

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

1. What type of treatment does this facility at this location, provide?

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

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

- Yes
- No

### **MODULE A: SUBSTANCE USE TREATMENT FACILITIES**

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

MARK "YES" OR "NO" FOR EACH

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

**A1a. To which of the following clients does this facility, at this location, 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*)?**

**MARK 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

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

**MARK ALL THAT APPLY**

- Alcohol
- Benzodiazepines
- Cocaine
- Methamphetamines
- Opioids
- Other(s) (*Specify:* \_\_\_\_\_)

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

- Yes
- No

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

- Yes
- No

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

- Yes    **SKIP TO A4a (BELOW)**
- No      **SKIP TO A5 (BELOW)**

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

MARK "YES" OR "NO" FOR EACH

	<u>YES</u>	<u>NO</u>
Inpatient detoxification (medical withdrawal) <i>(medically managed or monitored inpatient detoxification)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient treatment..... <i>(medically managed or monitored intensive inpatient treatment)</i>	<input type="checkbox"/>	<input type="checkbox"/>

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

- Yes      SKIP TO A5a (BELOW)
- No        SKIP TO A6 (BELOW)

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

MARK "YES" OR "NO" FOR EACH

	<u>YES</u>	<u>NO</u>
Residential detoxification (medical withdrawal) <i>(clinically managed residential detoxification or social detoxification)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Residential short-term treatment.... <i>(clinically managed high-intensity residential treatment, typically 30 days or less)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Residential long-term treatment..... <i>(clinically managed medium- or low-intensity residential treatment)</i>	<input type="checkbox"/>	<input type="checkbox"/>

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

- Yes      SKIP TO A6a (BELOW)
- No        SKIP TO A7 (BELOW)

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

MARK "YES" OR "NO" FOR EACH

	<u>YES</u>	<u>NO</u>
Outpatient detoxification..... <i>(ambulatory detoxification)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient methadone/ buprenorphine maintenance or naltrexone treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient day treatment or partial hospitalization..... <i>(20 or more hours per week)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Intensive outpatient treatment..... <i>(9 or more hours per week)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Regular outpatient treatment..... <i>(outpatient treatment, non-intensive)</i>	<input type="checkbox"/>	<input type="checkbox"/>

**\*A7. Which of the following services are offered by this facility at this location; that is, the location listed on the front cover?**

**MARK 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 Support 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 Services**

- 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*)

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- 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

**\*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.*

**MARK 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.)* → **SKIP TO A8a**
  - 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 waived 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.)*
- } **SKIP TO A8b**
- 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.
- } **SKIP TO A9**
- 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. → **SKIP TO A9**

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

**MARK 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

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

- Yes

No

**\*A8c. Which of the following medication services does this program provide for opioid use disorder?**

**MARK 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

**\*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.*

**MARK ALL THAT APPLY**

- This facility accepts clients using MAT for alcohol use disorder, but the medications originate from or are prescribed by another entity. **SKIP TO A9a**
- This facility administers/prescribes disulfiram for alcohol use disorder. **SKIP TO A9a**
- This facility administers/prescribes naltrexone for alcohol use disorder. **SKIP TO A9a**
- This facility administers/prescribes acamprosate for alcohol use disorder. **SKIP TO A9a**
- 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. **SKIP TO A9b**
- This facility does not treat alcohol use disorder. **SKIP TO A10**

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

**MARK 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

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

- Yes
- No

**\*A10. Which of the following clinical/therapeutic approaches listed below are used frequently at this facility?**

CLINICAL/THERAPEUTIC APPROACHES	MARK ALL THAT APPLY FOR EACH APPROACH	
	OPIOID USE DISORDER	OTHER SUBSTANCES
Substance use disorder counseling	<input type="checkbox"/>	<input type="checkbox"/>
12-step facilitation	<input type="checkbox"/>	<input type="checkbox"/>
Brief intervention	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive behavioral therapy	<input type="checkbox"/>	<input type="checkbox"/>
Contingency management/motivational incentives	<input type="checkbox"/>	<input type="checkbox"/>
Motivational interviewing	<input type="checkbox"/>	<input type="checkbox"/>
Trauma-related counseling	<input type="checkbox"/>	<input type="checkbox"/>
Anger management	<input type="checkbox"/>	<input type="checkbox"/>
Matrix Model	<input type="checkbox"/>	<input type="checkbox"/>
Community reinforcement plus vouchers	<input type="checkbox"/>	<input type="checkbox"/>
Relapse prevention	<input type="checkbox"/>	<input type="checkbox"/>
Telemedicine/telehealth therapy ( <i>including Internet, Web, mobile, and desktop programs</i> )	<input type="checkbox"/>	<input type="checkbox"/>
Other treatment approach ( <i>Specify: _____</i> )	<input type="checkbox"/>	<input type="checkbox"/>

