Survey of Structure and Operations (TCU SSO)

To be Completed by Program Director

Please answer the following questions by filling in the circle that describes your substance abuse program.

Telephone number of the program .....|___|___|___| |___|___|___| |___|___|___|___|

Today's Date: |___|___||___|___||___|___|
MO DAY YR

Are you: ○ Male ○ Female

Are you Hispanic or Latino? ○ *No* ○ *Yes*

Your Birth Year: 19|___|___|

Are you: [MARK ONE]

- ○ *American Indian/Alaska Native*
- ○ *Asian*
- ○ *Native Hawaiian or Other Pacific Islander*
- ○ *Black or African American*
- ○ *White*
- ○ *More than one race*
- ○ *Other* (please specify) _____

How many years have <u>you worked</u> –

a. in the drug treatment <u>field</u>? .....|___|___|
YEARS

b. at this <u>program</u>? .....|___|___|
YEARS

c. in your <u>current position</u>? .....|___|___|
YEARS

Your <u>job title</u>: [MARK ONE]

- ○ *Chief Executive Officer (CEO*)
- ○ *Chief Financial Officer (CFO)*
- ○ *Program Director*
- ○ *Clinical Director*
- ○ *Clinical Supervisor*
- ○ *Lead/Head Counselor*
- ○ *Other (*please specify*)* _____

A. STRUCTURAL RELATIONSHIPS

The following questions refer to your program's relationship with a parent organization. Please refer to the definitions below for clarification.

Definitions:

Program – A single intact clinic that provides substance abuse treatment services (e.g., outpatient treatment).

Parent Organization – A larger organization or agency of which your clinic is a part. There may be shared or separate financial accounting practices.

Sibling – Another single intact clinic that is operated separately from yours, but is also under your parent organization.

1. Does your Program operate under a parent organization?..... ○ *No* ○ *Yes*

   IF "YES," please list the name of the parent organization _____

   IF "NO," please skip to Section B, Question 1.

2. How many "siblings" do you have (how many other substance abuse treatment programs under this parent organization)? ..... |___|___|

3. What proportion of your program's financial books are independent of your parent organization? .....○ *All* ○ *Some* ○ *None* ○ *Don't Know*

4. Are you able to determine the percentage of your budget that is covered by your parent organization versus your program? ..... ○ *No* ○ *Yes*

   IF "YES," approximately what percentage of your budget is covered by –

   a. Your program? .....|___|___|___| %

   b. Your Parent Organization? .....|___|___|___| %

Please answer the following questions separately for Parent Organization and Sibling Programs.

	Parent		Sibling	
5. Do you share physical space with	○ *No*	○ *Yes*	○ *No*	○ *Yes*
6. Do you share staff with	○ *No*	○ *Yes*	○ *No*	○ *Yes*

Please provide a brief description of your Program's relationship with your Parent Organization and Siblings, particularly regarding circumstances that are unique to your Program or situation.

_____

_____

B. PROGRAM CHARACTERISTICS

1. Name of this program: _____
2. Street address of this program: _____
3. Zip code of this program: ..... |___|___|___|___|___|___|
4. How many years has this program been in operation? .....|___|___|
   # YEARS
5. Which of the following best describes this program? **[MARK ONE]**
   - ○ *Regular outpatient – less than 6 hours of structured programming per week (non-methadone)*
   - ○ *Intensive outpatient – minimum of 2 hours of structured programming on 3 days per week (non-methadone)*
   - ○ *Both Regular Outpatient and Intensive Outpatient (non-methadone)*
   - ○ *Outpatient methadone*
   - ○ *Therapeutic community*
   - ○ *Inpatient/residential*
   - ○ *Halfway house/work release*
   - ○ *Other* (please specify) _____
6. On which days does this program provide services? **[CHECK ALL THAT APPLY]**
   - ○ *Sunday*
   - ○ *Monday*
   - ○ *Tuesday*
   - ○ *Wednesday*
   - ○ *Thursday*
   - ○ *Friday*
   - ○ *Saturday*

7. Which one category best describes the primary setting of this program? **[MARK ONE]**

- ○ *Family/children services*
- ○ *Free-standing substance abuse services*
- ○ *Health center (including primary care setting)*
- ○ *Health Maintenance Organization or Integrated Health Plan Facility*
- ○ *Hospital or university*
- ○ *Jail or prison*
- ○ *Juvenile detention*
- ○ *Mental health service setting or community mental health clinic*
- ○ *Other multi-services*
- ○ *Private or group practice*
- ○ *Psychiatric or other specialized hospital*
- ○ *Social services*
- ○ *Other* (please specify) _____

