

## Take Part in the 2026 National Substance Use and Mental Health Services Survey

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

MARK ONE

Information is complete and correct; no changes needed.

All missing or incorrect information has been corrected.



## PLEASE READ THIS ENTIRE PAGE BEFORE COMPLETING THE QUESTIONNAIRE

### WOULD YOU PREFER TO COMPLETE THIS QUESTIONNAIRE ONLINE?

See the blue flyer enclosed in your survey packet for the web address and your unique user ID and password. You can log on and off the website as often as needed to complete the questionnaire. When you log on again, the program will take you to the next unanswered question. If you need more information, call the N-SUMHSS helpline at 1-833-302-1759.

### INSTRUCTIONS

- Most of the questions in this survey ask about “this facility.” By “this facility” we mean the specific treatment facility or program whose name and location are printed on the front cover. If you have any questions about how the term “this facility” applies to your facility, please call 1-833-302-1759.
- Please answer ONLY for the specific facility or program whose name and location are printed on the front cover, unless otherwise specified in the questionnaire.
- If the questionnaire has not been completed online, return the completed questionnaire in the envelope provided. Please keep a copy for your records.
- For additional information about this survey and definitions of some of the terms used, please visit our website at <https://info.nsumhss.samhsa.gov>.

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

ICF

1-833-302-1759

[ICFsupport@nsumhss.org](mailto:ICFsupport@nsumhss.org)

### IMPORTANT INFORMATION

**ASTERISKED QUESTIONS.** Information from asterisked (\*) questions may be published on [FindTreatment.gov](http://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](http://FINDTREATMENT.GOV).** Complete and accurate name and address information is needed for [FindTreatment.gov](http://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](http://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](http://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](http://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

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 → SKIP TO A1 if 1a = Yes; SKIP TO B1 if 1a = 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 (e.g., medical withdrawal, social detoxification, ambulatory detoxification, etc.)

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** serious mental illness (SMI) in adults

Treatment for co-occurring substance use **plus** 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 (e.g., medical withdrawal, social detoxification, ambulatory detoxification, etc.) clients from:

MARK ALL THAT APPLY

Alcohol

Benzodiazepines

Cocaine

Methamphetamines

Opioids

Other(s) (Specify: \_\_\_\_\_)

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

Yes

No

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

Yes

No

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

Yes → SKIP TO **A4a**

No → SKIP TO **A5**

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

MARK "YES" OR "NO" FOR EACH

YES NO

Hospital inpatient detoxification (e.g., medical withdrawal, social detoxification, medically managed or monitored inpatient detoxification, etc.)

Hospital 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 (e.g., medical withdrawal, clinically managed residential detoxification, social detoxification, etc.)

Residential short-term treatment (clinically managed high-intensity residential treatment, typically 30 days or less)

Residential long-term treatment (clinically managed medium- or low-intensity residential treatment)

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

Yes → SKIP TO **A6a**

No → SKIP TO **A7**

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

MARK "YES" OR "NO" FOR EACH  
YES NO

Outpatient detoxification (ambulatory detoxification)

Outpatient methadone/buprenorphine maintenance or naltrexone treatment

Outpatient day treatment or partial hospitalization (20 or more hours per week)

Intensive outpatient treatment (9 or more hours per week)

Regular outpatient treatment (outpatient treatment, non-intensive)

\*A7. Which of the following services are offered by **this facility at this location**—that is, the location listed on the front cover?

MARK ALL THAT APPLY

#### ASSESSMENT AND PRE-TREATMENT SERVICES

Screening for substance use

Screening for mental disorders

Comprehensive substance use assessment or diagnosis

Comprehensive mental health assessment or diagnosis (for example, psychological or psychiatric evaluation and testing)

Complete medical history and physical exam performed by a healthcare practitioner

Screening for tobacco use

Outreach to persons in the community who may need treatment

Interim services for clients when immediate admission is not possible

Professional interventionist/educational consultant

None of the assessment and pre-treatment services above are offered at this facility

**\*A7. (Continued)**

MARK ALL THAT APPLY

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

Drug and alcohol oral fluid testing

Breathalyzer or other blood alcohol testing

Drug or alcohol urine screening

Testing for Hepatitis B (*HBV*)

Testing for Hepatitis C (*HCV*)

HIV testing

STD testing

TB screening

Testing for metabolic syndrome *(weight, abdominal girth, BP, glucose, Hgb A1C, cholesterol, triglycerides)*

