SAMHDA

SUBSTANCE ABUSE & MENTAL HEALTH DATA ARCHIVE

ICPSR 34539

National Survey of Substance Abuse Treatment Services (N-SSATS), 2011

United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality

Questionnaire

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U.S. Department of Health and Human Services

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See OMB burden statement on last page

National Survey of Substance Abuse Treatment Services (N-SSATS)

March 31, 2011

Substance Abuse and Mental Health Services Administration (SAMHSA)

PLEASE REVIEW THE FACILITY INFORMATION PRINTED ABOVE.
CROSS OUT ERRORS AND ENTER CORRECT OR MISSING INFORMATION.

CHECK ONE

- ☐ Information is complete and correct, no changes needed
- ☐ All missing or incorrect information has been corrected

PLEASE READ THIS ENTIRE PAGE BEFORE COMPLETING THE QUESTIONNAIRE

Would you prefer to complete this questionnaire online? See the pink flyer enclosed in your questionnaire packet for the Internet address and your unique user ID and password. You can log on and off the website as often as needed to complete the questionnaire. When you log on again, the program will take you to the next unanswered question. If you need more information, call the N-SSATS helpline at 1-888-324-8337.

INSTRUCTIONS

- Most of the questions in this survey ask about ~~t~~his facility." By ~~t~~his facility" we mean the specific treatment facility or program whose name and location are printed on the front cover. If you have any questions about how the term ~~t~~his facility" applies to your facility, please call 1-888-324-8337.
- Please answer ONLY for the specific facility or program whose name and location are printed on the front cover, unless otherwise specified in the questionnaire.
- If the questionnaire has not been completed online, return the completed questionnaire in the envelope provided. Please keep a copy for your records.
- For additional information about this survey and definitions of some of the terms used, please visit our website at **http://info.nssats.com**.
- If you have any questions or need additional blank forms, contact:

MATHEMATICA POLICY RESEARCH
1-888-324-8337
NSSATSWeb@mathematica-mpr.com

IMPORTANT INFORMATION

∗ **Asterisked questions**. Information from asterisked (∗) questions will be published in SAMHSA's *National Directory of Drug and Alcohol Abuse Treatment Programs* and will be available online at **http://findtreatment.samhsa.gov**, SAMHSA's Substance Abuse Treatment Facility Locator.

Mapping feature in Locator. Complete and accurate name and address information is needed for the online Treatment Facility Locator so it can correctly map the facility location.

Eligibility for Directory/Locator. Only facilities designated as eligible by their state substance abuse office will be listed in the *National Directory* and online Treatment Facility Locator. Your state N-SSATS representative can tell you if your facility is eligible to be listed in the Directory/Locator. For the name and telephone number of your state representative, call the N-SSATS helpline at 1-888-324-8337.

SECTION A: FACILITY CHARACTERISTICS

Section A asks about characteristics of individual facilities and should be completed for this facility only, that is, the treatment facility or program at the location listed on the front cover.

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

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. **Intake, assessment, or referral**	1 ☐	0 ☐
2. **Detoxification**	1 ☐	0 ☐
3. **Substance abuse treatment** *(services that focus on initiating and maintaining an individual's recovery from substance abuse and on averting relapse)*	1 ☐	0 ☐
4. **Any other substance abuse services**	1 ☐	0 ☐

2. Did you answer "yes" to <u>detoxification</u> in option 2 of question 1 above?

1 ☐ Yes

0 ☐ No → **SKIP TO Q.3 (TOP OF NEXT COLUMN)**

2a. Does this facility detoxify clients from . . .

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Alcohol	1 ☐	0 ☐
2. Benzodiazepines	1 ☐	0 ☐
3. Cocaine	1 ☐	0 ☐
4. Methamphetamines	1 ☐	0 ☐
5. Opiates	1 ☐	0 ☐
6. Other *(Specify:*_____*)*	1 ☐	0 ☐

2b. Does this facility <u>routinely</u> use medications during detoxification?

