SAMHSA
Substance Abuse and Mental Health Services Administration

N-SUMHSS
NATIONAL SUBSTANCE USE AND MENTAL HEALTH SERVICES SURVEY

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

Take Part in the 2025 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.

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**, 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

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*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)*

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*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)*

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*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.   ⟶ SKIP TO **A8b**

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.)*

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)*.   ⟶ SKIP TO **A9**

This facility does not treat opioid use disorder

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*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***?

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

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*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.*

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

This facility administers/prescribes naltrexone for alcohol use disorder → SKIP TO **A9a**

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**

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*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:

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

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*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**

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*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)

█ OTHER LANGUAGES	
Arabic	Hmong
Any Chinese language	Italian
Creole	Japanese
Farsi	Korean
French	Polish
German	Portuguese
Greek	Russian
Hebrew	Tagalog
Hindi	Vietnamese

Any other language *(Specify:* _____ *)*

*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

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*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

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

No payment accepted *(free treatment for <u>all</u> 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:* _____ *)*

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

Yes ➞ SKIP TO **A18a**

No ➞ SKIP TO **A19**

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*A18a. What type of hospital?

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

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*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		

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*B2. **_Mental health treatment_** is provided in which of the following service settings **_at this facility_**, **_at this location_**?

	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   → SKIP TO **B5**

Other type of residential treatment facility

Veterans Affairs Medical Center _(VAMC)_ or other VA healthcare facility

Community Mental Health Center _(CMHC)_

Certified Community Behavioral Health Clinic _(CCBHC)_

Partial hospitalization/day treatment facility

Outpatient mental health facility   → SKIP TO **B4**

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

Other _(Specify: _____)_

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?

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*

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*?

<div align="right">MARK ALL THAT APPLY FOR EACH MEDICATION</div>

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

MARK ALL THAT APPLY

OTHER LANGUAGES	
Arabic	Hmong
Any Chinese language	Italian
Creole	Japanese
Farsi	Korean
French	Polish
German	Portuguese
Greek	Russian
Hebrew	Tagalog
Hindi	Vietnamese

    Any other language *(Specify: _____)*

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

	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, 2024, and ending March 31, 2025, 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   Indian Health Service

Department of Defense   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 indoor* area(s)

Permitted in *designated outdoor* area(s)   Permitted *anywhere inside*

Permitted *anywhere outside*   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 indoor* area(s)

Permitted in *designated outdoor* area(s)   Permitted *anywhere inside*

Permitted *anywhere outside*   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   Do **not** publish either address

  Publish the **mailing** 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 **E1** (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 31, 2025, did any patients receive **inpatient substance use disorder treatment** services **at this facility**?

   Yes ⟶ SKIP TO **D4a**

   No ⟶ SKIP TO **D5**

D4a. On March 31, 2025, 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 31, 2025, 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 31, 2025, 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 31, 2025, 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 31, 2025, 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 2025, did any clients receive *outpatient substance use disorder treatment* services *at this facility*?

Yes   ⟶ SKIP TO **D6a**

No   ⟶ SKIP TO **D7**

29

D6a. As of March 31, 2025, 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 31, 2025**.*
- ***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	

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 31, 2025, 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 31, 2025, 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 **E1**

MENTAL HEALTH COUNTS

D10. On **March 31, 2025**, 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 31, 2025**, 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 31, 2025**, 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 31, 2025**, 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%

D11. On **March 31, 2025**, 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 31, 2025**, 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 31, 2025**, 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 31, 2025**, 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 2025, 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 2025, 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 31, 2025**.
- **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%

D13. On **March 31, 2025**, 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, 2024, through March 31, 2025, 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 _____ %

MODULE E: RESPONDENT INFORMATION SECTION

RESPONDENT INFORMATION

E1. 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

    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

CERTIFY

You have reached the end of the N-SUMHSS. Before you submit your completed survey, please address the acknowledgment statement below.

The responses provided in this survey are true and accurate to the best of my knowledge.

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