

The CBHSQ Report

Short Report

July 11, 2017

BEHAVIORAL HEALTH WORKFORCE: QUALITY ASSURANCE PRACTICES IN SUBSTANCE ABUSE TREATMENT FACILITIES

AUTHORS

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INTRODUCTION

Nationwide, there is concern about shortages, retention, and training in the behavioral health workforce.¹ Needs in both sectors of the behavioral health workforce (i.e., substance abuse and mental health) are similar; however, it has been noted that minimum requirements for substance abuse workers are lower than those for mental health workers.² Substantial reforms in the organization and delivery of care in the United States have created concerns that substance abuse workers may need support and supervision to keep pace with changing practices.^{3,4} In the field of substance abuse treatment, some changes include a shift toward increased public financing, increased use of medication-assisted treatment, emphasis on evidence-based practices, use of peer support specialists, and changes in the profile of those needing services.^{5,6,7} Many calls have been made to improve and strengthen the training, education, and supervision of the substance abuse treatment workforce.^{1,8,9}

Members of the behavioral health workforce benefit from continued training and clinical supervision to maintain high-quality services. In addition, these practices and other organizational factors may prevent staff from experiencing burnout^{10,11} and may assist in overcoming challenges in retention of qualified workers. For example, clinical supervision has been shown to serve as a protective factor in substance abuse treatment counselors' turnover, emotional exhaustion, and job satisfaction.¹² In the substance abuse treatment field, staff turnover has been found to be as high as 50 percent in some contexts, with average annual estimates around 32 percent for counselors.^{13,14} Substance abuse treatment facilities can play a key role in supporting their workforce through training and supervision practices.



In Brief

- In 2013, quality assurance practices related to the behavioral health workforce were common standard operating procedures in substance abuse treatment facilities. Although use of these practices differed little by facility characteristics, use did vary by U.S. state.
- Almost all facilities (98.3 percent) monitored the continuing education requirements for professional staff.
- Almost all facilities (95.5 percent) had regularly scheduled case review with a supervisor, and many facilities (73.5 percent) had regularly scheduled case review by an appointed quality review committee.
- Nearly three-quarters of facilities (72.4 percent) used both types of case review practices (case review with a supervisor and case review by an appointed quality review committee); only 3.4 percent of facilities used neither type of case review practice.

This issue of *The CBHSQ Report* focuses on quality assurance practices related to the behavioral health workforce that are used in substance abuse treatment facilities in the United States (a [companion report on mental health treatment facilities](#) is also available). These practices include continuing education requirements for professional staff, regularly scheduled case review with a supervisor, and case review by an appointed quality review committee. This report uses data from the National Survey of Substance Abuse Treatment Services (N-SSATS) to describe the number of substance abuse treatment facilities that use these quality assurance practices related to the behavioral health workforce as standard operating procedures. In addition, this report examines whether the use of these practices differs by facility characteristics and by state in the United States (including territories and the District of Columbia).

DATA AND METHODS

N-SSATS, conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), is an annual survey of all known public and private substance abuse treatment facilities in the United States. N-SSATS is the only source of national and state-level data on the substance abuse services reported by both publicly and privately operated specialty substance abuse treatment facilities. N-SSATS is used to collect basic data on the number, location, and characteristics of specialty substance abuse treatment facilities and the people they serve throughout the 50 states, the District of Columbia, and other U.S. jurisdictions.¹⁵ N-SSATS is a point-prevalence survey that provides a picture of facilities' activities and gives an indication of the state of substance abuse treatment on a typical day but may not represent the full scope of practice in a given year.

The 2013 N-SSATS data used in this report are from the most recent available analytic data file with workforce information.¹⁶ Data come from 14,148 substance abuse treatment facilities. The facility response rate was 94.4 percent. This report examines use of three types of quality assurance practices: (1) requiring continuing education for staff, (2) regularly scheduled case review with a supervisor, and (3) case review by an appointed quality review committee. There was some missing data for each quality assurance practice; the numbers of facilities reporting data for each practice were 14,144, 14,147, and 14,140, respectively. There was also some missing data for facility characteristics (facility operation and type of care) and at the state level. The percentages described in this report were calculated using available data for each analysis presented, and the totals used to calculate the percentages are listed in the tables.

