This report presents an overview of patients admitted and outcomes collected from Hazelden Betty Ford across all sites from

January 1, 2025 through December 31, 2025

9,555
Unique Patients

22,146
Patient Encounters/Admits

REPORT STRUCTURE

I. DEMOGRAPHIC CHARACTERISTICS | *Who are the patients that Hazelden Betty Ford serves?*

Descriptive indicators of our patient population.

II. PATIENT DIAGNOSES | *What are the challenges that patients face?*

Examination of the types, co-occurrence, and complexity of our patients' substance use disorders, mental health challenges, and medical diagnoses.

III. TREATMENT DELIVERY-QUALITY ASSURANCE | *What does treatment look like for our patients?*

Metrics include number of patients served by level of care, discharge status, length of stay, step down rates, treatment responses as measured by Feedback Informed Treatment (FIT) scores.

IV. CLINICAL OUTCOMES | *What are the treatment outcomes we observed?*

Post-discharge outcomes from all levels of care in substance use disorder (SUD) programs (Center City, MN; Rancho Mirage, CA; Naples, FL; Newberg, OR) including: group comparative analysis, response rates, abstinence rates, craving, treatment programs and services participation, peer recovery support attendance, recovery capital, and quality of life.

V. FIVE-YEAR TREND DATA | *Are there any trends to identify?*

Trend data includes number of encounters, admits, and discharges; most common SUD and mental health diagnoses and co-occurring diagnoses; abstinence and quality of life rates (additional trends will be added as data become available).

VI. VOLUMES DATA | *Engagement in new patient and alumni initiatives.*

Enrollment into Family and Children's service programs and Life-Long Recovery initiatives.

EXECUTIVE SUMMARY

- Across all Hazelden Betty Ford Foundation (HBFF) sites and levels of care, alcohol (42.5%), nicotine (19.4%), and cannabis (12.3%) were the ***most common substance use disorders*** (SUD).

- 72% of HBFF patients had two or more SUD diagnoses and/or co-occurring mental health diagnoses. Anxiety (37.5%) and depressive (34.1%) disorders were the two most common ***co-occurring mental health*** diagnoses. Recent studies have found between 56 - 71% of those with any SUD disorder had two or more diagnoses. Furthermore, ~46% of those with a SUD were also diagnosed with a mental health disorder within the past year.[1-3]

- FIT scores showed improvement in multiple measures of patient mental health after HBFF treatment. ***Improvements in anxiety, depression, and PTSD symptoms*** were observed most often across all levels of care.

- In 2025, approximately 37% of HBFF patients reported ***continuous abstinence*** at 12 months. One-year continuous abstinence rates for HBFF patients are superior to those found in the SUD literature (i.e., 20% - 60%), furthermore, comparative estimates of continuous abstinence are often inflated by selective sampling of patients.[4,5]

- Approximately 36% of HBFF patients reported a ***return to substance use*** within 6 months; far less than the 50% - 60% reported in the scientific literature.[6]

- A 75% ***medication adherence*** rate was found among HBFF patients prescribed an addiction treatment medication, well above the scientific literature's reported average rates.[7]

- According to the 2025 Gallup annual Mood of the Nation survey, 81% of U.S. adults were very satisfied/somewhat satisfied with their overall quality of life. Summed throughout the one-year follow-up period, 86% of Hazelden Betty Ford patients rated their ***overall quality of life*** as good or better.[8]

- Throughout 2025, 85% of Hazelden Betty Ford patients rated their ***overall general health*** as good or better.

Note: Outcome data in this report were obtained from patients discharged from inpatient and outpatient substance use programs between January to December of 2025.

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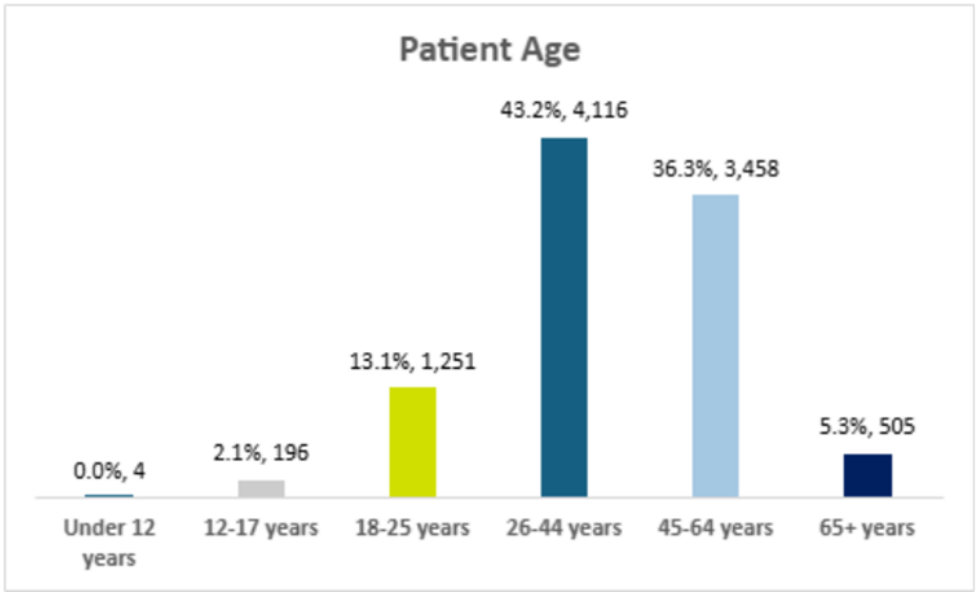
I. DEMOGRAPHIC CHARACTERISTICS

Who are the patients that the Hazelden Betty Ford Foundation serves?

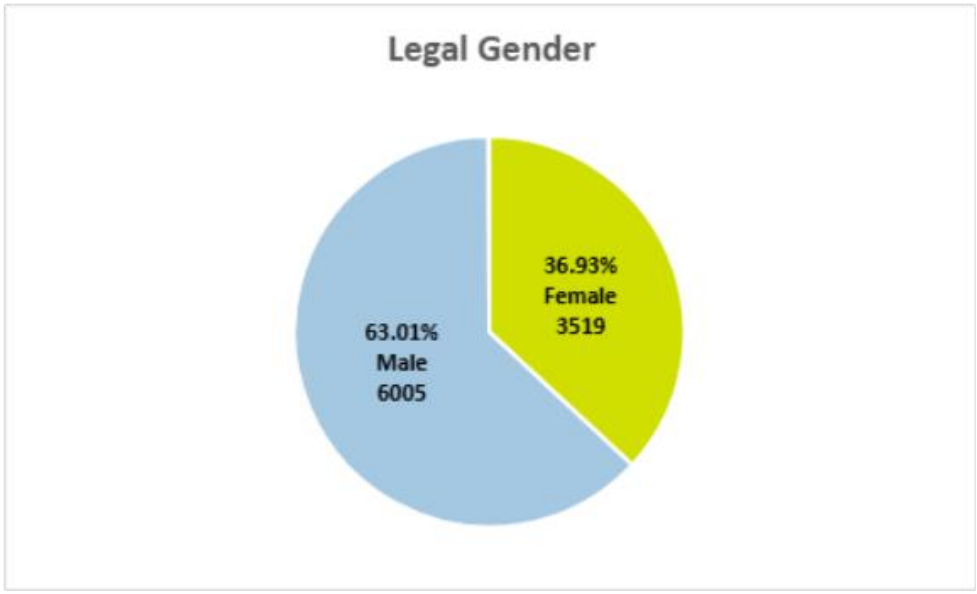
Demographic questions are used to describe and understand the characteristics of the people who use our services.

Figure 1. Age distribution of patients by developmental group



Most patients (43%) were between the ages 26-44, followed by ages 45-64 (36%). These numbers are consistent with nationwide estimates of individuals who received SUD treatment in the past year. [9,10]

Figure 2. Distribution of patients by legal gender listed on government identification



The majority of patients were male (63%), who have a higher prevalence of SUDs and greater admissions into treatment.[11]

Figure 3. Distribution of patients by self-reported race

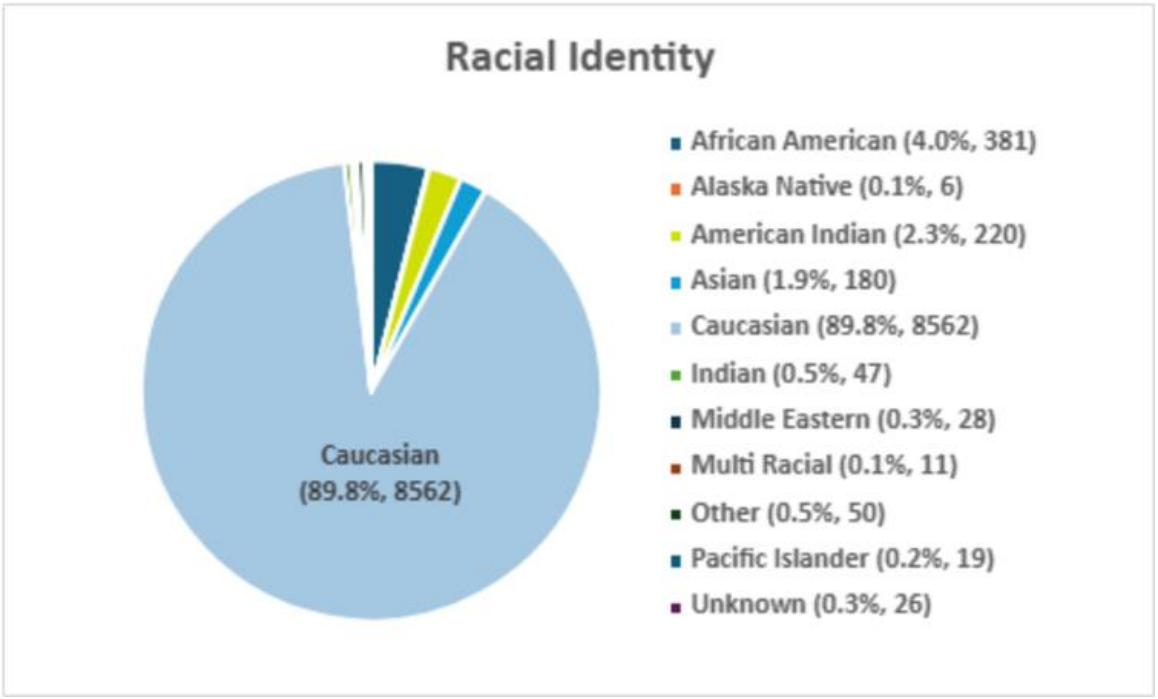
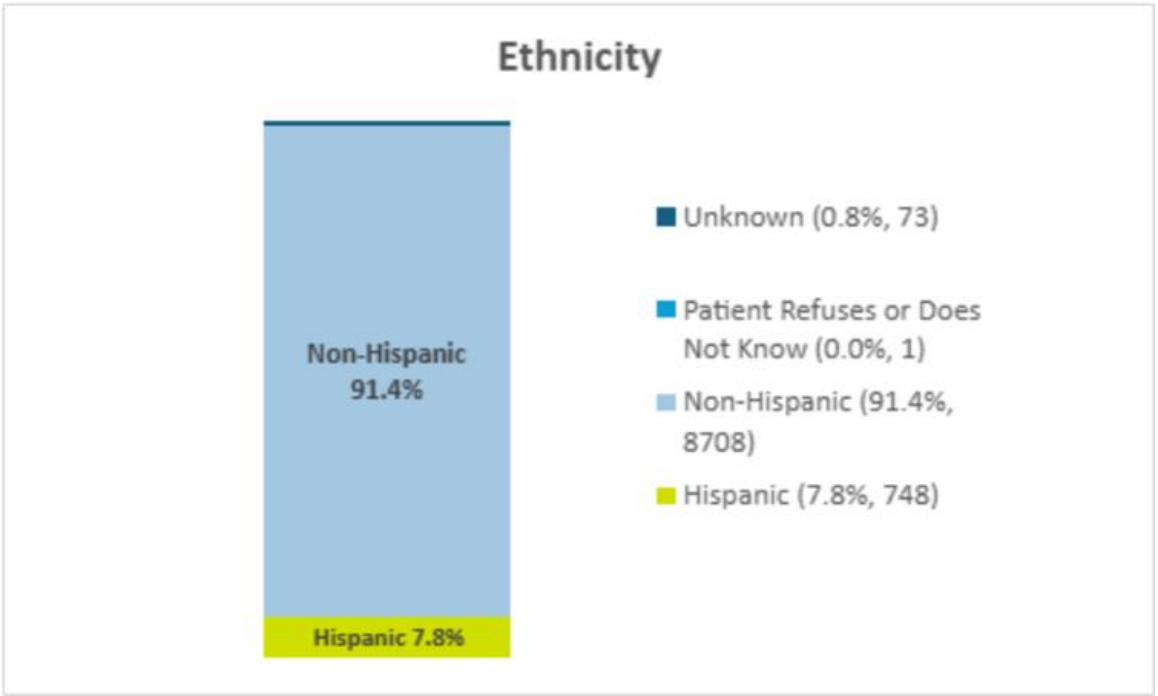


Figure 4. Ethnicity



The majority of patients (90%) identified as Caucasian, and non-Hispanic (91%). Racial minorities are underrepresented among the Hazelden Betty Ford patient population, highlighting racial disparities in accessing SUD treatment that exists nationwide.[9] Relationship and employment status are presented in *Figures 5* and *6*, respectively.

Figure 5. Distribution of patients by relational status

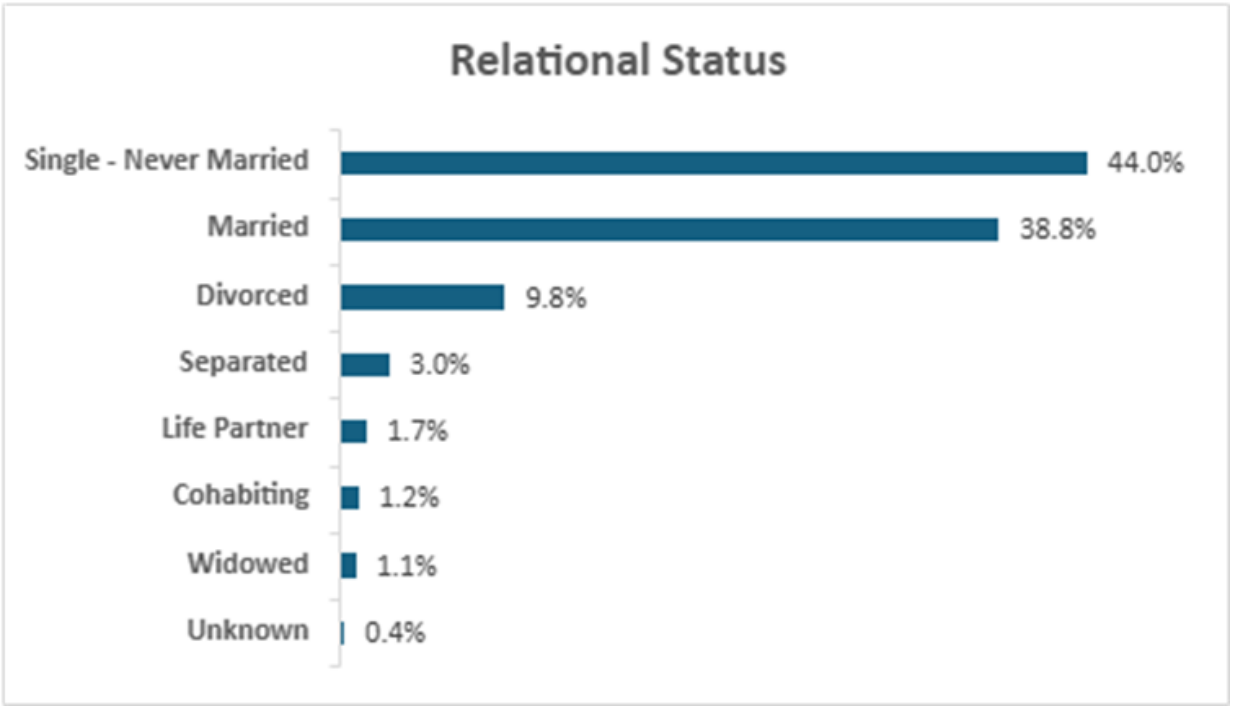
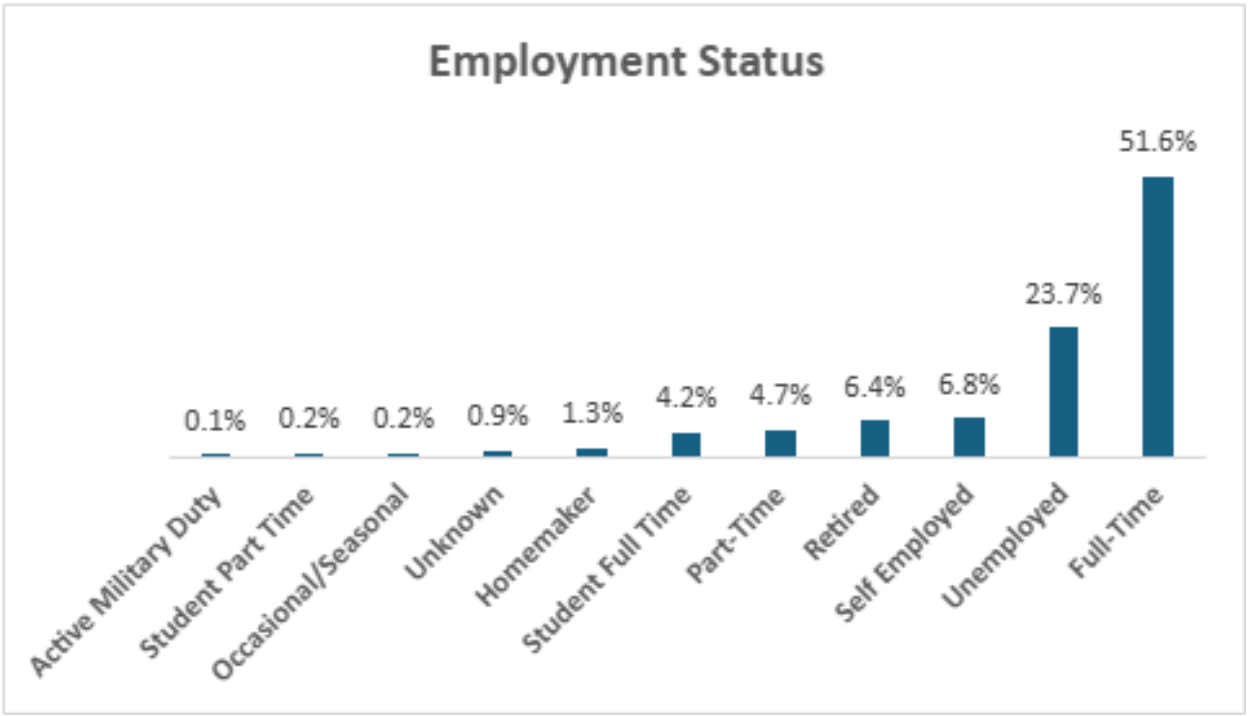


Figure 6. Distribution of patients by employment status



II. PATIENT DIAGNOSES

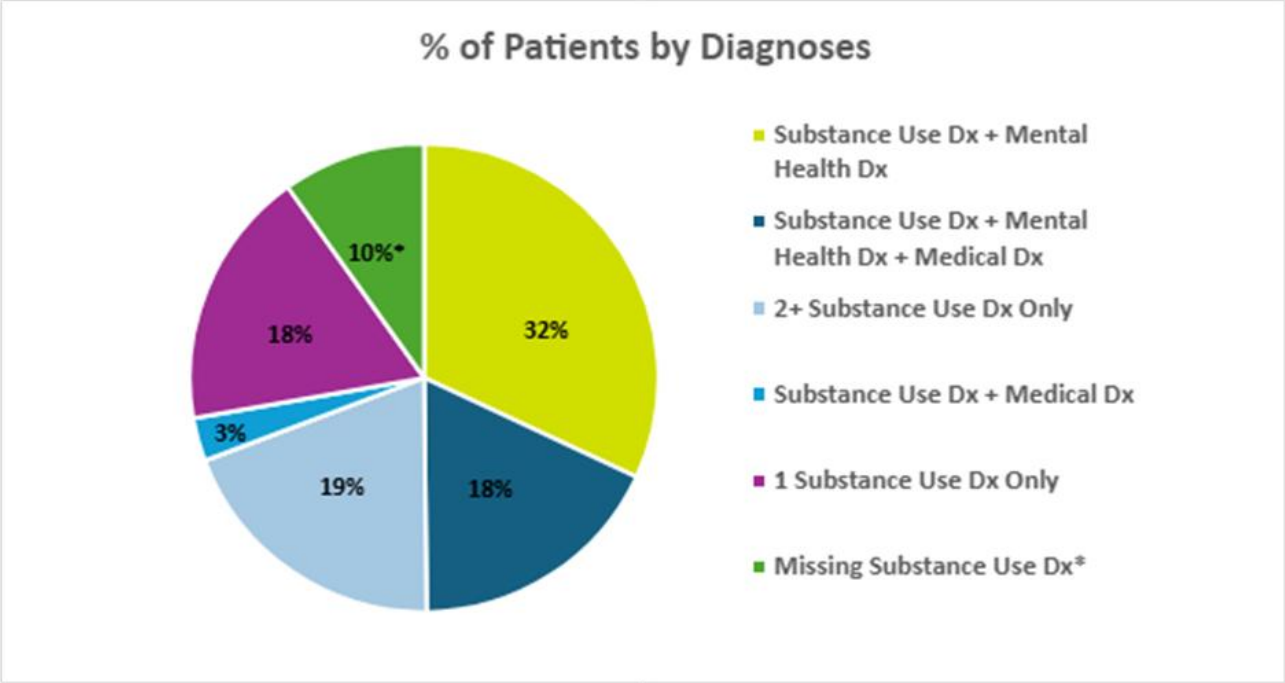
What are the challenges that patients face?

This section presents the frequency and severity of SUDs and co-occurring mental health conditions among Hazelden Betty Ford patients. The data were obtained using the final discharge diagnosis documented in PowerChart.

Like most individuals struggling with addiction, patients at Hazelden Betty Ford have multiple SUD diagnoses.[12,13] Furthermore, the co-occurrence of a mental health disorder (e.g. depression, anxiety) is the rule rather than the exception among individuals with addiction.[8]

As shown in *Figure 7*, only 18% of patients had a single SUD diagnosis. Meanwhile 72% of patients had two or more SUD diagnoses, and/or a co-occurring mental health or medical diagnosis.

Figure 7. Percentage of patients by documented final/discharged diagnoses



**Patient Dx not finalized at the time of data collection.*

Substance use disorders are diagnosed on a scale of mild, moderate, or severe. Severity is based on the number of symptoms a person has and how much it interferes with daily life.

Table 1 presents the diagnostic severity of SUDs among HBFF patients. Similarly, *Table 2* displays diagnostic severity of mental health conditions. Meanwhile, *Table 3* outlines the co-occurring prevalences among the various SUD and mental health diagnoses.

Table 1. Frequency and severity of substance use disorder diagnoses

SUD	Mild		Moderate		Severe		Unspecified		Overall		
	N	%	N	%	N	%	N	%	N	%	% of Patients with Final/Discharge Diagnosis (N = 9040)
Alcohol related disorders	200	2.5%	273	3.4%	6300	79.4%	1159	14.6%	7932	42.5%	87.7%
Nicotine dependence	942	26.0%	1667	46.0%	745	20.5%	272	7.5%	3626	19.4%	40.1%
Cannabis related disorders	512	22.2%	399	17.3%	1289	56.0%	102	4.4%	2302	12.3%	25.5%
Cocaine related disorders	94	9.0%	94	9.0%	824	79.0%	31	3.0%	1043	5.6%	11.5%
Other stimulant related disorders	105	10.9%	80	8.3%	691	72.0%	84	8.8%	960	5.1%	10.6%
Sedative, hypnotic, or anxiolytic related disorders	173	18.4%	97	10.3%	472	50.3%	197	21.0%	939	5.0%	10.4%
Other psychoactive substance related disorders	18	2.2%	30	3.6%	288	34.4%	500	59.8%	836	4.5%	9.2%
Opioid related disorders	49	6.4%	41	5.3%	549	71.2%	132	17.1%	771	4.1%	8.5%
Hallucinogen related disorders	42	20.3%	30	14.5%	122	58.9%	13	6.3%	207	1.1%	2.3%
Inhalant related disorders	9	13.8%	8	12.3%	33	50.8%	15	23.1%	65	0.3%	0.7%

Table 2. Frequency and severity of mental health diagnoses

Mental Health Diagnosis	Mild		Moderate		Severe		Unspecified		Overall		
	N	%	N	%	N	%	N	%	N	%	% of Patients with Final/Discharge Diagnosis (N = 9040)
Anxiety Disorders	1	0.0%	0	0.0%	4	0.1%	3737	99.9%	3742	37.5%	41.4%
Depressive Disorders	427	12.6%	630	18.6%	135	4.0%	2203	64.9%	3395	34.1%	37.6%
PTSD/Grief	1	0.1%	0	0.0%	0	0.0%	1921	99.9%	1922	19.3%	21.3%
ADHD	0	0.0%	1	0.2%	0	0.0%	610	99.8%	611	6.1%	6.8%
Eating Disorders	1	0.5%	9	4.7%	11	5.7%	172	89.1%	193	1.9%	2.1%
Impulse Disorders	1	1.0%	2	2.1%	2	2.1%	91	94.8%	96	1.0%	1.1%
Conduct Disorders	0	0.0%	0	0.0%	0	0.0%	8	100.0%	8	0.1%	0.1%

Table 3. Most Common SUD diagnoses by mental health diagnosis

Mental Health Diagnosis	1st most common SUD dx			2nd most common SUD dx			3rd most common SUD dx		
	SUD	%	N	SUD	%	N	SUD	%	N
ADHD	Alcohol	80.5%	662	Nicotine	54.6%	449	Cannabis	46.8%	385
Anxiety Disorders	Alcohol	86.8%	4024	Nicotine	48.0%	2225	Cannabis	32.3%	1500
Conduct Disorders	Cannabis	92.9%	13	Nicotine	71.4%	10	Alcohol	50.0%	7
Depressive Disorders	Alcohol	86.2%	3240	Nicotine	50.5%	1899	Cannabis	33.6%	1262
Eating Disorders	Alcohol	83.4%	196	Nicotine	55.7%	131	Cannabis	50.6%	119
Impulse Disorders	Nicotine	74.3%	81	Cannabis	72.5%	79	Alcohol	71.6%	78
PTSD/Grief	Alcohol	85.7%	1931	Nicotine	50.7%	1142	Cannabis	35.0%	788

III.TREATMENT DELIVERY – QUALITY ASSURANCE

What does treatment look like for our patients?

Quality measures are used to help us understand variations in care, assess the impact of specific programs, and guide improvement efforts.

Encounters per Patient

In 2025, 9,555 unique patients received care across all Hazelden Betty Ford sites. These unique patients, on average, had 2.32 episodes of care (i.e. FIN numbers). As shown in *Figure 8*, approximately 53% of patients accessed more than one episode of care in 2025. As shown in *Figure 9*, of the 21,146 episodes of care provided, 28% were for residential treatment.

