

Characteristics of Persons Housed by NY/NY III's Supportive Housing for Active Substance Users

The first paper from the *CASAHOPESM — Housing Opportunities Program Evaluation project*



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Executive Summary

Homeless individuals with active substance use disorders present a complex challenge to those working to end homelessness in the United States. Many housing programs mandate sobriety, requiring those with active substance use disorders to manage their addiction while simultaneously coping with the stressors of living on the street or in a shelter. However, without stable housing, it is often difficult to access much-needed physical health, mental health, and substance use services. As a result, this population can be caught in a cycle wherein lack of housing is a barrier to addressing substance use and substance use is a barrier to gaining housing. This cycle is associated with high utilization of medical services and criminal justice system involvement. Added to the cost of shelters, this approach can have the unintended consequence of imposing staggering costs to city, state, or federal governments while not necessarily improving the well-being of the population.

In November 2005 New York City and State signed the New York/New York III agreement. This agreement funded housing for nine target populations, one of which, Population E, is described as homeless individuals who actively use substances and do not have a serious and persistent mental illness (SPMI). Local housing providers received funding to offer a total of 500 units of scattered-site housing for Population E (an additional 250 units of congregate housing are being developed). These nine Population E housing providers are required to deliver case management but are prohibited from demanding alcohol and drug abstinence of their tenants.

While there are a number of programs in the country that have moved away from sobriety as a prerequisite for housing, to our knowledge this is the first large-scale, urban investment in supportive housing for actively substance using homeless individuals without mental illness. Providing supportive housing to those who use substances is a policy experiment with the potential to lead to a paradigm shift in how governments contend with intractable homelessness and underserved substance users. The promise is that this approach is a more humane way to help individuals stabilize their lives and reduce the economic burden to the community. The question remains whether this approach is effective in improving lives and saving taxpayer dollars.

The Conrad N. Hilton Foundation has funded CASAHOPE (Housing Opportunities Program Evaluation) to evaluate the unique work being done by Population E housing providers. CASAHOPE will answer key questions about whether it is feasible to develop non-abstinence based supportive housing programs for substance using homeless persons without SPMI; which program features (among those implemented) appear most promising; and the resources (e.g., costs) and organizational capacity (e.g., staff training) required to implement such programs. We will also examine the role of relevant governmental agencies (e.g., welfare, substance abuse, homeless services) in an attempt to understand what policies and intergovernmental agency partnerships can

best support these programs. We have partnered with the Corporation for Supportive Housing (CSH) to evaluate program implementation and provide technical assistance to the Population E providers.

The evaluation will rely on data from multiple sources: Population E tenants, program staff, key stakeholders, and government administrative databases. This paper is the first in a series and will establish a baseline description of the tenants entering housing. Subsequent papers will address the implementation and impact of Population E housing.

As part of the study, baseline interviews were conducted with 358 Population E tenants as close as possible to the date each tenant was housed. Research assistants collected data on physical health, mental health, substance use, substance abuse treatment history, housing history, employment history, and criminal justice history.

Detailed findings are presented herein. In sum, study participants had the following characteristics:

Demographics

- The vast majority of participants were African-American and male. The study sample had a slightly higher percentage of African-Americans compared to that reported in a study of homeless single adults in New York City, but gender rates were nearly identical.
- The average age was 48, comparable to the mean age for participants in similar housing programs. Interestingly, among those with a substance use disorder, alcohol use disorders were more common in tenants over 50 years old and drug use disorders were more common for tenants younger than 30.

Alcohol and Drug Use

- The majority of the sample met DSM-based clinical diagnostic criteria for an alcohol or drug use disorder. As expected, prevalence of substance use disorder was higher than rates reported among the general homeless population. While not all tenants met diagnostic criteria for alcohol or drug use disorders, almost all were active drug users and/or drinkers and had a history of substance use problems.
- Eighty-one percent of study participants had undergone substance abuse treatment in their lifetime. In fact, at the time of interview- roughly a quarter of the sample was in substance use treatment. This may be true in part because the majority of the sample was receiving public assistance benefits from New York City's Human Resources Administration (HRA), which requires those who report misusing substances to attend treatment.

Housing

- In the three years prior to being housed in Population E housing about two fifths of the sample had lived primarily in shelters and about two fifths primarily on the street.
- Study participants who had lived on the street were much more likely to have a substance use diagnosis and twice as likely to be heavy drinkers compared to those who had been housed in shelters. While this finding may be an effect of shelter rules prohibiting substance use, it is congruent with previous research and suggests that formerly street-homeless tenants may need additional or more intensive case management services compared to those coming from shelters.

Physical and Mental Health

- The average physical health of study participants was poorer than that of most people in the United States, a finding in line with previous study findings among the chronically homeless. Sixteen percent of participants had been in the emergency room in the past 30 days for a physical health condition and two thirds identified at least one chronic medical condition that interfered with their daily life.
- While the average mental health of study participants was on par with the general United States population, one quarter of participants had been prescribed psychiatric medication in the past year and 2% had been to the emergency room in the past 30 days for a psychological condition.

Criminal Justice

- The majority of the sample had been previously involved in the criminal justice system; those who had been incarcerated (64%) had spent on average 4.5 years in jails or prisons. Lifetime rates of incarceration were slightly higher than reported in other studies of the single adult homeless population. This is likely connected to tenants' illegal drug use, as tenants who met criteria for a drug use disorder were significantly more likely to have been arrested, detained, or incarcerated in the last year than those who met criteria for an alcohol use disorder.

Employment

- More than half of the study participants had not worked either on or off the books in the past three years. This may be related to the serious barriers to employment characterizing this sample, including poor physical health, or because tenants are still new to housing and not yet looking for work.

While the characteristics described above are largely similar to those described in other studies of individuals receiving low-threshold supportive housing in urban areas, it is important to view these findings in relation to the eligibility criteria and intake process set by the NY/NY III agreement. The original criteria were intended to pinpoint a hard-to-house population. They required that tenants be chronically homeless single adults with a substance use disorder that was a primary barrier to independent living and also have a disabling clinical condition. In an effort to increase referrals, requirements were changed well over a year after the first tenant was housed in the following ways: (1) potential tenants no longer need a disabling clinical condition, in addition to their substance use, to be considered for Population E and (2) the definition of “chronic” homelessness was changed to include individuals who have been homeless only six of the past 12 months.

It is noteworthy that while the large majority of the sample was heavily using, dependent on, or abusing substances, it is difficult to know if the tenants interviewed under-reported their use or are representative of the most severely addicted homeless persons in New York City. Although Population E housing has fewer barriers to entrance than traditional supportive housing, tenants must still be available and willing to cooperate with program workers. The most severely impaired individuals may have trouble tolerating an intake process of any kind. Given the amended eligibility criteria and entry processes required for enrollment in Population E housing, the sample characteristics described are in line with expectations.

Broadly speaking, study participants are representative of a disenfranchised population with diminished social capital. They have relatively low educational attainment, limited work histories, and report significant barriers to employment. These individuals have been living at the margins of society for long periods of time. Future papers will present data on outcomes for this population as well as lessons learned and costs associated with program implementation.

CHAPTER I

INTRODUCTION

In November 2005, Mayor Bloomberg and Governor Pataki announced the New York/New York III (NY/NY III) agreement, a \$1 billion commitment between the City and State to develop 9,000 new units of supportive housing in New York City. NY/NY III is larger in scope than the previous two NY/NY agreements and is the first to include housing for people *without* serious and persistent mental illness (SPMI). While the expanded target populations of NY/NY III signal the City and State's belief in supportive housing as an effective intervention, the optimism behind supportive housing is most clearly demonstrated by the inclusion of housing for actively substance using homeless individuals without SPMI, known as Population E. This housing was designed in response to the overcrowding of city shelters by substance using homeless individuals, a group that is typically seen as unwilling or unable to complete substance abuse treatment. Population E housing does not require tenants to enter treatment or stop using alcohol or drugs. While there are a number of programs in the country that have moved away from sobriety as a prerequisite for housing, this is the first large-scale, urban investment in supportive housing for actively substance using homeless individuals without serious mental illness.

The Conrad N. Hilton Foundation has funded CASAHOPE (Housing Opportunities Program Evaluation) to evaluate the promise of Population E housing. CASAHOPE aims to capitalize on the opportunity that this initiative presents and examine whether it is feasible to develop non-abstinence based supportive housing programs for substance using homeless persons without SPMI; which program features (among those implemented) appear most promising; and the resources (e.g., costs) and organizational capacity (e.g., staff training) required to implement such programs. We will also examine the role of relevant governmental agencies (e.g., welfare, substance abuse, homeless services) in an attempt to understand what policies and intergovernmental agency partnerships can best support these programs. The evaluation has 3 broad components: 1) direct data collection from housing tenants; 2) interviews with program staff and key government stakeholders to assess lessons learned during implementation; and 3) analysis of government administrative data. We have partnered with the Corporation for Supportive Housing (CSH) to evaluate program implementation and to provide technical assistance to the Population E providers.

This paper is the first in a series on the implementation and impact of Population E. The papers that follow will describe program execution, service provision and tenant outcomes, effects on government services utilization, and economic impacts. The current paper will focus specifically on results from the baseline assessment interview with tenants conducted by CASAHOPE research staff in 2008 and 2009. This paper will answer questions about which types of tenants are served and whether or not participants are representative of the broader homeless population.

The CASAHOPE Evaluation

In 2008 and 2009, in addition to rental subsidies for 500 scattered site physical units for Population E, nine housing providers were awarded contracts to develop their own infrastructure for supportive services. Providers were not allowed to require abstinence of participants but were expected to engage tenants in self-directed goal-setting. Each provider had latitude in devising the configuration of their program. Variations in models and their implementation offered an exceptional opportunity to explore and evaluate a range of naturally occurring models as they unfolded in “real-world” environments.

CASAHOPE recently completed data collection on tenant-level substance use, housing stability, mental health, employment, and other aspects of functioning over the course of the first year of housing. These data will provide information on whether this housing approach can lead to productive and engaged individuals and not just keep active users off the streets. We will also examine whether this approach leads to a significant improvement in housing stability and a reduction in the utilization and costs of expensive public services when compared to services as usual. This element of the evaluation is critical to answering the question of whether non-abstinence based housing for homeless persons without serious and persistent mental illness is a viable program from a broad public health and societal cost perspective.

In addition to studying the impact of Population E housing, CASAHOPE has partnered with the Corporation for Supportive Housing (CSH) to conduct an implementation evaluation. Through interviews with program staff and key government stakeholders, we will describe the key features of mature programs and the important variations across models. These interviews will document the background and history of Population E housing, important lessons learned from the process of program development, and the promising approaches that are being put into operation by providers.

Finally, CASAHOPE, in partnership with CSH, provided technical assistance to the nine housing providers from 2008 through 2010. CSH convened monthly learning collaborative sessions with program directors and supervisors. These sessions were a combination of structured and unstructured discussions (topics: benefit management, engagement, etc.) and formal presentations. The learning collaborative sessions for program administrators were so well received that CSH launched a learning collaborative for case managers in 2009. Similar to the administrator sessions, the case manager learning collaborative was a combination of structured discussions (topics: effective case management practices, coping with death and loss, etc.) and opportunities for venting, peer support, and exchange of “tricks of the trade”. CSH also designed and delivered a series of trainings for provider staff around essential practices in Housing First.

