Virginia State Opioid Response-III (SOR-III)

GPRA (Government Performance and Results Act) Survey

Follow-Up & Discharge Survey

Revised Version Launched January 21, 2023

This survey was compiled by OMNI Institute based on the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) Government Performance and Results Act (GPRA) Client Outcome Measures for Discretionary Programs.

It is designed for use by the Virginia subrecipients who are providing treatment and recovery services funded by the SOR grant.

For more information or questions, please contact the OMNI SOR support team at SORSupport@omni.org

SOR-III Follow-Up & Discharge Survey Contents

ADMINISTRATIVE SECTIONS FOR CSB/AGENCY STAFF TO COMPLETE:

INTERVIEW SECTIONS TO BE COMPLETED WITH CLIENT:

A. RECORD MANAGEMENT

[REPORTED BY PROGRAM STAFF. DO NOT INCLUDE IN CLIENT INTERVIEW.]

1. **Client ID** |__|__|__|__|__|__|__|__|__|__|__|__|
   [UNIQUE CLIENT ID – CAN BE SAME AS CCS3 ID OR OTHER UNIQUE IDENTIFIER]

2. **Interview Date** |__|__| / |__|__| / |__|__|__|__|
   Month Day Year

3. **Date of Admission** |__|__| / |__|__| / |__|__|__|__|
   Month Day Year

4. **Agency Name** _____

5. **Where are the SOR-funded services this client is receiving based?**
   - ○ CSB/Agency clinic (in person or virtual) ***[SKIP TO QUESTION 6]***
   - ○ Jail/Criminal Justice Setting (in person or virtual)
   - ○ Other, please specify:_____ ***[SKIP TO QUESTION 6]***

   5a. [IF IN JAIL/CRIMINAL JUSTICE SETTING] What type of justice setting is the client in?
   - ○ Jail (city, county, regional)
   - ○ Prison (state)
   - ○ Drug/Recovery Court
   - ○ Probation or Parole
   - ○ Other, please specify:_____

   5b. [IF IN JAIL/CRIMINAL JUSTICE SETTING] Is the client currently incarcerated?
   - ○ Yes
   - ○ No

6. **Which survey are you reporting? [CHOOSE ONLY ONE TYPE].**
   - ○ 6-month follow-up ***[CONTINUE TO FOLLOW-UP STATUS SECTION.]***
   - ○ Discharge ***[SKIP TO DISCHARGE STATUS AND SERVICES RECEIVED SECTION.]***

A. FOLLOW-UP STATUS

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT FOLLOW-UP. IF AT DISCHARGE, SKIP TO NEXT SECTION: DISCHARGE STATUS]

1. **Was the client able to be contacted for follow-up?**
   - ○ Yes
   - ○ No

2. **What is the follow-up status of the client? [THIS IS A REQUIRED FIELD: NA, REFUSED, AND MISSING WILL NOT BE ACCEPTED.]**
   - ○ Deceased at time of due date
   - ○ Completed interview within specified window
   - ○ Completed interview outside specified window
   - ○ Located, but refused, unspecified
   - ○ Located, but unable to gain institutional access
   - ○ Located, but otherwise unable to gain access
   - ○ Located, but withdrawn from project
   - ○ Unable to locate, moved
   - ○ Unable to locate, other (Specify) _____

3. **Is the client still receiving services from your program?**
   - ○ Yes
   - ○ No

[IF COMPLETING A FOLLOW-UP INTERVIEW, SKIP TO SECTION B. SUBSTANCE USE AND MENTAL HEALTH HISTORY.

IF COMPLETING AN ADMINISTRATIVE FOLLOW-UP, THEN SURVEY IS COMPLETE.]

A. DISCHARGE STATUS & SERVICES RECEIVED

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE.]

1. **What type of discharge is this?**
   - ○ Interview (Already conducting or conducting now)
   - ○ Administrative (No interview conducted)

2. **On what date was the client discharged?**
   |____|____| / |____|____| / |____|____|____|____|
   MONTH DAY YEAR

3. **What is the client's discharge status?**
   - ○ Completion/Graduate ***[SKIP TO Q4]***
   - ○ Termination ***[GO TO Q3A]***

   3a. If the client was terminated, what was the reason for termination? [SELECT ONE RESPONSE.]
   - ○ Left on own against staff advice with satisfactory progress
   - ○ Left on own against staff advice without satisfactory progress
   - ○ Involuntarily discharged due to nonparticipation
   - ○ Involuntarily discharged due to violation of rules
   - ○ Referred to another program or other services with satisfactory progress
   - ○ Referred to another program or other services with unsatisfactory progress
   - ○ Incarcerated due to offense committed while in treatment/recovery with satisfactory progress
   - ○ Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress
   - ○ Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress
   - ○ Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress
   - ○ Transferred to another facility for health reasons
   - ○ Death
   - ○ Other (Specify) _____

4. **Did the program order an HIV test for this client?**
   - ○ Yes ***[SKIP TO Q6]***
   - ○ No ***[GO TO Q5]***

DISCHARGE STATUS & SERVICES RECEIVED, cont'd.