Figure 8. Number/percentage of patients by number of encounters

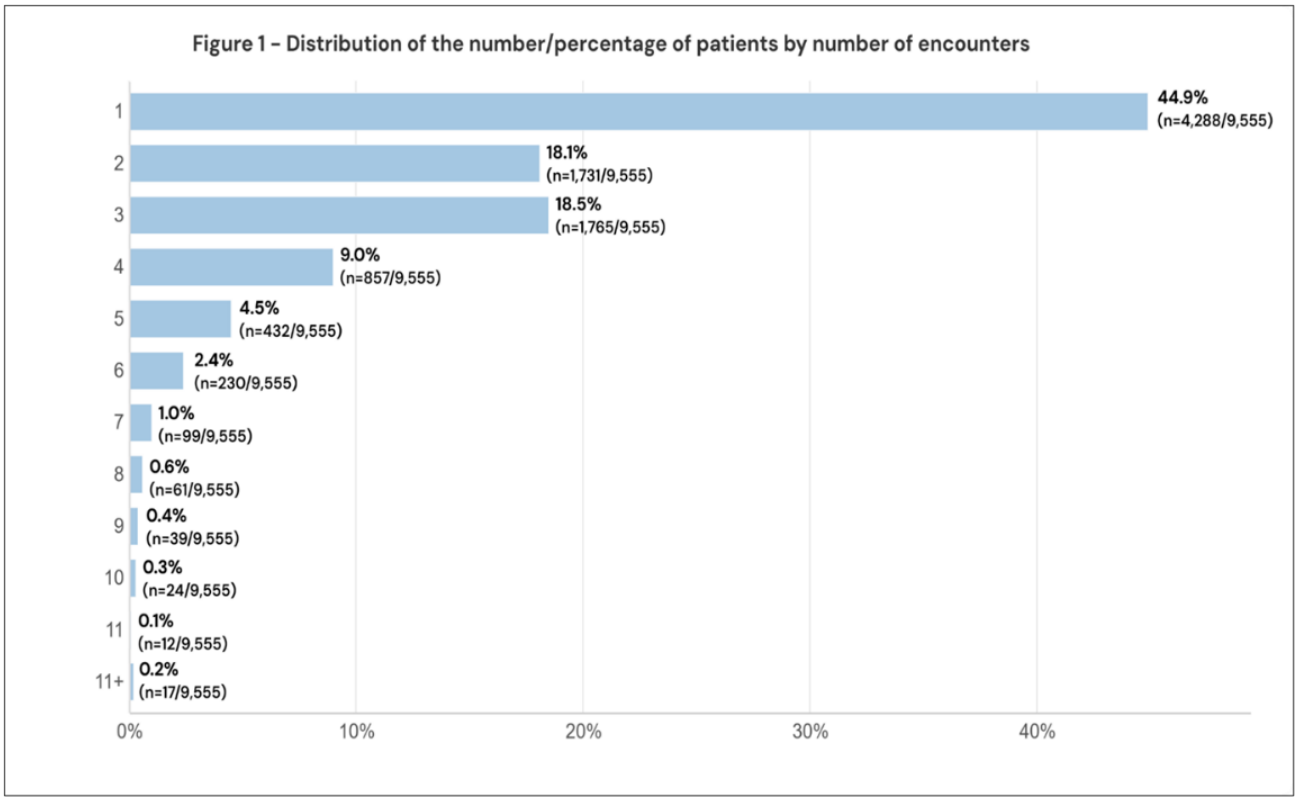
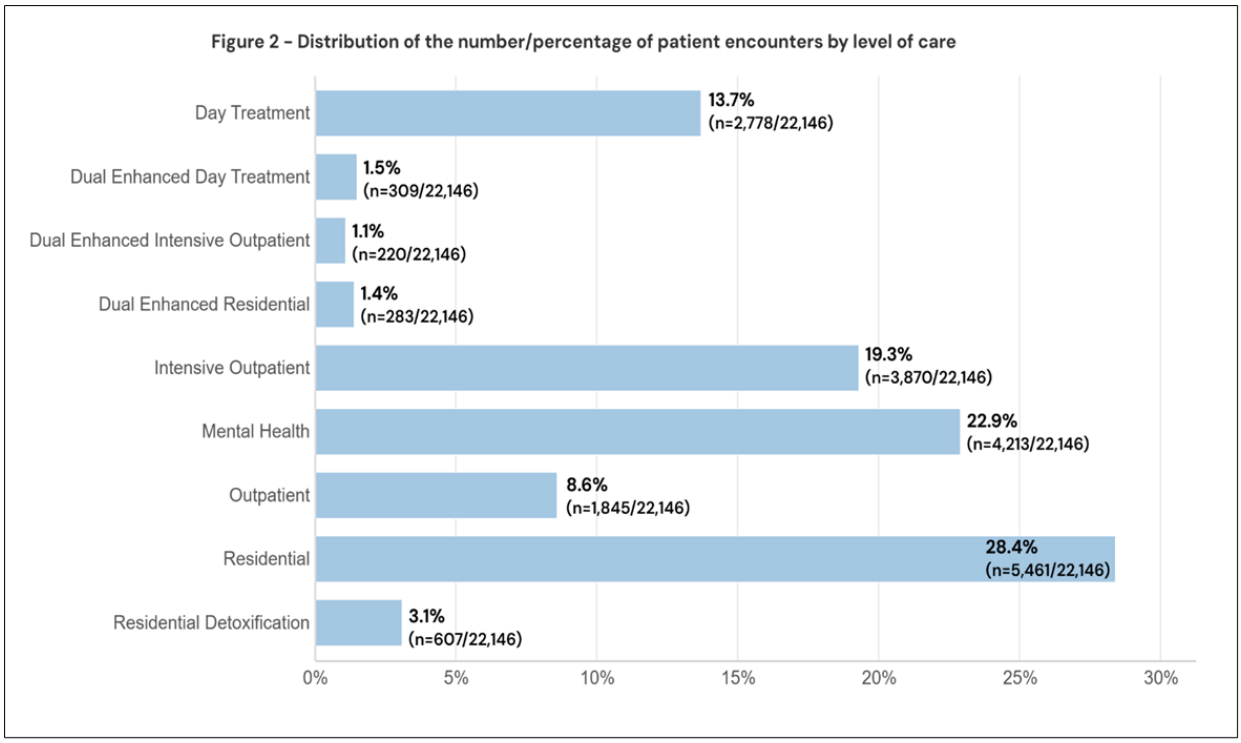


Figure 9. Number/percentage of patient encounters by level of care



Though successful outcomes of SUD treatment result from many factors, greater service intensity is typically associated with more favorable treatment outcomes.[13-15] For residential programs, treatment intensity is defined as length of stay (in days), and the number of therapy sessions for outpatient programs.

Average Length of Stay (ALOS) in days and Average Number of Treatment Sessions (ANOS) for each level of care are shown in *Table 4*.

Table 4. Average length of stay and average number of sessions by level of care

Level of Care	n	Average length of stay (± SD)	Average number of sessions (± SD)
Residential	6046	19.8 (±8.8)	21.5 (±9.2)
Residential Detoxification	670	2.1 (±1.3)	3.8 (±2.5)
Dual Enhanced Residential	287	21.5 (±8.6)	21.5 (±8.7)
Intensive Outpatient	3209	42.7 (±25.5)	19.7 (±12.5)
Outpatient	1342	67.2 (±48.6)	12.3 (±9.7)
Day Treatment	2828	23.2 (±12.3)	15.2 (±8.0)
Virtual Intensive Outpatient	519	41.0 (±24.6)	19.6 (±12.5)
Dual Enhanced Intensive Outpatient	184	43.0 (±29.2)	20.7 (±15.0)
Dual Enhanced Day Treatment	313	23.9 (±9.8)	15.3 (±6.8)
Virtual Outpatient	177	46.8 (±31.5)	10.5 (±7.5)

SD = *Standard Deviation*

Treatment Response – FIT Assessments

FIT Assessments are brief questionnaires that assess several patient health features upon entry into treatment and throughout the course of HBFF care. The calculated scores on the following questionnaires help guide the course of treatment.

As shown in the following *Tables 5* through *5f*, symptomology improved following treatment for the vast majority of measures.

Commitment to Sobriety Scale (CSS-5): Assesses a person's commitment to sobriety.

Score Range: 0-30	Yellow Zone Score Range: 16-20 Indicates further assessment is needed	Red Zone Score Range: 0-15 Indicates an intervention is needed

Table 5. CSS5 scores

Measure	Level of Care	N	Average Start Score (± SD)	Average End Score (± SD)	New Overall Progress
CSS5 Commitment to Sobriety Scale *Score Range: 0-30*	Residential	1542	26.8 (±4.6)	27.8 (± 3.6)	Improved
	Intensive Outpatient	924	27.4 (±3.6)	27.7 (±3.3)	Improved
	Mental Health	1135	27.6 (±3.3)	27.7 (±3.3)	No meaningful changes
	Day Treatment	1006	27.6 (±3.4)	27.7 (±3.1)	No meaningful changes
	Outpatient	299	28.4 (±2.7)	28.3 (±3.1)	No meaningful changes
	Virtual Intensive Outpatient	261	27.4 (±4.3)	28.0 (±3.6)	Improved
	Virtual Outpatient	68	28.8 (±3.4)	28.7 (±3.6)	No meaningful changes
	Dual Enhanced Residential	24	25.9 (±3.8)	27.3 (±3.9)	Improved
	Dual Enhanced Day Treatment	11	27.2 (±3.6)	27.4 (±3.3)	No meaningful changes

Self-Efficacy Scale: This single question measures a patient's confidence in their ability to stay clean and sober.

Score Range: 1-10	Yellow Zone Score Range: 4-6 Indicates further assessment is needed	Red Zone Score Range: 1-3 Indicates an intervention is needed

Table 5a. Self-Efficacy Scale scores

Measure	Level of Care	N	Average Start Score (± SD)	Average End Score (± SD)	New Overall Progress
Self-Efficacy Scale *Score Range: 1-10*	Residential	1544	8.8 (±1.9)	8.7 (±1.7)	No meaningful changes
	Intensive Outpatient	924	8.9 (±1.5)	9.1 (±1.4)	Improved
	Mental Health	1135	8.7 (±1.7)	8.8 (±1.6)	Improved
	Day Treatment	1006	8.8 (±1.7)	8.7 (±1.7)	No meaningful changes
	Outpatient	299	9.4 (±1.0)	9.5 (±0.9)	No meaningful changes
	Virtual Intensive Outpatient	261	9.0 (±1.3)	9.1 (±1.4)	Improved
	Virtual Outpatient	68	9.4 (±1.0)	9.4 (±1.1)	No meaningful changes
	Dual Enhanced Residential	24	9.0(±1.2)	9.0 (±1.3)	No meaningful changes
	Dual Enhanced Day Treatment	11	7.9 (±1.5)	8.4 (±1.6)	No meaningful changes

Generalized Anxiety Disorder (GAD-7): Instrument measures the severity of generalized anxiety, panic, social anxiety, and PTSD symptoms.

Score Range: 0-21	Yellow Zone Score Range: 10-14 Indicates further assessment is needed	Red Zone Score Range: 15-21 Indicates an intervention is needed

Table 5b. GAD-7 scores

Measure	Level of Care	N	Average Start Score (± SD)	Average End Score (± SD)	New Overall Progress
GAD-7 Generalized Anxiety Disorder 7-item Scale *Score Range: 0-21*	Residential	1679	12.2 (±5.8)	7.3 (±5.5)	Improved
	Intensive Outpatient	970	6.8 (±5.3)	4.9 (±4.6)	Improved
	Mental Health	1244	7.5 (±5.7)	5.9 (±5.1)	Improved
	Day Treatment	1053	7.8 (±5.7)	6.4 (±5.3)	Improved
	Outpatient	332	4.0 (±4.0)	3.6 (±4.1)	Improved
	Virtual Intensive Outpatient	246	6.0 (±5.0)	4.2 (±4.2)	Improved
	Virtual Outpatient	64	3.1 (±3.9)	2.8 (±4.2)	No meaningful changes
	Dual Enhanced Residential	192	13.2 (±5.7)	8.1 (±5.2)	Improved
	Dual Enhanced Day Treatment	186	9.5 (±5.2)	7.8 (±5.1)	Improved
	Dual Enhanced Intensive Outpatient	109	8.5 (±5.3)	6.5 (±4.9)	Improved

Patient Health Questionnaire (PHQ-9): Measures the severity of depression symptoms.

Score Range: 0-27	Yellow Zone Score Range: 10-14 Indicates further assessment is needed	Red Zone Score Range: 15-27 Indicates an intervention is needed

Table 5c. PHQ-9 scores

Measure	Level of Care	N	Average Start Score (± SD)	Average End Score (± SD)	New Overall Progress
PHQ-9 Patient Health Questionnaire *Score Range: 0-27*	Residential	1448	12.5 (±6.6)	7.2 (±5.7)	Improved
	Intensive Outpatient	1000	6.8 (±5.5)	5.1 (±5.0)	Improved
	Mental Health	1506	7.2 (±5.6)	6.1 (±5.6)	Improved
	Day Treatment	1206	7.5 (±5.7)	6.3 (±5.5)	Improved
	Outpatient	354	4.1 (±4.4)	3.8 (±4.5)	Improved
	Virtual Intensive Outpatient	235	5.7 (±5.0)	4.2 (±4.6)	Improved
	Virtual Outpatient	65	3.5 (±4.8)	3.0 (±4.8)	No meaningful changes
	Dual Enhanced Residential	196	14.9 (±6.5)	8.7 (±5.7)	Improved
	Dual Enhanced Day Treatment	181	10.0 (±6.0)	9.0 (±5.8)	Improved
	Dual Enhanced Intensive Outpatient	109	10.0 (±5.8)	7.8 (±5.2)	Improved

Posttraumatic Stress Disorder (PTSD) **Checklist (PCL-5)**: Assesses the 20 DSM-5 symptoms of PTSD.

Score Range: 0-80	Score Range: 0-33 No/low trauma severity	Red Zone Score Range: 34-80 Indicates an intervention is needed

Table 5d. PCL-5 scores

Measure	Level of Care	N	Average Start Score (± SD)	Average End Score (± SD)	New Overall Progress
PCL-5 PTSD Checklist *Score Range: 0-80*	Residential	210	34.5 (±22.1)	22.5 (±18.5)	Improved
	Intensive Outpatient	147	19.3 (±17.7)	15.0 (±15.8)	Improved
	Mental Health	179	25.3 (±20.4)	22.5 (±19.8)	Improved
	Day Treatment	198	23.6 (±19.0)	19.9 (±18.0)	Improved
	Outpatient	38	11.1 (±12.4)	10.0 (±12.3)	No meaningful changes
	Virtual Intensive Outpatient	58	16.5 (±17.7)	12.8 (±16.5)	Improved
	Virtual Outpatient	12	13.8 (±19.6)	11.9 (±19.3)	No meaningful changes
	Dual Enhanced Residential	110	41.1 (±19.4)	28.5 (±18.6)	Improved
	Dual Enhanced Day Treatment	163	30.8 (±16.8)	26.5 (±16.8)	Improved
	Dual Enhanced Intensive Outpatient	104	27.9 (±17.0)	22.1 (±16.7)	Improved

Desire for Substance Questionnaire (DSQ): Measures craving and desire for substances.

DSQ Subscale 1– Desire/Intention: Indicates a patient's desire or intention to use drugs or alcohol.

Score Range: 1-7	Yellow Zone Score Range: 3-4 Indicates further assessment is needed	Red Zone Score Range: 5-7 Indicates an intervention is needed

DSQ Subscale 2– Negative Reinforcement: Indicates if the patient feels that using drugs or alcohol would reduce their problems and make their life better/easier.

Score Range: 1-7	Yellow Zone Score Range: 4-5 Indicates further assessment is needed	Red Zone Score Range: 6-7 Indicates an intervention is needed

Table 5e. DSQ scores

Measures	Level of Care	N	Average Start Score (± SD)	Average End Score (± SD)	New Overall Progress
Desire for Substances Questionnaire (DSQ):					
DSQ Subscale 1 - *Desire/Intention* *Score range: 1-7*	Residential	1384	2.3 (±1.5)	1.8 (±1.2)	Improved
	Intensive Outpatient	1014	1.7 (±1.1)	1.4 (±0.9)	Improved
	Mental Health	1115	1.8 (±1.2)	1.6 (±1.1)	Improved
	Day Treatment	971	1.9 (±1.2)	1.7 (±1.1)	Improved
	Outpatient	342	1.2 (±0.6)	1.2 (±0.7)	No meaningful changes
	Virtual Intensive Outpatient	260	1.7 (±1.1)	1.4 (±0.9)	Improved
	Virtual Outpatient	71	1.3 (±0.9)	1.4 (±1.3)	No meaningful changes
	Dual Enhanced Residential	17	1.6 (±0.7)	2.0 (±1.2)	No meaningful changes
DSQ Subscale 2 – *Negative Reinforcement* *Score range: 1-7*	Residential	1384	2.5 (±1.7)	2.1 (±1.6)	Improved
	Intensive Outpatient	1014	1.9 (±1.3)	1.6 (±1.1)	Improved
	Mental Health	1115	2.1 (±1.5)	1.9 (±1.4)	Improved
	Day Treatment	971	2.2 (±1.6)	2.0 (±1.4)	Improved
	Outpatient	342	1.3 (±0.8)	1.3 (±0.9)	No meaningful changes
	Virtual Intensive Outpatient	260	1.8 (±1.3)	1.5 (±1.1)	Improved
	Virtual Outpatient	71	1.4 (±1.1)	1.4 (±1.2)	No meaningful changes
	Dual Enhanced Residential	17	2.6 (±1.5)	2.5 (±1.7)	No meaningful changes

Working Alliance Inventory – Short Revised (WAI-SR): Examines therapeutic alliance between the clinician and their patient.

- ***WAI Subscale - Bond:*** Measures the nature of the relationship; Is there trust, appreciation, respect.
- ***WAI Subscale - Goals:*** Measures whether the patient agrees with treatment goals; Does the therapist understand the goals, do therapist and patient share goals, etc.
- ***WAI Subscale - Task:*** Measures the patient's assessment of the treatment plan tactics, or tasks of therapy.

Table 5f. WAI-SR scores

Measures	Level of Care	N	Average Start Score (± SD)	Average End Score (± SD)	New Overall Progress
Working Alliance Inventory- Short Revised (WAI-SR):					
WAI-SR Subscale - *Bond* *Score range: 4-20*	Intensive Outpatient	583	24.9 (±3.4)	25.9 (±3.1)	Improved
	Mental Health	786	25.0 (±3.8)	25.5 (±3.7)	Improved
	Residential	755	23.4 (±4.9)	25.1 (±3.9)	Improved
	Day Treatment	656	24.9 (±4.0)	25.6 (±3.6)	Improved
	Outpatient	206	25.9 (±2.9)	25.9 (±2.8)	No meaningful changes
	Virtual Intensive Outpatient	168	24.6 (±4.4)	26.1 (±3.1)	Improved
	Virtual Outpatient	54	26.1 (±4.2)	26.7 (±2.7)	No meaningful changes
	Dual Enhanced Residential	18	22.3(±6.1)	25.1 (±4.4)	Improved
WA-SRI Subscale - *Goals* *Score range: 4-20*	Intensive Outpatient	583	24.4 (±3.6)	24.9 (±3.4)	Improved
	Mental Health	786	24.0 (±4.0)	24.5 (±3.8)	Improved
	Residential	755	23.0 (±4.2)	24.1 (±4.1)	Improved
	Day Treatment	656	23.9 (±4.0)	24.5 (±3.8	Improved
	Outpatient	206	24.5 (±3.6)	25.2(±3.2)	Improved
	Virtual Intensive Outpatient	168	24.0 (±3.8)	24.7 (±4.0)	Improved
	Virtual Outpatient	54	24.2 (±4.6)	24.7 (±3.6)	No meaningful changes
	Dual Enhanced Residential	18	22.7 (±3.8)	24.1 (±4.1)	No meaningful changes
WAI*-SR Subscale - *Task *Score range: 4-20*	Intensive Outpatient	583	24.3 (±3.5)	25.5 (±3.1)	Improved
	Mental Health	786	24.3 (±3.9)	25.2 (±3.5)	Improved
	Residential	755	22.9 (±4.6)	24.7 (±4.0)	Improved
	Day Treatment	656	24.2 (±4.1)	25.3 (±3.4)	Improved
	Outpatient	206	25.6 (±3.1)	25.7 (±2.8)	No meaningful changes
	Virtual Intensive Outpatient	168	24.1 (±4.3)	25.8 (±3.3)	Improved
	Virtual Outpatient	54	25.6 (±4.3)	26.4 (±3.2)	No meaningful changes
	Dual Enhanced Residential	18	22.3 (±4.4)	24.4 (±4.5)	Improved

Patient Disposition

Patient disposition following entry into HBFF care, is defined in terms of "Steps." Stepped care involves matching treatment to patients based on the least intensive intervention that is expected to be effective. Based on how the patient responds to treatment, the addiction service provided can increase (i.e., step up) or reduce (i.e., step down) the intensity of treatment. This approach optimizes the use of resources by reducing unnecessarily intensive treatment.[17]

In addition to being fiscally responsible, stepped care is crucial in addiction treatment outcomes as stepping down provides a gradual, structured transition from intensive to less intensive care, helping to prevent relapse by offering continuous clinical support and significantly improving long-term recovery success.[18,19]

The steps are labeled:

Step In: The patient's initial point of entry/encounter into HBFF treatment services.

Step Down: The patient discharges from one level of care and transitions to a less intensive level of care within 7 calendar days between encounters (e.g., Residential to Outpatient).

Step Up: The patient transitions to a higher level of care within 7 calendar days of discharge from a lower level of care.

Step Over: The patient transitions to the same level of care within 7 calendar days (e.g., from in-person to virtual intensive outpatient programming).

As shown in *Figures 10* through *10d*, following their initial point of entry (i.e., Step In), the majority of patients step down to a less intensive form of treatment. This indicates exceptional matching of patients with the appropriate level of care and demonstrates the continuity of care within the HBFF system that many addiction treatment providers do not offer. [20, 21]

Figure 10. Stepped care percentages for residential detoxification

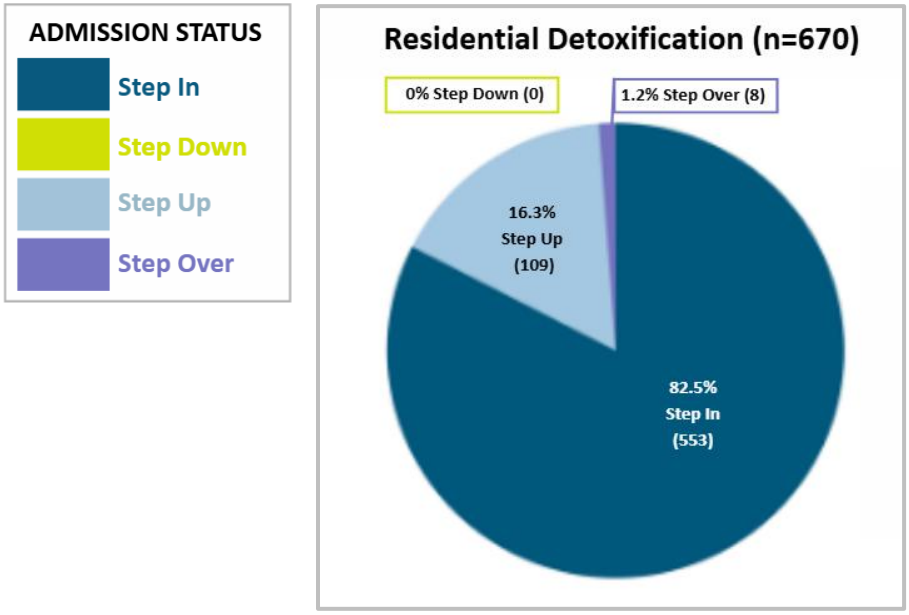


Figure 10a. Stepped care percentages for residential and dual enhanced residential

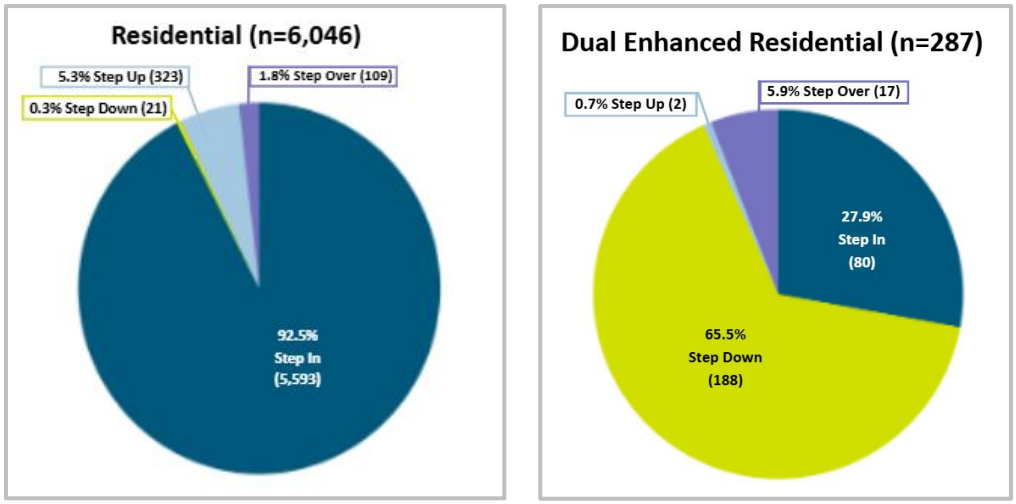


Figure 10b. Stepped care percentages for day treatment and dual enhanced day treatment

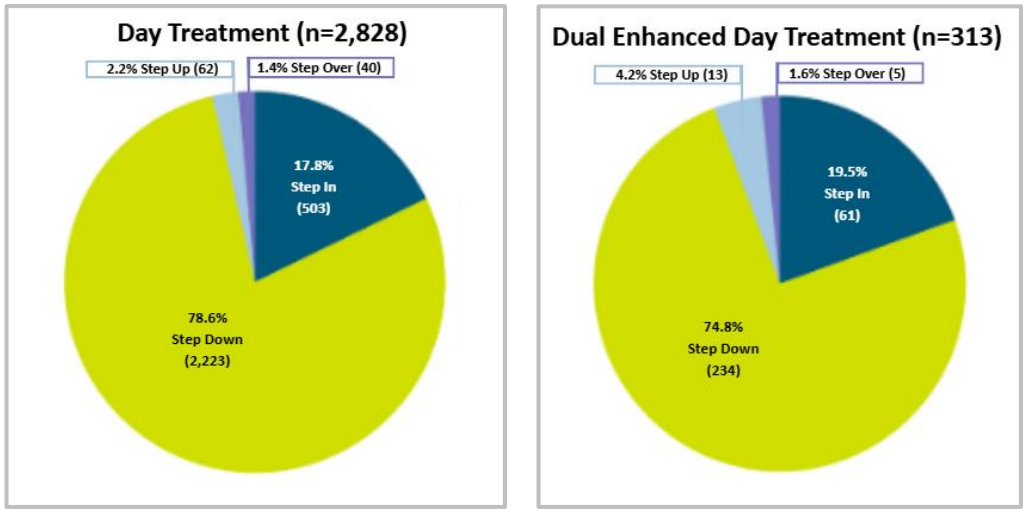


Figure 10c. Stepped care percentages for outpatient and virtual outpatient

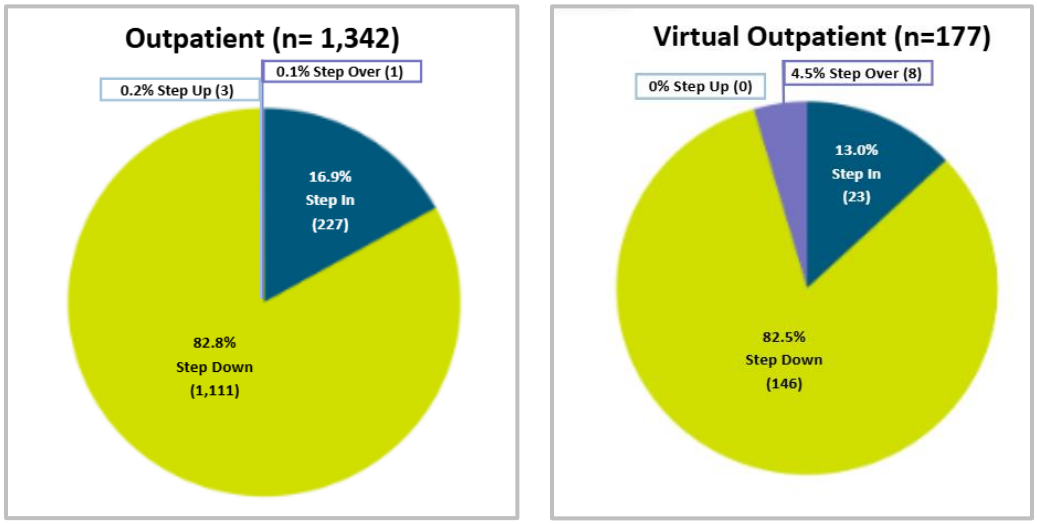
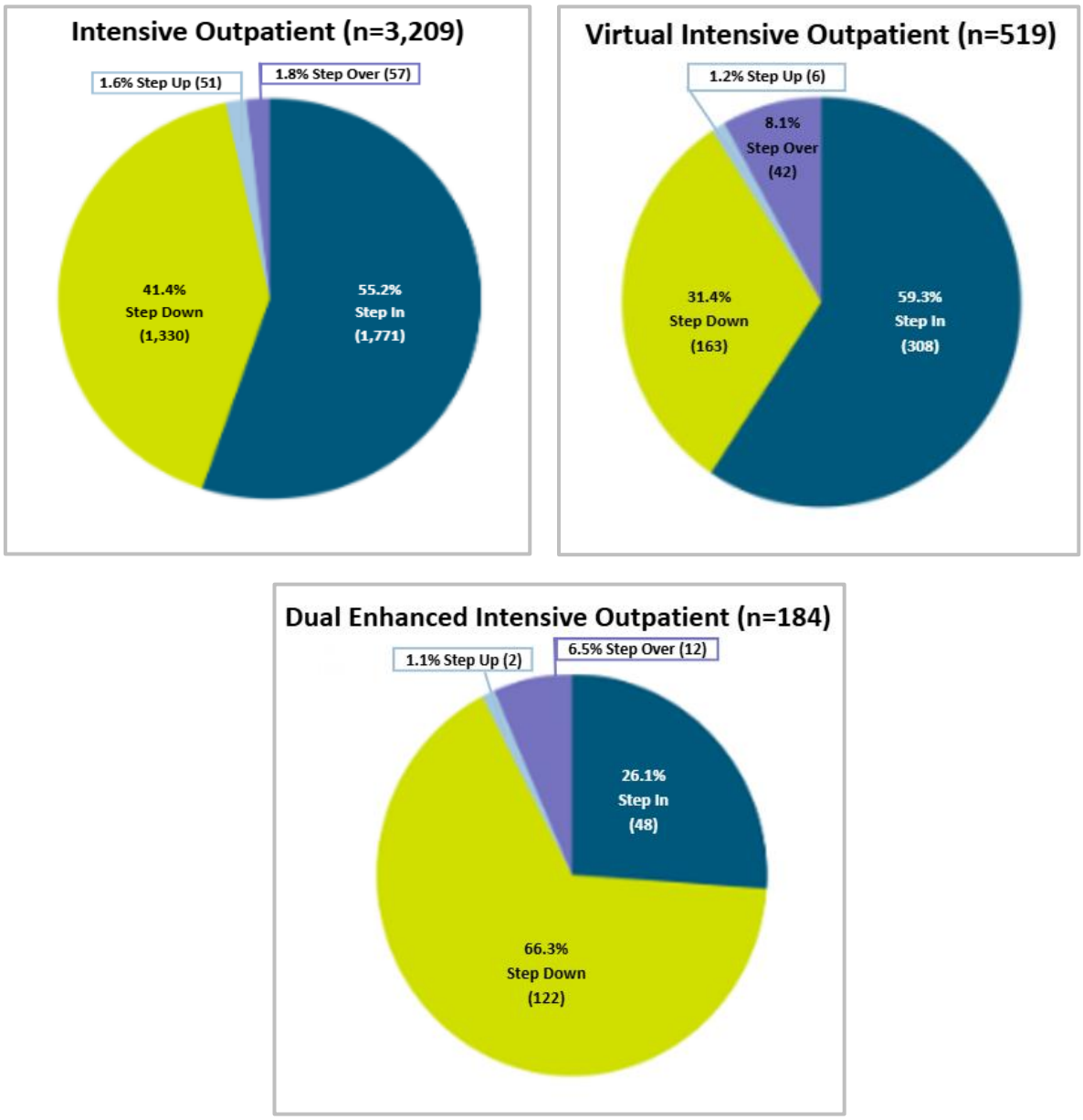


