Attachment B3: N-SUMHSS web survey prototype

NATIONAL SUBSTANCE USE AND MENTAL HEALTH SERVICES SURVEY (N-SUMHSS)

**1. What type of treatment does this facility <u>at this location</u>, provide?**

| |
|---|
| O Primarily Substance use treatment services |
| O Primarily Mental health services |
| O Mix of mental health and substance use treatment services |
| O No treatment for either substance use or mental health is provided at this location |

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

| |
|---|
| O Yes |
| O No |

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**SUBSTANCES USE TREATMENT FACILITIES**

**A1. Which of the following substance use treatment services are offered by this facility <u>at this location</u>, that is, the location listed on the front cover?**

| | **SELECT "YES" OR "NO" FOR EACH** |
|---|---|
| Intake, assessment, or referral | O Yes<br>O No |
| Detoxification (medical withdrawal) | O Yes<br>O No |
| Substance use disorder treatment<br>*(services that focus on initiating and maintaining an individual's recovery from substance use and on averting relapse)* | O Yes<br>O No |
| Treatment for co-occurring substance use <u>plus either</u> serious mental illness (SMI) in adults <u>and/or</u> serious emotional disturbance (SED) in children | O Yes<br>O No |
| Any other substance use treatment services (such as 12 step meeting facilitation, naloxone prescriptions, etc.) | O Yes<br>O No |

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**A1a. To which of the following clients does this facility, <u>at this location</u>, offer mental 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)*?**

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ Substance use treatment clients |
| ☐ Clients other than substance use treatment clients |
| ☐ No clients are offered mental health treatment services at this facility |

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***A2. Does this facility detoxify (medical withdrawal) clients from . . .**

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ Alcohol |
| ☐ Benzodiazepines |
| ☐ Cocaine |
| ☐ Methamphetamines |
| ☐ Opioids |
| ☐ Other(s):(Specify_____) |

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***A2a. Does this facility routinely use medication during detoxification (medical withdrawal)?**

| |
|---|
| O Yes |
| O No |

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**A3. Is this facility a solo practice; that is, an office with only one independent practitioner or counselor?**

| |
|---|
| O Yes |
| O No |

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***A4. Does this facility offer HOSPITAL INPATIENT substance use treatment services at this location; that is, the location listed on the front cover?**

| |
|---|
| O Yes |
| O No |

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***A4a. Which of the following INPATIENT services are offered at this facility?**

| | **SELECT "YES" OR "NO" FOR EACH** |
|---|---|
| Inpatient detoxification (Medical Withdrawal) *(medically managed or monitored inpatient detoxification)* | O Yes<br>O No |
| Inpatient treatment *(medically managed or monitored intensive inpatient treatment))* | O Yes<br>O No |

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***A5. Does this facility offer RESIDENTIAL (non-hospital) substance use treatment services at this location, that is, the location listed on the front cover?**

| |
|---|
| O Yes |
| O No |

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***A5a. Which of the following RESIDENTIAL services are offered at this facility?**

| | **SELECT "YES" OR "NO" FOR EACH** |
|---|---|
| Residential detoxification (medical withdrawal) *(clinically managed residential detoxification or social detoxification)* | O Yes<br>O No |
| Residential short-term treatment *(clinically managed high-intensity residential treatment, typically 30 days or less)* | O Yes<br>O No |
| Residential long-term treatment *(clinically managed medium- or low-intensity residential treatment)* | O Yes<br>O No |

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***A6. Does this facility offer OUTPATIENT substance use treatment services at this location; that is, the location listed on the front cover?**

| |
|---|
| O Yes |
| O No |

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***A6a. Which of the following OUTPATIENT services are offered at this facility?**

| | **SELECT "YES" OR "NO" FOR EACH** |
|---|---|
| Outpatient detoxification (Ambulatory detoxification) | O Yes<br>O No |
| Outpatient methadone/buprenorphine maintenance or naltrexone treatment | O Yes<br>O No |
| Outpatient day treatment or partial hospitalization (20 or more hours per week) | O Yes<br>O No |
| Intensive outpatient treatment (9 or more hours per week) | O Yes<br>O No |
| Regular outpatient treatment (outpatient treatment, non-intensive) | O Yes<br>O No |

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***A7. Which of the following services are offered by this facility <u>at this location</u>; that is, the location listed on the front cover? (SELECT ALL THAT APPLY)**

**Assessment and Pre-Treatment Services**

| |
|---|
| ☐ Screening for substance use |
| ☐ Screening for mental disorders |
| ☐ Comprehensive substance use assessment or diagnosis |
| ☐ Comprehensive mental health assessment or diagnosis *(for example, psychological or psychiatric evaluation and testing)* |
| ☐ Complete medical history and physical exam performed by a healthcare practitioner |
| ☐ Screening for tobacco use |
| ☐ Outreach to persons in the community who may need treatment |
| ☐ Interim services for clients when immediate admission is not possible |
| ☐ Professional interventionist/educational consultant |
| ☐ None of the assessment and pre-treatment services above are offered at this facility |

**Testing** *(include tests performed at this location, even if specimen is sent to an outside source for chemical analysis.)*

| |
|---|
| ☐ Drug and alcohol oral fluid testing |
| ☐ Breathalyzer or other blood alcohol testing |
| ☐ Drug or alcohol urine screening |
| ☐ Testing for Hepatitis B *(HBV)* |
| ☐ Testing for Hepatitis C *(HCV)* |
| ☐ HIV testing |
| ☐ STD testing |
| ☐ TB screening |
| ☐ Testing for metabolic syndrome (weight, abdominal girth, BP, glucose, Hgb A1C, cholesterol, triglycerides) |
| ☐ None of the testing services above are offered at this facility |

**Medical Services**

| |
|---|
| ☐ Hepatitis A *(HAV)* vaccination |
| ☐ Hepatitis B *(HBV)* vaccination |
| ☐ None of the medical services above are offered at this facility |

**Transitional Services**

| |
|---|
| ☐ Discharge planning |
| ☐ Aftercare/continuing care |
| ☐ Naloxone and overdose education |
| ☐ Outcome follow-up after discharge |
| ☐ None of the transitional services above are offered at this facility |

**Recovery Services**

| |
|---|
| ☐ Mentoring/peer support |
| ☐ Self-help groups *(for example, AA, NA, SMART Recovery)* |
| ☐ Assistance in locating housing for clients |
| ☐ Employment counseling or training for clients |
| ☐ Assistance with obtaining social services *(for example, Medicaid, WIC, SSI, SSDI)* |
| ☐ Recovery coach |
| ☐ None of the recovery support services above are offered at this facility |

**Education and Counseling**

| |
|---|
| ☐ HIV or AIDS education, counseling, or support |
| ☐ Hepatitis education, counseling, or support |
| ☐ Health education other than HIV/AIDS or Hepatitis |
| ☐ Substance use disorder education |
| ☐ Smoking/tobacco cessation counseling |
| ☐ Individual counseling |
| ☐ Group counseling |
| ☐ Family counseling |
| ☐ Marital/couples counseling |
| ☐ Vocational training or educational support *(for example, high school coursework, GED preparation, etc.)* |
| ☐ None of the education and counseling services above are offered at this facility |

