U.S. Department of Health and Human Services Attachment B1 (N-SSATS 2013 full questionnaire)

 FORM APPROVED:

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See OMB burden statement on last page

**National Survey of**

**Substance Abuse Treatment Services**

**(N-SSATS)**

**March 29, 2013**

Substance Abuse and Mental Health Services Administration (SAMHSA)

|  |
| --- |
|  |

***PLEASE REVIEW THE FACILITY INFORMATION PRINTED ABOVE.***

***CROSS OUT ERRORS AND ENTER CORRECT OR MISSING INFORMATION.***

CHECK ONE

 Information is complete and correct, no changes needed

 All missing or incorrect information has been corrected

 *PLEASE READ THIS ENTIRE PAGE BEFORE*

*COMPLETING THE QUESTIONNAIRE*

***INSTRUCTIONS***

* Most of the questions in this survey ask about “this facility.” By “this facility” we mean the specific treatment facility or program whose name and location are printed on the front cover. If you have any questions about how the term “this facility” applies to your facility, please call 1-888-324-8337.
* Please answer ONLY for the specific facility or program whose name and location are printed on the front cover, unless otherwise specified in the questionnaire.
* If the questionnaire has not been completed online, return the completed questionnaire in the envelope provided. Please keep a copy for your records.
* For additional information about this survey and definitions of some of the terms used, please visit our website at **http://info.nssats.com**.
* If you have any questions or need additional blank forms, contact:

**Would you prefer to complete this questionnaire online?** See the pink flyer enclosed in your questionnaire packet for the Internet address and your unique user ID and password. You can log on and off the website as often as needed to complete the questionnaire. When you log on again, the program will take you to the next unanswered question. If you need more information, call the N‑SSATS helpline at 1-888-324-8337.

MATHEMATICA POLICY RESEARCH

1-888-324-8337

NSSATSWeb@mathematica-mpr.com

***IMPORTANT INFORMATION***

**\*** **Asterisked questions**. Information from asterisked (**\***) questions will be published in SAMHSA’s *National Directory of Drug and Alcohol Abuse Treatment Programs* and will be available online at **http://findtreatment.samhsa.gov**, SAMHSA’s Substance Abuse Treatment Facility Locator.

 **Mapping feature in Locator**. Complete and accurate name and address information is needed for the online Treatment Facility Locator so it can correctly map the facility location.

 **Eligibility for Directory/Locator**. Only facilities designated as eligible by their state substance abuse office will be listed in the *National Directory* and online Treatment Facility Locator. Your state N-SSATS representative can tell you if your facility is eligible to be listed in the Directory/Locator. For the name and telephone number of your state representative, call the N‑SSATS helpline at 1-888-324-8337.

|  |
| --- |
| SECTION A: FACILITY**Section A asks about characteristics of individual facilities and should be completed for this facility only, that is, the treatment facility or program at the location listed on the front cover.**CHARACTERISTICS |

**1. Which of the following substance abuse services are offered by this facility at this location, that is, the location listed on the front cover?**

 **MARK “YES” OR “NO” FOR EACH**

 YES NO

 1. **Intake, assessment, or referral** 1 🞎 0 🞎

 2. **Detoxification** 1 🞎 0 🞎

 3. **Substance abuse treatment**

 *(services that focus on initiating and*

 *maintaining an individual’s recovery*

 *from substance abuse and on averting*

 *relapse)* 1 🞎 0 🞎

 4. **Any other substance abuse**

 **services** 1 🞎 0 🞎

**1a. Does this facility, at this location, offer mental health treatment services *(services focused on improving the mental well-being of individuals with mental disorders and on promoting their recovery)*?**

 1 🞎 Yes

 0 🞎 No

**2. Did you answer “yes” to detoxification in option 2 of question 1 above?**

 1 🞎 Yes

 0 🞎 No **SKIP TO Q.3 (TOP OF NEXT COLUMN)**

**2a. Does this facility detoxify clients from . . .**

 **MARK “YES” OR “NO” FOR EACH**

 YES NO

 1. Alcohol 1 🞎 0 🞎

 2. Benzodiazepines 1 🞎 0 🞎

 3. Cocaine 1 🞎 0 🞎

 4. Methamphetamines 1 🞎 0 🞎

 5. Opioids 1 🞎 0 🞎

 6. Other *(Specify:* 1 🞎 0 🞎

 *)*

**2b. Does this facility routinely use medications during detoxification?**

 1 🞎 Yes

SKIP TO Q.4 (NEXT COLUMN)

 0 🞎 No

**3. Did you answer “yes” to substance abuse treatment in option 3 of question 1?**

 1 🞎 Yes

 0 🞎 No **SKIP TO Q.34 (PAGE 11)**

**4. Is this facility operated by . . .**

 **MARK ONE ONLY**

 1 🞎 A private for-profit organization

**SKIP TO Q.5**

**(BELOW)**

 2 🞎 A private non-profit organization

 3 🞎 State government

**SKIP TO Q.7**

**(BELOW)**

 4 🞎 Local, county, or community

 government

 5 🞎 Tribal government

 6 🞎 Federal Government

**4a. Which Federal Government agency?**

 **MARK ONE ONLY**

 1 🞎 Department of Veterans Affairs

**SKIP TO**

**Q.7**

**(BELOW)**

 2 🞎 Department of Defense

 3 🞎 Indian Health Service

 4 🞎 Other *(Specify:* *)*

**5. Is this facility a solo practice, meaning, an office with only one independent practitioner or counselor?**

 1 🞎 Yes

 0 🞎 No

**6. Is this facility affiliated with a religious organization?**

 1 🞎 Yes

 0 🞎 No

**7.** **Is this facility a jail, prison, or other organization that provides treatment exclusively for incarcerated persons or juvenile detainees?**

