

U.S. Department of Health and Human Services

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See OMB burden statement on last page

2018 National Mental Health Services Survey (N-MHSS)

April 30, 2018

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 green flyer enclosed in your questionnaire packet for the Internet address and your unique User ID and Password. You can log on and off the survey 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 additional help or information, call the N-MHSS helpline at 1-866-778-9752.

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 1-866-778-9752.
- 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 this is a **separate inpatient psychiatric unit of a general hospital**, consider the psychiatric unit as the relevant “facility” for the purpose of this survey.
- For additional information about the survey and definitions for some of the terms, please visit our website at: <https://info.nmhss.org>.
- Return the completed questionnaire in the envelope provided, or fax it to 1-609-799-0005. (Please reference “N-MHSS” on your fax.)

Please keep a copy of your completed questionnaire for your records.

- If you have questions or need additional blank forms, contact:

MATHEMATICA POLICY RESEARCH

1-866-778-9752

NMHSS@mathematica-mpr.com

IMPORTANT INFORMATION

***Asterisked Questions.** Information from asterisked (*) questions is published in SAMHSA’s online Behavioral Health Treatment Services Locator, found at <https://findtreatment.samhsa.gov>, unless you designate otherwise in question C1, page 12, of this questionnaire.

Mapping Feature in online Locator. Complete and accurate name and address information is needed for SAMHSA’s online Behavioral Health Treatment Services Locator so it can correctly map the facility’s location.

Eligibility for online Locator. Only facilities that provide mental health treatment and complete this questionnaire are eligible to be listed in the online Behavioral Health Treatment Services Locator. If you have any questions regarding eligibility, please contact the N-MHSS helpline at 1-866-778-9752.

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.

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

MARK "YES" OR "NO" FOR EACH

- | | <u>YES</u> | <u>NO</u> |
|---|----------------------------|----------------------------|
| 1. Mental health intake..... | 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/or referral (also includes emergency programs that provide services in person or by telephone) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| *4. Mental health treatment (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 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 5. Substance abuse treatment..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 6. Administrative services for mental health treatment facilities | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

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

- 1 Yes
 0 No → **SKIP TO C3 (PAGE 12)**

***A3. Mental health treatment is provided in which of the following service settings at this facility, at this location?**

MARK "YES" OR "NO" FOR EACH

- | | <u>YES</u> | <u>NO</u> |
|---|----------------------------|----------------------------|
| 1. 24-hour hospital inpatient | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. 24-hour residential | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. Partial hospitalization/day treatment..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 4. Outpatient | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

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

- For definitions of facility types, go to: <https://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 Other type of residential treatment facility
- 6 Veterans Administration medical center (VAMC) or other VA health care facility
- 7 Community mental health center (CMHC)
- 8 Partial hospitalization/day treatment facility
- 9 Outpatient mental health facility
- 10 Multi-setting mental health facility (non-hospital residential plus either outpatient and/or partial hospitalization/day treatment)
- 11 Other (Specify: _____)

SKIP TO A7 (NEXT PAGE)

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

- 1 Yes
 0 No → **SKIP TO A6 (BELOW)**

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 C3 (PAGE 12)**

A6. Is this facility a Federally Qualified Health Center (FQHC)?

- FQHCs include: (1) all organizations that receive grants under Section 330 of the Public Health Service Act; and (2) other organizations that do not receive grants, but have met the requirements to receive grants under Section 330 according to the U.S. Department of Health and Human Services.
- For a complete definition of a FQHC, go to: <https://info.nmhss.org>

- 1 Yes
 0 No
 d Don't know

A7. What is the primary treatment focus of this facility, at this location?

- *Separate psychiatric units in general hospitals should answer for just their unit and NOT for the entire hospital.*

MARK ONE ONLY

- 1 Mental health treatment
- 2 Substance abuse treatment → **SKIP TO C3 (PAGE 12)**
- 3 Mix of mental health and substance abuse treatment (neither is primary)
- 4 General health care
- 5 Other service focus (*Specify:*
_____)

A8. Is this facility a jail, prison, or detention center that provides treatment exclusively for incarcerated persons or juvenile detainees?

