

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

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

|                                                                                                           |
|-----------------------------------------------------------------------------------------------------------|
| <input type="radio"/> Primarily Substance use treatment services                                          |
| <input type="radio"/> Primarily Mental health services                                                    |
| <input type="radio"/> Mix of mental health and substance use treatment services                           |
| <input type="radio"/> No treatment for either substance use or mental health is provided at this location |

**1a. Do you also provide substance use treatment services?**

Select "Yes" if this facility offers substance use treatment as a stand-alone service.  
Select "No" if it only offers substance use treatment as part of mental health treatment services for individual patients who need it.

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

**Pledge to Respondents:** The information you provide will be protected to the fullest extent allowable under the Public Health Service Act (42 USC 290aa(p)). This law permits the public release of identifiable information about an establishment only with the consent of that establishment and limits the use of the information to the purposes for which it was supplied. With the explicit consent of treatment facilities, information provided in response to survey questions marked with an asterisk may be published on [FindTreatment.gov](#), the National Directory of Drug and Alcohol Use Treatment Facilities, the National Directory of Mental Health Treatment Facilities, and other publicly available listings. Responses to non-asterisked questions will be published with no direct link to individual treatment facilities.

**Public Burden Statement:** An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0386. Public reporting burden for this collection of information is estimated to average XX minutes per facility, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 5600 Fishers Lane, Room 15E57-A, Rockville, Maryland 20857.



## 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

|                                                                                                                                                                  |                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| Intake, assessment, or referral                                                                                                                                  | <input type="radio"/> Yes<br><input type="radio"/> No |
| Detoxification (medical withdrawal)                                                                                                                              | <input type="radio"/> Yes<br><input type="radio"/> No |
| Substance use disorder treatment<br>(services that focus on initiating and maintaining an individual's recovery from substance use and on averting relapse)      | <input type="radio"/> Yes<br><input type="radio"/> 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 | <input type="radio"/> Yes<br><input type="radio"/> No |
| Any other substance use treatment services<br>(such as 12 step meeting facilitation, naloxone prescriptions, etc.)                                               | <input type="radio"/> Yes<br><input type="radio"/> No |

**A1a. To which of the following clients does this facility, at this location, offer mental health 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

|                                                                                                   |
|---------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Substance use treatment clients                                          |
| <input type="checkbox"/> Clients other than substance use treatment clients                       |
| <input type="checkbox"/> No clients are offered mental health treatment services at this facility |

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

**MARK ALL THAT APPLY**

|                                                  |
|--------------------------------------------------|
| <input type="checkbox"/> Alcohol                 |
| <input type="checkbox"/> Benzodiazepines         |
| <input type="checkbox"/> Cocaine                 |
| <input type="checkbox"/> Methamphetamines        |
| <input type="checkbox"/> Opioids                 |
| <input type="checkbox"/> Other(s):(Specify_____) |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

**MARK "YES" OR "NO" FOR EACH**

|                                                                                                                   |                                                       |
|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| Inpatient detoxification (medical withdrawal)<br><i>(medically managed or monitored inpatient detoxification)</i> | <input type="radio"/> Yes<br><input type="radio"/> No |
| Inpatient treatment <i>(medically managed or monitored intensive inpatient treatment)</i>                         | <input type="radio"/> Yes<br><input type="radio"/> No |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

**MARK "YES" OR "NO" FOR EACH**

|                                                                                                                                     |                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| Residential detoxification (medical withdrawal)<br><i>(clinically managed residential detoxification or social detoxification)</i>  | <input type="radio"/> Yes<br><br><input type="radio"/> No |
| Residential <b>short-term</b> treatment <i>(clinically managed high-intensity residential treatment, typically 30 days or less)</i> | <input type="radio"/> Yes<br><br><input type="radio"/> No |
| Residential <b>long-term</b> treatment <i>(clinically managed medium- or low-intensity residential treatment)</i>                   | <input type="radio"/> Yes<br><br><input type="radio"/> No |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

**MARK "YES" OR "NO" FOR EACH**

|                                                                                 |                                                       |
|---------------------------------------------------------------------------------|-------------------------------------------------------|
| Outpatient detoxification (Ambulatory detoxification)                           | <input type="radio"/> Yes<br><input type="radio"/> No |
| Outpatient methadone/buprenorphine maintenance or naltrexone treatment          | <input type="radio"/> Yes<br><input type="radio"/> No |
| Outpatient day treatment or partial hospitalization (20 or more hours per week) | <input type="radio"/> Yes<br><input type="radio"/> No |
| Intensive outpatient treatment (9 or more hours per week)                       | <input type="radio"/> Yes<br><input type="radio"/> No |
| Regular outpatient treatment (outpatient treatment, non-intensive)              | <input type="radio"/> Yes<br><input type="radio"/> No |



**\*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**

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

**MARK ALL THAT APPLY**

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

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

**Medical Services**

|                                                                                          |
|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Hepatitis A ( <i>HAV</i> ) vaccination                          |
| <input type="checkbox"/> Hepatitis B ( <i>HBV</i> ) vaccination                          |
| <input type="checkbox"/> None of the medical services above are offered at this facility |

**Transitional Services**

|                                                                                               |
|-----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Discharge planning                                                   |
| <input type="checkbox"/> Aftercare/continuing care                                            |
| <input type="checkbox"/> Naloxone and overdose education                                      |
| <input type="checkbox"/> Outcome follow-up after discharge                                    |
| <input type="checkbox"/> None of the transitional services above are offered at this facility |

**Recovery Support Services**

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

**Education and Counseling Services**

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

**Ancillary Services**

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

**Other Services**

|                                                                                                       |
|-------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Treatment for gambling disorder                                              |
| <input type="checkbox"/> Treatment for other addiction disorder ( <i>non-substance use disorder</i> ) |
| <input type="checkbox"/> None of the other services above are offered at this facility                |

## Pharmacotherapies

|                                                                                                                                                                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Disulfiram                                                                                                                                                                                  |
| <input type="checkbox"/> Naltrexone ( <i>oral</i> )                                                                                                                                                                  |
| <input type="checkbox"/> Naltrexone ( <i>extended-release, injectable</i> )                                                                                                                                          |
| <input type="checkbox"/> Acamprosate                                                                                                                                                                                 |
| <input type="checkbox"/> Nicotine replacement                                                                                                                                                                        |
| <input type="checkbox"/> Non-nicotine smoking/tobacco cessation medications ( <i>for example, bupropion, varenicline</i> )                                                                                           |
| <input type="checkbox"/> Medications for mental disorders                                                                                                                                                            |
| <input type="checkbox"/> Methadone                                                                                                                                                                                   |
| <input type="checkbox"/> Buprenorphine/naloxone                                                                                                                                                                      |
| <input type="checkbox"/> Buprenorphine without naloxone                                                                                                                                                              |
| <input type="checkbox"/> Buprenorphine sub-dermal implant                                                                                                                                                            |
| <input type="checkbox"/> Buprenorphine ( <i>extended-release, injectable</i> )                                                                                                                                       |
| <input type="checkbox"/> Medications for HIV treatment ( <i>for example, antiretroviral medications such as tenofovir, efavirenz, emtricitabine, atazanavir, and lamivudine</i> )                                    |
| <input type="checkbox"/> Medications for pre-exposure prophylaxis ( <i>PrEP: for example, emtricitabine and tenofovir disoproxil fumarate combination, and emtricitabine and tenofovir alafenamide combination</i> ) |
| <input type="checkbox"/> Medications for Hepatitis C ( <i>HCV</i> ) treatment ( <i>for example, sofosbuvir, ledipasvir, interferon, peginterferon, ribavirin</i> )                                                   |
| <input type="checkbox"/> Lofexidine                                                                                                                                                                                  |
| <input type="checkbox"/> Clonidine                                                                                                                                                                                   |
| <input type="checkbox"/> Medications for other medical conditions ( <i>Specify: _____</i> )                                                                                                                          |
| <input type="checkbox"/> 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**

|                                                                                                                                                                                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> This facility accepts clients using MAT, but the medications originate from or are prescribed by another entity. <i>(The medications may or may not be stored/delivered/monitored onsite.)</i>                                            |
| <input type="checkbox"/> This facility prescribes naltrexone to treat opioid use disorder. Naltrexone use is authorized through any medical staff with prescribing privileges.                                                                                     |
| <input type="checkbox"/> 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.                                       |
| <input type="checkbox"/> This facility is a <u>federally certified</u> Opioid Treatment Program (OTP). <i>(Most OTPs administer/dispense methadone; some only use buprenorphine, some provide all FDA-approved medication treatments for opioid use disorder.)</i> |
| <input type="checkbox"/> 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.                                                                     |
| <input type="checkbox"/> This facility uses methadone or buprenorphine for pain management, emergency cases, or research purposes. It is NOT a federally certified Opioid Treatment Program (OTP).                                                                 |
| <input type="checkbox"/> This facility does not treat opioid use disorder                                                                                                                                                                                          |

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

**MARK ALL THAT APPLY**

|                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> A prescribing entity in our network                                                                       |
| <input type="checkbox"/> A prescribing entity with which our facility has a business, contractual, or formal referral relationship |
| <input type="checkbox"/> A prescribing entity with which our facility has no formal relationship                                   |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

**MARK ALL THAT APPLY**

|                                                                                                                                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Maintenance services with methadone or buprenorphine                                                                                |
| <input type="checkbox"/> Maintenance services with medically supervised withdrawal (or taper) after a period of stabilization                                |
| <input type="checkbox"/> Detoxification (medical withdrawal) from opioids of abuse with methadone or buprenorphine                                           |
| <input type="checkbox"/> Detoxification (medical withdrawal) from opioids of abuse with lofexidine or clonidine                                              |
| <input type="checkbox"/> Relapse prevention with naltrexone                                                                                                  |
| <input type="checkbox"/> Other (for example, overdose risk reduction with naloxone, specify opioid use disorder service and pharmacotherapy used:<br>_____ ) |
| <input type="checkbox"/> 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**

|                                                                                                                                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> This facility accepts clients using MAT for alcohol use disorder, but the medications originate from or are prescribed by another entity                                                        |
| <input type="checkbox"/> This facility administers/prescribes disulfiram for alcohol use disorder                                                                                                                        |
| <input type="checkbox"/> This facility administers/prescribes naltrexone for alcohol use disorder                                                                                                                        |
| <input type="checkbox"/> This facility administers/prescribes acamprosate for alcohol use disorder                                                                                                                       |
| <input type="checkbox"/> 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 |
| <input type="checkbox"/> This facility does not treat alcohol use disorder                                                                                                                                               |

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

**MARK ALL THAT APPLY**

|                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> A prescribing entity in our network                                                                       |
| <input type="checkbox"/> A prescribing entity with which our facility has a business, contractual, or formal referral relationship |
| <input type="checkbox"/> A prescribing entity with which our facility has no formal relationship                                   |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

| CLINICAL/THERAPEUTIC APPROACHES                                                            | 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<br>(including Internet, Web, mobile, and desktop programs) | <input type="checkbox"/> | <input type="checkbox"/> |
| Other treatment approach<br>(Specify:_____)                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| None of the clinical/therapeutic approaches above are offered at this facility             | <input type="checkbox"/> | <input type="checkbox"/> |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

|                                                            |
|------------------------------------------------------------|
| <input type="radio"/> Marijuana                            |
| <input type="radio"/> Stimulants                           |
| <input type="radio"/> 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.

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

**MARK ONE ONLY**

|                                                                                                   |
|---------------------------------------------------------------------------------------------------|
| <input type="radio"/> Staff counselor who speaks a language other than English                    |
| <input type="radio"/> On-call interpreter ( <i>in person or by phone</i> ) brought in when needed |
| <input type="radio"/> BOTH staff counselor and on-call interpreter                                |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

**\*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**

|                                                                                          |
|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Hopi                                                            |
| <input type="checkbox"/> Lakota                                                          |
| <input type="checkbox"/> Navajo                                                          |
| <input type="checkbox"/> Ojibwa                                                          |
| <input type="checkbox"/> Yupik                                                           |
| <input type="checkbox"/> Other American Indian or Alaska Native language (Specify:_____) |

**Other Languages:**

|                                                             |
|-------------------------------------------------------------|
| <input type="checkbox"/> Arabic                             |
| <input type="checkbox"/> Any Chinese languages              |
| <input type="checkbox"/> Creole                             |
| <input type="checkbox"/> Farsi                              |
| <input type="checkbox"/> French                             |
| <input type="checkbox"/> German                             |
| <input type="checkbox"/> Greek                              |
| <input type="checkbox"/> Hebrew                             |
| <input type="checkbox"/> Hindi                              |
| <input type="checkbox"/> Hmong                              |
| <input type="checkbox"/> Italian                            |
| <input type="checkbox"/> Japanese                           |
| <input type="checkbox"/> Korean                             |
| <input type="checkbox"/> Polish                             |
| <input type="checkbox"/> Portuguese                         |
| <input type="checkbox"/> Russian                            |
| <input type="checkbox"/> Tagalog                            |
| <input type="checkbox"/> Vietnamese                         |
| <input type="checkbox"/> 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"<br>FOR<br>EACH CATEGORY<br>SERVED BY THIS<br>FACILITY |                             | IF SERVED, WHAT IS<br>THE LOWEST AGE SERVED |                                            | IF SERVED, WHAT IS<br>THE HIGHEST AGE SERVED |                                            |
|----------------|--------------------------------------------------------------------------|-----------------------------|---------------------------------------------|--------------------------------------------|----------------------------------------------|--------------------------------------------|
|                | Yes                                                                      | No                          | ____<br>YEARS                               | ____<br>No minimum<br>age                  | ____<br>YEARS                                | ____<br>No maximum<br>age                  |
| Female         | <input type="checkbox"/> Yes                                             | <input type="checkbox"/> No | <input type="text"/><br>YEARS               | <input type="checkbox"/> No minimum<br>age | <input type="text"/><br>YEARS                | <input type="checkbox"/> No maximum<br>age |
| Male           | <input type="checkbox"/> Yes                                             | <input type="checkbox"/> No | <input type="text"/><br>YEARS               | <input type="checkbox"/> No minimum<br>age | <input type="text"/><br>YEARS                | <input type="checkbox"/> No maximum<br>age |

**\*A15a. 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.**

**MARK ALL THAT APPLY**

|                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Adolescents                                                                              |
| <input type="checkbox"/> Young adults                                                                             |
| <input type="checkbox"/> Adult women                                                                              |
| <input type="checkbox"/> Pregnant/postpartum women                                                                |
| <input type="checkbox"/> Adult men                                                                                |
| <input type="checkbox"/> Seniors or older adults                                                                  |
| <input type="checkbox"/> Lesbian, gay, bisexual, transgender, or queer/questioning ( <i>LGBTQ</i> ) clients       |
| <input type="checkbox"/> Veterans                                                                                 |
| <input type="checkbox"/> Active duty military                                                                     |
| <input type="checkbox"/> Members of military families                                                             |
| <input type="checkbox"/> Criminal justice clients ( <i>other than DUI/DWI</i> )                                   |
| <input type="checkbox"/> Clients with co-occurring mental and substance use disorders                             |
| <input type="checkbox"/> Clients with co-occurring pain and substance use disorders                               |
| <input type="checkbox"/> Clients with HIV or AIDS                                                                 |
| <input type="checkbox"/> Clients who have experienced sexual abuse                                                |
| <input type="checkbox"/> Clients who have experienced intimate partner violence, domestic violence                |
| <input type="checkbox"/> Clients who have experienced trauma                                                      |
| <input type="checkbox"/> Specifically tailored programs or groups for any other types of clients (Specify: _____) |
| <input type="checkbox"/> 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 (A17).

|                                  |
|----------------------------------|
| <input type="radio"/> Yes        |
| <input type="radio"/> No         |
| <input type="radio"/> 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**

|                                                                                        |
|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> No payment accepted ( <i>free treatment for ALL clients</i> ) |
| <input type="checkbox"/> Cash or self-payment                                          |
| <input type="checkbox"/> Medicare                                                      |
| <input type="checkbox"/> Medicaid                                                      |
| <input type="checkbox"/> State-financed health insurance plan other than Medicaid      |
| <input type="checkbox"/> Federal military insurance ( <i>for example, TRICARE</i> )    |
| <input type="checkbox"/> Private health insurance                                      |
| <input type="checkbox"/> SAMHSA funding/block grants                                   |
| <input type="checkbox"/> IHS/Tribal/Urban ( <i>ITU</i> ) funds                         |
| <input type="checkbox"/> Other ( <i>Specify: _____</i> )                               |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

**MARK ONE ONLY**

|                                                                                                            |
|------------------------------------------------------------------------------------------------------------|
| <input type="radio"/> General hospital <i>(including VA hospital)</i>                                      |
| <input type="radio"/> Psychiatric hospital                                                                 |
| <input type="radio"/> 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?**

