

2012 National Mental Health Services Survey (N-MHSS) Locator Survey

Substance Abuse and Mental Health Services Administration

INSTRUCTIONS

- Most of the questions in this survey ask about “this facility”. By “this facility” we mean **[Facility Name 1], [Facility Name 2], [Location Address 1], [Location Address 2], [Location City, State, Zip]**. If you have any questions about how the term “this facility” applies to your facility, please call the N-MHSS helpline at 1-866-778-9752.
- Please answer **ONLY** for **[Facility Name 1], [Facility Name 2], [Location Address 1], [Location Address 2], [Location City, State, Zip]**, unless otherwise specified in the questionnaire.
- If this facility is a separate psychiatric unit of a general hospital, consider the psychiatric unit as the relevant “facility” for the purpose of this survey.
- Please keep a copy of your completed Web questionnaire for your records. You will be given the opportunity to review and print your responses at the end of the questionnaire.
- For additional information about this survey and definitions of some of the terms used, please visit our website at <http://info.nmhss.org>.
- If you have questions, please contact:

MATHEMATICA POLICY RESEARCH

1-866-778-9752

IMPORTANT INFORMATION

- **Asterisked Questions.** Information from asterisked (*) questions is published in SAMHSA’s online Mental Health Facility Locator at <http://store.samhsa.gov/MHLocator>, unless you designate otherwise in question A18 of this questionnaire
- **Mapping Feature in Locator.** Complete and accurate name and address information is needed for SAMHSA’s online Mental Health Facility Locator so it can correctly map the facility’s location
- **Eligibility for Locator.** Only facilities that provide mental health treatment services and complete this questionnaire are eligible to be listed in the online Mental Health Facility Locator. If you have any questions regarding eligibility, please contact the N-MHSS helpline at 1-866-778-9752

SECTION A: FACILITY CHARACTERISTICS

The following questions ask about the services currently offered at this facility only, that is, [Facility Name 1], [Facility Name 2] located at [Location Address 1], [Location Address 2], [Location City, State, Zip].

A1. Does this facility, at this location, offer:

MARK "YES" OR "NO" FOR EACH

- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|----------------------------|
| 1. Mental health intake services.....1 | <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Mental health diagnostic evaluation.....1 | <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. Mental health information and.....1
referral services <i>(also includes emergency programs that provide services in person or by telephone)</i> | <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 4. Mental health treatment services.....1
<i>(services focused on improving the mental well-being of individuals with mental disorders and on promoting their recovery)</i> | <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 5. Substance abuse treatment services....1 | <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 6. Administrative services.....1 | <input type="checkbox"/> | 0 <input type="checkbox"/> |

A2. Did you answer "yes" to mental health treatment services in question A1 above (option 4)?

- 1 Yes
 0 No → **SKIP TO B1 (PAGE 4)**

***A3. In which of these settings are mental health treatment services offered at this facility, at this location?**

MARK "YES" OR "NO" FOR EACH

- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|----------------------------|
| 1. 24-hour hospital inpatient setting1
<i>(psychiatric hospital or general hospital with a separate psychiatric unit)</i> | <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. 24-hour residential setting1
<i>(24-hour, overnight, psychiatric care in a residential non-inpatient setting such as a residential treatment center for adults or children)</i> | <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. Day treatment or partial hospitalization setting1
<i>(structured programs of treatment, activity, or other mental health services provided in clusters of 3 or more hours per day)</i> | <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 4. Outpatient mental health setting1
<i>(programs of mental health services provided to clients on an hourly schedule, on an individual or group basis)</i> | <input type="checkbox"/> | 0 <input type="checkbox"/> |

***A4. Which ONE category best describes this facility, at this location?**

- For definitions of facility types, log on to: <http://info.nmhss.org>

MARK ONE ONLY

- 1 Psychiatric hospital
- 2 Separate inpatient psychiatric unit of a general hospital *(consider this psychiatric unit as the relevant "facility" for the purpose of this survey)*
- 3 Residential treatment center for children
- 4 Residential treatment center for adults
- 5 Outpatient or day treatment or partial hospitalization mental health facility
- 6 Multi-setting mental health facility *(non-hospital residential plus outpatient or day treatment or partial hospitalization)*
- 7 Other *(Specify: _____)*

A5. Is this facility a solo practice or small group practice?