None of the testing services above are offered at this facility

**MEDICAL SERVICES**

Hepatitis A (*HAV*) vaccination

Hepatitis B (*HBV*) vaccination

None of the medical services above are offered at this facility

**TRANSITIONAL SERVICES**

Discharge planning

Aftercare/continuing care

Naloxone and overdose education

Outcome follow-up after discharge

None of the transitional services above are offered at this facility

**RECOVERY SUPPORT SERVICES**

Mentoring/peer support

Self-help groups *(for example, AA, NA, SMART Recovery)*

Assistance in locating housing for clients

Employment counseling or training for clients

Assistance with obtaining social services *(for example, Medicaid, WIC, SSI, SSDI)*

Recovery coach

None of the recovery support services above are offered at this facility

\*A7. (Continued)

MARK ALL THAT APPLY

**EDUCATION AND COUNSELING SERVICES**

HIV or AIDS education, counseling, or support

Hepatitis education, counseling, or support

Health education other than HIV/AIDS or hepatitis

Substance use disorder education

Smoking/tobacco cessation counseling

Individual counseling

Group counseling

Family counseling

Marital/couples counseling

Vocational training or educational support *(for example, high school coursework, GED preparation, etc.)*

None of the education and counseling services above are offered at this facility

**ANCILLARY SERVICES**

Case management services

Integrated primary care services

Social skills development

Child care for clients' children

Domestic violence services, including family or partner violence services, for physical, sexual, or emotional abuse

Early intervention for HIV

Transportation assistance to treatment

Mental health services

Suicide prevention services

Acupuncture

Residential beds for clients' children

None of the ancillary services above are offered at this facility

\*A7. (Continued)

MARK ALL THAT APPLY

**OTHER SERVICES**

Treatment for gambling disorder

Treatment for other addiction disorder (*non-substance use disorder*)

None of the other services above are offered at this facility

**PHARMACOTHERAPIES**

Disulfiram

Naltrexone (*oral*)

Naltrexone (*extended-release, injectable*)

Acamprosate

Nicotine replacement

Non-nicotine smoking/tobacco cessation medications (*for example, bupropion, varenicline*)

Medications for mental disorders

Methadone

Buprenorphine/naloxone

Buprenorphine without naloxone

Buprenorphine sub-dermal implant

Buprenorphine (*extended-release, injectable*)

Medications for HIV treatment (*for example, antiretroviral medications such as tenofovir, efavirenz, emtricitabine, atazanavir, and lamivudine*)

Medications for pre-exposure prophylaxis (*PrEP: for example, emtricitabine and tenofovir disoproxil fumarate combination, and emtricitabine and tenofovir alafenamide combination*)

Medications for Hepatitis C (*HCV*) treatment (*for example, sofosbuvir, ledipasvir, interferon, peginterferon, ribavirin*)

Lofexidine

Clonidine

Medications for other medical conditions (*Specify: \_\_\_\_\_*)


None of the pharmacotherapy services above are offered at this facility


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

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

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


MARK ALL THAT APPLY


This facility accepts clients using MAT, but the medications originate from or are prescribed by another entity. (The medications may or may not be stored/delivered/monitored onsite.)  SKIP TO **A8a**

This facility prescribes naltrexone to treat opioid use disorder. Naltrexone use is authorized through any medical staff with prescribing privileges. 

This facility utilizes prescribers of buprenorphine to treat opioid use disorder. Buprenorphine use is authorized through a DATA 2000 waived 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 

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

MARK ALL THAT APPLY

A prescribing entity in our network

A prescribing entity with which our facility has a business, contractual, or formal referral relationship

A prescribing entity with which our facility has no formal relationship

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

Yes

No

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

MARK ALL THAT APPLY

Maintenance services with methadone or buprenorphine

Maintenance services with medically supervised withdrawal (*or taper*) after a period of stabilization

Detoxification (*medical withdrawal*) from opioids of abuse with methadone or buprenorphine

Detoxification (*medical withdrawal*) from opioids of abuse with lofexidine or clonidine

Relapse prevention with naltrexone

Other (*for example, overdose risk reduction with naloxone; specify opioid use disorder service and pharmacotherapy used:* \_\_\_\_\_)

None of the medication services for opioid use disorder above are offered at this facility

