U.S. Department of Health and Human Services

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

2021 BEHAVIORAL HEALTH SCREENER

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

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

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

CHECK THIS BOX ☐ SKIP TO LOCATING (PAGE 7)

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

0 ☐ NO, NAME ADDRESS AND/OR PHONE INCORRECT

A2. RECORD CORRECT INFORMATION BELOW:

NAME:_____

STREET:_____

CITY/TOWN: _____ STATE: _____ ZIP:_____

PHONE: _____

A2a. INTERVIEWER: DID THE ADDRESS CHANGE?

1 ☐ YES

0 ☐ NO

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

SKIP TO A2d (NEXT PAGE)

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

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

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

2 ☐ NO MH/SA → ***SKIP TO END (PAGE 7)***

d ☐ DON'T KNOW

r ☐ REFUSED

SKIP TO A2b.1 (NEXT PAGE)

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

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

(_____) - _____ - _____
Area Code

INTERVIEWER: IF A NEW NUMBER IS RECORDED SAY: "Thank you for your time."

DIAL NEW PHONE NUMBER AND BEGIN WITH A1.

d ☐ DON'T KNOW → ***SKIP TO LOCATING (PAGE 7)***

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

1 ☐ YES
0 ☐ NO
2 ☐ MISSPELLED
3 ☐ ABBREVIATION IN NAME

SKIP TO A3 (BELOW)

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

1 ☐ YES
0 ☐ NO → ***SKIP TO LOCATING (PAGE 7)***

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

1 ☐ YES → **INTERVIEWER: COLLECT NEW FACILITY INFORMATION**
0 ☐ NO

A3. **Does this facility, <u>at this location</u>, provide mental health treatment, that is, interventions that treat a person's mental health problem or condition, reduce symptoms, and improve functioning?**

INTERVIEWER: PROBE IF NECESSARY: "Please include treatments such as therapy and psychotropic medication as providing mental health treatment."

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

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

INTERVIEWER: PROBE IF NECESSARY: "Administrative services include services related to the provision of administrative and operational functions (e.g., workforce/staff management, financial/billing management) of a mental health treatment facility or facilities. Administrative services do not include the direct provision of mental health treatment."

1 ☐ YES
0 ☐ NO

SKIP TO A5b (PAGE 4)

A4. 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

INTERVIEWER: PROBE IF NECESSARY: "That is, significant limitations in intellectual functioning."

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

8 ☐ None of these services → ***SKIP TO A5 (NEXT PAGE)***

A4a. For this facility at this location, that is, [FILL LOCATION ADDRESS], what is the main focus? Is it…

INTERVIEWER: OF THE CATEGORIES BELOW, FOR A4a.1 THROUGH A4a.7, ONLY LIST THE CATEGORIES THE RESPONDENT SELECTED IN A4; AND, END WITH A4a.8 AND A4a.9.

MARK ONE ONLY

1. Assisted living or nursing home care.....	1 ☐
2. Supported housing.....	2 ☐
3. Group homes.....	3 ☐
4. Clubhouse services.....	4 ☐
5. Emergency shelter such as homeless, domestic violence, etc.....	5 ☐
6. Care for only individuals with a developmental disability.....	6 ☐
7. Care at only a jail, prison, or detention center that provides treatment exclusively for incarcerated persons or juvenile detainees.....	7 ☐
8. Mental health treatment.....	8 ☐
9. Or, some other focus.....	9 ☐

INTERVIEWER: If selected, ask: "What is this facility's main focus?"

_____

A4b. INTERVIEWER: DID THIS FACILITY ANSWER ANY CATEGORY IN A4a BETWEEN A4a.1 THROUGH A4a.7?

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

0 ☐ NO → ***SKIP TO A5 (NEXT PAGE)***

A5. Is this facility an office with only one independent practitioner or a small group of practitioners?

1 ☐ YES

0 ☐ NO → ***SKIP TO A5b (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

A5b. INTERVIEWER: DID THIS FACILITY ANSWER [A3a AS "YES;"] OR [(ANSWER A4 AS "8" OR A4b AS "NO;") AND (ANSWER A5 AS "NO" OR A5a AS "YES?")] PLEASE USE SHADED BOXES FOR REFERENCE.

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

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

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

1 ☐ YES

0 ☐ NO → ***SKIP TO A9 (BELOW)***

2 ☐ RESPONDENT INDICATES THAT THEY ALREADY COMPLETED THIS PAST YEAR'S SUBSTANCE ABUSE SURVEY → ***SKIP TO A17 (NEXT PAGE)***

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

PROBE IF NECESSARY: Please report for only this location.