A Population in Need

Research clearly suggests that effectively helping homeless persons with substance use problems become stably housed is critical to solving the overall problem of homelessness. Studies conducted across the country have found that a significant portion of homeless persons (up to 78%) have substance use disorders (Levitt, Culhane, DeGenova, O'Quinn, & Bainbridge, 2009; Milby et al., 1996; O' Toole et al., 2004). In a 2009 survey by the United States Conference of Mayors, officials in 27 cities were asked to list the top three causes of homelessness. Substance abuse was tied with lack of affordable housing as the perceived largest cause of homelessness for single adults (reported by 67% of cities). In addition to precipitating homelessness, substance abuse may also contribute to a person's difficulty in overcoming homelessness and can lead to high utilization of expensive government-funded health and criminal justice services (Larimer et al., 2010). Once homeless, people who misuse substances are at risk of arrest, victimization, negative health effects, and diminished employment opportunities.

- Drugs and alcohol are often the direct cause of death among homeless individuals. One study found that, among men who used the single adult shelter system in New York City, the death rate due to substance use was 16 times higher than among the general population (New York City Departments of Health and Mental Hygiene and Homeless Services; DOHMH, DHS, 2005).
- Among this population, there is a high level co-occurring mental health and alcohol and/or drug use disorders (Substance Abuse and Mental Health Services Administration; SAMHSA, 2003).
- Homeless persons with substance use disorders are more likely than other homeless persons to report not working at all in the past year, to have worked fewer months at a greater number of jobs, and to have experienced a longer time period since their most recent job (Orwin et al., 1992).
- Homeless persons with substance use problems are more likely than their non-abusing peers to have arrest records. Substance related offenses make up 50% of all arrests of homeless individuals, and are largely for minor offenses such as trespassing in abandoned buildings or public intoxication (Snow, Baker, & Anderson, 1989).
- Homeless persons with substance use disorders also tend to be homeless for a longer period of time and sleep outdoors more frequently than non-substance abusing homeless person (McMurray-Avila, 2001).
- Studies have found that homeless persons with alcohol problems are 1.3-4 times more likely than their non-abusing peers to be victimized (Fischer, 1991).

Undoubtedly, homeless persons with substance use disorders are more vulnerable to the serious consequences of homelessness than those who do not misuse substances.

Barriers to Successful Substance Use Treatment

While homeless persons with substance use disorders are in high need of services, they often encounter considerable barriers to accessing this help. Obstacles include inadequate screening and assessment on the part of over-stretched case managers who have little time to build rapport with the individual, as well as complicated treatment intake procedures that often require the applicant to provide a fixed home address (SAMHSA, 2003). Duration of homelessness, gender, access to social and financial supports, and health insurance can all play a critical role in whether or not a homeless individual receives treatment (Zerger, 2002). Perception of need is also an important factor in whether or not a person actively seeks services. A nationwide study found that homeless individuals rated their top three needs as help finding a job, help finding affordable housing, and help with housing expenses; substance use treatment was the 13th most frequent response (Burt et al., 1999).

Once access to treatment is gained, there are often barriers to successful completion. In a multisite study of interventions for homeless individuals with alcohol and other drug problems, researchers found that retention problems were worse among homeless tenants than the general addicted population (Orwin, Garrison-Mogren, Jacobs, & Sonnefeld, 1999). All 8 evaluation sites in the study lost two-thirds or more of their homeless clients to premature exit, and the majority lost more than 80%. When homeless persons leave treatment early or receive poor discharge planning they tend to return to the same precarious circumstances that gave rise to their homelessness (SAMHSA, 2003). These persons are at a high risk for a number of serious health problems and are often very costly to society due to resumed utilization of expensive and inappropriate services (Orwin et al., 1999). Additionally, after a person has had negative experiences with an unresponsive treatment system, he or she may be difficult to re-engage in services (SAMHSA, 2003). For the minority who do complete treatment, there is often a lack of understanding around how to support their sobriety. This includes an under-appreciation of the social isolation that may come from being sober for someone whose social network consists of substance-using friends (McMurray-Avila, 2001).

Evolving Model of Treatment

The treatment system for homeless persons with substance use disorders continues to evolve according to public sentiment and political will. Historically, homeless persons with substance use problems were termed 'public inebriates' and placed in the drunk tanks of local jails to sober up. After the American Medical Association declared alcoholism a disease in 1956, the burden of care began to shift from the criminal justice system to the health care system. In 1971, Congress passed the Uniform Alcoholism and Intoxication Treatment Act, commonly known as the Hughes Act. The Hughes Act officially decriminalized public drunkenness and reinforced a medical treatment

approach that centers on hospital detoxification programs followed by physician-staffed rehabilitation programs. However, these medical programs, which continue to be highly utilized, are generally very expensive, short in duration, and largely unable to address a significant barrier to successful treatment for this population, namely lack of stable housing. In response to the shortcomings of the medical model, the 1970's saw a rise in what is called the social model. This model is peer-oriented and focuses on behavior change through learning. While these social model programs are less costly than their medical counterparts, they also struggle to sufficiently address this population's housing needs and have difficulty securing funding from public agencies (Zerger, 2002).

Responding to an epidemic of homelessness, exacerbated by the closing of mental institutions in many states in the 1980's, the federal government passed the McKinney-Vento Homeless Assistance Act in 1987. Funding streams were redesigned to support a continuum of care model in which homeless persons with substance use disorders pass through a series of programs based on their progress towards sobriety (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009). Under this model, the typical path to housing requires clients to (1) be willing and able to be abstinent from drugs and/or alcohol, (2) access services through a shelter or street-outreach team, (3) attend abstinence-based treatment, including detox and long-term residential programs, (4) complete treatment and move into transitional housing, and then, (5) locate permanent housing. If at any point on the path to permanent housing, the client is unable to maintain sobriety, he or she would likely have to begin again in the shelter or outreach system. This approach remains the dominant paradigm today.

The McKinney-Vento Homeless Act also authorized the creation of the Supportive Housing Program. This program, administered by the U.S. Department of Housing and Urban Development (HUD), funds transitional and permanent supportive housing projects throughout the United States. Supportive housing is affordable housing that links tenants with wrap-around supportive social services, and has been shown to improve lives, benefit communities, and decrease Medicaid costs (Culhane, Metraux, & Hadley, 2002; Galster, Tatian, & Pettit, 2004; Larimer et al., 2010; Martinez & Burt, 2006).

Supportive housing programs have grown considerably in the last 20 years and are now funded by a variety of public and private resources. One example is HUD's Shelter Plus Care program, which combines federally subsidized housing with city, state, or privately funded supportive services. Shelter Plus Care is targeted at homeless persons with disabilities, including chronic problems with alcohol and/or drugs. While HUD does not require abstinence for housing entry, those who fund the accompanying supportive services are given the freedom to determine abstinence requirements for individual programs. As a result, it is common for Shelter Plus Care programs to set a multi-month sobriety prerequisite for housing eligibility (Kertesz et al., 2007). These abstinence requirements are similar to those of other supportive housing programs across the country. While abstinence requirements are a natural extension of the way substance

use problems among the homeless have been traditionally treated, they can act as a barrier to services for a large population of persons who are either unwilling or unable to commit to sobriety.

A New Approach

Recently, as states and local municipalities have begun the difficult but necessary work of creating their own broad plans to end homelessness, major cities across the country have been adopting a different form of supportive housing to address the needs of the chronically homeless with substance use disorders—Housing First, or ‘low barrier’ housing. Housing First supports the fundamental right of every person to be housed and utilizes a low-demand philosophy that focuses on mitigating harm while minimizing strictures on substance use. Proponents of this approach suggest that supportive housing without proscriptions on substance use does not lead to increased use and often leads to decreased use. Through its elevation of tenant choice and focus on tenant-identified needs, most clearly demonstrated by the lack of substance abuse treatment requirements, Housing First represents a substantial break from traditional models.

There is reason to believe Housing First is both effective and cost saving for some populations. Perhaps the most studied example is Pathways to Housing in New York City. Pathways to Housing offers immediate housing with no requirements around sobriety or treatment to persons with serious and persistent mental illness (SPMI). Support services are provided by a multidisciplinary ACT team available 24 hours a day, 7 days a week. An observational study comparing outcomes for those entering Pathways to Housing versus usual care, i.e. a multi-stepped abstinence-based approach, found that five-year retention rates in housing were much better among the Housing First group (88%) than among those who received usual care (47%) (Tsemberis & Eisenberg, 2000). In a randomized controlled trial comparing Pathways to Housing with a control group that received usual care, those in the Housing First arm of the study had better housing stability, fewer psychiatric hospitalizations, and reported higher perceived choice than the control group (Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003; Padgett, Gulcur, & Tsemberis, 2006; Tsemberis, Gulcur, & Nakae, 2004). No differences were found in substance use or psychiatric symptoms between the groups, leading investigators to conclude that Housing First programs offer tenants a chance at stable housing without worsening psychiatric or substance misuse symptoms.

Similarly, an exploratory study of three Housing First programs for persons with mental illness—Downtown Emergency Service Center (DESC), Reaching Out and Engaging to Achieve Consumer Health (REACH), and Pathways to Housing—conducted by the U.S. Department of Housing and Urban Development (HUD) concluded that Housing First is a viable approach for housing chronically homeless persons with mental illness and co-occurring substance use disorders (Pearson, Locke, Montgomery, & Buron, 2007). While there were no substantial trends related to psychiatric or substance misuse symptoms,

all three programs achieved positive outcomes in the areas of housing stability and housing tenure, with some exception for tenants who had previously been living on the streets. Additionally, in a 2005 study, Canadian investigators profiled thirteen programs that housed actively substance using homeless persons in Canada, the United States, and the United Kingdom (Kraus, Goldberg, & Serge, 2005). The programs ranged in target population specifics (SPMI, non-SPMI, drinkers, drug users, etc.) and housing design (permanent, transitional, scattered site, congregate, etc.), but all thirteen utilized a Housing First model. All programs reported that their tenants had undergone positive changes in the areas of housing stabilization, income, physical and mental health, and substance use. Almost all programs identified safe and secure housing as a key factor in helping tenants move towards abstinence or reduce the negative consequences of their substance use. Most recently, a study of the U.S. Interagency Council on Homelessness' pilot program called the Collaborative Initiative to Help End Chronic Homelessness (CICH), found that chronically homeless adults with various disabling conditions, including substance use disorders, provided with supportive housing modeled after Housing First experienced significant improvement in clinical, social, and quality of life outcomes as well as housing stability (Mares & Rosenheck, 2010). Among baseline drug users crack, cocaine, and marijuana use decreased by 28–50% over the follow-up period.