 1 🞎 Yes **SKIP TO Q.41 (PAGE 1****2)**

 0 🞎 No

**8. Is this facility a hospital or located in or operated by a hospital?**

 1 🞎 Yes **SKIP TO Q.8a (TOP OF NEXT PAGE)**

 0 🞎 No **SKIP TO Q.9 (NEXT PAGE)**

**8a.** **What type of hospital?**

 **MARK ONE ONLY**

 1 🞎 General hospital *(including VA hospital)*

 2 🞎 Psychiatric hospital

 3 🞎 Other specialty hospital, for example,

 alcoholism, maternity, etc.

 *(Specify:* *)*

**\*9. What telephone number(s) should a potential client call to schedule an intake appointment?**

 1. (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ ext.\_\_\_\_\_

 2. (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ ext.\_\_\_\_\_

**10. Which of the following services are provided by this facility at this location, that is, the location listed on the front cover?**

 **MARK ALL THAT APPLY**

 **Assessment and Pre-Treatment Services**

 1 🞎 Screening for substance abuse

 2 🞎 Screening for mental health disorders

 3 🞎 Comprehensive substance abuse assessment

 or diagnosis

 4 🞎 Comprehensive mental health assessment or

 diagnosis *(for example, psychological or*

 *psychiatric evaluation and testing)*

 5 🞎 Screening for tobacco use

 6 🞎 Outreach to persons in the community who

 may need treatment

 7 🞎 Interim services for clients when immediate

 admission is not possible

 8 🞎 We do not offer any of these assessment and

 pre-treatment services

 **Testing** *(Include tests performed at this location,*

 *even if specimen is sent to an outside source for*

 *chemical analysis.)*

 9 🞎 Breathalyzer or other blood alcohol testing

 10 🞎 Drug or alcohol urine screening

 11 🞎 Screening for Hepatitis B

 12 🞎 Screening for Hepatitis C

 13 🞎 HIV testing

 14 🞎 STD testing

 15 🞎 TB screening

 16 🞎 We do not offer any of these testing services

 **Transitional Services**

 17 🞎 Discharge planning

 18 🞎 Aftercare/continuing care

 19 🞎 We do not offer any of these transitional services

 **Ancillary Services**

 20 🞎 Case management services

 21 🞎 Social skills development

 22 🞎 Mentoring/peer support

 23 🞎 Child care for clients’ children

 24 🞎 Assistance with obtaining social services

 (*for example, Medicaid, WIC, SSI, SSDI*)

 25 🞎 Employment counseling or training for clients

 26 🞎 Assistance in locating housing for clients

 27 🞎 Domestic violence—family or partner violence

 services *(physical, sexual, and emotional abuse)*

28 🞎 Early intervention for HIV

 29 🞎 HIV or AIDS education, counseling, or support

 30 🞎 Hepatitis education, counseling, or support

 31 🞎 Health education other than HIV/AIDS or hepatitis

 32 🞎 Substance abuse education

 33 🞎 Transportation assistance to treatment

 34 🞎 Mental health services

 35 🞎 Acupuncture

 **\*** 36 🞎 Residential beds for clients’ children

 37 🞎 Self-help groups *(for example, AA, NA,*

 *SMART Recovery)*

 38 🞎 Smoking cessation counseling

 39 🞎 We do not offer any of these ancillary services

 **Other Services**

 40 🞎 Treatment for gambling disorder

 41 🞎 Treatment for Internet use disorder

 42 🞎 Treatment for other addiction disorder

 *(non-substance abuse)*

 43 🞎 We do not offer any of these other services

 **Pharmacotherapies**

 44 🞎 Disulfiram *(Antabuse®)*

 45 🞎 Naltrexone (oral)

 46 🞎 Vivitrol® *(injectible Naltrexone)*

 47 🞎 Acamprosate *(Campral®)*

 48 🞎 Nicotine replacement

 49 🞎 Non-nicotine smoking/tobacco cessation

 medications *(for example, Bupropion,*

 *Varenicline)*

 50 🞎 Medications for psychiatric disorders

 51 🞎 Methadone

 52 🞎 Buprenorphine with naloxone *(Suboxone®)*

 53 🞎 Buprenorphine without naloxone

 54 🞎 We do not offer any of these pharmacotherapy

 services

**\*11. Does this facility operate an Opioid Treatment Program (OTP) at this location?**

* *OTPs are certified by SAMHSA’s Center for Substance Abuse Treatment to use the opioid drugs methadone and buprenorphine in the treatment of opioid (narcotic) addiction.*
* *Some SAMHSA-certified OTPs use only buprenorphine in the treatment of opioid (narcotic) addiction.*
* *Physicians with a waiver may prescribe
buprenorphine without being affiliated with
an OTP. Therefore, not all facilities that prescribe buprenorphine are OTPs.*

