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See OMB burden statement on last page

2018 National Mental Health Services Survey (N-MHSS)

April 30, 2018

Substance Abuse and Mental Health Services Administration (SAMHSA)
U.S. Department of Health and Human Services (HHS)

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

Prepared by Mathematica Policy Research

PLEASE READ THIS ENTIRE PAGE BEFORE COMPLETING THE QUESTIONNAIRE

Would you prefer to complete this questionnaire online? See the green flyer enclosed in your questionnaire packet for the Internet address and your unique User ID and Password. You can log on and off the survey 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: **https://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 any questions or need additional blank surveys, 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 https://findtreatment.samhsa.gov, in SAMHSA's *National Directory of Mental Health Treatment Facilities*, and other publicly-available listings, unless you designate otherwise in question C1, page 12, of this questionnaire.

Mapping feature in online 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 online Locator. Only facilities that provide mental health treatment and complete this questionnaire are eligible to be listed as mental health facilities 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 treatment 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 or operational services for mental health treatment facilities	1 ☐	0 ☐

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

1 ☐ Yes

0 ☐ No → **SKIP TO C2 (PAGE 12)**

***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. Partial hospitalization/ day treatment	1 ☐	0 ☐
4. Outpatient	1 ☐	0 ☐

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

- *For definitions of facility types, go to: https://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

4 ☐ Residential treatment center for adults

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 ☐ Partial hospitalization/day treatment facility

9 ☐ Outpatient mental health facility

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

11 ☐ Other *(Specify:* _____)

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

1 ☐ Yes

0 ☐ No → **SKIP TO A6 (TOP OF NEXT PAGE)**

***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 → **GO TO A6 (TOP OF NEXT PAGE)**

0 ☐ No → **SKIP TO C2 (PAGE 12)**

***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, go to: https://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 C2 (PAGE 12)**
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 C2 (PAGE 12)**
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 → GO TO A9a (TOP OF NEXT COLUMN)

***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 ☐ Indian Health Service
6 ☐ Department of Veterans Affairs
7 ☐ Other *(Specify:* _____ *)*

A10. Is this facility affiliated with a religious (or faith-based) 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, go to: https://info.nmhss.org*

MARK ALL THAT APPLY

1 ☐ Individual psychotherapy
2 ☐ Couples/family therapy
3 ☐ Group therapy
4 ☐ Cognitive behavioral therapy
5 ☐ Dialectical behavior therapy
6 ☐ Behavior modification
7 ☐ Integrated dual disorders treatment
8 ☐ Trauma therapy
9 ☐ Activity therapy
10 ☐ Electroconvulsive therapy
11 ☐ Telemedicine/telehealth therapy
12 ☐ Psychotropic medication
13 ☐ Other *(Specify:* _____ *)*
14 ☐ None of these mental health treatment approaches are offered

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

- *For definitions, go to: https://info.nmhss.org*

MARK ALL THAT APPLY

1 ☐ Assertive community treatment (ACT)
2 ☐ Intensive case management (ICM)
3 ☐ Case management (CM)
4 ☐ Court-ordered outpatient treatment

5 ☐ Chronic disease/illness management (CDM)
6 ☐ Illness management and recovery (IMR)
7 ☐ Integrated primary care services
8 ☐ Diet and exercise counseling

9 ☐ Family psychoeducation
10 ☐ Education services
11 ☐ Housing services
12 ☐ Supported housing
13 ☐ Psychosocial rehabilitation services
14 ☐ Vocational rehabilitation services
15 ☐ Supported employment

16 ☐ Therapeutic foster care
17 ☐ Legal advocacy
18 ☐ Psychiatric emergency walk-in services
19 ☐ Suicide prevention services
20 ☐ Consumer-run (peer support) services
21 ☐ Screening for tobacco use
22 ☐ Smoking/tobacco cessation counseling
23 ☐ Nicotine replacement therapy
24 ☐ Non-nicotine smoking/tobacco cessation medications (by prescription)

25 ☐ Other *(Specify:*

_____*)*

26 ☐ None of these services and practices are offered

***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 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

1 ☐ Children/adolescents with serious emotional disturbance (SED)
2 ☐ Transitional age young adults
3 ☐ Persons 18 and older with serious mental illness (SMI)
4 ☐ Seniors or older adults
5 ☐ Persons with Alzheimer's or dementia
6 ☐ Persons with co-occurring mental and substance use disorders
7 ☐ Persons with eating disorders
8 ☐ Persons with a diagnosis of post-traumatic stress disorder (PTSD)
9 ☐ Persons who have experienced trauma (excluding persons with a PTSD diagnosis)
10 ☐ Persons with traumatic brain injury (TBI)
11 ☐ Veterans
12 ☐ Active duty military
13 ☐ Members of military families
14 ☐ Lesbian, gay, bisexual, or transgender clients (LGBT)
15 ☐ Forensic clients (referred from the court/ judicial system)
16 ☐ Persons with HIV or AIDS
17 ☐ Other special program or group *(Specify:*

_____*)*

18 ☐ No dedicated or exclusively designed programs or groups are offered

***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 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 staff or an on call interpreter provides this service.*

1 ☐ Yes

0 ☐ No

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

1 ☐ Yes

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

A17a. At this facility, who provides mental health treatment services in a language other than English?

MARK ONE ONLY

1 ☐ Staff who speak a language other than English

2 ☐ On-call interpreter *(in person or by phone)* brought in when needed → **SKIP TO A18 (NEXT COLUMN)**

3 ☐ BOTH staff and on-call interpreter

***A17a1. Do staff provide mental health treatment services in Spanish at this facility?**

1 ☐ Yes

0 ☐ No → **SKIP TO A17b (TOP OF NEXT COLUMN)**

A17a2. Do staff at this facility provide mental health treatment services in any other languages?