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

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

1 ☐ YES

0 ☐ NO

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

1 ☐ YES

0 ☐ NO

A10. INTERVIEWER: IF THIS FACILITY ANSWERED A3 AS "YES" AND A6 AS "YES", ASK THIS QUESTION. OTHERWISE, SKIP TO A11 (BELOW).

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
3 ☐ Mix of mental health and substance use treatment (neither is primary)
4 ☐ General health care
5 ☐ Other service focus *(Specify: _____)*

A11. INTERVIEWER: DID THIS FACILITY ANSWER YES TO EITHER A7.2, A7.3, OR A9 ABOVE? PLEASE USE THE SHADED BOXES FOR REFERENCE.

1 ☐ YES
0 ☐ NO → ***SKIP TO A17 (NEXT PAGE)***

A12. Is [LOCATION ADDRESS] also the mailing address for this substance use treatment facility?

1 ☐ YES → ***SKIP TO A13 (BELOW)***
0 ☐ NO

A12a. What is the mailing address for [FACILITY NAME] located at [LOCATION ADDRESS]?

NAME:_____

STREET:_____

CITY/TOWN: _____ STATE:_____ ZIP:_____

A13. Does [FACILITY NAME] have a FAX number?

1 ☐ YES

A13a. What is that FAX number?(_____) **-** _____ -
_____
Area Code

0 ☐ NO

A14. ASK IF NEEDED, OTHERWISE, VERIFY AND RECORD WITHOUT ASKING: Who is the director of substance abuse programs at [FACILITY]? (RECORD BELOW)

_____

A15. Does [DIRECTOR NAME] or the person in charge of substance abuse programs at this facility have an EMAIL address?

1 ☐ YES

A15a.What is that EMAIL address?

0 ☐ NO

A15b.Name of Contact Person (if not Director)

SKIP TO A16 (NEXT PAGE)

A16. Does this facility have a website or web page with information about the facility's substance use treatment programs?

1 ☐ YES

0 ☐ NO → ***SKIP TO A17 (BELOW)***

A16a. What is this facility's website address?

RECORD: _____

A17. INTERVIEWER: DOES THIS FACILITY PROVIDE MENTAL HEALTH TREATMENT SERVICES (A5b = 1) AND ITS PRIMARY TREATMENT FOCUS IS NOT SUBSTANCE USE TREATMENT (A10 ≠ 2)?

1 ☐ YES

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

A18. Is [LOCATION ADDRESS] also the mailing address for this mental health treatment facility?

1 ☐ YES → ***SKIP TO A19 (BELOW)***

0 ☐ NO

2 ☐ Same as Substance Abuse Mailing Address → ***SKIP TO A19 (BELOW)***

A18a. What is the mailing address for the mental health facility located at [LOCATION ADDRESS]?

NAME: _____

STREET: _____

CITY/TOWN: _____ STATE: _____ ZIP: _____

A19. Does [FACILITY NAME] have a FAX number?

1 ☐ YES → **A19a. What is that FAX number?**(_____) **-** _____ - _____
Area Code

0 ☐ NO

2 ☐ Same as Substance Abuse Fax Number

A20. ASK IF NEEDED, OTHERWISE, VERIFY AND RECORD WITHOUT ASKING: Who is the director of mental health programs at [FACILITY]? (RECORD BELOW)

_____

A21. Does [DIRECTOR NAME] or the person in charge of mental health programs at this facility have an EMAIL address?

1 ☐ YES → **A21a.What is that EMAIL address?**

A21b.Name of Contact Person (if not Director)

0 ☐ NO

2 ☐ Same as Substance Abuse Director's Email Address

SKIP TO A22 (NEXT PAGE)

A22. Does this facility have a website or web page with information about the facility's mental health treatment program(s)?

1 ☐ YES

0 ☐ NO → ***SKIP TO END (BELOW)***

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

A22a. What is this facility's website address?

RECORD: [ ]

LOCATING: Thank you very much for your time.

INTERVIEWER: IF A2f IS "YES," OR A4a.9 IS VALUED, SEND THE CASE TO SUPERVISOR REVIEW.

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

Pledge to Respondents

The information you provide will be protected to the fullest extent allowable under Section 501(n) of the Public Health Service Act (42 USC 290aa(n)). This law permits the public release of identifiable information about an establishment only with the consent of that establishment and limits the use of the information to the purposes for which it was supplied. This information will be used to determine eligibility for inclusion in SAMHSA's online Behavioral Health Treatment Services Locator and other publically available listings.

NOTES: