

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

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

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

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.*

☐ Yes
☐ No

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

☐ Yes
☐ 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	☐ Yes ☐ No
Detoxification (medical withdrawal)	☐ Yes ☐ No
Substance use disorder treatment (services that focus on initiating and maintaining an individual's recovery from substance use and on averting relapse)	☐ Yes ☐ 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	☐ Yes ☐ No
Any other substance use treatment services (such as 12 step meeting facilitation, naloxone prescriptions, etc.)	☐ Yes ☐ 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

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

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

MARK ALL THAT APPLY

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

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

☐ Yes
☐ No

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

☐ Yes
☐ No

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

☐ Yes
☐ No

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

MARK "YES" OR "NO" FOR EACH

Inpatient detoxification (medical withdrawal) <i>(medically managed or monitored inpatient detoxification)</i>	☐ Yes ☐ No
Inpatient treatment <i>(medically managed or monitored intensive inpatient treatment)</i>	☐ Yes ☐ 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?**

☐ Yes
☐ No

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

MARK "YES" OR "NO" FOR EACH

Residential detoxification (medical withdrawal) <i>(clinically managed residential detoxification or social detoxification)</i>	☐ Yes ☐ No
Residential short-term treatment <i>(clinically managed high-intensity residential treatment, typically 30 days or less)</i>	☐ Yes ☐ No
Residential long-term treatment <i>(clinically managed medium- or low-intensity residential treatment)</i>	☐ Yes ☐ No

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

☐ Yes
☐ No

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

MARK "YES" OR "NO" FOR EACH

Outpatient detoxification (Ambulatory detoxification)	☐ Yes ☐ No
Outpatient methadone/buprenorphine maintenance or naltrexone treatment	☐ Yes ☐ No
Outpatient day treatment or partial hospitalization (20 or more hours per week)	☐ Yes ☐ No
Intensive outpatient treatment (9 or more hours per week)	☐ Yes ☐ No
Regular outpatient treatment (outpatient treatment, non-intensive)	☐ Yes ☐ 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

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

MARK ALL THAT APPLY

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

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

Medical Services

☐ Hepatitis A (<i>HAV</i>) vaccination
☐ Hepatitis B (<i>HBV</i>) vaccination
☐ None of the medical services above are offered at this facility

Transitional Services

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

Recovery Support Services

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

Education and Counseling Services

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

Ancillary Services

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

Other Services

☐ Treatment for gambling disorder
☐ Treatment for other addiction disorder (<i>non-substance use disorder</i>)
☐ None of the other services above are offered at this facility

Pharmacotherapies

☐ Disulfiram
☐ Naltrexone (<i>oral</i>)
☐ Naltrexone (<i>extended-release, injectable</i>)
☐ Acamprosate
☐ Nicotine replacement
☐ Non-nicotine smoking/tobacco cessation medications (<i>for example, bupropion, varenicline</i>)
☐ Medications for mental disorders
☐ Methadone
☐ Buprenorphine/naloxone
☐ Buprenorphine without naloxone
☐ Buprenorphine sub-dermal implant
☐ Buprenorphine (<i>extended-release, injectable</i>)
☐ Medications for HIV treatment (<i>for example, antiretroviral medications such as tenofovir, efavirenz, emtricitabine, atazanavir, and lamivudine</i>)
☐ Medications for pre-exposure prophylaxis (<i>PrEP: for example, emtricitabine and tenofovir disoproxil fumarate combination, and emtricitabine and tenofovir alafenamide combination</i>)
☐ Medications for Hepatitis C (<i>HCV</i>) treatment (<i>for example, sofosbuvir, ledipasvir, interferon, peginterferon, ribavirin</i>)
☐ Lofexidine
☐ Clonidine
☐ Medications for other medical conditions (<i>Specify: _____</i>)
☐ None of the pharmacotherapy services above are offered at this facility

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

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

MARK ALL THAT APPLY

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

***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

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

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

☐ Yes
☐ No

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

MARK ALL THAT APPLY

☐ Maintenance services with methadone or buprenorphine
☐ Maintenance services with medically supervised withdrawal (or taper) after a period of stabilization
☐ Detoxification (medical withdrawal) from opioids of abuse with methadone or buprenorphine
☐ Detoxification (medical withdrawal) from opioids of abuse with lofexidine or clonidine
☐ Relapse prevention with naltrexone
☐ Other (for example, overdose risk reduction with naloxone, specify opioid use disorder service and pharmacotherapy used: _____)
☐ None of the medication services for opioid use disorder above are offered at this facility

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

How does this facility treat alcohol use disorder?

