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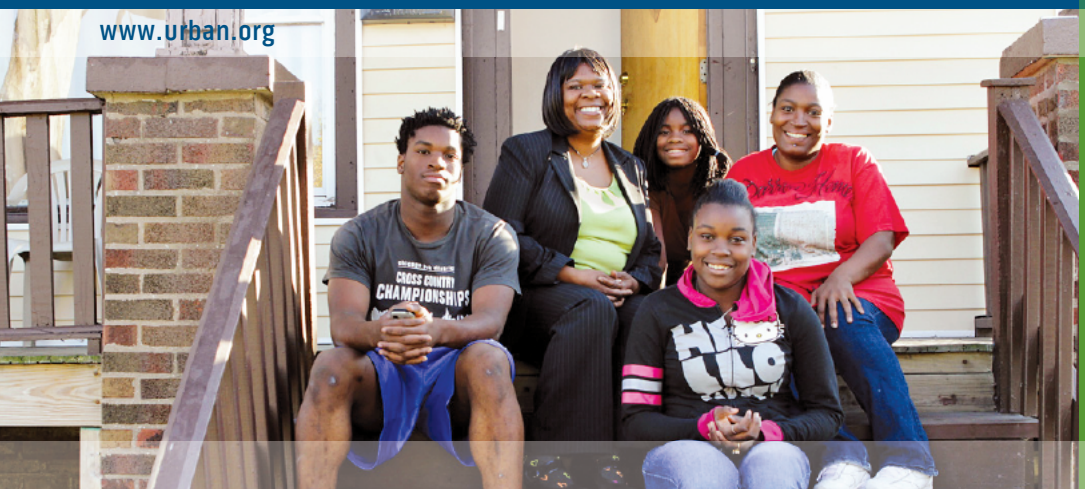
Supporting Vulnerable Public Housing Families



INSIDE THIS ISSUE

- The Demonstration produced a remarkably successful model for providing wraparound services to residents in public and assisted housing.
- Results are encouraging, but they also highlight significant employment and health barriers, along with challenges for neighborhoods, children, and youth.
- Housing authorities must be willing to take risks and experiment with how they provide services.

An Overview of the Chicago Family Case Management Demonstration

Susan J. Popkin, Brett Theodos, Liza Getsinger, and Joe Parilla

The Supporting Vulnerable Public Housing Families policy briefs present findings from the evaluation of the Chicago Family Case Management Demonstration, an innovative effort to test the feasibility of using public and assisted housing as a platform for providing services to vulnerable families. The Demonstration involved a unique partnership of city agencies, researchers, social service providers, and private foundations, including the Urban Institute, the Chicago Housing Authority (CHA), Heartland Human Care Services, and Housing Choice Partners (HCP) (Popkin et al. 2008). The briefs in this series describe service implementation and costs, along with participant outcomes across four domains: employment, health, housing and relocation, and children and youth (see text box).

At the end of the 1990s, the CHA, like many large housing authorities, was grappling with an array of entrenched problems: developments that were not functional, clean, or safe; neighborhoods that were isolated physically and socially from the rest of the city; and residents struggling with unemployment, substance abuse, and trauma. The CHA's troubles were the result of decades of neglect, poor management, and overwhelming crime and violence. In 1999, the CHA launched an ambitious 10-year Plan for Transformation, with the goal of transforming its distressed properties into healthy communities. The Plan has successfully replaced the CHA's notorious high-rise developments with new mixed-income housing, reinvested and improved its remaining public housing stock, and reversed the agency's long history of dysfunctional internal management (Vale and Graves 2010).

But addressing the many challenges facing CHA's residents has proved more difficult. CHA residents were especially disadvantaged: because of the terrible conditions in the family developments, many tenants who had bet-

SUPPORTING VULNERABLE PUBLIC HOUSING FAMILIES BRIEFS:

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ter options had left long ago, leaving behind a population dominated by the extremely vulnerable (Popkin et al. 2000). Like most housing authorities, the CHA had little experience providing case management or relocation counseling, and it initially struggled with developing adequate services. The CHA created its Service Connector program to provide case management and referral services for residents, mainly to help them meet the criteria for moving into mixed-income housing. Advocates and resident leaders criticized Service Connector for high caseloads and inadequate services.

And while Service Connector and CHA's relocation services evolved over time, and caseloads were gradually reduced, even the improved services were inadequate to meet the deep needs of CHA's most vulnerable residents, many of whom had long relied on the CHA's distressed developments as housing of last resort. These "hard to house" families faced numerous, complex barriers to moving toward self-sufficiency or even sustaining stable housing, including serious physical and mental health problems, weak (or nonexistent) employment histories and limited work skills, very low literacy levels, drug and alcohol abuse, family members' criminal histories, and serious credit problems (Popkin et al. 2008).

The Chicago Family Case Management Demonstration was a response to the critical need for effective strategies to address the needs of these hard-to-house families. The Demonstration ran from March 2007 to March 2010, providing residents from the CHA's Dearborn Homes and Madden/Wells developments with intensive case management services, transitional jobs, financial literacy training, and relocation counseling. The Urban Institute conducted a rigorous evaluation of the initiative.

The Demonstration has been remarkably successful in implementing a wraparound supportive service model for vulnerable public housing residents. The lead service provider was able to adapt the service model as residents relocated with vouchers or to mixed-income housing, while sustaining high levels of engagement. Participants perceived improvements in service quality and delivery, and providers felt more effective and engaged. Strikingly, participants reported gains in employment, health, improved housing and neighborhood conditions, and reduced levels of fear and anxiety. However, the Demonstration was less successful in facilitating moves to low-poverty, opportunity communities and in improving the trajectories for children and youth. The additional costs for the intensive services were relatively modest, suggesting that it would be feasible to take a carefully targeted intensive service model to scale.

An Innovative Service Model

The Chicago Family Case Management Demonstration targeted approximately 475 households from Dearborn Homes and Madden/Wells. The 3,000-unit Madden/Wells development, located on the city's near South Side, was one of the CHA's largest public housing complexes. In 2007, the CHA was partway through demolishing and replacing the development with a new, mixed-income community called Oakwood Shores, and only about 300 households lived in the remaining buildings. All the residents were African American, and most were long-term public housing residents with low incomes and poor physical and mental health. When the Demonstration began, the CHA was conducting staged relocation in Madden/Wells in preparation for the eventual closing of the development. In response to rapidly deteriorating conditions, the CHA first moved a group of residents in fall 2007, under an "emergency move" order, then decided to shutter Madden/Wells entirely by August 2008. As a result, all Madden/Wells households had to move during the Demonstration.[1]

The Dearborn Homes are an 800-unit development of six- and nine-story buildings on State Street, about a mile south of the Loop (Bowly 1978). During the first phases of the Plan for Transformation, the CHA used Dearborn as replacement housing for residents who were leaving other developments that were being demolished and had failed to meet the criteria for temporary vouchers or mixed-income housing. The resulting influx of residents from Robert Taylor Homes and Stateway Gardens created a volatile situation, with multiple gangs competing for territory within the development. Despite these problems, all around Dearborn is evidence of the rapid gentrification that has spilled over from the booming South Loop community: new grocery stores, a Starbucks, gourmet restaurants, and a hotel. The CHA received a federal grant that allowed it to comprehensively rehabilitate Dearborn; by 2010, about half the buildings were reopened. The redevelopment activity meant that nearly all Dearborn residents moved from their homes during the Demonstration, most of them temporarily to other units in Dearborn.

The Demonstration built on and enhanced the CHA's standard service package (table 1). Heartland, the lead service provider, was able to lower caseloads to about half the standard load for CHA service providers. Case managers also received new training in strength-based and change theory models, motivational interviewing, and family-focused case management. With reduced caseloads, case managers were able to conduct outreach to clients who previously had not engaged in services. Case managers also had time to meet more often with all their clients, seeing them weekly, reviewing issues, and attempting to engage other family members.

The intensive service model also offered three supplemental services. A Transitional Jobs (TJ) program aimed at helping residents with little or no work experience connect to the labor market. TJ relied on intensive

Table 1. Comparing the Basic CHA Service Model and Demonstration Services

SERVICE FEATURE	CHA SERVICE MODEL AT START OF DEMONSTRATION	DEMONSTRATION SERVICE MODEL
Engagement	50 percent	90 percent
Case manager–to-client ratio	1 case manager for 55 residents	1 case manager for 25 residents
Frequency of contact	Once a month	Two to four visits a month
Contact with household	Leaseholder	Family
Length of time case managers remain with residents, even after they move	3 months	3 years
Financial literacy training and matched savings program	Not available	Available
Clinical and substance abuse services	Referral to substance abuse counseling	On-site licensed clinical social worker; referral to substance abuse counseling
Transitional Jobs program	Not available	Available
Relocation counseling	Traditional relocation services (e.g., neighborhood tours for residents interested in vouchers, help locating apartment listings, assistance negotiating with landlords and the voucher program)	Augmented workshops and "second mover" counseling; traditional relocation services
Case manager training	Limited, varies with service provider	Additional training for case managers and ongoing clinical support groups

employment and interview training, rapid attachment to the workforce, three months of subsidized employment, and continued counseling and advocacy support for residents throughout the first year of employment. In addition, Heartland introduced Get Paid to Save (GPTS), a financial literacy program that offered training in budgeting and financial management, and provided a matched savings program. Finally, HCP provided enhanced relocation services, helping participants identify units and negotiate with landlords and the voucher program. HCP's intensive services sought to encourage participants to consider moves to low-poverty (less than 23.5 percent poor) and opportunity (less than 23.5 percent poor and less than 30 percent African American) neighborhoods; services included reduced caseloads and workshops that covered the benefits of opportunity areas, tenant rights and responsibilities, housekeeping, and school choice.

Evaluation

The Urban Institute rigorously evaluated the Demonstration to inform implementation and track outcomes for participants over time. In spring 2007, we conducted a baseline resident survey (n=331, response rate 77 percent). The survey asked about a range of domains, including housing and neighborhood conditions, service use, mental and physical health, employment and economic hardship, and children's health and behavior. We conducted a follow-up survey (n=287, response rate 90 percent) in summer 2009, approximately two years after the rollout of the Demonstration.[2]

To complement the survey, Urban Institute staff conducted 30 qualitative in-depth interviews (21 adults and 9 adolescents) with participants in summer 2008. We also gathered information from CHA administrative records and case manager reports, including whether residents chose to engage in the Demonstration services, whether participants were referred for additional services, and their relocation history. We assembled secondary data on neighborhood poverty, unemployment, crime, race, and other characteristics that we received from the Metro Chicago Information Center. In addition,

Urban Institute staff conducted a process study to assess the efficacy and cost of the Demonstration's implementation. We conducted in-depth qualitative interviews with case managers, project staff, relocation providers, and CHA administrators, monitored service implementation weekly, and met regularly with Heartland and HCP leadership and CHA staff. Finally, the team also thoroughly analyzed the costs associated with the intensive services.

We attempted to create a comparison group using CHA's administrative data to allow us to fully measure program impact on participant outcomes, but data limitations made this unfeasible. First, the CHA's database did not include measures on key outcomes variables, such as health or children's outcomes. Second, service providers only enter some key data fields when they collect intake information for a family action plan and do not update information over time. Finally, while service providers do enter data on service referrals, they do not record service uptake.

As an alternative, we considered creating a comparison group from the CHA Panel Study (Popkin, Levy, et al. 2010), which tracked long-term outcomes for a random sample of Madden/Wells residents from 2001 to 2009. The two surveys used many similar items, and the sample demographics are similar. However, the different time frames for the two studies, particularly the fact that the CHA Panel Study sample had relocated much earlier—mostly before 2007—also made it unfeasible to use the Panel Study as a true comparison group to assess program impact. We do draw on the CHA Panel Study as a benchmark for Demonstration sample outcomes where possible.

In addition, to understand more about how the Demonstration affected resident outcomes, we examined how different types of participants used the services. We developed a typology based on head-of-household baseline characteristics that categorizes Demonstration participants into three groups: "strivers," younger residents who mostly have high school degrees and are connected to the labor force; "aging and distressed," who suffer from high rates of mental and physical illness, lack high school degrees, and have little work experience; and "high risk," younger residents already showing high rates of chronic illness and labor force disconnection (Theodos et al. 2010).

A Successful Model

The Chicago Family Case Management Demonstration has produced a remarkably successful model for providing wraparound services to residents in public and assisted housing settings (Popkin, Theodos, et al. 2010).

- Heartland's staff quickly achieved high levels of engagement (about 90 percent), then adapted their basic service model as case managers learned more about resident needs. Case managers received additional training and support, and their improved performance was reflected in participants' improved perceptions of service quality and effectiveness. However, despite efforts to enhance relocation counseling, the Demonstration was less successful in helping participants move to lower-poverty areas that might offer them and their children greater opportunity.

- The average costs for the intensive services were relatively modest, about $2,900 a year or $900 more than the standard CHA service package.[3] Costs varied considerably by level of need and service take-up, with high-risk participants using the most services.

- Despite an extremely difficult labor market, self-reported employment among working-age Demonstration participants' employment rate *increased* from 49 percent in 2007 to 59 percent in 2009.[4] In contrast, the CHA Panel Study found *no* changes in respondents' levels of employment from 2001 through 2009. Further, the intensive Transitional Jobs program appears to have contributed to these employment gains (Parilla and Theodos 2010).

- In contrast to a decade of research from the HOPE VI and CHA Panel studies (Popkin, Levy, and Buron 2009; Price and Popkin 2010), Demonstration participants' health did not decline over time. Between 2007 and 2009, participants' health status remained remarkably stable; in fact, more respondents reported improvements than declines. Further, while there was no change in the proportion of respondents who reported poor mental health or clinical depression, respondents did report significant reductions in anxiety. Still, even with these gains, levels of chronic illness and mortality rates remain strikingly high (Popkin and Getsinger 2010). Thus, while the results from the Demonstration are encouraging, the modest progress underscores the depth of the challenges facing these families and service providers.

- By 2009, most Demonstration participants had moved at least once. In contrast to the CHA Panel Study (Buron and Popkin 2010), the majority remained in traditional public housing (59 percent), while just 28 percent moved into the private market with a Housing Choice Voucher. Surprisingly, there was less difference in the proportion of residents who moved to mixed-income communities: 13 percent of Demonstration participants made such moves, only 5 percentage points lower than the comparable figure for the CHA Panel sample. Participants perceived that relocating had major benefits, with four out of five reporting that they live in better quality housing than at baseline (Theodos and Parilla 2010).

- Demonstration participants also reported significant gains in neighborhood quality. Generally, they moved to neighborhoods

where they feel safer, have more connections with their neighbors, and report less physical and social disorder. However, fewer residents engaged in relocation services than in case management and other services. As a result of this and several other factors—resident preferences, resident needs, a compressed relocation schedule, and program design—relatively few households made opportunity moves: only 26 families moved to a low-poverty area, and just 4 moved to an opportunity area. As a result, in 2009, most were still living in neighborhoods that were high poverty and racially segregated (Theodos and Parilla 2010).

Significant Challenges Remain

While the Demonstration evaluation results are extremely encouraging, they also highlight the significant challenges that remain.

- Despite the significant increases in employment, wages and incomes did not change from 2007 to 2009. Respondents still report an average wage of just over $10 an hour, and most households are still living below the poverty level. And similar to the CHA Panel Study (Levy 2010), chronic health problems remain a significant barrier to finding and sustaining employment. Finally, we have concerns about whether these employment gains will last in this challenging economic climate.

- The Demonstration improved the life circumstances for most participants: they now live in better housing in safer neighborhoods and report lower levels of fear. Still, nearly all still live in high-poverty, racially segregated communities that offer little in the way of services, amenities, or access to opportunity. Further, while participants are better off in many ways, a substantial proportion report financial hardship, particularly in being able to afford utilities in the private market (Theodos and Parilla 2010).

- It has been easier to improve residents' life circumstances than to address their physical and emotional health. Even the intensive case management and clinical services the Demonstration provided were only able to make a small dent in health outcomes for participants—seemingly stabilizing their overall health, reducing anxiety, and lowering levels of alcohol consumption. While these results are encouraging, the modest progress underscores the depth of the challenges facing these families—and service providers.

- Finally, findings from the Chicago Family Case Management Demonstration paint a shocking picture of at-risk children and youth living in extremely troubled households. These children have endured years of living in violent and chaotic environments; in many cases, their parents were so distressed—suffering from mental and physical illness, struggling with substance abuse, dealing with histories of trauma—that they were unable to shield their children from the worst effects of the stresses surrounding them. Although the Demonstration took a family-focused approach, no services or case managers were explicitly dedicated to children and youth; at the follow-up, these children were still experiencing alarming levels of distress and exhibiting high levels of behavior problems[5] and delinquency (Getsinger and Popkin 2010).

Implications for Policy and Practice

When the CHA launched its ambitious Plan for Transformation in 1999, the agency was emerging from a decades-long legacy as one of the most troubled housing authorities in the nation. Over the past decade, the CHA has struggled with the challenges of redevelopment and relocation—and with developing a meaningful and effective resident services system, all while under the scrutiny of skeptical advocates, researchers, and residents.

> "The Chicago Housing Authority is now at the vanguard of using public and assisted housing as a platform for providing supportive services."

The experience of the Chicago Family Case Management Demonstration shows that the CHA is now at the vanguard of using public and assisted housing as a platform for providing supportive services for residents. This demonstration has produced a successful model for providing wraparound services to residents in public and assisted housing settings, with participants reporting gains in employment, health, and housing and neighborhood conditions at a relatively modest cost. The fact that significant challenges remain does not undermine the magnitude of this achievement. Indeed, the primary lesson of the Demonstration is that it would be feasible to take a carefully targeted intensive service

model to scale and that doing so might pay off by stabilizing some of the most vulnerable public housing families.

- **Housing authorities must be willing to take risks and experiment with service provision.** The key factors behind the success of the Demonstration were a housing authority committed to resident services, effective service providers willing to collaborate and participate in evaluation and performance monitoring, and a model that enabled continuous learning and adaptation. The CHA has already integrated lessons from the Demonstration into its larger resident services program and is seeking opportunities to test new ideas, such as incorporating services for youth into an intensive model. Other housing authorities could benefit from being equally willing to experiment and test novel approaches for serving their most vulnerable households.

- **Targeting high-risk families may have long-term payoffs.** High-risk families—those grappling with mental and physical health challenges and disconnection from the labor market, while struggling to raise their children—are the heaviest consumers of intensive services. Stabilizing these extremely needy households may have long-term payoffs for both their own well-being and reduced costs for development management. Developing an assessment tool that successfully identifies these high-need households is critical so service providers can target services more efficiently and effectively (Theodos et al. 2010).

- **The Transitional Jobs model is extremely promising.** Demonstration participants, like many CHA residents, clearly need supports and incentives to help them achieve employment. The Transitional Jobs program appears to be helping even distressed residents achieve this goal, at least in the short term. However, the program was not as successful at placing residents who were extremely unprepared for the workforce, namely those with literacy levels far below the requirements for entry-level work. The CHA should continue funding TJ, while also considering a more intensive training program for the neediest participants that focuses on literacy and developing soft skills.

- **Comprehensive mental health and substance abuse services are a critical need.** A substantial proportion of CHA's most vulnerable residents suffer from serious mental disorders—depression, schizophrenia, post-traumatic stress disorder—that require intensive clinical support and medication. The CHA should make continuing to provide clinical services through its FamilyWorks resident services program a priority. FamilyWorks currently serves only residents in CHA's traditional public housing communities. Many of CHA's vulnerable families are now voucher holders; meeting their needs is more challenging and will require a new approach to service provision. The challenge for the CHA and other housing authorities will be finding strategies (e.g., careful targeting or partnering with local providers) that allow the agency to provide clinical services to voucher holders on a broader scale. Other housing authorities could use the Demonstration as a model to replicate and test strategies for targeting services more effectively to residents. Finally, severity of the mental health and substance abuse problems among the CHA's most vulnerable residents suggests that many will require a more long-term solution than case management or counseling. The CHA and other housing authorities could consider incorporating small numbers of supportive housing units into existing public housing and mixed-income developments, as well as providing intensive wraparound services to voucher holders.

- **Relocation counseling needs to be intensive.** The Demonstration services were not sufficient to help residents overcome longstanding barriers to opportunity moves. Relocation counselors need sufficient time to work with residents before they are scheduled to move. Early in the process, counselors need to help residents learn what opportunity areas are and demystify the process of moving to and living in these communities. Of course, residents may choose to stay in nearby and impoverished communities for good reasons, and counselors should respect and support these families' decisions. Similarly, relocation counselors (in conjunction with case managers) need to continue to follow up with families to help them make second moves, especially families who are living in a private market apartment with a voucher.

- **The CHA should experiment with intensive service models that focus explicitly on children and youth.** The Demonstration service model successfully engaged vulnerable CHA families in intensive case management services, with important benefits for families in improved quality of life and for adult participants in stable health and improved employment. However, while the Demonstration used a family-focused model, it does not seem to have successfully reached youth. The CHA and other housing authorities should consider testing a modified service model that includes strategies to engage youth and offers evidence-based interventions to serve their needs. This new, youth-focused demonstration should also employ the typology we have developed to try to target the neediest families with intensive services.

- **Robust administrative systems are imperative to evaluate and measure the performance of any service model.** Even without a comprehensive evaluation, housing authorities and service providers can

develop performance measurement systems that allow them to track performance and resident outcomes. There are now several database systems for social service providers that enable them to track clients across different providers. Coordinating these administrative data systems in a way that follows residents through multiple programs and agencies will allow policymakers to evaluate how investments and interventions in one program affects the costs in other programs. Additionally, regular coordination, meeting, and review is critical to ensuring that service models stay on track and that providers are able to learn from experience and make mid-course corrections and adaptations to make their services more effective. ▪

Notes

1. By declaring an emergency move, the CHA obviated requirements in its Relocation Rights Contract with residents, which established that residents have 180 days to leave their home after receiving a move notice.