1 ☐ Yes

0 ☐ No → **SKIP TO Q.4 (NEXT COLUMN)**

3. Did you answer "yes" to <u>substance abuse treatment</u> in option 3 of question 1?

1 ☐ Yes

0 ☐ No → **SKIP TO Q.34 (PAGE 11)**

***4. What is the <u>primary</u> focus of this facility <u>at this location</u>, that is, the location listed on the front cover?**

MARK ONE ONLY

1 ☐ Substance abuse treatment services

2 ☐ Mental health services

3 ☐ Mix of mental health and substance abuse treatment services *(neither is primary)*

4 ☐ General health care

5 ☐ Other *(Specify:*_____*)*

5. Is this facility operated by . . .

MARK ONE ONLY

1 ☐ A private for-profit organization

2 ☐ A private non-profit organization

→ **SKIP TO Q.6 (BELOW)**

3 ☐ State government

4 ☐ Local, county, or community government

5 ☐ Tribal government

→ **SKIP TO Q.8 (PAGE 2)**

6 ☐ Federal Government

5a. Which Federal Government agency?

MARK ONE ONLY

1 ☐ Department of Veterans Affairs

2 ☐ Department of Defense

3 ☐ Indian Health Service

4 ☐ Other *(Specify:*_____*)*

→ **SKIP TO Q.8 (PAGE 2)**

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

1 ☐ Yes

0 ☐ No

7. Is this facility affiliated with a religious organization?

1 ☐ Yes

0 ☐ No

8. Is this facility a jail, prison, or other organization that provides treatment <u>exclusively</u> for incarcerated persons or juvenile detainees?

1 ☐ Yes → **SKIP TO Q.41 (PAGE 11)**

0 ☐ No

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

1 ☐ Yes

0 ☐ No → **SKIP TO Q.10 (BELOW)**

9a. What type of hospital?

MARK ONE ONLY

1 ☐ General hospital *(including VA hospital)*

2 ☐ Psychiatric hospital

3 ☐ Other specialty hospital, for example, alcoholism, maternity, etc.

(Specify:_____)

***10. What telephone number(s) should a potential client call to schedule an <u>intake</u> appointment?**

1. (_____) _____ - _____ ext._____

2. (_____) _____ - _____ ext._____

11. Which of the following services are provided by this facility <u>at this location</u>, that is, the location listed on the front cover?

MARK ALL THAT APPLY

Assessment and Pre-Treatment Services

1 ☐ Screening for substance abuse

2 ☐ Screening for mental health disorders

3 ☐ Comprehensive substance abuse assessment or diagnosis

4 ☐ Comprehensive mental health assessment or diagnosis *(for example, psychological or psychiatric evaluation and testing)*

5 ☐ Screening for tobacco use

6 ☐ Outreach to persons in the community who may need treatment

7 ☐ Interim services for clients when immediate admission is not possible

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

8 ☐ Breathalyzer or other blood alcohol testing

9 ☐ Drug or alcohol urine screening

10 ☐ Screening for Hepatitis B

11 ☐ Screening for Hepatitis C

12 ☐ HIV testing

13 ☐ STD testing

14 ☐ TB screening

Transitional Services

15 ☐ Discharge planning

16 ☐ Aftercare/continuing care

Ancillary Services

17 ☐ Case management services

18 ☐ Social skills development

19 ☐ Mentoring/peer support

20 ☐ Child care for clients' children

21 ☐ Assistance with obtaining social services (*for example, Medicaid, WIC, SSI, SSDI*)

22 ☐ Employment counseling or training for clients

23 ☐ Assistance in locating housing for clients

24 ☐ Domestic violence—family or partner violence services *(physical, sexual, and emotional abuse)*

25 ☐ Early intervention for HIV

26 ☐ HIV or AIDS education, counseling, or support

27 ☐ Hepatitis education, counseling, or support

28 ☐ Health education other than HIV/AIDS or hepatitis

29 ☐ Substance abuse education

30 ☐ Transportation assistance to treatment

31 ☐ Mental health services

32 ☐ Acupuncture

*33 ☐ Residential beds for clients' children

34 ☐ Self-help groups *(for example, AA, NA, SMART Recovery)*

35 ☐ Smoking cessation counseling

Pharmacotherapies

36 ☐ Antabuse®

37 ☐ Naltrexone (oral)

38 ☐ Vivitrol® (injectible Naltrexone)

39 ☐ Campral®

40 ☐ Nicotine replacement

41 ☐ Non-nicotine smoking/tobacco cessation medications *(for example, Bupropion, Varenicline)*