8. Primary catchment area for program: **[MARK ONE]**

○ *Rural* ○ *Suburban* ○ *Urban*

9. Is this facility operated by: **[MARK ONE]**

- ○ *A private for profit organization*
- ○ *A private non-profit organization*
- ○ *State government*
- ○ *Local, county, or community government*
- ○ *Tribal government*
- ○ *Federal government – If federal government, which government agency?* **[MARK ONE]**
  - ○ *Department of Veteran Affairs*
  - ○ *Department of Defense*
  - ○ *Indian Health Services*
  - ○ *Federal Bureau of Prisons*
  - ○ *Other* (please specify) _____

10. What percentage of revenue/funding within the last year came from:

a. Client payments (self-payment, deductibles, copayments) ..... |___|___|___|%

b. Private health insurance, fee for services ..... |___|___|___|%

c. Private health insurance, HMO, PPO/Managed Care ..... |___|___|___|%

d. Medicaid, not specified ..... |___|___|___|%

e. Medicaid, managed care ..... |___|___|___|%

f. Medicare ..... |___|___|___|%

g. Other government funds (VA, CHAMPUS, etc.) ..... |___|___|___|%

h. Other public funds (Federal, State, and local block grants, other grants, contracts, etc.) ..... |___|___|___|%

i. Other funds (such as from charities, donations, fund-raising events)
(Specify Largest Source: _____) ..... |___|___|___|%

j. Unknown ..... |___|___|___|%

11. In the last year, did you have any formal written arrangements or contracts with managed care organizations (MCOs) for the provision of substance abuse treatment? ..... ○ *No* ○ *Yes*

IF "YES,"

a. How many separate MCO contracts did you have? .....|___|___|___|
CONTRACTS

b. What percentage of your clients were billed under MCO contracts? ..... |___|___|___|%

12. Type of substance abuse problems treated: **[MARK ONE]**

○ *Alcohol problems only* ○ *Drug problems only* ○ *Both alcohol and drug problems*

13. Is this a special program for women with children? ..... ○ *No* ○ *Yes*

14. Is this program accredited or licensed by –

a. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)? .... ○ *No* ○ *Yes*

b. Commission on Accreditation of Rehabilitation Facilities (CARF)? ..... ○ *No* ○ *Yes*

c. State alcohol and drug abuse department? ..... ○ *No* ○ *Yes*

d. State mental health department? ..... ○ *No* ○ *Yes*

e. State Department of Public Health? ..... ○ *No* ○ *Yes*

f. Other? (please specify) _____..... ○ *No* ○ *Yes*

15. What is this program's –

a. *capacity (highest number of clients that can be served)?* .....|___|___|___|
CLIENTS

b. *average length of stay over the past year?* .....|___|___|___|
DAYS

16. Do you have a planned length of treatment? ..... ○ *No* ○ *Yes* ○ *Varies by client*

a. IF "YES" OR "VARIED," *what is your typical planned length of treatment*? .....|___|___|___|
DAYS

C. ASSESSMENTS

1. How many clients are served by this program –

a. *on today's date?* .....|___|___|___|
CLIENTS

b. *over a one-month period (average number)?* .....|___|___|___|
CLIENTS

c. *over a one-year period (annually)?* .....|___|___|___|___|
CLIENTS

2. How many hours per week does a "typical" client spend in –

a. *individual sessions?* .....|___|___|
HOURS PER WEEK

b. *group sessions?* .....|___|___|
HOURS PER WEEK

c. *case management?* .....|___|___|
HOURS PER WEEK

3. At **intake**, what types of assessments or diagnostic instruments does your program currently use with clients?

a. *Addiction Severity Index (ASI)* ..... ○ *No* ○ *Yes*

b. *Diagnostic Interview Schedule/Diagnostic and Statistical Manual IV (DIS/DSM-IV)* ..... ○ *No* ○ *Yes*

c. *Minnesota Multiphasic Personality Inventory (MMPI)* ..... ○ *No* ○ *Yes*

d. *Simple Screening Instrument (SSI)* ..... ○ *No* ○ *Yes*

e. *Substance Abuse Subtle Screening Inventory (SASSI)* ..... ○ *No* ○ *Yes*

f. *Symptom Checklist-90 (SCL-90)* ..... ○ *No* ○ *Yes*

g. *Texas Christian University Drug Screen (TCUDS)* ..... ○ *No* ○ *Yes*

h. *Other* (please specify) _____..... ○ *No* ○ *Yes*

_____

_____

4. **During treatment**, what types of assessments or diagnostic instruments does your program currently use with clients?