Figure 10d. Stepped care percentages for intensive outpatient, virtual intensive outpatient and dual enhanced intensive outpatient

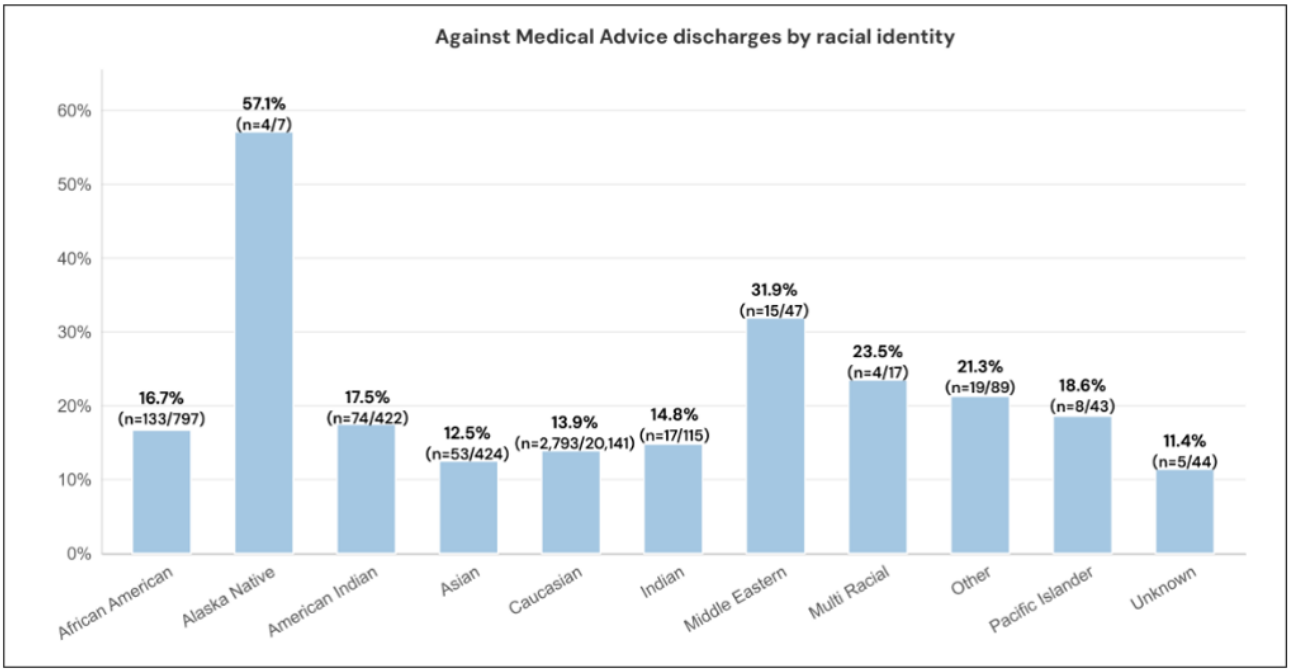


Discharge From Treatment

An Against Medical Advice (AMA) discharge occurs when a patient chooses to leave treatment. Meanwhile, an administrative discharge is a provider-initiated, involuntary termination of treatment. In either case, premature termination of treatment is associated with negative outcomes and re-admissions.[22-24]

The rates of AMA and administrative discharges were examined across categories of racial identity and ethnicity to assess health equity. Overall, there were 3,122 discharges against medical advice and 915 administrative discharges at HBFF in 2025. Alaska Natives constituted the highest proportion of AMA discharges at 57% (*Figure 11*).

Figure 11. AMA discharges by racial identity



A relatively higher percentage of AMA discharges were also seen among Middle Eastern clients; however, rates were similar among all other racial groups. There was little difference in AMA discharges between Hispanic and non-Hispanic clients (*Figure 12*). Administrative discharges did not vary significantly among the identified racial groups (*Figure 13*) or between Hispanic and non-Hispanic clients (*Figure 14*).

Figure 12. AMA discharges by ethnicity

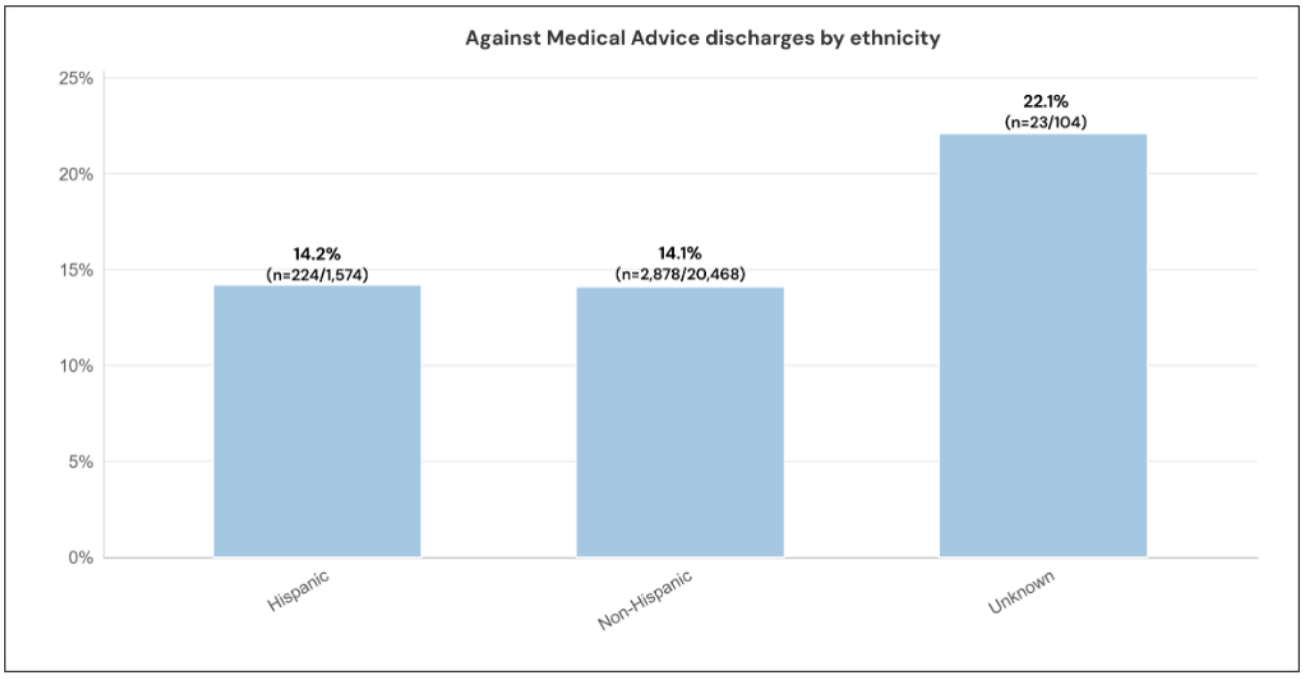


Figure 13. Administrative discharges by racial identity

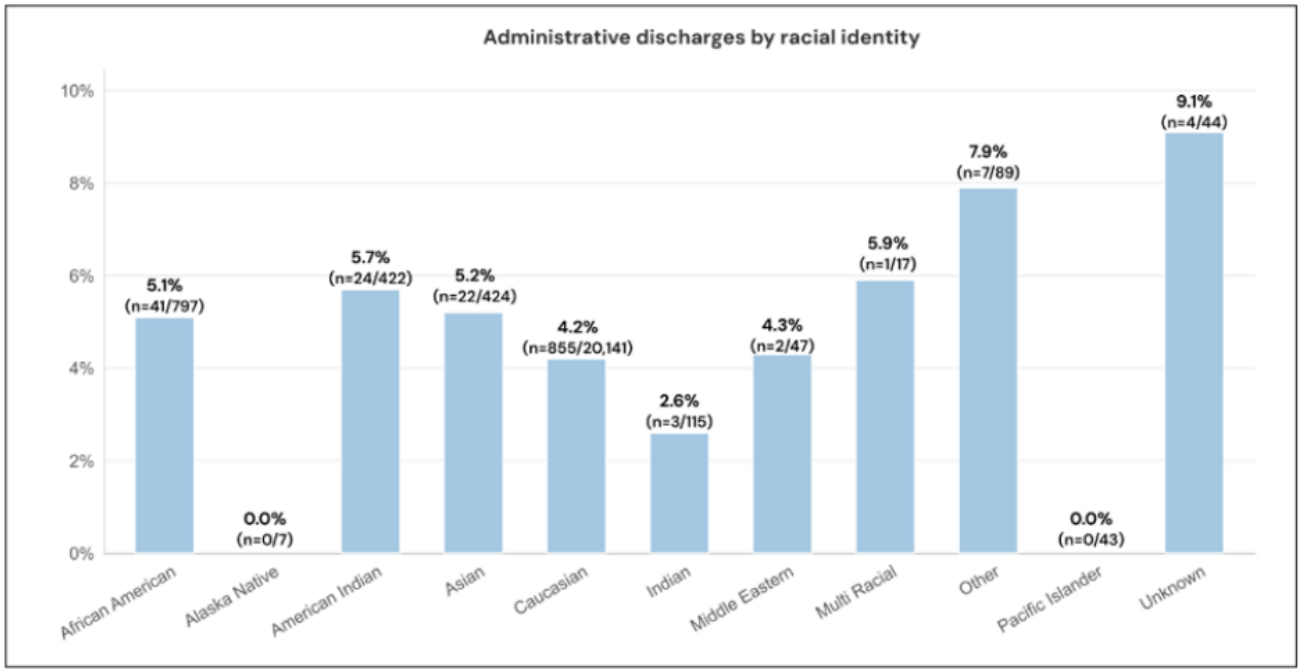
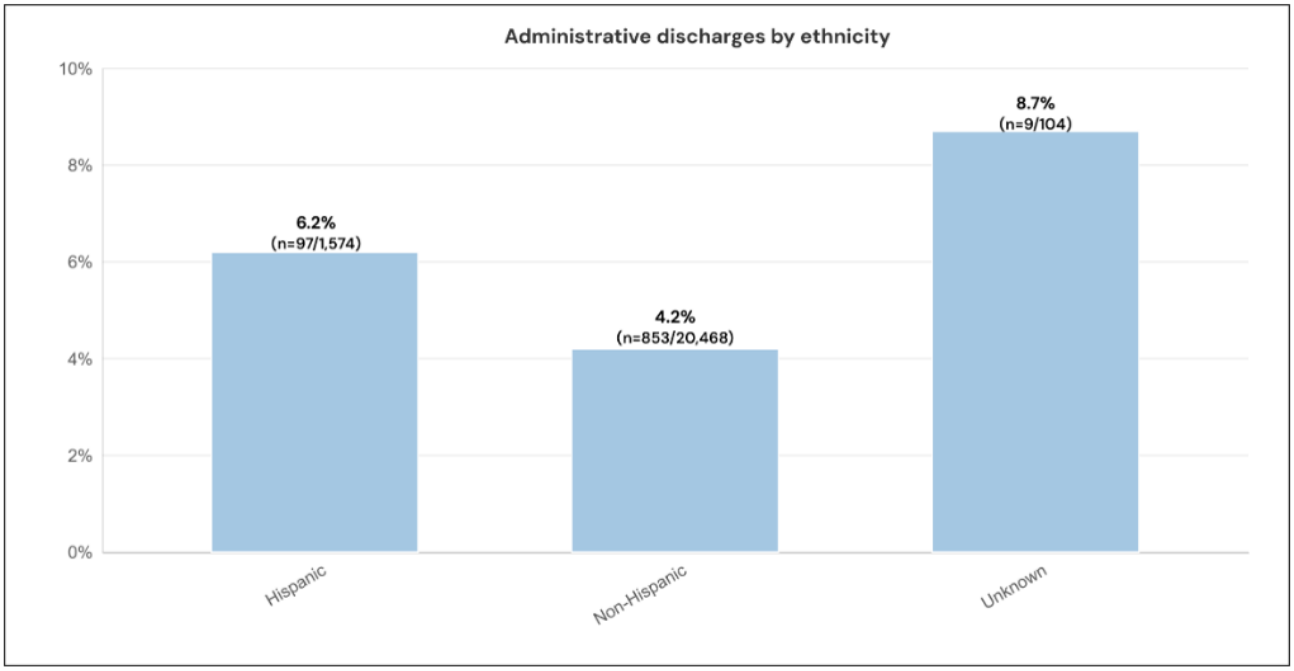


Figure 14. Administrative discharges by ethnicity



IV. CLINICAL OUTCOMES

Outcomes for Patients Discharging Between January and December 2025.

HBFF uses clinical outcomes data to inform quality assurance and improve patient care. Data collection specialists with the Butler Center for Research are rigorously trained in the standardized administration of various SUD and health measures to ensure data fidelity, integrity, and security. Following discharge, a random subset of HBFF patients is selected for post-discharge clinical outcomes monitoring. Surveys are assigned to patients at 1-, 3-, 6-, 9-, and 12-months post-discharge. Response rates are calculated as the number of completed surveys divided by the number of surveys assigned at each follow-up timepoint. This section presents the clinical outcomes data from patients discharged from adult inpatient and outpatient substance use programs between January to December of 2025.

Table 6. Characteristics of patients who were and were not internally randomized to receive the survey (N=9046)

Variables		Randomized (*N* = 6,163)	Non-Randomized (*N* = 2,883)
		n (%)	n (%)
Age**	12-17	121 (2%)	49 (1.7%)
	18-25	857 (13.9%)	324 (11.2%)
	26-44	2666 (43.3%)	1223 (42.4%)
	45-64	2194 (35.6%)	1122 (38.9%)
	65+	325 (5.3%)	165 (5.7%)
Birth Sex	Male	3920 (63.6%)	1819 (63.1%)
	Female	2189 (35.5%)	1043 (36.2%)
Gender Identity	Identifies as Male	3871 (62.8%)	1797 (62.3%)
	Identifies as Female	2142 (34.8%)	1024 (35.5%)
	Non-Binary	26 (0.4%)	11 (0.4%)
	Transgender Male (Female-to-Male)	9 (0.1%)	5 (0.2%)
	Transgender Female (Male-to Female)	13 (0.2%)	5 (0.2%)
	Other	100 (1.6%)	41 (1.4%)
Sexual Orientation	Straight/Heterosexual	5319 (86.3%)	2511 (87.1%)
	Other	832 (13.5%)	363 (12.6%)
Race**	White	5622 (91.2%)	2700 (93.7%)
	Other	541 (8.8%)	183 (6.3%)
Ethnicity**	Hispanic/Latino	522 (8.5%)	166 (5.8%)
	Not Hispanic/Latino	5613 (91.1%)	2681 (93%)
Marital Status	Single – Never Married	2757 (44.7%)	1231 (42.7%)
	Married/Life Partner	2521 (40.9%)	1217 (42.2%)
	Other	865 (14%)	422 (14.6%)
Educational Attainment	Less than High School	291 (4.7%)	130 (4.5%)
	High School/GED	1048 (17%)	465 (16.1%)
	Some College	1693 (27.5%)	818 (28.4%)
	Bachelors Degree	1721 (27.9%)	800 (27.7%)
	Graduate/Professional Degree	825 (13.4%)	393 (13.6%)
Multiple Substance Use Disorders**	Yes	5885 (95.5%)	2442 (84.7%)
	No	278 (4.5%)	441 (15.3%)
Medical Diagnosis	Yes	2865 (46.5%)	1314 (45.6%)
	No	3298 (53.5%)	1569 (54.4%)
Mental Health Diagnosis**	Yes	4809 (78%)	2154 (74.7%)
	No	1354 (22%)	729 (25.3%)
Substance Use Diagnosis†	Yes	5886 (95.5%)	2728 (94.6%)
	No	277 (4.5%)	155 (5.4%)

*Differences between randomized and non-randomized groups were assessed using chi-square tests (among categories with adequate n's) and Fisher's exact tests among categories with smaller n's). ** p < .01, * p < .05, † p < .10*
Note: Number of Diagnoses variable categories are not mutually exclusive. Otherwise, where intra-variable category percents do not total 100% it is due to missingness on that variable.

Summary

There were statistically significant differences in race and ethnicity between patients who were/were not randomized to receive the survey. However, minoritized demographics are purposely oversampled to increase their representation in outcomes collection. There was also a higher proportion of patients with multiple SUD and co-occurring mental health diagnoses among patients randomized to receive the survey. *Table 7* provides a complete list of demographics variables that differ between survey completers and non-completers. For most characteristics, group differences are relatively small and not clinically meaningful. Statistical significance is thought to be driven by the large sample size. Thus, these differences may not indicate that survey respondents are not representative of the entire HBFF patient population.

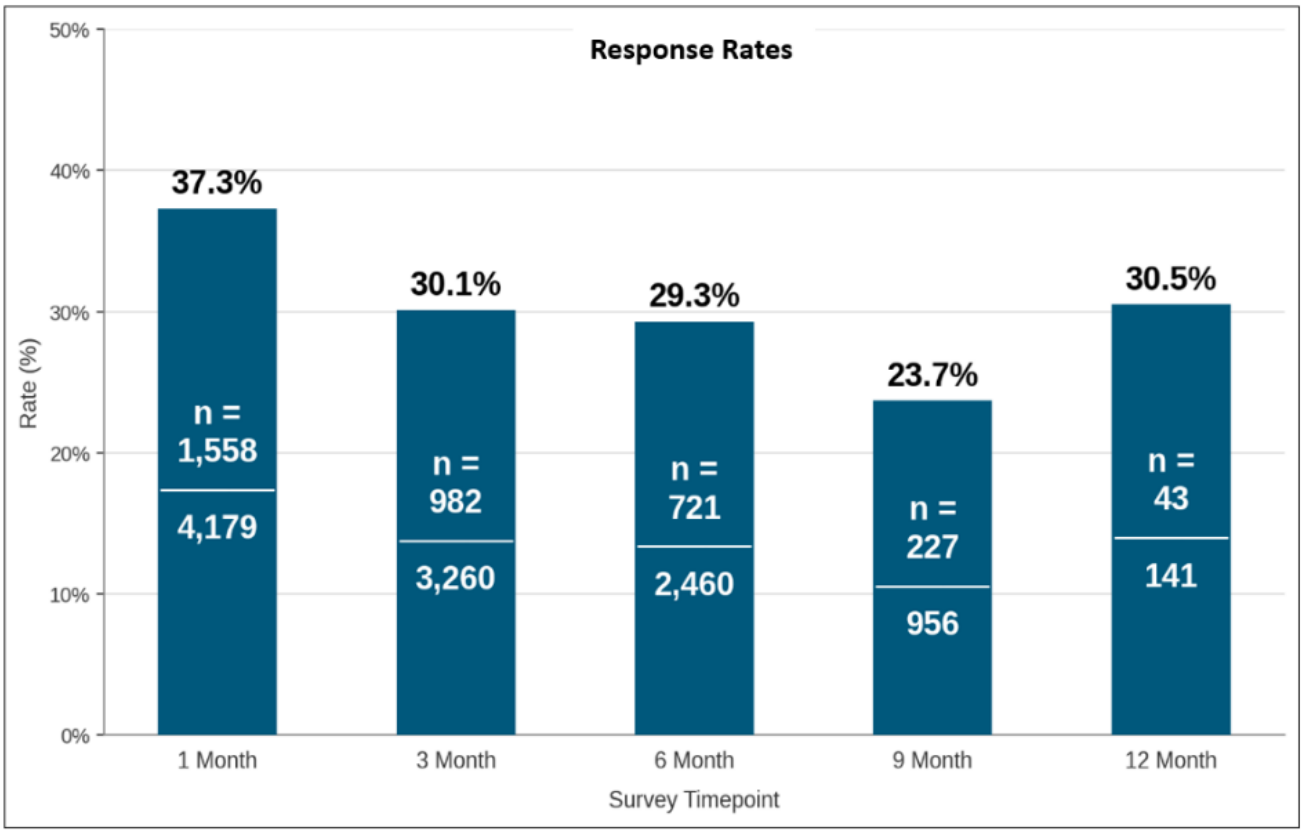
Overall response rates are shown in *Figure 15* and overall response rates by level of care are shown in *Figure 15a*.

Table 7. Characteristics of randomized patients who did and did not complete at least one survey (N=6161)

Variables		Completer (*N* = 2,364)	Non-Completer (*N* = 3,797)
		n (%)	n (%)
Age**	12-17	43 (1.8%)	78 (2.1%)
	18-25	309 (13.1%)	548 (14.4%)
	26-44	937 (39.6%)	1729 (45.5%)
	45-64	914 (38.7%)	1278 (33.7%)
	65+	161 (6.8%)	164 (4.3%)
Birth Sex	Male	1536 (65%)	2383 (62.8%)
	Female	812 (34.3%)	1376 (36.2%)
Gender Identity	Identifies as Male	1522 (64.4%)	2348 (61.8%)
	Identifies as Female	798 (33.8%)	1343 (35.4%)
	Non-Binary	7 (0.3%)	19 (0.5%)
	Transgender Male (Female-to-Male)	4 (0.2%)	5 (0.1%)
	Transgender Female (Male-to Female)	5 (0.2%)	8 (0.2%)
	Other	28 (1.2%)	72 (1.9%)
Sexual Orientation	Straight/Heterosexual	2039 (86.3%)	3278 (86.3%)
	Other	321 (13.6%)	511 (13.5%)
Race	White	2170 (91.8%)	3450 (90.9%)
	Other	194 (8.2%)	347 (9.1%)
Ethnicity	Hispanic/Latino	189 (8%)	333 (8.8%)
	Not Hispanic/Latino	2167 (91.7%)	3444 (90.7%)
Marital Status**	Single – Never Married	986 (41.7%)	1771 (46.6%)
	Married/Life Partner	1040 (44%)	1479 (39%)
	Other	333 (14.1%)	532 (14%)
Educational Attainment†	Less than High School	106 (4.5%)	185 (4.9%)
	High School/GED	376 (15.9%)	671 (17.7%)
	Some College	666 (28.2%)	1026 (27%)
	Bachelors Degree	672 (28.4%)	1049 (27.6%)
	Graduate/Professional Degree	340 (14.4%)	485 (12.8%)
Multiple Substance Use Disorders**	Yes	2280 (96.4%)	3603 (94.9%)
	No	84 (3.6%)	194 (5.1%)
Medical Diagnosis†	Yes	1131 (47.8%)	1732 (45.6%)
	No	1233 (52.2%)	2065 (54.4%)
Mental Health Diagnosis*	Yes	1884 (79.7%)	2923 (77%)
	No	480 (20.3%)	874 (23%)
Substance Use Diagnosis**	Yes	2280 (96.4%)	3604 (94.9%)
	No	84 (3.6%)	193 (5.1%)

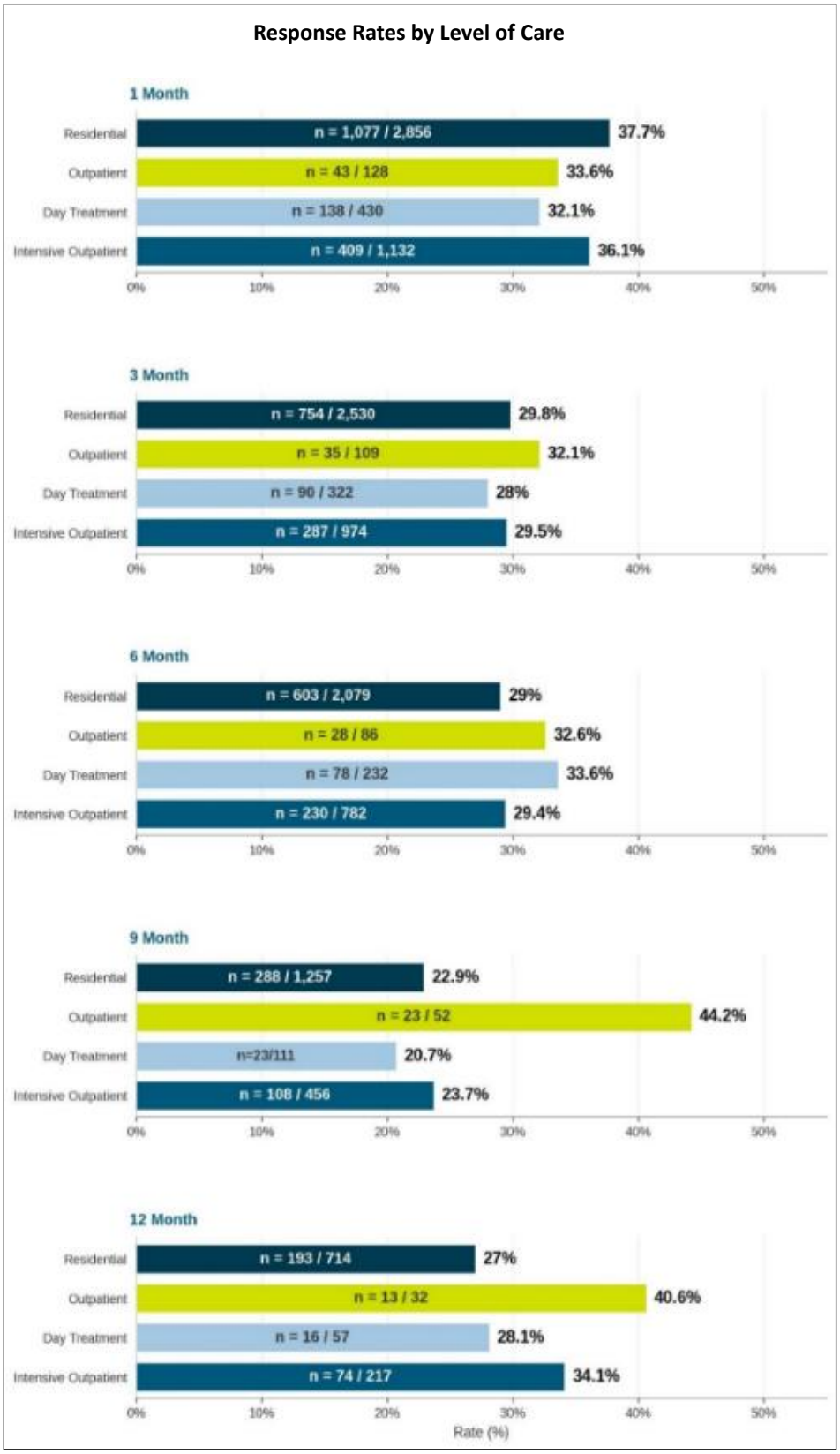
*Differences between randomized and non-randomized groups were assessed using chi-square tests (among categories with adequate n's) and Fisher's exact tests among categories with smaller n's). ** p < .01, * p < .05, † p < .10*
Note: Number of Diagnoses variable categories are not mutually exclusive. Otherwise, where intra-variable category percents do not total 100% it is due to missingness on that variable.