2. The largest source of attrition between 2007 and 2009 was mortality; we were able to locate, if not survey, nearly all original sample members.

3. This number is adjusted by the average take-up rate per service.

4. This result is significant at the .05 level.

5. Items for the problem behaviors scale were taken from the Behavior Problems Index. The heads of households were asked to indicate how often the children exhibited any one of seven specific negative behaviors: trouble getting along with teachers; being disobedient at school; being disobedient at home; spending time with kids who get in trouble; bullying or being cruel or mean; feeling restless or overly active; and being unhappy, sad, or depressed. The answers ranged from often and sometimes true to not true. We measure the proportion of children whose parents reported that they demonstrated two or more of these behaviors often or sometimes over the previous three months.

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Chicago Family Case Management Demonstration

The Chicago Family Case Management Demonstration was a partnership of the Urban Institute, the Chicago Housing Authority (CHA), Heartland Human Care Services, and Housing Choice Partners, intended to test the feasibility of providing wraparound supportive services for vulnerable public housing families. The demonstration ran from March 2007 to March 2010, targeting approximately 475 households from the CHA's Dearborn Homes and Madden/Wells developments with intensive case-management services, transitional jobs, financial literacy training, and relocation counseling.

The Urban Institute evaluated the Chicago Family Case Management demonstration to inform implementation and track outcomes for participants over time. In spring 2007, we conducted a baseline resident survey (n = 331, response rate 77 percent). The survey asked about a range of domains, including housing and neighborhood conditions, service use, mental and physical health, employment and economic hardship, and children's health and behavior. We conducted a follow-up survey (n = 287, response rate 90 percent) in summer 2009, approximately two years after the rollout of the demonstration. The largest source of attrition between 2007 and 2009 was mortality; we were able to locate, if not survey, nearly all original sample members.

To complement the survey, Urban Institute staff conducted 30 qualitative in-depth interviews (21 adults and 9 adolescents) with participants in summer 2008. We also gathered information from CHA administrative records and case manager reports, including whether residents chose to engage in the demonstration services, whether participants were referred for additional services, and their relocation history. In addition, we assembled secondary data on neighborhood poverty, unemployment, crime, race and other characteristics that we received from the Metro Chicago Information Center. Finally, we conducted a process study to assess the efficacy and cost of the demonstration's implementation. We conducted in-depth qualitative interviews with case managers, project staff, relocation providers, and CHA administrators, monitored service implementation weekly, and met regularly with Heartland and Housing Choice Partners leadership and CHA staff. We also thoroughly analyzed the costs associated with the intensive services.

The principal investigator for the Chicago Family Case Management Demonstration is Susan J. Popkin, Ph.D., director of the Urban Institute's Program on Neighborhoods and Youth Development. Funding for the demonstration was provided by the John D. and Catherine T. MacArthur Foundation, the Annie E. Casey Foundation, the Rockefeller Foundation, the Partnership for New Communities, JPMorgan Chase, and the Chicago Housing Authority.

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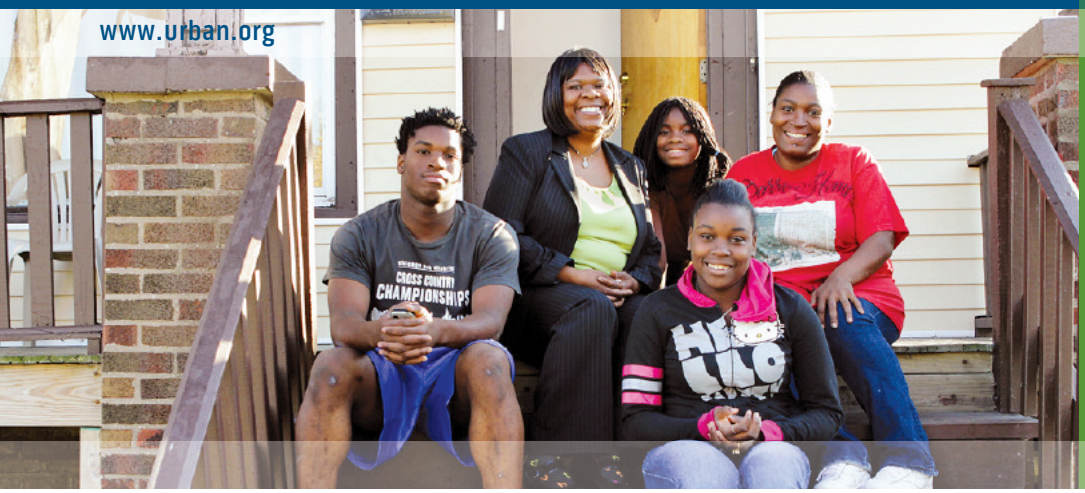


INSIDE THIS ISSUE

- The Demonstration implemented intensive services including case management, transitional jobs, financial literacy training, and relocation counseling.
- Resident engagement increased from 50 to nearly 90 percent.
- Additional costs for the intensive services were modest.

A New Model for Integrating Housing and Services

Susan J. Popkin, Brett Theodos, Liza Getsinger, and Joe Parilla

Ten years, ago the Chicago Housing Authority (CHA), like many housing authorities nationwide, was grappling with how to address the legacy of urban disinvestment: developments that were not functional, clean, or safe; neighborhoods that were physically and socially isolated from the rest of the city; and residents struggling with unemployment, substance abuse, and trauma. The CHA responded to these challenges with an ambitious 10-year Plan for Transformation. The Plan replaced the CHA's notorious high-rise developments with new mixed-income housing, reinvested in and improved its remaining public housing stock, and reversed its long history of dysfunctional internal management (Vale and Graves 2010).

But while the Plan for Transformation addressed the CHA's bricks-and-mortar issues, its Service Connector program, which provided case management and referral services for residents, was less successful. Advocates and resident leaders criticized the Service Connector program for high caseloads and inadequate services. And while Service Connector and the CHA's relocation services evolved over time, and caseloads were gradually reduced, even the improved services could not meet the deep needs of CHA's most vulnerable residents, who had long relied on the CHA's distressed developments as housing of last resort (Popkin 2006). These families faced numerous, complex barriers to their ability to move toward self-sufficiency or even sustain stable housing, including serious physical and mental health problems, weak (or nonexistent) employment histories and limited work skills, very low literacy levels, drug and alcohol abuse, family members' criminal histories, and serious credit problems (Popkin, Cunningham, and Burt 2005; Popkin et al. 2000).

The Chicago Family Case Management Demonstration was created to develop effective strategies for addressing the needs of these hard-to-house families. The Demonstration ran from March 2007 to March 2010, overlapping with the 2009 CHA Panel Study, which tracked a random sample of residents from CHA's Madden/Wells Homes from

> "The first part of getting any need met is to recognize what the need is."
>
> —Heartland Clinical Director

2001 to 2009 (Popkin, Levy, et al. 2010). The Demonstration—a partnership of the Urban Institute, the CHA, Heartland Human Care Services, and Housing Choice Partners—intended to test the feasibility of providing wraparound supportive services for vulnerable public housing families (Popkin et al. 2008). The program provided residents from the CHA's Dearborn Homes and Madden/Wells developments with intensive case management services, transitional jobs, financial literacy training, and relocation counseling (see text box on page 10).[1]

The Urban Institute conducted a rigorous evaluation, including a baseline and follow-up survey, administrative interviews, focus groups with service providers and program administrators, in-depth resident interviews, and analysis of program and administrative data. The evaluation tracked participant outcomes and monitored the collaboration among the service partners. The design allowed for continuous learning and mid-course corrections during implementation.

The Demonstration was remarkably successful in implementing a wraparound service model for vulnerable public housing residents. The lead service provider was able to adapt the service model as residents relocated with vouchers or to mixed-income housing, while sustaining high levels of engagement. Further, participants perceived improvements in service quality and delivery, and providers felt more effective and engaged. The Demonstration also generally improved the quality of coordination and cooperation between service agencies and the CHA. However, the Demonstration was less successful in engaging participants in relocation counseling and, thus, facilitating opportunity moves. The additional costs for the intensive services were relatively modest, suggesting that it would be feasible to take a carefully targeted intensive service model to scale. In this brief, we discuss the implementation of the Demonstration and our analysis of service costs. The other briefs in the series (see Popkin, Theodos, et al. 2010) describe the outcomes for participants across a range of domains, including employment, health, housing and neighborhoods, and children and youth.

The Chicago Family Case Management Demonstration Service Model

The Demonstration built on and enhanced the CHA's standard service package (table 1).[2] CHA Service Connector case managers had high caseloads and were only able to deal with clients who actively sought them out; as a result, the proportion of residents actively engaged in services hovered around 50 percent. The Demonstration allowed Heartland to dramatically lower caseloads to about half the standard load for CHA service providers. Heartland carefully selected its case management team; according to a senior administrator, staff looked for case managers with a unique combination of intuition, empathy, and emotional intelligence. Case managers also received new training in strength-based and change theory models, motivational interviewing, and family-focused case management. At each site, the managers reassigned clients and restructured responsibilities to fit the new model, such as moving active substance users to a case manager with clinical expertise in these issues. With these changes, case managers now had time to conduct outreach to clients who previously had not engaged in services. And, case managers had time to meet more often with all their clients, seeing them weekly, reviewing issues, and attempting to engage other family members.

Another innovation for the Demonstration was ensuring consistency of care over time. Instead of transitioning families to new providers when they moved—with vouchers, to other CHA developments, or to mixed-income units—the same case managers stayed with the families for the three years of the Demonstration, continuing to make weekly visits in the new location. Essentially, this model means that the service program offered both site-based services and long-term wraparound services for those who left the developments.

Heartland's intensive service model offered two supplemental services to enhance the case management and help residents improve their life circumstances. The Transitional Jobs (TJ) program, a more intensive version of the model used citywide by CHA's Opportunity Chicago workforce initiative, was aimed at helping residents with little or no work experience connect to the labor market.[3] The program relied on intensive employment and interview training, rapid attachment to the workforce, three months of subsidized employment, and continued counseling and advocacy support for residents throughout the first year of employment. The Demonstration also offered participants the opportunity to participate in Heartland's Get Paid to Save (GPTS) financial literacy program. GPTS offered training in budgeting and financial management, and it provided a matched savings program: for every dollar a resident saved in a dedicated account, the program provided two dollars. Participants could accumulate up to $1,000 in this way.

Like Heartland's intensive case management, HCP's enhanced relocation services built on CHA's traditional service model. Under the Relocation Rights Contract—the agreement between the CHA and its resident councils—residents were offered three replacement housing options: a unit in a new, mixed-income development; a Housing Choice Voucher; or a rehabilitated unit in traditional public housing. CHA's relocation service providers took residents who chose vouchers on tours of low-poverty (less than 23.5 percent poor) and opportunity (less than 23.5 percent poor and less than 30 percent

Table 1. Comparing the Basic CHA Service Model and Demonstration Services

SERVICE FEATURE	CHA SERVICE MODEL AT START OF DEMONSTRATION	DEMONSTRATION SERVICE MODEL
Engagement	50 percent	90 percent
Case manager–to-client ratio	1 case manager for 55 residents	1 case manager for 25 residents
Frequency of contact	Once a month	Two to four visits a month
Contact with household	Leaseholder	Family
Length of time case managers remain with residents, even after they move	3 months	3 years
Financial literacy training and matched savings program	Not available	Available
Clinical and substance abuse services	Referral to substance abuse counseling	On-site licensed clinical social worker; referral to substance abuse counseling
Transitional Jobs program	Not available	Available
Relocation counseling	Traditional relocation services (e.g., neighborhood tours for residents interested in vouchers, help locating apartment listings, assistance negotiating with landlords and the voucher program)	Augmented workshops and "second mover" counseling; traditional relocation services
Case manager training	Limited, varies with service provider	Additional training for case managers and ongoing clinical support groups

African American) neighborhoods. Whether or not residents chose to move to one of these neighborhoods, relocation counselors helped them identify a specific unit and negotiate with landlords and the voucher program; counselors also followed up with residents after the move. HCP's intensive services included reduced caseloads, increased engagement, and workshops that covered the benefits of opportunity areas, tenant rights and responsibilities, housekeeping, and school choice. Residents received $20 incentives for participation.

Creative Adaptations

Under the new model, case managers put their energy into outreach, going into the development and knocking on doors. When they did, case managers uncovered one tough problem after another: residents with schizophrenia who had stopped taking their medications and refused to open the door; women with severe depression; mothers at risk for losing custody of their children; grandmothers struggling to care for several grandchildren, some of whom were in trouble with the law; and substance abusers who were so in debt to drug dealers that the dealers had taken over their apartments (see sidebar).

Even with a more intensive case management model, participants did not always divulge their problems, nor were they immediately recognizable to case managers. In focus groups, case managers discussed the importance of up-front assessments in revealing untreated trauma among residents. One counselor discussed the connection between undiagnosed trauma and substance abuse in public housing:

> *People are expected to make rational decisions without the psychological barriers being addressed. Even though this person may act normal, if you don't do a viable*

Serving Families with Deep Challenges

Martin, a 65-year-old man, and his 15-year-old developmentally delayed son, Andrew, relocated from Madden/Wells to a smaller CHA development on the far South Side. Martin grew up in public housing; his family was very close, and he says he had a happy childhood. He dropped out of school after 8th grade because he had to work in his father's trucking business. Martin got married and had his first child when he was 18, and now has six children; he was married for 46 years, but now is divorced. Andrew's mother died in 2006, leaving Martin as his sole caregiver.

Martin has many health problems: he is diabetic, has asthma and congestive heart failure, had lung cancer a few years ago, has a serious drinking problem, and recently began using cocaine again. Even so, Martin says he is very concerned about staying healthy so he can care for his son, so he exercises (he says he has lost 100 pounds) and sees his doctor regularly. He and Andrew get by on Social Security and what Martin makes selling things at the local flea market.

Taking care of Andrew is difficult for Martin. Andrew cannot read or write well, has trouble communicating, and is often picked on at school. Martin worries constantly about Andrew, and often wonders what will happen to Andrew if he dies. Martin's main hope is that he will live long enough to see Andrew graduate from high school and move into an independent living program.

> *biopsychosocial [assessment] on this individual and ask them probing in-depth questions, you'll never find out this person's issues. They may laugh with you. They may talk with you. They may let you in their house. They may do some other stuff with you. The number one issue we have—the reason that people get high so much in public housing—is trauma. Unaddressed trauma that they never got help for. They continue to use drugs and alcohol as a result because that is their coping sphere.*

Heartland quickly realized the need for more intensive, clinical mental health services for participants. A year into the Demonstration, the CHA reconfigured and took direct control of its resident services programs, which had been managed through the Chicago Department of Human Services. Heartland and its other service providers had to negotiate new contracts in 2008; this renegotiation provided Heartland with resources to hire wellness counselors (i.e., clinical case workers) for each site and, eventually, a psychiatrist able to come to each site a few hours a week (Popkin and Getsinger 2010).

While case managers were generally positive about the new service model, their supervisors reported that it was clear from regular staff meetings that they were at risk of becoming overwhelmed by the depth of the problems they were uncovering. The case managers were not trained clinical mental health professionals; through the Demonstration, they faced with situations that even trained clinicians would find extremely challenging. Once Heartland recognized the level of emotional strain placed on case managers, they hired a clinical supervisor to provide ongoing support for case managers in their day-to-day work. The clinical supervisor instituted regular, small-group meetings to review cases and provide support where staff were able to freely vent their concerns and frustrations, work through challenging cases, obtain support when feeling overwhelmed, and receive ongoing reinforcement of the training they received. CHA's vice president of resident services reiterated the importance of this support system in an interview in December 2009:

> *The other thing was really important in terms of case management survival and building was we had put into place a kind of case management consultant on the team that was a part of Heartland staff. But it wasn't someone that directly supervised the case manager. So it was a safe place for case managers to learn, complain, and problem-solve without it directly impacting performance evaluation or review. And that system actually proved to be really valuable.*

In addition to ramping up the Demonstration's clinical support, Heartland changed its TJ program to serve a broader range of participants. Initially, TJ staff underestimated the severity of participants' barriers to employment. The coordinator reported that participants were failing to pass the mandatory drug screening, and that many lacked the 9th-grade literacy level required by many jobs. To meet the latter challenge, the TJ coordinator lowered the literacy standards for program entry and developed a pilot program that focused on improving literacy for participants (Parilla and Theodos 2010).

Likewise, the Heartland team refocused its financial literacy initiative when it became clear that it was only reaching families with the least barriers to self-sufficiency. As the GPTS coordinator explained, understanding resident needs when it came to financial literacy and saving was not easy:

> *One challenge [was determining] what our flexibility is or our ability to be adaptable within the parameters of the program and the parameters of the Demonstration as a*

whole. Just being able to adapt things, but adapt in a way that's useful for participants. So, maybe that's something bears further exploration even still. It's what really is useful and what do people really actually want.

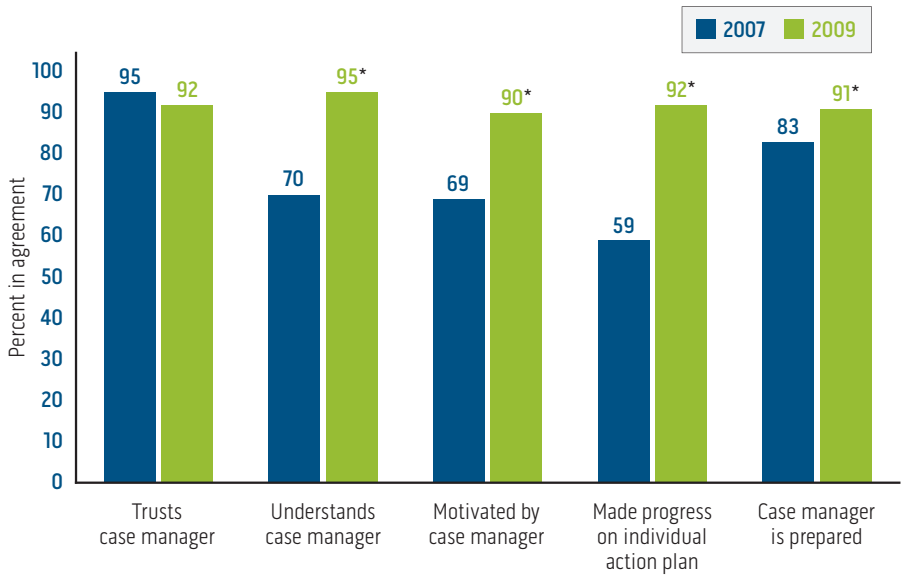
Heartland's response was to increase coordination with case management staff, increase outreach, conduct on-site workshops, and shift the program's focus to credit repair. While there was not sufficient time left in the Demonstration to assess how well this new approach worked, it reflects Heartland's creativity, willingness to strategize, and ability to adapt to new situations.

Many Challenges

The Demonstration's relocation counseling services encountered numerous challenges that undermined their success, and, despite the enhanced services, few families had relocated to high-opportunity neighborhoods by the 2009 follow-up survey (Theodos and Parilla 2010). First, the intense vulnerability of Demonstration participants prevented many of them from moving to a neighborhood of higher opportunity. Long-term CHA residents had not conducted a housing search in decades, if ever, and many were simply not up to the task. Second, the expedited closure of Madden/Wells limited HCP's work with those families. Relocation counselors reported they did not have sufficient time to adequately educate residents about their full housing and neighborhood choices, given that neighborhood tours, school choice information sessions, and other parts of intensive relocation counseling are time consuming. Third, residents often chose lower-opportunity neighborhoods because of familiarity, proximity to family and friends, or availability of public transit. Finally, the collaboration between Heartland and HCP did not always work smoothly. Poor communication between the relocation and service providers meant that residents' cases could be dropped with insufficient follow-up.

To increase the number of opportunity moves, HCP proposed incorporating "second mover" counseling, which meant conducting outreach to families who had used their vouchers to move to traditional high-poverty areas to try to encourage them to consider a second move to a low-poverty or opportunity area. However, this component was never fully implemented; CHA assigned HCP to conduct relocation at another CHA development that was slated for closing, which meant HCP's small staff had to shift their focus away from Dearborn and Madden/Wells. Because of these problems, in 2009, only 26 families had moved to a low-poverty area, and just 4 had moved to an opportunity area (Theodos and Parilla 2010).

Figure 1. Residents' Perceptions of Their Case Managers, 2007 and 2009



Sources: 2007 and 2009 Demonstration samples.

* Difference between 2007 and 2009 is significant at the $p < .05$ level.

Successful Engagement with Residents

When the Demonstration began in 2007, engagement levels among residents hovered around 50 percent.[4] By 2008, these engagement levels had risen to nearly 90 percent and remained at that level until the Demonstration ended in 2010. Case managers met with residents an average of three to four times a month, up from just once a month before the Demonstration. Perhaps most striking was that engagement rates remained high even as case managers began following relocated residents off site. Two years into the Demonstration, participants were living in various settings around the city, including the private market, other traditional public housing developments, and mixed-income housing. To our knowledge, the Demonstration was the first wraparound service model that successfully followed residents after relocation; this achievement represents a major innovation in service provision in a public or assisted housing setting.

Very High Marks for Case Managers

In 2007, Demonstration participants rated their case managers very highly. Even after starting out high, these figures rose significantly by 2009 (figure 1). The increases reflect both that engagement increased and that participants viewed the higher engagement as productive, not an intrusion or burden. The vast majority of participants said that their case manager was easy to talk to and to understand; nearly all said that they felt motivated and encouraged by their case managers, were more likely to attend meetings with their case manager, and felt these meetings were productive.

These high marks for case managers reflect Heartland's investment in its staff and, consequently, case managers' investment in the Demonstration model. At the end of the Demonstration, the clinical director said she felt that because case managers were seeing clients more regularly, they were more invested in their clients, and thus there was less staff turnover. Likewise, one site manager stated,

> *We are like family to them. Good and bad. The good is that they allow us to celebrate their successes. Bad is that they sometimes feel like you may be too close, so case managers definitely need to know when to back up and let their resident to grow within the space they have and come back to us.*

Participants' Service Use Varied Considerably

The Demonstration created and implemented a wraparound service model that produced motivated case managers and satisfied clients. However, while engagement was generally high, how participants used the services varied considerably.[5] Between March 2007 and September 2009, the 287 heads of household in our sample engaged in 3,163 services, approximately 11 services per head of household. But just half of household heads accounted for over 75 percent of total service use; the top quarter accounted for nearly 50 percent of all services, and the top tenth accounted for 25 percent.

Generally, our sample experienced gains in employment (Parilla and Theodos 2010) and declines in fear and anxiety (Popkin and Getsinger 2010). Participants also moved to better housing in safer neighborhoods that are still highly poor and segregated (Theodos and Parilla 2010). Because our study lacked an adequate comparison or control group, we are unable to assess the impact of services on these participant outcomes. But we can examine how different types of participants used the services. We developed a typology based on head-of-household baseline characteristics that categorizes the Demonstration participants into three groups: "strivers," younger residents who mostly have high school degrees and are connected to the labor force; "aging and distressed," who suffer from high rates of mental and physical illness, lack high school degrees, and have little work experience; and "high risk," younger residents already showing high rates of chronic illness and labor force disconnection (Theodos et al. 2010).

Virtually all participants (87 percent) used housing counseling services. Beyond that, strivers used primarily employment and child-related services, while participants from the two higher-need groups also used physical and mental health services. Most strivers reported participating in employment-related services (72 percent); the figure for the high-risk group was slightly lower (66 percent). In contrast, less than half (46 percent) of the aging and distressed group reported participating in these services. Additionally, 12 percent of strivers reported using physical health services, compared with 33 percent of high-risk and 43 percent of aging and distressed participants. Likewise, just 7 percent of strivers engaged in mental health services (i.e., independent counseling, group counseling, assessments), compared with 20 percent of high-risk and 32 percent of aging and distressed participants. Finally, not surprisingly, only a small proportion (4 percent) of aging and distressed households used child-related services such as summer and after-school programs, compared with about 40 percent of striving and high-risk families.[6]

Additional Costs of Intensive Services Were Relatively Modest

While the Demonstration produced high engagement levels and promising outcomes (Popkin, Theodos, et al. 2010), if the costs of the services were prohibitive, it would not be feasible to take this intensive model to scale. Because we did not have an adequate control or comparison group, we were unable to do a full cost-benefit or cost-effectiveness analysis.[7] We were, however, able to analyze per referral and per person costs, providing us with valuable information to better understand the costs of specific services, and how these household-level costs translate into the full-scale cost of the Demonstration. We used a bottom-up approach to estimating costs. This method calculates costs based on the unit of service, using data on internal and external program costs.[8]

To estimate service use, we used the CHA's administrative database, which tracks the type and number of referral for each household in its system, including all services that Heartland referred residents to through the Service Connector program, which ran through 2008, and the retooled FamilyWorks model, which replaced Service Connector. Heartland provided data on internal program costs, including data on staff salaries (fully loaded) and service duration for case managers, program supervisors, the wellness (clinical) team, the assets team, the employment team, and administrative support. For estimating external costs, Heartland provided information on where clients were referred and the title of the person providing the service, along with the estimated duration of service provision. HCP also provided information on the costs of relocation counseling.

Table 2. Referrals, Total Costs, and Unit Costs of Selected Demonstration Services

REFERRAL TYPE	TOTAL COST FOR REFERRAL CATEGORY	TOTAL REFERRALS	AVERAGE PER PERSON COST FOR REFERRAL CATEGORY
Employment	$1,304,947	794	$1,644
Housing services	$564,199	653	$864
Mental/physical health services	$126,729	233	$544
Substance abuse	$119,010	74	$1,608
Education	$116,354	169	$688
Child care/children/family	$60,660	375	$162
Financial education/assets	$37,851	106	$357
Public assistance meetings	$22,191	25	$888
Basic needs	$20,068	227	$88

Source: Urban Institute analysis of CHA administrative data.

To estimate external staff salaries, we used the Occupation Employment Survey, which provides average salaries by job type.

Costs vary tremendously across the different types of referrals, and much of what drives the costs are the intensity or duration of the service (table 2). Employment and substance abuse services are the most costly: Transitional Jobs includes a wage subsidy and frequent meeting withstaff for several weeks.[9] In-patient substance abuse treatment programs are time and staff intensive, and, therefore, very costly.

To estimate the total cost of Demonstration services, we multiplied the cost per referral by the number of people referred to that service. Because the CHA administrative data is referral data and does not track receipt of service, we created two total estimates; one that assumes all people who are referred receive that service, and a second that uses an estimated take-up rate to account for service no-shows. Heartland site managers provided us with the estimated take-up rates for each service. Because this approach to estimating cost requires several assumptions and estimates, it is a range rather than an exact figure.

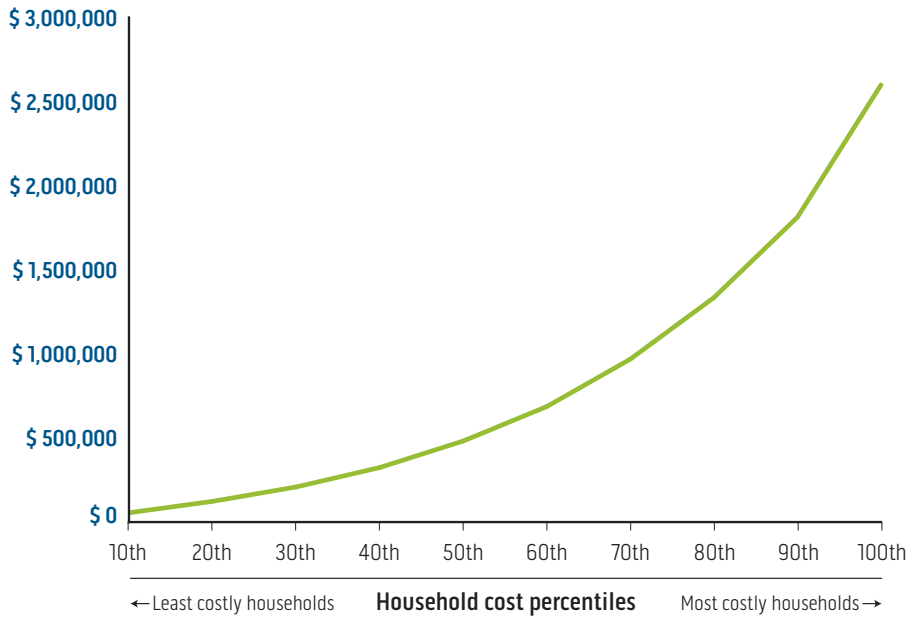
The estimated program service cost total, with no-shows taken into account, is roughly $2.1 million. The average cost for the 287 respondents in our 2009 follow-up sample is about $2,900 a year, about $900 more than the standard CHA service package. Our estimates include HCP's relocation services costs, as well as the TJ wage subsidy. When we assume that residents fully attended services, the total cost is roughly $2.6 million, or $3,600 annually per household. The CHA's service provider costs account for the largest share of the services, roughly two-thirds of the total, while external providers account for the remaining third. The Demonstration's costs are relatively modest compared with other intensive service programs. For example, the costs of a housing-first anti-homelessness program can be around $3,700 per individual a year (Gilmer, Manning, and Ettner 2009).

The cost per participant varies considerably. Unsurprisingly, higher average engagement leads to higher average per person costs. Just 10 percent of participants account for over 30 percent of the total cost of the Demonstration; 20 percent account for nearly 50 percent of the total cost; and 50 percent account for over 80 percent of the total costs (figure 2). On the other hand, some residents are minimally engaged and cost very little. For instance, the least-costly 20 percent accounted for only 5 percent of the total Demonstration costs.

Service Model Targets High-Risk Participants

Taken together, our analysis of service use and costs suggests that participants who fall into the high-risk group were the most likely to take up a range of services and, thus, the

Figure 2. Total Demonstration Costs, by Decile



Source: CHA administrative data.

most costly to serve. Substantial proportions of this group used every category of service—housing, employment, physical and mental health, and child-related—while strivers tended to use only housing, employment, and child services, and the aging and distressed tended to use only housing and health-related services. Yet, as argued elsewhere (Theodos et al. 2010), the high-risk group is likely the most appropriate target for an intensive service model: these adults are high need and young enough to benefit from employment programs, and most have children in their households. Although we are not able to do a full-cost benefit analysis here, our results suggest that this type of service investment is a promising strategy for effectively serving the needs of these extremely vulnerable families. While costly in the short run, the payoff may be substantial, especially if it helps stabilize their situations enough to avoid eviction or involvement in the child welfare or criminal justice systems.

Implications for Policy

The Chicago Family Case Management Demonstration has produced a successful model for providing wraparound services to residents in public and assisted housing settings. The lead service provider quickly achieved high levels of engagement, then adapted the basic service model as case managers learned more about resident needs. Case managers received additional training and support, and their improved performance was reflected in participants' improved perceptions of service quality and effectiveness. However, despite efforts to enhance relocation counseling, the Demonstration was less successful in helping participants to move to lower-poverty areas that might offer them and their children greater opportunity. The other briefs in our series (see Popkin, Theodos, et al. 2010) detail participant outcomes, including gains in employment and health, improvements in housing and neighborhood conditions, and reductions in fear and anxiety. The average costs for the intensive services were relatively modest (about $2,900 a year, or $900 more than the standard CHA service package, which does not include programs like TJ and GPTS), although costs varied considerably by level of need and service take-up. Still, the overall lesson of the Demonstration is that it would be feasible to take a carefully targeted, intensive service model to scale, and that doing so might pay off by stabilizing some of the most vulnerable public housing families.

- **It is possible to effectively combine housing and services to serve vulnerable families.** The Demonstration showed that it is feasible to partner wraparound services with a voucher. Most housing and services packages are place based, with the services provided on site in a specific development. The Demonstration showed that it was possible, at reasonable cost, to adapt this model to serve families who have moved to the private market with a voucher but still need assistance.

- **Housing authorities must be willing to take risks and experiment with service provision.** The key factors behind the success of the Demonstration were a housing authority committed to resident services, effective service providers willing to collaborate and participate in evaluation and performance monitoring, and a model that enabled continuous learning and adaptation. The CHA has already integrated lessons from the Demonstration into its larger resident services program and is seeking opportunities to test new ideas, such as incorporating services for youth into an intensive model. Other housing authorities could benefit from being equally willing to

experiment and test novel approaches for serving their most vulnerable households.

- **Targeting high-risk families may have long-term payoffs.** High-risk families—those grappling with mental and physical health challenges and disconnection from the labor market, while struggling to raise their children—are the heaviest consumers of intensive services. Stabilizing these extremely needy households may have long-term payoffs for both their own well-being and reduced costs for development management. Developing an assessment tool that successfully identifies these high-need households is critical so service providers can target services more efficiently and effectively (Theodos et al. 2010).

- **Performance measurement and evaluation should be part of any service model.** Even without a comprehensive evaluation, housing authorities and service providers can develop performance measurement systems that allow them to track performance. There are now several database systems for social service providers that enable them to track clients across different providers. Regular coordination, meeting, and review is critical to ensuring that service models stay on track and that providers are able to learn from experience and make mid-course corrections and adaptations to make their services more effective. Database systems not only should help providers gauge such outputs as resident participation, but also must collect data on resident outcomes, which allow agencies to assess the impact of service interventions on residents' well-being. ▪

Notes

1. Seven households were interviewed for both the CHA Panel Study and the Demonstration research.
2. This brief draws on material from Popkin et al. (2008) and Theodos et al. (2010).
3. For an overview of the Opportunity Chicago initiative, see Opportunity Chicago (2010).
4. A household was considered engaged if it had a FamilyWorks individual action plan and was meeting with its case manager.
5. To determine overall service use, variability in service use, and what services were used most frequently, we use the unit of the service (as defined as meetings, classes, counseling sessions, etc.). Some services are ongoing commitments (housing counseling, mental health counseling, job search assistance, etc.) whereas others are one-time commitments (TJ, GPTS, GED courses, etc.).
6. These differences were significant at the 5 percent level.
7. We attempted to construct a comparison group using CHA's administrative data but were unable to do so because of the limitations of that dataset, including the lack of information on key outcomes of interest.
8. In some cases, Heartland staff and outside organizations both provide a service. In those cases, we estimated the proportion of the service provided internally and externally, then created a weight that reflects these estimates. We used the weights to sum across the providers to give us one estimate per referral type.
9. The average cost of TJ for one client is $3,400. The wage subsidy accounts for roughly 85 percent of the cost of the service.

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Chicago Family Case Management Demonstration

The Chicago Family Case Management Demonstration was a partnership of the Urban Institute, the Chicago Housing Authority (CHA), Heartland Human Care Services, and Housing Choice Partners, intended to test the feasibility of providing wraparound supportive services for vulnerable public housing families. The demonstration ran from March 2007 to March 2010, targeting approximately 475 households from the CHA's Dearborn Homes and Madden/Wells developments with intensive case-management services, transitional jobs, financial literacy training, and relocation counseling.

The Urban Institute evaluated the Chicago Family Case Management demonstration to inform implementation and track outcomes for participants over time. In spring 2007, we conducted a baseline resident survey (n = 331, response rate 77 percent). The survey asked about a range of domains, including housing and neighborhood conditions, service use, mental and physical health, employment and economic hardship, and children's health and behavior. We conducted a follow-up survey (n = 287, response rate 90 percent) in summer 2009, approximately two years after the rollout of the demonstration. The largest source of attrition between 2007 and 2009 was mortality; we were able to locate, if not survey, nearly all original sample members.

To complement the survey, Urban Institute staff conducted 30 qualitative in-depth interviews (21 adults and 9 adolescents) with participants in summer 2008. We also gathered information from CHA administrative records and case manager reports, including whether residents chose to engage in the demonstration services, whether participants were referred for additional services, and their relocation history. In addition, we assembled secondary data on neighborhood poverty, unemployment, crime, race and other characteristics that we received from the Metro Chicago Information Center. Finally, we conducted a process study to assess the efficacy and cost of the demonstration's implementation. We conducted in-depth qualitative interviews with case managers, project staff, relocation providers, and CHA administrators, monitored service implementation weekly, and met regularly with Heartland and Housing Choice Partners leadership and CHA staff. We also thoroughly analyzed the costs associated with the intensive services.

The principal investigator for the Chicago Family Case Management Demonstration is Susan J. Popkin, Ph.D., director of the Urban Institute's Program on Neighborhoods and Youth Development. Funding for the demonstration was provided by the John D. and Catherine T. MacArthur Foundation, the Annie E. Casey Foundation, the Rockefeller Foundation, the Partnership for New Communities, JPMorgan Chase, and the Chicago Housing Authority.

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Supporting Vulnerable Public Housing Families

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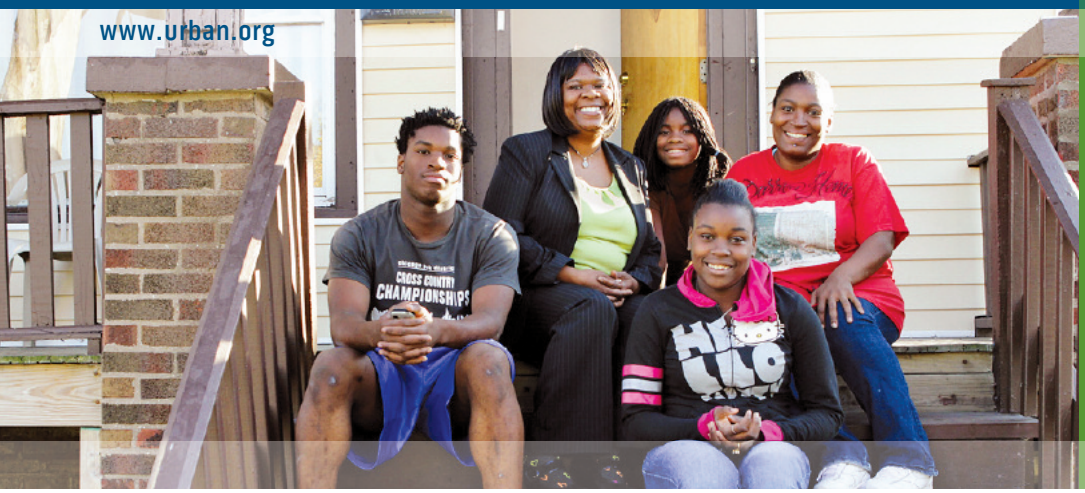


INSIDE THIS ISSUE

- Physical and mental health of Demonstration families remained stable.
- Chronic illness and mortality rates are extremely high.
- Substance abuse and mental illness remain serious problems.

Tackling the Biggest Challenge

Intensive Case Management and CHA Residents' Health

Susan J. Popkin and Liza Getsinger

The Urban Institute's HOPE VI Panel Study research has highlighted the health crisis hidden in distressed public housing developments in Chicago and in other communities across the nation (Popkin et al. 2002). While much public health research has linked the physical environment to well-being (see Lindberg et al. 2010), the range and severity of the challenges that the Panel Study uncovered was shocking. Respondents from all five study sites were in far worse health than other low-income minority households, reporting high rates of overall poor health, asthma, and depression (Manjarrez, Popkin, and Guernsey 2007; Popkin 2010; Popkin et al. 2002; Popkin, Levy, and Buron 2009). Not only did respondents report high rates of chronic disease, they were also clearly severely debilitated by their illnesses, and their poor health created a potential barrier to their ability to work (Levy and Woolley 2007).

In 2009, the Urban Institute followed up with the Chicago Panel Study respondents to assess how they were faring as the Chicago Housing Authority's (CHA) ambitious Plan for Transformation completed its first decade.[1] Respondents' well-being had improved in important ways: they were living in substantially higher-quality housing in much safer neighborhoods (Buron and Popkin 2010; Popkin and Price 2010). Given that respondents' lives had improved, it seemed plausible that their mental and physical health might have gotten better as well. However, the Panel Study respondents' health had actually worsened in the four years since they were last interviewed. In fact, the levels of reported health problems for the CHA Panel Study sample in 2009 were stunning, far higher than national averages, and the mortality rate was shockingly high. The only positive health news was that CHA Panel respondents reported significantly lower levels of anxiety than they had before relocation (Price and Popkin 2010). These findings clearly indicated the need for innovative strategies to address the health challenges facing CHA families.

The Chicago Family Case Management Demonstration ran from March 2007 to March 2010, overlapping with the 2009 CHA Panel Study (Popkin et al. 2010). The Demonstration—a partnership of the Urban Institute, the CHA, Heartland Human Care

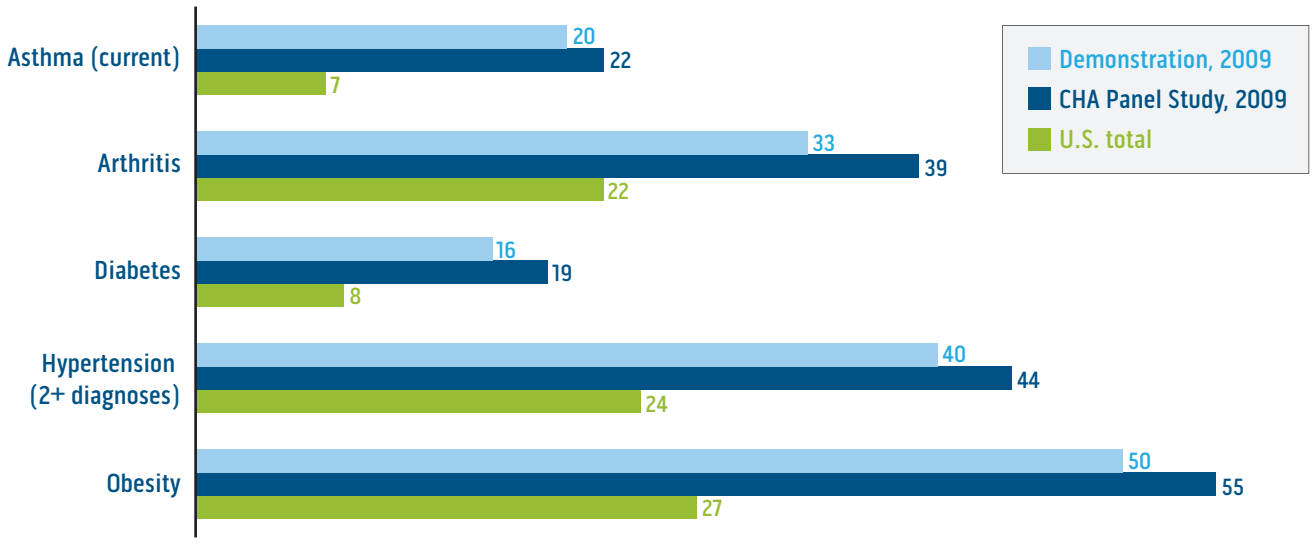
> Better housing in safer communities has not undone the damage that years of living in a dangerous environment has inflicted on CHA residents' health.

Services, and Housing Choice Partners—intended to test the feasibility of providing wraparound supportive services for vulnerable public housing families (Popkin et al. 2008). The Demonstration provided residents from the CHA's Dearborn Homes and Madden/Wells developments with intensive case management services, transitional jobs, financial literacy training, and relocation counseling. The Urban Institute conducted a rigorous evaluation, including a baseline and follow-up survey, administrative interviews, focus groups with service providers and program administrators, in-depth resident interviews, and analysis of program and administrative data (see text box on page 8). Where possible, outcomes for the Demonstration were compared with those from the 2009 CHA Panel Study.