42 ☐ Medications for psychiatric disorders

43 ☐ Methadone

44 ☐ Buprenorphine – Subutex® or generic

45 ☐ Buprenorphine – Suboxone®

***12. Does this facility operate an Opioid Treatment Program (OTP) at this location?**

- *Opioid Treatment Programs are certified by SAMHSA's Center for Substance Abuse Treatment to use opioid drugs such as **methadone** in the treatment of opioid (narcotic) addiction.*

1 ☐ Yes

0 ☐ No → **SKIP TO Q.13 (BELOW)**

***12a. Are ALL of the substance abuse clients at this facility currently in the Opioid Treatment Program?**

1 ☐ Yes

0 ☐ No

***12b. Does the Opioid Treatment Program at this location provide maintenance services, detoxification services, or both?**

MARK ONE ONLY

1 ☐ Maintenance services

2 ☐ Detoxification services

3 ☐ Both

13. For each type of counseling listed below, please indicate approximately what percent of the substance abuse clients at this facility receive that type of counseling as part of their substance abuse treatment program.

	MARK ONE BOX FOR EACH TYPE OF COUNSELING				
TYPE OF COUNSELING	NOT OFFERED	RECEIVED BY 25% OR LESS OF CLIENTS	RECEIVED BY 26% TO 50% OF CLIENTS	RECEIVED BY 51% TO 75% OF CLIENTS	RECEIVED BY MORE THAN 75% OF CLIENTS
1. Individual counseling.....	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
2. Group counseling.....	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
3. Family counseling	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
4. Marital/couples counseling	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

14. For each type of clinical/therapeutic approach listed below, please mark the box that best describes how often that approach is used at this facility.

- *Definitions of these approaches can be found at: http://info.nssats.com*

CLINICAL/THERAPEUTIC APPROACHES	MARK ONE FREQUENCY FOR EACH APPROACH				
	Never	Rarely	Sometimes	Always or Often	Not Familiar With This Approach
1. Substance abuse counseling	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
2. 12-step facilitation	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
3. Brief intervention	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
4. Cognitive-behavioral therapy	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
5. Contingency management/motivational incentives	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
6. Motivational interviewing	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
7. Trauma-related counseling	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
8. Anger management	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
9. Matrix Model	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
10. Community reinforcement plus vouchers	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
11. Rational emotive behavioral therapy (REBT)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
12. Relapse prevention	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
13. Other treatment approach *(Specify:* _____ _____ *)*	1 ☐	2 ☐	3 ☐	4 ☐	

15. Are any of the following practices part of this facility's standard operating procedures?

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Required continuing education for staff	1 ☐	0 ☐
2. Periodic drug testing of clients	1 ☐	0 ☐
3. Regularly scheduled case review with a supervisor	1 ☐	0 ☐
4. Case review by an appointed quality review committee	1 ☐	0 ☐
5. Outcome follow-up after discharge	1 ☐	0 ☐
6. Periodic utilization review	1 ☐	0 ☐
7. Periodic client satisfaction surveys conducted by the facility	1 ☐	0 ☐

CONTINUE WITH QUESTION 16 (NEXT COLUMN)

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

1 ☐ Yes

0 ☐ No → **SKIP TO Q.17 (BELOW)**

***16a. Does this facility serve only DUI/DWI clients?**

1 ☐ Yes

0 ☐ No

***17. Does this facility provide substance abuse treatment services in sign language at this location for the hearing impaired *(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.*

1 ☐ Yes

0 ☐ No

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

1 ☐ Yes

0 ☐ No → **SKIP TO Q.19 (NEXT COLUMN)**

18a. At this facility, who provides substance abuse treatment services in a language other than English?

