Alcohol and Drug Services Study (ADSS)

The National Treatment System: Outpatient Methadone Facilities

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Highlights

This report presents facility-level data on outpatient methadone treatment facilities nationwide from Phase I of the Alcohol and Drug Services Study (ADSS). Phase I of ADSS consisted of a mail questionnaire collected by telephone interview with facility directors at a nationally representative sample of 2,395 substance abuse treatment facilities, stratified by treatment type: hospital inpatient, non-hospital residential, outpatient predominantly alcohol, outpatient predominantly methadone, and combined treatment types. The data were collected for a point-prevalence date of October 1, 1996, and for the most recent 12-month reporting period of the facility. This report focuses on those facilities identified as being outpatient methadone, either as the only service provided or in combination with other types of substance abuse treatment. A sample of over 400 outpatient methadone facilities participated in the survey, with a weighted national estimate of 688 facilities providing outpatient methadone treatment.

This report provides national estimates for facilities that offer outpatient methadone treatment. It describes the relationship between methadone treatment practices and facility characteristics by examining facility size, ownership, amount of public revenue, urbanicity, level of facility affiliation, licensure, setting, services, and staffing composition. It provides information on treatment practices, such as methadone dosing level and staffing patterns, and describes the characteristics of clients in treatment. In addition, the ADSS Web-based report on the *National Substance Abuse Treatment System: Facilities, Clients, Services, and Staffing* provides information on methadone facilities in comparison with other types of substance abuse treatment (see http://www.samhsa.gov/oas/adss.htm). Highlights on methadone treatment from the national treatment system report and from this report follow.

Overview

- An estimated 6 percent of all substance abuse treatment facilities offered outpatient methadone treatment.

- An estimated 688 facilities provided outpatient methadone treatment and served an estimated 151,882 methadone clients, representing 14 percent of clients in the substance abuse treatment system.

- Outpatient methadone facilities on average were larger, had more private for-profit ownership, received more client self-payment, and were more likely to be located in large metropolitan areas than other types of substance abuse treatment facilities.

- Outpatient methadone facilities reported fewer treatment services and had higher client-to-staff ratios than other types of substance abuse treatment facilities.

Facility Characteristics

- An estimated 29 percent of outpatient methadone facilities were private for-profit, 53 percent were private non-profit, and 18 percent were publicly owned.

- Outpatient methadone facilities had a mean of 221 methadone clients and a median of 177 methadone clients in treatment on October 1, 1996, which is considerably higher than the mean of 88 and a median of 29 clients for other outpatient facilities.

- Most outpatient methadone facilities were located in large metropolitan (68 percent) and medium metropolitan (24 percent) statistical areas (MSAs). *(Table 4.1)*

- Private for-profit outpatient methadone facilities were much less likely to report accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) (6 percent of facilities) than were private non-profit methadone facilities (42 percent) and public methadone facilities (46 percent). *(Table 4.1)*

Services Provided

- Private for-profit outpatient methadone facilities offered generally fewer types of services than other methadone facilities (a mean of six treatment services and three support services vs. a mean of eight treatment services and four support services for private non-profit and public facilities). *(Table 4.1)*

- A large proportion of outpatient methadone facilities offered HIV/AIDS education/counseling/support (95 percent), TB screening (89 percent), and employment counseling/training (50 percent). *(Table 4.2)*

- Private for-profit outpatient methadone facilities were less likely to offer HIV support services and more likely to offer employment counseling/training than were private non-profit and public facilities. *(Table 4.2)*

- Private non-profit outpatient methadone facilities were more likely to offer child care and transportation. *(Table 4.2)*

Staffing

- Client-to-staff ratios in outpatient methadone facilities varied by facility ownership, with the lowest ratios in publicly owned facilities and the highest in private for-profit facilities. *(Table 4.3)*

- Clients in public outpatient methadone facilities were 3 times more likely to have access to medical staff and 1.5 times as likely to have access to direct-care staff as clients in for-profit outpatient methadone facilities. *(Table 4.3)*

- Higher methadone dosage was associated with higher client-to-staff ratios in outpatient methadone facilities. *(Table 5.5)*

- On average, outpatient methadone facilities had 16 full-time staff, 4 part-time staff, and 1 staff member on contract. *(Table 5.5)*

Methadone Dosing Policy

- The majority of outpatient methadone clients (91 percent) were in maintenance treatment and 9 percent were in detoxification. *(Table 3.1)*

- For outpatient methadone clients on stabilized methadone maintenance doses for at least 2 weeks, the facility mean methadone maintenance dose was 64 mg/day. *(Table 3.1)*

- Private for-profit outpatient methadone facilities were slightly more likely to offer high methadone dosages (70 mg/day or higher) than private non-profit facilities and considerably more likely than publicly owned facilities to do so. *(Table 5.2)*

- Forty-two percent of outpatient methadone facilities encouraging withdrawal from methadone within a year had a mean methadone maintenance dose of below 60 mg/day. *(Table 3.2)*

- Low dosage facilities (<60 mg/day) were more likely than medium and higher dose facilities to be in large metropolitan areas. *(Table 5.1)*

Policy on Withdrawal from Methadone

- Fifty-two percent of outpatient methadone facilities had policies permitting clients to remain in methadone treatment for an unlimited time; under a quarter of facilities (22 percent) had policies encouraging withdrawal from methadone within 12 months. *(Table 5.3)*

- Outpatient methadone facilities with no time limits on withdrawal from methadone were larger, had more public funding, were more likely to be located in large metropolitan areas, and were more likely to be affiliated with other organizations than outpatient methadone facilities that limited the time on methadone. *(Table 5.1)*

- Client payment source was related to methadone withdrawal policy. Clients with private managed care insurance were more likely to be in facilities with policies limiting patients' time on methadone. *(Table 6.1)*

Chapter 1. Introduction and Overview

Phase I of the Alcohol and Drug Services Study (ADSS) consisted of a mail questionnaire collected by telephone interview with facility directors at a national, stratified random sample of alcohol and drug treatment facilities. The sample frame was the Substance Abuse and Mental Health Service Administration's (SAMHSA's) 1995 inventory of substance abuse treatment facilities known to SAMHSA. The core universe of treatment facilities was supplemented with facilities identified from other sources, such as hospital listings, provider associations, and business directories. Facilities in the frame were stratified by treatment type: hospital inpatient, non-hospital residential, outpatient predominantly alcohol, outpatient predominantly methadone, and combined treatment types. Thus, ADSS is a nationally representative sample of substance abuse treatment facilities, excluding halfway houses without paid counselors, solo practitioners, correctional facilities, Department of Defense (DOD) facilities, Indian Health Service facilities, and facilities that are intake and referral only. ADSS builds upon the work of the 1990 Drug Services Research Survey (DSRS) (Batten et al., 1993) with a more complete sampling frame, an enhanced sampling design, and improved measures of financing and organization.

Phase I was conducted from December 1996 to June 1997, with data collected for a point-prevalence date of October 1, 1996, and for the most recent 12-month reporting period of the facility. The Phase I response rate was 91.4 percent with 2,395 facilities responding. Because the Phase I sampling design incorporated a stratified random probability sample, weights were developed to produce national estimates of facilities. The sampling weights adjust for facility non-response and for differential response rates within strata. ADSS results were post-stratified to match the sample frame. The data in this report were imputed to account for missing values. Overall, item non-response was very low, generally less than 10 percent. Further information about the data collection methodology for the study is presented in Appendix A and in the ADSS methodology report (Office of Applied Studies [OAS], 2003a). Description of variable construction appears in Appendix B, and standard error (SE) tables are presented in Appendix C. Later phases of ADSS are the Phase II facility and client record subsample and the Phase III client post-treatment follow-up study.

This report examines the provision of outpatient[1] methadone treatment in the United States and provides national estimates of the number of facilities that offer outpatient methadone treatment and the number of clients in outpatient methadone treatment. It provides information on treatment practices, such as methadone dose, and staffing patterns and describes the characteristics of clients in treatment based on responses made by facility directors.[2] ADSS Phase I includes survey data from more than 400 sampled methadone treatment facilities. Four hundred and eighty-two (482) sample facilities that offered methadone completed the ADSS Phase I facility survey. Of those, 418 had outpatient methadone treatment, with 324 offering outpatient methadone only and 94 facilities providing outpatient methadone in combination with another

[1] All comparisons reported in this chapter are significant, except where noted otherwise, using the Bonferroni correction to $p = .05$ based on the number of comparisons.

[2] Additional information on methadone treatment clients may be found in a forthcoming Phase II client record abstract report.

type of care. These produced a weighted national estimate of 688 facilities providing outpatient methadone treatment.

This report explores the relationship between methadone treatment practices and facility characteristics by examining facility size, ownership, amount of public revenue, urbanicity, level of facility affiliation, licensure, setting, services, and staffing composition. It also examines the characteristics of clients who receive methadone and discusses associations between client characteristics and methadone treatment practices.

Chapter 2. Background on Methadone Treatment

2.1 Background on Methadone Treatment Clients and Dosage Levels

Individuals dependent on opioids often have poor physical and mental health, increased risk of human immunodeficiency virus (HIV) infection, high mortality rates, disturbed family relationships, chronic unemployment, and a history of criminal behavior (Institute of Medicine [IOM], 1995). In addition to the high personal costs, the financial cost of untreated opioid dependence is estimated to be $20 billion annually (National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction, 1998). Methadone is the most commonly used drug to treat dependence on heroin and other opioids. In 1996, the Uniform Facility Data Set (UFDS) indicated that 124,000 people (about 13 percent of clients in the core UFDS set of facilities) were receiving narcotic substitutes (Office of Applied Studies [OAS], 1997). Less than 2 percent of individuals receiving opioid substitutes in 1997 were receiving levo alpha acetylmethadol (LAAM), a longer acting medication, and 98 percent were receiving methadone (OAS, 1999). Findings from the Drug Services Research Survey (DSRS) indicated that 92 percent of those receiving methadone in 1990 were in maintenance and 8 percent were in detoxification (Batten et al., 1993).

Methadone has been used for treatment of heroin dependence since the mid-1960s (Dole & Nyswander, 1976). Because methadone treatment replaces a short-acting opioid (heroin) with a long-acting opioid (methadone), it has been controversial since its inception (Cooper, 1992; Greenfield, 1999; Zweben & Payte, 1990), particularly with regard to adequate dose levels. Despite substantial medical consensus on appropriate treatment practices, many clients have received lower than the recommended dosage, and time in treatment has often been limited by treatment guidelines (D'Aunno, Folz-Murphy, & Lin, 1999; D'Aunno & Vaughn, 1992; Etheridge, Hubbard, Anderson, Craddock, & Flynn, 1997; McCarty, Frank, & Denmead, 1999). Experts have agreed, however, that the degree to which methadone treatment is effective depends on treatment practices that include adequate dosage, sufficient time in treatment, and essential treatment and support services (National Consensus Development Panel, 1998).

According to clinicians and researchers, adequate methadone dosage should be based on an individualized clinical process using the best judgment of a physician trained to administer methadone (Ball & Ross, 1991; Dole, 1988; IOM, 1995; National Consensus Development Panel, 1998). Good treatment practices include supplying dosages calculated high enough to prevent the onset of opioid abstinence syndrome for 24 hours or more, reduce or eliminate the craving for heroin, and block the euphoric effects of any heroin or other narcotic (Parrino, 1993). Dosages of 60 mg may be sufficient, but many patients may require higher dosages (National Consensus Development Panel, 1998). The potential consequences of inadequate methadone dose levels for thousands of heroin addicts in treatment include relapse to illicit heroin use (most often by needle injection), increasing risk of HIV infection, criminal behavior to support drug use, and higher mortality rates (Ball, Lange, Myers, & Friedman, 1988; Ball & Ross, 1991; IOM, 1995; Kang & De Leon, 1993a, 1993b; McGlothlin & Anglin, 1981; National Consensus Development Panel, 1998; Zanis & Woody, 1998). Caplehorn, Bell, Kleinbaum, and Gebski

(1993) estimated that the likelihood of heroin usage was reduced by 2 percent for each milligram increase in methadone.

Until recently, most clients did not receive the recommended methadone dosages (Cooper, 1992). In 1990, the DSRS estimated the median average daily dose was 50 mg/day (Batten et al., 1993). In the Drug Abuse Treatment System Survey (DATSS), D'Aunno and Vaughn (1992) similarly found low average daily doses of 46 mg/day. Resistance to higher dosages is due to negative attitudes among clients who may fear dependence on methadone and among some treatment providers and members of the general public who see the use of methadone for heroin as simply substituting one drug for another (Greenfield, 1999; Zweben & Payte, 1990). However, average dosage levels appear to be increasing. By 1995, D'Aunno et al. (1999) noted average daily doses had risen to 59 mg/day. Other studies have shown that dosage levels higher than 80 mg/day can be safe and efficacious (Cooper, 1989, 1992; D'Aunno & Vaughn, 1992; Dole, 1988; Goldstein, 1991; Maremmani, Nardini, Zolesi, & Castrogiovanni, 1994; McGlothlin & Anglin, 1981; Metzger & Platt, 1987; Strain, Bigelow, Liebson, & Stitzer, 1999). This report provides a national estimate of average dosage levels reported by methadone facility directors for October 1, 1996.

2.2 Background on Support Services, Time in Treatment, and Withdrawal Policy

Treatment and support services also have been shown to be a part of treatment practice that is critical for successful methadone treatment outcomes (National Consensus Development Panel, 1998). Methadone and minimal counseling reduces heroin use, but additional psychosocial services are necessary for better client outcomes (Glass, 1993). Clients who received medical services, family therapy, and employment counseling had better treatment outcomes than those who just received methadone and counseling (McLellan, Arndt, Metzger, Woody, & O'Brien, 1993). Methadone clients who reported receiving a range of social services (e.g., family, legal, educational, employment, and financial) were 3½ times more likely to stay in treatment than clients who did not report having such services (Condelli & Dunteman, 1993).