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 specialty designed program or group intended exclusively for DUI/DWI or other drunk driver offenders?**

- Yes      SKIP TO A11a
- No        SKIP TO A12

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

- Yes
- No

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

- Marijuana
- Stimulants
- Other substance(s) (*Specify:* \_\_\_\_\_ )

**\*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*)?**

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

- Yes
- No

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

- Yes      SKIP TO A14a
- No        SKIP TO A15

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

**MARK ONE ONLY**

- Staff counselor who speaks a language other than English      **SKIP TO A14a1**
- On-call interpreter (*in person or by phone*) brought in when needed      **SKIP TO A14a1**
- BOTH staff counselor and on-call interpreter                      **SKIP TO A15**

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

- Yes      SKIP TO A14a2
- No        SKIP TO A14b

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

- Yes      **SKIP TO A14b**
- No        **SKIP TO A15**

**\*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.*

**MARK 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 language
- Creole
- Farsi
- French
- German
- Greek
- Hebrew
- Hindi
- Hmong
- Italian
- Japanese
- Korean
- Polish
- Portuguese
- Russian
- Tagalog
- Vietnamese
- Any other language  
(Specify: \_\_\_\_\_)

**\*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, at this location?**

- 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.

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

**\*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 mark the box for that category.**

**MARK 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 co-occurring pain 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 groups for any other types of clients  
(Specify: \_\_\_\_\_)
- No specifically tailored programs or groups are offered

**\*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?**

• Do not include Medicare, Medicaid, or federal military insurance. These forms of client payments are included in the following question.

- Yes
- No
- Don't know

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

**MARK 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: \_\_\_\_\_)

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

- Yes     **SKIP TO A18a**
- No     **SKIP TO A19**

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

**MARK ONE ONLY**

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

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

- Yes
- No

**\*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?**

- Yes
- No

**\*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.*

**MARK 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)
- Healthcare Facilities Accreditation Program (HFAP)
- 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

**MODULE B: MENTAL DISORDERS TREATMENT FACILITIES**

**B1. Does this treatment facility, at this location, offer:**

MARK "YES" OR "NO" FOR EACH

	<u>YES</u>	<u>NO</u>
Mental health intake.....	<input type="checkbox"/>	<input type="checkbox"/>
Mental health diagnostic evaluation.....	<input type="checkbox"/>	<input type="checkbox"/>
Mental health information and/or..... referral <i>(also includes emergency programs that provide services in person or by telephone)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health treatment..... <i>(interventions such as therapy or psychotropic medication that treat a person's mental disorder or condition, reduce symptoms, and improve behavioral functioning and outcomes)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Treatment for co-occurring..... disorders <u>plus either</u> serious mental illness (SMI) in adults <u>and/or</u> serious emotional disturbance (SED) in children	<input type="checkbox"/>	<input type="checkbox"/>
Substance use treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Administrative or operational services..... for mental health treatment facilities	<input type="checkbox"/>	<input type="checkbox"/>

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

MARK "YES" OR "NO" FOR EACH

	<u>YES</u>	<u>NO</u>
24-hour hospital inpatient.....	<input type="checkbox"/>	<input type="checkbox"/>
24-hour residential.....	<input type="checkbox"/>	<input type="checkbox"/>
Partial hospitalization/day treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient.....	<input type="checkbox"/>	<input type="checkbox"/>

