Dave Purchase Memorial Survey

Public reporting burden of this collection of information is estimated to average 35 minutes per survey, including the time for reviewing instructions, administering questions and entering responses. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, US8-4, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-New).

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.

_____
(Must be 4 digits.)

PI1. Are you completing this survey by yourself or by speaking with an interviewer?

◯ Completing survey myself
◯ Completing survey with interviewer

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 SAVE YOUR SURVEY, 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 email address and a link will be sent to you to continue the survey later.

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].

Automatic, hidden variable: Survey date (today)

_____

Automatic, hidden variable: Start time of survey

_____

PI2. What is the name of your program?

_____
(IF REFUSED, LEAVE BLANK.)

PI3a. 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.

- ◯ January
- ◯ February
- ◯ March
- ◯ April
- ◯ May
- ◯ June
- ◯ July
- ◯ August
- ◯ September
- ◯ October
- ◯ November
- ◯ December
- ◯ Don't Know
- ◯ Refuse to Answer

PI3b. Enter the year. If you do not remember the exact year, please provide your best estimate. Please enter four digits.

_____
(IF REFUSED OR DON'T KNOW, LEAVE BLANK.)

Error Message: "The year the program started is later than [year]. Please confirm that this year is accurate."

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].

PI4. Did your program provide any services at any time between January 1, [year], and December 31, [year]?

- ◯ Yes
- ◯ No

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.

Automatic hidden variable: Respondent start time

_____

PC1. Was your program operated by a... Select all that apply.

- ☐ Community-based organization
- ☐ City health department
- ☐ County health department
- ☐ State health department
- ☐ Health care organization
- ☐ Academic institution or hospital
- ☐ Volunteers only
- ☐ Other (please specify)
- ☐ Refuse to Answer

PC1spec. Specify other program operator.

_____

PC2. What were your program's sources of funding? Select all that apply.	☐ 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) ☐ Don't Know ☐ Refuse to Answer
PC2spec. Specify other source of funding.	_____
PC3. 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.	◯ Less than $25,000 ◯ $25,000-$100,000 ◯ $100,001-$250,000 ◯ $250,001-$500,000 ◯ $500,001-$1 million ◯ Between $1 million and $2 million ◯ $2 million or more ◯ Don't Know ◯ Refuse to Answer
PC4. Did your program employ any full-time paid staff (that is, those working 30 hours per week or more)?	◯ No ◯ Yes ◯ Refuse to Answer
PC5. Did your program have any paid employees who formerly or currently injected drugs? Include paid outreach workers and those paid with stipends or salaries.	◯ No ◯ Yes ◯ Don't Know ◯ Refuse to Answer
PC6. Did your program have any volunteers who formerly or currently injected drugs? Include outreach volunteers.	◯ No ◯ Yes ◯ Don't Know ◯ Refuse to Answer
PC7. 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, not 60 hours, of overall coverage for that week. If you do not know or prefer not to answer, you may leave the response blank.	_____

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

- ☐ Alabama
- ☐ Alaska
- ☐ Arizona
- ☐ Arkansas
- ☐ California
- ☐ Colorado
- ☐ Connecticut
- ☐ Delaware
- ☐ District of Columbia
- ☐ Florida
- ☐ Georgia
- ☐ Hawaii
- ☐ Idaho
- ☐ Illinois
- ☐ Indiana
- ☐ Iowa
- ☐ Kansas
- ☐ Kentucky
- ☐ Louisiana
- ☐ Maine
- ☐ Maryland
- ☐ Massachusetts
- ☐ Michigan
- ☐ Minnesota
- ☐ Mississippi
- ☐ Missouri
- ☐ Montana
- ☐ Nebraska
- ☐ Nevada
- ☐ New Hampshire
- ☐ New Jersey
- ☐ New Mexico
- ☐ New York
- ☐ North Carolina
- ☐ North Dakota
- ☐ Ohio
- ☐ Oklahoma
- ☐ Oregon
- ☐ Pennsylvania
- ☐ Puerto Rico
- ☐ Rhode Island
- ☐ South Carolina
- ☐ South Dakota
- ☐ Tennessee
- ☐ Texas
- ☐ US Virgin Islands
- ☐ Utah
- ☐ Vermont
- ☐ Virginia
- ☐ Washington
- ☐ West Virginia
- ☐ Wisconsin
- ☐ Wyoming
- ☐ Refuse to Answer

PC8b. 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.

_____

PC9. 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.	☐ Urban ☐ Suburban ☐ Rural ☐ Refuse to Answer
PC10. How did your program deliver services? If your program had more than one location or service delivery type, select all that apply.	☐ 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 ☐ Refuse to Answer
PC10spec. Specify other service delivery type.	_____
PC11. 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)?	◯ No ◯ Yes ◯ Don't Know ◯ Refuse to Answer
PC12. Please choose the reason(s) for the disruption. Select all that apply.	☐ 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 ☐ Refuse to Answer
PC12spec. Specify other reason for disruption(s) to services.	_____
PC13. Did your program review your program's data for monitoring or evaluation purposes between January 1, [year], and December 31, [year]?	◯ No ◯ Yes ◯ Refuse to Answer
PC14. What computer software program did you use to manage your program's data? Select all that apply.	☐ None ☐ Excel ☐ Access ☐ Neo360 ☐ REDCap ☐ Qualtrics ☐ SurveyMonkey ☐ Other (please describe) ☐ Refuse to Answer
PC14spec. Specify other software used to manage client data.	_____
PC15. Did your program assign each client a unique ID?	◯ No ◯ Yes ◯ Refuse to Answer

PC16. 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.

