

ICPSR 2691

**SERVICES RESEARCH OUTCOMES STUDY,
1995-1996**

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

Part 1

PROGRAM DIRECTOR QUESTIONNAIRE

Summary

The Services Research Outcomes Study (SROS) was designed to provide (1) a 1990 cohort of clients to use as baseline for possible changes in treatment outcomes following increased funding to the national treatment system in the 1990s, (2) a before-to-after comparison to measure outcomes of treatment provided in 1990, (3) a follow-up of drug treatment clients five years after treatment to assess the level of sustained improvements in abstinence, and (4) a first look at multiple treatment episodes before and after treatment in a 1990 population. For the Client Records Abstraction Data (Part 2), client records of 2,222 individuals discharged during 1989-1990 were abstracted to provide information on demographic characteristics of clients, criminal justice involvement, medical conditions, drug history including intravenous drug use, urine test results, drug treatment history, treatment services, and discharge and billing information. Client Follow-Up Interviews (Part 3), conducted during 1995 and 1996, covered the clients' entire life span, with special attention to their behavior and circumstances during the five years before entry to the index (SROS) treatment in 1989-1990 and after leaving that treatment until the time of the interview. Additional questions were asked on patterns of alcohol and drug consumption, criminal activity, employment, health, social support, and other behavior relevant to treatment goals. Drugs included cocaine, crack, heroin, nontreatment methadone, other opiates/synthetics, barbiturates, benzodiazapine, other sedatives/hypnotics, methamphetamines, other amphetamines, marijuana/hash/THC, PCP/LSD, other hallucinogens, inhalants, over-the-counter medications, and alcohol. The Facility Director Interviews (Part 1) covered topics such as facility staff and organization, revenue and charges, staff hours and compensation, costs, and program characteristics.

Universe

(1) The 120 drug treatment facilities participating in Phase II of the Drug Services Research Study (DSRS), and (2) the clients discharged from those facilities in the 12 months ending August 31, 1990.

Data Type

survey data

Data Source

personal interviews, client records, and facility records

Additional Information for Study 2691

<http://webapp.icpsr.umich.edu/cocoon/SAMHDA-STUDY/02691.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 B. Questionnaire

* Indicates that variable was altered to decrease disclosure risk

— (Strikethrough) Indicates that variable was removed from this file to decrease disclosure risk

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
OFFICE OF APPLIED STUDIES

SERVICES RESEARCH OUTCOMES STUDY

Conducted by:

National Opinion Research Center
at the University of Chicago
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Chicago, IL 60637

PROGRAM DIRECTOR INTERVIEW

AFFIX PROGRAM LABEL HERE

Notice :

The information entered on this form will be handled in the strictest confidence and will not be released to unauthorized personnel. This research is authorized under The Anti-Drug Abuse Act of 1988 (P.L. 100-690) which was codified at 42 U.S.C. 290aa-4.

Public respondent burden for this collection of information is estimated to average 1 ½ hours per response, including time for reviewing instructions and completing the collection of information. Send comments regarding this burden estimate, or any other aspects of this collection of information, including suggestions for reducing this burden to: Public Health Service Reports Clearance Officer, ATTN: PRA, Hubert Humphrey Building, Room 721B, 200 Independence Avenue, S.W., Washington, DC 20201; and to the Paperwork Reduction Project (0930-0167), Office of Management and Budget, Washington, DC 20503.

SROS Facility ID: **9999** FAC_ID Interview ID: **9999999**
INTID

Completion Date _____
MONTHCOMP DAYCOMP
YEARCOMP

Signature _____
Title _____

**SERVICES RESEARCH OUTCOMES STUDY
PROGRAM DIRECTOR INTERVIEW**

IMPORTANT NOTE: IN THIS QUESTIONNAIRE THE TERM "PROGRAM: REFERS ONLY TO THE SPECIFIC SUBSTANCE ABUSE TREATMENT PROGRAM WHOSE NAME AND ADDRESS APPEARS O THE FRONT OF THIS QUESTIONNAIRE.

GENERAL INSTRUCTIONS

1. Thank you for participating in the Services Research Outcomes Study (SROS).
2. Please answer all applicable questions by entering the requested information in the underlined blank spaces or by CIRCLING the code numbers. The code numbers follow the answers, as below:

Yes 1

No 2

In this example, circling 1 indicates YES, circling 2 indicates NO.

