National Syringe Services Program Evaluation

Survey Years 2-3

Contents

OVERVIEW

Abbreviations

R	Respondent
DK	Don't know
REF	Refused to answer
NA	Not applicable (question asked of R but this is a codable response option)
EQ	Equal to
GT	Greater than
GE	Greater than or equal to
LE	Less than or equal to
LT	Less than
NE	Not equal to

Key Terms

Term	Prefix / format	Definition
Calculated variable	CALC_	Item identifier (not prefix for variable name) for variables calculated by the CAPI program that appear in the CRQ.
Message	**INTERVIEWER:**	Message displayed to the interviewer that is <u>not</u> to be read to R. May be triggered by an edit check. Distinct from Interviewer Instruction. 'FIELD NOTE' indicates instructions that will be added as a field note rather than directly included in the question.
Filter question		A question that determines whether the respondent should receive subsequent question or set of questions, typically on a related topic.
Logic Check	Check_	Logic that must be checked (by the CAPI program) in order to determine proper routing to the next item in the CAPI programmed questionnaire.
Interviewer instruction		Instruction to interviewer regarding survey administration. Standard instructions are 'Give Respondent Flashcard {letter}', 'READ choices', 'DO NOT READ choices', & 'CHECK ALL that apply'.
Introductory statement	INTRO_	Transitional statement read to R at the beginning of a new topic (e.g., Section, set of questions, etc.). Prefix is followed by section abbreviation, series, or first item in set to which it applies.
Range		Range of valid response values for items collecting or computing numeric data. E.g., the valid range of responses to number of sex partners in past 12 months is 0 to 7000.
Section		Section of the Questionnaire. Each section has a unique two letter abbreviation.
Soft Edit Check	SoftEdit_	A check to determine whether the response entered is implausible. If yes, CAPI program displays message to interviewer; program may advance after closing the error message dialog box.

CALC_YR	**Hidden variable: Year of recall period. This is the period that the participant will be asked to recall throughout the survey. This needs to be updated manually by survey staff each time the survey is administered.** *Field note: Must be 4 digits.*
YEAR	Recall year _ _ _ _

PI1.	**Are you completing this survey by yourself or by speaking with an interviewer?**
ADMIN	Mode of administration Completing survey myself.. 0 Completing survey with interviewer.. 1

Check_INTRO.	If R self-administering survey (PI1 [ADMIN] EQ 0), go to INTRO_SA. Else, go to INTRO_IA.

INTRO_SA.	Thank you for taking the time to complete this program survey. When answering questions, please refer to the period from January 1, [YEAR], to December 31, [YEAR] unless otherwise stated. If program data are not available, please use your best estimate to complete the questions below. If your program only operated during some of the specified time period, please provide information reflective of the time period(s) during which your program did operate. If you need any clarifications about any of the questions in this survey or how this information will be used, please contact [project coordinator name, phone, email]. If you need to step away, **PLEASE REMEMBER TO <u>SAVE YOUR SURVEY</u>,** as not saving it will result in losing your responses. To save, first click on the save button at the bottom of the screen. You will then be prompted to enter an <u>email address</u> and a link will be sent to you to continue the survey later.

INTRO_IA.	Thank you for taking the time to complete this program survey. When answering questions, please refer to the period from January 1, [YEAR], to December 31, [YEAR] unless otherwise stated. If program data are not available, please use your best estimate to complete the questions below. If your program only operated during some of the specified time period, please provide information reflective of the time period(s) during which your program did operate. If you need any clarifications about any of the questions in this survey or how this information will be used, please let me know.

During the survey, you may need to refer to your records to answer some questions. If you are unable to answer a question today, but later find the answer in your records, you can reach us later to provide this additional information by contacting [project coordinator name, phone, email].

CALC_SDATE

Automatic, hidden variable: Survey date (today)

Automatic start date

_ _ / _ _ / _ _ _ _

CALC_START

Automatic, hidden variable: Start time of survey

Preliminary information: Start time

__ : __

PI2.
PROGNAM

What is the name of your program?
[FIELD NOTE: IF REFUSED, LEAVE BLANK]
Name of program

—— ——

{text response; max characters = 100}

PI3a.
SDATE_M

What month and year did the program start? Start by selecting the month. If you do not remember the exact month, please provide your best estimate.
SDATE month
January...1........
February..2........
March...3........
April...4........
May...5........
June..6........
July...7........
August..8........
September...9.........
October...10.........
November...11........
December...12........
Don't Know..99.........
Refuse to Answer...77.........

PI3b.

Enter the year. If you do not remember the exact year, please provide your best estimate.
Please enter four digits.
[FIELD NOTE: IF REFUSED OR DON'T KNOW, LEAVE BLANK]

SDATE_Y   SDATE year

---- ---- ---- -----

Range..1950-[YEAR]....

SoftEdit_SDATE_Y	If [SDATE_Y] > [YEAR], then display error message: "The year the SSP started is later than [YEAR]. Please confirm that this year is accurate."

