

U.S. Department of Health and Human Services

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

National Survey of Substance Abuse Treatment Services (N-SSATS)

March 31, 2017

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

Would you prefer to complete this questionnaire online? See the pink flyer enclosed in your 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.

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 <https://info.nssats.com>.
- If you have any questions or need additional blank forms, contact:

MATHEMATICA POLICY RESEARCH
1-888-324-8337
NSSATSWeb@mathematica-mpr.com

IMPORTANT INFORMATION

* **Asterisked questions.** Information from asterisked (*) questions may be published in SAMHSA’s online Behavioral Health Treatment Services Locator (found at <https://findtreatment.samhsa.gov>) and in SAMHSA’s *National Directory of Drug and Alcohol Abuse Treatment Programs*, unless you designate otherwise in question 39, page 12 of this questionnaire.

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

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

SECTION A: FACILITY CHARACTERISTICS

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.

*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 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Detoxification | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. Substance abuse treatment
<i>(services that focus on initiating and maintaining an individual's recovery from substance abuse and on averting relapse)</i> | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 4. Any other substance abuse services | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

1a. To which of the following clients does this facility, at this location, offer mental health treatment services (*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*)?

MARK ALL THAT APPLY

- 1 Substance abuse clients
- 2 Clients other than substance abuse clients
- 3 No clients are offered mental health treatment services

2. Did you answer "yes" to detoxification in option 2 of question 1 above?

- 1 Yes
- 0 No → SKIP TO Q.3 (NEXT COLUMN)

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

MARK "YES" OR "NO" FOR EACH

- | | YES | NO |
|------------------------------------|----------------------------|----------------------------|
| 1. Alcohol..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Benzodiazepines | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. Cocaine | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 4. Methamphetamines..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 5. Opioids | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 6. Other (<i>Specify: _____</i>) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

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

- 1 Yes
- 0 No → SKIP TO Q.4 (BELOW)

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

- 1 Yes
- 0 No → SKIP TO Q.35 (PAGE 12)

4. 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 12)
- 0 No

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

- 1 Yes
- 0 No

*6. What is the primary focus of this facility at this location, that is, the location listed on the front cover?

MARK ONE ONLY

- 1 Substance abuse treatment services
- 2 Mental health services
- 3 Mix of mental health and substance abuse treatment services (*neither is primary*)
- 4 General health care
- 5 Other (*Specify: _____*)

*7. Is this facility operated by . . .

MARK ONE ONLY

- 1 A private for-profit organization → SKIP TO Q.8 (BELOW)
- 2 A private non-profit organization
- 3 State government
- 4 Local, county, or community government → SKIP TO Q.9 (NEXT PAGE)
- 5 Tribal government
- 6 Federal Government

*7a. Which Federal Government agency?

MARK ONE ONLY

- 1 Department of Veterans Affairs
- 2 Department of Defense
- 3 Indian Health Service
- 4 Other (*Specify: _____*) → SKIP TO Q.9 (NEXT PAGE)

8. Is this facility affiliated with a religious organization?

- 1 Yes
- 0 No

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

- 1 Yes
0 No → SKIP TO Q.10 (BELOW)

***9a. 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: _____)

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

1. (_____) _____ - _____ ext. _____
2. (_____) _____ - _____ ext. _____

***11. 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/tobacco 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® (*injectable 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

***12. How does this facility treat opioid (narcotic) addiction?**

MARK ALL THAT APPLY

- 1 This facility does not treat opioid addiction.
- 2 This facility uses methadone or buprenorphine for pain management, emergency cases, or research purposes. It is NOT a federally-certified OTP.
- 3 This facility is "drug free." It does not use medications to treat opioid addiction or accept clients using medication to treat opioid addiction.
- 4 This facility accepts clients who are on methadone, buprenorphine and/or naltrexone (Vivitrol®) maintenance or treatment, but these medications originate from or are prescribed by another entity. (The medications may or may not be stored/delivered/monitored onsite.)
- 5 This facility prescribes and/or administers buprenorphine and/or naltrexone (Vivitrol®). This facility is NOT a federally-certified OTP. Buprenorphine use is authorized through a Data 2000 waived physician.
- 6 This facility administers and/or dispenses methadone, buprenorphine and/or naltrexone (Vivitrol®) as a federally-certified Opioid Treatment Program (OTP). A Data 2000 waived physician may or may not also be onsite. (While most OTPs use methadone, some only use buprenorphine.)