Researchers also have suggested that time in treatment is an important predictor of post-treatment success (Hubbard et al., 1989; IOM, 1990). Longer stays in methadone treatment are associated with less likelihood of clients being involved in criminal activities and less risky behavior, such as needle use or sharing (French, Zarkin, Hubbard, & Rachal, 1991; Kang & De Leon, 1993a, 1993b). In the early 1990s, average lengths of stay were variously estimated to range from 11 through 21 months (Batten et al., 1992; D'Aunno et al., 1999; Etheridge et al., 1997). Although length of stay is not addressed in this report, the forthcoming ADSS Phase II client abstract report presents the average stay for each treatment type.

Units with higher average dose levels tend to have clients who remain in treatment longer (Caplehorn & Bell, 1991; Caplehorn et al., 1993; D'Aunno & Vaughn, 1992; Joe, Simpson, & Hubbard, 1991). Caplehorn and Bell (1991) found that patients receiving 80 mg/day and above were twice as likely to remain in treatment compared with those who were receiving 60 to 79 mg/day; and clients who received 60 to 79 mg/day were twice as likely to remain in treatment as were those receiving less than 60 mg/day. Moreover, the likelihood of clients leaving treatment

during the first 3 years of maintenance decreased by 1.47 percent for each milligram increase in the maximum daily dose of methadone (Caplehorn, Dalton, Cluff, & Petrenas, 1994).

Research also indicates that facility methadone withdrawal policy can influence the length of time a client stays in treatment. Although many practitioners discourage withdrawal from methadone for most heroin addicts (Cooper, 1992; Dole, 1988; Dole & Nyswander, 1976; Goldstein, 1991), Kang, Magura, Nwakeze, and Demsky (1997) found that detoxification from methadone was routinely advocated in many programs. Seventy-three percent of methadone units in 1990 encouraged clients to detoxify in fewer than 12 months, but this decreased to 45 percent in 1995 (D'Aunno et al., 1999). The National Consensus Development Panel (1998) noted that duration and continuity of treatment are important factors in the effectiveness of methadone treatment. This report provides information on facility policy on withdrawal from methadone.

2.3 Background on Facility Organizational Characteristics

Facility organizational characteristics, such as specialization in methadone treatment, facility setting, ownership, facility policy, legal affiliation with other entities, and staffing patterns, may influence methadone treatment.

2.3.1 Single and Combined Modality Facilities

Facilities may differ according to the proportion of their clients receiving methadone. The majority of facilities that dispense methadone are outpatient methadone-only substance abuse facilities. D'Aunno et al. (1999) found that the proportion of methadone units that were methadone-only facilities increased from 30 percent in 1988 to 50 percent in 1995, and the proportion continued to increase to two thirds of methadone facilities in 1996 (ADSS Phase I). In 1995, methadone dosage level and time in treatment were similar in methadone-only facilities and in facilities where methadone is mixed with other types of care (D'Aunno et al., 1999). Average dosage was 59 mg/day in both methadone-only and mixed programs, while average time in treatment was 23 months in methadone-only facilities and 20 months in mixed facilities.

2.3.2 Setting

Both physical setting and urban location have been associated with differences in treatment practices (D'Aunno & Vaughn, 1992). Facilities set in hospitals or other medical settings tend to have more licensing, more quality assurance programs, and more frequent medical assessment (Price, 1997). Facilities in less urban areas are likely to have lower average methadone doses compared with facilities located in large, central metropolitan areas (D'Aunno et al., 1999). Clients treated in facilities in community health centers were likely to have less influence on dosage levels than those in hospital settings (D'Aunno et al., 1999).

2.3.3 Ownership

Ownership and funding also are influential. Historically, methadone treatment has been associated with the public sector that includes most private non-profit and all publicly owned facilities (Institute of Medicine [IOM], 1990). Public funding supports access to methadone

treatment (Friedmann, Alexander, & D'Aunno, 1999; Hubbard et al., 1989; IOM, 1990, 1995) and influences treatment practices as well (D'Aunno et al., 1999; Friedmann et al., 1999). Public funding sources were found to pay for 80 percent of methadone treatment in 1993 (IOM, 1995).

D'Aunno and his colleagues found ownership was associated with differences in treatment practices (D'Aunno & Vaughn, 1992; D'Aunno et al., 1999). Private for-profit methadone programs were significantly more likely to provide lower average daily doses, shorter time to detoxification, and lower average lengths of stay compared with private non-profit facilities (D'Aunno et al., 1999). Public units offered greater access to treatment services than private for-profit units (Friedmann et al., 1999).

2.3.4 Regulation

Methadone treatment also has been influenced by Federal, State, and local regulation and licensing practices. Methadone treatment has been strictly regulated since its inception because of concerns about possible drug diversion and a philosophy supporting drug-free treatment (IOM, 1995; National Consensus Development Panel, 1998). State regulation also has affected access to methadone treatment. In 1998, 8 States had no methadone treatment programs (Idaho, Mississippi, Montana, New Hampshire, North Dakota, South Dakota, Vermont, and West Virginia), and minimal coverage was provided in 17 other States (McCarty et al., 1999). Medicaid covered methadone treatment in 25 States, but type of coverage varied across States.

2.3.5 Affiliation with Other Organizations

Facility affiliation has been relatively common in methadone treatment because many early methadone treatment units were legally part of larger medical organizations interested in drug abuse research (IOM, 1995). In 1988, just under half of methadone treatment units (45 percent) were not free-standing (i.e., non-hospital residential) but were located in hospitals or community mental health centers (D'Aunno et al., 1999). Treatment practices are affected by location in a medical organization. For example, primary care services were more likely to be offered to clients when methadone was delivered under medical auspices (Friedmann et al., 1999; Price, 1997). Furthermore, facilities in hospital settings have been associated with more medical services and higher levels of regulation than facilities in other settings (D'Aunno et al., 1999).

2.3.6 Staffing

D'Aunno et al. (1999) found that staff education and training had an impact on treatment practices. This report presents facility mean staff size by staff educational level. It also provides client-to-staff ratios by facility ownership and by facility treatment practices, including average methadone dosage and average withdrawal time.

2.4 Preview of Remaining Discussion

The remaining five chapters of this report present findings from ADSS Phase I, with data presented in tables at the end of the chapters. Chapter 3 discusses methadone treatment facilities and practices for October 1, 1996, the ADSS point-prevalence date. Chapter 4 describes

treatment facility characteristics and ownership. Chapter 5 presents findings on treatment facility characteristics and treatment practices, including dosage and withdrawal policy by facility organizational, services, and staffing characteristics. Chapter 6 examines methadone client demographic characteristics and their relationship to facility treatment practices, including dosage and withdrawal policy. Chapter 7 presents conclusions drawn from the reported data.

Chapter 3. ADSS Findings on Outpatient Methadone Treatment Facilities and Treatment Practices

On October 1, 1996, the substance abuse treatment system was comprised of an estimated 12,387 treatment facilities.[3] About 6 percent of all facilities, an estimated 688 facilities, offered outpatient methadone treatment. Alcohol and Drug Services Study (ADSS) data suggest that methadone facilities differed in important ways from other facilities. They were larger, had more private for-profit ownership, relied more on client self-payment, and were located in larger metropolitan areas. They also reported fewer treatment and support services than other types of care and had higher client-to-staff ratios. The full national universe of outpatient methadone facilities was estimated to be serving more than 150,000 clients on the point-prevalence date of the survey, October 1, 1996, representing 14 percent of clients in the treatment system. Many methadone clients had indicators of severe problems. Not surprisingly, they were dependent on opiates, but they also were more likely than other clients in treatment for substance abuse to be older and receive disability benefits.[4] This report describes methadone facility organizational characteristics, methadone treatment practices, support services, staffing patterns, and clients in treatment and examines the relationships among these factors.

As Table 3.1 shows, an estimated 688 facilities provided outpatient methadone treatment on October 1, 1996, with an estimated 151,882 clients in outpatient methadone treatment on that date.[5] About 91 percent of methadone clients were in maintenance treatment while about 9 percent were in detoxification treatment, similar to methadone treatment patterns in 1990 (Batten et al., 1993). ADSS findings suggest that facility directors reported methadone dosage and withdrawal policies that conform to recommendations of many researchers and that are noted as important factors by the National Consensus Development Panel (Cooper, 1992; Dole, 1988; Dole & Nyswander, 1976; Goldstein, 1991; National Consensus Development Panel, 1998). Current reports about dosage and withdrawal policies are in contrast to 1990 results (Batten et al., 1993). In 1990, the median daily dosage reported by facility directors was 50 mg or less (Batten et al., 1993). By 1995, D'Aunno et al. (1999) noted average daily dosage of 59 mg per day. ADSS results indicate that in 1996 the facility-reported mean daily dose (for clients who had been on stable methadone doses for at least 2 weeks) had increased to 64 mg per day in outpatient methadone facilities. Half of facilities reported average client dosages in a narrow band ranging from 58 to 70 mg, and the median dose of 65 mg was virtually identical to the mean (64 mg).

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[3] See Chapter 1 of the report titled *Alcohol and Drug Services Study (ADSS): The National Substance Abuse Treatment System: Facilities, Clients, Services, and Staffing* (Office of Applied Studies [OAS], 2003b), "Organizational Characteristics of Substance Abuse Treatment Facilities."

[4] See Chapter 2 of the report titled *Alcohol and Drug Services Study (ADSS): The National Substance Abuse Treatment System: Facilities, Clients, Services, and Staffing* (OAS, 2003b), "Client Populations in Substance Abuse Treatment Facilities."

[5] Except as noted in the text, estimates for methadone facilities in this report include all facilities reporting any outpatient treatment methadone clients on October 1, 1996, including facilities that offer only outpatient methadone treatment and those that offer it in combination with another type of care.

In Table 3.1, facilities are classified into three dosage groups. Facilities with lower average doses, less than 60 mg a day, represented about a fourth (26 percent) of outpatient methadone facilities. Facilities with moderate average doses, between 60 and 69 mg a day, characterized somewhat more than a third of facilities (36 percent), and facilities providing higher average doses, 70 mg or more per day, constituted more than a third of facilities (39 percent).

Withdrawal policies also have changed. In 1990, most facilities encouraged withdrawal before 12 months (D'Aunno et al., 1999). However, in 1996, ADSS findings show that 52 percent of facilities permitted clients to remain in methadone treatment for an unlimited time, and most facilities (78 percent) did not encourage withdrawal before a year. However, one in five facilities still encouraged withdrawal within 1 year: 11 percent by 6 months and another 11 percent within 7 to 12 months.

As Table 3.1 shows, on average, methadone facilities provided a mean of 7.5 treatment services and 3.45 support services. The treatment services were from a group of selected services that included comprehensive assessment/diagnosis, individual therapy, group therapy, family counseling, relapse prevention, self-help groups, aftercare, outcome follow-up, dual-diagnosis treatment, detoxification, and acupuncture. The support services were from a group of selected services that included HIV/AIDS education, transportation, TB screening, employment counseling, smoking cessation, academic education classes, child care, and prenatal care.

Table 3.2 shows that facilities that allowed clients to remain on methadone for longer periods before withdrawal from methadone was encouraged were more likely to provide higher methadone doses. The sharpest contrast is between facilities with no time limits on methadone and those that encouraged withdrawal from methadone in 12 months or less. Forty-one percent of facilities with no time limits had average daily dosages of 70 mg or higher, while only 31 percent of facilities with limits under 1 year had the high average dose.

In contrast, 42 percent of facilities that encouraged withdrawal from methadone within a year had a mean dose of less than 60 mg. Although facilities with unlimited time policies were less likely to provide low dosages (19 percent), a considerable group, 40 percent, provided moderate dosages.

Table 3.1 ADSS Phase I: National Estimates of the Number of Outpatient Methadone Treatment Facilities, Outpatient Methadone Clients, and Selected Treatment Practices on October 1, 1996

Facility Sample Size—Unweighted Number of Outpatient Methadone Facilities (*n*)	418
Number of Outpatient Methadone Facilities—Weighted Estimate (*N*)	688
Number of Methadone Clients in Outpatient Methadone Facilities—Weighted Estimate	151,882
Percent of Outpatient Methadone Clients in Methadone Maintenance	90.6
Percent of Outpatient Methadone Clients in Detoxification	9.4
Methadone Maintenance Dose (Facility Average)[a]	
Mean	64.4
25th percentile	58.2
Median	64.6
75th percentile	69.7
Percent of Facilities with Average Methadone Maintenance Dose[a]	
Under 60 mg	25.8
60-69 mg	35.5
70 mg or more	38.7
Percent of Facilities—Withdrawal from Methadone Encouraged[b]	
Within 6 months	11.3
7-12 months	10.9
13-24 months	15.9
More than 24 months	10.3
Unlimited	51.6
Number of Selected Treatment Services Offered	
Mean	7.50
25th percentile	6.03
Median	7.91
75th percentile	8.91
Number of Selected Support Services Offered	
Mean	3.45
25th percentile	2.00
Median	2.94
75th percentile	4.06

[a] Ninety-seven percent of sampled outpatient methadone facilities offering maintenance reported the average methadone maintenance dose (636 facilities, weighted).

[b] Ninety-eight percent of all sampled outpatient methadone facilities reported the amount of time before withdrawal from methadone was encouraged (661 facilities, weighted).

Exclusions: ADSS Phase I excludes intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, and Department of Defense and Indian Health Service facilities.

Source: Alcohol and Drug Services Study, Phase I facilities data (weighted). Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Table 3.2 ADSS Phase I: Percentage Distribution of Outpatient Methadone Facilities, by Facility Mean Methadone Maintenance Dose, by Facility Policy on Withdrawal from Methadone, October 1, 1996

Facility Withdrawal Policy (Time to Begin Withdrawal)	Facility Mean Methadone Maintenance Dose			
	Total, All Outpatient Methadone Facilities	Less Than 60 mg	60 to 69 mg	70 or More mg
Estimated number of facilities (weighted)	633[a]	163	225	245
All methadone facilities (100%)	100.0	25.8	35.5	38.7
Limited time, within a year (22%)	100.0	41.6	27.7	30.7
Limited time, more than a year (26%)	100.0	27.1	32.3	40.7
Unlimited time (52%)	100.0	18.7	40.4	40.9

[a] Data on both average methadone maintenance dose and facility withdrawal policy were available for 92 percent of facilities offering maintenance (633 of 688 facilities, weighted).