_____

PC17. 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?

- ◯ No
- ◯ Yes
- ◯ Don't Know
- ◯ Refuse to Answer

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

- ◯ No
- ◯ Yes
- ◯ Don't Know
- ◯ Refuse to Answer

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. Which demographic groups did your program provide services to in [year]? Select all that apply.

- ☐ Cisgender men
- ☐ Cisgender women
- ☐ Transgender 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, or bisexual persons
- ☐ Other (please describe)
- ☐ None
- ☐ Refuse to Answer

CC1spec. Specify other demographic group served.

_____

CC2. Which demographic groups in your community did your program have difficulty reaching in [year]? Select all that apply.

- ☐ Cisgender men
- ☐ Cisgender women
- ☐ Transgender 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, or bisexual persons
- ☐ Other (please describe)
- ☐ None
- ☐ Refuse to Answer

CC2spec. Specify other demographic group your program had difficulty reaching.

_____

CC3. Approximately what percentage of your clients did not have health insurance? Please use your records if available but provide your best estimate if no records are kept or are not readily available.

- ◯ Less than 25%
- ◯ 25-50%
- ◯ 51-75%
- ◯ More than 75%
- ◯ Don't Know
- ◯ Refuse to Answer

CC4. For each of the following substances, please indicate the approximate percentage of your clients who were injecting 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.

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

CC4specA. From the previous question, specify 'Other 1' substance injected by clients. _____

CC4specB. From the previous question, specify 'Other 2' substance injected by clients. _____

CC4specC. From the previous question, specify 'Other 3' substance injected by clients. _____

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

- ☐ 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

CR1spec. Specify other source of support

_____

CR2. What types of external challenges did your program face, not including challenges related to funding? Select all that apply.

- ☐ 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
- ☐ Refuse to Answer

CR2spec. Specify other external challenges

_____

CR3. What types of internal challenges did your program face? Select all that apply.

- ☐ Staff burnout
- ☐ Staff shortage
- ☐ Limited/no funding
- ☐ Limited/no resources or supplies (other than funding)
- ☐ Other (please describe)
- ☐ Did not face internal challenges
- ☐ Refuse to Answer

CR3spec. Specify other internal challenges

_____

CR4. How would you describe your program's relationship with your local health department(s)?

- ◯ Very good
- ◯ Somewhat good
- ◯ Neither good nor poor
- ◯ Somewhat poor
- ◯ Very poor
- ◯ Nonexistent
- ◯ Refuse to Answer

CR5. How would you describe your program's relationship with law enforcement?

- ◯ Very good
- ◯ Somewhat good
- ◯ Neither good nor poor
- ◯ Somewhat poor
- ◯ Very poor
- ◯ Nonexistent
- ◯ Refuse to Answer

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

SYR1. 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.

_____

SYR2. Did your program provide syringes to clients based on the clients' needs, without any restrictions?

- ◯ No
- ◯ Yes
- ◯ Refuse to Answer

SYR3. Did your program provide clients with extra syringes to distribute to other people in the community (i.e., secondary exchange or peer delivery)?

- ◯ No
- ◯ Yes
- ◯ Refuse to Answer

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?

- ◯ No
- ◯ Yes
- ◯ Refuse to Answer

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.

- ☐ 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

PN2. 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.

_____

PN3. 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.

_____

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

- ☐ 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
- ☐ Refuse to Answer

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

- ☐ No barriers
- ☐ High cost of naloxone
- ☐ Shortage of naloxone
- ☐ Legal/political climate
- ☐ Other (please describe)
- ☐ Don't Know
- ☐ Refuse to Answer

PN5spec. Specify other barrier in providing naloxone

_____

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.

	Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer
Syringes	◯	◯	◯	◯	◯
Cookers	◯	◯	◯	◯	◯
Cottons	◯	◯	◯	◯	◯
Syringe/pill filters like Sterifilt®	◯	◯	◯	◯	◯
Saline or sterile water	◯	◯	◯	◯	◯
Ties/tourniquets	◯	◯	◯	◯	◯
Alcohol pads	◯	◯	◯	◯	◯
Wound care kits	◯	◯	◯	◯	◯
Sharps containers for carrying used syringes	◯	◯	◯	◯	◯
Fentanyl test strips	◯	◯	◯	◯	◯
Safer smoking kits	◯	◯	◯	◯	◯
Other (please describe)	◯	◯	◯	◯	◯

PS1spec. Specify other injection and drug use supplies _____

PS2. For each of the following safer sex supplies, please indicate the extent to which the supply was provided.

	Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer
External condoms (male condoms)	◯	◯	◯	◯	◯
Internal condoms (female condoms)	◯	◯	◯	◯	◯
Lubricant	◯	◯	◯	◯	◯
Dental dams	◯	◯	◯	◯	◯

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

	Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer
HIV rapid testing	◯	◯	◯	◯	◯
HIV laboratory-based testing	◯	◯	◯	◯	◯
Hepatitis C virus (HCV) rapid testing	◯	◯	◯	◯	◯
Hepatitis C virus (HCV) laboratory-based 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)	◯	◯	◯	◯	◯

PS3spec. Specify other onsite testing service _____

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

	Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer
Hepatitis A vaccination	◯	◯	◯	◯	◯
Hepatitis B vaccination	◯	◯	◯	◯	◯
Influenza vaccination	◯	◯	◯	◯	◯
COVID-19 vaccination	◯	◯	◯	◯	◯
Other (please describe)	◯	◯	◯	◯	◯

PS4spec. Specify other vaccination _____

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

	Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer
HIV treatment	○	○	○	○	○
PrEP (pre-exposure prophylaxis)	○	○	○	○	○
PEP (post-exposure prophylaxis)	○	○	○	○	○
Hepatitis C treatment	○	○	○	○	○
STI treatment other than hepatitis or HIV	○	○	○	○	○
Medications for opioid use disorder (MOUD)	○	○	○	○	○
Medications for non-opioid substance use disorders	○	○	○	○	○
Medications for mental health disorders	○	○	○	○	○
Other (please describe)	○	○	○	○	○

PS5spec. Specify other medication _____

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 onsite, either by the program itself or by partners, at the location(s) where your program operated? Select all that apply.

- ☐ Buprenorphine/naloxone (Suboxone)
- ☐ Buprenorphine (Subutex)
- ☐ Methadone
- ☐ Naltrexone (Vivitrol)
- ☐ Refuse to Answer

PS7. For each of the following other medical services, please indicate the extent to which the service was provided onsite, either by the program itself or by partners, at the location(s) where your program operated.

	Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer
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)	◯	◯	◯	◯	◯

PS7spec. Specify other onsite medical services _____

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.

◯ No
◯ Yes
◯ Refuse to Answer

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

☐ 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

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

	Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer
Case management	○	○	○	○	○
Childcare	○	○	○	○	○
Drop-in center	○	○	○	○	○
Enrollment in Medicaid or other health insurance	○	○	○	○	○
Family violence, domestic violence, or intimate partner violence services	○	○	○	○	○
Food/meals, including SNAP, WIC, food pantries, or meal delivery services	○	○	○	○	○
Housing support	○	○	○	○	○
Hygiene-related services (e.g., laundry, showers)	○	○	○	○	○
Job-related services (e.g., placement assistance, skills training)	○	○	○	○	○
Legal services/counseling	○	○	○	○	○
Substance use counseling provided by certified addiction counselors or other recovery support services	○	○	○	○	○
Other (please describe)	○	○	○	○	○

PS10spec. Specify other social service

_____

The next questions pertain to referrals 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 referrals to testing services did your program provide? Select all that apply.

- ☐ 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

PS11spec. Specify other testing referral

_____

PS12. What types of referrals for vaccinations did your program provide? Select all that apply.	☐ No vaccination referrals provided ☐ Hepatitis A vaccination ☐ Hepatitis B vaccination ☐ Influenza vaccination ☐ COVID-19 vaccination ☐ Other (please describe) ☐ Refuse to Answer
PS12spec. Specify other vaccination referral	_____
PS13. What types of referrals to treatment did your program provide? Select all that apply.	☐ 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
PS13spec. Specify other treatment referral	_____
PS14. What types of referrals to other medical services did your program provide? Select all that apply.	☐ 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
PS14spec. Specify other medical services referrals	_____

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...

- ◯ Too short
- ◯ Just right
- ◯ Too long
- ◯ Refuse to Answer

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

- ◯ Self-administered online
- ◯ Self-administered via an electronic document (Word or PDF) that can be completed and returned by email
- ◯ Interviewer-administered to me over the phone
- ◯ Interviewer-administered to me in person
- ◯ Refuse to Answer

PE3. What topic(s) were missing from this survey and need to be added in the future?

_____

PE4. How would you like to see this information used? Select all that apply.

- ☐ Increase awareness
- ☐ Increase community support
- ☐ Increase funding
- ☐ Inform policy/law
- ☐ Other (please describe)
- ☐ Refuse to Answer

PE4spec. Specify other use for this information

_____

PE5. Please use the space below for any other suggestions or comments for improving this survey to make it useful to programs.

_____

You have now completed the survey. Thank you so much for your participation.

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 only 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 never be reported.

PE6. Would you be willing to share your data with others aside from the survey team? Please remember that identifying information will never be reported.

- ◯ No, data cannot be shared
- ◯ Yes, data can be shared

Automatic, hidden variable: Interview end date (today)

_____

End time of interview

_____