INTRO_PI.	First, we would like to ask a series of questions about your program and the services your program provided between January 1, [YEAR], and December 31, [YEAR]. Following these questions, we will then ask a few of the same questions about 2020. The COVID-19 pandemic likely impacted program operations and services provided by programs nationwide during 2020, so this information will be extremely important to help understand these impacts and the continuing challenges to programs moving forward.

PI4.   **Did your program provide any services at <u>any time</u> between January 1, [YEAR], and December 31, [YEAR]?**

OPRCL   Operated during recall period

No.. 0

Yes.. 1

Check_PI4.	If R did not operate at any time during the recall period (PI4 [OPRCL] EQ 0), go to INTRO_MD1. Else, go to INTRO_PC.

PROGRAM CHARACTERISTICS

INTRO_PC.	The next set of questions is about your program background and overall set-up. All information is important, and we appreciate your time and effort in completing this survey. However, we understand if you cannot answer some of these questions; in these situations, you have an option to select "don't know" or "refuse to answer" responses, whichever best applies.

S_TIME1	**Automatic hidden variable: Respondent start time** Respondent start time __ : __

Was your program operated by a...

PC1.   **Select all that apply.**

OPBY   Program operator

Community-based organization..

City health department...

County health department..

State health department...

Health care organization..

Academic institution or hospital..

Volunteers only...

Other (please specify)..

Check_PC1spec.	If R selected 'Other (please specify)' (PC1(7) [OPBY(7)] EQ 1), go to PC1spec [OPBY_S]. Else, go to PC2 [SFUND].

PC1spec.
OPBY_S

Specify other program operator.
Specify other program operator

——

{text response; max characters = 100}

PC2.
SFUND

What were your program's sources of funding?
Select all that apply.
Sources of funding
City government...
County government..
State government..
Federal government...
Non-profit foundation/organization...
Individual donations..
Personal funds from program managers or staff..............................
Corporate donation..
Other (please specify)..

Check_PC2spec.	If R selected 'Other (please specify)' (PC2(9) [SFUND(9)] EQ 1), go to PC2spec [SFUND_S]. Else, go to PC3 [BUDGET].

PC2spec.
SFUND_S

Specify other source of funding.
Specify other funding source

——

{text response; max characters = 100}

PC3.
BUDGET

What was your total program budget? If your program is part of a larger, multi-service organization, please only provide the budget for your part of the program. Please provide the best estimate to your knowledge.
Total program budget
Less than $25,000... 1
$25,000–$100,000.. 2
$100,001–$250,000.. 3
$250,001–$500,000.. 4
$500,001–$1 million.. 5
Between $1 million and $2 million.. 6
$2 million or more.. 7

PC4.
FTSTAF

Did your program employ any full-time paid staff (that is, those working 30 hours per week or more)?

Full-time paid staff

No.. 0

Yes... 1

Refuse to Answer... 7

PC5.
PWIDST

Did your program have any <u>paid employees</u> who formerly or currently injected drugs? Include paid outreach workers and those paid with stipends or salaries.

Current or former PWID staff

No.. 0

Yes... 1

Don't Know.. 9

Refuse to Answer... 7

PC6.
PWIDVL

Did your program have any <u>volunteers</u> who formerly or currently injected drugs? Include outreach volunteers.

Current or former PWID volunteers

No.. 0

Yes... 1

Don't Know.. 9

Refuse to Answer... 7

PC7.
NUMHRS

What were your program's total hours of operation in a typical week? If your program had more than one location (including mobile locations), consider the hours of operation for the overall program. For example, if your program had 3 locations, and each was open from 1-5pm for 5 days per week, that would be 20 hours, <u>not</u> 60 hours, of overall coverage for that week. If you do not know or prefer not to answer, you may leave the response blank.

Number of hours per week

— — —

Range...0-168

INTRO_GEO.	To help us understand geographic coverage of syringe services programs, please enter the state and county(ies) where your program operates. If your program has multiple locations, please list counties for all locations. Please also consider mobile units in your responses.

PC8a.
SSPSTAT

Please specify the state(s) or territory(ies) where your program is located: Select all that apply.

State(s) or territory(ies)

Alabama..01................

Alaska...02................

Arizona..04................

Arkansas..05................

California..06................

Colorado..08................

Connecticut...09................

Delaware...10................

District of Columbia...11................

Florida..12................
Georgia...13................
Hawaii...15................
Idaho..16................
Illinois..17................
Indiana...18................
Iowa...19................
Kansas..20................
Kentucky...21................
Louisiana..22................
Maine...23................
Maryland..24................
Massachusetts...25................
Michigan...26................
Minnesota...27................
Mississippi..28................
Missouri..29................
Montana...30................
Nebraska..31................
Nevada...32................
New Hampshire..33................
New Jersey..34................
New Mexico...35................
New York...36................
North Carolina..37................
North Dakota..38................
Ohio...39................
Oklahoma..40................
Oregon..41................
Pennsylvania..42................
Puerto Rico..72................
Rhode Island..44................
South Carolina..45................
South Dakota..46................
Tennessee..47................
Texas..48................
US Virgin Islands..78................
Utah...49................
Vermont..50................
Virginia...51................
Washington..53................
West Virginia..54................
Wisconsin..55................
Wyoming...56................
Refuse to Answer..77................

