

# National Survey of Substance Abuse Treatment Services (N-SSATS)

**March 31, 2004**

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMPLE

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

CHECK ONE

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



**PLEASE READ THIS ENTIRE PAGE BEFORE  
COMPLETING THE QUESTIONNAIRE**

**INSTRUCTIONS**

- Most of the questions in this survey ask about “this facility.” By “this facility” we mean the substance abuse treatment facility or program listed on the front cover. If you have any questions about how the term “this facility” applies to your facility, please call 1-888-324-8337.
- Please answer **ONLY** for the facility printed on the cover, unless otherwise specified in the questionnaire.
- Return the completed questionnaire in the envelope provided. Please keep a copy for your records.
- If you have any questions or need additional blank forms, contact:

MATHEMATICA POLICY RESEARCH, INC.  
1-888-324-8337

If you prefer, you may complete this questionnaire online. See the pink flyer enclosed in your questionnaire packet for the Internet address and your unique user name and password. If you need more information, call the N-SSATS hotline at 1-888-324-8337.

**Important Information**

\* **Asterisked questions.** Information from asterisked (\*) questions will be published in SAMHSA’s National Directory of Drug and Alcohol Abuse Treatment Programs and will be available online at <http://findtreatment.samhsa.gov>, SAMHSA’s Substance Abuse Treatment Facility Locator.

**Mapping feature in Locator.** Complete and accurate name and address information is needed for the online Treatment Facility Locator so it can correctly map the facility location.

**Eligibility for Directory/Locator.** Only facilities approved by their State substance abuse office will be listed in the National Directory and online Treatment Facility Locator. Your State N-SSATS representative can tell you if your facility is State-approved. For the name and telephone number of your State representative, call the N-SSATS hotline at 1-888-324-8337 or go to <http://www.dasis.samhsa.gov> and click on “DASIS Contacts” then “N-SSATS Contacts by State.”

# SECTION A: FACILITY CHARACTERISTICS

Section A asks about characteristics of individual facilities and should be completed for only the facility listed on the front cover.

1. Which of the following substance abuse services are offered by this facility, that is, the facility named on the front cover?

MARK "YES" OR "NO" FOR EACH

- |  | <u>YES</u>                 | <u>NO</u>                  |
|--|----------------------------|----------------------------|
| 1. Intake, assessment, or referral .....   | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Detoxification .....  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. Substance abuse treatment<br>(services that focus on initiating and maintaining an individual's recovery from substance abuse and on averting relapse)..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 4. Any other substance abuse services .....  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

1a. Did you answer "yes" to substance abuse treatment in question 1 above?

- 1  Yes → SKIP TO Q. 2 (TOP OF NEXT COLUMN)
- 0  No

1b. Did you answer "yes" to detoxification in question 1 above?

- 1  Yes → GO TO Q.2 (TOP OF NEXT COLUMN)
- 0  No → SKIP TO Q.31 (PAGE 10)

\*2. What is the primary focus of this facility?

MARK ONE ONLY

- 1  Substance abuse treatment services
- 2  Mental health services
- 3  Mix of mental health and substance abuse treatment services (neither is primary)
- 4  General health care
- 5  Other (Specify: \_\_\_\_\_)

3. Is this facility operated by . . .

MARK ONE ONLY

- 1  A private for-profit organization
- 2  A private non-profit organization
- 3  State government
- 4  Local, county, or community government
- 5  Tribal government
- 6  Federal government

→ SKIP TO Q.4 (PAGE 2)

→ SKIP TO Q.6 (PAGE 2)

3a. Which federal government agency?

MARK ONE ONLY

- 1  Department of Veterans Affairs
- 2  Department of Defense
- 3  Indian Health Service
- 4  Other (Specify: \_\_\_\_\_)

→ SKIP TO Q.6 (PAGE 2)

4. Is this facility a private solo practice, that is, an office with a single practitioner or therapist?

- 1  Yes  
0  No

5. Is this facility affiliated with a religious organization?

- 1  Yes  
0  No

6. Is this facility a jail, prison, or other organization that provides treatment exclusively for incarcerated persons?

- 1  Yes → SKIP TO Q.37 (PAGE 10)  
0  No

7. Is this facility located in, or operated by, a hospital?

- 1  Yes  
0  No → SKIP TO Q.8 (TOP OF NEXT COLUMN)

7a. What type of hospital?