Figure 15. Response rates



NOTE: BCR collected follow-up survey data from patients discharged from adult inpatient and outpatient substance use programs who were randomized to receive post-discharge surveys in 2025. This analysis includes patients whose encounter status was 'Discharged' and who were assigned at least one follow-up survey. Response rates are calculated as the number of completed surveys divided by the number of surveys assigned at each follow-up timepoint (1, 3, 6, 9, and 12 months post-discharge). Response rates for later timepoints (6+ months) may be artificially low as many patients assigned surveys have not yet reached their survey window close date. Number of surveys (# Surveys) assigned/completed includes all surveys with assignment/open dates 60+ days prior to the current date (to capture response rates only among those with ample time to complete assigned surveys; data pulled in early February 2026). This differs from all other table/figure logic to best reflect overall response rates.

Figure 15. Response rates by level of care



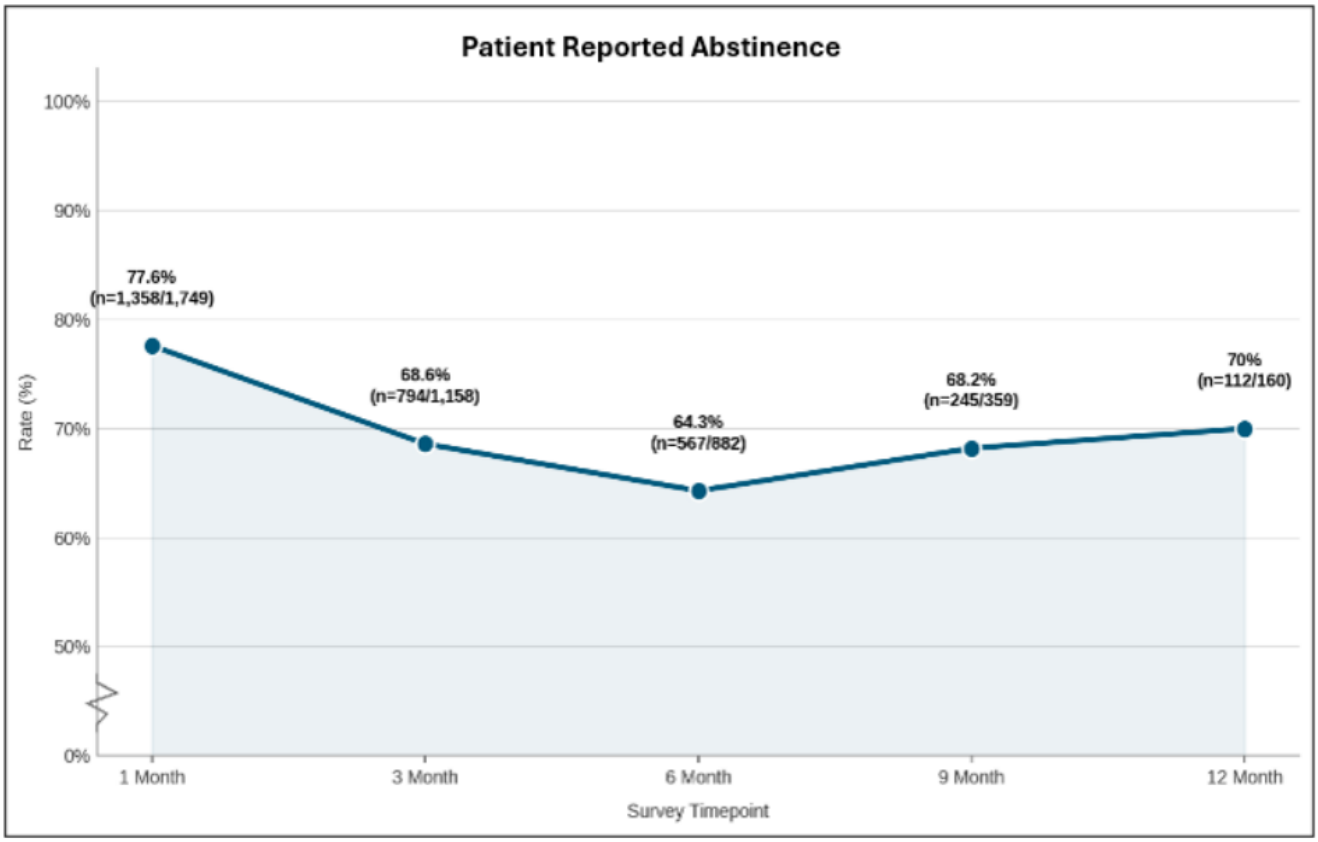
NOTE: Number of surveys (# Surveys) assigned/completed includes all surveys with assignment dates 60+ days prior to the current date (to capture response rates only among those with ample time to complete assigned surveys). This differs from all other table/figure logic to best reflect overall response rates.

Abstinence

Abstinence from alcohol and drugs is a commonly used metric for measuring success in SUD treatment. Patients were asked if they were abstinent from alcohol or drugs since they discharged or since last surveyed. *Figure 16* displays the percentage of patients responding "Yes" to this question at each timepoint. Patient-reported abstinence by level of care is shown in *Figure 16a*.

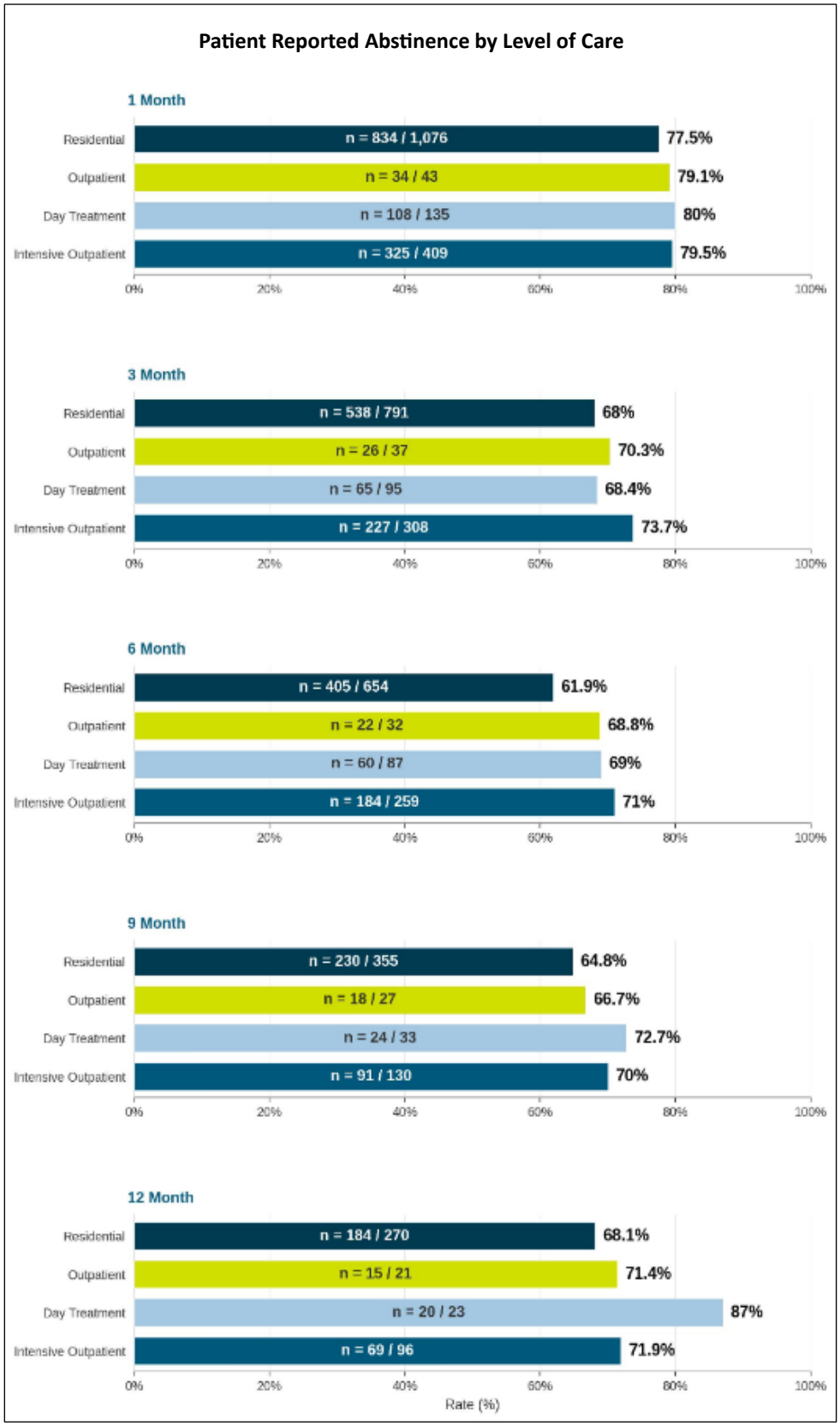
Finally, abstinence as a function of duration of the treatment period (i.e., length of engagement) is shown in *Figure 16b*, analysis revealed a significant positive association between length of engagement and abstinence (i.e., a longer duration of treatment is associated with higher rates of abstinence; $p<0.05$).

Figure 16. Self-reported abstinence



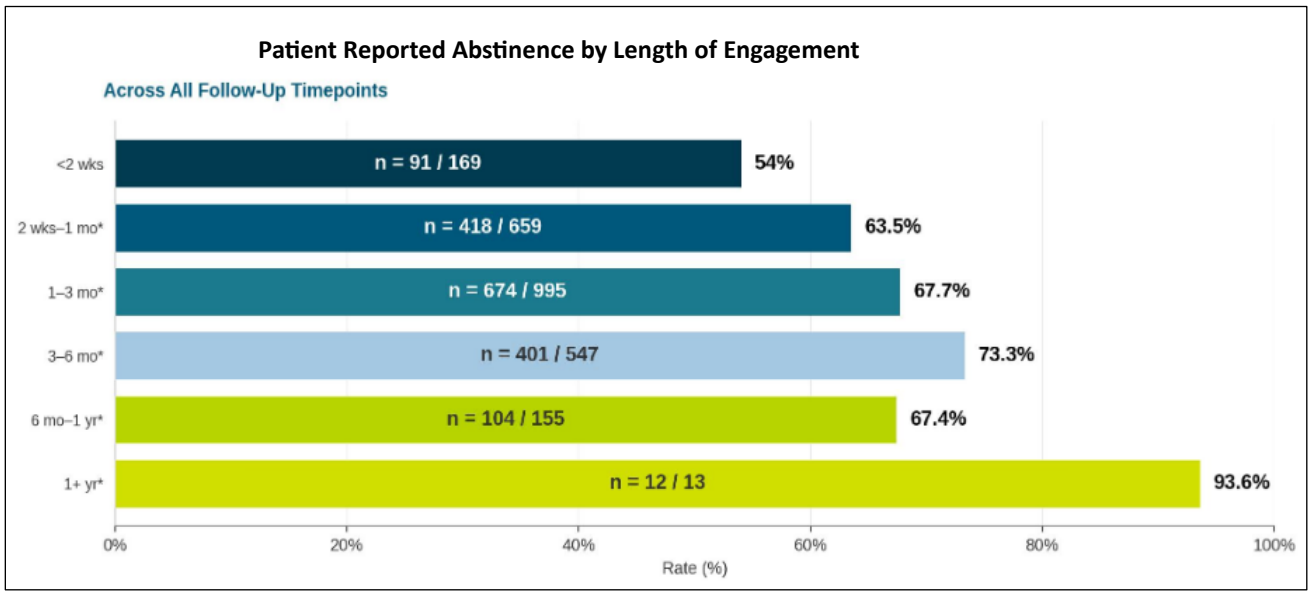
NOTE: Figure 16 is roughly the inverse of Table 3 (in PPR visuals file), where patients first responded to a general abstinence/return to use question (e.g., "have you used any drugs or alcohol"). Number of surveys (# Surveys) includes survey completers (individual patients) with non-missing information on included variables.

Figure 16a. Self-reported abstinence by level of care



NOTE: Number of surveys (# Surveys) includes survey completers (individual patients) with non-missing information on included variables

Figure 16b. Self-reported abstinence by length of engagement



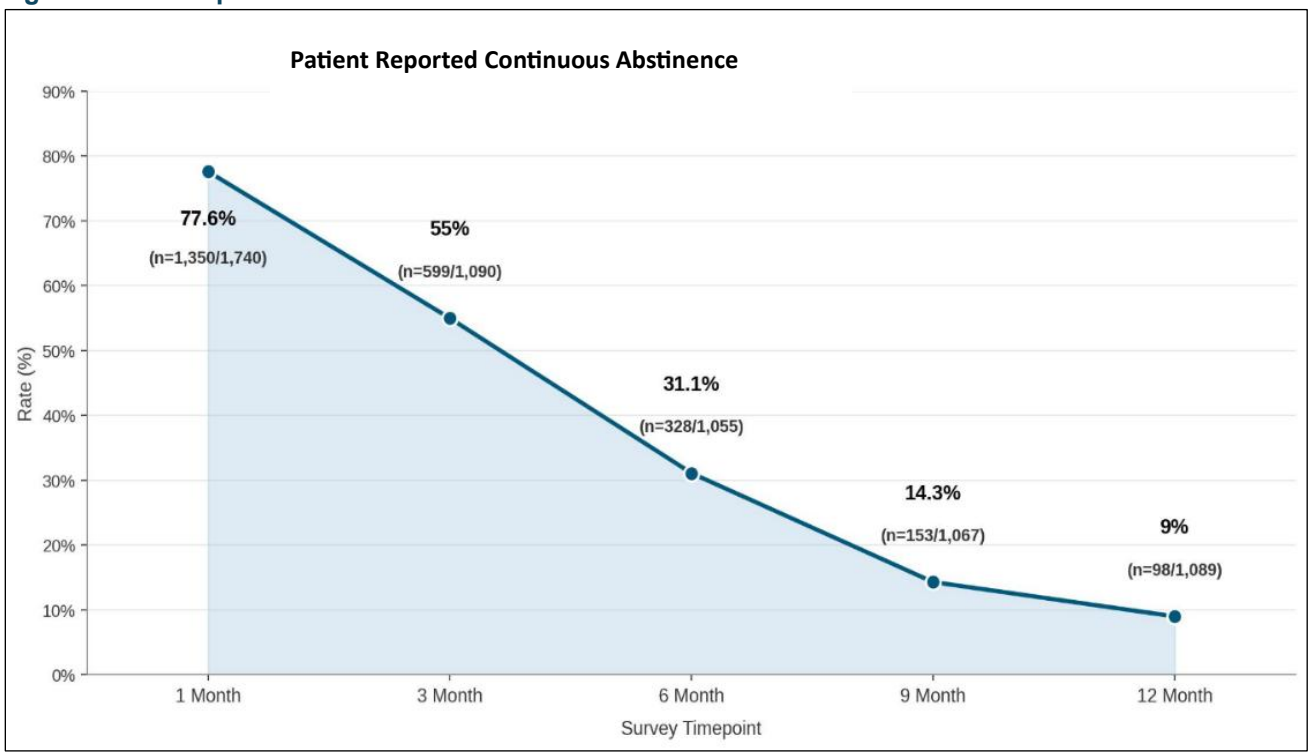
*NOTE: Number of patients (# Patients) includes survey completers (individual patients) with non-missing information on included variables. Level of analysis: Individual patients (one row per patient; ex: 1 pt contributing 5 surveys with abstinence reported 3 of 5 times contributes a personal rate of 60%, and the group rate is the average of all patients' personal rates). Significant differences across length of engagement groups were tested on this outcome measure. Where marked, *p < .05 indicating a significant difference between that LOE group and the baseline LOE group (Up to 2 weeks of LOE) and that there is a less than 5% probability that the observed results occurred by random chance*

Continuous Abstinence

Continuous abstinence is when a patient reports that they've been 100% abstinent since discharge, through the current survey point. *Figure 17* displays the percentage of patients responding "Yes" to this question at each timepoint. Patient-reported continuous abstinence by level of care is shown in *Figure 17a*. Rates of abstinence and continuous abstinence among HBFF patients are notably higher than those in the published literature.[25-28]

Continuous abstinence as a function of duration of the treatment period (i.e., length of engagement) is shown in *Figure 17b*. Analysis revealed a significant positive association between length of stay and continuous abstinence (i.e., a longer duration of treatment is associated with higher rates of abstinence; $p<0.05$).

Figure 17. Self-reported continuous abstinence

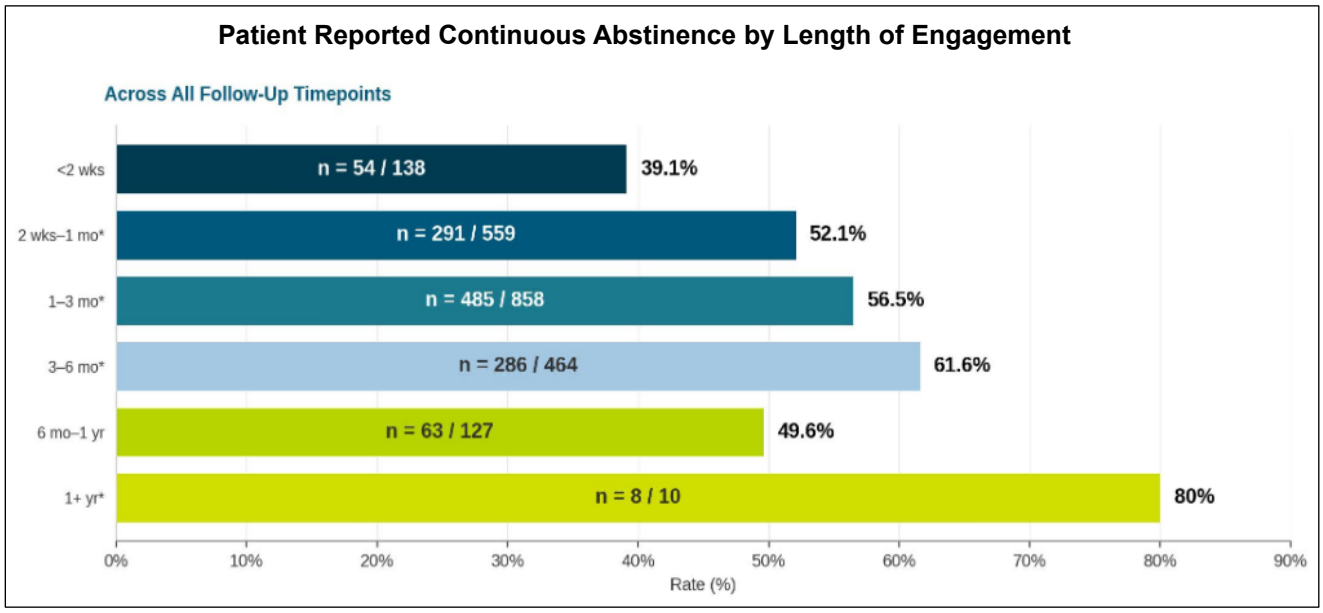


NOTE: Number of surveys (# Surveys) includes survey completers (individual patients) with non-missing information on included variables. Continuous abstinence reflects no return to use since discharge at that survey timepoint. If patients had valid information containing data on continued abstinence since discharge at a later timepoint, gaps in missing data were filled in using this information.

Figure 17a. Self-reported continuous abstinence by level of care

NOTE: Number of surveys (# Surveys) includes survey completers (individual patients) with non-missing information on included variables. Continuous abstinence reflects no return to use since discharge at that survey timepoint. If patients had valid information containing data on continued abstinence since discharge at a later timepoint, gaps in missing data from earlier timepoints were filled in using this information.

Figure 17b. Self-reported continuous abstinence (since discharge/last survey) by length of engagement



*NOTE: Number of patients (# Patients) includes survey completers (individual patients) with non-missing information on included variables. Each patient's continuous abstinence status is at their FURTHEST covered timepoint. A patient is counted as "continuously abstinent" if he/she reported abstinence since discharge through their latest covered timepoint. If patients had valid information containing data on continued abstinence since discharge at a later timepoint, gaps in missing data from earlier timepoints were filled in using this information. Level of analysis: Individual patients (due to cumulative nature of responses). Significant differences across length of engagement groups were tested on this outcome measure. Where marked, *p < .05 indicating a significant difference between that LOE group and the baseline LOE group (Up to 2 weeks of LOE) and that there is a less than 5% probability that the observed results occurred by random chance alone (AKA the significant difference is likely real).*

Recovery Capital

Recovery capital refers to all the internal and external resources that a person can access in support of their recovery process. The BARC-10 is a measure used to the tools and resources a patient has available to support their SUD recovery (i.e., recovery capital).

Average BARC-10 scores are shown in Table 8. BARC-10 scores of 47 or higher that are sustained over time indicate higher chances for long-term recovery.[29] Thus, the percentage of HBFF patients with BARC-10 scores of >47 is shown in *Table 9*. BARC-10 by level of care is shown in *Table 10* and BARC-10 as a function of duration of the length of engagement is shown in *Table 11*.

Table 8. Recovery capital – average BARC-10 score

Timepoint	# Surveys	Average BARC-10 score
1 Month	1627	50.81
3 Month	1062	50.68
6 Month	803	51.39
9 Month	324	51.79
12 Month	153	52.03

NOTE: Number of surveys (# Surveys) includes survey completers (individual patients) with non-missing information on included variables.

Table 9. Percentage of patients with BARC-1O scores of 47+ (indicating likely long-term remission) at 2+ timepoints

Timepoint	# Surveys	47+ score at 2+ timepoints rate (%)
3 Month	689	72.6%
6 Month	936	73.4%
9 Month	1004	74.3%
12 Month	1027	74.7%

NOTE: Number of surveys (# Surveys) includes survey completers (individual patients) with non-missing information on included variables and relevant timepoints. Counts/rates represent a score of 47+ on the BARC-10 across at least 2 timepoints (which may/may not include the current timepoint). Numbers of surveys eligible for inclusion are smaller due to respondents needing to have non-missing information at multiple timepoints (ex: To have ANY data at 3 Months, a respondent must have data at BOTH months 3 and 1. Meanwhile, to have ANY data at 12 Months, a respondent must have data at BOTH month 12 and one+ prior timepoint).

Table 10. Average BARC-10 score by level of care

Timepoint	Level of Care	# Surveys	Average BARC-10 score
1 month	Intensive outpatient	386	52.26
	Day treatment	131	51.76
	Outpatient	39	50.74
	Residential	999	50.36
3 month	Intensive outpatient	287	51.38
	Day treatment	90	51.23
	Outpatient	35	53.77
	Residential	732	50.36
6 month	Intensive outpatient	240	52.56
	Day treatment	80	52.45
	Outpatient	31	52.81
	Residential	599	50.59
9 month	Intensive outpatient	123	53.04
	Day treatment	31	53.48
	Outpatient	26	51.15
	Residential	314	51.44
12 month	Intensive outpatient	90	53.66
	Day treatment	23	53.52
	Outpatient	21	51.10
	Residential	260	51.03

NOTE: Number of surveys (# Surveys) includes survey completers (individual patients) with non-missing information on included variables.

Table 11. Average BARC-10 score by length of engagement

Timepoint	Length of Engagement	# Surveys	Average BARC-10 score
1 month	Up to 2 weeks (0-14 days)	87	48.7
	2 weeks-1 month (15-30 days)	416	50.2
	1-3 months (31-90 days)	665	51.2
	3-6 months (91-180 days)	363	51.4
	6 months-1 year (181-365 days)	89	50.7
	1+ year (366+ days)	7	49.6
3 month	Up to 2 weeks (0-14 days)	50	49.2
	2 weeks-1 month (15-30 days)	266	50.2
	1-3 months (31-90 days)	417	50.4
	3-6 months (91-180 days)	259	51.9
	6 months-1 year (181-365 days)	80	51.1
	1+ year (366+ days)	6	52.8
6 month	Up to 2 weeks (0-14 days)	43	50.8
	2 weeks-1 month (15-30 days)	195	51.5
	1-3 months (31-90 days)	297	50.7
	3-6 months (91-180 days)	216	52.1
	6 months-1 year (181-365 days)	67	52.4
	1+ year (366+ days)	4	49.0
9 month	Up to 2 weeks (0-14 days)	22	50.4
	2 weeks-1 month (15-30 days)	90	51.6
	1-3 months (31-90 days)	141	51.7
	3-6 months (91-180 days)	72	53.19
	6 months-1 year (181-365 days)	25	52.0
	1+ year (366+ days)	5	48.2
12 month	Up to 2 weeks (0-14 days)	7	54.1
	2 weeks-1 month (15-30 days)	54	50.7
	1-3 months (31-90 days)	85	52.5
	3-6 months (91-180 days)	42	51.0
	6 months-1 year (181-365 days)	13	54.3
	1+ year (366+ days)	2	46.5

NOTE: Number of surveys (# Surveys) includes survey completers (individual patients) with non-missing information on included variables. Values from these timepoint-specific descriptive analyses differ from Section E BARC-10 calculations in two ways: (1) Section E pools each patient's BARC-10 totals across all timepoints where they completed all 10 items into a single per-patient mean score; and (2) Section E reports are at the patient level (rather than survey level) to satisfy the independence-of-observations statistical assumption required for significance testing.

Craving

Craving is a core feature of all SUDs and plays a significant role in substance use and relapse.[30] Patients were asked to what extent they experienced craving for their substance(s) of choice. As shown in *Table 12*, at each time point, the majority of patients (i.e., 71-79%) reported having no or mild cravings.

Table 12. Craving for substance(s) of choice (since discharge/last survey)

Timepoint	# Surveys	# No/mild craving	No/mild craving rate (%)
1 month	1754	1260	71.8%
3 month	1157	836	72.3%
6 month	880	649	73.8%
9 month	361	285	78.9%
12 month	160	127	79.4%

NOTE: Number of surveys (# Surveys) includes survey completers (individual patients) with non-missing information on included variables.

Adherence

Adherence to prescribed SUD treatment medications (e.g., acamprosate or naltrexone) was assessed using the question: “Have you taken your anti-craving medication, as prescribed?”

As shown in *Table 13*, of those patients who have a prescription for an anti-craving medication, the majority reported medication compliance. The percentage of patients reporting a prescribed treatment medication decreased throughout the year of follow-up. In *Table 14* medication adherence is shown as a function of SUD diagnosis. Medication adherence was high for all diagnostic groups but was substantially greater among patients with opioid use disorder (OUD).

Table 13. SUD treatment medication prescription and use by follow-up

Timepoint	# Surveys	# SUD Rx	SUD Rx Rate (%)	# SUD Rx & non-missing Rx adherence info	# Take Rx as prescribed	Take Rx as prescribed rate (%)
1 month	1726	770	44.6%	765	599	78.3%
3 month	1152	492	42.7%	487	361	74.1%
6 month	865	327	37.8%	325	239	73.5%
9 month	363	109	30.0%	108	83	76.9%
12 month	164	54	32.9%	54	40	74.1%

NOTE: Number of surveys (# Surveys) includes survey completers (individual patients) with non-missing information on included variables.
Counts/rates of those taking medication as prescribed (# Take Rx as prescribed/rate) calculated only among those with an Rx. "Rx" = Prescription.