   a. *Addiction Severity Index (ASI)* ..... ○ *No* ○ *Yes*

   b. *Diagnostic Interview Schedule/Diagnostic and Statistical Manual IV (DIS/DSM-IV)* ..... ○ *No* ○ *Yes*

   c. *Minnesota Multiphasic Personality Inventory (MMPI)* ..... ○ *No* ○ *Yes*

   d. *Simple Screening Instrument (SSI)* ..... ○ *No* ○ *Yes*

   e. *Substance Abuse Subtle Screening Inventory (SASSI)* ..... ○ *No* ○ *Yes*

   f. *Symptom Checklist-90 (SCL-90)* ..... ○ *No* ○ *Yes*

   g. *Texas Christian University Drug Screen (TCUDS)* ..... ○ *No* ○ *Yes*

   h. *Other* (please specify) _____..... ○ *No* ○ *Yes*

   _____

   _____

5. Does your program attempt to contact clients after discharge to document their outcomes? ..... ○ *No* ○ *Yes*

6. Do you collect and report a uniform set of data? ..... ○ *No* ○ *Yes*

   IF "YES," what system is used?

   a. *Client Oriented Data Acquisition Process (CODAP)* ..... ○ *No* ○ *Yes*

   b. *National Survey of Substance Abuse Treatment Services (N-SSATS)* ..... ○ *No* ○ *Yes*

   c. *Treatment Episode Data Set (TEDS)* ..... ○ *No* ○ *Yes*

   d. *Other* (please specify) _____ ..... ○ *No* ○ *Yes*

   _____

   _____

D. MONITORING

1. Does the program have a central computerized system for the following information?

   a. Financial/accounting (non-payroll) ..... ○ *No* ○ *Yes*
   b. Payroll ..... ○ *No* ○ *Yes*
   c. Program census data (e.g., numbers served, gender, ethnicity) ..... ○ *No* ○ *Yes*
   d. Receipt of services (e.g., weekly/monthly) ..... ○ *No* ○ *Yes*
   e. Individual client assessments ..... ○ *No* ○ *Yes*
   f. Individual client records (e.g., client charts) ..... ○ *No* ○ *Yes*

2. Does your program have a system for obtaining *documented* costs for each *unit* of service (e.g., 1 hour of therapy, 1 day of treatment, etc.)?..... ○ *No* ○ *Yes*

3. Does your program currently use any organizational assessments to examine –

   a. Program motivation for change (e.g., program needs, training needs)? ... ○ *No* ○ *Yes*
   b. Resources (e.g., staffing, computer access)? ..... ○ *No* ○ *Yes*
   c. Staff attributes (e.g., efficacy, adaptibility)? ..... ○ *No* ○ *Yes*
   d. Organizational climate (e.g., communication, stress)? ..... ○ *No* ○ *Yes*

E. SERVICES

1. Are the following services provided by this program?

   a. Assessment Services

   1. Comprehensive Substance Abuse Assessment/Diagnosis .. ○ *No* ○ *Yes* ○ *By referral only*
   2. Comprehensive Mental Health Assessment/Diagnosis ..... ○ *No* ○ *Yes* ○ *By referral only*

   b. Substance Abuse Therapy and Counseling

   1. Individual Therapy ..... ○ *No* ○ *Yes* ○ *By referral only*
   2. Group Therapy (not including Relapse Prevention) ..... ○ *No* ○ *Yes* ○ *By referral only*
   3. Family Counseling ..... ○ *No* ○ *Yes* ○ *By referral only*
   4. Aftercare Counseling ..... ○ *No* ○ *Yes* ○ *By referral only*
   5. Relapse Prevention Groups ..... ○ *No* ○ *Yes* ○ *By referral only*
   6. Pharmacotherapies/Prescription Medication ..... ○ *No* ○ *Yes* ○ *By referral only*

c. Biological Testing

1. *Drug/Alcohol Urine Screening* ..... ○ *No* ○ *Yes* ○ *By referral only*
2. *Blood Alcohol Testing (including Breathalyzer)* ..... ○ *No* ○ *Yes* ○ *By referral only*
3. *TB Screening* ..... ○ *No* ○ *Yes* ○ *By referral only*
4. *HIV Testing* ..... ○ *No* ○ *Yes* ○ *By referral only*
5. *Hepatitis Testing* ..... ○ *No* ○ *Yes* ○ *By referral only*
6. *STD Testing* ..... ○ *No* ○ *Yes* ○ *By referral only*

