EVALUATION OF SAMHSA HOMELESS PROGRAMS SUPPORTING STATEMENT

B. COLLECTION OF INFORMATION EMPLOYING STATISTICAL METHODS

1. Respondent Universe and Sampling Methods

<u>Client Interview – Baseline & Client Interview – 6-Month Follow-up:</u> The targeted universe for the <u>Client Interview</u> is all enrolled and accepted clients who receive services under the GBHI/SSH 2009 - 2012 grants. Eligibility for the receipt of GBHI/SSH services is limited to homeless individuals with substance use disorders, mental health disorders, or co-occurring substance use and mental health disorders. Based on the target enrollment numbers for the grantees, the expected total number of clients receiving services is 7,356.

<u>Stakeholder Survey:</u> Stakeholder names will be generated based on data extraction from SAMHSA documents (e.g., grantee applications) and reviewed through follow-up with grantees for all grantee programs funded from 2009-2012. The numbers of grantee partnerships vary widely so it is expected that grantees will recommend between 3 and 10 essential partners who have provided services under their GBHI/SSH initiative for the contractor to contact. These stakeholder partners will be contacted through email and provided a link to the web survey with a username and password for secure log-in.

2. Information Collection Procedures

Client Interview – Baseline & Client Interview – 6-Month Follow-up:

As described in Section A.6, the *Client Interview* will collect data from individuals at baseline and at 6-month follow-up. Data collection at the follow-up point is necessary to measure the short- and longer-term outcomes of the GBHI/SSH programs implemented by the grantees. Because measuring these outcomes is one of the primary objectives of the GBHI/SSH initiative, less frequent data collection would greatly endanger the utility of the GBHI/SSH initiative to all clients.

The process of administering the *Client Interview – Baseline* and *6-Month Follow-up* is designed to protect client privacy, reduce client discomfort and burden, and ensure that the collected data are of the highest quality. GBHI/SSH grantee staff will collect the *Client Interview – Baseline* and *6-Month Follow-up* data immediately following the administration of the SAMHSA-required GPRA/NOMS interview. As described in detail in Attachment 4, these grantee interviewers are trained interviewers who have received training on interview administration, participant engagement, participant protection, and tracking procedures, from the grantee as well as from SAMHSA per OMB approved procedures developed for the GPRA/NOMS measures (OMB Nos. 0930-0208 & 0930-0285). Under the current data collection, the contractor also held training sessions with all grantees to detail the steps involved in administering the client interview and the procedures to follow to ensure protection of respondent's rights and

safeguarding of client data. Grantee programs will be provided with a Client Interview Script (Attachment 5), a Client Interview Consent Form (Attachment 6), a Client Interview Process and Procedures Guide, a Question-by-Question Guide, and a Frequently Asked Questions (FAQ) Guide.

To begin the *Client Interview* – *Baseline* or *6-Month Follow-up*, the administrator will provide the client with a brief introduction to the interview and ask the client if they will agree to hear more. If the client agrees to proceed, the administrator will read the informed consent for the client interview to the client, who will sign it if he or she understands and agrees with its contents. The consent form will explain the purpose of the cross-site evaluation and the interview, describe the interview length and procedures, describe risks or benefits and steps the evaluation is taking to protect the client's privacy, inform the client of the incentive, and inform them that the interview is voluntary and that he or she may refuse to answer a question or stop the interview at any point without penalty. The consent form will also include the OMB approval expiration dates, the statement of survey burden, and the statement that the study is federally sponsored. This process will take place in a private location to protect client privacy. The administrator will write the GBHI/SSH site ID number, the client's GPRA/NOMS ID number, and the Interviewer ID number on the first page of the interview. This is the only identifying information the evaluation will have access to; the evaluation will not know the client's name or be able to connect client interview answers to a particular client.

The Client Interview – Baseline and 6-Month Follow-up each have two parts. In the first part of each interview, the administrator will read the questions to the client and mark the answers on the scantron form. This part of the interview is comprised of sections related to military service, employment, criminal justice, co-occurring disorders, housing and homeless history, housing satisfaction and choice, perception of housing coercion, readiness to change, services needed and received, client treatment burden, and trauma symptoms. The second part of the *Client Interview* - Baseline and the 6-Month Follow-up includes sections related to perception of care, treatment coercion, and treatment choice. These sections will be completed by the client without the administrator present. The client will be provided information about the kinds of questions they will be answering and assistance in the correct way to use the scantron. The client will again be reminded he or she can refuse to answer questions or stop the interview completely. He or she will also be instructed not to write any identifying information on the form, like their name. If a client is illiterate, the administrator can assist the client in two ways. First, before the client answers anything, the administrator can explain how to answer yes/no questions or Likert scale questions by pointing out what those answers look like or explain which directions imply 'better' or 'worse'. Second, the administrator may remain in the room with the client but in a location that prevents the administrator from seeing the client's responses. While in the room the administrator may read each question to the client using a blank copy of the instrument that is not the instrument the client is filling out. As needed, the administrator may remind the client of the answer format and may point out what the answer options look like using the blank instrument. In the event this happens, the administrator will be instructed to follow two rules: 1) consistently remind the client to protect or hide their instrument or answers while the administrator is helping them using the blank instrument and 2) always point out or describe all possible answer choices for a given question to reduce the potential for bias. Once the client completes this portion of the survey, he or she will place the survey into a tamper proof/evident,

postage-paid envelope and return it to the administrator who will mail both sections to the contractor for processing. Once received, they will both be scanned into a secure dataset.

All clients who complete the *Client Interview – Baseline* will be asked to participate in the *Client Interview – 6-Month Follow-up*. If they agree, the client will be given another informed consent outlining the same content as the baseline consent form. Again, they will be informed that participation is voluntary and they will not be penalized for non-participation. The 6-month follow-up will be administered by the grantee staff in the same scantron format as the baseline following the same procedures outlined above. Client interviews will be identified only with the client GPRA/NOMS number which will be necessary to link the baseline data with the follow-up data and to link the GPRA/NOMS data with the *Client Interview – Baseline* and the *6-Month Follow-up*. The contractor will not have any contact with the clients between baseline and follow-up. However, follow-up success will benefit from the fact that GBHI/SSH grantees are providing case management or other services that keep them in ongoing engagement with the clients. Furthermore, they are conducting their own administrative data collection that requires them to maintain contact with the clients. A detailed description of grantee processes for maintaining client contact and rates of retention are detailed in Attachment 4.

<u>Stakeholder Survey</u>: The contractor will obtain limited contact information for stakeholders, including full name and e-mail address, to notify them of the survey. Stakeholders will be contacted through e-mail and issued a username and password to access the web-based survey for their grantee program. Each respondent will login to a secure web-based form to complete the survey. They will also be given the grantee program's identification number which they will be asked to enter during the web survey. This will be the only identifying information linked to the stakeholder's responses which will be used to link the responses to the appropriate grantee program. The stakeholders will be required to give electronic informed consent (Attachment 7) before they begin answering questions. At no point will survey responses be linked to a specific stakeholder. The stakeholder web survey will only be administered one time.

3. Methods to Maximize Response Rates

<u>Client Interview – Baseline & Client Interview – 6-Month Follow-up</u>: The ability to gain the cooperation of potential respondents is key to the success of this endeavor. All grantees are required by SAMHSA to administer the GPRA/NOMS interview to 100% of clients who enter treatment under the GBHI/SSH grants. In addition, a minimum of 80% of clients must also receive the 6-month follow-up GPRA/NOMS interview. In order to increase the likelihood of client response and ease the burden placed on both client and grantee, the *Client Interview* will be administered immediately following the GPRA/NOMS interview. The contractor anticipates an 80% to 85% response rate for the *Client Interview – Baseline* and a 15% to 20% attrition rate for the *Client Interview –6-Month Follow-up* (see Attachment 4). The contractor will employ several strategies to maintain high response rates in the *Client Interview – Baseline* and 6-Month *Follow-up*:

- Stress the importance of the project as well as the contractor's commitment to respondent privacy.
- Train survey staff for handling sensitive information collection in a respectful manner.

- Administer the survey immediately following the administration of the SAMHSArequired GPRA/NOMS interview.
- Offer cash equivalent incentives (e.g., gift cards) for survey response.

Stakeholder Survey: To recruit participants for the stakeholder survey, the contractor will ask grantee project directors to nominate representatives from each of their key partner agencies or organizations and will then contact the nominees to ask that they participate in the survey. In a recent study that also used a web survey of partners of grantees, the evaluation team achieved a response rate of 60% (1,353 respondents of 2,278 invited), with an average of 8 respondents in each of 169 sites. As in that study, it is anticipated that all nominees will have access to the web because they represent agencies or organizations and their involvement in partnering with the grantee is part of their job – and can therefore access the web via a computer in their office. Additional findings regarding prior response rates to similar stakeholder web-based surveys implemented by the contractor is presented in Attachment 4. Although web survey respondents will not be provided incentives, nominees are nominated because they are actively involved in the partnership and therefore are typically motivated to share their experiences and perspectives. To be successful and useful, the stakeholder web survey does not need to achieve response rates at the same level of the client interview. The main consideration is that some partners from each site respond; it is not necessary that all, or even most, partners in a site respond. The contractor will use several strategies to achieve sufficient response rates in the stakeholder survey:

- Ask grantee project directors to inform their nominated partners about the survey and encourage them to participate.
- Send nominees an initial email invitation that explains the study and its importance, why they are being asked to participate, how they can contact the contractor for additional information, and how to access the web survey.
- Send reminder emails to non-respondents and, if approved by SAMHSA, ask grantee project directors to also encourage non-respondents to participate.
- Keep the survey to a reasonable length that encourages participation and will not lead to "word of mouth" comments among nominees that discourage participation.
- If needed, allow respondents some other way to take the survey other than over the web (e.g. mailed hard copy or conducted over the telephone).

4. Test of Procedures

Client Interview – Baseline & Client Interview – 6-Month Follow-up: A pencil-and-paper version of the baseline and 6-month follow-up client interviews were tested with six respondents (using contractor staff, including previous homeless consumers) and found that the baseline interview, including informed consent, takes approximately 20 minutes to complete. The 6-month follow-up interview, including informed consent, takes approximately 24 minutes. The practice tests were timed using a variety of answer patterns; the time required to complete the surveys varies with client characteristics, particularly history of homelessness, housing stability and substance use. The range of times from the baseline interview testing was 16 minutes to 23 minutes and the range of times from the 6-month follow-up interview was 20 minutes to 31 minutes.

In preparation for potential implementation of the CSAT GBHI Client Interviews, two other pilot tests were implemented each replicating these findings regarding timing and acceptability of the test procedures with active clients (see Attachment 4). Further, as described in Attachment 4, the surveys and accompanying procedures were reviewed with the grantees who confirmed the utility of the potential data and that they believed the supplemental surveys would be acceptable to clients and not overly burdensome to the program and specifically the GPRA/NOMS interviewers.

In addition, under the original OMB approval, baseline interviews were conducted with over 3,600 clients and 6-month follow-up interviews were conducted with over 1,000 clients. The interview procedures have worked well, with high participation rates. Grantee staff who administered the client interviews reported no substantial problems but rather that the interviews worked well and were well-received by clients.

<u>Stakeholder Survey:</u> A pencil-and-paper version of the web survey was tested with six respondents (using contractor staff, including previous stakeholders) and it was found to take approximately 17 minutes to complete, including the informed consent. The web survey contains a number of skip patterns and response times will vary based on the services offered by the stakeholder. The practice tests were completed using hypothetical stakeholders who offered a range of services from none (e.g., a stakeholder who supplies funding only) to full services (e.g., a stakeholder who offers housing, substance abuse and mental health services) which will be uncommon. It is also likely that the web-based form will take less time than the paper version as the skip patterns will run automatically for the respondent. The range of times from the testing was 13 minutes to 20 minutes.

5. Statistical Consultants

As noted in Section A.8, SAMHSA has consulted extensively with an expert panel who will continue to provide expert advice throughout the course of the evaluation. In addition, the contractor team is comprised of several experts who will be directly involved in the data collection and statistical analysis. Also, contractor in-house experts will be consulted throughout the program on various statistical aspects of the design, methodological issues, economic analysis, database management, and data analysis. Exhibit 4 provides details of these team members and advisors.

Exhibit 4. Data Collection and Analysis Team Members and Advisors

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REFERENCES

- Ball, S. A., Martino, S., Nich, C., Frankforter, T. L., van Horn, D., Crits-Christoph, P., et al. (2007). Site matters: Multisite randomized trial of motivational enhancement therapy in community drug abuse clinics. *Journal of Consulting and Clinical Psychology*, *75*, 556–567.
- Bassuk, E. L., Weinreb, L. F., Buckner, J. C., Browne, A., Salomon, A., & Bassuk, S. S. (1996). The characteristics and needs of sheltered homeless and low-income housed mothers. *Journal of the American Medical Association*, *276*, 640–646.
- Borsari, B., & Carey, K. B. (2000). Effects of a brief motivational intervention with college student drinkers. *Journal of Consulting and Clinical Psychology*, *68*, 728–733.
- Broner, N. (2010, March). *Sustaining jail diversion: A qualitative study of strategic planning by SAMHSA's jail diversion targeted expansion capacity grants.* Presented at the CMHS National GAINS Center Conference, Orlando, FL.
- Broner, N. (2010, April). *Using program evaluation to improve outcomes and inform program management and sustainability.* Presented at the SAMHSA CMHS Annual Services for Supportive Housing Grantee Conference, Alexandria, VA.
- Broner, N., Trudeau, J., & Embry, V. (2012, October). *Expanding a complex multi-site evaluation to address multiple federal programs*. Presented at the American Evaluation Association Conference, Minneapolis, MN.
- Brown, J. M., & Miller, W. R. (1993). Impact of motivational interviewing on participation and outcome in residential alcoholism treatment. *Psychology of Addictive Behaviors*, *7*, 211–218.
- Browne, A., & Bassuk, S. S. (1997). Intimate violence in the lives of homeless and poor housed women: prevalence and patterns in an ethnically diverse sample. *American Journal of Orthopsychiatry*, 72, 261–277.
- Burt, M. R. (2009). *Life after transitional housing: Tracking homeless families after they leave HUD-assisted transitional housing.* Urban Institute.
- Burt, M. R., Aron, L. Y., Douglas, T., Valente, J., Lee, E., & Iwen, B. (1999). *Homelessness: Programs and the people they serve*. Washington, DC: Interagency Council on the Homeless.
- Caton, C., Wilkins, C., & Anderson, J. (2007). People who experience long-term homelessness: Characteristics and interventions. In D. Dennis, G. Locke, & J. Khadduri (Eds.), *Toward understanding homelessness: The 2007 National Symposium on Homelessness Research* (pp. 4-1 through 4-44). Washington, DC: U.S. Department of Housing and Urban Development and U.S. Department of Health and Human Services. Retrieved October 26, 2009, from http://aspe.hhs.gov/hsp/homelessness/symposium07/
- Cheng, A. L., & Kelly, P. J. (2008). Impact of an integrated service system on client outcomes by gender in a national sample of a mentally ill homeless population. *Gender Medicine*, *5*, 395–404.
- Conrad, K. J., Hultman, C. I., Pope, A. R., Lyons, J. S., Baxter, W. C., Daghestani, A. N., et al. (1997). Case managed residential care for homeless addicted veterans: Results of a true experiment. *Medical Care*, *36*, 40–53.