Table 14. SUD treatment medication prescription and use by diagnosis

Timepoint	# Surveys	# SUD Rx	SUD Rx Rate (%)	# SUD Rx & non-missing Rx adherence info	# Take Rx as prescribed	Take Rx as prescribed rate (%)
Alcohol use disorder	1823	873	47.9%	865	674	77.9%
Opioid use disorder	87	56	64.4%	55	51	92.7%
Stimulant use disorder	98	24	24.5%	23	17	73.9%
Alcohol and opioid use disorder	176	98	55.7%	98	78	79.6%

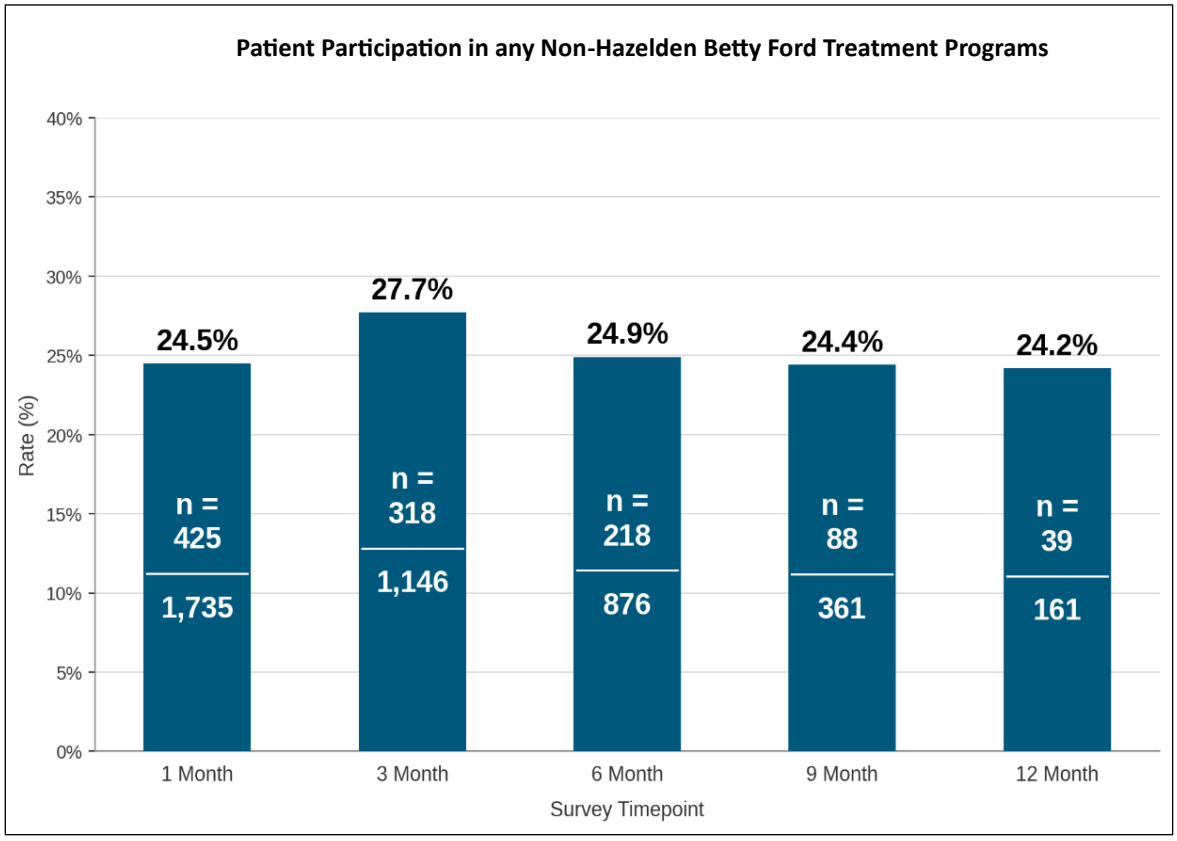
NOTE: Number of surveys (# Surveys) includes survey completers (individual patients) with non-missing information on included variables.
Counts/rates of those taking medication as prescribed (# Take Rx as prescribed/rate) calculated only among those with an Rx. "Rx" = Prescription.

Continuing care

Continuing care or "aftercare" is often used to describe treatment that follows an initial episode of care. Continuing care includes a variety of modalities such as peer-recovery support and/or self-help meetings. Active participation in continuing care has been shown to increase positive SUD treatment outcomes.[31]

Patients were asked if they participated in any non-Hazelden Betty Ford addiction treatment programs or services since discharge/last follow-up survey (*Figure 18*).

Figure 18. Percent participation in any non-Hazelden Betty Ford TX programs (since discharge/last survey)



NOTE: Number of surveys (# Surveys) includes survey completers (individual patients) with non-missing information on included variables. "Tx" = Treatment.

Table 15. Peer recovery group support attendance frequency (since discharge/last survey)

Timepoint	# Surveys	Daily	4+ times/week	1-3 times/week	2-4 times/month	1 time/month or less	Never
1 month	1757	11.3% (199)	18.3% (321)	40.5% (711)	6.4% (113)	5.6% (99)	17.9% (314)
3 month	1152	7.2% (83)	13.4% (154)	41.3% (476)	9.5% (109)	9.1% (105)	19.5% (225)
6 month	881	5.1% (45)	12.4% (109)	39.0% (344)	8.1% (71)	11.4% (100)	24.1% (212)
9 month	366	4.1% (15)	10.4% (38)	36.9% (135)	8.7% (32)	12.3% (45)	27.6% (101)
12 month	162	4.9% (8)	12.3% (20)	37.0% (60)	6.8% (11)	14.2% (23)	24.7% (40)

NOTE: Number of surveys (# Surveys) includes survey completers (individual patients) with non-missing information on included variables. Values represent percents (%) and counts (#).

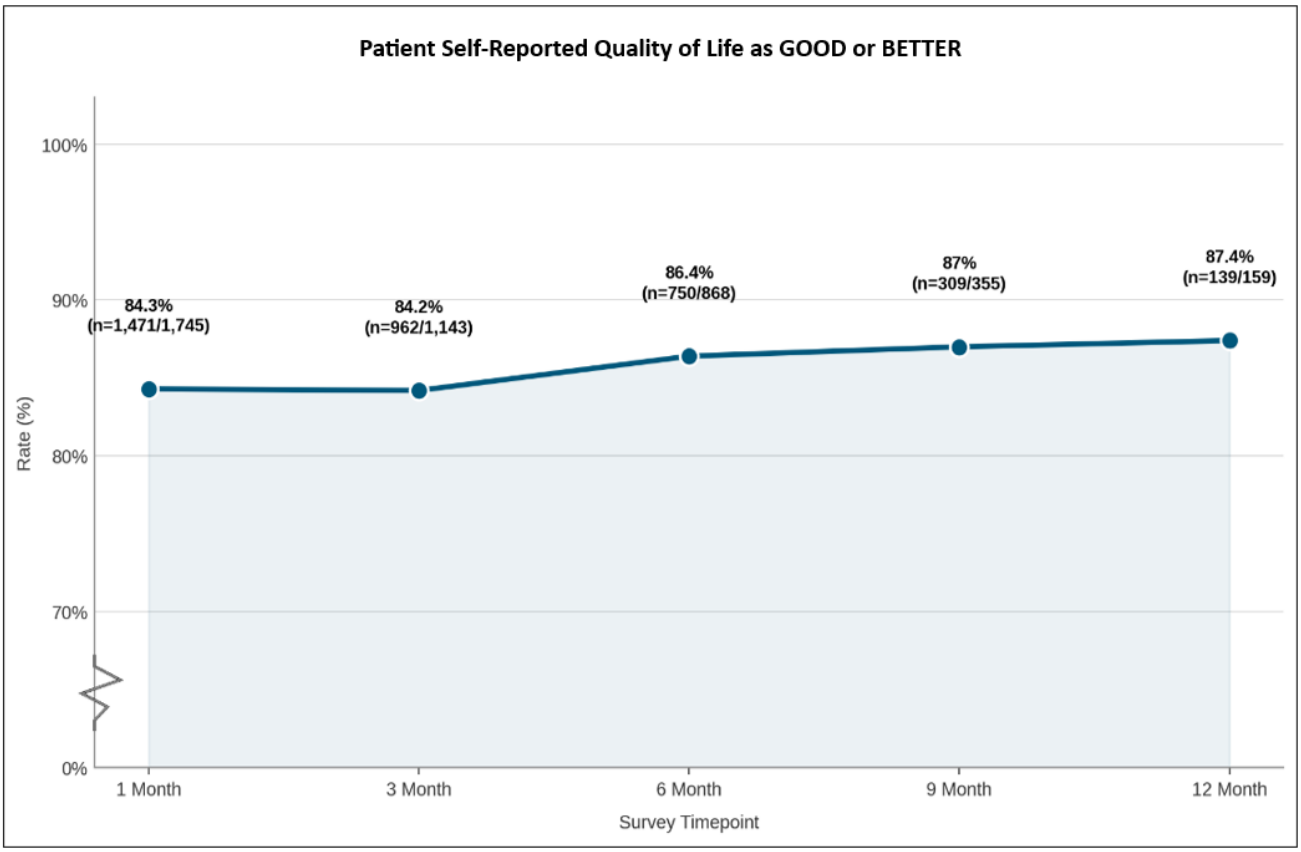
Quality of Life

Quality of life has been increasingly recognized as an important indicator of holistic recovery for individuals with SUDs. Consideration of an individual's quality of life can benefit assessment and treatment of addictive disorders.[34]

Patients were asked to rate their overall quality of life on a scale from poor to excellent. A significant portion of patients rated their quality of life as good or better at every survey follow-up period (*Figure 19*). Generally, quality of life is notably higher among HBFF-treated patients than what is typically reported in the scientific literature.[32-34]

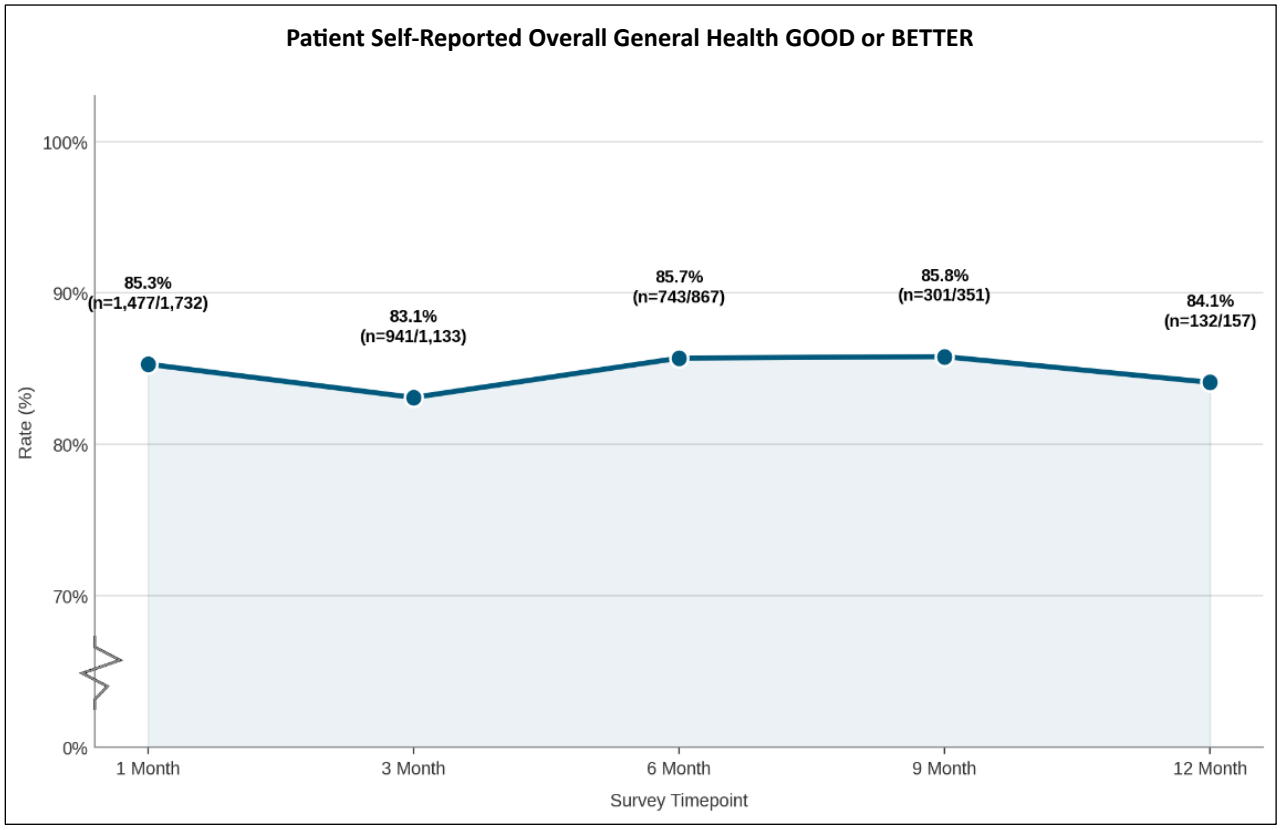
Similarly, patients were asked to rate their overall general health on a scale from poor to excellent. Ratings were high at every survey follow-up period (*Figure 20*).

Figure 19. Patient self-reported overall quality of life as GOOD or BETTER



NOTE: Number of surveys (# Surveys) includes survey completers (individual patients) with non-missing information on included variables.

Figure 20. Patient self-reported overall general health as GOOD or BETTER



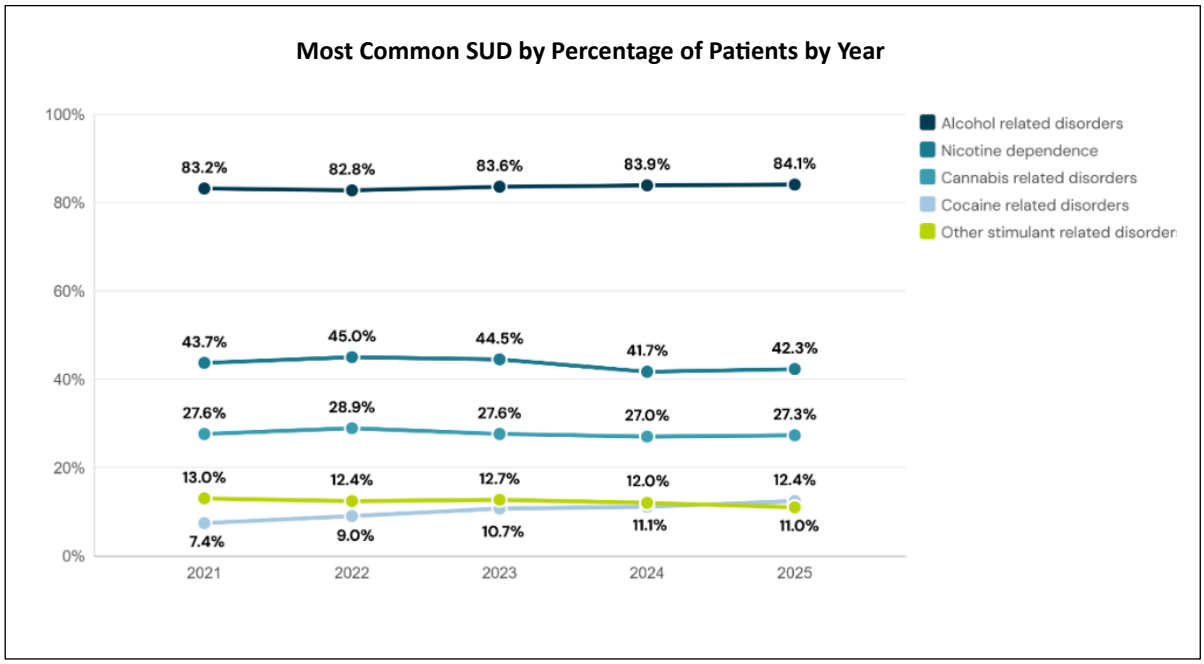
NOTE: Number of surveys (# Surveys) includes survey completers (individual patients) with non-missing information on included variables.

V. FIVE-YEAR TREND DATA

Are there any trends to identify?

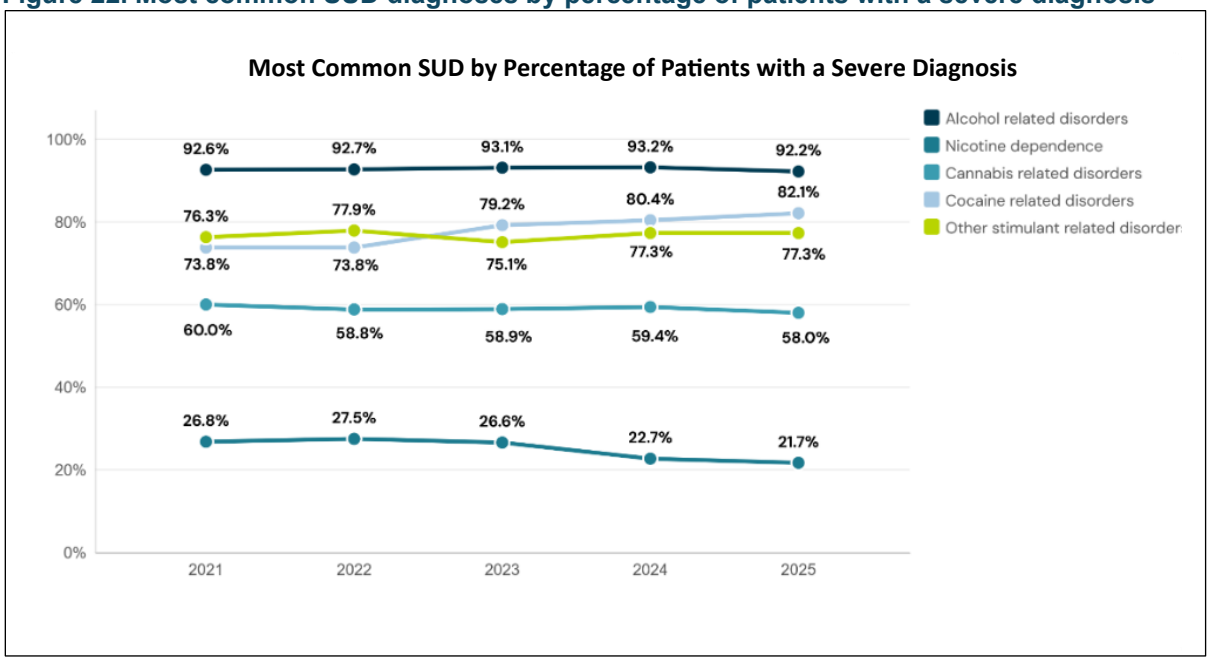
This section outlines important patient information over the past five years. Trend data helps to identify patterns that can improve operational efficiency and patient safety and outcomes.

Figure 21. Most common SUD diagnoses by percentage of patients by year



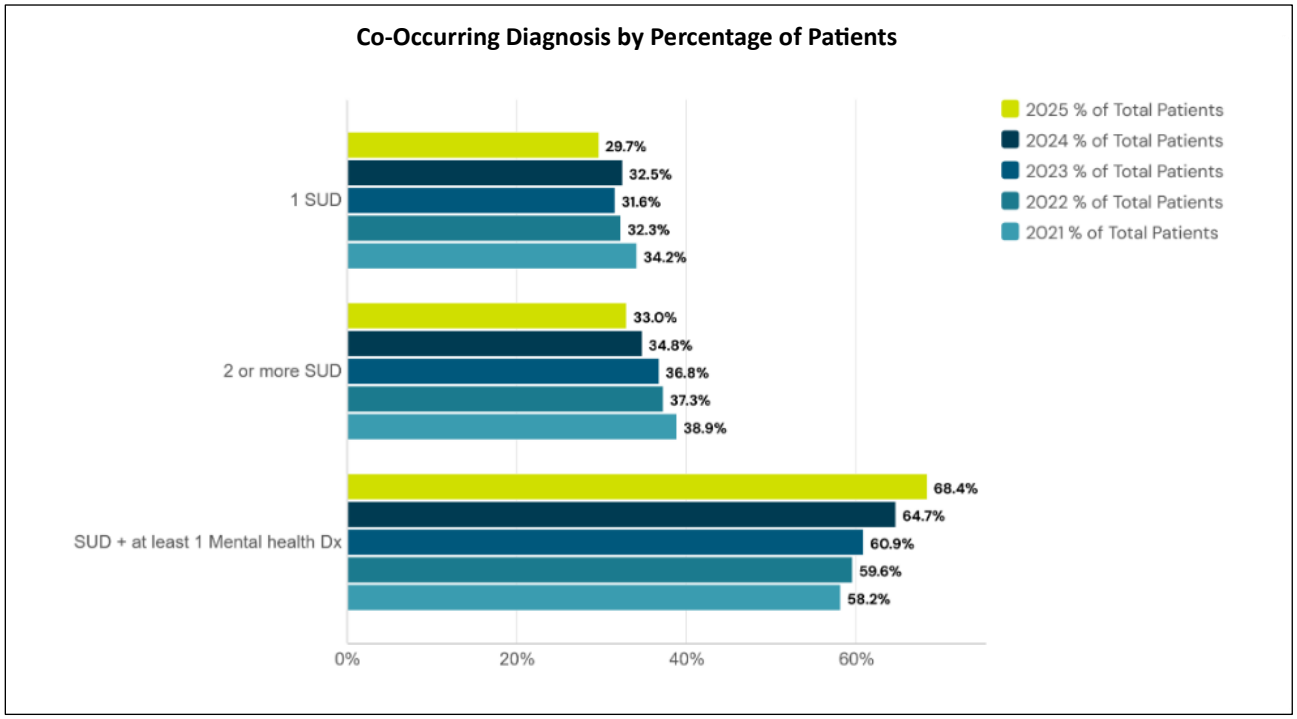
Alcohol-related disorders were the most commonly diagnosed each year for the past 5 years.

Figure 22. Most common SUD diagnoses by percentage of patients with a severe diagnosis



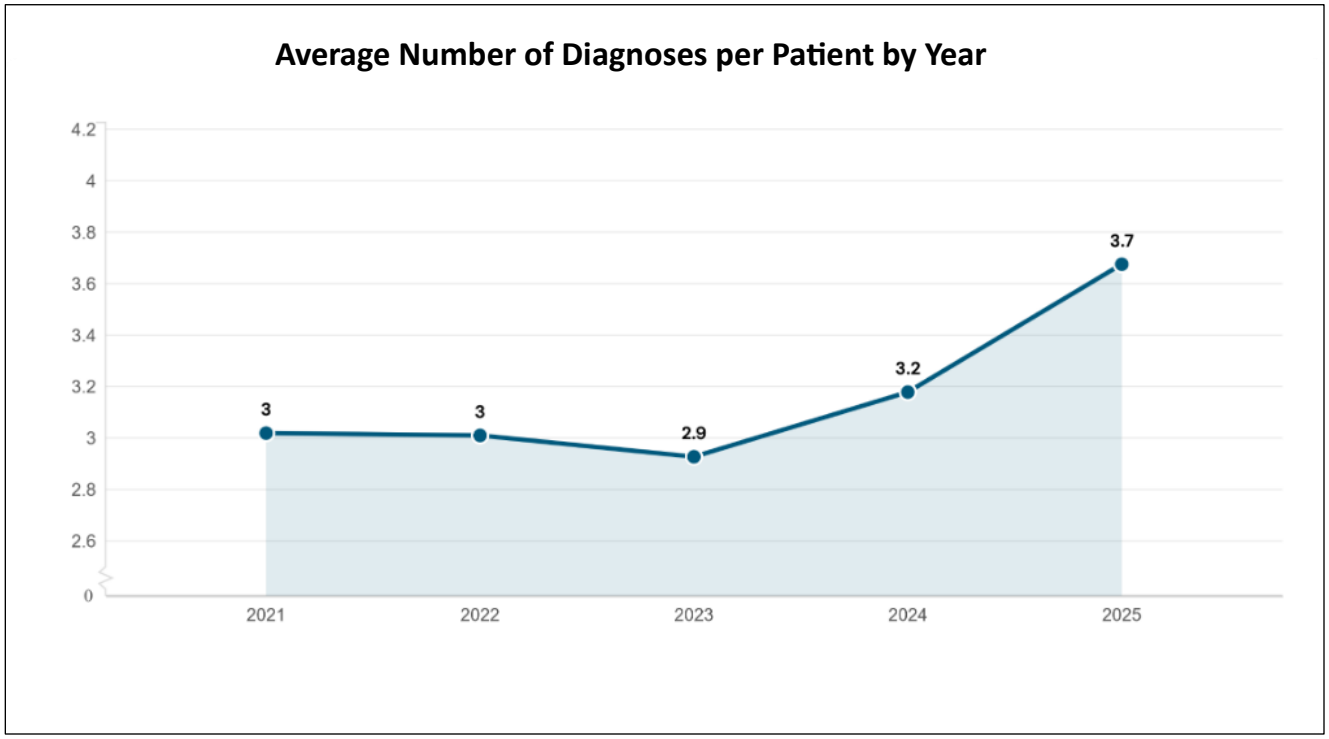
Alcohol-related disorders were diagnosed as the most severe each year for the past 5 years.

Figure 23. Co-occurring SUD diagnoses by percentage of patients



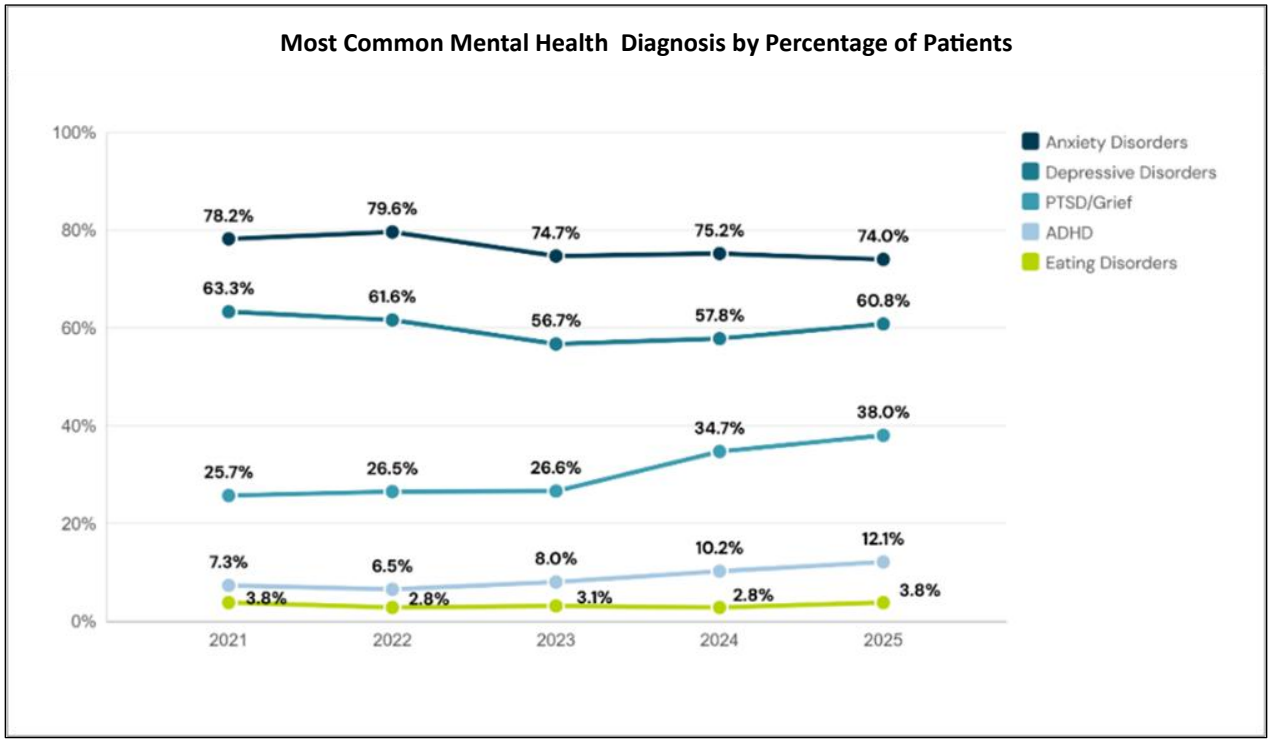
Over the past 5 years, the most patients had SUD and at least 1 mental health diagnosis.

Figure 24. Average number of diagnoses per patient by year



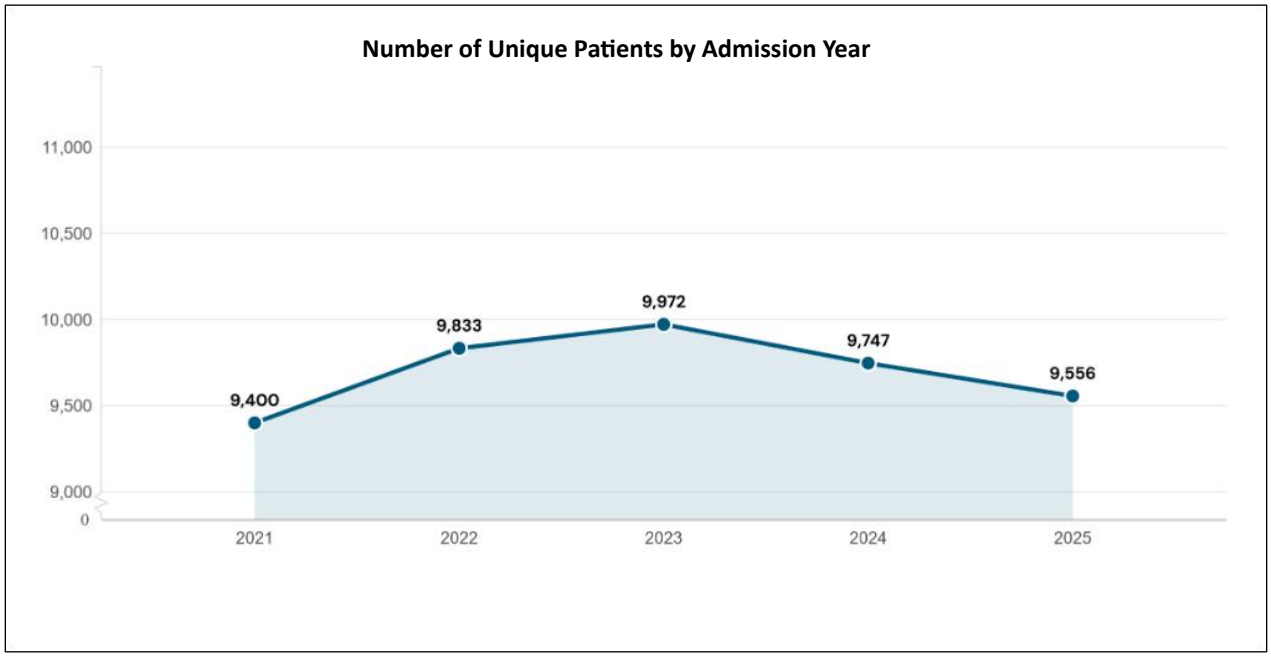
The average number of diagnoses per patient was found to be consistent over the past 5 years.

