

DRUG AND ALCOHOL SERVICES INFORMATION SYSTEM (DASIS) UNIFORM FACILITY DATA SET (UFDS) OCTOBER 1, 1997

This questionnaire asks about the facility listed below. Please check the accuracy of the information. Update items that are blank or inaccurate by entering the correct information in the space provided on the lower half of this page. If you are reporting data for the first time, please provide all of the information requested.

IF NO CHANGES ARE NEEDED (ALL INFORMATION IS COMPLETE AND CORRECT), MARK (X) THIS BOX →

STATE ID _____	Don't <u>Know</u> -1 <input type="checkbox"/>	NFR ID _____ - ____	Don't <u>Know</u> -1 <input type="checkbox"/>
EIN ID:** _____	-1 <input type="checkbox"/>	FDA ID _____ - ____	-1 <input type="checkbox"/>

**The EIN ID number is your employer identification number or your federal tax identification number. Your accounting or personnel departments may have this number.

Facility Director's Name		
Facility Name		
Mailing Address		
City	State	ZIP Code

Street Name		
City	State	ZIP Code
County	Telephone No.	Ext. (if any)
Facility Director's Telephone No.	Ext. (if any)	Facility Fax Number:
		TTY/TDD Number:

Why is completing this questionnaire important?

Your participation makes a difference. The UFDS survey is the ONLY source of data on ALL known substance abuse treatment and prevention programs in the nation. When substance abuse policy makers and program managers need up-to-date national information on characteristics of substance abuse programs and the numbers and types of clients served, they rely on the UFDS. UFDS data are used to formulate the Nation's annual drug control strategy and to make many other important decisions regarding substance abuse policy.

This survey is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services.

Instructions

- The reference date for UFDS is October 1, 1997.
- Use a # 2 pencil. If you wish to change an answer, please erase cleanly.
- See example below for the proper way to record a number in a box.
- Return the completed questionnaire in the envelope provided.

If you have any questions concerning this questionnaire, or if you need additional blank forms, contact:

MATHEMATICA POLICY RESEARCH, INC.
1-888-324-UFDS (8337)

Correct

1	9
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Incorrect

1	19
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1. On October 1, 1997 was the facility named on the cover providing substance abuse treatment, prevention, administrative, or other nontreatment services?

1 Yes → SKIP TO Q.2

2 No

1a. (If No) When did this facility close or stop providing substance abuse services? RECORD MONTH AND YEAR

MONTH: |__| |__|

YEAR: 19 |__| |__|

SKIP TO Q.27, PAGE 10

-1 Don't Know

2. Who is the owner of this substance abuse facility?

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

SKIP TO Q.3

6 Federal Government

2a. Which federal government agency?

MARK ONE ONLY

1 Department of Veterans Affairs

2 Department of Defense

3 Bureau of Prisons

4 Indian Health Service

5 Other (Specify: _____)

3. Does this facility operate or participate in a hotline that provides substance abuse counseling and referral services?

911 is not considered a hotline

1 Yes

2 No → SKIP TO Q.4

3a. Please enter the hotline telephone number(s) and hours of operation. If 24 hours, check the box.

PHONE NUMBER(S): HOURS OF OPERATION 24 HOURS

(____)-_____ Weekdays

Weekends

(____)-_____ Weekdays

Weekends

4. On October 1, 1997, which of the following services were provided by this facility at this site?

MARK ALL THAT APPLY

1 **Substance Abuse Treatment** (services that focus on initiating and maintaining an individual's recovery from substance abuse and on averting relapse, including detoxification)

2 **Substance Abuse Prevention** (prevention activities directed at individuals not identified to be in need of treatment, such as information dissemination or education)

3 **Other Substance Abuse Services** (such as intake, assessment, and referral)

4 **Administrative Services** (such as billing, personnel, and scheduling)

5. Did you check box 1 in Q.4?

1 Yes

2 No → SKIP TO Q.27, PAGE 10

5a. Is a drunk driving or DUI/DWI program the ONLY substance abuse service provided by this facility?