In addition to being linked with positive tenant-level outcomes, there is also reason to believe Housing First may lead to decreased use of crisis services and increased cost savings. A study of Seattle's 1811 Eastlake, a Housing First program that targets chronically homeless persons with severe alcohol problems and high utilization of costly health care services, found significant cost savings to the public after 6 months relative to the wait-list control group (Larimer et al., 2010). This study also found a reduction in alcohol consumption among those who received the Housing First intervention despite no requirement of alcohol abstinence to remain housed. In Chicago, a randomized study of housing for homeless persons with chronic medical illness discharged from area hospitals found that those offered housing based on a Housing First model had fewer hospital days and emergency department visits than those who received usual care in the form of discharge planning from hospital social workers (Sadowski, Kee, VanderWeele, & Buchanan, 2009). Additionally, a study of Rhode Island's pilot Housing First Program in 2008 estimated high cost savings due to a dramatic decline in the use of government-funded services by those housed (Hirsch, Glasser, D'Addabbo, & Cigna, 2008).

These studies have demonstrated the ethical and financial promise of Housing First for many substance-using groups. Nevertheless, more research is needed for tenants without SPMI and those who use substances other than or in addition to alcohol. These groups may require a different type of program and respond differently to a Housing First approach. As an example of important population differences, those with SPMI commonly receive social security benefits, which may enhance the stabilizing effects of housing as well as alter the potential cost impacts.

Overall, housing without sobriety requirements for homeless persons without SPMI offers a new approach that if demonstrated effective, could have considerable impact on improving the problem of homelessness. In addition, the implementation of effective, well organized programs targeted at this population could dramatically increase access to treatment for individuals with substance use disorders who fail to seek treatment. However, to date virtually no research has been reported on how to implement this kind of housing, for what types of tenants, and whether even high fidelity programs lead to effective outcomes. Little evidence exists regarding costs, cost savings, and potential return on investment of such programs. These are the gaps in knowledge CASAHOPE will inform.

The current paper focuses specifically on results from the baseline interview with tenants conducted by CASA* research staff in 2008 and 2009. This paper presents key characteristics of tenants served, including demographics, alcohol and drug use, housing history, physical and mental health, criminal justice involvement, and employment history.

**The National Center on Addiction and Substance Abuse at Columbia University is neither affiliated with, nor sponsored by, the National Court Appointed Special Advocate Association (also known as "CASA") or any of its member organizations with the name of "CASA."*

CHAPTER II

METHODS

The Sample

Three hundred and fifty-eight tenants were interviewed, representing 65% of the total 550 Population E tenants who had been housed by August 2009. Of the 192 tenants housed but not interviewed, 11 refused to participate in the interview and 94 were ineligible for the study because they were housed prior to the NY/NY III agreement. The remaining 87 tenants either did not respond to invitations to participate or were not interviewed because a sufficient number of tenants at their agency had already been interviewed, as described below.

New York City's Human Resources Administration (HRA) processed all applications from potential Population E clients, which were primarily submitted by shelters and outreach teams (Appendix A). The original eligibility criteria for Population E required that tenants be chronically homeless single adults with a substance abuse disorder that was a primary barrier to independent living and who also had a disabling clinical condition. Chronic homelessness was defined as living in a shelter or on the street for at least 12 out of the last 24 months or 2 out of the last 4 years, not necessarily consecutively. The disabling clinical condition was defined as any clinical condition serious enough to be a barrier to independent living, such as a physical illness (e.g. heart problems, Hepatitis C, etc.), mental health issues (including depression, mood, and anxiety disorders but not severe and persistent mental health issues), cognitive impairments or developmental disabilities. On April 13, 2009, the eligibility requirements were changed: (1) potential tenants no longer needed a disabling clinical condition to be considered for Population E and (2) the definition of chronic homelessness was changed to include individuals who have been homeless only 6 of the previous 12 months.

Formal selection criteria for the study were as follows: participants were included if they were in Population E and housed after the NY/NY III agreement. Ninety-four tenants in Population E had already been housed prior to NY/NY III through pre-existing scattered-site programs and were grandfathered into Population E. These tenants were not interviewed, as they had been stably housed for over one year when the study began. To collect a more representative sample, the three agencies housing more than 60 tenants apiece were each limited to 60 tenant interviews. Sample size from each agency ranged from 7-62 clients.

The mean age (48.32) and percentage of males (88%) of our sample were equivalent to the mean age (48) and percentage of males (87%) of the entire Population E at the time of the study (New York City Human Resources Administration, 2009).

Procedures

Tenants entering Population E consented to have their housing agencies share their new contact information with CASAHOPE researchers. Tenants were contacted by letter, telephone call, and/or home visit to invite them to participate in the study. Tenants who consented were interviewed by trained staff, on average two months after their initial move-in date (range 0 to 439 days). Tenants could choose to have the 45-minute interview conducted in their homes or any other location including coffee shops, restaurants, or parks. Participants were compensated for their time with a choice of public transit vouchers or gift cards to restaurants, movie theaters, and stores with an approximate value of \$25 for those who completed the interview at or near home and \$50 for those who traveled to complete the interview. Procedures were reviewed and approved by the governing Institutional Review Board (IRB) at CASA.

Measurement

All participants were administered a battery of standardized measures by trained interviewers upon enrollment in the study (Appendix B). Measures were selected to assess: a) demographics, b) substance use problems, c) physical health, d) mental health, e) housing history, f) employment skills and work history, and g) barriers to employment. Assessments for substance use problems included contemplation ladders for readiness to abstain from alcohol and drugs (Hogue, A., Dauber, S., & Morgenstern, J., 2010), prior treatment history, the alcohol and drug abuse and dependence modules of the Mini-International Neuropsychiatric Interview (MINI; Sheehan et al., 1998), and select questions from the Alcohol Use Disorders Identification Test (AUDIT; Saunders, Aasland, Babor, De La Fuente, & Grant, 1993) and the Drug Use Questionnaire (DUQ; Hien & First, 1991). Physical and mental health was assessed using the SF-12 health status questionnaire (SF-12; Ware, Kosinski, & Keller, 1996) and the Borderline Symptoms Inventory (Mann, Wise, Segall, Goldberg, & Goldstein, 1988). Partial measures were administered from the Treatment Services Review (TSR; McLellan, Alterman, Cacciola, Metzger, & O'Brien, 1992), contemplation ladder for job readiness (modified from Biener & Abrams, 1991; Rustin & Tate, 1993), and Job Skills Inventory and Barriers to Employment (modified from Danziger, S. et al., 2002).

CHAPTER III

DEMOGRAPHICS

Table 1. Study participant demographics (n = 358)

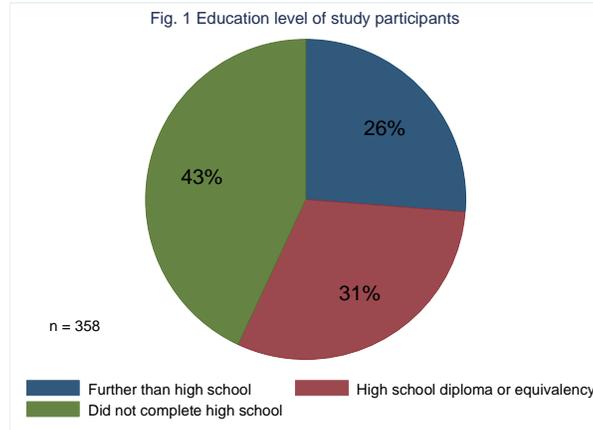
	No.	%
Age, mean (SD)	48(10)	
Male	315	88
Race/ethnicity		
African American	221	62
Latino only	54	15
Other race/multiple races	27	8
White	56	16
Veterans ^a	32	14
Education		
Less than high school	154	43
High school diploma or equivalency	110	31
Greater than high school	94	26
Public benefits		
Social security income	59	16
Social security disability	23	6
Public assistance	229	65
Social security income-applied ^b	56	15
Social security disability-applied ^b	8	2
Public assistance-applied ^b	17	5

^a237 people were asked this question

^bApplied but not currently receiving benefits

Nearly two-thirds of tenants housed in the Population E category of the NY/NY III program were interviewed. The majority of study participants (55%) were African American males. There was, however, a sizable minority of White and Hispanic males who together constitute one quarter of participants. The majority of participants had completed high school (Fig. 1) and over three fourths were receiving public assistance or social security income. The average age of study participants was 48 years old, with three quarters of the sample being between the ages of 40 and 59 years old.

Nine agencies provided supportive housing to NY/NY III Population E tenants. There were no statistically meaningful differences among providers in tenants' age, ethnicity, or substance use diagnosis.



Questions about veteran status were added to the baseline interview for the last two-thirds of the participant sample. Fourteen percent of those interviewed were veterans. Of the 32 reported veterans 4 served in Vietnam, 1 served in World War II and Korea, and 27 were not involved in any active combat. Four participants reported receiving veteran's benefits.

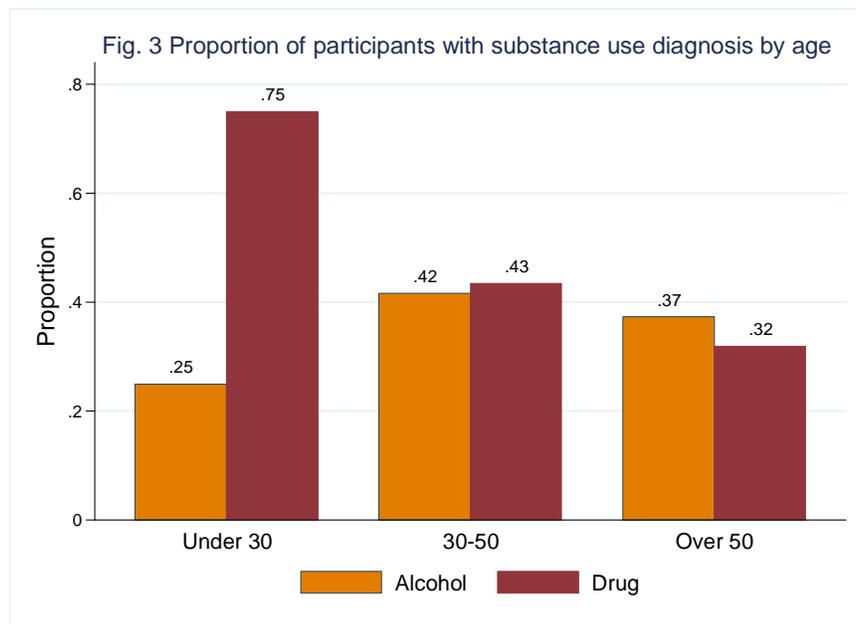
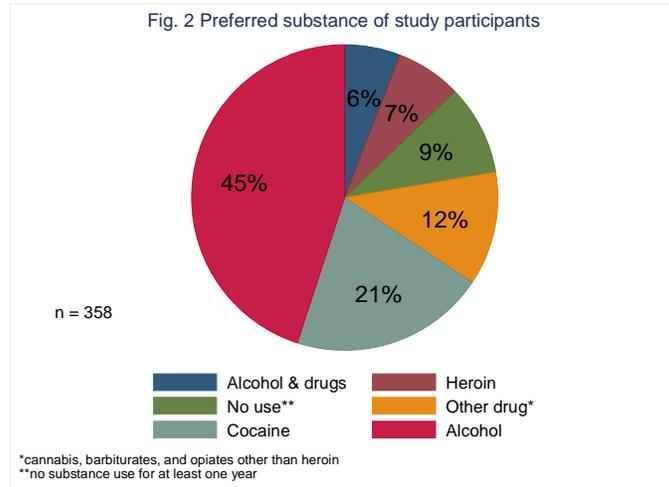
CHAPTER IV