As a result of the findings from the five-site HOPE VI Panel Study research, one key goal of the Demonstration was to improve participants' mental and physical health. The Demonstration's baseline participant survey in 2007 reinforced the decision to increase the focus on mental health; high levels of crime and fear were adversely affecting respondents' general well-being, with those who were more fearful also reporting higher levels of anxiety and physical mobility problems (Roman and Knight 2010). Heartland incorporated health services into intensive case management (along with transitional jobs, financial literacy, and relocation counseling) rather than creating a separate service. As Heartland staff began implementing this model, lowering caseloads and increasing engagement, case managers quickly identified a critical need for additional services to address participants' deep mental illness and substance abuse challenges (Popkin et al. 2008). While Heartland was unable to offer other health services directly, the agency partnered with a local hospital to arrange for a visiting nurse to come to the sites and provided periodic health screenings, such as checking blood pressures.

The Demonstration intentionally targeted vulnerable public housing families—that is, those facing multiple, complex challenges. Given the results from previous research, we expected their health trajectory would be similar to—or even worse than—the CHA Panel Study sample. But results from the 2009 follow-up survey painted a much different picture than we had anticipated: in contrast to the Panel Study sample, Demonstration participants' health did not deteriorate over time, and their anxiety levels improved as much, or more, in a shorter time. While some signs are positive, rates of chronic illness and mortality for the Demonstration population

Figure 1. Chronic Illness (percent)



Sources: 2009 Demonstration sample, 2009 CHA Panel Study sample, and 2008 National Health Interview Survey.

are extremely high, and substance abuse and mental illness remain serious problems for many participants.

This brief reviews the findings from the Demonstration on physical and mental health, considers the possible explanations for the differences from the Panel Study, and discusses the implications for policy and practice.

Demonstration Participants' Health Remained Stable Over Time

Given that the Demonstration population comprised "hard to house" households—with complex challenges such as mental illness, substance abuse, and histories of lease violations—in two of the CHA's last remaining distressed developments (Popkin et al. 2008), we expected that their health outcomes would be even worse than those for the CHA Panel Study. Instead, between baseline and follow-up, their health status remained remarkably stable. There were no significant changes in respondents' ratings of their overall health; in fact, more respondents reported improvements than declines. In 2007, 54 percent of residents rated their health as fair or poor, compared with 48 percent in 2009. Twenty-four percent of respondents reported health improvements between 2007 and 2009; multivariate analyses indicate that these improvements are associated with lower levels of substance abuse (not being a regular drinker) and seeing a mental health counselor.[2] In contrast, 9 percent of respondents reported worse health in 2009 than in 2007; multivariate analyses showed that these declines were associated with having a chronic illness and poor mental health at baseline.[3] The fact that physical and mental health remained stable is an important finding, and more research is needed to better understand why this occurred and if these findings will hold up over time.

Levels of Chronic Illness Remain High but Are Lower than the CHA Panel Study

Like the CHA Panel Study respondents, the Demonstration respondents report extremely high levels of chronic illness and disability. As with their overall health ratings, respondents' reports of chronic illness did not change significantly over the course of the Demonstration.

- In 2009, nearly half of respondents reported having an illness that required ongoing care, and 51 percent reported having two or more chronic health conditions. Demonstration respondents report slightly lower levels of chronic illness than those in the Panel Study, but both groups' rates of illness far exceed national averages (figure 1).[4]

- Demonstration participants not only report having been diagnosed with serious, chronic diseases at high rates, but they are also very debilitated by their health problems, reporting severe difficulty with activities of daily living at levels well above national averages. Over a third (39 percent) of respondents report severe difficulty with three or more activities, compared with only 4 percent of the general population and 6 percent of black women.[5]

- Similar to the CHA Panel Study findings, chronic health conditions present a major barrier to employment for many Demonstration participants; 27 percent reported that they had been unable to work over the past 12 months because of their health, and about one third reported receiving Supplemental Security Income.

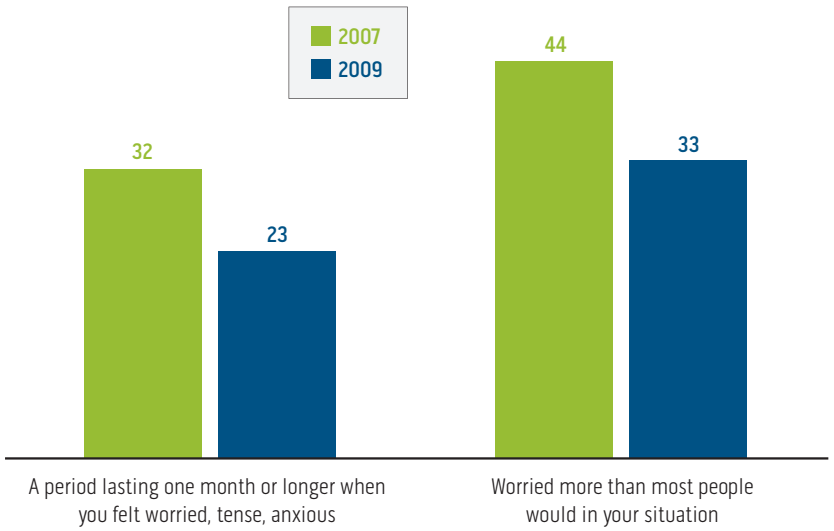
Rhonda's story illustrates how a combination of chronic health conditions can make it difficult to hold a job. When we interviewed Rhonda, a former Madden/Wells resident, in summer 2008, she described her struggles with substance abuse, depression, and severe hypertension. She had recently been fired from the fast-food job she had held for several years because of her recurring health problems.

> *I got sick, due to high blood pressure. And I kept constantly getting sick and they [her employer] told me that they were going to end up having to let me go or I need to do something to take care of myself. Because every time I got sick on the job they got tired of me calling the paramedics, saying [I'm] making them their store look bad.… I was the cook. Standing around that heat really got to me. When I got sick, ended up in the hospital, and then the doctors they checked me out [...] I was in there for about no more than about an hour. And then they sent me home. And when I went home I didn't have no doctor statement, and then that's when they fired me.*

Mental Health and Substance Abuse Remain Significant Challenges

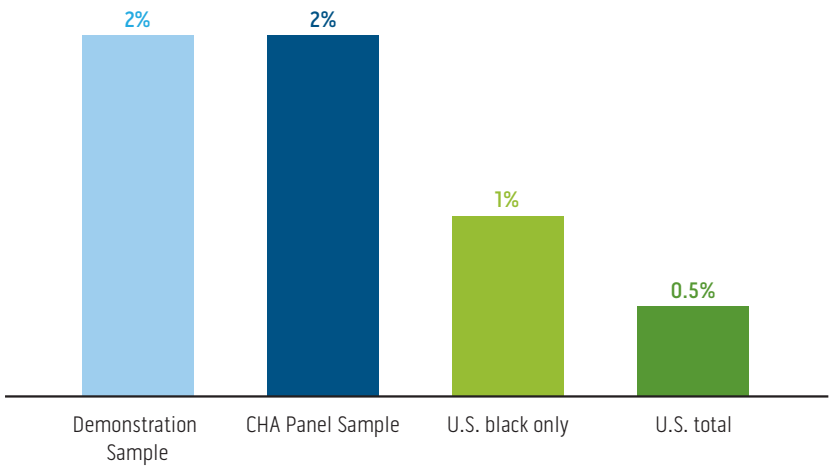
The original Demonstration service model did not include distinct mental health services. The plan was to have Heartland's case managers provide support through their more frequent contacts with clients and refer clients to external service providers as needed. However, as case managers began implementing the intensive model, which included more frequent visits with clients, they uncovered one tough problem after another: residents with schizophrenia who had stopped taking their medications and refused to open the door, women suffering from severe depression, and substance abusers so in debt to drug dealers that the dealers had taken over their apartments. Because of the often-overwhelming distress among Demonstration participants, it became apparent early on that case managers required additional support. As a result of the growing need,

Figure 2. Anxiety and Worry among Demonstration Respondents (percent)



Sources: 2007 and 2009 Demonstration samples.

Figure 3. Annualized Mortality Rate in Demonstration and Comparison Populations



Sources: 2009 Demonstration Sample, 2005 CHA Panel Study Sample, and 2005 National Vital Statistics Reports.

Heartland instituted regular clinical consultation groups to its staff (Popkin et al. 2008).

A year into the Demonstration, the CHA reconfigured and took direct control of its resident services programs, which had been managed through the Chicago Department of Human Services. Heartland and its other service providers had to negotiate new contracts in 2008; this renegotiation provided Heartland with resources to hire "wellness counselors" (i.e., clinical case workers) for each site and, eventually, a psychiatrist able to come to each site a few hours a week (Popkin et al. 2010). The Demonstration's clinical director, reflecting back on the challenges of working with this extremely needy population, said in 2009, "This population, from my opinion, is much more vulnerable than the rest of the CHA population. There is a much higher clinical need…and it's a much harder to reach population."

At the follow-up in 2009, 14 percent of Demonstration respondents reported attending either group or one-on-one counseling. But, despite the shifted focus on mental health and substance abuse services, the proportion of respondents' screening as having poor overall mental health (23 percent) or clinical depression (12 percent) did not change significantly.[6] The lack of change is not surprising, given that these serious, chronic conditions are difficult to treat in a community setting; for many low-income, minority women, effective treatment requires a combination of intensive therapy and medication (Miranda et al. 2003). While overall mental health did not improve, as in the CHA Panel Study, respondents did report significant reductions in anxiety. The Demonstration participants' level of anxiety and worry declined by nearly 10 percentage points from 2007 to 2009, although their levels of anxiety remain higher than those for the Panel Study sample, reflecting the higher levels of distress in this population (figure 2).

In addition to the clinical mental health issues, the Demonstration population included a high proportion of individuals struggling with serious substance abuse problems. Many were women like Jasmine (see sidebar) battling a toxic combination of addiction, depression, and domestic violence, which made addressing their needs extremely challenging. Heartland initially assigned one case manager based in Dearborn to focus exclusively on outreach to substance abusers; after the agency added clinical staff in 2008, the wellness counselor at Madden/Wells also focused on working with substance abusers. In addition to conducting outreach and working to engage these clients, case managers ran weekly support groups and helped get them into drug treatment programs (Popkin et al. 2010).

Annette, a 30-year-old mother to five children (including two foster children) and a former Wells resident, spoke about using alcohol to help her cope with her worries:

> *When I'm depressed, I go buy me something to drink. I mean, that ain't good but I try to go get me something to drink or something. Just so I won't have to sit here. But then I know once that drink gone, I'm back at the same problem all over again.*

In 2009, 9 percent of respondents reported having been in a treatment program for drugs or alcohol use at some point. However, the survey responses do not accurately reflect the level of problems—or of the services Heartland provided. For obvious reasons, respondents were reluctant to discuss their substance use with interviewers and, despite our efforts, obtaining accurate information was difficult. The best indicator we have is respondents' reports of alcohol use, and there we did see a significant reduction from baseline to follow-up.

Heartland's substance abuse outreach coordinator told us in June 2008 that he saw numerous clients struggling with a complex mix of mental health and substance use disorders that made addressing their needs particularly challenging. As he said:

> *Biggest challenge I think is post-traumatic stress disorder. I think in an environment like this, it is very prevalent and it's not being addressed. As a counselor with some clinical background and therapeutic values, you have to be able to work around that….And at least 95 percent of my caseload are females. And when I talk to them about their substance abuse issues and they tell me when it started…it's mostly "That I witnessed my son getting killed," "I was raped"….You know, and I know they've never had any grief counseling or anything like that. You know they just went up, went along with their normal life.*

Mortality Rates Are Shockingly High

One of the most disturbing findings from the HOPE VI Panel Study was that death rates for the five-site sample far exceeded national averages (Manjarrez et al. 2007). The 2009 CHA Panel Study showed that for CHA families, this grim trend had continued; mortality rates were shockingly high (Price and Popkin 2010). Sadly, despite encouraging trends in general health, the same trend is evident among the Demonstration population: between 2007 and 2009, 13 people (2 percent) of the sample died. This figure is twice as high the rate for the U.S. black population and four times the rate for nation as a whole (figure 3).[7] After controlling for such factors as age, a multivariate analysis found that Demonstration participants who were disabled, regular drinkers, and were not engaged in services were more likely to have died by follow-up.[8]

Jasmine's Story

Jasmine is a severely depressed 35-year-old single mother raising four children while coping with domestic violence and substance use. Growing up, Jasmine lived with her mother, stepfather, and three siblings on the South Side of Chicago. Jasmine had a troubled childhood, and she says her parents were emotionally and physically abusive. She struggled in high school and dropped out her senior year but eventually completed her GED.

Jasmine has continued to face serious challenges. She developed a serious, yet preventable, health condition that went untreated and eventually left her nearly blind. Her disability and limited education made it difficult to find work. Jasmine moved into the Dearborn Homes because her disability payments did not allow for her to provide for herself and her newborn son. After moving to public housing, she became severely depressed, and she says she used drugs and alcohol to help her cope with her pain.

Jasmine and her four children have recently moved out of the Dearborn Homes and into another public housing development, but their situation remains precarious. Jasmine's new boyfriend has become dangerously abusive; she says he is putting her and her children's lives in jeopardy. Her substance use problems have also worsened, and the Department of Children and Family Services recently required her to complete a three-month residential treatment program for alcohol addiction and domestic violence. While she was in treatment, her children were placed in foster care. After she completed the program, she regained custody on the condition that she attend weekly parenting classes. Despite her many problems, Jasmine says she believes that with the support of her case manager and her family, she can overcome her struggles with addiction and mental illness.

Policy Implications

As with the CHA Panel Study, the results from the Demonstration evaluation suggest that it has been easier to improve residents' life circumstances than to address their physical and emotional health. The CHA has provided residents with better housing in safer communities—in both public housing and the private market (Theodos and Parilla 2010). But these changes have not undone the damage that years of living in a dangerous, stressful environment has inflicted on residents' health. Even the intensive case management and clinical services the Demonstration provided were only able to make a small dent in health outcomes for participants—seemingly stabilizing their overall health, reducing anxiety, and lowering levels of alcohol consumption. While these results are encouraging, the modest progress underscores the depth of the challenges facing these families—and service providers.

To truly improve the quality of life for its most vulnerable residents, the CHA and its service partners will have to seriously commit to addressing the critical need for comprehensive mental health and substance abuse services. Specifically, the CHA should take the following four steps:

- **Provide clinical mental health services on site for its residents; make services accessible for voucher holders.** A substantial proportion of CHA's most vulnerable residents suffers from serious mental disorders—depression, schizophrenia, PTSD—that require intensive clinical support and medication. CHA should make continuing to provide clinical services through its FamilyWorks resident services program a priority. FamilyWorks currently serves only residents in CHA's traditional public housing communities. Many of CHA's vulnerable families are now voucher holders; meeting their needs is more challenging and will require a new approach to service provision. The challenge for the CHA and other housing authorities will be finding strategies (e.g., careful targeting or partnering with local providers) that allow the agency to provide clinical services to voucher holders on a broader scale. Other housing authorities could use the Demonstration as a model to replicate and test strategies for targeting services more effectively to residents.

- **Invest in permanent supportive housing for the most vulnerable residents.** The severity of the mental health and substance abuse problems among CHA's most vulnerable residents suggests that many will require a more long-term solution than case management or counseling. Families with these complex challenges might fare better in permanent family supportive housing, which offers intensive services on site. The CHA and other housing authorities could consider incorporating small numbers of supportive housing units into existing public housing and mixed-income developments, as well as providing intensive wraparound services to voucher holders.

- **Strengthen its partnerships with public and nonprofit agencies that can provide improved health services for its residents.** For example, the CHA should work with the Department of Public Health to ensure that federally qualified health centers are located near its developments. The U.S. Department of Health and Human Services Public Housing Primary Care Centers provide one avenue for funding such centers. Another possibility is reaching out to local hospitals and medical centers in Chicago that can provide mobile vans to offer regular primary health care and dental care to CHA's residents. Finally, the CHA should explore other options, such as public health interventions that train residents to be community health workers.

- **Promote healthy living and physical activity.** CHA residents will not be physically active unless they feel safe being outside. Therefore, the most critical thing that the CHA can do is work to sustain the safety improvements in its public housing and mixed-income developments that have so improved the overall quality of life for its residents. The agency should also look for resources or partnerships to create recreation centers in or near its developments, or potentially to provide "scholarships" for gym membership for CHA residents. ▪

Notes

1. The MacArthur Foundation funded the follow-up of the Chicago Panel Study (Popkin et al. 2010) as part of its efforts to assess the Plan for Transformation at 10. See Vale and Graves (2010) for a review of this research.

2. Change in health status was modeled using a multivariate logistic regression; the dependent variable was whether self-reported health improved between baseline and follow-up. Those who saw a one-on-one or group counselor at follow-up ($p < .05$) and those who were not regular drinkers at baseline ($p <. 10$) were more likely to report positive change, controlling for housing assistance status in 2009, gender, age, overall mental health, and ongoing illness in 2007.

3. Change in health status was modeled using a multivariate logistic regression; the dependent variable was whether self-reported health declined from excellent or very good at baseline to fair or poor at follow-up. Those who had chronic illnesses ($p < .05$) and those who were anxious at baseline ($p < .05$) were more likely to report worsening health, controlling for housing assistance status in 2009, gender, age, overall mental health, and depression in 2007.

4. The reason for this difference is not entirely clear; the average age of both the CHA Panel and Demonstration populations is the same, and both groups report poor health overall. National health data in this brief are published by the U.S. Department of Health and Human Services as the 2008 National Health Interview Survey (NHIS) age-adjusted summary health statistics for U.S. adults. Many health problems vary significantly by gender and race; because most adults in the Demonstration sample are women and all are black, a sample of black women nationally is used as the comparison group. NHIS data are broken down by sex and race, but not further by poverty status. Nationally, approximately a third of all black women live in households with incomes below the poverty level. Therefore, the comparison data are biased slightly upward in terms of better health because the national population of black women is relatively better off economically than the Demonstration and HOPE VI samples. However, even limiting the comparisons to similar gender, race, and age groups, adults in the Demonstration and HOPE VI studies experience health problems more often than other demographically similar groups.

5. Respondents were asked how difficult it is to perform each of seven activities: walk a quarter-mile; climb 10 steps without resting; stand for two hours; sit for two hours; stoop, bend, or kneel; reach over their heads; and carry 10 pounds. Severe difficulty is defined as a response of "very difficult" or "can't do at all." Comparisons are from the non-age-adjusted NHIS sample adult file from 2008.

6. Overall mental health is based on the mental health inventory five-item scale. Major depressive episodes are based on the Composite International Diagnostic Interview Short Form major depression index for episodes over the past year.

7. The mortality rate for the general population is calculated by determining the probability that each respondent would survive based on averages for people of their age and sex, using a 2005 National Vital Statistics Reports life table.

8. Mortality was modeled using a multivariate logistic regression. Those who were disabled, were regular drinkers, and who had never seen a case manager were more likely to have died by 2009 (all $p < .05$) . Gender, age, and general mental and physical health were controlled for and were not associated with mortality.

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Chicago Family Case Management Demonstration

The Chicago Family Case Management Demonstration was a partnership of the Urban Institute, the Chicago Housing Authority (CHA), Heartland Human Care Services, and Housing Choice Partners, intended to test the feasibility of providing wraparound supportive services for vulnerable public housing families. The demonstration ran from March 2007 to March 2010, targeting approximately 475 households from the CHA's Dearborn Homes and Madden/Wells developments with intensive case-management services, transitional jobs, financial literacy training, and relocation counseling.

The Urban Institute evaluated the Chicago Family Case Management demonstration to inform implementation and track outcomes for participants over time. In spring 2007, we conducted a baseline resident survey (n = 331, response rate 77 percent). The survey asked about a range of domains, including housing and neighborhood conditions, service use, mental and physical health, employment and economic hardship, and children's health and behavior. We conducted a follow-up survey (n = 287, response rate 90 percent) in summer 2009, approximately two years after the rollout of the demonstration. The largest source of attrition between 2007 and 2009 was mortality; we were able to locate, if not survey, nearly all original sample members.

To complement the survey, Urban Institute staff conducted 30 qualitative in-depth interviews (21 adults and 9 adolescents) with participants in summer 2008. We also gathered information from CHA administrative records and case manager reports, including whether residents chose to engage in the demonstration services, whether participants were referred for additional services, and their relocation history. In addition, we assembled secondary data on neighborhood poverty, unemployment, crime, race and other characteristics that we received from the Metro Chicago Information Center. Finally, we conducted a process study to assess the efficacy and cost of the demonstration's implementation. We conducted in-depth qualitative interviews with case managers, project staff, relocation providers, and CHA administrators, monitored service implementation weekly, and met regularly with Heartland and Housing Choice Partners leadership and CHA staff. We also thoroughly analyzed the costs associated with the intensive services.

The principal investigator for the Chicago Family Case Management Demonstration is Susan J. Popkin, Ph.D., director of the Urban Institute's Program on Neighborhoods and Youth Development. Funding for the demonstration was provided by the John D. and Catherine T. MacArthur Foundation, the Annie E. Casey Foundation, the Rockefeller Foundation, the Partnership for New Communities, JPMorgan Chase, and the Chicago Housing Authority.

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The authors wish to thank the dedicated staff from the CHA, Heartland Human Care Services, and Housing Choice Partners, the many colleagues who have contributed to and commented on this research, and, most of all, the Demonstration participants, who have so generously shared their stories with us.

