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

2020 National Mental Health Services Survey (N-MHSS)

April 30, 2020

Substance Abuse and Mental Health Services Administration (SAMHSA)
U.S. Department of Health and Human Services (HHS)

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 any questions or need additional blank surveys, contact:

MATHEMATICA
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, in SAMHSA's *National Directory of Mental Health Treatment Facilities*, and other publicly-available listings, unless you designate otherwise in question C1, page 15, 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 as mental health facilities 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

	YES	NO
1. Mental health intake	1 ☐	0 ☐
2. Mental health diagnostic evaluation	1 ☐	0 ☐
3. Mental health information and/or referral *(also includes emergency programs that provide services in person or by telephone)*	1 ☐	0 ☐
*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 ☐	0 ☐
*5. Treatment for co-occurring disorders plus either serious mental illness (SMI) in adults and/or serious emotional disturbance (SED) in children	1 ☐	0 ☐
6. Substance use disorder treatment	1 ☐	0 ☐
7. Administrative or operational services for mental health treatment facilities	1 ☐	0 ☐

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

1 ☐ Yes → **SKIP TO A3 (TOP OF NEXT COLUMN)**

0 ☐ No → **SKIP TO C2 (PAGE 15)**

***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

	YES	NO
1. 24-hour hospital inpatient	1 ☐	0 ☐
2. 24-hour residential	1 ☐	0 ☐
3. Partial hospitalization/day treatment	1 ☐	0 ☐
4. Outpatient	1 ☐	0 ☐

***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

SKIP TO A7 (NEXT PAGE)

6 ☐ Veterans Affairs Medical Center (VAMC) or other VA health care facility

7 ☐ Community Mental Health Center (CMHC)

8 ☐ Certified Community Behavioral Health Clinic (CCBHC)

9 ☐ Partial hospitalization/day treatment facility

10 ☐ Outpatient mental health facility

11 ☐ Multi-setting mental health facility *(non-hospital residential plus either outpatient and/or partial hospitalization/day treatment)*

SKIP TO A5 (TOP OF NEXT PAGE)

12 ☐ Other *(Specify:* _____ *)*

A5. Is this facility either 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 C2 (PAGE 15)**

***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*
- *For a complete definition of a FQHC, go to: https://info.nmhss.org*

1 ☐ Yes

0 ☐ No

d ☐ Don't know

A7. Does this facility, at this location, provide any of the following services?

MARK ALL THAT APPLY

1 ☐ Assisted living or nursing home care

2 ☐ Supported housing

3 ☐ Group homes

4 ☐ Clubhouse services

5 ☐ Emergency shelter *(such as homeless, domestic violence, etc.)*

6 ☐ Care for only individuals with a developmental disability *(that is, significant limitations in intellectual functioning)*

7 ☐ None of these services

A8. 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 use treatment → **SKIP TO C2 (PAGE 15)**

3 ☐ Mix of mental health and substance use treatment *(neither is primary)*

4 ☐ General health care

5 ☐ Other service focus *(Specify:* _____ *)*

A9. Is this facility a jail, prison, or detention center that provides treatment exclusively for incarcerated persons or juvenile detainees?

1 ☐ Yes → **SKIP TO C2 (PAGE 15)**

0 ☐ No → **SKIP TO A10 (TOP OF NEXT PAGE)**

***A10. 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 A11 (BELOW)

***A10a. 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:*

_____*)*

A11. Is this facility affiliated with a religious (or faith-based) organization?

1 ☐ Yes
0 ☐ No

***A12. Which of these mental health treatment modalities are offered at this facility, at this location?**

● *For definitions of treatment modalities, 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 ☐ Cognitive remediation
7 ☐ Integrated mental health and substance use treatment
8 ☐ Trauma therapy
9 ☐ Activity therapy
10 ☐ Electroconvulsive therapy
11 ☐ Transcranial Magnetic Stimulation (TMS)
12 ☐ Ketamine Infusion Therapy (KIT)
13 ☐ Eye Movement Desensitization and Reprocessing (EMDR) therapy
14 ☐ Telemedicine/telehealth therapy *(including Internet, Web, mobile, and desktop programs)*
15 ☐ Other *(Specify:*

_____*)*

16 ☐ None of these mental health treatment modalities are offered

***A13. Does this facility offer pharmacotherapy, that is, the use of antipsychotics for the treatment of serious mental illness (SMI)?**

