2020 National Mental Health Services Survey (N-MHSS)

April 30, 2020

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

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

CHECK ONE

☐ Information is complete and correct, no changes needed
☐ All missing or incorrect information has been corrected
Would you prefer to complete this questionnaire online? See the green flyer enclosed in your questionnaire packet for the Internet address and your unique User ID and Password. You can log on and off the survey website as often as needed to complete the questionnaire. When you log on again, the program will take you to the next unanswered question. If you need additional help or information, call the N-MHSS helpline at 1-866-778-9752.

**INSTRUCTIONS**

- Most of the questions in this survey ask about “this facility.” By “this facility” we mean the specific treatment facility or program whose name and location are printed on the front cover. If you have any questions about how the term “this facility” applies to your facility, please call 1-866-778-9752.

- Please answer ONLY for the specific facility or program whose name and location are printed on the front cover, unless otherwise specified in the questionnaire.

- If this is a separate inpatient psychiatric unit of a general hospital, consider the psychiatric unit as the relevant “facility” for the purpose of this survey.

- For additional information about the survey and definitions for some of the terms, please visit our website at: [https://info.nmhss.org](https://info.nmhss.org).

- Return the completed questionnaire in the envelope provided, or fax it to 1-609-799-0005. (Please reference “N-MHSS” on your fax.) **Please keep a copy of your completed questionnaire for your records.**

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

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

**IMPORTANT INFORMATION**

*Asterisked questions.* Information from asterisked (*) questions is published in SAMHSA’s online Behavioral Health Treatment Services Locator, found at [https://findtreatment.samhsa.gov](https://findtreatment.samhsa.gov), in SAMHSA’s *National Directory of Mental Health Treatment Facilities*, and other publicly-available listings, unless you designate otherwise in question A32, page 10, of this questionnaire.

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

**Eligibility for online Locator.** Only facilities that provide mental health treatment and complete this questionnaire are eligible to be listed as mental health facilities in the online Behavioral Health Treatment Services Locator. If you have any questions regarding eligibility, please contact the N-MHSS helpline at 1-866-778-9752.
A1. Does this treatment facility, at this location, offer:

MARK “YES” OR “NO” FOR EACH

YES NO
1. Mental health intake........................................... 1 0
2. Mental health diagnostic evaluation........ 1 0
3. Mental health information and/or referral (also includes emergency programs that provide services in person or by telephone) 1 0
4. Mental health treatment (interventions such as therapy or psychotropic medication that treat a person’s mental health problem or condition, reduce symptoms, and improve behavioral functioning and outcomes) 1 0
5. Treatment for co-occurring disorders plus either serious mental illness (SMI) in adults and/or serious emotional disturbance (SED) in children 1 0
6. Substance use disorder treatment........ 1 0
7. Administrative or operational services for mental health treatment facilities 1 0

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

1  Yes → SKIP TO A3 (TOP OF NEXT COLUMN)
0  No → SKIP TO C1 (PAGE 15)

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

MARK “YES” OR “NO” FOR EACH

YES NO
1. 24-hour hospital inpatient ...................................... 1 0
2. 24-hour residential........................................... 1 0
3. Partial hospitalization/day treatment........ 1 0
4. Outpatient.......................................................... 1 0

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

For definitions of facility types, go to: https://info.nmhss.org

MARK ONE ONLY

1  Psychiatric hospital
2  Separate inpatient psychiatric unit of a general hospital (consider this psychiatric unit as the relevant “facility” for the purpose of this survey)
3  Residential treatment center for children
4  Residential treatment center for adults
5  Other type of residential treatment facility
6  Veterans Affairs Medical Center (VAMC) or other VA health care facility
7  Community Mental Health Center (CMHC)
8  Certified Community Behavioral Health Clinic (CCBHC)
9  Partial hospitalization/day treatment facility
10  Outpatient mental health facility
11  Multi-setting mental health facility (non-hospital residential plus either outpatient and/or partial hospitalization/day treatment)
12  Other (Specify: ________________________________)

SKIP TO A7 (NEXT PAGE)

SKIP TO A5 (TOP OF NEXT PAGE)
A5. Is this facility either a solo or a small group practice?