ALCOHOL AND DRUG USE

Table 2. Alcohol and substance use disorders of study participants

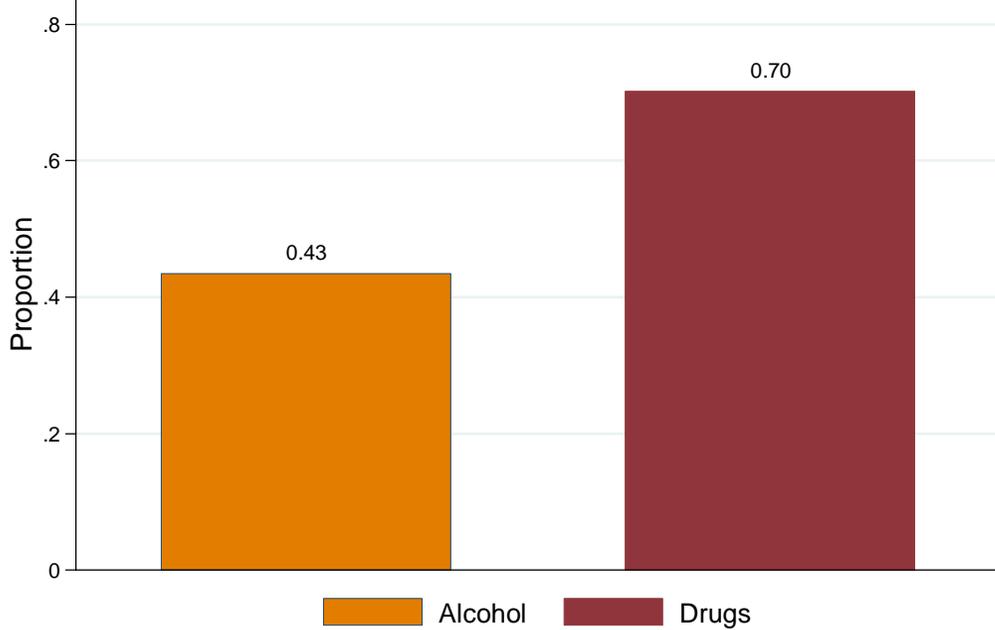
	No.	%
Preferred substance		
Alcohol	161	45
Cocaine	74	21
Heroin	25	7
Other drugs	43	12
Alcohol and drugs	21	6
Six or more drinks in one sitting		
never	198	55
less than monthly	43	12
monthly	28	8
weekly	51	14
daily or almost daily	38	11
Alcohol or drug use disorders		
Alcohol dependence only	63	18
Alcohol abuse only	11	3
Drug dependence only	59	16
Drug abuse only	19	5
Alcohol & drug disorder	66	18
Currently in treatment	102	28
Treatment in the last 5 years	245	68
Number of times in treatment past 5 years mean(SD)	3.7(4.3)	

Tenants enrolled in our study reported a range of substance use behaviors. For example, 11% of participants were heavy drinkers while 26% reported that they did not drink at all. The most commonly used drugs were marijuana (25% of participants) and crack cocaine (17%). Alcohol and drug abuse and dependence was assessed using the MINI, which focuses on substance related problems experienced in the previous 12 months. The majority of study participants met DSM-IV diagnostic criteria for an alcohol or drug use disorder in the past year. Of those who did not meet criteria, many were active drug users (26%) or heavy drinkers (9%), and most (81%) had undergone substance abuse treatment in the past. Among those with a substance use disorder, the type of substance use diagnosis varied by age. Alcohol use disorders were more common in tenants over 50 years old. Drug use disorders were more common for tenants younger than 30 (Fig. 3).



We measured the readiness of tenants to change their substance use behavior. The motivation assessment takes into account both current use and how close subjects are to a decision to quit using. Tenants with drug use disorders were almost two times more likely than those with an alcohol use disorder to have motivation to quit (Fig. 4). Participant readiness for treatment has been shown to be a reliable predictor of participation in treatment (Hogue, Dauber, & Morgenstern, 2010). This may explain why there were nearly two times as many participants with drug use disorders in a formal treatment program as those with alcohol disorders. As a whole, the sample was not naïve to treatment. Essentially, two thirds of tenants had been in treatment during 4 of the previous 5 years.

Fig. 4 Participants with a substance use diagnosis who are motivated to change their usage behavior*



*motivation takes into account current use and how close respondents are to a decision to quit

CHAPTER V

HOUSING

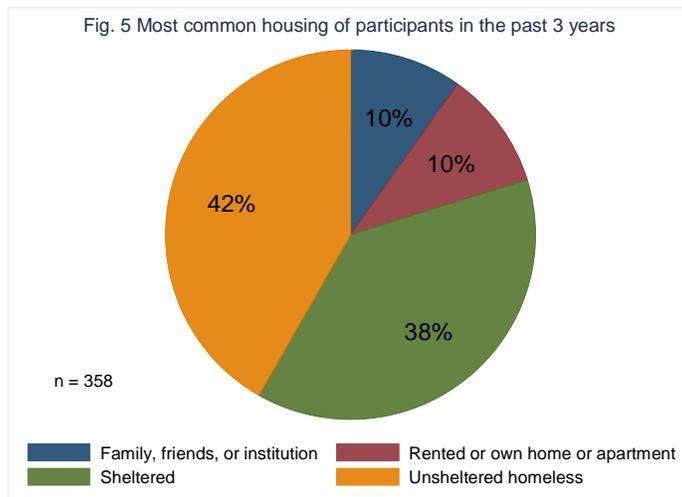
Table 3. Housing characteristics of study participants

	No.	%
Most common housing in the last 3 years		
Rented or own home or apartment	37	10
Shelter	136	38
Unsheltered homeless	149	42
Friends, family or treatment center	35	10
Last time client lived in the same place for over 3 months		
past 6 month	73	20
6 months < x < 1 year ago	16	4
1-3 years ago	81	23
> 3 years ago	186	52

Table 4. Characteristics of study participants whose most common living arrangement was shelter (n=136) or street (n=149) homeless

	shelter		street	
	No.	%	No.	%
Race/ethnicity				
African American	72	0.55	106	0.78
Latino	29	0.22	14	0.10
White	30	0.23	16	0.12
Alcohol or substance use diagnosis	74	54	104	70
6 or more drinks in one sitting				
Never	83	0.61	68	0.46
Less than monthly	18	0.13	15	0.01
Monthly	8	0.06	14	0.09
Weekly	17	0.13	28	
Daily or almost daily	10	0.07	24	0.16

Most study participants reported long periods of housing mobility. In the last three years, half of participants had lived at least three months in the same house or apartment (Fig. 5). Looking at the previous year only, one fourth of the population lived three months in the same house or apartment. The majority of participants (62%) spent the previous year on the streets or in a shelter.



There were significant differences among tenants who spent the greater part of the last three years in a shelter versus on the street. Unsheltered homeless were more likely to be African American. They were also more likely to have a substance use diagnosis and two times more likely to be heavy drinkers than participants who lived in shelters.

CHAPTER VI

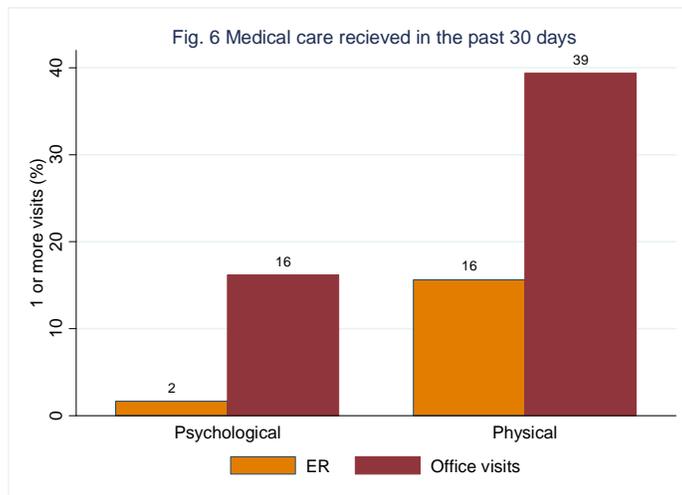
PHYSICAL AND MENTAL HEALTH

Table 5. Physical and mental health of study participants

	No.	%
SF-12 ^a mean (SD)		
Physical health composite score	41.5 (12)	
Mental health composite score	47.5 (12)	
Visited the emergency department in the last 30 days		
For medical condition	56	16
For psychological condition	6	2
Visited professional in office in the last 30 days		
For medical condition	141	39
For psychological condition	58	16
Chronic conditions		
1	91	25
> 1	146	40
Most common chronic conditions		
Hypertension	60	17
Back pain	54	15
Arthritis	51	14

^aThe SF-12 is a twelve question survey used to measure health status.

Participant responses to the SF-12 health survey were standardized to the mean score of the United States population. The average physical health score was lower than most people in the United States. The poor physical health of tenants is demonstrated by the relatively large number of people who reported visiting a doctor's office (39%) or emergency department (16%) in the previous 30 days (Fig. 6). When tenants were asked if they had any chronic medical condition that continued to interfere with their life, 65% reported at least one chronic medical condition.



Using the SF-12, participants were asked how emotional difficulties influenced their well-being and ability to work or participate in other activities. The mental health score of our study population was near the mean of the U. S. population. There were substantial numbers of tenants (25%) who were prescribed psychiatric medications in the last year. Most of these tenants (85%) reported taking their medication every day in the previous month. Thus, while tenants did report receiving help for emotional health, it seems the difficulties did not generally qualify participants as SPMI.

CHAPTER VII

CRIMINAL JUSTICE

Table 6. Criminal justice history of study participants

	No.	%
Ever incarcerated	230	64
Life time months incarcerated mean (SD)	54(73)	
Arrest or incarceration in the last year	131	37
Currently on probation or parole	15	4

A substantial number of participants had recent involvement with the criminal justice system. Well over one-third had been arrested, detained or incarcerated in the previous year. Nearly two-thirds had been arrested in their lifetimes, and the average time incarcerated was 4.5 years. At the time of interview very few participants (4%) were on probation or parole. Interestingly, those who met criteria for a drug disorder were significantly more likely to have been arrested, detained, or incarcerated in the previous year than those who met criteria for an alcohol disorder. This suggests that much of the sample's criminal justice involvement was related to illegal drug use.