SKIP TO Q.13 (BELOW)

***12a. Are ALL of the substance abuse clients at this facility currently receiving methadone, buprenorphine, or naltrexone (Vivitrol®)?**

- 1 Yes
- 0 No

***12b. Which of the following medication services does this program provide?**

MARK ALL THAT APPLY

- 1 Maintenance services with methadone or buprenorphine
- 2 Maintenance services with medically-supervised withdrawal after a pre-determined time
- 3 Detoxification services with methadone or buprenorphine
- 4 Relapse prevention with naltrexone (Vivitrol®)

***13. 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.**

TYPE OF COUNSELING	MARK ONE BOX FOR EACH 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	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
2. Group counseling	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
3. Family counseling	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
4. Marital/couples counseling	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

***14. 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.**

- For definitions of these approaches, go to: <https://info.nssats.com>

CLINICAL/THERAPEUTIC APPROACHES	MARK ONE FREQUENCY FOR EACH APPROACH				
	NEVER	RARELY	SOMETIMES	ALWAYS OR OFTEN	NOT FAMILIAR WITH THIS APPROACH
1. Substance abuse counseling	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
2. 12-step facilitation	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
3. Brief intervention	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
4. Cognitive-behavioral therapy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
5. Dialectical behavior therapy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
6. Contingency management/motivational incentives	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
7. Motivational interviewing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
8. Trauma-related counseling	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
9. Anger management	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
10. Matrix Model	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
11. Community reinforcement plus vouchers	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
12. Rational emotive behavioral therapy (<i>REBT</i>)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
13. Relapse prevention	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
14. Computerized substance abuse treatment/telemedicine (including Internet, Web, mobile, and desktop programs)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
15. Other treatment approach (<i>Specify: _____</i>)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	<input type="checkbox"/>

15. 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

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

- 1 Yes
- 0 No → SKIP TO Q.17 (BELOW)

*16a. Does this facility serve only DUI/DWI clients?

- 1 Yes
- 0 No

*17. Does this facility provide substance abuse treatment services in sign language at this location for the deaf and hard of hearing (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

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

- 1 Yes
- 0 No → SKIP TO Q.19 (PAGE 6)

18a. 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.19 (PAGE 6)
- 3 BOTH staff counselor and on-call interpreter

*18a1. Do staff counselors provide substance abuse treatment in Spanish at this facility?

- 1 Yes
- 0 No → SKIP TO Q.18b (BELOW)

18a2. Do staff counselors at this facility provide substance abuse treatment in any other languages?

- 1 Yes
- 0 No → SKIP TO Q.19 (PAGE 6)

*18b. 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 Farsi
- 11 French
- 12 German
- 13 Greek
- 14 Hebrew
- 15 Hindi
- 16 Hmong
- 17 Italian
- 18 Japanese
- 19 Korean
- 20 Polish
- 21 Portuguese
- 22 Russian
- 23 Tagalog
- 24 Vietnamese
- 25 Any other language

(Specify: _____)

***19. 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?**

Type of Client	MARK "YES" OR "NO" FOR EACH CATEGORY		IF SERVED, WHAT IS THE LOWEST AGE SERVED		IF SERVED, WHAT IS THE HIGHEST AGE SERVED	
	SERVED BY THIS FACILITY					
1. Female	<input type="checkbox"/> Yes	<input type="checkbox"/> No	____ YEARS	<input type="checkbox"/> No minimum age	____ YEARS	<input type="checkbox"/> No maximum age
2. Male	<input type="checkbox"/> Yes	<input type="checkbox"/> No	____ YEARS	<input type="checkbox"/> No minimum age	____ YEARS	<input type="checkbox"/> No maximum age

***19a. Many facilities have clients in one or more of the following categories. For which client categories does this facility at this location offer a substance abuse treatment program or group specifically tailored for clients in that category? If this facility treats clients in any of these categories but does not have a specifically tailored program or group for them, do not mark the box for that category.**

MARK ALL THAT APPLY

- 1 Adolescents
- 2 Young adults
- 3 Adult women
- 4 Pregnant/postpartum women
- 5 Adult men
- 6 Seniors or older adults
- 7 Lesbian, gay, bisexual, transgender (*LGBT*) clients
- 8 Veterans
- 9 Active duty military
- 10 Members of military families
- 11 Criminal justice clients (*other than DUI/DWI*)
- 12 Clients with co-occurring mental and substance abuse disorders
- 13 Clients with HIV or AIDS
- 14 Clients who have experienced sexual abuse
- 15 Clients who have experienced intimate partner violence, domestic violence
- 16 Clients who have experienced trauma
- 17 Specifically tailored programs or groups for any other types of clients
(Specify: _____)
- 18 No specifically tailored programs or groups are offered

***20. 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.21 (NEXT PAGE)

***20a. Which of the following HOSPITAL INPATIENT services are offered at this facility?**

MARK "YES" OR "NO" FOR EACH

- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|
| 1. Hospital inpatient detoxification
(Similar to ASAM Levels IV-D and III.7-D, <i>medically managed or monitored inpatient detoxification</i>) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Hospital inpatient treatment
(Similar to ASAM Levels IV and III.7, <i>medically managed or monitored intensive inpatient treatment</i>) | <input type="checkbox"/> | <input type="checkbox"/> |

NOTE: ASAM is the American Society of Addiction Medicine.
For more information on ASAM please go to <https://info.nssats.com>.