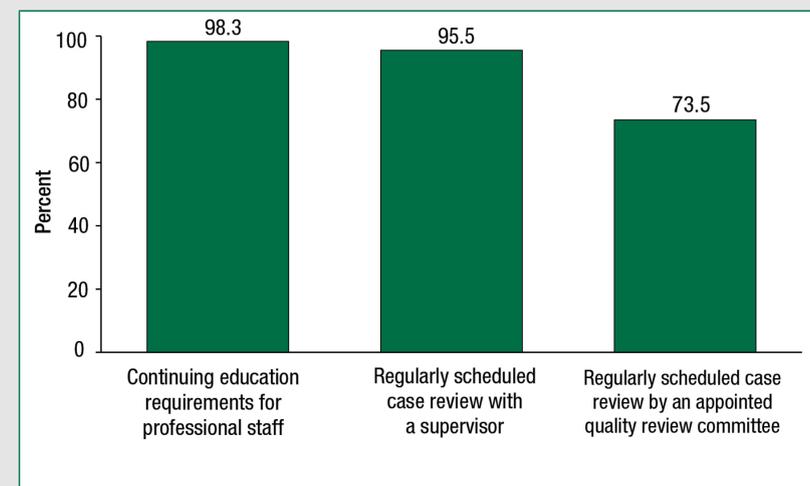
Because N-SSATS is considered a census of facilities and provides actual counts rather than estimates, statistical significance and confidence intervals are not applicable. The differences between percentages mentioned in this report were assessed using Cohen's *h*. The results described here have a Cohen's *h* effect size ≥ 0.20 , which indicates that there were meaningful differences between the groups.¹⁷

QUALITY ASSURANCE PRACTICES IN SUBSTANCE ABUSE TREATMENT FACILITIES

In 2013, quality assurance practices related to the behavioral health workforce were common standard operating procedures in substance abuse treatment facilities (Figure 1). Specifically, 98.3 percent of substance abuse treatment facilities required continuing education for staff as a standard operating procedure; 95.5 percent of substance abuse treatment facilities used regularly scheduled case review with a supervisor as a standard operating procedure; and 73.5 percent of substance abuse treatment facilities used case review by an appointed quality review committee as a standard operating procedure.

In general, the percentages did not vary by facility characteristics (Table 1). Compared with the U.S. percentage overall, a lower percentage of facilities operated by tribal governments used case review by an appointed quality review committee as a standard operating procedure (60.4 vs. 73.5 percent), whereas a higher percentage of facilities operated by state governments used this practice (84.3 percent).

Figure 1. Substance abuse treatment facilities using workforce quality assurance practices as standard operating procedures: 2013



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services (N-SSATS), 2013.

Table 1. Substance abuse treatment facilities using workforce quality assurance practices as standard operating procedures, by facility characteristics: 2013

	Continuing education requirements for professional staff				Regularly scheduled case review with a supervisor				Regularly scheduled case review by an appointed quality review committee			
	Total	n	Percentage	h ¹	Total	n	Percentage	h ¹	Total	n	Percentage	h ¹
U.S. total	14,144	13,900	98.3	N/A	14,147	13,507	95.5	N/A	14,140	10,391	73.5	N/A
Facility operation												
Private for-profit	4,572	4,466	97.7		4,574	4,218	92.2		4,571	2,954	64.6	
Private nonprofit	7,820	7,701	98.5		7,820	7,618	97.4		7,817	6,129	78.4	
State government	351	345	98.3		351	340	96.9		351	296	84.3	↑
Local government	738	734	99.5		739	720	97.4		739	554	75.0	
Tribal government	293	291	99.3		293	273	93.2		293	177	60.4	↓
Federal government	370	363	98.1		370	338	91.4		369	281	76.2	
Type of care												
Inpatient	751	739	98.4		753	682	90.6		751	569	75.8	
Residential (nonhospital)	3,450	3,377	97.9		3,450	3,372	97.7		3,450	2,683	77.8	
Outpatient	11,540	11,360	98.4		11,541	10,997	95.3		11,536	8,398	72.8	

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services (N-SSATS), 2013.