Figure 25. Most common mental health diagnoses by percentage of patients



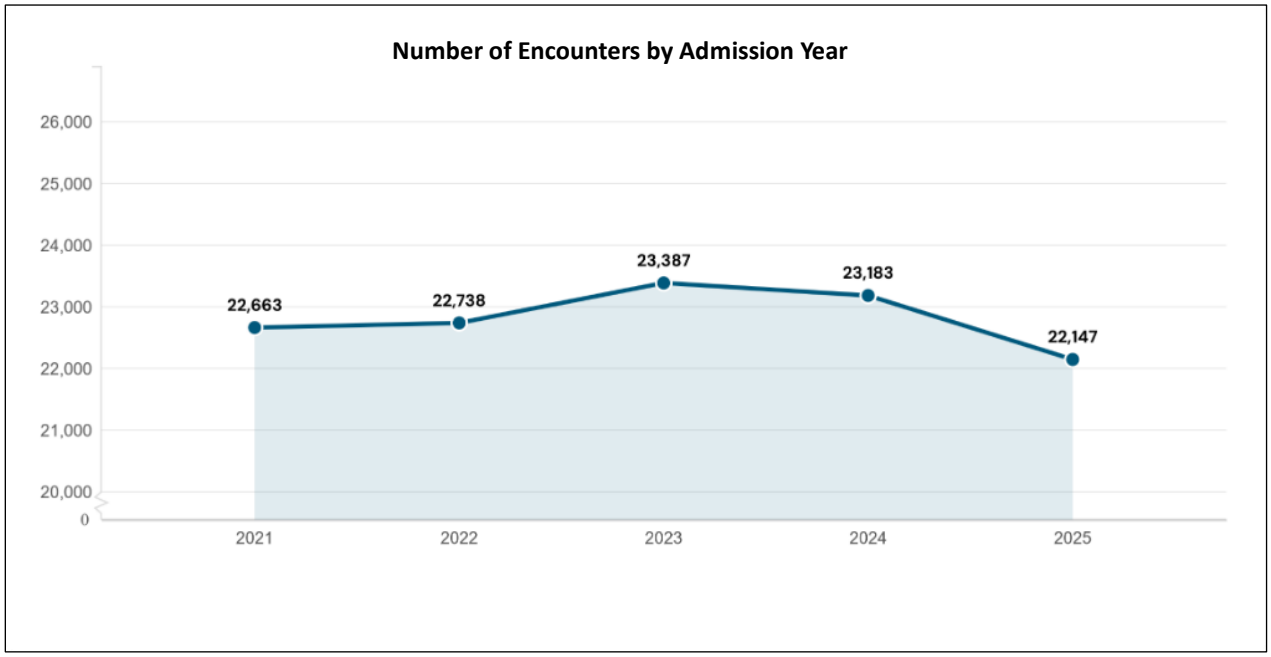
Anxiety disorders were the most common dual diagnoses each year for the past 5 years.

Figure 26. Number of unique patients by admission year



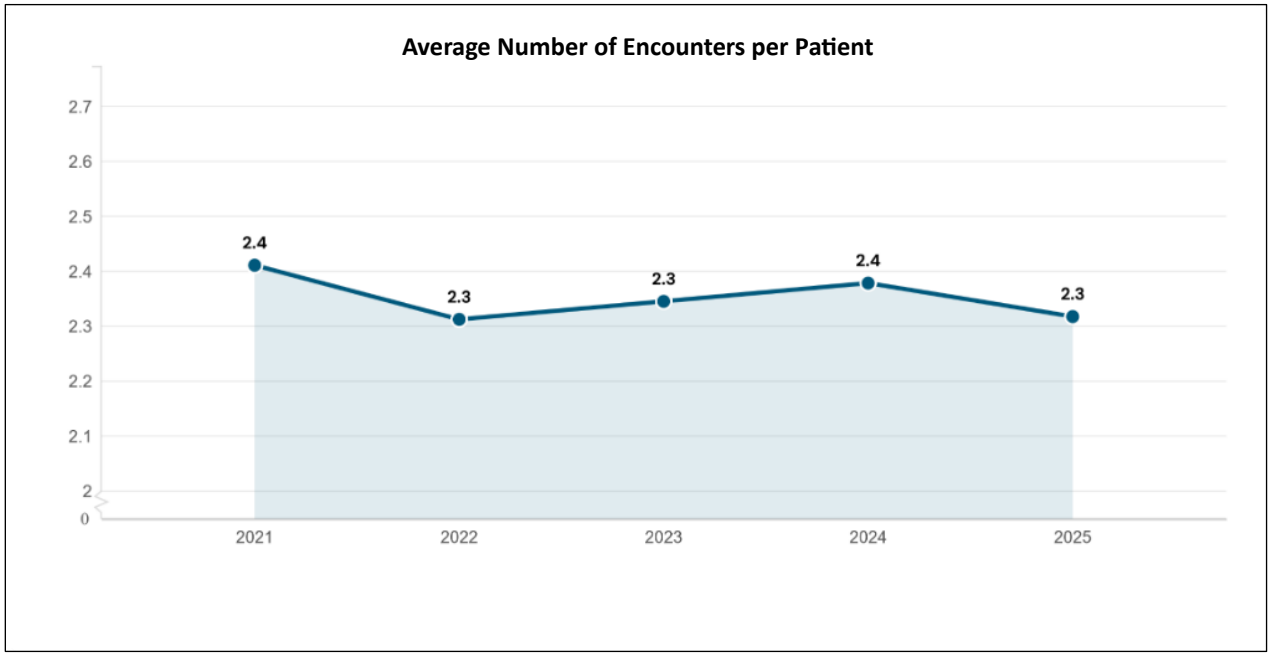
The number of patients admitted decreased each year for the past 2 years.

Figure 27. Number of encounters by admission year



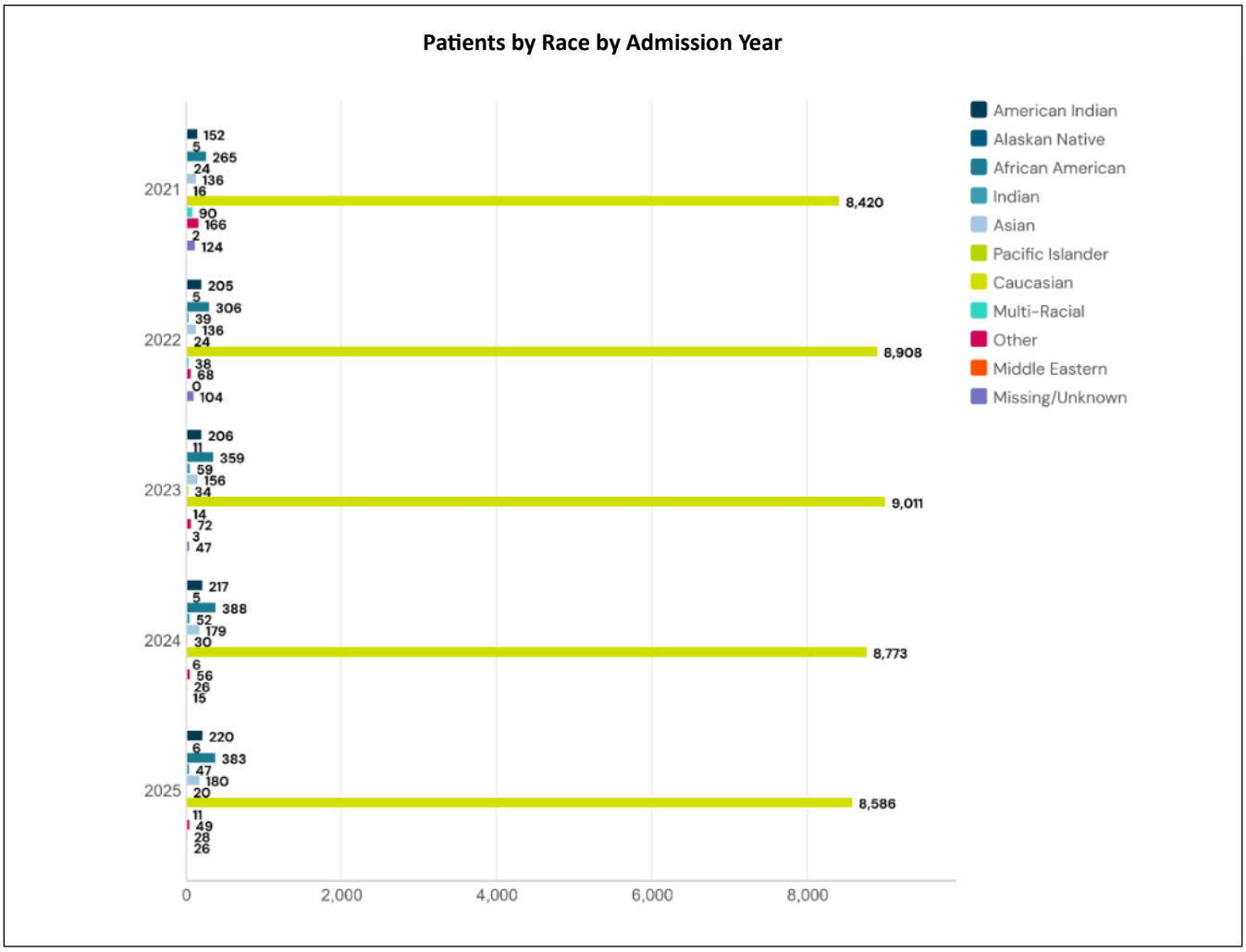
The number of unique encounters decreased each year for the past 2 years.

Figure 28. Average number of encounters per patient



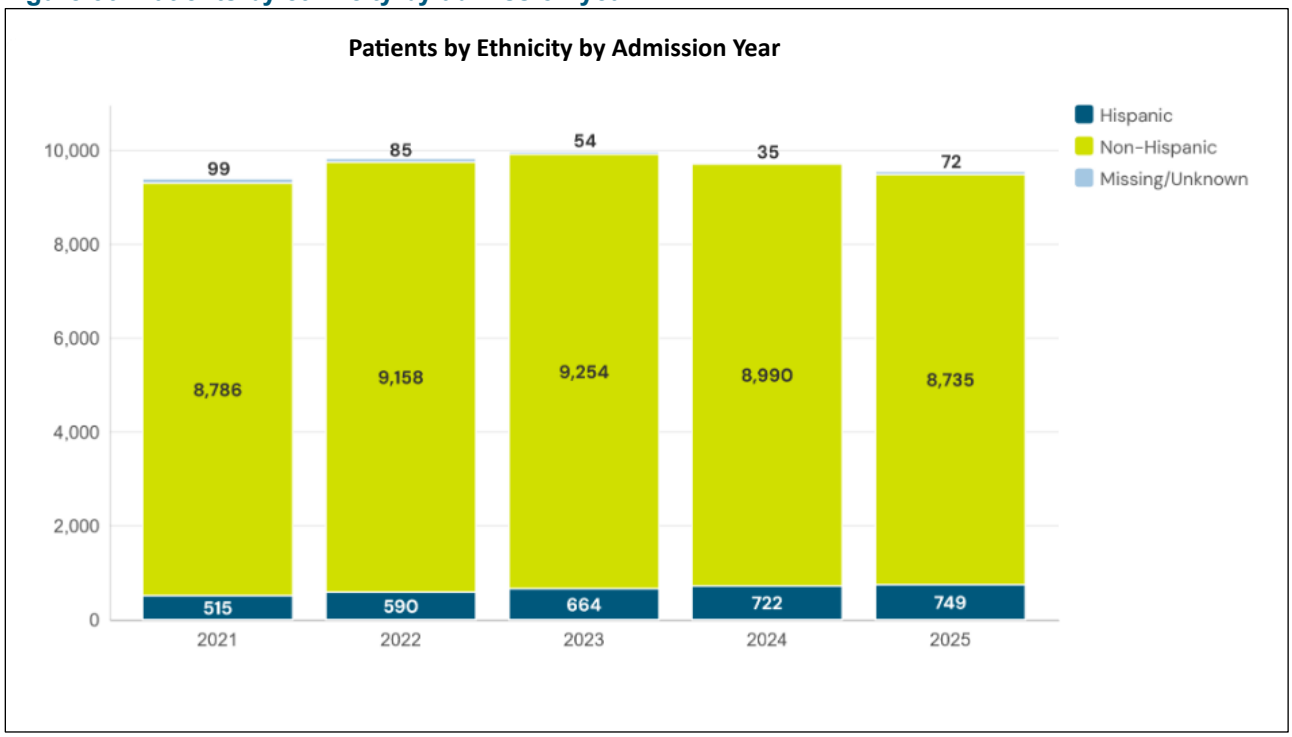
The average number of encounters per patient was relatively consistent over the past year, only varying by ±0.1.

Figure 29. Patients by race by admission year



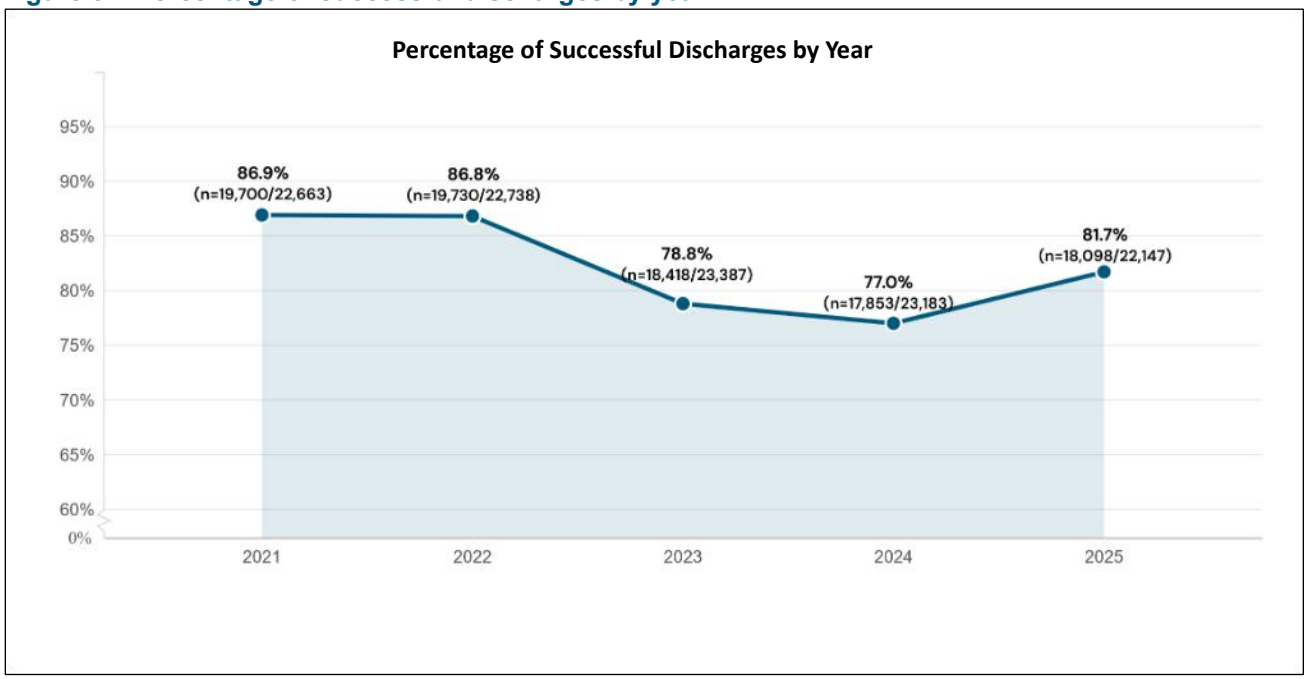
The majority of patients identified as Caucasian over the past 5 years.

Figure 30. Patients by ethnicity by admission year



The majority of patients identified as non-Hispanic over the past 5 years.

Figure 31. Percentage of successful discharges by year



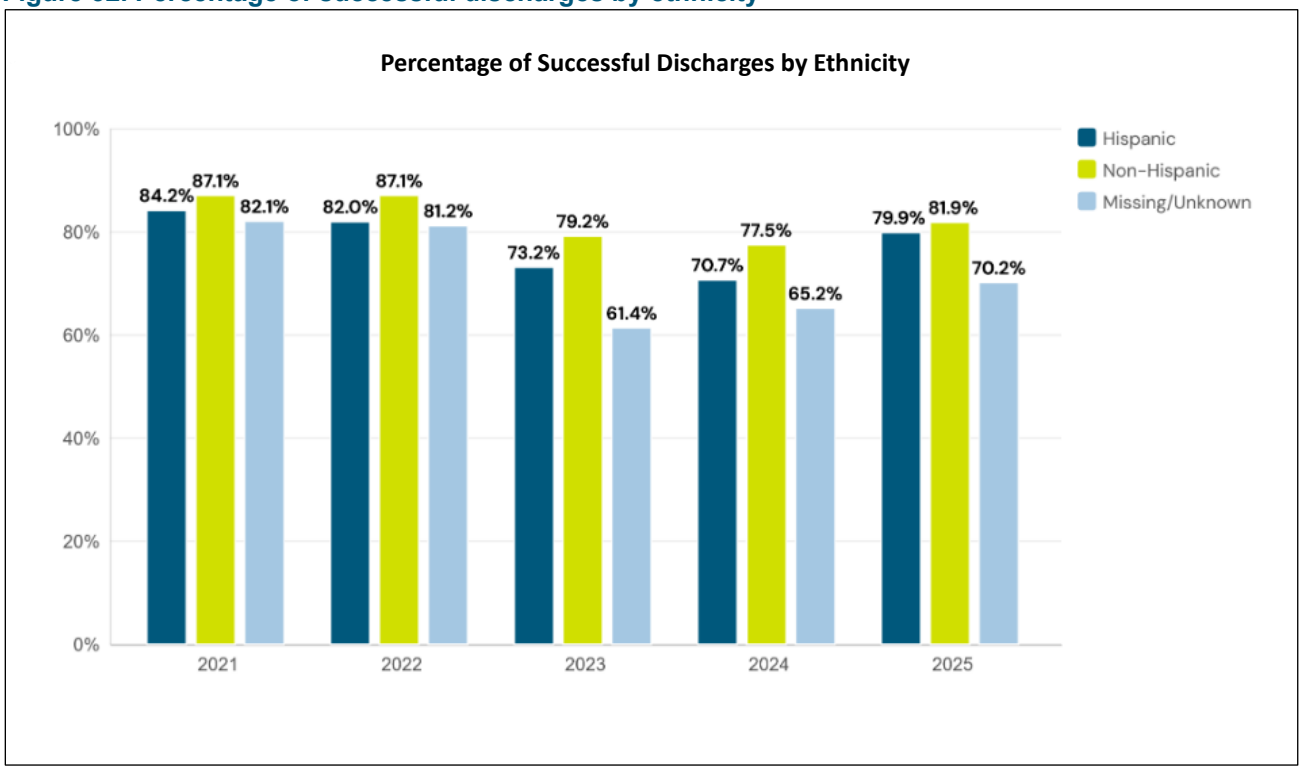
Successful discharges are all discharges that are not AMA or Administrative discharges.
In 2025, the number of successful discharges were greater than the past two years.

Table 16. Percentage of successful discharges by race

Percentage of Successful Discharges by Race											
	African American	Alaskan Native	American Indian	Asian	Caucasian	Indian	Middle Eastern	Missing/ Unknown	Multi-Racial	Other	Pacific Islander
2025	78.3%	0.0%	76.8%	82.5%	82.0%	82.6%	63.8%	81.8%	70.6%	70.9%	81.4%
2024	73.2%	0.0%	74.9%	70.3%	77.5%	68.0%	60.6%	63.6%	41.7%	79.4%	66.2%
2023	75.2%	0.0%	73.0%	73.1%	79.2%	70.1%	80.0%	72.6%	47.4%	70.8%	81.8%
2022	81.1%	0.0%	85.4%	84.9%	87.1%	82.3%	0.0%	81.8%	78.0%	77.2%	82.0%
2021	85.7%	0.0%	84.3%	86.6%	87.1%	83.3%	83.3%	81.4%	88.4%	70.9%	83.9%

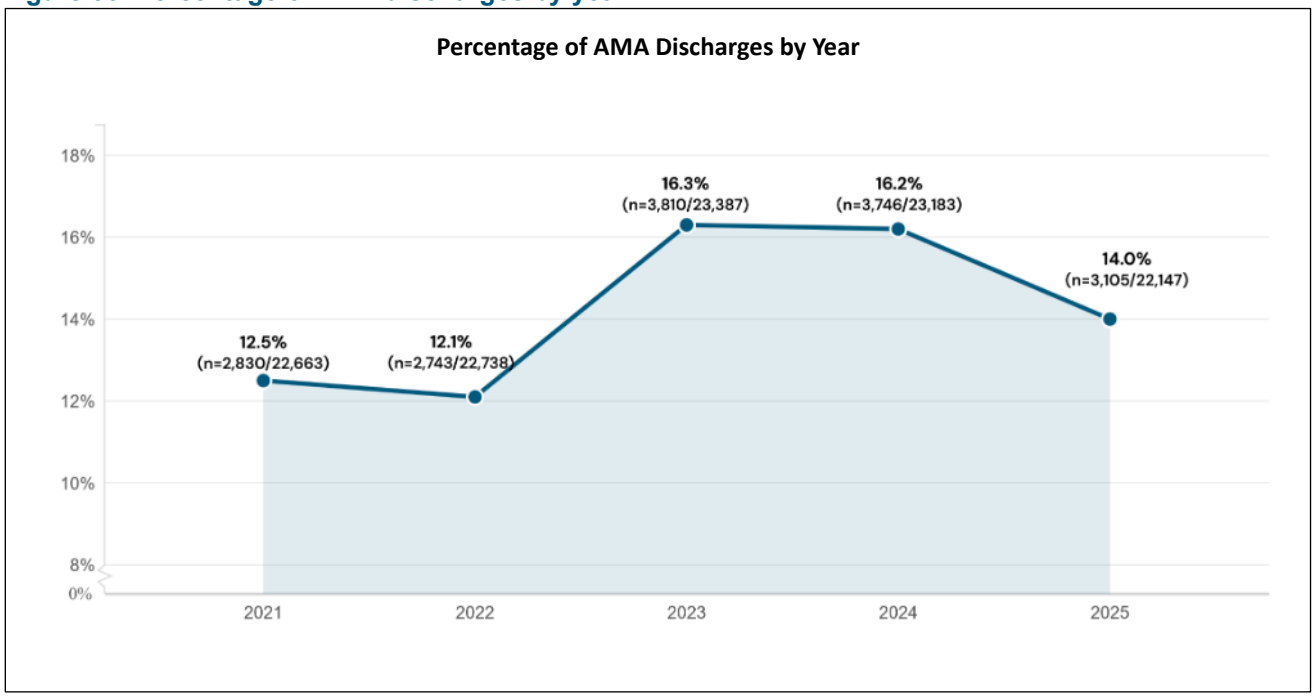
Caucasian patients were less likely to be administratively discharged. This finding is generally consistent over the past 5 years.

Figure 32. Percentage of successful discharges by ethnicity



The data indicates a slight decrease in successful discharge rates over the past 3 years, across all ethnic groups.

Figure 33. Percentage of AMA discharges by year



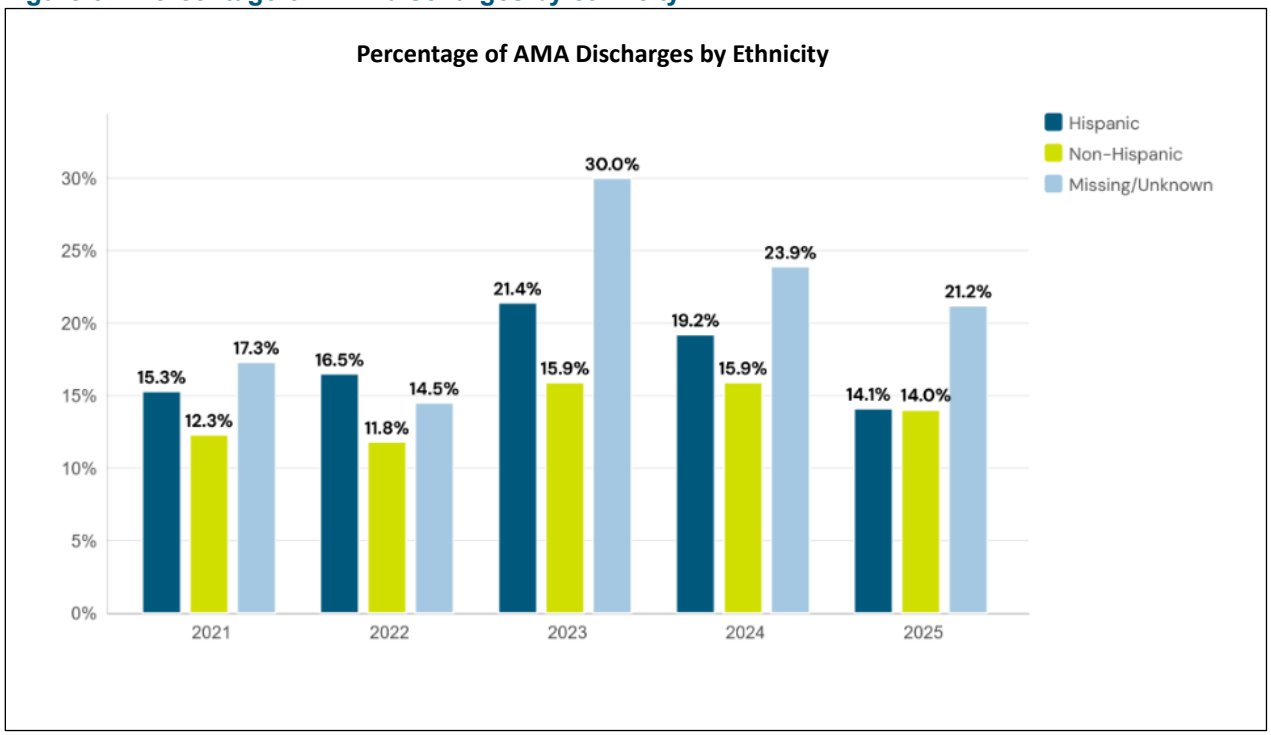
The percentage of AMA discharges decreased over the past two years.

Table 17. Percentage of AMA discharges by race

Percentage of AMA Discharges by Race											
	African American	Alaskan Native	American Indian	Asian	Caucasian	Indian	Middle Eastern	Missing/ Unknown	Multi-Racial	Other	Pacific Islander
2025	16.6%	57.1%	17.5%	12.3%	13.8%	14.8%	31.9%	9.1%	23.5%	20.9%	18.6%
2024	19.0%	0.0%	18.6%	18.6%	15.8%	21.9%	27.3%	22.7%	58.3%	14.7%	20.6%
2023	19.3%	14.3%	21.8%	18.5%	15.9%	23.1%	20.0%	19.4%	42.1%	24.2%	12.5%
2022	17.3%	33.3%	13.9%	13.5%	11.8%	16.5%	0.0%	13.6%	15.3%	20.7%	14.0%
2021	13.9%	0.0%	15.4%	12.5%	12.3%	16.7%	16.7%	15.7%	11.6%	14.2%	16.1%

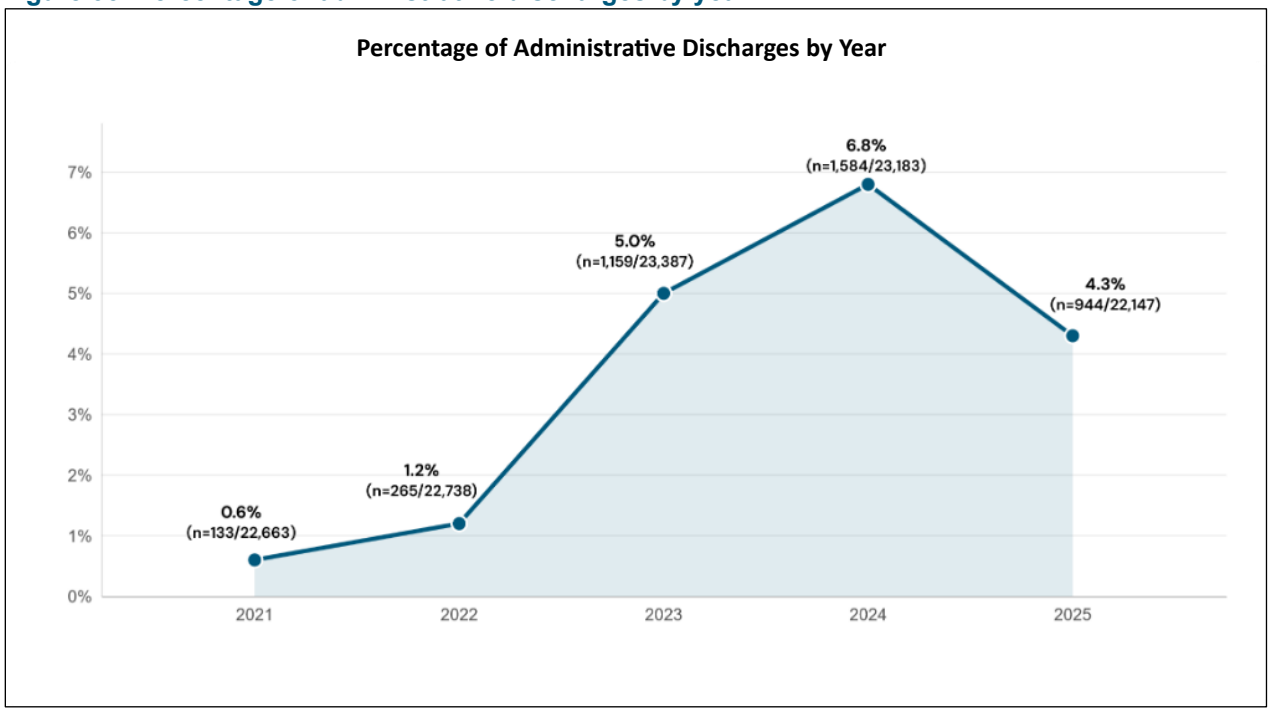
Caucasian patients were less likely to be discharged AMA. This finding is generally consistent over the past 5 years.

