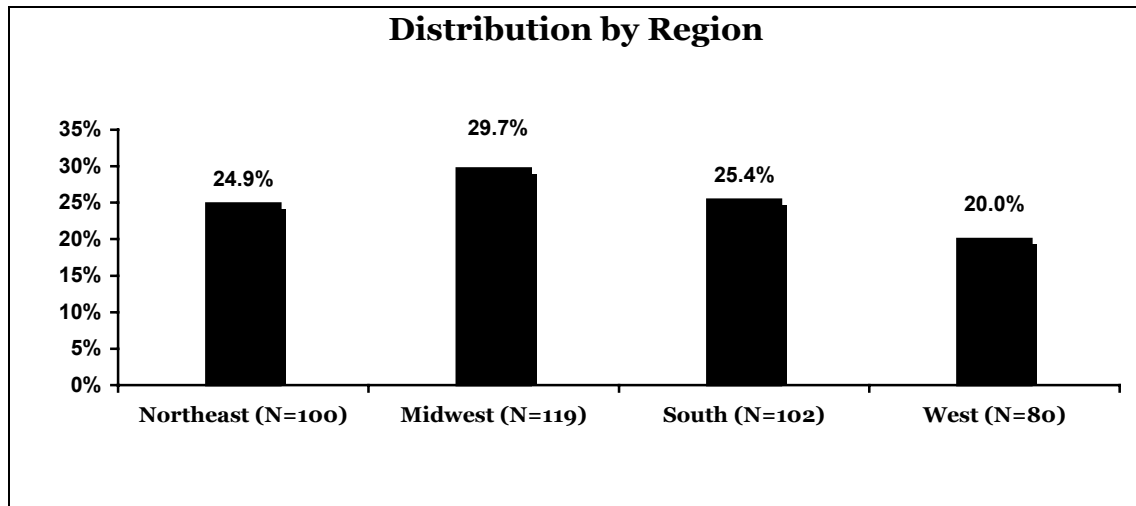
It is the investigators' policy that individual participating treatment facilities are not identified in any published reports. All NTCS data are reported in the aggregate. Separately, each participating center receives periodic individualized feedback reports comparing the center to the rest of the 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 (Private Centers)

Four hundred-one privately funded treatment centers from 45 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 (12); Maine (1); Massachusetts (13); New Hampshire (1); New Jersey (13); New York (35); Pennsylvania (21); Rhode Island (2); Vermont (2)

Midwest: Illinois (18); Indiana (10); Iowa (6); Kansas (5); Michigan (16); Minnesota (17); Missouri (11); Nebraska (4); Ohio (19); South Dakota (1); Wisconsin (12)

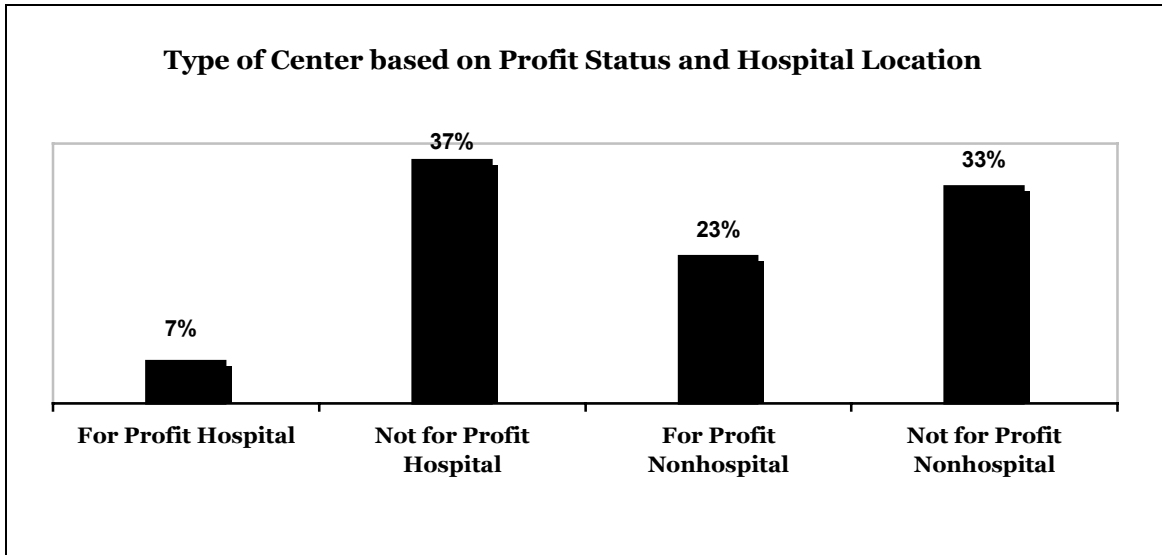
South: Alabama (6); Arkansas (1); Delaware (2); District of Columbia (2); Florida (27); Georgia (14); Kentucky (9); Louisiana (4); Maryland (4); North Carolina (5); Oklahoma (1); South Carolina (3); Tennessee (7); Texas (12); Virginia (3); West Virginia (2)

West: Arizona (9); California (22); Colorado (11); Hawaii (1); Idaho (6); Montana (4); New Mexico (1); Oregon (9); Utah (3); Washington State (14)

Regional distributions are shown only for informational purposes. The sample is representative of private facilities throughout the nation, but is not designed to be representative of any given state or sub-national region.