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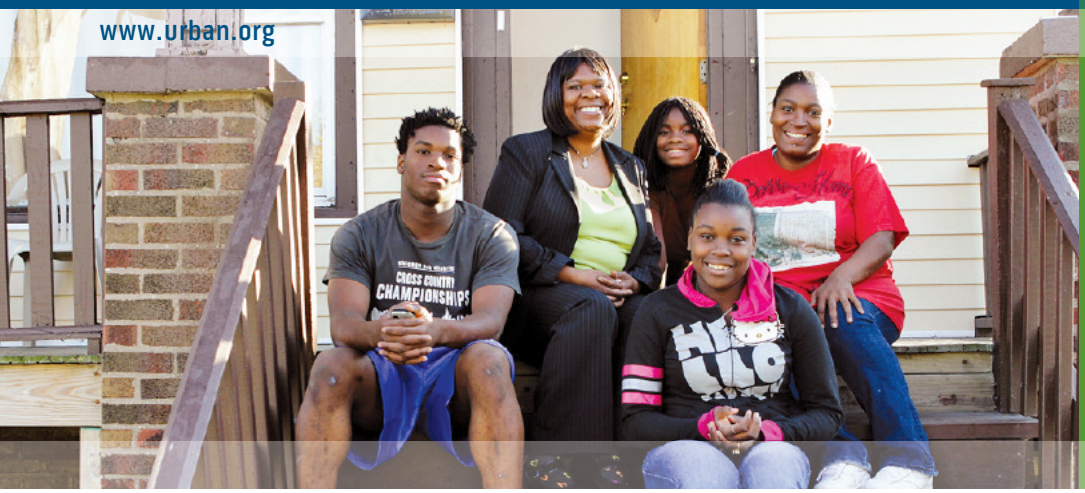


INSIDE THIS ISSUE

- Employment increased, but earnings did not, and public assistance receipt remained stable.
- Transitional Jobs reached a range of residents and helped them find jobs.
- Stable employment will be difficult to find without first addressing residents' serious health challenges.

Moving "Hard to House" Residents to Work

The Role of Intensive Case Management

Joe Parilla and Brett Theodos

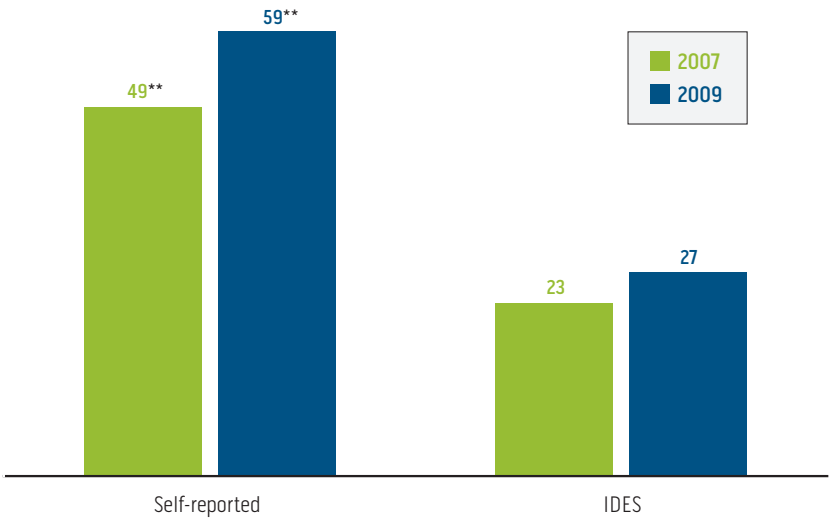
The Chicago Housing Authority's (CHA) Plan for Transformation, an ambitious overhaul of the city's public housing stock, has attempted to integrate public housing residents into the economic and social fabric of Chicago. Research from the CHA Panel Study, which tracked a sample of Madden/Wells development residents from 2001 to 2009, showed that, eight years after the Plan's inception, most residents were living in better housing and in substantially safer neighborhoods (Buron and Popkin 2010a, b; Price and Popkin 2010). However, nothing from the CHA Panel Study or the full five-site HOPE VI Panel Study[1] shows that these quality-of-life improvements have translated into employment gains for CHA residents. Residents continue to face well-documented barriers to self-sufficiency, resulting in stagnant employment rates (Levy 2010; Levy and Kaye 2004; Levy and Woolley 2007).

The CHA Panel Study findings highlight the challenge of connecting CHA residents to the labor market. That challenge is even bigger for the CHA's "hard to house" residents—those with multiple complex problems, such as serious mental and physical ailments, addiction, domestic violence, and histories of lease violations. The Chicago Family Case Management Demonstration was an innovative effort to test the feasibility of providing wraparound supportive services, including work supports, for vulnerable public housing families (Popkin et al. 2008). The Demonstration—a partnership of the Urban Institute, the CHA, Heartland Human Care Services, and Housing Choice Partners—provided households from the CHA's Dearborn Homes and Madden/Wells developments with intensive case management services, Transitional Jobs, financial literacy training, and relocation counseling. The Urban Institute conducted a rigorous evaluation, including a baseline and follow-up survey, administrative interviews, focus groups with service providers and program administrators, in-depth resident interviews, and analysis of program and administrative data (see text box on page 9). The goal of the Demonstration was for residents to be stably housed in better circumstances and to increase their self-sufficiency.[2]

This brief explores the employment experiences of Demonstration participants,

Despite an extremely difficult labor market, self-reported employment among working-age Demonstration participants increased, and the Transitional Jobs program contributed to these gains.

Figure 1. Change in Employment, 2007–09 (percent)



Sources: 2007 and 2009 Demonstration sample, and Illinois Department of Employment Security.
** Difference between 2007 and 2009 is significant at the $p < .05$ level

including the influence of the intensive case management, participation in the Transitional Jobs program, and the work requirement that CHA began using in 2009. Using a similar methodology as the HOPE VI Panel Study, it examines outcomes for working-age nondisabled Demonstration participants.[3]

Surprisingly, despite an extremely difficult labor market, self-reported employment *increased,* a notable divergence from a decade of research on public housing transformation (Briggs, Popkin, and Goering 2010; Levy 2010; Turner, Popkin, and Rawlings 2009). Further, the intensive Transitional Jobs program that was part of the Demonstration appears to have contributed to these employment gains. Yet, despite increases in employment, the economic situation for most CHA families remains tenuous. Although employment increased, earnings did not, and public assistance receipt remained stable. For those who remained unemployed, the Demonstration's services failed to address a multitude of personal and structural barriers to work.

Moving Public Housing Residents to Work

A central goal of the transformation of public housing that began in the 1990s is to help residents become more self-sufficient (Popkin et al. 2004; Turner et al. 2009). Public housing residents face numerous barriers to employment: low educational attainment, poor mental and physical health, limited access to social networks that facilitate job access, and physical isolation from opportunity (Turney et al. 2006). Different initiatives have attempted to help residents overcome these barriers—by relocating residents to higher-opportunity areas, encouraging employment and earnings through alternative rent structures, and providing job training and case management services.

The most successful effort was the U.S. Department of Housing and Urban Development's (HUD) Jobs-Plus program, which sought to connect public housing residents to employment through employment services, rent incentives, and community support for work. Where Jobs-Plus was properly implemented, residents experienced marked employment and earnings increases (Bloom et al. 2005).

The Moving to Opportunity (MTO) demonstration offered residents from high-poverty public housing developments the chance to move to low-poverty "opportunity" areas in the hope that residents would increase their economic well-being. While MTO participants experienced significant improvements in quality of life, their employment and educational attainment did not improve relative to a control group that received no assistance (Briggs et al. 2010). The results from the five-city HOPE VI Panel Study were similar: respondents moved to safer, lower-poverty neighborhoods, but their employment rates remained stagnant (Levy and Woolley 2007).

Other research has shown that job attachment and retainment for low-skilled workers requires a long-term, open-ended service commitment. An evaluation of 12 models in the Employment Retention and Advancement project found successful programs required job search assistance, a stipend for employed former welfare recipients, reemployment assistance, and work site visits (Hendra et al. 2010). Similarly, Project Match, a Chicago-based workforce development program, combined a human development approach with comprehensive pre- and post-employment services for an open-ended period. For their "high advancement" group, earnings jumped 105 percent over 10 years (Herr and Wagner 2009).

Employment Results of the Chicago Family Case Management Demonstration

The CHA's resident services programs emphasize connecting residents to the labor market.[4] The Demonstration, which built on the CHA's Service Connector model, included self-sufficiency programs and services along with intensive case management, a Transitional Jobs program, and referrals to GED programs and other continuing education classes at community colleges. Midway through the Demonstration in 2008, the CHA revamped its resident services, renaming its case management system FamilyWorks and increasing the emphasis on helping residents make a final housing choice and find employment. FamilyWorks drew on early findings from the Demonstration by adding clinical case management (Popkin et al. 2010a). This change was followed by the CHA's 2009 introduction of a new, controversial work requirement as a condition of occupancy across the CHA's public housing stock. As a part of the requirement, every adult age 18 to 61 (or age 17 and not attending school full time) in a public housing unit is expected to be working or engaging in employment-related activities 15 hours a week in 2009, and 20 hours a week thereafter, unless the authorized adult is exempt or granted Safe Harbor.[5]

Surprising—and Tenuous—Gains in Employment

As discussed above, the only housing-related self-sufficiency program to improve employment among public housing residents was Jobs-Plus, which included specific workforce interventions. Even though the Chicago Family Case Management Demonstration provided employment services, Panel Study findings on persistently high unemployment rates led us to have low expectations for whether the Demonstration's services could improve outcomes for especially vulnerable residents. Further, the 2008 recession could have outweighed any employment gains, potentially resulting in higher unemployment among the sample. However, the survey results show surprisingly positive findings: Demonstration participants' self-reported employment rate increased from 49 percent in 2007 to 59 percent in 2009 (figure 1).[6] In contrast, the CHA Panel Study found *no* changes in respondents' levels of employment from 2001 through 2009.[7]

We also assessed Demonstration participants' changes in employment using administrative data. There, the change in employment is not statistically significant, although the trend is similar. According to the Illinois Department of Employment Security (IDES), Demonstration participants' employment increased from 23 to 27 percent.

There are at least two possible explanations for the difference between self-reported employment and employment measured by IDES. First, IDES only collects employment information from businesses that register for unemployment insurance, which many small businesses do not do (Carlson 1995). Many CHA residents may work for businesses that are not registered with IDES and, therefore, are not counted in this measure. Second, those respondents might hold jobs that are part of the informal economy—a commercial system comprising legal and illegal activities that are not taxed, such as informal child care or braiding hair (Turner et al. 2009; Venkatesh 2006).

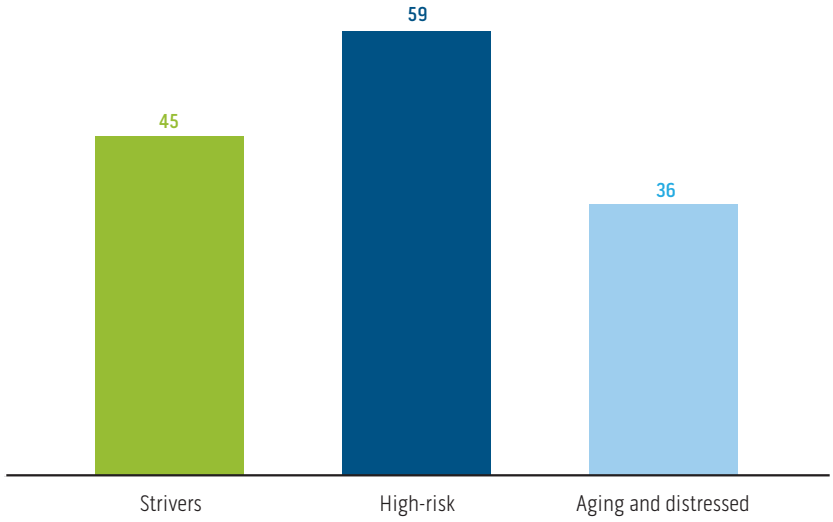
In a logistic regression analysis, we examined the factors associated with individuals that gained employment between the two periods. The following characteristics were associated with obtaining employment:[8] having a high school diploma or GED, having a supportive family,[9] and participating in the Demonstration's Transitional Jobs program.[10] Interestingly, while self-reported employment increased for the Demonstration sample, wages and incomes did not change in the aggregate from 2007 to 2009. Respondents still report an average wage of just over $10 an hour and most households are still living below the poverty level. Further, there is no difference in wages between residents listed as employed in IDES and those that only self-reported as employed, suggesting that there may not be a wage premium associated with formal employment, at least as defined by IDES.

Since wages did not improve, it is not surprising that the reported levels of public assistance receipt remained unchanged as well. In 2009, 37 percent of households received SSI; 68 percent of households received food stamps, and 10 percent of households received Temporary Assistance for Needy Families, roughly the same as in 2007.

Transitional Jobs—a Successful Short-Term Strategy

Demonstration participants were a particularly vulnerable subset of CHA's resident population, and many had been disconnected from the labor market for years. Even those who were working often lacked the education and skills to help them access anything but the lowest-paying jobs. Heartland designed its Transitional Jobs (TJ) program, part of the CHA's larger Opportunity Chicago workforce initiative, to serve the hardest to employ. TJ attempts to connect participants to the labor market, relying on intensive employment and interview training, rapid attachment to the workforce, three months of subsidized employment, and continued counseling and advocacy support throughout the first year of employment. For residents with no work experience, the 90-day trial period serves as a glimpse into the responsibilities and benefits of employment,

Figure 2. Transitional Jobs Participation Rate by Cluster (percent)



Source: 2009 Demonstration sample.

as Heartland's TJ coordinator explained in a focus group in December 2009:

> *It's [through] the work experience that folks really realize what it takes to work. They do take those skills with them. That's a transferable skill – going to work on time. And then understanding "I can make some good money doing this… or some money doing this."*

Heartland incorporated TJ into the Demonstration; TJ staff conducted active outreach to participants, and case managers referred clients to the program and helped support them once they enrolled. Initially, the Demonstration staff underestimated the severity of participants' barriers to employment. The TJ coordinator reported problems with enrolling residents in the program because they failed the mandatory drug screening and did not meet the 9th grade education level that many employers required (Popkin et al. 2008). The program adapted to the latter challenge by instituting a pilot program focused on improving literacy levels for participants. It also lowered the literacy standards for entry into the program (Popkin et al. 2010a).

Despite these adjustments, Heartland administrators and case managers believe there is still room for improvement. Specifically, several staff noted that the one-week training period is too short to address severe deficiencies in soft skills, such as showing up to work on time, dressing appropriately, and being respectful of supervisors and coworkers. Further, case managers have seen residents become disheartened when they complete TJ and are still unable to find employment, as one case manager explained:

> *Even though Heartland has a lot of job training programs, [the participants] get tired of going through the same old training again and not finding employment. So they just want to put in an application and go straight to work. They see [TJ] as a waste of their time.*

Overall, analysis from the follow-up survey indicates that the TJ program reached a range of participants, including those with the most complex needs. Our typology categorizes residents into three groups: "strivers," younger residents who mostly have high school degrees and are connected to the labor force; "aging and distressed," who suffer from high rates of mental and physical illness, lack high school degrees, and have little work experience; and "high risk," younger residents already showing high rates of chronic illness and labor force disconnection (Theodos et al. 2010). TJ served residents from all three groups, but reached a majority of those categorized as high risk (figure 2).

Transitional Jobs has also helped residents obtain employment. Nearly 60 percent of residents that were not working in 2007 and employed in 2009 participated in TJ. While the program has successfully placed hard-to-employ residents in temporary employment, its ability to push job seekers toward sustained employment is uncertain. Of the households that had participated in TJ during the previous two years, 60 percent were not working in 2009, a much higher rate than the 40 percent that were out of work across our whole sample (Popkin et al. 2010a).

CHA's Work Requirement: Early Success?

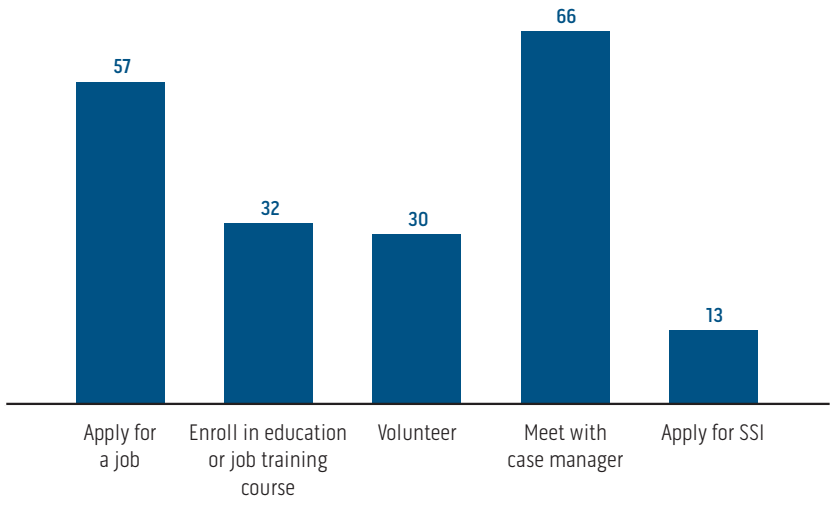
In addition to the TJ services, Demonstration participants had access to an intensive financial literacy program called Get Paid to Save and to the full range of Service Connector (later, FamilyWorks) services for literacy, edu-

cation, and job readiness and retention. In addition to working or volunteering, engagement in these employment-related services satisfied CHA's work requirement. Indeed, even though the work requirement began only six months before the 2009 follow-up survey, the policy had already considerably altered nonworking Demonstration participants' behavior. Among heads of household living in traditional public housing or mixed-income housing and unemployed in 2009, 57 percent said they had looked or applied for a job, 32 percent had enrolled in a job training or education program, 30 percent had volunteered or participated in community service, 66 percent had met with their case managers, and 13 percent had applied for SSI (figure 3). These findings are similar to those from the CHA Panel Study survey, which also took place in summer 2009 (Levy 2010). In interviews, CHA administrators spoke positively about the impact of the work requirement and indicated that they believed the economic downturn had not necessarily derailed employment prospects for CHA residents.

Demonstration Participants Still Face Significant Barriers

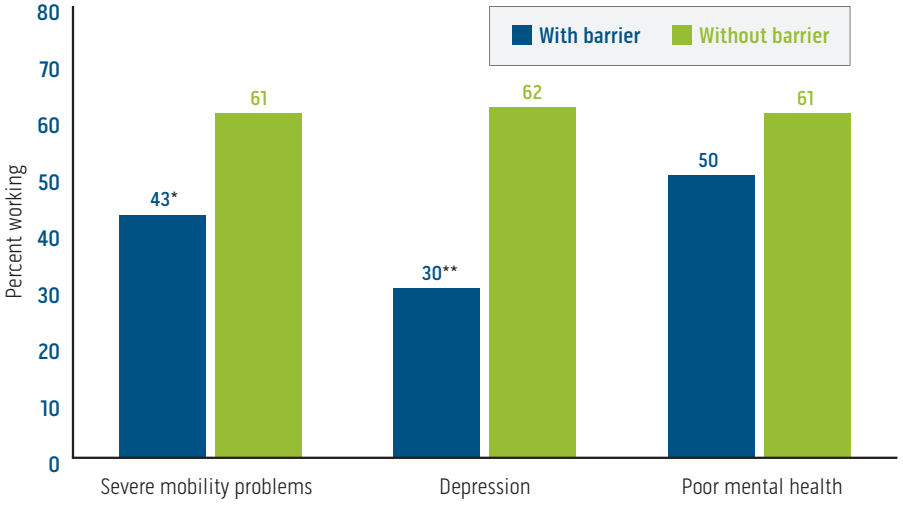
Demonstration participants faced many challenges that made obtaining—and sustaining—regular employment challenging. Indeed, many had been disconnected from the labor market for more than a decade. For the aging-and-distressed and high-risk groups, the barriers to employment were particularly pronounced (Popkin et al. 2008; Theodos et al. 2010). Even with the gains described above, employment rates for these public housing residents remain extremely low. Although the Demonstration appears to have improved or at least stabilized participants' health, rates of chronic physical illness, disability, mental illness, and substance abuse are extremely high (Popkin and Getsinger 2010). Similar to the findings from the Panel

Figure 3. CHA Work Requirement Impact (percent)



Source: 2009 Demonstration sample.

Figure 4. Employment and Health



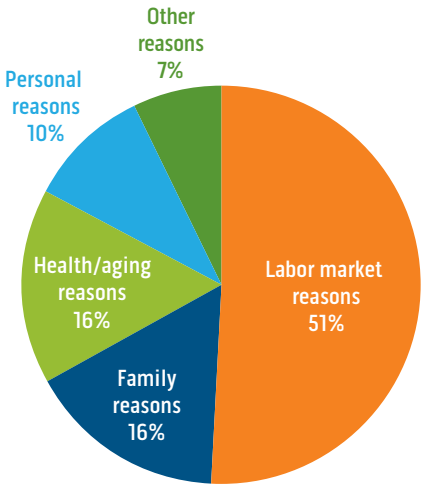
Source: 2009 Demonstration sample.
* Difference between those with and without barrier is significant at the $p < .10$ level.
** Difference between those with and without barrier is significant at the $p < .05$ level.

Study (Levy 2010; Levy and Woolley 2007), we find that chronic health problems remain a barrier to finding and sustaining employment (figure 4).

The limited types of jobs for which Demonstration participants qualify partly explain why these health challenges present such a challenging barrier. The most frequently cited jobs for these respondents are in cleaning services, security, child care, and food service—industries that require physical stamina and in which health benefits and sick leave are rare (Pérez and Muñoz 2001).

Further, the recession that began in 2008 appears to have affected Demonstration participants' employment prospects, disproportionately damaging prospects for minority workers. Unemployment rates for blacks and Hispanics increased on average by 3.6 percentage points a year from 2007 to 2009, while the rate for whites increased by 2.5 percentage points (Reidenbach and Weller 2010). At the follow-up survey in 2009, over half of working-age Demonstration participants who were not employed cited economic or labor-market reasons (figure 5). Heartland staff believe that the ground-level impact of the recession on residents is undeniable. Low-skilled workers are struggling to compete for jobs, and long-term employment will be a challenge in this economic environment.

Figure 5. Employment Barriers



Source: 2009 Demonstration sample.

The Costs of Moving CHA Residents to Work

There is still some reason for optimism. Despite significant challenges, the intensive case management and work supports appear to have increased employment and successfully engaged even some of the most disconnected participants. However, if the costs of these services outweigh the modest gains for CHA residents, then these findings are of only limited interest.