5. **[IF 4=NO] Did the program refer this client for HIV testing with another provider?**
   - ○ Yes
   - ○ No

6. **Did the program provide Naloxone and/or Fentanyl Test Strips to this client at any time during their involvement in grant funded services?**
   - ○ Naloxone
   - ○ Fentanyl Test Strips
   - ○ Both Naloxone and Fentanyl Test Strips
   - ○ Neither

7. **Is the client fully vaccinated against the virus that causes COVID-19?**
   - ○ Yes
   - ○ No, partially vaccinated with plans to receive the subsequent vaccination on time
   - ○ No, partially vaccinated with no plan to receive the subsequent vaccination
   - ○ No, client refused vaccination
   - ○ REFUSED

SERVICES RECEIVED UNDER GRANT FUNDING [*Reported by program staff at discharge.*]

Identify the number of DAYS of services provided to the client during the client's course of treatment/recovery.

Modality	Days
1. Case Management	|__|__|__|
2. Intensive Outpatient Treatment	|__|__|__|
3. Inpatient/Hospital (Other Than Withdrawal Management)	|__|__|__|
4. Outpatient Therapy	|__|__|__|
5. Outreach	|__|__|__|
6. Medication	
a. Methadone	|__|__|__|
b. Buprenorphine	|__|__|__|
c. Naltrexone – Short Acting	|__|__|__|
d. Naltrexone – Long Acting (report 28 days for each one injection)	|__|__|__|
e. Disulfiram	|__|__|__|
f. Acamprosate	|__|__|__|
g. Nicotine Replacement	|__|__|__|
h. Bupropion	|__|__|__|
i. Varenicline	|__|__|__|
7. Residential/Rehabilitation	|__|__|__|
8. Withdrawal Management (Select Only 1)	
a. Hospital Inpatient	|__|__|__|
b. Free Standing Residential	|__|__|__|
c. Ambulatory Detoxification	|__|__|__|
9. After Care	|__|__|__|
10. Recovery Support	|__|__|__|
11. Other (Specify)_____	|__|__|__|

Identify the number of SESSIONS provided to the client during the client's course of treatment/recovery.

Treatment Services	Sessions
1. Screening	|__|__|__|
2. Brief Intervention	|__|__|__|
3. Brief Treatment	|__|__|__|
4. Referral to Treatment	|__|__|__|
5. Assessment	|__|__|__|
6. Treatment Planning	|__|__|__|
7. Recovery Planning	|__|__|__|
8. Individual Counseling	|__|__|__|
9. Group Counseling	|__|__|__|
10. Contingency Management	|__|__|__|
11. Community Reinforcement	|__|__|__|
12. Cognitive Behavioral Therapy	|__|__|__|
13. Family/Marriage Counseling	|__|__|__|
14. Co-Occurring Treatment Services	|__|__|__|
15. Pharmacological Interventions	|__|__|__|
16. HIV/AIDS Counseling	|__|__|__|
17. Cultural Interventions/Activities	|__|__|__|
18. Other Clinical Services (Specify)_____	|__|__|__|

Case Management Services	Sessions
1. Family Services (E.g. Marriage Education, Parenting, Child Development)	|__|__|__|
2. Child Care	|__|__|__|
3. Employment Service	
a. Pre-Employment	|__|__|__|
b. Employment Coaching	|__|__|__|
4. Individual Services Coordination	|__|__|__|
5. Transportation	|__|__|__|
6. HIV/AIDS Services & Counseling	|__|__|__|
7. Transitional Drug-Free Housing Services	|__|__|__|
8. Housing Support	|__|__|__|
9. Health Insurance Enrollment	|__|__|__|
10. Other Services (Specify)_____	|__|__|__|

Medical Services	Sessions
1. Medical Care	|__|__|__|
2. Alcohol/Drug Testing	|__|__|__|
3. OB/GYN Services	|__|__|__|
4. HIV/AIDS Medical Support & Testing	|__|__|__|
5. Hepatitis Medical Support & Testing	|__|__|__|
6. Other STI Support & Testing	|__|__|__|
7. Dental Care	|__|__|__|
8. Other Medical Services (Specify) _____	|__|__|__|

After Care Services	Sessions
1. Continuing Care	|__|__|__|
2. Relapse Prevention	|__|__|__|
3. Recovery Coaching	|__|__|__|
4. Self-Help and Mutual Support Groups	|__|__|__|
5. Spiritual Support	|__|__|__|
6. Other Services (Specify)_____	|__|__|__|

Education Services	Sessions
1. Substance Misuse Education	|__|__|__|
2. HIV/AIDS Education	|__|__|__|
3. Hepatitis Education	|__|__|__|
4. Other STI Education Services	|__|__|__|
5. Naloxone Training	|__|__|__|
6. Fentanyl Test Strip Training	|__|__|__|
7. Other Services (Specify)_____	|__|__|__|

Recovery Support Services	Sessions
1. Peer Coaching or Mentoring	|__|__|__|
2. Vocational Services	|__|__|__|
3. Recovery Housing	|__|__|__|
4. Recovery Planning	|__|__|__|
5. Case Management Services to Specifically Support Recovery	|__|__|__|
6. Alcohol- and Drug-Free Social Activities	|__|__|__|
7. Information and Referral	|__|__|__|
8. Other Recovery Support Services (Specify)	|__|__|__|
9. Other Peer-to-Peer Recovery Support Services (Specify) _____	|__|__|__|

DISCHARGE STATUS & SERVICES RECEIVED, cont'd.