In which counties does your program provide services? Please include brick and mortar locations, mobile services, deliveries, and other ways you provide services. If you do not know or prefer not to answer, you may leave the response blank.

PC8b.

SSPCNTY   County(ies)

——

{text response; max characters = 255}

PC9.
SRVAREA

Did your program serve communities that you would consider urban, suburban, or rural? Please consider all the locations in which your program operates and select all that apply.

Service area type

Urban...

Suburban...

Rural...

Refuse to Answer... 7

PC10.
SDELIV

How did your program deliver services? If your program had more than one location or service delivery type, select all that apply.

Service delivery type

Brick and mortar building/storefront..

Mobile unit, such as an RV, van, or car..

Tent or outdoor area..

Home delivery..

"Backpack" delivery...

Mail order...

Syringe vending machine...

Other (please describe)...

Don't Know...99

Refuse to Answer...77

Check_PC10spec.	If R selected 'Other (please describe)' (PC10(8) [SDELIV(8)] EQ 1), go to PC10spec [SDELIV_S]. Else, go to PC11 [DSRPT].

PC10spec.
SDELIV_S

Specify other service delivery type.

Specify other service delivery type

— —

{text response; max characters = 100}

PC11.
DSRPT

Did your program have to stop providing services for any period of time between January 1, [YEAR], and December 31, [YEAR] (that is, you did not provide services for at least one day or more when you had expected to be open)?

Stop providing services

No.. 0

Yes... 1

Don't Know... 9

Refuse to Answer... 7

Check_PC12.	If R had to stop providing services (PC11 [DSRPT] EQ 1), go to PC12 [WHYDSRP]. Else, go to PC13 [INEVAL].

PC12.
WHYDSRP

Please choose the reason(s) for the disruption.
Select all that apply.

Why services disrupted

Inadequate funding for materials or supplies...

Inadequate funding for operations..

Lack of personnel to staff the program...

Legal or political intervention...

COVID-19 pandemic...

Other (please describe)...

Don't Know... 9

Refuse to Answer.. 7

Check_PC12spec.	If R selected 'Other (please describe)' (PC12(6) [WHYDSRP(6)] EQ 1), go to PC12spec [WHYDSRP_S]. Else, go to PC13 [INEVAL].

PC12spec. **Specify other reason for disruption(s) to services.**

WHYDSRP_S Specify other disruption

—— ——

{text response; max characters = 100}

PC13. **Did your program review your program's data for monitoring or evaluation purposes between January 1, [YEAR], and December 31, [YEAR]?**

INEVAL Did program review internal data

No.. 0

Yes... 1

Refuse to Answer.. 7

PC14. **What computer software program did you use to manage your program's data? Select all that apply.**

SFTWR Software to manage client data

None...

Excel...

Access...

Neo360...

REDCap...

Qualtrics...

SurveyMonkey..

Other (please describe) ....

Refuse to Answer...77

Check_PC14spec.	If R selected 'Other (please describe)' (PC14 [SFTWR] EQ 8), go to PC14spec [SFTWR_S]. Else, go to PC15 [UNIQID].

PC14spec. **Specify other software used to manage client data.**

SFTWR_S Specify other software

—— ——

{text response; max characters = 100}

PC15. **Did your program assign each client a unique ID?**

UNIQID Did program assign unique ID

No	....	0
Yes	....	1
Refuse to Answer	....	7

PC16.
NUMCLI
How many unique clients did your program serve? Please provide the best estimate to your knowledge. If you do not know or prefer not to answer, you may leave the response blank.

Number of unique clients

— — — — — — — —

Range..0–99999999

PC17.
RESRSTR
Did your program have residency restrictions on who could access services, that is, only people from certain geographic locations could receive services from your program?

Residency restrictions

No.. 0

Yes.. 1

Don't Know.. 9

Refuse to Answer... 7

PC18.
IDDOC
Did your program require clients to provide identifying documents (for example, a driver's license) to enroll or receive services?

Require identifying documents

No.. 0

Yes.. 1

Don't Know.. 9

Refuse to Answer... 7

CLIENT CHARACTERISTICS

INTRO_CC.	The next questions are about the characteristics of the clients served by your program. As a reminder, as you answer these questions, please think about your program's operations between January 1, [YEAR], and December 31, [YEAR].

CC1.
DEMSRV
Which demographic groups did your program reach in [YEAR]? Select all that apply.

Demographic groups served

Cisgender women...

Cisgender men..

Transgender women..

Transgender men...

Genderqueer/non-binary persons...

American Indian or Alaska Native persons...

Asian persons...

Black or African American persons..

Hispanic or Latinx persons...

Native Hawaiian or Other Pacific Islander persons...

White persons...

Persons aged <18 years...

Persons aged 18 to 29 years...

Persons aged 30 to 39 years...

Persons aged ≥40 years..

Lesbian, gay, bisexual, or queer persons...

Other (please describe)..

Refuse to Answer..77

Check_CC1spec.	If R selected 'Other (please describe)' (CC1 [DEMSRV] EQ 16), go to CC1spec [DEMSRV_S]. Else, go to CC2 [DEMRCH].