MARK ONE ONLY

1 ☐ Staff counselor who speaks a language other than English → **GO TO Q.18b (BELOW)**

2 ☐ On-call interpreter (*in person or by phone*) brought in when needed → **SKIP TO Q.19 (NEXT COLUMN)**

3 ☐ BOTH staff counselor and on-call interpreter → **GO TO Q.18b (BELOW)**

***18b. In what other languages do staff counselors at this facility provide substance abuse treatment?**

MARK ALL THAT APPLY

American Indian or Alaska Native:

1 ☐ Hopi
2 ☐ Lakota
3 ☐ Navajo
4 ☐ Yupik
5 ☐ Other American Indian or Alaska Native language

(Specify:_____)

Other Languages:

6 ☐ Arabic
7 ☐ Any Chinese language
8 ☐ Creole
9 ☐ French
10 ☐ German
11 ☐ Hmong
12 ☐ Italian
13 ☐ Korean
14 ☐ Polish
15 ☐ Portuguese
16 ☐ Russian
17 ☐ Spanish
18 ☐ Tagalog
19 ☐ Vietnamese
20 ☐ Any other language *(Specify:_____*

_____

_____*)*

***19. This question has two parts:**

Column A – Please indicate the **types of clients** accepted into treatment at this location.

Column B – For each "yes" in Column A: Indicate whether this facility offers a specially designed substance abuse treatment program or group exclusively for that type of client at this location.

TYPE OF CLIENT	Column A: CLIENTS ACCEPTED INTO TREATMENT		Column B: OFFERS SPECIALLY DESIGNED PROGRAM OR GROUP	
	YES	NO	YES	NO
1. Adolescents	1 ☐	0 ☐	1 ☐	0 ☐
2. Clients with co-occurring mental and substance abuse disorders	1 ☐	0 ☐	1 ☐	0 ☐
3. Criminal justice clients *(other than DUI/DWI)*	1 ☐	0 ☐	1 ☐	0 ☐
4. Persons with HIV or AIDS	1 ☐	0 ☐	1 ☐	0 ☐
5. Lesbian, gay, bisexual, or transgender (LGBT) clients	1 ☐	0 ☐	1 ☐	0 ☐
6. Seniors or older adults	1 ☐	0 ☐	1 ☐	0 ☐
7. Adult women	1 ☐	0 ☐	1 ☐	0 ☐
8. Pregnant or postpartum women	1 ☐	0 ☐	1 ☐	0 ☐
9. Adult men	1 ☐	0 ☐	1 ☐	0 ☐
10. Specially designed programs or groups for any other types of clients (*Specify below:* _____ _____*)*			1 ☐	0 ☐

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

1 ☐ Yes

0 ☐ No → **SKIP TO Q.21 (BELOW)**

***20a. Which of the following HOSPITAL INPATIENT services are offered at this facility?**

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Hospital inpatient detoxification (Similar to ASAM Levels IV-D and III.7-D, *medically managed or monitored inpatient detoxification)*	1 ☐	0 ☐
2. Hospital inpatient treatment (Similar to ASAM Levels IV and III.7, *medically managed or monitored intensive inpatient treatment)*	1 ☐	0 ☐

NOTE: ASAM is the American Society of Addiction Medicine.

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

1 ☐ Yes

0 ☐ No → **SKIP TO Q.22 (TOP OF NEXT COLUMN)**

***21a. Which of the following RESIDENTIAL services are offered at this facility?**

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Residential detoxification (Similar to ASAM Level III.2-D, *clinically managed residential detoxification or social detoxification)*	1 ☐	0 ☐
2. Residential short-term treatment (Similar to ASAM Level III.5, *clinically managed high-intensity residential treatment, typically 30 days or less)*	1 ☐	0 ☐
3. Residential long-term treatment (Similar to ASAM Levels III.3 and III.1, *clinically managed medium- or low-intensity residential treatment, typically more than 30 days)*	1 ☐	0 ☐

***22. Does this facility offer OUTPATIENT substance abuse services at this location, that is, the location listed on the front cover?**

1 ☐ Yes

0 ☐ No → **SKIP TO Q.23 (BELOW)**

***22a. Which of the following OUTPATIENT services are offered at this facility?**

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Outpatient detoxification *(*Similar to ASAM Levels I-D and II-D, *ambulatory detoxification)*	1 ☐	0 ☐
2. Outpatient methadone maintenance	1 ☐	0 ☐
3. Outpatient day treatment or partial hospitalization (Similar to ASAM Level II.5, *20 or more hours per week)*	1 ☐	0 ☐
4. Intensive outpatient treatment (Similar to ASAM Level II.1, *9 or more hours per week)*	1 ☐	0 ☐
5. Regular outpatient treatment (Similar to ASAM Level I, *outpatient treatment, non-intensive)*	1 ☐	0 ☐

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

1 ☐ Yes

0 ☐ No → **SKIP TO Q.24 (PAGE 7)**

23a. Do you want the availability of a sliding fee scale published in SAMHSA's Directory/Locator?
(For information on Directory/Locator eligibility, see the inside front cover.)

