

FORM APPROVED:

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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)

SAMPLE

***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 “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 1-888-324-8337.
- 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](mailto: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 at this location, that is, the location listed on the front cover?

MARK "YES" OR "NO" FOR EACH

- |   | YES                        | NO                         |
|---|----------------------------|----------------------------|
| 1. Intake, assessment, or referral .....  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Detoxification.....  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. Substance abuse treatment<br>(services that focus on initiating and maintaining an individual's recovery from substance abuse and on averting relapse) ..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 4. Any other substance abuse services .....   | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

2. Did you answer "yes" to detoxification 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 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Benzodiazepines .....  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. Cocaine .....          | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 4. Methamphetamines.....  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 5. Opiates .....          | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 6. Other (Specify: _____) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

2b. Does this facility routinely use medications during detoxification?

- 1  Yes  
 0  No → SKIP TO Q.4 (NEXT COLUMN)

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

- 1  Yes  
 0  No → SKIP TO Q.34 (PAGE 11)

\*4. What is the primary focus of this facility at this location, 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 } SKIP TO Q.6 (BELOW)  
 2  A private non-profit organization }  
 3  State government }  
 4  Local, county, or community government } SKIP TO Q.8 (PAGE 2)  
 5  Tribal government }  
 6  Federal Government

5a. Which Federal Government agency?

MARK ONE ONLY

- 1  Department of Veterans Affairs }  
 2  Department of Defense } SKIP TO Q.8 (PAGE 2)  
 3  Indian Health Service }  
 4  Other (Specify: \_\_\_\_\_)

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?

- Yes  
 No

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

- Yes → SKIP TO Q.41 (PAGE 11)  
 No

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

- Yes  
 No → SKIP TO Q.10 (BELOW)

9a. What type of hospital?

MARK ONE ONLY

- General hospital (including VA hospital)  
 Psychiatric hospital  
 Other specialty hospital, for example, alcoholism, maternity, etc.  
(Specify: \_\_\_\_\_)

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

1. (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_  
2. (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_

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

MARK ALL THAT APPLY

**Assessment and Pre-Treatment Services**

- Screening for substance abuse  
 Screening for mental health disorders  
 Comprehensive substance abuse assessment or diagnosis  
 Comprehensive mental health assessment or diagnosis (for example, psychological or psychiatric evaluation and testing)  
 Screening for tobacco use  
 Outreach to persons in the community who may need treatment

- 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.)

- Breathalyzer or other blood alcohol testing  
 Drug or alcohol urine screening  
 Screening for Hepatitis B  
 Screening for Hepatitis C  
 HIV testing  
 STD testing  
 TB screening

**Transitional Services**

- Discharge planning  
 Aftercare/continuing care

**Ancillary Services**

- Case management services  
 Social skills development  
 Mentoring/peer support  
 Child care for clients' children  
 Assistance with obtaining social services (for example, Medicaid, WIC, SSI, SSDI)  
 Employment counseling or training for clients  
 Assistance in locating housing for clients  
 Domestic violence—family or partner violence services (physical, sexual, and emotional abuse)  
 Early intervention for HIV  
 HIV or AIDS education, counseling, or support  
 Hepatitis education, counseling, or support  
 Health education other than HIV/AIDS or hepatitis  
 Substance abuse education  
 Transportation assistance to treatment  
 Mental health services  
 Acupuncture  
 Residential beds for clients' children  
 Self-help groups (for example, AA, NA, SMART Recovery)  
 Smoking cessation counseling

**Pharmacotherapies**

- Antabuse®  
 Naltrexone (oral)  
 Vivitrol® (injectible Naltrexone)  
 Campral®  
 Nicotine replacement  
 Non-nicotine smoking/tobacco cessation medications (for example, Bupropion, Varenicline)  
 Medications for psychiatric disorders  
 Methadone  
 Buprenorphine – Subutex® or generic  
 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.**

| TYPE OF COUNSELING                  | MARK ONE BOX FOR EACH 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 <input type="checkbox"/>               | 1 <input type="checkbox"/>         | 2 <input type="checkbox"/>        | 3 <input type="checkbox"/>        | 4 <input type="checkbox"/>           |
| 2. Group counseling.....            | 0 <input type="checkbox"/>               | 1 <input type="checkbox"/>         | 2 <input type="checkbox"/>        | 3 <input type="checkbox"/>        | 4 <input type="checkbox"/>           |
| 3. Family counseling .....          | 0 <input type="checkbox"/>               | 1 <input type="checkbox"/>         | 2 <input type="checkbox"/>        | 3 <input type="checkbox"/>        | 4 <input type="checkbox"/>           |
| 4. Marital/couples counseling ..... | 0 <input type="checkbox"/>               | 1 <input type="checkbox"/>         | 2 <input type="checkbox"/>        | 3 <input type="checkbox"/>        | 4 <input type="checkbox"/>           |