MARK ONE ONLY

- 1  General hospital (including VA hospital)  
2  Psychiatric hospital  
3  Other specialty hospital, for example, alcoholism, maternity, etc.

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

\*8. What telephone number(s) should a potential client call to schedule an intake appointment?

INTAKE TELEPHONE NUMBER(S)

1. (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_  
2. (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_

9. Does this facility operate a hotline that responds to substance abuse problems?

- A hotline is a telephone service that provides information, referral, or immediate counseling, frequently in a crisis situation.
- If this facility is part of a group of facilities that operates a central hotline to respond to substance abuse problems, you should mark "yes."
- DO NOT consider 911 or the local police number a hotline for the purpose of this survey.

- 1  Yes  
0  No → SKIP TO Q.10 (PAGE 3)

\*9a. Please enter the hotline telephone number(s) below.

HOTLINE TELEPHONE NUMBER(S)

1. (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_  
2. (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_

10. Which of the following services are provided by this facility at *this location*?

MARK ALL THAT APPLY

**Assessment Services**

- 1  Comprehensive substance abuse assessment or diagnosis
- 2  Comprehensive mental health assessment or diagnosis (for example, psychological or psychiatric evaluation and testing)

**Substance Abuse Therapy and Counseling**

- 3  Family counseling
- 4  Group therapy, not including relapse prevention
- 5  Individual therapy
- 6  Relapse prevention groups
- 7  Aftercare counseling

**Pharmacotherapies**

- 8  Antabuse
- 9  Naltrexone
- 10  Buprenorphine (Subutex, Suboxone)
- 11  Methadone

**Testing** (Include tests performed at this location, even if specimen is sent to outside source for chemical analysis.)

- 12  Breathalyzer or other blood alcohol testing
- 13  Drug or alcohol urine screening
- 14  Screening for Hepatitis B
- 15  Screening for Hepatitis C
- 16  HIV testing
- 17  STD testing
- 18  TB screening

**Transitional Services**

- 19  Assistance with obtaining social services (for example, Medicaid, WIC, SSI, SSDI)
- 20  Discharge planning
- 21  Employment counseling or training for clients
- 22  Assistance in locating housing for clients

**Other Services**

- 23  Case management services
- 24  Child care for clients' children
- 25  Domestic violence—family or partner violence services (physical, sexual, and emotional abuse)
- 26  HIV or AIDS education, counseling, or support
- 27  Outcome follow-up after discharge
- 28  Transportation assistance to treatment
- 29  Acupuncture
- \*30  Residential beds for clients' children

\*11. Does this facility operate an Opioid Treatment Program (OTP) at this location?

- Opioid Treatment Programs are certified by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, to use opioid drugs such as **methadone** in the treatment of opiate (narcotic) addiction.

- 1  Yes
- 0  No → SKIP TO Q.12 (BELOW)

\*11a. Is the Opioid Treatment Program at this location a maintenance program, a detoxification program, or both?

MARK ONE ONLY

- 1  Maintenance program
- 2  Detoxification program
- 3  Both

\*11b. Are ALL of the substance abuse clients at this facility currently in the Opioid Treatment Program?

- 1  Yes
- 0  No

\*12. Does this facility offer a special program for DUI/DWI or other drunk driver offenders?

- Mark "yes" if this facility serves only DUI/DWI clients OR if this facility has a special DUI/DWI program.

- 1  Yes
- 0  No → SKIP TO Q.13 (PAGE 4)

\*12a. Are ALL of the substance abuse treatment clients at this facility enrolled in the DUI/DWI program?

- 1  Yes
- 0  No

**\*13. Does this facility provide substance abuse treatment services in sign language (for example, American Sign Language, Signed English, or Cued Speech) for the hearing impaired?**

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

- 1  Yes  
0  No

**\*14. Does this facility provide substance abuse treatment services in a language other than English?**

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

- 1  Yes  
0  No → **SKIP TO Q.15 (TOP OF NEXT COLUMN)**

**14a. At this facility, who provides substance abuse treatment services in a language other than English?**

**MARK ONE ONLY**

- 1  Staff counselor that speaks a language other than English  
2  On-call interpreter brought in when needed → **SKIP TO Q.15 (TOP OF NEXT COLUMN)**  
3  BOTH staff counselor and on-call interpreter