1 Yes → SKIP TO Q.27, PAGE 10

2 No

6. Which ONE category best describes the SETTING of this substance abuse treatment facility?

MARK ONE

- 1 General hospital, may include an outpatient substance abuse unit on site
- 2 Psychiatric hospital, may include an outpatient substance abuse unit on site
- 3 Other specialized hospital, may include an outpatient substance abuse unit on site (for example, alcoholism, maternity, children's, orthopedic)
- 4 Solo practice
- 5 Group practice
- 6 School (elementary, secondary, college/university)
- 7 Jail, prison or juvenile detention center
- 8 Other criminal justice (TASC, pretrial diversion, court referral, probation, parole, community corrections)

➔ **SKIP TO Q.7**

9 Other setting

6a. More specifically would you describe this facility as:

MARK YES OR NO FOR EACH
YES NO

- 1 2 a. OUTPATIENT substance abuse treatment facility
- 1 2 b. Community MENTAL health center or other mental health facility that provides a variety of services
- 1 2 c. Community Health Center, including Migrant Health Center, Urban Indian Program, Health Care for the Homeless Center
- 1 2 d. Halfway House
- 1 2 e. Therapeutic Community
- 1 2 f. Other RESIDENTIAL substance abuse treatment facility
- 1 2 g. Community or religious organization/agency that provides a variety of social services
- 1 2 h. Other (*Specify:* _____)

7. Is this facility owned or operated by a managed care organization (for example, an HMO)?

- 1 Yes
- 2 No

8. On October 1, 1997, did this facility have letters of agreement or contracts with managed care organizations for providing substance abuse treatment services?

- 1 Yes, had formal written agreements or contracts with managed care organizations
- 2 No formal written agreements or contracts with managed care organizations → **SKIP TO Q.9**
- 1 Don't know → **SKIP TO Q.9**

8a. With how many managed care organizations did you have formal written agreements or contracts?

Number:

9. On October 1, 1997 was this facility structured as a parent organization or master site with one or more affiliate sites that provide substance abuse treatment services?

- 1 Yes
- 2 No → **SKIP TO Q.10, PAGE 3**

9a. On October 1, 1997, how many affiliate sites did this facility have that provide substance abuse treatment services?

Number:

10. On October 1, 1997, was this facility an affiliate of a parent organization or master site?

- 1 Yes
- 2 No → **SKIP TO Q.10b**

10a. Please provide the following information for the parent organization/master site.

Organization: _____

Contact Name: _____

Mailing Address: _____

City: _____ State: _____

ZIP: _____ Telephone Number: (____) _____ - _____

10b. The rest of this questionnaire should be answered for those services, activities, etc. provided at this site by the facility listed on the cover of this questionnaire. Parent organizations or master sites should not include affiliate sites in their responses. Can you respond for only the services, activities, etc. provided at this site?

- 1 Yes → **SKIP TO Q.11**
- 2 No

10c. If responding for only this site is not possible, for approximately how many sites will you be reporting in total?

MARK ONE ONLY

- 2 sites
- 3-5 sites
- 6-10 sites
- More than 10 sites

11. **Waiting Lists.** If a program is full, does this facility maintain a formal waiting list of people waiting for substance abuse services?

- **Formal waiting list:** a record of the names, addresses, and telephone numbers of applicants eligible for admission. *The list must include the date of application and nature of follow-up contacts.*

- 1 Yes
- 2 No → **SKIP TO Q.12, PAGE 4**

11a. On October 1, 1997, how many people were on the waiting list?

Number on Waiting List:

12. Number of Active Clients on October 1, 1997. In each of the categories listed below, please enter the number of active clients who were receiving substance abuse treatment at this facility on October 1, 1997:

- DO NOT count codependents, parents, other relatives, friends (i.e., "collaterals"), or other nontreatment clients.

IF NONE,
CHECK BOX

	NUMBER	
a. Hospital Inpatients - Detoxification on October 1, 1997 and were <u>not</u> discharged that day	[] [] [] []	<input type="checkbox"/>
b. Hospital Inpatients - Rehabilitation on October 1, 1997 and were <u>not</u> discharged that day	[] [] [] []	<input type="checkbox"/>
c. Residential (24-Hour Care) - Detoxification on October 1, 1997 and were <u>not</u> discharged that day	[] [] [] []	<input type="checkbox"/>
d. Residential (24-Hour Care) - Rehabilitation on October 1, 1997 and were <u>not</u> discharged that day	[] [] [] []	<input type="checkbox"/>
e. Outpatients (Less Than 24-Hour Care) who received a substance abuse treatment service between September 1 and October 1, 1997 and were still enrolled on October 1, 1997. . . . DO NOT INCLUDE CLIENTS WHOSE ONLY SERVICE IS ATTENDING A DUI/DWI PROGRAM	[] [] [] []	<input type="checkbox"/>
f. Intensive Outpatients* who received a substance abuse treatment service—including day treatment—between September 1 and October 1, 1997 and were still enrolled on October 1, 1997 * (Services provided to a client that last 2 hours or more per day/3 or more days a week)	[] [] [] []	<input type="checkbox"/>
g. TOTAL NUMBER OF ACTIVE CLIENTS (add a - f)	[] [] [] []	<input type="checkbox"/>