**Ancillary Services**

| |
|---|
| ☐ Case management services |
| ☐ Integrated primary care services |
| ☐ Social skills development |
| ☐ Child care for clients' children |
| ☐ Domestic violence services, including family or partner violence services, for physical, sexual, or emotional abuse |
| ☐ Early intervention for HIV |
| ☐ Transportation assistance to treatment |
| ☐ Mental health services |
| ☐ Suicide prevention services |
| ☐ Acupuncture |
| ☐ Residential beds for clients' children |
| ☐ None of the ancillary services above are offered at this facility |

**Other Services**

| |
|---|
| ☐ Treatment for gambling disorder |
| ☐ Treatment for other addiction disorder *(non-substance use disorder)* |
| ☐ None of the other services above are offered at this facility |

**Pharmacotherapies**

| |
|---|
| ☐ Disulfiram |
| ☐ Naltrexone *(oral)* |
| ☐ Naltrexone *(extended-release, injectable)* |
| ☐ Acamprosate |
| ☐ Nicotine replacement |
| ☐ Non-nicotine smoking/tobacco cessation medications *(for example, bupropion, varenicline)* |
| ☐ Medications for mental disorders |
| ☐ Methadone |
| ☐ Buprenorphine/naloxone |
| ☐ Buprenorphine without naloxone |
| ☐ Buprenorphine sub-dermal implant |
| ☐ Buprenorphine *(extended-release, injectable)* |
| ☐ Medications for HIV treatment *(for example, antiretroviral medications such as tenofovir, efavirenz, emtricitabine, atazanavir, and lamivudine)* |
| ☐ Medications for pre-exposure prophylaxis (PrEp: e.g. emtricitabine and tenofovir disoproxil fumarate combination, and emtricitabine and tenofovir alafenamide combination) |

| |
|---|
| ☐ Medications for Hepatitis C *(HCV)* treatment *(for example, sofosbuvir, ledipasvir, interferon, peginterferon, ribavirin)* |
| ☐ Lofexidine |
| ☐ Clonidine |
| ☐ Medications for other medical conditions |
| ☐ None of the pharmacotherapy services above are offered at this facility |

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***A8. Facilities may treat a range of substance use disorders. The next series of questions focuses only on how this facility treats opioid use disorder.**

**How does this facility treat opioid use disorder?**

- *Medication-assisted treatment (MAT) includes the use of methadone, buprenorphine products and/or naltrexone for the treatment of opioid use disorder. For this question, MAT refers to any or all of these medications unless specified otherwise.*

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ This facility accepts clients using MAT, but the medications originate from or are prescribed by another entity. *(The medications may or may not be stored/delivered/monitored onsite.)* |
| ☐ This facility prescribes naltrexone to treat opioid use disorder. Naltrexone use is authorized through any medical staff with prescribing privileges. |
| ☐ This facility utilizes prescribers of buprenorphine to treat opioid use disorder. Buprenorphine use is authorized through a DATA 2000 waivered physician, physician assistant, or nurse practitioner. |
| ☐ This facility is a federally-certified Opioid Treatment Program *(OTP)*. *(Most OTPs administer/dispense methadone; some only use buprenorphine, some provide all FDA-approved medication treatments for opioid use disorder.)* |
| ☐ This facility treats opioid use disorder, but it does not use medication-assisted treatment *(MAT)*, nor does it accept clients using MAT to treat opioid use disorder. |
| ☐ This facility uses methadone or buprenorphine for pain management, emergency cases, or research purposes. It is NOT a federally-certified Opioid Treatment Program *(OTP).* |
| ☐ This facility does not treat opioid use disorder |

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***A8a. For those clients using MAT, but whose medications originate from or are prescribed by another entity, the clients obtain their prescriptions from**

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ A prescribing entity in our network |
| ☐ A prescribing entity with which our facility has a business, contractual, or formal referral relationship |
| ☐ A prescribing entity with which our facility has no formal relationship |

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***A8b. Does this facility serve only opioid use disorder clients?**

| |
|---|
| O Yes |
| O No |

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***A8c. Which of the following medication services does this program provide for <u>opioid use disorder</u>?**

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ Maintenance services with methadone or buprenorphine |
| ☐ Maintenance services with medically-supervised withdrawal (or taper) after a period of stabilization |
| ☐ Detoxification (medical withdrawal) from opioids of abuse with methadone or buprenorphine |
| ☐ Detoxification (medical withdrawal) from opioids of abuse with lofexidine or clonidine |
| ☐ Relapse prevention with naltrexone |
| ☐ Other *(e.g. Overdose risk reduction with Naloxone, Specify opioid use disorder service and pharmacotherapy used: _____ )* |
| ☐ None of the medication services for opioid use disorder above are offered at this facility |

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***A9. Facilities may treat a range of substance use disorders. The next series of questions focuses only on how this facility treats alcohol use disorder.**

**How does this facility treat alcohol use disorder?**

- *These medications have been approved by the FDA to treat alcohol use disorder: naltrexone, acamprosate, and disulfiram. For this question, MAT refers to any or all of these three medications.*

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ This facility accepts clients using MAT for alcohol use disorder, but the medications originate from or are prescribed by another entity |
| ☐ This facility administers/prescribes disulfiram for alcohol use disorder |
| ☐ This facility administers/prescribes naltrexone for alcohol use disorder |
| ☐ This facility administers/prescribes acamprosate for alcohol use disorder |
| ☐ This facility treats alcohol use disorder, but it does not use medication-assisted treatment (MAT) for alcohol use disorder, nor does it accept clients using MAT to treat alcohol use disorder |
| ☐ This facility does not treat alcohol use disorder |

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***A9a. For those clients using MAT, but whose medications originate from or are prescribed by another entity, the clients obtain their prescriptions from**

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ A prescribing entity in our network |
| ☐ A prescribing entity with which our facility has a business, contractual, or formal referral relationship |
| ☐ A prescribing entity with which our facility has no formal relationship |

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***A9b. Does this facility serve only alcohol use disorder clients?**

| |
|---|
| O Yes |
| O No |

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***A10. Which of the following clinical/therapeutic approaches listed below are used frequently at this facility? SELECT ALL THAT APPLY FOR EACH APPROACH**

| CLINICAL/THERAPEUTIC APPROACHES | OPIOID USE DISORDER | OTHER SUBSTANCES |
|---|---|---|
| Substance use disorder counseling | ☐ | ☐ |
| 12-step facilitation | ☐ | ☐ |
| Brief intervention | ☐ | ☐ |
| Cognitive behavioral therapy | ☐ | ☐ |
| Contingency management/motivational incentives | ☐ | ☐ |
| Motivational interviewing | ☐ | ☐ |
| Trauma-related counseling | ☐ | ☐ |
| Anger management | ☐ | ☐ |
| Matrix Model | ☐ | ☐ |
| Community reinforcement plus vouchers | ☐ | ☐ |
| Relapse prevention | ☐ | ☐ |
| Telemedicine/telehealth therapy *(including Internet, Web, mobile, and desktop programs)* | ☐ | ☐ |
| Other treatment approach *(Specify:_____)* | ☐ | ☐ |
| None of the clinical/therapeutic approaches above are offered at this facility | ☐ | ☐ |

