U.S. Department of Health and Human Services

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See OMB burden statement on last page

2014 National Mental Health Services Survey (N-MHSS)

April 30, 2014

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 blue 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 additional help or information, call the N-MHSS helpline at 1-866-778-9752.

INSTRUCTIONS

- Most of the questions in this survey ask about "this facility." By "this 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 "this facility" applies to your facility, please call 1-866-778-9752.
- 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 this is **a separate inpatient psychiatric unit of a general hospital**, consider the psychiatric unit as the relevant "facility" for the purpose of this survey.
- For additional information about the survey and definitions for some of the terms, please visit our website at: **http://info.nmhss.org**.
- Return the completed questionnaire in the envelope provided, or fax it to 1-609-799-0005. (Please reference "N-MHSS" on your fax.)

Please keep a copy of your completed questionnaire for your records.

- If you have questions or need additional blank forms, contact:

MATHEMATICA POLICY RESEARCH

1-866-778-9752
NMHSS@mathematica-mpr.com

IMPORTANT INFORMATION

* **Asterisked Questions.** Information from asterisked (*) questions is published in SAMHSA's online Behavioral Health Treatment Services Locator, found at http://findtreatment.samhsa.gov, unless you designate otherwise in question C1, page 11, of this questionnaire.

Mapping Feature in Locator. Complete and accurate name and address information is needed for SAMHSA's online Behavioral Health Treatment Services Locator so it can correctly map the facility's location.

Eligibility for Locator. Only facilities that provide mental health treatment and complete this questionnaire are eligible to be listed in the online Behavioral Health Treatment Services Locator. If you have any questions regarding eligibility, please contact the N-MHSS helpline at 1-866-778-9752.

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.

A1. Does this facility, at this location, offer:

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Mental health intake	1 ☐	0 ☐
2. Mental health diagnostic evaluation	1 ☐	0 ☐
3. Mental health information and/or referral *(also includes emergency programs that provide services in person or by telephone)*	1 ☐	0 ☐
*4. Mental health treatment *(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)*	1 ☐	0 ☐
5. Substance abuse treatment	1 ☐	0 ☐
6. Administrative services	1 ☐	0 ☐

A2. Did you answer "yes" to mental health treatment in question A1 above (option 4)?

1 ☐ Yes

0 ☐ No → **SKIP TO C4 (PAGE 11)**

***A3. Mental health treatment is provided in which of the following service settings at this facility, at this location?**

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. 24-hour hospital inpatient	1 ☐	0 ☐
2. 24-hour residential	1 ☐	0 ☐
3. Less than 24-hour partial hospitalization/ day treatment	1 ☐	0 ☐
4. Less than 24-hour outpatient	1 ☐	0 ☐

***A4. Which ONE category BEST describes this facility, at this location?**

- *For definitions of facility types, log on to: http://info.nmhss.org*

MARK ONE ONLY

1 ☐ Psychiatric hospital

2 ☐ Separate inpatient psychiatric unit of a general hospital *(consider this psychiatric unit as the relevant "facility" for the purpose of this survey)*

3 ☐ Residential treatment center for children only

4 ☐ Residential treatment center for adults only

5 ☐ Other type of residential treatment facility

6 ☐ Veterans Administration medical center (VAMC) or other VA health care facility

→ **SKIP TO A7 (NEXT PAGE)**

7 ☐ Community mental health center (CMHC)

8 ☐ Outpatient mental health facility

9 ☐ Multi-setting mental health facility (non-hospital residential plus outpatient or partial hospitalization/day treatment)

10 ☐ Other *(Specify:* _____ *)*

A5. Is this facility a solo practice or small group practice?

1 ☐ Yes

0 ☐ No → **SKIP TO A6 (BELOW)**

A5a. 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.*

1 ☐ Yes

0 ☐ No → **SKIP TO C4 (PAGE 11)**

A6. 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, log on to: http://info.nmhss.org*

1 ☐ Yes

0 ☐ No

d ☐ Don't know

A7. What is the primary treatment focus of this facility, at this location?

- *Separate psychiatric units in general hospitals should answer for just their unit and NOT for the entire hospital.*

MARK ONE ONLY

1 ☐ Mental health treatment

2 ☐ Substance abuse treatment → **SKIP TO C4 (PAGE 11)**

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

4 ☐ General health care

5 ☐ Other service focus *(Specify:*

_____*)*

A8. Is this facility a jail, prison, or detention center that provides treatment exclusively for incarcerated persons or juvenile detainees?