**\*14b. In what other languages do staff counselors provide substance abuse treatment at this facility?**

**MARK ALL THAT APPLY**

American Indian or Alaska Native:

- 1  Hopi  
2  Lakota  
3  Navajo  
4  Yupik  
5  Other American Indian or Alaska Native language  
(Specify: \_\_\_\_\_)

Other Languages:

- 6  Arabic  
7  Chinese  
8  Creole  
9  French  
10  German  
11  Hmong  
12  Korean  
13  Polish  
14  Portuguese  
15  Russian  
16  Spanish  
17  Vietnamese  
18  Other language (Specify: \_\_\_\_\_)

**\*15. This question has two parts. Column A asks about the types of clients accepted into treatment at this facility. Column B asks whether this facility offers specially designed treatment programs or groups for each type of client.**

**Column A: For each type of client listed below:**

Indicate whether this facility accepts these clients into treatment at this location.

**Column B: For each "yes" in Column A:** Indicate whether this facility offers a specially designed substance abuse treatment program or group exclusively for that type of client at this location.

**EXAMPLE:** If this facility accepts adolescents for treatment but does not have a specially designed program or group just for adolescents, mark YES in Column A and NO in Column B. If this facility accepts adolescents and has a special program or group just for adolescents, mark YES in both Columns A and B.

Type of Client	Column A		Column B	
	MARK "YES" OR "NO" FOR EACH		FOR EACH "YES" IN COLUMN A, MARK "YES" OR "NO" IN THIS COLUMN	
	CLIENTS ACCEPTED IN TREATMENT		SPECIALLY DESIGNED PROGRAM OR GROUP	
	Yes	No	Yes	No
1. Adolescents	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
2. Clients with co-occurring mental and substance abuse disorders	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
3. Criminal justice clients (other than DUI/DWI clients)	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
4. Persons with HIV or AIDS	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
5. Gays or lesbians	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
6. Seniors or older adults	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
7. Adult women	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
8. Pregnant or postpartum women	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
9. Adult men	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
10. Specially designed programs or groups for any other types of clients (Specify: _____)			1 <input type="checkbox"/>	0 <input type="checkbox"/>

**\*16. Does this facility offer either of the following HOSPITAL INPATIENT substance abuse services at this location?**

MARK "YES" OR "NO" FOR EACH

YES   NO

1. Inpatient detoxification..... 1    0
2. Inpatient treatment ..... 1    0

**\*17. Does this facility offer any of the following RESIDENTIAL (non-hospital) substance abuse services at this location?**

MARK "YES" OR "NO" FOR EACH

YES   NO

1. Residential detoxification..... 1    0
2. Residential short-term treatment  
(30 days or less)..... 1    0
3. Residential long-term treatment  
(more than 30 days) ..... 1    0

**\*18. Does this facility offer any of the following OUTPATIENT substance abuse services at this location?**

MARK "YES" OR "NO" FOR EACH

YES   NO

1. Outpatient detoxification..... 1    0
2. Outpatient methadone  
maintenance ..... 1    0
3. Outpatient day treatment or  
partial hospitalization program  
(20 or more hours per week) ..... 1    0
4. Intensive outpatient treatment  
(defined as a minimum of  
2 hours per day on 3 or more  
days per week) ..... 1    0
5. Regular outpatient treatment  
(fewer hours per week than  
intensive) ..... 1    0

**\*19. Does this facility use a sliding fee scale?**

1  Yes

0  No → SKIP TO Q.19b (BELOW)

**19a. Do you want the availability of a sliding fee scale published in SAMHSA's Directory/Locator?**  
(For information on Directory/Locator eligibility, see the inside front cover.)