- Yes □
- No □ → SKIP TO A6 (BELOW)

*A5a. Is this facility licensed or accredited as a mental health clinic or mental health center?

- Yes □
- No □ → SKIP TO C1 (PAGE 15)

*A6. Is this facility a Federally Qualified Health Center (FQHC)?

- Yes □
- No □ → SKIP TO C1 (PAGE 15)

A8. What is the primary treatment focus of this facility, at this location?

- Mental health treatment □
- Substance use treatment □ → SKIP TO C1 (PAGE 15)
- Mix of mental health and substance use treatment (neither is primary) □
- General health care □
- Other service focus (Specify: __________________________) □

A9. Is this facility a jail, prison, or detention center that provides treatment exclusively for incarcerated persons or juvenile detainees?

- Yes □ → SKIP TO C1 (PAGE 15)
- No □ → SKIP TO A10 (TOP OF NEXT PAGE)

A7. Does this facility, at this location, provide any of the following services?

- Assisted living or nursing home care □
- Group homes □
- Clubhouse services □
- Emergency shelter (such as homeless, domestic violence, etc.) □
- Care for only individuals with a developmental disability (that is, significant limitations in intellectual functioning) □
- None of these services □
**A10.** Is this facility operated by:

MARK ONE ONLY

1. □ A private for-profit organization  
2. □ A private non-profit organization  
3. □ A public agency or department

**A10a.** Which public agency or department?

MARK ONE ONLY

1. □ State Mental Health Authority (SMHA)  
2. □ Other state government agency or department *(e.g., Department of Health)*  
3. □ Regional/district authority or county, local, or municipal government  
4. □ Tribal government  
5. □ Indian Health Service  
6. □ Department of Veterans Affairs  
7. □ Other *(Specify:)*  

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**A11.** Is this facility affiliated with a religious (or faith-based) organization?

1. □ Yes  
0. □ No

**A12.** Which of these mental health treatment modalities are offered at this facility, at this location?

- For definitions of treatment modalities, go to: [https://info.nmhss.org](https://info.nmhss.org)

MARK ALL THAT APPLY

1. □ Individual psychotherapy  
2. □ Couples/family therapy  
3. □ Group therapy  
4. □ Cognitive behavioral therapy  
5. □ Dialectical behavior therapy  
6. □ Cognitive remediation therapy  
7. □ Behavior modification  
8. □ Integrated mental health and substance use treatment  
9. □ Trauma therapy  
10. □ Activity therapy  
11. □ Electroconvulsive therapy  
12. □ Transcranial Magnetic Stimulation (TMS)  
13. □ Ketamine Infusion Therapy (KIT)  
14. □ Eye Movement Desensitization and Reprocessing (EMDR) therapy  
15. □ Telemedicine/telehealth therapy *(including Internet, Web, mobile, and desktop programs)*  
16. □ Other *(Specify:)*  

17. □ None of these mental health treatment modalities are offered
A13. Does this facility offer pharmacotherapy, that is, the use of antipsychotics for the treatment of serious mental illness (SMI)?

Yes ☐ No ☐ SKIT TO A14 (TOP OF NEXT PAGE)

*A13a. Which of the following antipsychotics are used for the treatment of SMI at this facility, at this location?

<table>
<thead>
<tr>
<th>FIRST-GENERATION ANTIPSYCHOTIC</th>
<th>NOT USED AT THIS FACILITY</th>
<th>ORAL</th>
<th>INJECTABLE</th>
<th>LONG-ACTING INJECTABLE</th>
<th>RECTAL</th>
<th>TOPICAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Chlorpromazine (Thorazine®)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>2. Droperidol (Inapsine®)</td>
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<td>3. Fluphenazine (Prolixin®)</td>
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<td>4. Haloperidol (Haldol®)</td>
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<td>☐</td>
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<td>5. Loxapine (Loxitane®)</td>
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<tr>
<td>6. Perphenazine (Trilafon/Etrafon/Triavil/Triptafen®)</td>
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<td>7. Pimozide (Orap®)</td>
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<td>8. Prochlorperazine (Compazine/Compro®)</td>
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<td>9. Thiothixene (Navane®)</td>
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<tr>
<td>10. Thioridazine (Mellaril/Melleril®)</td>
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<tr>
<td>11. Trifluoperazine (Stelazine®)</td>
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<tr>
<td>12. Other first-generation antipsychotics (Specify: ___________________________________________)</td>
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</table>