 1 🞎 Yes, facility operates an OTP

 0 🞎 No **SKIP TO Q.12 (NEXT COLUMN)**

**\*11a. Are ALL of the substance abuse clients at this facility currently in the Opioid Treatment Program?**

 1 🞎 Yes

 0 🞎 No

|  |
| --- |
| **GO TO Q.11b (NEXT COLUMN)** |

**\*11b. Does the Opioid Treatment Program at this location provide maintenance services, detoxification services, or both?**

 **MARK ONE ONLY**

 1 🞎 Maintenance services

 2 🞎 Detoxification services

 3 🞎 Both

**12. For each type of counseling listed below, please indicate approximately what percent of the substance abuse clients at this facility receive that type of counseling as part of their substance abuse treatment program.**

|  |  |
| --- | --- |
|  | **MARK ONE BOX FOR EACHTYPE OF COUNSELING** |
| **Type of Counseling** | **Not Offered** | **Received by 25% or Less of Clients** | **Received by 26% to 50% of Clients** | **Received by 51% to 75% of Clients** | **Received by More Than 75% of Clients** |
| 1. Individual counseling | 0 🞎 | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 |
| 2. Group counseling | 0 🞎 | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 |
| **3.** Family counseling | **0 🞎** | **1 🞎** | **2 🞎** | **3 🞎** | **4 🞎** |
| 4. Marital/couples counseling | 0 🞎 | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 |

**13. For each type of clinical/therapeutic approach listed below, please mark the box that best describes how often that approach is used at this facility.**

* *Definitions of these approaches can be found at: http://info.nssats.com*

|  |  |
| --- | --- |
|  | **MARK ONE FREQUENCY FOR EACH APPROACH** |
| **Clinical/Therapeutic Approaches** | **Never** | **Rarely** | **Sometimes** | **Always or Often** | **Not Familiar With This Approach** |
|  1. Substance abuse counseling  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 | 5 🞎 |
|  2. 12-step facilitation  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 | 5 🞎 |
|  3. Brief intervention  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 | 5 🞎 |
|  4. Cognitive-behavioral therapy  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 | 5 🞎 |
|  5. Contingency management/motivational incentives  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 | 5 🞎 |
|  6. Motivational interviewing  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 | 5 🞎 |
|  7. Trauma-related counseling  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 | 5 🞎 |
|  8. Anger management  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 | 5 🞎 |
|  9. Matrix Model  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 | 5 🞎 |
| 10. Community reinforcement plus vouchers  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 | 5 🞎 |
| 11. Rational emotive behavioral therapy (REBT)  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 | 5 🞎 |
| 12. Relapse prevention  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 | 5 🞎 |
| 13. Computerized substance abuse treatment (including Internet, Web, mobile, and desktop programs)  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 | 5 🞎 |
| 14. Other treatment approach *(Specify:*  | 1 🞎 | 2 🞎 | 3 🞎 | 4 🞎 |  |
|  *)* |  |  |  |  |  |

**14. Are any of the following practices part of this facility’s standard operating procedures?**

 **MARK ALL THAT APPLY**

 1 🞎 Required continuing education for staff

 2 🞎 Periodic drug testing of clients

 3 🞎 Regularly scheduled case review with

 a supervisor

 4 🞎 Case review by an appointed quality review

 committee

 5 🞎 Outcome follow-up after discharge

 6 🞎 Periodic utilization review

 7 🞎 Periodic client satisfaction surveys conducted

 by the facility

 8 🞎 None of these practices are part of the

 standard operating procedures

**\*15. Does this facility, at this location, offer a specially designed program or group intended exclusively for DUI/DWI or other drunk driver offenders?**

 1 🞎 Yes

 0 🞎 No **SKIP TO Q.16 (BELOW)**

**\*15a. Does this facility serve only DUI/DWI clients?**

 1 🞎 Yes

 0 🞎 No

**\*16.** **Does this facility provide substance abuse treatment services in sign language at this location for the hearing impaired *(for example, American Sign Language, Signed English, or Cued Speech)*?**

* *Mark “yes” if either a staff counselor or an on‑call interpreter provides this service.*

 1 🞎 Yes

 0 🞎 No

**\*17. Does this facility provide substance abuse treatment services in a language other than English at this location?**

 1 🞎 Yes

 0 🞎 No **SKIP TO Q.18 (PAGE 5)**

**17a. At this facility, who provides substance abuse treatment services in a language other than English?**

 **MARK ONE ONLY**

 1 🞎 Staff counselor who speaks a language

 other than English

 2 🞎 On-call interpreter (*in person or by phone*)

 brought in when needed **SKIP TO Q.18**

 **(PAGE 5)**

 3 🞎 BOTH staff counselor and on-call

 Interpreter

**\*17a1. Do staff counselors provide substance abuse treatment in Spanish at this facility?**

 1 🞎 YES

 0 🞎 NO **SKIP TO Q.17b (BELOW)**

**17a2. Do staff counselors at this facility provide substance abuse treatment in any other languages?**

 1 🞎 YES

 0 🞎 NO **SKIP TO Q.18 (PAGE 5)**

**\*17b. In what other languages do staff counselors provide substance abuse treatment 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 American Indian or