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> 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?**

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> 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**

|                                                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> State substance use treatment agency                                                                                    |
| <input type="checkbox"/> State mental health department                                                                                          |
| <input type="checkbox"/> State department of health                                                                                              |
| <input type="checkbox"/> Hospital licensing authority                                                                                            |
| <input type="checkbox"/> The Joint Commission                                                                                                    |
| <input type="checkbox"/> Commission on Accreditation of Rehabilitation Facilities (CARF)                                                         |
| <input type="checkbox"/> National Committee for Quality Assurance (NCQA)                                                                         |
| <input type="checkbox"/> Council on Accreditation (COA)                                                                                          |
| <input type="checkbox"/> Healthcare Facilities Accreditation Program (HFAP)                                                                      |
| <input type="checkbox"/> SAMHSA certification for opioid treatment program (OTP)                                                                 |
| <input type="checkbox"/> Drug Enforcement Agency (DEA)                                                                                           |
| <input type="checkbox"/> Other national organization or federal, state, or local agency ( <i>Specify:</i><br>_____)                              |
| <input type="checkbox"/> 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

|                                                                                                                                                                                                                |                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| Mental health intake                                                                                                                                                                                           | <input type="radio"/> Yes<br><input type="radio"/> No |
| Mental health diagnostic evaluation                                                                                                                                                                            | <input type="radio"/> Yes<br><input type="radio"/> No |
| Mental health information and/or referral <i>(also includes emergency programs that provide services in person or by telephone)</i>                                                                            | <input type="radio"/> Yes<br><input type="radio"/> No |
| 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="radio"/> Yes<br><input type="radio"/> No |
| 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="radio"/> Yes<br><input type="radio"/> No |
| Substance use treatment                                                                                                                                                                                        | <input type="radio"/> Yes<br><input type="radio"/> No |
| Administrative or operational services for mental health treatment facilities                                                                                                                                  | <input type="radio"/> Yes<br><input type="radio"/> No |

**\*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**

|                                       |                                                       |
|---------------------------------------|-------------------------------------------------------|
| 24-hour hospital inpatient            | <input type="radio"/> Yes<br><input type="radio"/> No |
| 24-hour residential                   | <input type="radio"/> Yes<br><input type="radio"/> No |
| Partial hospitalization/day treatment | <input type="radio"/> Yes<br><input type="radio"/> No |
| Outpatient                            | <input type="radio"/> Yes<br><input type="radio"/> No |

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

- For definitions of facility types, go to: [INSERT LINK](#)

**MARK ONE ONLY**

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

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

**\*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.

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

**MARK ALL THAT APPLY**

|                                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Assisted living or nursing home care                                                                                         |
| <input type="checkbox"/> Group homes                                                                                                                  |
| <input type="checkbox"/> Clubhouse services                                                                                                           |
| <input type="checkbox"/> Emergency shelter ( <i>such as homeless, domestic violence, etc.</i> )                                                       |
| <input type="checkbox"/> Care for individuals with a developmental disability ( <i>that is, significant limitations in intellectual functioning</i> ) |
| <input type="checkbox"/> 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**

|                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Individual psychotherapy                                                                         |
| <input type="checkbox"/> Couples/family therapy                                                                           |
| <input type="checkbox"/> Group therapy                                                                                    |
| <input type="checkbox"/> Cognitive behavioral therapy                                                                     |
| <input type="checkbox"/> Dialectical behavior therapy                                                                     |
| <input type="checkbox"/> Cognitive remediation therapy                                                                    |
| <input type="checkbox"/> Integrated mental and substance use disorder treatment                                           |
| <input type="checkbox"/> Activity therapy (for example, art therapy)                                                      |
| <input type="checkbox"/> Electroconvulsive therapy                                                                        |
| <input type="checkbox"/> Transcranial Magnetic Stimulation (TMS)                                                          |
| <input type="checkbox"/> Ketamine Infusion Therapy (KIT)                                                                  |
| <input type="checkbox"/> Eye Movement Desensitization and Reprocessing (EMDR) therapy                                     |
| <input type="checkbox"/> Telemedicine/telehealth therapy ( <i>including internet, web, mobile, and desktop programs</i> ) |
| <input type="checkbox"/> Abnormal Involuntary Movement Scale (AIMS) Test                                                  |
| <input type="checkbox"/> Other ( <i>Specify: _____</i> )                                                                  |
| <input type="checkbox"/> 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)?**

