U.S. Department of Health and Human Services

OMB No: xxxx-xxxx
APPROVAL EXPIRES: xx/xx/20xx
See OMB burden statement on last page

2016 BEHAVIORAL HEALTH SCREENER

Hello, I am calling on behalf of SAMHSA, the Substance Abuse and Mental Health Services Administration. SAMHSA is currently updating their database of behavioral health treatment facilities. I would like to ask you a few questions about your facility to assist us with this update.

A1. First, I'd like to confirm that this is [FACILITY NAME], located at [LOCATION ADDRESS] and [PHONE NUMBER]. Is that correct?

IF RESPONDENT IS CLEARLY <u>NOT</u> AT A FACILITY OFFERING MENTAL HEALTH OR SUBSTANCE ABUSE SERVICES (e.g., Joe's Pizza or Collision Insurance),

CHECK THIS BOX ☐ SKIP TO LOCATING (PAGE 6)

1 ☐ YES, NAME ADDRESS AND PHONE CORRECT → ***SKIP TO A3 (NEXT PAGE)***

0 ☐ NO, NAME ADDRESS AND/OR PHONE INCORRECT

A2. RECORD CORRECT INFORMATION BELOW:

NAME:_____

STREET:_____

CITY/TOWN: _____ STATE: _____ ZIP:_____

PHONE: _____

A2a. INTERVIEWER: DID THE ADDRESS CHANGE?

1 ☐ YES

0 ☐ NO

2 ☐ THE LOCATION ADDRESS HAS BEEN EDITED BUT IT IS THE SAME ADDRESS

→ **SKIP TO A2d (NEXT PAGE)**

A2b. Is there another mental health treatment or substance abuse facility in your organization that is currently located at [LOCATION ADDRESS]?

1 ☐ YES → ***SKIP TO A2b.1 (NEXT PAGE)***

0 ☐ NO → ***SKIP TO A2d (NEXT PAGE)***

2 ☐ NO MH/SA → ***SKIP TO END (PAGE 6)***

d ☐ DON'T KNOW

r ☐ REFUSED

→ **SKIP TO A2b.1 (NEXT PAGE)**

A2b.1. **<u>INTERVIEWER</u>: COLLECT NEW FACILITY INFORMATION WHILE RESPONDENT IS ON THE PHONE. IF A2b = 1 CONTINUE TO A2c. IF A2b = d OR r SKIP TO END.**

A2c. **We need to collect information about [LOCATION ADDRESS]. Could you give me the TELEPHONE number for that location?**

(_____) - _____ - _____ → **INTERVIEWER: IF A NEW NUMBER IS RECORDED SAY: "Thank yo DIAL NEW PHONE NUMBER AND BEGIN WITH A1.**
Area Code

d ☐ DON'T KNOW → ***SKIP TO LOCATING (PAGE 6)***

A2d. **INTERVIEWER: DID THE FACILITY NAME CHANGE?**

1 ☐ YES
0 ☐ NO
2 ☐ MISSPELLED → **SKIP TO A3 (BELOW)**
3 ☐ ABBREVIATION IN NAME

A2e. **Was this facility ever called [FACILITY NAME]?**

1 ☐ YES
0 ☐ NO → ***SKIP TO LOCATING (PAGE 6)***

A2f. **Did this name change result in a new license number for this facility?**

1 ☐ YES → **<u>INTERVIEWER:</u>** **COLLECT NEW FACILITY INFORMATION WHILE**
0 ☐ NO

A3. **Does this facility, <u>at this location</u>, offer mental health treatment, that is, interventions such as therapy or psychotropic medication that treat a person's mental health problem or condition, reduce symptoms, and improve behavioral functioning and outcomes?**

1 ☐ YES → ***SKIP TO A4 (NEXT PAGE)***
0 ☐ NO
2 ☐ RESPONDENT INDICATES THAT THEY ALREADY COMPLETED THIS PAST YEAR'S MENTAL HEALTH SURVEY → ***SKIP TO A6 (PAGE 4)***

A3a. **Does this facility provide administrative services for a mental health treatment facility?**

1 ☐ YES → **SKIP TO A5b (PAGE 4)**
0 ☐ NO

A4. Does this facility, at this location, provide any of the following services:

MARK ALL THAT APPLY

1 ☐ Assisted living or supported housing

2 ☐ Nursing home care

3 ☐ Group homes

4 ☐ Clubhouse services

5 ☐ Care at only a jail, prison, or detention center that provides treatment exclusively for incarcerated persons or juvenile detainees

6 ☐ None of these services → ***SKIP TO A5 (BELOW)***

A4a. [FILL ALL CODED CATEGORIES FROM A4.1 THROUGH A4.5 AND ASK ONE AT A TIME]: Is [FILL] this facility's main focus at [FILL LOCATION ADDRESS]?

		MARK "YES" OR "NO" FOR EACH	
		YES	NO
1.	Assisted living or supported housing.....	1 ☐	0 ☐
2.	Nursing home care.....	1 ☐	0 ☐
3.	Group homes.....	1 ☐	0 ☐
4.	Clubhouse services.....	1 ☐	0 ☐
5.	Care at only a jail, prison, or detention center that provides treatment exclusively for incarcerated persons or juvenile detainees..... ..... juvenile detainees.....	1 ☐	0 ☐

A4b. INTERVIEWER: DID THIS FACILITY ANSWER ANY CATEGORY IN A4a AS "YES?"