I. Organizational Structure

A) Center Type

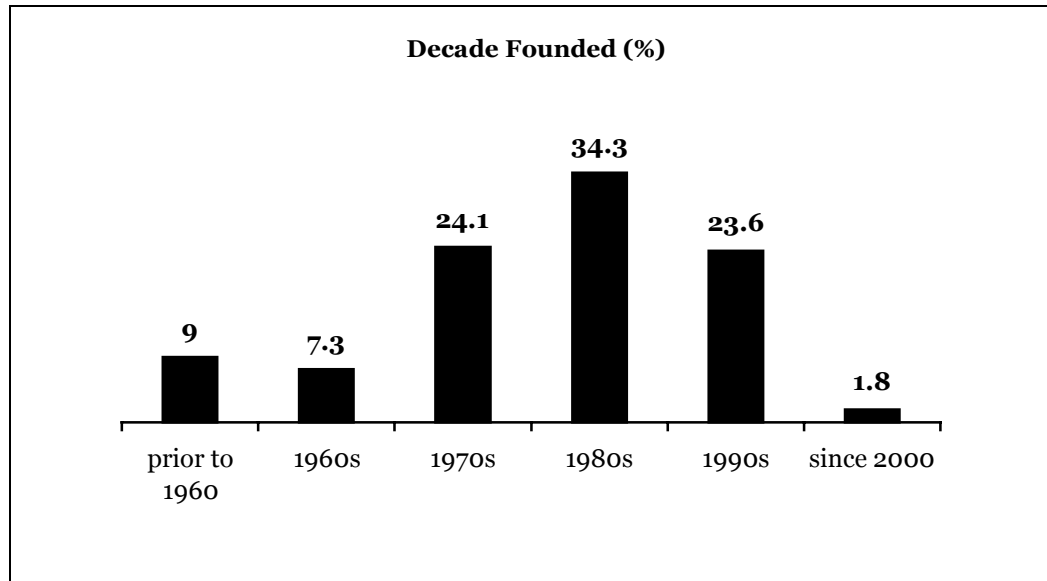


Because sample selection criteria were based on programs' funding sources, all treatment centers in this sample received less than 50% of their annual operating revenues from government grants and/or contracts. (The average center in this sample received only 10% of its revenues from state or Federal sources.) Participating centers operated on either for profit or not for profit basis and were located in either hospital or nonhospital settings. The sample consists of four types of centers: for profit hospitals, not for profit hospitals, for profit nonhospitals, and not for profit nonhospitals.

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

B) Center Age

The average private center was 24 years old. Center age ranged from 1 to 150 years.



C) Accreditation

Over 60% of the private centers were accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO). Additionally, 12.1% of the centers were accredited by the Rehabilitation Accreditation Commission (CARF). Nearly 5% of participating centers were accredited by both JCAHO and CARF. Thirty-two percent of the centers held neither JCAHO nor CARF accreditation.

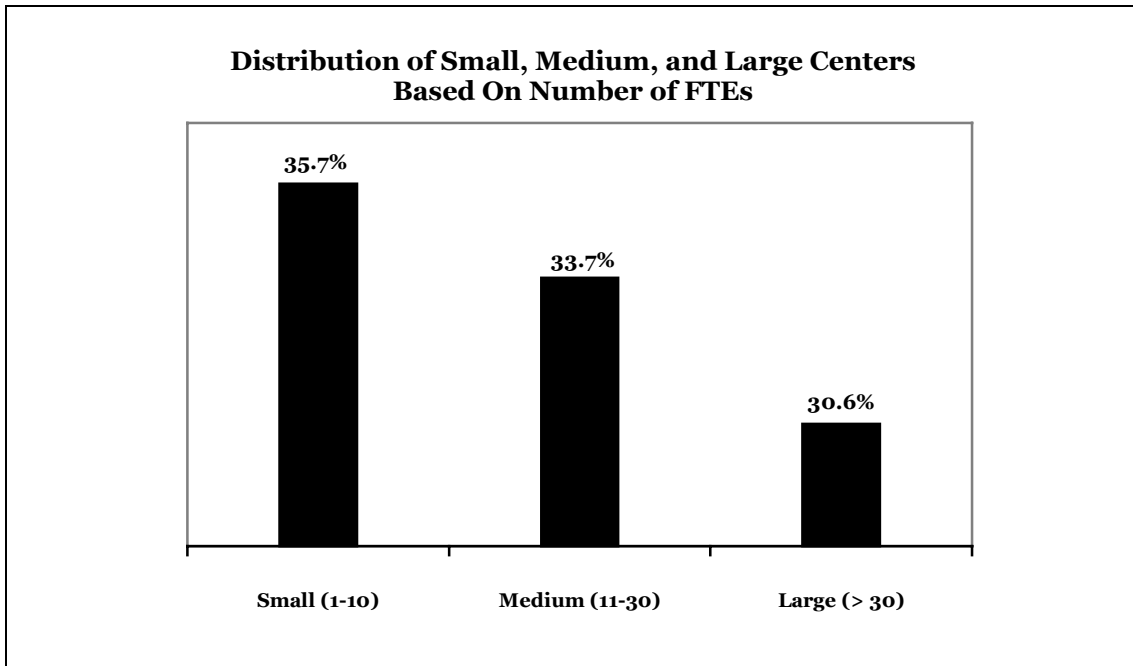
Nearly all of the centers in this sample (94.0%) were state licensed. Because many of these facilities operate with entirely private revenues, some units are not subject to state licensing requirements.

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

The size of a program can be measured in many ways. Because the number of staff determines the amount and intensity of counseling services that can be provided at any given time, we most often measure program size in terms of the number of staff.

Staff are measured in terms of the number of full-time equivalents (i.e., the total number of staff hours worked per week, divided by 40) and in terms of total employees (i.e., the total number of persons employed by the center, regardless of the number of hours each person works). Participating treatment centers varied considerably on both measures of staff size.

	<u>Mean</u>	<u>Range</u>
FTEs	39.2	1 to 422
Total Employees	50.1	1 to 494



E) Counselor Characteristics

The average private center employed 14 counselors (range 0 to 290). On average, participating centers reported the following counselor characteristics:

	<u>Mean %</u>
Masters Degree or higher	52.2%
Certified in addictions	59.0%
Female	59.4%
Racial/Ethnic Minority	19.1%
Recovering	44.5%

On average, 52.2% of counselors held Masters Degrees or higher. However, in 10.1% of private centers, all counselors possessed at least a Masters Degree. Conversely, 19.7% of centers employed no Masters-level counselors.

Over half (59.0%) of counselors, on average, were certified alcohol/drug abuse counselors. In more than one-quarter of centers (28.6%) all employed counselors were certified, while 6.0% of centers employed no certified substance abuse counselors.

On average, not for profit freestanding centers employed a significantly greater percentage of racial/ethnic minority counselors than not for profit hospitals (24.2% versus 15.1%; $p < .01$), while comparisons to for-profit facilities were not statistically significant.¹

For profit freestanding centers employed a significantly greater percentage of counselors who were in personal recovery than all other types of centers. For example, in for profit nonhospitals, an average of 56.7% of counselors were in recovery, compared to 37.6% of the counselors in the average for profit hospital ($p < .001$).

¹ When between-group comparisons are described, only statistically significant differences are reported. Unless shown, any other apparent between-group difference should be assumed to be non-significant.