 Alaska Native language

 *(Specify:*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*)*

 **Other Languages:**

 7 🞎 Arabic

 8 🞎 Any Chinese language

 9 🞎 Creole

 10 🞎 French

 11 🞎 German

 12 🞎 Greek

 13 🞎 Hmong

 14 🞎 Italian

 15 🞎 Japanese

 16 🞎 Korean

 17 🞎 Polish

 18 🞎 Portuguese

 19 🞎 Russian

 20 🞎 Tagalog

 21 🞎 Vietnamese

 22 🞎 Any other language

 *(Specify:*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*)*

 **18. Individuals seeking substance abuse treatment can vary by age, gender or other characteristics. Which categories of individuals listed below are served by this facility, at this location?**

* **for each “yes” in column a:** Please indicate in **column b** if this facility serves only that type of client.
* **for each “no” in column b:** Please indicate in \***column c** if this facility offers a substance abuse treatment program or group specifically tailored for those individuals.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **MARK YES OR NO FOR EACH CATEGORY** | **IF YES IN COLUMN A** | **IF NO IN COLUMN B** |
|  | **Column A** | **Column B** | \***Column C** |
|  | **Served by this Facility** | **This Facility****Serves Only** | **Offers Specifically Tailored Programs or Groups** |
| **Type Of Client** | YES | NO | YES | NO | YES | NO |
|  1. Adolescents | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
|  2. Adult women | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
|  3. Adult men | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |

**18a. Many facilities have clients with one or more of the following characteristics. For which characteristic(s) does this facility offer a substance abuse treatment program or group specifically tailored** **for those individuals, at this location.**

 **MARK ALL THAT APPLY**

 1 🞎 Pregnant/postpartum women

 2 🞎 Seniors or older adults

 3 🞎 Lesbian, gay, bisexual, transgender, or questioning *(LGBTQ)* clients

 4 🞎 Veterans

 5 🞎 Active duty military

 6 🞎 Members of military families

 7 🞎 Criminal justice clients *(other than DUI/DWI)*

 8 🞎 Clients with co-occurring mental and substance abuse disorders

 9 🞎 Persons with HIV or AIDS

 10 🞎 Persons who have experienced sexual abuse

 11 🞎 Persons who have experienced intimate partner violence or physical abuse

 12 🞎 Persons who have experienced other types of trauma

 13 🞎 Specifically tailored programs or groups for any other types of clients

 *(Specify below:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*)*

**\*19.** **Does this facility offer HOSPITAL INPATIENT substance abuse services at this location, that is, the location listed on the front cover?**

 1 🞎 Yes

 0 🞎 No **SKIP TO Q.20 (PAGE 6)**

**\*19a. Which of the following HOSPITAL INPATIENT services are offered at this facility?**

 **MARK “YES” OR “NO” FOR EACH**

 YES NO

 1. Hospital inpatient detoxification 1 🞎 0 🞎

 (Similar to ASAM Levels IV-D and III.7-D, *medically managed or monitored inpatient detoxification)*

 2. Hospital inpatient treatment 1 🞎 0 🞎

 (Similar to ASAM Levels IV and III.7, *medically managed or monitored intensive inpatient treatment)*

|  |
| --- |
| NOTE: ASAM is the American Society of Addiction Medicine. |

**\*20. Does this facility offer RESIDENTIAL (non‑hospital) substance abuse services at this location, that is, the location listed on the front cover?**

 1 🞎 Yes

 0 🞎 No **SKIP TO Q.21 (BELOW)**

**\*20a. Which of the following RESIDENTIAL services are offered at this facility?**

 **MARK “YES” OR “NO” FOR EACH**

 YES NO

 1. Residential detoxification 1 🞎 0 🞎

 (Similar to ASAM Level III.2-D,

 *clinically managed residential*

 *detoxification or social detoxification)*

 2. Residential short-term treatment 1 🞎 0 🞎

 (Similar to ASAM Level III.5, *clinically*

 *managed high-intensity residential*

 *treatment, typically 30 days or less)*

 3. Residential long-term treatment 1 🞎 0 🞎

 (Similar to ASAM Levels III.3

 and III.1, *clinically managed*

 *medium- or low-intensity residential*

 *treatment, typically more than 30 days)*

**\*21. Does this facility offer OUTPATIENT substance abuse services at this location, that is, the location listed on the front cover?**