1 ☐ Yes → **SKIP TO C4 (PAGE 11)**

0 ☐ No

***A9. Is this facility operated by:**

MARK ONE ONLY

1 ☐ A private for-profit organization → **SKIP TO A10 (NEXT COLUMN)**

2 ☐ A private non-profit organization → **SKIP TO A10 (NEXT COLUMN)**

3 ☐ A public agency or department

***A9a. Which public agency or department?**

MARK ONE ONLY

1 ☐ State mental health authority (SMHA)

2 ☐ Other state government agency or department (e.g., Department of Health)

3 ☐ Regional/district authority or county, local, or municipal government

4 ☐ Tribal government

5 ☐ Department of Veterans Affairs

6 ☐ Indian Health Service

7 ☐ Other *(Specify:*

_____*)*

A10. Is this facility affiliated with a religious organization?

1 ☐ Yes

0 ☐ No

***A11. Which of these mental health treatment approaches are offered at this facility, at this location?**

- *For definitions of treatment approaches, log on to: http://info.nmhss.org*

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Individual psychotherapy	1 ☐	0 ☐
2. Couples/family therapy	1 ☐	0 ☐
3. Group therapy	1 ☐	0 ☐
4. Cognitive/behavioral therapy	1 ☐	0 ☐
5. Dialectical behavior therapy	1 ☐	0 ☐
6. Behavior modification	1 ☐	0 ☐
7. Integrated dual disorders treatment	1 ☐	0 ☐
8. Trauma therapy	1 ☐	0 ☐
9. Activity therapy	1 ☐	0 ☐
10. Electroconvulsive therapy	1 ☐	0 ☐
11. Telemedicine therapy	1 ☐	0 ☐
12. Psychotropic medication	1 ☐	0 ☐
13. Other *(Specify:*	1 ☐	0 ☐

_____*)*

***A12. Which of these services and practices are offered at this facility, at this location?**

- *For definitions, log on to: http://info.nmhss.org*

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Assertive community treatment (ACT)	1 ☐	0 ☐
2. Intensive case management (ICM)	1 ☐	0 ☐
3. Case management (CM)	1 ☐	0 ☐
4. Chronic disease/illness management (CDM)	1 ☐	0 ☐
5. Consumer-run (peer support) services	1 ☐	0 ☐
6. Court-ordered outpatient treatment	1 ☐	0 ☐
7. Diet and exercise counseling	1 ☐	0 ☐
8. Education services	1 ☐	0 ☐
9. Family psychoeducation	1 ☐	0 ☐
10. Housing services	1 ☐	0 ☐
11. Illness management and recovery (IMR)	1 ☐	0 ☐
12. Integrated primary care services	1 ☐	0 ☐
13. Legal advocacy	1 ☐	0 ☐
14. Nicotine replacement therapy	1 ☐	0 ☐
15. Non-nicotine smoking/tobacco cessation medications (by prescription)	1 ☐	0 ☐
16. Psychiatric emergency walk-in services	1 ☐	0 ☐
17. Psychosocial rehabilitation services	1 ☐	0 ☐
18. Screening for tobacco use	1 ☐	0 ☐
19. Suicide prevention services	1 ☐	0 ☐
20. Supported employment	1 ☐	0 ☐
21. Supported housing	1 ☐	0 ☐
22. Therapeutic foster care	1 ☐	0 ☐
23. Tobacco cessation counseling	1 ☐	0 ☐
24. Vocational rehabilitation services	1 ☐	0 ☐
25. Other *(Specify:*	1 ☐	0 ☐

_____)

***A13. What age groups are accepted for treatment at this facility?**

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Children (12 or younger)	1 ☐	0 ☐
2. Adolescents (13-17)	1 ☐	0 ☐
3. Young adults (18-25)	1 ☐	0 ☐
4. Adults (26-64)	1 ☐	0 ☐
5. Seniors (65 or older)	1 ☐	0 ☐

***A14. Does this facility offer a mental health treatment program or group designed exclusively for:**

- *If you treat these clients for mental health, but do not have a specifically tailored program or group for them, check "NO."*