- *The Directory/Locator will explain that sliding fee scales are based on income and other factors.*

1  Yes

0  No

**\*19b. Does this facility offer treatment at no charge to clients who cannot afford to pay?**

1  Yes

0  No → SKIP TO Q.20 (PAGE 6)

**19c. Do you want the availability of free care for eligible clients published in SAMHSA's Directory/Locator?**

- *The Directory/Locator will explain that potential clients should call the facility for information on eligibility.*

1  Yes

0  No

**\*20. Which of the following types of payments are accepted by this facility for substance abuse treatment?**

MARK "YES," "NO," OR "DON'T KNOW" FOR EACH

- |  | YES                        | NO                         | DON'T<br>KNOW               |
|--|----------------------------|----------------------------|-----------------------------|
| 1. Cash or self-payment .....  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | -1 <input type="checkbox"/> |
| 2. Medicare.....   | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | -1 <input type="checkbox"/> |
| 3. Medicaid .....  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | -1 <input type="checkbox"/> |
| 4. A State-financed health Insurance plan other than Medicaid (for example, State children's health insurance plan (SCHIP) or high risk insurance pools) ..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | -1 <input type="checkbox"/> |
| 5. Federal military insurance such as TRICARE or Champ VA .....  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | -1 <input type="checkbox"/> |
| 6. Private health insurance.....   | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | -1 <input type="checkbox"/> |
| 7. No payment accepted (free treatment for ALL clients) .....  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | -1 <input type="checkbox"/> |
| 8. Other.....  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | -1 <input type="checkbox"/> |

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

**21. Does this facility receive any public funds such as federal, state, county, or local government funds for substance abuse treatment programs?**

- Do not include Medicare, Medicaid, or federal military insurance.

- 1  Yes  
 0  No  
 -1  Don't Know

**22. Does this facility have agreements or contracts with managed care organizations for providing substance abuse treatment services?**

- 1  Yes  
 0  No  
 -1  Don't Know

## SECTION B: CLIENT COUNT INFORMATION

**IMPORTANT:** Questions in Section B ask about two different time periods, i.e., the single day of September 30, 2003, and the 12-month period ending on September 30, 2003. Please pay special attention to the period specified in each question.

**FOR MENTAL HEALTH FACILITIES:** When answering questions about the number of clients at this facility, count all clients receiving substance abuse treatment, even if substance abuse is a secondary diagnosis.

**23. Questions 24 through 28 ask about the number of clients in treatment at this facility at specified times.**

**Please check the option below that best describes how client counts will be reported in these questions.**

**MARK ONE ONLY**

- 1  Questions 24 through 28 will include client counts for this facility alone → **SKIP TO Q.24 (PAGE 7)**
- 2  Questions 24 through 28 will include client counts for this facility combined with other facilities → **SKIP TO Q.24 (PAGE 7)**
- 3  Client counts for this facility will be reported in another facility's questionnaire

**23a. Whom should we contact for client count information?**

- Please record all of the information requested.

_____	} → <b>SKIP TO Q.31 (PAGE 10)</b>
CONTACT PERSON	
_____	
PHONE NUMBER	
_____	
FACILITY NAME	
_____	
CITY/STATE	

## HOSPITAL INPATIENT

24. On March 31, 2004, did any patients receive HOSPITAL INPATIENT substance abuse services at this facility?

- 1  Yes  
0  No → SKIP TO Q.25 (TOP OF NEXT COLUMN)

24a. On March 31, 2004, how many patients received the following HOSPITAL INPATIENT substance abuse services at this facility?

- **COUNT** a client in **one service only**, even if the client received both services.
- **DO NOT** count codependents, relatives, friends, or other non-treatment clients.

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

NUMBER

1. Inpatient detoxification \_\_\_\_\_  
2. Inpatient treatment \_\_\_\_\_

HOSPITAL INPATIENT  
TOTAL BOX

24b. How many of the patients from the HOSPITAL INPATIENT TOTAL BOX were under the age of 18?

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

Number under age 18 \_\_\_\_\_

24c. How many of the patients from the HOSPITAL INPATIENT TOTAL BOX received methadone or buprenorphine dispensed by this facility?

- *Include clients who received these drugs for detoxification or maintenance purposes.*

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

NUMBER

1. Methadone \_\_\_\_\_  
2. Buprenorphine \_\_\_\_\_

24d. On March 31, 2004, how many hospital inpatient beds at this facility were specifically designated for substance abuse treatment?

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

Number of beds \_\_\_\_\_

## RESIDENTIAL (NON-HOSPITAL)

25. On March 31, 2004, did any clients receive RESIDENTIAL (non-hospital) substance abuse services at this facility?

- 1  Yes  
0  No → SKIP TO Q.26 (PAGE 8)

25a. On March 31, 2004, how many clients received the following RESIDENTIAL substance abuse services at this facility?

- **Count** a client in **one service only**, even if the client received multiple services.
- **DO NOT** count codependents, relatives, friends, or other non-treatment clients.

