NATIONAL TREATMENT CENTER STUDY

SUMMARY REPORT:

A National Sample of Therapeutic Communities (Report No. 9)

A comprehensive report detailing the findings of the first wave of on-site interviews with a nationally representative sample of therapeutic communities participating in the National Treatment Center Study conducted by the Institute for Behavioral Research, University of Georgia.

August 2005

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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:

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

This report is based on data from a national sample of 380 community-based therapeutic communities (TCs). The central criterion for inclusion in the study was that the program self-identified as a therapeutic community. This allowed for measurement of a wide range of programs that identify themselves as TCs. Although data such as membership in Therapeutic Communities of America (TCA) were collected during the in-depth interview, such criteria were not used in selecting the sample. By using self-identified TCs as the sample, we were better able to capture the diversity of TCs in the United States. Data were collected via face-to-face interviews with TC administrators and/or clinical directors, and 86% of TCs that passed screening eligibility for inclusion in the study sample participated in these interviews.

Of particular interest for this study was the extent to which modern TCs have diverged from or adapted the "essential elements" of the traditional therapeutic community model described by George De Leon in his book *Therapeutic Communities: Theory, Model, and Method* (2000). According to De Leon, the traditional TC for substance abuse was associated with a particular treatment philosophy based upon "right living" and "community as method" delivered in long-term residential programs directed and managed by the clients. These programs were characterized by the use of confrontational group therapy, treatment phases, and a hierarchy based on tenure in the program and community roles. In response to pressures from the evolving field of substance abuse treatment, the therapeutic community approach to treatment has modified in practice and philosophy, incorporating professional staff, special populations of clientele (e.g., women, adolescents, dually diagnosed), new treatment techniques (e.g., less confrontational approaches) and a variety of treatment modalities including outpatient levels of care.

Face-to-face on-site interviews contained questions to examine the extent to which these self-identified TCs are consistent with De Leon's model of the traditional therapeutic community and the ways these TCs have modified from the "essential elements" he described. TC administrators were asked a set of scaled questions adapted from De Leon's "Survey of Essential Elements Questionnaire (SEEQ)" (*Journal of Substance Abuse Treatment*, Vol. 16, No. 4, pp. 307-313, 1999) about the extent to which practices and beliefs guide clients' experiences within the TC. Scores ranged from 0 to 5, such that 5 represents "a very great extent," and is indicative of the traditional TC model.

The following table presents mean scores for these scaled questions (range 0 to 5). In general, scores were high (> 4). Because the traditional TC model is based upon long-term residential programs, programs are grouped into (residential-only) TCs and modified (non-residential/mixed modality) TCs. The table shows that traditional TCs scored significantly higher than modified TCs on several dimensions related to other practices and beliefs that characterize the "classic" TC model.

TRADITIONAL TC CHARACTERISTICS

	Average Score	
	Traditional TCs (N=177)	**Modified TCs (N=203)**
The treatment problem to be addressed is not the drug, but the whole person.	4.85	4.83
Right living involves positive social values, such as work ethic, social productivity, and community responsibility.	4.81***	4.60
The most important role of the clinical staff is to facilitate the clients' commitment to the shared community values.	4.32	4.24
There are cardinal rules, which if violated, can lead to termination from the program (e.g., no drug use, no violence or sexual acting out).	4.83	4.71
Clients are stratified by levels of responsibility and clinical status, such as Junior, Intermediate, and Senior.	4.12*	3.77

	Average Score	
	Traditional TCs (N=177)	**Modified TCs (N=203)**
Senior residents act as role models for more junior clients.	4.50*	4.24
Clients are aware of the therapeutic goals of fellow residents and try to assist them to achieve these goals.	4.21*	3.98
General meetings are convened as needed to address negative (or extraordinary positive) behavior, attitudes, or incidents at the facility.	4.69*	4.46
Peer feedback occurs more frequently than staff counseling.	3.94*	3.64
Clients confront the negative behavior and attitudes of each other and the community.	4.46	4.23
Encounter groups are used to confront negative behaviors and attitudes.	3.70	3.38
Disciplinary actions are designed as learning experiences.	4.80**	4.59
There are periodic "house runs" or thorough inspection of the premises.	4.69***	4.11
The program is designed as three main stages: orientation/induction, primary treatment, and re-entry, with sub-phases in each stage.	4.39*	4.06

*p < .05; ** p < .01; ***p < .001

This is the first major, national study of community based therapeutic communities and the services they deliver. The 380 TCs in this sample are nationally representative (i.e., they are reflective of the distribution and characteristics of therapeutic communities in the U.S. in 2003).

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

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 TC will receive individualized feedback reports comparing the TC to the rest of the sample, and to aggregated data from other similar TCs. Those individualized reports are not released to the general public.

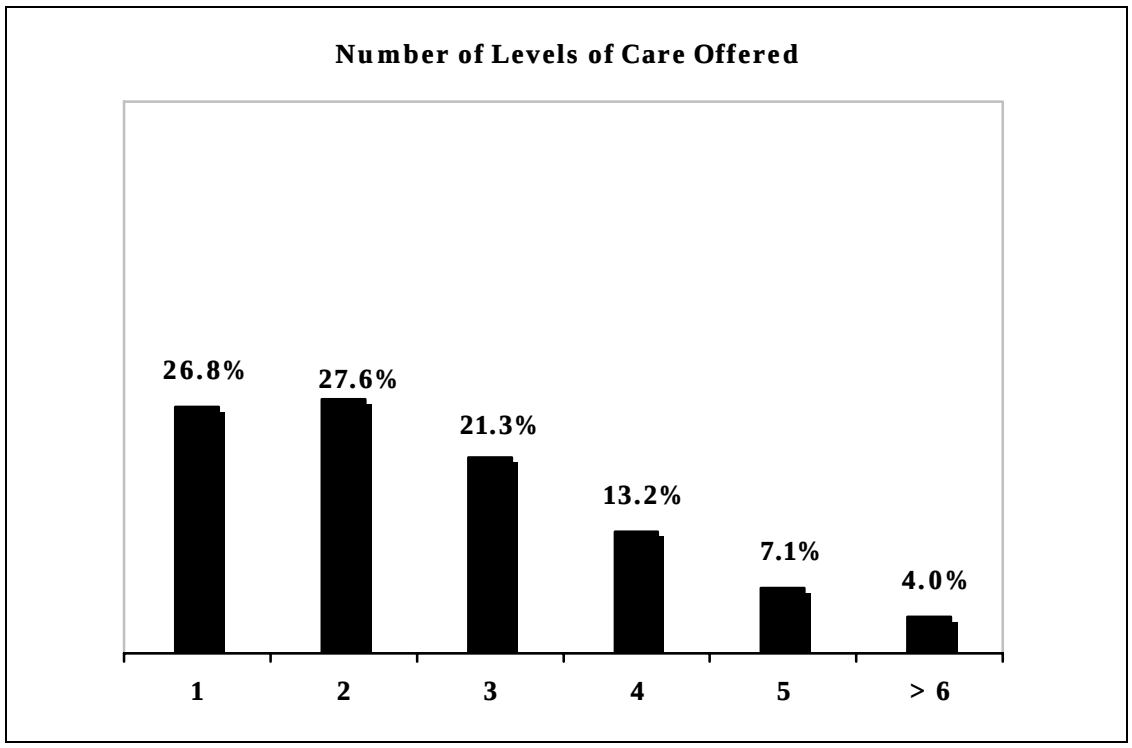
Other findings from the NTCS may be found on our website, www.uga.edu/ntcs.

