

**ICPSR 4099**

**National Survey of Substance Abuse  
Treatment Services (N-SSATS), 2003**

*United States Department of Health and Human  
Services. Substance Abuse and Mental Health  
Services Administration. Office of Applied Studies*

Part 1  
**QUESTIONNAIRE**



## Summary

The National Survey of Substance Abuse Treatment Services (N-SSATS) is designed to collect information from all facilities in the United States, both public and private, that provide substance abuse treatment. N-SSATS provides the mechanism for quantifying the dynamic character and composition of the United States substance abuse treatment delivery system. The objectives of N-SSATS are to collect multipurpose data that can be used to assist the Substance Abuse and Mental Health Services Administration (SAMHSA) and state and local governments in assessing the nature and extent of services provided and in forecasting treatment resource requirements, update SAMHSA's Inventory of Substance Abuse Treatment Services (I-SATS), analyze general treatment services trends, and generate the National Directory of Drug and Alcohol Abuse Treatment Programs and its online Abuse Treatment Facility Locator equivalent, the Substance Abuse Treatment Facility Locator:

<http://findtreatment.samhsa.gov>. Data are collected on topics including ownership, services offered, primary focus (substance abuse, mental health, both, general health, other), hotline operation, methadone/LAAM dispensing, languages in which treatment is provided, type of treatment provided, number of clients (total and under age 18), number of beds, types of payment accepted, sliding fee scale, special programs offered, facility accreditation and licensure/certification, and managed care agreements. N-SSATS was formerly titled the Uniform Facility Data Set (UFDS).

## **Universe**

All facilities that were on the Inventory of Substance Abuse Treatment Services (I-SATS) as of approximately six weeks before the survey reference date of March 31, 2003.

## **Data Type**

survey data

## **Data Source**

mail, telephone, and Web-based surveys

## **Additional Information for Study 4099**

<http://webapp.icpsr.umich.edu/cocoon/SAMHDA-STUDY/04099.xml>

## **Study Citation**

We appreciate the [appropriate citation](#) for study documentation obtained from SAMHDA. The study description for this study includes a [suggested bibliographic citation](#) for the data.

# 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  | □          | 0 □       |
| 2. Detoxification .....   | 1 □        | 0 □       |
| 3. Substance abuse treatment<br>(services that focus on initiating and maintaining an individual's recovery from substance abuse and on averting relapse) ..... | 1 □        | 0 □       |
| 4. Halfway house or other transitional housing.....   | 1 □        | 0 □       |
| 5. Other substance abuse services<br>(such as administrative or preventive services).....   | 1 □        | 0 □       |

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

- 1 □ Yes → SKIP TO Q.2  
0 □ No

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

- 1 □ Yes → SKIP TO Q.2  
0 □ No

1c. Did you answer "yes" to halfway house or other transitional housing in question 1 above?

- 1 □ Yes → SKIP TO Q.32 (PAGE 10)  
0 □ No → SKIP TO Q.37 (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 → SKIP TO Q.4  
3  State government  
4  Local, county, or community government → SKIP TO Q.6 (PAGE 2)  
5  Tribal government  
6  Federal government

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. (PAGE 2)

4. Is this 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
- 0  No

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

- 1  Yes
- 0  No → SKIP TO Q.8

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. 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.9

\*8a. Please enter the hotline telephone number(s) below.

HOTLINE TELEPHONE NUMBER(S)

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

\*9. What telephone number(s) should a potential client call to schedule an intake appointment?

INTAKE 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)

**Testing** (Include testing service even if specimen is sent to outside source for chemical analysis.)

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

**Transitional Services**

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

**Other Services**

- 22  Case management services
- 23  Child care
- 24  Domestic violence—family or partner violence services (physical, sexual, and emotional abuse)
- 25  HIV or AIDS education, counseling, or support
- 26  Outcome follow-up after discharge
- 27  Transportation assistance to treatment
- 28  Acupuncture
- 29  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** and **LAAM** in the treatment of opiate (narcotic) addiction.

1  Yes →

PLEASE REVIEW THE OTP NUMBER (FORMERLY THE FDA NUMBER) ON THE FRONT COVER AND UPDATE IF INCORRECT OR MISSING.