**\*B3. Which ONE category BEST describes this facility, at this location?**

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

MARK ONE ONLY

- Psychiatric hospital
  - Separate inpatient psychiatric unit of a general hospital (*consider this psychiatric unit as the relevant "facility" for the purpose of this survey*)
  - State hospital
  - Residential treatment center for children
  - Residential treatment center for adults
  - Other type of residential treatment facility
  - Veterans Affairs Medical Center (VAMC) or other VA health care facility
  - Community Mental Health Center (CMHC)
  - Certified Community Behavioral Health Clinic (CCBHC)
  - Partial hospitalization/day treatment facility
  - Outpatient mental health facility
  - Multi-setting mental health facility (*non-hospital residential plus either outpatient and/or partial hospitalization/day treatment*)
  - Other (*Specify: \_\_\_\_\_*)
- 
- SKIP TO B5
- SKIP TO B4

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

- Yes      **SKIP TO B4a**
- No        **SKIP TO B5**

**\*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.

- Yes
- No

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

MARK 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

**\*B6. Which of these treatment modalities for mental disorders are offered at this facility, at this location?**

•For definitions of treatment modalities, go to: [INSERT LINK](#)

**MARK 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(s) (*Specify: \_\_\_\_\_*)
- None of these mental health treatment modalities are offered at this facility

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

- Yes      **SKIP TO B7a**
- No      **SKIP TO B8**

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

FIRST-GENERATION ANTIPSYCHOTIC	MARK ALL THAT APPLY FOR EACH MEDICATION					
	NOT USED AT THIS FACILITY	ORAL	INJECTABLE	LONG-ACTING INJECTABLE	RECTAL	TOPICAL
Chlorpromazine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Droperidol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluphenazine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Haloperidol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loxapine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perphenazine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pimozide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thiothixene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thioridazine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trifluoperazine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other first-generation antipsychotics (Specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	MARK ALL THAT APPLY FOR EACH MEDICATION					
SECOND-GENERATION ANTIPSYCHOTIC	NOT USED AT THIS FACILITY	ORAL	INJECTABLE	LONG-ACTING INJECTABLE	RECTAL	TOPICAL
Aripiprazole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asenapine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brexpiprazole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cariprazine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clozapine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iloperidone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lurasidone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Olanzapine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Olanzapine/Fluoxetine combination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paliperidone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quetiapine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risperidone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ziprasidone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other second-generation antipsychotics (Specify: _____ _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

•For definitions, go to: [INSERT LINK](#)

**MARK 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

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

**MARK 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

**\*B10. What age groups are accepted for treatment at this facility?**

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

MARK "YES" OR "NO" FOR EACH

	<u>YES</u>	<u>NO</u>
Young children (0-5).....	<input type="checkbox"/>	<input type="checkbox"/>
Children (6-12).....	<input type="checkbox"/>	<input type="checkbox"/>
Adolescents (13-17).....	<input type="checkbox"/>	<input type="checkbox"/>
Young adults (18-25).....	<input type="checkbox"/>	<input type="checkbox"/>
Adults (26-64).....	<input type="checkbox"/>	<input type="checkbox"/>
Older adults (65 or older).....	<input type="checkbox"/>	<input type="checkbox"/>

**\*B11. Does this facility offer a mental health treatment program or group that is dedicated or designed exclusively for clients in any of the following categories?**

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

MARK ALL THAT APPLY

- 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

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

- Yes
- No

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

- Yes
- No

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

- Yes
- No

**\*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*)?**

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

- Yes
- No

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

- Yes     **SKIP TO B16a**
- No     **SKIP TO B17**

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

**MARK ONE ONLY**

- Staff counselor who speaks a language other than English     **SKIP TO B16a1**
- On-call interpreter (*in person or by phone*) brought in when needed     **SKIP TO B17**
  
- BOTH staff counselor and on-call interpreter     **SKIP TO B16a1**

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

- Yes
- No

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

- Yes      **SKIP TO B16b**
- No      **SKIP TO B17**

**\*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.*

**MARK 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 language
- Creole
- Farsi
- French
- German
- Greek
- Hebrew
- Hindi
- Hmong
- Italian
- Japanese
- Korean
- Polish
- Portuguese
- Russian
- Tagalog

- Vietnamese
- Any other language  
(Specify: \_\_\_\_\_)