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***A11. Does this facility, at this location, offer a specially designed program or group intended exclusively for DUI/DWI or other drunk driver offenders?**

| |
|---|
| O Yes |
| O No |

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***A11a. Does this facility serve only DUI/DWI clients?**

| |
|---|
| O Yes |
| O No |

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**A12. Does this facility provide treatment services for…?**

| |
|---|
| O Marijuana |
| O Stimulants |
| O Other substance(s) *(Specify:_____ )* |

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***A13. Does this facility provide substance use 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)*?**

- *Select "yes" if either a staff counselor or an on-call interpreter provides this service.*

| |
|---|
| O Yes |
| O No |

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***A14. Does this facility provide substance use treatment services in a language other than English at this location?**

| |
|---|
| O Yes |
| O No |

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**A14a. At <u>this</u> facility, who provides substance use treatment services in a language <u>other than English</u>?**

**SELECT ONLY ONE**

| |
|---|
| **o** Staff counselor who speaks a language other than English |
| **o** On-call interpreter *(in person or by phone)* brought in when needed |
| **o** BOTH staff counselor and on-call interpreter |

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***A14a1. Do staff counselors provide substance use treatment in Spanish at this facility?**

| |
|---|
| O Yes |
| O No |

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**A14a2. Do staff counselors at this facility provide substance use treatment in any other languages?**

| |
|---|
| O Yes |
| O No |

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***A14b. In what other languages do staff counselors provide substance use treatment at this facility?**

- *Do not count languages provided only by on-call interpreters.*

**SELECT ALL THAT APPLY**

**American Indian or Alaska Native**

| |
|---|
| ☐ Hopi |
| ☐ Lakota |
| ☐ Navajo |
| ☐ Ojibwa |
| ☐ Yupik |
| ☐ Other American Indian or Alaska Native language (Specify:_____) |

**Other Languages:**

| |
|---|
| ☐ Arabic |
| ☐ Any Chinese languages |
| ☐ Creole |
| ☐ Farsi |
| ☐ French |
| ☐ German |
| ☐ Greek |
| ☐ Hebrew |
| ☐ Hindi |
| ☐ Hmong |
| ☐ Italian |
| ☐ Japanese |
| ☐ Korean |
| ☐ Polish |
| ☐ Portuguese |
| ☐ Russian |
| ☐ Tagalog |
| ☐ Vietnamese |
| ☐ Any Other language (Specify:_____) |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**Mental Health Treatment Facilities, and other publicly-available listings, unless you designate otherwise in question C8 of this questionnaire.**

***A15. Individuals seeking substance use treatment can vary by age, sex or other characteristics. Which categories of individuals listed below are served by this facility, <u>at this location</u>?**

- **Indicate only the highest or lowest age the facility would accept. *Do not indicate* the highest or lowest age currently receiving services in the facility**

| | | LOWEST AGE SERVED | HIGHEST AGE SERVED |
|---|---|---|---|
| Male | O Yes<br>O No | _____<br>O No minimum Age | _____<br>O No Maximum Age |
| Female | O Yes<br>O No | _____<br>O No minimum Age | _____<br>O No Maximum Age |

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***A15. 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 use 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 select the box for that category.**

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ Adolescents |
| ☐ Young adults |
| ☐ Adult women |
| ☐ Pregnant/postpartum women |
| ☐ Adult men |
| ☐ Seniors or older adults |
| ☐ Lesbian, gay, bisexual, transgender, or queer/questioning *(LGBTQ)* clients |
| ☐ Veterans |
| ☐ Active duty military |
| ☐ Members of military families |
| ☐ Criminal justice clients *(other than DUI/DWI)* |
| ☐ Clients with co-occurring mental and substance use disorders |
| ☐ Clients with HIV or AIDS |
| ☐ Clients who have experienced sexual abuse |
| ☐ Clients who have experienced intimate partner violence, domestic violence |
| ☐ Clients who have experienced trauma |
| ☐ Specifically tailored programs or groups for any other types of clients (Specify:_____) |
| ☐ Specifically tailored programs or group for any other types of clients (Specify:_____) |
| ☐ No specifically tailored programs or groups are offered |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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***A16. Does this facility receive any funding or grants from the Federal Government or state, county or local governments, to support its substance use treatment programs?**

| |
|---|
| O Yes |
| O No |
| O Don't know |

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***A17. Which of the following types of client payments or insurance are accepted by this facility for substance use treatment?**

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ No payment accepted *(free treatment for ALL clients)* |
| ☐ Cash or self-payment |
| ☐ Medicare |
| ☐ Medicaid |
| ☐ State-financed health insurance plan other than Medicaid |
| ☐ Federal military insurance *(e.g., TRICARE)* |
| ☐ Private health insurance |
| ☐ SAMHSA funding/block grants |
| ☐ IHS/Tribal/Urban *(ITU)* funds |
| ☐ Other *(Specify: _____ )* |

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***A18. Is this facility a hospital or located in or operated by a hospital?**

| |
|---|
| O Yes |
| O No |

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***A18a. What type of hospital?**

**SELECT ONLY ONE**

| |
|---|
| o General hospital *(including VA hospital)* |
| o Psychiatric hospital |
| o Other specialty hospital, for example, alcoholism, maternity, etc. (Specify:_____) |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**A19. Does this facility operate as a skilled nursing facility (SNF) that provides services for substance use disorders?**

| |
|---|
| O Yes |
| O No |

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***A20. Does this facility operate transitional housing, a halfway house, or a sober home for substance use clients at this location; that is, the location listed on the front cover of the paper survey?**

| |
|---|
| O Yes |
| O No |

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***A21. Is this facility or program licensed, certified, or accredited to provide substance use treatment services by any of the following organizations?**

- *Do not include personal-level credentials or general business licenses such as a food service license.*

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ State substance use treatment agency |
| ☐ State mental health department |
| ☐ State department of health |
| ☐ Hospital licensing authority |
| ☐ The Joint Commission |
| ☐ Commission on Accreditation of Rehabilitation Facilities *(CARF)* |
| ☐ National Committee for Quality Assurance *(NCQA)* |
| ☐ Council on Accreditation *(COA)* |
| ☐ SAMHSA certification for opioid treatment program (OTP) |
| ☐ Drug Enforcement Agency *(DEA)* |
| ☐ Other national organization or federal, state, or local agency *(Specify: _____ )* |
| ☐ This facility is not licensed, certified, or accredited to provide substance use services by any of these organizations |

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## MENTAL DISORDERS TREATMENT FACILITIES

**B1. Does this treatment facility, <u>at this location</u>, offer:**

| | **SELECT "YES" OR "NO" FOR EACH** |
|---|---|
| | O Yes |

| | |
|---|---|
| Mental health intake | O No |
| Mental health diagnostic evaluation | O Yes<br>O No |
| Mental health information and/or referral *(also includes emergency programs that provide services in person or by telephone)* | O Yes<br>O No |
| Treatment for co-occurring disorders plus either serious mental illness (SMI) in adults and/or serious emotional disturbance (SED) in children | O Yes<br>O No |
| Substance use treatment | O Yes<br>O No |
| Administrative or operational services for mental health treatment facilities | O Yes<br>O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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***B2. Mental health treatment is provided in which of the following service settings at this facility, at this location?**

| | SELECT "YES" OR "NO" FOR EACH |
|---|---|
| | O Yes |

| | |
|---|---|
| 24-hour hospital inpatient | O No |
| 24-hour residential | O Yes<br>O No |
| Partial hospitalization/day treatment | O Yes<br>O No |
| Outpatient | O Yes<br>O No |