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

I. Clinical Service Delivery

A) Level of Care

The majority of TCs in this sample (54.5%) offered one or two distinct levels of care (see graph below). Just over a third (35.8%) of the TCs provided both residential and outpatient services. Ten percent of the TCs were outpatient only. However, the majority of the TCs offered only residential treatment.



Percentage of TCs Offering Traditional, Outpatient Only, and Mixed Levels Of Care

Residential Only	Outpatient Only	Mixed LOC
53.4%	10.8%	35.8%

B) Length of Stay

TCs offered a variety of levels of care and lengths of stay. Traditional, long-term residential TCs comprised the greatest percentage of TCs in this sample. The following table shows the percentage of TCs offering varying lengths of stay.

	Traditional TCs (N=203)	Modified TCs (N=177)	All TCs (N=380)
Residential			
Long-term (>180 Days)	52.2%	35.6%	44.5%
Six-month	41.9%	31.1%	36.8%
Three-month	29.1%	31.6%	30.3%
Short-term (< 30 days)	11.3%	26.6%	18.4%
Outpatient			
Partial Hospitalization (at least 20 hours/week)	N/A	24.9%	11.6%
Intensive Outpatient (9-20 hours/week)	N/A	59.9%	27.9%
Outpatient (<9 hours/week)	N/A	87.0%	40.5%
Aftercare	37.4%	61.6%	48.7%

*Note: Percentages do not add to 100% as TCs may offer more than one level of care/length of stay.

C) Therapeutic Orientation

In addition to the specific aspects of TC philosophy that were measured, TCs were also asked about the extent to which they emphasize a variety of other treatment techniques.

For instance, TC administrators were asked to what extent their TC 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."

	Average Score	
	Traditional TCs	**Modified TCs**
Supportive Group Therapy	4.7	4.8
Confrontational Group Therapy	3.3	3.0
Supportive Individual Counseling	4.6	4.6
Individual Psychotherapy	2.6**	3.2
Family Therapy	3.2**	3.7
Medical/Psychiatric Model	2.7	2.9
Use of Medications	2.7	2.8
Spiritual	3.9	3.8

**$p < .01$

Traditional TCs did not report a significantly greater emphasis on confrontational group therapy compared to modified TCs. Rather, TCs in general tended to report the greatest degree of emphasis on supportive group therapy and supportive individual counseling, reflected in the highest mean scores. Traditional TCs, however, reported significantly less emphasis on individual psychotherapy and family therapy than modified TCs. Relatively speaking, the areas receiving the least amount of emphasis were medical/psychiatric model and the use of medications.

D) Twelve-step Model

Administrators were asked whether the TC's treatment program was based on a 12-step model. More than half (56.1%) indicated that the 12-step model best characterized their program.

More than 74% of the TCs reported that attendance at 12-step meetings during the course of treatment is a "requirement." Traditional TCs were significantly more likely than modified TCs to require 12-step attendance (77% versus 68%; $p < .001$).

Twelve step meetings were held on-site at 72.8% of the TCs. Alcoholics Anonymous (AA) and Narcotics Anonymous were the most commonly held twelve-step meetings followed by Cocaine Anonymous (CA) and Al-Anon.

Percentage of TCs Offering 12-Step Meetings

	Traditional TCs	Modified TCs	All TCs
AA	66.0%	59.0%	62.9%
NA	58.0%	53.0%	55.5%
CA	17.0%	15.0%	15.8%
Al-Anon	1.0%	6.0%	3.4%

E) Comprehensive/Wraparound Services

TCs 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.

	Average Score	
	Traditional TCs	**Modified TCs**
Medical	4.3	4.4
Dental	4.1*	3.8
Employment	3.7	3.9
Legal	4.0	3.9
Family/Social	4.4*	4.6
Psychological/Emotional	4.4*	4.6
Financial	3.4	3.5