1 ☐ Yes

0 ☐ No → **SKIP TO A14 (TOP OF NEXT PAGE)**

***A13a. Which of the following antipsychotics are used for the treatment of SMI at this facility, at this location?**

	MARK ALL THAT APPLY FOR EACH MEDICATION			
FIRST-GENERATION ANTIPSYCHOTIC	**ORAL**	**INJECTABLE**	**LONG-ACTING INJECTABLE**	**NOT USED AT THIS FACILITY**
1. Chlorpromazine (*Thorazine®*)	1 ☐	2 ☐	3 ☐	4 ☐
2. Droperidol (*Inapsine®*)	1 ☐	2 ☐	3 ☐	4 ☐
3. Fluphenazine (*Prolixin®*)	1 ☐	2 ☐	3 ☐	4 ☐
4. Haloperidol (*Haldol®*)	1 ☐	2 ☐	3 ☐	4 ☐
5. Loxapine (*Loxitane®*)	1 ☐	2 ☐	3 ☐	4 ☐
6. Perphenazine (*Trilafon/Etrafon/Triavil/Triptafen®*)	1 ☐	2 ☐	3 ☐	4 ☐
7. Pimozide (*Orap®*)	1 ☐	2 ☐	3 ☐	4 ☐
8. Prochlorperazine (*Compazine/Compro®*)	1 ☐	2 ☐	3 ☐	4 ☐
9. Thiothixene (*Navane®*)	1 ☐	2 ☐	3 ☐	4 ☐
10. Thioridazine (*Mellaril/Melleril®*)	1 ☐	2 ☐	3 ☐	4 ☐
11. Trifluoperazine (*Stelazine®*)	1 ☐	2 ☐	3 ☐	4 ☐
12. Other first-generation antipsychotics *(Specify: _____)*	1 ☐	2 ☐	3 ☐	4 ☐

	MARK ALL THAT APPLY FOR EACH MEDICATION			
SECOND-GENERATION ANTIPSYCHOTIC	**ORAL**	**INJECTABLE**	**LONG-ACTING INJECTABLE**	**NOT USED AT THIS FACILITY**
13. Aripiprazole (*Abilify®*)	1 ☐	2 ☐	3 ☐	4 ☐
14. Asenapine *(Saphris/Sycrest®)*	1 ☐	2 ☐	3 ☐	4 ☐
15. Clozapine (*Clozaril®*)	1 ☐	2 ☐	3 ☐	4 ☐
16. IIoperidone (*Fanapt®*)	1 ☐	2 ☐	3 ☐	4 ☐
17. Olanzapine (*Zyprexa®*)	1 ☐	2 ☐	3 ☐	4 ☐
18. Paliperidone (*Invega Trinza®*)	1 ☐	2 ☐	3 ☐	4 ☐
19. Quetiapine (*Seroquel®*)	1 ☐	2 ☐	3 ☐	4 ☐
20. Risperidone (*Risperdal®)*	1 ☐	2 ☐	3 ☐	4 ☐
21. Ziprasidone (*Geodon®*)	1 ☐	2 ☐	3 ☐	4 ☐
22. Other second-generation antipsychotics *(Specify: _____)*	1 ☐	2 ☐	3 ☐	4 ☐

***A14. 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 treatment
5 ☐ Assisted Outpatient Treatment (AOT)

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

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

17 ☐ Therapeutic foster care
18 ☐ Legal advocacy
19 ☐ Psychiatric emergency walk-in services
20 ☐ Suicide prevention services
21 ☐ Peer support services

22 ☐ Testing for Hepatitis B (HBV)
23 ☐ Testing for Hepatitis C (HCV)
24 ☐ HIV testing
25 ☐ STD testing
26 ☐ TB screening
27 ☐ Screening for tobacco use

28 ☐ Smoking/vaping/tobacco cessation counseling
29 ☐ Nicotine replacement therapy
30 ☐ Non-nicotine smoking/tobacco cessation medications (by prescription)

31 ☐ Other *(Specify:* _____*)*
32 ☐ None of these services and practices are offered

A15. Did you answer "yes" to treatment for co-occurring mental illness/serious emotional disturbance (SED) in children and substance use disorders in question A1 above (option 5)?

1 ☐ Yes
0 ☐ No → **SKIP TO A17 (TOP OF NEXT PAGE)**

A16. Which of the following services are provided to clients with co-occurring mental health and substance use disorders at this facility?