- *The Directory/Locator will explain that sliding fee scales are based on income and other factors.*

1 ☐ Yes

0 ☐ No

***24. Does this facility offer treatment at no charge to clients who cannot afford to pay?**

1 ☐ Yes

0 ☐ No → **SKIP TO Q.25 (BELOW)**

24a. Do you want the availability of free care for eligible clients published in SAMHSA's Directory/Locator?

- *The Directory/Locator will explain that potential clients should call the facility for information on eligibility.*

1 ☐ Yes

0 ☐ No

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

- *Do <u>not</u> include Medicare, Medicaid, or federal military insurance. These forms of client payments are included in Q.26 below.*

1 ☐ Yes

0 ☐ No

d ☐ Don't Know

***26. Which of the following types of client payments or insurance are accepted by this facility for <u>substance abuse treatment</u>?**

MARK "YES," "NO," OR "DON'T KNOW" FOR EACH

	YES	NO	DON'T KNOW
1. No payment accepted *(free treatment for ALL clients)*	1 ☐	0 ☐	d ☐
2. Cash or self-payment	1 ☐	0 ☐	d ☐
3. Medicare	1 ☐	0 ☐	d ☐
4. Medicaid	1 ☐	0 ☐	d ☐
5. A state-financed health insurance plan other than Medicaid	1 ☐	0 ☐	d ☐
6. Federal military insurance such as TRICARE or Champ VA	1 ☐	0 ☐	d ☐
7. Private health insurance	1 ☐	0 ☐	d ☐
8. Access To Recovery *(ATR)* vouchers	1 ☐	0 ☐	d ☐
9. IHS/638 contract care funds	1 ☐	0 ☐	d ☐
10. Other	1 ☐	0 ☐	d ☐

(Specify:_____)

SECTION B: REPORTING CLIENT COUNTS

27. Questions 28 through 33 ask about the number of clients in treatment. If possible, report clients for this facility only. However, we realize that is not always possible. Please indicate whether the clients you report will be for . . .

MARK ONE ONLY

1 ☐ Only this facility → **SKIP TO Q.28 (PAGE 8)**

2 ☐ This facility plus others

3 ☐ Another facility will report this facility's client counts → **SKIP TO Q.34 (PAGE 11)**

27a. How many facilities will be included in your client counts?

THIS FACILITY	1
+ ADDITIONAL FACILITIES	
TOTAL FACILITIES	

27b. 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

1 ☐ By listing the names and location addresses of these additional facilities in the ~~"~~Additional Facilities Included in Client Counts" section on page 12 of this questionnaire or attaching a sheet of paper to this questionnaire

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

HOSPITAL INPATIENT CLIENT COUNTS

28. On March 31, 2011, did any patients receive HOSPITAL INPATIENT substance abuse services at this facility?

1 ☐ Yes

0 ☐ No → **SKIP TO Q.29 (NEXT COLUMN)**

28a. On March 31, 2011, how many patients received the following HOSPITAL INPATIENT substance abuse 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")

1. Hospital inpatient detoxification _____
   (Similar to ASAM Levels IV-D and III.7-D, *medically managed or monitored inpatient detoxification)*
2. Hospital inpatient treatment _____
   (Similar to ASAM Levels IV and III.7, *medically managed or monitored intensive inpatient treatment)*

HOSPITAL INPATIENT TOTAL BOX ☐

28b. How many of the patients from the HOSPITAL INPATIENT TOTAL BOX were under the age of 18?

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

Number under age 18 _____

28c. How many of the patients from the HOSPITAL INPATIENT TOTAL BOX received:

- *Include patients who received these drugs for detoxification or maintenance purposes.*

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

1. Methadone dispensed at this facility _____
2. Buprenorphine dispensed or prescribed at this facility _____

28d. On March 31, 2011, how many hospital inpatient beds at this facility were specifically designated for substance abuse treatment?