- 1 Yes → **SKIP TO C3 (PAGE 12)**
- 0 No



***A9. Is this facility operated by:**

MARK ONE ONLY

- 1 A private for-profit organization
 - 2 A private non-profit organization
 - 3 A public agency or department
- **SKIP TO A10 (NEXT COLUMN)**
→ **SKIP TO A9a (TOP OF NEXT COLUMN)**

***A9a. Which public agency or department?**

MARK ONE ONLY

- 1 State mental health authority (SMHA)
- 2 Other state government agency or department (e.g., Department of Health)
- 3 Regional/district authority or county, local, or municipal government
- 4 Tribal government
- 5 Indian Health Service
- 6 Department of Veterans Affairs
- 7 Other (*Specify:*
_____)

A10. Is this facility affiliated with a religious organization?

- 1 Yes
- 0 No

***A11. Which of these mental health treatment approaches are offered at this facility, at this location?**

- *For definitions of treatment approaches, go to: <https://info.nmhss.org>*

MARK ALL THAT APPLY

- 1 Individual psychotherapy
- 2 Couples/family therapy
- 3 Group therapy
- 4 Cognitive behavioral therapy
- 5 Dialectical behavior therapy
- 6 Behavior modification
- 7 Integrated dual disorders treatment
- 8 Trauma therapy
- 9 Activity therapy
- 10 Electroconvulsive therapy
- 11 Telemedicine therapy
- 12 Psychotropic medication
- 13 Other (*Specify:*
_____)
- 14 None of these mental health treatment approaches are offered

***A12. Which of these services and practices are offered at this facility, at this location?**

- For definitions, go to: <https://info.nmhss.org>

MARK ALL THAT APPLY

- 1 Assertive community treatment (ACT)
- 2 Intensive case management (ICM)
- 3 Case management (CM)
- 4 Court-ordered outpatient treatment

- 5 Chronic disease/illness management (CDM)
- 6 Illness management and recovery (IMR)
- 7 Integrated primary care services
- 8 Diet and exercise counseling

- 9 Family psychoeducation
- 10 Education services
- 11 Housing services
- 12 Supported housing
- 13 Psychosocial rehabilitation services
- 14 Vocational rehabilitation services
- 15 Supported employment

- 16 Therapeutic foster care
- 17 Legal advocacy
- 18 Psychiatric emergency walk-in services
- 19 Suicide prevention services
- 20 Consumer-run (peer support) services

- 21 Screening for tobacco use
- 22 Smoking/tobacco cessation counseling
- 23 Nicotine replacement therapy
- 24 Non-nicotine smoking/tobacco cessation medications (by prescription)

- 25 Other (Specify: _____)

- 26 None of these services and practices are offered

***A13. What age groups are accepted for treatment at this facility?**

MARK "YES" OR "NO" FOR EACH

- | | <u>YES</u> | <u>NO</u> |
|-----------------------------------|----------------------------|----------------------------|
| 1. Children (12 or younger) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Adolescents (13-17) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. Young adults (18-25) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 4. Adults (26-64) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 5. Seniors (65 or older) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

***A14. Does this facility offer a mental health treatment program or group that is dedicated or designed exclusively for clients in any of the following categories?**



- 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 Children/adolescents with serious emotional disturbance (SED)
- 2 Transitional age young adults
- 3 Persons 18 and older with serious mental illness (SMI)
- 4 Seniors or older adults
- 5 Persons with Alzheimer's or dementia
- 6 Persons with co-occurring mental and substance use disorders
- 7 Persons with eating disorders
- 8 Persons with a diagnosis of post-traumatic stress disorder (PTSD)
- 9 Persons who have experienced trauma (excluding persons with a PTSD diagnosis)
- 10 Persons with traumatic brain injury (TBI)
- 11 Veterans
- 12 Active duty military
- 13 Members of military families
- 14 Lesbian, gay, bisexual, or transgender clients (LGBT)
- 15 Forensic clients (referred from the court/judicial system)
- 16 Persons with HIV or AIDS
- 17 Other special program or group (Specify: _____)

- 18 No dedicated or exclusively designed programs or groups are offered

***A15. Does this facility offer a crisis intervention team that handles acute mental health issues at this facility and/or off-site?**

- 1 Yes
- 0 No

***A16. Does this facility provide mental health 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 staff or an on call interpreter provides this service.