8. Has this client attended 60% or more of their planned services?
- ○ Yes
- ○ No

9. Did this client receive any services via telehealth or a virtual platform?
- ○ Yes
- ○ No

10. Has this client previously been diagnosed with an opioid use disorder?
- ○ Yes
- ○ No ***[SKIP to Q11]***

10a. [IF YES] In the past 30 days, which FDA-approved medication did the client receive for the treatment of this opioid use disorder? ***[CHECK ALL THAT APPLY.]***
- ○ Methadone ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Buprenorphine ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Naltrexone ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Extended–release Naltrexone ***[IF RECEIVED]*** Specify how many doses received |___|___|
- ○ Client did not receive an FDA-approved medication for a diagnosed opioid use disorder ***[SKIP TO QUESTION 11]***

10b. *[IF RECEIVED ONE OF THE MEDICATIONS ABOVE]* Has this client taken the medication as prescribed?
- ○ Yes
- ○ No

11. Has this client previously been diagnosed with an alcohol use disorder?
- ○ Yes
- ○ No ***[SKIP TO Q12]***

11a. *[IF YES]* In the past 30 days, which FDA-approved medication did the client receive for the treatment of this alcohol use disorder? ***[CHECK ALL THAT APPLY.]***
- ○ Naltrexone ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Extended–release Naltrexone ***[IF RECEIVED]*** Specify how many doses received |___|___|
- ○ Disulfiram ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Acamprosate ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Client did not receive an FDA-approved medication for a diagnosed alcohol use disorder ***[SKIP TO QUESTION 12]***

11b. *[IF RECEIVED ONE OF THE MEDICATIONS ABOVE]* Has this client taken the medication as prescribed?
- ○ Yes
- ○ No

12. Has this client previously been diagnosed with a stimulant use disorder?

○ Yes
○ No ***[SKIP TO Q13]***

12a. In the past 30 days, which evidence-based interventions did the client receive for the treatment of this stimulant use disorder? *[CHECK ALL THAT APPLY.]*

○ Contingency Management ***[IF RECEIVED]*** Specify how many days received |___|___|
○ Community Reinforcement ***[IF RECEIVED]*** Specify how many days received |___|___|
○ Cognitive Behavioral Therapy ***[IF RECEIVED]*** Specify how many days received |___|___|
○ Other treatment approach ***[IF RECEIVED]*** Specify how many days received |___|___|
○ Client did not receive any intervention for a stimulant use disorder ***[SKIP TO QUESTION 13]***

12b. *[IF RECEIVED ONE OF THE INTERVENTIONS ABOVE]* Has this client attended and participated in evidence-based interventions for stimulant use disorder?

○ Yes
○ No

13. Has this client previously been diagnosed with a tobacco use disorder?

○ Yes
○ No ***[SKIP TO SECTION B AND BEGIN CLIENT INTERVIEW. IF THIS IS AN ADMINISTRATIVE DISCHARGE, THE SURVEY IS COMPLETE.]***

13a. In the past 30 days, which FDA-approved medication did the client receive for the treatment of this tobacco use disorder? *[CHECK ALL THAT APPLY.]*

○ Nicotine Replacement ***[IF RECEIVED]*** Specify how many days received |___|___|
○ Bupropion ***[IF RECEIVED]*** Specify how many days received |___|___|
○ Varenicline ***[IF RECEIVED]*** Specify how many days received |___|___|
○ Client did not receive an FDA-approved medication for a diagnosed tobacco use disorder ***[SKIP TO SECTION B AND BEGIN CLIENT INTERVIEW. IF THIS IS AN ADMINISTRATIVE DISCHARGE, THE SURVEY IS COMPLETE.]***

13b. *[IF RECEIVED ONE OF THE MEDICATIONS ABOVE]* Has this client taken the medication as prescribed?

○ Yes
○ No

[CONTINUE TO SECTION B AND BEGIN CLIENT INTERVIEW.
IF THIS IS AN ADMINISTRATIVE DISCHARGE, THE SURVEY IS COMPLETE.]

B. SUBSTANCE USE AND MENTAL HEALTH HISTORY

NOTE TO ADMINISTRATOR, PLEASE DON'T READ ALOUD:
USING THE TABLE BELOW, PLEASE INDICATE THE FOLLOWING:

A. THE NUMBER OF DAYS, IN THE PAST 30 DAYS, THAT THE CLIENT REPORTS USING A SUBSTANCE.

The client should be encouraged to list the substances on their own. If they are unsure, the list from the table below can be read to the client. Please note that not all substance use is considered harmful or illicit – it may be that a substance is prescribed by a licensed provider, or that the client uses the substance in accordance with official, national safety guidelines. In such instances, clarification from the client should be sought, but **if the substance is only taken as prescribed or used on each occasion in accordance with official, national safety guidelines, then it is not considered misuse**. If no use of a listed substance is reported, please enter a zero ('0') in the corresponding 'Number of Days Used' column.

B. The route by which the substance is used.

Mark one route only. But, if the client identifies more than one route, choose the corresponding route with the highest associated number value (numbers 1 – 6). Responses should capture the past 30 days of use.