Exclusions: ADSS Phase I excludes intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, and Department of Defense and Indian Health Service facilities.

Source: Alcohol and Drug Services Study, Phase I facilities data (weighted). Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Chapter 4. ADSS Findings on Facility Characteristics and Ownership

Table 4.1 shows the distribution of facility organizational characteristics by type of ownership. Of the 688 outpatient methadone facilities estimated in the Alcohol and Drug Services Study (ADSS), 30 percent were private for-profit, 53 percent were private non-profit, and 18 percent were publicly owned. Most outpatient methadone facilities were large, urban, and generally publicly funded. Overall, outpatient methadone facilities had a mean of 221 methadone clients in treatment on the point-prevalence date of October 1, 1996.[6] A third of facilities had up to 120 methadone clients in treatment, the middle third had between 121 and 265 methadone clients in treatment, and the top third had more than 265 methadone clients in treatment. Most methadone facilities were located in large metropolitan (68 percent) and medium metropolitan (24 percent) statistical areas. Less than 8 percent of methadone facilities were in smaller areas. No outpatient methadone facilities reported that they were in rural and small urban areas with populations of fewer than 20,000. These ADSS findings about geographic location are consistent with those reported by D'Aunno et al. (1999).

Overall, outpatient methadone facilities were likely to have connections to other organizations. About two thirds of facilities reported a legal affiliation with another organization: One in six was a parent facility, and almost half (49 percent) were legally a part of another organization. Virtually all methadone facilities reported treatment licensing or accreditation from some entity (in addition to the required drug-dispensing authorization). The most prevalent sources of treatment licensing or accreditation were State alcohol or drug abuse agencies (90 percent), other State public health agencies (44 percent), and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) (32 percent).

Prior research has shown that facilities with private non-profit and public ownership have provided the bulk of methadone treatment since the mid-1960s (D'Aunno et al., 1999; D'Aunno & Vaughn, 1992; Etheridge et al., 1997; Hubbard et al., 1989; IOM, 1990; OAS, 1999). As shown in Table 4.1, ADSS data confirm that most methadone facilities were private non-profit (53 percent) or publicly owned (18 percent), and the remainder (30 percent) were private for-profit facilities. The proportion of private for-profit facilities has grown since 1990 when 20 percent of outpatient facilities reported private for-profit ownership (Batten et al., 1993).

Private for-profit outpatient methadone facilities were much less dependent on public revenue than other facilities.[7] Seventy-nine percent of private for-profit facilities received less than half of their revenue from public sources (Table 4.1). Private for-profit facilities did not

[6] Discussed in Chapter 1 of the report titled *Alcohol and Drug Services Study (ADSS): The National Substance Abuse Treatment System: Facilities, Clients, Services, and Staffing* (Office of Applied Studies [OAS], 2003b), "Organizational Characteristics of Substance Abuse Treatment Facilities."

[7] Revenue categorized as public included funds from Medicaid, Medicaid managed care, Medicare, other Federal Government funds (VA, CHAMPUS, etc.), and other public funds (e.g., Federal, State, and local block grants, contracts, and other public sources).

report as high a level of affiliation with other organizations as did other facilities. Half reported no affiliations with other organizations compared with 31 percent of unaffiliated private non-profit and 19 percent of public facilities. Only about 1 percent of private-for-profit outpatient methadone facilities were in hospital settings or in community mental health centers. Although most private for-profit facilities were licensed by State alcohol or drug agencies (87 percent), private non-profit facilities had higher proportions of this type of licensing (97 percent). Private for-profit facilities were much less likely to report JCAHO accreditation (6 percent) than either private non-profit facilities (42 percent) or public facilities (46 percent). They did, however, report more State public health agency licensing (40 percent) than publicly owned facilities (25 percent).

As noted by Friedmann et al. (1999), private for-profit facilities provided substantially fewer services than other facilities. Overall in ADSS, private for-profit methadone facilities reported that they provided a mean of 6 selected treatment services and 3 selected support services compared with about 8 treatment and 4 support services for private non-profit and public facilities.

In contrast, private non-profit outpatient methadone facilities were generally larger, received more of their funding from public sources, had higher levels of licensing or accreditation, and offered slightly more of the selected services. Forty-one percent of private non-profit facilities were large (over 265 clients in treatment on the survey date) compared with 16 percent of public facilities. Most private non-profit facilities (88 percent) received more than half their revenue from public sources. Almost all private non-profit methadone facilities (97 percent) reported licensing by State alcohol or drug agencies, a higher proportion than for private for-profit and publicly owned facilities (87 and 74 percent, respectively). The majority of private non-profit facilities (52 percent) had State public health agency licensing compared with 25 percent of publicly owned facilities. Private non-profit facilities also were more frequently licensed by State mental health agencies (15 percent) than were privately owned facilities (9 percent).

Publicly owned outpatient methadone facilities were the smallest, were largely publicly funded, were often in large urban areas, and were more likely to be affiliated with other organizations. Almost half of publicly owned facilities (49 percent) were small, serving 120 or fewer clients, significantly more than private non-profit facilities (28 percent). Two thirds had more than 90 percent of their funding from public sources. They were more likely than private for-profit facilities to be affiliated with another organization. Three fourths had State alcohol or drug agency licensing (74 percent), and almost half (46 percent) had JCAHO accreditation. Unlike other facilities, a substantial proportion (39 percent) were situated in hospital settings. Publicly owned outpatient methadone facilities offered slightly more treatment services (8.5, mean) than other ownership types. They offered about the same number of support services (3.7, mean) as private non-profit facilities.

ADSS data confirm earlier findings (Friedmann et al., 1999) that clients in private for-profit facilities have access to fewer services and less staff than those in private non-profit or publicly owned facilities. Table 4.2 shows the association between ownership and the provision of selected treatment and support services. Overall, at least 60 percent of outpatient methadone

facilities offered each of the following treatment services: comprehensive assessment/diagnosis, individual therapy, group therapy, detoxification, family counseling, relapse prevention, aftercare, self-help groups, and dual-diagnosis treatment. However, private for-profit facilities were significantly less likely to offer comprehensive assessment/diagnosis, individual therapy, group therapy, relapse prevention groups, and dual-diagnosis treatment than other types of facilities. Private for-profit facilities also were significantly less likely than publicly owned facilities to offer family counseling and self-help groups and significantly less likely than private non-profit facilities to provide aftercare. They offered detoxification in the same proportion as other types of facilities, about three fourths of all facilities.

In respect to the selected support services reported in ADSS, the majority of outpatient methadone facilities offered HIV/AIDS education/counseling/support, TB screening, and employment counseling/training. Private for-profit facilities were least likely to offer HIV support services (86 percent of private for-profit vs. 98 percent for private non-profit and 99 percent for publicly owned facilities). Private for-profit facilities also were less likely than private non-profit facilities to offer such support services as transportation and child care. Private non-profit facilities were more likely than publicly owned facilities to offer support services in such areas as child care and prenatal care. Private for-profit facilities were more likely to offer employment counseling/training.

Table 4.3 shows that mean client-to-staff ratios also varied by outpatient methadone facility ownership. The lowest client-to-staff ratio was in publicly owned facilities (15.9 clients per direct-care staff member), and the highest ratio was in private for-profit facilities (26.7 clients per direct-care staff member). Clients in public facilities were nearly 3 times more likely to have access to medical staff and about 1.5 times as likely to have access to direct-care staff as clients in for-profit facilities. Differences in ratios for counseling staff show a similar pattern. The distribution of staffing ratios supports other findings (Etheridge et al., 1997; Friedmann et al., 1999; Price, 1997) that access to staff is more likely in public and private non-profit facilities compared with private for-profit facilities.

Table 4.1 ADSS Phase I: Percentage Distribution of Outpatient Methadone Treatment Facilities by Selected Facility Characteristics, by Facility Ownership, National Estimates, October 1, 1996

	Total, All Facilities	Facility Ownership		
		Private For-Profit	Private Non-Profit	Public
Number of Facilities (Weighted Estimate)	688	203	364	121
Type of Care	100.0	100.0	100.0	100.0
Methadone only	67.5	88.8	62.0	48.0
Methadone combined with other care	32.5	11.2	38.0	52.0
Facility Size				
Small (1-120 methadone clients)	33.8	33.8	28.4	49.3
Medium (121-265 methadone clients)	31.9	32.1	30.9	34.4
Large (>265 methadone clients)	34.3	34.1	40.7	16.3
Percent Public Revenue[a]				
0% to 50%	30.0	78.6	12.1	3.8
51% to 90%	33.5	13.6	45.8	28.5
91% to 100%	36.6	7.7	42.1	67.7
Urbanicity[b]				
MSA large metro (>1 million population)	68.3	64.2	66.2	81.2
MSA medium metro (250,000-1 million population)	24.3	25.9	25.9	17.0
Small metro (<250,000 population) and non-metro	7.4	9.9	7.9*	1.8*
Level of Affiliation				
Parent facility	16.4	10.8	21.2	11.5*
Affiliate	49.0	39.2	47.8	69.2
Non-affiliate	34.6	50.0	31.0	19.3
Certification Type[c,d]				
State alcohol or drug abuse agency	89.7	86.7	96.7	73.7
State mental health agency	12.7	8.7	15.1	12.1
State public health agency	43.9	40.0	52.3	24.5
Hospital licensing authority	6.6	1.2*	8.8	9.0*
Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)	32.4	5.8	41.7	46.2
Setting[c]				
Hospital (outpatient treatment)	15.3	0.5	15.5	39.3
Community mental health center	4.0	0.6	4.1*	9.5
Other outpatient	80.3	98.4	78.9	54.3
Mean Number of Selected Services Offered				
Total, all selected services	11.0	9.2	11.5	12.2
Treatment services	7.5	6.3	7.8	8.5
Support services	3.5	2.9	3.7	3.7

[a] At least 98 percent of facilities responded to revenue questions.
[b] Based on Beale code (Butler & Beale, 1994). MSA = metropolitan statistical area.
[c] Not mutually exclusive.
[d] At least 96 percent of facilities responded to licensing questions.
* The Coefficient of Variation (CV) for this estimate is greater than or equal to 0.3, indicating this number should be interpreted with caution.

Exclusions: ADSS Phase I excludes intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, and Department of Defense and Indian Health Service facilities.

Source: Alcohol and Drug Services Study, Phase I facilities data (weighted). Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Table 4.2 ADSS Phase I: Percentage of Outpatient Methadone Facilities Offering Selected Treatment and Support Services, by Facility Ownership, National Estimates, October 1, 1996

Services	Total, All Facilities	Ownership		
		Private For-Profit	Private Non-Profit	Public
Treatment Services				
Individual therapy	96.8	92.7	98.8	98.0
Comprehensive assessment/diagnosis	89.4	76.6	94.2	96.4
Group therapy	81.9	60.4	89.3	95.3
Detoxification	76.8	79.9	75.7	74.6
Family counseling	74.1	66.6	74.8	84.4
Relapse prevention	72.2	53.3	77.6	87.7
Aftercare	70.5	54.8	80.5	66.3
Self-help or mutual help groups	62.7	55.5	61.6	78.3
Dual-diagnosis treatment	60.4	36.6	68.5	76.3
Outcome follow-up	53.5	48.0	53.1	64.0
Acupuncture	12.8	10.6	10.2	24.2
Support Services				
HIV/AIDS education/counseling/support	94.6	85.9	97.9	99.1
TB screening	89.1	92.7	85.2	94.5
Employment counseling/training	50.3	57.3	47.4	47.4
Transportation	37.3	12.1	48.5	45.8
Academic education/GED classes	19.0	7.1	26.1	17.4
Prenatal care	18.9	19.1	20.9	12.5
Child care	18.9	4.6	29.1	12.3
Smoking cessation	17.1	10.0	12.4	43.1

Exclusions: ADSS Phase I excludes intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, and Department of Defense and Indian Health Service facilities.

Source: Alcohol and Drug Services Study, Phase I facilities data (weighted). Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Table 4.3 ADSS Phase I: Mean Client-to-Staff Ratios in Outpatient Methadone Facilities, by Methadone Facility Ownership, October 1, 1996

Client-to-Staff (FTE) Ratios (Facility Mean)[a,b]	Total, All Facilities	Ownership		
		Private For-Profit	Private Non-Profit	Public
Clients to all direct-care staff	22.4	26.7	22.1	15.9
Clients to medical staff	149.1	210.4	140.7	72.8
Clients to all counseling staff	40.9	55.8	36.8	29.7

[a] Medical staff includes physicians and registered nurses. Counseling staff includes doctoral, master's, and bachelor-level counselors and non-degreed counselors. All direct-care staff includes medical staff, other medical personnel, such as LPNs and physician's assistants, and counseling staff.

[b] Staff in facilities that provide methadone treatment in combination with another type of care (224 of the estimated 688 outpatient methadone facilities) could not be separated by type of care. Therefore, the client-to-staff ratios were calculated using all clients and all staff in outpatient methadone facilities, including clients and staff in other types of care. The ratios presented are facility means (i.e., the mean of the ratios at each facility).

Exclusions: ADSS Phase I excludes intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, and Department of Defense and Indian Health Service facilities.

Source: Alcohol and Drug Services Study, Phase I facilities data (weighted). Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Chapter 5. ADSS Findings on Facility Characteristics and Treatment Practices

5.1 Dosage

Table 5.1 examines associations between outpatient methadone facility organizational characteristics and reported average dosage levels. Low-dose facilities (those with average daily dosages of less than 60 mg) were more likely to be in large metropolitan areas (84 percent of low-dose facilities) than were other facilities (69 percent of moderate-dose and 61 percent of high-dose facilities). Medium-dose facilities were more likely to be publicly owned (28 percent of facilities) than other facilities. High-dose facilities were more likely than low-dose facilities to have Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) accreditation (38 vs. 22 percent, respectively). Moreover, high-dose facilities were more often affiliated with another organization than low-dose facilities (60 vs. 32 percent, respectively).