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

MARK ALL THAT APPLY

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

***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

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

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

☐ Yes
☐ No

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

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

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

☐ Yes
☐ No

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

☐ Yes
☐ No

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

☐ Marijuana
☐ Stimulants
☐ Other substance(s) (Specify: _____)

***A13. Does this facility provide substance use treatment services in sign language at this location for the deaf and hard of hearing (for example, American Sign Language, Signed English, or Cued Speech)?**

- MARK "YES" if either a staff counselor or an on-call interpreter provides this service.

☐ Yes
☐ No

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

☐ Yes
☐ No

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

MARK ONE ONLY

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

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

☐ Yes
☐ No

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

☐ Yes
☐ 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

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

Other Languages:

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

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

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

TYPE OF CLIENT	MARK "YES" OR "NO" FOR EACH CATEGORY SERVED BY THIS FACILITY		IF SERVED, WHAT IS THE LOWEST AGE SERVED		IF SERVED, WHAT IS THE HIGHEST AGE SERVED	
	Yes	No	_____ YEARS	No minimum age	_____ YEARS	No maximum age
Female	☐ Yes	☐ No	_____ YEARS	☐ No minimum age	_____ YEARS	☐ No maximum age
Male	☐ Yes	☐ No	_____ YEARS	☐ No minimum age	_____ YEARS	☐ No maximum 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

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

☐ Yes
☐ No
☐ Don't know

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

MARK ALL THAT APPLY

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

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

☐ Yes
☐ No

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

MARK ONE ONLY

☐ General hospital <i>(including VA hospital)</i>
☐ Psychiatric hospital
☐ Other specialty hospital (for example, alcoholism, maternity, etc.) (Specify: _____)

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

☐ Yes
☐ No

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

☐ Yes
☐ No

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

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

MARK ALL THAT APPLY

☐ State substance use treatment agency
☐ State mental health department
☐ State department of health
☐ Hospital licensing authority
☐ The Joint Commission
☐ Commission on Accreditation of Rehabilitation Facilities (CARF)
☐ National Committee for Quality Assurance (NCQA)
☐ Council on Accreditation (COA)
☐ Healthcare Facilities Accreditation Program (HFAP)
☐ SAMHSA certification for opioid treatment program (OTP)
☐ Drug Enforcement Agency (DEA)
☐ Other national organization or federal, state, or local agency (<i>Specify:</i> _____)
☐ 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	☐ Yes ☐ No
Mental health diagnostic evaluation	☐ Yes ☐ No
Mental health information and/or referral <i>(also includes emergency programs that provide services in person or by telephone)</i>	☐ Yes ☐ 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>	☐ Yes ☐ 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	☐ Yes ☐ No
Substance use treatment	☐ Yes ☐ No
Administrative or operational services for mental health treatment facilities	☐ Yes ☐ 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	☐ Yes ☐ No
24-hour residential	☐ Yes ☐ No
Partial hospitalization/day treatment	☐ Yes ☐ No
Outpatient	☐ Yes ☐ No

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

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

MARK ONE ONLY

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

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

☐ Yes
☐ 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.

☐ Yes
☐ No

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

MARK ALL THAT APPLY

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

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

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

MARK ALL THAT APPLY

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

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

☐ Yes
☐ 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	☐	☐	☐		☐			☐
Droperidol	☐		☐					☐
Fluphenazine	☐	☐	☐					☐
Haloperidol	☐	☐	☐					☐
Loxapine	☐	☐	☐				☐	☐
Perphenazine	☐	☐	☐					☐
Pimozide	☐	☐				☐		☐
Prochlorperazine	☐	☐	☐		☐			☐
Thiothixene	☐	☐	☐					☐
Thioridazine	☐	☐						☐
Trifluoperazine	☐	☐	☐					☐
Other first-generation antipsychotic #1 (Specify:_____)	☐	☐	☐	☐	☐	☐	☐	☐
Other first-generation antipsychotic #2 (Specify:_____)	☐	☐	☐	☐	☐	☐	☐	☐
Other first-generation antipsychotic #3 (Specify:_____)	☐	☐	☐	☐	☐	☐	☐	☐