<table>
<thead>
<tr>
<th>SECOND-GENERATION ANTIPSYCHOTIC</th>
<th>NOT USED AT THIS FACILITY</th>
<th>ORAL</th>
<th>INJECTABLE</th>
<th>LONG-ACTING INJECTABLE</th>
<th>RECTAL</th>
<th>TOPICAL</th>
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</thead>
<tbody>
<tr>
<td>13. Aripiprazole (Abilify®)</td>
<td>☐</td>
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<td>14. Asenapine (Saphris/Sycrest®)</td>
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<td>15. Brexpiprazole (Rexulti®)</td>
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<td>16. Cariprazine (Vraylar®)</td>
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<td>17. Clozapine (Clozaril®)</td>
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<td>18. Iloperidone (Fanapt®)</td>
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<td>19. Lurasidone (Latuda®)</td>
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<td>20. Olanzapine (Zyprexa®)</td>
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<tr>
<td>21. Olanzapine/Fluoxetine combination (Symbyax®)</td>
<td>☐</td>
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<tr>
<td>22. Paliperidone (Invega Trinza®)</td>
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<tr>
<td>23. Quetiapine (Seroquel®)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>24. Risperidone (Risperdal®)</td>
<td>☐</td>
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<tr>
<td>25. Ziprasidone (Geodon®)</td>
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<tr>
<td>26. Other second-generation antipsychotics (Specify: ___________________________________________)</td>
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</tbody>
</table>
*A14. Which of these services and practices are offered at this facility, at this location?

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

MARK ALL THAT APPLY

1. Assertive community treatment (ACT)
2. Intensive case management (ICM)
3. Case management (CM)
4. Court-ordered treatment
5. Assisted Outpatient Treatment (AOT)
6. Chronic disease/illness management (CDM)
7. Illness management and recovery (IMR)
8. Integrated primary care services
9. Diet and exercise counseling
10. Family psychoeducation
11. Education services
12. Housing services
13. Supported housing
14. Psychosocial rehabilitation services
15. Vocational rehabilitation services
16. Supported employment
17. Therapeutic foster care
18. Legal advocacy
19. Psychiatric emergency walk-in services
20. Suicide prevention services
21. Peer support services
22. Testing for Hepatitis B (HBV)
23. Testing for Hepatitis C (HCV)
24. HIV testing
25. STD testing
26. TB screening
27. Screening for tobacco use
28. Smoking/vaping/tobacco cessation counseling
29. Nicotine replacement therapy
30. Non-nicotine smoking/tobacco cessation medications (by prescription)
31. Other (Specify: ________________________________)
32. None of these services and practices are offered

A15. Did you answer “yes” to treatment for co-occurring disorders plus either serious mental illness (SMI) in adults and/or serious emotional disturbance (SED) in children in question A1 above (option 5)?

1. Yes
2. No → SKIP TO A17 (TOP OF NEXT PAGE)

A16. Which of the following services are provided to clients with co-occurring mental health and substance use disorders at this facility?

MARK ALL THAT APPLY

1. Detoxification (medical withdrawal)
2. Medication assisted treatment for alcohol use disorder (for example, disulfiram, acamprosate)
3. Medication assisted treatment for opioid use disorder (for example, buprenorphine, methadone, naltrexone)
4. Individual counseling
5. Group counseling
6. 12-Step groups
7. Case management
8. None of these services are offered
*A17. 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

<table>
<thead>
<tr>
<th>Category</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young children (0-5)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Children (6-12)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Adolescents (13-17)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Young adults (18-25)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Adults (26-64)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Older adults (65 or older)</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

*A18. Does this facility offer a mental health treatment program or group that is dedicated or designed exclusively for clients in any of the following categories?

- If this facility treats clients in any of these categories, but does not have a specifically tailored program or group for them, DO NOT mark the box for that category.