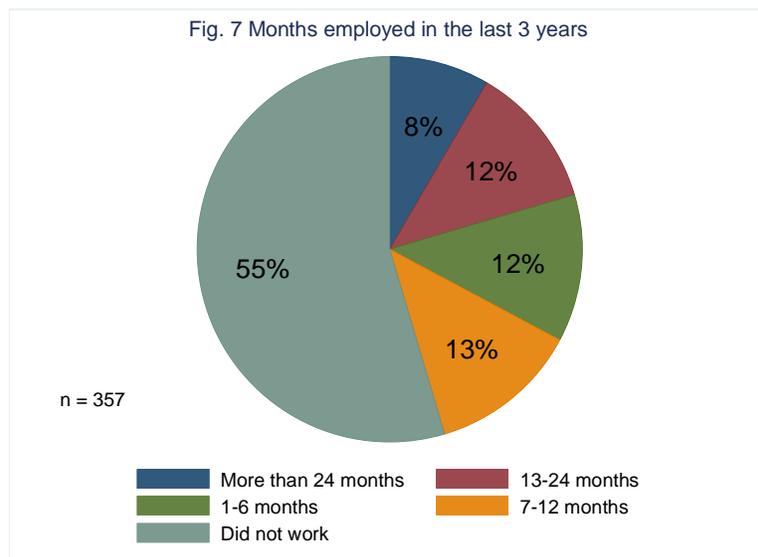
CHAPTER VIII

EMPLOYMENT

Table 7. Employment characteristics of study participants

	No.	%
Employment in the last 3 years		
Did not work	196	55
1-6 months	44	12
7-12 months	45	13
13-24 months	43	12
More than 24 months	30	8
Work on or off the books in the last 30 days		
	85	24
Most often endorsed barriers to employment		
Poor health, physical disability	127	35
Lack of training, skills or experience	34	9
Own drug or alcohol	23	6

Tenants reported that their primary barrier to employment was physical disability, which was four times more likely to be endorsed than the second-highest ranked barrier, lack of necessary skills or experience. When participants were given a list of common job skills, such as talking on the phone to customers, word processing, data entry, and working with a cash register, 69% of participants identified three or more skills they had used on the job. However, endorsing basic jobs skills did not necessarily translate into finding employment. Whereas one-fourth of study participants worked on or off the books in the previous 30 days, more than half had not worked at all in the previous three years (Fig.7). When asked if they had looked for work in the past 30 days, only 25% of the sample reported doing so.



CHAPTER IX

DISCUSSION

Cities and housing agencies across the country are looking to include elements of a ‘low barrier’ approach into plans to end homelessness. NY/NY III’s Population E housing is the first to create large numbers of scattered-site Housing First units for homeless persons without serious and persistent mental illness (SPMI) who actively use alcohol or drugs. Overall, the findings presented in this paper indicate that those placed in NY/NY III Population E were experiencing high rates of substance abuse and dependence, long-term unstable housing, serious medical conditions, incarceration, and unemployment. These problems are traditional obstacles to self-sufficient living and can be associated with high costs to the public.

The study sample had a slightly higher percentage of African-Americans compared to that reported in a study of homeless single adults in New York City, but gender rates were nearly identical (Levitt et al., 2009). The large number of male study participants reflects the fact that men make up about 75% of the chronically homeless population in the United States (Caton, Wilkins, & Anderson, 2007).

The study sample also had a higher rate of enrollment in public benefits than is found in the broader homeless population in New York City, which may be due to case managers’ persistent efforts to help tenants apply for benefits before and after entering housing (Levitt et al., 2009). The percentage of study participants receiving supplemental social security income (SSI) or social security disability insurance (SSD) is considerably lower than rates reported in similar studies of Housing First for tenants with serious mental illness (Pearson et al., 2007). In the Housing First model tenants are required to contribute 30% of their income to rent. For participants in our study, this contribution generally comes from public assistance; however, studies of supportive housing for the mentally ill report that this contribution largely comes from SSI or SSD (Kertesz et al., 2009). This distinction is important when considering program implementation and costs and will be discussed further in future papers.

The mean age of participants in our study was the same as the mean age for participants in Housing First programs in many different regions of the country (Larimer et al., 2010; Mares & Rosenheck, 2010; Sadowski et al., 2009). In addition, the mean age of our sample was similar to that of all persons placed in Population E housing (48), as reported by New York City’s Human Resources Administration (HRA) August 2009 Progress Report. It is noteworthy that Population E is the oldest population among the nine categories of NY/NY III housing (HRA, 2009). It may be that older substance using homeless persons are more willing or able to access this housing than their younger counterparts. It seems likely that older persons are more susceptible to chronic illness and/or fatigue with the streets and therefore less inclined to remain homeless and more agreeable to the housing intake process. Interestingly, among those with a substance

use disorder, alcohol use disorders were more common in tenants over 50 years old and drug use disorders were more common for tenants younger than 30, a finding in line with previous research (Hecht & Coyle, 2001).

As expected, prevalence of substance use disorder was higher than rates reported among the general homeless population (Levitt et al., 2009; Milby et al., 1996). While not all tenants met diagnostic criteria for alcohol or drug use disorders, almost all were active drug users and/or drinkers and had a history of substance use problems. It is possible that the tenants interviewed might not represent the most severely addicted homeless persons in New York City. Although Population E housing has fewer barriers to entrance than traditional supportive housing, tenants must still be available and willing to cooperate with program workers. The most severely addicted may have trouble tolerating an intake process of any kind. It is also possible that the study sample is an accurate reflection of substance use severity among the chronically homeless in New York City. We could find no study published within the last decade that reported on the range of substance use severity among chronically homeless substance users in New York City.

It is important to note that tenants may have under-reported their substance use. Self-report of substance use can be prone to reporting bias, and this may be particularly true for those housed in Population E. While sobriety is not a requirement of the housing, tenants may be accustomed to programs with punitive consequences for alcohol or drug use, and thus fearful that reporting use will lead to eviction. Also, on average, interviews were conducted 2 months after the tenant was housed. It is possible that delay between housing and interview date decreased the magnitude of substance use problems reported by the sample, as tenants may have already begun stabilizing their substance use in the first months of housing prior to the interview.

Over half of the tenants entering Population E expressed desire to quit drinking or using drugs altogether, suggesting that they may be willing to engage in behavioral change interventions. Tenants with drug use disorders were almost two times more likely than those with an alcohol use disorder to have motivation to quit. This may be due to the perceived higher consequences of drug use, for example increased risk of criminal justice involvement and overdose. At the time of interview- roughly a quarter of the sample was in substance use treatment. This may be true in part because the majority of the sample was receiving public assistance benefits from New York City's Human Resources Administration (HRA), which requires those who report misusing substances to attend treatment.

Tenants who spent the last year on the streets were more likely to have a substance use diagnosis and be heavy drinkers than those who stayed primarily in shelters. This may be because drugs and alcohol are generally banned from shelters and more readily found in the streets, or because social support networks on the street are often organized around substance use. This finding is congruent with previous research and

suggests that formerly street-homeless tenants may need additional or more intensive case management services compared to those coming from shelters (Levitt et al., 2009).

While the mental health of our study population was near average for the general population, one might expect our sample to report comparatively more psychological difficulties. Previous studies have found that 15-50% of chronically homeless adults have a history of mental illness (Burt et al., 1999; SAMHSA, 2003; Tsemberis et al., 2004). Because Population E was not designed to house persons with serious and persistent mental illness, it is likely that individuals with SPMI who might otherwise have been eligible for Population E were diverted to another NY/NY III housing population specifically targeted for those with mental illness. Tenants' physical health was considerably worse than the general population, in line with previous study findings among the chronically homeless (Mares & Rosenheck, 2010). Because poor physical health is often associated with utilization of high-cost health care services, we will describe cost analysis findings in future papers.

This sample also had high rates of involvement in the criminal justice system. Lifetime rates of incarceration were slightly higher than reported in other studies of the single adult homeless population (Burt et al., 1999; Levitt et al., 2009). This is likely connected to tenants' substance use, as substance-related offenses make up 50% of all arrests of homeless individuals (Snow et al., 1989). Accordingly, those tenants who met criteria for a drug disorder were significantly more likely to have been arrested, detained, or incarcerated in the last year than those who met criteria for an alcohol disorder. Information on the cost of the population's criminal justice involvement will also be included in future papers.

Only a small portion of the sample reported working or looking for work in the past 30 days. This may be related to the serious barriers to employment characterizing this sample, particularly poor physical health, or because tenants are still new to housing and not yet looking for work. We will revisit this question in subsequent papers.

Broadly speaking, participants in this study are representative of a disenfranchised population with diminished social capital. They had relatively low educational attainment, limited work histories, and reported significant barriers to employment. These individuals had been living at the margins of society for long periods of time. Study data confirm that they clearly fit the profile of clients who could benefit from supportive housing.

Limitations

Findings are limited by the study design, which assessed substance using homeless persons without serious and persistent mental illness (SPMI) housed in New York City and thus can be generalized only to other urban areas. It is also important to note that the tenants housed in this program may not be representative of all potentially

program-eligible persons in New York City. While Population E housing is low-threshold housing, prospective tenants need to be both accessible to outreach workers who are familiar with the program and capable of attending an initial interview with provider staff. More impaired or disenfranchised individuals may not have been able or willing to navigate this process. In addition, all study data were generated from tenant self-report assessments. As discussed above, self-report of substance use can be particularly prone to reporting bias. Finally, because these tenants were often hard to reach and difficult to schedule, interviews were completed, on average, 2 months after participants were housed. While this reflects a still early phase of housing, it is possible that some tenant characteristics, such as entitlements receipt and substance use, had already been affected by housing itself and by case management services from provider agencies.

Next Steps

This paper is the first in a series that will utilize data from multiple sources, including tenants, program staff, key stakeholders, and government administrative databases, to investigate the unique work being done by Population E housing providers. CASA and CSH will deliver the next paper in the series, a joint investigation of program implementation, in the second half of 2011. This paper will describe fundamental features of effective Population E housing programs, summarize how different programs implemented different aspects of the Housing First model, and provide recommendations for future implementation of similar programs for substance users. Subsequent papers in late 2011 and 2012 will answer key questions about tenant housing stability, functioning, and service receipt after one year of housing as well as the economic impact of the initiative.