 1 🞎 Yes

 0 🞎 No **SKIP TO Q.22 (TOP OF NEXT COLUMN)**

**\*21a. Which of the following OUTPATIENT services are offered at this facility?**

 **MARK “YES” OR “NO” FOR EACH**

 YES NO

 1. Outpatient detoxification 1 🞎 0 🞎

 *(*Similar to ASAM Levels I-D and II-D,

 *ambulatory detoxification)*

 2. Outpatient methadone/buprenorphine

 maintenance 1 🞎 0 🞎

 3. Outpatient day treatment or

 partial hospitalization 1 🞎 0 🞎

 (Similar to ASAM Level II.5,

 *20 or more hours per week)*

 4. Intensive outpatient treatment 1 🞎 0 🞎

 (Similar to ASAM Level II.1,

 *9 or more hours per week)*

 5. Regular outpatient treatment 1 🞎 0 🞎

 (Similar to ASAM Level I,

 *outpatient treatment, non-intensive)*

**\*22. Does this facility use a sliding fee scale?**

 1 🞎 Yes

 0 🞎 No **SKIP TO Q.23 (BELOW)**

**22a. Do you want the availability of a sliding fee**

 **scale published in SAMHSA’s Directory/Locator?**

*(For information on Directory/Locator eligibility, see the inside front cover.)*

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

 1 🞎 Yes

 0 🞎 No

**\*23. Does this facility offer treatment at no charge to clients who cannot afford to pay?**

 1 🞎 Yes

 0 🞎 No **SKIP TO Q.24 (BELOW)**

**23a. Do you want the availability of free care for eligible clients published in SAMHSA’s Directory/Locator?**

* *The Directory/Locator will explain that potential clients should call the facility for information on eligibility.*

 1 🞎 Yes

 0 🞎 No

**24. Does this facility receive any funding or grants from the Federal Government, or state, county or local governments, to support its substance abuse treatment programs?**

* *Do not include Medicare, Medicaid, or federal military insurance. These forms of client payments are included in Q.25 on next page.*

 1 🞎 Yes

 0 🞎 No

 d 🞎 Don’t Know

**\*25. Which of the following types of client payments or insurance are accepted by this facility for substance abuse treatment?**

 **MARK “YES,” “NO,” OR “DON’T KNOW” FOR EACH**

 DON’T

 YES NO KNOW

 1. No payment accepted *(free treatment for ALL clients)* 1 🞎 0 🞎 d 🞎

 2. Cash or self-payment 1 🞎 0 🞎 d 🞎

 3. Medicare 1 🞎 0 🞎 d 🞎

 4. Medicaid 1 🞎 0 🞎 d 🞎

 5. State-financed health insurance plan other than Medicaid 1 🞎 0 🞎 d 🞎

 6. Federal military insurance *(e.g., TRICARE)* 1 🞎 0 🞎 d 🞎

 7. Private health insurance 1 🞎 0 🞎 d 🞎

 8. Access To Recovery *(ATR)* vouchers 1 🞎 0 🞎 d 🞎

 9. IHS/638 contract care funds 1 🞎 0 🞎 d 🞎

 10. Other 1 🞎 0 🞎 d 🞎

 *(Specify:* *)*

**26. For each of the following activities, please indicate if staff members routinely use computer or electronic resources, paper only, or a combination of both to accomplish their work . . .**

|  |  |
| --- | --- |
|  | **Mark one Method for Each Activity** |
| **Work Activity** | **Computer/Electronic Only** | **Paper Only** | **Both Electronicand Paper** | **N/A** |
| 1. Intake | 1 🞎 | 2 🞎 | 3 🞎 | na 🞎 |
| 2. Assessment | 1 🞎 | 2 🞎 | 3 🞎 | na 🞎 |
| 3. Treatment plan | 1 🞎 | 2 🞎 | 3 🞎 | na 🞎 |
| 4. Discharge | 1 🞎 | 2 🞎 | 3 🞎 | na 🞎 |
| 5. Referrals | 1 🞎 | 2 🞎 | 3 🞎 | na 🞎 |
| 6. Issue/receive lab results | 1 🞎 | 2 🞎 | 3 🞎 | na 🞎 |
| 7. Billing | 1 🞎 | 2 🞎 | 3 🞎 | na 🞎 |
| 8. Outcomes management | 1 🞎 | 2 🞎 | 3 🞎 | na 🞎 |
| 9. Medication prescribing/dispensing | 1 🞎 | 2 🞎 | 3 🞎 | na 🞎 |
| 10. Health records | 1 🞎 | 2 🞎 | 3 🞎 | na 🞎 |
| 11. Interoperability with other providers *(such as primary care, mental health providers, etc.)* | 1 🞎 | 2 🞎 | 3 🞎 | na 🞎 |

|  |
| --- |
| SECTION B:REPORTING CLIENT COUNTS |

**27. Questions 28 through 33 ask about the number of clients in treatment. If possible, report clients for this facility only. However, we realize that is not always possible. Please indicate whether the clients you report will be for . . .**

 **MARK ONE ONLY**

 1 🞎 Only this facility **SKIP TO Q.28 (TOP OF**

 **NEXT**

 **COLUMN)**

 2 🞎 This facility plus others

 3 🞎 Another facility will report this facility’s

 client counts **SKIP TO Q.34 (PAGE 11)**

**27a. How many facilities will be included in your client counts?**

|  |
| --- |
|  THIS FACILITY1 |
|  + ADDITIONAL FACILITIES |
|  **TOTAL FACILITIES***†* |
| *†* For Section B, please include all of these facilities in the client counts that you report in questions 28 through 33. |