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

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

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

MARK ALL THAT APPLY

This facility accepts clients using MAT for alcohol use disorder, but the medications originate from or are prescribed by another entity

This facility administers and/or prescribes disulfiram for alcohol use disorder

This facility administers and/or prescribes naltrexone for alcohol use disorder

This facility administers and/or 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

This facility does not treat alcohol use disorder

→ SKIP TO **A9a**

→ SKIP TO **A9b**

→ SKIP TO **A10**

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

MARK ALL THAT APPLY

A prescribing entity in our network

A prescribing entity with which our facility has a business, contractual, or formal referral relationship

A prescribing entity with which our facility has no formal relationship

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

Yes

No

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

MARK ALL THAT APPLY FOR EACH APPROACH

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

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

Yes → SKIP TO **A11a**

No → SKIP TO **A12**

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

Yes

No

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

MARK ALL THAT APPLY

Marijuana

Stimulants

Other substance(s) (Specify: \_\_\_\_\_)

\*A13. Does **this facility** provide substance use treatment services in **sign language, at this location**, for the deaf and hard of hearing (for example, American Sign Language, Signed English, or Cued Speech)?

- Mark “yes” if either a staff counselor or an on-call interpreter provides this service.

Yes

No

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

Yes → SKIP TO **A14a**

No → SKIP TO **A15**

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

MARK ONE ONLY

Staff counselor who speaks a language other than English → SKIP TO **A14a1**

On-call interpreter (*in person or by phone*) brought in when needed → SKIP TO **A15**

**Both** staff counselor and on-call interpreter → SKIP TO **A14a1**

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

Yes → SKIP TO **A14a2**

No → SKIP TO **A14b**

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

Yes → SKIP TO **A14b**

No → SKIP TO **A15**

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

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

MARK ALL THAT APPLY

AMERICAN INDIAN OR ALASKA NATIVE

Hopi

Lakota

Navajo

Ojibwa

Yupik

Other American Indian or Alaska Native language (*Specify:* \_\_\_\_\_)

\*A14b. (Continued)

MARK ALL THAT APPLY

**OTHER LANGUAGES**

- |                      |            |
|----------------------|------------|
| Arabic               | 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 |    | IF SERVED, WHAT IS THE LOWEST AGE SERVED |                | IF SERVED, WHAT IS THE HIGHEST AGE SERVED |                |
|----------------|--------------------------------------|----|--|----------------|---|----------------|
|                | SERVED BY THIS FACILITY              |    |  |                |   |                |
| Female         | Yes                                  | No | <input type="text"/><br>YEARS            | No minimum age | <input type="text"/><br>YEARS             | No maximum age |
| Male           | Yes                                  | No | <input type="text"/><br>YEARS            | No minimum age | <input type="text"/><br>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

Veterans

Active duty military

Members of military families

Criminal justice clients (*other than DUI/DWI*)

Clients with co-occurring mental and substance use disorders

Clients with co-occurring pain and substance use disorders

Clients with HIV or AIDS

Clients who have experienced sexual abuse

Clients who have experienced intimate partner violence, domestic violence

Clients who have experienced trauma

Specifically tailored programs or groups for any other types of clients

(Specify: \_\_\_\_\_)

No specifically tailored programs or groups are offered

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

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

Yes

No

Don't know

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

MARK ALL THAT APPLY

No payment accepted (*free treatment for all clients*)

Cash or self-payment

Medicare

Medicaid

State-financed health insurance plan other than Medicaid

Federal military insurance (*such as TRICARE*)

Private health insurance

SAMHSA funding/block grants

IHS/Tribal/Urban (*ITU*) funds

Other (*Specify:* \_\_\_\_\_)

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

Yes  SKIP TO **A18a**

No  SKIP TO **A19**

\*A18a. What type of hospital?