Our evaluation included a detailed cost analysis for the Demonstration. Table 1 details the take-up, per person cost, and total cost of each employment-related service from March 2008 to September 2009. TJ, because of the three-month wage subsidy (approximately $3,000 total) provided to participants, has the highest per person ($3,402) and total costs ($116,138). These costs are also borne entirely by the Demonstration, whereas GED courses, which are referred out, do not show up in the direct costs. While these costs seem reasonable given the outcomes thus far, a definitive conclusion regarding the effectiveness of training and other investments must be reserved until long-term monitoring reveals whether gains in employment are sustained.

Policy Implications

Given the challenges facing Demonstration participants, we anticipated that even with intensive case management and work supports, we might see no gains in employment rates; in fact, with the recession, we thought we might see decreases. Instead, our follow-up results reveal that, despite an extremely difficult labor market, self-reported employment among working-age Demonstration participants increased, a notable divergence from a decade of HOPE VI research. Further, the intensive Transitional Jobs program appears to have contributed to these employment gains.

However, the Demonstration did not cure all the problems faced by these extremely vulnerable public housing residents. The increase in self-reported employment rate did not translate to higher incomes or less reliance on public assistance, at least during the course of our study. We also have concerns about whether these employment gains will last in this challenging economic climate. And for out-of-work residents, the Demonstration's services were not enough to lift them over a multitude of personal and structural barriers to work. The experience of the Demonstration—coupling intensive case management with employment services—offers lessons not only for the CHA's practices, but also for other housing authorities grappling with similar challenges.

- **The Transitional Jobs model is extremely promising.** Demonstration participants, like many CHA residents, clearly need supports and incentives to help them achieve employment. The Transitional Jobs program appears to be helping even distressed residents achieve this goal, at least in the short term. According to our survey, the majority of residents that gained employment between 2007 and 2009 participated in TJ. However, the program was not as successful at placing residents who were extremely unprepared for the workforce, namely those with literacy levels far below the requirements for entry-level work. Heartland's experiment with adding literacy

Table 1. Employment-Related Service Take-Up and Cost

	SHARE ENROLLED	FULL COST		DEMONSTRATION COST	
	Demonstration	Per person	Total (annual)	Per person	Total (annual)
GED course	9%	$1,472	$21,099	—	—
Continuing education course	4%	$166	$775	$128	$597
Employment skills training	25%	$755	$17,617	$545	$12,717
Financial literacy	23%	$357	$17,664	$357	$17,664
Transitional Jobs	18%	$3,402	$116,138	$3,402	$116,138

Note: Not all services were provided by the Demonstration's providers. "Full cost" columns detail the costs borne by the Demonstration's service providers and all external providers. "Demonstration cost" columns represent costs borne by Heartland.

to the TJ program occurred too late in the Demonstration for us to fully evaluate, but the initial results were promising. Further, service providers consistently stated that a one-week training program was not enough to fully address many of the barriers to employment that residents face. And some TJ participants are unable to maintain stable employment after their three-month subsidy period. The CHA should continue funding TJ, while also considering a more intensive training program for the neediest participants that focuses on literacy and developing soft skills.

The findings from the Demonstration have ramifications for housing authorities nationwide. Our results indicate the need for a two-tiered training strategy. The first tier would target a two- to three-week TJ program to residents with the requisite literacy and education for entry-level employment. The second, more intensive program would resemble the revised TJ model and last four to six weeks, with more emphasis on improving literacy.

As the country enters a period of extended high unemployment, public and assisted housing residents need the supports and incentives provided through such programs as Transitional Jobs more than ever. The Demonstration proves that strategic partnerships between housing authorities and service providers are associated with real gains. Yet, answering the question of whether this model is scalable requires replication by housing authorities in other cities.

- **A successful job-training program must address stark mental and physical health barriers to work.** Aside from the economy, the most frequently cited barriers that keep CHA residents from working are health related. Depression, anxiety, and substance abuse preclude working-age individuals from being mentally prepared to hold down a job. Many residents do not have the physical capacity to work because of chronic physical health problems including diabetes, hypertension, and asthma. Stable employment will be difficult to obtain without first addressing these serious health challenges.

- **The CHA must rigorously evaluate the impact of the work requirement.** While the CHA did not implement its work requirement for public housing residents until halfway through the Demonstration, it had some effect on the behavior of nonworking Demonstration participants. The CHA plans to raise the hours requirement from 15 hours a week to 20, and has hinted that it will expand the work requirement to include voucher holders as well. Given the CHA's position at the vanguard of innovative public housing workforce strategies, its findings from the first few years of the work requirement will undoubtedly reverberate throughout public housing authorities nationwide. ▪

Notes

1. See Popkin, Levy, and Buron (2009) for a full description of the five-site HOPE VI Panel Study research.

2. See Popkin et al. (2010b) for an overview of the Demonstration.

3. Our sample, which consists of adults between 18 and 61 years old who do not receive Supplemental Security Income (SSI) or Social Security Disability Insurance, represents 62 percent of the overall Demonstration sample.

4. For an overview of the Opportunity Chicago initiative, see "A Partnership for Change: How Opportunity Chicago Helped Create New Workforce Pathways for Public Housing Residents," http://www.opportunitychicago.org/pages/story/documents/OC_partnership_for_change.pdf.

5. A resident may be eligible for an exemption, which he or she receives at annual reexamination, or may be approved for Safe Harbor, in which case he or she has 90 days to become compliant with the work requirement. Property managers will continue to reexamine a resident's Safe Harbor status every 90 days to determine continued eligibility throughout fiscal year 2010. For more information, see the CHA's Admissions and Continued Occupancy Policy at http://www.chicagometropolis2020.org/documents/CHA_Admissions_and_Continued_Occupancy_Policy.pdf.

6. This result is significant at the .05 level.

7. Results from the HOPE VI Panel Study are used to benchmark our findings. But because of the different time frames, different relocation studies, and small sample sizes, we are unable to determine impact or make definitive outcome comparisons.

8. Change in employment was modeled using a multivariate logistic regression; the dependent variable was whether employment status changed from not working to employed between 2007 and 2009. Having a high school degree or GED, having a supportive family, and participating in Transitional Jobs were significant at the .05 level, controlling for physical health, depression, housing assistance, gender, the presence of children in the household, and age.

9. Family support is measured by a scale composed of 13 questions from the Social Support Survey/Family Support Scale. Cronbach's alpha is 0.73. The response category to questions were strongly agree, somewhat agree, somewhat disagree, and strongly disagree.

10. We found the Transitional Jobs program a significant factor leading to employment for residents with sufficient literacy levels.

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Chicago Family Case Management Demonstration

The Chicago Family Case Management Demonstration was a partnership of the Urban Institute, the Chicago Housing Authority (CHA), Heartland Human Care Services, and Housing Choice Partners, intended to test the feasibility of providing wraparound supportive services for vulnerable public housing families. The demonstration ran from March 2007 to March 2010, targeting approximately 475 households from the CHA's Dearborn Homes and Madden/Wells developments with intensive case-management services, transitional jobs, financial literacy training, and relocation counseling.

The Urban Institute evaluated the Chicago Family Case Management demonstration to inform implementation and track outcomes for participants over time. In spring 2007, we conducted a baseline resident survey (n = 331, response rate 77 percent). The survey asked about a range of domains, including housing and neighborhood conditions, service use, mental and physical health, employment and economic hardship, and children's health and behavior. We conducted a follow-up survey (n = 287, response rate 90 percent) in summer 2009, approximately two years after the rollout of the demonstration. The largest source of attrition between 2007 and 2009 was mortality; we were able to locate, if not survey, nearly all original sample members.

To complement the survey, Urban Institute staff conducted 30 qualitative in-depth interviews (21 adults and 9 adolescents) with participants in summer 2008. We also gathered information from CHA administrative records and case manager reports, including whether residents chose to engage in the demonstration services, whether participants were referred for additional services, and their relocation history. In addition, we assembled secondary data on neighborhood poverty, unemployment, crime, race and other characteristics that we received from the Metro Chicago Information Center. Finally, we conducted a process study to assess the efficacy and cost of the demonstration's implementation. We conducted in-depth qualitative interviews with case managers, project staff, relocation providers, and CHA administrators, monitored service implementation weekly, and met regularly with Heartland and Housing Choice Partners leadership and CHA staff. We also thoroughly analyzed the costs associated with the intensive services.

The principal investigator for the Chicago Family Case Management Demonstration is Susan J. Popkin, Ph.D., director of the Urban Institute's Program on Neighborhoods and Youth Development. Funding for the demonstration was provided by the John D. and Catherine T. MacArthur Foundation, the Annie E. Casey Foundation, the Rockefeller Foundation, the Partnership for New Communities, JPMorgan Chase, and the Chicago Housing Authority.

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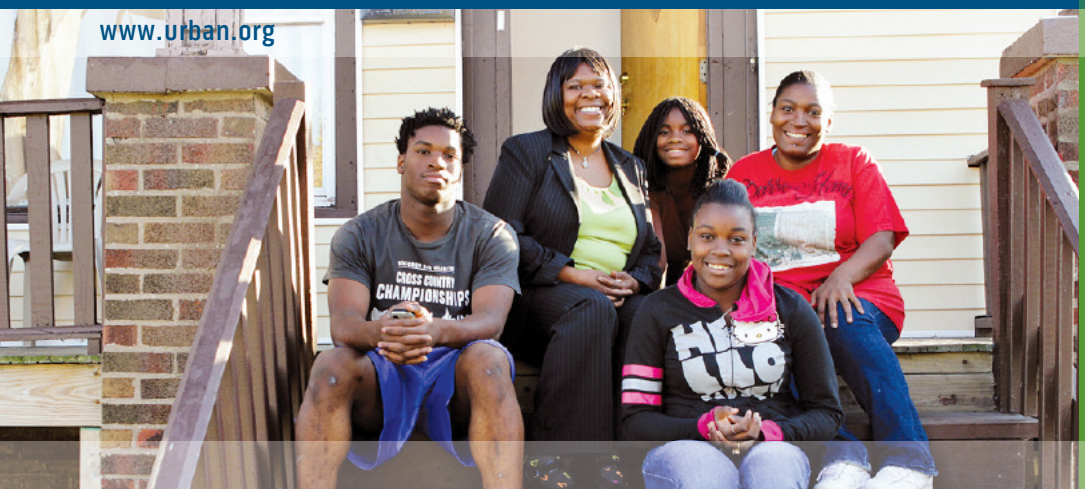

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- Demonstration participants live in much higher quality homes and apartments.
- Residents accessed areas where they feel safer, but very few made moves to neighborhoods of opportunity.
- Relocation counseling for vulnerable families needs to be intensive, long term, and integrated with other services.

Relocating Vulnerable Public Housing Families

Brett Theodos and Joe Parilla

By the 1990s, when the Chicago Housing Authority (CHA) initiated its ambitious Plan for Transformation, the agency's distressed, high-rise public housing developments were icons of failed federal housing policy. As the CHA implemented its 10-year revitalization strategy to "transform" 25,000 units, it faced the daunting challenge of relocating thousands of residents. The agency had little experience providing relocation counseling or case management. Further, CHA residents were especially disadvantaged: because of the terrible conditions in the family developments, many tenants who had had better options had left long ago, leaving behind a population dominated by the extremely vulnerable (Buron and Popkin 2010).

Not surprisingly, the CHA struggled with relocation. The process was initially very contentious; two lawsuits were filed against the agency, and a court-appointed independent monitor oversaw relocation (Popkin 2006). The Relocation Rights Contract, negotiated in 2000, formally spelled out the CHA's obligations to leaseholders during the housing transformation. The contract defined the terms for lease compliance and the steps residents could take to "cure" lease violations and remain eligible to move into the new mixed-income developments. The contract also specified the services to be offered to residents while they waited for permanent housing; by mid-decade, the CHA had developed a comprehensive relocation and case management system (Popkin 2010).

When the Plan for Transformation began, the CHA's family public housing developments were among the poorest, most troubled communities in the nation. As extensive social science literature has shown, living in communities with concentrated poverty undermines residents' safety and mental health, and it seriously limits access to employment, social networks, quality schools, and adequate health care (Cutler and Glaeser 1997; Ellen and Turner 1997; Massey and Denton 1993; Roman and Knight 2010; Wilson 1987). CHA's public housing is now dramatically better, thanks to improved management and new construction and design ideas

Demonstration residents universally live in better housing and feel safer, but nearly all remain in high-poverty, racially segregated neighborhoods.

(Business and Professional People for the Public Interest 2009).

The CHA's transformation efforts have undoubtedly changed the face of public housing in Chicago; the notorious developments are gone and are gradually being replaced with new, mixed-income housing. Evidence about how the original residents have fared is mixed but generally more positive than many originally expected (Vale and Graves 2010). The CHA Panel Study, which tracked a sample of residents from the Madden/Wells development from 2001 to 2009, shows that, eight years after the Plan's inception, most of these residents are living in better housing in substantially safer neighborhoods (Popkin et al. 2010). Still, even with these gains, most former Madden/Wells residents are living in moderately poor, predominantly minority communities that offer little opportunity for them and their families (Buron and Popkin 2010).

In addition, the Plan has not been able to help CHA's most vulnerable families—those "hard to house" families with multiple, complex problems such as serious mental and physical ailments, addiction, domestic violence, and histories of lease violations. These problems often make them ineligible for mixed-income housing or unable to negotiate the private market with a Housing Choice Voucher. These families risk being left behind in CHA's remaining traditional public housing developments, barely better off than before the Plan for Transformation began.

The Chicago Family Case Management Demonstration was an innovative effort to improve the circumstances and life chances of CHA's most vulnerable families, with the goal of ensuring that participants were stably housed in better conditions.[1] The Demonstration—a partnership of the Urban Institute, the CHA, Heartland Human Care Services (Heartland), and Housing Choice Partners (HCP)—provided households from the CHA's Dearborn Homes and Madden/Wells developments with intensive case management services to test the feasibility of providing wraparound supportive services in public and assisted housing, Transitional Jobs, financial literacy training, and relocation counseling and support (Popkin et al. 2008). The Urban Institute conducted a rigorous evaluation, including a baseline and follow-up survey, administrative interviews, focus groups with service providers and program administrators, in-depth resident interviews, and analysis of program and administrative data (see text box on page 11).

Initially, the CHA planned to relocate only some of the residents in Madden/Wells and none of the families in Dearborn (Popkin et al. 2008). But as conditions in Madden/Wells deteriorated, the CHA accelerated its plans and closed the development in summer 2008. At the same time, the agency received additional federal funds to comprehensively rehabilitate Dearborn. As a result, nearly all Demonstration participants had to move.

Generally, participants now live in much better housing in neighborhoods where they feel safer. However, most still live in public housing, and their new neighborhoods are still poor and racially segregated. This brief explores relocation outcomes for Demonstration participants, including their experiences with relocation services and their housing and neighborhood outcomes.

Moving Public Housing Residents to Better Neighborhoods

In most American cities, public housing has been located in poor, predominantly minority communities. Housing Choice (Section 8) Vouchers offer residents the potential to move to a broader range of areas, but the realities of rental markets, discrimination, voucher program rules, and residents' own preferences often mean that voucher holders also end up in high-poverty, racially segregated areas. Over the past two decades, federal housing policy has emphasized mobility and deconcentration strategies to help voucher holders move to areas that provide greater social and economic opportunity (Turner, Popkin, and Rawlings 2009). The theory behind these approaches is that public housing residents will experience greater well-being in more diverse, higher-opportunity neighborhoods (Joseph, Chaskin, and Webber 2007). However, these efforts have only moderately benefited low-income minority families. Evidence from two longitudinal studies of relocation—the five-site HOPE VI Panel Study and the Moving to Opportunity (MTO) Demonstration—shows these efforts helped them move to better housing in safer neighborhoods (Briggs, Popkin, and Goering 2010; Popkin, Levy, and Buron 2009). But these safer neighborhoods are generally still poor and racially segregated, and relocating does not appear to help residents overcome personal and structural barriers to better employment, earnings, health, or educational outcomes (Briggs et al. 2010; Levy 2010).

The transition from public housing to the private rental market with a voucher is challenging. New voucher holders can have difficulty accessing transportation to search for apartments, bypassing discriminatory or unscrupulous landlords, passing tenant screenings, and finding large units (if necessary) (Buron, Levy, and Gallagher 2007). As a result of these barriers (along with resident preferences, social networks, and knowledge), public housing residents often relocate to high-poverty areas when receiving a voucher. Voucher holders often settle in neighborhoods near their pre-voucher housing (Oakley and Burchfield 2009; Popkin and Cunningham 2000).

Relocation counseling is one strategy to help voucher holders access better neighborhoods. Relocation counseling may involve neighborhood tours for residents interested in vouchers, help locating apartment listings, assistance negotiating with landlords, housekeeping and tenant's rights workshops, and school quality information sessions. Research

on the CHA's Housing Opportunity Program and MTO residents who received relocation counseling and restricted vouchers (only usable in areas with less than 10 percent poverty) shows that participants were more likely to move to higher-opportunity neighborhoods than those not receiving relocation counseling (Cunningham and Sawyer 2005; Turner and Briggs 2008; Turner et al. 2008). The intensity of the counseling may matter as well; in a study of four cities, Varady and Walker (2000) find little difference in outcomes between voucher holders who participated in *moderate* relocation counseling and those who received no counseling at all.

Moving Out

When the Demonstration began in 2007, the CHA was conducting staged relocation in Madden/Wells in preparation for closing the development and anticipated only minimal relocation in Dearborn, which was to remain a traditional public housing development.[2] The 3,000-unit Madden/Wells development, located on the city's near South Side, was one of the CHA's largest public housing complexes. In 2007, the CHA was partway through demolishing and replacing Madden/Wells with a new, mixed-income community called Oakwood Shores, and only about 300 households lived in the remaining buildings. All the residents were African American, and most were long-term public housing residents with low incomes and poor physical and mental health (Popkin et al. 2010). In response to rapidly deteriorating conditions, the CHA first moved a group of residents in fall 2007, under an "emergency move" order, then decided to shutter the development entirely by August 2008.[3]

The trajectory for Dearborn residents was very different. Dearborn is an 800-unit development of six- and nine-story buildings on State Street, about a mile south of the Loop (Bowly 1978). During the first phases of the Plan for Transformation, the CHA used Dearborn as replacement housing for residents who were leaving other developments that were being demolished and had failed to meet the criteria for temporary vouchers or mixed-income housing. The resulting influx of residents from Robert Taylor Homes and Stateway Gardens created a volatile situation, with multiple gangs competing for territory within the development. The CHA received a federal grant that allowed it to comprehensively rehabilitate Dearborn; by 2010, about half the buildings were reopened. All around the development is evidence of the rapid gentrification that has spilled over from the booming South Loop community: new grocery stores, a Starbucks, gourmet restaurants, and a hotel. The redevelopment activity meant that nearly all Dearborn residents moved from their homes during the Demonstration, most of them temporarily to other units in Dearborn.

HCP provided relocation counseling for Demonstration participants, while Heartland provided post-relocation support as part of its intensive case management services. HCP's relocation services for the Demonstration included reduced caseloads and workshops intended to help educate residents and encourage them to consider making nontraditional moves to "opportunity areas" that were lower poverty. The workshops highlighted the benefits of opportunity areas, tenant rights and responsibilities, housekeeping, and school choice. Residents received a modest incentive for participation in each workshop. HCP also incorporated "second mover" counseling, conducting outreach to families that had used their vouchers to move to traditional high-poverty areas to try to encourage them to consider a second move to an opportunity area.

Because of the expedited closing of Madden/Wells and the CHA's decision to rehabilitate Dearborn, nearly all Demonstration participants had to find a new place to live, at least temporarily. Relocation counselors strove to help residents make a permanent housing decision that avoided the disruption of having to move multiple times. Seventy-five percent of participants moved just once; another 8 percent had yet to relocate from their Dearborn apartment when we followed up in 2009. Still, a not-inconsequential share of participants—15 percent—moved two or more times between 2007 and 2009; half of these residents had relocated with vouchers.

> "Moving to Oakwood Shores bettered my family, because the housing [at Madden/Wells] had all the people hanging out in the hall. At [Oakwood Shores], can't just live here and not do anything."

Demonstration participants had three relocation options: move to another public housing development (or, for Dearborn residents, another building within the development); relocate to a private-market apartment

with a voucher; or, if they qualified, move into a mixed-income development. Most participants (59 percent) moved into public housing, including 73 percent of Dearborn residents and 47 percent of those from Madden/Wells, while just 28 percent (mostly from Madden/Wells) chose vouchers. This pattern is very different than that for CHA Panel Study respondents (Buron and Popkin 2010); more than half of Panel Study respondents moved with vouchers in 2001, and just 12 percent remained in traditional public housing (figure 1). Demonstration participants' relocation decisions were influenced by a combination of factors: over 80 percent said they had to move because their development was being demolished or rehabilitated. Participants who made a second move cited a range of reasons, including finding a safer neighborhood (35 percent), losing their rental assistance (12 percent), and wanting a larger apartment (7 percent). In in-depth interviews, respondents told us that they chose public housing to avoid utility and other rent charges, because it was familiar, and because they could find attractive, newly rehabilitated units—a real contrast from previous residents' assessments of CHA developments.