- 1 Yes
 0 No → **SKIP TO A6**

A5a. Is this facility licensed or accredited as a mental health clinic or mental health center?

- Do not count the licenses or credentials of individual practitioners.
- 1 Yes
 0 No → **SKIP TO B1 (PAGE 4)**

A6. Is this facility a jail, prison, or detention center that provides treatment exclusively for incarcerated persons or juvenile detainees?

- 1 Yes → SKIP TO B1 (PAGE 4)
 0 No

***A7. Is this facility operated by:**

MARK ONE ONLY

- 1 A private for-profit organization
 2 A private non-profit organization
 3 State mental health agency (SMHA)
 4 Other state government agency or department (e.g., Department of Health)
 5 Regional/district authority or local, county or municipal government
 6 Tribal government
 7 U.S. Federal agency

MARK ONE ONLY

- a Department of Veterans Affairs
 b Department of Defense
 c Indian Health Service
 d Other Federal agency (*Specify:* _____)

- 8 Other (*Specify:* _____)

***A8. Does this facility, at this location, provide treatment services that specifically address:**

MARK "YES" OR "NO" FOR EACH

- | | YES | NO |
|---|----------------------------|----------------------------|
| 1. Schizophrenia or other psychoses..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Mood disorders (e.g., bipolar,.....
depression) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. Autism/autism spectrum disorders..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 4. Attention deficit or conduct disorders.....
(e.g., ADHD, disruptive behavior
disorder) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 5. Anxiety disorders (e.g., PTSD,.....
obsessive-compulsive disorder,
phobia disorder) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 6. Eating disorders (e.g., anorexia.....
nervosa, bulimia) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 7. Other (<i>Specify</i>
_____) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

***A9. What age groups are accepted for treatment at this facility?**

MARK "YES" OR "NO" FOR EACH

- | | YES | NO |
|---------------------------------------|----------------------------|----------------------------|
| 1. Children (aged 17 or younger)..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Young adults (18-25)..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. Adults (26 or older)..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

***A10. This question has two parts.**

Column A – Please indicate the types of clients treated at this location.

Column B – For each "yes" in Column A, indicate whether this facility offers a specially-designed mental health treatment program or group exclusively for that type of client.

TYPE OF CLIENT	Column A		Column B	
	CLIENTS TREATED		OFFERS SPECIALLY DESIGNED PROGRAM OR GROUP	
	YES	NO	YES	NO
1. Children with serious emotional disturbance (SED)	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
2. Adults with serious mental illness (SMI)	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
3. Seniors or older adults	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
4. Individuals with Alzheimer's or dementia	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
5. Individuals with co-occurring mental and substance abuse disorders	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
6. Individuals with post-traumatic stress disorder (PTSD)	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
7. Veterans	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
8. Active duty military	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
9. Members of military families	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
10. Individuals with traumatic brain injury (TBI)	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
11. Lesbian, gay, bisexual, transgender, or questioning clients (LGBTQ)	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
12. Forensic clients (referred from the court/judicial system)	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
13. Other special program			1 <input type="checkbox"/>	0 <input type="checkbox"/>
<i>(Specify below:</i> _____)				

***A11. Which of these services are offered at this facility, at this location?**

- For definitions of these services, log on to: <http://info.nmhss.org>

MARK "YES" OR "NO" FOR EACH

- | | YES | NO |
|--|----------------------------|----------------------------|
| 1. Consumer-run (peer support) services..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Psychiatric emergency walk-in services. | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. Telemedicine therapy..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

