ICPSR | INTER-UNIVERSITY CONSORTIUM FOR POLITICAL AND SOCIAL RESEARCH

ICPSR 34945

National Mental Health Services Survey (N-MHSS), 2010

United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality

Questionnaire

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U.S. Department of Health and Human Services
OMB No. 0930-0119
APPROVAL EXPIRES: 02/28/2013
See OMB burden statement on last page

2010 National Mental Health Services Survey (N-MHSS)

Substance Abuse and Mental Health Services Administration

FACILITY INFORMATION

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

Would You Rather Complete the Questionnaire Online?

You can also complete this questionnaire online. See the pink flyer in your questionnaire packet for the internet address and your unique user ID and password. If you need additional help or information, call the N-MHSS helpline at 1-866-778-9752.

INSTRUCTIONS

- **Most questions ask about this facility, that is, the facility whose name and location are printed on the front cover.** If you have any questions about how the phrase this facility applies to your facility, please call the N-MHSS helpline at 1-866-778-9752
- Answer ONLY for the specific facility whose name and location are printed on the front cover, unless otherwise specified in the questionnaire
- If this is **a separate psychiatric unit of a general hospital**, consider the psychiatric unit as the relevant "facility" for the purpose of this survey
- For additional information about the survey and definitions for some of the terms, please visit our website at: **http://info.nmhss.org**
- Return the completed questionnaire in the envelope provided, or fax it to 1-609-799-0005. (Please reference "N-MHSS" on your fax.)

Please keep a copy of your completed questionnaire for your records.

- If you have questions or need additional blank forms, contact:

MATHEMATICA POLICY RESEARCH

1-866-778-9752

IMPORTANT INFORMATION

- **Asterisked Questions.** Information from asterisked (*) questions is published in SAMHSA's online Mental Health Facilities Locator, found as a link on the Mental Health Services Locator at http://mentalhealth.samhsa.gov/databases/, unless you designate otherwise in question A26, page 5, of this questionnaire
- **Mapping Feature in Locator.** Complete and accurate name and address information is needed for SAMHSA's online Mental Health Facilities Locator so it can correctly map the facility's location
- **Eligibility for Locator.** Only facilities that provide mental health treatment services and complete this questionnaire are eligible to be listed in the online Mental Health Facilities Locator. If you have any questions regarding eligibility, please contact the N-MHSS helpline at 1-866-778-9752

SECTION A: FACILITY CHARACTERISTICS

Section A asks about the services currently offered at this facility only, that is, the facility at the location printed on the front cover.

A1. Does this facility at this location (the location listed on the front cover) offer:

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Intake services	1 ☐	0 ☐
2. Diagnostic evaluation	1 ☐	0 ☐
3. Information and referral services *(Includes emergency programs that provide services only by telephone)*	1 ☐	0 ☐
4. Substance abuse treatment services	1 ☐	0 ☐
5. Mental health treatment services *(services focused on improving the mental well-being of individuals or promoting their recovery)*	1 ☐	0 ☐
6. Administrative services	1 ☐	0 ☐

A2. Did you answer "yes" to mental health treatment services in question A1 above (option 5)?

1 ☐ Yes

0 ☐ No → **SKIP TO C1 (PAGE 10)**

***A3. In which of these settings are mental health treatment services offered at this facility, at this location?**

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. **24-hour hospital inpatient services** (psychiatric hospitals or general hospitals with separate psychiatric units)	1 ☐	0 ☐
2. **24-hour residential services** (24-hour, overnight, psychiatric care in a residential non-inpatient setting such as residential treatment centers for adults or children, or multi-service community mental health centers)	1 ☐	0 ☐
3. **Outpatient, day treatment or partial hospitalization services** (less than 24-hour, not overnight, ambulatory outpatient counseling, day treatment or partial hospitalization)	1 ☐	0 ☐

A4. Is this facility an individual or small group practice that is not licensed or certified as a clinic or mental health center?

1 ☐ Yes → **SKIP TO C1 (PAGE 10)**

0 ☐ No

***A5. Which ONE category best describes this facility, at this location?**

☐ *For definitions of facility types, log on to: http://info.nmhss.org or refer to definitions in your questionnaire packet*

MARK ONE ONLY

1 ☐ Psychiatric hospital

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

3 ☐ Residential treatment center for children

4 ☐ Residential treatment center for adults

5 ☐ Outpatient, day treatment or partial hospitalization mental health facility

6 ☐ Multi-setting (non-hospital) mental health facility

7 ☐ Other *(Specify*: _____*)*

A6. What is the primary treatment focus of this facility, at this location?

☐ *Separate psychiatric units in a general hospital should answer for just their unit and NOT for the entire hospital*

MARK ONE ONLY

1 ☐ Mental health services

2 ☐ Substance abuse services → **SKIP TO C1 (PAGE 10)**

3 ☐ Mix of mental health and substance abuse services (neither is primary)

4 ☐ General health care (neither mental health nor substance abuse services is primary) → **SKIP TO C1 (PAGE 10)**

5 ☐ Other service focus *(Specify below:*

_____*)*

***A7. Is this facility operated by:**

MARK ONE ONLY

1 ☐ A private for-profit organization

2 ☐ A private non-profit organization

3 ☐ State mental health agency (SMHA)

4 ☐ State department of corrections or juvenile justice →**SKIP TO C1 (PAGE 10)**

5 ☐ Other state government (e.g., Department of Health)

6 ☐ Regional or district authority (e.g., hospital district authority)

7 ☐ Local, county or municipal government

8 ☐ U.S. Department of Veterans Affairs

9 ☐ Other *(Specify*:

_____)

A8. Is this facility affiliated with a religious organization?

1 ☐ Yes

0 ☐ No

***A9. What telephone number(s) should a potential client/patient call to schedule a mental health intake appointment at this facility?**

INTAKE TELEPHONE NUMBER(S):

1. (____) _____ - _____ ext._____

2. (____) _____ - _____ ext._____

***A10. Which of these mental health treatment approaches are offered at this facility, at this location?**

☐ *For definitions of treatment approaches, log on to: http://info.nmhss.org or refer to definitions in your questionnaire packet*

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Activity therapy	1 ☐	0 ☐
2. Behavior modification	1 ☐	0 ☐
3. Cognitive/behavioral therapy	1 ☐	0 ☐
4. Couples/family therapy	1 ☐	0 ☐
5. Electroconvulsive therapy	1 ☐	0 ☐
6. Group therapy	1 ☐	0 ☐
7. Individual psychotherapy	1 ☐	0 ☐
8. Integrated dual disorders treatment	1 ☐	0 ☐
9. Psychotropic medication therapy	1 ☐	0 ☐
10. Telemedicine therapy	1 ☐	0 ☐
11. Other *(Specify: _____)*	1 ☐	0 ☐

***A11. Which of these supportive services and practices are offered at this facility, at this location?**

☐ *For definitions of supportive practices, log on to: http://info.nmhss.org or refer to definitions in your questionnaire packet*

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Assertive community treatment	1 ☐	0 ☐
2. Case management	1 ☐	0 ☐
3. Chronic disease/illness management (CDM)	1 ☐	0 ☐
4. Consumer-run services	1 ☐	0 ☐
5. Education services	1 ☐	0 ☐
6. Family psychoeducation	1 ☐	0 ☐
7. Housing services	1 ☐	0 ☐
8. Illness management and recovery (IMR)	1 ☐	0 ☐
9. Legal advocacy	1 ☐	0 ☐
10. Psychiatric emergency walk-in services	1 ☐	0 ☐
11. Psychosocial rehabilitation services	1 ☐	0 ☐
12. Smoking cessation services	1 ☐	0 ☐
13. Suicide prevention services	1 ☐	0 ☐
14. Supported employment	1 ☐	0 ☐
15. Supported housing	1 ☐	0 ☐
16. Therapeutic foster care	1 ☐	0 ☐
17. Vocational rehabilitation services	1 ☐	0 ☐
18. Other *(Specify: _____)*	1 ☐	0 ☐

***A12. What age categories of clients/patients are accepted for treatment at this facility?**

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Youth (aged 17 or younger)	1 ☐	0 ☐
2. Adults (18-64)	1 ☐	0 ☐
3. Seniors (65 or older)	1 ☐	0 ☐