- 1 Yes
- 0 No

***A17. 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 A18 (NEXT COLUMN)**

A17a. At this facility, who provides mental health treatment services in a language other than English?

MARK ONE ONLY

- 1 Staff who speak a language other than English
- 2 On-call interpreter (in person or by phone) brought in when needed → **SKIP TO A18 (NEXT COLUMN)**
- 3 BOTH staff and on-call interpreter

***A17a1. Do staff provide mental health treatment services in Spanish at this facility?**

- 1 Yes
- 0 No → **SKIP TO A17b (TOP OF NEXT COLUMN)**

A17a2. Do staff at this facility provide mental health treatment services in any other languages?

- 1 Yes → **SKIP TO A17b (TOP OF NEXT COLUMN)**
- 0 No → **SKIP TO A18 (NEXT COLUMN)**

***A17b. 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 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: _____)

A18. Which of these quality improvement practices are part of this facility's standard operating procedures?

MARK "YES" OR "NO" FOR EACH

- | | <u>YES</u> | <u>NO</u> |
|---|----------------------------|----------------------------|
| 1. Continuing education requirements for professional staff | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Regularly scheduled case review with a supervisor | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. Regularly scheduled case review by an appointed quality review committee | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 4. Client outcome follow-up after discharge | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 5. Periodic utilization review | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 6. Periodic client satisfaction surveys | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

***A19. 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

A20. In the 12-month period beginning May 1, 2017, and ending April 30, 2018, have staff at this facility used seclusion or restraint with clients?

- 1 Yes
- 0 No

A20a. Does this facility have any policies in place to minimize the use of seclusion or restraint?

- 1 Yes
- 0 No

A21. For each of the following functions, please indicate if staff members routinely use computer or electronic resources, paper only, or a combination of both to complete the function.

| Function | Computer/ Electronic Only | Paper Only | Both Electronic and Paper | N/A |
|---|---------------------------------|----------------------------|---------------------------------|----------------------------|
| 1. Intake | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | N <input type="checkbox"/> |
| 2. Scheduling appointments | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | N <input type="checkbox"/> |
| 3. Assessment/ evaluation | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | N <input type="checkbox"/> |
| 4. Treatment plan | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | N <input type="checkbox"/> |
| 5. Client progress monitoring | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | N <input type="checkbox"/> |
| 6. Discharge | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | N <input type="checkbox"/> |
| 7. Referrals | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | N <input type="checkbox"/> |
| 8. Issue/receive lab results | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | N <input type="checkbox"/> |
| 9. Prescribing/ dispensing medication | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | N <input type="checkbox"/> |
| 10. Checking medication interactions | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | N <input type="checkbox"/> |
| 11. Health records | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | N <input type="checkbox"/> |
| 12. Collaboration with a client's other providers (such as primary care provider) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | N <input type="checkbox"/> |
| 13. Billing | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | N <input type="checkbox"/> |
| 14. Client or family satisfaction surveys | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | N <input type="checkbox"/> |

***A22. Does this facility use a sliding fee scale?**

- *Not applicable to Veterans Administration facilities.*

- 1 Yes → **SKIP TO A22a (TOP OF NEXT PAGE)**
- 0 No → **SKIP TO A23 (NEXT PAGE)**

A22a. Do you want the availability of a sliding fee scale published in SAMHSA's online Behavioral Health Treatment Services Locator?

- *Not applicable to Veterans Administration facilities.*
- *The Locator will explain that sliding fee scales are based on income and other factors.*

1 Yes
 0 No

***A23. Does this facility offer treatment at no charge to clients who cannot afford to pay?**

- *Not applicable to Veterans Administration facilities.*

1 Yes
 0 No → **SKIP TO A24 (TOP OF NEXT COLUMN)**

A23a. Do you want the availability of treatment at no charge for eligible clients published in SAMHSA's online Behavioral Health Treatment Services Locator?