MARK ALL THAT APPLY

1. ☐ Children/adolescents with serious emotional disturbance (SED)
2. ☐ Young adults
3. ☐ Persons 18 and older with serious mental illness (SMI)
4. ☐ Older adults
5. ☐ Persons with Alzheimer’s or dementia
6. ☐ Persons with co-occurring mental and substance use disorders
7. ☐ Persons with eating disorders
8. ☐ Persons experiencing first-episode psychosis
9. ☐ Persons who have experienced intimate partner violence, domestic violence
10. ☐ Persons with a diagnosis of post-traumatic stress disorder (PTSD)
11. ☐ Persons who have experienced trauma (excluding persons with a PTSD diagnosis)
12. ☐ Persons with traumatic brain injury (TBI)
13. ☐ Veterans
14. ☐ Active duty military
15. ☐ Members of military families
16. ☐ Lesbian, gay, bisexual, transgender, or queer/questioning (LGBTQ) clients
17. ☐ Forensic clients (referred from the court/judicial system)
18. ☐ Persons with HIV or AIDS
19. ☐ Other special program or group (Specify: ________________________________________________)
20. ☐ No dedicated or exclusively designed programs or groups are offered
Does this facility offer a crisis intervention team that handles acute mental health issues at this facility and/or off-site?

- Yes
- No

Does this facility offer services for psychiatric emergencies onsite?

- Yes
- No

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

- Yes
- No

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)?

- Yes
- No

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

- Yes
- No, only English

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

- Staff who speak a language other than English
- On-call interpreter (in person or by phone) brought in when needed
- BOTH staff and on-call interpreter

Does staff provide mental health treatment services in Spanish at this facility?

- Yes
- No

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

- Yes
- No, only English

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

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

MARK ALL THAT APPLY

American Indian or Alaska Native:

- Hopi
- Lakota
- Navajo
- Other American Indian or Alaska Native language (Specify: ________________________)

Other Languages:

- Arabic
- Any Chinese language
- Creole
- Farsi
- French
- German
- Greek
- Hebrew
- Hindi
- Any other language (Specify: ________________________)

Which of these quality improvement practices are part of this facility’s standard operating procedures?

MARK “YES” OR “NO” FOR EACH

1. Continuing education requirements for professional staff
2. Regularly scheduled case review with a supervisor
3. Regularly scheduled case review by an appointed quality review committee
4. Client outcome follow-up after discharge
5. Continuous quality improvement processes
6. Periodic client satisfaction surveys
7. Clinical provider peer review (CPPR)
8. Root cause analysis (RCA)
**A25.** Which of the following statements BEST describes this facility’s smoking policy for clients?

MARK ONE ONLY

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

**A26.** In the 12-month period beginning May 1, 2019, and ending April 30, 2020, have staff at this facility used seclusion or restraint with clients?

1. Yes
0. No

**A26a.** Does this facility have any policies in place to minimize the use of seclusion or restraint?

1. Yes
0. No

**A27.** Please indicate what method staff members routinely use to accomplish the following work activities.

<table>
<thead>
<tr>
<th>WORK ACTIVITY</th>
<th>MARK ALL THAT APPLY FOR EACH ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ELECTRONIC HEALTH RECORDS (EHR)</td>
</tr>
<tr>
<td>1. Intake</td>
<td>1 ☐</td>
</tr>
<tr>
<td>2. Scheduling appointments</td>
<td>1 ☐</td>
</tr>
<tr>
<td>3. Assessment/evaluation</td>
<td>1 ☐</td>
</tr>
<tr>
<td>4. Treatment plan</td>
<td>1 ☐</td>
</tr>
<tr>
<td>5. Client progress monitoring</td>
<td>1 ☐</td>
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<tr>
<td>6. Discharge</td>
<td>1 ☐</td>
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<tr>
<td>7. Referrals</td>
<td>1 ☐</td>
</tr>
<tr>
<td>8. Issue/receive lab results</td>
<td>1 ☐</td>
</tr>
<tr>
<td>9. Medication prescribing/dispensing</td>
<td>1 ☐</td>
</tr>
<tr>
<td>10. Checking medication interactions</td>
<td>1 ☐</td>
</tr>
<tr>
<td>11. Store and maintain client health and/or treatment records</td>
<td>1 ☐</td>
</tr>
<tr>
<td>12. Send client health and/or treatment information to providers or sources outside your organization</td>
<td>1 ☐</td>
</tr>
<tr>
<td>13. Receive client health and/or treatment information from providers or sources outside your organization</td>
<td>1 ☐</td>
</tr>
<tr>
<td>14. Billing</td>
<td>1 ☐</td>
</tr>
<tr>
<td>15. Client or family satisfaction surveys</td>
<td>1 ☐</td>
</tr>
<tr>
<td>16. Updating availability of beds</td>
<td>1 ☐</td>
</tr>
</tbody>
</table>