d. Transitional Services

1. *Referral to other Transitional Services* ..... ○ *No* ○ *Yes* ○ *By referral only*
2. *Discharge Planning* ..... ○ *No* ○ *Yes* ○ *By referral only*
3. *Assistance with obtaining Social Services* ..... ○ *No* ○ *Yes* ○ *By referral only*
4. *Employment Counseling/Training* ..... ○ *No* ○ *Yes* ○ *By referral only*
5. *Housing Assistance* ..... ○ *No* ○ *Yes* ○ *By referral only*

e. Medical Services

1. *Diagnosis, Testing, Treatment* ..... ○ *No* ○ *Yes* ○ *By referral only*
2. *Detoxification* ..... ○ *No* ○ *Yes* ○ *By referral only*
3. *Psychiatric* ..... ○ *No* ○ *Yes* ○ *By referral only*
4. *Smoking Cessation* ..... ○ *No* ○ *Yes* ○ *By referral only*
5. *Prenatal Care* ..... ○ *No* ○ *Yes* ○ *By referral only*

f. Other Services

1. *12-Step or Support Groups (AA/NA/CA)* ..... ○ *No* ○ *Yes* ○ *By referral only*
2. *Case Management Services* ..... ○ *No* ○ *Yes* ○ *By referral only*
3. *HIV/AIDS Education/Counseling/Support* ..... ○ *No* ○ *Yes* ○ *By referral only*
4. *Outcome Follow-Up (Post-Discharge)* ..... ○ *No* ○ *Yes* ○ *By referral only*
5. *Transportation Assistance to Treatment* ..... ○ *No* ○ *Yes* ○ *By referral only*
6. *Domestic Violence – Family/Partner Violence Services* ... ○ *No* ○ *Yes* ○ *By referral only*
7. *Child Care* ..... ○ *No* ○ *Yes* ○ *By referral only*
8. *Acupuncture* ..... ○ *No* ○ *Yes* ○ *By referral only*
9. *Education Classes (e.g., for GED)* ..... ○ *No* ○ *Yes* ○ *By referral only*
10. *Legal Counseling or Services* ..... ○ *No* ○ *Yes* ○ *By referral only*
11. *Financial Services* ..... ○ *No* ○ *Yes* ○ *By referral only*
12. *Parenting Instruction* ..... ○ *No* ○ *Yes* ○ *By referral only*

F. CLIENT CHARACTERISTICS

For the following questions, please provide number of clients served within a one-year period. This timeframe should correspond to the most recent annual reporting period for which you have data. You should refer to your most recent annual report provided to your state, parent organization, or other funding entity in answering these questions.

1. In the last year, how many clients were – **# CLIENTS**

   a. Female? .....|___|___|___|

   b. Male? .....|___|___|___|

2. In the last year, how many clients were Hispanic or Latino? .....|___|___|___|

3. In the last year, how many clients were –

   a. American Indian/Alaskan Native? .....|___|___|___|

   b. Asian? .....|___|___|___|

   c. Native Hawaiian or Other Pacific Islander? .....|___|___|___|

   d. Black or African American? .....|___|___|___|

   e. White? .....|___|___|___|

   f. More than one race? .....|___|___|___|

   g. Other? (specify) _____..... |___|___|___|

4. In the last year, how many clients were –

   a. Under 18 years of age (children and adolescents)? ..... |___|___|___|

   b. 18 to 20 years of age (young adults)?..... |___|___|___|

   c. 21 to 64 years of age? ..... |___|___|___|

   d. 65 and older? ..... |___|___|___|

5. In the last year, how many clients were –

   a. referred from the criminal justice system? .....|___|___|___|

   b. dual diagnosis clients (e.g., mental health and substance abuse)? .....|___|___|___|

   c. pregnant women? .....|___|___|___|

6. Are the numbers on this page (Client Characteristics 1-5) actual client counts or your best estimate? .....○ *Actual count* ○ *Estimate*

7. In the last year, how many clients reported the following as their primary drug problem?

	# CLIENTS
a. No drug problem	|___|___|___|
b. Alcohol	|___|___|___|
c. Cocaine/crack	|___|___|___|
d. Marijuana/hashish	|___|___|___|
e. Heroin	|___|___|___|
f. Non-prescription methadone	|___|___|___|
g. Other opiates and synthetics	|___|___|___|
h. PCP	|___|___|___|
i. Hallucinogens	|___|___|___|
j. Methamphetamines	|___|___|___|
k. Other amphetamines	|___|___|___|
l. Other stimulants	|___|___|___|
m. Benzodiazepines	|___|___|___|
n. Other tranquilizers	|___|___|___|
o. Barbiturates	|___|___|___|
p. Other sedatives/hypnotics	|___|___|___|
q. Inhalants	|___|___|___|
r. Club drugs (e.g., MDMA/Ecstasy, GHB, Rohypnol, Ketamine)	|___|___|___|
s. Over-the-counter medications	|___|___|___|
t. Other (specify) _____	|___|___|___|