MARK ONE ONLY

General hospital (*including VA hospital*)

Psychiatric hospital

Other specialty hospital (*for example, alcoholism, maternity, etc.*) (*Specify:* \_\_\_\_\_)

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

Yes

No

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

Yes

No

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

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

MARK ALL THAT APPLY

State substance use treatment agency

State mental health department

State department of health

Hospital licensing authority

The Joint Commission

Commission on Accreditation of Rehabilitation Facilities (CARF)

National Committee for Quality Assurance (NCQA)

Council on Accreditation (COA)

Healthcare Facilities Accreditation Program (HFAP)

SAMHSA certification for opioid treatment program (OTP)

Drug Enforcement Agency (DEA)

Other national organization or federal, state, or local agency (Specify: \_\_\_\_\_)

This facility is not licensed, certified, or accredited to provide substance use services by any of these organizations

## MODULE B: MENTAL DISORDERS TREATMENT FACILITIES

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

MARK "YES" OR "NO" FOR EACH

YES NO

Mental health intake

Mental health diagnostic evaluation

Mental health information and/or referral

(also includes emergency programs that provide services in person or by telephone)

Mental health treatment (interventions such as therapy or psychotropic medication that treat a person's mental disorder or condition, reduce symptoms, and improve behavioral functioning and outcomes)

Treatment for co-occurring disorders **plus** serious mental illness (SMI) in adults

Treatment for co-occurring disorders **plus** serious emotional disturbance (SED) in children

Substance use treatment

Administrative or operational services for mental health treatment facilities

\*B2. **Mental health treatment** is provided in which of the following service settings **at this facility, at this location?**

MARK "YES" OR "NO" FOR EACH

YES NO

24-hour hospital inpatient

24-hour residential

Partial hospitalization/day treatment

Outpatient

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

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

MARK ONE ONLY

Psychiatric hospital

Separate inpatient psychiatric unit of a general hospital  
(consider this psychiatric unit as the relevant "facility" for the purpose of this survey)

State hospital

Residential treatment center for children

Residential treatment center for adults

Other type of residential treatment facility

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

Community Mental Health Center (CMHC)

Certified Community Behavioral Health Clinic (CCBHC)

Partial hospitalization/day treatment facility

Outpatient mental health facility

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

Other (Specify: \_\_\_\_\_)

→ SKIP TO B5

→ SKIP TO B4

B4. Is **this facility** either a solo or a small group practice (e.g., up to 5 providers)?

Yes → SKIP TO B4a

No → SKIP TO B5

\*B4a. Is **this facility** licensed or accredited as a mental health clinic or mental health center?

- Do not count the licenses or credentials of individual practitioners.

Yes

No

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

MARK ALL THAT APPLY

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

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

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

MARK ALL THAT APPLY

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

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

Yes  SKIP TO **B7a**

No  SKIP TO **B8**

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

MARK ALL THAT APPLY FOR EACH MEDICATION

| FIRST-GENERATION ANTIPSYCHOTIC | NOT USED AT THIS FACILITY | ORAL | INJECTABLE | LONG-ACTING INJECTABLE | RECTAL | TOPICAL | INHALATION | DON'T KNOW |
|--------------------------------|---------------------------|------|------------|------------------------|--------|---------|------------|------------|
| Chlorpromazine                 |                           |      |            |                        |        |         |            |            |
| Droperidol                     |                           |      |            |                        |        |         |            |            |
| Fluphenazine                   |                           |      |            |                        |        |         |            |            |
| Haloperidol                    |                           |      |            |                        |        |         |            |            |
| Loxapine                       |                           |      |            |                        |        |         |            |            |
| Perphenazine                   |                           |      |            |                        |        |         |            |            |
| Pimozide                       |                           |      |            |                        |        |         |            |            |
| Prochlorperazine               |                           |      |            |                        |        |         |            |            |
| Thiothixene                    |                           |      |            |                        |        |         |            |            |
| Thioridazine                   |                           |      |            |                        |        |         |            |            |
| Trifluoperazine                |                           |      |            |                        |        |         |            |            |

Other first-generation antipsychotics

(Specify: \_\_\_\_\_)

(Specify: \_\_\_\_\_)

(Specify: \_\_\_\_\_)

| SECOND-GENERATION ANTIPSYCHOTIC   | NOT USED AT THIS FACILITY | ORAL/ SUBLINGUAL | INJECTABLE | LONG-ACTING INJECTABLE | RECTAL | TOPICAL | TRANSDERMAL | DON'T KNOW |
|-----------------------------------|---------------------------|------------------|------------|------------------------|--------|---------|-------------|------------|
| Aripiprazole                      |                           |                  |            |                        |        |         |             |            |
| Asenapine                         |                           |                  |            |                        |        |         |             |            |
| Brexpiprazole                     |                           |                  |            |                        |        |         |             |            |
| Cariprazine                       |                           |                  |            |                        |        |         |             |            |
| Clozapine                         |                           |                  |            |                        |        |         |             |            |
| Iloperidone                       |                           |                  |            |                        |        |         |             |            |
| Lurasidone                        |                           |                  |            |                        |        |         |             |            |
| Olanzapine                        |                           |                  |            |                        |        |         |             |            |
| Olanzapine/Fluoxetine combination |                           |                  |            |                        |        |         |             |            |
| Paliperidone                      |                           |                  |            |                        |        |         |             |            |
| Quetiapine                        |                           |                  |            |                        |        |         |             |            |
| Risperidone                       |                           |                  |            |                        |        |         |             |            |
| Ziprasidone                       |                           |                  |            |                        |        |         |             |            |