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Children/adolescents with serious emotional disturbance (SED)	1 ☐	0 ☐
2. Transitional age young adults	1 ☐	0 ☐
3. Persons with serious mental illness (SMI)	1 ☐	0 ☐
4. Seniors or older adults	1 ☐	0 ☐
5. Persons with Alzheimer's or dementia	1 ☐	0 ☐
6. Persons with co-occurring mental and substance use disorders	1 ☐	0 ☐
7. Persons with eating disorders	1 ☐	0 ☐
8. Persons with HIV or AIDS	1 ☐	0 ☐
9. Persons with post-traumatic stress disorder (PTSD)	1 ☐	0 ☐
10. Veterans	1 ☐	0 ☐
11. Active duty military	1 ☐	0 ☐
12. Members of military families	1 ☐	0 ☐
13. Persons with traumatic brain injury (TBI)	1 ☐	0 ☐
14. Lesbian, gay, bisexual, or transgender clients (LGBT)	1 ☐	0 ☐
15. Forensic clients (referred from the court/ judicial system)	1 ☐	0 ☐
16. Other special program *(Specify:*	1 ☐	0 ☐

_____)

***A15. Does this facility offer a crisis intervention team that handles acute mental health issues at this facility and/or off-site?**

1 ☐ Yes

0 ☐ No

***A16. Does this facility offer mental health treatment services for the hearing-impaired?**

1 ☐ Yes

0 ☐ No

***A17. Does this facility provide mental health treatment services in a language <u>other than English</u> at this location?**

1 ☐ Yes

0 ☐ No, only English → **SKIP TO A18 (NEXT COLUMN)**

***A17a. Do staff provide mental health treatment services in Spanish at this facility?**

1 ☐ Yes

0 ☐ No

A17b. Do staff at this facility provide mental health treatment services in any other languages?

1 ☐ Yes

0 ☐ No → **SKIP TO A18 (NEXT COLUMN)**

***A17c. In what other languages do staff provide mental health treatment services <u>at this facility</u>?**

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

MARK ALL THAT APPLY

American Indian or Alaska Native:

1 ☐ Hopi
2 ☐ Lakota
3 ☐ Navajo
4 ☐ Ojibwa
5 ☐ Yupik
6 ☐ Other Native American Indian or Alaska Native Language *(Specify:* _____)

Other Languages:

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

A18. Which of these quality improvement practices are part of this facility's <u>standard operating procedures</u>?

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Continuing education requirements for professional staff	1 ☐	0 ☐
2. Regularly scheduled case review with a supervisor	1 ☐	0 ☐
3. Regularly scheduled case review by an appointed quality review committee	1 ☐	0 ☐
4. Client outcome follow-up after discharge	1 ☐	0 ☐
5. Periodic utilization review	1 ☐	0 ☐
6. Periodic client satisfaction surveys	1 ☐	0 ☐

***A19. Which statement below BEST describes this facility's <u>smoking policy</u> for <u>clients</u>?**

MARK ONE ONLY

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

A20. In the 12-month period beginning May 1, 2013, and ending April 30, 2014, have staff <u>at this facility</u> used seclusion or restraint with clients?

1 ☐ Yes

0 ☐ No

A20a. Does this facility have any policies in place to minimize the use of seclusion or restraint?

1 ☐ Yes

0 ☐ No

A21. For each of the following functions, please indicate if staff members routinely use computer or electronic resources, paper only, or a combination of both to complete the function.

Function	Computer/ Electronic Only	Paper Only	Both Electronic and Paper	N/A
1. Intake	1 ☐	2 ☐	3 ☐	N ☐
2. Scheduling appointments	1 ☐	2 ☐	3 ☐	N ☐
3. Assessment/evaluation	1 ☐	2 ☐	3 ☐	N ☐
4. Treatment plan	1 ☐	2 ☐	3 ☐	N ☐
5. Client progress monitoring	1 ☐	2 ☐	3 ☐	N ☐
6. Discharge	1 ☐	2 ☐	3 ☐	N ☐
7. Referrals	1 ☐	2 ☐	3 ☐	N ☐
8. Issue/receive lab results	1 ☐	2 ☐	3 ☐	N ☐
9. Prescribing/dispensing medication	1 ☐	2 ☐	3 ☐	N ☐
10. Checking medication interactions	1 ☐	2 ☐	3 ☐	N ☐
11. Health records	1 ☐	2 ☐	3 ☐	N ☐
12. Collaboration with a client's other providers (such as primary care provider)	1 ☐	2 ☐	3 ☐	N ☐
13. Billing	1 ☐	2 ☐	3 ☐	N ☐
14. Client or family satisfaction surveys	1 ☐	2 ☐	3 ☐	N ☐