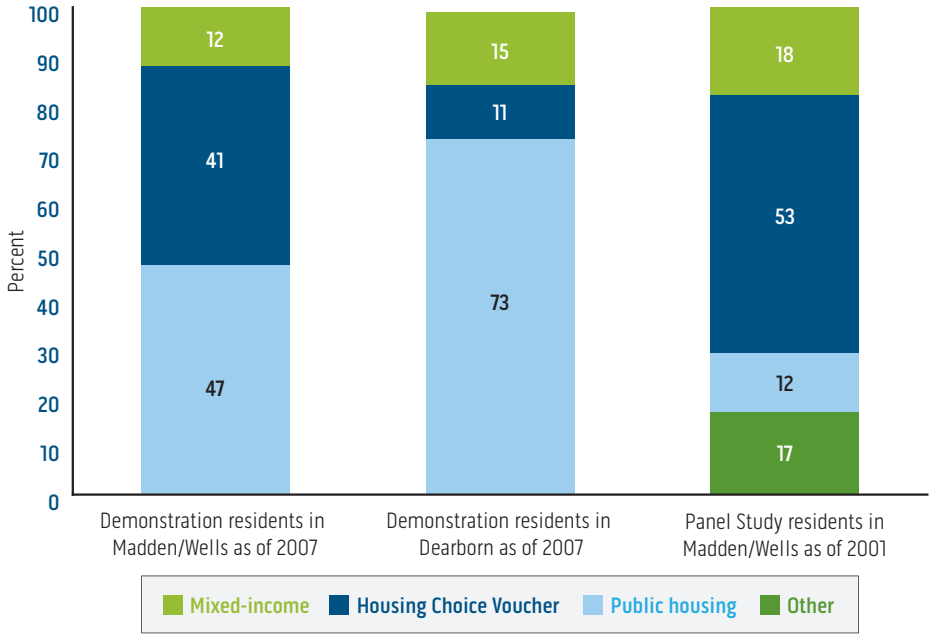
Given the vulnerability of the Demonstration population, we expected the housing search to be daunting for some residents, particularly those affected by Madden/Wells' expedited move-out schedule. It is no surprise, then, that a third of households reported difficulty finding housing. The biggest problem residents faced was affordability (23 percent), followed by finding a home with enough bedrooms (19 percent) and finding a landlord who would accept the voucher.

Private-market landlords and mixed-income developments often have screening criteria that are not required for families moving into public housing developments (Theodos et al. 2010). In 2009, roughly one in five participants said that they had trouble qualifying for a mixed-income development or a voucher, citing poor credit histories, owed rent, and a lack of employment as their primary reasons. Additionally, a small group of residents noted legal barriers. In interviews, many residents discussed uncertainty around whether they met the move-in criteria for these developments. Tanya, a single mother living in Dearborn, described being confused and frustrated by relocation:

> *They've been going back and forth with me trying to see if I can relocate to something else. Because I would like to move outside of here…How come I can't move into some of this new stuff they're building? But by I'm going through identity theft and there's a lot of stuff on my record… If you know they look at that and it's kind of hard, and I've been going through this for a few years because it ain't easy to clear it up. You know I even put in for that Section 8 [down there] when they opened it back up not too long ago. And I got a letter saying that I didn't get picked, you know. So, that was that.*

There was little difference from the CHA Panel Study in the proportion that ultimately moved to a new, mixed-income community. As figure 1 shows, 18 percent of CHA Panel Study respondents moved to a mixed-income development; the comparable figure for the Demonstration was only 5 percentage points lower. This finding suggests that the intensive case management services participants received may have helped them overcome some of the barriers to qualifying for the new developments.

Figure 1. Housing Assistance as of 2009 for CHA Residents



Source: Authors' analysis of CFCM Demonstration and HOPE VI Panel Study data.
Note: The public housing category also includes four residents living in project-based section 8 and two in senior housing. Madden/Wells residents in 2001 were surveyed by the HOPE VI Panel Study. "Other" responses include residents who left housing assistance altogether and became home owners.

Demonstration Participants Live in Better Housing

Demonstration participants experienced striking gains in housing quality. Four in five participants report that their current housing is in better condition than in 2007, with only 7 percent saying their present housing is worse. Over 80 percent of residents rank their current housing quality as good, very good, or excellent.

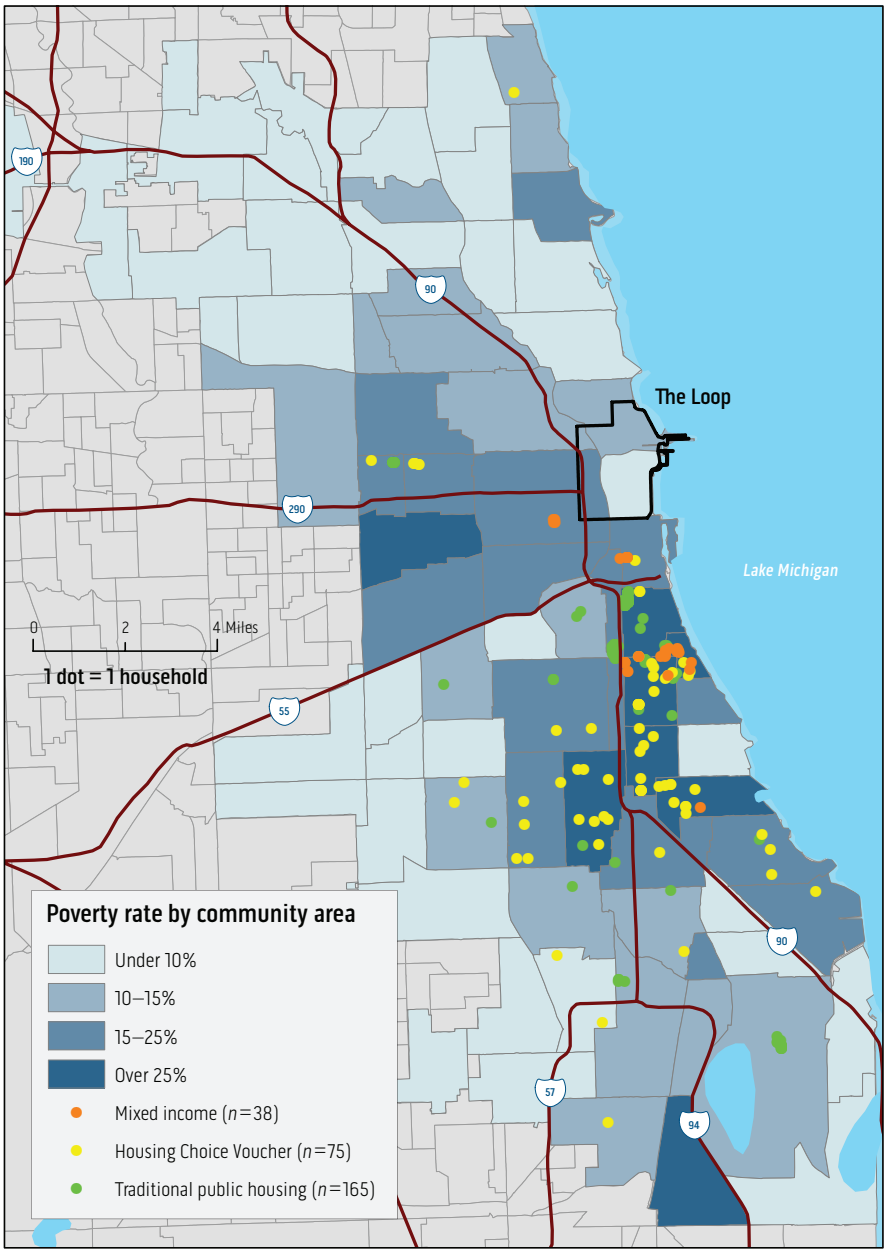
In 2007, respondents reported that their units were plagued with countless problems: water leaks, broken heat, cockroaches, mice, mold, and peeling paint. Stunningly, in 2009, more than half the respondents report virtually *no* housing problems (52 percent), another 23 percent report one problem, and the rest report two or more.

The magnitude of the gains vary only modestly by housing assistance. Mixed-income developments appear to have fewer problems than public housing developments or private-market apartments rented with a voucher. This makes sense, as most mixed-income developments were built within the past five years. Voucher holders' units, which tend to be older, are more likely to have problems with rats, mice, and cockroaches, though still at much lower rates than in residents' 2007 public housing units.

Demonstration Participants Still Live in High-Poverty Neighborhoods

HCP's relocation services were intended to help Demonstration participants access neighborhoods that offered greater opportunity, including high-quality schools, job opportunities, and safer streets. Conditions in Dearborn and Madden/Wells were so bad in 2007 that almost any move would have improved the quality of life for these families. However, for various reasons, public housing residents tend to relocate to other low-income, predominantly minority neighborhoods (Popkin et al. 2009; Turner et al. 2008).

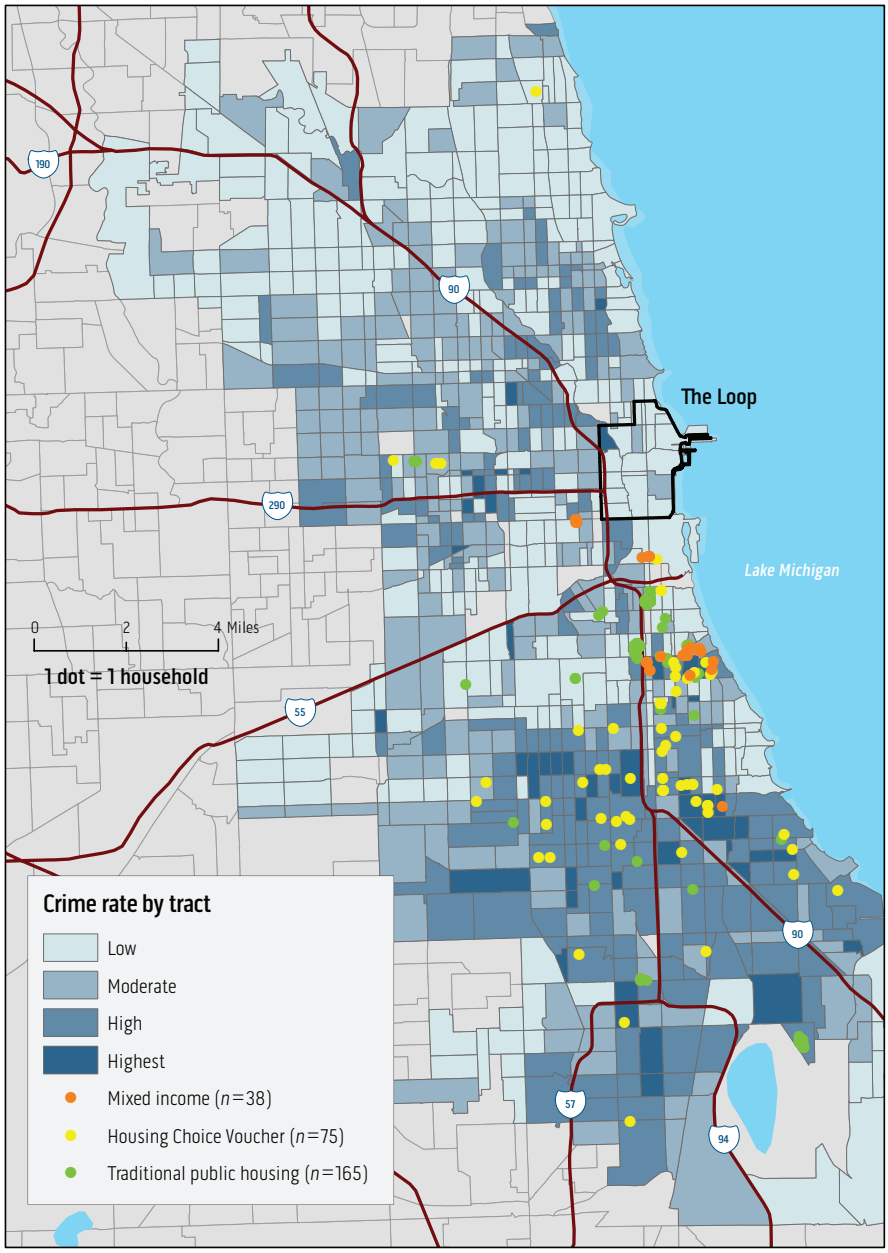
Figure 2. Neighborhood Poverty Rates for Demonstration Residents in 2009



Source: Metro Chicago Information Center.
Note: Poverty rate is the percentage of households whose annual income is below $15,000.

Demonstration participants generally did not travel far from their original development (figure 2). All remain within Chicago, clustering on the South and West sides of the city. Most remain in highly poor communities, with average poverty rates of 28 percent.[4] Likewise, most Demonstration participants still live in predominantly African American neighborhoods (79 percent black on average), although this represents a decrease from 2007

Figure 3. Neighborhood Violent Crime Rates for Demonstration Residents



Source: Metro Chicago Information Center.

Notes: Map reflects residents' locations as of 2009 with violent crime rate data from 2008. Violent crime includes homicide, robbery, battery, aggravated assault, and rape. The low violent crime category is defined as 0–1.9 crimes per 1,000 people, moderate as 2.0–5.6 per 1,000, high as 5.7–16.1 per 1,000, and highest as 16.2–50.4 per 1,000.

(86 percent black). The violent crime statistics are compelling and distressing. Most residents remain in the most violent neighborhoods in the city (figure 3),[5] with no improvement from their original communities.

Demonstration Participants Feel Safer

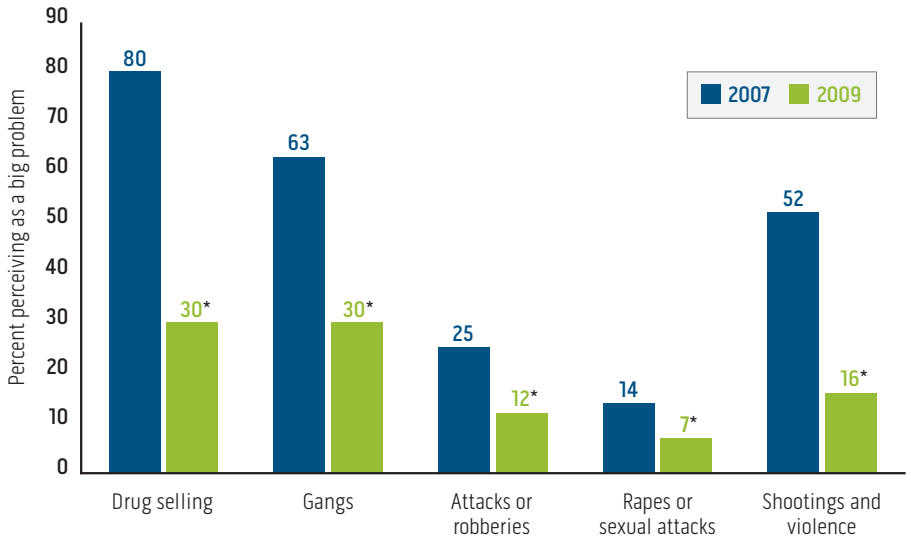
Although most Demonstration participants moved to communities that differed little from their original developments, they believe their quality of life has improved dramatically. These findings are very similar to those from the CHA Panel Study (Buron and Popkin 2010; Popkin and Price 2010). We are not entirely sure what creates this discrepancy, but it may reflect the fact that Madden/Wells and Dearborn were intensely violent—more than showed up in official statistics—and moving somewhere else—even to a rehabilitated Dearborn—improved participants' circumstances substantially.

Demonstration participants report large increases in neighborhood collective efficacy, a measure of social cohesion and social control closely correlated with crime (Sampson, Earls, and Raudenbush 1997). In 2009, respondents were twice as likely to say that their neighbors could be trusted (43 versus 21 percent) and that they shared the same values (58 versus 28 percent). Residents also perceived their new neighbors to have more of a stake in controlling delinquent behavior in their community. They reported that their neighbors were more likely to react to poor behavior such as kids skipping school, spray painting, disrespecting an adult, or fighting in front of their homes.

Likewise, Demonstration participants report dramatically decreased neighborhood problems. As figure 4 shows, respondents described significantly less physical and social disorder and violent crime (attacks or robbery, rape or sexual assault, and shootings).

Angelina, who moved from Madden/Wells to Oakwood Shores, explains why she feels so much safer in her new community:

Figure 4. Resident Perceptions of Neighborhood Disorder, 2007 and 2009



Source: Authors' analysis of CFCM Demonstration data.

* Difference between 2007 and 2009 is significant at the $p < .05$ level.

[Oakwood Shores is a] better community. Nice and quiet. Moving to Oakwood Shores bettered my family, because the housing [at Madden/Wells] had all the people hanging out in the hall. So you have people in and out the hallway, and there wasn't any lock on the outside on the door, or security to be buzzed in. You got kids hanging in the hallway before going to school. At [Oakwood Shores], can't just live here and not do anything.

Given these dramatic improvements in residents' perceptions of neighborhood quality, it is not surprising that residents are less fearful of their surroundings. The share of individuals who were *never* afraid to walk around outdoors increased from 34 to 56 percent. In addition to feeling safer, less than half as many households reported that police not coming when called was a big problem in their new neighborhood as did in their old one.

All Demonstration participants perceive significant gains in neighborhood quality. In a multivariate logistic regression analysis, we found no household-level determinants that led to living in a better neighborhood. In short, almost everyone's neighborhood improved, regardless of their housing assistance, family structure, education, employment, or health. Such widespread improvement leads us to conclude that much of this gain was simply a product of leaving Madden/Wells and Dearborn. For those that stayed in Dearborn, they likely benefited from the rehabilitation and increased security in the new buildings.

Some Residents Experience Hardship after Relocation

While most families benefited from relocation, a small minority of Demonstration participants experienced housing-related hardship after relocation. Despite the intensive services, some participants were at risk of losing their housing assistance: 3 percent said they had received a one-strike warning from their property managers or the CHA, 5 percent said they were threatened with eviction, 1 percent were evicted, and 3 percent reported that they did not have a place to stay at some point during the past 12 months. Nonpayment of rent was the main reason residents were evicted or threatened with eviction.

While we could not determine the impact of the intensive case management on resident outcomes as the study lacked an adequate control or comparison group, our bivariate findings indicate minimal differences between those that engaged in lease compliance and those that did not for such outcomes as one-strike warnings, eviction threats, and evictions. In fact, a higher percentage of engagers was non–lease compliant. One likely explanation is that residents are not engaging with these housing services until they are deemed non–lease compliant.

More commonly, Demonstration participants (especially those living in private apartments and mixed-income developments) report having trouble making their utility payments. In 2007, only about a third of the participants reported paying separately for utilities (i.e., utilities were included in their rent). But by 2009, four-fifths did. Of those who were responsible for paying for their utilities in 2009, 21 percent had been more than 15 days late paying their utility bill in the past year. Late payment was much higher among voucher holders; nearly half of these households had difficulty paying their utilities (45 percent). This finding is similar to that of other studies following public housing residents transitioning to vouchers (Levy 2010; Levy and Woolley 2007). In our in-depth interviews, respondents confirmed the added economic burden of including utilities in their monthly budget. Crystal explained the downside of moving with a voucher or into a mixed-income development:

With the voucher—it all depends on the amount of my voucher—I probably would be able to find a house. But, see, the only

reason why I haven't really jumped out there like a lot of people is because here I don't pay utilities. So, if I move, I got other bills that I don't have here. So, I haven't really jumped out there because I don't want to move somewhere I can't afford. I just really [have] been taking my time with it. Because wherever I go, I want to be able to afford it.

While residents are struggling with the burden of increased utilities, more of them report paying their rent on time. The percentage of residents making late rent payments declined from 38 percent in 2007 to 17 percent in 2009. These findings are similar to those from the CHA Panel Study, showing that relocated residents choose to pay rent on time while delaying utility payments (Levy 2010). Case managers noted that property managers at mixed-income and private developments were much more likely to evict residents for not being lease compliant. This increased stringency has forced residents to place a higher premium on paying rent on time because they are more at risk for eviction. Indeed, just 8 percent of voucher holders and 5 percent of mixed-income residents paid their rent late, as opposed to 23 percent of public housing residents.

Relocation Counseling in the Demonstration

All CHA residents in developments slated for demolition or rehabilitation receive relocation counseling (Popkin 2010); for the Demonstration, HCP offered an enhanced relocation package. These services focused on preparing residents to be private-market renters, helping them move to lower-poverty neighborhoods, and encouraging them to factor school quality into their relocation decision. The costs of the relocation counseling services were $2,500 per household per year. (HCP was paid once for all the families on its caseload. The organization received incentives from the CHA for placing residents in opportunity neighborhoods.) The relocation costs include relocation counselor and supervisor salaries; funding for workshops on housekeeping, tenant rights and responsibilities, and school choice; neighborhood tours; and follow-up counseling.

In 2009, more than half of respondents reported meeting with a relocation counselor at least once. These rates fall below the 90 percent of households that reported meeting with their case manager. Forty percent of families attended a housing choice or school choice meeting, over a third attended a housekeeping meeting, and almost a third went on a relocation tour. Of those who attended, nearly all thought that the services were at least somewhat helpful.

However, while Demonstration participants engaged with HCP's services, relatively few made "opportunity moves." By the end of 2008, HCP had provided showings in 88 opportunity areas (census tracts that were less than 23.5 percent poor and 30 percent African American) and 75 low-poverty areas (less than 23.5 percent poor). Yet by 2010, only 26 families had moved to a low-poverty area, and just 4 had moved to an opportunity area.

Our interviews with CHA staff, service providers, and participants suggest several reasons for this low success rate. First was the extreme vulnerability of Demonstration participants; eight years into the Plan for Transformation, these families had not been able to make a permanent housing decision. Most were extremely long-term CHA residents (21 years on average at baseline); most had not conducted a true housing search in decades, if ever.

Second, the expedited closure of Madden/Wells limited HCP's ability to work with those families. The households caught up in the emergency closure in 2008 received no enhanced services; as the relocation schedule was moved up for remaining residents, relocation counselors reported they did not have sufficient time to adequately educate residents about their full housing and neighborhood choices. As a senior HCP administrator noted, "Time is the most important…time is so critical." Faced with a tight timeline, counselors focused on teaching residents the relocation basics—tenant's rights, proper housekeeping, and lease-compliance rules—as opposed to providing residents with information about schools, jobs, and safety. One CHA administrator felt that HCP performed admirably in difficult circumstances, noted that HCP "handled the curveball of closing the entire Wells site very well."