BEGIN INTERVIEW HERE:

We'll start with questions about your substance use and mental health history. This section contains questions about diagnoses and treatments you have received. Remember, your answers to this survey are confidential and will not affect the treatment services you receive. You may choose to skip any questions you do not want to answer.

1. During the past 30 days, how many days have you used any substance, and how do you take the substance?

○ REFUSED

	Number of Days Used	**Route**			
		1. Oral	**2.** Intranasal		**3.** Vaping
		4. Smoking	**5.** Non-IV Injection	**6.** Intravenous (IV) Injection	
		0. Other			
Alcohol					
Alcohol	|___|___|	|___|			
Other (Specify)	|___|___|	|___|			
Opioids					
Heroin	|___|___|	|___|			
Morphine	|___|___|	|___|			
Fentanyl (Prescription Diversion Or Illicit Source)	|___|___|	|___|			
Dilaudid	|___|___|	|___|			
Demerol	|___|___|	|___|			

	Number of Days Used	Route			
		1. Oral	2. Intranasal		3. Vaping
		4. Smoking	5. Non-IV Injection	6. Intravenous (IV) Injection	
		0. Other			
Percocet	|___|___|	|___|			
Codeine	|___|___|	|___|			
Tylenol 2, 3, 4	|___|___|	|___|			
OxyContin/Oxycodone	|___|___|	|___|			
Non-prescription methadone	|___|___|	|___|			
Non-prescription buprenorphine	|___|___|	|___|			
Other (Specify)	|___|___|	|___|			
Cannabis					
Cannabis (Marijuana)	|___|___|	|___|			
Synthetic Cannabinoids	|___|___|	|___|			
Other (Specify)	|___|___|	|___|			
Sedative, Hypnotic, or Anxiolytics					
Sedatives	|___|___|	|___|			
Hypnotics	|___|___|	|___|			
Barbiturates	|___|___|	|___|			
Anxiolytics/Benzodiazepines	|___|___|	|___|			
Other (Specify)	|___|___|	|___|			
Cocaine					
Cocaine	|___|___|	|___|			
Crack	|___|___|	|___|			
Other (Specify)	|___|___|	|___|			
Other Stimulants					
Methamphetamine	|___|___|	|___|			
Stimulant medications	|___|___|	|___|			
Other (Specify)	|___|___|	|___|			
Hallucinogens & Psychedelics					
PCP	|___|___|	|___|			
MDMA	|___|___|	|___|			
LSD	|___|___|	|___|			
Mushrooms	|___|___|	|___|			
Mescaline	|___|___|	|___|			
Salvia	|___|___|	|___|			
DMT	|___|___|	|___|			
Other (Specify)	|___|___|	|___|			
Inhalants					
Inhalants	|___|___|	|___|			
Other (Specify)	|___|___|	|___|			

	Number of Days Used	Route		
		1. Oral	2. Intranasal	3. Vaping
		4. Smoking	5. Non-IV Injection	6. Intravenous (IV) Injection
		0. Other		
Other Psychoactive Substances				
Non-prescription GHB	|___|___|	|___|		
Ketamine	|___|___|	|___|		
MDPV/Bath Salts	|___|___|	|___|		
Kratom	|___|___|	|___|		
Khat	|___|___|	|___|		
Other tranquilizers	|___|___|	|___|		
Other downers	|___|___|	|___|		
Other sedatives	|___|___|	|___|		
Other hypnotics	|___|___|	|___|		
Other (Specify)	|___|___|	|___|		
Tobacco and Nicotine				
Tobacco	|___|___|	|___|		
Nicotine (Including Vape Products)	|___|___|	|___|		
Other (Specify)	|___|___|	|___|		

2. Have you been diagnosed with an alcohol use disorder, if so which FDA-approved medication did you receive for the treatment of this alcohol use disorder in the past 30 days? *[CHECK ALL THAT APPLY.]*

- ○ Naltrexone ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Extended–release Naltrexone ***[IF RECEIVED]*** Specify how many doses received |___|___|
- ○ Disulfiram ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Acamprosate ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ DID NOT RECEIVE AN FDA-APPROVED MEDICATION FOR A DIAGNOSED ALCOHOL USE DISORDER
- ○ CLIENT DOES NOT REPORT SUCH A DIAGNOSIS

3. Have you have been diagnosed with an opioid use disorder, if so which FDA-approved medication did you receive for the treatment of this opioid use disorder in the past 30 days? *[CHECK ALL THAT APPLY.]*

- ○ Methadone ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Buprenorphine ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Naltrexone ***[IF RECEIVED]*** Specify how many days received |___|___|
- ○ Extended–release Naltrexone ***[IF RECEIVED]*** Specify how many doses received |___|___|
- ○ DID NOT RECEIVE AN FDA-APPROVED MEDICATION FOR A DIAGNOSED OPIOID USE DISORDER
- ○ CLIENT DOES NOT REPORT SUCH A DIAGNOSIS

4. **Have you been diagnosed with a <u>stimulant</u> use disorder, if so which evidence-based interventions did you receive for the treatment of this disorder in the past 30 days?** ***[CHECK ALL THAT APPLY.]***
   - ○ Contingency Management ***[IF RECEIVED]*** Specify how many days received |___|___|
   - ○ Community Reinforcement ***[IF RECEIVED]*** Specify how many days received |___|___|
   - ○ Cognitive Behavioral Therapy ***[IF RECEIVED]*** Specify how many days received |___|___|
   - ○ Other evidence-based intervention ***[IF RECEIVED]*** Specify how many days received |___|___|
   - ○ DID NOT RECEIVE ANY INTERVENTION FOR A DIAGNOSED STIMULANT USE DISORDER
   - ○ CLIENT DOES NOT REPORT SUCH A DIAGNOSIS