1 ☐ YES → ***SKIP TO A5b (NEXT PAGE)***

0 ☐ NO

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

1 ☐ YES

0 ☐ NO → ***SKIP TO A5b (NEXT PAGE)***

A5a. Is this <u>facility</u> 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

A5b. INTERVIEWER: DID THIS FACILITY ANSWER A3a AS "YES;" OR ((ANSWER A4 AS "6" OR A4b AS "NO;") AND (ANSWER A5 AS "NO" OR A5a AS "YES?")) PLEASE USE SHADED BOXES FOR REFERENCE.

1 ☐ YES (THIS FACILITY IS ELIGIBLE FOR THE MH SURVEY)

0 ☐ NO (THIS FACILITY IS NOT ELIGIBLE FOR THE MH SURVEY)

A6. Does this facility, that is, the facility located at [LOCATION ADDRESS], have a licensed, certified or accredited substance abuse treatment program or unit at this address?

1 ☐ YES

0 ☐ NO → ***SKIP TO A9 (BELOW)***

2 ☐ RESPONDENT INDICATES THAT THEY ALREADY COMPLETED THIS PAST YEAR'S SUBSTANCE ABUSE SURVEY → ***SKIP TO A16 (NEXT PAGE)***

A7. Which of the following substance abuse services are offered by this facility, at this location?

PROBE IF NECESSARY: Please report for only this location.

	MARK "YES" OR "NO" FOR EACH	
	YES	NO
1. Intake, assessment, or referral	1 ☐	0 ☐
2. Detoxification	1 ☐	0 ☐
3. Substance abuse treatment, that is, services that focus on initiating and maintaining an individual's recovery from substance abuse and on averting relapse	1 ☐	0 ☐

A8. Is this facility a solo practice, meaning, an office with only one independent practitioner or counselor?

1 ☐ YES

0 ☐ NO

A9. Does this facility operate transitional housing or a halfway house for substance abuse clients at this location?

1 ☐ YES

0 ☐ NO

A10. INTERVIEWER: DID THIS FACILITY ANSWER YES TO EITHER A7.2, A7.3, OR A9 ABOVE? PLEASE USE THE SHADED BOXES FOR REFERENCE.

1 ☐ YES

0 ☐ NO → ***SKIP TO A16 (NEXT PAGE)***

A11. Is [LOCATION ADDRESS] also the mailing address for this substance abuse treatment facility?

1 ☐ YES → ***SKIP TO A12 (NEXT PAGE)***

0 ☐ NO → ***SKIP TO A11a (NEXT PAGE)***

A11a. What is the mailing address for [FACILITY NAME] located at [LOCATION ADDRESS]?

NAME:_____

STREET:_____

CITY/TOWN: _____ STATE:_____ ZIP:_____

A12. Does [FACILITY NAME] have a FAX number?

1 ☐ YES → **A12a. What is that FAX number?**(_____) **-** _____ -_____
Area Code

0 ☐ NO

A13. ASK IF NEEDED, OTHERWISE, VERIFY AND RECORD WITHOUT ASKING: Who is the director of substance abuse programs at [FACILITY]? (RECORD BELOW)

_____

A14. Does [DIRECTOR NAME] or the person in charge of substance abuse programs at this facility have an EMAIL address?

1 ☐ YES → **A14a.What is that EMAIL address?**

0 ☐ NO **A14b.Name of Contact Person (if not Director)**

A15. Does this facility have a website or web page with information about the facility's substance abuse treatment programs?

1 ☐ YES

0 ☐ NO → ***SKIP TO A16 (BELOW)***

A15a. What is this facility's website address?

RECORD:

A16. INTERVIEWER: DOES THIS FACILITY PROVIDE MENTAL HEALTH SERVICES (A5b = 1)?

1 ☐ YES

0 ☐ NO → ***SKIP TO END (NEXT PAGE)***

A17. Is [LOCATION ADDRESS] also the mailing address for this mental health treatment facility?

1 ☐ YES → ***SKIP TO A18 (NEXT PAGE)***

0 ☐ NO

2 ☐ Same as Substance Abuse Mailing Address → ***SKIP TO A18 (NEXT PAGE)***

A17a. What is the mailing address for the mental health facility located at [LOCATION ADDRESS]?

NAME:_____

STREET:_____

CITY/TOWN: _____ STATE: _____ ZIP:_____

A18. Does [FACILITY NAME] have a FAX number?

1 ☐ YES → **A18a. What is that FAX number?**(_____) **-** _____ -_____
Area Code

0 ☐ NO

2 ☐ Same as Substance Abuse Fax Number

A19. ASK IF NEEDED, OTHERWISE, VERIFY AND RECORD WITHOUT ASKING: Who is the director of mental health programs at [FACILITY]? (RECORD BELOW)

_____

A20. Does [DIRECTOR NAME] or the person in charge of mental health programs at this facility have an EMAIL address?

1 ☐ YES → **A20a.What is that EMAIL address?**

A20b.Name of Contact Person (if not Director)

0 ☐ NO

2 ☐ Same as Substance Abuse Director's Email Address

A21. Does this facility have a website or web page with information about the facility's mental health treatment program(s)?

1 ☐ YES

0 ☐ NO → **SKIP TO END (BELOW)**

2 ☐ Same as Substance Abuse Web Site → **SKIP TO END (BELOW)**

A21a. What is this facility's website address?

RECORD:

LOCATING: Thank you very much for your time.

END: Those are all the questions I have. Thank you very much for your time.

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.

NOTES:

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