- Drake, R. E., McHugo, G. J. & Noordsy, D. L. (1993). Treatment of alcoholism among schizophrenic patients: Four-year-outcomes. *American Journal of Psychiatry*, *150*, 328–329.
- Drake, R. E., Yovetich, N. A., Bebout, R. R., Harris, M., & McHugo, G. J. (1997). Integrated treatment for dually diagnosed homeless adults. *Journal of Nervous and Mental Disease*, *185*, 298–305.
- Ganju, V. (1999). *The MHSIP Consumer Survey: History, development, revisions, applications, commonly-asked questions*. Washington, DC: National Institute of Mental Health, Mental Health Statistics Improvement Program. Planning, Research & Evaluation, Texas Department of MHMR. Retrieved February 2, 2010 from http://www.mhsip.org/mhsiptest/documents/MHSIPConsumerSurvey.pdf.
- Goodman, L., Saxe, L., & Harvey, M. (1991). Homelessness as psychological trauma. *American Psychologist*, *46*, 1219-1225.
- Greenberg, G. A., & Rosenheck, R. A. (2008). Jail incarceration, homelessness and mental health: A national study. *Psychiatric Services*, 59, 170–177.
- Greenwood, R. M., Schaefer-McDanile, N. J., Winkel, G., & Tsemberis, S. J. (2005). Decreasing psychiatric symptoms by increasing choice in services for adults with histories of homelessness. *American Journal of Community Psychology*, *36*, 223–238.
- Hiday, V., Swartz, M., Swanson, J., Borum, R., & Wagner, H. (1999). Criminal victimization of persons with severe mental illness. *Psychiatric Services*, *50*, 62–68.
- Joseph, H., & Langrod, J. G. (2004). The homeless. In J. H. Lowinson, P. Ruiz, R. B. Millman, & J. G. Langrod (Eds.), *Substance abuse: A comprehensive textbook* (4th ed.; pp. 1141–1168). Philadelphia: Lippincott, Williams, & Wilkins.
- Kertesz, S. G., Crouch, K., Milby, J. B., Cusimano, R. E., & Schumacher, J. E. (2009). Housing First for homeless persons with active addiction: Are we overreaching? *The Milbank Quarterly*, *87*, 495–534.
- Kline, A., Callahan, L., Butler, M., St. Hill, L., Losonczy, M. F., & Smelson, D. A. (2009). The relationship between military service era and psychosocial treatment needs among homeless veterans with a co-occurring substance abuse and mental health disorder. *Journal of Dual Diagnosis*, 5, 357–374.
- Lang, A. J., & Stein, M. B. (2005). An abbreviated PTSD checklist for use as a screening instrument in primary care. *Behaviour Research and Therapy*, 43, 585–594.
- Mallett, S., Rosenthal, D., & Keys, D. (2005). Young people, drug use, and family conflict: Pathways into homelessness. *Journal of Adolescence*, *28*, 185–199.
- Martell, D. A., Rosner, R., & Harmon, R. B. (1995). Base-rate estimates of criminal behavior by homeless mentally ill persons in New York City. *Psychiatric Services*, *46*, 596–601.
- Miller, W. R., Benefield, G., & Tonigan, J. S. (1993). Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology*, *61*, 455–461.

- Mueser, K. T., Drake, R. E., & Miles, K. M. (1997). The course and treatment of substance use disorder in persons with severe mental illness. In L. S. Onken, J. D. Blaine, S. Genser, & A. M. Horton (Eds.), *Treatment of drug-dependent individuals with comorbid mental disorders* (pp. 86–109). Rockville, MD: National Institute on Drug Abuse.
- National Coalition for the Homeless. (2009). *Substance abuse and homelessness*. Retrieved October 17, 2009, from http://www.nationalhomeless.org/factsheets/addiction.html
- National Law Center on Homelessness and Poverty; National Coalition for the Homeless. (2009). *Homes not handcuffs: The criminalization of homelessness in U.S. cities*. Washington, DC: Authors. Retrieved November 10, 2009, from http://www.nationalhomeless.org/publications/crimreport/crimreport_2009.pdf
- Nelson, G., Aubry, T., & Lafrance, A. (2007). A review of the literature on the effectiveness of housing and support, Assertive Community Treatment, and intensive case management interventions for persons with mental illness who have been homeless. *American Journal of Orthopsychiatry*, *77*, 350–361.
- North, C. S., Eyrich, K. M., Pollio, D. E., & Spitznagel, E. L. (2004). Are rates of psychiatric disorders in the homeless population changing? *American Journal of Public Health*, *94*, 103–108.
- Pickett-Schenk, S. A., Cook, J. A., Grey, J. A., Banghart, M., Rosenheck, R. A., & Randolph, F. (2002). Employment histories of homeless persons with mental illness. *Community Mental Health Journal*, *38*, 199-211.
- Project MATCH Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, *58*, 7–29.
- Rapp, R., Xu, J., Carr, C., Lane, D., Wang, J., & Carlson, R. (2006). Treatment barriers identified by substance abusers assessed at a centralized intake unit. Journal of Substance Abuse Treatment, 30(3), 227-235. doi:10.1016/j.jsat.2006.01.002
- Robbins, P. C., Callahan, L., & Monahan, J. (2009). Perceived coercion to treatment and housing satisfaction in housing-first and supportive housing programs. *Psychiatric Services*, *60*, 1251–1253.
- Rollnick, S., Heather, N., Gold, R., & Hall, W. (1992). Development of a short "readiness to change" questionnaire for use in brief, opportunistic interventions among excessive drinkers. *British Journal of Addiction*, *87*, 743–754.
- Rosenblum, A., Magura, S., Kayman, D. J., & Fong, C. (2005). Motivationally enhanced group counseling for substance users in a soup kitchen: A randomized clinical trial. *Drug and Alcohol Dependence*, *80*, 91–103.
- Shaheen, G., & Rio, J. (2007). Recognizing work as a priority in preventing or ending homelessness. *Journal of Primary Prevention*, *28*, 341-358.
- Shelton, K., Taylor, P., Bonner, A., & van den Bree, M. (2009). Risk factors for homelessness: Evidence from a population-based study. *Psychiatric Services*, *60*, 465–472. doi:10.1176/appi.ps.60.4.465