N/A = not applicable.

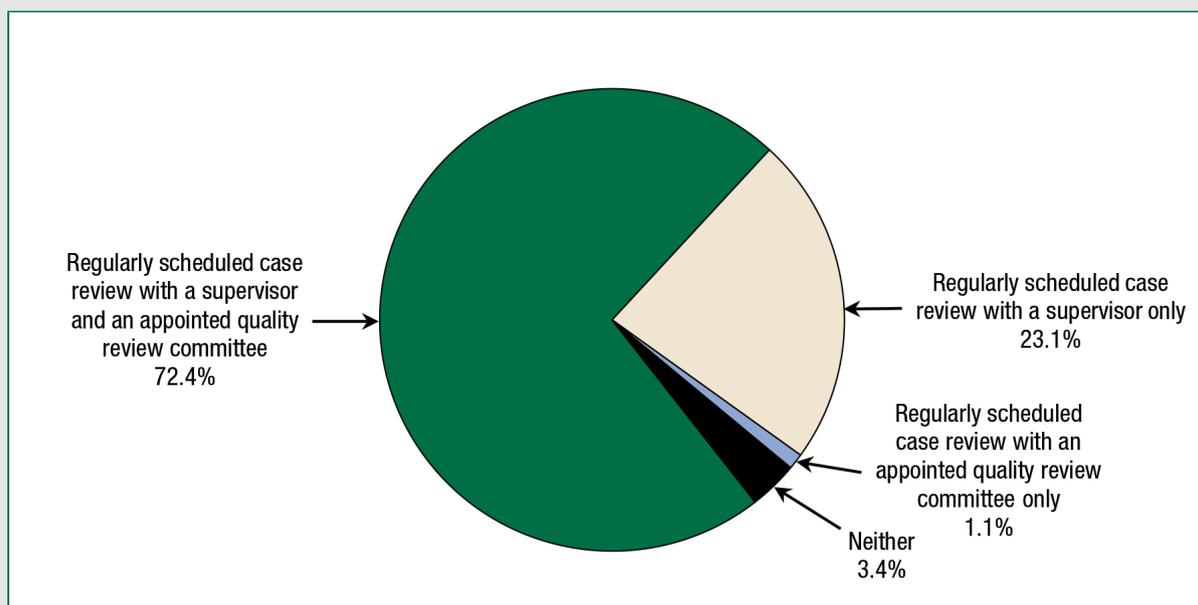
¹ Cohen's h was calculated by comparing the percentage of facilities in each facility operation with the overall U.S. percentage. Only comparisons in which Cohen's h was ≥ 0.20 are noted with an arrow indicating whether the percentage was higher or lower than the overall U.S. percentage.

Note: Totals vary across quality assurance practices because of missing data.

CASE REVIEW PATTERNS

The majority of substance abuse treatment facilities (72.4 percent) used both types of case review practices as standard operating procedures (regularly scheduled case review with a supervisor and case review by an appointed quality review committee; Figure 2). The next most common pattern (23.1 percent) was for facilities to use regularly scheduled case review with a supervisor as a standard operating procedure but not case review by an appointed quality review committee. The least common pattern (1.1 percent) was for facilities to use case review by an appointed quality review committee but not case review with a supervisor. The remaining 3.4 percent of facilities used neither case review practice as a standard operating procedure.

Figure 2. Substance abuse treatment facilities using regularly scheduled case review practices: percentages, 2013



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services (N-SSATS), 2013.

STATE RESULTS

States varied in their use of the three quality assurance practices examined in this report (Table 2). Three states had higher percentages compared with the percentage for the United States overall for two of the three practices and were not different from the U.S. percentage for the other practice. The percentage of facilities that used regularly scheduled case review with a supervisor and case review by an appointed quality review committee as standard operating procedures was higher in Alabama and New York than in the United States overall. The percentage of facilities that required continuing education for staff and used case review by an appointed quality review committee as standard operating procedures was higher in Ohio than in the United States overall.