0  No → SKIP TO Q.12

\*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 DUI/DWI or other drunk driver offenders?

- 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**

**\*14a. In what other language(s) is substance abuse treatment offered 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 Language(s):

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 if this facility offers a specially designed substance abuse treatment program or group exclusively for that type of client at this location.

- For 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.

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

	<b>A</b>		<b>B</b>	
	<b>CLIENTS ACCEPTED IN TREATMENT</b>		<b>SPECIALLY DESIGNED PROGRAM OR GROUP</b>	
	<b>YES</b>	<b>NO</b>	<b>YES</b>	<b>NO</b>
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. Pregnant or postpartum women .....	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
8. Women .....	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
9. Men.....	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
10. Specially designed programs or groups for other types of clients .....	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

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

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

- 1  Yes
- 0  No → SKIP TO Q.17

**\*16a. Which of the following HOSPITAL INPATIENT substance abuse services are offered?**

MARK "YES" OR "NO" FOR EACH

- |                                   | <u>YES</u>                 | <u>NO</u>                  |
|-----------------------------------|----------------------------|----------------------------|
| 1. Inpatient detoxification ..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Inpatient treatment .....      | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

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

- 1  Yes
- 0  No → SKIP TO Q.18

**\*17a. Which of the following RESIDENTIAL substance abuse services are offered?**

MARK "YES" OR "NO" FOR EACH

- |  | <u>YES</u>                 | <u>NO</u>                  |
|--|----------------------------|----------------------------|
| 1. Residential detoxification .....                          | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Residential short-term treatment (30 days or less) .....  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. Residential long-term treatment (more than 30 days) ..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

**\*18. Does this facility offer OUTPATIENT substance abuse services at this location?**

- 1  Yes
- 0  No → SKIP TO Q.19

**\*18a. Which of the following OUTPATIENT substance abuse services are offered?**

MARK "YES" OR "NO" FOR EACH

- |  | <u>YES</u>                 | <u>NO</u>                  |
|--|----------------------------|----------------------------|
| 1. Outpatient detoxification .....   | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Outpatient methadone or LAAM maintenance .....  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. Outpatient day treatment or partial hospitalization program (20 or more hours per week) .....             | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 4. Intensive outpatient treatment (defined as a minimum of 2 hours per day on 3 or more days per week) ..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 5. Regular outpatient treatment (fewer hours per week than intensive) .....                                  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

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

- 1  Yes →

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

**DO YOU WANT THE AVAILABILITY OF A SLIDING FEE SCALE PUBLISHED IN THE DIRECTORY/LOCATOR?**

- 1  Yes
- 0  No

- 0  No

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

- 1  Yes →

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

**DO YOU WANT THE AVAILABILITY OF FREE CARE FOR ELIGIBLE CLIENTS PUBLISHED IN THE DIRECTORY/LOCATOR?**

- 1  Yes
- 0  No

- 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

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

- 1  Yes  
0  No

## SECTION B: CLIENT COUNT INFORMATION

**IMPORTANT:** Questions in Section B ask about different time periods, e.g., March 31, 2003, and the 12-month period ending on March 31, 2003. Please pay special attention to the date specified in each question.

**23. Did this facility offer substance abuse treatment or detoxification services on March 31, 2003?**

- 1  Yes  
0  No → **SKIP TO Q.32 (PAGE 10)**

**24. The next questions ask about the number of clients in treatment at this facility on March 31, 2003. Please check the option below that best describes how client counts will be reported in this questionnaire.**

- We would prefer to get this information separately for this facility. However, if this facility is part of an organization with multiple facilities or sites that provide substance abuse treatment, and data cannot be separated, it is acceptable to report the combined counts of multiple facilities.
- If you have any questions on how to proceed, please call the N-SSATS hotline at 1-888-324-8337.

**MARK ONE ONLY**

- 1  This questionnaire will include client counts for this facility alone → **SKIP TO Q.25 (PAGE 7)**
- 2  This questionnaire will include client counts for this facility combined with other facilities in the organization → **SKIP TO Q.25 (PAGE 7)**
- 3  Client counts for this facility will be reported in another facility's questionnaire

**24a. Whom should we contact for client count information?**

- Please record all of the information requested.