***21. 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.22 (BELOW)

***21a. 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)

***22. 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.23 (TOP OF NEXT COLUMN)

***22a. 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 or Vivitrol® treatment..... 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)

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

- 1 Yes
0 No → SKIP TO Q.24 (BELOW)

23a. Do you want the availability of a sliding fee scale published in SAMHSA's online Locator and Directory?

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

- 1 Yes
0 No

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

- 1 Yes
0 No → SKIP TO Q.25 (BELOW)

24a. Do you want the availability of free care for eligible clients published in SAMHSA's online Locator and Directory?

- The online Locator and Directory will explain that potential clients should call the facility for information on eligibility.

- 1 Yes
0 No

***25. 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.26 on the next page.

- 1 Yes
0 No
d Don't Know

***26. 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

- | | YES | NO | DON'T
KNOW |
|--|----------------------------|----------------------------|----------------------------|
| 1. No payment accepted (<i>free treatment for ALL clients</i>) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 2. Cash or self-payment | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 3. Medicare | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 4. Medicaid | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 5. State-financed health insurance plan other than Medicaid | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 6. Federal military insurance (<i>e.g., TRICARE</i>)..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 7. Private health insurance | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 8. Access To Recovery (<i>ATR</i>) vouchers | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 9. IHS/Tribal/Urban (<i>ITU</i>) funds..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 10. Other (<i>Specify: _____</i>)..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |

27. 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.

WORK ACTIVITY	MARK ONE METHOD FOR EACH ACTIVITY			
	COMPUTER/ ELECTRONIC ONLY	PAPER ONLY	BOTH ELECTRONIC AND PAPER	NA
1. Intake	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	na <input type="checkbox"/>
2. Scheduling appointments	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	na <input type="checkbox"/>
3. Assessment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	na <input type="checkbox"/>
4. Treatment plan	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	na <input type="checkbox"/>
5. Client progress monitoring	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	na <input type="checkbox"/>
6. Discharge	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	na <input type="checkbox"/>
7. Referrals	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	na <input type="checkbox"/>
8. Issue/receive lab results	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	na <input type="checkbox"/>
9. Billing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	na <input type="checkbox"/>
10. Outcomes management	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	na <input type="checkbox"/>
11. Medication prescribing/dispensing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	na <input type="checkbox"/>
12. Health records	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	na <input type="checkbox"/>
13. Interoperability with other providers (<i>such as primary care, mental health providers, criminal justice, etc.</i>)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	na <input type="checkbox"/>

SECTION B: REPORTING CLIENT COUNTS

28. Questions 29 through 34 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.29 (TOP OF NEXT COLUMN)
- 2 This facility plus others
- 3 Another facility will report this facility's client counts → SKIP TO Q.35 (PAGE 12)

28a. How many facilities will be included in your client counts? _____

THIS FACILITY	<input style="width: 100%;" type="text" value="1"/>
+ ADDITIONAL FACILITIES	<input style="width: 100%;" type="text"/>
TOTAL FACILITIES^a	
<input style="width: 100%;" type="text"/>	

^aFor Section B, please include all of these facilities in the client counts that you report in questions 29 through 34.

28b. 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

HOSPITAL INPATIENT CLIENT COUNTS

29. On March 31, 2017, did any patients receive HOSPITAL INPATIENT substance abuse services at this facility?

- 1 Yes
- 0 No → SKIP TO Q.30 (PAGE 10)

29a. On March 31, 2017, 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**

NOTE: ASAM is the American Society of Addiction Medicine. For more information on ASAM please go to <https://info.nssats.com>.

29b. 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 _____

29c. 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 _____
3. Vivitrol® administered at this facility _____

29d. On March 31, 2017, 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**

30. On March 31, 2017, did any clients receive RESIDENTIAL (non-hospital) substance abuse services at this facility?

- 1 Yes
- 0 No → SKIP TO Q.31 (NEXT COLUMN)

30a. On March 31, 2017, 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

30b. 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 _____

30c. 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 _____
- 3. Vivitrol® administered at this facility _____

30d. On March 31, 2017, how many residential beds were specifically designated for substance abuse treatment?

ENTER A NUMBER
(IF NONE, ENTER "0")

Number of beds _____

OUTPATIENT CLIENT COUNTS

31. During the month of March 2017, did any clients receive OUTPATIENT substance abuse services at this facility?

- 1 Yes
- 0 No → SKIP TO Q.32 (PAGE 11)

31a. How many clients received each of the following OUTPATIENT substance abuse services at this facility during March 2017?