5. **Have you been diagnosed with a <u>tobacco</u> use disorder, if so which FDA-approved medication did you receive for the treatment of this tobacco use disorder in the past 30 days?** ***[CHECK ALL THAT APPLY.]***
   - ○ Nicotine Replacement ***[IF RECEIVED]*** Specify how many days received |___|___|
   - ○ Bupropion ***[IF RECEIVED]*** Specify how many days received |___|___|
   - ○ Varenicline ***[IF RECEIVED]*** Specify how many days received |___|___|
   - ○ DID NOT RECEIVE AN FDA-APPROVED MEDICATION FOR A DIAGNOSED TOBACCO USE DISORDER
   - ○ CLIENT DOES NOT REPORT SUCH A DIAGNOSIS

6. **In the past 30 days, did you experience an overdose or take too much of a substance that resulted in needing supervision or medical attention?**
   - ○ Yes ***[IF YES, SPECIFY BELOW, IN QUESTION 7]***
   - ○ No ***[IF NO, MOVE TO QUESTION 8]***
   - ○ REFUSED ***[MOVE TO QUESTION 8]***

7. ***[IF YES TO #6]*** **In the past 30 days, after taking too much of a substance or overdosing, what intervention did you receive? You may indicate more than one.**
   - ○ Naloxone (Narcan)
   - ○ Care in an Emergency Department
   - ○ Care from a Primary Care Provider
   - ○ Admission to a hospital
   - ○ Supervision by someone else
   - ○ Other (Specify) _____
   - ○ REFUSED

8. **Not including this current episode, how many times in your life have you been treated at an inpatient or outpatient facility for a substance use disorder?**
   - ○ One time
   - ○ Two times
   - ○ Three times
   - ○ Four times
   - ○ Five times
   - ○ Six or more times
   - ○ Never ***[SKIP TO QUESTION 10]***
   - ○ REFUSED ***[SKIP TO QUESTION 10]***

9. **Approximately when was the last time you received inpatient or outpatient treatment for a substance use disorder?**
   - ○ Less than 6 months ago
   - ○ Between 6 months and one year ago
   - ○ One to two years ago
   - ○ Two to three years ago
   - ○ Three to four years ago
   - ○ Five or more years ago
   - ○ REFUSED

10. **Have you ever been diagnosed with a mental health illness by a health care professional?**
   - ○ Yes ***[CONTINUE TO QUESTION 10A]***
   - ○ No ***[SKIP TO SECTION C. LIVING CONDITIONS]***
   - ○ REFUSED ***[SKIP TO SECTION C. LIVING CONDITIONS]***

10a. [IF YES] PLEASE ASK THE CLIENT TO SELF-REPORT THEIR MENTAL HEALTH ILLNESSES AS LISTED IN THE TABLE BELOW. THE CLIENT SHOULD BE ENCOURAGED TO REPORT THEIR OWN MENTAL HEALTH ILLNESSES BUT IF PREFERRED, THE LIST CAN BE READ TO THE CLIENT. PLEASE INDICATE ALL THAT APPLY.

	SELF-REPORTED
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	
Brief psychotic disorder	○
Delusional disorder	○
Schizoaffective disorders	○
Schizophrenia	○
Schizotypal disorder	○
Shared psychotic disorder	○
Unspecified psychosis	○
Mood [affective] disorders	
Bipolar disorder	○
Major depressive disorder, recurrent	○
Major depressive disorder, single episode	○
Manic episode	○
Persistent mood [affective] disorders	○
Unspecified mood [affective] disorder	○
Phobic Anxiety and Other Anxiety Disorders	
Agoraphobia without panic disorder	○
Agoraphobia with panic disorder	○
Agoraphobia, unspecified	○
Generalized anxiety disorder	○
Panic disorder	○

Phobic anxiety disorders	○
Social phobias (Social anxiety disorder)	○
Specific (isolated) phobias	○
Obsessive-compulsive disorders	
Excoriation (skin-picking) disorder	○
Hoarding disorder	○
Obsessive-compulsive disorder	○
Obsessive-compulsive disorder with mixed obsessional thoughts and acts	○
Reaction to severe stress and adjustment disorders	
Acute stress disorder; reaction to severe stress, and adjustment disorders	○
Adjustment disorders	○
Body dysmorphic disorder	○
Dissociative and conversion disorders	○
Dissociative identity disorder	○
Post traumatic stress disorder	○
Somatoform disorders	○
Behavioral syndromes associated with physiological disturbances and physical factors	
Eating disorders	○
Sleep disorders not due to a substance or known physiological condition	○
Disorders of adult personality and behavior	
Antisocial personality disorder	○
Avoidant personality disorder	○
Borderline personality disorder	○
Dependent personality disorder	○
Histrionic personality disorder	○
Intellectual disabilities	○
Obsessive-compulsive personality disorder	○
Other specific personality disorders	○
Paranoid personality disorder	○
Personality disorder, unspecified	○
Pervasive and specific developmental disorders	○
Schizoid personality disorder	○

○ NONE OF THE ABOVE

C. LIVING CONDITIONS

I'd like to ask you some questions about where you have been living lately. Your answers to these questions are confidential and you may choose to skip any questions you do not want to answer.