CONTACT PERSON

PHONE NUMBER

FACILITY NAME

CITY/STATE

→ **SKIP TO  
Q.32  
(PAGE 10)**

**HOSPITAL INPATIENT**  
(RESPOND FOR MARCH 31, 2003)

25. On March 31, 2003, did any patients receive HOSPITAL INPATIENT substance abuse services at this facility?

- 1  Yes  
0  No → SKIP TO Q.26

25a. On March 31, 2003, how many patients received the following HOSPITAL INPATIENT substance abuse services at this facility?

- COUNT a client in one service category only, even if the client received both services.
- DO NOT count codependents, parents, other relatives, friends (that is, "collaterals"), or other non-treatment clients.

PROVIDE A NUMBER OR MARK "NONE" FOR EACH

- |                             | <u>NUMBER</u> | <u>NONE</u>                 |
|-----------------------------|---------------|-----------------------------|
| 1. Inpatient detoxification | _____         | or <input type="checkbox"/> |
| 2. Inpatient treatment      | _____         | or <input type="checkbox"/> |

HOSPITAL INPATIENT  
TOTAL BOX

25b. How many of the patients from the HOSPITAL INPATIENT TOTAL BOX were under the age of 18?

PROVIDE A NUMBER OR MARK "NONE"

NONE

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

25c. How many of the patients from the HOSPITAL INPATIENT TOTAL BOX received methadone or LAAM dispensed at this facility?

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

PROVIDE A NUMBER OR MARK "NONE" FOR EACH

- |              | <u>NUMBER</u> | <u>NONE</u>                 |
|--------------|---------------|-----------------------------|
| 1. Methadone | _____         | or <input type="checkbox"/> |
| 2. LAAM      | _____         | or <input type="checkbox"/> |

25d. On March 31, 2003, how many of the hospital inpatient beds at this facility were specifically designated for substance abuse treatment?

PROVIDE A NUMBER OR MARK "NONE"

NUMBER      NONE

\_\_\_\_\_ or

**RESIDENTIAL (NON-HOSPITAL)**  
(RESPOND FOR MARCH 31, 2003)

26. On March 31, 2003, did any clients receive RESIDENTIAL (non-hospital) substance abuse services at this facility?

- 1  Yes  
0  No → SKIP TO Q.27 (PAGE 8)

26a. On March 31, 2003, how many clients received the following RESIDENTIAL substance abuse services at this facility?

- COUNT a client in one service category only, even if the client received multiple services.
- DO NOT count codependents, parents, other relatives, friends (that is, "collaterals"), or other non-treatment clients.

PROVIDE A NUMBER OR MARK "NONE" FOR EACH

- |  | <u>NUMBER</u> | <u>NONE</u>                 |
|--|---------------|-----------------------------|
| 1. Residential detoxification                          | _____         | or <input type="checkbox"/> |
| 2. Residential short-term treatment (30 days or less)  | _____         | or <input type="checkbox"/> |
| 3. Residential long-term treatment (more than 30 days) | _____         | or <input type="checkbox"/> |

RESIDENTIAL  
TOTAL BOX

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

PROVIDE A NUMBER OR MARK "NONE"

NONE

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

26c. How many of the clients from the RESIDENTIAL TOTAL BOX received methadone or LAAM dispensed at this facility?

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

PROVIDE A NUMBER OR MARK "NONE" FOR EACH

- |              | <u>NUMBER</u> | <u>NONE</u>                 |
|--------------|---------------|-----------------------------|
| 1. Methadone | _____         | or <input type="checkbox"/> |
| 2. LAAM      | _____         | or <input type="checkbox"/> |

26d. On March 31, 2003, how many of the residential beds at this facility were specifically designated for substance abuse treatment?

PROVIDE A NUMBER OR MARK "NONE"

NUMBER      NONE

\_\_\_\_\_ or

**OUTPATIENT**  
(RESPOND FOR THE MONTH OF MARCH 2003)

27. During the month of March 2003, did any clients receive **OUTPATIENT substance abuse services** at this facility?

- 1  Yes  
0  No → **SKIP TO Q.28 (PAGE 9)**

27a. As of March 31, 2003, 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 2003

**AND**

(2) were still enrolled in treatment as of March 31, 2003.