F) Medical Staff

Because physicians and nurses directly impact treatment centers' capacity to offer the most intensive levels of care and to dispense medications, we also examined the number of medical staff available to each participating center. Interviews inquired about the availability of both physicians and nurses, and whether they were on the payroll of the center, available on a contractual basis, or not available at all.

<u>CENTERS EMPLOYING PHYSICIANS AND NURSES</u>		
	<u>% On Payroll or Contract</u>	<u>% Neither Payroll nor Contract</u>
Physicians	76.9%	23.1%
Nurses	61.8%	38.2%

As shown, just over three quarters of centers had at least one physician available on staff or on contract, while just over 60% of centers had at least one nurse available.

The availability of medical staff was significantly associated with the physical location of the treatment center. Hospital-based centers were significantly more likely to employ physicians and nurses than centers not located in hospitals.

II. Caseload Characteristics

A) Demographics

<u>CLIENT DEMOGRAPHICS</u>	
	<u>Mean % of Caseload</u>
Women	38.2%
Adolescents	11.0%
Minorities	30.6%
Relapsers	54.5%
Parolees/Probationers	34.2%

Most centers' caseloads comprised a mix of gender, age, and racial/ethnic groups. Over half of the centers (52.3%) did not serve adolescents, while about 3% of the centers served only adolescents. Of the centers that served adolescents, patients under age 18 comprised an average of 23.1% of their caseloads.

For profit and not for profit freestanding centers, on average, served a significantly greater percentage of clients on parole/probation than hospital based centers (41.0% versus 18.4% in for profit and 27.1% in not for profit hospitals; $p < .001$).

Regional Variation in Caseloads

Centers in the Northeast served a significantly greater mean percentage of racial and ethnic minorities than the Midwest (40.5% versus 24.3%; $p < .001$) or the West (40.5% versus 24.6%; $p < .001$).

In addition, centers in the Northeast served a significantly greater mean percentage of relapsers than those in the Midwest, South, and West (65.7% versus 51.4%; $p < .001$; 65.7% versus 51.8%; $p < .001$; 65.7% versus 48.1%; $p < .001$ respectively).

Centers in the Northeast served a significantly greater percentage of people on probation/parole than those in the South (38.8% versus 27.0%; $p < .01$).

B) Primary Diagnosis

<u>CLINICAL DIAGNOSTIC SUBGROUPS:</u>	
<u>Primary Diagnosis</u>	
	<u>Mean %</u>
Alcohol Dependence or Abuse	50.1%
Cocaine Dependence or Abuse	18.6%
Opiate Dependence or Abuse	18.0%
Marijuana Dependence or Abuse	14.1%
Methamphetamine Dependence or Abuse	7.6%
Club Drugs Dependence or Abuse	2.2%

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

Nine percent of private centers did not serve clients with a primary diagnosis of opiate dependence or abuse. Nearly half of centers (44.7%) have not encountered persons with a primary diagnosis of club drugs dependence or abuse.

Not for profit hospitals, on average, served a significantly greater proportion of clients with a primary diagnosis of alcohol dependence or abuse than not for profit nonhospitals (53.0% versus 45.5%; $p < .05$).

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 centers in the Northeast, South, and West regions (57.3% versus 45.5%; $p < .001$; 57.3% versus 48.3%; $p < .05$; 57.3% versus 47.6%; $p < .05$).

Centers in the Midwest (15%) and West (13%) treated a significantly smaller percentage of clients with a primary diagnosis of cocaine dependence or abuse than centers in the Northeast (23.3%) and the South (22.5%).

Centers in the Northeast (26.2%) treated a significantly greater percentage of clients with a primary diagnosis of opiate dependence or abuse than centers in the Midwest (11.1%), South (18.6%), and West (17.2%). In addition, centers in the Midwest treated a significantly smaller percentage of clients with a primary diagnosis of opiate dependence or abuse than centers in the South (11.1% versus 18.2%; $p < .05$).

Centers in the West treated a significantly greater percentage of clients with a primary diagnosis of methamphetamine dependence or abuse (16.5%) than those in the Northeast (1.9%), Midwest (7.2%), or South (6.5%). The difference between the proportion of primary methamphetamine cases in Northeast versus Midwest and Southern centers was also statistically significant.

Centers in the South region treated a significantly greater mean percentage of clients with a primary diagnosis of club drugs dependence or abuse than those in the Midwest (3.9% versus 1.6%; $p < .05$).

C) Referral Sources

<u>AVERAGE PERCENTAGE OF CLIENTS REFERRED FROM SOURCE</u>				
	<u>For Profit Hospital</u>	<u>Not for Profit Hospital</u>	<u>For Profit Non-Hospital</u>	<u>Not for Profit Non-Hospital</u>
	<u>Mean %</u>	<u>Mean %</u>	<u>Mean %</u>	<u>Mean %</u>
Self-referrals*	32.0%	23.8%	19.50%	22.8%
Program alumni	17.0%	11.8%	13.3%	11.9%
EAPs	10.1%	8.2%	8.9%	5.7%
Other workplace	7.8%	7.0%	6.9%	4.1%
Legal system**	10.5%	18.0%	29.9%	27.8%
Drug court	2.4%	8.3%	8.9%	10.7%
Social services	12.0%	17.1%	14.7%	16.9%
Hospital/System*	23.0%	22.8%	13.0%	14.1%
Physicians*	9.8%	10.7%	5.5%	5.5%
Other Health Care	16.2%	15.1%	17.1%	15.1%
Clergy*	2.6%	2.0%	1.0%	3.9%
Schools	5.9%	7.1%	6.4%	8.5%

*Between-group differences significant at $p < .05$; ** $p < .01$ (see text)

Centers received client referrals from a variety of sources. The most common referral sources were client self-referrals, the legal system, from within the hospital/treatment system in which the center is located, and physicians. (Note that percentages in the columns above do not sum to 100% because patients are often referred from multiple sources.)

Within this sample, some significant differences in referral sources were found between center types. Notably, for profit hospitals received significantly more self-referrals than for profit nonhospitals; hospitals (both for profit and not for profit) received significantly fewer referrals from the legal system than freestanding centers; not for profit hospitals received significantly more referrals than not for profit nonhospitals from within their hospital/treatment system; not for profit hospitals received significantly more referrals from physicians in private practice than both for profit and not for profit freestanding centers; and lastly, not for profit nonhospitals received a significantly more referrals than for profit nonhospitals from clergy.