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

NUMBER

1. Residential detoxification \_\_\_\_\_  
2. Residential short-term treatment (30 days or less) \_\_\_\_\_  
3. Residential long-term treatment (more than 30 days) \_\_\_\_\_

RESIDENTIAL  
TOTAL BOX

25b. How many of the clients from the RESIDENTIAL TOTAL BOX were under the age of 18?

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

Number under age 18 \_\_\_\_\_

25c. How many of the clients from the RESIDENTIAL TOTAL BOX received methadone or buprenorphine dispensed by this facility?

- *Include clients who received these drugs for detoxification or maintenance purposes.*

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

NUMBER

1. Methadone \_\_\_\_\_  
2. Buprenorphine \_\_\_\_\_

25d. On March 31, 2004, how many residential beds at this facility were specifically designated for substance abuse treatment?

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

Number of beds \_\_\_\_\_

**OUTPATIENT**

26. During the month of March 2004, did any clients receive **OUTPATIENT substance abuse services** at this facility?

- 1  Yes  
 0  No → **SKIP TO Q.27 (PAGE 9)**

26a. As of March 31, 2004, how many active clients were enrolled in each of the following **OUTPATIENT substance abuse services** at this facility?

 Active outpatient clients are individuals who:

- (1) were seen at this facility for a substance abuse treatment or detox service at least once during the month of March 2004  
**AND**  
 (2) were still enrolled in treatment as of March 31, 2004.

- **COUNT** a client in **one service only**, even if the client received multiple services.
- **DO NOT** count codependents, relatives, friends, or other non-treatment clients.

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

NUMBER

1. Outpatient detoxification \_\_\_\_\_
2. Outpatient methadone maintenance \_\_\_\_\_
3. Outpatient day treatment or partial hospitalization (20 or more hours per week) \_\_\_\_\_
4. Intensive outpatient treatment (defined as a minimum of 2 hours per day on 3 or more days per week) \_\_\_\_\_
5. Regular outpatient treatment (fewer hours per week than intensive) \_\_\_\_\_

**OUTPATIENT TOTAL BOX**

26b. How many of the clients from the **OUTPATIENT TOTAL BOX** were under the age of 18?

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

Number under age 18 \_\_\_\_\_

26c. How many of the clients from the **OUTPATIENT TOTAL BOX** received methadone or buprenorphine dispensed by this facility?

- Include clients who received these drugs for detoxification or maintenance purposes.

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

NUMBER

1. Methadone \_\_\_\_\_
2. Buprenorphine \_\_\_\_\_

26d. The number you recorded in the **OUTPATIENT TOTAL BOX** (question 26a) represents the number of clients enrolled in outpatient substance abuse treatment at this facility on **March 31, 2004**. Considering staff resources available at that time, did this facility have the capacity to accommodate a larger outpatient enrollment on March 31, 2004?

- 1  Yes  
 0  No → **GO TO Q.27 (PAGE 9)**

26e. Based on the number of staff available at this facility in March 2004, how many clients could have been enrolled in outpatient substance abuse treatment on March 31, 2004? This is generally referred to as outpatient capacity.

**OUTPATIENT CAPACITY ON MARCH 31, 2004**

27. Thinking about all your substance abuse treatment clients—including hospital inpatient, residential, and/or outpatient—approximately what percent of the substance abuse treatment clients enrolled at this facility on March 31, 2004, were being treated for . . .

1. Abuse of both alcohol and drugs \_\_\_\_\_ %
2. Alcohol abuse only \_\_\_\_\_ %
3. Drug abuse only \_\_\_\_\_ %

TOTAL                      %

↑

**THIS SHOULD TOTAL 100%.  
IF NOT, PLEASE RECONCILE.**

28. In the 12 months beginning April 1, 2003 and ending March 31, 2004, how many admissions for substance abuse treatment did this facility have? Count every admission and re-admission in this 12-month period. If a person was admitted 3 times, count this as 3 admissions.