3. Numbers in parentheses next to underlined blank spaces are NOT codes to be circled. Print the requested answer in the blank space, as follows:

(1) Print information here

4. Questions in this report ask about a 12-month period. Accordingly, we ask about staffing patterns and financial information pertaining to 1990. If 1990 data are not available and you are unable to provide an estimate, 1993 data are acceptable.
5. Personnel or financial records provide the best basis for answering these questions. However, if these records are not available, please estimate answers based on your best knowledge.
6. Further instructions of filling in tables or answering questions with more specialized formats are supplied throughout the questionnaire.
7. The NORC abstractor will meet with you and schedule a time to collect this completed questionnaire.

**If you have any questions concerning this form,
please call the SROS Hotline, 1-800-884-7508**

1. First, please indicate the job title for up to five key program personnel, including yourself. Next please indicate the month and year each person was first associated with the program.

Job Titles for Key Personnel (Director, Medical Director, etc.)	Date First Associated with this Program in Any Position	
	MONTH	YEAR
(1) JOB1	MONTH1 ____	YEAR1 19 ____
(2) JOB2	MONTH2 ____	YEAR2 19 ____
(3) JOB3	MONTH3 ____	YEAR3 19 ____
(4) JOB4	MONTH4 ____	YEAR4 19 ____
(5) JOB5	MONTH5 ____	YEAR5 19 ____

2. Has your program undergone any change in ownership or administrative oversight since January 1, 1990?

Yes 1 (ANSWER 2A-2D)
 CHANGE
 No 2 (SKIP TO 3)

2A. Which of the following describes the type of change in ownership or administrative oversight since January 1, 1990? (CIRCLE ALL THAT APPLY)

- Change in private ownership 1 OWNER
- Change in private administration 2 ADMIN
- Reorganization of public agency,
to which program report 3 REORG
- Other (SPECIFY) 4 OTHCHANG
~~SPECIFY~~

2B. Since January 1, 1990, how many times has such a change occurred?
___ ___ Numbers of times

NUMCHANG

2C. What was the overall effect of the change(s) on the program?
(CIRCLE ONE ONLY)

- Major alternations in almost
every aspect of the program 1 OVEFFECT
- Significant changes in at least
one aspect of the program 2
- Minor changes only 3
- No effect 4

2D. What do you believe was the overall effect of the change(s) on program effectiveness? (CIRCLE ONE ONLY)

- Improved clinical effectiveness 1 EFFECTIV
- Reduced clinical effectiveness 2
- No change in clinical effectiveness 3

3. Please answer the following questions about revenues and expenses for this program. We would like to collect information on the costs of providing care in 1990, when most of the patients we will following up were discharged from treatment. Financial records for 1990 would provide the best basis for answering these questions. If records are not available, please estimate. If this is not possible, please provide information on costs for 1993.

3A. What is the ending date of the 12-month period on which you are reporting?

MONTHEND DAYEND YEAREND
 _____ Month _____ Day _____ Year

3B. During the 12-month period, what were the total revenues generated by this program, including out-of-pocket fees, third-party payments, donations, and contract fees?

REVENUE*
 \$ _____

3C. During the 12-month period, did the program receive revenues from public agencies--local, state or federal?

PUBREV Yes 1 **(ANSWER 3D)**
 No 2 **(SKIP TO 3E)**

3D. What percent of revenues were from public agencies-- local, state or federal?

PUBREV2 _____ Percent

3E. During the 12-month period, did the program receive revenues from private insurance for alcohol or drug services?

PRIVREV Yes 1 **(ANSWER 3F)**
 No 2 **(SKIP TO 3G)**

3F. What percent of revenues in this program were covered by private insurance for alcohol or drug services?

PRIVREV2 ____ ____ Percent

3G. During the 12-month period, was this program covered to any extent by public insurance, such as medical assistance, CHAMPUS, or Medicare, for alcohol or drug services?

PUBINS Yes 1 **(ANSWER 3H)**

No 2 **(SKIP TO 3I)**

3H. What percent of revenues were covered by public insurance?

PUBINS2 ____ ____ Percent

3I. During the 12-month period, were any patients in this program unable to pay even half the full cost of planned services from their own resources, including private insurance coverage?

NPAYHLF Yes 1 **(ANSWER3J)**

No 2 **(SKIP TO 4)**

3J. What percent of patients were unable to pay even half the full cost?

NPAYHLF2

____ ____ Percent

4. During the 12-month period, what was the typical charge for the main type of service offered by this program? (**CIRCLE ALL THAT APPLY TO THIS PROGRAM**)

4A. \$_____ Per outpatient visit
OUTPAT _____ NOT APPLICABLE

4B. _____ Per 24-hour stay
HOUR24 _____ NOT APPLICABLE

4C. \$ _____ Per other program

OTHPROG _____ **OTHPROG2**
SPECIFY _____

5. The next question provide a basis for analyzing staff turnover and estimating typical of delivering patient care. Again we would like to collect information on the same year for which you provided cost data in question 3.