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

MARK "YES" OR "NO" FOR EACH

	<u>YES</u>	<u>NO</u>
Continuing education requirements for professional staff	<input type="checkbox"/>	<input type="checkbox"/>
Regularly scheduled case review with a supervisor	<input type="checkbox"/>	<input type="checkbox"/>
Regularly scheduled case review by an appointed quality review committee	<input type="checkbox"/>	<input type="checkbox"/>
Client outcome follow-up after discharge...	<input type="checkbox"/>	<input type="checkbox"/>
Continuous quality improvement processes	<input type="checkbox"/>	<input type="checkbox"/>
Periodic client satisfaction surveys.....	<input type="checkbox"/>	<input type="checkbox"/>
Clinical provider peer review (CPPR).....	<input type="checkbox"/>	<input type="checkbox"/>
Root cause analysis (RCA) .....	<input type="checkbox"/>	<input type="checkbox"/>

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

	MARK ALL THAT APPLY		
	NOT USED AT THIS FACILITY	CHEMICAL	PHYSICAL
Seclusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restraint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- Yes
- No

**\*B19. 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**

- 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:* \_\_\_\_\_)

**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.*

**MARK 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

## **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.

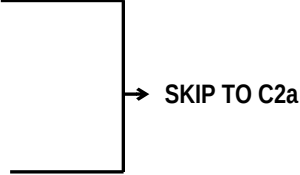
•For a complete definition of a FQHC, go to:

[INSERT LINK](#)

- Yes
- No
- Don't know

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

**MARK ONE ONLY**

- A private for-profit organization **SKIP TO C3**
  - A private non-profit organization **SKIP TO C3**
  - State government
  - Local, county, or community government
  - Tribal government
  - Federal Government
- 

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

**MARK ONE ONLY**

- Department of Veterans Affairs
- Department of Defense
- Indian Health Service
- Other (Specify: \_\_\_\_\_)

### **C3. Is this facility affiliated with a religious (or faith-based) organization?**

- Yes
- No

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

**MARK ONE ONLY**

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

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

**MARK ONE ONLY**

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

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

- *Sliding fee scales are based on income and other factors.*
  - Yes     **SKIP TO C6a**
  - No     **SKIP TO C7**

**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.*
  - Yes
  - No

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

- Yes     **SKIP TO C7a**
- No     **SKIP TO C8**

**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.*

Yes

No

**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](#)*

Yes    **SKIP TO C8a**

No    **SKIP TO C9**

**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?**

**MARK ALL THAT APPLY**

Publish the street address

Publish the mailing address

Do not publish either address

**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.*

Yes

No

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

Yes

No

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## **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:**

**MARK ONE ONLY**

- Only this facility      **SKIP TO D4**
- This facility plus others      **SKIP TO D2**
- Another facility will report this facility's client counts      **SKIP TO D10 or E1**

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

THIS FACILITY	<input style="width: 50px; height: 20px;" type="text" value="1"/>
+ ADDITIONAL FACILITIES	<input style="width: 50px; height: 20px;" type="text"/>
<b>TOTAL FACILITIES<sup>α</sup></b>	
<input style="width: 50px; height: 20px;" type="text"/>	

<sup>α</sup>For this section, please include all of these facilities in the client counts that you will report in the following questions.

**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?**

**MARK ONE ONLY**

- 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
- Please call me for a list of the additional facilities included in these counts

## **SUBSTANCE USE TREATMENT COUNTS**

**HOSPITAL INPATIENT CLIENT COUNTS**

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

- Yes      **SKIP TO D4a**
- No        **SKIP TO D5**

**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")**

Inpatient detoxification (medical withdrawal) \_\_\_\_\_  
(medically managed or monitored  
inpatient detoxification)

Inpatient treatment \_\_\_\_\_  
(medically managed or monitored  
intensive inpatient treatment)

**HOSPITAL INPATIENT  
TOTAL BOX**

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

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

Number under age 18 \_\_\_\_\_

**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.*

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

Methadone dispensed 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 \_\_\_\_\_

**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 \_\_\_\_\_

**D4e. On March 31, 2021, how many hospital inpatient beds were specifically designated for  
substance use disorder treatment?**

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

Number of beds \_\_\_\_\_

**RESIDENTIAL (NON-HOSPITAL)  
CLIENT COUNTS**

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

- Yes      SKIP TO D5a
- No        SKIP TO D6

**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 medium- or low-intensity residential treatment, typically more  
than 30 days)

**RESIDENTIAL  
TOTAL BOX**

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

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

Number under age 18 \_\_\_\_\_

**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.*

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

Methadone dispensed 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 \_\_\_\_\_