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

**MARK ALL THAT APPLY**

| FIRST-GENERATION ANTIPSYCHOTIC                          | NOT USED AT THIS FACILITY | ORAL                     | INJECTABLE               | LONG-ACTING INJECTABLE   | RECTAL                   | TOPICAL                  | Inhalation               | DON'T KNOW               |
|---------------------------------------------------------|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Chlorpromazine                                          | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |                          | <input type="checkbox"/> |                          |                          | <input type="checkbox"/> |
| Droperidol                                              | <input type="checkbox"/>  |                          | <input type="checkbox"/> |                          |                          |                          |                          | <input type="checkbox"/> |
| Fluphenazine                                            | <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"/> |
| Loxapine                                                | <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"/> |
| Pimozide                                                | <input type="checkbox"/>  | <input type="checkbox"/> |                          |                          |                          | <input type="checkbox"/> |                          | <input type="checkbox"/> |
| Prochlorperazine                                        | <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"/> |
| Thioridazine                                            | <input type="checkbox"/>  | <input type="checkbox"/> |                          |                          |                          |                          |                          | <input type="checkbox"/> |
| Trifluoperazine                                         | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |                          | <input type="checkbox"/> |
| Other first-generation antipsychotic #1 (Specify:_____) | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other first-generation antipsychotic #2 (Specify:_____) | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other first-generation antipsychotic #3 (Specify:_____) | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| SECOND-GENERATION ANTIPSYCHOTIC                          | NOT USED AT THIS FACILITY | ORAL/ SUBLINGUAL         | INJECTABLE               | LONG-ACTING INJECTABLE   | RECTAL                   | TOPICAL/ TRANSDERMAL     | DON'T KNOW               |
|----------------------------------------------------------|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Aripiprazole                                             | <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"/> |
| Brexipiprazole                                           | <input type="checkbox"/>  | <input type="checkbox"/> |                          |                          |                          |                          | <input type="checkbox"/> |
| Cariprazine                                              | <input type="checkbox"/>  | <input type="checkbox"/> |                          |                          |                          |                          | <input type="checkbox"/> |
| Clozapine                                                | <input type="checkbox"/>  | <input type="checkbox"/> |                          |                          |                          |                          | <input type="checkbox"/> |
| Iloperidone                                              | <input type="checkbox"/>  | <input type="checkbox"/> |                          |                          |                          |                          | <input type="checkbox"/> |
| Lurasidone                                               | <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"/> |
| Olanzapine/<br>Fluoxetine<br>combination                 | <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"/> |
| Quetiapine                                               | <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"/> |
| Ziprasidone                                              | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          | <input type="checkbox"/> |
| Other second-generation antipsychotic #1 (Specify:_____) | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other second-generation antipsychotic #2 (Specify:_____) | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other second-generation antipsychotic #3 (Specify:_____) | <input type="checkbox"/>  | <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**

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

|                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Psychiatric emergency walk-in services                                                                    |
| <input type="checkbox"/> Suicide prevention services                                                                               |
| <input type="checkbox"/> Peer support services                                                                                     |
| <input type="checkbox"/> Testing for Hepatitis B (HBV)                                                                             |
| <input type="checkbox"/> Testing for Hepatitis C (HCV)                                                                             |
| <input type="checkbox"/> Laboratory tests (for example, WBC for clozapine therapy, Lithium levels, CBZ levels, valproate levels)   |
| <input type="checkbox"/> Metabolic syndrome monitoring (weight, abdominal girth, BP, glucose, Hgb A1C, cholesterol, triglycerides) |
| <input type="checkbox"/> HIV testing                                                                                               |
| <input type="checkbox"/> STD testing                                                                                               |
| <input type="checkbox"/> TB screening                                                                                              |
| <input type="checkbox"/> Screening for tobacco use                                                                                 |
| <input type="checkbox"/> Smoking/vaping/tobacco cessation counseling                                                               |
| <input type="checkbox"/> Nicotine replacement therapy                                                                              |
| <input type="checkbox"/> Non-nicotine smoking/tobacco cessation medications (by prescription)                                      |
| <input type="checkbox"/> Other(s) (Specify: _____)                                                                                 |
| <input type="checkbox"/> 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**

|                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Detoxification (medical withdrawal)                                                                       |
| <input type="checkbox"/> Medication-assisted treatment for alcohol use disorder (for example, disulfiram, acamprosate)             |
| <input type="checkbox"/> Medication-assisted treatment for opioid use disorder (for example, buprenorphine, methadone, naltrexone) |
| <input type="checkbox"/> Individual counseling                                                                                     |
| <input type="checkbox"/> Group counseling                                                                                          |
| <input type="checkbox"/> 12-Step groups                                                                                            |
| <input type="checkbox"/> Case management                                                                                           |
| <input type="checkbox"/> Other ( <i>Specify:</i> _____)                                                                            |
| <input type="checkbox"/> 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**

|                            |                                                       |
|----------------------------|-------------------------------------------------------|
| Young children (0-5)       | <input type="radio"/> Yes<br><input type="radio"/> No |
| Children (6-12)            | <input type="radio"/> Yes<br><input type="radio"/> No |
| Adolescents (13-17)        | <input type="radio"/> Yes<br><input type="radio"/> No |
| Young adults (18-25)       | <input type="radio"/> Yes<br><input type="radio"/> No |
| Adults (26-64)             | <input type="radio"/> Yes<br><input type="radio"/> No |
| Older adults (65 or older) | <input type="radio"/> Yes<br><input type="radio"/> No |

**\*B11. Does this facility currently 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**

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

**MARK ONE ONLY**

|                                                                                                   |
|---------------------------------------------------------------------------------------------------|
| <input type="radio"/> Staff counselor who speaks a language other than English                    |
| <input type="radio"/> On-call interpreter ( <i>in person or by phone</i> ) brought in when needed |
| <input type="radio"/> BOTH staff counselor and on-call interpreter                                |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

**\*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**

|                                                                                           |
|-------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Hopi                                                             |
| <input type="checkbox"/> Lakota                                                           |
| <input type="checkbox"/> Navajo                                                           |
| <input type="checkbox"/> Ojibwa                                                           |
| <input type="checkbox"/> Yupik                                                            |
| <input type="checkbox"/> Other American Indian or Alaska Native language (Specify: _____) |

**Other Languages:**

|                                                              |
|--------------------------------------------------------------|
| <input type="checkbox"/> Arabic                              |
| <input type="checkbox"/> Any Chinese languages               |
| <input type="checkbox"/> Creole                              |
| <input type="checkbox"/> Farsi                               |
| <input type="checkbox"/> French                              |
| <input type="checkbox"/> German                              |
| <input type="checkbox"/> Greek                               |
| <input type="checkbox"/> Hebrew                              |
| <input type="checkbox"/> Hindi                               |
| <input type="checkbox"/> Hmong                               |
| <input type="checkbox"/> Italian                             |
| <input type="checkbox"/> Japanese                            |
| <input type="checkbox"/> Korean                              |
| <input type="checkbox"/> Polish                              |
| <input type="checkbox"/> Portuguese                          |
| <input type="checkbox"/> Russian                             |
| <input type="checkbox"/> Tagalog                             |
| <input type="checkbox"/> Vietnamese                          |
| <input type="checkbox"/> 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**