Q.12g

12h. Are the numbers entered in the TOTAL box Q.12g actual active client counts for October 1, 1997 or your best estimate?

- 1 Actual count 2 Estimate

13. Approximately what percentage of the clients in the Q.12g TOTAL box were being treated on October 1, 1997 for:

a. Alcohol Abuse Only	[] [] []	.00%
b. Drug Abuse Only	[] [] []	.00%
c. Both Alcohol and Drug Abuse	[] [] []	.00%
TOTAL CLIENTS	100 %	

14. Did you enter a number larger than zero in either the Hospital Inpatient (Q.12a or Q.12b) or Residential—24 Hour Care (Q.12c or Q.12d) categories in Q.12?

- 1 Yes 2 No → **SKIP TO Q.15, PAGE 5**

14a. On October 1, 1997, how many of the beds at this facility could have been used for:

NUMBER OF BEDS

a. Hospital Inpatient Substance Abuse Treatment	[] [] [] []	<input type="checkbox"/> NONE
b. Non-Hospital Residential (24-Hour) Substance Abuse Treatment	[] [] [] []	<input type="checkbox"/> NONE

CHARACTERISTICS OF ACTIVE CLIENTS ON OCTOBER 1, 1997

15. Please complete the following table for the number of active clients reported in Q.12 (page 4).

- Enter the TOTAL from Q.12g into the three TOTAL boxes in Column 1 below.
- Column 1. Enter the number of active clients for each age, race, and sex category in Column 1. For each category with no clients, enter zero, "0."
- Columns 2-4. For each age, race, and sex category with a number greater than zero in Column 1 complete Columns 2-4 to show how many clients were in each of the three types of care. The SUM of each row in Columns 2, 3 and 4 MUST EQUAL the Column 1 total for that row.

NUMBER OF ACTIVE CLIENTS BY TYPE OF CARE

Client Category	1	2	3	4
	TOTAL	HOSPITAL INPATIENT From Q.12a + Q.21b	RESIDENTIAL (24-HOUR CARE) From Q.12c + Q.12d	OUTPATIENT From Q.21e + Q.12f
AGE				
Under 18 years	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
18-20	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
21-24	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
25-34	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
35-44	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
45-64	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
65 and Over	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
Don't Know	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
TOTAL NUMBER OF ACTIVE CLIENTS	_ , _ _ _ (from Q.12g)	_ , _ _ _	_ , _ _ _	_ , _ _ _
RACE/ETHNICITY				
White, not of Hispanic Origin	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
Black, not of Hispanic Origin	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
Hispanic	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
Asian or Pacific Islander	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
American Indian/Alaskan Native ..	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
Other	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
Don't Know	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
TOTAL NUMBER OF ACTIVE CLIENTS	_ , _ _ _ (from Q.12g)	_ , _ _ _	_ , _ _ _	_ , _ _ _
GENDER				
Male	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
Female	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
Don't Know	_ , _ _ _	_ , _ _ _	_ , _ _ _	_ , _ _ _
TOTAL NUMBER OF ACTIVE CLIENTS	_ , _ _ _ (from Q.12g)	_ , _ _ _	_ , _ _ _	_ , _ _ _

15a. Are the numbers entered in Q.15 actual active client counts for October 1, 1997 or your best estimate?