1. **In the past 30 days, where have you been living most of the time?**
   [DO NOT READ RESPONSE OPTIONS TO CLIENT, SELECT ONLY ONE]
   [15 OR MORE DAYS IS CONSIDERED MOST OF THE TIME.]

   - ○ Shelter (Safe Havens, Transitional Living Center [TLC], Low-Demand Facilities, Reception Centers, Other Temporary Day or Evening Facility)
   - ○ Street/Outdoors (Sidewalk, Doorway, Park, Public Or Abandoned Building)
   - ○ Institution (Hospital, Nursing Home, Jail/Prison)
   - ○ Housed: ***[IF HOUSED, CHECK APPROPRIATE SUBCATEGORY:]***
     - ○ Own/Rental Apartment, Room, Trailer, Or House
     - ○ Someone Else's Apartment, Room, Trailer, Or House (including couch surfing)
     - ○ Dormitory/College Residence
     - ○ Halfway House or Transitional Housing
     - ○ Residential Treatment
     - ○ Recovery Residence/Sober Living
   - ○ Other Housed (Specify) _____
   - ○ REFUSED

2. **Do you currently live with any person who, over the past 30 days, has regularly used alcohol or other substances?**
   - ○ Yes
   - ○ No
   - ○ No, lives alone
   - ○ REFUSED

3. **How satisfied are you with the conditions of your living space?**
   - ○ Very dissatisfied
   - ○ Dissatisfied
   - ○ Neither satisfied nor dissatisfied
   - ○ Satisfied
   - ○ Very satisfied
   - ○ REFUSED

C. LIVING CONDITIONS (Continued)

4. **During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs?**
   - ○ Not at all
   - ○ Somewhat
   - ○ Considerably
   - ○ Extremely
   - ○ NOT APPLICABLE ***[SELECT IF INDIVIDUAL REPORTED NO SUBSTANCES USED IN PAST 30 DAYS ON QUESTION B1.]***
   - ○ REFUSED

5. **During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities?**
   - ○ Not at all
   - ○ Somewhat
   - ○ Considerably
   - ○ Extremely
   - ○ NOT APPLICABLE ***[SELECT IF INDIVIDUAL REPORTED NO SUBSTANCES USED IN PAST 30 DAYS ON QUESTION B1.]***
   - ○ REFUSED

6. **During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems?**
   - ○ Not at all
   - ○ Somewhat
   - ○ Considerably
   - ○ Extremely
   - ○ NOT APPLICABLE ***[SELECT IF INDIVIDUAL REPORTED NO SUBSTANCES USED IN PAST 30 DAYS ON QUESTION B1.]***
   - ○ REFUSED

D. EDUCATION, EMPLOYMENT, AND INCOME

Now I have some questions about your education, your employment status, and your income. Your answers are confidential and you may choose to skip any questions you do not want to answer.

1. **Are you currently enrolled in school or a job training program? *[IF ENROLLED]* Is that full time or part time? *[IF INCARCERATED, SELECT 'NOT ENROLLED']***
   - ○ NOT ENROLLED
   - ○ ENROLLED, FULL TIME
   - ○ ENROLLED, PART TIME
   - ○ REFUSED

2. **What is the highest level of education you have finished, whether or not you received a degree?**
   - ○ LESS THAN 12TH GRADE
   - ○ 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT
   - ○ VOCATIONAL/TECHNICAL (VOC/TECH) DIPLOMA
   - ○ SOME COLLEGE OR UNIVERSITY
   - ○ BACHELOR'S DEGREE (FOR EXAMPLE: BA, BS)
   - ○ GRADUATE WORK/GRADUATE DEGREE
   - ○ OTHER (SPECIFY)_____
   - ○ REFUSED

3. **Are you currently employed? *[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CLIENT WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK.] [IF CLIENT IS INCARCERATED AND HAS NO WORK OUTSIDE OF JAIL, SELECT "NOT LOOKING FOR WORK."]***
   - ○ EMPLOYED, FULL TIME (35+ HOURS/WEEK, OR WOULD BE, IF NOT FOR LEAVE OR AN EXCUSED ABSENCE)
   - ○ EMPLOYED, PART TIME
   - ○ UNEMPLOYED—BUT LOOKING FOR WORK
   - ○ NOT EMPLOYED, NOT LOOKING FOR WORK
   - ○ NOT WORKING DUE TO A DISABILITY
   - ○ RETIRED, NOT WORKING
   - ○ OTHER (SPECIFY) _____
   - ○ REFUSED

4. **Do you, individually, have enough money to pay for the following living expenses? Choose all that apply.**
   - ○ Food
   - ○ Clothing
   - ○ Transportation
   - ○ Rent/Housing
   - ○ Utilities (Gas/Water/Electric)
   - ○ Telephone Connection (Cell or Landline)
   - ○ Childcare
   - ○ Health Insurance
   - ○ Not enough money for any of the above
   - ○ REFUSED

EDUCATION, EMPLOYMENT, AND INCOME, cont'd.