***A13. Does this facility offer a mental health treatment program or group designed exclusively for:**

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Youth with serious emotional disturbance (SED)	1 ☐	0 ☐
2. Transition-aged young adults aged 18-25	1 ☐	0 ☐
3. Adults with serious mental illness (SMI)	1 ☐	0 ☐
4. Individuals with Alzheimer's or dementia	1 ☐	0 ☐
5. Individuals with co-occurring mental health and substance abuse disorders	1 ☐	0 ☐
6. Individuals with co-occurring mental health and non-substance abuse disorders	1 ☐	0 ☐
7. Individuals with post-traumatic stress disorder (PTSD)	1 ☐	0 ☐
8. Veterans	1 ☐	0 ☐
9. Individuals with traumatic brain injury (TBI)	1 ☐	0 ☐
10. Gay, lesbian, bisexual, or transgendered clients	1 ☐	0 ☐
11. Forensic clients (referred from the court/ judicial system)	1 ☐	0 ☐
12. Other special program *(Specify:*	1 ☐	0 ☐

_____*)*

***A14. Does this facility offer mental health services for the hearing-impaired?**

1 ☐ Yes

0 ☐ No

***A15. In what languages do staff provide mental health treatment services at this facility?**

☐ *Do not count languages provided only by on-call interpreters*

MARK ALL THAT APPLY

1 ☐ English

2 ☐ Spanish

3 ☐ Other *(Specify:* _____*)*

***A16. Does this facility operate a crisis intervention team to handle acute mental health issues?**

MARK ONE ONLY

1 ☐ Yes, only within this facility

2 ☐ Yes, only offsite

3 ☐ Yes, both within this facility and offsite

4 ☐ No, we do not have a crisis intervention team

A17. At this facility, which of these functions are computerized?

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Reporting results (e.g., laboratory results, psychological testing)	1 ☐	0 ☐
2. Physician Order Entry (CPOE) or outpatient prescriptions or directions	1 ☐	0 ☐
3. Sending and receiving clinical data from other providers	1 ☐	0 ☐
4. Creating and transmitting referrals to other providers or services (e.g., employment placement, housing assistance, vocational training)	1 ☐	0 ☐
5. Creating and maintaining treatment plans	1 ☐	0 ☐
6. Client or family satisfaction surveys	1 ☐	0 ☐
7. Checking medication interactions	1 ☐	0 ☐
8. Preparing and submitting bills or claims	1 ☐	0 ☐
9. Scheduling clients/patients	1 ☐	0 ☐
10. Process note-taking	1 ☐	0 ☐
11. Other *(Specify:* _____*)*	1 ☐	0 ☐

A18. Which of these quality assurance practices are part of this facility's standard operating procedures?

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Monitoring continuing education requirements for professional staff	1 ☐	0 ☐
2. Regularly scheduled case review with a supervisor	1 ☐	0 ☐
3. Regularly scheduled case review by an appointed quality review committee	1 ☐	0 ☐
4. Client/patient outcome follow-up after discharge	1 ☐	0 ☐
5. Periodic utilization review	1 ☐	0 ☐
6. Periodic client/patient satisfaction surveys	1 ☐	0 ☐

***A19. Does this facility offer treatment at no charge to clients/patients who cannot afford to pay?**

1 ☐ Yes

0 ☐ No → **SKIP TO A20 (BELOW)**

A19a. Do you want the availability of free care for eligible clients/patients published in SAMHSA's online Mental Health Facilities Locator?

☐ *The Locator will inform potential clients/patients to call the facility for information on eligibility*

1 ☐ Yes

0 ☐ No

***A20. Does this facility use a sliding fee scale?**

1 ☐ Yes

0 ☐ No → **SKIP TO A21 (TOP OF NEXT COLUMN)**

A20a. Do you want the availability of a sliding fee scale published in SAMHSA's online Mental Health Facilities Locator?