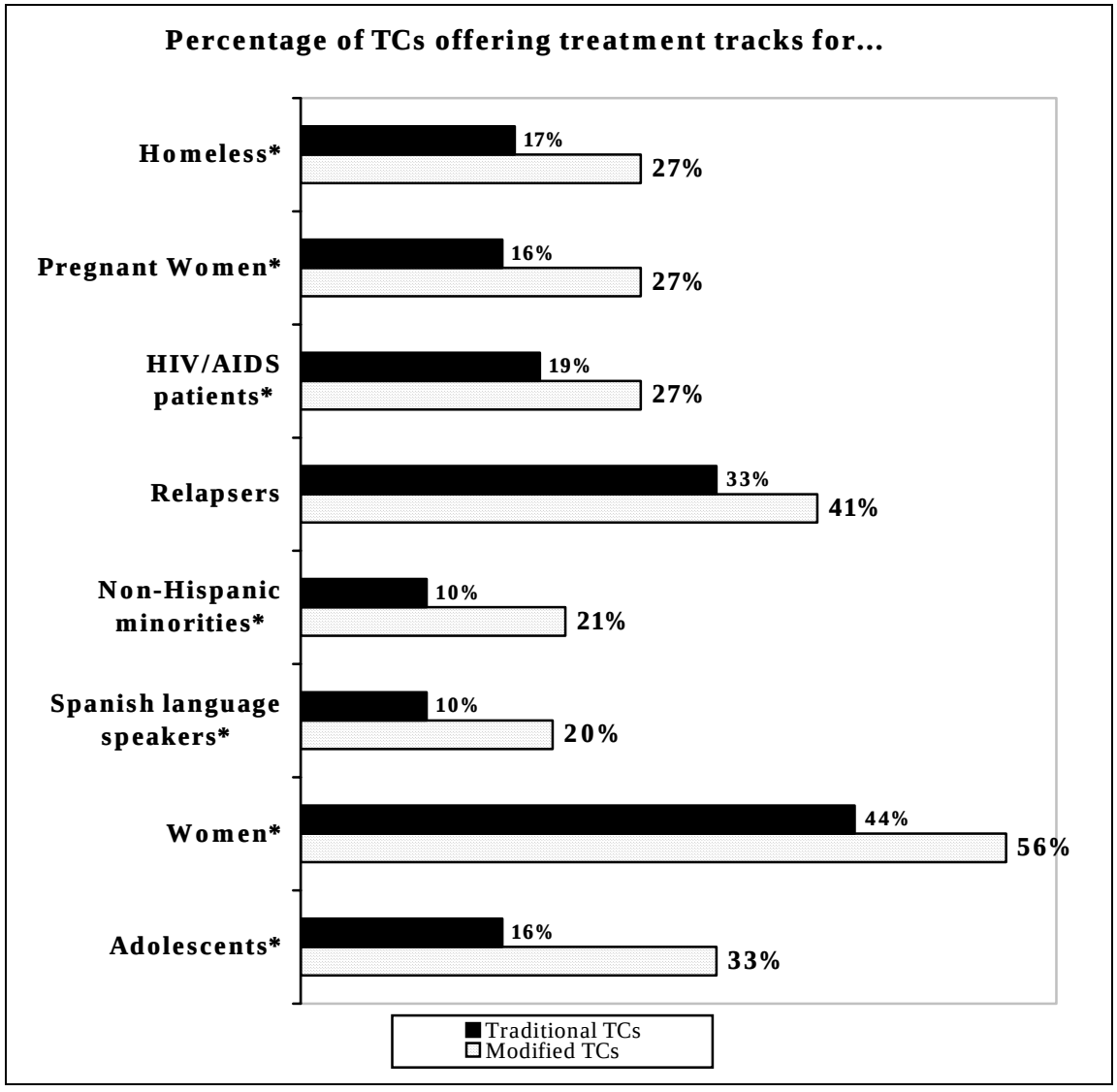
*$p < .05$

The relatively high mean scores on the provision of comprehensive services for all TCs is consistent with De Leon's notion that TCs address the "whole person." As shown, traditional (residential only) TCs were significantly more likely to make provisions for dental problems and significantly less likely to make provisions for family/social and psychological emotional problems than modified (non-residential/mixed modality) TCs.

In addition to the services presented in the table above, TC administrators reported on the availability of childcare and transportation services for clients. Nearly one-quarter (22.9%) of the TCs offered a childcare program for substance abuse patients with children. Eighty-five percent of TCs provided clients with transportation assistance if needed. Traditional TCs were significantly more likely than modified TCs to provide transportation assistance (89% versus 81%; $p < .05$).

F) Treatment Tracks

TCs have modified from the "essential elements" set forth by De Leon in order to meet the needs of specialized populations of clients. Seventy-five percent of the TCs in this sample provided at least one separate treatment track for a specific demographic group. Traditional TCs were significantly less likely to offer treatment tracks for certain populations than modified TCs ($p < .05$).



*p < .05

G) Dual Diagnosis

Other researchers have demonstrated that the co-occurrence of substance abuse and psychiatric disorders tends to be high. In the average TC, more than one-third of the caseload was dually diagnosed with both substance abuse and psychiatric problems.

One specific way TCs have modified their services is to meet the needs of the dually diagnosed client by providing "integrated care." 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 of TCs, traditional TCs were significantly less likely than modified TCs to offer integrated care for dually diagnosed clients.

Percentage of TCs Offering Integrated Care

	Traditional TCs	Modified TCs
Integrated Care (TC treats both substance abuse and psychiatric problems)	45.1%*	55.5%

*$p < .05$

In TCs with a dual diagnosis program, TC administrators reported that, on average, 72% of dually diagnosed clients received some type of psychiatric medication. Overall, 32% of the TCs reported currently using selective serotonin reuptake inhibitors (SSRIs), which are designed to treat psychiatric problems.

H) Evidence-Based Practices

Intake/Assessment

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 TCs Using Standardized Intake/Assessment Measures

	Traditional TCs	Modified TCs
Use any Standardized Addiction Measures	71.0%**	85.0%
ASAM PPC	53.0%**	70.0%
ASI	49.0%**	63.0%

**p < .01

A substantial proportion of the sampled TCs reported using standardized addiction measures. Traditional TCs, however, were significantly less likely to use such measures, including ASAM patient placement criteria and the ASI, than modified TCs.