***A22. Does this facility use a sliding fee scale?**

- *Not applicable to Veterans Administration facilities.*

1 ☐ Yes

0 ☐ No → **SKIP TO A23 (NEXT COLUMN)**

A22a. Do you want the availability of a sliding fee scale published in SAMHSA's online Behavioral Health Treatment Services Locator?

- *Not applicable to Veterans Administration facilities.*
- *The Locator will explain that sliding fee scales are based on income and other factors.*

1 ☐ Yes

0 ☐ No

***A23. Does this facility offer treatment at no charge to clients who cannot afford to pay?**

- *Not applicable to Veterans Administration facilities.*

1 ☐ Yes

0 ☐ No → **SKIP TO A24 (BELOW)**

A23a. Do you want the availability of free care for eligible clients published in SAMHSA's online Behavioral Health Treatment Services Locator?

- *Not applicable to Veterans Administration facilities.*
- *The Locator will inform potential clients to call the facility for information on eligibility.*

1 ☐ Yes

0 ☐ No

***A24. Which of the following types of client payments, insurance, or funding are accepted by this facility for mental health treatment services?**

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

	YES	NO	DON'T KNOW
1. Cash or self-payment	1 ☐	0 ☐	d ☐
2. Private health insurance	1 ☐	0 ☐	d ☐
3. Medicare	1 ☐	0 ☐	d ☐
4. Medicaid	1 ☐	0 ☐	d ☐
5. State-financed health insurance plan other than Medicaid	1 ☐	0 ☐	d ☐
6. State mental health agency (or equivalent) funds	1 ☐	0 ☐	d ☐
7. State welfare or child and family services agency funds	1 ☐	0 ☐	d ☐
8. State corrections or juvenile justice agency funds	1 ☐	0 ☐	d ☐
9. State education agency funds	1 ☐	0 ☐	d ☐
10. Other state government funds	1 ☐	0 ☐	d ☐
11. County or local government funds	1 ☐	0 ☐	d ☐
12. Community Service Block Grants	1 ☐	0 ☐	d ☐
13. Community Mental Health Block Grants	1 ☐	0 ☐	d ☐
14. Federal military insurance (such as TRICARE)	1 ☐	0 ☐	d ☐
15. U.S. Department of Veterans Affairs funds	1 ☐	0 ☐	d ☐
16. IHS/638 contract care funds	1 ☐	0 ☐	d ☐
17. Other *(Specify:*	1 ☐	0 ☐	d ☐

_____)

A25. From which of these 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 "YES" OR "NO" FOR EACH

	YES	NO
1. State mental health authority	1 ☐	0 ☐
2. State substance abuse agency	1 ☐	0 ☐
3. State department of health	1 ☐	0 ☐
4. Hospital licensing authority	1 ☐	0 ☐
5. The Joint Commission (JC)	1 ☐	0 ☐
6. Commission on Accreditation of Rehabilitation Facilities (CARF)	1 ☐	0 ☐
7. Council on Accreditation (COA)	1 ☐	0 ☐
8. Department of Family and Children's Services	1 ☐	0 ☐
9. Other national, state, or local organization *(Specify:*	1 ☐	0 ☐

_____)

***A26. What telephone number(s) should a potential client call to schedule an intake appointment?**

INTAKE TELEPHONE NUMBER(S):

1. (____) _____ - _____ ext._____

2. (____) _____ - _____ ext._____

SECTION B: CLIENT/PATIENT COUNT INFORMATION

Questions B3 – B8 ask about the number of clients/patients treated at this facility on specific dates.

Please look carefully at the dates specified, as questions will ask for either a single day count, a one-month count, or a 12-month count.

Include ALL clients/patients receiving mental health treatment in your counts, even if a mental health disorder is a secondary diagnosis or has not yet been formally determined.