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

Number of beds _____

RESIDENTIAL (NON-HOSPITAL) CLIENT COUNTS

29. On March 31, 2011, did any clients receive RESIDENTIAL (non-hospital) substance abuse services at this facility?

1 ☐ Yes

0 ☐ No → **SKIP TO Q.30 (PAGE 9)**

29a. On March 31, 2011, how many clients received the following RESIDENTIAL substance abuse 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")

1. Residential detoxification _____
   (Similar to ASAM Level III.2-D, *clinically managed residential detoxification or social detoxification)*
2. Residential short-term treatment _____
   (Similar to ASAM Level III.5, *clinically managed high-intensity residential treatment, typically 30 days or less)*
3. Residential long-term treatment _____
   (Similar to ASAM Levels III.3 and III.1, *clinically managed medium- or low-intensity residential treatment, typically more than 30 days)*

RESIDENTIAL TOTAL BOX ☐

29b. How many of the clients from the RESIDENTIAL TOTAL BOX were under the age of 18?

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

Number under age 18 _____

29c. How many of the clients from the RESIDENTIAL TOTAL BOX received:

- *Include clients who received these drugs for detoxification or maintenance purposes.*

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

1. Methadone dispensed at this facility _____
2. Buprenorphine dispensed or prescribed at this facility _____

29d. On March 31, 2011, how many residential beds at this facility were specifically designated for substance abuse treatment?

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

Number of beds _____

OUTPATIENT CLIENT COUNTS

30. During the month of March 2011, did any clients receive OUTPATIENT substance abuse services at this facility?

1 ☐ Yes

0 ☐ No → **SKIP TO Q.31 (PAGE 10)**

30a. How many clients received each of the following OUTPATIENT substance abuse services at this facility during March 2011?

- ***ONLY INCLUDE*** *clients who received treatment in March* ***AND*** *were still enrolled in treatment on March 31, 2011.*
- ***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")

1. Outpatient detoxification (Similar to ASAM Levels I-D and II-D, *ambulatory detoxification)* _____
2. Outpatient methadone maintenance *(Count methadone clients on this line only)* _____
3. Outpatient day treatment or partial hospitalization (Similar to ASAM Level II.5, *20 or more hours per week)* _____
4. Intensive outpatient treatment (Similar to ASAM Level II.1, *9 or more hours per week)* _____
5. Regular outpatient treatment (Similar to ASAM Level I, *outpatient treatment, non-intensive)* _____

OUTPATIENT TOTAL BOX ☐

30b. How many of the clients from the OUTPATIENT TOTAL BOX were under the age of 18?

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

Number under age 18 _____

30c. How many of the clients from the OUTPATIENT TOTAL BOX received:

- *Include clients who received these drugs for detoxification or maintenance purposes.*

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

1. Methadone dispensed at this facility _____
2. Buprenorphine dispensed or prescribed at this facility _____

ALL SUBSTANCE ABUSE TREATMENT SETTINGS

Including Hospital Inpatient, Residential (non-hospital) and/or Outpatient

31. This question asks you to categorize the substance abuse treatment clients at this facility into three groups: clients in treatment for (1) abuse of both alcohol and drugs other than alcohol; (2) abuse only of alcohol; or (3) abuse only of drugs other than alcohol.

Enter the percent of clients on March 31, 2011, who were in each of these three groups:

Clients in treatment for abuse of:

1. BOTH alcohol and drugs other than alcohol _____%
2. ONLY alcohol _____%
3. ONLY drugs other than alcohol _____%

TOTAL 100 %

32. Approximately what percent of the substance abuse treatment clients enrolled at this facility on March 31, 2011, had a diagnosed co-occurring mental and substance abuse disorder?

PERCENT OF CLIENTS (IF NONE, ENTER "0") %

33. Using the most recent 12-month period for which you have data, approximately how many substance abuse 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 abuse treatment, even if substance abuse was their secondary diagnosis.*

NUMBER OF SUBSTANCE ABUSE ADMISSIONS IN A 12-MONTH PERIOD

SECTION C: GENERAL INFORMATION

Section C should be completed for this facility only.

***34. Does this facility operate a halfway house or other transitional housing for substance abuse clients at this location, that is, the location listed on the front cover?**

1 ☐ Yes

0 ☐ No

35. Which statement below BEST describes this facility's smoking policy?

MARK ONE ONLY

1 ☐ Smoking is not permitted on the property or within any building

2 ☐ Smoking is permitted only outdoors

3 ☐ Smoking is permitted outdoors and in designated indoor area(s)

4 ☐ Smoking is permitted anywhere without restriction

5 ☐ Other *(Specify:_____)*

36. Is this facility or program licensed, certified, or accredited to provide substance abuse services by any of the following organizations?