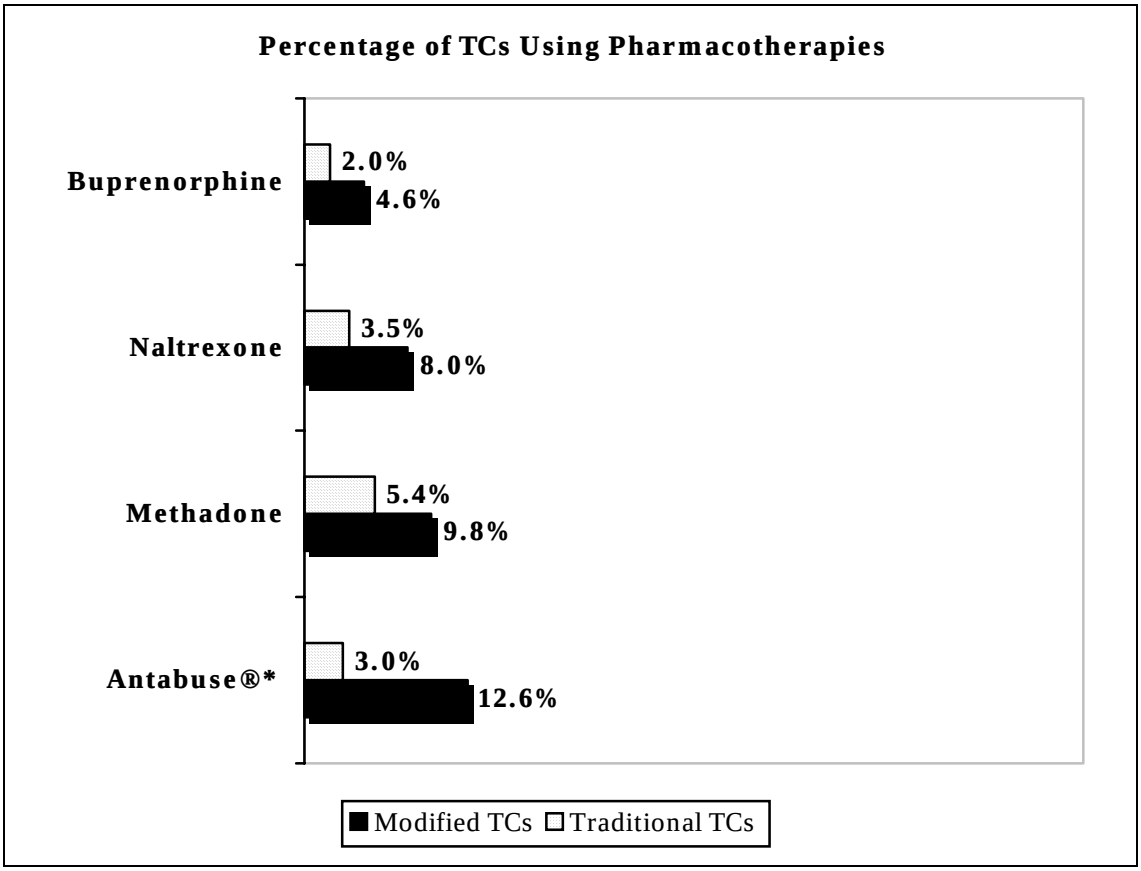
Medical and Psychiatric Assessments

At intake, an average of 33% of clients received psychiatric assessments that were conducted by a psychiatric nurse or psychiatrist and an average 62.5% of clients received physicals that were conducted by a nurse practitioner or physician.