5A. During 12-month period, how many annual hours were considered full-time or full-time equivalent in your program?

FULLTIME _____, _____ Hours

Answers to each of the following questions should be entered in the appropriate row and column on the Table on page 8.

- 5B. For each of the staff categories, please indicate if your program had any paid staff in these categories for the 12-month period. **(CIRCLE CODE FOR YES OR NO IN EACH CATEGORY)**

- 5C. How many paid staff members in each of the following categories of personnel left this program in this 12-month period? Include full-time staff, staff shared with other programs, and contract staff who provide regular services. **(READ EACH PERSONNEL CATEGORY LISTED IN THE TABLE. ENTER NUMBER IN COLUMN “C” FOR EACH CATEGORY.)**

- 5D. How many staff members did you have at the end of the 12-month period in this program in each category? Include full-time staff, part-time staff, staff shared with other programs, and contract staff who provide regular services. **(READ EACH PERSONNEL CATEGORY LISTED IN THE TABLE. ENTER NUMBER IN COLUMN “D” FOR EACH CATEGORY.)**

- 5E. How many hours of each staff category were devoted to services and operations in this program during the 12-month period? **(READ EACH PERSONNEL CATEGORY LISTED IN THE TABLE . ENTER NUMBER IN COLUMN “E” FOR EACH CATEGORY.)**

- 5F. What was the average hourly (or contract/consultant) rate paid for each category during the 12-month period? **(READ EACH PERSONNEL CATEGORY LISTED IN THE TABLE. ENTER NUMBER IN COLUMN “F” FOR EACH CATEGORY.)**

- 5G. What was the fringe benefit rate (if any) applied to each category during the 12-month period? **(READ EACH PERSONNEL CATEGORY LISTED I THE TABLE. ENTER NUMBER IN COLUMN “G” FOR EACH CATEGORY.)**

TABLE FOR QUESTIONS 5B-G	STAFF SIZE AND COSTS						
	B. Paid staff during 12 months		C. Number of staff <i>who left</i> during 12 months	D. Number of staff at <i>end</i> of 12 months	E. Number of hours worked in <i>services and</i> <i>operations</i> during 12 months	F. Average hourly rate (\$)	G. Fringe benefit rate (%)
STAFF1	a. Psychiatrists	Y N	LEFT1	NUMBER1	HOURS1	WAGE1	BENEFIT1
STAFF2	b. Other Physicians	Y N	LEFT2	NUMBER2	HOURS2	WAGE2	BENEFIT2
STAFF3	c. Registered Nurses	Y N	LEFT3	NUMBER3	HOURS3	WAGE3	BENEFIT3
STAFF4	d. Other Licensed Nurses	Y N	LEFT4	NUMBER4	HOURS4	WAGE4	BENEFIT4
STAFF5	e. All Other Medical Personnel	Y N	LEFT5	NUMBER5*	HOURS5	WAGE5	BENEFIT5
STAFF6	f. Psychologists (graduate level)	Y N	LEFT6	NUMBER6	HOURS6	WAGE6	BENEFIT6
STAFF7	g. Social Workers (graduate level)	Y N	LEFT7	NUMBER7	HOURS7	WAGE7	BENEFIT7
STAFF8	h. Other Degreed Counselors (certified)	Y N	LEFT8	NUMBER8*	HOURS8	WAGE8	BENEFIT8
STAFF9	i. Non-Degreed Counselors (certified)	Y N	LEFT9	NUMBER9*	HOURS9	WAGE9	BENEFIT9
STAFF10	j. Other Therapists or Rehabilitation Specialists	Y N	LEFT10	NUMBER10	HOURS10	WAGE10	BENEFIT10
STAFF11	k. Other Professional Staff	Y N	LEFT11	NUMBER11	HOURS11	WAGE11	BENEFIT11
STAFF12	l. Administrative/Clerical Staff	Y N	LEFT12	NUMBER12	HOURS12	WAGE12	BENEFIT12
STAFF13	m. All other staff	Y N	LEFT13	NUMBER13	HOURS13	WAGE13	BENEFIT13

6. During the 12-month period, did your program receive supporting services from volunteers?

VOLUNT Yes 1 (ANSWER 6A & 6B)
No 2 (SKIP TO 7)

6A. How many hours of volunteer support did your program receive?

VHOURS _____ hours

6B. What hourly rate would you estimate as the average market value of the volunteer time?

VWAGE \$_____ per hour

7. Did your program (or its parent organization) *own* the facility in which patients were treated?

OWNFACE Yes 1 (ANSWER 7A)
No 2 (SKIP TO 8)

7A. What was the fair market rental value for the space occupied by the program, including its share of space used in common with other programs or occupants of the facility? (ENTER AMOUNT AND CIRCLE APPLICABLE TIME PERIOD.)