III. Clinical Service Delivery

Administrators reported the level(s) of care available in each participating treatment center. The availability of detox, hospital inpatient, non-hospital rehabilitation, and various outpatient services were measured, as well as the availability of adult and adolescent inpatient psychiatric services. As expected, the more frequent availability of inpatient services in hospital settings was the most striking difference in level of care offerings between the four types of centers.

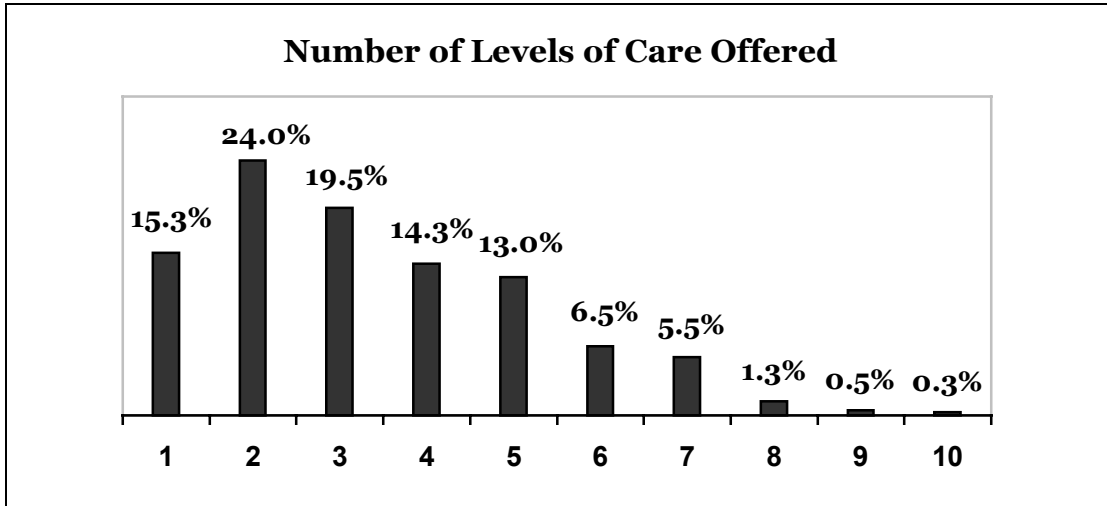
A) Level of Care

	<u>For Profit Hospital</u>	<u>Not for Profit Hospital</u>	<u>For Profit Non- Hospital</u>	<u>Not for Profit Non- Hospital</u>
Inpatient Detox***	65.4%	60.7%	33.3%	28.4%
Inpatient Adult	65.4%	40.3%	34.8%	28.4%
Chemical Dependency (<28 days)**				
Inpatient Adolescent Chemical Dependency (<28 days)	11.5%	8.8%	15.6%	10.4%
Residential (>29 days)*	19.2%	15.5%	20.0%	27.6%
Adult Psychiatric (Inpatient)***	34.6%	34.9%	10.1%	12.0%
Adolescent Psychiatric (Inpatient)	11.5%	14.0%	6.7%	9.7%
Outpatient Detox	3.8%	12.0%	9.0%	17.2%
Partial Hospitalization (at least 20 hrs/wk)***	61.5%	53.0%	35.6%	32.1%
Intensive Outpatient (9 - 20 hrs/wk)	73.1%	77.3%	64.4%	76.1%
Outpatient (<9 hrs/wk)***	30.8%	58.7%	65.6%	75.4%
Aftercare	73.1%	65.3%	61.1%	59.1%

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

B) Continuum of Care

The next graph considers the total number of levels of care offered, using the categories shown in the preceding table. The majority of centers (57.8%) offered between 2 and 4 distinct levels of care.



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

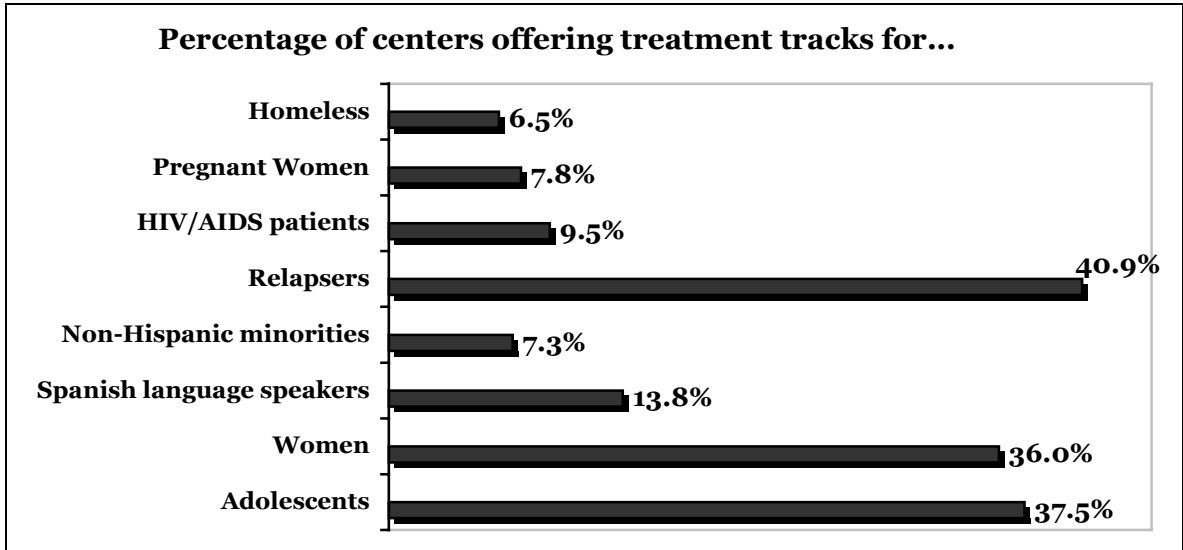
	<u>For Profit Hospital</u>	<u>Not for Profit Hospital</u>	<u>For Profit Non-Hospital</u>	<u>Not for Profit Non-Hospital</u>
IPONLY	7.7%	10.7%	11.1%	13.4%
OPONLY*	23.1%	24.7%	50.0%	47.8%
MIXED*	69.2%	64.7%	38.9%	38.8%

*Between-group differences significant at $p < .001$ (see text).