5. **What is your personal annual income, meaning the total pre-tax income from all sources, earned in the past year?**
   - ○ $0 to $9,999
   - ○ $10,000 to $14,999
   - ○ $15,000 to $19,999
   - ○ $20,000 to $34,999
   - ○ $35,000 to $49,999
   - ○ $50,000 to $74,999
   - ○ $75,000 to $99,999
   - ○ $100,000 to $199,999
   - ○ $200,000 or more
   - ○ REFUSED

6. **Do you have access to transportation when you need it (for example, car, public transportation or Medicaid-provided transportation)?**
   - ○ Always
   - ○ More than half the time
   - ○ Half the time
   - ○ Less than half the time
   - ○ Never
   - ○ REFUSED

E. LEGAL

Now I have some questions about whether you've been arrested recently or have a case pending. I want to remind you that your answers to these questions will not impact your legal standing. You may choose to skip any questions you do not want to answer.

1. **In the past 30 days, how many times have you been arrested?** ***[ENTER NUMBER OF TIMES. ENTER 0 IF THE CLIENT INDICATES NO ARRESTS IN THE PAST 30 DAYS]***

   |___|___| TIMES ○ REFUSED

2. **Are you currently awaiting charges, trial, or sentencing?**
   - ○ Yes
   - ○ No
   - ○ REFUSED

3. **Are you currently on parole or probation or intensive pretrial supervision?**
   - ○ Probation
   - ○ Parole
   - ○ Intensive Pretrial Supervision
   - ○ No
   - ○ REFUSED

4. **Do you currently participate in a drug court program or are you in a deferred prosecution agreement?**
   - ○ Drug court program
   - ○ Deferred prosecution agreement
   - ○ No, neither of these
   - ○ REFUSED

F. MENTAL & PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

Now I have some questions about your physical, mental and treatment history. I want to remind you that your answers to these questions are confidential, and you may choose to skip any questions you do not want to answer.

1. **How would you rate your quality of life over the past 30 days?**
   - ○ Very poor
   - ○ Poor
   - ○ Neither poor nor good
   - ○ Good
   - ○ Very good
   - ○ REFUSED

2. **How satisfied are you with your health?**
   - ○ Very dissatisfied
   - ○ Dissatisfied
   - ○ Neither satisfied nor dissatisfied
   - ○ Satisfied
   - ○ Very satisfied
   - ○ REFUSED

3. **How satisfied are you with your ability to perform your daily activities?**
   - ○ Very dissatisfied
   - ○ Dissatisfied
   - ○ Neither satisfied nor dissatisfied
   - ○ Satisfied
   - ○ Very satisfied
   - ○ REFUSED

4. **In the past 30 days, how many days have you:** ***[ENTER '0' IN DAYS IF THE CLIENT REPORTS THAT THEY HAVE NOT EXPERIENCED THE CONDITION. SELECT REFUSED FOR NO RESPONSE]*****:**

	Days	REFUSED
a. Experienced serious depression	|____|____|	○
b. Experienced serious anxiety or tension	|____|____|	○
c. Experienced hallucinations	|____|____|	○
d. Experienced trouble understanding, concentrating, or remembering	|____|____|	○
e. Experienced trouble controlling violent behavior	|____|____|	○
f. Attempted suicide	|____|____|	○
g. Been prescribed medication for a psychological/emotional problem	|____|____|	○

[IF CLIENT REPORTS 1 OR MORE DAY TO ANY QUESTION IN #4, PLEASE ENSURE THAT THEY ARE SEEN BY A LICENSED PROFESSIONAL AS SOON AS POSSIBLE.]

F. MENTAL & PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (cont'd.)

5. **How much have you been bothered by these psychological or emotional problems in the past 30 days?**
   - ○ Not at all
   - ○ Slightly
   - ○ Moderately
   - ○ Considerably
   - ○ Extremely
   - ○ NO REPORTED MENTAL HEALTH COMPLAINTS IN THE PAST 30 DAYS
   - ○ REFUSED

6. **In the past 30 days, where have you gone to receive medical care? You may select more than one response.**
   - ○ Primary Care Provider
   - ○ Urgent Care
   - ○ The Emergency Department
   - ○ A specialist doctor
   - ○ No care was sought
   - ○ Other (Specify) _____

7. **Do you currently have medical/health insurance?**
   - ○ Yes
   - ○ No *[SKIP TO NEXT SECTION]*
   - ○ REFUSED *[SKIP TO NEXT SECTION]*

7a. *[IF YES]* What type of insurance do you have *(Select all that apply)*?
- ○ Medicare
- ○ Medicaid
- ○ Private Insurance or Employer Provided
- ○ TRICARE or other military health care
- ○ An assistance program [for example, a medication assistance program]
- ○ Any other type of health insurance or health coverage plan (Specify)_____
- ○ REFUSED

G. SOCIAL CONNECTEDNESS

Next, we'll talk through some questions about social connectedness. Please remember your answers to these questions are confidential and you may choose to skip any questions you do not want to answer.