Other second-generation antipsychotics

(Specify: \_\_\_\_\_)

(Specify: \_\_\_\_\_)

(Specify: \_\_\_\_\_)

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

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

MARK ALL THAT APPLY

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

CONTINUED ON NEXT COLUMN

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

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

MARK ALL THAT APPLY

- Detoxification (e.g., medical withdrawal, social detoxification, ambulatory detoxification, etc.)
- 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

Forensic clients (referred from the court/judicial system)

Clients with HIV or AIDS

Other special program or group (Specify: \_\_\_\_\_)

No dedicated or exclusively designed programs or groups are offered at this facility

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

Yes

No

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

Yes

No

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

Yes

No

\*B15. Does **this facility** provide mental health treatment services in **sign language at this location** for the deaf and hard of hearing (for example, American Sign Language, Signed English, or Cued Speech)?

- Mark "yes" if either a staff counselor or an on-call interpreter provides this service.

Yes

No

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

Yes  → SKIP TO **B16a**

No  → SKIP TO **B17**

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

MARK ONE ONLY

Staff counselor who speaks a language other than English  → SKIP TO **B16a1**

On-call interpreter (*in person or by phone*) brought in when needed  → SKIP TO **B17**

**Both** staff counselor and on-call interpreter  → SKIP TO **B16a1**

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

Yes

No

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

Yes  → SKIP TO **B16b**

No  → SKIP TO **B17**

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

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

MARK ALL THAT APPLY

**AMERICAN INDIAN OR ALASKA NATIVE**

Hopi

Lakota

Navajo

Ojibwa

Yupik

Other American Indian or Alaska Native language (*Specify: \_\_\_\_\_*)

MARK ALL THAT APPLY

**OTHER LANGUAGES**

Arabic

Any Chinese language

Creole

Farsi

French

German

Greek

Hebrew

Hindi

Any other language (*Specify: \_\_\_\_\_*)

Hmong

Italian

Japanese

Korean

Polish

Portuguese

Russian

Tagalog

Vietnamese

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

MARK "YES" OR "NO" FOR EACH  
 YES NO

Continuing education requirements for professional staff

Regularly scheduled case review with a supervisor

Regularly scheduled case review by an appointed quality review committee

Client outcome follow-up after discharge

Continuous quality improvement processes

Periodic client satisfaction surveys

Clinical provider peer review (CPPR)

Root cause analysis (RCA)

B18. In the 12-month period beginning April 1, 2025, and ending March 31, 2026, have staff **at this facility** used:

MARK ALL THAT APPLY

|           | NOT USED AT THIS FACILITY | CHEMICAL | PHYSICAL |
|-----------|---------------------------|----------|----------|
| Seclusion |                           |          |          |
| Restraint |                           |          |          |

B18a. Regardless of whether **this facility** uses seclusion or restraint, 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

Local, county, or community government

Tribal government

Federal Government → SKIP TO C2a

→ SKIP TO C3

\*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](https://www.findtreatment.gov), the *National Directory of Mental Health Treatment Facilities*, and the *National Directory of Drug and Alcohol Use Treatment Facilities*?

- [FindTreatment.gov](https://www.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](https://www.samhsa.gov/data), the *National Directory of Mental Health Treatment Facilities*, and the *National Directory of Drug and Alcohol Use Treatment Facilities*?