CC1spec.
DEMSRV_S

Specify other demographic group reached.

Specify other group

— —

{text response; max characters = 100}

CC2.
DEMRCH

Which demographic groups in your community did your program have difficulty reaching in [YEAR]? Select all that apply.

Difficulty reaching demographic groups

Cisgender men..

Cisgender women..

Transgender men...

Transgender women...

Genderqueer/non-binary persons...

American Indian or Alaska Native persons...

Asian persons...

Black or African American persons..

Hispanic or Latinx persons...

Native Hawaiian or Other Pacific Islander persons...

White persons...

Persons aged <18 years..

Persons aged 18 to 29 years..

Persons aged 30 to 39 years..

Persons aged ≥40 years..

Lesbian, gay, bisexual, or queer persons..

Other (please describe)...

Refuse to Answer..77

Check_CC2spec.	If R selected 'Other (please describe)' (CC2 [DEMRCH] EQ 16), go to CC2spec [DEMRCH_S]. Else, go to CC3 [DEMRCH].

CC2spec.
DEMRCH_S

Specify other demographic group your program had difficulty reaching.

Specify other group

— —

{text response; max characters = 100}

CC3.
INSUR

Approximately what percentage of your clients did <u>not</u> have health insurance? Please use your records if available but provide your best estimate if no records are kept or are not readily available.

Client insurance

Less than 25%.. 1

25-50%.. 2

51-75%.. 3

More than 75%.. 4

Don't Know.. 9

Refuse to Answer... 7

CC4.
INJDRUG

For each of the following substances, please indicate the approximate percentage of your clients who were <u>injecting</u> each substance on a weekly or more frequent basis. Please use your records if available but provide your best estimate if no records are kept or are not readily available.

Substances injected by clients

	None	Less than 25%	25-50%	51-75%	More than 75%	Don't Know	Refuse to Answer
INJDRUGA	Heroin, by itself..						
INJDRUGB	Speedball, which is heroin and cocaine together...						
INJDRUGC	Goofball, which is heroin and methamphetamine together..						
INJDRUGD	Methamphetamine, by itself, also known as meth or speed...						
INJDRUGE	Fentanyl, by itself or in combination with other drugs...						
INJDRUGF	Powder cocaine, by itself...						
INJDRUGG	Crack cocaine, by itself..						
INJDRUGH	Painkillers, such as Oxycontin, Dilaudid, or Percocet...						
INJDRUGI	Benzodiazepines or other downers, such as Valium, Xanax, or Klonopin...................................						
INJDRUGJ	Other 1 (please describe)...						
INJDRUGK	Other 2 (please describe)...						
INJDRUGL	Other 3 (please describe)...						

Check_CC4specA.	If R selected 'Other 1 (please describe)' (CC4 [INJDRUGJ]), go to CC4specA [INJDRUGJ_S]. Else, go to Check_CC4specB.

CC4specA.
INJDRUGJ_S

From the previous question, specify 'Other 1' substance injected by clients.

Specify other substance injected

—— ——

{text response; max characters = 100}

Check_CC4specB.	If R selected 'Other 2 (please describe)' (CC4 [INJDRUGK]), go to CC4specB [INJDRUGK_S]. Else, go to Check_CC4specC.

CC4specB.
INJDRUGK_S

From the previous question, specify 'Other 2' substance injected by clients.

Specify other substance injected

—— ——

{text response; max characters = 100}

Check_CC4specC.	If R selected 'Other 3 (please describe)' (CC4 [INJDRUGL]), go to CC4specC [INJDRUGL_S]. Else, go to INTRO_CR.

CC4specC.
INJDRUGL_S

From the previous question, specify 'Other 3' substance injected by clients.

Specify other substance injected

—— ——

{text response; max characters = 100}

COMMUNITY RELATIONS AND CHALLENGES

INTRO_CR.	The next questions are about your program's relationships with members of the community and any related challenges. As a reminder, as you answer these questions, please think about your program's operations between January 1, [YEAR], and December 31, [YEAR].

CR1.
SUPADV

Which individuals or types of organizations advocated for your program or provided any type of support? Select all that apply.

Sources of support or advocacy

Local health officials..

Law enforcement..

HIV or other medical providers...

Religious organizations..

Local politicians..

Local residents..

Drug user unions..

Other community-based organizations..

Other (please describe)...

No advocate support..

Refuse to Answer..77

Check_CR1spec.	If R selected 'Other (please describe)' (CR1(8) [SUPADV(8)] EQ 1), go to CR1spec [SUPADV_S]. Else, go to CR2 [CHLNG].

CR1spec.
SUPADV_S

Specify other source of support

Specify other source of support

—— ——

{text response; max characters = 100}

CR2.
ECHLNG

What types of <u>external</u> challenges did your program face, not including challenges related to funding? Select all that apply.

Types of external challenges

Limited/no law enforcement support...

Active police harassment/arrest of program clients...

Program operations disrupted by government or law enforcement...

Local policy/law that restricts program services...

Lack of support from local health officials..

Lack of community support...

Active community harassment..

COVID-19 pandemic..