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***B3. Which ONE category <u>BEST</u> describes this facility, at this location?**

- For definitions of facility types, go to: INSERT LINK

**SELECT ONLY ONE**

| |
|---|
| o Psychiatric hospital |
| o Separate inpatient psychiatric unit of a general hospital *(consider this psychiatric unit as the relevant "facility" for the purpose of this survey)* |
| o State hospital |
| o Residential treatment center for children |
| o Residential treatment center for adults |
| o Other type of residential treatment facility |
| o Veterans Affairs Medical Center (VAMC) or other VA health care facility |
| o Community Mental Health Center (CMHC) |
| o Certified Community Behavioral Health Clinic (CCBHC) |
| o Partial hospitalization/day treatment facility |
| o Outpatient mental health facility |
| o Multi-setting mental health facility *(non-hospital residential plus either outpatient and/or partial hospitalization/day treatment)* |
| o Other *(Specify: _____ )* |

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**B4. Is this facility either a solo or a small group practice?**

| |
|---|
| O Yes |
| O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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***B4a. 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.

| |
|---|
| O Yes |
| O No |

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**B5. Does this facility, at this location, provide any of the following services?**

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ Assisted living or nursing home care |
| ☐ Group homes |
| ☐ Clubhouse services |
| ☐ Emergency shelter *(such as homeless, domestic violence, etc.)* |
| ☐ Care for individuals with a developmental disability *(that is, significant limitations in intellectual functioning)* |
| ☐ None of these services are offered at this facility |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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***B6. Which of these <u>treatment modalities for mental disorders</u> are offered at this facility, at this location?**

- For definitions of treatment modalities, go to: INSERT LINK

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ Individual psychotherapy |
| ☐ Couples/family therapy |
| ☐ Group therapy |
| ☐ Cognitive behavioral therapy |
| ☐ Dialectical behavior therapy |
| ☐ Cognitive remediation therapy |
| ☐ Integrated mental and substance use disorder treatment |
| ☐ Activity therapy (for example, art therapy) |
| ☐ Electroconvulsive therapy |
| ☐ Transcranial Magnetic Stimulation (TMS) |
| ☐ Ketamine Infusion Therapy (KIT) |
| ☐ Eye Movement Desensitization and Reprocessing (EMDR) therapy |
| ☐ Telemedicine/telehealth therapy *(including Internet, Web, mobile, and desktop programs)* |
| ☐ Abnormal Involuntary Movement Scale (AIMS) Test |
| ☐ Other *(Specify: _____ )* |
| ☐ None of these mental health treatment modalities are offered at this facility |

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***B7. Does this facility offer the use of antipsychotics for the treatment of serious mental illness (SMI)?**

| |
|---|
| O Yes |
| O No |

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***B7a. Which of the following antipsychotics are used for the treatment of SMI at this facility, at this location?**

**SELECT ALL THAT APPLY**

| FIRST-GENERATION ANTIPSYCHOTIC | NOT USED AT THIS FACILITY | ORAL | INJECTABLE | LONG-ACTING INJECTABLE | RECTAL | TOPICAL |
|---|---|---|---|---|---|---|
| Chlorpromazine | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Droperidol | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Fluphenazine | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Haloperidol | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Loxapine | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Perphenazine | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pimozide | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thiothixene | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thioridazine | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Trifluoperazine | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other first-generation antipsychotics<br>(Specify:_____ ) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| SECOND-GENERATION ANTIPSYCHOTIC | NOT USED AT THIS FACILITY | ORAL | INJECTABLE | LONG-ACTING INJECTABLE | RECTAL | TOPICAL |
|---|---|---|---|---|---|---|
| Aripiprazole | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Asenapine | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Brexpiprazole | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cariprazine | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Clozapine | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Iloperidone | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lurasidone | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Olanzapine | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Olanzapine/<br>Fluoxetine combination | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Paliperidone | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Quetiapine | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Risperidone | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Ziprasidone | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other first-generation antipsychotics | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| | | | | | | |
|---|---|---|---|---|---|---|
| (Specify:_____) | | | | | | |

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***B8. Which of these services and practices are offered at this facility, at this location?**

- *For definitions, go to:* INSERT LINK

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ Assertive community treatment (ACT) |
| ☐ Intensive case management (ICM) |
| ☐ Case management (CM) |
| ☐ Court-ordered treatment |
| ☐ Assisted Outpatient Treatment (AOT) |
| ☐ Chronic disease/illness management (CDM) |
| ☐ Illness management and recovery (IMR) |
| ☐ Integrated primary care services |
| ☐ Diet and exercise counseling |
| ☐ Family psychoeducation |
| ☐ Education services |
| ☐ Housing services |
| ☐ Supported housing |
| ☐ Psychosocial rehabilitation services |
| ☐ Vocational rehabilitation services |
| ☐ Supported employment |
| ☐ Therapeutic foster care |
| ☐ Legal advocacy |

| |
|---|
| ☐ Psychiatric emergency walk-in services |
| ☐ Suicide prevention services |
| ☐ Peer support services |
| ☐ Testing for Hepatitis B (HBV) |
| ☐ Testing for Hepatitis C (HCV) |
| ☐ Laboratory tests (for example, WBC for clozapine therapy, Lithium levels, CBZ levels, valproate levels) |
| ☐ Metabolic syndrome monitoring (weight, abdominal girth, BP, glucose, Hgb A1C, cholesterol, triglycerides) |
| ☐ HIV testing |
| ☐ STD testing |
| ☐ TB screening |
| ☐ Screening for tobacco use |
| ☐ Smoking/vaping/tobacco cessation counseling |
| ☐ Nicotine replacement therapy |
| ☐ Non-nicotine smoking/tobacco cessation medications (by prescription) |
| ☐ Other(s) *(Specify: _____)* |
| ☐ None of these services and practices are offered at this facility |

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**B9. Which of the following services are provided to clients with co-occurring mental health and substance use at this facility?**

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ Detoxification (medical withdrawal) |
| ☐ Medication-assisted treatment for alcohol use disorder (for example, disulfiram, camprosate) |
| ☐ Medication-assisted treatment for opioid use disorder (for example, buprenorphine, methadone, naltrexone) |
| ☐ Individual counseling |
| ☐ Group counseling |
| ☐ 12-Step groups |
| ☐ Case management |
| ☐ Other |
| ☐ None of these services are offered at this facility |

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***B10. 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, select YES to that category

| | **SELECT "YES" OR "NO" FOR EACH** |
|---|---|
| Young children (0-5) | O Yes<br>O No |
| Children (6-12) | O Yes<br>O No |
| Adolescents (13-17) | O Yes<br>O No |
| Young adults (18-25) | O Yes<br>O No |
| Adults (26-64) | O Yes<br>O No |
| Older adults (65 or older) | O Yes<br>O No |

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***B11. 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>** select the box for that category.

