

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]. 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 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Speedball, which is heroin and cocaine together	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Goofball, which is heroin and methamphetamine together	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Methamphetamine, by itself, also known as meth or speed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fentanyl, by itself or in combination with other drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Powder cocaine, by itself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crack cocaine, by itself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Painkillers, such as Oxycontin, Dilaudid, or Percocet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Benzodiazepines or other downers, such as Valium, Xanax, or Klonopin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other 1 (please describe)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other 2 (please describe)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other 3 (please describe)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cookers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cottons	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Syringe/pill filters like Sterifilt®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saline or sterile water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ties/tourniquets	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol pads	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wound care kits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sharps containers for carrying used syringes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fentanyl test strips	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Safer smoking kits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (please describe)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Internal condoms (female condoms)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lubricant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dental dams	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HIV laboratory-based testing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatitis C virus (HCV) rapid testing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatitis C virus (HCV) laboratory-based testing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
STI testing other than hepatitis or HIV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TB skin testing or laboratory-based screening for latent TB	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pregnancy testing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COVID-19 testing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (please describe)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatitis B vaccination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Influenza vaccination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COVID-19 vaccination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (please describe)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PrEP (pre-exposure prophylaxis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PEP (post-exposure prophylaxis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatitis C treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
STI treatment other than hepatitis or HIV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medications for opioid use disorder (MOUD)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medications for non-opioid substance use disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medications for mental health disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (please describe)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wound care/treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental health services (excluding medications) provided by a licensed physician, psychologist, nurse practitioner, or social worker	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
General medical care (primary care or urgent care)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reproductive health care excluding STI testing (e.g., pap smears)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family planning, contraception, or prenatal care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (please describe)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Childcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drop-in center	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Enrollment in Medicaid or other health insurance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family violence, domestic violence, or intimate partner violence services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Food/meals, including SNAP, WIC, food pantries, or meal delivery services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Housing support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hygiene-related services (e.g., laundry, showers)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Job-related services (e.g., placement assistance, skills training)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Legal services/counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance use counseling provided by certified addiction counselors or other recovery support services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (please describe)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

Next, we would like to ask you a few questions about the services you provided in 2020.

MD1. Did your program provide any services at any time between January 1, 2020, and December 31, 2020?

- Yes
- No

The next set of questions is about the services your program provided from January 1, 2020, to December 31, 2020. To the extent possible, please refer to your records to answer these questions. If your program only operated during some of this time period, please provide information reflective of the time period(s) during which your program did operate.

MD2. How many unique clients did your program serve between January 1, 2020, and December 31, 2020? Please provide the best estimate to your knowledge. If you do not know or prefer not to answer, you may leave the response blank.

MD3. Between January 1, 2020, and December 31, 2020, 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.

MD4. Between January 1, 2020, and December 31, 2020, did your program provide syringes to clients based on the clients' needs, without any restrictions?

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

MD5. Did your program distribute naloxone kits between January 1, 2020, and December 31, 2020?

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

MD6. What was your total program budget between January 1, 2020, and December 31, 2020? 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
-

MD7. Which of the following testing services were provided onsite, either by the program itself or by partners, at the location(s) where your program operated? Select all that apply.

- No testing services were provided onsite
 - HIV rapid testing
 - HIV laboratory-based testing
 - Hepatitis C virus (HCV) rapid testing
 - Hepatitis C virus (HCV) laboratory-based testing
 - Don't Know
 - Refuse to Answer
-

MD8. Which of the following medications for opioid use disorder (MOUD) were provided onsite, either by the program itself or by partners, at the location(s) where your program operated? Select all that apply.

- No medications were provided onsite
- Buprenorphine/naloxone (Suboxone)
- Buprenorphine (Subutex)
- Methadone
- Naltrexone (Vivitrol)
- Don't Know
- Refuse to Answer

MD9. Which of the following other medical services were provided onsite, either by the program itself or by partners, at the location(s) where your program operated? Select all that apply.

- No other medical services were provided onsite
- 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
- Don't Know
- Refuse to Answer

MD10. Did your program provide referrals for buprenorphine (including Suboxone or Subutex) between January 1, 2020, and December 31, 2020?

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

MD11. Between January 1, 2020, and December 31, 2020, 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
- Don't Know
- Refuse to Answer

MD12. How was your program impacted by the COVID-19 pandemic in 2020? Select all that apply.

- Reduced hours or days of operation
- Reduced funding
- Site closure(s)
- Staff shortage or loss
- Change to a MORE restrictive syringe distribution model (e.g., from needs-based to 1-for-1)
- Changes to a LESS restrictive syringe distribution model (e.g., from 1-for-1 to needs-based)
- Changes in physical space (e.g., moved services outdoors, markers for social distancing, plexiglass)
- Disruptions in supply of syringes
- Disruptions in other supplies
- Disruptions in HIV, HCV, or other bloodborne pathogens testing
- Disruptions in substance use disorder treatment linkage (e.g., stopped services, new regulatory practices)
- Changes in other direct client services, such as food distribution, showers, housing assistance.
- New/increased access to telehealth for clients
- Lack of personal protective equipment (PPE)
- Other (please specify)
- Program was not impacted by COVID-19 in 2020
- Don't Know
- Refuse to Answer

MD12spec. Specify other ways your program was impacted by COVID-19.

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