Other (please describe)..

Did not face external challenges..

Check_CR2spec.	If R selected 'Other (please describe)' (CR2(9) [ECHLNG(9)] EQ 1), go to CR2spec [ECHLNG_S]. Else, go to CR3 [ICHLNG].

CR2spec.
ECHLNG_S

Specify other external challenges

Specify other external challenges

— —

{text response; max characters = 255}

CR3.
ICHLNG

What types of <u>internal</u> challenges did your program face? Select all that apply.

Types of internal challenges

Staff burnout..

Staff shortage...

Limited/no funding..

Limited/no resources or supplies (other than funding)......................................

Other (please describe)..

Did not face internal challenges...

Check_CR3spec.	If R selected 'Other (please describe)' (CR3(5) [ICHLNG(5)] EQ 1), go to CR3spec [ICHLNG_S]. Else, go to CR4 [RLHO].

CR3spec.
ICHLNG_S

Specify other internal challenges

Specify other internal challenges

— —

{text response; max characters = 255}

CR4.
RLHO

How would you describe your program's relationship with your local health department(s)?

Relationship with local health officials

Very good.. 1

Somewhat good.. 2

Neither good nor poor.. 3

Somewhat poor.. 4

Very poor... 5

Nonexistent.. 6

CR5.
RLAW

How would you describe your program's relationship with law enforcement?

Relationship with law enforcement

Very good.. 1

Somewhat good.. 2

Neither good nor poor.. 3

Somewhat poor.. 4

Very poor... 5

Nonexistent.. 6

SYRINGE COLLECTION, DISTRIBUTION, AND DISPOSAL

INTRO_SYR.	The next set of questions pertain to syringe services provided by your program between January 1, [YEAR], and December 31, [YEAR].

SYR1.
NUMSYR

How many total sterile syringes did your program provide to clients? Please provide your best estimate if records are not readily available. If you do not know or prefer not to answer, you may leave the response blank.

Number of sterile syringes provided

— — — — — — —

Range..0-9999999

SYR2.
CLINEED

Did your program provide syringes to clients based on the clients' needs, without any restrictions?

Needs-based provision of syringes

No... 0

Yes.. 1

SYR3.
SECXCHNG

Did your program provide clients with extra syringes to distribute to other people in the community (i.e., secondary exchange or peer delivery)?

Secondary exchange

No... 0

Yes.. 1

Check_SYR4.	If R selected 'Yes' (SYR3 [SECXCHNG] EQ 1), go to SYR4 [SETRAIN]. Else, go to INTRO_PN.

SYR4. | Did your program provide training or other support for clients to distribute new, sterile syringes to others (i.e., secondary exchange) and/or facilitate syringe disposal?

SETRAIN Secondary exchange training

No.. 0

Yes... 1

Refuse to Answer... 7

PROVISION OF NALOXONE AND OTHER OVERDOSE REVERSAL MEDICATIONS

INTRO_PN. | In this section, we will ask you about overdose prevention services your program may have provided, such as overdose prevention training and naloxone distribution. As a reminder, we are asking about services provided by your program between January 1, [YEAR], and December 31, [YEAR].

PN1. **What overdose prevention or treatment services did your program provide? Select all that apply.**

WHATOD What OD prevention or treatment services provided

None...

Naloxone kits..

Naloxone prescription...

Fentanyl test strips...

Overdose prevention and response training for opioids......................................

Overdose prevention and response training for drugs other

than opioids (e.g., cocaine, methamphetamine)..

Refuse to Answer...77

Check_PN2. | If R provided naloxone kits (PN1 [WHATOD] EQ 1), go to PN2 [NALKIT].
Else, go to INTRO_PS1.

How many naloxone kits were distributed by your program? Please provide the number of kits distributed regardless of how many doses were contained in each kit. If your program does not collect these data, please provide your best estimate. If you do not know or prefer not to answer, you may leave the response blank.

PN2.

NALKIT Number of naloxone kits distributed

— — — —

Range...0-9999

How many doses were distributed in each naloxone kit by your program? If you do not know or prefer not to answer, you may leave the response blank.

PN3.

NALDOS Number of doses distributed in each naloxone kit

— —

Range...1-99

PN4. **In what ways did your program distribute naloxone kits? Select all that apply.**

NALDIS How distributed naloxone

Direct distribution from staff to client..

In-person delivery (kit delivered directly to client)...

Mail delivery (kit mailed to client)...

Secondary distribution (client distributes kit to peers).......................................

Provider referral for prescription or referral to pharmacy..................................

Offered at community-based overdose education events (open

to the public)...

Offered at overdose education events for staff or clients of

other organizations...

PN5.   **What barriers, if any, did your program experience in providing naloxone to your clients? Select all that apply.**

BARNAL   Barriers to providing naloxone

No barriers...

High cost of naloxone...

Shortage of naloxone...

Legal/political climate..

Other (please describe)

Check_PN5spec.	If R selected 'Other (please describe)' (PN5(5) [BARNAL(5)] EQ 1), go to PN5spec [BARNAL_S]. Else, go to INTRO_PS1.