- *Not applicable to Veterans Administration facilities.*
- *The Locator will inform potential clients to call the facility for information on eligibility.*

1 Yes
 0 No

***A24. Which of the following types of client payments, insurance, or funding are accepted by this facility for mental health treatment services?**

MARK "YES," "NO" OR "DON'T KNOW" FOR EACH

| | <u>YES</u> | <u>NO</u> | <u>DON'T KNOW</u> |
|---|----------------------------|----------------------------|----------------------------|
| 1. Cash or self-payment | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 2. Private health insurance | 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. State mental health agency (or equivalent) funds | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 7. State welfare or child and family services agency funds | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 8. State corrections or juvenile justice agency funds | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 9. State education agency funds | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 10. Other state government funds | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 11. County or local government funds | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 12. Community Service Block Grants | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 13. Community Mental Health Block Grants | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 14. Federal military insurance (<i>such as TRICARE</i>) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 15. U.S. Department of Veterans Affairs funds | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 16. IHS/Tribal/Urban (<i>ITU</i>) funds | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 17. Other | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |

(Specify: _____)

A25. From which of these agencies or organizations does this facility have licensing, certification, or accreditation?

- 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 mental health authority..... | 1 <input type="checkbox"/> | o <input type="checkbox"/> | d <input type="checkbox"/> |
| 2. State substance abuse agency .. | 1 <input type="checkbox"/> | o <input type="checkbox"/> | d <input type="checkbox"/> |
| 3. State department of health | 1 <input type="checkbox"/> | o <input type="checkbox"/> | d <input type="checkbox"/> |
| 4. State or local Department of Family and Children's Services ... | 1 <input type="checkbox"/> | o <input type="checkbox"/> | d <input type="checkbox"/> |
| 5. Hospital licensing authority..... | 1 <input type="checkbox"/> | o <input type="checkbox"/> | d <input type="checkbox"/> |
| 6. The Joint Commission..... | 1 <input type="checkbox"/> | o <input type="checkbox"/> | d <input type="checkbox"/> |
| 7. Commission on Accreditation of Rehabilitation Facilities (CARF) | 1 <input type="checkbox"/> | o <input type="checkbox"/> | d <input type="checkbox"/> |
| 8. Council on Accreditation (COA) . | 1 <input type="checkbox"/> | o <input type="checkbox"/> | d <input type="checkbox"/> |
| 9. Centers for Medicare and Medicaid Services | 1 <input type="checkbox"/> | o <input type="checkbox"/> | d <input type="checkbox"/> |
| 10. Other national organization, or federal, state, or local agency | 1 <input type="checkbox"/> | o <input type="checkbox"/> | d <input type="checkbox"/> |

(Specify: _____)

***A26. What telephone number(s) should a potential client call to schedule an intake appointment?**

INTAKE TELEPHONE NUMBER(S):

- (____) _____ - _____ ext. _____
- (____) _____ - _____ ext. _____

SECTION B: CLIENT/PATIENT COUNT INFORMATION

Questions B3 – B8 ask about the number of clients/patients treated at this facility on specific dates.

Please look carefully at the dates specified, as questions will ask for either a single day count, a one-month count, or a 12-month count.

Include ALL clients/patients receiving mental health treatment in your counts, even if a mental health disorder is a secondary diagnosis or has not yet been formally determined.

B1. Although reporting for only the clients/patients treated at this facility is preferred, we realize that may not be possible. Will the client/patient counts reported in this questionnaire include:

MARK ONE ONLY

- Only this facility → SKIP TO B3 (PAGE 8)
- This facility plus others → SKIP TO B2 (BELOW)
- Another facility in the organization will report client/patient counts for this facility

B1a. Please record the name and telephone number of the facility that will report your client/patient counts.

Facility name: _____

Telephone: (____) - ____ - _____

After recording the facility name and telephone number in B1a → SKIP TO C1 (PAGE 12)

B2. How many facilities will be included in the reported client/patient counts?

| | |
|-------------------------|--------------------------------|
| THIS FACILITY | <input type="text" value="1"/> |
| + ADDITIONAL FACILITIES | <input type="text"/> |
| <hr/> | |
| = TOTAL FACILITIES | <input type="text"/> |

On page 13 of this questionnaire, list the name and location address of each facility included in your client/patient counts. If you prefer, we will contact you for a list of the other facilities included in your client/patient counts.