ONLY INCLUDE clients who received treatment in March AND were still enrolled in treatment on March 31, 2017.

- 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 or Vivitrol® treatment _____
(Count methadone/buprenorphine/Vivitrol® 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

31b. 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 _____

31c. 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 _____

3. Vivitrol® administered at this facility _____

31d. On average, during March 2017, 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%)

**ALL SUBSTANCE ABUSE
TREATMENT SETTINGS**
Including Hospital Inpatient,
Residential (non-hospital) and/or Outpatient

32. 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 substances other than alcohol; (2) abuse only of alcohol; or (3) abuse only of substances other than alcohol.

Enter the percent of clients on March 31, 2017, who were in each of these three groups:

Clients in treatment for abuse of:

- 1. BOTH alcohol and substances other than alcohol _____%
- 2. ONLY alcohol _____%
- 3. ONLY substances other than alcohol _____%

TOTAL 100%

33. Approximately what percent of the substance abuse treatment clients enrolled at this facility on March 31, 2017, had a diagnosed co-occurring mental and substance abuse disorder?

PERCENT OF CLIENTS
(IF NONE, ENTER "0") %

34. 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

***35. 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

***36. Which of the following statements BEST describes this facility's smoking policy for clients?**

MARK ONE ONLY

- 1 Not permitted to smoke anywhere outside or within any building
2 Permitted in designated outdoor area(s)
3 Permitted anywhere outside
4 Permitted in designated indoor area(s)
5 Permitted anywhere inside
6 Permitted anywhere without restriction

***37. 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

- | | | YES | NO | DON'T
KNOW |
|--|---|--------------------------|----|----------------------------|
| 1. State substance abuse agency | 1 | <input type="checkbox"/> | 0 | d <input type="checkbox"/> |
| 2. State mental health department | 1 | <input type="checkbox"/> | 0 | d <input type="checkbox"/> |
| 3. State department of health | 1 | <input type="checkbox"/> | 0 | d <input type="checkbox"/> |
| 4. Hospital licensing authority | 1 | <input type="checkbox"/> | 0 | d <input type="checkbox"/> |
| 5. The Joint Commission | 1 | <input type="checkbox"/> | 0 | d <input type="checkbox"/> |
| 6. Commission on Accreditation of Rehabilitation Facilities (CARF) .. | 1 | <input type="checkbox"/> | 0 | d <input type="checkbox"/> |
| 7. National Committee for Quality Assurance (NCQA) | 1 | <input type="checkbox"/> | 0 | d <input type="checkbox"/> |
| 8. Council on Accreditation (COA) | 1 | <input type="checkbox"/> | 0 | d <input type="checkbox"/> |
| 9. Healthcare Facilities Accreditation Program (HFAP) | 1 | <input type="checkbox"/> | 0 | d <input type="checkbox"/> |
| 10. Other national organization or federal, state, or local agency | 1 | <input type="checkbox"/> | 0 | d <input type="checkbox"/> |
| (Specify: _____) | | | | |

***38. 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 Q.39 (BELOW)

***38a. If eligible, the website address for this facility will appear in the *Directory* and online Locator. Please provide the address exactly as it should be entered in order to reach your site.**

Web Address: _____

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

- 1 Yes
0 No

40. The *Directory* may be published on CD. If so, would you like to receive a free copy of the CD? (The *Directory* will also be available at <http://store.samhsa.gov> in PDF format; search for *Directory*.)

- 1 Yes
0 No

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 COUNTS

Complete this section if you reported clients for this facility plus other facilities, as indicated in Question 28.

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 EMAIL
ADDRESS: _____

HOSPITAL INPATIENT RESIDENTIAL OUTPATIENT

FACILITY NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

PHONE: _____

FACILITY EMAIL
ADDRESS: _____

HOSPITAL INPATIENT RESIDENTIAL OUTPATIENT

FACILITY NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

PHONE: _____

FACILITY EMAIL
ADDRESS: _____

HOSPITAL INPATIENT RESIDENTIAL OUTPATIENT

FACILITY NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

PHONE: _____

FACILITY EMAIL
ADDRESS: _____

HOSPITAL INPATIENT RESIDENTIAL OUTPATIENT

FACILITY NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

PHONE: _____

FACILITY EMAIL
ADDRESS: _____

HOSPITAL INPATIENT RESIDENTIAL OUTPATIENT

FACILITY NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

PHONE: _____

FACILITY EMAIL
ADDRESS: _____

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 may be published in SAMHSA's online Behavioral Health Treatment Services Locator, the *National Directory of Drug and Alcohol Abuse Treatment Programs*, and other publically available listings. Responses to non-asterisked questions will be published with no direct link to individual treatment facilities.

**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 xxxx-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.