**27b. To avoid double-counting clients, we need to know which facilities are included in your counts. How will you report this information to us?**

 **MARK ONE ONLY**

 1  By listing the names and location addresses

 of these additional facilities in the “Additional

 Facilities Included in Client Counts” section

 on page 13 of this questionnaire or attaching

 a sheet of paper to this questionnaire

 2  Please call me for a list of the additional

 facilities included in these counts

**28. On March 29, 2013, did any patients receive HOSPITAL INPATIENT substance abuse services at this facility?**

**hospital inpatient client counts**

 1 🞎 Yes

 0 🞎 No **SKIP TO Q.29 (PAGE 9)**

**28a.** **On March 29, 2013, how many patients received the following HOSPITAL INPATIENT substance abuse services at this facility?**

* ***count*** *a patient in* ***one service only****, even if the patient received both services*.
* ***do not*** *count family members, friends, or other non‑treatment patients.*

 **ENTER A NUMBER FOR EACH**

 **(IF NONE, ENTER “0”)**

 1. Hospital inpatient detoxification \_\_\_\_\_\_\_\_\_\_\_\_\_

 (Similar to ASAM Levels IV-D

 and III.7-D, *medically managed or*

 *monitored inpatient detoxification)*

 2. Hospital inpatient treatment \_\_\_\_\_\_\_\_\_\_\_\_\_

 (Similar to ASAM Levels IV

 and III.7, *medically managed or*

 *monitored intensive inpatient treatment)*

|  |  |
| --- | --- |
| **HOSPITAL INPATIENT****TOTAL BOX** |  |

**28b. How many of the patients from the HOSPITAL INPATIENT TOTAL BOX were under the age of 18?**

 **ENTER A NUMBER**

 **(IF NONE, ENTER “0”)**

 Number under age 18 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**28c. How many of the patients from the HOSPITAL INPATIENT TOTAL BOX received:**

* *Include patients who received these drugs for detoxification or maintenance purposes.*

 **ENTER A NUMBER FOR EACH**

 **(IF NONE, ENTER “0”)**

 1. Methadone dispensed

 at this facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. Buprenorphine dispensed or

 prescribed at this facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**28d. On March 29, 2013, how many hospital inpatient beds were specifically designated for substance abuse treatment?**

 **ENTER A NUMBER**

 **(IF NONE, ENTER “0”)**

 Number of beds \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**residential (non-hospital)**

**client counts**

**29. On March 29, 2013, did any clients receive RESIDENTIAL (non‑hospital) substance abuse services at this facility?**

 1 🞎 Yes

 0 🞎 No **SKIP TO Q.30 (PAGE 10)**

**29a. On March 29, 2013, how many clients received the following RESIDENTIAL substance abuse services at this facility?**

* ***count*** *a client in* ***one service only****, even if the client received multiple services*.
* ***do not*** *count family members, friends, or other non‑treatment clients.*

 **ENTER A NUMBER FOR EACH**

 **(IF NONE, ENTER “0”)**

 1. Residential detoxification \_\_\_\_\_\_\_\_\_\_\_\_

 (Similar to ASAM Level III.2-D,

 *clinically managed residential*

 *detoxification or social detoxification)*

 2. Residential short-term treatment \_\_\_\_\_\_\_\_\_\_\_\_

 (Similar to ASAM Level III.5,

 *clinically managed high-intensity*

 *residential treatment, typically*

 *30 days or less)*

 3. Residential long-term treatment \_\_\_\_\_\_\_\_\_\_\_\_\_

 (Similar to ASAM Levels III.3 and III.1,

 *clinically managed medium- or low-*

 *intensity residential treatment, typically*

 *more than 30 days)*

|  |  |
| --- | --- |
|  **RESIDENTIAL** **TOTAL BOX** |  |

**29b. How many of the clients from the RESIDENTIAL TOTAL BOX were under the age of 18?**

 **ENTER A NUMBER**

 **(IF NONE, ENTER “0”)**

 Number under age 18 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**29c. How many of the clients from the RESIDENTIAL TOTAL BOX received:**

* *Include clients who received these drugs for detoxification or maintenance purposes.*

 **ENTER A NUMBER FOR EACH**

 **(IF NONE, ENTER “0”)**

 1. Methadone dispensed

 at this facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. Buprenorphine dispensed or

 prescribed at this facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**29d. On March 29, 2013, how many residential beds were specifically designated for substance abuse treatment?**

 **ENTER A NUMBER**

 **(IF NONE, ENTER “0”)**

 Number of beds \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**outpatient client counts**

**30. During the month of March 2013, did any clients receive OUTPATIENT substance abuse services at this facility?**

 1 🞎 Yes

 0 🞎 No **SKIP TO Q.31 (PAGE 11)**

**30a.** **How many clients received each of the following OUTPATIENT substance abuse services at this facility during March 2013?**

👉

* ***only include*** *clients who received treatment in March* ***AND*** *were still enrolled in treatment on March 29, 2013.*
* ***count*** *a client in* ***one service only****, even if the client received multiple services.*
* ***do not*** *count family members, friends, or other non‑treatment clients.*