CONTINUE WITH QUESTION B3 (TOP OF NEXT PAGE)

PATIENT COUNTS: 24-HOUR HOSPITAL INPATIENT

B3. On April 30, 2018, did any patients receive 24-hour hospital inpatient mental health treatment at this facility, at this location?

- Yes → GO TO B3a (TOP OF NEXT COLUMN)
 No → SKIP TO B4 (PAGE 9)

B3a. On April 30, 2018, how many patients received 24-hour hospital inpatient mental health treatment at this facility?

- **DO NOT** count family members, friends, or other non-treatment persons.

HOSPITAL INPATIENTS
TOTAL BOX

CONTINUE WITH QUESTION B3b (BELOW)

B3b. For each category below, please provide a breakdown of the Hospital Inpatients reported in the B3a TOTAL BOX above. Use either numbers OR percents, whichever is more convenient.

- If numbers are used—each category total should equal the number reported in the B3a TOTAL BOX above.
- If percents are used—each category total should equal 100%.

| | | NUMBER | OR | PERCENT |
|---|---|---|--|--|
| GENDER | Male..... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> |
| | Female..... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> |
| | CATEGORY TOTAL: (Should=B3a or 100%) | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text" value="100%"/> |
| AGE | 0 – 17..... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> |
| | 18 – 64..... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> |
| | 65 and older..... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> |
| CATEGORY TOTAL: (Should=B3a or 100%) | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text" value="100%"/> | |
| ETHNICITY | Hispanic or Latino..... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> |
| | Not Hispanic or Latino..... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> |
| | Unknown or not collected..... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> |
| CATEGORY TOTAL: (Should=B3a or 100%) | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text" value="100%"/> | |
| RACE | American Indian or Alaska Native..... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> |
| | Asian..... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> |
| | Black or African American..... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> |
| | Native Hawaiian or Other Pacific Islander.... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> |
| | White..... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> |
| | Two or more races..... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> |
| Unknown or not collected..... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> | |
| CATEGORY TOTAL: (Should=B3a or 100%) | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text" value="100%"/> | |
| LEGAL STATUS | Voluntary..... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> |
| | Involuntary, non-forensic..... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> |
| | Involuntary, forensic..... | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text"/> |
| CATEGORY TOTAL: (Should=B3a or 100%) | <input style="width: 60px; height: 20px;" type="text"/> | | <input style="width: 60px; height: 20px;" type="text" value="100%"/> | |

B3c. On April 30, 2018, how many hospital inpatient beds at this facility were specifically designated for providing mental health treatment?

NUMBER OF BEDS
 (If none, enter '0')

CLIENT COUNTS: 24-HOUR RESIDENTIAL (NON-HOSPITAL)

B4. On April 30, 2018, did any clients receive 24-hour residential mental health treatment at this facility, at this location?

- 1 Yes → GO TO B4a (TOP OF NEXT COLUMN)
- 0 No → SKIP TO B5 (PAGE 10)

B4a. On April 30, 2018, how many clients received 24-hour residential mental health treatment at this facility?

- **DO NOT** count family members, friends, or other non-treatment persons.

RESIDENTIAL CLIENTS
TOTAL BOX

CONTINUE WITH QUESTION B4b (BELOW)

B4b. For each category below, please provide a breakdown of the Residential Clients reported in the B4a TOTAL BOX above. Use either numbers OR percents, whichever is more convenient.