- [FindTreatment.gov](https://www.samhsa.gov/data), 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](https://www.samhsa.gov/data), 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 location address and/or mailing address to be listed on [FindTreatment.gov](https://www.samhsa.gov/data), 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 **location** address

Publish only a partial **location** address  
(i.e., City, State, ZIP)

Publish the **mailing** address

Publish only a partial **mailing** address  
(i.e., City, State, ZIP)

Do **not** publish either address

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

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

Yes

No

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

Yes

No

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## MODULE D: CLIENT COUNTS SECTION

D1. The next set of questions asks about the number of clients in treatment. Although reporting for only the clients/patients treated **at this facility** is preferred, we realize that may not be possible. Will the client/patient counts reported in this questionnaire include:

MARK ONE ONLY

Only this facility  → SKIP TO **D4**

This facility plus others  → SKIP TO **D2**

Another facility will report this facility's client counts  → SKIP TO **E1** (no client counts to report)

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

|                                     |   |
|-------------------------------------|---|
| THIS FACILITY                       | 1 |
| + ADDITIONAL FACILITIES             |   |
| <b>TOTAL FACILITIES<sup>†</sup></b> |   |

<sup>†</sup>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, 2026, did any patients receive **hospital inpatient substance use disorder treatment services at this facility**?

Yes  → SKIP TO **D4a**

No  → SKIP TO **D5**

D4a. On March 31, 2026, 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<br><i>(e.g., medical withdrawal, social detoxification, medically managed or monitored inpatient detoxification, etc.)</i> |  |
| Inpatient treatment<br><i>(medically managed or monitored intensive inpatient treatment)</i>  |  |
| <b>HOSPITAL INPATIENT TOTAL</b>   |  |

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, 2026, 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, 2026, 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, 2026, 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<br><i>(e.g., medical withdrawal, clinically managed, social detoxification, etc.)</i>                           |  |
| Residential short-term treatment<br><i>(clinically managed high-intensity residential treatment, typically 30 days or less)</i>            |  |
| Residential long-term treatment<br><i>(clinically managed medium- or low-intensity residential treatment, typically more than 30 days)</i> |  |
| <b>RESIDENTIAL TOTAL</b>   |  |

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, 2026, 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 2026, did any clients receive **outpatient substance use disorder treatment** services **at this facility**?

Yes **SKIP TO D6a**

No **SKIP TO D7**

D6a. As of March 31, 2026, 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, 2026.**
- **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<br><i>(ambulatory detoxification)</i>   |  |
| Outpatient methadone/buprenorphine maintenance or naltrexone treatment<br><i>(count methadone/buprenorphine/naltrexone clients on this line only)</i> |  |
| Outpatient day treatment or partial hospitalization<br><i>(20 or more hours per week)</i>   |  |
| Intensive outpatient treatment<br><i>(9 or more hours per week)</i>   |  |
| Regular outpatient treatment<br><i>(outpatient treatment, non-intensive)</i>  |  |
| <b>OUTPATIENT TOTAL</b>   |  |

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

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

Number under age 18

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

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

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

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

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

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

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

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

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

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

Enter the clients on March 31, 2026, 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 |
|--|--------|----|---------|
| <b>Both</b> alcohol <b>and</b> substances other than alcohol |        |    | %       |
| <b>Only</b> alcohol  |        |    | %       |
| <b>Only</b> substances other than alcohol                    |        |    | %       |
| <b>TOTAL</b><br><i>(D4a + D5a + D6a)</i>                     |        |    | 100%    |

D8. Approximately what percent of the substance use treatment clients enrolled **at this facility on March 31, 2026, 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

### HOSPITAL INPATIENT CLIENT COUNTS

D10. On **March 31, 2026**, 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, 2026**, 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, 2026**, 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, 2026**, 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  |        |    | %       |
|              | Unknown or not collected                        |        |    | %       |
|              | <b>CATEGORY TOTAL: (Should = TOTAL or 100%)</b> |        |    | 100%    |
| AGE          | 0-17  |        |    | %       |
|              | 18-64   |        |    | %       |
|              | 65 and older                                    |        |    | %       |
|              | Unknown or not collected                        |        |    | %       |
|              | <b>CATEGORY TOTAL: (Should = TOTAL or 100%)</b> |        |    | 100%    |
| ETHNICITY    | Hispanic or Latino                              |        |    | %       |
|              | Not Hispanic or Latino                          |        |    | %       |
|              | Unknown or not collected                        |        |    | %       |
|              | <b>CATEGORY TOTAL: (Should = TOTAL or 100%)</b> |        |    | 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                        |        |    | %       |
|              | <b>CATEGORY TOTAL: (Should = TOTAL or 100%)</b> |        |    | 100%    |
| LEGAL STATUS | Voluntary                                       |        |    | %       |
|              | Involuntary, non-forensic                       |        |    | %       |
|              | Involuntary, forensic                           |        |    | %       |
|              | Unknown or not collected                        |        |    | %       |
|              | <b>CATEGORY TOTAL: (Should = TOTAL or 100%)</b> |        |    | 100%    |