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ Children/adolescents with serious emotional disturbance (SED) |
| ☐ Young adults |
| ☐ Persons 18 and older with serious mental illness (SMI) |
| ☐ Older adults |
| ☐ Persons with Alzheimer's disease or dementia |
| ☐ Persons with co-occurring mental and substance use disorders |
| ☐ Persons with eating disorders |
| ☐ Persons experiencing first-episode psychosis |
| ☐ Persons who have experienced intimate partner violence, domestic violence |
| ☐ Persons with a diagnosis of post-traumatic stress disorder (PTSD) |
| ☐ Persons who have experienced trauma (excluding persons with a PTSD diagnosis) |
| ☐ Persons with traumatic brain injury (TBI) |
| ☐ Veterans |
| ☐ Active duty military |
| ☐ Members of military families |
| ☐ Lesbian, gay, bisexual, transgender, or queer/questioning (LGBTQ) clients |
| ☐ Forensic clients (referred from the court/judicial system) |
| ☐ Persons with HIV or AIDS |
| ☐ Other special program or group *(Specify: _____)* |
| ☐ Other special program or group *(Specify: _____)* |

☐ No dedicated or exclusively designed programs or groups are offered at this facility

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***B12. Does this facility offer a crisis intervention team that handles acute mental health issues at this facility and/or off-site?**

| |
|---|
| O Yes |
| O No |

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***B13. Does this facility offer services for psychiatric emergencies onsite?**

| |
|---|
| O Yes |
| O No |

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***B14. Does this facility offer mobile/off-site psychiatric crisis services?**

| |
|---|
| O Yes |
| O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

*** Information from asterisked (*) questions may be published in SAMHSA's Online Behavioral Health Treatment Services Locator (found at https:findtreatment.samhsa.gov) in SAMHSA's National Directory of Drug and Alcohol Abuse Treatment Programs and the National Directory of Mental Health Treatment Facilities, and other publicly-available listings, unless you designate otherwise in question C8 of this questionnaire.**

***B15. 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)*?**

- *Select "yes" if either a staff counselor or an on-call interpreter provides this service*

| |
|---|
| O Yes |
| O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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***B16. Does <u>this</u> facility provide mental health treatment services in a language <u>other than English</u> at this location?**

| |
|---|
| O Yes |
| O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**B16a. At <u>this</u> facility, who provides mental treatment services in a language <u>other than English</u>?**

**SELECT ONLY ONE**

| |
|---|
| o Staff counselor who speaks a language other than English |
| o On-call interpreter *(in person or by phone)* brought in when needed |
| o BOTH staff counselor and on-call interpreter |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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***B16a1. Do staff counselors provide mental health treatment in Spanish at this facility?**

| |
|---|
| O Yes |
| O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**B16a2. Do staff counselors at this facility provide mental health treatment in any other languages?**

| |
|---|
| O Yes |
| O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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***B16b. In what other languages do staff counselors provide mental health treatment at this facility?**

- *Do not count languages provided only by on-call interpreters.*

**SELECT ALL THAT APPLY**

**American Indian or Alaska Native**

| |
|---|
| ☐ Hopi |
| ☐ Lakota |
| ☐ Navajo |
| ☐ Ojibwa |
| ☐ Yupik |
| ☐ Other American Indian or Alaska Native language (Specify:_____) |

**Other Languages:**

| |
|---|
| ☐ Arabic |
| ☐ Any Chinese languages |
| ☐ Creole |
| ☐ Farsi |
| ☐ French |
| ☐ German |
| ☐ Greek |
| ☐ Hebrew |
| ☐ Hindi |
| ☐ Hmong |
| ☐ Italian |
| ☐ Japanese |
| ☐ Korean |
| ☐ Polish |
| ☐ Portuguese |
| ☐ Russian |
| ☐ Tagalog |
| ☐ Vietnamese |
| ☐ Any Other language (Specify:_____) |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**B17. Which of these quality improvement practices are part of this facility's <u>standard operating procedures</u>?**

| | SELECT "YES" OR "NO" FOR EACH |
|---|---|
| | O Yes |

| | |
|---|---|
| Continuing education requirements for professional staff | O No |
| Regularly scheduled case review with a supervisor | O Yes<br>O No |
| Regularly scheduled case review by an appointed quality review committee | O Yes<br>O No |
| Client outcome follow-up after discharge | O Yes<br>O No |
| Continuous quality improvement processes | O Yes<br>O No |
| Periodic client satisfaction surveys | O Yes<br>O No |
| Clinical provider peer review (CPPR) | O Yes<br>O No |
| Root cause analysis (RCA) | O Yes<br>O No |

| | |
|---|---|
| | |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**B18. In the 12-month period beginning April 1, 2020, and ending March 31, 2021, have staff <u>at this facility</u> used:**

**SELECT ALL THAT APPLY**

| | Not Used at This Facility | Chemical | Physical |
|---|---|---|---|
| **Seclusion** | ☐ | ☐ | ☐ |
| **Restrain** | ☐ | ☐ | ☐ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**B18a. Does this facility have any policies in place to minimize the use of seclusion or restraint?**

| |
|---|
| O Yes |
| O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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***B19. Which of the following types of client payments, insurance, or funding are accepted by this facility for mental health treatment services?**

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ Cash or self-payment |
| ☐ Private health insurance |
| ☐ Medicare |
| ☐ Medicaid |
| ☐ State-financed health insurance plan other than Medicaid |
| ☐ State mental health agency *(or equivalent)* funds |
| ☐ State welfare or child and family services agency funds |
| ☐ State corrections or juvenile justice agency funds |
| ☐ State education agency funds |
| ☐ Other state government funds |
| ☐ County or local government funds |
| ☐ Community Service Block Grants |
| ☐ Community Mental Health Block Grants |
| ☐ Federal grants (specify:_____) |
| ☐ Federal military insurance *(such as TRICARE)* |
| ☐ U.S. Department of Veterans Affairs funds |
| ☐ IHS/Tribal/Urban *(ITU)* funds |
| ☐ Private or Community foundation |
| ☐ Other *(Specify: _____)* |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**B20. 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.*

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ State mental health authority |
| ☐ State substance use treatment agency |
| ☐ State department of health |
| ☐ State or local Department of Family and Children's Services |
| ☐ Hospital licensing authority |
| ☐ The Joint Commission |
| ☐ Commission on Accreditation of Rehabilitation Facilities *(CARF)* |
| ☐ Council on Accreditation *(COA)* |
| ☐ Centers for Medicare and Medicaid Services *(CMS)* |
| ☐ Other national organization, or federal, state, or local agency |
| ☐ *(Specify: _____)* |
| ☐ This facility does not have licensing, certification, or accreditation from any of these organizations |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**MODULE C: FOR ALL TREATMENT FACILITIES**

***C1. 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:*
  INSERT LINK

| |
|---|
| O Yes |
| O No |
| O Don't know |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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***C2. Is this facility operated by**

**SELECT ONLY ONE**

| |
|---|
| O A private for-profit organization |

| | |
|---|---|
| O | A private non-profit organization |
| O | State government |
| O | Local, county, or community government |
| O | Tribal government |
| O | Federal Government |

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***C2a. Which Federal Government agency?**

**SELECT ONLY ONE**

| |
|---|
| O Department of Veterans Affairs |
| O Department of Defense |
| O Indian Health Service |
| O Other *(Specify:_____)* |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**
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**C3. Is this facility affiliated with a religious (or faith-based) organization?**

| |
|---|
| O Yes |
| O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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***C4. Which of the following statements BEST describes this facility's smoking policy for clients?**