In contrast to other research about facility ownership and methadone dosage level (D'Aunno et al., 1999), Table 5.2 shows that private for-profit facilities were slightly more likely to offer high dosages (45 percent of for-profit facilities) than private non-profit facilities (41 percent of facilities) and considerably more likely to do so than publicly owned facilities (19 percent of facilities). Over half of publicly owned facilities (56 percent) offered moderate dosages. The second section of Table 5.2 shows that mixed funding is associated with more moderate doses. Facilities with a majority of private funding (50 percent or less public funding) and those with mostly public funding (90 percent or more) had higher dosages than those with more mixed income (51 to 90 percent public funding). More than 40 percent of facilities with the lowest public funding and of those with mostly public funding were in the high-dose category compared with only about a fourth of facilities with more mixed funding sources.

5.2 Withdrawal Policy and Time Limits

The length of time before outpatient methadone facilities encouraged patients to withdraw from methadone varied by facility organizational structure (Table 5.1). Facilities with methadone time limits were generally smaller, having a smaller proportion of facilities in the large facility category (only 28 percent of facilities) compared with facilities with no time limits (41 percent of facilities were large). Facilities with time limits also were less likely to have mean public revenue above 90 percent of total revenue. They were less often in large metropolitan areas than facilities with no time limits (58 percent of facilities with limited time vs. 81 percent of facilities with no time limits on methadone), and they reported a higher proportion of non-affiliation with other organizations (41 vs. 29 percent, respectively). They also were more often licensed by State departments of mental health (18 percent vs. 9 percent of facilities with no time limits). In contrast, facilities with no time limits were larger, had higher percentages of public funding, were more often located in large metropolitan areas, and were more likely to be affiliated with other organizations.

Table 5.3 shows methadone facilities segmented into three methadone withdrawal categories, based on the facilities' withdrawal policy: 12 or fewer months, 13 or more months,

and no time limits. Overall, about 52 percent of facilities had no time limits on methadone use in treatment. About 26 percent of facilities had time limits above 12 months, and 22 percent had limits of 12 months or less. Facilities with the highest level of public funding (over 90 percent public revenue) were more likely to have unlimited time on methadone (63 percent of such facilities had no limits) compared with facilities with lower levels of public funding (47 percent of facilities with medium public funding and 42 percent of facilities with low public funding had no limits on methadone). Facilities in mid-sized metropolitan areas (250,000 to 1,000,000 population) were less likely to have unlimited methadone use in treatment (only 29 percent of such facilities had no limits on methadone) compared with facilities in small metropolitan and non-metropolitan areas (50 percent of facilities had no limits) and facilities in large metropolitan areas (60 percent of facilities had no limits). Facilities licensed by their State mental health agency were generally more likely to have limits on methadone use, with about 41 percent of such facilities having limits of 13 months or more and an additional 25 percent having limits of 12 months or less.

5.3 Services

There was little relationship between the number of services offered and facility dosage level or withdrawal policy. On average, outpatient methadone facilities provided a mean of 11 selected treatment and support services.[8,9] Table 5.4 shows that, overall, at least 70 percent of facilities provided the following selected treatment services: comprehensive assessment and diagnosis, individual therapy, group therapy, family counseling, relapse prevention, aftercare, and/or detoxification. In addition, a substantial percentage of facilities provided the following support services: HIV/AIDS counseling or education, TB screening, and employment counseling or training.

Some differences in types of treatment services offered were apparent when facilities were examined by reported methadone dosage level and by facility withdrawal policy. For example, low-dose facilities more often provided family counseling, relapse prevention, and outcome follow-up than high-dose facilities. Moderate-dose facilities were more similar to high-dose facilities in their provision of treatment services, such as comprehensive assessment/diagnosis, individual therapy, dual-diagnosis treatment, and acupuncture. However, moderate-dose facilities were more similar to low-dose facilities in their rates of providing group therapy, relapse prevention, and aftercare services. High-dose facilities offered acupuncture more often than low-dose facilities (13 percent of high-dose facilities vs. 7 percent of low-dose facilities). There were no significant differences in the provision of treatment services by withdrawal policy.

[8] Treatment services included comprehensive assessment/diagnosis, individual therapy, group therapy, family counseling, relapse prevention, self-help groups, aftercare, outcome follow-up, dual-diagnosis treatment, detoxification, and acupuncture.

[9] Support services included HIV/AIDS education, transportation, TB screening, employment counseling, smoking cessation, academic education classes, child care, and prenatal care.

There also was variation in the type of support services offered at outpatient methadone facilities. TB screening was more likely to be offered at moderate-dose facilities (97 percent of facilities) than at low-dose facilities (80 percent). Facilities that allowed clients unlimited time on methadone more often offered transportation, employment counseling or training, smoking cessation, and academic education or GED classes than facilities with limited time policies.

Variations in substance abuse testing practices by methadone dosage level and by facility withdrawal policy were small and insignificant.

5.4 Staffing Patterns

Staffing patterns varied by average methadone dosage and withdrawal policy (Table 5.5). On average, outpatient methadone facilities had 16 full-time staff, 4 part-time staff, and 1 contract staff or consultant. The methadone facilities had a mean of nearly 18 full-time equivalent (FTE) direct-care staff (including physicians, registered nurses, other medical personnel, such as physician's assistants, and degreed and non-degreed counselors). There was an average of about 4 medical staff FTEs (physicians and registered nurses only) and about 10 counselor FTEs, of which 6 were degreed counselors (doctor's, master's, or bachelor's level) and 4 were non-degreed counselors.

Overall, there was a ratio of 22 clients to each direct-care staff FTE in the facilities. The ratio of clients to medical staff was highest (149 clients per medical staff FTE), given the relatively small number of medical FTEs, and the ratio of clients to all counseling staff was lowest (about 41 clients per counselor FTE).

Generally, higher dosage was associated with higher client-to-staff ratios. High-dose facilities had significantly higher client-to-staff ratios than moderate- or low-dose facilities for all direct-care staff and for counseling staff. The client to medical staff ratio was lowest in moderate-dose facilities. There also was a relationship between staffing patterns and withdrawal policies. Facilities permitting unlimited time on methadone had more full-time staff and slightly fewer contract staff than those with limited time policies. These results indicate that higher dosage policy was associated with fewer staff, but unlimited time policy was associated with more staff.

Table 5.1 ADSS Phase I: Percentage Distribution of Outpatient Methadone Treatment Facilities by Selected Facility Characteristics, by Facility Mean Methadone Maintenance Dose and by Facility Policy on Withdrawal from Methadone, National Estimates, October 1, 1996

	Total, All Facilities	Facility Mean Methadone Maintenance Dose [Q-B14][a]			Percent of Facilities Reporting - Time Before Withdrawal from Methadone Is Encouraged [Q-B16][b]	
		<60 mg	60-69 mg	70+ mg	Limited	Unlimited
Number of Facilities (Weighted Estimate)	688[a,b]	164	226	246	320	341
Facility Size	100.0	100.0	100.0	100.0	100.0	100.0
Small (1-120 methadone clients)	33.8	32.4	33.4	29.7	34.4	31.9
Medium (121-265 methadone clients)	31.9	44.8	27.8	29.6	37.4	27.6
Large (>265 methadone clients)	34.3	22.8	38.8	40.7	28.2	40.6
Ownership						
Private for-profit	29.5	32.7	23.4	36.3	34.7	26.1
Private non-profit	52.9	50.3	49.2	55.1	51.6	51.3
Public	17.5	17.0	27.5	8.7	13.7	22.6
Percent Public Revenue[c]						
0% to 50%	30.0	30.0	21.6	35.2	34.1	24.0
51% to 90%	33.5	34.9	44.9	24.5	38.0	31.1
91% to 100%	36.6	35.1	33.6	40.3	28.0	45.0
Urbanicity[d]						
MSA large metro (>1 million population)	68.3	83.7	69.2	60.5	57.6	80.7
MSA medium metro (250,000-1 million population)	24.3	15.0*	25.9	30.2	36.8	14.0
Small metro (<250,000 population) and non-metro	7.4	1.3*	4.8	9.3*	5.6*	5.3
Level of Affiliation						
Parent facility	16.4	23.0	13.3	9.6	15.2	13.5
Affiliate	49.0	31.5	52.7	59.5	43.4	57.9
Non-affiliate	34.6	45.6	34.0	31.0	41.4	28.6
Certification Type[e,f]						
State alcohol or drug abuse agency	89.7	88.3	91.7	89.1	89.7	89.2
State mental health agency	12.7	16.7*	9.9	12.2	18.2	8.6
State public health agency	43.9	33.1	43.8	52.8	42.2	46.7
Hospital licensing authority	6.6	3.2	6.3	9.7	5.7	7.8
Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)	32.4	22.4	33.1	38.3	28.5	35.7
Setting[e]						
Hospital (outpatient treatment)	15.3	11.6	14.5	14.7	14.1	14.9
Community mental health center	4.0	3.3	5.8*	2.7	5.9	2.6
Other outpatient	80.3	87.7	80.0	79.3	81.4	80.3

[a] Ninety-seven percent of the sampled outpatient methadone facilities offering maintenance reported average methadone maintenance dose (636 facilities, weighted).

[b] Ninety-eight percent of all sampled outpatient methadone facilities reported the amount of time before withdrawal from methadone was encouraged (661 facilities, weighted).

[c] At least 98 percent of facilities responded to revenue questions.

[d] Based on Beale code (Butler & Beale, 1994). MSA = metropolitan statistical area.

[e] Not mutually exclusive.

[f] At least 96 percent of facilities responded to licensing questions.

* The Coefficient of Variation (CV) for this estimate is greater than or equal to 0.3, indicating this number should be interpreted with caution.

Exclusions: ADSS Phase I excludes intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, and Department of Defense and Indian Health Service facilities.

Source: Alcohol and Drug Services Study, Phase I facilities data (weighted). Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Table 5.2 ADSS Phase I: Percentage Distribution of Outpatient Methadone Treatment Facilities by Facility Mean Methadone Maintenance Dose, by Selected Facility Characteristics, October 1, 1996

Facility Characteristics	Total, All Facilities	Facility Mean Methadone Maintenance Dose[a]		
		Less Than 60 mg	60 to 69 mg	70 mg or More
Number of Facilities (Weighted Estimate)	636[a]	164	226	246
Percent of Facilities	100.0	25.8	35.5	38.7
Ownership				
Private for-profit	100.0	27.8	26.9	45.3
Private non-profit	100.0	25.0	33.9	41.1
Public	100.0	25.9	55.9	19.2
Percent Public Funding				
0% to 50%	100.0	27.4	26.3	46.3
51% to 90%	100.0	26.4	46.2	27.4
91% to 100%	100.0	25.0	32.6	42.4

[a] Ninety-seven percent of the sampled outpatient methadone facilities offering maintenance reported average methadone maintenance dose (636 facilities, weighted).

Exclusions: ADSS Phase I excludes intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, and Department of Defense and Indian Health Service facilities.

Source: Alcohol and Drug Services Study, Phase I facilities data (weighted). Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Table 5.3 ADSS Phase I: Percentage Distribution of Outpatient Methadone Treatment Facilities by Facility Withdrawal Policy, by Selected Methadone Facility Characteristics, October 1, 1996

Facility Characteristics	Total, All Facilities	Facility Withdrawal Policy[a]		
		Limited Time		
		12 or Fewer Months	13 or More Months	No Time Limits
Number of Facilities (Weighted Estimate)	661[a]	147	173	341
Percent of Facilities	100.0	22.2	26.2	51.6
Percent Public Revenue				
0% to 50%	100.0	29.2	28.1	42.4
51% to 90%	100.0	19.6	34.0	46.5
91% to 100%	100.0	18.9	18.1	63.0
Urbanicity				
MSA large metro (>1 million population)	100.0	18.3	21.8	59.9
MSA medium metro (250,000 to <1 million population)	100.0	34.0	37.2	28.8
Small metro (<250,000 population) and non-metro	100.0	18.4	31.3	50.3
Certification Type				
State mental health agency	100.0	25.3	40.9	33.8
Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)	100.0	14.5	28.6	56.9

[a] Ninety-eight percent of all sampled outpatient methadone facilities reported the amount of time before withdrawal from methadone was encouraged (661 facilities, weighted).

Exclusions: ADSS Phase I excludes intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, and Department of Defense and Indian Health Service facilities.

Source: Alcohol and Drug Services Study, Phase I facilities data (weighted). Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Table 5.4 ADSS Phase I: Percentage of Outpatient Methadone Treatment Facilities Offering Selected Services, by Facility Mean Methadone Maintenance Dose and by Facility Policy on Withdrawal from Methadone, National Estimates, October 1, 1996

	Total, All Facilities	Facility Mean Methadone Maintenance Dose [Q-B14][a]			Time Before Withdrawal from Methadone Is Encouraged [Q-B16][b]	
		<60 mg	60-69 mg	70+ mg	Limited	Unlimited
Number of Facilities (Weighted Estimate)	688[a,b]	164	226	246	320	341
Substance Abuse Testing[c] [Q-C6]						
Routine alcohol screening	65.2	54.5	69.8	64.3	65.5	63.9
Routine drug screening	98.8	95.8	100.0	99.6	97.8	99.7
Mean Number of Services Offered	11.0	10.7	11.3	10.6	11.0	11.4
Selected Treatment Services Offered [Q-C9]						
Comprehensive assessment/diagnosis	89.4	80.9	92.3	91.0	89.6	88.4
Individual therapy	96.8	95.6	97.6	96.4	97.6	95.9
Group therapy, not including relapse prevention	81.9	84.1	87.4	74.6	77.4	85.3
Family counseling	74.1	81.3	75.0	65.1	76.4	70.1
Relapse prevention	72.2	79.9	72.5	64.0	66.6	75.8
Self-help or mutual-help groups	62.7	66.8	61.1	57.7	56.7	65.7
Aftercare	70.5	72.5	73.5	64.6	68.4	70.6
Outcome follow-up	53.5	64.9	58.5	41.2	54.1	51.7
Dual-diagnosis treatment	60.4	48.6	64.9	60.8	54.3	63.6
Detoxification	76.8	69.2	73.9	80.0	76.1	75.8
Acupuncture	12.8	6.9	18.2	12.8	13.5	13.2
Selected Support Services Offered [Q-C9]						
HIV/AIDS education/counseling/support	94.6	96.0	95.6	93.7	93.8	95.5
Transportation	37.3	30.9	38.3	34.9	29.6	40.4
TB screening	89.1	80.2	97.0	93.8	90.8	90.9
Employment counseling/training	50.3	35.8	48.7	62.5	44.0	57.0
Smoking cessation	17.1	15.1	21.6	14.9	13.4	21.6
Academic education/GED classes	19.0	17.1	18.2	19.4	10.0	26.6
Child care	18.9	19.6	15.7	16.5	19.6	13.7
Prenatal care	18.9	19.4	20.8	15.9	19.0	18.7

[a] Ninety-seven percent of the sampled outpatient methadone facilities offering maintenance reported average methadone maintenance dose (636 facilities, weighted).