Table 2. Substance abuse treatment facilities using workforce quality assurance practices as standard operating procedures, by state: 2013

	Continuing education requirements for professional staff				Regularly scheduled case review with a supervisor				Regularly scheduled case review by an appointed quality review committee			
	Total	n	Percentage	h ¹	Total	n	Percentage	h ¹	Total	n	Percentage	h ¹
U.S. total	14,144	13,900	98.3	N/A	14,147	13,507	95.5	N/A	14,140	10,391	73.5	N/A
Alaska	93	91	97.8		93	92	98.9	↑	93	72	77.4	
Alabama	154	153	99.4		154	152	98.7	↑	154	127	82.5	↑
Arkansas	89	88	98.9		89	87	97.8		89	74	83.1	↑
Arizona	313	312	99.7		313	297	94.9		313	201	64.2	↓
California	1,550	1,524	98.3		1,551	1,502	96.8		1,551	1,147	74.0	
Colorado	488	465	95.3		488	460	94.3		487	272	55.9	↓
Connecticut	212	206	97.2		212	208	98.1		212	153	72.2	
District of Columbia	37	37	100.0	↑	37	36	97.3		37	30	81.1	
Delaware	42	42	100.0	↑	42	40	95.2		42	31	73.8	
Florida	621	611	98.4		622	586	94.2		620	449	72.4	
Georgia	360	354	98.3		360	348	96.7		359	286	79.7	
Hawaii	123	120	97.6		123	123	100.0	↑	123	86	69.9	
Iowa	144	143	99.3		144	138	95.8		144	112	77.8	
Idaho	117	115	98.3		117	115	98.3		117	88	75.2	
Illinois	649	644	99.2		649	619	95.4		649	481	74.1	
Indiana	275	270	98.2		275	255	92.7		275	167	60.7	↓
Kansas	210	209	99.5		210	182	86.7	↓	210	112	53.3	↓
Kentucky	328	326	99.4		328	298	90.9		328	262	79.9	
Louisiana	166	163	98.2		166	156	94.0		166	128	77.1	
Massachusetts	316	307	97.2		316	305	96.5		316	232	73.4	
Maryland	360	352	97.8		360	346	96.1		360	260	72.2	
Maine	222	212	95.5		222	209	94.1		222	144	64.9	
Michigan	489	475	97.1		489	437	89.4	↓	489	370	75.7	
Minnesota	354	351	99.2		354	349	98.6		354	244	68.9	
Missouri	258	255	98.8		258	245	95.0		258	199	77.1	
Mississippi	101	101	100.0	↑	101	96	95.0		101	81	80.2	
Montana	72	72	100.0	↑	72	70	97.2		72	49	68.1	
North Carolina	433	423	97.7		433	394	91.0		432	310	71.8	
North Dakota	65	63	96.9		65	49	75.4	↓	65	59	90.8	↑
Nebraska	114	112	98.2		114	109	95.6		113	83	73.5	
New Hampshire	55	54	98.2		55	51	92.7		55	43	78.2	
New Jersey	372	357	96.0		372	340	91.4		372	270	72.6	
New Mexico	139	136	97.8		139	138	99.3	↑	139	106	76.3	
Nevada	81	79	97.5		81	75	92.6		81	59	72.8	
New York	904	891	98.6		905	898	99.2	↑	905	808	89.3	↑
Ohio	378	378	100.0	↑	378	363	96.0		378	335	88.6	↑
Oklahoma	223	222	99.6		223	211	94.6		223	161	72.2	
Oregon	246	244	99.2		246	242	98.4		246	190	77.2	
Pennsylvania	539	532	98.7		539	523	97.0		539	416	77.2	
Rhode Island	62	61	98.4		62	59	95.2		62	50	80.6	
South Carolina	111	109	98.2		111	105	94.6		111	92	82.9	↑
South Dakota	63	62	98.4		63	61	96.8		63	50	79.4	
Tennessee	221	219	99.1		221	216	97.7		221	183	82.8	↑
Texas	461	452	98.0		461	441	95.7		461	324	70.3	
Utah	171	169	98.8		171	168	98.2		171	137	80.1	
Virginia	226	220	97.3		226	217	96.0		226	142	62.8	↓
Vermont	44	44	100.0	↑	44	43	97.7		44	34	77.3	
Washington	451	449	99.6		451	438	97.1		451	262	58.1	↓
Wisconsin	318	317	99.7		318	309	97.2		318	150	47.2	↓
West Virginia	101	96	95.0		101	92	91.1		100	75	75.0	
Wyoming	53	53	100.0	↑	53	52	98.1		53	43	81.1	
Territories												
Guam	4	4	100.0	N/A	4	4	100.0	N/A	4	4	100.0	N/A
Micronesia	1	1	100.0	N/A	1	1	100.0	N/A	1	1	100.0	N/A
Palau	1	1	100.0	N/A	1	1	100.0	N/A	1	0	0.0	N/A
Puerto Rico	161	151	93.8	N/A	161	153	95.0	N/A	161	144	89.4	N/A
Virgin Islands	3	3	100.0	N/A	3	3	100.0	N/A	3	3	100.0	N/A

N/A = not applicable.¹Cohen's $h \geq .20$, state percentage compared to U.S. percentages. Arrow indicates whether percentage is higher or lower than U.S. Percentage.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services (N-SSATS), 2013.

STATE RESULTS (CONTINUED)

Twelve states had a higher percentage of facilities compared with the percentage for the United States overall for one of the three practices and were not different from the U.S. percentages for the other two practices. Compared with the United States overall, Delaware, the District of Columbia, Mississippi, Montana, Vermont, and Wyoming had higher percentages of facilities that required continuing education as a standard operating procedure but did not differ otherwise. Alaska, Hawaii, and New Mexico had higher percentages of facilities that used regularly scheduled case review with a supervisor as a standard operating procedure but did not differ otherwise. Arkansas, South Carolina, and Tennessee had a higher percentage of facilities that used case review by an appointed quality review committee as a standard operating procedure but did not differ otherwise.

One state had lower percentages of facilities using two of the three practices than the percentage for the United States overall and was not different from the U.S. percentage for the other practice. The percentages of facilities using regularly scheduled case review with a supervisor and case review by an appointed quality review committee as standard operating procedures were lower in Kansas compared with the percentages in the United States overall.

Seven states had a lower percentage of facilities using one of the three practices as a standard operating procedure than the percentage for the United States overall but were not different from the U.S. percentages for the other two practices. Arizona, Colorado, Indiana, Virginia, Washington, and Wisconsin reported a lower percentage of facilities using case review by an appointed quality review committee than the U.S. percentage, whereas Michigan reported a lower percentage of facilities using regularly scheduled case review with a supervisor as a standard operating procedure than the U.S. percentage.

North Dakota showed mixed results. The percentage of facilities using regularly scheduled case review with a supervisor as a standard operating procedure was lower than the U.S. percentage overall, yet the percentage using case review by an appointed quality review committee was higher than in the United States overall.

DISCUSSION

The 2013 N-SSATS data used in this report indicate that quality assurance practices related to the behavioral health workforce are common in substance abuse treatment facilities. Continuing education was the most commonly used practice, followed closely by regularly scheduled case review with a supervisor. Although case review by an appointed quality review committee was a less commonly used standard operating procedure than review with a supervisor or requiring continuing education, it was still common in facilities. Nearly three-quarters of facilities used both types of case review in their standard operating procedures.

Facilities can play a role in supporting the behavioral health workforce by including the practices outlined in this report in their standard operating procedures.^{1,2} The best quality outcomes are likely to be produced when they go beyond the provision of basic continuing education and clinical supervision.^{18,19} For example, continuing education that is interactive or tailored to individuals' practices and clinical supervisor expertise, especially in the areas of competencies and procedural knowledge, tends to yield better outcomes.^{18,19,20} Furthermore, studies indicate that formal documentation and evaluation are important when supervision is conducted in groups,²¹ which has implications for case review by a quality review committee. Some practices may be more easily integrated into existing facility procedures, such as continuing education requirements for professional staff, compared with other practices that require greater time, resources, coordination, and funds (e.g., case review by a quality review committee). Online tools, video conferencing, and electronic health records might facilitate continuing education and case review for facilities in understaffed or under-resourced areas.²² Additional resources to support the behavioral health workforce can be found at <http://www.samhsa.gov/workforce> and <http://www.integration.samhsa.gov/workforce/education-training>.