Figure 34. Percentage of AMA discharges by ethnicity



Non-Hispanic patients were less likely to be discharged AMA, over the past 5 years.

Figure 35. Percentage of administrative discharges by year



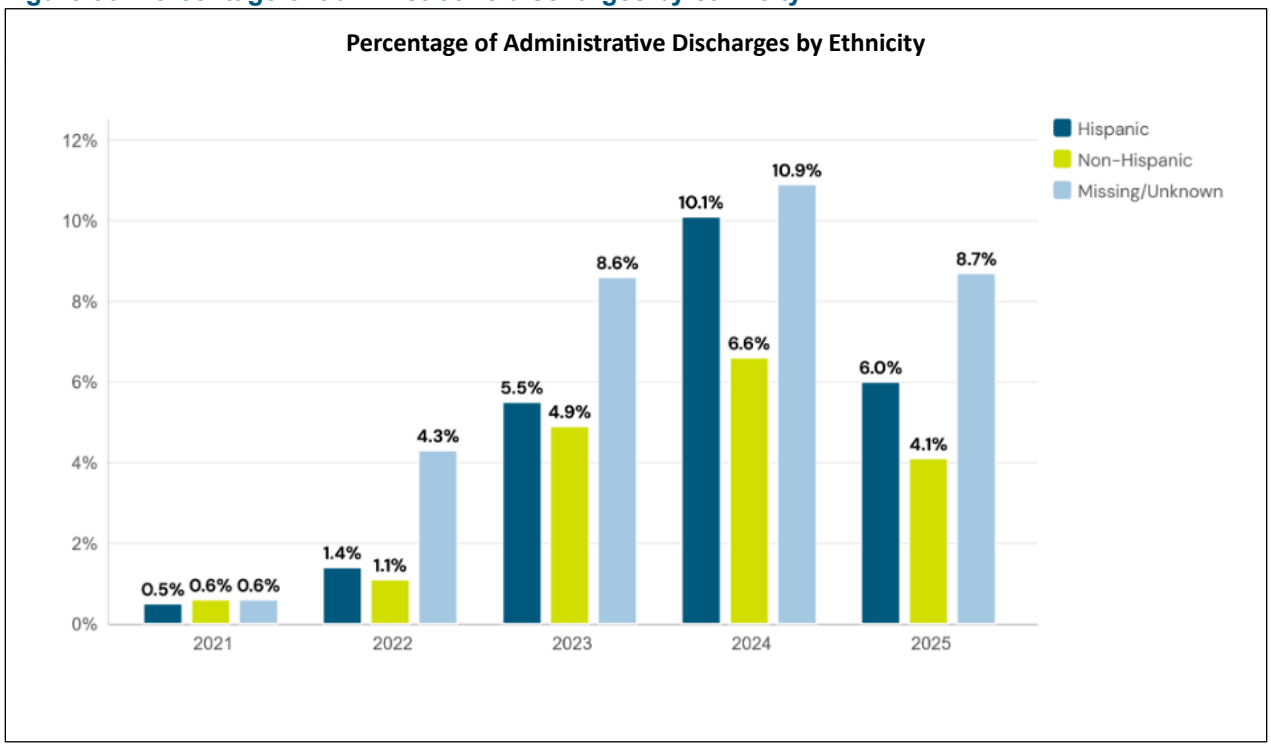
The percentage of administrative discharges in 2025 was lower in comparison to 2024 and 2023, but higher than 2022 and 2021.

Table 18. Percentage of administrative discharges by race

Percentage of Administrative Discharges by Race											
	African American	Alaskan Native	American Indian	Asian	Caucasian	Indian	Middle Eastern	Missing/ Unknown	Multi-Racial	Other	Pacific Islander
2025	5.0%	0.0%	5.7%	5.2%	4.2%	2.6%	4.3%	9.1%	5.9%	8.1%	18.6%
2024	7.9%	0.0%	6.4%	11.0%	6.7%	10.2%	12.1%	13.6%	0.0%	5.8%	20.6%
2023	5.5%	10.7%	5.2%	8.4%	4.8%	6.8%	0.0%	8.1%	10.5%	5.0%	12.5%
2022	1.5%	11.1%	0.7%	1.6%	1.1%	1.3%	0.0%	4.5%	6.8%	2.2%	14.0%
2021	0.4%	0.0%	0.3%	0.8%	0.6%	0.0%	0.0%	2.9%	0.0%	0.6%	16.1%

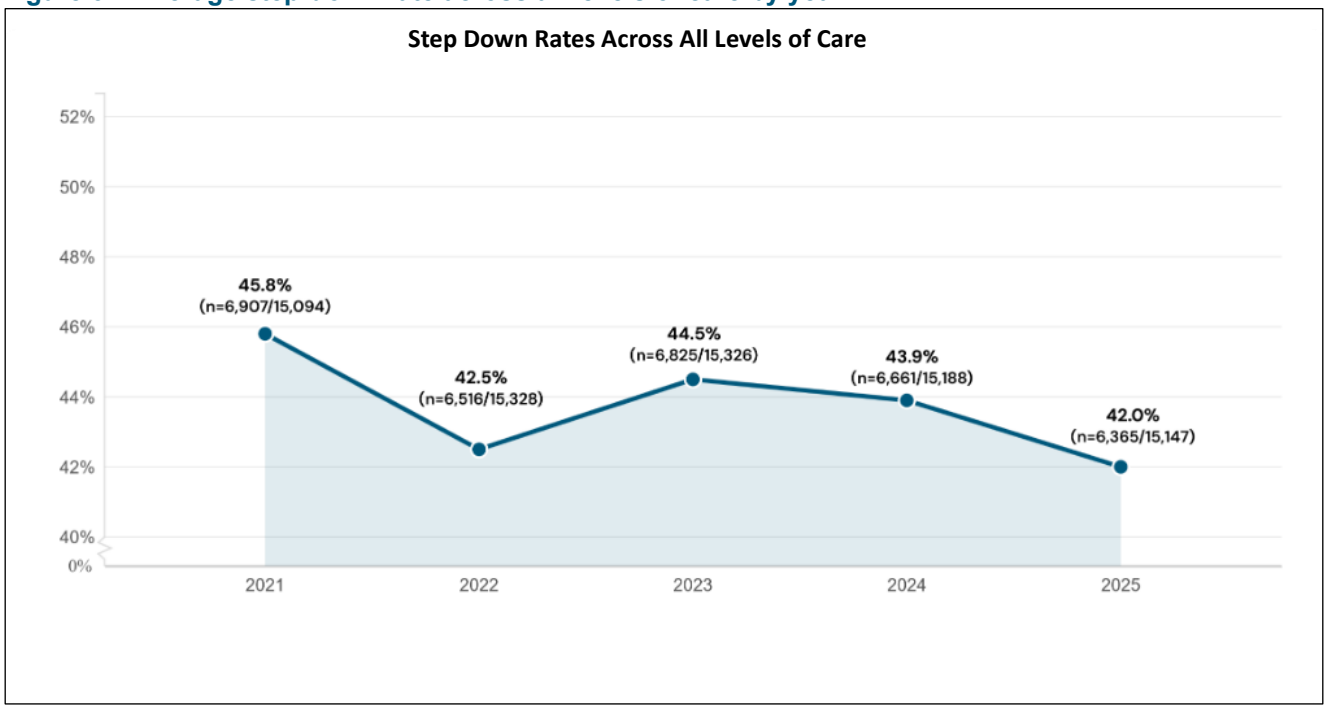
Caucasian patients were less likely to be administratively discharged. This finding is generally consistent over the past 5 years.

Figure 36. Percentage of administrative discharges by ethnicity



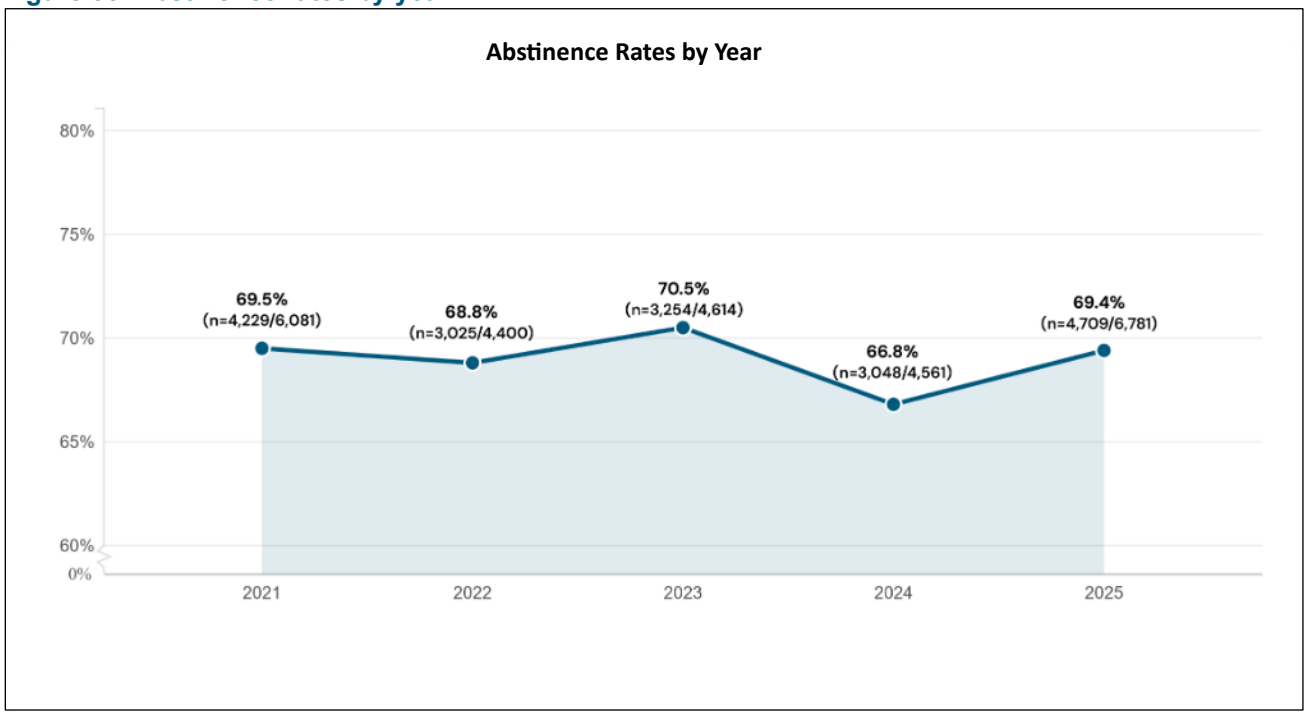
Non-Hispanic patients were less likely to be administratively discharged, over the past 5 years.

Figure 37. Average step-down rate across all levels of care by year



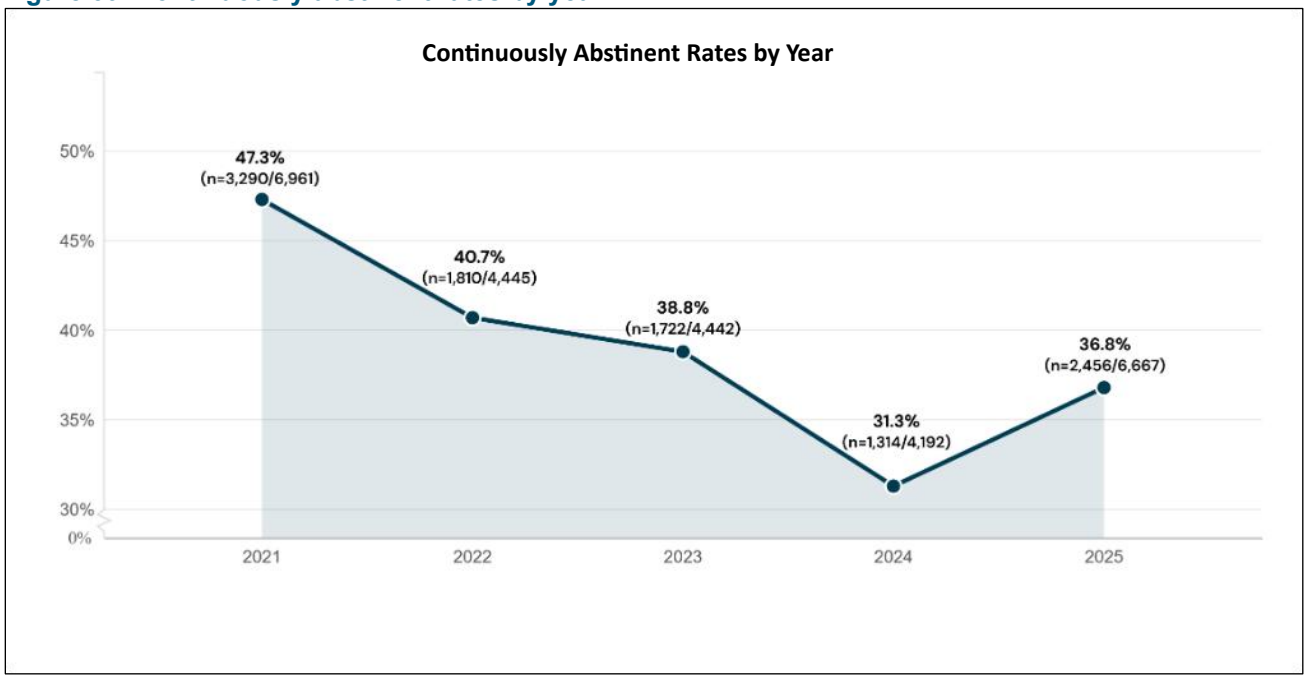
Over the past 5 years, the percentage of patient step-down rates have remained relatively consistent.

Figure 38. Abstinence rates by year



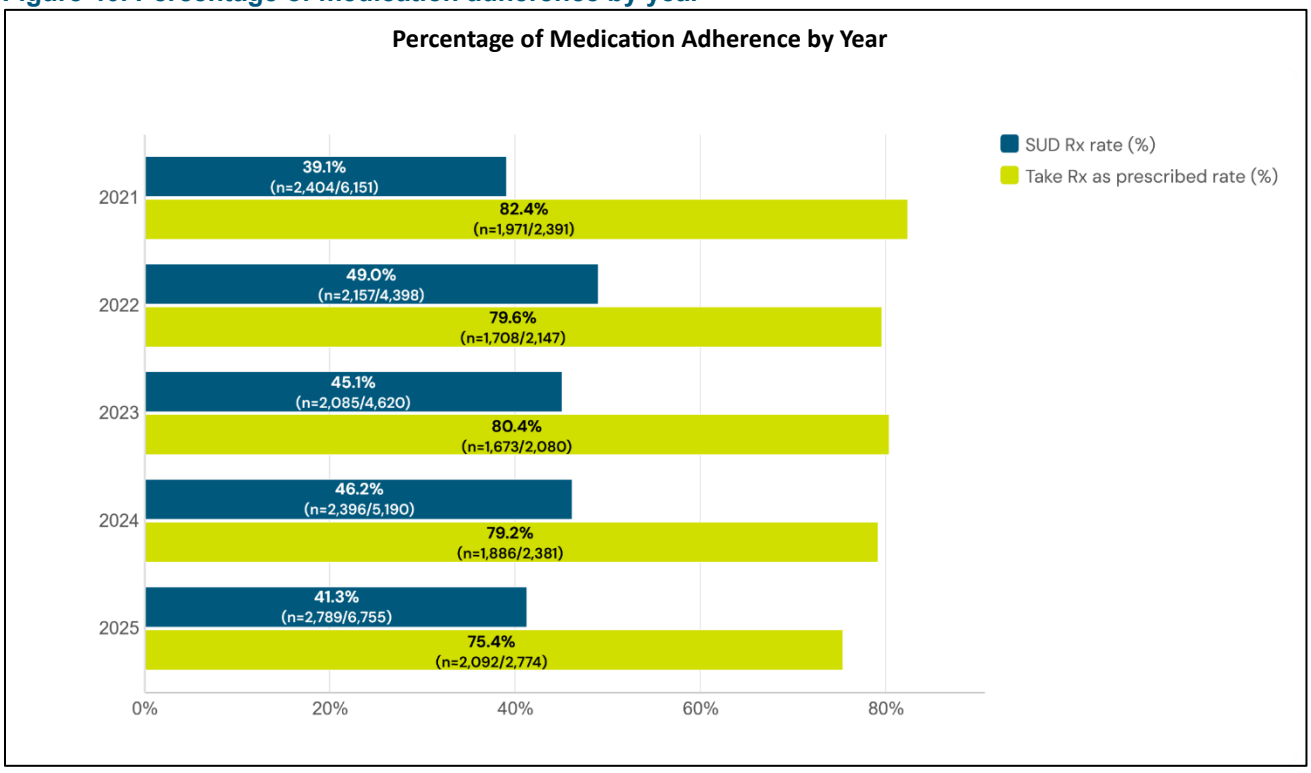
Abstinence rates have remained consistent over the past 5 years.

Figure 39. Continuously abstinent rates by year



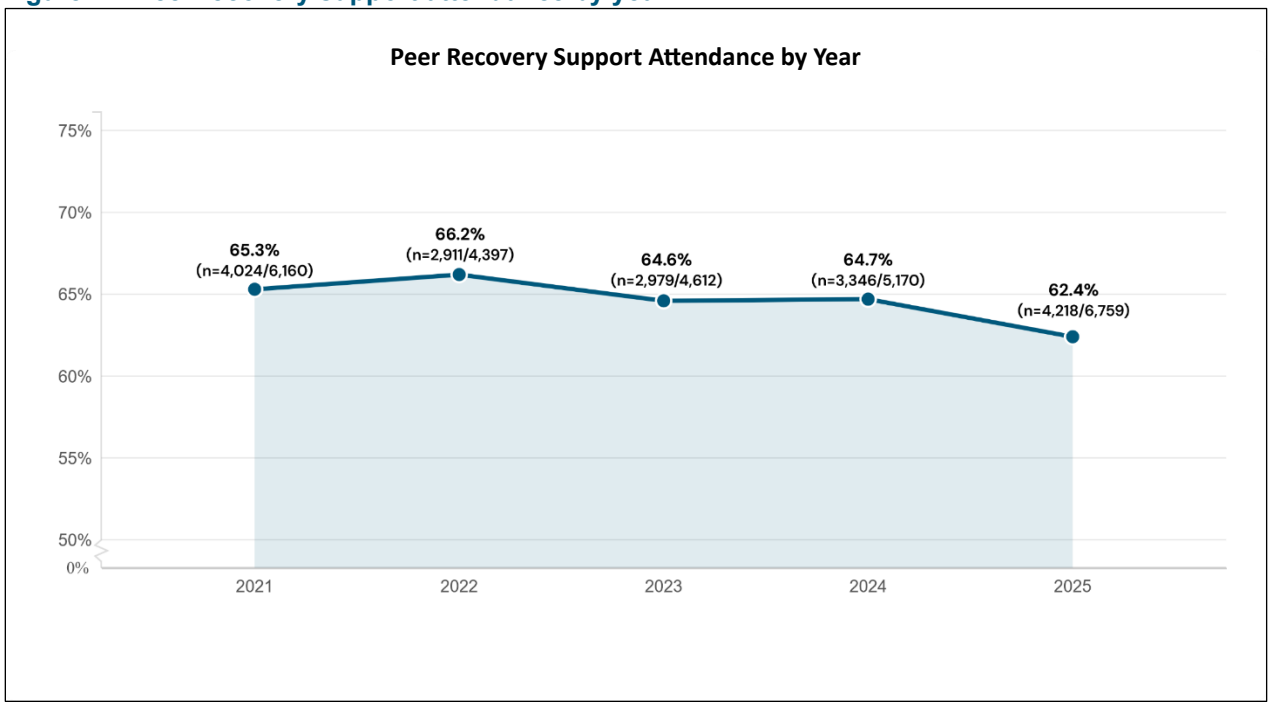
Within the past 5 years, rates of continuous abstinence peaked in 2021 and subsequently saw a decrease over the next 4 years.

Figure 40. Percentage of medication adherence by year



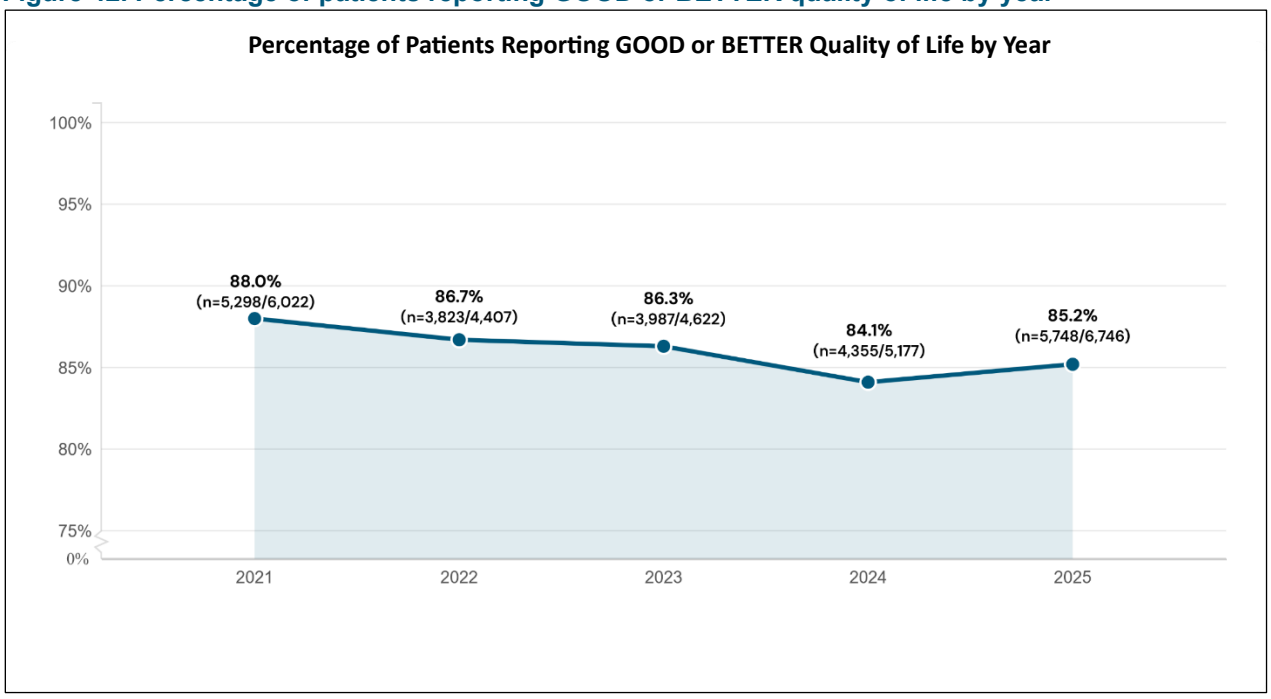
In 2025, medication adherence was lower than in the previous 3 years.

Figure 41. Peer recovery support attendance by year



Over the past 5 years, peer recovery support attendance has remained relatively consistent.

Figure 42. Percentage of patients reporting GOOD or BETTER quality of life by year



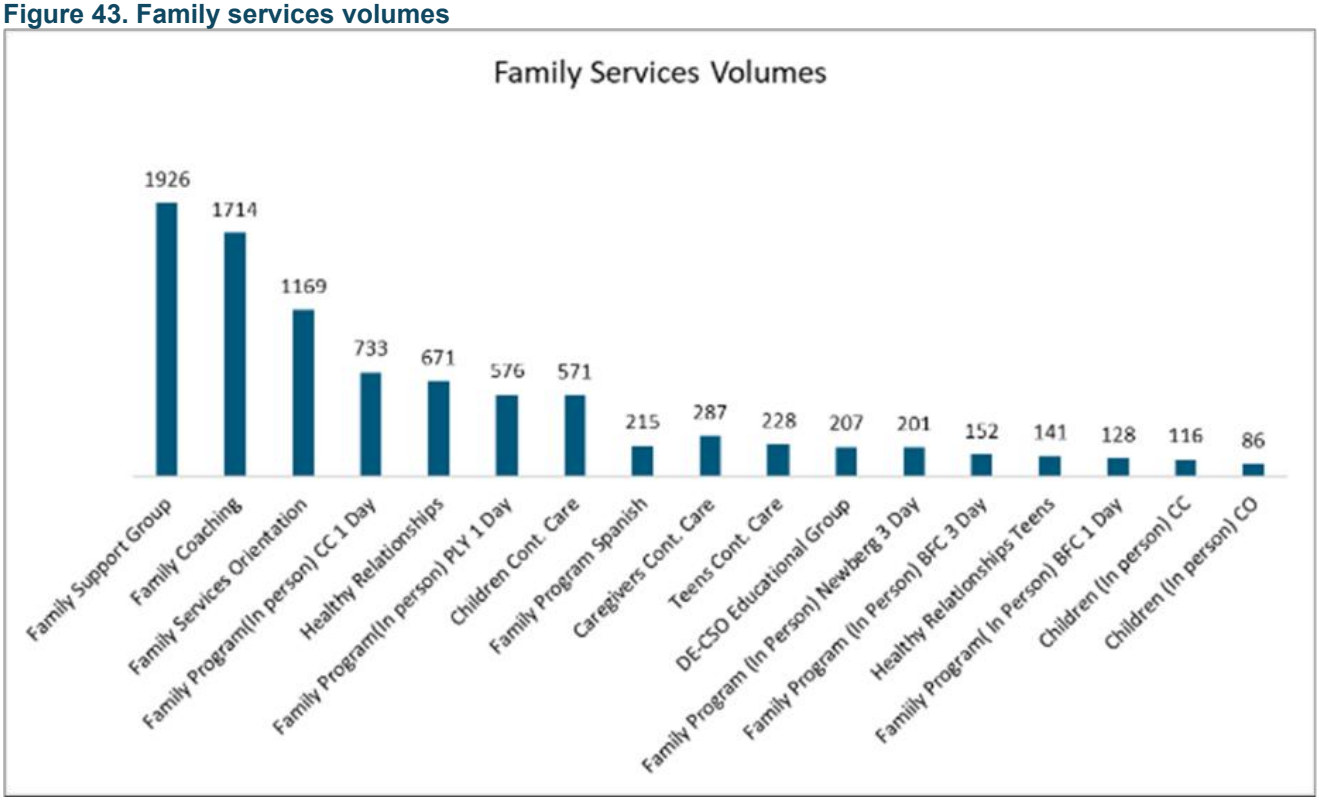
Over the past 5 years, the percentage of patients reporting GOOD or BETTER quality of life has remained relatively consistent.

VI.VOLUMES DATA

Engagement in new patient and alumni initiatives.

Families supporting loved ones with SUDs often shoulder profound emotional, psychological, and functional challenges. The family-focused SUD programs at HBFF seek to support families of loved ones with SUDs. *Figure 43* details the engagement in these various services.

Figure 43. Family services volumes



Life-Long Recovery (LLR)

At Hazelden Betty Ford Foundation we recognize that recovery is a lifelong process requiring sustained support beyond initial treatment. Life-long recovery (LLR) is a program improvement initiative designed to strengthen HBFF's aftercare offerings by enhancing the structure and frequency of recovery support through increased check-in calls and increased engagement with alumni programming and the MORE (My Ongoing Recovery Experience) for Lifelong Recovery digital platform. These enhancements aim to improve patient outcomes such as quality of life, recovery capital, and relapse prevention.