Freestanding centers were significantly more likely to offer outpatient-only services than hospitals. By contrast, hospitals (for profit and not for profit) were significantly more likely than nonhospitals to offer mixed levels of care (some combination of inpatient and outpatient services) ($p < .000$). However, hospitals were no more likely to operate on an inpatient-only basis than non-hospital facilities.

B) Treatment Tracks

Almost 72% of the centers provided at least one separate treatment track for specific demographic groups.



Considering the differences in the availability of treatment tracks across different center types, it is notable that for profit hospitals were significantly less likely to offer separate treatment tracks for women and relapsers than other center types. Women's treatment tracks were offered by only 7.7% of for profit hospital facilities, compared to 26.7% of non profit hospitals, 44% of for profit freestanding centers, and 46.6% of nonprofit freestanding centers ($p < .001$). Treatment tracks for relapsers were offered by 23.1% of for profit hospital facilities, compared to 26.7% of non profit hospitals, 48.4% of for profit freestanding centers, and 43.9% of nonprofit freestanding centers ($p < .10$).

Not for profit freestanding facilities were significantly more likely than other types of private centers to offer separate tracks for Spanish language speakers.

Other differences between center types on the availability of treatment tracks for demographic groups were not statistically significant.

C) Innovation and Evidence-Based Practices

Intake/Assessment

Medical and Psychiatric Assessments

At intake, an average 35.9% of clients received psychiatric assessments that were conducted by a psychiatric nurse or psychiatrist, and an average of 55.6% of clients received physicals that were conducted by a nurse practitioner or physician. These percentages differ significantly, however, for not for profit hospitals versus both for profit and nonprofit freestanding units, with a significantly greater percentage of clients receiving psychiatric assessments (46.2% versus 29.5 and 27.7%; $p < .01$) and physicals (67.9% versus 47.7% and 45.2%; $p < .01$) in not for profit hospitals versus for profit freestanding centers and nonprofit freestanding centers, respectively.