SECOND-GENERATION ANTIPSYCHOTIC	NOT USED AT THIS FACILITY	ORAL/ SUBLINGUAL	INJECTABLE	LONG-ACTING INJECTABLE	RECTAL	TOPICAL/ TRANSDERMAL	DON'T KNOW
Aripiprazole	☐	☐	☐	☐			☐
Asenapine	☐	☐				☐	☐
Brexipiprazole	☐	☐					☐
Cariprazine	☐	☐					☐
Clozapine	☐	☐					☐
Iloperidone	☐	☐					☐
Lurasidone	☐	☐					☐
Olanzapine	☐	☐	☐	☐			☐
Olanzapine/ Fluoxetine combination	☐	☐					☐
Paliperidone	☐	☐	☐	☐			☐
Quetiapine	☐	☐					☐
Risperidone	☐	☐	☐	☐			☐
Ziprasidone	☐	☐	☐				☐
Other second-generation antipsychotic #1 (Specify:_____)	☐	☐	☐	☐	☐	☐	☐
Other second-generation antipsychotic #2 (Specify:_____)	☐	☐	☐	☐	☐	☐	☐
Other second-generation antipsychotic #3 (Specify:_____)	☐	☐	☐	☐	☐	☐	☐

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

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

MARK ALL THAT APPLY

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

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

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

MARK ALL THAT APPLY

☐ Detoxification (medical withdrawal)
☐ Medication-assisted treatment for alcohol use disorder (for example, disulfiram, acamprosate)
☐ Medication-assisted treatment for opioid use disorder (for example, buprenorphine, methadone, naltrexone)
☐ Individual counseling
☐ Group counseling
☐ 12-Step groups
☐ Case management
☐ Other (<i>Specify:</i> _____)
☐ 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)	☐ Yes ☐ No
Children (6-12)	☐ Yes ☐ No
Adolescents (13-17)	☐ Yes ☐ No
Young adults (18-25)	☐ Yes ☐ No
Adults (26-64)	☐ Yes ☐ No
Older adults (65 or older)	☐ Yes ☐ 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

☐ Children/adolescents with serious emotional disturbance (SED)
☐ Young adults
☐ Clients 18 and older with serious mental illness (SMI)
☐ Older adults
☐ Clients with Alzheimer's disease or dementia
☐ Clients with co-occurring mental and substance use disorders
☐ Clients with eating disorders
☐ Clients experiencing first-episode psychosis
☐ Clients who have experienced intimate partner violence, domestic violence
☐ Clients with a diagnosis of post-traumatic stress disorder (PTSD)
☐ Clients who have experienced trauma (excluding clients with a PTSD diagnosis)
☐ Clients with traumatic brain injury (TBI)
☐ Veterans
☐ Active duty military
☐ Members of military families
☐ Lesbian, gay, bisexual, transgender, or queer/questioning (LGBTQ) clients
☐ Forensic clients (referred from the court/judicial system)
☐ Clients with HIV or AIDS
☒ Other special program or group (<i>Specify:</i> _____)
☐ No dedicated or exclusively designed programs or groups are offered at this facility

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

☐ Yes
☐ No

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

☐ Yes
☐ No

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

☐ Yes
☐ No

***B15. Does this facility provide mental health treatment services in sign language at this location for the deaf and hard of hearing (for example, American Sign Language, Signed English, or Cued Speech)?**

- MARK "YES" if either a staff counselor or an on-call interpreter provides this service

☐ Yes
☐ No

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

☐ Yes
☐ No

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

MARK ONE ONLY

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

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

☐ Yes
☐ No

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

☐ Yes
☐ 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

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

Other Languages:

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

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	☐ Yes ☐ No
Regularly scheduled case review with a supervisor	☐ Yes ☐ No
Regularly scheduled case review by an appointed quality review committee	☐ Yes ☐ No
Client outcome follow-up after discharge	☐ Yes ☐ No
Continuous quality improvement processes	☐ Yes ☐ No
Periodic client satisfaction surveys	☐ Yes ☐ No
Clinical provider peer review (CPPR)	☐ Yes ☐ No
Root cause analysis (RCA)	☐ Yes ☐ 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

	Not Used at This Facility	Chemical	Physical
Seclusion	☐	☐	☐
Restrain	☐	☐	☐

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

☐ Yes
☐ No

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

MARK ALL THAT APPLY

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

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

MODULE C: FOR ALL TREATMENT FACILITIES

*C1. Is this facility a Federally Qualified Health Center (FQHC)?