Figure 44 presents LLR enrollment at the two treatment facilities at which it has been piloted. *Figure 45* shows the two most common SUD diagnoses at each facility, and *Figure 46* shows the two most common mental health conditions. Response rates to LLR coaching calls are shown in *Table 19*. LLR data collection was still ongoing at end of 2025.

Treatment outcomes for LLR participants are shown in *Figure 48* (Quality of Life), *Figure 49* (Return to Use), and *Figure 50* (Recovery Capital).

Figure 44. Lifelong recovery enrollment

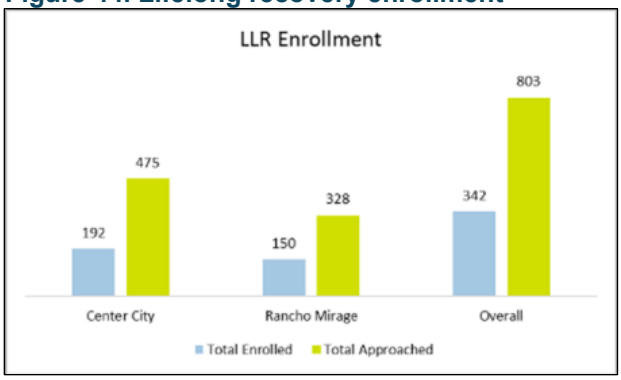


Table 19. Lifelong recovery coaching response rates

Site	Coaching Calls Attempted	Coaching Calls Completed	% Overall Calls Completed	% Calls Completed in Window
Center City	689	260	37.70%	46.90%
Rancho Mirage	539	208	38.60%	43.30%
Overall	1228	468	38.10%	45.30%

Figure 45. Two most common substance use disorders - Center City and Rancho Mirage

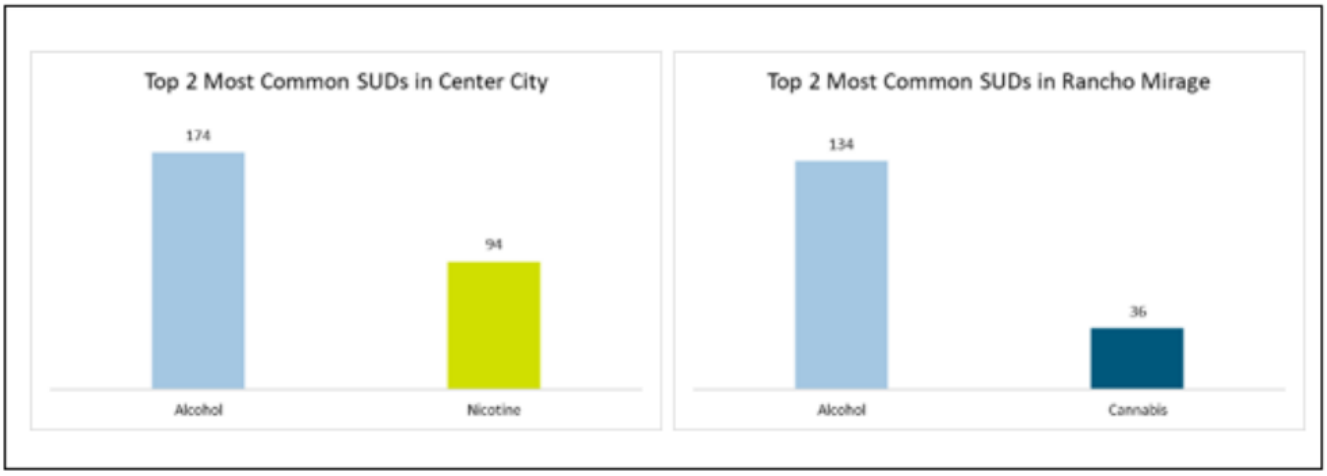


Figure 46. Two most common mental health conditions - Center City and Rancho Mirage

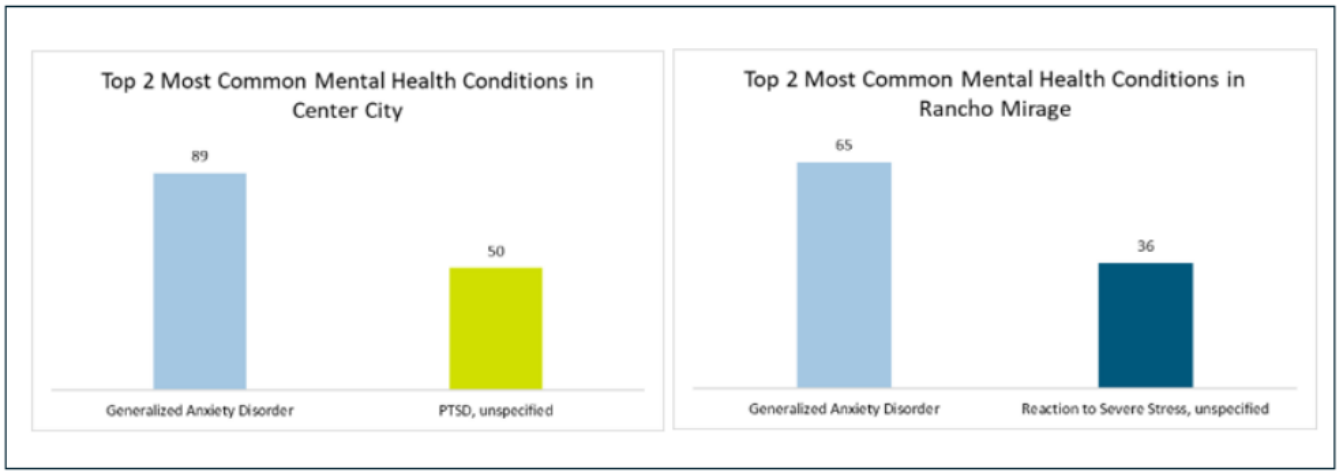


Figure 47. Alumni 14-day call

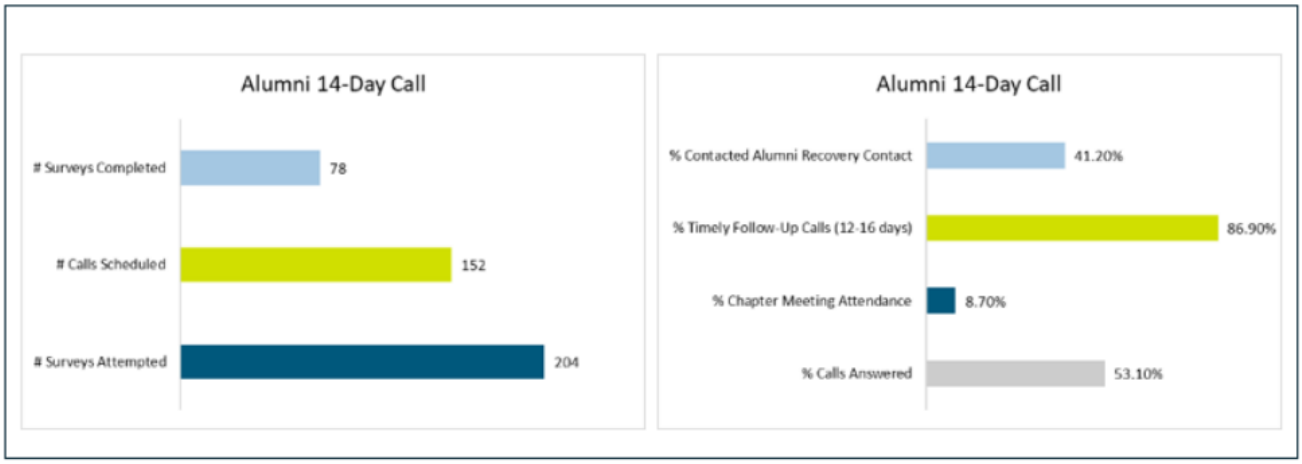


Table 20. Response rates to alumni coaching calls

Timepoint	# Surveys Completed	# Surveys in Progress	# Incomplete Surveys	# Total Surveys	Completion Rate
Baseline	302	0	0	302	100%
1 month	153	22	123	298	51.3%
3 month	64	64	67	195	32.8%
6 month	16	29	2	47	34%
Total	585	128	240	953	61.4%

Figure 48. Quality of life

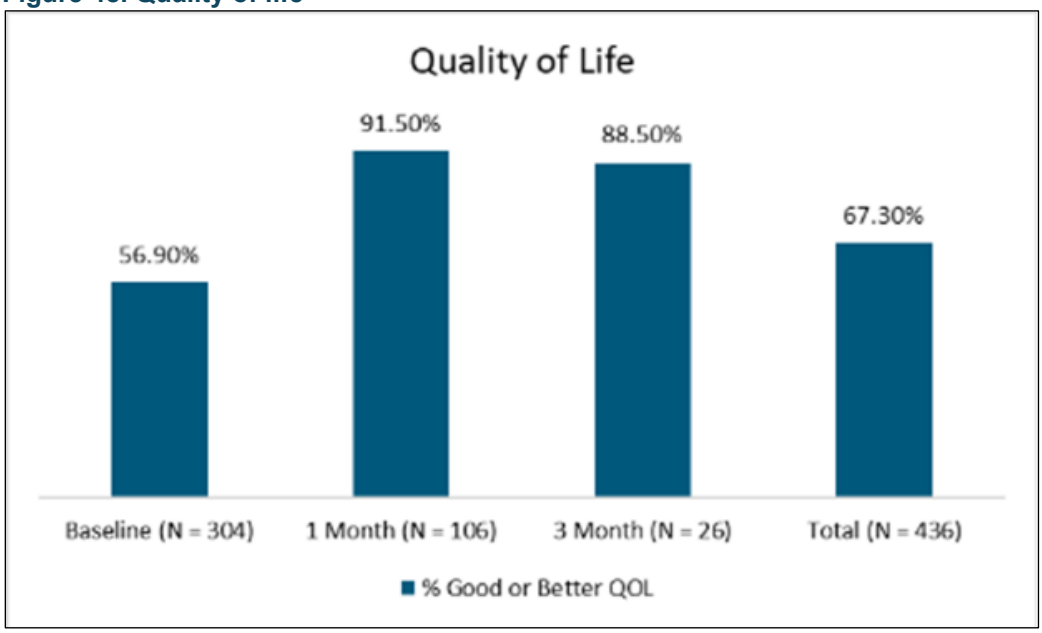


Figure 49. Return to use

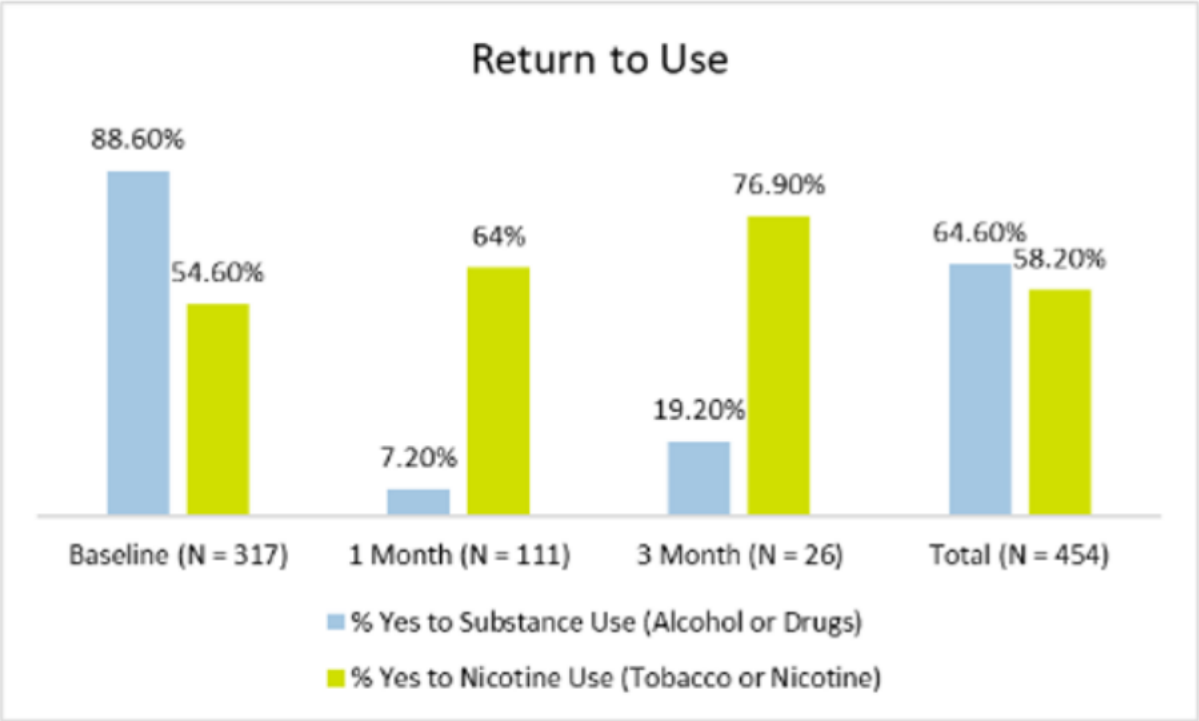
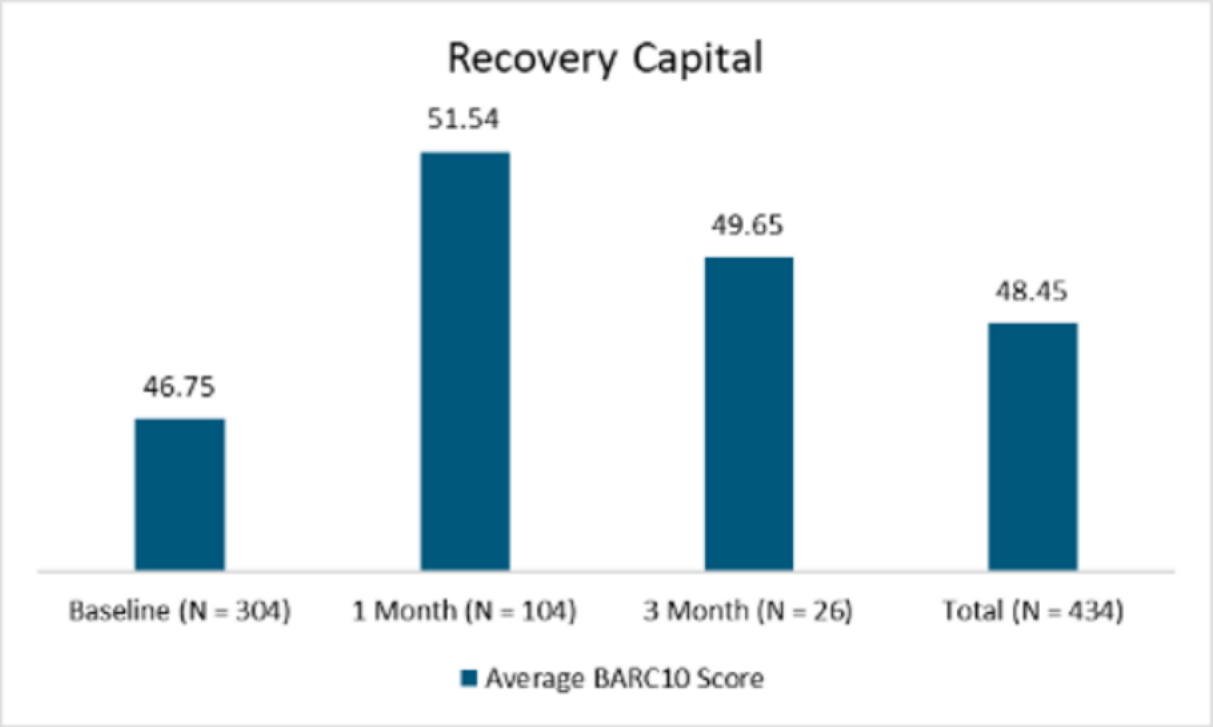


Figure 50. Recovery capital



GLOSSARY

Administrative discharge: A provider-initiated, involuntary termination of treatment.

AMA: Against Medical Advice; When a patient chooses to leave treatment without the support of the attending health professional.

ALOS: Average Length of Stay; calculated by taking the number of days from the discharged encounter divided by the number of total discharged encounters.

ANOS: Average Number of Sessions; calculated by taking the number of sessions from the discharged encounters divided by the number of total discharged encounters.

Day Treatment: also known as partial hospitalization, this is the highest level of outpatient drug and alcohol rehab available, with programming that typically meets 4-5 days a week for five to six hours a day for approximately 3-4 weeks. Some people start drug rehab in day treatment level of care and others transition into this program after completing residential addiction treatment.

Employment Status: patients were allowed to select as many responses as were applicable.

FIN: Financial Identification Number; unique patient identifier assigned to individuals per episode of care.

Intensive Outpatient: treatment is 3-4 days a week and includes a variety of groups and individual sessions. Clients may be able to attend school or work while also living at home. Treatment lasts approximately 6-8 weeks.

Legal Gender: refers to gender listed on a government issued document (i.e., birth certificate, driver's license). Patients were asked both their legal gender identity and their gender identity.

Levels of Care: several factors, including severity and length of time someone has used drugs or alcohol impact the decision of which type of care to seek. For this reason, different levels of care exist within the addiction treatment industry (i.e.: residential detoxification, residential, day treatment, intensive outpatient, outpatient).

Mental Health: services are available to new patients, current patients enrolled in substance use programming, family members, and concerned significant others of individuals who have a substance use disorder.

Outpatient: for those who are demonstrating stability in many areas and can benefit from less frequent clinical support in weekly group settings and monthly individual sessions. The number of sessions may be reduced as your clinical milestones are met. These groups are available for those who may be transitioning from a more structured treatment setting or may be a place to start to explore benefits of a recovery lifestyle.

Patient Encounter: a patient interaction with the health care system. An encounter can happen as an inpatient, an outpatient, and with a clinic visit.

PowerChart: An electronic medical record (EMR) system developed by Cerner Corporation, designed to streamline patient care and optimize clinical workflows in healthcare settings.

Race/Ethnicity: race and ethnicity were self-reported.

Residential: recommended for individuals whose use and symptoms may make it difficult to manage at other levels of care. Patients live on campus for approximately 4-6 weeks and participate in both individual and group therapy; social support, education, and skills development are also provided. Staff are present 24 hours a day, 7 days per week.

Residential Detoxification: an initial step in the addiction treatment process, withdrawal symptoms are medically managed and clients are overseen by medical professionals. Individuals remain until they are physically and psychologically stabilized.

MORE INFORMATION

Data sources for this report include the CDU (*cerner_encounter_dm, cerner_patient_dm, cerner_encounter_diagnosis_pc_dm, cerner_cm_by_fin_dm, axiom_goal_dm & cerner_encounter_engagement_enhanced_dm, cerner_fit_rollup_dm*) and survey data from the Butler Center for Research SRS platform (*srs_respondent_survey_bcr_dm, srs_respondent_survey_dm*).

REFERENCES

1. McCabe SE, West BT, Jutkiewicz EM, Boyd CJ. Multiple DSM-5 substance use disorders: A national study of US adults. Hum Psychopharmacol. 2017 Sep;32(5):10.1002/hup.2625. doi: 10.1002/hup.2625. Epub 2017 Jul 27. PMID: 28750478; PMCID: PMC5898189.
2. John WS, Zhu H, Mannelli P, Schwartz RP, Subramaniam GA, Wu LT. Prevalence, patterns, and correlates of multiple substance use disorders among adult primary care patients. Drug Alcohol Depend. 2018 Jun 1;187:79-87. doi: 10.1016/j.drugalcdep.2018.01.035. Epub 2018 Mar 27. PMID: 29635217; PMCID: PMC5959766.
3. Substance Abuse and Mental Health Services Administration. (2025). Key substance use and mental health indicators in the United States: Results from the 2024 National Survey on Drug Use and Health (HHS Publication No. PEP25-07-007, NSDUH Series H-60). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/data-we-collect/nsduh-national-surveydrug-use-and-health/national-releases
4. McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *JAMA, 284*(13), 1689-1692. doi:10-1001/jama.284.13.1689.
5. Eddie D, Bergman BG, Hoffman LA, Kelly JF. Abstinence versus moderation recovery pathways following resolution of a substance use problem: Prevalence, predictors, and relationship to psychosocial well-being in a U.S. national sample. Alcohol Clin Exp Res. 2022 Feb;46(2):312-325. doi: 10.1111/acer.14765. Epub 2022 Jan 4. PMID: 34931320; PMCID: PMC8858850.
6. McLellan, A. T., McKay, J. R., Forman, R., Cacciola, J., & Kemp, J. (2005). Reconsidering the evaluation of addiction treatment: From retrospective follow-up to concurrent recovery monitoring. *Addiction*, 100, 447-458. doi:10.1111/j.1360-0443.2005.01012.x.
7. Lawrence, D., Miller, J. H., & Flexner, C. W. (2017). Medication adherence. *Journal of Clinical Pharmacology, 00*(0), 1-6. doi:10-1002/jcph.82.
8. Gallup. (2022, February 2). *Americans Offer Gloomy State of the Nation Report.* https://news.gallup.com/poll/389309/americans-offer-gloomy-date-nation-report.aspx
9. Center for Behavioral Health Statistics and Quality. (2021). Racial/ethnic differences in substance use, substance use disorders, and substance use treatment utilization among people aged 12 or older (2015-2019) (Publication No. PEP21-07-01-001). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https:// www.samhsa.gov/data/
10. *Treatment Episode Data Set (TEDS) 2022: Admissions to and Discharges from Substance Use Treatment Services Reported by Single State Agencies | SAMHSA Publications and Digital Products*. (n.d.). Retrieved from https://library.samhsa.gov/product/teds-2022-admissions-and-discharges-substance-use-treatment/pep24-07-023
11. McHugh, R. K., Votaw, V. R., Sugarman, D. E., & Greenfield, S. F. (2018). Sex and Gender Differences in Substance Use Disorders. *Clinical Psychology Review*, *66*, 12–23. https://doi.org/10.1016/j.cpr.2017.10.012
12. Andersson, H. W., Mosti, M. P., & Nordfjaern, T. (2023). Inpatients in substance use treatment with co-occurring psychiatric disorders: A prospective cohort study of characteristics and relapse predictors. *BMC Psychiatry*, *23*, 152. https://doi.org/10.1186/s12888-023-04632-z
13. Jegede, O., Rhee, T. G., Stefanovics, E. A., Zhou, B., & Rosenheck, R. A. (2022). Rates and correlates of dual diagnosis among adults with psychiatric and substance use disorders in a nationally representative U.S sample. *Psychiatry Research*, *315*, 114720. https://doi.org/10.1016/j.psychres.2022.114720
14. Baird, A., Cheng, Y., & Xia, Y. (2023). Determinants of outpatient substance use disorder treatment length-of-stay and completion: The case of a treatment program in the southeast U.S. *Scientific Reports*, *13*(1), 13961. https://doi.org/10.1038/s41598-023-41350-8
15. Hser, Y.-I., Evans, E., Huang, D., & Anglin, D. M. (2004). Relationship between drug treatment services, retention, and outcomes. *Psychiatric Services*, *55*(7), 767–774. https://doi.org/10.1176/appi.ps.55.7.767
16. Walker, M. A. (2009). Program characteristics and the length of time clients are in substance abuse treatment. *The Journal of Behavioral Health Services & Research*, *36*(3), 330–343. https://doi.org/10.1007/s11414-008-9128-0
17. Assessment and treatment planning using the stepped care approach. (2009). In *Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings*. World Health Organization. https://www.ncbi.nlm.nih.gov/books/NBK310659/
18. McKay, J. R., Foltz, C., Leahy, P., Stephens, R., Orwin, R. G., & Crowley, E. M. (2004). Step down continuing care in the treatment of substance abuse: Correlates of participation and outcome effects. *Evaluation and Program Planning*, *27*(3), 321–331. https://doi.org/10.1016/j.evalprogplan.2004.04.005
19. Proctor, S. L., & Herschman, P. L. (2014). The Continuing Care Model of Substance Use Treatment: What Works, and When Is "Enough," "Enough?" *Psychiatry Journal*, *2014*, 692423. https://doi.org/10.1155/2014/692423
20. Amoako, E. O., Zerden, L. D., Hughes, T. D., Gertner, A. K., Williams, J., Belden, C. M., & Ware, O. D. (2024). Examining facilitative services for entry into substance use disorder treatment: A cluster analysis of treatment facilities. *PLOS ONE*, *19*(5), e0304094. https://doi.org/10.1371/journal.pone.0304094

21. *National Survey Of Substance Abuse Treatment Services (N-SSATS): 2020, Data On Substance Abuse Treatment Facilities | CBHSQ Data*. (n.d.). Retrieved January 13, 2026, from https://www.samhsa.gov/data/report/national-survey-substance-abuse-treatment-services-n-ssats-2020-data-substance-abuse

22. Lail, P., & Fairbairn, N. (2018). PATIENTS WITH SUBSTANCE USE DISORDERS LEAVING AGAINST MEDICAL ADVICE: STRATEGIES FOR IMPROVEMENT. *Journal of Addiction Medicine*, *12*(6), 421–423. https://doi.org/10.1097/ADM.0000000000000432

23. Simon, R., Snow, R., & Wakeman, S. (2020). Understanding why patients with substance use disorders leave the hospital against medical advice: A qualitative study. *Substance Abuse*, *41*(4), 519–525. https://doi.org/10.1080/08897077.2019.1671942

24. White, W. L., Scott, C. K., Dennis, M. L., & Boyle, M. G. (2005). It's Time to Stop Kicking People Out of Addiction Treatment. *Counselor (Deerfield Beach, Fla.)*, *6*(2), 12–25.

25. Fitzmaurice, G. M., Lipsitz, S. R., & Weiss, R. D. (2020). Within-treatment frequency of use versus abstinence as a predictor of longitudinal post-treatment follow-up assessments of drug use. *Drug and Alcohol Dependence*, *208*, 107857. https://doi.org/10.1016/j.drugalcdep.2020.107857

26. Frimpong, J. A., Guerrero, E. G., Kong, Y., & Kim, T. (2016). Abstinence at Successful Discharge in Publicly Funded Addiction Health Services. *The Journal of Behavioral Health Services & Research*, *43*(4), 661–675. https://doi.org/10.1007/s11414-016-9497-8

27. Harris, K. M., Griffin, B. A., McCaffrey, D. F., & Morra1, A. R. (2008). Inconsistencies in Self-Reported Drug Use by Adolescents in Substance Abuse Treatment: Implications for Outcomes and Performance Measurement. *Journal of Substance Abuse Treatment*, *34*(3), 347–355. https://doi.org/10.1016/j.jsat.2007.05.004

28. Pasman, E., Evans-Polce, R. J., Schepis, T. S., Engstrom, C. W., McCabe, V. V., Drazdowski, T. K., & McCabe, S. E. (2025). Nonabstinence Among US Adults in Recovery From an Alcohol or Other Drug Problem. *Journal of Addiction Medicine*, *19*(3), 338–342. https://doi.org/10.1097/ADM.0000000000001408

29. Vilsaint, C. L., Kelly, J. F., Bergman, B. G., Groshkova, T., Best, D., & White, W. (2017). Development and validation of a Brief Assessment of Recovery Capital (BARC-10) for alcohol and drug use disorder. *Drug and Alcohol Dependence*, *177*, 71–76. https://doi.org/10.1016/j.drugalcdep.2017.03.022

30. Vafaie, N., & Kober, H. (2022). Association of Drug Cues and Craving With Drug Use and Relapse: A Systematic Review and Meta-analysis. *JAMA Psychiatry*, *79*(7), 641–650. https://doi.org/10.1001/jamapsychiatry.2022.1240

31. McKay, J. R. (2009). Continuing Care Research: What We've Learned and Where We're Going. *Journal of Substance Abuse Treatment*, *36*(2), 131–145. https://doi.org/10.1016/j.jsat.2008.10.004

32. Bratu, M. L., Sandesc, D., Anghel, T., Tudor, R., Shaaban, L., Ali, A., Toma, A.-O., Bratosin, F., Turcu, I., Gantsa, A., Fericean, R. M., Bondrescu, M., & Barata, P. I. (2023). Evaluating the Aspects of Quality of Life in Individuals with Substance Use Disorder: A Systematic Review Based on the WHOQOL Questionnaire. *Journal of Multidisciplinary Healthcare*, *16*, 4265–4278. https://doi.org/10.2147/JMDH.S440764

33. Armoon, B., Fleury, M.-J., Bayat, A.-H., Bayani, A., Mohammadi, R., & Griffiths, M. D. (2022). Quality of life and its correlated factors among patients with substance use disorders: A systematic review and meta-analysis. *Archives of Public Health*, *80*(1), 179. https://doi.org/10.1186/s13690-022-00940-0

34. Milliken, A. L., Collamore, K. O., & Ryan-Pettes, S. R. (2025). Quality of life measures in treatment for active substance misuse: A scoping review. *Quality of Life Research*, *34*(12), 3407–3424. https://doi.org/10.1007/s11136-025-04072-0

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