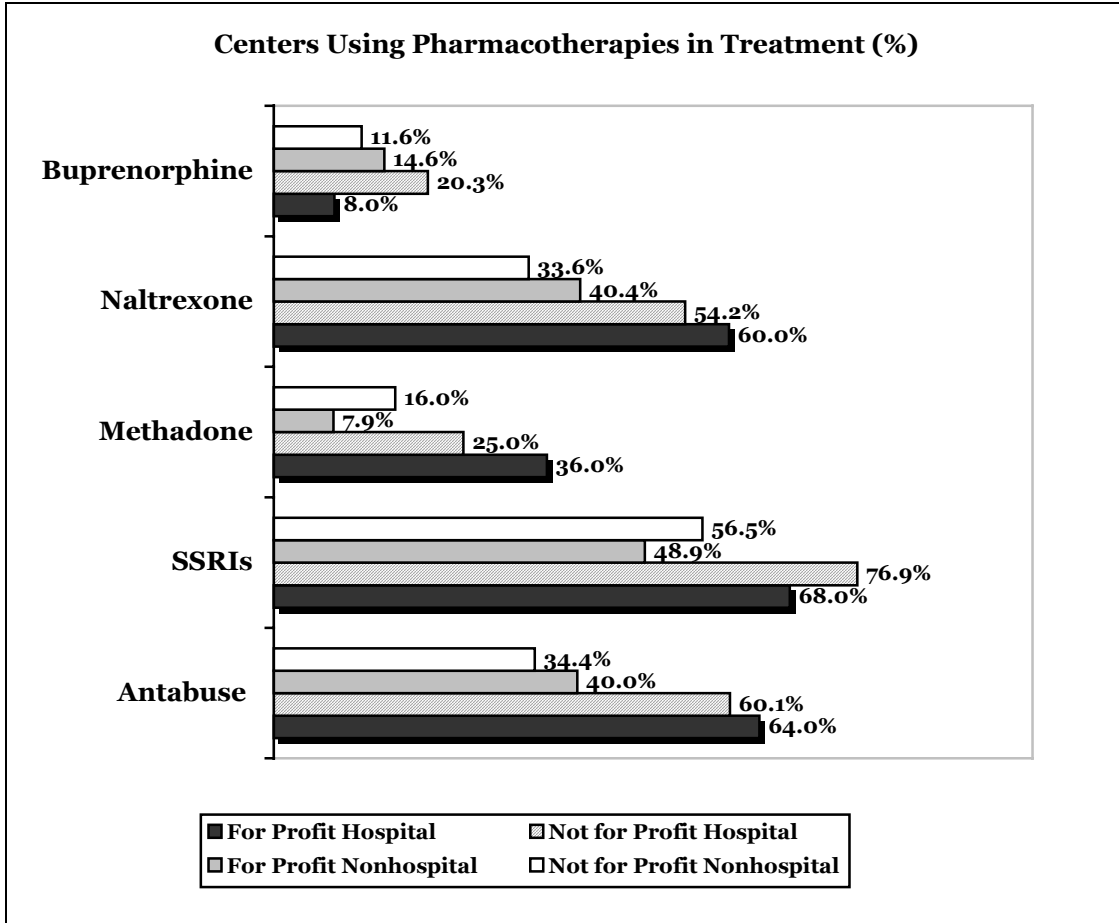
Standardized Addiction Measures

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

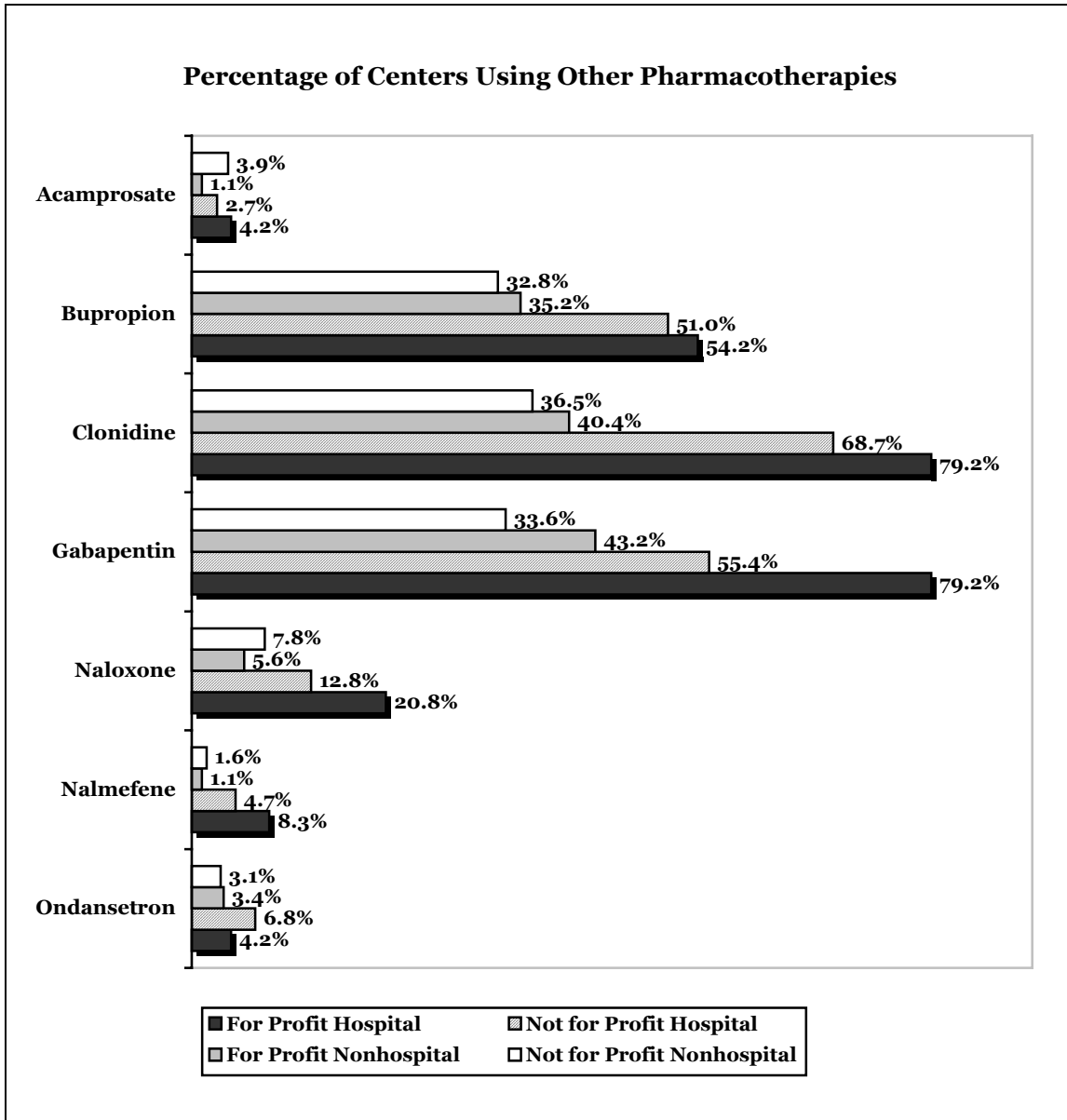
	<u>Mean %</u>
Use any Standardized Addiction Measures	80.5%
ASAM (Level of Care)	76.9%
ASI	36.4%

Pharmacotherapies



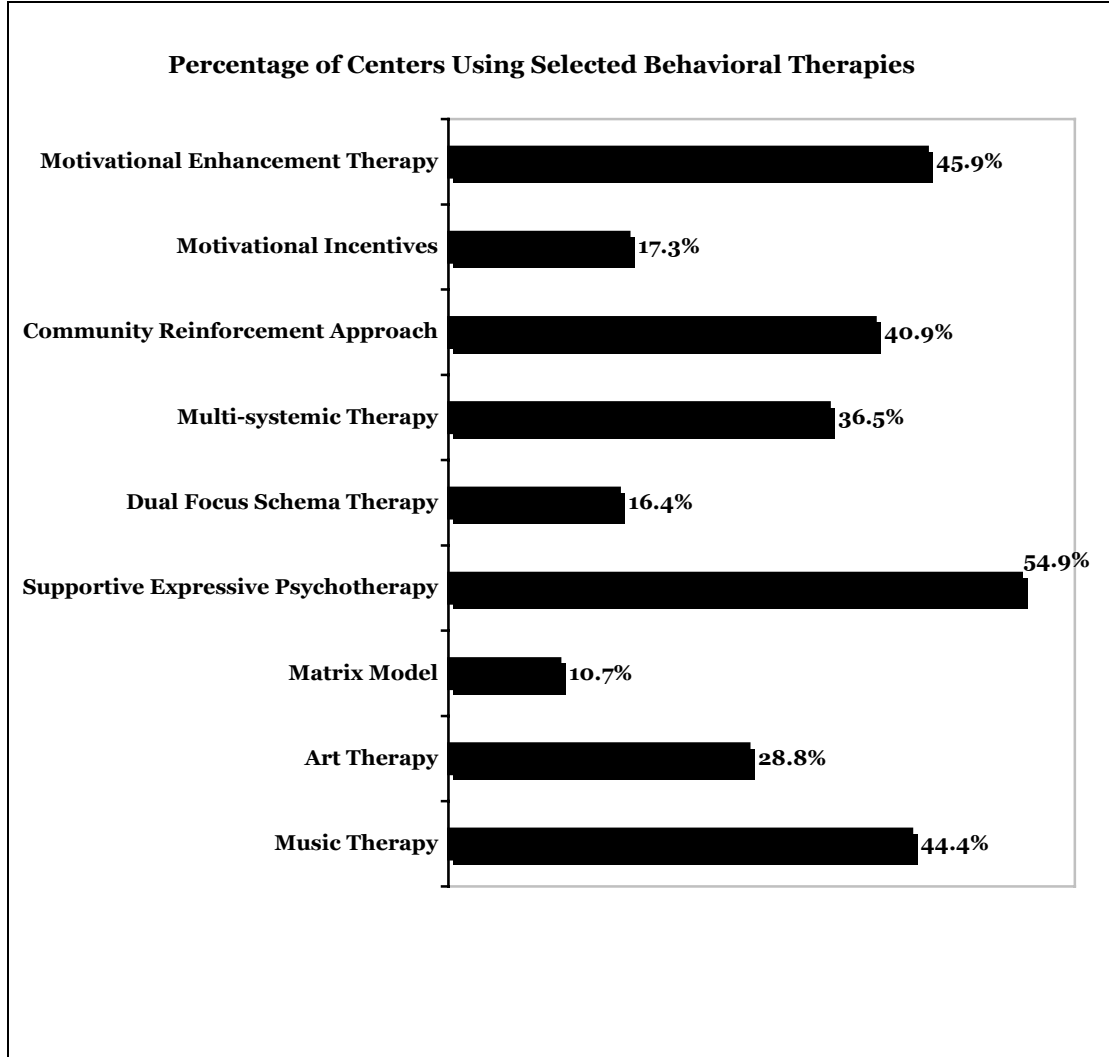
Hospital based centers were significantly more likely to use Antabuse, Methadone, and Naltrexone than freestanding centers ($p < .001$). In addition, centers located in hospitals (especially not for profits) were significantly more likely to use SSRIs (selective serotonin reuptake inhibitors) than freestanding centers ($p < .001$).