MARK ALL THAT APPLY

1 ☐ Detoxification (medical withdrawal)
2 ☐ Medication assisted treatment for alcohol use disorder (for example, disulfiram, acamprosate)
3 ☐ Medication assisted treatment for opioid use disorder (for example, buprenorphine, methadone, naltrexone)
4 ☐ Individual counseling
5 ☐ Group counseling
6 ☐ 12-Step groups
7 ☐ Case management
8 ☐ None of these services are offered

***A17. What age groups are accepted for treatment <u>at this facility</u>?**

- *If any of the ages that you accept fall within a category below, mark YES to that category.*

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Young children (0-5)	1 ☐	0 ☐
2. Children (6-12)	1 ☐	0 ☐
3. Adolescents (13-17)	1 ☐	0 ☐
4. Young adults (18-25)	1 ☐	0 ☐
5. Adults (26-64)	1 ☐	0 ☐
6. Older adults (65 or older)	1 ☐	0 ☐

***A18. Does this facility offer a mental health treatment program or group that is <u>dedicated or designed exclusively</u> for clients in any of the following categories?**

☞

- *If this facility treats clients in any of these categories, but <u>does not</u> have a specifically tailored program or group for them, **<u>DO NOT</u>** mark the box for that category.*

MARK ALL THAT APPLY

1 ☐ Children/adolescents with serious emotional disturbance (SED)
2 ☐ Young adults
3 ☐ Persons 18 and older with serious mental illness (SMI)
4 ☐ 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 experiencing first-episode psychosis
9 ☐ Persons who have experienced intimate partner violence, domestic violence
10 ☐ Persons with a diagnosis of post-traumatic stress disorder (PTSD)
11 ☐ Persons who have experienced trauma (excluding persons with a PTSD diagnosis)
12 ☐ Persons with traumatic brain injury (TBI)
13 ☐ Veterans
14 ☐ Active duty military
15 ☐ Members of military families
16 ☐ Lesbian, gay, bisexual, transgender, or queer/questioning (LGBTQ) clients
17 ☐ Forensic clients (referred from the court/ judicial system)
18 ☐ Persons with HIV or AIDS
19 ☐ Other special program or group *(Specify: _____)*
20 ☐ No dedicated or exclusively designed programs or groups are offered

***A19. 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

***A20. Does this facility offer services for psychiatric emergencies onsite?**

1 ☐ Yes

0 ☐ No

***A21. Does this facility offer mobile/off-site psychiatric crisis services?**

1 ☐ Yes

0 ☐ No

***A22. 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

***A23. 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 A24 (NEXT COLUMN)**

A23a. 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 A24 (NEXT COLUMN)**

3 ☐ BOTH staff and on-call interpreter

***A23a1. Do staff provide mental health treatment services in Spanish at this facility?**

1 ☐ Yes → **SKIP TO A23a2 (TOP OF NEXT COLUMN)**

0 ☐ No → **SKIP TO A23b (NEXT COLUMN)**

A23a2. Do staff at this facility provide mental health treatment services in any other languages?

1 ☐ Yes

0 ☐ No → **SKIP TO A24 (BELOW)**

***A23b. 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:* _____ *)*

A24. Which of these quality improvement practices are part of this facility's standard operating procedures?

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Continuing education requirements for professional staff	1 ☐	0 ☐
2. Regularly scheduled case review with a supervisor	1 ☐	0 ☐
3. Regularly scheduled case review by an appointed quality review committee	1 ☐	0 ☐
4. Client outcome follow-up after discharge	1 ☐	0 ☐
5. Continuous quality improvement processes	1 ☐	0 ☐
6. Periodic client satisfaction surveys	1 ☐	0 ☐
7. Clinical provider peer review (CPPR)	1 ☐	0 ☐
8. Root cause analysis (RCA)	1 ☐	0 ☐

***A25. 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

A26. In the 12-month period beginning May 1, 2019, and ending April 30, 2020, have staff at this facility used seclusion or restraint with clients?

1 ☐ Yes
0 ☐ No

A26a. Does this facility have any policies in place to minimize the use of seclusion or restraint?

1 ☐ Yes
0 ☐ No

A27. Please indicate what method staff members routinely use to accomplish the following work activities.

NOTE: Electronic resources include tools such as electronic health records (EHR) and web portals. Please consider e-fax, pdf, or scanned documents as paper documents.