☐ *The Locator will explain that sliding fee scales are based on income and other factors*

1 ☐ Yes

0 ☐ No

***A21. Which of the following types of payments or funding are accepted by this facility for mental health treatment services?**

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Medicaid	1 ☐	0 ☐
2. Medicare	1 ☐	0 ☐
3. State mental health agency (or equivalent) funds	1 ☐	0 ☐
4. State welfare or child or family services agency funds	1 ☐	0 ☐
5. State corrections or juvenile justice agency funds	1 ☐	0 ☐
6. State education agency funds	1 ☐	0 ☐
7. Local government funds	1 ☐	0 ☐
8. U.S. Department of Veterans Affairs funds	1 ☐	0 ☐
9. Community Service Block Grants	1 ☐	0 ☐
10. Community Mental Health Block Grants	1 ☐	0 ☐
11. Client/patient fees (i.e., out-of-pocket)	1 ☐	0 ☐
12. Private insurance	1 ☐	0 ☐
13. Other public funds *(Specify:* _____*)*	1 ☐	0 ☐
14. Other private funds *(Specify:* _____*)*	1 ☐	0 ☐

A22. Does any single payment or funding source listed in A21 account for more than half of this facility's funding?

1 ☐ Yes

0 ☐ No → **SKIP TO A23 (BELOW)**

A22a. Please identify that single payment or funding source by marking the corresponding number from question A21.

MARK ONE ONLY

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐

8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐

***A23. Which statement below BEST describes this facility's smoking policy?**

MARK ONE ONLY

1 ☐ Smoking is not permitted on the property or within any building

2 ☐ Smoking is permitted only outdoors

3 ☐ Smoking is permitted outdoors and in designated indoor area(s)

4 ☐ Smoking is permitted anywhere without restriction

5 ☐ Other *(Specify:* _____*)*

A24. In the 12-month period beginning May 1, 2009, and ending April 30, 2010…

MARK "YES" OR "NO" FOR EACH

	YES	NO
1. Have staff at this facility used seclusion or restraint practices with clients/patients?	1 ☐	0 ☐
2. Has your facility adopted any initiatives toward the reduction of seclusion and restraint practices?	1 ☐	0 ☐

A25. From which of these 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 "YES" OR "NO" FOR EACH

	YES	NO
1. State mental health agency	1 ☐	0 ☐
2. State substance abuse agency	1 ☐	0 ☐
3. State department of health	1 ☐	0 ☐
4. Hospital licensing authority	1 ☐	0 ☐
5. JC (Joint Commission)	1 ☐	0 ☐
6. CARF (Commission on Accreditation of Rehabilitation Facilities)	1 ☐	0 ☐
7. COA (Council on Accreditation)	1 ☐	0 ☐
8. Department of Family and Children's Services	1 ☐	0 ☐
9. U.S. Department of Health and Human Services	1 ☐	0 ☐
10. Medicare	1 ☐	0 ☐
11. Medicaid	1 ☐	0 ☐
12. Other national, state, or local organization *(Specify: _____)*	1 ☐	0 ☐

A26. Information from asterisked questions will be published in SAMHSA's online Mental Health Facilities Locator. Do you want this facility to be listed in the Locator?

☐ *The Mental Health Facilities Locator can be found as a link on the Mental Health Services Locator at* http://mentalhealth.samhsa.gov/databases/

1 ☐ Yes
0 ☐ No

***A27. Does this facility have a website or web page with information about the facility's mental health treatment programs?**

1 ☐ Yes → Please check the front cover of this questionnaire to confirm that the website address for this facility is correct EXACTLY as listed. If incorrect or missing, enter the correct address.

0 ☐ No

SECTION B: CLIENT/PATIENT COUNT INFORMATION

Questions B2 - B7 ask about the number of clients/patients treated at this facility on specific dates.

Please look carefully at the dates specified, as questions will ask for either a single day count, a one-month count, or a 12-month count.

Include ALL clients/patients receiving mental health treatment services in your counts, even if a mental health disorder is a secondary diagnosis or has not yet been formally determined.

B1. 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

1 ☐ Only this facility → **SKIP TO B3 (PAGE 6)**
2 ☐ This facility plus others → **SKIP TO B2 (BELOW)**
3 ☐ Another facility in the organization will report client counts for this facility

B1a. Please record the name and phone number of the facility that will report your client counts.

Facility name:_____

Telephone: (_____) - _____- _____

After recording the facility name and telephone number in B1a → SKIP TO C1 (PAGE 10)

B2. How many facilities will be included in the reported client counts?

THIS FACILITY	1
+ ADDITIONAL FACILITIES	
= TOTAL FACILITIES	

On a separate piece of paper or on the back cover of this questionnaire, list the name and location address of each facility included in your client counts. If you prefer, we will contact you for a list of the other facilities included in your client counts.