- *FOR OUTPATIENT CLIENTS, consider an admission to be the initiation of a treatment program or course of treatment. Count admissions into treatment, not individual treatment visits.*
- *IF DATA FOR THIS TIME PERIOD are not available, use the most recent 12-month period for which you have data.*

NUMBER OF SUBSTANCE ABUSE ADMISSIONS IN 12-MONTH PERIOD

29. How many facilities are included in the client counts reported in questions 24 through 28?

- 1  Only this facility → **SKIP TO Q.30**
- 2  This facility plus others → ENTER TOTAL NUMBER OF FACILITIES BELOW (INCLUDE THIS FACILITY):

NUMBER OF FACILITIES

↓

↓

When we receive your questionnaire, we will contact you for a list of the other facilities included in your client counts.

If you prefer, attach a separate piece of paper listing the name and location address of each facility included in your client counts.

**Please continue with Question 30.**

30. For which of the numbers you just reported did you provide actual client counts and for which did you provide your best estimate?

- *Mark "N/A" for any type of care not provided by this facility on March 31, 2004.*

MARK "ACTUAL," "ESTIMATE," OR "N/A" FOR EACH

	ACTUAL	ESTIMATE	N/A
1. Hospital inpatient clients (Q.24a, Pg. 7).....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	0 <input type="checkbox"/>
2. Residential clients (Q.25a, Pg. 7).....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	0 <input type="checkbox"/>
3. Outpatient clients (Q.26a, Pg. 8).....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	0 <input type="checkbox"/>
4. 12-month admissions (Q.28) .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	0 <input type="checkbox"/>

**PLEASE TURN TO BACK COVER TO COMPLETE SECTION C: GENERAL INFORMATION**

## SECTION C: GENERAL INFORMATION

Section C should be completed for only this facility.

**\*31. Does this facility operate a halfway house or other transitional housing for substance abuse clients?**

- 1  Yes  
0  No

**32. Does this facility or program have licensing, certification, or accreditation from any of the following organizations?**

- Only include facility-level licensing, accreditation, etc., related to the provision of substance abuse services.
- Do not include general business licenses, fire marshal approvals, personal-level credentials, food service licenses, etc.

MARK "YES," "NO," OR "DON'T KNOW" FOR EACH

DON'T  
YES NO KNOW

- |   |                            |                            |                             |
|---|----------------------------|----------------------------|-----------------------------|
| 1. State substance abuse agency.....  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | -1 <input type="checkbox"/> |
| 2. State mental health department...  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | -1 <input type="checkbox"/> |
| 3. State public health department or board of health.....                     | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | -1 <input type="checkbox"/> |
| 4. Hospital licensing authority .....   | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | -1 <input type="checkbox"/> |
| 5. JCAHO (Joint Commission on Accreditation of Healthcare Organizations)..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | -1 <input type="checkbox"/> |
| 6. CARF (The Rehabilitation Accreditation Commission) .....                   | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | -1 <input type="checkbox"/> |
| 7. NCQA (National Committee for Quality Assurance).....                       | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | -1 <input type="checkbox"/> |
| 8. COA (Council on Accreditation for Children & Family Services).....         | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | -1 <input type="checkbox"/> |
| 9. Another state or local agency or other organization .....                  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | -1 <input type="checkbox"/> |
| (Specify: _____)  |                            |                            |                             |

**33. Does this facility have Internet access?**

- 1  Yes  
0  No

**\*34. Does this facility have a Web site or Web page with information about the facility's substance abuse treatment programs?**

- 1  Yes →

Please check the front cover of this questionnaire to confirm that the Web site address for this facility is correct EXACTLY as listed. If incorrect or missing, enter the correct address.

- 0  No

**35. If eligible, does this facility want to be listed in the National Directory and online Treatment Facility Locator? (See inside front cover for eligibility information.)**

- 1  Yes  
0  No

**36. Would you like to receive a free paper copy of the next National Directory of Drug and Alcohol Abuse Treatment Programs when it is published?**

- 1  Yes  
0  No

**37. 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.**

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

Title: \_\_\_\_\_

Phone Number: (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

Fax Number: (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Thank you for your participation. Please return this questionnaire in the envelope provided.  
If you no longer have the envelope, please mail this questionnaire to:**

**MATHEMATICA POLICY RESEARCH, INC.**  
ATTN: Melissa Wood - Project 8945  
P.O. Box 2393  
Princeton, NJ 08543-2393

Public burden for this collection of information is estimated to average 35 minutes per response 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, Room 16-105, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857. 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 number for this project is 0930-0106.

**MPR DOCUMENT INFORMATION:**

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