**SELECT ONLY ONE**

| |
|---|
| O Not permitted to smoke anywhere outside or within any building |
| O Permitted in designated outdoor area(s) |
| O Permitted anywhere outside |
| O Permitted in designated indoor area(s) |
| O Permitted anywhere inside |
| O Permitted anywhere without restriction |

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***C5. Which of the following statements BEST describes this facility's vaping policy for clients?**

**SELECT ONLY ONE**

| |
|---|
| O Not permitted to smoke anywhere outside or within any building |
| O Permitted in designated outdoor area(s) |
| O Permitted anywhere outside |
| O Permitted in designated indoor area(s) |
| O Permitted anywhere inside |
| O Permitted anywhere without restriction |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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***C6. Does this facility use a sliding fee scale?**

- Sliding fee scales are based on income and other factors

| |
|---|
| O Yes |
| O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**C6a. Do you want the availability of a sliding fee scale published in SAMHSA's online Behavioral Health Treatment Services Locator and *Directory*?**

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

| |
|---|
| o Yes |
| o No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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***C7. Does this facility offer treatment at no charge or minimal payment (for example, $1) to clients who cannot afford to pay?**

| |
|---|
| O Yes |
| O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**C7a. 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 and *Directory*?**

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

| |
|---|
| O Yes |
| O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**C8. If eligible, does this facility want to be listed in SAMHSA's online Behavioral Health Treatment Services Locator and Directory?** *(See inside front cover for eligibility information)*

- *The Behavioral Health Treatment Services Locator can be found at* INSERT LINK
- *The Directory will be available at INSERT LINK*

| |
|---|
| O Yes |
| O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**C8a. Does this facility want the street address and/or mailing address to be listed in SAMHSA's online Behavioral Health Treatment Services Locator and Directory?**

**SELECT ALL THAT APPLY**

| |
|---|
| ☐ Publish the street address |

| |
|---|
| ☐ Publish the mailing address |
| ☐ Do not publish either address |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**C8b. 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.

| |
|---|
| O Yes |
| O No |

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**C9. Is this facility part of an organization with multiple facilities or sites that provide substance use or mental disorder treatment?**

| |
|---|
| O Yes |

| |
|---|
| O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**C10. What is the name, address, and phone number of the facility that is the parent, or lead site (HQ), of the organization?**

**FILL IN THE FOLLOWING**

| | |
|---|---|
| | |

| | |
|---|---|
| Name: | _____ |
| Address: | _____ |
| Phone Number: | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**MODULE D: CLIENT COUNTS SECTION**

**D1. The next set of questions ask about the number of clients in treatment. 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?**

**SELECT ONLY ONE**

| |
|---|
| **O** Only this facility |
| **O** This facility plus others |
| **O** Another facility will report this facility's client counts |

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**D2. How many facilities will be included in your client counts?**

| | |
|---|---|
| This Facility | 1 |
| Additional Facilities | _____ |
| **Total** | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D3. To avoid double-counting clients, we need to know which facilities are included in your counts. How will you report this information to us?**

**SELECT ONLY ONE**

| |
|---|
| O By listing the names and location addresses of these additional facilities in the “Additional Facilities Included in Client Counts” section on this questionnaire or attaching a sheet of paper to this questionnaire |
| O Please call me for a list of the additional facilities included in these counts |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D4. On March 31, 2021, did any patients receive INPATIENT substance use disorder treatment services at this facility?**

| |
|---|
| O Yes |
| O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D4a. On March 31, 2021, how many patients received the following HOSPITAL INPATIENT substance use disorder treatment 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)**

| | |
|---|---|
| Impatient detoxification (medical withdrawal) (medically managed or monitored inpatient detoxification) | _____ |
| Impatient treatment (medically managed or monitored intensive inpatient treatment) | _____ |
| HOSPITAL INPATIENT TOTAL BOX | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D4b. How many of the patients from the HOSPITAL INPATIENT TOTAL BOX were <u>under</u> the age of 18?**

**ENTER A NUMBER FOR EACH (IF NONE ENTER 0)**

| | |
|---|---|
| | |

| | |
|---|---|
| Number under age 18 | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D4c. How many of the patients from the HOSPITAL INPATIENT TOTAL BOX received:**

- *Include patients who received these drugs for detoxification (medical withdrawal), maintenance, or relapse prevention treatment for opioid use disorder.*

| | |
|---|---|
| | |

| | |
|---|---|
| Methadone dispense at this facility for opioid use disorder | _____ |
| Buprenorphine products dispensed or prescribed at this facility for opioid use disorder | _____ |
| Naltrexone administered at this facility for opioid use disorder | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D4d. How many of the patients from the HOSPITAL INPATIENT TOTAL BOX received:**
*Include patients who received these medications for alcohol use disorder.*
**ENTER A NUMBER FOR EACH (IF NONE ENTER 0)**

| | |
|---|---|
| | |

| | |
|---|---|
| Disulfiram dispensed or prescribed at this facility for alcohol use disorder | _____ |
| Naltrexone dispensed or prescribed at this facility for alcohol use disorder | _____ |
| Acamprosate dispensed or prescribed at this facility for alcohol use disorder | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D4e. On March 31, 2021, how many hospital inpatient <u>beds</u> were <u>specifically designated</u> for substance use disorder treatment?**
**ENTER A NUMBER FOR EACH (IF NONE ENTER 0)**

| | |
|---|---|
| Number of Beds | _____ |

| | |
|---|---|
| | |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D5. On March 31, 2021, did any clients receive RESIDENTIAL (non-hospital) substance use disorder treatment services at this facility?**

| |
|---|
| O Yes |

| |
|---|
| O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D5a. On March 31, 2021, how many clients received the following RESIDENTIAL substance use disorder treatment 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)**

| | |
|---|---|
| | |

| | |
|---|---|
| Residential detoxification (medical withdrawal) *(clinically managed residential detoxification or social detoxification)* | _____ |
| Residential short-term treatment ( *clinically managed high-intensity residential treatment, typically 30 days or less)* | _____ |
| Residential long-term treatment( *clinically managed high-intensity residential treatment, typically 30 days or less)* | _____ |
| Residential Total Box | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

*** Information from asterisked (*) questions may be published in SAMHSA's Online Behavioral Health Treatment Services Locator (found at https:findtreatment.samhsa.gov) in SAMHSA's National Directory of Drug and Alcohol Abuse Treatment Programs and the National Directory of Mental Health Treatment Facilities, and other publicly-available listings, unless you designate otherwise in question C8 of this questionnaire.**

**D5b. How many of the clients from the RESIDENTIAL TOTAL BOX were <u>under</u> the age of 18?**

**ENTER A NUMBER FOR EACH (IF NONE ENTER 0)**

| | |
|---|---|
| Number under age 18 | _____ |

| | |
|---|---|
| | |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D5c. How many of the clients from the RESIDENTIAL TOTAL BOX received:**

- *Include clients who received these drugs for detoxification, maintenance, or relapse prevention for opioid use disorder.*

| | |
|---|---|
| Methadone dispense at this facility for opioid use disorder | _____ |

| | |
|---|---|
| | |
| Buprenorphine products dispensed or prescribed at this facility for opioid use disorder | _____ |
| Naltrexone administered at this facility for opioid use disorder | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D5d. How many of the clients from the RESIDENTIAL TOTAL BOX received:**
*Include clients who received these medications for alcohol use disorder.*