1. **In the past 30 days, did you attend any voluntary mutual support groups for recovery? In other words, did you participate in a non-professional, peer-operated organization that assists individuals who have addiction-related problems such as: Alcoholics Anonymous, Narcotics Anonymous, Secular Organization for Sobriety, Women for Sobriety, religious/faith-affiliated recovery mutual support groups, etc.? Attendance could have been in person or virtual.**
   - ○ Yes
   - ○ No
   - ○ REFUSED

   1a. [If Yes] Specify How Many Times: |___|___| ○ REFUSED

2. **In the past 30 days, did you have interactions with family and/or friends that are supportive of your recovery?**
   - ○ Yes
   - ○ No
   - ○ REFUSED

3. **How satisfied are you with your personal relationships?**
   - ○ Very dissatisfied
   - ○ Dissatisfied
   - ○ Neither satisfied nor dissatisfied
   - ○ Satisfied
   - ○ Very satisfied
   - ○ REFUSED

4. **In the past 30 days did you realize that you need to change those social connections or places that negatively impact your recovery?**
   - ○ Yes
   - ○ No
   - ○ REFUSED

H. PROGRAM-SPECIFIC QUESTIONS

Finally, I will ask you a handful of program-specific question, including a brief assessment of recovery capital (BARC-10) and questions about any work you've done with a peer supporter. Your answers to these questions are confidential and you may choose to skip any questions you do not want to answer.

1. BRIEF ASSESSMENT OF RECOVERY CAPITAL (BARC-10)

[CHECK ANSWER IN APPROPRIATE COLUMN FOR EACH STATEMENT]

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree	RF
1a. There are more important things to me in life than using substances	○	○	○	○	○	○	○
1b. In general I am happy with my life	○	○	○	○	○	○	○
1c. I have enough energy to complete the tasks I set for myself	○	○	○	○	○	○	○
1d. I am proud of the community I live in and feel a part of it	○	○	○	○	○	○	○
1e. I get lots of support from friends	○	○	○	○	○	○	○
1f. I regard my life as challenging and fulfilling without the need for using drugs or alcohol	○	○	○	○	○	○	○
1g. My living space has helped to drive my recovery journey	○	○	○	○	○	○	○
1h. I take full responsibility for my actions	○	○	○	○	○	○	○
1i. I am happy dealing with a range of professional people	○	○	○	○	○	○	○
1j. I am making good progress on my recovery journey	○	○	○	○	○	○	○

H. PROGRAM-SPECIFIC QUESTIONS, CONT'D.

2. Do you currently work with a peer supporter (e.g., Peer Recovery Specialist, Peer Recovery Coach)?

- ○ Yes **[IF YES, ASK 2A – 2D]**
- ○ No **[IF NO, SKIP TO 2E]**
- ○ REFUSED **[SKIP 2A-2E. SURVEY IS COMPLETE.]**

2a. ***[IF 2 = YES]*** **How were you connected to the peer supporter that you work with?**

- ○ I worked with a peer supporter as a part of my treatment at the CSB/Agency
- ○ I was connected with a peer supporter through an AA/NA sponsor
- ○ I was connected with a peer supporter through a jail or prison program
- ○ I was connected with a peer supporter at a hospital or other medical setting
- ○ I developed a relationship with a peer supporter through a support or recovery group
- ○ Other (Please specify) _____
- ○ REFUSED

2b. ***[IF 2 = YES]*** **Is your contact with a peer supporter mandatory or voluntary?**

- ○ Voluntary
- ○ Mandatory, through my treatment program
- ○ Mandatory, through courts/parole
- ○ Mandatory, other (specify) _____
- ○ REFUSED

2c. ***[IF 2 = YES]*** **How helpful has working with a peer supporter been to your recovery?**

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Considerably
- ○ Extremely
- ○ REFUSED

2d. ***[IF 2 = YES]*** **If you had not worked with a peer supporter, where do you think you would be in your recovery now?**

- ○ Not as far along in recovery
- ○ In the same place
- ○ Further along in recovery
- ○ REFUSED

THE INTERVIEW IS NOW COMPLETE. PLEASE ENTER THIS SURVEY INTO THE ONLINE ENTRY FORM WITHIN FOUR DAYS AFTER COMPLETING THIS INTERVIEW. THIS FORM CAN BE FOUND ON THE RESOURCES PAGE OF THE SOR SUPPORT PORTAL:
https://www.virginiasorsupport.org/gpra-survey-materials

H. PROGRAM-SPECIFIC QUESTIONS, CONT'D.

2e. ***[IF 2 = NO]*** **What are the main reasons you are not working with a peer supporter?** ***[CHECK ALL THAT APPLY]***

- ○ I am not interested in working with a peer supporter
- ○ I am interested and am planning to connect with a peer supporter soon
- ○ I'm interested, but there is not a peer supporter available for me to work with
- ○ I'm interested, but I don't feel comfortable working with any of the peer supporters available
- ○ I'm interested, but it is hard for me to find time to work with a peer supporter
- ○ I'm interested, but it is hard for me to get transportation to work with a peer supporter
- ○ I didn't know working with a peer supporter was an option
- ○ Other (specify) _____
- ○ REFUSED

THE INTERVIEW IS NOW COMPLETE.

PLEASE ENTER THIS SURVEY INTO THE ONLINE ENTRY FORM WITHIN FOUR DAYS AFTER COMPLETING THIS INTERVIEW. THIS FORM CAN BE FOUND ON THE RESOURCES PAGE OF THE SOR SUPPORT PORTAL:

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