B1. 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

1 ☐ Only this facility → **SKIP TO B3 (PAGE 7)**

2 ☐ This facility plus others → **SKIP TO B2 (BELOW)**

3 ☐ Another facility in the organization will report client/patient counts for this facility

B1a. Please record the name and telephone number of the facility that will report your client/patient counts.

Facility name:_____

Telephone: (_____) - _____- _____

After recording the facility name and telephone number in B1a → SKIP TO C1 (PAGE 11)

B2. How many facilities will be included in the reported client/patient counts?

THIS FACILITY	1
+ ADDITIONAL FACILITIES	
= TOTAL FACILITIES	

On page 12 of this questionnaire, list the name and location address of each facility included in your client/patient counts. If you prefer, we will contact you for a list of the other facilities included in your client/patient counts.

CONTINUE WITH QUESTION B3 (TOP OF NEXT PAGE)

PATIENT COUNTS: 24-HOUR HOSPITAL INPATIENT

B3. On April 30, 2014, did any patients receive <u>24-hour hospital inpatient</u> mental health treatment at this facility, at this location?

1 ☐ Yes → **GO TO B3a (TOP OF NEXT COLUMN)**

0 ☐ No → **SKIP TO B4 (PAGE 8)**

B3a. On April 30, 2014, how many patients received <u>24-hour hospital inpatient</u> mental health treatment at this facility?

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

HOSPITAL INPATIENTS TOTAL BOX ☐

CONTINUE WITH QUESTION B3b (BELOW)

B3b. For each category below, please provide a breakdown of the <u>Hospital Inpatients</u> reported in the B3a TOTAL BOX above. Use either numbers OR percents, whichever is more convenient.

- *If numbers are used—each category total should equal the number reported in the B3a TOTAL BOX above.*
- *If percents are used—each category total should equal 100%.*

		NUMBER	OR	PERCENT
GENDER	Male			
	Female			
	CATEGORY TOTAL: *(Should=B3a or 100%)*			100%
AGE	0 – 17			
	18 – 64			
	65 and older			
	CATEGORY TOTAL: *(Should=B3a or 100%)*			100%
ETHNICITY	Hispanic or Latino			
	Not Hispanic or Latino			
	Unknown or not collected			
	CATEGORY TOTAL: *(Should=B3a or 100%)*			100%
RACE	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=B3a or 100%)*			100%
LEGAL STATUS	Voluntary			
	Involuntary, non-forensic			
	Involuntary, forensic			
	CATEGORY TOTAL: *(Should=B3a or 100%)*			100%

B3c. On April 30, 2014, how many hospital inpatient beds at this facility were <u>specifically designated</u> for providing mental health treatment?

NUMBER OF BEDS ☐

(If none, enter '0')

CLIENT COUNTS: 24-HOUR RESIDENTIAL (NON-HOSPITAL)

B4. **On April 30, 2014, did any clients receive <u>24-hour residential</u> mental health treatment at this facility, at this location?**

1 ☐ Yes → **GO TO B4a (TOP OF NEXT COLUMN)**

0 ☐ No → **SKIP TO B5 (PAGE 9)**

B4a. **On April 30, 2014, how many clients received <u>24-hour residential</u> mental health treatment at this facility?**

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

RESIDENTIAL CLIENTS TOTAL BOX ☐

CONTINUE WITH QUESTION B4b (BELOW)

B4b. **For each category below, please provide a breakdown of the <u>Residential Clients</u> reported in the B4a TOTAL BOX above. Use either numbers OR percents, whichever is more convenient.**

- *If numbers are used—each category total should equal the number reported in the B4a TOTAL BOX above.*
- *If percents are used—each category total should equal 100%.*

		NUMBER	OR	PERCENT
GENDER	Male	☐		☐
	Female	☐		☐
	CATEGORY TOTAL: *(Should=B4a or 100%)*	☐		100%
AGE	0 – 17	☐		☐
	18 – 64	☐		☐
	65 and older	☐		☐
	CATEGORY TOTAL: *(Should=B4a or 100%)*	☐		100%
ETHNICITY	Hispanic or Latino	☐		☐
	Not Hispanic or Latino	☐		☐
	Unknown or not collected	☐		☐
	CATEGORY TOTAL: *(Should=B4a or 100%)*	☐		100%
RACE	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=B4a or 100%)*	☐		100%
LEGAL STATUS	Voluntary	☐		☐
	Involuntary, non-forensic	☐		☐
	Involuntary, forensic	☐		☐
	CATEGORY TOTAL: *(Should=B4a or 100%)*	☐		100%