CONTINUE WITH QUESTION B3 (TOP OF NEXT PAGE)

24-HOUR HOSPITAL INPATIENT COUNTS

B3. On April 30, 2010, did any patients receive 24-hour hospital inpatient mental health treatment services at this facility, at this location?

1 ☐ Yes → **GO TO B3a (TOP OF NEXT COLUMN)**

0 ☐ No → **SKIP TO B4 (PAGE 7)**

B3a. On April 30, 2010, how many patients received 24-hour hospital inpatient mental health treatment services at this facility?

- *Do NOT count family members, friends, or other non-treatment patients*

HOSPITAL INPATIENTS TOTAL BOX ☐

CONTINUE WITH QUESTION B3b (BELOW)

B3b. For each category below, please provide a breakdown of the Hospital Inpatients reported in the B3a TOTAL BOX above. Use either numbers OR percents, whichever is more convenient.

- *If numbers are used—each category total should equal the number reported in the B3a TOTAL BOX above*
- *If percents are used—each category total should equal 100%*

		NUMBER	OR	PERCENT
GENDER	Male			
	Female			
	CATEGORY TOTAL: *(Should=B3a or 100%)*			100%
AGE	0 – 17			
	18 – 64			
	65 and older			
	CATEGORY TOTAL: *(Should=B3a or 100%)*			100%
ETHNICITY	Hispanic or Latino			
	Not Hispanic or Latino			
	Unknown or not collected			
	CATEGORY TOTAL: *(Should=B3a or 100%)*			100%
RACE	American Indian or Alaska Native			
	Asian			
	Black or African American			
	Native Hawaiian or Other Pacific Islander			
	White			
	Two or more races			
	Unknown or not collected			
	CATEGORY TOTAL: *(Should=B3a or 100%)*			100%
LEGAL STATUS	Voluntary			
	Involuntary, non-forensic			
	Involuntary, forensic			
	CATEGORY TOTAL: *(Should=B3a or 100%)*			100%

B3c. On April 30, 2010, how many hospital inpatient beds at this facility were specifically designated for providing mental health treatment services?

NUMBER OF BEDS ☐

(If none, enter '0')

24-HOUR RESIDENTIAL (NON-HOSPITAL) CLIENT COUNTS

B4. On April 30, 2010, did any clients receive 24-hour residential mental health treatment services at this facility, at this location?

1 ☐ Yes → **GO TO B4a (TOP OF NEXT COLUMN)**

0 ☐ No → **SKIP TO B5 (PAGE 8)**

B4a. On April 30, 2010, how many clients received 24-hour residential mental health treatment services at this facility?

- *Do NOT count family members, friends, or other non-treatment clients*

RESIDENTIAL CLIENTS TOTAL BOX ____

CONTINUE WITH QUESTION B4b (BELOW)

B4b. For each category below, please provide a breakdown of the Residential Clients reported in the B4a TOTAL BOX above. Use either numbers OR percents, whichever is more convenient.

- *If numbers are used—each category total should equal the number reported in the B4a TOTAL BOX above*
- *If percents are used—each category total should equal100%*

		NUMBER	OR	PERCENT
GENDER	Male			
	Female			
	CATEGORY TOTAL: *(Should=B4a or 100%)*			100%
AGE	0 – 17			
	18 – 64			
	65 and older			
	CATEGORY TOTAL: *(Should=B4a or 100%)*			100%
ETHNICITY	Hispanic or Latino			
	Not Hispanic or Latino			
	Unknown or not collected			
	CATEGORY TOTAL: *(Should=B4a or 100%)*			100%
RACE	American Indian or Alaska Native			
	Asian			
	Black or African American			
	Native Hawaiian or Other Pacific Islander			
	White			
	Two or more races			
	Unknown or not collected			
	CATEGORY TOTAL: *(Should=B4a or 100%)*			100%
LEGAL STATUS	Voluntary			
	Involuntary, non-forensic			
	Involuntary, forensic			
	CATEGORY TOTAL: *(Should=B4a or 100%)*			100%

B4c. On April 30, 2010, how many residential beds at this facility were specifically designated for providing mental health treatment services?