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

**B18. In the 12-month period beginning April X, 202X, and ending March XX, 202X, have staff at this facility used:**

**MARK ALL THAT APPLY**

|                  | <b>Not Used at This Facility</b> | <b>Chemical</b>          | <b>Physical</b>          |
|------------------|----------------------------------|--------------------------|--------------------------|
| <b>Seclusion</b> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Restrain</b>  | <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?**

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> 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**

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

**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**

|                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> State mental health authority                                                                          |
| <input type="checkbox"/> State substance use treatment agency                                                                   |
| <input type="checkbox"/> State department of health                                                                             |
| <input type="checkbox"/> State or local Department of Family and Children's Services                                            |
| <input type="checkbox"/> Hospital licensing authority                                                                           |
| <input type="checkbox"/> The Joint Commission                                                                                   |
| <input type="checkbox"/> Commission on Accreditation of Rehabilitation Facilities (CARF)                                        |
| <input type="checkbox"/> Council on Accreditation (COA)                                                                         |
| <input type="checkbox"/> Centers for Medicare and Medicaid Services (CMS)                                                       |
| <input type="checkbox"/> Other national organization, or federal, state, or local agency ( <i>Specify:</i><br>_____)            |
| <input type="checkbox"/> 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]

|                                  |
|----------------------------------|
| <input type="radio"/> Yes        |
| <input type="radio"/> No         |
| <input type="radio"/> Don't know |

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

MARK ONE ONLY

|                                                              |
|--------------------------------------------------------------|
| <input type="radio"/> A private for-profit organization      |
| <input type="radio"/> A private non-profit organization      |
| <input type="radio"/> State government                       |
| <input type="radio"/> Local, county, or community government |
| <input type="radio"/> Tribal government                      |
| <input type="radio"/> Federal Government                     |

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

MARK ONE ONLY

|                                                      |
|------------------------------------------------------|
| <input type="radio"/> Department of Veterans Affairs |
| <input type="radio"/> Department of Defense          |
| <input type="radio"/> Indian Health Service          |
| <input type="radio"/> Other (Specify: _____)         |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

**MARK ONE ONLY**

|                                                                                             |
|---------------------------------------------------------------------------------------------|
| <input type="radio"/> <u>Not permitted</u> to smoke anywhere outside or within any building |
| <input type="radio"/> Permitted in <u>designated outdoor</u> area(s)                        |
| <input type="radio"/> Permitted <u>anywhere outside</u>                                     |
| <input type="radio"/> Permitted in <u>designated indoor</u> area(s)                         |
| <input type="radio"/> Permitted <u>anywhere inside</u>                                      |
| <input type="radio"/> Permitted <u>anywhere without restriction</u>                         |

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

**MARK ONE ONLY**

|                                                                                             |
|---------------------------------------------------------------------------------------------|
| <input type="radio"/> <u>Not permitted</u> to smoke anywhere outside or within any building |
| <input type="radio"/> Permitted in <u>designated outdoor</u> area(s)                        |
| <input type="radio"/> Permitted <u>anywhere outside</u>                                     |
| <input type="radio"/> Permitted in <u>designated indoor</u> area(s)                         |
| <input type="radio"/> Permitted <u>anywhere inside</u>                                      |
| <input type="radio"/> Permitted <u>anywhere without restriction</u>                         |

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

- Sliding fee scales are based on income and other factors.

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

**C6a. Do you want the availability of a sliding fee scale published on FindTreatment.gov, the *National Directory of Mental Health Treatment Facilities*, and the *National Directory of Drug and Alcohol Use Treatment Facilities*?**

- FindTreatment.gov, the National Directory of Mental Health Treatment Facilities, and the National Directory of Drug and Alcohol Use Treatment Facilities will explain that potential clients should call the facility for information on eligibility.

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

**C7a. Do you want the availability of treatment at no charge or minimal payment (for example, \$1) for eligible clients published on FindTreatment.gov, the *National Directory of Mental Health Treatment Facilities*, and the *National Directory of Drug and Alcohol Use Treatment Facilities*?**

- FindTreatment.gov, the National Directory of Mental Health Treatment Facilities, and the National Directory of Drug and Alcohol Use Treatment Facilities will explain that potential clients should call the facility for information on eligibility.

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

**C8. If eligible, does this facility want to be listed** on FindTreatment.gov (<https://findtreatment.gov>), the *National Directory of Mental Health Treatment Facilities*, and the *National Directory of Drug and Alcohol Use Treatment Facilities* (<https://www.samhsa.gov/data>)?

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

**C8a. Does this facility want the street address and/or mailing address to be listed** on FindTreatment.gov, the *National Directory of Mental Health Treatment Facilities*, and the *National Directory of Drug and Alcohol Use Treatment Facilities*?

**MARK ALL THAT APPLY**

|                                                               |
|---------------------------------------------------------------|
| <input type="checkbox"/> Publish the <u>street</u> address    |
| <input type="checkbox"/> Publish the <u>mailing</u> address   |
| <input type="checkbox"/> Do <u>not</u> 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.