[b] Ninety-eight percent of all sampled outpatient methadone facilities reported the amount of time before withdrawal from methadone was encouraged (661 facilities, weighted).

[c] At least 99 percent of facilities responded to substance abuse testing questions.

Exclusions: ADSS Phase I excludes intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, and Department of Defense and Indian Health Service facilities.

Source: Alcohol and Drug Services Study, Phase I facilities data (weighted). Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Table 5.5 ADSS Phase I: Mean Number of Staff and Mean Client-to-Staff Ratios in Outpatient Methadone Facilities, by Facility Mean Methadone Maintenance Dose and by Facility Policy on Withdrawal from Methadone, National Estimates, October 1, 1996

	Total, All Facilities	Facility Mean Methadone Maintenance Dose [Q-B14][a]			Time Before Withdrawal from Methadone Is Encouraged [Q-B16][b]	
		<60 mg	60-69 mg	70+ mg	Limited	Unlimited
Number of Facilities (Weighted Estimate)	688[a,b]	164	226	246	320	341
Number of Staff (Mean Number) [Q-A9][c]						
Full-time	15.7	16.7	15.3	14.6	14.0	16.8
Part-time	4.2	2.8	5.4*	3.5	4.7	3.2
Contract/consultant	1.3	1.5	1.2	1.3	1.5	1.1
Number of FTEs (Mean Number)[d]						
All direct-care staff (medical, counseling, other)	17.8	25.3*	15.3	15.4	15.3	20.2
Medical staff (MDs, DOs, RNs)	4.4	6.6*	3.8	3.3	3.1	5.6*
All counselors (degreed and non-degreed)	10.6	15.1*	9.0	9.4	9.4	11.7
Degreed counselors	6.4	7.3	6.3	6.1	6.2	6.6
Non-degreed counselors	4.1	8.0	2.7	3.3*	3.1*	5.1*
Client-to-Staff (FTE) Ratio (Facility Mean) [Q-B1j2 / Q-A9][e]						
Clients to all direct-care staff	22.4	19.7	22.3	26.6	24.2	21.7
Clients to medical staff	149.1	160.6	135.2	169.3	161.8	143.4
Clients to all counselors	40.9	36.2	38.2	51.2	45.0	39.4
Clients to degreed counselors	62.6	58.0	64.9	71.2	67.3	61.8

[a] Ninety-seven percent of the sampled outpatient methadone facilities offering maintenance reported average methadone maintenance dose (636 facilities, weighted).

[b] Ninety-eight percent of all sampled outpatient methadone facilities reported the amount of time before withdrawal from methadone was encouraged (661 facilities, weighted).

[c] Eight sample facilities are excluded from the staffing count section because they could not report staff by full-time/part-time/contract status. However, their full-time equivalents (FTEs) are included in the FTE and rates sections.

[d] Medical staff includes physicians and registered nurses. Counseling staff includes doctoral, master's, and bachelor-level counselors and non-degreed counselors. All direct-care staff includes medical staff, other medical personnel, such as LPNs and physician's assistants, and counseling staff.

[e] Staff in facilities that provide methadone treatment in combination with another type of care (224 of the estimated 688 outpatient methadone facilities) could not be separated by type of care. Therefore, the client-to-staff ratios were calculated using all clients and all staff in outpatient methadone facilities, including clients and staff in other types of care. The ratios presented are facility means (i.e., the mean of the ratios at each facility).

* The Coefficient of Variation (CV) for this estimate is greater than or equal to 0.3, indicating this number should be interpreted with caution.

Exclusions: ADSS Phase I excludes intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, and Department of Defense and Indian Health Service facilities.

Source: Alcohol and Drug Services Study, Phase I facilities data (weighted). Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Chapter 6. ADSS Findings on Clients in Methadone Treatment and Treatment Practices

6.1 Client Characteristics

Information about client characteristics is based on responses of facility directors who reported aggregate client data. Based on these reports, 151,882 clients were receiving outpatient methadone treatment on October 1, 1996 (Table 6.1). Most (116,192, or 77 percent) were in outpatient methadone-only facilities, and 35,690 were in facilities that reported providing methadone and other types of care (data not shown). About 19 percent of the outpatient methadone clients had a dual diagnosis of substance abuse and a mental disorder; most clients (80 percent) were self-referred or had been referred by family or friends.[10]

About 60 percent of outpatient methadone clients were male. Half of methadone clients were non-Hispanic white, 26 percent were non-Hispanic black, 21 percent were Hispanic, and 3 percent belonged to other or unknown racial/ethnic groups. Distributions of outpatient methadone clients by gender and race/ethnicity differ from those reported in the 1990 Drug Services Research Survey (DSRS) facility study where there were fewer white clients (40 percent) and somewhat higher percentages of black (30 percent) and Hispanic clients (28 percent) (Batten et al., 1993). The methadone population had aged since 1990. In 1996, aggregate data reported by facility directors indicated that 24 percent of outpatient methadone clients were 45 years or older compared with 1990, when only 16 percent of clients were 45 years or older (Batten et al., 1993).

Between 1990 and 1996, there was a slight increase in source of client payment from private sources, primarily private insurance. Clients with expected payment from private sources increased from less than 1 percent of outpatient methadone clients in 1990 (Batten et al., 1993) to almost 6 percent in 1996. There were decreases in unknown payment sources (9 percent, 1990; 1 percent, 1996) and client self-payment (42 percent, 1990; 38 percent, 1996) (Batten et al., 1993). Medicaid as an expected payment source, however, was almost the same in 1996 (36 percent) as it was in 1990 (37 percent) (Batten et al., 1993).

Client source of payment varied by facility ownership. Medicaid was the expected source of payment for about 40 percent of outpatient methadone clients in private non-profit facilities compared with about 20 percent in other facilities (data not presented). Clients with no known payment source at admission were more likely to be in public facilities than in private for-profit facilities.

[10] The percentage of dual-diagnosis clients and referral source information are reported for clients in outpatient methadone-only facilities.

6.2 Dosage

Table 6.1 shows the distribution of outpatient methadone client characteristics by facility dosage level and withdrawal policy. Most clients (77 percent) were in facilities providing average methadone doses of 60 mg or more per day (36 percent in moderate-dose facilities [60 to 69 mg per day] and 41 percent in high-dose facilities [70 mg or more per day]). Twenty-three percent of clients were in low-dose facilities (under 60 mg per day).[11] There was no difference in the distribution of men and women by facility dosage levels, while there was some variation by age group and race/ethnicity. Clients aged 45 or older were more likely to be in high-dose facilities than those in the 25 to 34 age range (46 vs. 37 percent, respectively). Moreover, black clients were more likely to be in low-dose facilities (33 percent) than white clients (21 percent) or Hispanic clients (17 percent). This finding is consistent with other studies (D'Aunno et al., 1999).

There also was variation in the facility dosage-level distribution of clients by their expected source of payment for treatment. Clients whose expected source of payment was private managed care insurance or public payment other than Medicaid or Medicare were much more likely to be in low-dose facilities (43 and 38 percent, respectively) than clients with self-payment or Medicaid payment (21 and 18 percent, respectively). Almost half of clients with no expected payment source (48 percent) or private fee-for-service insurance (47 percent) were in moderate-dose facilities. More than 40 percent of Medicaid clients also were in moderate-dose facilities. A large proportion of clients with Medicare as the expected payment source (71 percent) were in high-dose facilities.

6.3 Methadone Withdrawal Policy

A slight majority of outpatient methadone clients (55 percent) were in facilities that allowed unlimited time on methadone (Table 6.1).[12] Hispanic clients were more likely to be in facilities with no time limits (68 percent) than either black clients (57 percent) or white clients (49 percent). Clients aged 45 or older were more likely to be in facilities with unlimited time on methadone (60 percent) than clients who were between the ages of 35 and 44 (55 percent). A slight majority of clients with dual diagnoses (58 percent) were in facilities that limited time on methadone.

Client payment source also was related to withdrawal policy. Clients whose expected payment source was private managed care insurance were more likely to be in facilities with time limits (63 percent) than clients with no expected payment source at admission (33 percent), self-payment (51 percent), or Medicaid payment (36 percent). The majority of clients with other public payment sources (55 percent) also were in facilities with limited time on methadone. Clients who had no expected payment source (67 percent), clients whose expected payment source was Medicaid (64 percent), and clients whose expected payment source was Medicare (80 percent) were more likely to be in facilities with unlimited time on methadone.

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[11] Facility directors provided dosage information at 636 of 688 facilities (weighted), treating an estimated 147,793 clients.

[12] Facility directors provided methadone withdrawal information at 661 of 688 facilities (weighted), treating an estimated 150,222 clients.

Table 6.1 ADSS Phase I: Number and Percentage Distribution of Clients in Outpatient Methadone Treatment Facilities by Facility Mean Methadone Maintenance Dose, by Facility Policy on Withdrawal from Methadone and by Selected Client Characteristics, National Estimates, October 1, 1996

[Q-B2]	Number of Methadone Clients	Total, All Clients	Facility Mean Methadone Maintenance Dose [Q-B14][a] (Mean Percentage)			Time Before Withdrawal from Methadone Is Encouraged [Q-B16][b] (Mean Percentage)	
			< 60 mg	60-69 mg	70+ mg	Limited	Unlimited
Total Methadone Clients (Weighted Estimate)	151,882[a,b]		33,947	53,382	60,464	67,639	82,583
Percentage of Total		100.0	23.0	36.1	40.9	45.0	55.0
Gender							
Male	91,648	100.0	22.4	36.2	41.4	43.0	57.0
Female	58,963	100.0	23.8	36.4	39.8	48.1	51.9
Unknown	1,271	100.0	29.0*	6.2*	64.7	48.6*	51.4*
Race/Ethnicity							
White, non-Hispanic	75,727	100.0	20.6	36.2	43.2	51.1	49.0
Black, non-Hispanic	39,438	100.0	33.0	30.5	36.6	43.5	56.6
Hispanic	31,821	100.0	17.2	39.5	43.3	32.3	67.7
Asian or Pacific Islander	1,040	100.0	13.6*	49.1*	37.2*	29.3*	70.7
American Indian/Alaskan Native	585	100.0	21.6	37.8	40.7	47.1	52.9
Unknown	3,271	100.0	14.0*	72.9	13.2*	53.6	46.4
Age (Years)							
Under 18	354*	100.0	4.3*	70.1	25.5	72.4	27.6*
18-24	8,898	100.0	26.3	35.5	38.3	45.1	54.9
25-34	38,240	100.0	25.8	36.9	37.4	51.6	48.4
35-44	62,470	100.0	21.7	38.0	40.3	45.3	54.7
45 or older	35,719	100.0	21.9	31.9	46.3	39.6	60.4
Unknown	6,201	100.0	20.5*	37.0	42.5*	30.5	69.5
Dual-Diagnosis Clients[c]	21,558[c]	100.0	16.1	37.6	46.3	58.0	42.0
Client Payment Source							
No payment	3,703	100.0	29.2	47.7	23.2*	33.0	67.0
Client self-payment	58,143	100.0	20.9	33.3	45.9	50.7	49.3
Private fee-for-service	2,106	100.0	27.9	46.8	25.3*	49.9	50.2
Private managed care	6,480	100.0	42.6	29.1	28.2	63.1	36.9
Medicaid	54,499	100.0	18.3	42.7	39.0	36.1	63.9
Medicare	4,979*	100.0	6.0*	22.6*	71.4	20.2*	79.8
Other public source	20,260	100.0	38.4	30.4	31.2	55.1	44.9
Unknown	1,712	100.0	16.2*	14.7*	69.2	44.4*	55.6*

[a] Ninety-seven percent of sampled outpatient methadone facilities offering maintenance reported average methadone maintenance dose. Clients in those facilities total 147,793 (weighted).

[b] Ninety-eight percent of all sampled outpatient methadone facilities reported the amount of time before withdrawal from methadone was encouraged. Clients in those facilities total 150,222 (weighted).

[c] Data on methadone clients with a dual diagnosis (substance abuse and a mental disorder) are available just for methadone-only facilities (and not for facilities with methadone in combination with other types of treatment). Therefore, the count of dually diagnosed methadone clients does not include clients in combination facilities.

* The Coefficient of Variation (CV) for this estimate is greater than or equal to 0.3, indicating this number should be interpreted with caution.

Exclusions: ADSS Phase I excludes intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, and Department of Defense and Indian Health Service facilities.

Source: Alcohol and Drug Services Study, Phase I facilities data (weighted). Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Chapter 7. Conclusions

Alcohol and Drug Services Study (ADSS) data suggest that more outpatient methadone facilities in 1996 provided higher methadone doses than in 1990. The facility average daily methadone dose of 64 mg per day in 1996 was considerably higher than the facility average dose of 50 mg per day reported in 1990 (Batten et al., 1993). Over 40 percent of methadone clients in 1996 were in facilities with a mean daily dose of 70 mg or higher. Higher dosage facilities were more likely to have withdrawal policies allowing unlimited time on methadone.