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

MARK "YES," "NO," OR "DON'T KNOW" FOR EACH

	YES	NO	DON'T KNOW
1. State substance abuse agency	1 ☐	0 ☐	d ☐
2. State mental health department	1 ☐	0 ☐	d ☐
3. State department of health	1 ☐	0 ☐	d ☐
4. Hospital licensing authority	1 ☐	0 ☐	d ☐
5. The Joint Commission	1 ☐	0 ☐	d ☐
6. Commission on Accreditation of Rehabilitation Facilities (CARF)	1 ☐	0 ☐	d ☐
7. National Committee for Quality Assurance (NCQA)	1 ☐	0 ☐	d ☐
8. Council on Accreditation (COA)	1 ☐	0 ☐	d ☐
9. Another state or local agency or other organization	1 ☐	0 ☐	d ☐

(Specify:_____)

37. Does this facility have a National Provider Identifier (NPI) number?

1 ☐ Yes

0 ☐ No → **SKIP TO Q.38 (BELOW)**

37a. What is the NPI number for this facility?

NPI | | | | | | | | | | |

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

1 ☐ Yes →

0 ☐ No

Please check the front cover of this questionnaire to confirm that the website address for this facility is correct EXACTLY as listed. If incorrect or missing, enter the correct address.

39. If eligible, does this facility want to be listed in the *National Directory* and online Treatment Facility Locator? *(See inside front cover for eligibility information.)*

1 ☐ Yes

0 ☐ No

40. Would you like to receive a free copy of the next *National Directory of Drug and Alcohol Abuse Treatment Programs* when it is published?

1 ☐ Yes

0 ☐ No → **SKIP TO Q.41 (BELOW)**

40a. Would you prefer to receive a CD or paper copy of the *Directory*?

1 ☐ CD

2 ☐ Paper

41. 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.*

Name: _____

Title: _____

Phone Number: (_____) _____ - _____

Fax Number: (_____) _____ - _____

Email Address: _____

Facility Email Address: _____

ADDITIONAL FACILITIES INCLUDED IN CLIENT COUNTS

Complete this section if you reported clients for this facility plus other facilities, as indicated in Question 27.

FACILITY NAME: ____________________
____
ADDRESS: ____________________
CITY: ____________________
STATE: ____________ ZIP: ________
PHONE: ____________________
FACILITY EMAIL ADDRESS: ____________________

FACILITY NAME: ____________________
____
ADDRESS: ____________________
CITY: ____________________
STATE: ____________ ZIP: ________
PHONE: ____________________
FACILITY EMAIL ADDRESS: ____________________

FACILITY NAME: ____________________
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ADDRESS: ____________________
CITY: ____________________
STATE: ____________ ZIP: ________
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FACILITY EMAIL ADDRESS: ____________________

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FACILITY EMAIL ADDRESS: ____________________

FACILITY NAME: ____________________
____
ADDRESS: ____________________
CITY: ____________________
STATE: ____________ ZIP: ________
PHONE: ____________________
FACILITY EMAIL ADDRESS: ____________________

If you require additional space, please continue on the next page.

ANY ADDITIONAL COMMENTS

Pledge to respondents

The information you provide will be protected to the fullest extent allowable under the Public Health Service Act, 42 USC Sec 501(n). This law permits the public release of identifiable information about an establishment only with the consent of that establishment and limits the use of the information to the purposes for which it was supplied. With the explicit consent of eligible treatment facilities, information provided in response to survey questions marked with an asterisk will be published in SAMHSA's *National Directory of Drug and Alcohol Abuse Treatment Programs* and the Substance Abuse Treatment Facility Locator. Responses to non-asterisked questions will be published only in statistical summaries so that individual treatment facilities cannot be identified.

Thank you for your participation. Please return this questionnaire in the envelope provided.
If you no longer have the envelope, please mail this questionnaire to:

MATHEMATICA POLICY RESEARCH
ATTN: RECEIPT CONTROL - Project 06667
P.O. Box 2393
Princeton, NJ 08543-2393