**ENTER A NUMBER FOR EACH (IF NONE ENTER 0)**

| | |
|---|---|
| Disulfiram dispensed or prescribed at this facility | _____ |

| | |
|---|---|
| for alcohol use disorder | |
| Naltrexone dispensed or prescribed at this facility for alcohol use disorder | _____ |
| Acamprosate dispensed or prescribed at this facility for alcohol use disorder | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D5e. On March 31, 2021, how many residential <u>beds</u> were <u>specifically designated</u> for substance use disorder treatment?**

**ENTER A NUMBER FOR EACH (IF NONE ENTER 0)**

| | |
|---|---|
| Number of beds | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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## OUTPATIENT CLIENT COUNTS

**D6. During the month of March 2021, did any clients receive OUTPATIENT substance use disorder treatment services at this facility?**

| |
|---|
| O Yes |

O No

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D6a. As of March 31, 2021, how many active clients were receiving each of the following OUTPATIENT substance use disorder treatment services at this facility?**

*An active client is a client who received treatment in March **AND** was still enrolled in treatment on March 31, 2021.*

- ***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.*

| | |
|---|---|
| Outpatient detoxification (medical withdrawal) (ambulatory detoxification) | _____ |
| Outpatient methadone/buprenorphine maintenance or naltrexone treatment (count methadone/ buprenorphine/naltrexone clients on this line only) | _____ |
| Outpatient day treatment or partial hospitalization (20 or more hours per week) | _____ |
| Intensive Outpatient treatment (9 or more hours per week) | _____ |
| Regular outpatient treatment (outpatient treatment, non-intensive) | _____ |
| Outpatient Total Box | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D6b. How many of the clients from the OUTPATIENT TOTAL BOX were <u>under</u> the age of 18?**

**ENTER A NUMBER FOR EACH (IF NONE ENTER 0)**

| | |
|---|---|
| Number under age 18 | _____ |

| | |
|---|---|
| | |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D6c. How many of the clients from the OUTPATIENT TOTAL BOX received:**

- *Include clients who received these drugs for detoxification (medical withdrawal), maintenance, or relapse prevention for <u>opioid use disorder</u>*

**ENTER A NUMBER FOR EACH (IF NONE ENTER 0)**

| | |
|---|---|
| Methadone dispense at this facility for opioid use | |

| | |
|---|---|
| disorder | _____ |
| Buprenorphine products dispensed or prescribed at this facility for opioid use disorder | _____ |
| Naltrexone administered at this facility for opioid use disorder | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

*** Information from asterisked (*) questions may be published in SAMHSA's Online Behavioral Health Treatment Services Locator (found at https:findtreatment.samhsa.gov) in SAMHSA's National Directory of Drug and Alcohol Abuse Treatment Programs and the National Directory of Mental Health Treatment Facilities, and other publicly-available listings, unless you designate otherwise in question C8 of this questionnaire.**

**D6d. How many of the clients from the OUTPATIENT TOTAL BOX received:**

- *Include clients who received these medications for <u>alcohol use disorder</u>*

**ENTER A NUMBER FOR EACH (IF NONE ENTER 0)**

| | |
|---|---|
| | |

| | |
|---|---|
| Disulfiram dispensed or prescribed at this facility for alcohol use disorder | _____ |
| Naltrexone dispensed or prescribed at this facility for alcohol use disorder | _____ |
| Acamprosate dispensed or prescribed at this facility for alcohol use disorder | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**ALL SUBSTANCE USE TREATMENT SETTING**

**D7. This question asks you to categorize the substance use treatment clients at this facility into three groups: clients in treatment for (1) use of <u>both</u> alcohol and substances other than alcohol; (2) use <u>only</u> of alcohol; or (3) use <u>only</u> of substances other than alcohol.**

**Enter the percent of clients on March 31, 2021, who were in each of these three groups.**

**Use either numbers OR percentage, whichever is more convenient.**

- *If numbers are used—each category total should equal the number reported in the combined total patients and clients that are recorded in QXAa, QXBa, and QXCa.*
- *If percents are used—each category total should equal 100%.*

**Clients in treatment for use of:**

| | NUMBER | PERCENT |
|---|---|---|
| BOTH alcohol and substances other than alcohol | _____ | _____ |
| ONLY alcohol | _____ | _____ |
| ONLY substances other than alcohol | _____ | _____ |
| Total | _____ | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D8. Approximately what percent of the substance use treatment clients enrolled at this facility on March 31, 2021, had a diagnosed co-occurring mental disorder and substance use disorder?**

| | |
|---|---|
| Percent of Clients (If none, enter "0") | _____ |

| | |
|---|---|
| | |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D9. Using the most recent 12-month period for which you have data, approximately how many substance use disorder treatment ADMISSIONS did this facility have?**

- **OUTPATIENT CLIENTS:** *Count admissions into treatment, <u>not</u> 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 use disorder treatment, even if substance use disorder was their secondary diagnosis*

| | |
|---|---|
| Number of substance use disorder treatment admissions in a 12-month period | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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## MENTAL HEALTH COUNTS

## HOSPITAL INPATIENT CLIENT COUNTS

**D10. On March 31, 2021, did any patients receive 24-hour hospital inpatient treatment for mental disorders at this facility, at this location?**

| |
|---|
| O Yes |
| O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

*** Information from asterisked (*) questions may be published in SAMHSA's Online Behavioral Health Treatment Services Locator (found at https:findtreatment.samhsa.gov) in SAMHSA's National Directory of Drug and Alcohol Abuse Treatment Programs and the National Directory of Mental Health Treatment Facilities, and other publicly-available listings, unless you designate otherwise in question C8 of this questionnaire.**

**D10a. On March 31, 2021, how many patients received 24-hour hospital inpatient treatment for mental disorders at this facility?**

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

| | |
|---|---|
| Hospital Inpatients Total Box | _____ |

| | |
|---|---|
| | |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

*** Information from asterisked (*) questions may be published in SAMHSA's Online Behavioral Health Treatment Services Locator (found at https:findtreatment.samhsa.gov) in SAMHSA's National Directory of Drug and Alcohol Abuse Treatment Programs and the National Directory of Mental Health Treatment Facilities, and other publicly-available listings, unless you designate otherwise in question C8 of this questionnaire.**

**D10b. On March 31, 2021, how many hospital inpatient beds at this facility were specifically designated for providing treatment of mental disorders?**

| | |
|---|---|
| Number of Beds (If none, enter "0") | _____ |

| | |
|---|---|
| | |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D10c. For each category below, please provide a breakdown of the Hospital Inpatients on March 31, 2021 reported in the 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 TOTAL BOX above.*
- *If percents are used—each category total should equal 100%*

**SEX**

| | NUMBER | PERCENT |
|---|---|---|
| Male | _____ | _____ |
| Female | _____ | _____ |
| Total | _____ | _____ |

**AGE**

| | NUMBER | PERCENT |
|---|---|---|
| 0-17 | _____ | _____ |
| 18-64 | _____ | _____ |
| 65 and older | _____ | _____ |
| Total | _____ | _____ |

**ETHNICITY**

| | NUMBER | PERCENT |
|---|---|---|
| Hispanic or Latino | _____ | _____ |
| Not Hispanic or Latino | _____ | _____ |
| Unknown or not collected | _____ | _____ |
| Total | _____ | _____ |