- FQHCs include: (1) all organizations that receive grants under Section 330 of the Public Health Service Act; and (2) other organizations that do not receive grants, but have met the requirements to receive grants under Section 330 according to the U.S. Department of Health and Human Services.
- For a complete definition of a FQHC, go to:[INSERT LINK]

☐ Yes
☐ No
☐ Don't know

*C2. Is this facility operated by...

MARK ONE ONLY

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

*C2a. Which Federal Government agency?

MARK ONE ONLY

☐ Department of Veterans Affairs
☐ Department of Defense
☐ Indian Health Service
☐ Other (Specify: _____)

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

☐ Yes
☐ No

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

MARK ONE ONLY

☐ <u>Not permitted</u> to smoke anywhere outside or within any building
☐ Permitted in <u>designated outdoor</u> area(s)
☐ Permitted <u>anywhere outside</u>
☐ Permitted in <u>designated indoor</u> area(s)
☐ Permitted <u>anywhere inside</u>
☐ Permitted <u>anywhere without restriction</u>

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

MARK ONE ONLY

☐ <u>Not permitted</u> to smoke anywhere outside or within any building
☐ Permitted in <u>designated outdoor</u> area(s)
☐ Permitted <u>anywhere outside</u>
☐ Permitted in <u>designated indoor</u> area(s)
☐ Permitted <u>anywhere inside</u>
☐ 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.

☐ Yes
☐ 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.

☐ Yes
☐ No

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

☐ Yes
☐ 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.

☐ Yes
☐ 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>)?

☐ Yes
☐ 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

☐ Publish the <u>street</u> address
☐ Publish the <u>mailing</u> address
☐ 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.

☐ Yes
☐ No

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

☐ Yes
☐ No

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

Name:

Address:

Phone Number: _____

MODULE D: CLIENT COUNTS SECTION

D1. The next set of questions ask about the number of clients in treatment. Although reporting for only the clients/patients treated at this facility is preferred, we realize that may not be possible. Will the client/patient counts reported in this questionnaire include:

MARK ONE ONLY

☐ Only this facility
☐ This facility plus others
☐ 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	_____
Total Facilities	_____

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

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

MARK ONE ONLY

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

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

☐ Yes
☐ 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) (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?

☐ Yes
☐ 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?

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

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 (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?

☐ Yes
☐ 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	_____	_____
CATEGORY TOTAL: <i>(Should=TOTAL or 100%)</i>	_____	_____

AGE

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

ETHNICITY

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

LEGAL STATUS

	NUMBER	PERCENT
Voluntary	_____	_____

Involuntary, non-forensic	_____	_____
Involuntary, forensic	_____	_____
CATEGORY TOTAL: <i>(Should=TOTAL 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?

☐ Yes
☐ 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	_____	_____
CATEGORY TOTAL: (Should=TOTAL or 100%)	_____	_____

AGE

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

ETHNICITY

	NUMBER	PERCENT
Hispanic or Latino	_____	_____
Not Hispanic or Latino	_____	_____
Unknown or not collected	_____	_____
CATEGORY TOTAL: (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	_____	_____
CATEGORY TOTAL: (Should=TOTAL or 100%)	_____	_____

LEGAL STATUS

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

Involuntary, forensic	_____	_____
CATEGORY TOTAL: <i>(Should=TOTAL 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*?

☐ Yes
☐ 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 HOSPITALIZATION/DAY TREATMENT CLIENTS	
--	-------

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

AGE

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

ETHNICITY

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

LEGAL STATUS

	NUMBER	PERCENT
Voluntary	_____	_____

Involuntary, non-forensic	_____	_____
Involuntary, forensic	_____	_____
CATEGORY TOTAL: <i>(Should=TOTAL 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	_____ % (If none, enter '0')
-------------------------------------	--

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	_____ (If none, enter '0')
---	--

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

PERCENT MILITARY VETERANS	_____ % (If none, enter '0')
---------------------------	--

RESPONDENT INFORMATION

E1. Who was primarily responsible for completing this form?

This information will only be used if we need to contact you about your responses. It will not be published.

MARK ONE ONLY	☐ Ms. ☐ Mr. ☐ Mrs. ☐ Dr. ☐ Other (Specify:_____)
Name:	_____
Title:	_____
Phone Number:	_____
Ext	_____
Fax:	_____
Email Address:	_____
Facility Email:	_____

ADDITIONAL FACILITIES INCLUDED IN CLIENT/PATIENT COUNTS

Facility Name:	
Address:	
City:	
State:	
Zip:	
Phone:	
Facility Email:	

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