Pharmaco- and Behavioral Therapies

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

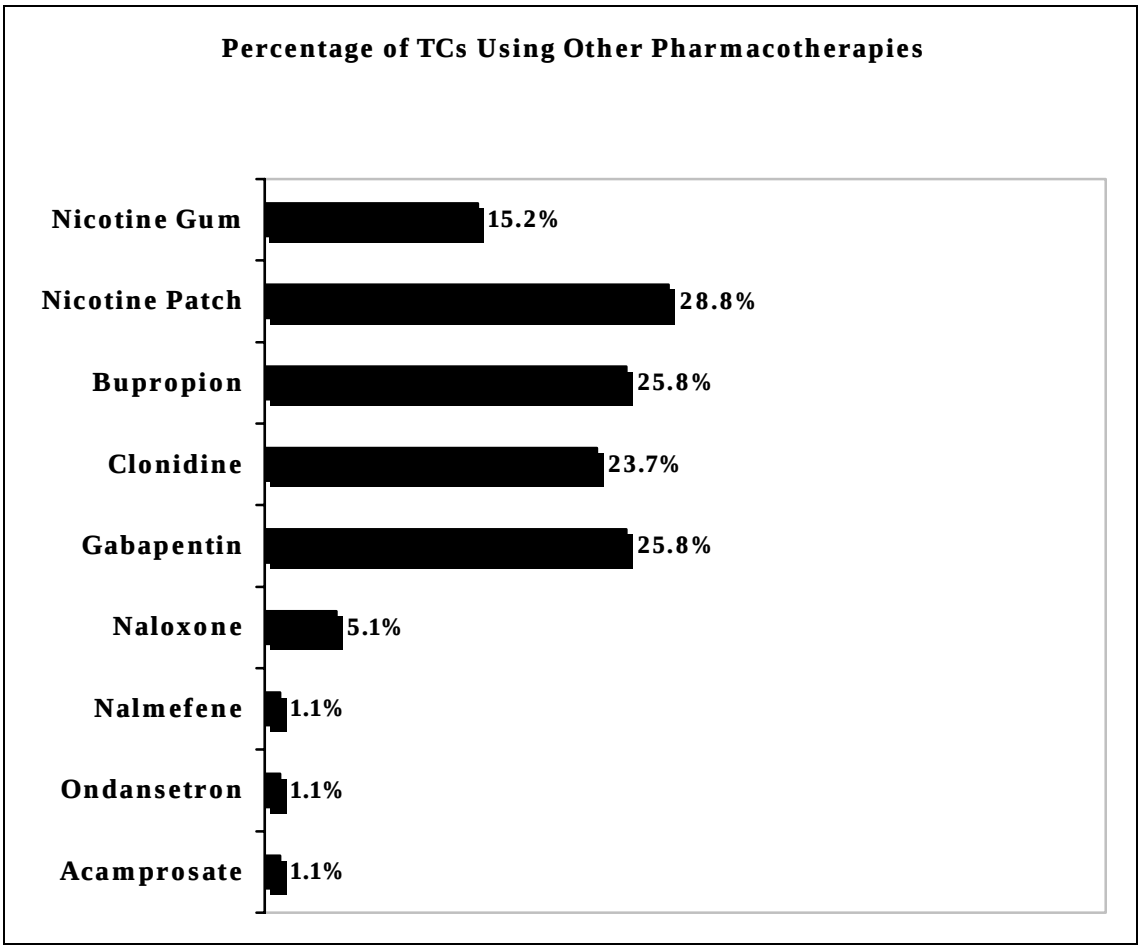
Pharmacotherapies



*p < .05

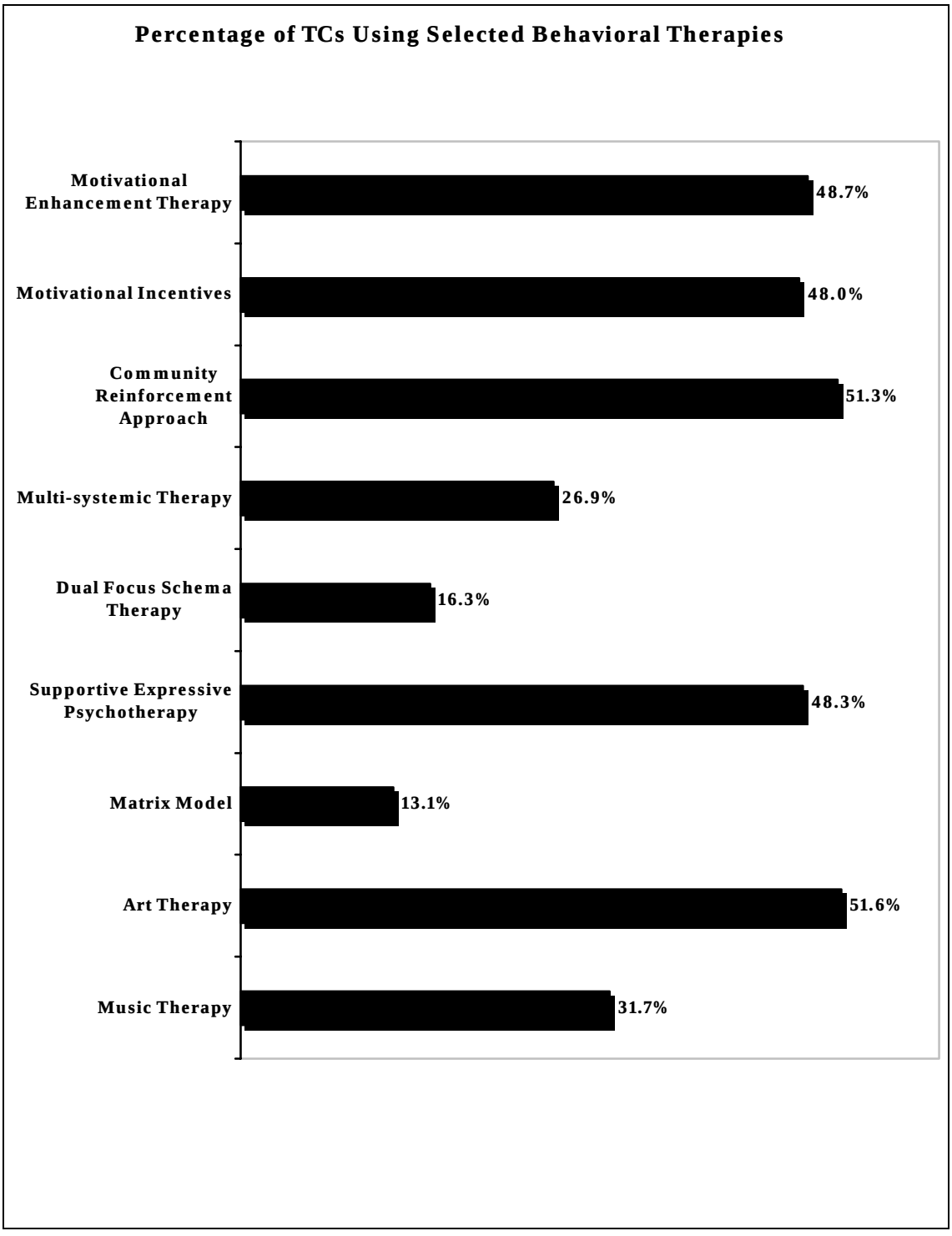
As shown, the overall use of substance abuse treatment medications in TCs was low. While there were few significant differences between program types, traditional TCs were significantly less likely to use Antabuse® (disulfiram) than modified TCs (3.0% versus 12.6%; p < .05).

Other Pharmacotherapies



Compared to the treatment-related medications (p. 15), the use of smoking cessation-related pharmacotherapies was considerably higher. It may be that over-the-counter availability of nicotine replacement therapies (e.g., patch, gum) has facilitated the adoption of these medications. There were no significant differences in the use of these medications between traditional and modified TCs.

Behavioral Therapies



There were no significant differences in the use of behavioral therapies between traditional and modified TCs.

I) Outcomes

TCs reported that on average 61.7% of substance abusing clients complete their prescribed treatment program or plan. There were no significant differences between traditional (residential only) and modified (non-residential/mixed modality) TCs.

	Traditional TCs	Modified TCs
Average percentage of clients completing treatment program	60.5%	63.1%

There is some evidence that telephone follow-ups after discharge can improve long-term treatment outcomes. Just over half (53.5%) of the TCs reported collecting follow-up data on patient outcomes after discharge.

II. Caseload Characteristics

A) Primary Diagnosis

Clinical Diagnostic Subgroups: Primary Diagnosis	Average % of Caseload
Alcohol Dependence or Abuse	34.7%
Cocaine Dependence or Abuse	34.0%
Opiate Dependence or Abuse	18.4%
Marijuana Dependence or Abuse	19.9%
Methamphetamine Dependence or Abuse	15.4%
Club Drugs Dependence or Abuse	3.2%

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

Traditional TCs treated a significantly smaller percentage of clients with primary diagnosis of alcohol dependence than modified TCs (31.5% versus 38.4%; $p < .05$).

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

B) Demographics

Client Demographics

	Average % of Caseload
Women	38.9%
Adolescents	16.1%
Minorities	51.8%
Relapsing Clients	68.8%
Parolees/Probationers	58.8%

Most TCs' caseloads included a mix of gender, age, and racial/ethnic groups. Of note, 20.7% of the TCs did not treat women, while 18.9% of the TCs served only women.

Well over half of the TCs (68.4%) did not serve adolescents, while about 10% of the TCs served only adolescents (N=40). Of the TCs that served both adults and adolescents (N=78), patients under age 18 comprised an average of 26.7% of their caseloads.

Traditional TCs treated a significantly greater percentage of relapsing clients than modified TCs (72.7% versus 64.4%; $p < .01$).