1 ☐ Yes → **GO TO A17b (TOP OF NEXT COLUMN)**

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

***A17b. In what other languages do staff provide mental health treatment services at this facility?**

- *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 American Indian or Alaska Native language *(Specify:* _____ *)*

Other Languages:

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

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

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

MARK ONE ONLY

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

A20. In the 12-month period beginning May 1, 2017, and ending April 30, 2018, have staff at this facility 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 activities, please indicate if staff members routinely use computer or electronic resources, paper only, or a combination of both to accomplish their work.

NOTE: Electronic resources include tools such as electronic health records (EHR) and web portals. Please consider e-fax, pdf, or scanned documents as paper documents.

	MARK ONE METHOD FOR EACH ACTIVITY			
WORK ACTIVITY	**COMPUTER/ ELECTRONIC ONLY**	**PAPER ONLY**	**BOTH ELECTRONIC AND PAPER**	**NA**
1. Intake	1 ☐	2 ☐	3 ☐	na ☐
2. Scheduling appointments	1 ☐	2 ☐	3 ☐	na ☐
3. Assessment/evaluation	1 ☐	2 ☐	3 ☐	na ☐
4. Treatment plan	1 ☐	2 ☐	3 ☐	na ☐
5. Client progress monitoring	1 ☐	2 ☐	3 ☐	na ☐
6. Discharge	1 ☐	2 ☐	3 ☐	na ☐
7. Referrals	1 ☐	2 ☐	3 ☐	na ☐
8. Issue/receive lab results	1 ☐	2 ☐	3 ☐	na ☐
9. Medication prescribing/dispensing	1 ☐	2 ☐	3 ☐	na ☐
10. Checking medication interactions	1 ☐	2 ☐	3 ☐	na ☐
11. Store and maintain client health and/or treatment records	1 ☐	2 ☐	3 ☐	na ☐
12. Send client health and/or treatment information to providers or sources outside your organization	1 ☐	2 ☐	3 ☐	na ☐
13. Receive client health and/or treatment information from providers or sources outside your organization	1 ☐	2 ☐	3 ☐	na ☐
14. Billing	1 ☐	2 ☐	3 ☐	na ☐
15. Client or family satisfaction surveys	1 ☐	2 ☐	3 ☐	na ☐

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

- *Sliding fee scales are based on income and other factors.*
- *Not applicable to Veterans Administration facilities.*

1 ☐ Yes

0 ☐ No → **SKIP TO A23 (BELOW)**

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

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

1 ☐ Yes

0 ☐ No

***A23. Does this facility offer treatment at no charge or minimal payment (for example, $1) to clients who cannot afford to pay?**

- *Not applicable to Veterans Administration facilities.*

1 ☐ Yes

0 ☐ No → **SKIP TO A24 (TOP OF NEXT COLUMN)**

A23a. Do you want the availability of treatment at no charge or minimal payment (for example, $1) for eligible clients published in SAMHSA's online Behavioral Health Treatment Services Locator?

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

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/Tribal/Urban *(ITU)* funds	1 ☐	0 ☐	d ☐
17. Other	1 ☐	0 ☐	d ☐

(Specify: _____)

A25. 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 "YES," "NO" OR "DON'T KNOW" FOR EACH

		YES	NO	DON'T KNOW
1.	State mental health authority	1 ☐	0 ☐	d ☐
2.	State substance abuse agency	1 ☐	0 ☐	d ☐
3.	State department of health	1 ☐	0 ☐	d ☐
4.	State or local Department of Family and Children's Services	1 ☐	0 ☐	d ☐
5.	Hospital licensing authority	1 ☐	0 ☐	d ☐
6.	The Joint Commission	1 ☐	0 ☐	d ☐
7.	Commission on Accreditation of Rehabilitation Facilities *(CARF)*	1 ☐	0 ☐	d ☐
8.	Council on Accreditation *(COA)*	1 ☐	0 ☐	d ☐
9.	Centers for Medicare and Medicaid Services *(CMS)*	1 ☐	0 ☐	d ☐
10.	Other national organization, or federal, state, or local agency	1 ☐	0 ☐	d ☐

(Specify: _____ *)*

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 (NEXT PAGE)**

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 12)

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

THIS FACILITY	1
+ ADDITIONAL FACILITIES	
= TOTAL FACILITIES	

On page 13 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, 2018, 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 (TOP OF NEXT PAGE)**

B3a. On April 30, 2018, 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 persons.*

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, 2018, 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, 2018, 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 (TOP OF NEXT PAGE)**

B4a. On April 30, 2018, 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 persons.*

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, 2018, 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 2018, 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 (TOP OF NEXT PAGE)**

B5a. During the <u>month</u> of April 2018, 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, 2018</u>****.*
- ***DO NOT*** *count family members, friends, or other non-treatment persons.*

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, 2018, 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, 2017 through April 30, 2018, 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: https://findtreatment.samhsa.gov*

1 ☐ Yes

0 ☐ No → **SKIP TO C2 (BELOW)**

C1a. To increase public awareness of behavioral health services, SAMHSA may be sharing facility contact information with large commercially available Internet search engines, such as Google, Bing, Yahoo!, etc. Do you want your facility information shared on these Internet search engines?

- *Information to be shared would be: facility name, location address, telephone number, and website address.*

1 ☐ Yes

0 ☐ No

C2. 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: _____

Phone Number: (_____) _____ - _____ Ext._____

Fax Number: (_____) _____ - _____

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, and/or 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 50345_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 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 eligible treatment facilities, information provided in response to survey questions marked with an asterisk may be published in SAMHSA's online Behavioral Health Treatment Services Locator, 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.