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

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

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> 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

|                                                                                  |
|----------------------------------------------------------------------------------|
| <input type="radio"/> Only this facility                                         |
| <input type="radio"/> This facility plus others                                  |
| <input type="radio"/> Another facility will report this facility's client counts |

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

|                         |       |
|-------------------------|-------|
| This Facility           | 1     |
| + Additional Facilities | _____ |
| <b>Total Facilities</b> | _____ |

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**

|                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="radio"/> 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 |
| <input type="radio"/> Please call me for a list of the additional facilities included in these counts                                                                                                                                       |

**D4. On March XX, 202X, did any patients receive INPATIENT substance use disorder treatment services at this facility?**

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

**D4a. On March XX, 202X, 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)<br>(medically managed or monitored inpatient detoxification) | _____ |
| Inpatient treatment (medically managed or monitored intensive inpatient treatment)                         | _____ |
| HOSPITAL INPATIENT TOTAL                                                                                   | _____ |

**D4b. How many of the patients from the HOSPITAL INPATIENT TOTAL were under the age of 18?**  
**ENTER A NUMBER FOR EACH (IF NONE, ENTER "0")**

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

**D4c. How many of the patients from the HOSPITAL INPATIENT TOTAL 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 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 XX, 202X, how many hospital inpatient beds were specifically designated for substance use disorder treatment?**

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

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

**D5. On March XX, 202X, did any clients receive RESIDENTIAL (non-hospital) substance use disorder treatment services at this facility?**

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

**D5a. On March XX, 202X, 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) <i>(clinically managed residential detoxification or social detoxification)</i>         | _____ |
| Residential short-term treatment <i>(clinically managed high-intensity residential treatment, typically 30 days or less)</i>            | _____ |
| Residential long-term treatment <i>(clinically managed medium- or low-intensity residential treatment, typically more than 30 days)</i> | _____ |
| Residential Total                                                                                                                       | _____ |

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

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

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

**D5c. How many of the clients from the RESIDENTIAL TOTAL 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 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 XX, 202X, how many residential beds were specifically designated for substance use disorder treatment?**

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

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

## OUTPATIENT CLIENT COUNTS

**D6. During the month of March 202X, did any clients receive OUTPATIENT substance use disorder treatment services at this facility?**

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

**D6a. As of March XX, 202X, 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 XX, 202X.*

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

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

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

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

**D6c. How many of the clients from the OUTPATIENT TOTAL 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 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 | _____ |

**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 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 XX, 202X, who were in each of these three groups.**

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

- *If numbers are used—the total should equal the number reported in the combined total patients and clients that are recorded in D4a, D5a, and D6a.*
- *If percents are used—the total should equal 100%.*

**Clients in treatment for use of:**

|                                                       | NUMBER | PERCENT |
|-------------------------------------------------------|--------|---------|
| BOTH alcohol <u>and</u> substances other than alcohol | _____  | _____   |
| ONLY alcohol                                          | _____  | _____   |
| ONLY substances other than alcohol                    | _____  | _____   |
| Total<br>(D4a + D5a + D6a)                            | _____  | _____   |

**D8. Approximately what percent of the substance use treatment clients enrolled at this facility on March XX, 202X, 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 XX, 202X, did any patients receive 24-hour hospital inpatient treatment for mental disorders at this facility, at this location?**

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

**D10a. On March XX, 202X, 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 | _____ |
|---------------------------|-------|

**D10b. On March XX, 202X, 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 XX, 202X reported in *hospital inpatients total* (D10a) above. Use either numbers OR percents, whichever is more convenient.**

*If numbers are used—each category total should equal the number reported for hospital inpatients total (D10a) above.*

*If percents are used—each category total should equal 100%*

**SEX**

|                                                      | NUMBER | PERCENT |
|------------------------------------------------------|--------|---------|
| Male                                                 | _____  | _____   |
| Female                                               | _____  | _____   |
| <b>CATEGORY TOTAL:</b> <i>(Should=TOTAL or 100%)</i> | _____  | _____   |

**AGE**

|                                                      | NUMBER | PERCENT |
|------------------------------------------------------|--------|---------|
| 0-17                                                 | _____  | _____   |
| 18-64                                                | _____  | _____   |
| 65 and older                                         | _____  | _____   |
| <b>CATEGORY TOTAL:</b> <i>(Should=TOTAL or 100%)</i> | _____  | _____   |

**ETHNICITY**

|                                                      | NUMBER | PERCENT |
|------------------------------------------------------|--------|---------|
| Hispanic or Latino                                   | _____  | _____   |
| Not Hispanic or Latino                               | _____  | _____   |
| Unknown or not collected                             | _____  | _____   |
| <b>CATEGORY TOTAL:</b> <i>(Should=TOTAL or 100%)</i> | _____  | _____   |

**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                             | _____  | _____   |
| <b>CATEGORY TOTAL:</b> <i>(Should=TOTAL or 100%)</i> | _____  | _____   |

**LEGAL STATUS**

|           | NUMBER | PERCENT |
|-----------|--------|---------|
| Voluntary | _____  | _____   |

|                                                          |       |       |
|----------------------------------------------------------|-------|-------|
| Involuntary, non-forensic                                | _____ | _____ |
| Involuntary, forensic                                    | _____ | _____ |
| <b>CATEGORY TOTAL:</b> <i>(Should=TOTAL<br/>or 100%)</i> | _____ | _____ |

## RESIDENTIAL (NON-HOSPITAL) CLIENT COUNTS

D11. On March XX, 202X, did any patients receive 24-hour residential mental disorder treatment at this facility, at this location?

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

D11a. On March XX, 202X, 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 | _____ |
|---------------------------|-------|

D11b. On March XX, 202X, 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 XX, 202X reported in *residential clients total* (D11a) above.**

- If numbers are used—each category total should equal the number reported for residential clients total (D11a) above.
- If percents are used—each category total should equal 100%.