Other Pharmacotherapies



Hospital based centers (for profit and not for profit) were significantly more likely to use clonidine, naloxone, gabapentin, and bupropion than for profit and not for profit nonhospitals ($p < .05$). Nearly 80% of for profit hospitals reported using clonidine and gabapentin. Additionally, 20% of for profit hospitals reported using naloxone. Only a small proportion of centers reported using acamprosate, nalmefene, and ondansetron.

Behavioral Therapies



Centers utilize a diverse array of treatment techniques. Among them, not for profit nonhospitals were significantly less likely to use dual focused schema therapy than for profit hospitals, not for profit hospitals, and for profit nonhospitals (10.1% versus 25.0%, 18.2%, and 20.0%; $p < .10$), and were significantly more likely to use motivational incentives than these other center types (24.6% versus 0.0%, 15.4%, and 14.4%; $p < .05$).

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.”

	<u>For Profit Hospital</u>	<u>Not for Profit Hospital</u>	<u>For Profit Non Hospital</u>	<u>Not for Profit Non Hospital</u>
	<u>Mean Score</u>	<u>Mean Score</u>	<u>Mean Score</u>	<u>Mean Score</u>
Supportive Group Therapy	4.8	4.7	4.7	4.7
Confrontational Group Therapy	2.1	2.3	2.2	2.2
Family Therapy	4.1	3.7	3.6	3.6
Supportive Individual Counseling	4.0	4.1	4.0	4.3
Individual Behavioral Therapy	2.7	3.1	2.9	3.3
Medical/ Psychiatric Model*	3.8	3.9	3.4	3.1
Use of Medications *	3.5	3.6	3.0	2.8
Spirituality	3.4	3.9	3.5	3.7

*Between-group differences significant at $p < .05$ (see text).

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 individual behavioral therapy.

Not for profit hospitals reported significantly higher scores than not for profit nonhospitals for emphasis on a medical/psychiatric model and the use of medications ($p < .001$). Consistent with the graphs shown earlier, not for profit hospitals reported significantly higher scores for the use of medications than for profit nonhospitals ($p < .05$).

E) Twelve-step Model

Administrators were asked whether the center's treatment program was based on a 12-step model. Three-quarters (75.6%) 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 South (87.0%) significantly more likely than those in the Northeast (68.0%) and the West (47.0%) to base their treatment models on a 12-step approach ($p < .01$).

More than 66% 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 66.5% 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	60.8%
NA	47.1%
CA	10.2%
Al-Anon	18.0%

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.

	<u>For Profit Hospital</u>	<u>Not for Profit Hospital</u>	<u>For Profit Non Hospital</u>	<u>Not for Profit Non Hospital</u>
	<u>Mean Score</u>	<u>Mean Score</u>	<u>Mean Score</u>	<u>Mean Score</u>
Medical*	4.0	4.4	3.9	3.7
Dental	2.5	2.9	3.1	2.9
Employment	2.6	3.1	2.8	3.0
Legal	2.6	3.0	3.2	3.0
Family/Social*	4.2	4.5	4.3	4.2
Psychological/ Emotional*	4.7	4.6	4.3	4.5
Financial	2.7	2.9	2.9	2.9

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

In addition, center administrators reported on the availability of *childcare* and *transportation* services for clients who need them. Less than 8% of the centers offer a childcare program for substance abuse patients with children. Not for profit nonhospitals are significantly more likely to offer a childcare program than other private centers (14% versus 8%; $p < .05$). Just over half (53.6%) of centers provide clients with transportation assistance if needed.

F) Other Behavioral Health Services

PERCENTAGE OF CENTERS OFFERING SPECIFIC PROGRAMS

Eating Disorders	21.7%
Pathological Gambling	24.7%
Internet Addiction	9.8%
Sex Addiction	19.9%
Smoking/Nicotine Addiction	32.7%
Dual Diagnosis (Treats both substance abuse and psychiatric problems)	64.9%

As shown, most (64.9%) of the substance abuse treatment centers in this sample also offer integrated care for clients with co-occurring addiction and psychiatric conditions. However, the availability of specific programs for other behavioral health problems is much less common.

Comparing these data across the four types of centers, we note that hospital based centers (for profit and not for profit) were significantly more likely to offer integrated care for the treatment of dually diagnosed clients than for profit and not for profit nonhospitals (80.8% and 72.0% in for profit and not for profit hospitals versus 54.4% and 60.9% in for profit and not for profit nonhospitals; $p < .01$).

G) Outcomes

Center administrators reported that on average 68.4% of substance abusing clients complete their prescribed treatment program or plan. There were no differences in reported completion rates across programs of different profit status or hospital affiliation.

Just over forty percent (41.5%) of the centers in this sample reported that they collect data on patient outcomes after discharge.

IV. Organizational Performance

A) Voluntary Turnover

Counselors and Nurses

On average, centers lost 13.8% of counseling staff in the 12 months prior to our interview due to voluntary turnover. However, approximately 44% of centers reported no counselor turnover in that time period.

A total of 242 centers (60% of the sample) employed nurses. On average, 16.2% of the nurses at these centers left voluntarily over the past year. As was the case with counselor turnover, a substantial portion of centers with nurses (47.1%) reported no turnover among those staff, while other centers reported high turnover.

On average, administrators reported that it typically takes 8.8 weeks to fill a vacant nursing position (range 0 to 72 weeks) and 9.3 weeks to fill a vacant counselor position (range 0 to 52 weeks).

B) Layoffs

In addition to voluntary turnover, 11.2% of the centers reported at least some counselor layoffs during the year prior to our interview. Less than four percent of the centers reported any nurse layoffs during the past year.