*NOTE: Electronic resources include tools such as electronic health records (EHR) and web portals. Please consider e-fax, pdf, or scanned documents as paper documents.*
**A28.** Does this facility use a sliding fee scale?
- Sliding fee scales are based on income and other factors.
- Not applicable to Veterans Affairs facilities.

1 ☐ Yes  
0 ☐ No ➔ SKIP TO A29 (BELOW)

**A28a.** Do you want the availability of a sliding fee scale published in SAMHSA's online Behavioral Health Treatment Services Locator?
- The Locator will inform potential clients to call the facility for information on eligibility.
- Not applicable to Veterans Affairs facilities.

1 ☐ Yes  
0 ☐ No

**A29.** Does this facility offer treatment at no charge or minimal payment (for example, $1) to clients who cannot afford to pay?
- Not applicable to Veterans Affairs facilities.

1 ☐ Yes  
0 ☐ No ➔ SKIP TO A30 (TOP OF NEXT COLUMN)

**A29a.** Do you want the availability of treatment at no charge or minimal payment (for example, $1) for eligible clients published in SAMHSA's online Behavioral Health Treatment Services Locator?
- The Locator will inform potential clients to call the facility for information on eligibility.
- Not applicable to Veterans Affairs facilities.

1 ☐ Yes  
0 ☐ No

**A30.** Which of the following types of client payments, insurance, or funding are accepted by this facility for mental health treatment services?
- For definitions, go to: [https://info.nmhss.org](https://info.nmhss.org)

MARK ALL THAT APPLY:

1 ☐ Cash or self-payment
2 ☐ Private health insurance
3 ☐ Medicare
4 ☐ Medicaid
5 ☐ State-financed health insurance plan other than Medicaid
6 ☐ State mental health agency (or equivalent) funds
7 ☐ State welfare or child and family services agency funds
8 ☐ State corrections or juvenile justice agency funds
9 ☐ State education agency funds
10 ☐ Other state government funds
11 ☐ County or local government funds
12 ☐ Community Service Block Grants
13 ☐ Community Mental Health Block Grants
14 ☐ Federal grants
15 ☐ Federal military insurance (such as TRICARE)
16 ☐ U.S. Department of Veterans Affairs funds
17 ☐ IHS/Tribal/Urban (ITU) funds
18 ☐ Private or Community foundation
19 ☐ Other (Specify: ___________________________)

Other (Specify: ___________________________)

Other (Specify: ___________________________)

Other (Specify: ___________________________)

Other (Specify: ___________________________)

Other (Specify: ___________________________)

Other (Specify: ___________________________)

Other (Specify: ___________________________)

Other (Specify: ___________________________)

Other (Specify: ___________________________)
A31. 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
1 ☐ State mental health authority
2 ☐ State substance abuse agency
3 ☐ State department of health
4 ☐ State or local Department of Family and Children’s Services
5 ☐ Hospital licensing authority
6 ☐ The Joint Commission
7 ☐ Commission on Accreditation of Rehabilitation Facilities (CARF)
8 ☐ Council on Accreditation (COA)
9 ☐ Centers for Medicare and Medicaid Services (CMS)
10 ☐ Other national organization, or federal, state, or local agency

(Specify: ________________________________)
11 ☐ We do not have licensing, certification, or accreditation from any of these organizations

A32. If eligible, does this facility want to be listed in SAMHSA’s online Behavioral Health Treatment Services Locator and Mental Health Directory?

- The Locator can be found at: https://findtreatment.samhsa.gov
- The Directory will be available at https://www.samhsa.gov/data

1 ☐ Yes
0 ☐ No → SKIP TO B1 (TOP OF NEXT COLUMN)

A32a. Does this facility want the street address and/or mailing address to be listed in SAMHSA’s online Behavioral Health Treatment Services Locator and Mental Health Directory?