	MARK ALL THAT APPLY FOR EACH ACTIVITY			
WORK ACTIVITY	ELECTRONIC HEALTH RECORDS (EHR)	COMPUTER-BASED (NON-EHR)	PAPER	NA
1. Intake	1 ☐	2 ☐	3 ☐	na ☐
2. Scheduling appointments	1 ☐	2 ☐	3 ☐	na ☐
3. Assessment/evaluation	1 ☐	2 ☐	3 ☐	na ☐
4. Treatment plan	1 ☐	2 ☐	3 ☐	na ☐
5. Client progress monitoring	1 ☐	2 ☐	3 ☐	na ☐
6. Discharge	1 ☐	2 ☐	3 ☐	na ☐
7. Referrals	1 ☐	2 ☐	3 ☐	na ☐
8. Issue/receive lab results	1 ☐	2 ☐	3 ☐	na ☐
9. Medication prescribing/dispensing	1 ☐	2 ☐	3 ☐	na ☐
10. Checking medication interactions	1 ☐	2 ☐	3 ☐	na ☐
11. Store and maintain client health and/or treatment records	1 ☐	2 ☐	3 ☐	na ☐
12. Send client health and/or treatment information to providers or sources outside your organization	1 ☐	2 ☐	3 ☐	na ☐
13. Receive client health and/or treatment information from providers or sources outside your organization	1 ☐	2 ☐	3 ☐	na ☐
14. Billing	1 ☐	2 ☐	3 ☐	na ☐
15. Client or family satisfaction surveys	1 ☐	2 ☐	3 ☐	na ☐
16. Updating availability of beds	1 ☐	2 ☐	3 ☐	na ☐

***A28. Does this facility use a sliding fee scale?**

- *Sliding fee scales are based on income and other factors.*
- *Not applicable to Veterans Affairs facilities.*

1 ☐ Yes

0 ☐ No **SKIP TO A29 (BELOW)** →

A28a. Do you want the availability of a sliding fee scale published in SAMHSA's online Behavioral Health Treatment Services Locator?

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

1 ☐ Yes

0 ☐ No

***A29. Does this facility offer treatment at no charge or minimal payment (for example, $1) to clients who cannot afford to pay?**

- *Not applicable to Veterans Affairs facilities.*

1 ☐ Yes →

0 ☐ No **SKIP TO A30 (TOP OF NEXT COLUMN)**

A29a. Do you want the availability of treatment at no charge or minimal payment (for example, $1) for eligible clients published in SAMHSA's online Behavioral Health Treatment Services Locator?

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

1 ☐ Yes

0 ☐ No

***A30. Which of the following types of client payments, insurance, or funding are accepted by this facility for mental health treatment services?**

MARK ALL THAT APPLY

1 ☐ Cash or self-payment

2 ☐ Private health insurance

3 ☐ Medicare

4 ☐ Medicaid

5 ☐ State-financed health insurance plan other than Medicaid

6 ☐ State mental health agency *(or equivalent)* funds

7 ☐ State welfare or child and family services agency funds

8 ☐ State corrections or juvenile justice agency funds

9 ☐ State education agency funds

10 ☐ Other state government funds

11 ☐ County or local government funds

12 ☐ Community Service Block Grants

13 ☐ Community Mental Health Block Grants

14 ☐ Federal grants

15 ☐ Federal military insurance *(such as TRICARE)*

16 ☐ U.S. Department of Veterans Affairs funds

17 ☐ IHS/Tribal/Urban *(ITU)* funds

18 ☐ Private or Community foundation

19 ☐ Other *(Specify: _____)*

A31. 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 ALL THAT APPLY

1 ☐ State mental health authority
2 ☐ State substance abuse agency
3 ☐ State department of health
4 ☐ State or local Department of Family and Children's Services
5 ☐ Hospital licensing authority
6 ☐ The Joint Commission
7 ☐ Commission on Accreditation of Rehabilitation Facilities *(CARF)*
8 ☐ Council on Accreditation *(COA)*
9 ☐ Centers for Medicare and Medicaid Services *(CMS)*
10 ☐ Other national organization, or federal, state, or local agency

(Specify: _____)

11 ☐ We do not have licensing, certification, or accreditation from any of these organizations

A32. If eligible, does this facility want to be listed in SAMHSA's online Behavioral Health Treatment Services Locator and Mental Health Directory?

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

1 ☐ Yes
0 ☐ No **SKIP TO B1 (TOP OF NEXT COLUMN)**

A32a. Does this facility want the street address and/or mailing address to be listed in SAMHSA's online Behavioral Health Treatment Services Locator and Mental Health Directory?