 **ENTER A NUMBER FOR EACH**

 **(IF NONE, ENTER “0”)**

 1. Outpatient detoxification \_\_\_\_\_\_\_\_\_

 (Similar to ASAM

 Levels I-D and II-D,

 *ambulatory detoxification)*

 2. Outpatient methadone/ \_\_\_\_\_\_\_\_\_

buprenorphine maintenance

 *(Count methadone/buprenorphine*

 *clients on this line only)*

 3. Outpatient day treatment \_\_\_\_\_\_\_\_\_

 or partial hospitalization

 (Similar to ASAM Level II.5,

 *20 or more hours per week)*

 4. Intensive outpatient treatment \_\_\_\_\_\_\_\_\_

 (Similar to ASAM Level II.1,

 *9 or more hours per week)*

 5. Regular outpatient treatment \_\_\_\_\_\_\_\_\_

 (Similar to ASAM Level I,

 *outpatient treatment,*

 *non-intensive)*

|  |  |
| --- | --- |
|  **OUTPATIENT****TOTAL BOX** |  |

**30b. How many of the clients from the OUTPATIENT TOTAL BOX were under the age of 18?**

 **ENTER A NUMBER**

 **(IF NONE, ENTER “0”)**

 Number under age 18 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**30c. How many of the clients from the OUTPATIENT TOTAL BOX received:**

* *Include clients who received these drugs for detoxification or maintenance purposes.*

 **ENTER A NUMBER FOR EACH**

 **(IF NONE, ENTER “0”)**

 1. Methadone dispensed

 at this facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. Buprenorphine dispensed or

 prescribed at this facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**30d. On average, during March 2013, were the outpatient substance abuse treatment services at this facility operating over, under, or at capacity?**

 **MARK ONE ONLY**

 1 🞎 Well over capacity (over 120%)

 2 🞎 Somewhat over capacity (106 to 120%)

 3 🞎 At or about capacity (95 to 105%)

 4 🞎 Somewhat under capacity (80 to 94%)

 5 🞎 Well under capacity (under 80%)

**31. This question asks you to categorize the substance abuse treatment clients at this facility into three groups: clients in treatment for (1) abuse of both alcohol and drugs other than alcohol; (2) abuse only of alcohol; or (3) abuse only of drugs other than alcohol.**

**all substance abuse treatment settings**

**Including Hospital Inpatient,**

**Residential (non‑hospital) and/or Outpatient**

 **Enter the percent of clients on March 29, 2013, who were in each of these three groups:**

 **Clients in treatment for abuse of:**

 1. BOTH alcohol and drugs

 other than alcohol \_\_\_\_\_\_\_\_\_\_\_%

 2. ONLY alcohol \_\_\_\_\_\_\_\_\_\_\_%

 3. ONLY drugs other than alcohol \_\_\_\_\_\_\_\_\_\_\_%

|  |  |
| --- | --- |
| **TOTAL** |  100 % |

**32. Approximately what percent of the substance abuse treatment clients enrolled at this facility on March 29, 2013, had a diagnosed co-occurring mental and substance abuse disorder?**

|  |  |
| --- | --- |
| **PERCENT OF CLIENTS****(IF NONE, ENTER “0”)** | % |

**33. Using the most recent 12-month period for which you have data, approximately how many substance abuse treatment ADMISSIONS did this facility have?**

* **OUTPATIENT CLIENTS:** *Count admissions into treatment, not individual treatment visits. Consider an admission to be the initiation of a treatment program or course of treatment. Count any re‑admission as an admission.*
* **IF THIS IS A MENTAL HEALTH FACILITY:** *Count all admissions in which clients received substance abuse treatment, even if substance abuse was their secondary diagnosis.*

|  |  |
| --- | --- |
| **NUMBER OF SUBSTANCE ABUSE ADMISSIONS IN A****12-MONTH PERIOD** |  |

SECTION C:

GENERAL INFORMATION

**Section C should be completed for this facility only.**

**\*34. Does this facility operate transitional housing or a halfway house for substance abuse clients at this location, that is, the location listed on the front cover?**

 1 🞎 Yes

 0 🞎 No

 **35. Which statement below BEST describes this facility’s smoking policy?**

 **MARK ONE ONLY**

 1 🞎 Smoking is not permitted on the property or

 within any building

 2 🞎 Smoking is permitted only outdoors

 3 🞎 Smoking is permitted outdoors and

 in designated indoor area(s)

 4 🞎 Smoking is permitted anywhere without

 restriction

 5 🞎 Other *(Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*

**36. Is this facility or program licensed, certified, or accredited to provide substance abuse services by any of the following organizations?**

* *Do not include personal-level credentials or general business licenses such as a food service license.*