- COUNT a client in one service only, even if the client received multiple services.
- DO NOT count codependents, parents, other relatives, friends (that is, "collaterals"), or other non-treatment clients.

ENTER A NUMBER OR MARK "NONE" FOR EACH

- |  | <u>NUMBER</u> | <u>NONE</u>                 |
|--|---------------|-----------------------------|
| 1. Outpatient detoxification   | _____         | or <input type="checkbox"/> |
| 2. Outpatient methadone or LAAM maintenance  | _____         | or <input type="checkbox"/> |
| 3. Outpatient day treatment or partial hospitalization (20 or more hours per week)                     | _____         | or <input type="checkbox"/> |
| 4. Intensive outpatient treatment (defined as a minimum of 2 hours per day on 3 or more days per week) | _____         | or <input type="checkbox"/> |
| 5. Regular outpatient treatment (fewer hours per week than intensive)                                  | _____         | or <input type="checkbox"/> |

**OUTPATIENT TOTAL BOX**

27b. How many of the clients from the **OUTPATIENT TOTAL BOX** were under the age of 18?

PROVIDE A NUMBER OR MARK "NONE"

NONE

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

27c. How many of the clients from the **OUTPATIENT TOTAL BOX** received methadone or LAAM dispensed at this facility?

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

PROVIDE A NUMBER OR MARK "NONE" FOR EACH

NUMBER      NONE

- |              |       |                             |
|--------------|-------|-----------------------------|
| 1. Methadone | _____ | or <input type="checkbox"/> |
| 2. LAAM      | _____ | or <input type="checkbox"/> |

27d. The number you recorded in the **OUTPATIENT TOTAL BOX** (question 27a) represents clients enrolled in outpatient substance abuse treatment at this facility on March 31, 2003. Considering staff resources available during the month of March 2003, did this facility have the capacity to accommodate a larger outpatient enrollment on March 31, 2003?

- 1  Yes  
0  No → **GO TO Q.28 (PAGE 9)**

27e. Considering the available staff resources, how many **additional** clients could have been enrolled in outpatient substance abuse treatment at this facility on March 31, 2003? Use the worksheet below to calculate your response.

OUTPATIENT CAPACITY	_____
MINUS NUMBER FROM OUTPATIENT TOTAL BOX	- _____
ADDITIONAL OUTPATIENTS THAT COULD HAVE BEEN ENROLLED IN TREATMENT ON MARCH 31, 2003	_____

**HOSPITAL INPATIENT, RESIDENTIAL,  
AND OUTPATIENT**  
(RESPOND FOR DATES SPECIFIED IN EACH QUESTION)

**28. Approximately what percent of all substance abuse treatment clients enrolled at this facility on March 31, 2003, were being treated for . . .**

If no substance abuse clients were enrolled on March 31, 2003, check here →  **AND SKIP TO Q.29**

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

**TOTAL** %

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

**29. In the 12 months beginning April 1, 2002 and ending March 31, 2003, 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 as the initiation of a treatment episode.*
- *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**

**30. How many facilities are included in the client counts reported in questions 25 through 29?**

- 1  Only this facility → **SKIP TO Q.31**
- 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 31.**

**31. 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, 2003.*

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

	ACTUAL	ESTIMATE	N/A
1. Hospital inpatient client counts (Q.25a, Pg. 7) .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	0 <input type="checkbox"/>
2. Residential client counts (Q.26a, Pg. 7) .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	0 <input type="checkbox"/>
3. Outpatient client counts (Q.27a, Pg. 8) .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	0 <input type="checkbox"/>
4. 12-month admissions (Q.29) .....	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.

**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

		YES	NO	DON'T 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 →  
0  No

The Web site address for this facility will appear in the Directory/Locator.

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.

**35. If eligible, does this facility want to be listed in the National Directory and online Treatment 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: Receipt Control - 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.

**\*SEE IMPORTANT NOTICE ON INSIDE FRONT COVER.**