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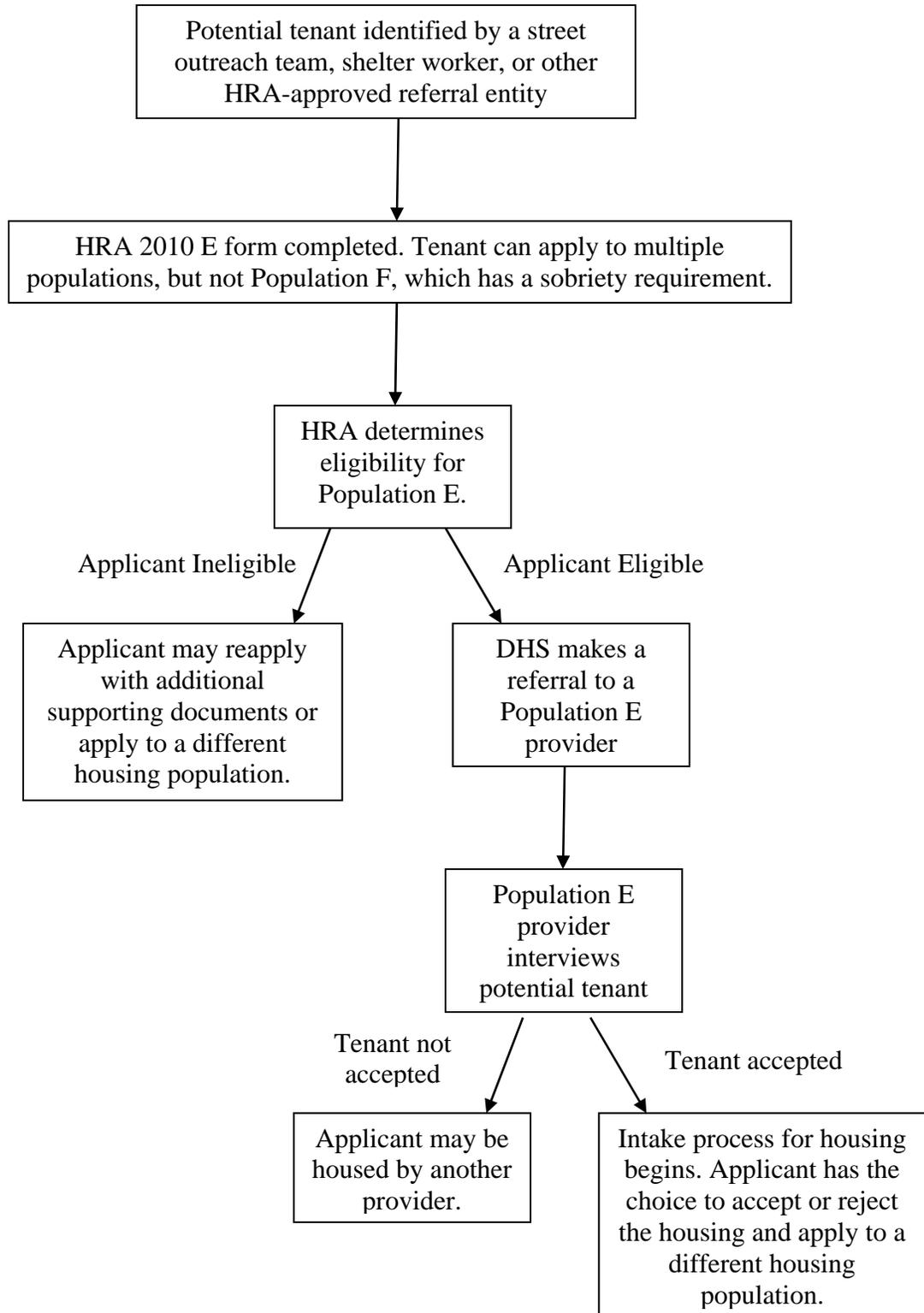
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Appendix A

Process to House NY/NYIII Population E Tenant



Q7. In addition to being hispanic, do you also consider yourself to be any of the following races? (Choose one)

- White
- Black, African American, or Negro
- American Indian or Alaskan Native
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Some other race
- More than one race
- I am hispanic only.
- Don't Know
- Refuse to Answer

Q8. Which best describes your educational background? (Choose one)

- Did not complete high school
- GED
- High School Diploma
- Some college or Associates Degree
- Bachelor's Degree
- Masters, doctoral, or other professional degree
- Don't Know
- Refuse to Answer

Q9. What types of public assistance do you currently receive? (Check all that apply)

- SSI
- Welfare
- SSD
- Applied SSI
- Applied Welfare
- Applied SSD
- Don't Know
- Refuse to Answer
- Not Applicable

- Q16. Are you a veteran?
- Yes
 - No
 - Don't Know
 - Refuse to Answer
 - Not Applicable
- Q17. Do you receive veterans benefits?
- Yes
 - No
 - Don't Know
 - Refuse to Answer
 - Not Applicable
- Q18. Were you in combat?
- Yes
 - No
 - Don't Know
 - Refuse to Answer
 - Not Applicable
- Skip to Q20***
- Skip to Q20***
- Q19. In which wars were you in combat? (Check all that apply)
- World War II
 - Korean War
 - Vietnam
 - First Gulf War
 - Iraq War
 - Afghanistan War
 - Other
 - Don't Know
 - Refuse to Answer
 - Not Applicable

Alcohol and Drug Questions

- Q20. Of drugs and alcohol, which is a bigger problem for you? (Choose one)
- Neither
 - Drugs
 - Alcohol
 - Both are equal
 - Don't Know
 - Refuse to Answer

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.

Q21. During the past 30 days, how many days did you have 3 or more drinks of alcohol (including beer and wine) in one sitting?

— —
Don't Know
Refuse to Answer

Q22. How many drinks containing alcohol do you have on a typical day when you are drinking? (Choose one)

Does not drink
1 or 2
3 or 4
5 or 6
7, 8, or 9
10 or more
Refuse to Answer

Q23. How often do you have six or more drinks on one occasion? (Choose one)

Never
Less than monthly
Monthly
Weekly
Daily or almost daily
Don't Know
Refuse to Answer

If Q21 + Q22 + Q23 is equal to 0, then skip to Q25.

Q24. Please select the response which best describes how you currently feel about your drinking. (Choose one)

- 01 I do not have a problem with drinking, and I do not intend to cut down or quit now.
 - 02 I might have a problem with drinking, but I do not intend to cut down or quit now.
 - 03 I am thinking about cutting down on my drinking, but I am not thinking about quitting drinking altogether.
 - 04 I am thinking about quitting drinking altogether, but I still have not made any definite plans.
 - 05 I am close to making a decision to quit drinking alcohol.
 - 06 I have decided to quit drinking alcohol, at least for now.
 - 07 I have decided to quit drinking alcohol and plan never to drink again.
- Don't Know
Refuse to Answer

Q25. In the past 12 months, have you had 3 or more alcoholic drinks in one sitting?

Yes
No *Skip to instruction before Q38*
Refuse to Answer

Q26. In the past 12 months did you have 3 or more drinks in one sitting on 3 or more occasions?

Yes

No

Skip to instruction before Q38

Refuse to Answer

Q27. In the past 12 months did you need to drink more in order to get the same effect that you got when you first started drinking?

Yes

No

Don't Know

Refuse to Answer

Q28. In the past 12 months when you cut down your drinking, did your hands shake, did you sweat or feel agitated? Did you drink to avoid these symptoms or to avoid being hungover, for example, "the shakes," sweating, or agitation?

Yes

No

Don't Know

Refuse to Answer

Q29. In the past 12 months during times when you drank alcohol, did you end up drinking more than you planned when you started?

Yes

No

Don't Know

Refuse to Answer

Q30. In the past 12 months have you tried to reduce or stop drinking alcohol but failed?

Yes

No

Don't Know

Refuse to Answer

Q31. In the past 12 months on the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or recovering from the effects of alcohol?

Yes

No

Don't Know

Refuse to Answer

Q32. In the past 12 months did you spend less time working, enjoying hobbies, or being with others because of your drinking?

Yes

No

Don't Know

Refuse to Answer

Q33. In the past 12 months have you continued to drink even though you knew that the drinking caused you health or mental problems?

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

If Q27 + Q28 + Q29 + Q30 + Q31 + Q32 + Q33 is not less than 3, then skip to instruction before Q38.

If Q27 + Q28 + Q29 + Q30 + Q31 + Q32 + Q33 is less than 3, then skip to Q34.

If MINIADT is greater than 2 then skip to Q34

If not, then skip to Q34.

Q34. In the past 12 months, have you been intoxicated, high, or hungover more than once when you had other responsibilities at school, at work, or at home? Did this cause any problems?

Interviewer: Code this item **YES** only if this caused problems.

- Yes
- No
- Refuse to Answer

Q35. In the past 12 months, were you intoxicated more than once in any situation where you were physically at risk, for example, driving a car, riding a motorbike, using machinery, boating, etc?

- Yes
- No
- Refuse to Answer

Q36. In the past 12 months, did you have legal problems more than once because of your drinking, for example, an arrest or disorderly conduct?

- Yes
- No
- Refuse to Answer

Q37. In the past 12 months, did you continue to drink even though your drinking caused problems with your family or other people?

- Yes
- No
- Refuse to Answer

This next set of questions is about your use of specific drugs over the past 30 days, including today.

Q38. In the past 30 days, were there any days that you used marijuana?

- Yes
- No **Skip to Q40**
- Don't Know
- Refuse to Answer

Q39. How many days in the past 30 have you used Marijuana? — —
Don't Know
Refuse to Answer

Q40. In the past 30 days, were there any days that you used cocaine/crack?
Yes
No **Skip to Q42**
Don't Know
Refuse to Answer

Q41. How many days in the past 30 have you used cocaine/crack?
— —
Don't Know
Refuse to Answer

Q42. In the past 30 days, were there any days that you used heroin?
Yes
No **Skip to instruction before Q44**
Don't Know
Refuse to Answer

Q43. How many days in the past 30 have you used Heroin? — —
Don't Know
Refuse to Answer

If Q40 + Q42 is equal to 0, then skip to Q45.

Q44. Have you used needles (a set of "works") to shoot drugs in the past 30 days? (Choose one)
No
Yes: for cocaine
Yes: for heroin
Yes: For cocaine and heroin
Refuse to Answer

Q45. In the past 30 days, were there any days that you used illegal or non-prescribed methadone?
Yes
No **Skip to Q47**
Don't Know
Refuse to Answer

Q46. How many days in the past 30 have you used illegal or non-prescribed Methadone?
— —
Don't Know
Refuse to Answer

Q47. In the past 30 days, were there any days that you used Crystal Meth (Tina, Ice, Meth)?

Yes

No

Skip to instruction before Q49

Don't Know

Refuse to Answer

Q48. How many days in the past 30 have you used Crystal Meth (Tina, Ice, Meth)?

— —

Don't Know

Refuse to Answer

If Q40 + Q47 + Q38 + Q42 is equal to 0, then skip to Q50.

Q49. Please select the response which best describes how you currently feel about your drug use. (Choose one)

I do not have a problem with drugs, and I do not intend to cut down or quit now.

I might have a problem with drugs, but I do not intend to cut down or quit now.

I am thinking about cutting down on drug use, but I am not thinking about quitting drugs altogether.

I am thinking about quitting using drugs altogether, but I still have not made any definite plans.

I am close to making a decision to quit using drugs.

I have decided to quit using drugs, at least for now.

I have decided to quit using drugs and plan never to use drugs again.

Don't Know

Refuse to Answer

Q50. In the past 12 months, did you take any of these drugs more than once to get high, to feel better, or to change your mood?

Heroin, methadone(illegal), other opiates/analgesics (percocet, diluaded), barbiturates, other sedatives (valium, librium, xanax), cocaine, amphetamines, cannabis, hallucinogens, or inhalants.

Yes

No

Skip to instruction before Q63

Refuse to Answer

Q51. Which substance has caused you the most serious problems, such as problems with family, friends, or the law; problems feeling dependent on the drug, or health or emotional problems? (Choose one)

- Heroin
- Methadone, illegal
- Other opiates/analgesics
- Barbiturates, all routes
- Other sedatives/hypnotics/tranquilizers
- Cocaine
- Amphetamines
- Cannabis
- Hallucinogens
- Inhalants
- Refuse to Answer

Q52. Considering the [Response to Q51], in the past 12 months, have you found that you needed to use more [Response to Q51] to get the same effect that you did when you first started taking it?