MARK ALL THAT APPLY
1 ☐ Publish the street address
2 ☐ Publish the mailing address
3 ☐ Do not publish either address

A32b. 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.

1 ☐ Yes
0 ☐ No

SECTION B: CLIENT/PATIENT COUNT INFORMATION

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

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

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

B1. Although reporting for only the clients/patients treated at this facility is preferred, we realize that may not be possible. Will the client/patient counts reported in this questionnaire include:

MARK ONE ONLY
1 ☐ Only this facility → SKIP TO B3 (NEXT PAGE)
2 ☐ This facility plus others → SKIP TO B2 (BELOW)
3 ☐ Another facility in the organization will report client/patient counts for this facility

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

Facility name: ________________________________
Telephone: (_____) - _______ - _________

After recording the facility name and telephone number in B1a → SKIP TO C1 (PAGE 13)

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

THIS FACILITY

+ ADDITIONAL FACILITIES

= TOTAL FACILITIES

On page 14 of this questionnaire, list the name and location address of each facility included in your client/patient counts. If you prefer, we will contact you for a list of the other facilities included in your client/patient counts.

CONTINUE WITH QUESTION B3 (TOP OF NEXT PAGE)
B3. On April 30, 2020, did any patients receive 24-hour hospital inpatient mental health treatment at this facility, at this location?

- Yes  ➔ GO TO B3a (TOP OF NEXT COLUMN)
- No   ➔ SKIP TO B4 (TOP OF NEXT PAGE)

B3a. On April 30, 2020, how many patients received 24-hour hospital inpatient mental health treatment at this facility?

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

HOSPITAL INPATIENTS TOTAL BOX

CONTINUE WITH QUESTION B3b (BELOW)

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

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Number or Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SEX</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>CATEGORY TOTAL:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Should=B3a or 100%)</td>
</tr>
<tr>
<td><strong>AGE</strong></td>
<td></td>
</tr>
<tr>
<td>0 – 17</td>
<td></td>
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<tr>
<td>18 – 64</td>
<td></td>
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<tr>
<td>65 and older</td>
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<tr>
<td>CATEGORY TOTAL:</td>
<td></td>
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<tr>
<td></td>
<td>(Should=B3a or 100%)</td>
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<tr>
<td><strong>ETHNICITY</strong></td>
<td></td>
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<tr>
<td>Hispanic or Latino</td>
<td></td>
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<tr>
<td>Not Hispanic or Latino</td>
<td></td>
</tr>
<tr>
<td>Unknown or not collected</td>
<td></td>
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<tr>
<td>CATEGORY TOTAL:</td>
<td></td>
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<tr>
<td></td>
<td>(Should=B3a or 100%)</td>
</tr>
<tr>
<td><strong>RACE</strong></td>
<td></td>
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<tr>
<td>American Indian or Alaska Native</td>
<td></td>
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<tr>
<td>Asian</td>
<td></td>
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<tr>
<td>Black or African American</td>
<td></td>
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<tr>
<td>Native Hawaiian or other Pacific Islander</td>
<td></td>
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<tr>
<td>White</td>
<td></td>
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<tr>
<td>Two or more races</td>
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<tr>
<td>Unknown or not collected</td>
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<tr>
<td>CATEGORY TOTAL:</td>
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<tr>
<td></td>
<td>(Should=B3a or 100%)</td>
</tr>
<tr>
<td><strong>LEGAL STATUS</strong></td>
<td></td>
</tr>
<tr>
<td>Voluntary</td>
<td></td>
</tr>
<tr>
<td>Involuntary, non-forensic</td>
<td></td>
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<tr>
<td>Involuntary, forensic</td>
<td></td>
</tr>
<tr>
<td>CATEGORY TOTAL:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Should=B3a or 100%)</td>
</tr>
</tbody>
</table>

B3c. On April 30, 2020, how many hospital inpatient beds at this facility were specifically designated for providing mental health treatment?

NUMBER OF BEDS

(If none, enter '0')
B4. On April 30, 2020, did any clients receive 24-hour residential mental health treatment at this facility, at this location?