ENDNOTES

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SUGGESTED CITATION

Sherman, L. J., Lynch, S. E., Greeno, C. G. and Hoeffel, E. M. *Behavioral health workforce: Quality assurance practices in substance abuse treatment facilities*. The CBHSQ Report: July 11, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.

SUMMARY

Background: Nationwide, there is concern about challenges in the retention of the behavioral health workforce, which includes substance abuse treatment. Members of the substance abuse treatment workforce benefit from continued training and clinical supervision to maintain high-quality services and prevent emotional exhaustion, burnout, and turnover. Substance abuse treatment facilities can play a key role in supporting their workforce through training and supervision practices. **Method:** Data from the 2013 National Survey of Substance Abuse Treatment Services (N-SSATS) were used to examine the percentage of facilities that used quality assurance practices related to the behavioral health workforce and whether the percentage of facilities differed based on facility characteristics and by U.S. state (as evidenced by Cohen's h effect size ≥ 0.20). **Results:** Almost all facilities (98.3 percent) required continuing education for staff. Almost all facilities (95.5 percent) had regularly scheduled case review with a supervisor, and many facilities (73.5 percent) had case review by an appointed quality review committee; only 3.4 percent of facilities used neither type of case review practice. States differed in the use of quality assurance practices. **Conclusion:** Given that quality assurance practices related to the behavioral health workforce are common standard operating procedures in substance abuse treatment facilities, opportunities to enhance the quality of the practices should be supported.

Keywords: Behavioral health workforce, substance abuse treatment, continuing education, clinical supervision, case review, training

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KEYWORDS

Alabama, Alaska, All US States and Territories, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Federated States of Micronesia, Florida, Georgia, Guam, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Palau, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virgin Islands, Virginia, Washington, West Virginia, Wisconsin, Wyoming, Short Report, Substance Abuse Facility Data, 2013, Researchers, Workforce Development

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The National Survey of Substance Abuse Treatment Services (N-SSATS) is an annual survey designed to collect information from facilities in the United States, both public and private, that provide substance abuse treatment. N-SSATS provides a mechanism for quantifying the dynamic character and composition of the United States substance abuse treatment delivery system. The objectives of N-SSATS are to collect multipurpose data that can be used to assist SAMHSA and State and local governments in assessing the nature and extent of services provided and in forecasting treatment resource requirements, to update SAMHSA's Inventory of Behavioral Health Services (I-BHS), to analyze general treatment services trends, and to generate the Substance Abuse Treatment facility Locator [<http://findtreatment.samhsa.gov/>].

The responsibility for N-SSATS is maintained by SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ). N-SSATS collects three types of information from facilities: (1) characteristics of individual facilities such as services offered, types of treatment provided, and payment options; (2) client count information such as counts of clients served by service type and number of beds designated for treatment; and (3) general information such as licensure, certification, or accreditation, and facility website availability.

In 2013, N-SSATS collected information from 14,148 facilities from all 50 states, the District of Columbia, Puerto Rico, the Federated States of Micronesia, Guam, Palau, and the U.S. Virgin Islands. Information and data for this report are based on data reported to N-SSATS for the survey reference date March 29, 2013.

The N-SSATS Report is prepared by the Center for Behavioral Health Statistics and Quality (CBHSQ), SAMHSA, Synectics for Management Decisions, INC., Arlington, VA; and by RTI International in Research Triangle Park, NC.

Latest N-SSATS reports:

<http://www.samhsa.gov/data/substance-abuse-facilities-data-nssats>

Latest N-SSATS public use files and variable definitions:

<http://datafiles.samhsa.gov>

Other Substance abuse reports:

<http://www.samhsa.gov/data>



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