**SEX**

|                                               | NUMBER | PERCENT |
|-----------------------------------------------|--------|---------|
| Male                                          | _____  | _____   |
| Female                                        | _____  | _____   |
| <b>CATEGORY TOTAL:</b> (Should=TOTAL or 100%) | _____  | _____   |

**AGE**

|                                               | NUMBER | PERCENT |
|-----------------------------------------------|--------|---------|
| 0-17                                          | _____  | _____   |
| 18-64                                         | _____  | _____   |
| 65 and older                                  | _____  | _____   |
| <b>CATEGORY TOTAL:</b> (Should=TOTAL or 100%) | _____  | _____   |

**ETHNICITY**

|                                               | NUMBER | PERCENT |
|-----------------------------------------------|--------|---------|
| Hispanic or Latino                            | _____  | _____   |
| Not Hispanic or Latino                        | _____  | _____   |
| Unknown or not collected                      | _____  | _____   |
| <b>CATEGORY TOTAL:</b> (Should=TOTAL or 100%) | _____  | _____   |

**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                      | _____  | _____   |
| <b>CATEGORY TOTAL:</b> (Should=TOTAL or 100%) | _____  | _____   |

**LEGAL STATUS**

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

|                                                          |       |       |
|----------------------------------------------------------|-------|-------|
| Involuntary, forensic                                    | _____ | _____ |
| <b>CATEGORY TOTAL:</b> <i>(Should=TOTAL<br/>or 100%)</i> | _____ | _____ |

### OUTPATIENT CLIENT COUNTS

**D12.** During the *month* of March 202X, did any clients receive *less than 24-hour treatment* of mental disorders *at this facility, at this location*?

|                           |
|---------------------------|
| <input type="radio"/> Yes |
| <input type="radio"/> No  |

**D12a.** During the month of March 202X, 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 XX, 202X.**
- **DO NOT** count family members, friends, or other non-treatment persons.

|                                                                         |       |
|-------------------------------------------------------------------------|-------|
| OUTPATIENT CLIENTS AND PARTIAL<br>HOSPITALIZATION/DAY TREATMENT CLIENTS | <hr/> |
|-------------------------------------------------------------------------|-------|

**D12b. For each category below, please provide a breakdown of the Clients in Less Than 24-Hour Care reported in *outpatient clients and partial hospitalization/day treatment clients total* (D12a) above. Use either numbers OR percents, whichever is more convenient.**

*If numbers are used—each category total should equal the number reported in **outpatient clients and partial hospitalization/day treatment clients total** (D12a) above..*

*If percents are used—each category total should equal 100%.*

#### **SEX**

|                                                      | NUMBER | PERCENT |
|------------------------------------------------------|--------|---------|
| Male                                                 | _____  | _____   |
| Female                                               | _____  | _____   |
| <b>CATEGORY TOTAL:</b> <i>(Should=TOTAL or 100%)</i> | _____  | _____   |

#### **AGE**

|                                                      | NUMBER | PERCENT |
|------------------------------------------------------|--------|---------|
| 0-17                                                 | _____  | _____   |
| 18-64                                                | _____  | _____   |
| 65 and older                                         | _____  | _____   |
| <b>CATEGORY TOTAL:</b> <i>(Should=TOTAL or 100%)</i> | _____  | _____   |

#### **ETHNICITY**

|                                                      | NUMBER | PERCENT |
|------------------------------------------------------|--------|---------|
| Hispanic or Latino                                   | _____  | _____   |
| Not Hispanic or Latino                               | _____  | _____   |
| Unknown or not collected                             | _____  | _____   |
| <b>CATEGORY TOTAL:</b> <i>(Should=TOTAL or 100%)</i> | _____  | _____   |

#### **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                             | _____  | _____   |
| <b>CATEGORY TOTAL:</b> <i>(Should=TOTAL or 100%)</i> | _____  | _____   |

#### **LEGAL STATUS**

|           | NUMBER | PERCENT |
|-----------|--------|---------|
| Voluntary | _____  | _____   |

|                                                          |       |       |
|----------------------------------------------------------|-------|-------|
| Involuntary, non-forensic                                | _____ | _____ |
| Involuntary, forensic                                    | _____ | _____ |
| <b>CATEGORY TOTAL:</b> <i>(Should=TOTAL<br/>or 100%)</i> | _____ | _____ |

**D13. On March XX, 202X, 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 | <div>_____ %</div> <div>(If none, enter '0')</div> |
|-------------------------------------|----------------------------------------------------|

**D14. In the 12-month period of April X, 202X through March XX, 202X, 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 | <div>_____</div> <div>(If none, enter '0')</div> |
|-------------------------------------------------------------------|--------------------------------------------------|

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

|                           |                                                    |
|---------------------------|----------------------------------------------------|
| PERCENT MILITARY VETERANS | <div>_____ %</div> <div>(If none, enter '0')</div> |
|---------------------------|----------------------------------------------------|

## 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   | <p><input type="radio"/> Ms.</p> <p><input type="radio"/> Mr.</p> <p><input type="radio"/> Mrs.</p> <p><input type="radio"/> Dr.</p> <p><input type="radio"/> Other (Specify:_____)</p> |
| Name:           | _____                                                                                                                                                                                   |
| Title:          | _____                                                                                                                                                                                   |
| Phone Number:   | _____                                                                                                                                                                                   |
| Ext             | _____                                                                                                                                                                                   |
| Fax:            | _____                                                                                                                                                                                   |
| Email Address:  | _____                                                                                                                                                                                   |
| Facility Email: | _____                                                                                                                                                                                   |

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

|                 |       |
|-----------------|-------|
| Facility Name:  | <hr/> |
| Address:        | <hr/> |
| City:           | <hr/> |
| State:          | <hr/> |
| Zip:            | <hr/> |
| Phone:          | <hr/> |
| Facility Email: | <hr/> |

- ☐ Hospital Inpatient
- ☐ Residential
- ☐ Outpatient
- ☒ Partial hospitalization/day treatment