B4c. **On April 30, 2014, how many residential beds at this facility were <u>specifically designated</u> for providing mental health treatment?**

NUMBER OF BEDS ☐

(If none, enter '0')

CLIENT COUNTS: LESS THAN 24-HOUR CARE (INCLUDE OUTPATIENT CLIENTS AND PARTIAL HOSPITALIZATION/DAY TREATMENT CLIENTS)

B5. **During the <u>month</u> of April 2014, did any clients receive <u>less than 24-hour</u> mental health treatment at this facility, at this location?**

INCLUDE OUTPATIENT CLIENTS AND PARTIAL HOSPITALIZATION/DAY TREATMENT CLIENTS ON THIS PAGE.

1 ☐ Yes → **GO TO B5a (TOP OF NEXT COLUMN)**

0 ☐ No → **SKIP TO B6 (PAGE 10)**

B5a. **During the <u>month</u> of April 2014, how many clients received <u>less than 24-hour</u> mental health treatment at this facility?**

- ***ONLY INCLUDE*** *those seen at this facility <u>at least once</u> during the month of April,* ***AND <u>who were still enrolled in treatment on April 30, 2014</u>****.*
- ***DO NOT*** *count family members, friends, or other non-treatment clients.*

OUTPATIENT CLIENTS AND PARTIAL HOSPITALIZATION/DAY TREATMENT CLIENTS TOTAL BOX ☐

CONTINUE WITH QUESTION B5b (BELOW)

B5b. **For each category below, please provide a breakdown of the <u>Clients in Less Than 24-Hour Care</u> reported in the B5a TOTAL BOX above. Use either numbers OR percents, whichever is more convenient.**

- *If numbers are used—each category total should equal the number reported in the B5a TOTAL BOX above.*
- *If percents are used—each category total should equal 100%.*

		NUMBER	OR	PERCENT
GENDER	Male			
	Female			
	CATEGORY TOTAL: *(Should=B5a or 100%)*			100%
AGE	0 – 17			
	18 – 64			
	65 and older			
	CATEGORY TOTAL: *(Should=B5a or 100%)*			100%
ETHNICITY	Hispanic or Latino			
	Not Hispanic or Latino			
	Unknown or not collected			
	CATEGORY TOTAL: *(Should=B5a or 100%)*			100%
RACE	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=B5a or 100%)*			100%
LEGAL STATUS	Voluntary			
	Involuntary, non-forensic			
	Involuntary, forensic			
	CATEGORY TOTAL: *(Should=B5a or 100%)*			100%

ALL MENTAL HEALTH CARE SETTINGS

Including 24-Hour Hospital Inpatient, 24-Hour Residential (non-hospital), and Less Than 24-Hour Outpatient and Partial Hospitalization/Day Treatment

B6. On April 30, 2014, approximately what percent of the mental health treatment clients/patients enrolled at this facility had diagnosed co-occurring mental and substance use disorders?

PERCENT WITH CO-OCCURRING DIAGNOSIS ____ %

(If none, enter '0')

B7. In the 12-month period of May 1, 2013 through April 30, 2014, how many mental health 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 HEALTH DISORDER IS A SECONDARY DIAGNOSIS:*** *Count all admissions where clients/patients received mental health treatment.*

NUMBER OF MENTAL HEALTH TREATMENT ADMISSIONS IN 12-MONTH PERIOD ____

(If none, enter '0')

B8. What percent of the admissions reported in question B7 above were military veterans? Please give your best estimate.

PERCENT MILITARY VETERANS ____ %

(If none, enter '0')

SECTION C: GENERAL INFORMATION

C1. If eligible, does this facility want to be listed in SAMHSA's online Behavioral Health Treatment Services Locator?

- *The Locator can be found at:* http://findtreatment.samhsa.gov

1 ☐ Yes

0 ☐ No

C2. Does this facility have a website or web page with information about the facility's mental health treatment program(s)?