**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 \_\_\_\_\_

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

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

Number of beds \_\_\_\_\_

**OUTPATIENT CLIENT COUNTS**

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

- Yes      SKIP TO D6a
- No        SKIP TO D7

**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.

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

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**

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

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

Number under age 18 \_\_\_\_\_

**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 opioid use disorder.*

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

Methadone dispensed 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 \_\_\_\_\_

**D6d. How many of the clients from the OUTPATIENT 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 \_\_\_\_\_

**ALL SUBSTANCE USE TREATMENT SETTINGS**

**D7. This question asks you to categorize the substance use treatment clients at this facility including Hospital Inpatient, Residential (non-hospital) and/or Outpatient**

**three groups: clients in treatment for**

- (1) use of both alcohol and substances other than alcohol; (2) use only of alcohol; or**
- (3) use only 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	OR	PERCENT
BOTH alcohol <u>and</u> substances other than alcohol.....	[ ]	[ ]	[ ]
ONLY alcohol.....	[ ]	[ ]	[ ]
ONLY substances other than alcohol.....	[ ]	[ ]	[ ]
<b>TOTAL:</b>	QXAa + QXBa + QXCa		100%

**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")

%

**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, *not* individual treatment visits. Consider an admission to be the initiation of a treatment program or course of treatment. Count any re-admission as an admission.
- **IF THIS IS A MENTAL HEALTH FACILITY:** Count all admissions in which clients received substance use disorder treatment, even if substance use disorder was their secondary diagnosis.

NUMBER OF SUBSTANCE USE  
DISORDER TREATMENT  
ADMISSIONS IN  
A 12-MONTH PERIOD

## 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?**

- Yes    **SKIP TO D10a**
- No     **SKIP TO D11**

**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

--

**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')*

**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%.*

		NUMBE R	O R	PERCENT
SEX	Male.....			
	Female.....			
	<b>CATEGORY TOTAL:</b> <i>(Should=TOTAL or 100%)</i>			100%

<b>AGE</b>	0-17.....		
	18-64.....		
	65 and older.....		
	<b>CATEGORY TOTAL: (Should=TOTAL or 100%)</b>		100%
<b>ETHNICITY</b>	Hispanic or Latino.....		
	Not Hispanic or Latino.....		
	Unknown or not collected.....		
	<b>CATEGORY TOTAL: (Should=TOTAL or 100%)</b>		100%
<b>RACE</b>	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.....		
<b>CATEGORY TOTAL: (Should=TOTAL or 100%)</b>		100%	
<b>LEGAL STATUS</b>	Voluntary.....		
	Involuntary, non-forensic.....		
	Involuntary, forensic.....		
	<b>CATEGORY TOTAL: (Should=B3b1 or 100%)</b>		100%

**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?**

- Yes
- No

**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

**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')*

**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%.*

<u>NUMBER</u>	<u>OR</u>	<u>PERCENT</u>
---------------	-----------	----------------



<b>SEX</b>	Male.....	<input type="text"/>	<input type="text"/>
	Female.....	<input type="text"/>	<input type="text"/>
	<b>CATEGORY TOTAL: (Should=TOTAL or 100%)</b>	<input type="text"/>	<input type="text" value="100%"/>
<b>AGE</b>	0-17.....	<input type="text"/>	<input type="text"/>
	18-64.....	<input type="text"/>	<input type="text"/>
	65 and older.....	<input type="text"/>	<input type="text"/>
	<b>CATEGORY TOTAL: (Should=TOTAL or 100%)</b>	<input type="text"/>	<input type="text" value="100%"/>
<b>ETHNICITY</b>	Hispanic or Latino.....	<input type="text"/>	<input type="text"/>
	Not Hispanic or Latino.....	<input type="text"/>	<input type="text"/>
	Unknown or not collected.....	<input type="text"/>	<input type="text"/>
	<b>CATEGORY TOTAL: (Should=TOTAL or 100%)</b>	<input type="text"/>	<input type="text" value="100%"/>
<b>RACE</b>	American Indian or Alaska Native.....	<input type="text"/>	<input type="text"/>
	Asian.....	<input type="text"/>	<input type="text"/>
	Black or African American.....	<input type="text"/>	<input type="text"/>
	Native Hawaiian or other Pacific Islander.....	<input type="text"/>	<input type="text"/>
	White.....	<input type="text"/>	<input type="text"/>
	Two or more races.....	<input type="text"/>	<input type="text"/>
	Unknown or not collected.....	<input type="text"/>	<input type="text"/>
<b>CATEGORY TOTAL: (Should=TOTAL or 100%)</b>	<input type="text"/>	<input type="text" value="100%"/>	
<b>LEGAL STATUS</b>	Voluntary.....	<input type="text"/>	<input type="text"/>
	Involuntary, non-forensic.....	<input type="text"/>	<input type="text"/>
	Involuntary, forensic.....	<input type="text"/>	<input type="text"/>
	<b>CATEGORY TOTAL: (Should=TOTAL or 100%)</b>	<input type="text"/>	<input type="text" value="100%"/>