- If numbers are used—each category total should equal the number reported in the B4a TOTAL BOX above.
- If percents are used—each category total should equal 100%.

| | | NUMBER | OR | PERCENT |
|---|---|---|--|--|
| GENDER | Male | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| | Female | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| | CATEGORY TOTAL: (Should=B4a or 100%) | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text" value="100%"/> |
| AGE | 0 – 17 | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| | 18 – 64 | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| | 65 and older | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| CATEGORY TOTAL: (Should=B4a or 100%) | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text" value="100%"/> | |
| ETHNICITY | Hispanic or Latino | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| | Not Hispanic or Latino | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| | Unknown or not collected | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| CATEGORY TOTAL: (Should=B4a or 100%) | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text" value="100%"/> | |
| RACE | American Indian or Alaska Native | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| | Asian | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| | Black or African American | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| | Native Hawaiian or Other Pacific Islander | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| | White | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| | Two or more races | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| | Unknown or not collected | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| CATEGORY TOTAL: (Should=B4a or 100%) | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text" value="100%"/> | |
| LEGAL STATUS | Voluntary | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| | Involuntary, non-forensic | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| | Involuntary, forensic | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text"/> |
| CATEGORY TOTAL: (Should=B4a or 100%) | <input style="width: 50px; height: 20px;" type="text"/> | | <input style="width: 50px; height: 20px;" type="text" value="100%"/> | |

B4c. On April 30, 2018, how many residential beds at this facility were specifically designated for providing mental health treatment?

NUMBER OF BEDS

(If none, enter '0')

CLIENT COUNTS: LESS THAN 24-HOUR CARE (INCLUDE OUTPATIENT CLIENTS AND PARTIAL HOSPITALIZATION/DAY TREATMENT CLIENTS)

B5. During the month of April 2018, did any clients receive less than 24-hour mental health treatment at this facility, at this location?

INCLUDE OUTPATIENT CLIENTS AND PARTIAL HOSPITALIZATION/DAY TREATMENT CLIENTS ON THIS PAGE.

- Yes → GO TO B5a (TOP OF NEXT COLUMN)
 No → SKIP TO B6 (PAGE 11)

B5a. During the month of April 2018, how many clients received less than 24-hour mental health treatment at this facility?

- **ONLY INCLUDE** those seen at this facility at least once during the month of April, **AND who were still enrolled in treatment on April 30, 2018.**
- **DO NOT** count family members, friends, or other non-treatment persons.

OUTPATIENT CLIENTS AND PARTIAL HOSPITALIZATION/DAY TREATMENT CLIENTS TOTAL BOX

CONTINUE WITH QUESTION B5b (BELOW)

B5b. For each category below, please provide a breakdown of the Clients in Less Than 24-Hour Care reported in the B5a TOTAL BOX above. Use either numbers OR percents, whichever is more convenient.

- If numbers are used—each category total should equal the number reported in the B5a TOTAL BOX above.
- If percents are used—each category total should equal 100%.

| | | NUMBER | OR | PERCENT |
|---|---|--------|------|---------|
| GENDER | Male..... | | | |
| | Female..... | | | |
| | CATEGORY TOTAL: (Should=B5a or 100%) | | | 100% |
| AGE | 0 – 17..... | | | |
| | 18 – 64..... | | | |
| | 65 and older..... | | | |
| | CATEGORY TOTAL: (Should=B5a or 100%) | | | 100% |
| ETHNICITY | Hispanic or Latino..... | | | |
| | Not Hispanic or Latino..... | | | |
| | Unknown or not collected..... | | | |
| | CATEGORY TOTAL: (Should=B5a or 100%) | | | 100% |
| RACE | American Indian or Alaska Native..... | | | |
| | Asian..... | | | |
| | Black or African American..... | | | |
| | Native Hawaiian or Other Pacific Islander.... | | | |
| | White..... | | | |
| | Two or more races..... | | | |
| | Unknown or not collected..... | | | |
| CATEGORY TOTAL: (Should=B5a or 100%) | | | 100% | |
| LEGAL STATUS | Voluntary..... | | | |
| | Involuntary, non-forensic..... | | | |
| | Involuntary, forensic..... | | | |
| | CATEGORY TOTAL: (Should=B5a or 100%) | | | 100% |

ALL MENTAL HEALTH CARE SETTINGS

Including 24-Hour Hospital Inpatient, 24-Hour Residential (non-hospital),
and Less Than 24-Hour Outpatient and Partial Hospitalization/Day Treatment

- B6. On April 30, 2018, approximately what percent of the mental health treatment clients/patients enrolled at this facility had diagnosed co-occurring mental and substance use disorders?