**RACE**

| | NUMBER | PERCENT |
|---|---|---|
| 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 | _____ | _____ |
| Total | _____ | _____ |

**LEGAL STATUS**

| | **NUMBER** | **PERCENT** |
|---|---|---|
| Voluntary | _____ | _____ |
| Involuntary, non-forensic | _____ | _____ |
| Involuntary, forensic | _____ | _____ |
| Total | _____ | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

*** Information from asterisked (*) questions may be published in SAMHSA's Online Behavioral Health Treatment Services Locator (found at https:findtreatment.samhsa.gov) in SAMHSA's National Directory of Drug and Alcohol Abuse Treatment Programs and the National Directory of Mental Health Treatment Facilities, and other publicly-available listings, unless you designate otherwise in question C8 of this questionnaire.**

## RESIDENTIAL (NON-HOSPITAL) CLIENT COUNTS

**D11. On March 31, 2021, did any patients receive 24-hour residential mental disorder treatment at this facility, at this location?**

| |
|---|
| O Yes |

| |
|---|
| O No |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

*** Information from asterisked (*) questions may be published in SAMHSA's Online Behavioral Health Treatment Services Locator (found at https:findtreatment.samhsa.gov) in SAMHSA's National Directory of Drug and Alcohol Abuse Treatment Programs and the National Directory of Mental Health Treatment Facilities, and other publicly-available listings, unless you designate otherwise in question C8 of this questionnaire.**

**D11a. On March 31, 2021, how many patients received 24-hour residential treatment of mental disorders at this facility?**

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

| | |
|---|---|
| Residential Clients Total Box | _____ |

| | |
|---|---|
| | |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

*** Information from asterisked (*) questions may be published in SAMHSA's Online Behavioral Health Treatment Services Locator (found at https:findtreatment.samhsa.gov) in SAMHSA's National Directory of Drug and Alcohol Abuse Treatment Programs and the National Directory of Mental Health Treatment Facilities, and other publicly-available listings, unless you designate otherwise in question C8 of this questionnaire.**

**D11b. On March 31, 2021, how many residential beds at this facility were specifically designated for providing mental disorder treatment?**

| | |
|---|---|
| Number of Beds (If none, enter "0") | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D11c. For each category below, please provide a breakdown of the Residential Clients on March 31, 2021 reported in the 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 TOTAL BOX above.*
- *If percents are used—each category total should equal 100%.*

**SEX**

| | NUMBER | PERCENT |
|---|---|---|
| Male | _____ | _____ |

| | | |
|---|---|---|
| Female | _____ | _____ |
| Total | _____ | _____ |

**AGE**

| | NUMBER | PERCENT |
|---|---|---|
| 0-17 | _____ | _____ |
| 18-64 | _____ | _____ |
| 65 and older | _____ | _____ |
| Total | _____ | _____ |

**ETHNICITY**

| | NUMBER | PERCENT |
|---|---|---|
| Hispanic or Latino | _____ | _____ |
| Not Hispanic or Latino | _____ | _____ |
| Unknown or not collected | _____ | _____ |
| Total | _____ | _____ |

**RACE**

| | NUMBER | PERCENT |
|---|---|---|
| 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 | _____ | _____ |
| Total | _____ | _____ |

**LEGAL STATUS**

| | NUMBER | PERCENT |
|---|---|---|
| Voluntary | _____ | _____ |
| Involuntary, non-forensic | _____ | _____ |
| Involuntary, forensic | _____ | _____ |
| Total | _____ | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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## OUTPATIENT CLIENT COUNTS

**D12a. During the month of March 2021, how many clients received less than 24-hour treatment of mental disorders at this facility?**

- ***ONLY INCLUDE*** *those seen at this facility at least once during the month of March,* ***AND who were still enrolled in treatment on March 31, 2021.***
- ***DO NOT*** *count family members, friends, or other non-treatment persons.*

| | |
|---|---|
| OUTPATIENT CLIENTS AND PARTIAL HOSPITALIZATION/DAY TREATMENT CLIENTS | _____ |

| | |
|---|---|
| | |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D12b. For each category below, please provide a breakdown of the Clients in Less Than 24-Hour Care reported in the 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 TOTAL BOX above.*
- *If percents are used—each category total should equal 100%.*

**SEX**

| | NUMBER | PERCENT |
|---|---|---|
| Male | _____ | _____ |

| | | |
|---|---|---|
| Female | _____ | _____ |
| Total | _____ | _____ |

**AGE**

| | NUMBER | PERCENT |
|---|---|---|
| 0-17 | _____ | _____ |
| 18-64 | _____ | _____ |
| 65 and older | _____ | _____ |
| Total | _____ | _____ |

**ETHNICITY**

| | NUMBER | PERCENT |
|---|---|---|
| Hispanic or Latino | _____ | _____ |
| Not Hispanic or Latino | _____ | _____ |
| Unknown or not collected | _____ | _____ |
| Total | _____ | _____ |

**RACE**

| | NUMBER | PERCENT |
|---|---|---|
| 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 | _____ | _____ |
| Total | _____ | _____ |

**LEGAL STATUS**

| | NUMBER | PERCENT |
|---|---|---|
| Voluntary | _____ | _____ |
| Involuntary, non-forensic | _____ | _____ |
| Involuntary, forensic | _____ | _____ |
| Total | _____ | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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## D13. On March 31, 2021, approximately what percent of the clients/patients enrolled at this facility had diagnosed co-occurring mental and substance use disorders?

| | |
|---|---|
| PERCENT WITH CO-OCCURRING DIAGNOSIS | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D14. In the 12-month period of April 1, 2020 through March 31, 2021, how many <u>mental disorder treatment</u> 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. <u>Count admissions</u> into treatment, <u>not</u> individual treatment visits.*
- ***WHEN A MENTAL DISORDER IS A SECONDARY DIAGNOSIS:*** *Count all admissions where clients/patients received mental health treatment.*

| | |
|---|---|
| NUMBER OF MENTAL DISORDER TREATMENT ADMISSIONS IN 12-MONTH PERIOD | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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**D15. What percent of the admissions reported in the previous question were military veterans? Please give your best estimate.**

| | |
|---|---|
| PERCENT MILITARY VETERANS | _____ |

**(Buttons: *SAVE PROGRESS, START PAGE OVER, SUBMIT AND CONTINUE*)**

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## RESPONDENT INFORMATION

**E1. 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

| | |
|---|---|
| Select One | O Ms.<br>O Mr. |

| | |
|---|---|
| | o Mrs.<br>o Dr.<br>o Other (Specify:_____) |
| Name: | _____ |
| Title: | _____ |
| Phone Number: | _____ |
| Fax Number: | _____ |
| Email Address: | _____ |
| Facility Email Address: | _____ |

**ADDITIONAL FACILITIES INCLUDED IN CLIENT/PATIENT COUNTS**

| | |
|---|---|
| Select One | o Hospital Inpatient<br>o Residential<br>o Outpatient |

| | |
|---|---|
| | o Partial Hospitalization/Day Treatment |
| Facility Name: | _____ |
| Address: | _____ |
| City: | _____ |
| State: | _____ |
| Zip: | _____ |
| Telephone: | _____ |
| Facility Email: | _____ |
| Address: | _____ |