C) Referral Sources

Average Percentage of Clients Referred From Source

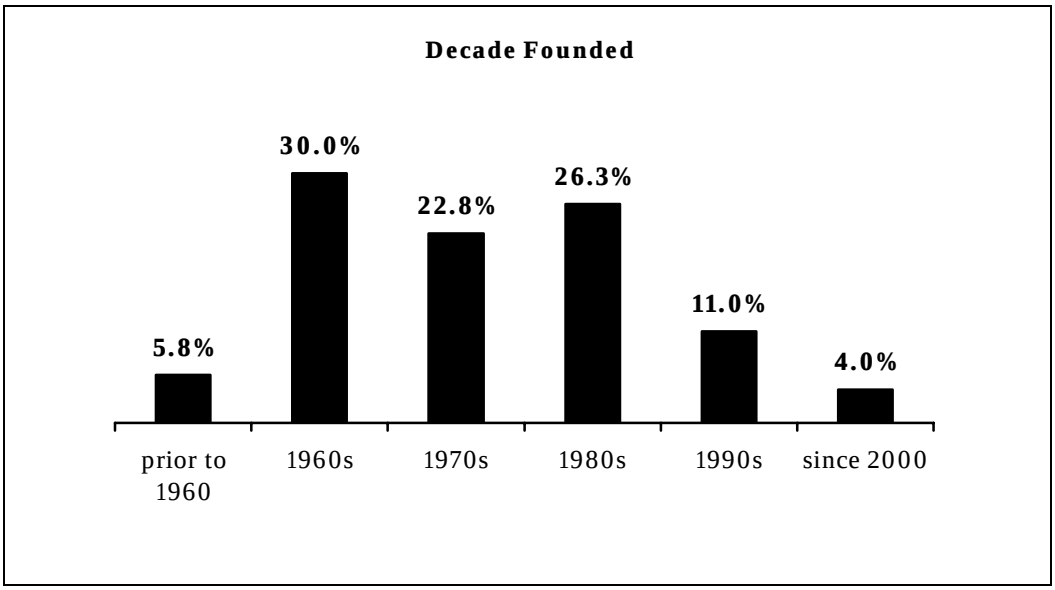
	Mean %
Self-referrals	21.1%
Program alumni	10.6%
Employee Assistance Programs	3.4%
Direct non-EAP workplace referrals	2.3%
Legal system	40.7%
Drug court	16.5%
Social services	21.6%
Within Hospital/Treatment System	8.4%
Physicians	3.0%
Other Health Care	18.2%
Clergy	2.8%
Schools	8.2%

TCs 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.)

III. Organizational Structure

A) TC Age

The average TC was 20 years old. TC age ranged from 1 to 55 years.



B) Ownership, Profit Status, and Funding Sources

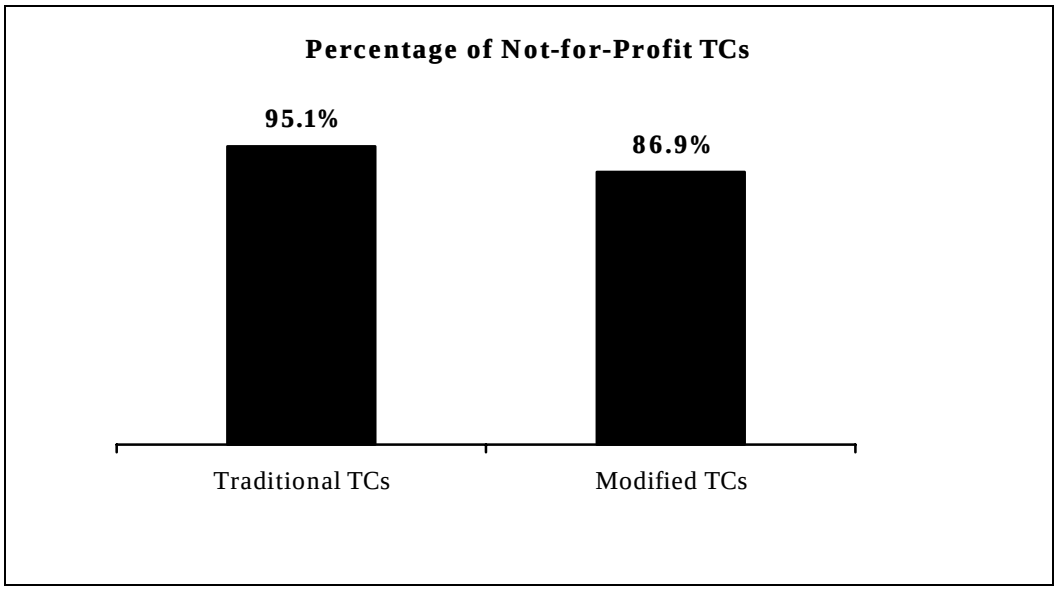
The 380 TCs participating in this study include privately owned non-profit programs relying heavily on federal, state and/or local government funds. Nearly half of the TCs receive greater than 50% funding from these public sources.

TC Ownership

Government Owned	8.5%
Hospital	<1%
Individual	6.6%
Religious Order	4.0%
University	<1%
Private Foundation	29.4%
Board of Directors	26.0%
Other *	24.4%

*Primarily 503(c) non-profit corporations

Profit Status



*p < .05

Over 90% of the TCs in this sample were not-for-profit. Traditional TCs were significantly more likely to be not-for-profit than modified TCs (95.1% versus 86.9%; p < .05).

Funding Sources

Historically, funding for TCs consisted of revenues primarily from community run businesses and financial donations. Many of the TCs were free to clients. Thus, TCs have historically received very little private funding (self-pay, insurance, etc.) as well as very little revenue from federal healthcare programs such as Medicaid and Medicare. This is still the case in this national sample of TCs. The average TC received between 1% and 2% of revenue from private insurance or HMO (Health Maintenance Organizations), PPO (Preferred Provider Organizations), and POS (Point-of-Service Contracts). Over 85% of the TCs received no revenue from private insurance.

TCs in this sample received revenue from a combination of funding sources in 2003. On average, TCs received the most revenue from state, federal, and local governments, and the criminal justice system.

Average Percentage of Total Revenues Received From Source

Medicaid	7.3%
Medicare	<1%
Private (Indemnity) Insurance	1.5%
HMO, PPO, and POS	2.2%
Self Pay	9.7%
Criminal Justice System	10.3%
Federal Block Grants Administered by State	16.2%
Other Federal	5.8%
Other State	18.1%
Other County, City, Local	13.3%
Charity	6.2%
Endowments	<1%
Other	5.6%