1 ☐ Yes

0 ☐ No → **SKIP TO C3 (BELOW)**

***C2a. What is this facility's website address?**

- *Please enter the address exactly as it should be entered in order to access your site.*
- *Do not enter http:// (for example, enter www.yourfacility.com)*

Website: _____

C3. Does this facility have a National Provider Identifier (NPI) number?

- *Do not include the NPI numbers of individual practitioners and of groups of practitioners.*

1 ☐ Yes

0 ☐ No → **SKIP TO C4 (NEXT COLUMN)**

C3a. What is the NPI number for this facility?

- *If the facility has more than one NPI number, please provide only the primary number.*

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

(*NPI is a 10-digit numeric ID*)

C4. 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

1 ☐ Ms. 2 ☐ Mrs. 3 ☐ Mr. 4 ☐ Dr.

5 ☐ Other *(Specify:* _____*)*

NAME:

TITLE:

TELEPHONE NUMBER:

(| | |) - | | | - | | | | | | | | |

Area Code Extension

FAX NUMBER:

(| | |) - | | | - | | | | |

Area Code

EMAIL ADDRESS:

FACILITY EMAIL ADDRESS:

ADDITIONAL FACILITIES INCLUDED IN CLIENT/PATIENT COUNTS

Complete this section if you reported clients/patients for this facility plus additional facilities, as indicated in Question B2.

For each additional facility, please mark if that facility offers hospital inpatient, residential, outpatient mental health treatment, partial hospitalization/day treatment at that location.

FACILITY NAME: ____________________

____

ADDRESS: ____________________

CITY: ____________________

STATE: ____________________ ZIP: __________

TELEPHONE: ____________________

FACILITY EMAIL ADDRESS: ____________________

☐ HOSPITAL INPATIENT ☐ RESIDENTIAL ☐ OUTPATIENT

☐ PARTIAL HOSPITALIZATION/DAY TREATMENT

FACILITY NAME: ____________________

____

ADDRESS: ____________________

CITY: ____________________

STATE: ____________________ ZIP: __________

TELEPHONE: ____________________

FACILITY EMAIL ADDRESS: ____________________

☐ HOSPITAL INPATIENT ☐ RESIDENTIAL ☐ OUTPATIENT

☐ PARTIAL HOSPITALIZATION/DAY TREATMENT

FACILITY NAME: ____________________

____

ADDRESS: ____________________

CITY: ____________________

STATE: ____________________ ZIP: __________

TELEPHONE: ____________________

FACILITY EMAIL ADDRESS: ____________________

☐ HOSPITAL INPATIENT ☐ RESIDENTIAL ☐ OUTPATIENT

☐ PARTIAL HOSPITALIZATION/DAY TREATMENT

FACILITY NAME: ____________________

____

ADDRESS: ____________________

CITY: ____________________

STATE: ____________________ ZIP: __________

TELEPHONE: ____________________

FACILITY EMAIL ADDRESS: ____________________

☐ HOSPITAL INPATIENT ☐ RESIDENTIAL ☐ OUTPATIENT

☐ PARTIAL HOSPITALIZATION/DAY TREATMENT

FACILITY NAME: ____________________

____

ADDRESS: ____________________

CITY: ____________________

STATE: ____________________ ZIP: __________

TELEPHONE: ____________________

FACILITY EMAIL ADDRESS: ____________________

☐ HOSPITAL INPATIENT ☐ RESIDENTIAL ☐ OUTPATIENT

☐ PARTIAL HOSPITALIZATION/DAY TREATMENT

FACILITY NAME: ____________________

____

ADDRESS: ____________________

CITY: ____________________

STATE: ____________________ ZIP: __________

TELEPHONE: ____________________

FACILITY EMAIL ADDRESS: ____________________

☐ HOSPITAL INPATIENT ☐ RESIDENTIAL ☐ OUTPATIENT

☐ PARTIAL HOSPITALIZATION/DAY TREATMENT

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

ANY ADDITIONAL COMMENTS

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_1
P.O. Box 2393
Princeton, NJ 08543-2393

PLEDGE TO RESPONDENTS

The information you provide will be protected to the fullest extent allowable under Section 501(n) of the Public Health Service Act (42 USC 290aa(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 Mental Health Treatment Facilities and the online Behavioral Health Treatment Services Locator. Responses to non-asterisked questions will be published only in statistical summaries so that individual treatment facilities cannot be identified.