PN5spec.   **Specify other barrier in providing naloxone**

BARNAL_S   Specify other barrier in providing naloxone

— —

{text response; max characters = 255}

PROVISION OF SERVICES

INTRO_PS1.	The next set of questions are about the services your program provided or needed between January 1, [YEAR], and December 31, [YEAR]. This information will help us understand the services that programs are already providing, trying to expand, or adding to meet client needs. Please indicate next to each service whether your program 1) *fully provided the service* (that is, the service was provided at a level that fully met client needs), 2) *partially provided the service* (that is, the service was provided inconsistently or at a level that did not meet client needs), 3) *did not provide the service and was not able to meet client needs*, or 4) *did not provide the service and most clients did not need the service*. If service provision varied between January 1, [YEAR], and December 31, [YEAR], choose the option that best describes the provision of services during the majority of time during this period.

PS1.   **For each of the following safer injection and drug use supplies, please indicate the extent to which the supply was provided.**

INJSUP   Safer injection and drug use supplies

	Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer/ Not Applicable

INJSUPA	Syringes..				
INJSUPB	Cookers..				
INJSUPC	Cottons..				
INJSUPD	Syringe/pill filters like Sterifilt®...				
INJSUPE	Saline or sterile water...				
INJSUPF	Ties/tourniquets...				
INJSUPG	Alcohol pads...				
INJSUPH	Wound care kits..				
INJSUPI	Sharps containers for carrying used syringes....................................				
INJSUPJ	Fentanyl test strips...				
INJSUPK	Safer smoking kits...				
INJSUPL	Other (please describe)...				

Check_PS1spec.	If R selected 'Other (please describe)' (PS1 [INJSUPL]), go to PS1spec [INJSUP_S]. Else, go to PS2 [SEXSUP].

PS1spec. **Specify other <u>injection and drug use supplies</u>**
INJSUP_S   Specify other injection and drug use supplies

— —

{text response; max characters = 100}

PS2. **For each of the following <u>safer sex supplies</u>, please indicate the extent to which the supply was provided.**
SEXSUP   Safer sex supplies

	Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer
SEXSUPA External condoms (male condoms)...					
SEXSUPB Internal condoms (female condoms)..					
SEXSUPC Lubricant...					
SEXSUPD Dental dams...					

PS3. **For each of the following <u>testing services</u>, please indicate the extent to which the service was provided <u>onsite</u>, either by the program itself or by partners, at the location(s) where your program operated.**
ONTEST   Onsite testing services

	Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer/ Not Applicable
ONTESTA HIV rapid testing...					
ONTESTB HIV laboratory-based testing..					
ONTESTC Hepatitis C virus (HCV) rapid testing...					
ONTESTD Hepatitis C virus (HCV) laboratory-based testing...............................					
ONTESTE STI testing other than hepatitis or HIV...					
ONTESTF TB skin testing or laboratory-based screening for latent TB..					
ONTESTG Pregnancy testing..					

| ONTESTH | COVID-19 testing.. | | | | | |
| ONTESTI | Other (please describe).. | | | | | |

PS3spec.   **Specify other <u>onsite testing service</u>**

ONTEST_S   Specify other testing

— —

{text response; max characters = 100}

PS4.   **For each of the following <u>vaccinations</u>, please indicate the extent to which the service was provided <u>onsite</u>, either by the program itself or by partners, at the location(s) where your program operated.**

ONVAX   Onsite vaccinations

	Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer/ Not Applicable
ONVAXA Hepatitis A vaccination..					
ONVAXB Hepatitis B vaccination..					
ONVAXC Influenza vaccination...					
ONVAXD COVID-19 vaccination..					
ONVAXE Other (please describe)...					

PS4spec.   **Specify other <u>vaccination</u>**

ONVAX_S   Specify other vaccination

— —

{text response; max characters = 100}

PS5.   **For each of the following <u>medications</u>, please indicate the extent to which the medication was prescribed and/or dispensed <u>onsite</u>, either by the program itself or by partners, at the location(s) where your program operated.**

ONMED   Onsite medications

	Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer/ Not Applicable
ONMEDA HIV treatment..					
ONMEDB PrEP (pre-exposure prophylaxis)...					
ONMEDC PEP (post-exposure prophylaxis)...					
ONMEDD Hepatitis C treatment...					
ONMEDE STI treatment other than hepatitis or HIV..					
ONMEDF Medications for opioid use disorder (MOUD)......................................					

ONMEDG	Medications for non-opioid substance use disorders...
ONMEDH	Medications for mental health disorders...
ONMEDI	Other (please describe)...

| Check_PS5spec. | If R selected 'Other (please describe)' (PS5 [ONMEDI]), go to PS5spec [ONMED_S]. Else, go to Check_PS6. |

PS5spec. **Specify other medication**

ONMED_S   Specify other medication

— —

{text response; max characters = 100}

| Check_PS6. | If R provided MOUD (PS5 [ONMEDF] EQ "Fully provided" OR "Partially provided"), go to PS6 [MOUD_S]. Else, go to PS7 [ONMSRV]. |

PS6.