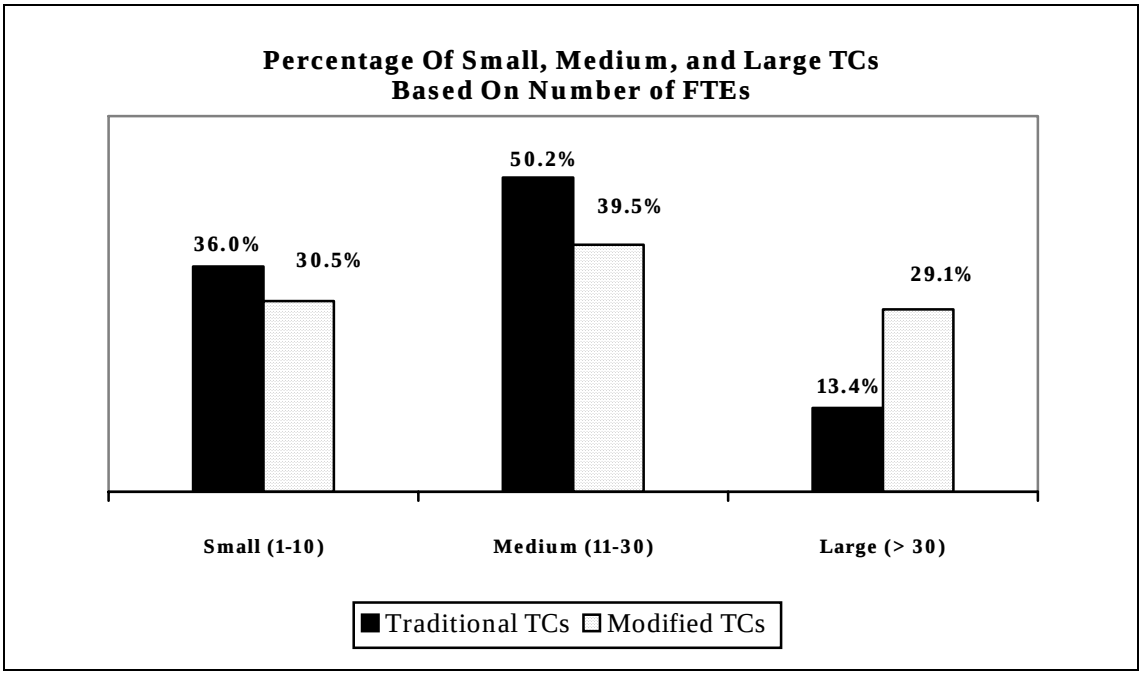
C) Accreditation

Sixteen percent of the therapeutic communities were accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). Similarly, 17.4% of the therapeutic communities were accredited by the Rehabilitation Accreditation Commission (CARF).

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

	Average	Range
FTEs	24.7	0 to 530
Total Employees	30.4	0 to 610

Traditional (residential only) TCs on average employed a significantly lower number of FTEs than modified (non-residential/mixed modality) TCs (18.2 versus 32.3; $p < .001$).



E) Counselor Characteristics

The average therapeutic community employed 12 counselors (range 0 to 280). TCs, on average, reported the following counselor characteristics.

	Average %
Masters Degree or higher	29.0%
Certified	46.9%
Female	56.7%
Racial/Ethnic Minority	44.0%
Recovering	57.1%

Within the average TC, about 29.0% of counselors held a Master's degree or higher, while 71% of counselors held a college degree or less. Some TCs (29.6%) did not employ Master's level counselors. In a small minority of the TCs (5.9%), all counseling staff possessed at least a Master's degree.

Nearly half (46.9%) of the TC counselors, on average, were certified alcohol/drug abuse counselors. In 20% of TCs all employed counselors were certified, while 16.9% of TCs employed no certified substance abuse counselors.

Traditional TCs, on average, employed a significantly smaller percentage of counselors with a Master's degree or higher than modified TCs (26.2% versus 32.1%; $p < .05$). In comparison, traditional TCs on average employed a significantly greater percentage of counselors in personal recovery than modified TCs (64.8% versus 48.1%; $p < .000$).

F) Medical Staff

TCs Employing Physicians and Nurses: % On Payroll or Contract

	Traditional TCs	Modified TCs
Physicians	52.7%**	69.5%
Nurses	35.2%**	48.0%

**$p < .01$

Traditional TCs were significantly less likely than modified TCs to employee physicians and nurses.

IV. Organizational Performance

A) Voluntary Turnover

Counselors and Nurses

Staff turnover is often viewed as a problem in substance abuse treatment organizations, particularly because it may disrupt client care and the quality of care received.

Among the sample of TCs, the average TC lost 21.9% of counseling staff during a 12 month period preceding our interview due to counselors deciding to seek employment elsewhere. This rate reflects voluntary turnover, and therefore does not include the loss of counseling staff through layoffs or terminations. Although this rate of turnover is considerable, it is important to note that 39% of the TCs in this sample did not lose any counselors for voluntary reasons in the past year.

A total of 155 TCs (41.1%) employed nurses. Among those TCs that employed nurses, the average voluntary turnover rate for nurses was 22.4%. As was the case with counselor turnover, a portion of the TCs (68%) experienced no turnover among nurses, while other TCs reported high turnover. Traditional TCs reported a significantly higher turnover rate among nurses than modified TCs (28.3% versus 15.0%; $p < .05$).

On average, administrators reported that it typically takes 18.6 weeks to fill a counseling position and 9.8 weeks to fill a nursing position (range 0 to 52 weeks).

B) Layoffs

In addition to voluntary turnover, 13.3% of the TCs reported counselor layoffs during the past year. Less than two percent of the TCs reported nurse layoffs during the past year.

C) Counselor Salaries

Average Counselor Salary	
Minimum	$23,580.91
Maximum	$35,375.07
Average	$29,116.36

D) Expansion, Reduction, and Threat of Closure

Half of the 380 therapeutic communities in the NTCS reported no change in the number of clients, programs, or staff in the preceding two years. Over a third of the TCs reported expansions in at least one of these three areas, whereas 4% to 8% 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 TC. However, between 3% and 6% of TCs 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	39.0%	36.0%	33.6%
Reduction only	6.6%	4.0%	8.2%
Both	5.3%	3.7%	6.6%
No Changes	49.1%	56.3%	51.6%
	100%	100%	100%

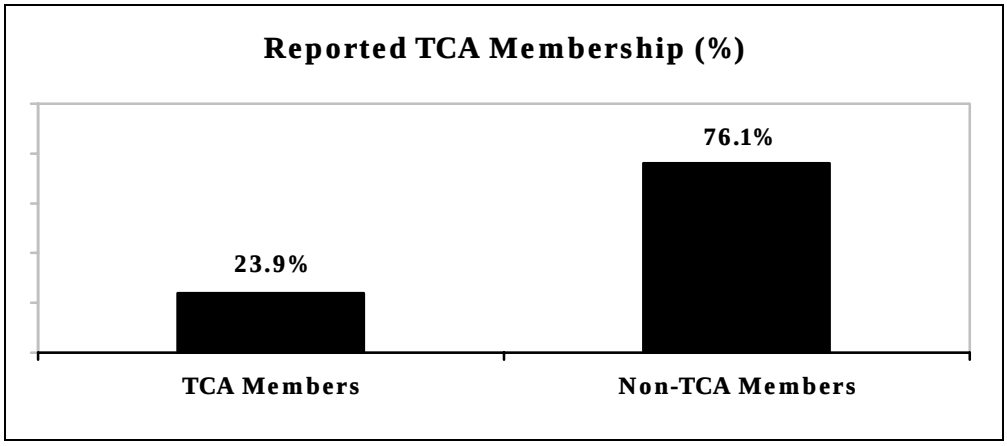
Traditional TCs were significantly less likely than modified TCs to both expand and reduce the number of clients, programs, and services. Approximately one-third of the traditional TCs expanded programs compared to over half of modified TCs ($p < .01$).