- Yes
- No
- Refuse to Answer

Q53. When you reduced or stopped using [Response to Q51], did you have withdrawal symptoms (aches, shaking, fever, weakness, nausea, sweating, heart pounding, difficulty sleeping, or feeling agitated, anxious, irritable, or depressed) Did you use and drug(s) to keep yourself from getting sick (withdrawal symptoms) or so that you would feel better?

Interviewer: If "Yes" to either question, code as "Yes"

- Yes
- No
- Refuse to Answer

Q54. Considering the [Response to Q51], in the past 12 months have you often found that when you used [Response to Q51], you often ended up taking more than you thought you would?

- Yes
- No
- Refuse to Answer

Q55. Considering the [Response to Q51], in the past 12 months have you tried to reduce or stop taking [Response to Q51], but failed?

- Yes
- No
- Refuse to Answer

Q56. Considering the [Response to Q51], in the past 12 months on the days that you used [Response to Q51], did you spend substantial time (> 2 hours) in obtaining, using or in recovering from [Response to Q51], or thinking about [Response to Q51]?

- Yes
- No
- Refuse to Answer

Q57. Considering the [Response to Q51], in the past 12 months did you spend less time working, enjoying hobbies, or being with others because of your [Response to Q51] use?

- Yes
- No
- Refuse to Answer

Q58. Considering the [Response to Q51], in the past 12 months have you continued to use [Response to Q51] even though it caused you health or mental problems?

- Yes
- No
- Refuse to Answer

If Q52 + Q53 + Q54 + Q55 + Q56 + Q57 + Q58 is not less than 3, then skip to instruction before Q63.

If Q52 + Q53 + Q54 + Q55 + Q56 + Q57 + Q58 is less than 3, then skip to Q59.

If MINIDDT is greater than 2 then skip to Q59

If not, then skip to Q59.

Q59. Considering your use of [Response to Q51], in the past 12 months, have you felt intoxicated, high, or hungover from [Response to Q51] more than once, when you had responsibilities at school, work, or at home? Did this cause any problem?

Interviewer: Code YES only if caused problems.

- Yes
- No
- Refuse to Answer

Q60. Have you been high, or intoxicated from [Response to Q51] in the past 12 months, more than once in any situation where you were physically at risk, (for example, driving a car, riding a motorbike, using machinery, boating, etc.)?

Interviewer: If "Yes" to either question, code as "Yes"

- Yes
- No
- Refuse to Answer

Q61. Considering the [Response to Q51], in the past 12 months did you have legal problems more than once because of your drug use, for example, an arrest or disorderly conduct?

- Yes
- No
- Refuse to Answer

Q62. Considering the [Response to Q51], in the past 12 months did you continue to use [Response to Q51] even though it caused problems with your family or other people?

Yes
No
Refuse to Answer

If MINIDAT is greater than 0 then skip to instruction before Q63

If not, then skip to instruction before Q63.

The following set of items asks about your experiences with treatment for alcohol and/or drug abuse. When responding to these items, please consider treatments such as detox, outpatient, residential, or methadone maintenance as treatment. Do not count AA or NA.

Q63. Have you ever been in treatment for alcohol or drug abuse? Treatment includes detox, outpatient, residential, or methadone maintenance, but not NA or AA.

Yes
No ***Skip to Q68***
Don't Know
Refuse to Answer

Q64. Have you been in treatment for alcohol or drug abuse in the past 5 years?

Yes
No ***Skip to Q68***
Don't Know
Refuse to Answer

Q65. How many times have you been treated for alcohol or drug abuse in the past 5 years? Please count all episodes of detox, rehab, outpatient, residential, and methadone maintenance. Do not count NA or AA.

— —
Don't Know
Refuse to Answer

Q66. Are you currently in drug or alcohol treatment such as detox, outpatient, residential or methadone maintenance, but not NA or AA?

Yes
No ***Skip to Q68***
Refuse to Answer

Q67. What kind of treatment program are you in? (Choose one)

Drug and/or alcohol treatment only
Methadone Maintenance Only
Both: Drug and/or alcohol AND Methadone
Don't Know
Refuse to Answer
Not Applicable

Q68. Have you attended any self-help groups such as AA, NA, CMA, or CA in the past 30 days?

Yes

No

Skip to instruction before Q70

Don't Know

Refuse to Answer

Q69. How many days have you attended self-help groups such as AA, NA, CMA, CA in the past 30 days?

— —

Don't Know

Refuse to Answer

Health Questions

The following questions ask for your views about your health. This information will help us keep track of how you feel and how well you are able to do your usual activities. Please answer every question by using your mouse to point to and click on the answer you have selected. If you are unsure about how to answer a question, please give the best answer you can.

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Q70. In general would you say your health is: (Choose one)

Excellent

Very Good

Good

Fair

Poor

Refuse to Answer

Q71. During a typical day, does your health now limit you in moderate activities: such as moving a table, pushing a vacuum cleaner, bowling or playing golf? (Choose one)

Yes, limited a lot.

Yes, limited a little.

No, not limited at all.

Refuse to Answer

Q72. During a typical day, does your health now limit you in climbing several flights of stairs? (Choose one)

Yes, limited a lot.

Yes, limited a little.

No, not limited at all.

Refuse to Answer

- Q73. During the past 4 weeks, how much of the time have you accomplished less than you would like as a result of your physical health? (Choose one)
- All of the Time
 - Most of the time
 - Some of the time
 - A little of the time
 - None of the time
 - Refuse to Answer
- Q74. During the past 4 weeks, how much of the time were you limited in the kind of work or other activities as a result of your physical health? (Choose one)
- All of the Time
 - Most of the time
 - Some of the time
 - A little of the time
 - None of the time
 - Refuse to Answer
- Q75. During the past 4 weeks, how much of the time have you accomplished less than you would like as a result of emotional problems (such as feeling depressed or anxious)? (Choose one)
- All of the Time
 - Most of the time
 - Some of the time
 - A little of the time
 - None of the time
 - Refuse to Answer
- Q76. During the past 4 weeks, how much of the time did you not do work or other activities as carefully as usual as a result of any emotional problems (such as feeling depressed or anxious)? (Choose one)
- All of the Time
 - Most of the time
 - Some of the time
 - A little of the time
 - None of the time
 - Refuse to Answer
- Q77. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Choose one)
- Not at all
 - A little bit
 - Moderately
 - Quite a bit
 - Extremely
 - Refuse to Answer

Q78. How much of the time during the past 4 weeks have you felt calm and peaceful? (Choose one)

- All of the Time
- Most of the time
- Some of the time
- A little of the time
- None of the time
- Refuse to Answer

Q79. How much of the time during the past 4 weeks did you have a lot of energy? (Choose one)

- All of the Time
- Most of the time
- Some of the time
- A little of the time
- None of the time
- Refuse to Answer

Q80. How much of the time during the past 4 weeks have you felt downhearted and blue? (Choose one)

- All of the Time
- Most of the time
- Some of the time
- A little of the time
- None of the time
- Refuse to Answer

Q81. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)? (Choose one)

- All of the Time
- Most of the time
- Some of the time
- A little of the time
- None of the time
- Refuse to Answer

Q82. How many times in your life have you been hospitalized for medical problems?

— — —
Refuse to Answer

Q83. Do you have any chronic medical problems which continue to interfere with your life?

- Yes
- No *Skip to Q85*
- Refuse to Answer *Skip to Q85*

Q84. Please specify up to 3 chronic medical problems you have which continue to interfere with your life.
(Check all that apply)

- Allergies (all types)
- Asthma
- Arthritis (joint pain)
- Back Pain (or other back issues)
- Cardio: Heart Problems
- Cardio: Hypertension
- Diabetes
- Foot problems
- Hearing Problems (including tinnitus)
- Hepatitis (any types)
- HIV
- Liver Problems (including cirrhosis)
- Seizures (for any reason)
- Ulcers (Gastrointestinal)
- Vision Problems (cataracts, glaucoma)
- Wounds (chronic wounds that do not heal)
- Other
- Refuse to Answer

Q85. Please specify up to 2 chronic medical problems you have which continue to interfere with your life.

Q86. Have you been hospitalized for emotional or psychological problems over the past 12 months?

- Yes
- No *Skip to Q88*
- Refuse to Answer

Q87. How many times were you hospitalized for emotional or psychological problems over the past 12 months?

— —
Refuse to Answer

Q88. Have you been prescribed medications in the past 12 months for emotional or psychological problems?

- Yes
- No
- Refuse to Answer

Q89. Did you visit an emergency room in the past 30 days for help with emotional or psychological difficulties?

Yes

No

Skip to Q91

Don't Know

Refuse to Answer

Q90. How many days in the past 30 have you gone to the Emergency Room for help with emotional or psychological difficulties?

— —

Don't Know

Refuse to Answer

Q91. In the past 30 days, have you seen a professional at an office or clinic to help you with emotional or psychological difficulties?

Yes

No

Skip to Q93

Don't Know

Refuse to Answer

Q92. How many days in the past 30 days have you seen a professional at an office or in a clinic to help you with emotional or psychological difficulties?

— —

Don't Know

Refuse to Answer

Q93. Are you currently taking any medications for emotional or psychological difficulties?

Yes

No

Skip to Q95

Don't Know

Refuse to Answer

Q94. How many days in the past 30 did you take medication for any emotional or psychological difficulties?

— —

Don't Know

Refuse to Answer

Q95. Did you visit an emergency room in the past 30 days for help with a physical medical condition?

Yes

No

Skip to Q

Don't Know

Refuse to Answer

Q96. How many days in the past 30 have did you go to the Emergency Room for help with a physical medical condition?

— —
Don't Know
Refuse to Answer

Q. Did you visit a doctor's office or a medical clinic for help with a physical medical condition in the past 30 days?

Yes
No **Skip to Q0**
Don't Know
Refuse to Answer

Q. How many days in the past 30 days did you visit a doctor's office or a medical clinic for help with a physical medical condition?

— —
Don't Know
Refuse to Answer

Q0. Did you stay overnight in a hospital in the past 30 days for help with a physical medical condition?

Yes
No **Skip to Q101**
Don't Know
Refuse to Answer

Q100. How many days in the past 30 days did you stay overnight in a hospital in the past 30 days for help with a physical medical condition?

— —
Don't Know
Refuse to Answer

Q101. Are you taking any prescribed medication on a regular basis for a physical medical condition?

Yes
No **Skip to Q103**
Don't Know
Refuse to Answer

Q102. How many days in the past 30 did you take medication for a physical medical condition?