- 1 Actual active client counts
- 2 Estimate

16. Does this facility dispense the opioid substitutes methadone or LAAM at this site?

- 1 Yes → (Make certain your FDA ID number on the cover has been recorded and is correct)
 2 No → **SKIP TO Q.17**

16a. On October 1, 1997, approximately how many of the clients in the TOTAL box at Q.12g (page 4) were receiving:

Number

- a. Methadone at this site |__|,|__|__|__|
 b. LAAM at this site |__|,|__|__|__|

17. On October 1, 1997, about how many of the clients recorded in the TOTAL box at Q.12g were:

- Provide your answers *either* as numbers or percentages. Your best estimate is fine. If a reasonable estimate is not possible, mark the “Unknown” box.
- For 17a and 17b, the number entered should not exceed the total number of females reported in Q.15.
- The active clients in Q.12 can be reported more than once in categories a-h below.

	Number	OR	Percentage	Unknown
a. Pregnant?	__ , __ __ __		__ __ __ .00 %	<input type="checkbox"/> -1
b. Women with dependent children?	__ , __ __ __		__ __ __ .00 %	<input type="checkbox"/> -1
c. Injection drug users at the time of admission?	__ , __ __ __		__ __ __ .00 %	<input type="checkbox"/> -1
d. Known as having an active case of tuberculosis (TB)?	__ , __ __ __		__ __ __ .00 %	<input type="checkbox"/> -1
e. HIV positive?	__ , __ __ __		__ __ __ .00 %	<input type="checkbox"/> -1
f. Clients who had previously received substance abuse treatment from you or another facility?	__ , __ __ __		__ __ __ .00 %	<input type="checkbox"/> -1
g. Covered by managed care arrangements	__ , __ __ __		__ __ __ .00 %	<input type="checkbox"/> -1
h. Criminal justice referred clients (excluding DUI/DWI)	__ , __ __ __		__ __ __ .00 %	<input type="checkbox"/> -1

18. From October 1, 1996 to September 30, 1997—or during the most recent 12-month period for which information is available— what was this facility’s:

- DO NOT INCLUDE NONTREATMENT CLIENTS

a. <u>Total number of substance abuse treatment admissions</u> —count <u>every admission</u> for the year, which includes each admission for clients readmitted for treatment or clients entering more than one type of care	12 - MONTH ADMISSIONS	__ __ , __ __ __
b. <u>Unduplicated count of substance abuse treatment clients</u> —count <u>every client</u> treated during that time period—both new clients and clients already receiving treatment. HOWEVER, count each client only once, even if a client was readmitted or treated more than once during the time period. (This count should be <u>no less than</u> the total reported at Q.12g)	12 - MONTH CLIENTS	__ __ , __ __ __

19. Is the number entered in:

	<u>Actual Count</u>	<u>Best Estimate</u>
a. Q.18a an actual admissions count for the year or your best estimate?	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Q.18b an actual unduplicated count for the year or your best estimate?	<input type="checkbox"/> 1	<input type="checkbox"/> 2

20. As of October 1, 1997, which of these services were being provided at this substance abuse facility?

MARK ALL THAT APPLY

Assessment Services

- 1 Comprehensive substance abuse assessment/diagnosis
- 2 Comprehensive mental health assessment/diagnosis (for example, psychological/psychiatric evaluation and testing)
- 3 Other (Specify: _____)

Therapy

- 4 Family counseling
- 5 Group therapy, not including relapse prevention
- 6 Individual therapy
- 7 Pharmacotherapies/prescription medication
- 8 Relapse prevention groups
- 9 Other (Specify: _____)

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

- 10 Blood alcohol testing (including breathalyzer)
- 11 Drug/alcohol urine screening
- 12 Hair analysis
- 13 Hepatitis testing
- 14 HIV testing
- 15 STD testing
- 16 TB screening
- 17 Other (Specify: _____)

Health Services

- 18 Family planning
- 19 Medical care (including physical exams)
- 20 Prenatal care
- 21 Perinatal care
- 22 TB treatment
- 23 Health education (for example, nutrition, contagious diseases, STD other than HIV/AIDS)
- 24 HIV/AIDS education/counseling/support
- 25 Smoking cessation
- 26 Other (Specify: _____)

Continuing Care

- 27 Aftercare counseling
- 28 Alumni(ae) groups
- 29 Other (Specify: _____)

Programs for Special Groups

- 30 Adolescents
- 31 Dually-diagnosed (mental and substance abuse disorders)
- 32 Persons with HIV/AIDS
- 33 Pregnant/Postpartum women
- 34 Other (Specify: _____)