1 □ Yes ➔ GO TO B4a (TOP OF NEXT COLUMN)
0 □ No ➔ SKIP TO B5 (TOP OF NEXT PAGE)

B4a. On April 30, 2020, how many clients received 24-hour residential mental health treatment at this facility?

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

**RESIDENTIAL CLIENTS TOTAL BOX**

**CONTINUE WITH QUESTION B4b (BELOW)**

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

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

<table>
<thead>
<tr>
<th>Category</th>
<th>NUMBER OR PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SEX</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
</tr>
<tr>
<td><strong>CATEGORY TOTAL: (Should=B4a or 100%)</strong></td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td><strong>AGE</strong></td>
<td></td>
</tr>
<tr>
<td>0–17</td>
<td></td>
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<tr>
<td>18–64</td>
<td></td>
</tr>
<tr>
<td>65 and older</td>
<td></td>
</tr>
<tr>
<td><strong>CATEGORY TOTAL: (Should=B4a or 100%)</strong></td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td><strong>ETHNICITY</strong></td>
<td></td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td></td>
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<tr>
<td>Not Hispanic or Latino</td>
<td></td>
</tr>
<tr>
<td>Unknown or not collected</td>
<td></td>
</tr>
<tr>
<td><strong>CATEGORY TOTAL: (Should=B4a or 100%)</strong></td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td><strong>RACE</strong></td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
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<tr>
<td>Asian</td>
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<td>Black or African American</td>
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<tr>
<td>Native Hawaiian or other Pacific Islander</td>
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<tr>
<td>White</td>
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<tr>
<td>Two or more races</td>
<td></td>
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<tr>
<td>Unknown or not collected</td>
<td></td>
</tr>
<tr>
<td><strong>CATEGORY TOTAL: (Should=B4a or 100%)</strong></td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td><strong>LEGAL STATUS</strong></td>
<td></td>
</tr>
<tr>
<td>Voluntary</td>
<td></td>
</tr>
<tr>
<td>Involuntary, non-forensic</td>
<td></td>
</tr>
<tr>
<td>Involuntary, forensic</td>
<td></td>
</tr>
<tr>
<td><strong>CATEGORY TOTAL: (Should=B4a or 100%)</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

B4c. On April 30, 2020, how many residential beds at this facility were specifically designated for providing mental health treatment?

**NUMBER OF BEDS**

(If none, enter '0')
**B5.** During the month of April 2020, did any clients receive less than 24-hour mental health treatment at this facility, at this location?

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

1 □ Yes → GO TO B5a (TOP OF NEXT COLUMN)
0 □ No → SKIP TO B6 (TOP OF NEXT PAGE)

**B5a.** During the month of April 2020, how many clients received less than 24-hour mental health treatment at this facility?

- ONLY INCLUDE those seen at this facility at least once during the month of April, AND who were still enrolled in treatment on April 30, 2020.
- DO NOT count family members, friends, or other non-treatment persons.

OUTPATIENT CLIENTS AND PARTIAL HOSPITALIZATION/DAY TREATMENT CLIENTS TOTAL BOX

CONTINUE WITH QUESTION B5b (BELOW)

---

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

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Number/Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>CATEGORY TOTAL:</td>
<td></td>
</tr>
<tr>
<td>(Should=B5a or 100%)</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>0 – 17</td>
<td></td>
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<tr>
<td>18 – 64</td>
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<td>65 and older</td>
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<tr>
<td>CATEGORY TOTAL:</td>
<td></td>
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<tr>
<td>(Should=B5a or 100%)</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td></td>
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<tr>
<td>Not Hispanic or Latino</td>
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<tr>
<td>Unknown or not collected</td>
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<tr>
<td>CATEGORY TOTAL:</td>
<td></td>
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<tr>
<td>(Should=B5a or 100%)</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
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<tr>
<td>American Indian or Alaska Native</td>
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<td>Asian</td>
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<td>Black or African American</td>
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<tr>
<td>CATEGORY TOTAL:</td>
<td></td>
</tr>
<tr>
<td>(Should=B5a or 100%)</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Legal Status</strong></td>
<td></td>
</tr>
<tr>
<td>Voluntary</td>
<td></td>
</tr>
<tr>
<td>Involuntary, non-forensic</td>
<td></td>
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<tr>
<td>Involuntary, forensic</td>
<td></td>
</tr>
<tr>
<td>CATEGORY TOTAL:</td>
<td></td>
</tr>
<tr>
<td>(Should=B5a or 100%)</td>
<td>100%</td>
</tr>
</tbody>
</table>
B6. On April 30, 2020, approximately what percent of the mental health treatment clients/patients enrolled at this facility had **diagnosed co-occurring** mental and substance use disorders?

