

Peer Respite Service Utilization Survey

This survey asks about services you might have used in the past 30 days.

Inpatient Treatment, Emergency Room, and Crisis Services

First, we'd like to know about inpatient treatment settings. How many times during the past 30 days:

- *Did you spend the night in any of the following treatment settings?*
- *If Yes, how many nights of the past 30 you stayed there?*

1. Inpatient psychiatric program/hospital
 - Yes: Total number of nights _____
 - No
2. Inpatient substance use treatment or detox program
 - Yes: Total number of nights _____
 - No

We'd also like to know how many times you visited an emergency room or used crisis-related services for a psychiatric or emotional problem.

3. In the past 30 days, have you gone to an emergency room for a psychiatric or emotional problem?
 - Yes: Number of emergency room visits _____
 - No
4. In the past 30 days, have you used walk-in or mobile crisis services for a psychiatric or emotional problem?
 - Yes:
Number of times _____
Average duration of this type of service _____
 - No

Outpatient Services

Next, we'd like to know about outpatient services you might have received. These are places from which you may have received services for an emotional or psychiatric problem including visits for problems related to alcohol or drug use.

- *In the past month, how many visits did you attend at these programs for an emotional or psychiatric problem, or for an alcohol or drug problem?*
 - *On average how long did each type of visit last?*
5. Psychiatrist
 - Yes:
Number of outpatient visits of this type _____
Average duration of this type of visit _____
 - No

6. Other Mental Health Professional (e.g., social worker, psychologist, nurse, etc.)

- Yes:
Number of outpatient visits of this type _____
Average duration of this type of visit _____

No

7. Alcohol or Drug Counseling

- Yes:
Number of outpatient visits of this type _____
Average duration of this type of visit _____

No

8. Day Hospital/Day Treatment Center

- Yes:
Number of outpatient visits of this type _____
Average duration of this type of visit _____

No

9. Psychiatric Rehabilitation Program

- Yes:
Number of outpatient visits of this type _____
Average duration of this type of visit _____

No

10. Peer Counseling/Peer Support

- Yes:
Number of outpatient visits of this type _____
Average duration of this type of visit _____

No

11. Case Management or Coordinator

- Yes:
Number of outpatient visits of this type _____
Average duration of this type of visit _____

No

12. Other Service (Specify: _____)

- Yes:
Number of outpatient visits of this type _____
Average duration of this type of visit _____

No

13. Other Service (Specify: _____)

- Yes:
Number of outpatient visits of this type _____
Average duration of this type of visit _____

No