Transitional Services

- 35 Assistance with obtaining Social Services (i.e., Medicaid, WIC, SSI, SSDI)
- 36 Discharge planning
- 37 Employment counseling/training
- 38 Housing assistance
- 32 Referral to other services
- 40 Other (Specify: _____)

Community Outreach

- 41 Drug and alcohol education
- 42 Outreach/early intervention
- 43 Media presentations (T.V., radio, brochures)
- 44 Membership in a community partnership program
- 45 Other (Specify: _____)

Other Services

- 46 Academic education/GED classes
- 47 Acupuncture
- 48 Case management services
- 49 Child care
- 50 Communication skills
- 51 Detoxification from substance of abuse
- 52 Domestic violence - family/partner violence services (physical, sexual and emotional abuse)
- 53 Home visits
- 54 Life skills for independent living
- 55 Outcome follow-up (post-discharge)
- 56 Parenting/family skills development
- 57 Self-help groups, including 12-step programs
- 58 Socialization/recreational services (for example, scheduled activities such as camping, sporting events)
- 59 Transportation assistance to treatment
- 60 Other (Specify: _____)

23. To answer Q.22, did you primarily use:

MARK ONE ONLY

- 1 An audited financial statement for the substance abuse treatment facility on the cover
- 2 An unaudited financial statement for the substance abuse treatment facility on the cover
- 3 The annual budget for the substance abuse treatment facility on the cover
- 4 A financial statement, budget, or records from an administrative parent
- 5 Estimates based on other records, budgets, or statements
- 6 Other estimates

24. Does the revenue or funding information reported in Q.22 include revenues or funding for a site OTHER THAN the one identified on the cover of this questionnaire?

- 1 Yes
- 2 No → **SKIP TO Q.25**

24a. Please complete a block below for each site whose revenue or funding information is included in Q.22. Make a photocopy of this page if more address blocks are needed or send your own printout.

NFR ID # _____ - ____	<input type="checkbox"/> -1 Don't Know
State ID # _____	<input type="checkbox"/> -1 Don't Know
Name _____	

Location Address _____	

City _____	
State _____	ZIP Code _ _ _ _ _ _ _ _
Telephone (_ _ _ _ _)- _ _ _ _ _ - _ _ _ _ _ _ _ _	
Ext. (if any) _____	

NFR ID # _____ - ____	<input type="checkbox"/> -1 Don't Know
State ID # _____	<input type="checkbox"/> -1 Don't Know
Name _____	

Location Address _____	

City _____	
State _____	ZIP Code _ _ _ _ _ _ _ _
Telephone (_ _ _ _ _)- _ _ _ _ _ - _ _ _ _ _ _ _ _	
Ext. (if any) _____	

25. Were you able to provide revenue or funding sources in Q.22 for at least 75 percent of the total reported revenue?

- 1 Yes → **SKIP TO Q.26, PAGE 10**
- 2 No

25a. Is there another organization that can provide the revenue or funding information for your facility?

- 1 Yes → **GO TO Q.25b, PAGE 10**
- 2 No →

Please explain: _____

SKIP TO Q.26, PAGE 10

25b. Please provide the following information for that organization.

Name of Organization _____		

Mailing Address _____		

City _____	State _____	ZIP Code _____
Name (Contact Person) _____		
Telephone (_ _ _ _)- _ _ _ _ - _ _ _ _		Ext. (if any) _____

26. In addition to the funding you received for providing substance abuse treatment services, did you receive any Federal or State funding earmarked for prevention activities during the same 12-month period reported in Q.21a, page 8?

- 1 Yes
- 2 No
- 1 Don't Know

27. Please provide the following information about the person primarily responsible for completing this form.

- 1. Name: _____
- 2. Telephone Number:(_____) - _____
- 3. FAX Number:(_____) - _____ OR No FAX Number
- 4. Internet Address: _____ OR No Internet Address

28. When completed, you will be able to access the 1997 National Directory and the 1997 UFDS Data Report on the World Wide Web via SAMHSA's home page at www.samhsa.gov. If you would like to receive a paper copy of the National Directory or the data report, or the National Directory on diskette, please indicate below.

- 1 National Directory - paper copy
- 2 National Directory - diskette (requires minimum of 8 MB RAM and 386 or higher processor)
- 3 Report of UFDS survey findings - paper copy

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: Pat Nemeth
P.O. Box 2393
Princeton, NJ 08543-2393