E) 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 TC's closure in the coming year. On average TCs reported a very low (1.70) likelihood of closure. Three-quarters of the TCs reported that closure in the coming year was not at all likely.

V. TCA Membership

Although membership in Therapeutic Communities of America (TCA) was not used as a criterion for sampling, administrators were asked whether or not their TC was a TCA member. Nearly one-quarter of the TCs (23.9%) reported membership in TCA. The following tables compare the organizational structure and clinical service delivery of TCA and non-TCA members as well as the extent to which TCA and non-TCA members resemble the traditional TC model described by De Leon (2000).



A) "Essential Elements" and TCA Membership

Administrators were asked on a scale of 0 to 5, with 5 representing "a very great extent," the extent to which these practices and beliefs characterize their TC. Higher scores are also indicative of the traditional TC model. TCA members scored significantly higher than non-TCA members on these scaled questions.

TRADITIONAL TC CHARACTERISTICS

	Average Score	
	TCA Members (N=91)	**TCA Non-members (N=289)**
The treatment problem to be addressed is not the drug, but the whole person.	4.90	4.82
Right living involves positive social values, such as work ethic, social productivity, and community responsibility.	4.88***	4.66
The most important role of the clinical staff is to facilitate the clients' commitment to the shared community values.	4.64***	4.17
There are cardinal rules, which if violated, can lead to termination from the program (e.g., no drug use, no violence or sexual acting out).	4.80	4.77
Clients are stratified by levels of responsibility and clinical status, such as Junior, Intermediate, and Senior.	4.57***	3.76
Senior residents act as role models for more junior clients.	4.62*	4.30
Clients are aware of the therapeutic goals of fellow residents and try to assist them to achieve these goals.	4.44***	3.99

	TCA Members	TCA Non-members
General meetings are convened as needed to address negative (or extraordinary positive) behavior, attitudes, or incidents at the facility.	4.62	4.57
Peer feedback occurs more frequently than staff counseling.	4.16**	3.68
Clients confront the negative behavior and attitudes of each other and the community.	4.70***	4.26
Encounter groups are used to confront negative behaviors and attitudes.	4.47***	3.26
Disciplinary actions are designed as learning experiences.	4.78	4.68
There are periodic "house runs" or thorough inspection of the premises.	4.69*	4.34
The program is designed as three main stages: orientation/induction, primary treatment, and re-entry, with sub-phases in each stage.	4.48	4.16

*p < .05; **p < .01; ***p < .001

B) Clinical Service Delivery and TCA Membership

- TCA and non-TCA members were equally likely to offer traditional, outpatient, and mixed levels of care.

- TCA members were significantly less likely to be based on a 12-step model or require 12-step attendance during the course of treatment.

- TCA members were significantly less likely than non-TCA members to emphasize supportive individual counseling, a medical/psychiatric model, and spiritual counseling. However, TCA members were nearly 1.5 times more likely to emphasize confrontational group therapy than non-TCA members ($p < .001$).

- TCA members were significantly more likely to offer a specialized treatment track for adolescents than non-TCA members (36.0% versus 20.0%; $p < .01$), and were significantly more likely to offer integrated care for dually diagnosed clients than non-TCA members (59.1% versus 47.0%; $p < .001$).

C) Caseload Characteristics and TCA Membership

- On average, TCA members treated a significantly smaller percentage of clients with a primary diagnosis of alcohol dependence than non-TCA members (20.9% versus 39.0%; $p < .001$). TCA members treated a significantly greater percentage of clients with a primary diagnosis of marijuana dependence or abuse (26.8% versus 17.7%; $p< .01$).

- TCA members, on average, treated a significantly smaller percentage of women than non-TCA members (32.5% versus 40.9%; $p < .05$), but treated a significantly greater percentage of racial/ethnic minorities (59.3% versus 49.4%; $p < .01$) and clients on probation/parole (68.2% versus 55.2%; $p < .001$).

- In addition, TCA members received a significantly greater percentage of referrals from the legal system, on average, than non-TCA members (52.6% versus 37.2%; $p < .001$).

D) Organizational Structure and TCA Membership

- TCA members were significantly larger than non-TCA members based on the average number of FTEs (35.5 versus 21.2; $p < .01$).

- Members of TCA employed, on average, a significantly smaller percentage of Master's degree and certified counselors (19.6% versus 31.9%; $p < .001$ and 38.9 versus 49.4%; $p < .05$, respectively). TCA members employed a significantly greater average percentage of minority counselors (52.8% versus 41.2%; $p < .01$).

Additional Data from the National Treatment Center Study

Participating TCs 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 TC. 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.

Therapeutic Communities

In 2000, UGA was awarded a grant from NIDA to study the structure, staffing, and service provision of a national sample of therapeutic communities (TCs) across the US. Of particular interest in this study was the extent to which modern TCs have adapted or diverged from the "essential elements" of the traditional therapeutic community model described by De Leon. The TC interviews also asked about the program's clinical services and the availability of specialized treatment services.

TCs 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 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. Eligible TCs were those who self-identified as "therapeutic communities." The 380 participating TCs reflect a response rate of 86%.

Administrators of each participating TC provided data in face-to-face interviews that were conducted between late 2002 and early 2004. The majority of participating TCs were interviewed in 2003. Interviews focused on organizational structure, management practices, personnel (number and type), case mix, services offered, and the TC's adoption and use of various evidence-based treatment techniques, including pharmacotherapies and psychosocial therapies for addiction treatment. A particular focus was on the extent to which modern TCs have adapted or diverged from the "essential elements" of the traditional therapeutic community model described by De Leon.

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 TC 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.

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.

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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