The relationship between facility ownership and treatment practices differs from results of the past. Private non-profit facilities were found proportionally represented in all dosage categories, but there were significantly more private for-profit facilities in the high-dose group and significantly fewer public facilities. Facility accreditation characteristics also appeared to be associated with dosage levels. Facilities providing higher dosages were more likely to have accreditation from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and from hospital licensing authorities.

Private for-profit facilities offered fewer services than private non-profit and publicly owned facilities. Public facilities offered slightly more treatment services than private non-profit facilities. High-dose facilities and lower dosage facilities tended to provide about the same number of selected services, but low-dose facilities were more likely than high-dose facilities to offer several group counseling activities and outcome follow-up. High-dose facilities had slightly fewer full-time staff and considerably higher client-to-staff ratios than lower dose facilities.

There were also relationships between client characteristics, expected source of payment, and methadone dosage. Methadone clients with self-payment and payment through Medicare were more likely than other payment groups to be treated in high-dose facilities. Clients with payment through private managed care arrangements and through "other public payment" were more likely to be in low-dose facilities. Non-Hispanic blacks were more likely than other racial/ethnic groups to be in low-dose facilities.

Facilities that had policies encouraging withdrawal from methadone had a higher level of private for-profit ownership and somewhat smaller facility size than facilities that had unlimited time on methadone. Facilities allowing unlimited time on methadone had larger percentages of older clients and of Medicaid clients than facilities with withdrawal limits.

ADSS data suggest that in 1996 facilities were following some but not all treatment practices recommended by the National Consensus Development Panel (1998). Facilities with withdrawal policies allowing more time on methadone were more likely to provide higher doses of methadone. However, facilities providing the highest doses did not offer more of the selected services than other facilities. Facilities with unlimited time on methadone offered only slightly more services than facilities encouraging withdrawal. Publicly owned facilities offered the most services and were more likely to allow unlimited time on methadone, but they tended to provide lower doses. Although many private for-profit facilities followed higher dosage practices, they were less likely to provide many of the selected treatment and support services studied. Overall,

treatment practice had changed since 1990, with more facilities providing higher average dosages and fewer encouraging early withdrawal from methadone. There remains great variation in the provision of methadone treatment.

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Appendix A

ADSS Phase I Methodology

Appendix A: ADSS Phase I Methodology

Phase I of the Alcohol and Drug Services Study (ADSS) consisted of a national mail/telephone survey of substance abuse treatment facilities. Data collected were based on reports of facility directors. The survey, conducted in 1996-1997, was based on a nationally representative, stratified random sample of 2,395 alcohol and drug treatment facilities, sampled from the Substance Abuse and Mental Health Services Administration's (SAMHSA's) national inventory of substance abuse treatment facilities. This appendix provides a summary of the methodology for Phase I of the ADSS. For more detailed information, see the ADSS methodology report.[13]

Facility Sample Frame. The sample frame for ADSS Phase I was the enhanced 1996 National Master Facility Inventory (NMFI) created by SAMHSA. The ADSS sampling frame of 18,368 consisted of 13,787 substance abuse treatment facilities previously known to SAMHSA and listed on the National Facility Register (NFR) and an additional 4,581 facilities identified from other sources, such as hospital listings, provider associations, and business directories. Types of facilities excluded from the ADSS sampling frame were intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, Department of Defense facilities, and Indian Health Service facilities.

Facility Stratification. The strata used to select the ADSS facility sample reflect the types of care offered within the Nation's substance abuse treatment system: hospital inpatient, non-hospital residential, outpatient-predominantly methadone, outpatient-non-methadone, and combined. For the outpatient, non-methadone type of care, the sample was further stratified to reflect whether or not facility clients were almost exclusively alcohol abusers. A seventh stratum was included for facilities whose type of care could not be determined based on existing information at the time of sampling.

Facility Sample Size. A total sample size of about 2,400 facilities was planned. Approximately 300 facilities per stratum were considered minimal to provide estimates with the necessary precision and stability. Stratified proportional samples are known to produce optimal design effects. Based on needed minimums and design effect considerations, target strata sizes for the ADSS Phase I sample were determined: 316 facilities each for the hospital inpatient, non-hospital residential, outpatient-predominantly methadone, outpatient-almost exclusively alcohol, and combined strata, and 560 facilities for the outpatient-other strata. The target for the unknown stratum was set to zero as facilities would be reclassified based on their Phase I responses.

Facility Sampling. Facility selection into the ADSS sample was based on a probability proportional to size (PPS), with size calculated as the 0.7th power of the facility's most recent

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[13] Ritter, G.A., Levine, H.J., Mohadjer, L., Krenzke, T., Lee, M.T., Reif, S., & Horgan, C.M. (2003). Phase I methodology—ADSS Facility Survey. In Office of Applied Studies (Ed.), *Alcohol and Drug Services Study (ADSS): Methodology report: Phases I, II, and III* (Chapter 1; available at http://www.samhsa.gov/oas/adss.htm). Rockville, MD: Substance Abuse and Mental Health Services Administration.

point-prevalence client count from their response to SAMHSA's annual Uniform Facility Data Set (UFDS) census of facilities. Facilities with no prior UFDS point-prevalence count were given an estimated size based on other existing information from the NFR or UFDS. Factors used for such estimates included the facility's stratum, location, capacity, annual admissions, annual revenues, and whether the facility treated drug abusers only, alcohol abusers only, or both.

The ADSS Phase I sample was released in two waves to ensure the target number of facilities per strata and in recognition of some incompleteness and misclassification of initial strata groups. Information on response rate, reclassification of stratum designation, and the distribution of facilities in the unknown stratum for the first wave of 2,447 facilities was used to determine the distribution of facilities released in the second wave. In all, an oversample of 3,643 facilities was released as the ADSS Phase I sample, allowing for closed or otherwise ineligible or out-of-scope facilities.

Comparison of the ADSS and UFDS Facility Universes. Because the ADSS facility universe is an expansion of the original frame previously used for the annual UFDS survey, comparison of national estimates from the two survey frames was undertaken to determine whether the addition of facilities from the business listings and other sources in ADSS made any important changes to the survey universe.

Looking at the facility organizational characteristics for the 12,387 facilities estimated in ADSS Phase I versus the characteristics for only the original NFR portion of the ADSS estimate (10,035 facilities or 81 percent of the ADSS estimate of facilities,) a few small differences are noted.

For the full ADSS frame, there was a slightly lower proportion of non-hospital residential facilities (17 percent residential) compared with the NFR portion of the frame (19 percent residential). Conversely, for the full ADSS frame, there was a slightly higher proportion of outpatient non-methadone facilities (61 percent outpatient non-methadone) compared with the NFR portion of the frame (59 percent outpatient non-methadone).

There were other small differences of 2 to 3 percentage points between the full ADSS frame and original NFR frame. In the full ADSS universe, there was a slightly larger representation of private for-profit facilities (23 percent in the full ADSS universe vs. 20 percent in the NFR universe) and correspondingly fewer non-profit facilities. There was a slightly higher percentage of medium-sized facilities in the full universe (24 percent) compared with the NFR universe (22 percent) and correspondingly fewer very large facilities in the complete ADSS sample (23.5 percent) than the NFR (25.5 percent). There were no differences in percent public revenue, urbanicity, or level of affiliation with other organizations. The small differences that might exist between sample estimates are largely due to somewhat greater representation of private for-profit, medium-sized, outpatient non-methadone facilities among the newly identified facilities.

Instrument Development and Data Collection. The ADSS Phase I data collection consisted of three steps: a telephone screener to confirm eligibility status and to update the mailing address; a mailing of the ADSS Phase I facility questionnaire; and a telephone call to

collect the responses prepared by the facility's administrator. The last step often took a number of follow-up telephone calls to complete, sometimes to more than one person at the facility.

Instrument development was the result of an extensive process of planning, development, and review. The ADSS advisory group, formed to help in the development process, was comprised of members of the research community, including representatives from SAMHSA and members of other U.S. Department of Health and Human Services (DHHS) agencies, representatives of the National Association of State Alcohol and Drug Abuse Directors (NASADAD), provider organizations, and private treatment providers. Final instruments used in ADSS were subject to both internal institutional review board (IRB) review and governmental Office of Management and Budget (OMB) approval. Both the screener and the facility questionnaire were revised based on pilot results. The revised screener was estimated to take about 10 minutes to complete. The revised facility questionnaire was estimated to require about 3 hours of preparation and an additional 50 minutes of telephone time to provide the responses.

ADSS Screener. The screener was a telephone call to sampled ADSS facilities to verify name and mailing address and to gather additional information regarding the facility's ADSS eligibility, stratum classification, and size. Questions included the facility's types of care, setting, ownership, managed care arrangements, and whether the facility provided treatment or only performed intake and referral. This information was necessary to confirm that facilities still were in business and to refine stratification assignment.

Of the 3,643 Phase I facilities for which screening was attempted, 221 were out of business,18 refused, and 3,404 facilities responded to the screener. Ultimately, 2,771 of the 3,404 responding facilities were determined by the screener to be eligible to receive the ADSS Phase I questionnaire. Screened facilities were designated ineligible for the ADSS survey because of duplicate listings (n = 55), out-of-scope setting (n = 186), out-of-scope ownership (n = 14), or lack of substance abuse treatment (n = 378). Further breakdown of the ineligible categories follows. Facilities ineligible for ADSS based on out-of-scope setting included correctional facilities (n = 103), halfway houses without paid counselors (n = 14), and solo practitioners (n = 69). Facilities ineligible for ADSS based on ownership included Department of Defense facilities (n = 8) and Indian Health Service facilities (n = 6). Facilities ineligible for ADSS because of lack of treatment included administrative-only units (n = 35), facilities with prevention services only (n = 319), and facilities providing only intake and referral (n = 24). Overall, 2,771 eligible facilities responded to the screener out of 2,789 eligible facilities (2,771 respondents and 18 refusals), for a screener response rate of 99.4 percent.

ADSS Facility Questionnaire. The ADSS Phase I Facility Survey was conducted from December 1996 to June 1997, using the ADSS Facility Questionnaire. It was mailed to facilities that met ADSS eligibility criteria on the basis of screener responses. The questionnaire collected point-prevalence information for October 1, 1996, concerning the facility's organizational structure, the number of clients served, and client characteristics. It also asked for the facility's most recent 12-month data on admissions and discharges; special treatment programs; special populations served; treatment services offered; managed care participation; and annual costs and revenues. The questionnaire was organized in four sections: Section A involved facility organization and staffing, Section B concerned point-prevalence client counts, Section C

concerned 12-month client counts and treatment services, and Section D involved financial data. Questionnaires were mailed to facility directors to allow them time to assemble the detailed information necessary for responses. Data were collected by telephone interviews beginning approximately 2 weeks after the questionnaire was mailed.

ADSS Phase I Response Rate. Table A.1 shows each survey step and the resulting response rate for the ADSS Phase I survey. Of the 2,771 facilities originally mailed Phase I questionnaires, 168 were designated ineligible because they were out of business or did not provide substance abuse treatment as of October 1, 1996. Of the remaining 2,603 eligible facilities, 2,395 completed the interview and 208 refused, for a questionnaire response rate of 92 percent.

Table A.1 Number of Facilities in the ADSS Phase I Survey Results

Mailed Questionnaire	2,771
Out of Business/Closed/No Treatment	168
Eligible	2,603
Refusals/No Contact	208
Eligible Completers	2,395
Phase I Questionnaire Response Rate	92.0% (2,395 out of 2,603)

Phase I Cumulative Response Rate. The cumulative response rate for ADSS Phase I is calculated as the product of the Phase I screener response rate (.994) and the Phase I questionnaire response rate (.920) for a cumulative response rate of .914 or 91.4 percent.

Weighting. The Phase I sampling design incorporated a stratified random probability sample. Weights were developed for the Phase I sample to facilitate overall and by-stratum estimates of facility-level and client-level characteristics of the Nation's substance abuse treatment system. Final Phase I weights were constructed in a multi-step process involving calculation of initial base weights, trimming to guard against excessive influence by a few highly weighted facilities, adjustment for facility non-response, and poststratification adjustment of the facility estimates to initial frame counts.

Because the Phase I sample was selected using a complex multi-stage design, resampling is the appropriate method of calculating the stability of computed statistics. Replicate weights based on the stratified jackknife procedure (JKn) are included in the ADSS Phase I dataset for the purpose of standard error (SE) calculation.

Imputation. In the Phase I data file, imputation was used to fill in missing values for key responses concerning staffing, point-prevalence counts, characteristics of clients, admissions, revenues, and costs. Variables for which missing responses were imputed generally had item non-response of well under 10 percent, except for total revenue and total cost, which had 10 to 11 percent missing values across the full sample; missing values within hospital inpatient facilities were higher. Phase I imputation involved a number of methods designed to approximate

the true missing value and at the same time maintain variability and preserve joint relationships among responses. Listed in order of preference these methods include logical imputation, substitution from an external source, and imputation by statistical method. The statistical imputation methods used in ADSS Phase I were non-deterministic, based on random regression[14] and random within class hot-decking.[15]

Imputation was performed to blocks of items at a time—staffing, point-prevalence counts, admissions, revenues, and costs. Within each block, missing totals were imputed first, followed by imputation of missing components in a manner to produce internally consistent responses. Upon completion of a block, pre-imputation to post-imputation comparisons were done to ensure that key statistics of the data remained invariant. Imputation error variances, measuring the amount of error introduced, also were calculated to provide added assurance that the imputation process did not compromise the quality of ADSS data. More detailed information about frame construction, sample design, sampling method, the data collection process, weighting, and imputation can be found in the ADSS methodology report.[16]

[14] Montaquila, J., & Ponickowski, C. (1995). An evaluation of alternative imputation methods. In *Proceedings of the Section on Survey Research Methods.* Alexandria, VA: American Statistical Association.