PERCENT WITH
CO-OCCURRING
DIAGNOSIS

(If none, enter '0')

- B7. In the 12-month period of May 1, 2017 through April 30, 2018, how many mental health treatment admissions, readmissions, and incoming transfers did this facility have? *Exclude returns from unauthorized absence, such as escape, AWOL, or elopement.*

- **IF DATA FOR THIS TIME PERIOD ARE NOT AVAILABLE:** Use the most recent 12-month period for which data are available.
- **OUTPATIENT CLIENTS:** Consider each initiation to a course of treatment as an admission. Count admissions into treatment, not individual treatment visits.
- **WHEN A MENTAL HEALTH DISORDER IS A SECONDARY DIAGNOSIS:** Count all admissions where clients/patients received mental health treatment.

NUMBER OF MENTAL HEALTH
TREATMENT ADMISSIONS IN
12-MONTH PERIOD

(If none, enter '0')

- B8. What percent of the admissions reported in question B7 above were military veterans? Please give your best estimate.

PERCENT
MILITARY
VETERANS

(If none, enter '0')

SECTION C: GENERAL INFORMATION

C1. If eligible, does this facility want to be listed in SAMHSA's online Behavioral Health Treatment Services Locator?

- *The Locator can be found at:
<https://findtreatment.samhsa.gov>*

- 1 Yes
0 No → **SKIP TO C2 (BELOW)**

C1a. To increase public awareness of behavioral health services, SAMHSA may be sharing facility contact information with large commercially available Internet search engines, such as Google, Bing, Yahoo!, etc. Do you want your facility information shared on these Internet search engines?

- *Information to be shared would be: facility name, location address, telephone number, and website address.*

- 1 Yes
0 No

C2. 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 C3 (NEXT COLUMN)**

***C2a. What is this facility's website address?**

- *Please enter the address exactly as it should be entered in order to access your site.*
- *Do not enter http:// (for example, enter www.yourfacility.com)*

Website: _____

C3. 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/PATIENT COUNTS

Complete this section if you reported clients/patients for this facility plus additional facilities, as indicated in Question B2.

For each additional facility, please mark if that facility offers hospital inpatient, residential, outpatient mental health treatment, and/or partial hospitalization/day treatment at that location.

FACILITY NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

TELEPHONE: _____

FACILITY EMAIL ADDRESS: _____

- HOSPITAL INPATIENT RESIDENTIAL OUTPATIENT
 PARTIAL HOSPITALIZATION/DAY TREATMENT

FACILITY NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

TELEPHONE: _____

FACILITY EMAIL ADDRESS: _____

- HOSPITAL INPATIENT RESIDENTIAL OUTPATIENT
 PARTIAL HOSPITALIZATION/DAY TREATMENT

FACILITY NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

TELEPHONE: _____

FACILITY EMAIL ADDRESS: _____

- HOSPITAL INPATIENT RESIDENTIAL OUTPATIENT
 PARTIAL HOSPITALIZATION/DAY TREATMENT

FACILITY NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

TELEPHONE: _____

FACILITY EMAIL ADDRESS: _____

- HOSPITAL INPATIENT RESIDENTIAL OUTPATIENT
 PARTIAL HOSPITALIZATION/DAY TREATMENT

FACILITY NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

TELEPHONE: _____

FACILITY EMAIL ADDRESS: _____

- HOSPITAL INPATIENT RESIDENTIAL OUTPATIENT
 PARTIAL HOSPITALIZATION/DAY TREATMENT

FACILITY NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

TELEPHONE: _____

FACILITY EMAIL ADDRESS: _____

- HOSPITAL INPATIENT RESIDENTIAL OUTPATIENT
 PARTIAL HOSPITALIZATION/DAY TREATMENT

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

ANY ADDITIONAL COMMENTS

**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 50345_1
P.O. Box 2393
Princeton, NJ 08543-2393

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 0aa(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 Mental Health Treatment Facilities*, and other publically available listings. Responses to non-asterisked questions will be published with no direct link to individual treatment facilities.

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 45 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, 5600 Fishers Lane, Room 15E57-B, Rockville, Maryland 20857.