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 <input type="checkbox"/>           | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/>      |
| 2. 12-step facilitation.....                           | 1 <input type="checkbox"/>           | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/>      |
| 3. Brief intervention.....                             | 1 <input type="checkbox"/>           | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/>      |
| 4. Cognitive-behavioral therapy .....                  | 1 <input type="checkbox"/>           | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/>      |
| 5. Contingency management/motivational incentives..... | 1 <input type="checkbox"/>           | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/>      |
| 6. Motivational interviewing.....                      | 1 <input type="checkbox"/>           | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/>      |
| 7. Trauma-related counseling .....                     | 1 <input type="checkbox"/>           | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/>      |
| 8. Anger management .....                              | 1 <input type="checkbox"/>           | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/>      |
| 9. Matrix Model .....                                  | 1 <input type="checkbox"/>           | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/>      |
| 10. Community reinforcement plus vouchers.....         | 1 <input type="checkbox"/>           | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/>      |
| 11. Rational emotive behavioral therapy (REBT).....    | 1 <input type="checkbox"/>           | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/>      |
| 12. Relapse prevention.....                            | 1 <input type="checkbox"/>           | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/>      |
| 13. Other treatment approach ( <i>Specify:</i> _____ ) | 1 <input type="checkbox"/>           | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |                                 |

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

MARK "YES" OR "NO" FOR EACH

YES NO

- Required continuing education for staff ..... 1  0
- Periodic drug testing of clients ..... 1  0
- Regularly scheduled case review with a supervisor ..... 1  0
- Case review by an appointed quality review committee..... 1  0
- Outcome follow-up after discharge ..... 1  0
- Periodic utilization review..... 1  0
- 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 specialty 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



**\*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

- |   | <u>YES</u> | <u>NO</u> |
|---|------------|-----------|
| 1. <b>Hospital inpatient detoxification</b> ..... 1 <input type="checkbox"/> 0 <input type="checkbox"/><br>(Similar to ASAM Levels IV-D and III.7-D, <i>medically managed or monitored inpatient detoxification</i> ) |            |           |
| 2. <b>Hospital inpatient treatment</b> ..... 1 <input type="checkbox"/> 0 <input type="checkbox"/><br>(Similar to ASAM Levels IV and III.7, <i>medically managed or monitored intensive inpatient treatment</i> )     |            |           |

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

- |   | <u>YES</u> | <u>NO</u> |
|---|------------|-----------|
| 1. <b>Residential detoxification</b> ..... 1 <input type="checkbox"/> 0 <input type="checkbox"/><br>(Similar to ASAM Level III.2-D, <i>clinically managed residential detoxification or social detoxification</i> )                                       |            |           |
| 2. <b>Residential short-term treatment</b> ..... 1 <input type="checkbox"/> 0 <input type="checkbox"/><br>(Similar to ASAM Level III.5, <i>clinically managed high-intensity residential treatment, typically 30 days or less</i> )                       |            |           |
| 3. <b>Residential long-term treatment</b> ..... 1 <input type="checkbox"/> 0 <input type="checkbox"/><br>(Similar to ASAM Levels III.3 and III.1, <i>clinically managed medium- or low-intensity residential treatment, typically more than 30 days</i> ) |            |           |

**\*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

- |  | <u>YES</u> | <u>NO</u> |
|--|------------|-----------|
| 1. <b>Outpatient detoxification</b> ..... 1 <input type="checkbox"/> 0 <input type="checkbox"/><br>(Similar to ASAM Levels I-D and II-D, <i>ambulatory detoxification</i> )                  |            |           |
| 2. <b>Outpatient methadone maintenance</b> ..... 1 <input type="checkbox"/> 0 <input type="checkbox"/>   |            |           |
| 3. <b>Outpatient day treatment or partial hospitalization</b> ..... 1 <input type="checkbox"/> 0 <input type="checkbox"/><br>(Similar to ASAM Level II.5, <i>20 or more hours per week</i> ) |            |           |
| 4. <b>Intensive outpatient treatment</b> ..... 1 <input type="checkbox"/> 0 <input type="checkbox"/><br>(Similar to ASAM Level II.1, <i>9 or more hours per week</i> )                       |            |           |
| 5. <b>Regular outpatient treatment</b> ..... 1 <input type="checkbox"/> 0 <input type="checkbox"/><br>(Similar to ASAM Level I, <i>outpatient treatment, non-intensive</i> )                 |            |           |

**\*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 not 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 substance abuse treatment?

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

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

(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 | <input style="width: 50px;" type="text"/> |
|                         |   |
| <b>TOTAL FACILITIES</b> | <input style="width: 50px;" type="text"/> |

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  %

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<br>KNOW              |
|---|----------------------------|----------------------------|----------------------------|
| 1. State substance abuse agency .....                                 | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 2. State mental health department .....                               | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 3. State department of health .....                                   | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 4. Hospital licensing authority .....                                 | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 5. The Joint Commission .....   | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 6. Commission on Accreditation of Rehabilitation Facilities (CARF) .. | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 7. National Committee for Quality Assurance (NCQA) .....              | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 8. Council on Accreditation (COA) .....                               | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
| 9. Another state or local agency or other organization .....          | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | d <input type="checkbox"/> |
- (*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 → 

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.
- 0  No

**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: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

FACILITY EMAIL ADDRESS: \_\_\_\_\_

FACILITY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

FACILITY EMAIL ADDRESS: \_\_\_\_\_

FACILITY EMAIL ADDRESS: \_\_\_\_\_

FACILITY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

FACILITY EMAIL ADDRESS: \_\_\_\_\_

FACILITY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

FACILITY EMAIL ADDRESS: \_\_\_\_\_

FACILITY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

FACILITY EMAIL ADDRESS: \_\_\_\_\_

FACILITY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

FACILITY EMAIL ADDRESS: \_\_\_\_\_

FACILITY EMAIL ADDRESS: \_\_\_\_\_

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

**ANY ADDITIONAL COMMENTS**

SAMPLE

**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**

Public burden for this collection of information is estimated to average 40 minutes per response including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer, Room 7-1044, 1 Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB number for this project is 0930-0106.