[15] Kalton, G., & Kish, L. (1984). Some efficient random imputation methods. *Communication in Statistics, 13,* 1919-1939.

[16] See footnote 13.

Appendix B

Variable Definitions

Appendix B: Variable Definitions

The variables used in this report were constructed from the Alcohol and Drug Services Study (ADSS) Phase I Facility Questionnaire. See the ADSS methodology report for a copy of the questionnaire.[17] Data items included facility organization and staffing, point-prevalence client data, methadone detoxification and maintenance client counts, methadone dosage data, and facility financial data. Constructed variables include type of care, facility size, ownership, percent public revenue, urbanicity, level of affiliation, number of treatment services, number of support services, setting, client-to-staff ratio, facility mean methadone maintenance dose, and methadone withdrawal time. Categories for each variable are listed with a description of how they were constructed.

Facility Type of Care (ADSS Phase I Question B1). Facilities were asked whether they offered specific types of substance abuse treatment on the point-prevalence date of October 1, 1996. The majority of facilities offered a single type of care and were categorized as such. Although many combinations of the four types of care are represented in the combination category, they were grouped together to create cell sizes large enough for analysis and so indicate facilities offering multiple types of care. Only facilities offering outpatient methadone treatment, either alone or in combination with another type of care, were included in this report. In Phase I, facilities were coded as follows:

- ***hospital inpatient only***—offered hospital inpatient (including hospital inpatient detoxification or rehabilitation) and no other types of care.
- ***non-hospital residential only***—offered residential care (including residential detoxification or rehabilitation) and no other types of care.
- ***outpatient methadone only***—offered outpatient methadone and no other types of care.
- ***outpatient non-methadone only***—offered outpatient non-methadone care and no other types of care.
- ***combination facilities***—offered more than one of the types of care listed above. Any combination is included in this category.

Facility Size (ADSS Phase I Question B1). Facilities were categorized by the number of methadone clients reported as in treatment on the point-prevalence date of October 1, 1996. The categories represent approximately thirds of the weighted client counts in methadone facilities, and they are used to facilitate comparisons among facilities of similar size:

- ***small***—1 to 120 methadone clients.
- ***medium***—121 to 265 methadone clients.
- ***large***—more than 265 methadone clients.

[17] Office of Applied Studies. (2003). *Alcohol and Drug Services Study (ADSS): Methodology report: Phases I, II, and III* (available at http://www.samhsa.gov/oas/adss.htm). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Ownership (ADSS Phase I Question A6). Facilities were asked to describe their ownership on October 1, 1996:

- ***private for-profit***.
- ***private non-profit***.
- ***public***—collapses categories for city or county government agency, State government agency, Federal Government agency, or tribal government.

Mean Percent Public Revenue (ADSS Phase I Questions D7 and D8). Facilities were asked to break down their annual revenue by 10 different sources. Of these 10 categories, 5 were "public revenue" categories: Medicaid (not specified), Medicaid (managed care), Medicare, other Federal Government funds (VA, CHAMPUS, etc.), and other public funds (block grants, contracts, grants, etc.). The percentage of revenue from each of these five sources was summed and calculated as a percentage of total revenue for each sample facility, creating a public revenue variable. This public revenue percentage was categorized based, in part, on frequency distributions. The frequency distribution of the public revenue variable was divided into thirds: 0 to 50 percent, 51 to 90 percent, and 91 to 100 percent:

- ***0 to 50 percent***—public revenue was 0 percent up to and including 50 percent of the facilities' total revenue.
- ***51 to 90 percent***—more than 50 percent up to and including 90 percent of total revenue.
- ***91 to 100 percent***—more than 90 percent up to and including 100 percent.

Urbanicity. Based on facility ZIP code, facilities were coded according to the Beale Rural-Urban Continuum Codes developed by the U.S. Department of Agriculture to categorize facilities by level of urbanicity.[18] The Beale classification uses 10 county-based categories. For this report, the 10 Beale categories were collapsed into 3 categories, combining several categories as follows:

- ***large metro***—central or fringe counties in metropolitan statistical areas (MSAs) with a population of 1 million or more. Beale Code equals 0 (central counties) or 1 (fringe counties).
- ***medium metro***—counties in MSAs with population of 250,000 to 1 million. Beale Code equals 2.
- ***small metro and non-metro***—includes the following:
  small metro—counties in MSAs with population <250,000. Beale Code equals 3.
  non-metro, urban—urban population of 20,000 or more, in non-metropolitan counties. Beale Code equals 4 (adjacent to a metro area) or 5 (not adjacent to a metro area).
  non-metro, small urban—urban population of 2,500 to 19,999, in non-metropolitan counties. Beale Code equals 6 (adjacent to a metro area) or 7 (not adjacent to a metro area).

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[18] Butler, M.A., & Beale, C.L. (1994). *Rural-urban continuum codes for metropolitan and nonmetropolitan counties, 1993* (Staff Report No. AGES 9425; http://www.ers.usda.gov:80/briefing/rural/data/code93.txt). Washington, DC: U.S. Department of Agriculture, Economic Research Service.

non-metro, rural—completely rural with <2,500 population, in non-metropolitan counties. Beale Code equals 8 (adjacent to a metro area) or 9 (not adjacent to a metro area).

Level of Affiliation (ADSS Phase I Questions A11 and A16). Level of affiliation refers to whether a facility is an independent entity or an integral part of a larger organization. This variable was created to capture organizational configurations in the substance abuse treatment system. Facilities were asked if they were a parent organization to other substance abuse facilities on October 1, 1996 (A16), and whether they were legally part of another organization on October 1, 1996 (A11). Using these questions, facilities were classified for this report as follows:

- ***parent***—If the facility answered "yes" to being a parent, whether or not they were legally part of another organization.
- ***affiliate***—If the facility was not a parent to other substance abuse facilities, but was legally part of another organization.
- ***non-affiliate***—If the facility was not a parent to other substance abuse facilities and was not legally part of another organization.

Number of Treatment Services (ADSS Phase I Question C9). Facilities were asked whether they offered each of 19 selected services. For this report, the 19 services were classified into two groups—treatment services and support services. The following 11 were classified as treatment services: comprehensive assessment/diagnosis, self-help or mutual-help groups, detoxification, individual therapy, group therapy (not including relapse prevention), relapse prevention groups, family counseling, combined substance abuse and mental health treatment, acupuncture, aftercare, and outcome follow-up. Facilities were categorized by the number of these 11 treatment services they offered.

Number of Support Services (ADSS Phase I Question C9). Facilities were asked whether they offered each of 19 services. For this report, eight (8) of the services were classified as support services: child care, transportation, employment counseling/training, academic education/GED classes, HIV/AIDS education/counseling/ support, TB screening, prenatal care, and smoking cessation. Facilities were categorized by the number of these eight support services they offered.

Setting (ADSS Phase I Question A5). Facilities were asked to identify the settings or locations (14 settings listed plus "other" category) that best applied as of October 1, 1996. Because facilities checked all that applied, a facility may be represented in more than one of the categories below. For this report, the settings were collapsed into the following types of settings where outpatient methadone treatment is usually offered:

- ***hospital (inpatient and outpatient)***—general hospital, Veterans Affairs (VA) hospital, or psychiatric/other specialized hospital. Outpatient treatment at this setting.
- ***community mental health center***—outpatient treatment at a community mental health center.
- ***other outpatient***—outpatient, other than above (i.e., excluding outpatient set at a hospital or at a community mental health center).

Client-to-Staff Ratio (ADSS Phase I Questions A9 and B1). A client-to-staff ratio variable was created to examine the distribution of caseloads in the substance abuse treatment system. The point-prevalence client count was divided by the point-prevalence direct-care full-time equivalent (FTE) staff count to calculate a ratio at each facility. The direct-care staff category was created to include physicians, nurses, other medical personnel, doctoral-level counselors, master's level counselors, other degreed counselors (B.A., B.S.), and non-degreed counselors. FTE estimates for part-time and contract staff were derived from ADSS Phase II data because Phase I did not collect FTE data for those categories.[19]

Facility Mean Methadone Maintenance Dose (ADSS Phase I Question B14). A facility average methadone maintenance dose was calculated from the following variable.

B14. At that time, what was the average daily dosage (in milligrams) of methadone given to clients maintained for at least 2 weeks on a level dosage? _____ mgs.

Methadone Withdrawal Time (ADSS Phase I Question B16). In order to obtain information on facility withdrawal practices, information was obtained on methadone withdrawal time using the following variable.

B16. On October 1, 1996, how long after clients started on methadone treatment were they typically encouraged to withdraw from methadone? (CHECK ONLY ONE BOX.)

a. Within 6 months
b. 7-12 months
c. 13-24 months
d. More than 24 months
e. Unlimited time on methadone

[19] The average number of hours worked by a part-time and contract staff was 14.34 hours per week. Full-time was defined in ADSS as 35 hours per week. Therefore, part-time and contract staff were counted as .41 FTE.

Appendix C

Standard Error Tables

Appendix C: Standard Error Tables

The Alcohol and Drug Services Study (ADSS) was designed to produce statistically unbiased national estimates that are representative of substance abuse treatment facilities and clients in treatment. Because ADSS is based on sample data, the statistics presented in this report may differ from the figures that would have been obtained if the whole universe were surveyed. The potential difference between sample statistics and statistics from a complete census is the standard error (SE) of the estimate. The SEs are calculated using WesVar v.3.0, a software program that employs replication to calculate statistics based on data from complex surveys. WesVar v.3.0 was developed by Westat, Inc. This appendix presents SEs for selected tables appearing earlier in this report.

Table 3.1C Standard Errors - ADSS Phase I: National Estimates of the Number of Outpatient Methadone Treatment Facilities, Outpatient Methadone Clients, and Selected Treatment Practices on October 1, 1996

Facility Sample Size—Unweighted Number of Outpatient Methadone Facilities (*n*)	418
Number of Outpatient Methadone Facilities—Weighted Estimate (*N*)	36.9
Number of Methadone Clients in Outpatient Methadone Facilities—Weighted Estimate	9,454
Percent of Outpatient Methadone Clients in Methadone Maintenance	1.30
Percent of Outpatient Methadone Clients in Detoxification	1.30
Methadone Maintenance Dose (Facility Average)[a]	
Mean	0.75
25th percentile	1.39
Median	0.51
75th percentile	1.02
Percent of Facilities with Average Methadone Maintenance Dose[a]	
Under 60 mg	2.62
60-69 mg	2.82
70 mg or more	2.95
Percent of Facilities—Withdrawal from Methadone Encouraged[b]	
Within 6 months	1.60
7-12 months	1.58
13-24 months	1.91
More than 24 months	2.11
Unlimited	2.66
Number of Selected Treatment Services Offered	
Mean	0.10
25th percentile	0.24
Median	0.02
75th percentile	0.02
Number of Selected Support Services Offered	
Mean	0.09
25th percentile	0.01
Median	0.01
75th percentile	0.23

[a] Ninety-seven percent of sampled outpatient methadone facilities offering maintenance reported the average methadone maintenance dose (636 facilities, weighted).

[b] Ninety-eight percent of all sampled outpatient methadone facilities reported the amount of time before withdrawal from methadone was encouraged (661 facilities, weighted).

Exclusions: ADSS Phase I excludes intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, and Department of Defense and Indian Health Service facilities.

Source: Alcohol and Drug Services Study, Phase I facilities data (weighted). Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Table 4.1C Standard Errors - ADSS Phase I: Percentage Distribution of Outpatient Methadone Treatment Facilities by Selected Facility Characteristics, by Facility Ownership, National Estimates, October 1, 1996

	Total, All Facilities	Facility Ownership: Private For-Profit	Facility Ownership: Private Non-Profit	Facility Ownership: Public
Number of Facilities (Weighted Estimate)	36.94	17.66	27.93	16.88
Type of Care				
Methadone only	2.77	1.27	4.18	7.39
Methadone combined with other care	2.77	1.27	4.18	7.39
Facility Size				
Small (1-120 methadone clients)	2.96	5.30	4.07	7.18
Medium (121-265 methadone clients)	2.54	4.54	3.40	5.93
Large (>265 methadone clients)	2.85	4.58	4.14	3.48
Percent Public Revenue[a]				
0% to 50%	2.53	2.36	3.31	1.94
51% to 90%	2.56	1.47	3.79	6.08
91% to 100%	2.63	1.63	3.84	6.38
Urbanicity[b]				
MSA large metro (>1 million population)	3.04	4.35	4.35	5.11
MSA medium metro (250,000-1 million population)	2.77	4.28	3.93	5.24
Small metro (<250,000 population) and non-metro	2.00	0.63*	3.44*	2.86
Level of Affiliation				
Parent facility	2.53	2.00	4.20	3.89*
Affiliate	2.77	4.92	3.63	6.35
Non-affiliate	2.87	5.36	4.02	5.44
Certification Type[c,d]				
State alcohol or drug abuse agency	1.35	2.04	0.67	6.60
State mental health agency	1.89	3.33	2.90	1.68
State public health agency	2.87	4.57	4.24	5.69
Hospital licensing authority	1.00	0.36*	1.51	3.41*
Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)	2.93	0.71	4.42	7.60
Setting[c]				
Hospital (outpatient treatment)	2.14	0.13	3.03	7.18
Community mental health center	0.78	0.14	1.26	2.67
Other outpatient	2.25	0.37	3.33	7.07
Mean Number of Selected Services Offered				
Total, all selected services	0.15	0.31	0.19	0.34
Treatment services	0.10	0.21	0.12	0.15
Support services	0.09	0.15	0.13	0.25

[a] At least 98 percent of facilities responded to revenue questions.

[b] Based on Beale code (Butler & Beale, 1994). MSA = metropolitan statistical area.

[c] Not mutually exclusive.

[d] At least 96 percent of facilities responded to licensing questions.

* The Coefficient of Variation (CV) for this estimate is greater than or equal to 0.3, indicating this number should be interpreted with caution.