You indicated that your program provided onsite medications for opioid use disorders (MOUD) between January 1, [YEAR], and December 31, [YEAR]. Which of the following MOUD did your program provide <u>onsite,</u> either by the program itself or by partners, at the location(s) where your program operated? Select all that apply.

MOUD_S   Which MOUD provided

Buprenorphine/naloxone (Suboxone)..

Buprenorphine (Subutex)..

Methadone..

Naltrexone (Vivitrol)..

Other (please describe) ....

Refuse to Answer... 7

| Check_PS6spec. | If R selected 'Other (please describe)' (PS6 [MOUD_S]), go to PS6spec [MOUD_SS]. Else, go to PS7 [ONMSRV]. |

PS6spec. **Specify other <u>MOUD</u>**

MOUD_SS   Specify other MOUD

— —

{text response; max characters = 100}

PS7.

For each of the following <u>other medical services</u>, please indicate the extent to which the service was provided <u>onsite</u>, either by the program itself or by partners, at the location(s) where your program operated.

ONMSRV   Other onsite medical services

	Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer/ Not Applicable
ONMSRVA	Substance use disorder treatment services (excluding medications)..				
ONMSRVB	Wound care/treatment..				
ONMSRVC	Mental health services (excluding medications) provided by a licensed physician, psychologist,				

	nurse practitioner, or social worker..
ONMSRVD	General medical care (primary care or urgent care)..
ONMSRVE	Reproductive health care excluding STI testing (e.g., pap smears)...
ONMSRVF	Family planning, contraception, or prenatal care...
ONMSRVG	Other (please describe)..

Check_PS7spec.	If R selected 'Other (please describe)' (PS7 [ONMSRVG]), go to PS7spec [ONMSRV_S]. Else, go to PS8 [CPNAV].

PS7spec. **Specify other <u>onsite</u> medical services**

ONMSRV_S   Specify other onsite medical services

—— ——

{text response; max characters = 100}

PS8. **Did your program provide client navigation services/peer navigation? Client/peer navigation provides individualized support for program clients in accessing and sustaining engagement with health and other services.**

CPNAV   Did program provide client/peer navigation services

No.. 0

Yes... 1

Refuse to Answer... 7

Check_PS9.	If R provided client/peer navigation services (PS8) [CPNAV] EQ 1), go to PS9 [CPNAV_S]. Else, go to PS10 [SOCSRV].

PS9. **What services were covered by your client navigation/peer navigation program? Select all that apply.**

CPNAV_S   Client/peer navigation services

HIV care..

PrEP (pre-exposure prophylaxis for HIV prevention)...

HCV care..

Medications for opioid use disorder (MOUD) ....

Medications for non-opioid substance use disorders...

Legal records (e.g., birth certificate, social security card, state ID/driver's license)..

Medicaid or other health insurance..

Social support services (e.g., housing)..

Refuse to Answer...77

PS10. **For each of the following <u>social and other services</u>, please indicate the extent to which the service was provided.**

SOCSRV   Social and other services

		Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer/ Not Applicable
SOCSRVA	Case management..					
SOCSRVB	Childcare..					

SOCSRVC	Drop-in center..
SOCSRVD	Enrollment in Medicaid or other health insurance..
SOCSRVE	Family violence, domestic violence, or intimate partner violence services...
SOCSRVF	Food/meals, including SNAP, WIC, food pantries, or meal delivery services...
SOCSRVG	Housing support...
SOCSRVH	Hygiene-related services (e.g., laundry, showers)..
SOCSRVI	Job-related services (e.g., placement assistance, skills training)...
SOCSRVJ	Legal services/counseling..
SOCSRVK	Substance use counseling provided by certified addiction counselors or other recovery support services...
SOCSRVL	Other (please describe)..

Check_PS10spec.	If R selected 'Other (please describe)' (PS10) [SOCSRVL]), go to PS10spec [SOCSRV_S]. Else, go to INTRO_PS2.

PS10spec.   **Specify other <u>social service</u>**

SOCSRV_S   Specify other social service

— —

{text response; max characters = 100}

INTRO_PS11.	The next questions pertain to <u>referrals</u> provided by your program between January 1, [YEAR], and December 31, [YEAR]. By "referral," we mean directing clients to specific offsite providers where they can receive specific services.

PS11.   **What types of <u>referrals to testing services</u> did your program provide? Select all that apply.**

REFTEST   Testing referrals

No testing referrals provided..

HIV testing...

Hepatitis C virus (HCV) testing...

STI testing other than hepatitis or HIV..

TB skin testing or laboratory-based screening for latent TB...............................

Pregnancy testing...

COVID-19 testing..

Other (please describe)...

Refuse to Answer.. 77

Check_PS11spec.	If R selected 'Other (please describe)' (PS11(8) [REFTEST(8)] EQ 1), go to PS11spec [REFTEST_S]. Else, go to PS12 [RCOVAX].

PS11spec.   **Specify other <u>testing referral</u>**

REFTEST_S   Specify other testing referral

———

{text response; max characters = 100}

PS12. **What types of <u>referrals for vaccinations</u> did your program provide? Select all that apply.**
REFVAX Vaccination referral

No vaccination referrals provided...

Hepatitis A vaccination...