- Srebnik, D., Livingston, J., Gordon, L., & King, D. (1995). Housing choice and community success for individuals with serious and persistent mental illness. *Community Mental Health Journal*, *31*(2), 139-152.
- Stephens, R. S., Roffman, R. A., & Curtin, L. (2000). Comparison of extended versus brief treatments for marijuana use. *Journal of Consulting and Clinical Psychology*, *68*, 898–908.
- Trudeau, J., Barrick, K., & Roehl, J. (2010). *Independent Evaluation of the National Weed and Seed Strategy*. (Draft Report). Washington, DC: U.S. Department of Justice, Community Capacity Development Office.
- Tsemberis, S. J., Moran, L., Shinn, M., Asmussen, S. M., & Shern, D. L. (2003). Consumer preference programs for individuals who are homeless and have psychiatric disabilities: A drop-in center and a supported housing program. *American Journal of Community Psychology*, *32*, 305-317.
- Tucker, J., Vuchinich, R., & Rippens, P. (2004). A factor analytic study of influences on patterns of help-seeking among treated and untreated alcohol dependent persons. Journal of Substance Abuse Treatment, 26(3), 237-242. doi:10.1016/S0740-5472(03)00209-5
- U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2009). *The 2008 annual homeless assessment report to Congress*. Washington, DC: Author.
- U.S. Department of Veterans Affairs, Veterans Administration. (2009). *Homeless veterans: Overview of homelessness*. Washington, DC: Author. Retrieved on November 17, 2009, from http://www1.va.gov/homeless/page.cfm?pg=1
- van den Bree, M. B. M., Shelton, K., Bonner, A., Moss, S., Thomas, H., & Taylor, P. J. (2009). A longitudinal population-based study of factors in adolescence predicting homelessness in young adulthood. *Journal of Adolescent Health*, *45*, 571–578.
- Vangeest, J. B., & Johnson, T. P. (2002). Substance abuse and homelessness: Direct or indirect effects? *Annals of Epidemiology*, *12*, 455–461.
- Weathers, F., Litz, B., Huska, J., & Keane, T. (1994). *The PTSD Checklist–Civilian Version (PCL-C) for DSM-IV*. Boston: National Center for PTSD. Weathers, F., Litz, B., Huska, J., & Keane, T. (1994). *The PTSD Checklist–Civilian Version (PCL-C) for DSM-IV*. Boston: National Center for PTSD.
- Wright, D., Bowman, K., Butler, D., & Eyerman, J. (2005). Non-response bias from the national household survey on drug abuse incentive experiment. *Journal of Economic and Social Measurement*, *30*, 219-231.

List of Attachments

Attachment 1: Client Interview – Baseline

Attachment 2: Client Interview – 6-Month Follow-up

Attachment 3: Stakeholder Survey

Attachment 4: SAMHSA Response to Original OMB Comments (3/3/2011)

Attachment 5: Client Interview Script

Attachment 6: Client Interview Consent Form

Attachment 7: Stakeholder Survey Consent Form