Exclusions: ADSS Phase I excludes intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, and Department of Defense and Indian Health Service facilities.

Source: Alcohol and Drug Services Study, Phase I facilities data (weighted). Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Table 5.1C Standard Errors - ADSS Phase I: Percentage Distribution of Outpatient Methadone Treatment Facilities by Selected Facility Characteristics, by Facility Mean Methadone Maintenance Dose and by Facility Policy on Withdrawal from Methadone, National Estimates, October 1, 1996

	Total, All Facilities	Facility Mean Methadone Maintenance Dose [Q-B14][a]			Percent of Facilities Reporting - Time Before Withdrawal from Methadone Is Encouraged [Q-B16][b]	
		<60 mg	60-69 mg	70+ mg	Limited	Unlimited
Number of Facilities (Weighted Estimate)	36.9[a,b]	18.4	21.5	24.0	25.2	25.1
Facility Size						
Small (1-120 methadone clients)	2.96	6.24	5.57	3.13	4.35	4.34
Medium (121-265 methadone clients)	2.54	5.83	3.96	2.70	3.93	3.24
Large (>265 methadone clients)	2.85	2.91	4.55	3.00	3.92	3.67
Ownership						
Private for-profit	2.15	4.99	3.51	3.89	3.84	3.22
Private non-profit	2.66	5.42	4.97	3.95	3.86	3.95
Public	2.32	3.39	5.37	1.73	2.75	3.79
Percent Public Revenue[c]						
0% to 50%	2.53	5.39	3.78	3.95	3.88	3.24
51% to 90%	2.56	5.46	4.96	3.74	3.97	3.63
91% to 100%	2.63	4.91	5.15	4.39	4.19	4.08
Urbanicity[d]						
MSA large metro (>1 million population)	3.04	4.54	5.18	5.65	4.43	2.95
MSA medium metro (250,000-1 million population)	2.77	4.53*	5.33	5.57	4.59	2.85
Small metro (<250,000 population) and non-metro	2.00	0.53	0.80	2.93*	1.79*	1.43
Level of Affiliation						
Parent facility	2.53	4.58	3.02	2.74	3.08	2.32
Affiliate	2.77	4.00	4.98	4.59	4.13	3.71
Non-affiliate	2.87	5.69	4.48	4.70	4.75	3.65
Certification Type[e,f]						
State alcohol or drug abuse agency	1.35	2.33	1.99	2.10	2.41	1.68
State mental health agency	1.89	5.46*	2.20	2.84	3.20	1.65
State public health agency	2.87	6.54	5.02	4.26	4.12	3.97
Hospital licensing authority	1.00	0.74	1.53	2.43	1.70	1.19
Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)	2.93	5.86	5.04	4.29	4.49	4.14
Setting[e]						
Hospital (outpatient treatment)	2.14	2.79	3.53	3.89	3.54	2.36
Community mental health center	0.78	0.66	2.15*	0.50	1.67	0.36
Other outpatient	2.25	2.30	3.93	4.14	3.74	2.57

[a] Ninety-seven percent of the sampled outpatient methadone facilities offering maintenance reported average methadone maintenance dose (636 facilities, weighted).

[b] Ninety-eight percent of all sampled outpatient methadone facilities reported the amount of time before withdrawal from methadone was encouraged (661 facilities, weighted).

[c] At least 98 percent of facilities responded to revenue questions.

[d] Based on Beale code (Butler & Beale, 1994). MSA = metropolitan statistical area.

[e] Not mutually exclusive.

[f] At least 96 percent of facilities responded to licensing questions.

* The Coefficient of Variation (CV) for this estimate is greater than or equal to 0.3, indicating this number should be interpreted with caution.

Exclusions: ADSS Phase I excludes intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, and Department of Defense and Indian Health Service facilities.

Source: Alcohol and Drug Services Study, Phase I facilities data (weighted). Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Table 5.4C Standard Errors - ADSS Phase I: Percentage of Outpatient Methadone Treatment Facilities Offering Selected Services, by Facility Mean Methadone Maintenance Dose and by Facility Policy on Withdrawal from Methadone, National Estimates, October 1, 1996

	Total, All Facilities	Facility Mean Methadone Maintenance Dose [Q-B14][a]			Time Before Withdrawal from Methadone Is Encouraged [Q-B16][b]	
		<60 mg	60-69 mg	70+ mg	Limited	Unlimited
Number of Facilities (Weighted Estimate)	36.9[a,b]	18.4	21.5	24.0	25.2	25.1
Percent of Facilities	--	2.62	2.82	2.96	2.66	2.66
Substance Abuse Testing[c] [Q-C6]						
Routine alcohol screening	2.63	6.30	4.08	4.22	4.09	3.86
Routine drug screening	0.97	4.09	--	0.11	2.10	0.07
Mean Number of Services Offered	0.15	0.28	0.23	0.25	0.21	0.21
Selected Treatment Services Offered [Q-C9]						
Comprehensive assessment/diagnosis	1.41	5.15	0.92	1.25	1.53	2.43
Individual therapy	0.47	1.58	0.52	0.73	0.39	0.95
Group therapy, not including relapse prevention	1.77	2.08	1.38	4.21	3.65	1.47
Family counseling	2.12	2.13	3.66	4.43	3.29	3.31
Relapse prevention	2.45	2.60	3.47	4.83	4.13	3.19
Self-help or mutual-help groups	3.20	5.59	5.16	5.82	4.42	4.09
Aftercare	2.20	3.37	4.28	3.99	3.74	3.02
Outcome follow-up	2.78	4.01	4.37	5.18	3.95	3.67
Dual-diagnosis treatment	2.85	6.13	4.48	5.18	4.20	3.55
Detoxification	2.88	6.46	5.37	4.52	3.96	4.04
Acupuncture	1.80	1.05	4.28	2.60	2.05	2.87
Selected Support Services Offered [Q-C9]						
HIV/AIDS education/counseling/support	1.35	0.60	0.66	3.70	2.81	0.51
Transportation	2.88	6.20	4.84	4.48	4.21	3.72
TB screening	2.36	6.17	0.52	1.98	2.43	2.87
Employment counseling/training	2.85	4.74	4.57	5.02	4.16	4.07
Smoking cessation	1.61	2.74	3.43	2.31	2.30	2.38
Academic education/GED classes	2.02	4.90	2.75	3.53	1.12	3.64
Child care	2.58	5.37	4.33	2.97	3.92	1.94
Prenatal care	2.09	5.23	4.26	2.12	3.11	2.77

-- Not applicable.

[a] Ninety-seven percent of the sampled outpatient methadone facilities offering maintenance reported average methadone maintenance dose (636 facilities, weighted).

[b] Ninety-eight percent of all sampled outpatient methadone facilities reported the amount of time before withdrawal from methadone was encouraged (661 facilities, weighted).

[c] At least 99 percent of facilities responded to substance abuse testing questions.

Exclusions: ADSS Phase I excludes intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, and Department of Defense and Indian Health Service facilities.

Source: Alcohol and Drug Services Study, Phase I facilities data (weighted). Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Table 5.5C Standard Errors - ADSS Phase I: Mean Number of Staff and Mean Client-to-Staff Ratios in Outpatient Methadone Facilities, by Facility Mean Methadone Maintenance Dose and by Facility Policy on Withdrawal from Methadone, National Estimates, October 1, 1996

	Total, All Facilities	Facility Mean Methadone Maintenance Dose [Q-B14][a]			Time Before Withdrawal from Methadone Is Encouraged [Q-B16][b]	
		<60 mg	60-69 mg	70+ mg	Limited	Unlimited
Number of Facilities (Weighted Estimate)	36.9[a,b]	18.4	21.5	24.0	25.2	25.1
Number of Staff (Mean Number) [Q-A9][c]						
Full-time	0.69	1.28	1.30	0.90	1.01	0.96
Part-time	0.56	0.28	1.67*	0.31	1.18	0.20
Contract/consultant	0.10	0.17	0.14	0.18	0.14	0.11
Number of FTEs (Mean Number)[c]						
All direct-care staff (medical, counseling, other)	2.7	9.8*	1.4	3.4	3.0	4.8
Medical staff (MDs, DOs, RNs)	0.9	3.81*	0.5	0.6	0.7	1.83*
All counselors (degreed and non-degreed)	1.5	5.5*	0.9	2.0	1.6	2.7
Degreed counselors	0.5	1.3	0.7	0.8	0.7	0.8
Non-degreed counselors	1.1	4.35*	0.4	1.29*	1.02*	2.09*
Client-to-Staff (FTE) Ratio (Facility Mean) [Q-B1j2 / Q-A9][e]						
Clients to direct-care staff	0.87	1.19	1.18	1.85	1.52	0.74
Clients to medical staff	5.84	7.87	6.58	12.33	10.37	5.84
Clients to all counselors	1.73	3.28	1.85	3.86	3.16	1.72
Clients to degreed counselors	2.66	4.91	4.40	4.34	4.12	3.21

[a] Ninety-seven percent of the sampled outpatient methadone facilities offering maintenance reported average methadone maintenance dose (636 facilities, weighted).

[b] Ninety-eight percent of all sampled outpatient methadone facilities reported the amount of time before withdrawal from methadone was encouraged (661 facilities, weighted).

[c] Eight sample facilities are excluded from the staffing count section because they could not report staff by full-time/part-time/contract status. However, their full-time equivalents (FTEs) are included in the FTE and rates sections.

[d] Medical staff includes physicians and registered nurses. Counseling staff includes doctoral, master's, and bachelor-level counselors and non-degreed counselors. All direct-care staff includes medical staff, other medical personnel, such as LPNs and physician's assistants, and counseling staff.

[e] Staff in facilities that provide methadone treatment in combination with another type of care (224 of the estimated 688 outpatient methadone facilities) could not be separated by type of care. Therefore, the client-to-staff ratios were calculated using all clients and all staff in outpatient methadone facilities, including clients and staff in other types of care. The ratios presented are facility means (i.e., the mean of the ratios at each facility).

* The Coefficient of Variation (CV) for this estimate is greater than or equal to 0.3, indicating this number should be interpreted with caution.

Exclusions: ADSS Phase I excludes intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, and Department of Defense and Indian Health Service facilities.

Source: Alcohol and Drug Services Study, Phase I facilities data (weighted). Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Table 6.1C Standard Errors - ADSS Phase I: Number and Percentage Distribution of Clients in Outpatient Methadone Treatment Facilities by Facility Mean Methadone Maintenance Dose, by Facility Policy on Withdrawal from Methadone and by Selected Client Characteristics, National Estimates, October 1, 1996

[Q-B2]	Number of Methadone Clients[a]	Total, All Clients	Facility Mean Methadone Maintenance Dose [Q-B14][a]			Time Before Detoxification from Methadone Is Encouraged [Q-B16][b]	
			<60 mg	60-69 mg	70+ mg	Limited	Unlimited
Total Methadone Clients (Weighted Estimate)	9,454[a,b]		3,312	4,813	7,137	6,252	5,212
Gender							
Male	5,272	--	2.11	2.55	3.19	2.15	2.15
Female	4,363	--	2.81	3.26	3.66	2.75	2.75
Unknown	385	--	16.88*	3.78*	17.42	21.40*	21.40*
Race/Ethnicity							
White, non-Hispanic	5,172	--	2.50	3.38	3.44	3.18	3.18
Black, non-Hispanic	2,866	--	3.18	2.70	4.60	1.93	1.93
Hispanic	2,084	--	2.27	2.88	3.37	2.28	2.28
Asian or Pacific Islander	245	--	4.94*	16.66*	12.48*	9.72*	9.72
American Indian/Alaskan Native	60	--	4.83	5.87	6.79	4.49	4.49
Unknown	561	--	5.78*	8.01	5.22*	9.55	9.55
Age (Years)							
Under 18	267*	--	15.56*	6.20	20.36*	12.91	12.91*
18-24	853	--	5.01	3.81	4.98	4.40	4.40
25-34	3,450	--	3.67	4.06	3.38	3.40	3.40
35-44	3,261	--	1.79	2.57	2.78	2.39	2.39
45 or older	3,326	--	2.81	3.75	5.74	2.27	2.27
Unknown	957	--	7.15*	9.21	14.16*	7.85	7.85
Dual-Diagnosis Clients[c]	1,699[c]	--	2.29	5.34	4.90	4.64	4.64
Client Payment Source							
No payment	686	--	7.48	10.08	8.96*	8.93	8.93
Client self-payment	4,038	--	3.40	2.86	3.89	3.24	3.24
Private fee-for-service	358	--	6.60	10.42	8.25*	10.03	10.03
Private managed care	681	--	5.06	5.12	4.78	5.32	5.32
Medicaid	4,100	--	2.58	3.28	3.15	3.57	3.57
Medicare	1,993*	--	4.42*	15.79*	19.63	14.13*	14.13
Other public source	1,932	--	4.85	5.13	5.59	5.05	5.05
Unknown	482	--	10.80*	10.36*	15.16	31.66*	31.66*

[a] Ninety-seven percent of sampled outpatient methadone facilities offering maintenance reported average methadone maintenance dose. Clients in those facilities total 147,793 (weighted).

[b] Ninety-eight percent of all sampled outpatient methadone facilities reported the amount of time before withdrawal from methadone was encouraged. Clients in those facilities total 150,222 (weighted).

[c] Data on methadone clients with a dual diagnosis (substance abuse and a mental disorder) are available just for methadone-only facilities (and not for facilities with methadone in combination with other types of treatment). Therefore, the count of dually diagnosed methadone clients does not include clients in combination facilities.

* The Coefficient of Variation (CV) for this estimate is greater than or equal to 0.3, indicating this number should be interpreted with caution.

Exclusions: ADSS Phase I excludes intake/referral-only facilities, halfway houses without paid counseling staff, solo practices, correctional facilities, and Department of Defense and Indian Health Service facilities.

Source: Alcohol and Drug Services Study, Phase I facilities data (weighted). Office of Applied Studies, Substance Abuse and Mental Health Services Administration.