8. Are the numbers on this page (Client Characteristics 7a-t) actual client counts or your best estimate? ..... ○ *Actual count* ○ *Estimate*

G. PROGRAM STAFF

Please answer the following questions according to your current staffing pattern. For the purpose of this study, "counselors" refers to all staff members who have direct contact with clients and may include counselors, social workers, case managers, clinical supervisors, therapists, etc. Please include full-time, part-time and contractual employees when answering the following questions.

1. Current number of counselors with direct client contact: .....|___|___|
   # COUNSELORS

2. *Average* counselor caseload (clients per counselor): .....|___|___|
   # CLIENTS

3. How many counselors – **# COUNSELORS**

   a. were hired in the last 6 months? ..... |___|___|

   b. left the program in the last 6 months? ..... |___|___|

   c. have less than 2 years with the program? ..... |___|___|

   d. have 2-5 years with the program? ..... |___|___|

   e. have 6-9 years with the program? ..... |___|___|

   f. have 10 or more years with the program? ..... |___|___|

   g. have a Master's degree or higher? ..... |___|___|

   h. are in recovery? ..... |___|___|

   i. are full time employees? ..... |___|___|

   j. are contractual? ..... |___|___|

H. PROGRAM CHANGES

Please rate the degree of change your Program has experienced in the last year.

1. Is your client census –

   ○ *rapidly decreasing* ○ *slowly decreasing* ○ *stable* ○ *slowly increasing* ○ *rapidly increasing*

2. Is your budget –

   ○ *rapidly decreasing* ○ *slowly decreasing* ○ *stable* ○ *slowly increasing* ○ *rapidly increasing*

3. Is your use of technology for program management (e.g., staff and financial resources) –

   ○ *rapidly decreasing* ○ *slowly decreasing* ○ *stable* ○ *slowly increasing* ○ *rapidly increasing*

4. Is your use of technology for clinical management (e.g., clients and their care) –

   ○ *rapidly decreasing* ○ *slowly decreasing* ○ *stable* ○ *slowly increasing* ○ *rapidly increasing*

5. In the last year, was there a change in your –

   a. CEO/Director of Parent Organization? ..... ○ *No* ○ *Yes*

   b. Program/Clinical Director? ..... ○ *No* ○ *Yes*

   c. Chief Financial Officer? ..... ○ *No* ○ *Yes*

   d. Other management positions? ..... ○ *No* ○ *Yes*

6. In the last year, have there been significant changes in –

   a. Ownership? ..... ○ *No* ○ *Yes*

   b. Affiliation? ..... ○ *No* ○ *Yes*

   c. Funding sources? ..... ○ *No* ○ *Yes*

   d. Type of clients treated? ..... ○ *No* ○ *Yes*

   e. Management philosophy? ..... ○ *No* ○ *Yes*

   f. Treatment philosophy? ..... ○ *No* ○ *Yes*

   g. Other? (please specify) _____ ..... ○ *No* ○ *Yes*

7. Do you anticipate major growth or expenses in the coming year due to –

   a. Capital expansion? ..... ○ *No* ○ *Yes*

   b. Large purchases? ..... ○ *No* ○ *Yes*

   c. Relocation? ..... ○ *No* ○ *Yes*

   d. Management changes? ..... ○ *No* ○ *Yes*

   e. Other? (please specify) _____..... ○ *No* ○ *Yes*

8. Which of the following best describes your primary method for determining a client's discharge or termination date?

   ○ *Date of last session*

   ○ *Date of discharge paperwork completed*

   ○ *A specified length of time after last session*

   IF "YES," please specify _____

   ○ *Other* (please specify) _____

9. Which of the following best describes your primary method for documenting a client's termination from treatment?

   ○ *Systematically documented at time of discharge for each client individually*

   ○ *Documented after the fact for each client individually*

   ○ *Estimated periodically for a group of clients*

   ○ *Discharge is not documented*

   ○ *Other* (please specify) _____

10. Do you have the capability to estimate the percent of time your staff spends in various activities (group sessions, individual sessions, documentation, case management, educational sessions etc.)? ..... ○ *No* ○ *Yes*

11. How much time would it take to provide your best estimate of the percent time your staff spends in various activities (e.g., group counseling, intake assessments)? .....|___|___|___|
    # MINUTES