***A12. Does this facility offer mental health services for the hearing-impaired?**

- 1 Yes
- 0 No

***A13. Does this facility provide mental health treatment services in a language other than English at this location?**

- 1 Yes
- 0 No, only English → **SKIP TO A14**

***A13a. In what other languages do staff provide mental health treatment services at this facility?**

- *Do not count languages provided only by on-call interpreters.*

MARK ALL THAT APPLY

American Indian or Alaska Native:

- 1 Hopi
- 2 Lakota
- 3 Navajo
- 4 Ojibwa
- 5 Yupik
- 6 Other Native American Indian or Alaska Native language

(Specify: _____)

Other Languages:

- 1 Arabic
- 2 Any Chinese Language
- 3 Creole
- 4 French
- 5 German
- 6 Greek
- 7 Hmong
- 8 Italian
- 9 Japanese
- 10 Korean
- 11 Polish
- 12 Portuguese
- 13 Russian
- 14 Spanish
- 15 Tagalog
- 16 Vietnamese
- 17 Any other language (Specify: _____)

***A14. Does this facility offer treatment at no charge to clients who cannot afford to pay?**

- 1 Yes
- 0 No → **SKIP TO A15**

A14a. Do you want the availability of free care for eligible clients published in SAMHSA's online Mental Health Facility Locator?

- *The Locator will inform potential clients to call the facility for information on eligibility.*

- 1 Yes
- 0 No

***A15. Does this facility use a sliding fee scale?**

- 1 Yes
- 0 No → **SKIP TO A16**

A15a. Do you want the availability of a sliding fee scale published in SAMHSA's online Mental Health Facility Locator?

- *The Locator will explain that sliding fee scales are based on income and other factors.*

- 1 Yes
- 0 No

***A16. Which of the following types of client payments or insurance are accepted by this facility for mental health treatment services?**

MARK "YES" OR "NO" FOR EACH

	<u>YES</u>	<u>NO</u>
1. Medicaid.....	1 <input type="checkbox"/>	0 <input type="checkbox"/>
2. Medicare.....	1 <input type="checkbox"/>	0 <input type="checkbox"/>
3. State-financed health insurance plan other than Medicaid.....	1 <input type="checkbox"/>	0 <input type="checkbox"/>
4. Federal military insurance (e.g., TRICARE).....	1 <input type="checkbox"/>	0 <input type="checkbox"/>
5. Cash or self-payment (i.e., out-of-pocket).....	1 <input type="checkbox"/>	0 <input type="checkbox"/>
6. Private health insurance.....	1 <input type="checkbox"/>	0 <input type="checkbox"/>
7. IHS/638 contract care funds.....	1 <input type="checkbox"/>	0 <input type="checkbox"/>

***A17. What telephone number(s) should a potential client call to schedule a mental health intake appointment at this facility?**

INTAKE TELEPHONE NUMBER(S):

1. () - ext. _____

2. () - ext. _____

A18. Information from asterisked questions will be published in SAMHSA's online Mental Health Facility Locator. If eligible, does this facility want to be listed in the Locator?

- *The Mental Health Facility Locator can be found at <http://store.samhsa.gov/MHLocator>*

Yes

No

A19. Does this facility have a website or web page with information about the facility's mental health treatment programs?

Yes

No → **SKIP TO A20**

***A19a. What is this facility's website address?**

- *Please enter the address exactly as it should be entered in order to access your site.*

Website: _____

A20. Does this facility have a National Provider Identifier (NPI) number?

- *Exclude the NPI numbers of individual practitioners and of groups of practitioners.*

Yes

No → **SKIP TO B1 (PAGE 4)**

A20a. What is the NPI number for this facility?

- *If the facility has more than one NPI number, please provide only the primary number.*

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SECTION B: CONTACT INFORMATION

B1. Who was primarily responsible for completing this form? *This information will only be used if we need to contact you about your responses. It will not be published.*

MARK ONE ONLY

1 Ms. 2 Miss 3 Mrs. 4 Mr. 5 Dr.

6 Other (Specify: _____)

FIRST NAME:

LAST NAME:

