SAMHSA
Substance Abuse and Mental Health Services Administration

N-SUMHSS
NATIONAL SUBSTANCE USE AND MENTAL HEALTH SERVICES SURVEY

OMB No. 0930-0386
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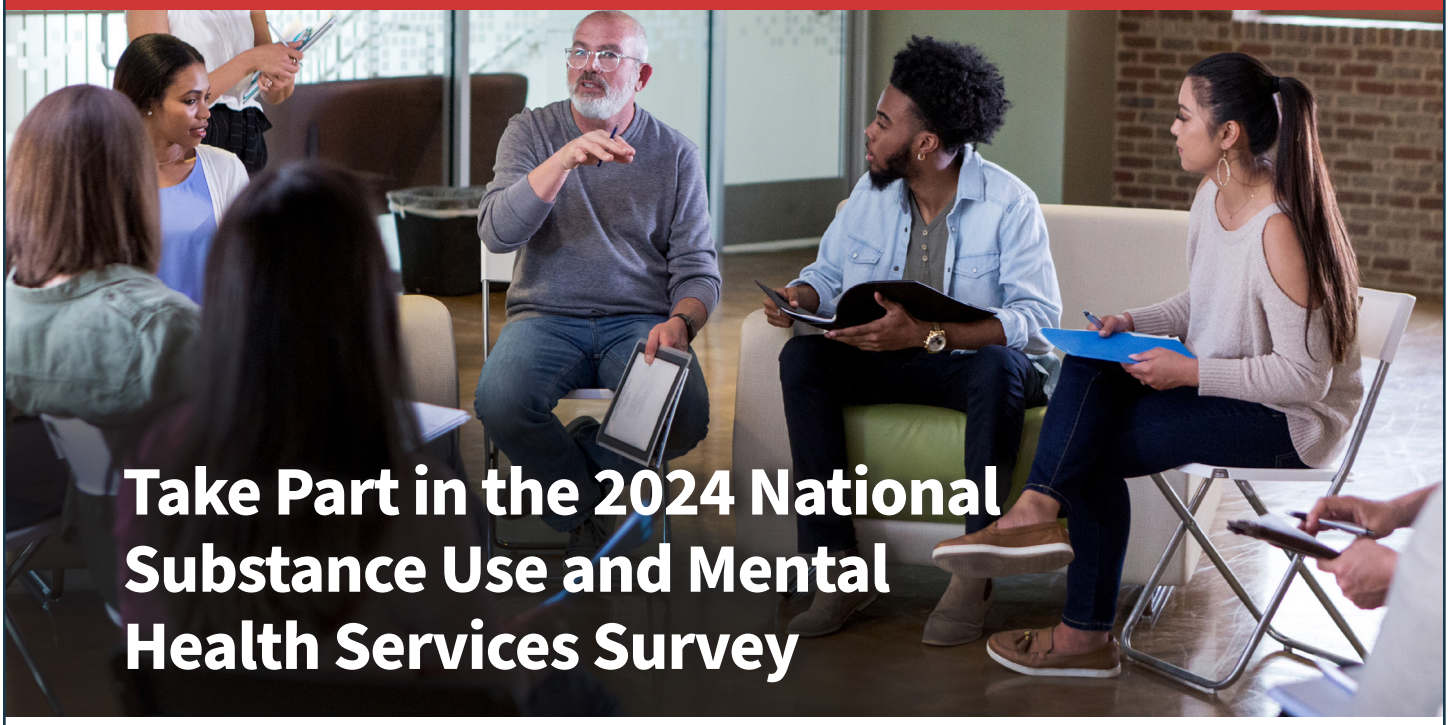

Take Part in the 2024 National Substance Use and Mental Health Services Survey

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

MARK ONE

- ○ Information is complete and correct; no changes needed.
- ○ All missing or incorrect information has been corrected.

PLEASE READ THIS ENTIRE PAGE BEFORE COMPLETING THE QUESTIONNAIRE

WOULD YOU PREFER TO COMPLETE THIS QUESTIONNAIRE ONLINE?

See the blue flyer enclosed in your survey packet for the web 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-SUMHSS helpline at 1-833-302-1759.

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 1-833-302-1759.
- 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 **https://info.nsumhss.samhsa.gov**.

If you have any questions or need additional blank surveys, contact:
ICF
1-833-302-1759
ICFsupport@nsumhss.org

IMPORTANT INFORMATION

ASTERISKED QUESTIONS. Information from asterisked (*) questions may be published on **FindTreatment.gov** (**https://findtreatment.gov**), in SAMHSA's *National Directory of Drug and Alcohol Use Treatment Facilities,* the *National Directory of Mental Health Treatment Facilities*, and other publicly-available listings, unless you designate otherwise in question C8, on page 26 of this questionnaire.

MAPPING FEATURE ON FINDTREATMENT.GOV. Complete and accurate name and address information is needed for **FindTreatment.gov** so it can correctly map the facility location.

ELIGIBILITY FOR ONLINE DIRECTORIES. Facilities that provide mental health treatment and complete this questionnaire may be eligible to be listed as mental health facilities on **FindTreatment.gov** and the *National Directory of Mental Health Treatment Facilities*. For substance use treatment facilities, only those designated as eligible by their state substance abuse office and that complete this questionnaire will be listed as substance use facilities on **FindTreatment.gov** and the *National Directory of Drug and Alcohol Use Treatment Facilities*. Your state N-SUMHSS representative can tell you if your facility is eligible to be listed on **FindTreatment.gov** and in the directories. For the name and telephone number of your state representative, call the N-SUMHSS helpline at 1-833-302-1759.

NATIONAL SUBSTANCE USE AND MENTAL HEALTH SERVICES SURVEY (N-SUMHSS)

1. What type of treatment does ***this facility***, ***at this location***, provide?

- ○ Primarily substance use treatment services → SKIP TO **2**
- ○ Primarily mental health services → SKIP TO **1a**
- ○ Mix of mental health and substance use treatment services → SKIP TO **2**
- ○ No treatment for either substance use or mental health is provided at this location → SKIP TO **E1**

1a. Do you also provide substance use treatment services?

Select "Yes" if this facility offers substance use treatment as a stand-alone service.
Select "No" if it only offers substance use treatment as part of mental health treatment services for individual patients who need it.

- ○ Yes
- ○ No → SKIP TO **B1**

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

- ○ Yes → SKIP TO **E1**
- ○ No

MODULE A: SUBSTANCE USE TREATMENT FACILITIES

*A1. Which of the following substance use treatment 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
Intake, assessment, or referral	○	○
Detoxification *(medical withdrawal)*	○	○
Substance use disorder treatment *(services that focus on initiating and maintaining an individual's recovery from substance use and on averting relapse)*	○	○
Treatment for co-occurring substance use ***plus either*** serious mental illness *(SMI)* in adults ***and/or*** serious emotional disturbance *(SED)* in children	○	○
Any other substance use treatment services *(such as 12-step meeting facilitation, naloxone prescriptions, etc.)*	○	○

A1a. To which of the following clients does ***this facility, at this location***, offer mental health treatment services (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)?

MARK ALL THAT APPLY

- ○ Substance use treatment clients
- ○ Clients other than substance use treatment clients
- ○ No clients are offered mental health treatment services at this facility

*A2. Does ***this facility*** detoxify (medical withdrawal) clients from:

MARK ALL THAT APPLY

- ○ Alcohol
- ○ Benzodiazepines
- ○ Cocaine
- ○ Methamphetamines
- ○ Opioids
- ○ Other(s) *(Specify: _____)*

*A2a. Does ***this facility routinely*** use medication during detoxification (medical withdrawal)?

- ○ Yes
- ○ No

A3. Is ***this facility*** a solo practice—that is, an office with only one independent practitioner or counselor?

- ○ Yes
- ○ No

*A4. Does ***this facility*** offer ***hospital inpatient*** substance use treatment services ***at this location***—that is, the location listed on the front cover?

- ○ Yes → SKIP TO **A4a**
- ○ No → SKIP TO **A5**

*A4a. Which of the following ***inpatient*** services are offered ***at this facility***?

	MARK "YES" OR "NO" FOR EACH YES	NO
Inpatient detoxification *(medical withdrawal) (medically managed or monitored inpatient detoxification)*	○	○
Inpatient treatment *(medically managed or monitored intensive inpatient treatment)*	○	○

*A5. Does ***this facility*** offer ***residential*** (non-hospital) substance use treatment services ***at this location***—that is, the location listed on the front cover?

- ○ Yes → SKIP TO **A5a**
- ○ No → SKIP TO **A6**

*A5a. Which of the following ***residential*** services are offered ***at this facility***?

	MARK "YES" OR "NO" FOR EACH YES	NO
Residential detoxification *(medical withdrawal) (clinically managed residential detoxification or social detoxification)*	○	○
Residential short-term treatment *(clinically managed high-intensity residential treatment, typically 30 days or less)*	○	○
Residential long-term treatment *(clinically managed medium- or low-intensity residential treatment)*	○	○

*A6. Does ***this facility*** offer ***outpatient*** substance use treatment services ***at this location***—that is, the location listed on the front cover?

- ○ Yes → SKIP TO **A6a**
- ○ No → SKIP TO **A7**

*A6a. Which of the following ***outpatient*** services are offered ***at this facility***?

	MARK "YES" OR "NO" FOR EACH YES	NO
Outpatient detoxification *(ambulatory detoxification)*	○	○
Outpatient methadone/buprenorphine maintenance or naltrexone treatment	○	○
Outpatient day treatment or partial hospitalization *(20 or more hours per week)*	○	○
Intensive outpatient treatment *(9 or more hours per week)*	○	○
Regular outpatient treatment *(outpatient treatment, non-intensive)*	○	○

*A7. Which of the following services are offered 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 use
- ○ Screening for mental disorders
- ○ Comprehensive substance use assessment or diagnosis
- ○ Comprehensive mental health assessment or diagnosis *(for example, psychological or psychiatric evaluation and testing)*
- ○ Complete medical history and physical exam performed by a healthcare practitioner
- ○ Screening for tobacco use
- ○ Outreach to persons in the community who may need treatment
- ○ Interim services for clients when immediate admission is not possible
- ○ Professional interventionist/educational consultant
- ○ None of the assessment and pre-treatment services above are offered at this facility

*A7. (Continued)
MARK ALL THAT APPLY

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

- ○ Drug and alcohol oral fluid testing
- ○ Breathalyzer or other blood alcohol testing
- ○ Drug or alcohol urine screening
- ○ Testing for Hepatitis B *(HBV)*
- ○ Testing for Hepatitis C *(HCV)*
- ○ HIV testing
- ○ STD testing
- ○ TB screening
- ○ Testing for metabolic syndrome *(weight, abdominal girth, BP, glucose, Hgb A1C, cholesterol, triglycerides)*
- ○ None of the testing services above are offered at this facility

MEDICAL SERVICES

- ○ Hepatitis A *(HAV)* vaccination
- ○ Hepatitis B *(HBV)* vaccination
- ○ None of the medical services above are offered at this facility

TRANSITIONAL SERVICES

- ○ Discharge planning
- ○ Aftercare/continuing care
- ○ Naloxone and overdose education
- ○ Outcome follow-up after discharge
- ○ None of the transitional services above are offered at this facility

RECOVERY SUPPORT SERVICES

- ○ Mentoring/peer support
- ○ Self-help groups *(for example, AA, NA, SMART Recovery)*
- ○ Assistance in locating housing for clients
- ○ Employment counseling or training for clients
- ○ Assistance with obtaining social services *(for example, Medicaid, WIC, SSI, SSDI)*
- ○ Recovery coach
- ○ None of the recovery support services above are offered at this facility

*A7. (Continued)
MARK ALL THAT APPLY

EDUCATION AND COUNSELING SERVICES

- ○ HIV or AIDS education, counseling, or support
- ○ Hepatitis education, counseling, or support
- ○ Health education other than HIV/AIDS or hepatitis
- ○ Substance use disorder education
- ○ Smoking/tobacco cessation counseling
- ○ Individual counseling
- ○ Group counseling
- ○ Family counseling
- ○ Marital/couples counseling
- ○ Vocational training or educational support *(for example, high school coursework, GED preparation, etc.)*
- ○ None of the education and counseling services above are offered at this facility

ANCILLARY SERVICES

- ○ Case management services
- ○ Integrated primary care services
- ○ Social skills development
- ○ Child care for clients' children
- ○ Domestic violence services, including family or partner violence services, for physical, sexual, or emotional abuse
- ○ Early intervention for HIV
- ○ Transportation assistance to treatment
- ○ Mental health services
- ○ Suicide prevention services
- ○ Acupuncture
- ○ Residential beds for clients' children
- ○ None of the ancillary services above are offered at this facility

*A7. (Continued)

MARK ALL THAT APPLY

OTHER SERVICES

- ○ Treatment for gambling disorder
- ○ Treatment for other addiction disorder *(non-substance use disorder)*
- ○ None of the other services above are offered at this facility

PHARMACOTHERAPIES

- ○ Disulfiram
- ○ Naltrexone *(oral)*
- ○ Naltrexone *(extended-release, injectable)*
- ○ Acamprosate
- ○ Nicotine replacement
- ○ Non-nicotine smoking/tobacco cessation medications *(for example, bupropion, varenicline)*
- ○ Medications for mental disorders
- ○ Methadone
- ○ Buprenorphine/naloxone
- ○ Buprenorphine without naloxone
- ○ Buprenorphine sub-dermal implant
- ○ Buprenorphine *(extended-release, injectable)*
- ○ Medications for HIV treatment *(for example, antiretroviral medications such as tenofovir, efavirenz, emtricitabine, atazanavir, and lamivudine)*
- ○ Medications for pre-exposure prophylaxis *(PrEp: for example, emtricitabine and tenofovir disoproxil fumarate combination, and emtricitabine and tenofovir alafenamide combination)*
- ○ Medications for Hepatitis C *(HCV)* treatment *(for example, sofosbuvir, ledipasvir, interferon, peginterferon, ribavirin)*
- ○ Lofexidine
- ○ Clonidine
- ○ Medications for other medical conditions *(Specify: _____)*
- ○ None of the pharmacotherapy services above are offered at this facility

*A8. Facilities may treat a range of substance use disorders. The next series of questions focuses ***only*** on how ***this facility*** treats ***opioid*** use disorder.

How does ***this facility*** treat ***opioid use disorder?***

- ***Medication-assisted treatment*** *(MAT) includes the use of methadone, buprenorphine products, and/or naltrexone for the treatment of opioid use disorder. For this question, MAT refers to* ***any or all*** *of these medications unless specified otherwise.*

MARK ALL THAT APPLY

- ○ This facility accepts clients using MAT, but the medications originate from or are prescribed by another entity. *(The medications may or may not be stored/delivered/monitored onsite.)* → SKIP TO **A8a**
- ○ This facility prescribes naltrexone to treat opioid use disorder. Naltrexone use is authorized through any medical staff with prescribing privileges.
- ○ This facility utilizes prescribers of buprenorphine to treat opioid use disorder. Buprenorphine use is authorized through a DATA 2000 waivered physician, physician assistant, or nurse practitioner.
- ○ This facility is a federally certified Opioid Treatment Program *(OTP). (Most OTPs administer/dispense methadone; some only use buprenorphine; some provide all FDA-approved medication treatments for opioid use disorder.)*

→ SKIP TO **A8b**

- ○ This facility treats opioid use disorder, but it does not use medication-assisted treatment *(MAT)*, nor does it accept clients using MAT to treat opioid use disorder.
- ○ This facility uses methadone or buprenorphine for pain management, emergency cases, or research purposes. It is NOT a federally certified Opioid Treatment Program *(OTP)*.
- ○ This facility does not treat opioid use disorder

→ SKIP TO **A9**

*A8a. For those clients using MAT ***for opioid use disorder***, but whose medications originate from or are prescribed by another entity, the clients obtain their prescriptions from:

MARK ALL THAT APPLY

- ○ A prescribing entity in our network
- ○ A prescribing entity with which our facility has a business, contractual, or formal referral relationship
- ○ A prescribing entity with which our facility has no formal relationship

*A8b. Does ***this facility*** serve ***only*** opioid use disorder clients?

- ○ Yes
- ○ No

*A8c. Which of the following medication services does this program provide for ***opioid use disorder***?

MARK ALL THAT APPLY

- ○ Maintenance services with methadone or buprenorphine
- ○ Maintenance services with medically supervised withdrawal *(or taper)* after a period of stabilization
- ○ Detoxification *(medical withdrawal)* from opioids of abuse with methadone or buprenorphine
- ○ Detoxification *(medical withdrawal)* from opioids of abuse with lofexidine or clonidine
- ○ Relapse prevention with naltrexone
- ○ Other *(for example, overdose risk reduction with naloxone; specify opioid use disorder service and pharmacotherapy used: _____)*
- ○ None of the medication services for opioid use disorder above are offered at this facility

*A9. Facilities may treat a range of substance use disorders. The next series of questions focuses ***only*** on how ***this facility*** treats ***alcohol*** use disorder.

How does ***this facility*** treat ***alcohol use disorder***?

- *These medications have been approved by the FDA to treat alcohol use disorder: naltrexone, acamprosate, and disulfiram. For this question, MAT refers to **any or all** of these three medications.*

MARK ALL THAT APPLY

- ○ This facility accepts clients using MAT for alcohol use disorder, but the medications originate from or are prescribed by another entity
- ○ This facility administers/prescribes disulfiram for alcohol use disorder → SKIP TO **A9a**
- ○ This facility administers/prescribes naltrexone for alcohol use disorder
- ○ This facility administers/prescribes acamprosate for alcohol use disorder
- ○ This facility treats alcohol use disorder, but it does not use medication-assisted treatment *(MAT)* for alcohol use disorder, nor does it accept clients using MAT to treat alcohol use disorder → SKIP TO **A9b**
- ○ This facility does not treat alcohol use disorder → SKIP TO **A10**

*A9a. For those clients using MAT ***for alcohol use disorder***, but whose medications originate from or are prescribed by another entity, the clients obtain their prescriptions from:

MARK ALL THAT APPLY

- ○ A prescribing entity in our network
- ○ A prescribing entity with which our facility has a business, contractual, or formal referral relationship
- ○ A prescribing entity with which our facility has no formal relationship

*A9b. Does ***this facility*** serve ***only*** alcohol use disorder clients?

- ○ Yes
- ○ No

*A10. Which of the following clinical/therapeutic approaches listed below are used frequently ***at this facility***?

MARK ALL THAT APPLY FOR EACH APPROACH

CLINICAL/THERAPEUTIC APPROACHES	OPIOID USE DISORDER	OTHER SUBSTANCES
Substance use disorder counseling	○	○
12-step facilitation	○	○
Brief intervention	○	○
Cognitive behavioral therapy	○	○
Contingency management/motivational incentives	○	○
Motivational interviewing	○	○
Trauma-related counseling	○	○
Anger management	○	○
Matrix model	○	○
Community reinforcement plus vouchers	○	○
Relapse prevention	○	○
Telemedicine/telehealth therapy *(including internet, web, mobile, and desktop programs)*	○	○
Other treatment approach *(Specify: _____)*	○	○
None of the clinical/therapeutic approaches above are offered at this facility	○	○

*A11. Does ***this facility***, ***at this location***, offer a ***specially designed*** program or group intended ***exclusively*** for DUI/DWI or other drunk driver offenders?

- ○ Yes → SKIP TO **A11a**
- ○ No → SKIP TO **A12**

*A11a. Does ***this facility*** serve ***only*** DUI/DWI clients?

- ○ Yes
- ○ No

A12. Does ***this facility*** provide treatment services for:

MARK ALL THAT APPLY

- ○ Marijuana
- ○ Stimulants
- ○ Other substance(s) *(Specify: _____)*

*A13. Does ***this facility*** provide substance use 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 a staff counselor or an on-call interpreter provides this service.*

- ○ Yes
- ○ No

*A14. Does ***this facility*** provide substance use treatment services in a language ***other than English at this location***?

- ○ Yes → SKIP TO **A14a**
- ○ No → SKIP TO **A15**

A14a. ***At this facility***, who provides substance use treatment services in a language ***other than English***?

MARK ONE ONLY

- ○ Staff counselor who speaks a language other than English → SKIP TO **A14a1**
- ○ On-call interpreter *(in person or by phone)* brought in when needed → SKIP TO **A15**
- ○ ***Both*** staff counselor and on-call interpreter → SKIP TO **A14a1**

*A14a1. Do ***staff counselors*** provide substance use treatment in Spanish ***at this facility***?

- ○ Yes → SKIP TO **A14a2**
- ○ No → SKIP TO **A14b**

A14a2. Do ***staff counselors at this facility*** provide substance use treatment in any other languages?

- ○ Yes → SKIP TO **A14b**
- ○ No → SKIP TO **A15**

*A14b. In what other languages do ***staff counselors*** provide substance use treatment ***at this facility***?

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

MARK ALL THAT APPLY

AMERICAN INDIAN OR ALASKA NATIVE

- ☐ Hopi
- ☐ Lakota
- ☐ Navajo
- ☐ Ojibwa
- ☐ Yupik
- ☐ Other American Indian or Alaska Native language *(Specify:* _____ *)*

*A14b. (Continued)

MARK ALL THAT APPLY

OTHER LANGUAGES

- ○ Arabic
- ○ Any Chinese language
- ○ Creole
- ○ Farsi
- ○ French
- ○ German
- ○ Greek
- ○ Hebrew
- ○ Hindi
- ○ Any other language *(Specify: _____)*
- ○ Hmong
- ○ Italian
- ○ Japanese
- ○ Korean
- ○ Polish
- ○ Portuguese
- ○ Russian
- ○ Tagalog
- ○ Vietnamese

*A15. Individuals seeking substance use treatment can vary by age, sex, or other characteristics. Which categories of individuals listed below are served by ***this facility***, ***at this location***?

- *Indicate only the highest or lowest age the facility would accept. Do not indicate the highest or lowest age **currently receiving services** in the facility.*

TYPE OF CLIENT	MARK "YES" OR "NO" FOR EACH CATEGORY SERVED BY THIS FACILITY		IF SERVED, WHAT IS THE LOWEST AGE SERVED		IF SERVED, WHAT IS THE HIGHEST AGE SERVED	
Female	○ Yes	○ No	___ YEARS	○ No minimum age	___ YEARS	○ No maximum age
Male	○ Yes	○ No	___ YEARS	○ No minimum age	___ YEARS	○ No maximum age

*A15a. Many facilities have clients in one or more of the following categories. For which client categories does ***this facility at this location*** currently offer a substance use treatment program or group ***specifically tailored*** for clients in that category?

- *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

- ○ Adolescents
- ○ Young adults
- ○ Adult women
- ○ Pregnant/postpartum women
- ○ Adult men
- ○ Seniors or older adults
- ○ Lesbian, gay, bisexual, transgender, or queer/questioning *(LGBTQ)* clients
- ○ Veterans
- ○ Active duty military
- ○ Members of military families
- ○ Criminal justice clients *(other than DUI/DWI)*
- ○ Clients with co-occurring mental and substance use disorders
- ○ Clients with co-occurring pain and substance use disorders
- ○ Clients with HIV or AIDS
- ○ Clients who have experienced sexual abuse
- ○ Clients who have experienced intimate partner violence, domestic violence
- ○ Clients who have experienced trauma
- ○ Specifically tailored programs or groups for any other types of clients

  (Specify: _____)
- ○ No specifically tailored programs or groups are offered

*A16. Does ***this facility*** receive any funding or grants from the Federal Government, or state, county, or local governments, to support its substance use treatment programs?

- *Do **not** include Medicare, Medicaid, or federal military insurance. These forms of client payments are included in the following question (A17).*

- ○ Yes
- ○ No
- ○ Don't know

*A17. Which of the following types of client payments or insurance are accepted by ***this facility*** for ***substance use treatment***?

MARK ALL THAT APPLY

- ○ No payment accepted *(free treatment for all clients)*
- ○ Cash or self-payment
- ○ Medicare
- ○ Medicaid
- ○ State-financed health insurance plan other than Medicaid
- ○ Federal military insurance *(such as TRICARE)*
- ○ Private health insurance
- ○ SAMHSA funding/block grants
- ○ IHS/Tribal/Urban *(ITU)* funds
- ○ Other *(Specify: _____)*

*A18. Is ***this facility*** a hospital or located in or operated by a hospital?

- ○ Yes → SKIP TO **A18a**
- ○ No → SKIP TO **A19**

*A18a. What type of hospital?

MARK ONE ONLY

- ○ General hospital *(including VA hospital)*
- ○ Psychiatric hospital
- ○ Other specialty hospital *(for example, alcoholism, maternity, etc.) (Specify: _____)*

A19. Does ***this facility*** operate as a skilled nursing facility *(SNF)* that provides services for substance use disorders?

- ○ Yes
- ○ No

*A20. Does ***this facility*** operate transitional housing, a halfway house, or a sober home for clients with substance use disorder ***at this location***—that is, the location listed on the front cover of the paper survey?

- ○ Yes
- ○ No

*A21. Is ***this facility*** or program licensed, certified, or accredited to provide substance use treatment services by any of the following organizations?

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

MARK ALL THAT APPLY

- ○ State substance use treatment agency
- ○ State mental health department
- ○ State department of health
- ○ Hospital licensing authority
- ○ The Joint Commission
- ○ Commission on Accreditation of Rehabilitation Facilities *(CARF)*
- ○ National Committee for Quality Assurance *(NCQA)*
- ○ Council on Accreditation *(COA)*
- ○ Healthcare Facilities Accreditation Program *(HFAP)*
- ○ SAMHSA certification for opioid treatment program *(OTP)*
- ○ Drug Enforcement Agency *(DEA)*
- ○ Other national organization or federal, state, or local agency *(Specify:_____)*
- ○ This facility is not licensed, certified, or accredited to provide substance use services by any of these organizations

MODULE B: MENTAL DISORDERS TREATMENT FACILITIES

B1. Does this treatment facility, ***at this location***, offer:

	MARK "YES" OR "NO" FOR EACH YES	NO
Mental health intake	○	○
Mental health diagnostic evaluation	○	○
Mental health information and/or referral *(also includes emergency programs that provide services in person or by telephone)*	○	○
Mental health treatment *(interventions such as therapy or psychotropic medication that treat a person's mental disorder or condition, reduce symptoms, and improve behavioral functioning and outcomes)*	○	○
Treatment for co-occurring disorders ***plus either*** serious mental illness *(SMI)* in adults ***and/or*** serious emotional disturbance *(SED)* in children	○	○
Substance use treatment	○	○
Administrative or operational services for mental health treatment facilities	○	○

*B2. ***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
24-hour hospital inpatient	○	○
24-hour residential	○	○
Partial hospitalization/day treatment	○	○
Outpatient	○	○

*B3. Which ***one*** category ***best*** describes ***this facility***, ***at this location***?

- *For definitions of facility types, go to: https://info.nsumhss.samhsa.gov*

MARK ONE ONLY

- ○ Psychiatric hospital
- ○ Separate inpatient psychiatric unit of a general hospital *(consider this psychiatric unit as the relevant "facility" for the purpose of this survey)*
- ○ State hospital
- ○ Residential treatment center for children
- ○ Residential treatment center for adults
- ○ Other type of residential treatment facility
- ○ Veterans Affairs Medical Center *(VAMC)* or other VA healthcare facility

→ SKIP TO **B5**

- ○ Community Mental Health Center *(CMHC)*
- ○ Certified Community Behavioral Health Clinic *(CCBHC)*
- ○ Partial hospitalization/day treatment facility
- ○ Outpatient mental health facility
- ○ Multi-setting mental health facility *(non-hospital residential **plus either** outpatient **and/or** partial hospitalization/day treatment)*
- ○ Other *(Specify:_____)*

→ SKIP TO **B4**

B4. Is ***this facility*** either a solo or a small group practice?

- ○ Yes → SKIP TO **B4a**
- ○ No → SKIP TO **B5**

*B4a. 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.*

- ○ Yes
- ○ No

B5. Does ***this facility***, ***at this location***, provide any of the following services?

MARK ALL THAT APPLY

- ○ Assisted living or nursing home care
- ○ Group homes
- ○ Clubhouse services
- ○ Emergency shelter *(such as homeless, domestic violence, etc.)*
- ○ Care for individuals with a developmental disability *(that is, significant limitations in intellectual functioning)*
- ○ None of these services are offered at this facility

*B6. Which of these ***treatment modalities for mental disorders*** are offered ***at this facility***, ***at this location***?

- *For definitions of treatment modalities, go to: https://info.nsumhss.samhsa.gov*

MARK ALL THAT APPLY

- ○ Individual psychotherapy
- ○ Couples/family therapy
- ○ Group therapy
- ○ Cognitive behavioral therapy
- ○ Dialectical behavior therapy
- ○ Cognitive remediation therapy
- ○ Integrated mental and substance use disorder treatment
- ○ Activity therapy *(for example, art therapy)*
- ○ Electroconvulsive therapy
- ○ Transcranial Magnetic Stimulation *(TMS)*
- ○ Ketamine Infusion Therapy *(KIT)*
- ○ Eye Movement Desensitization and Reprocessing *(EMDR)* therapy
- ○ Telemedicine/telehealth therapy *(including internet, web, mobile, and desktop programs)*
- ○ Abnormal Involuntary Movement Scale *(AIMS)* Test
- ○ Other(s) *(Specify:* _____ *)*
- ○ None of these mental health treatment modalities are offered at this facility

*B7. Does ***this facility*** offer the use of antipsychotics for the treatment of serious mental illness *(SMI)*?

- ○ Yes → SKIP TO **B7a**
- ○ No → SKIP TO **B8**

*B7a. Which of the following antipsychotics are used for the treatment of SMI ***at this facility***, ***at this location***?

MARK ALL THAT APPLY FOR EACH MEDICATION

FIRST-GENERATION ANTIPSYCHOTIC	NOT USED AT THIS FACILITY	ORAL	INJECTABLE	LONG-ACTING INJECTABLE	RECTAL	TOPICAL	INHALATION	DON'T KNOW
Chlorpromazine	○	○	○		○			○
Droperidol	○		○					○
Fluphenazine	○	○	○					○
Haloperidol	○	○	○					○
Loxapine	○	○	○				○	○
Perphenazine	○	○	○					○
Pimozide	○	○				○		○
Prochlorperazine	○	○	○		○			○
Thiothixene	○	○	○					○
Thioridazine	○	○						○
Trifluoperazine	○	○	○					○
Other first-generation antipsychotics								
(Specify:_____)	○	○	○	○	○	○	○	○
(Specify:_____)	○	○	○	○	○	○	○	○
(Specify:_____)	○	○	○	○	○	○	○	○

SECOND-GENERATION ANTIPSYCHOTIC	NOT USED AT THIS FACILITY	ORAL/ SUBLINGUAL	INJECTABLE	LONG-ACTING INJECTABLE	RECTAL	TOPICAL	TRANSDERMAL	DON'T KNOW
Aripiprazole	○	○	○	○				○
Asenapine	○	○					○	○
Brexpiprazole	○	○						○
Cariprazine	○	○						○
Clozapine	○	○						○
Iloperidone	○	○						○
Lurasidone	○	○						○
Olanzapine	○	○	○	○				○
Olanzapine/Fluoxetine combination	○	○						○
Paliperidone	○	○	○	○				○
Quetiapine	○	○						○
Risperidone	○	○	○	○				○
Ziprasidone	○	○	○					○
Other second-generation antipsychotics								
(Specify:_____)	○	○	○	○	○	○	○	○
(Specify:_____)	○	○	○	○	○	○	○	○
(Specify:_____)	○	○	○	○	○	○	○	○

*B8. Which of these services and practices are offered ***at this facility***, ***at this location***?

- *For definitions, go to: https://info.nsumhss.samhsa.gov*

MARK ALL THAT APPLY

- ○ Assertive community treatment *(ACT)*
- ○ Intensive case management *(ICM)*
- ○ Case management *(CM)*
- ○ Court-ordered treatment
- ○ Assisted Outpatient Treatment *(AOT)*
- ○ Chronic disease/illness management *(CDM)*
- ○ Illness management and recovery *(IMR)*
- ○ Integrated primary care services
- ○ Diet and exercise counseling
- ○ Family psychoeducation
- ○ Education services
- ○ Housing services
- ○ Supported housing
- ○ Psychosocial rehabilitation services
- ○ Vocational rehabilitation services
- ○ Supported employment
- ○ Therapeutic foster care
- ○ Legal advocacy
- ○ Psychiatric emergency walk-in services
- ○ Suicide prevention services
- ○ Peer support services
- ○ Testing for Hepatitis B *(HBV)*
- ○ Testing for Hepatitis C *(HCV)*
- ○ Laboratory tests *(for example, WBC for clozapine therapy, lithium levels, CBZ levels, valproate levels)*
- ○ Metabolic syndrome monitoring *(weight, abdominal girth, BP, glucose, Hgb A1C, cholesterol, triglycerides)*
- ○ HIV testing
- ○ STD testing

CONTINUED ON NEXT COLUMN

- ○ TB screening
- ○ Screening for tobacco use
- ○ Smoking/vaping/tobacco cessation counseling
- ○ Nicotine replacement therapy
- ○ Non-nicotine smoking/tobacco cessation medications *(by prescription)*
- ○ Other(s) *(Specify:_____)*
- ○ None of these services and practices are offered at this facility

B9. Which of the following services are provided to clients with co-occurring mental health and substance use ***at this facility***?

MARK ALL THAT APPLY

- ○ Detoxification *(medical withdrawal)*
- ○ Medication-assisted treatment for alcohol use disorder *(for example, disulfiram, acamprosate)*
- ○ Medication-assisted treatment for opioid use disorder *(for example, buprenorphine, methadone, naltrexone)*
- ○ Individual counseling
- ○ Group counseling
- ○ 12-step groups
- ○ Case management
- ○ Other *(Specify _____)*
- ○ None of these services are offered at this facility

*B10. What age groups are accepted for treatment ***at this facility***?

- *If any of the ages that you accept fall within a category below, mark "YES" to that category.*

MARK "YES" OR "NO" FOR EACH

	YES	NO
Young children (0-5)	○	○
Children (6-12)	○	○
Adolescents (13-17)	○	○
Young adults (18-25)	○	○
Adults (26-64)	○	○
Older adults (65 or older)	○	○

*B11. Does ***this facility*** currently 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

- ○ Children/adolescents with serious emotional disturbance *(SED)*
- ○ Young adults
- ○ Clients 18 and older with serious mental illness *(SMI)*
- ○ Older adults
- ○ Clients with Alzheimer's disease or dementia
- ○ Clients with co-occurring mental and substance use disorders
- ○ Clients with eating disorders
- ○ Clients experiencing first-episode psychosis
- ○ Clients who have experienced intimate partner violence, domestic violence
- ○ Clients with a diagnosis of post-traumatic stress disorder *(PTSD)*
- ○ Clients who have experienced trauma *(excluding persons with a PTSD diagnosis)*
- ○ Clients with traumatic brain injury *(TBI)*
- ○ Veterans
- ○ Active duty military
- ○ Members of military families
- ○ Lesbian, gay, bisexual, transgender, or queer/questioning *(LGBTQ)* clients
- ○ Forensic clients *(referred from the court/judicial system)*
- ○ Clients with HIV or AIDS
- ○ Other special program or group *(Specify: _____)*
- ○ No dedicated or exclusively designed programs or groups are offered at this facility

*B12. Does ***this facility*** offer a crisis intervention team that handles acute mental health issues ***at this facility*** and/or off-site?

- ○ Yes
- ○ No

*B13. Does ***this facility*** offer services for psychiatric emergencies onsite?

- ○ Yes
- ○ No

*B14. Does ***this facility*** offer mobile/off-site psychiatric crisis services?

- ○ Yes
- ○ No

*B15. 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 a staff counselor or an on-call interpreter provides this service.*

- ○ Yes
- ○ No

*B16. Does ***this facility*** provide mental health treatment services in a language ***other than English at this location***?

- ○ Yes → SKIP TO **B16a**
- ○ No → SKIP TO **B17**

B16a. ***At this facility***, who provides mental treatment services in a language ***other than English***?

MARK ONE ONLY

- ○ Staff counselor who speaks a language other than English → SKIP TO **B16a1**
- ○ On-call interpreter *(in person or by phone)* brought in when needed → SKIP TO **B17**
- ○ ***Both*** staff counselor and on-call interpreter → SKIP TO **B16a1**

*B16a1. Do ***staff counselors*** provide mental health treatment in Spanish ***at this facility***?

- ○ Yes
- ○ No

B16a2. Do ***staff counselors at this facility*** provide mental health treatment in any other languages?

- ○ Yes → SKIP TO **B16b**
- ○ No → SKIP TO **B17**

*B16b. In what other languages do ***staff counselors*** provide mental health treatment ***at this facility***?

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

MARK ALL THAT APPLY

AMERICAN INDIAN OR ALASKA NATIVE

- ○ Hopi
- ○ Lakota
- ○ Navajo
- ○ Ojibwa
- ○ Yupik
- ○ Other American Indian or Alaska Native language *(Specify: _____)*

MARK ALL THAT APPLY

OTHER LANGUAGES

- ○ Arabic
- ○ Any Chinese language
- ○ Creole
- ○ Farsi
- ○ French
- ○ German
- ○ Greek
- ○ Hebrew
- ○ Hindi
- ○ Hmong
- ○ Italian
- ○ Japanese
- ○ Korean
- ○ Polish
- ○ Portuguese
- ○ Russian
- ○ Tagalog
- ○ Vietnamese
- ○ Any other language *(Specify: _____)*

B17. Which of these quality improvement practices are part of ***this facility's standard operating procedures***?

MARK "YES" OR "NO" FOR EACH

	YES	NO
Continuing education requirements for professional staff	○	○
Regularly scheduled case review with a supervisor	○	○
Regularly scheduled case review by an appointed quality review committee	○	○
Client outcome follow-up after discharge	○	○
Continuous quality improvement processes	○	○
Periodic client satisfaction surveys	○	○
Clinical provider peer review *(CPPR)*	○	○
Root cause analysis *(RCA)*	○	○

B18. In the 12-month period beginning April 1, 2023, and ending March 29, 2024, have staff ***at this facility*** used:

MARK ALL THAT APPLY

	NOT USED AT THIS FACILITY	CHEMICAL	PHYSICAL
Seclusion	○	○	○
Restraint	○	○	○

B18a. Does ***this facility*** have any policies in place to minimize the use of seclusion or restraint?

- ○ Yes
- ○ No

*B19. Which of the following types of client payments, insurance, or funding are accepted by ***this facility*** for mental health treatment services?

MARK ALL THAT APPLY

- ○ Cash or self-payment
- ○ Private health insurance
- ○ Medicare
- ○ Medicaid
- ○ State-financed health insurance plan other than Medicaid
- ○ State mental health agency *(or equivalent)* funds
- ○ State welfare or child and family services agency funds
- ○ State corrections or juvenile justice agency funds
- ○ State education agency funds
- ○ Other state government funds
- ○ County or local government funds
- ○ Community Services Block Grants (CSBG)
- ○ Community Mental Health Services Block Grants (MHBG)
- ○ Other federal grants *(Specify: _____)*
- ○ Federal military insurance *(such as TRICARE)*
- ○ U.S. Department of Veterans Affairs funds
- ○ IHS/Tribal/Urban *(ITU)* funds
- ○ Private or community foundation
- ○ Other *(Specify: _____)*

B20. 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 ALL THAT APPLY

- ○ State mental health authority
- ○ State substance use treatment agency
- ○ State department of health
- ○ State or local Department of Family and Children's Services
- ○ Hospital licensing authority
- ○ The Joint Commission
- ○ Commission on Accreditation of Rehabilitation Facilities *(CARF)*
- ○ Council on Accreditation *(COA)*
- ○ Centers for Medicare and Medicaid Services *(CMS)*
- ○ Other national organization, or federal, state, or local agency *(Specify: _____)*
- ○ This facility does not have licensing, certification, or accreditation from any of these organizations

MODULE C: ALL TREATMENT FACILITIES

*C1. 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.nsumhss.samhsa.gov*

- ○ Yes
- ○ No
- ○ Don't know

*C2. Is ***this facility*** operated by:

MARK ONE ONLY

- ○ A private for-profit organization
- ○ A private non-profit organization
- ○ State government → SKIP TO **C3**
- ○ Local, county, or community government
- ○ Tribal government
- ○ Federal Government → SKIP TO **C2a**

*C2a. Which Federal Government agency?

MARK ONE ONLY

- ○ Department of Veterans Affairs
- ○ Department of Defense
- ○ Indian Health Service
- ○ Other *(Specify:_____)*

C3. Is ***this facility*** affiliated with a religious (or faith-based) organization?

- ○ Yes
- ○ No

*C4. Which of the following statements ***best*** describes ***this facility's smoking policy*** for ***clients***?

MARK ONE ONLY

- ○ ***Not permitted*** to smoke anywhere outside or within any building
- ○ Permitted in ***designated outdoor*** area(s)
- ○ Permitted ***anywhere outside***
- ○ Permitted in ***designated indoor*** area(s)
- ○ Permitted ***anywhere inside***
- ○ Permitted ***anywhere without restriction***

*C5. Which of the following statements ***best*** describes ***this facility's vaping policy*** for ***clients***?

MARK ONE ONLY

- ○ ***Not permitted*** to vape anywhere outside or within any building
- ○ Permitted in ***designated outdoor*** area(s)
- ○ Permitted ***anywhere outside***
- ○ Permitted in ***designated indoor*** area(s)
- ○ Permitted ***anywhere inside***
- ○ Permitted ***anywhere without restriction***

*C6. Does ***this facility*** use a sliding fee scale?

- *Sliding fee scales are based on income and other factors.*

- ○ Yes → SKIP TO **C6a**
- ○ No → SKIP TO **C7**

C6a. Do you want the availability of a sliding fee scale published on FindTreatment.gov, the *National Directory of Mental Health Treatment Facilities*, and the *National Directory of Drug and Alcohol Use Treatment Facilities*?

- FindTreatment.gov, the *National Directory of Mental Health Treatment Facilities,* and the *National Directory of Drug and Alcohol Use Treatment Facilities* will explain that potential clients should call the facility for information on eligibility.

- ○ Yes
- ○ No

*C7. Does ***this facility*** offer treatment at no charge or minimal payment (for example, $1) to clients who cannot afford to pay?

- ○ Yes → SKIP TO **C7a**
- ○ No → SKIP TO **C8**

C7a. Do you want the availability of treatment at no charge or minimal payment (for example, $1) for eligible clients published on FindTreatment.gov, the *National Directory of Mental Health Treatment Facilities*, and the *National Directory of Drug and Alcohol Use Treatment Facilities*?

- FindTreatment.gov, the *National Directory of Mental Health Treatment Facilities,* and the *National Directory of Drug and Alcohol Use Treatment Facilities* will explain that potential clients should call the facility for information on eligibility.

○ Yes

○ No

C8. If eligible, does ***this facility*** want to be listed on FindTreatment.gov, the *National Directory of Mental Health Treatment Facilities*, and the *National Directory of Drug and Alcohol Use Treatment Facilities* (https://www.samhsa.gov/data)? *(See inside front cover for eligibility information)*

○ Yes → SKIP TO **C8a**

○ No → SKIP TO **C9**

C8a. Does ***this facility*** want the street address and/or mailing address to be listed on FindTreatment.gov, the *National Directory of Mental Health Treatment Facilities*, and the *National Directory of Drug and Alcohol Use Treatment Facilities*?

MARK ALL THAT APPLY

○ Publish the ***street*** address

○ Publish the ***mailing*** address

○ Do ***not*** publish either address

C8b. To increase public awareness of behavioral health services, SAMHSA may be sharing facility information with large commercially available internet search engines (such as Google, Bing, Yahoo!, etc.), businesses (such as any .com, .org, .edu, etc.) or individuals asking for this information for any purpose. Do you want your facility information shared?

- *Information to be shared would be: facility name, location address, telephone number, website address, and all* ***asterisked*** *items in the questionnaire.*

○ Yes

○ No

C9. Is ***this facility*** part of an organization with multiple facilities or sites that provide substance use or mental disorder treatment?

○ Yes

○ No

C10. What is the name, address, and phone number of the facility that is the parent, or lead site (HQ), of the organization?

Name: _____

Address: _____ Phone Number: _____

MODULE D: CLIENT COUNTS SECTION

D1. The next set of questions asks about the number of clients in treatment. 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

- ○ Only this facility → SKIP TO **D4**
- ○ This facility plus others → SKIP TO **D2**
- ○ Another facility will report this facility's client counts → SKIP TO **EHR1** (no client counts to report)

D2. How many facilities will be included in your client counts?

THIS FACILITY	1
+ ADDITIONAL FACILITIES	
TOTAL FACILITIES†	

†For this section, please include all of these facilities in the client counts that you will report in the following questions.

D3. 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

- ○ By listing the names and location addresses of these additional facilities in the "Additional Facilities Included in Client Counts" section on this questionnaire, or attaching a sheet of paper to this questionnaire
- ○ Please call me for a list of the additional facilities included in these counts

If your facility does not provide substance use treatment services as indicated in Question 1a → SKIP TO **D10**

SUBSTANCE USE TREATMENT COUNTS

HOSPITAL INPATIENT CLIENT COUNTS

D4. On March 29, 2024, did any patients receive ***inpatient substance use disorder treatment*** services ***at this facility***?

- ○ Yes → SKIP TO **D4a**
- ○ No → SKIP TO **D5**

D4a. On March 29, 2024, how many patients received the following ***hospital inpatient*** substance use disorder treatment 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")

Inpatient detoxification *(medical withdrawal)* *(medically managed or monitored inpatient detoxification)*	
Inpatient treatment *(medically managed or monitored intensive inpatient treatment)*	
HOSPITAL INPATIENT TOTAL	

D4b. How many of the patients from the ***hospital inpatient total*** were ***under*** the age of 18?

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

Number under age 18 _____

D4c. How many of the patients from the ***hospital inpatient total*** received:

- *Include patients who received these drugs for detoxification (medical withdrawal), maintenance, or relapse prevention treatment for* ***opioid use disorder****.*

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

Methadone dispensed at this facility for opioid use disorder	
Buprenorphine products dispensed or prescribed at this facility for opioid use disorder	
Naltrexone administered at this facility for opioid use disorder	

D4d. How many of the patients from the ***hospital inpatient total*** received:

- *Include patients who received these medications for* ***alcohol use disorder****.*

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

Disulfiram dispensed or prescribed at this facility for alcohol use disorder	
Naltrexone dispensed or prescribed at this facility for alcohol use disorder	
Acamprosate dispensed or prescribed at this facility for alcohol use disorder	

D4e. On March 29, 2024, how many hospital inpatient ***beds*** were ***specifically designated*** for substance use disorder treatment?

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

Number of beds _____

RESIDENTIAL (NON-HOSPITAL) **CLIENT COUNTS**

D5. On March 29, 2024, did any clients receive ***residential*** (non-hospital) ***substance use disorder treatment*** services ***at this facility***?

- ○ Yes → SKIP TO **D5a**
- ○ No → SKIP TO **D6**

D5a. On March 29, 2024, how many clients received the following ***residential*** substance use disorder treatment services ***at this facility***?

- ***Count*** *a patient 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")

Residential detoxification *(medical withdrawal)* *(clinically managed residential detoxification or social detoxification)*	
Residential short-term treatment *(clinically managed high-intensity residential treatment, typically 30 days or less)*	
Residential long-term treatment *(clinically managed medium- or low-intensity residential treatment, typically more than 30 days)*	
RESIDENTIAL TOTAL	

D5b. How many of the clients from the ***residential total*** were ***under*** the age of 18?

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

Number under age 18 ____

D5c. How many of the clients from the ***residential total*** received:

- *Include clients who received these drugs for detoxification, maintenance, or relapse prevention for* ***opioid use disorder****.*

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

Methadone dispensed at this facility for opioid use disorder	
Buprenorphine products dispensed or prescribed at this facility for opioid use disorder	
Naltrexone administered at this facility for opioid use disorder	

D5d. How many of the clients from the ***residential total*** received:

- *Include clients who received these medications for* ***alcohol use disorder****.*

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

Disulfiram dispensed or prescribed at this facility for alcohol use disorder	
Naltrexone dispensed or prescribed at this facility for alcohol use disorder	
Acamprosate dispensed or prescribed at this facility for alcohol use disorder	

D5e. On March 29, 2024, how many residential ***beds*** were ***specifically designated*** for substance use disorder treatment?

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

Number of beds ____

OUTPATIENT CLIENT COUNTS

D6. During the month of March 2024, did any clients receive ***outpatient substance use disorder treatment*** services ***at this facility***?

- ○ Yes → SKIP TO **D6a**
- ○ No → SKIP TO **D7**

D6a. As of March 29, 2024, how many active clients were receiving each of the following ***outpatient*** substance use disorder treatment services ***at this facility***?

- *An active client is a client who received treatment in March **AND was still enrolled in treatment on March 29, 2024**.*
- ***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")

Outpatient detoxification *(medical withdrawal)* *(ambulatory detoxification)*	
Outpatient methadone/buprenorphine maintenance or naltrexone treatment *(count methadone/buprenorphine/naltrexone clients on this line only)*	
Outpatient day treatment or partial hospitalization *(20 or more hours per week)*	
Intensive outpatient treatment *(9 or more hours per week)*	
Regular outpatient treatment *(outpatient treatment, non-intensive)*	
OUTPATIENT TOTAL	

D6b. How many of the clients from the ***outpatient total*** were ***under*** the age of 18?

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

Number under age 18 ____

D6c. How many of the clients from the ***outpatient total*** received:

- *Include clients who received these drugs for detoxification (medical withdrawal), maintenance, or relapse prevention for **opioid use disorder**.*

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

Methadone dispensed at this facility for opioid use disorder	
Buprenorphine products dispensed or prescribed at this facility for opioid use disorder	
Naltrexone administered at this facility for opioid use disorder	

D6d. How many of the clients from the ***outpatient total*** received:

- *Include clients who received these medications for **alcohol use disorder**.*

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

Disulfiram dispensed or prescribed at this facility for alcohol use disorder	
Naltrexone dispensed or prescribed at this facility for alcohol use disorder	
Acamprosate dispensed or prescribed at this facility for alcohol use disorder	

ALL SUBSTANCE USE TREATMENT SETTINGS
Including Hospital Inpatient, Residential (non-hospital), **and/or Outpatient**

D7. This question asks you to categorize the substance use treatment clients ***at this facility*** into three groups: clients in treatment for (1) use of ***both*** alcohol and substances other than alcohol; (2) use ***only*** of alcohol; or (3) use ***only*** of substances other than alcohol.

Enter the percent of clients on March 29, 2024, who were in each of these three groups.

Use either numbers ***or*** percentage, whichever is more convenient.

- *If numbers are used—the total should equal the number reported in the combined total patients and clients that are recorded in D4a, D5a, and D6a.*
- *If percents are used—the total should equal 100%.*

Clients in treatment for use of:

	NUMBER	OR	PERCENT
Both alcohol ***and*** substances other than alcohol			%
Only alcohol			%
Only substances other than alcohol			%
TOTAL *(D4a + D5a + D6a)*			100%

D8. Approximately what percent of the substance use treatment clients enrolled ***at this facility on March 29, 2024, had a diagnosed co-occurring mental disorder and substance use disorder***?

(IF NONE, ENTER "0")

Percent of clients _____ %

D9. Using the most recent 12-month period for which you have data, approximately how many substance use disorder 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 readmission as an admission.*
- IF THIS IS A MENTAL HEALTH FACILITY*: Count all admissions in which clients received substance use disorder treatment, even if substance use disorder was their secondary diagnosis.*

Number of substance use disorder treatment admissions in a 12-month period _____

If your facility does not provide mental health treatment services as indicated in Question 1 → SKIP TO **EHR1**

MENTAL HEALTH COUNTS

HOSPITAL INPATIENT CLIENT COUNTS

D10. On ***March 29, 2024***, did any patients receive ***24-hour hospital inpatient*** treatment for mental disorders ***at this facility***, ***at this location***?

- ○ Yes → SKIP TO **D10a**
- ○ No → SKIP TO **D11**

D10a. On ***March 29, 2024***, how many patients received ***24-hour hospital inpatient*** treatment for mental disorders ***at this facility***?

- ***Do not*** *count family members, friends, or other non-treatment persons.*

Hospital inpatients total _____

D10b. On ***March 29, 2024***, how many hospital inpatient beds ***at this facility*** were ***specifically designated*** for providing treatment of mental disorders?

(IF NONE, ENTER "0")

Number of beds _____

D10c. For each category below, please provide a breakdown of the ***Hospital Inpatients*** on ***March 29, 2024***, reported in ***hospital inpatients total*** (D10a) above. Use either numbers ***OR*** percents, whichever is more convenient.

- *If numbers are used—each category total should equal the number reported in* ***hospital inpatients total*** *(D10a) above.*
- *If percents are used—each category total should equal 100%.*

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

RESIDENTIAL (NON-HOSPITAL) **CLIENT COUNTS**

D11. On ***March 29, 2024***, did any patients receive ***24-hour residential*** mental disorder treatment ***at this facility***, ***at this location***?

- ○ Yes → SKIP TO **D11a**
- ○ No → SKIP TO **D12**

D11a. On ***March 29, 2024***, how many patients received ***24-hour residential treatment*** of mental disorders ***at this facility***?

- ***Do not*** *count family members, friends, or other non-treatment persons.*

Residential clients total _____

D11b. On ***March 29, 2024***, how many residential beds ***at this facility*** were ***specifically designated*** for providing mental disorder treatment?

(IF NONE, ENTER "0")

Number of beds _____

D11c. For each category below, please provide a breakdown of the ***Residential Clients*** on ***March 29, 2024***, reported in ***residential clients total*** (D11a) above. Use either numbers OR percents, whichever is more convenient.

- *If numbers are used—each category total should equal the number reported in **residential clients total** (D11a) above.*
- *If percents are used—each category total should equal 100%.*

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

LESS THAN 24-HOUR TREATMENT CLIENT COUNTS

D12. During the ***month*** of March 2024, did any clients receive ***less than 24-hour treatment*** of mental disorders ***at this facility***, ***at this location***?

- ○ Yes → SKIP TO **D12a**
- ○ No → SKIP TO **D13**

D12a. During the ***month*** of March 2024, how many clients received ***less than 24-hour treatment*** of mental disorders ***at this facility***?

- ***Only include*** *those seen at this facility* ***at least once*** *during the month of March,* AND ***who were still enrolled in treatment on March 29, 2024****.*
- ***Do not*** *count family members, friends, or other non-treatment persons.*

Outpatient clients and partial hospitalization/day treatment clients total _____

D12b. For each category below, please provide a breakdown of the ***Clients in Less Than 24-Hour Care*** reported in ***outpatient clients and partial hospitalization/day treatment clients total*** (D12a) above. Use either numbers OR percents, whichever is more convenient.

- *If numbers are used—each category total should equal the number reported in* ***outpatient clients and partial hospitalization/day treatment clients total*** *(D12a) above.*
- *If percents are used—each category total should equal 100%.*

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

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

D13. On ***March 29, 2024***, approximately what percent of the clients/patients enrolled ***at this facility*** had ***diagnosed co-occurring*** mental and substance use disorders?

(IF NONE, ENTER "0")

Percent with co-occurring diagnosis _____ %

D14. In the 12-month period of April 1, 2023, through March 29, 2024, how many ***mental disorder 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 DISORDER IS A SECONDARY DIAGNOSIS: *Count all admissions where clients/patients received mental health treatment.*

(IF NONE, ENTER "0")

Number of mental disorder treatment admissions in 12-month period _____

D15. What percent of the admissions reported in the previous question were ***military veterans***? Please give your best estimate.

(IF NONE, ENTER "0")

Percent military veterans _____ %

ELECTRONIC HEALTH RECORDS (EHRs)

The next questions ask about electronic health records (EHRs). For the purpose of this survey, EHRs are an electronic version of a patient's medical history that is maintained by the provider over time and may include all of the key clinical data relevant to that person's care under a particular provider.

EHR1. Does your facility use an EHR system? *Do not include billing record systems.*

MARK ONE ONLY

- ○ Yes, we exclusively use an EHR system. No paper charts.
- ○ Yes, we use a combination of an EHR system and paper charts.
- ○ No, but we plan to implement an EHR system. → SKIP TO **EHR13**
- ○ No, and we have no plan to implement an EHR system. → SKIP TO **EHR14**

EHR1a. If your facility is part of a larger organization, please indicate whether EHRs are used across all or some facilities within your organization.

MARK ONE ONLY

- ○ All of the facilities within this organization use EHRs.
- ○ Some of the facilities within this organization use EHRs.
- ○ Don't know if other facilities within the organization use EHRs.
- ○ This is the only facility in this organization.

EHR2. Please indicate the name of this facility's EHR system vendor(s).

MARK ALL THAT APPLY

- ○ Accumedic
- ○ AMS
- ○ Cerner
- ○ CCP (Co-Centrix)
- ○ Core Solutions
- ○ Echo Group
- ○ E-Clinical Works (ECW)
- ○ EPIC
- ○ Foothold
- ○ HiNext
- ○ IMA
- ○ Methasoft (Netalytics)
- ○ Meditech
- ○ Methware
- ○ Netsmart (MyAvatar, MyEvolv)
- ○ NextGen
- ○ Precision Care
- ○ Qualifacts/Credible (CareLogic EHR)
- ○ Smart Management
- ○ SAMMS
- ○ Ten Eleven
- ○ Tower Systems
- ○ Valant
- ○ Welligent
- ○ Other *(Specify*:_____ *)*
- ○ Don't know

EHR3. Does this facility's EHR integrate or incorporate any type of clinical information (e.g., medications, lab test results) that is received ***electronically*** from providers outside your organization ***without the need for manual entry***?

- *This refers to the ability to add or incorporate the information into the EHR without special effort (this does not refer to automatically adding data without provider review). This could be done using software to convert scanned documents into indexed, discrete data that can be integrated/included in the EHR.*
- *Electronic does not refer to e-Fax or scanned documents.*
- *Please consider all organizations outside of your network.*

○ Yes ○ No

EHR4. Do external organization(s) provide this facility with "read only" access to EHR clinical information?

- *This means that appropriate staff have the ability to view patient health information in a third party's EHR in accordance with HIPAA and 42CFR but not modify the record.*

○ Yes ○ No ○ Don't know

EHR5. How often do staff at this facility ***electronically*** search or query for clients' health information (e.g., medications, outside encounters) from other providers or external sources ***outside*** this facility?

- *Electronic does not refer to e-Fax or scanned documents.*

MARK ONE ONLY

- ○ Almost every day
- ○ At least once a week
- ○ At least once a month
- ○ Less than once a month
- ○ Never
- ○ Staff don't have capability to search or query

EHR6. Please indicate if this facility participates in a state, regional, and/or local Health Information Exchange Organization (HIO).

- *A Health Information Exchange Organization (HIO) is an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.*

MARK ONE ONLY

- ○ HIO is available in my area and we are actively exchanging data in at least one HIO → SKIP TO **EHR7**
- ○ HIO is available in my area but we are not participating → SKIP TO **EHR6a**
- ○ HIO is not available in my area → SKIP TO **EHR7**
- ○ Not familiar with an HIO → SKIP TO **EHR7**
- ○ Don't know if this facility participates in an HIO → SKIP TO **EHR7**

EHR6a. Why does this facility not participate in the HIO?

EHR7. When treating a patient previously seen by another health provider/organization, how often does your facility have the patient health information (e.g., medication, labs) ***electronically*** available from that provider/organization?

MARK ONE ONLY

- ○ Always
- ○ Sometimes
- ○ Rarely
- ○ Never

EHR8. Does this facility use your EHR to:

MARK "YES", "NO", OR "NOT APPLICABLE" FOR EACH ITEM BELOW. IF YOU DON'T KNOW OR ARE UNSURE, PLEASE LEAVE BLANK.

	MARK ONE PER ROW		
	YES	NO	NOT APPLICABLE
Record patient history	○	○	○
Record patient demographic information	○	○	○
Record social determinants of health (employment, housing)	○	○	○
Record patients' medications	○	○	○
Record patients' allergies	○	○	○
Record diagnoses	○	○	○
Record problem lists	○	○	○
Record behavioral health screenings or tools	○	○	○
Record clinical or progress notes	○	○	○
Record treatment plans	○	○	○
Monitor client progress	○	○	○
Electronically send prescriptions to the pharmacy	○	○	○
Review warnings or alerts of medication allergies, drug-drug interactions or contraindications	○	○	○
Reconcile medications when admitting, discharging, and/or transitioning clients between care settings	○	○	○
Order lab tests	○	○	○
View lab results	○	○	○
Record referrals	○	○	○
Record discharge plans	○	○	○
Check state's prescription drug monitoring program (PDMP) prior to prescribing a controlled substance	○	○	○

EHR9. Does this facility have an Opioid Treatment Program (OTP)?

○ Yes → SKIP TO **EHR9a**

○ No → SKIP TO **EHR10**

○ Not Applicable → SKIP TO **EHR10**

EHR9a. Does this facility track dispensed medications in its EHR?

○ Yes

○ No

EHR10. Does this facility's EHR allow clients to…

MARK "YES", "NO", OR "NOT APPLICABLE" FOR EACH ITEM BELOW

	YES	NO	NOT APPLICABLE
Exchange secure messages with their clinicians, counselors or other medical staff?	○	○	○
View their medical record (e.g., health and behavioral health information) online?	○	○	○
Download their medical record?	○	○	○

EHR11. Are there any other functionalities that are missing from your EHR system that would be useful to serving your clients?

○ Yes *(Specify*: _____ *)* ○ No

EHR12. Overall, how satisfied or dissatisfied are you with your EHR system?

MARK ONE ONLY

○ Very satisfied
○ Somewhat satisfied
○ Neither satisfied nor dissatisfied
○ Somewhat dissatisfied
○ Very dissatisfied

SKIP TO **EHR15**

EHR13. When does this facility plan to implement an EHR system?

MARK ONE ONLY

○ Within the next 6 months
○ 6 months to 1 year
○ 1 to 2 years
○ More than 2 years

SKIP TO **EHR15**

EHR14. Why does this facility not plan to implement an EHR system?

EHR15. Who was primarily responsible for completing this set of EHR questions?

This information will only be used if we need to contact you about your responses. It will not be published.

MARK ONE ONLY

☐ Ms ☐ Mrs ☐ Mr ☐ Dr ☐ Other *(specify)* _____

Name _____ Title _____

Phone _____ Ext. _____ Fax _____

Email _____ Facility Email _____

MODULE E: RESPONDENT INFORMATION SECTION

RESPONDENT INFORMATION

E1. Who was primarily responsible for completing this form, overall?

- *This information will only be used if we need to contact you about your responses. It will not be published.*

MARK ONE ONLY

◯ Ms. ◯ Mr. ◯ Mrs. ◯ Dr. ◯ Other *(Specify: _____)*

Name: _____

Title: _____

Phone: _____ Ext. _____ Fax: _____

Email: _____

Facility Email: _____

ADDITIONAL FACILITIES INCLUDED IN CLIENT/PATIENT COUNTS

Facility Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Facility Email: _____

◯ Hospital inpatient ◯ Residential ◯ Outpatient ◯ Partial hospitalization/day treatment

Facility Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Facility Email: _____

◯ Hospital inpatient ◯ Residential ◯ Outpatient ◯ Partial hospitalization/day treatment

Facility Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Facility Email: _____

◯ Hospital inpatient ◯ Residential ◯ Outpatient ◯ Partial hospitalization/day treatment

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: ICF, ATTN: N-SUMHSS, 908 Beaver Creek Drive, Martinsville, VA 24112

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 treatment facilities, information provided in response to survey questions marked with an asterisk may be published on FindTreatment.gov, the National Directory of Drug and Alcohol Use Treatment Facilities, 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.

Public Burden Statement: 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 control number for this project is 0930-0386. Public reporting burden for this collection of information is estimated to average 55 minutes per facility, per year, 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, 5600 Fishers Lane, Room 15E57-A, Rockville, Maryland 20857.

OMB No. 0930-0386 EXPIRES: 03/31/2027

SUPPLEMENT FOR SUBSTANCE USE VETERANS AFFAIRS FACILITIES MARCH 29, 2024

PLEASE ANSWER THE FOLLOWING QUESTIONS FOR YOUR VETERANS AFFAIRS FACILITY.

VA1_SU. Which of the following ***suicide-related services*** are offered ***at this facility***?

MARK ALL THAT APPLY

- ○ Evidence-based suicide prevention interventions *(interventions such as psychotherapies, medications, and/or public health strategies specifically aimed at decreasing rates of suicide)* → SKIP TO **VA2_SU**
- ○ Suicide risk screening → SKIP TO **VA3_SU**
- ○ Suicide risk evaluation → SKIP TO **VA4_SU**
- ○ We do not offer any of these suicide-related services → SKIP TO **VA5_SU**

VA2_SU. Which of the following evidence-based suicide prevention interventions are used ***at this facility***?

- *Evidence-based suicide prevention interventions may include psychotherapies, medications, and/or public health strategies specifically aimed at decreasing rates of suicide.*

MARK ALL THAT APPLY

- ○ Cognitive Behavioral Therapy for Suicide Prevention *(CBT-SP)*
- ○ Cognitive Behavioral Therapy *(CBT)*
- ○ Dialectical Behavior Therapy *(DBT)*
- ○ Problem Solving Therapy *(PST)*
- ○ Safety Planning/Crisis Response Planning
- ○ Ketamine Infusions
- ○ Lithium Treatment
- ○ Clozapine Treatment
- ○ Caring Communications
- ○ Home Support
- ○ World Health Organization-Brief Intervention and Contact *(WHO-BIC)*
- ○ Gate Keeper Training
- ○ Lethal Means Safety Counseling
- ○ Other *(Specify:* _____ *)*

VA3_SU. Which of the following ***standardized suicide screening tools*** are used or made available ***at this facility***?

MARK ALL THAT APPLY

- ◯ Columbia-Suicide Severity Rating Scale *(C-SSRS)* Screener
- ◯ Patient Health Questionnaire *(PHQ-9)* Item 9
- ◯ Other *(Specify: _____)*
- ◯ We do not use standardized suicide screening tools

VA4_SU. Which of the following ***standardized suicide evaluation tools*** are used or made available ***at this facility***?

MARK ALL THAT APPLY

- ◯ Columbia-Suicide Severity Rating Scale *(C-SSRS)*
- ◯ The Mini International Neuropsychiatric Interview *(MINI)*
- ◯ VA Comprehensive Suicide Risk Evaluation *(CSRE)*
- ◯ Suicide Assessment Five-step Evaluation and Triage *(SAFE-T)*
- ◯ Other *(Specify: _____)*
- ◯ We do not use standardized suicide evaluation tools

VA5_SU. How many of the substance use inpatients that you reported in the ***hospital inpatient total box*** were identified as being at high risk of suicide?

- *The **hospital inpatient total box** can be found at question D4a on page 28 of the survey.*

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

Number at high risk of suicide ____

VA6_SU. How many of the substance use residential clients that you reported in the ***residential total box*** were identified as being at high risk of suicide?

- *The **residential total box** can be found at question D5a on page 29 of the survey.*

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

Number at high risk of suicide ____

VA7_SU. How many of the substance use outpatient clients that you reported in the ***outpatient total box*** were identified as being at high risk of suicide?

- *The **outpatient total box** can be found at question D6a on page 30 of the survey.*

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

Number at high risk of suicide ____

OMB No. 0930-0386 EXPIRES: 03/31/2027

SUPPLEMENT FOR MENTAL HEALTH VETERANS AFFAIRS FACILITIES MARCH 29, 2024

PLEASE ANSWER THE FOLLOWING QUESTIONS FOR YOUR VETERANS AFFAIRS FACILITY.

VA1_MH. Does ***this facility*** have a standardized process or workflow for referring clients to appropriate care settings depending on their individual mental health treatment plan?

- ◯ Yes
- ◯ No

VA2_MH. Is the facility engaging in the follow-up of clients of mental health care with suicidal thoughts and suicidal behavior, beginning in the immediate period following their inpatient facility visits?

- ◯ Yes
- ◯ No

VA3_MH. Which of the following suicide prevention services are offered ***at this facility***?

MARK ALL THAT APPLY

- ☐ Lethal Means Safety training
- ☐ Free Gun Locks
- ☐ Suicide prevention-related community outreach or workshops
- ☐ We do not offer any of these suicide prevention services

VA4_MH. When are staff who have contact with clients trained on suicide prevention strategies? Please include staff such as clerks, schedulers, and those who are in telephone contact with veterans.

MARK ALL THAT APPLY

- ☐ When they begin working
- ☐ At trainings held at regular intervals
- ☐ None of these staff are trained on suicide prevention strategies

VA5_MH. Which of the following suicide risk screening programs has ***this facility*** implemented?

MARK ALL THAT APPLY

- ☐ Indicated *(those known to be at risk)*
- ☐ Selected *(those at increased risk)*
- ☐ Universal *(total client population)*
- ☐ We have not implemented a suicide risk screening program

VA6_MH. For clients receiving inpatient mental health treatment, does ***this facility*** identify warning signs for suicide and violence that clinicians should assess?

- ◯ Yes
- ◯ No

VA7_MH. Does ***this facility*** assess each client's level of risk for suicide to determine appropriate action?

- ○ Yes
- ○ No

VA8_MH. Does ***this facility*** maintain a list of clients who are high risk for suicide?

- ○ Yes → SKIP TO **VA8a_MH**
- ○ No → SKIP TO **VA9_MH**

VA8a_MH. Does ***this facility*** have a process for ensuring that high risk for suicide clients are followed up with when mental health or substance abuse appointments are missed?

- ○ Yes
- ○ No

VA9_MH. Please indicate how many full-time Suicide Prevention Coordinators *(SPCs)*, care managers for high suicide risk clients, and program support assistants for high risk clients are currently employed at your facility.

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

Number of SPCs	____
Number of care managers	____
Number of program support assistants	____

VA10_MH. How many of the mental health treatment inpatients that you reported in the ***March 29, 2024, hospital inpatients total box*** were identified as being at high risk of suicide?

- *The **hospital inpatients total box** can be found at question D10a on page 32 of the survey.*

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

Number at high risk of suicide _____

VA11_MH. How many of the mental health treatment residential clients that you reported in the ***March 29, 2024, residential clients total box*** were identified as being at high risk of suicide?

- *The **residential clients total box** can be found at question D11a on page 33 of the survey.*

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

Number at high risk of suicide _____

VA12_MH. How many of the mental health treatment outpatient clients that you reported in the ***March 29, 2024, outpatient clients and partial hospitalization/day treatment clients total box*** were identified as being at high risk of suicide?

- *The **outpatient clients and partial hospitalization/day treatment clients total box** can be found at question D12a on page 35 of the survey.*

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

Number at high risk of suicide _____