MARK ALL THAT APPLY

1 ☐ Publish the street address
2 ☐ Publish the mailing address
3 ☐ Do not publish either 1

A32b. To increase public awareness of behavioral health services, SAMHSA may be sharing facility information with large commercially available Internet search engines (such as Google, Bing, Yahoo!, etc.), businesses (such as any .com, .org, .edu, etc.) or individuals asking for this information for any purpose. Do you want your facility information shared?

- *Information to be shared would be: facility name, location address, telephone number, website address, and all **asterisked** items in the questionnaire.*

1 ☐ Yes
0 ☐ No

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

1 ☐ Only this facility **SKIP TO B3 (NEXT PAGE)**
2 ☐ This facility plus others **SKIP TO B2 (BELOW)**
3 ☐ 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 13)

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

THIS FACILITY	1
+ ADDITIONAL FACILITIES	
= TOTAL FACILITIES	

On page 14 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, 2020, did any patients receive <u>24-hour hospital inpatient</u> mental health treatment at this facility, at this location?

1 ☐ Yes → **GO TO B3a (TOP OF NEXT COLUMN)**

0 ☐ No → **SKIP TO B4 (TOP OF NEXT PAGE)**

B3a. On April 30, 2020, how many patients received <u>24-hour hospital inpatient</u> 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 <u>Hospital Inpatients</u> 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
SEX	Male			
	Female			
	CATEGORY TOTAL: *(Should=B3a or 100%)*			100%
AGE	0 – 17			
	18 – 64			
	65 and older			
	CATEGORY TOTAL: *(Should=B3a or 100%)*			100%
ETHNICITY	Hispanic or Latino			
	Not Hispanic or Latino			
	Unknown or not collected			
	CATEGORY TOTAL: *(Should=B3a 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=B3a or 100%)*			100%
LEGAL STATUS	Voluntary			
	Involuntary, non-forensic			
	Involuntary, forensic			
	CATEGORY TOTAL: *(Should=B3a or 100%)*			100%

B3c. On April 30, 2020, how many hospital inpatient beds at this facility were <u>specifically designated</u> for providing mental health treatment?

NUMBER OF BEDS ☐

(If none, enter '0')

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

B4. On April 30, 2020, did any clients receive <u>24-hour residential</u> mental health treatment at this facility, at this location?

1 ☐ Yes ⟶ **GO TO B4a (TOP OF NEXT COLUMN)**

0 ☐ No ⟶ **SKIP TO B5 (TOP OF NEXT PAGE)**

B4a. On April 30, 2020, how many clients received <u>24-hour residential</u> 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 <u>Residential Clients</u> 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
SEX	Male	☐		☐
	Female	☐		☐
	CATEGORY TOTAL: *(Should=B4a or 100%)*	☐		100%
AGE	0 – 17	☐		☐
	18 – 64	☐		☐
	65 and older	☐		☐
	CATEGORY TOTAL: *(Should=B4a or 100%)*	☐		100%
ETHNICITY	Hispanic or Latino	☐		☐
	Not Hispanic or Latino	☐		☐
	Unknown or not collected	☐		☐
	CATEGORY TOTAL: *(Should=B4a 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=B4a or 100%)*	☐		100%
LEGAL STATUS	Voluntary	☐		☐
	Involuntary, non-forensic	☐		☐
	Involuntary, forensic	☐		☐
	CATEGORY TOTAL: *(Should=B4a or 100%)*	☐		100%

B4c. On April 30, 2020, how many residential beds at this facility were <u>specifically designated</u> 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 <u>month</u> of April 2020, did any clients receive <u>less than 24-hour</u> mental health treatment at this facility, at this location?**

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

1 ☐ Yes → **GO TO B5a (TOP OF NEXT COLUMN)**

0 ☐ No → **SKIP TO B6 (TOP OF NEXT PAGE)**

B5a. **During the <u>month</u> of April 2020, how many clients received <u>less than 24-hour</u> mental health treatment at this facility?**

- ***ONLY INCLUDE*** *those seen at this facility <u>at least once</u> during the month of April,* ***AND <u>who were still enrolled in treatment on April 30, 2020</u>****.*
- ***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
SEX	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, 2020, 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, 2019 through April 30, 2020, 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. 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 ☐ Mr. 3 ☐ Mrs. 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
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 the Public Health Service Act (42 USC 290aa(p)). 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 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 publicly-available listings. Responses to non-asterisked questions will be published with no direct link to individual treatment facilities.