**OUTPATIENT CLIENT COUNTS**

**D12. During the month of March 2021, did any clients receive less than 24-hour treatment of mental disorders at this facility, at this location?**

- Yes    **SKIP TO D12a**
- No     **SKIP TO D13**

**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  
  
TOTAL BOX

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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%.*

		NUMBE R	O R	PERCENT
SEX	Male.....			
	Female.....			

		<b>CATEGORY TOTAL: (Should=TOTAL or 100%)</b>	<input type="text"/>	<input type="text" value="100%"/>
<b>AGE</b>	0-17.....		<input type="text"/>	<input type="text"/>
	18-64.....		<input type="text"/>	<input type="text"/>
	65 and older.....		<input type="text"/>	<input type="text"/>
	<b>CATEGORY TOTAL: (Should=TOTAL or 100%)</b>		<input type="text"/>	<input type="text" value="100%"/>
<b>ETHNICITY</b>	Hispanic or Latino.....		<input type="text"/>	<input type="text"/>
	Not Hispanic or Latino.....		<input type="text"/>	<input type="text"/>
	Unknown or not collected.....		<input type="text"/>	<input type="text"/>
	<b>CATEGORY TOTAL: (Should=TOTAL or 100%)</b>		<input type="text"/>	<input type="text" value="100%"/>
<b>RACE</b>	American Indian or Alaska Native.....		<input type="text"/>	<input type="text"/>
	Asian.....		<input type="text"/>	<input type="text"/>
	Black or African American.....		<input type="text"/>	<input type="text"/>
	Native Hawaiian or other Pacific Islander.....		<input type="text"/>	<input type="text"/>
	White.....		<input type="text"/>	<input type="text"/>
	Two or more races.....		<input type="text"/>	<input type="text"/>
	Unknown or not collected.....		<input type="text"/>	<input type="text"/>
<b>CATEGORY TOTAL: (Should=TOTAL or 100%)</b>		<input type="text"/>	<input type="text" value="100%"/>	
<b>LEGAL STATUS</b>	Voluntary.....		<input type="text"/>	<input type="text"/>
	Involuntary, non-forensic.....		<input type="text"/>	<input type="text"/>
	Involuntary, forensic.....		<input type="text"/>	<input type="text"/>
	<b>CATEGORY TOTAL: (Should=TOTAL or 100%)</b>		<input type="text"/>	<input type="text" value="100%"/>

**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**

	%
--	---

*(If none, enter '0')*

**D14. In the 12-month period of April 1, 2020 through March 31, 2021, how many mental disorder 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 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**

(If none,  
enter '0')

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

**PERCENT  
MILITARY  
VETERANS**

 %

(If none,  
enter '0')

**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.*

**MARK ONE ONLY**

- Ms.     Mr.     Mrs.     Dr.     Other (Specify\_\_\_\_)

Attachment B1: 2021 N-SUMHSS Questionnaire

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

Fax Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

Facility Email Address: \_\_\_\_\_

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

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

Attachment B1: 2021 N-SUMHSS Questionnaire

PARTIAL HOSPITALIZATION/DAY TREATMENT

FACILITY NAME: \_\_\_\_\_

\_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

FACILITY EMAIL

ADDRESS: \_\_\_\_\_

HOSPITAL INPATIENT

RESIDENTIAL

OUTPATIENT

PARTIAL HOSPITALIZATION/DAY TREATMENT