RESIDENTIAL (NON-HOSPITAL) CLIENT COUNTS

D11. On **March 31, 2026**, 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, 2026**, 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, 2026**, 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, 2026**, 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  |        |    | %           |
|              | Unknown or not collected                        |        |    | %           |
|              | <b>CATEGORY TOTAL: (Should = TOTAL or 100%)</b> |        |    | <b>100%</b> |
| AGE          | 0-17  |        |    | %           |
|              | 18-64   |        |    | %           |
|              | 65 and older                                    |        |    | %           |
|              | Unknown or not collected                        |        |    | %           |
|              | <b>CATEGORY TOTAL: (Should = TOTAL or 100%)</b> |        |    | <b>100%</b> |
| ETHNICITY    | Hispanic or Latino                              |        |    | %           |
|              | Not Hispanic or Latino                          |        |    | %           |
|              | Unknown or not collected                        |        |    | %           |
|              | <b>CATEGORY TOTAL: (Should = TOTAL or 100%)</b> |        |    | <b>100%</b> |
| 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                        |        |    | %           |
|              | <b>CATEGORY TOTAL: (Should = TOTAL or 100%)</b> |        |    | <b>100%</b> |
| LEGAL STATUS | Voluntary                                       |        |    | %           |
|              | Involuntary, non-forensic                       |        |    | %           |
|              | Involuntary, forensic                           |        |    | %           |
|              | Unknown or not collected                        |        |    | %           |
|              | <b>CATEGORY TOTAL: (Should = TOTAL or 100%)</b> |        |    | <b>100%</b> |

**LESS THAN 24-HOUR TREATMENT CLIENT COUNTS**

D12. During the **month** of March 2026, 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 2026, 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, 2026.**
- **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  |        |    | %       |
|              | Unknown or not collected                        |        |    | %       |
|              | <b>CATEGORY TOTAL: (Should = TOTAL or 100%)</b> |        |    | 100%    |
| AGE          | 0-17  |        |    | %       |
|              | 18-64   |        |    | %       |
|              | 65 and older                                    |        |    | %       |
|              | Unknown or not collected                        |        |    | %       |
|              | <b>CATEGORY TOTAL: (Should = TOTAL or 100%)</b> |        |    | 100%    |
| ETHNICITY    | Hispanic or Latino                              |        |    | %       |
|              | Not Hispanic or Latino                          |        |    | %       |
|              | Unknown or not collected                        |        |    | %       |
|              | <b>CATEGORY TOTAL: (Should = TOTAL or 100%)</b> |        |    | 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                        |        |    | %       |
|              | <b>CATEGORY TOTAL: (Should = TOTAL or 100%)</b> |        |    | 100%    |
| LEGAL STATUS | Voluntary                                       |        |    | %       |
|              | Involuntary, non-forensic                       |        |    | %       |
|              | Involuntary, forensic                           |        |    | %       |
|              | Unknown or not collected                        |        |    | %       |
|              | <b>CATEGORY TOTAL: (Should = TOTAL or 100%)</b> |        |    | 100%    |

ALL MENTAL HEALTH TREATMENT SETTINGS

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

D13. On **March 31, 2026**, 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, 2025, through March 31, 2026, 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, 1902 Reston Metro Plaza, Reston, VA 20190

**Pledge to Respondents:** The information you provide will be protected to the fullest extent allowable under the Public Health Service Act (42 USC 290aa(p)). This law permits the public release of identifiable information about an establishment only with the consent of that establishment and limits the use of the information to the purposes for which it was supplied. With the explicit consent of treatment facilities, information provided in response to survey questions marked with an asterisk may be published on [FindTreatment.gov](http://FindTreatment.gov), the National Directory of Drug and Alcohol Use Treatment Facilities, the National Directory of Mental Health Treatment Facilities, and other publicly available listings. Responses to non-asterisked questions will be published with no direct link to individual treatment facilities.

**Public Burden Statement:** An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0386. Public reporting burden for this collection of information is estimated to average 55 minutes per facility, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 5600 Fishers Lane, Room 15E57-A, Rockville, Maryland 20857.