— —
Don't Know
Refuse to Answer

Q103. During the last month, I hurt myself by cutting, burning, strangling, headbanging, etc. (Choose one)

- Not at all
- Once or twice
- Once a week
- 2 to 3 times a week
- 4 to 6 times a week
- Daily or more often
- Don't Know
- Refuse to Answer
- Not Applicable

Q104. During the last month, I told other people that I was going to kill myself. (Choose one)

- Not at all
- Once or twice
- Once a week
- 2 to 3 times a week
- 4 to 6 times a week
- Daily or more often
- Don't Know
- Refuse to Answer
- Not Applicable

Q105. During the last month, I tried to commit suicide. (Choose one)

- Not at all
- Once or twice
- Once a week
- 2 to 3 times a week
- 4 to 6 times a week
- Daily or more often
- Don't Know
- Refuse to Answer
- Not Applicable

Q106. During the last month, I got drunk. (Choose one)

- Not at all
- Once or twice
- Once a week
- 2 to 3 times a week
- 4 to 6 times a week
- Daily or more often
- Don't Know
- Refuse to Answer
- Not Applicable

Q107. During the last month, I took drugs. (Choose one)

- Not at all
- Once or twice
- Once a week
- 2 to 3 times a week
- 4 to 6 times a week
- Daily or more often
- Don't Know
- Refuse to Answer
- Not Applicable

Q108. During the last month, I took medication that had not been prescribed or if had been prescribed, I took more than the prescribed dose. (Choose one)

- Not at all
- Once or twice
- Once a week
- 2 to 3 times a week
- 4 to 6 times a week
- Daily or more often
- Don't Know
- Refuse to Answer
- Not Applicable

Q109. During the last month, I had outbreaks of uncontrolled anger or physically attacked others. (Choose one)

- Not at all
- Once or twice
- Once a week
- 2 to 3 times a week
- 4 to 6 times a week
- Daily or more often
- Don't Know
- Refuse to Answer
- Not Applicable

Legal Questions

Q110. Are you currently on probation or parole?

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

Q111. How many months were you incarcerated in your life?

- — —
- Refuse to Answer

Q112. Were you arrested, detained, or incarcerated in the past 12 months?

Yes

No

Don't Know

Refuse to Answer

Skip to Q116

Q113. How many months in the past 12 months were you under arrest, detained, or incarcerated?

— —

Don't Know

Refuse to Answer

Q114. Were you arrested, detained, or incarcerated in the past 30 days?

Yes

No

Don't Know

Refuse to Answer

Skip to Q116

Q115. How many days in the past 30 days were you arrested, detained, or incarcerated?

— —

Don't Know

Refuse to Answer

Housing Questions

Q116. For how many days in the past 30 days have you been homeless or in a shelter?

— —

Don't Know

Refuse to Answer

Q117. When was the last time that you lived in the same apartment or house for 3 months or longer? (Choose one)

In the past 6 months

More than 6 months ago but less than 1 year ago

1 to 3 years ago

More than 3 years ago

Don't Know

Refuse to Answer

Q118. How would you describe the most common housing you lived in the past 3 years? (Choose one)

- Rented Public Housing (Gov't housing project)
- Rented Subsidized Housing (Rent reduced; Section 8 housing)
- Rented other (not public or subsidized)
- Own home or apartment (Housing owned by participant or family)
- Emergency of temporary housing (shelter)
- Homeless (on street or abandoned building)
- Treatment Center
- Other (living with friends or relatives)
- Refuse to Answer
- Not Applicable

Employment Questions

Q119. What is/was your usual (or last) occupation? (Choose one)

- Higher Execs, major professionals, owners of large businesses
- Business Mgrs of med.sized business, lesser professions (nurses, opticians, social workers, teachers)
- Admin. personnel, managers, minor professionals, small business owners (car dealership, bakery, reporter)
- Clerical and Sales, technicians, sm businesses (bank teller, bookkeeper, clerk, secretary)
- Skilled manual - usually having had training (baker, barber, chef, electrician, fireman, tailor, welder)
- Semi-skilled (hospital aide, painter, bus driver, waiter, machine operator)
- Unskilled (attendant, janitor, construction helper, porter, unemployed)
- Homemaker
- Student, disabled, no occupation
- Don't Know
- Refuse to Answer

Q120. How many months were you employed in the past 3 years? (Choose one)

- Didn't work.
- 1 to 6 months
- 7 to 12 months
- 13 to 24 months
- More than 24 months
- Don't Know
- Refuse to Answer

Q121. Think of your (current/most recent) job. How often (does/did) it require you to talk to customers face to face? (Choose one)

- Daily
- Weekly
- Monthly
- Never
- Refuse to Answer

Q122. Think of your (current/most recent) job. How often (does/did) it require you to talk over the phone with customers? (Choose one)

- Daily
- Weekly
- Monthly
- Never
- Refuse to Answer

Q123. Think of your (current/most recent) job. How often (does/did) it require you to read instructions or reports? (Choose one)

- Daily
- Weekly
- Monthly
- Never
- Refuse to Answer

Q124. Think of your (current/most recent) job. How often (does/did) it require you to write letters or memos? (Choose one)

- Daily
- Weekly
- Monthly
- Never
- Refuse to Answer

Q125. Think of your (current/most recent) job. How often (does/did) it require you to work with a computer, such as word processing or data entry? (Choose one)

- Daily
- Weekly
- Monthly
- Never
- Refuse to Answer

Q126. Think of your (current/most recent) job. How often (does/did) it require you to work with another electronic machine such as a cash register, bar code scanner, or calculator? (Choose one)

- Daily
- Weekly
- Monthly
- Never
- Refuse to Answer

Q127. Think of your (current/most recent) job. How often (does/did) it require you to do arithmetic, including making change? (Choose one)

- Daily
- Weekly
- Monthly
- Never
- Refuse to Answer

Q128. Think of your (current/most recent) job. How often (does/did) it require you to fill out forms? (Choose one)

- Daily
- Weekly
- Monthly
- Never
- Refuse to Answer

Q129. Think of your (current/most recent) job. How often (does/did) it require you to keep a close watch over gauges, dials, or instruments of any kind? (Choose one)

- Daily
- Weekly
- Monthly
- Never
- Refuse to Answer

Q130. Think of your (current/most recent) job. How often (does/did) it require you to supervise other people who report to you? (Choose one)

- Daily
- Weekly
- Monthly
- Never
- Refuse to Answer

Q131. How many days were you paid for working on the books in the past 30 days?

- —
- Don't Know
- Refuse to Answer

Q132. How many days were you paid for working off the books in the past 30 days?

- —
- Don't Know
- Refuse to Answer

If Q120 + Q131 is greater than 0, then skip to Q134.

Q133. Please look at the responses and choose the one that most closely describes your thoughts and feelings about getting a job today. (Choose one)

I am not interested in having a job, and I do not intend to look for one at this time.

I might like to have a job in the future, but I am not currently looking for one.

I would like to have a job now, but I am not currently looking for one

I would like to have a job now, and I intend to start looking for one soon

I would like to have a job now, and I have done something in the last month to get one

I would like to have a job now, and I have done something this past week to get one.

Don't Know

Refuse to Answer

Skip to instruction before Q135.

Q134. Please look at the responses and choose the one that most closely describes your thoughts and feelings about getting full-time work today. (Choose one)

I am not interested in having full-time work, and I do not intend to look for it at this time.

I might like to have full-time work in the future, but I am not currently looking for it.

I would like to have full-time work now, but I am not currently looking for it

I would like to have full-time work now, and I intend to start looking for it soon

I would like to have full-time work now, and I have done something in the last month to get it

I would like to have full-time work now, and I have done something this past week to get it

Don't Know

Refuse to Answer

Instructions: Some people may have trouble getting or keeping a job even if they want to work. Other people have personal reasons for not working. Please think about the **past 12 months**. Please look at the cards and choose all the issues/reasons that have made getting or keeping a job challenging for you in the **past 12 months**.

Q135. No work available in line of work or area?

Yes

No

Refuse to Answer

Not Applicable

Q136. Couldn't find work?

Yes

No

Refuse to Answer

Not Applicable

Q137. Lack necessary school, training, skills or experience.

Yes

No

Refuse to Answer

Not Applicable

Q138. Employers think too young or too old.	Yes No Refuse to Answer Not Applicable
Q139. Other types of discrimination?	Yes No Refuse to Answer Not Applicable
Q140. Child care problems?	Yes No Refuse to Answer Not Applicable
Q141. Family responsibilities?	Yes No Refuse to Answer Not Applicable
Q142. In school or other training?	Yes No Refuse to Answer Not Applicable
Q143. Ill health, physical disability?	Yes No Refuse to Answer Not Applicable
Q144. Transportation problems?	Yes No Refuse to Answer Not Applicable
Q145. Own mental health problem or depression?	Yes No Refuse to Answer Not Applicable
Q146. Child's mental or physical health problem?	Yes No Refuse to Answer Not Applicable

- Q147. Own drug or alcohol problem? Yes
No
Refuse to Answer
Not Applicable
- Q148. Legal problems Yes
No
Refuse to Answer
Not Applicable
- Q149. Do not need to work? Yes
No
Refuse to Answer
Not Applicable
- Q150. Do not want to work? Yes
No
Refuse to Answer
Not Applicable
- Q151. Could not make enough money or find a job with enough benefits to make it worthwhile? Yes
No
Refuse to Answer
Not Applicable
- Q152. Other reason? Yes
No *Skip to instruction before Q154*
Refuse to Answer *Skip to instruction before Q154*
Not Applicable *Skip to instruction before Q154*
- Q153. What is the other challenge you have to getting or keeping work?

Q154. Reason Number 1? (Choose one)

- No work available in line of work
- Couldn't find work
- Lack necessary school, training, skills or experience
- Employers think too young or too old
- Other types of discrimination
- Child care problems
- Family responsibilities
- In school or other training
- Ill health, physical disability
- Transportation problems
- Own mental health problem or depression
- Child's mental or physical health problem
- Own drug or alcohol
- Legal problems
- Do not need to work
- Do not want to work
- Could not make enough money...
- Other reason
- Don't Know
- Refuse to Answer
- Not Applicable

Q155. Reason Number 2? (Choose one)

Q156. Reason Number 3? (Choose one)

Q157. Reason Number 4? (Choose one)

Q158. Reason Number 5? (Choose one)

Q159. How many days in the past 30 did you spend in an education program (e.g., GED, ESL, ABE, college, reading/literacy)?

- —
- Don't Know
- Refuse to Answer

Q160. How many days in the past 30 did you spend in job search or job training (e.g., SAP, ESP, Begin Program, Special Pops, InVEST, POISED)?

- —
- Don't Know
- Refuse to Answer
- Not Applicable

Q161. How many days in the past 30 did you spend in WEP (Work Experience Program)?

- —
- Don't Know
- Refuse to Answer
- Not Applicable

Q162. In the past 30 days have you experienced significant problems obtaining basic life needs, other than housing; such as satisfactory childcare, food, clothing, etc.

- Yes
- No ***Skip to instruction before Q164***
- Don't Know
- Refuse to Answer

Q163. How many days in the past 30 days have you experienced significant problems obtaining basic life needs, other than housing; such as satisfactory childcare, food, clothing, etc.

- —
- Don't Know
- Refuse to Answer

That's it. That was the last question! THANK YOU VERY MUCH! Your time, honesty, and willingness to participate in this study are deeply appreciated. If you have any questions or comments, please do not hesitate to ask us.