\$_____ per Month 1 (SKIP TO 9) VALUE
Year 2 (SKIP TO 9) VALUE2

8. During the 12-month period, what was the lease or rental cost per year or month of the space occupied by the program, including its share used in common with other programs or occupants of the facility? (ENTER AMOUNT AND CIRCLE APPLICABLE TIME PERIOD.)

\$_____ per Month 1 RENT
Year 2 RENT2

9. What was the annual or average monthly cost of utilities, taxes, and other, similar space-related charges applicable to the program? (ENTER AMOUNT AND CIRCLE APPLICABLE TIME PERIOD.)

\$_____ per Month 1 UTILITY
Year 2 UTILITY2

16. Did you provide financial data for 1990 or 1993?
(CIRCLE ONE ONLY)

DATAYR 1990 1 **(SKIP TO 17)**
 1993 2 **(ANSWER 16A)**

16A. How would the 1993 financial information you provided differ from 1990 financial information?
(CIRCLE ONE AND SPECIFY PERCENT WHERE APPLICABLE)

DATADIF All financial information is about the same 1 **PERCDIFF**
 Figures from 1993 would be higher than 1990 by about 2 **(SPECIFY: ____ %)**
 Figures from 1993 would be lower than 1990 by about 3 **(SPECIFY: ____ %)**
 Other **(SPECIFY)** 4

DATADIF2

17. For research purposes, we have found it useful to receive the financial statements of programs/organizations. Does your program have a financial statement?

STATMNT Yes 1 **(ANSWER 17A)**
 No 2 **(SKIP TO 18)**

17A. May we have a copy of it for the year that you provided financial information and for the most recent complete fiscal year?
(CIRCLE ONE ONLY)

COPYST Yes, (report/reports attached) 1
 Yes, (report/reports to be mailed to NORC) 2
 No, would not be specific enough to be useful 3
 No, confidential 4
 No, other reasons **(SPECIFY)** 5

COPY2

18. During the 12-month period, to what extent did clients in your program participate in establishing their own treatment goals? **(CIRCLE ONE ONLY)**

- PARTIC** A great extent 1
- A moderate extent 2
- A small extent 3
- No extent 4

19. To what extent did your program adopt complete abstinence from alcohol and drugs as a treatment goal? **(CIRCLE ONE ONLY)**

- ABSTIN** A great extent 1
- A moderate extent 2
- A small extent 3
- No extent 4

20. To what extent did your program attempt to obtain follow-up data from each client or about each client after they left treatment? **(CIRCLE ONE ONLY)**

- FOLLOW** A great extent 1 **(ANSWER 20A-20C)**
- A moderate extent 2 **(ANSWER 20A-20C)**
- A small extent 3 **(ANSWER 20A-20C)**
- No extent 4 **(SKIP TO 21)**

20A. Were follow-up data obtained by telephone, mail, personal interview, or another method? **(CIRCLE ALL THAT APPLY)**

- PHONE** Telephone 1
- MAIL** Mail 2
- INTVIEW** Personal interview 3
- OTHMETH** Other method **(SPECIFY)** 4

~~OTHMETH2~~

20B. Were follow-up data obtained by program staff, other staff in your program, or an outside consultant, contractor, or researcher? **(CIRCLE ALL THAT APPLY)**

- DATA COL1** Program staff 1
- DATA COL2** Other staff in program 2
- DATA COL3** Outside consultant/contractor/researcher 3

20C. Are any reports available on the follow-up data?

- REPORT Yes 1 (ANSWER 20D)
- No 2 (SKIP TO 21)

20D. May we have a copy of the report or reports?

- COPYREP Yes, (report/reports attached) 1
- Yes, (report/reports to be mailed to NORC) 2
- No, would not be specific enough to be useful 3
- No, confidential 4
- No, other reasons (SPECIFY) 5

COPYREP2

21. Does this program have or sponsor any kind of voluntary (no charge) alumni groups for participants after leaving the program?

- ALUMNI Yes 1
- No 2

22. Is your program accredited or licensed by (CIRCLE ONE NUMBER FOR EACH ITEM)

YES NO

JCANO 1 2 The joint Commission on the Accreditation of Healthcare Organization (JCAHO)?

CARF 1 2 The Commission on the Accreditation of Rehabilitation Facilities (CARF)?

Thank you very much for completing the SROS Program Director Interview.

If you have any additional comments, questions, or suggestions concerning this form or any other aspect of SROS, please write them on the following page. Please record the date on the front cover with your signature before returning to the National Opinion Research Center.