<table>
<thead>
<tr>
<th>PERCENT WITH CO-OCCURRING DIAGNOSIS</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(If none, enter '0')</td>
<td></td>
</tr>
</tbody>
</table>

B7. In the 12-month period of May 1, 2019 through April 30, 2020, how many mental health treatment admissions, readmissions, and incoming transfers did this facility have? **Exclude returns from unauthorized absence, such as escape, AWOL, or elopement.**

- **IF DATA FOR THIS TIME PERIOD ARE NOT AVAILABLE:** Use the most recent 12-month period for which data are available.
- **OUTPATIENT CLIENTS:** Consider each initiation to a course of treatment as an admission. **Count admissions into treatment, not individual treatment visits.**
- **WHEN A MENTAL HEALTH DISORDER IS A SECONDARY DIAGNOSIS:** Count all admissions where clients/patients received mental health treatment.

<table>
<thead>
<tr>
<th>NUMBER OF MENTAL HEALTH TREATMENT ADMISSIONS IN 12-MONTH PERIOD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(If none, enter '0')</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>PERCENT MILITARY VETERANS</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(If none, enter '0')</td>
<td></td>
</tr>
</tbody>
</table>
C1. Who was primarily responsible for completing this form?

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

MARK ONE ONLY

1 □ Ms.  2 □ Mr.  3 □ Mrs.  4 □ Dr.  5 □ Other (Specify: ____________________________ )

Name: ______________________________________________________________

Title: ______________________________________________________________________

Phone Number: (______) _______ - ________ Ext. _______

Fax Number: (______) _______ - _______

Email Address: ______________________________________________________________________

Facility Email Address: ______________________________________________________________________
Complete this section if you reported clients/patients for this facility plus additional facilities, as indicated in Question B2. For each additional facility, please mark if that facility offers hospital inpatient, residential, outpatient mental health treatment, and/or partial hospitalization/day treatment at that location.

<table>
<thead>
<tr>
<th>FACILITY NAME:</th>
<th>FACILITY NAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS:</td>
<td>ADDRESS:</td>
</tr>
<tr>
<td>CITY:</td>
<td>CITY:</td>
</tr>
<tr>
<td>STATE:</td>
<td>STATE:</td>
</tr>
<tr>
<td>ZIP:</td>
<td>ZIP:</td>
</tr>
<tr>
<td>TELEPHONE:</td>
<td>TELEPHONE:</td>
</tr>
<tr>
<td>EMAIL ADDRESS:</td>
<td>EMAIL ADDRESS:</td>
</tr>
</tbody>
</table>

- [ ] HOSPITAL INPATIENT
- [ ] RESIDENTIAL
- [ ] OUTPATIENT
- [ ] PARTIAL HOSPITALIZATION/DAY TREATMENT

If you require additional space, please continue on the next page.
Thank you for your participation. Please return this questionnaire in the envelope provided. If you no longer have the envelope, please mail this questionnaire to:

MATHEMATICA
ATTN: RECEIPT CONTROL - Project 50345_1
P.O. Box 2393
Princeton, NJ 08543-2393

PLEDGE TO RESPONDENTS: The information you provide will be protected to the fullest extent allowable under the Public Health Service Act (42 USC 290aa(p)). This law permits the public release of identifiable information about an establishment only with the consent of that establishment and limits the use of the information to the purposes for which it was supplied. With the explicit consent of treatment facilities, information provided in response to survey questions marked with an asterisk may be published in SAMHSA’s online Behavioral Health Treatment Services Locator, the National Directory of Mental Health Treatment Facilities, and other publicly-available listings. Responses to non-asterisked questions will be published with no direct link to individual treatment facilities.

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 0930-0119. Public reporting burden for this collection of information is estimated to average 45 minutes per respondent, 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.