NUMBER OF BEDS ____

(If none, enter '0')

OUTPATIENT, DAY TREATMENT OR PARTIAL HOSPITALIZATION CLIENT COUNTS

B5. During the month of April 2010, did any clients receive outpatient, day treatment or partial hospitalization mental health treatment services at this facility, at this location?

1 ☐ Yes → **GO TO B5a (TOP OF NEXT COLUMN)**

0 ☐ No → **SKIP TO B6 (PAGE 9)**

B5a. During the month of April 2010, how many clients received outpatient, day treatment or partial hospitalization mental health treatment services at this facility?

- ***ONLY INCLUDE*** *those seen at this facility at least once during the month of April,* ***AND who were still enrolled in treatment on April 30, 2010***
- ***DO NOT*** *count family members, friends, or other non-treatment clients*

OUTPATIENT, DAY TREATMENT OR PARTIAL HOSPITALIZATION CLIENTS TOTAL BOX ☐

CONTINUE WITH QUESTION B5b (BELOW)

B5b. For each category below, please provide a breakdown of the Outpatient, Day Treatment or Partial Hospitalization Clients reported in the B5a TOTAL BOX above. Use either numbers OR percents, whichever is more convenient.

- *If numbers are used—each category total should equal the number reported in the B5a TOTAL BOX above*
- *If percents are used—each category total should equal 100%*

		NUMBER	OR	PERCENT
GENDER	Male			
	Female			
	CATEGORY TOTAL: *(Should=B5a or 100%)*			100%
AGE	0 – 17			
	18 – 64			
	65 and older			
	CATEGORY TOTAL: *(Should=B5a or 100%)*			100%
ETHNICITY	Hispanic or Latino			
	Not Hispanic or Latino			
	Unknown or not collected			
	CATEGORY TOTAL: *(Should=B5a or 100%)*			100%
RACE	American Indian or Alaska Native			
	Asian			
	Black or African American			
	Native Hawaiian or Other Pacific Islander			
	White			
	Two or more races			
	Unknown or not collected			
	CATEGORY TOTAL: *(Should=B5a or 100%)*			100%
LEGAL STATUS	Voluntary			
	Involuntary, non-forensic			
	Involuntary, forensic			
	CATEGORY TOTAL: *(Should=B5a or 100%)*			100%

ALL MENTAL HEALTH CARE SETTINGS

Including 24-hour Hospital Inpatient, 24-Hour Residential (non-hospital), and Outpatient, Day Treatment or Partial Hospitalization

B6. On April 30, 2010, approximately what percent of the mental health treatment clients/patients enrolled at this facility had diagnosed co-occurring mental health and substance abuse disorders?

PERCENT WITH CO-OCCURRING DIAGNOSIS ____ %

(If none, enter '0')

B7. In the 12-month period of May 1, 2009 through April 30, 2010, how many mental health 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 HEALTH DISORDER IS A SECONDARY DIAGNOSIS:*** *Count all admissions where clients/patients received mental health treatment services*

NUMBER OF MENTAL HEALTH TREATMENT ADMISSIONS IN 12-MONTH PERIOD ____

(If none, enter '0')

B8. What percent of the admissions reported in question B7 above were military veterans? Please give your best estimate.

PERCENT MILITARY VETERANS ____ %

(If none, enter '0')

SECTION C: CONTACT INFORMATION

C1. 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

1 ☐ Ms. 2 ☐ Miss 3 ☐ Mrs. 4 ☐ Mr. 5 ☐ Dr.

6 ☐ Other *(Specify: _____)*

FIRST NAME:

LAST NAME:

TITLE:

EMAIL ADDRESS:

PHONE NUMBER:

(☐☐☐) - ☐☐☐ - ☐☐☐☐ ☐☐☐☐☐

Area Code Extension

FAX NUMBER:

(☐☐☐) - ☐☐☐ - ☐☐☐☐ ☐☐☐☐☐

Area Code Extension

Please use the box below to provide additional comments or to elaborate on any of the information requested or provided in this questionnaire. Use additional sheets of paper if more space is needed. If applicable, indicate the number of the question to which your comments refer.

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
ATTN: RECEIPT CONTROL - Project 06533
P.O. Box 2393
Princeton, NJ 08543-2393