Hepatitis B vaccination...

Influenza vaccination...

COVID-19 vaccination...

Other (please describe)..

Refuse to Answer...77

Check_PS12spec.	If R selected 'Other (please describe)' (PS12(6) [REFVAX(6)] EQ 1), go to PS12spec [REFVAX_S].
	Else, go to PS13 [REFMED].

PS12spec. **Specify other <u>vaccination referral</u>**
REFVAX_S Specify other vaccination referral

———

{text response; max characters = 100}

PS13. **What types of <u>referrals to treatment</u> did your program provide? Select all that apply.**
REFMED Referrals to treatment

No treatment referrals provided..

HIV treatment..

PrEP (pre-exposure prophylaxis)..

PEP (post-exposure prophylaxis)..

Hepatitis C treatment...

STI treatment other than hepatitis or HIV...

Buprenorphine (including Suboxone or Subutex)...

Medications for opioid use disorder (MOUD) other than

buprenorphine...

Naloxone..

Medications for non-opioid substance use disorders..................................

Medications for mental health disorders..

Other (please describe)..

Refuse to Answer...77

Check_PS13spec.	If R selected 'Other (please describe)' (PS13(12) [REFMED(12)] EQ 1), go to PS13spec [REFMED_S].
	Else, go to PS14 [RMSRV].

PS13spec. **Specify other <u>treatment referral</u>**
REFMED_S Specify other treatment referral

———

{text response; max characters = 100}

PS14. **What types of <u>referrals to other medical services</u> did your program provide? Select all that apply.**

RMSRV   Other medical services referrals

No referrals to other medical services provided..

Substance use disorder treatment services (excluding
medications) ....

Wound care/treatment...

Mental health services (excluding medications) provided by a
licensed physician, psychologist, nurse practitioner, or social
worker...

General medical care (primary care or urgent care)..............................

Reproductive health care excluding STI testing (e.g., pap
smears)..

Family planning, contraception, or prenatal care..................................

Other (please describe)...

Refuse to Answer..77

Check_PS14spec.	If R selected 'Other (please describe)' (PS14(8) [RMSRV(8)] EQ 1), go to PS14spec [RMSRV_S]. Else, go to INTRO_PE.

PS14spec. **Specify <u>other medical services referrals</u>**

RMSRV_S   Specify other medical services referrals

— —

{text response; max characters = 100}

<div align="center">

PROCESS EVALUATION

</div>

INTRO_PE.	We value your input and would like to ask you a few questions about your experience taking this survey so that we can improve it and ensure that the information you provide is useful.

PE1. **The length of the survey was…**

SLNGTH   Survey length

Too short.. 1

Just right.. 2

Too long.. 3

Refuse to Answer.. 7

PE2. **If you were taking the survey again, what format would you prefer? Select only one.**

PREFMT   Preferred survey format

Self-administered online   1

Self-administered via an electronic document (Word or PDF)
that can be completed and returned by email................................ 2

Interviewer-administered to me over the phone.......................... 3

Interviewer-administered to me in person..................................... 4

Refuse to Answer.. 7

PE3.
MISTOP

What topic(s) were missing from this survey and need to be added in the future?

Missing topics

— —

{text response; max characters = 255}

PE4.
HOWUSE

How would you like to see this information used? Select all that apply.

How this information used

Increase awareness..

Increase community support...

Increase funding...

Inform policy/law..

Other (please describe)...

Refuse to Answer.. 7

Check_PE4spec.	If R selected 'Other (please describe)' (PE4(5) [HOWUSE(5)] EQ 1), go to PE4spec [HOWUSE_S]. Else, go to PE5 [OTHSUG].

PE4spec.
HOWUSE_S

Specify other use for this information

Specify other use for this information

— —

{text response; max characters = 100}

PE5.
OTHSUG

Please use the space below for any other suggestions or comments for improving this survey to make it useful to programs.

Other suggestions or comments

— —

{text response; max characters = 255}

| DATA_PE. | You have now completed the survey. Thank you so much for your participation. Once you submit your survey, you will not be able to go back to previous questions or change any of your answers, so please make sure you are ready before proceeding.

Before we end, we would like to document your preference on how information about your program is shared with others aside from the survey team. Others could include, for example, researchers, health department staff, and other syringe services programs. The survey team includes staff at the North American Syringe Exchange Network (NASEN), the University of Washington (UW), New York University (NYU), and the Centers for Disease Control and Prevention (CDC). As a reminder, data from this survey will <u>only</u> be reported in aggregate (that is, your responses will be grouped with those from other programs) in formats like presentations, publications and reports. Program names and any other information that could potentially identify a program, such as the state or county where a program operates, will <u>never</u> be reported. |
|---|---|

PE6.
DATASHR

Would you be willing to share your data with others aside from the survey team? Please remember that identifying information will never be reported.

Individual data sharing preference

No, data cannot be shared.. 0

Yes, data can be shared... 1

CALC_EDATE	
	Automatic, hidden variable: Interview end date (today)
EDATE	**End date**
	_ _ / _ _ / _ _ _ _

CALC_END	
	End time of interview
END	End time
	_ _ : _ _