 **MARK “YES,” “NO,” OR “DON’T KNOW” FOR EACH**

 DON’T

 YES NO KNOW

 1. State substance abuse agency 1 🞎 0 🞎 d 🞎

 2. State mental health department 1 🞎 0 🞎 d 🞎

 3. State department of health 1 🞎 0 🞎 d 🞎

 4. Hospital licensing authority 1 🞎 0 🞎 d 🞎

 5. The Joint Commission 1 🞎 0 🞎 d 🞎

 6. Commission on Accreditation

 of Rehabilitation Facilities (CARF).. 1 🞎 0 🞎 d 🞎

 7. National Committee for

 Quality Assurance (NCQA) 1 🞎 0 🞎 d 🞎

 8. Council on Accreditation (COA) 1 🞎 0 🞎 d 🞎

 9. Another state or local agency

 or other organization 1 🞎 0 🞎 d 🞎

 *(Specify:* *)*

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

* *Do NOT include the NPI numbers of individual practitioners and groups of practitioners.*

 1 🞎 Yes

 0 🞎 No **SKIP TO Q.38 (BELOW)**

**37a. What is the NPI number for this facility?**

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

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **NPI** |  |  |  |  |  |  |  |  |  |  |
|  | *(NPI is a 10-digit numeric ID)* |

**\*38. Does this facility have a website or web page with information about the facility’s substance abuse treatment programs?**

Please check the front cover of this questionnaire to confirm that the website address for this facility is correct EXACTLY as listed. If incorrect or missing, enter the correct address.

 1 🞎 Yes

 0 🞎 No

**39. If eligible, does this facility want to be listed in the *National Directory* and online Treatment Facility Locator?** *(See inside front cover for eligibility information.)*

 1 🞎 Yes

 0 🞎 No

**40. Would you like to receive a free copy of the next *National Directory of Drug and Alcohol Abuse Treatment Programs* when it is published?**

 1 🞎 Yes

 0 🞎 No **SKIP TO Q.41 (TOP OF NEXT COLUMN)**

**40a. Would you prefer to receive a CD or paper copy of the *Directory*?**

 1 🞎 CD

 2 🞎 Paper

**41. 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 🞎 Mrs. | 3 🞎 Mr. | 4 🞎 Dr. |

 5 🞎 Other *(Specify:* *)*

 Name:

 Title:

 Phone Number: (\_\_\_\_\_) \_\_\_\_ - Ext.

 Fax Number: (\_\_\_\_\_) \_\_\_\_ -

 Email Address:

 Facility Email Address:

|  |
| --- |
| ADDITIONAL FACILITIES INCLUDED IN CLIENT COUNTSComplete this section if you reported clients for this facility plus other facilities, as indicated in Question 27.For each additional facility, please mark if that facility offers hospital inpatient, residential and/or outpatient substance abuse services at that location. |

|  |  |
| --- | --- |
| FACILITY NAME:  ADDRESS: CITY: STATE: ZIP: PHONE: FACILITY EMAILADDRESS:  | FACILITY NAME:  ADDRESS: CITY: STATE: ZIP: PHONE: FACILITY EMAILADDRESS:  |
| 🞎 HOSPITAL INPATIENT | 🞎 RESIDENTIAL | 🞎 OUTPATIENT | 🞎 HOSPITAL INPATIENT | 🞎 RESIDENTIAL | 🞎 OUTPATIENT |

|  |  |
| --- | --- |
| FACILITY NAME:  ADDRESS: CITY: STATE: ZIP: PHONE: FACILITY EMAILADDRESS:  | FACILITY NAME:  ADDRESS: CITY: STATE: ZIP: PHONE: FACILITY EMAILADDRESS:  |
| 🞎 HOSPITAL INPATIENT | 🞎 RESIDENTIAL | 🞎 OUTPATIENT | 🞎 HOSPITAL INPATIENT | 🞎 RESIDENTIAL | 🞎 OUTPATIENT |

|  |  |
| --- | --- |
| FACILITY NAME:  ADDRESS: CITY: STATE: ZIP: PHONE: FACILITY EMAILADDRESS:  | FACILITY NAME:  ADDRESS: CITY: STATE: ZIP: PHONE: FACILITY EMAILADDRESS:  |
| 🞎 HOSPITAL INPATIENT | 🞎 RESIDENTIAL | 🞎 OUTPATIENT | 🞎 HOSPITAL INPATIENT | 🞎 RESIDENTIAL | 🞎 OUTPATIENT |

|  |
| --- |
| If you require additional space, please continue on the next page. |

ANY ADDITIONAL COMMENTS

**Pledge to respondents**

The information you provide will be protected to the fullest extent allowable under Section 501(n) of the Public Health Service Act (42 USC 290aa(n)). This law permits the public release of identifiable information about an establishment only with the consent of that establishment and limits the use of the information to the purposes for which it was supplied. With the explicit consent of eligible treatment facilities, information provided in response to survey questions marked with an asterisk will be published in SAMHSA’s *National Directory of Drug and Alcohol Abuse Treatment Programs* and the Substance Abuse Treatment Facility Locator. Responses to non-asterisked questions will be published only in statistical summaries so that individual treatment facilities cannot be identified.

**Thank you for your participation. Please return this questionnaire in the envelope provided.**

**If you no longer have the envelope, please mail this questionnaire to:**

**MATHEMATICA POLICY RESEARCH**

ATTN: RECEIPT CONTROL - Project 06667

P.O. Box 2393

Princeton, NJ 08543-2393

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-xxxx. Public reporting burden for this collection of information is estimated to average 40 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 2-1057, Rockville, Maryland 20857.