C) Expansion, Reduction, and Threat of Closure

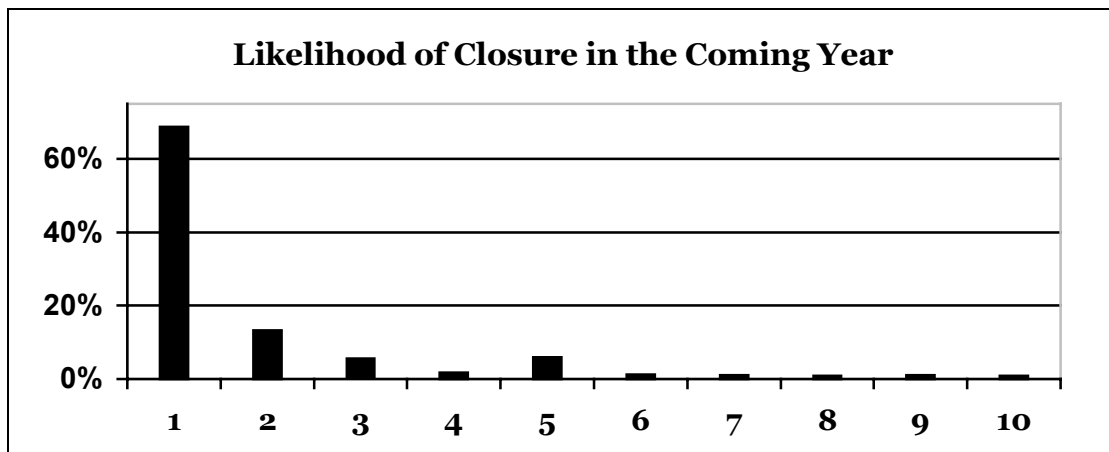
Approximately half of the 401 private centers in this study reported no change in the number of clients, programs, or staff in the preceding two years. One-third of the centers reported expansions in at least one of these three areas, whereas about 10% reported reductions in these areas in the preceding two years. By and large, patterns of expansion and reduction did not co-occur within the same treatment center. However, about 4% of centers reported expansions in some areas and reductions in others over the past 2 years.

	<u>% Reporting change in # of Clients</u>	<u>% Reporting change in # of Programs</u>	<u>% Reporting change in # of Staff</u>
Expansion only	38.3%	31.7%	31.8%
Reduction only	9.0%	9.1%	11.9%
Both	3.8%	3.5%	4.5%
No Changes	48.9%	55.7%	51.8%
	100%	100%	100%

Considering centers of different profit status and hospital affiliation, we found that not-for-profit, nonhospital facilities were the most likely to report recent expansion in all three domains. A significantly larger proportion of not for profit, nonhospital centers reported expansions in clients (54.5%), programs (46.3%), and staff (49.3%) in the past two years than other private centers ($p < .01$).

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 (1.86) likelihood of closure. Nearly 70% 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.

	<u>MEAN LIKELIHOOD OF CLOSURE</u>	
OVERALL	1.86	
	<u>Reported reductions in past year</u>	<u>Expanded or remained stable</u>
# Clients*	2.39	1.76
# Programs	2.02	1.80
# Staff*	2.40	1.73

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

E) Counselor Salaries

<u>AVERAGE COUNSELOR SALARY</u>	
Minimum	\$29,986.97
Maximum	\$43,092.35
Average	\$37,802.29

Not for profit nonhospitals reported on average significantly lower minimum counselor salaries than for profit nonhospitals (\$27,001.47 versus \$34,942.81; $p < .05$).

F) Revenue Sources

Administrators reported total actual dollars received from each of the following sources in the past 12 months. Consistent with the sampling criteria for this study, centers received the majority of their operating revenues from insurance reimbursements and out-of-pocket payments.

<u>AVERAGE PERCENTAGE OF TOTAL REVENUES RECEIVED FROM SOURCE</u>	
Medicaid	17.1%
Medicare	6.7%
Private (Indemnity) Insurance	14.5%
HMO, PPO, and POS	20.6%
Self Pay	22.1%
Criminal Justice System	1.3%
Federal Block Grants Administered by State	2.1%
Other Federal	<1.0%
Other State	2.6%
Other County, City, Local	2.5%
Charity	3.3%
Endowments	<1.0%
Other	3.8%

**PERCENTAGE OF CENTERS RECEIVING
NO REVENUES FROM SOURCE**

Medicaid	43.2%
Medicare	55.7%
Private (Indemnity) Insurance	33.6%
HMO, PPO, and POS	35.3%
Self Pay	10.2%
Criminal Justice System	80.6%
Federal Block Grants Administered by State	83.8%
Other Federal	90.8%
Other State	78.5%
Other County, City, Local	79.7%
Charity	76.8%
Endowments	94.7%
Other	75.7%

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 another treatment center. We are unable to make data files directly available.

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.

Privately Funded Treatment Centers

The NTCS began in 1995 with a study of 450 privately funded substance abuse treatment centers. Unique to this study, "private" centers are defined as those receiving less than 50% of their annual operating revenues from government grants or contracts (including block grant funds and criminal justice dollars). The average private center participating in this study received only about 10% 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 privately funded treatment centers in those sampled counties were then enumerated using published directories, yellow pages listings, and survey sampling databases. 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 stratum.

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 (non-maintenance) addiction treatment services meeting ASAM level of care criteria were available. Additionally, because the research design focused on privately funded 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 in 1995-1996. These interviews were repeated in 1997-'98, 2000-'01, and 2002-'04. 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.

Over time, centers that have closed or declined to participate have been replaced with other eligible private centers from within the same geographic stratum, such that we maintain the geographic representativeness of the sample and a target sample size of about 400 centers at each wave of data collection. 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.

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 Private Treatment Center sample. Each uses sampling and data collection techniques similar to those described above.

Publicly Funded Treatment Centers

A companion study of publicly funded treatment centers began in 2002. In that study, "public" centers are those that receive more than 50% of their annual operating revenues from government grants or contracts, including block grants and criminal justice funds. On average, centers in the public center study receive about 84% of their revenues from these sources. Summary reports from the public 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.

All components of the NTCS are funded through research grants from the National Institute on Drug Abuse (R01DA13110, R01DA14482, and R01DA14976). The University of Georgia's Institutional Review Board has approved the protocol for this study.

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