Third, resident preferences led them to choose neighborhoods similar to those they left. In many cases, families had lived in Madden/Wells or Dearborn for generations, with friends and family residing nearby. When faced with economic hardship, families used these close, firmly rooted social networks as a safety net. Residents reported that moving to a better neighborhood on the city's North side, especially without access to a car, would have left them physically isolated from the networks on which they depend (and who depend on them). Also, many households saw the neighborhoods surrounding Madden/Wells and Dearborn as improving, and they wanted to remain to participate in, and benefit from, that process. In some cases, preferences for better housing amenities—more space, a single-family home, a yard—led residents to stay in high-poverty, but more affordable, communities. And some residents, perhaps because of their distrust of the CHA or disillusionment with case management, simply did not want to participate in relocation counseling.

Finally, the collaboration between Heartland and HCP did not sufficiently address residents' relocation needs. According to our stakeholder interviews, the initial relationship between HCP and Heartland "was a bit rocky"

because each did not understand the other's role within the Demonstration. By professional mandate and financial incentive, but also by organizational culture, HCP's main goal was to help residents move to opportunity areas. Heartland's case managers addressed families' broader needs, and they often felt that a family's best relocation option was one that made it feel comfortable, not the opportunity neighborhoods advocated by HCP. Recognizing this disconnect, the Demonstration's organizers arranged for Heartland staff to sit in on an HCP workshop. This reduced, but did not eliminate, the stresses between the two agencies. Poor communication between the relocation and service providers sometimes created problems as well. And HCP's second mover counseling, intended to help participants make a more informed second move, was never fully implemented.

Implications

Many policymakers and scholars regard the HOPE VI Program as one of the most successful urban redevelopment programs in the history of the United States. But despite its accomplishments, the HOPE VI program's record in meeting the needs of the original residents is mixed. To help these residents attain greater self-sufficiency, a team of service providers and researchers created the Chicago Family Case Management Demonstration, which ran from March 2007 through March 2010. While the Demonstration successfully engaged vulnerable households, and many families saw employment gains and reduced anxiety, the relocation picture was mixed. Nevertheless, residents are universally living in much higher quality homes and apartments. And generally, they have moved to neighborhoods where they feel safer, have more connections with their neighbors, and report less physical and social disorder.

However, fewer residents engaged in relocation services than in case management and other services. As a result of this and several other factors—resident preferences, resident needs, a compressed relocation schedule, and program design—relatively few households made opportunity moves. By 2009, most were still living in neighborhoods that were high poverty and racially segregated.

What, then, should be done to help families living in and relocating from distressed public housing? We draw several lessons from our evaluation of the Demonstration's relocation efforts:

- **Invest in intensive relocation counseling.** Under the Demonstration, the intensity of services was not sufficient to help residents overcome longstanding barriers to opportunity moves. To see significant gains, public housing authorities need to provide long-term, high-touch services.

- **Relocation counseling needs to be integrated with other services.** Poor communication between the relocation and service providers creates problems. A more integrated approach, where one organization provides the full suite of services, may better serve residents. By working with clients for several years and meeting multiple times a month, case managers build the most rapport with residents. Rather than duplicating this process with another service provider, case managers should participate more directly in the relocation counseling. The relocation counseling should be based on a trusting relationship, not limited engagement workshops. But given the demands on a case manager's time, dedicated relocation staff may continue to benefit residents.

- **Provide relocation counselors ample time to work with residents prior to their move.** Relocation counselors need sufficient time to work with residents before they are scheduled to move. As one HCP staff member reported, relocation service providers need to start working with households even before they receive notice of a pending move. Early on, counselors need to help residents learn what opportunity areas are and demystify the process of moving to and living in these communities. Of course, residents may choose to stay in nearby and impoverished communities for good reasons, and counselors should respect and support these families' decisions.

- **Follow up with families to help them make second moves.** Similarly, relocation counselors (in conjunction with case managers) need to continue to follow up with families to help them make second moves, especially families living in a private-market apartment with a voucher. This point needs to be stressed, as families with vouchers have little opportunity to receive ongoing case management support.

- **Devote federal attention and funds to resident services.** Federal policy has a role to play in many of these considerations. With its Choice Neighborhoods initiative, the Obama administration has the opportunity to build on nearly two decades of experience with HOPE VI. The program's allowance of funds being allocated for services is promising. Similarly, funds will be needed for other relocation efforts, and the development of best practices is critical. Finally, additional work is needed to help voucher families access middle- and upper-income communities by allowing for higher voucher payments in more expensive communities. HUD is rolling out a trial of zip-code level adjustments to fair-market rents, which if targeted appropriately, may help families access these communities. ▪

Notes

1. See Popkin et al. (2010) for an overview of the Demonstration.

2. Parts of the discussion about the developments was drawn from Theodos et al. (2010).

3. By declaring an emergency move, the CHA obviated requirements in its Relocation Rights Contract with residents, which established that residents had 180 days to leave their homes after receiving a move notice.

4. We use community areas as proxies for neighborhoods. Community areas refer to the work of the Social Science Research Committee at University of Chicago, which has unofficially divided the city into 77 community areas. Community areas represent much larger areas than census tracts, of which there are 865 in Chicago.

5. We define violent crime as Part 1 Personal Crime, which includes homicide, aggravated assault, robbery, battery, and rape. These variables are measured in census tracts, not community areas.

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Chicago Family Case Management Demonstration

The Chicago Family Case Management Demonstration was a partnership of the Urban Institute, the Chicago Housing Authority (CHA), Heartland Human Care Services, and Housing Choice Partners, intended to test the feasibility of providing wraparound supportive services for vulnerable public housing families. The demonstration ran from March 2007 to March 2010, targeting approximately 475 households from the CHA's Dearborn Homes and Madden/Wells developments with intensive case-management services, transitional jobs, financial literacy training, and relocation counseling.

The Urban Institute evaluated the Chicago Family Case Management demonstration to inform implementation and track outcomes for participants over time. In spring 2007, we conducted a baseline resident survey (n = 331, response rate 77 percent). The survey asked about a range of domains, including housing and neighborhood conditions, service use, mental and physical health, employment and economic hardship, and children's health and behavior. We conducted a follow-up survey (n = 287, response rate 90 percent) in summer 2009, approximately two years after the rollout of the demonstration. The largest source of attrition between 2007 and 2009 was mortality; we were able to locate, if not survey, nearly all original sample members.

To complement the survey, Urban Institute staff conducted 30 qualitative in-depth interviews (21 adults and 9 adolescents) with participants in summer 2008. We also gathered information from CHA administrative records and case manager reports, including whether residents chose to engage in the demonstration services, whether participants were referred for additional services, and their relocation history. In addition, we assembled secondary data on neighborhood poverty, unemployment, crime, race and other characteristics that we received from the Metro Chicago Information Center. Finally, we conducted a process study to assess the efficacy and cost of the demonstration's implementation. We conducted in-depth qualitative interviews with case managers, project staff, relocation providers, and CHA administrators, monitored service implementation weekly, and met regularly with Heartland and Housing Choice Partners leadership and CHA staff. We also thoroughly analyzed the costs associated with the intensive services.

The principal investigator for the Chicago Family Case Management Demonstration is Susan J. Popkin, Ph.D., director of the Urban Institute's Program on Neighborhoods and Youth Development. Funding for the demonstration was provided by the John D. and Catherine T. MacArthur Foundation, the Annie E. Casey Foundation, the Rockefeller Foundation, the Partnership for New Communities, JPMorgan Chase, and the Chicago Housing Authority.

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Cover photograph © 2010 by Shauna Bittle.

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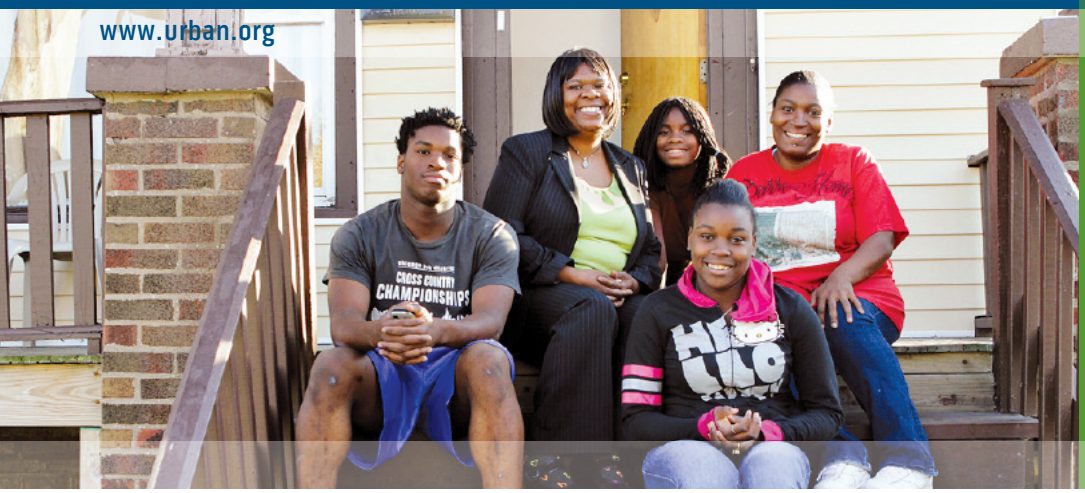
Supporting Vulnerable Public Housing Families



INSIDE THIS ISSUE

- Children are exhibiting alarming levels of distress.
- Children of higher-functioning parents are doing better; children in the most distressed households are suffering the most.
- Without effective intervention, many children will face the same struggles as their parents.

Reaching the Next Generation

The Crisis for CHA's Youth

Liza Getsinger and Susan J. Popkin

The Chicago Housing Authority (CHA's) ambitious Plan for Transformation, launched in 1999, sought to replace the agency's notoriously distressed developments with new, mixed-income communities and refurbished public housing. In the late 1990s, the CHA's troubled developments were home to thousands of vulnerable families. Most residents were children, many of whom had suffered serious health consequences as a result of the poorly maintained housing and psychological trauma from the overwhelming violence and social disorganization. Books like *There Are No Children Here* (Kotlowitz 1991) and *Our America* (Jones and Newman 1997) documented the plight of CHA's children, describing struggling parents, abused and neglected children, and families caught up in the drug trade and gang wars. In these communities, having lost a family member to the gang violence or drugs or to federal prison was so common as to be unremarkable (Popkin et al. 2000). Given the level of distress of the CHA's resident population, in order for the Plan to be successful, it had to not only replace the housing that had blighted Chicago communities, but also attempt to improve the life chances for the families that had endured these conditions.

A large body of research documents how living in distressed, high-poverty communities worsens the life chances of children. Children growing up in these neighborhoods are at risk for poor physical and mental health, risky sexual behavior, delinquency, and other negative outcomes (Leventhal, Dupéré, and Brooks-Gunn 2009; Sampson, Morenoff, and Gannon-Rowley 2002). The strains associated with poverty and community violence make it more difficult for parents to devote the time and positive attention that children need in order to develop the social skills and behaviors to succeed as young adults. A supportive and functioning family and community can sometimes buffer the effects of poverty and community violence, but the lack of a safe and stable home life can increase children's vulnerability to external stressors, leading to a decreased capacity to learn and adapt throughout adulthood (Shonkoff 2010). Further, children growing up in high-stress environments are more likely to develop depression and other mental health issues, which often manifest themselves as behavior problems (Conger, Conger, and Martin 2010; Conger, Patterson, and Ge 1995).

CHA children are struggling with enduring violence in their communities, parents with mental health and substance abuse challenges, and the stresses of moving.

A Snapshot of Families with Children

- 145 families (51 percent) have children under the age of 18.
- 19 families (7 percent) have children age 18 and over.
- Median age of older children is 14.5.
- Most children live in households headed by a single mother.
- 44 children live in "grandfamilies."
- A third of children live in very large households (5 to 10 members).

Research on the Moving to Opportunity (MTO) demonstration tracked outcomes for families from high-poverty public housing in five cities that were offered the chance to move to low-poverty communities with vouchers. The hope was that this move would improve children's educational outcomes, mental health, and well-being. To date, outcomes for MTO youth have been mixed; although families' quality of life has improved significantly, these gains have not translated into better health and educational outcomes. Puzzlingly, girls have improved mental health and reduced risky behavior relative to the control group, but boys have not; there has been no effect on educational attainment (Popkin, Leventhal, and Weismann 2010, Briggs, Popkin, and Goering 2010).

Like MTO, the Plan for Transformation appears to have substantially improved residents' quality of life but, so far, has not fundamentally changed the life chances for CHA children. The CHA Panel Study, which tracked a sample of 198 Madden/Wells residents from 2001 to 2009, found little evidence of improvements in children's behavior or educational engagement. Further, many older youth were already parenting or involved in the criminal justice system by the end of the panel study (Gallagher 2010).

Chicago Family Case Management Demonstration—Implications for Children

Evidence from the Panel Study suggested that a substantial proportion of vulnerable, "hard to house" families were being left behind in CHA's remaining traditional public housing developments and not benefiting from the transformation under way. The Chicago Family Case Management Demonstration was an innovative effort to address this problem, testing the feasibility of providing wraparound supportive services for vulnerable public housing families (Popkin et al. 2008). The Demonstration—a partnership of the Urban Institute, the CHA, Heartland Human Care Services, and Housing Choice Partners—provided households from the CHA's Dearborn Homes and Madden/Wells developments with intensive case management services, transitional jobs, financial literacy training, and relocation counseling. The Urban Institute conducted a rigorous evaluation, including a baseline and follow-up survey, administrative interviews, focus groups with service providers and program administrators, in-depth resident interviews, and analysis of program and administrative data (see text box on page 9).

While the primary goal of the Demonstration was to engage heads of household with intensive services, case managers tried to address the needs of all family members. The hypothesis was that using a family-focused approach would benefit children as well as parents, although no services were specifically targeted to youth. The Demonstration successfully engaged adult participants, stabilized health, increased employment, and helped families move to better housing in safer communities (Popkin et al. 2010). Perhaps not surprisingly, there is no evidence that these benefits have translated into better outcomes for children and youth. Indeed, the findings from the survey and baseline and follow-up interviews paint a portrait of children in crisis, struggling with the trauma of enduring violence in their communities, parents with mental health and substance abuse challenges, and the stresses of relocation.

This brief profiles these vulnerable children and suggests strategies for building on the successes of the Demonstration to improve the life chances of CHA's children and youth.

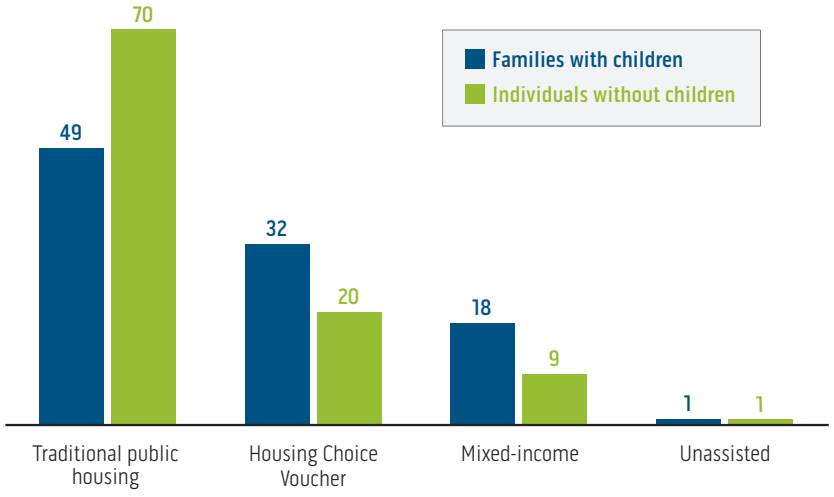
A Profile of Children in Hard-to-House Families

At baseline in 2007 and follow-up in 2009, we interviewed 155 parents of 217 children; all our survey data on children are parental reports only. Both times, we interviewed parents about one or two focal children, selected at random, asking parents about their children's health, behavior, and school engagement. The voices of the children in this brief come from a small sample of in-depth interviews conducted in August 2008 with 21 adults and 9 youth. The children and youth in our sample range from 2 to 20 years old. For this analysis, we have divided the children into two categories: older children (age 8 and older) and younger children.[1] Our sample includes 120 girls (42 younger and 78 older) and 97 boys (33 younger and 64 older). This brief focuses solely on the older children.

Changes in Children's Quality of Life

In 2007, Dearborn Homes and Madden/ Wells were extremely distressed, high-crime communities, dominated by drug dealing and gang activity. Madden/Wells was in the final stages of relocation, and conditions were deteriorating rapidly, leaving the few remaining residents at the mercy of the drug dealers who had moved into the now-vacant turf. Dearborn was caught up in a gang war that had divided the development in half. Residents from both developments reported extremely high levels of problems with drug activity and violent crime; for children, these conditions were toxic

Figure 1. Type of Housing Assistance by Household Type (percent)



Source: 2009 Demonstration sample.

(Popkin et al. 2008). Many of the youth we interviewed in summer 2008 talked of living in constant fear and adapting their behavior in order to survive. As Robert, a 12-year-old boy who grew up in Wells, said:

> *It was kinda tough because it was, like, every day, I had to watch my back. 'Cause they used to shoot a lot over there [in Wells]. It was kinda hard because I ain't like always having to watch my back…when I played, I gotta watch my back, make sure people don't be doing nothin' bad around me or nothing, and I can't get used to that. But I had to get used to it. Then I stopped being afraid and I just stopped watching my back. So, I stopped being afraid.*

At the start of the Demonstration, not all families were slated for relocation; the CHA originally planned to keep a few buildings in Madden/Wells open and had no plans for major relocation in Dearborn. But because of deteriorating conditions, the CHA decided to expedite closing of Madden/Wells; the agency then received HUD funds that allowed it to move forward with a full gut-rehabilitation in Dearborn, necessitating relocation there as well. Over the three years of the Demonstration, roughly three-quarters of families with children moved at least once, and nearly a fifth moved twice or more. In 2009, 59 percent of the participants in our sample lived in traditional public housing, 26 percent had vouchers, and 13 percent lived in mixed-income developments (Theodos and Parilla 2010). Families with children were more likely than other residents to choose vouchers or move to mixed-income housing (figure 1).

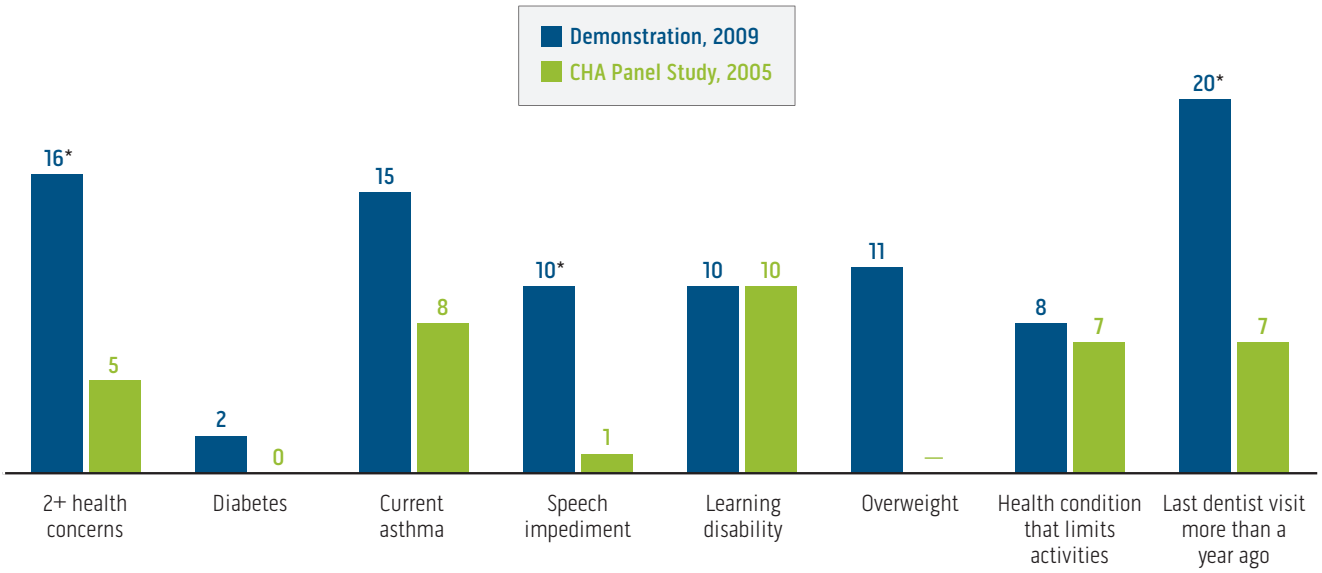
At the follow-up, most adult participants were satisfied with their new housing, and most reported substantially better conditions. Further, although the official crime rates for their new communities were similar, participants reported feeling dramatically safer, with far fewer problems with drug activity and violent crime (Theodos and Parilla 2010). Likewise, a number of the youth we interviewed in 2008 said that leaving Dearborn and Madden/Wells allowed them to escape the violence and chaos. Jamie, whose family had taken a voucher and was now living in a single-family home on Chicago's South Side, stated that her proudest moment in life was, "Us moving here, and finding this house. Because since we got moved here been some good things happened." But for other youth, moving was a very difficult experience and provided new stresses and fears. Twelve-year-old Robert, whose family moved from Wells with a voucher into an apartment on the far Southside, discussed feeling isolated in his new neighborhood, disconnected from peer groups, and unsure of his new environments:

> *I can't really go outside, have fun 'cause sometimes, I got to stay in the house and every, over there, I used to can go outside. And over here, I can't even go out the door. I don't even know some people over here. And I don't know if they can try to kill me or anything. I could turn my back and anything can happen. So I just try to stay in the house and be away from everything.*

Children Experiencing Alarming Levels of Distress

In 2007, the families in the Demonstration were among the most vulnerable in the CHA population: extremely poor, long-term public housing residents, most disconnected from the labor force, and suffering high rates of chronic disease, mental illness, and substance abuse (Popkin et al. 2008). According to analysis of data from the baseline and follow-up surveys, the children in these households are faring little better than their parents,

Figure 2. Youth Health Conditions, Demonstration and CHA Panel Comparison (percent)



Sources: 2005 Chicago Panel sample and 2009 Demonstration sample.
Note: Overweight question was not asked of the 2005 Chicago Panel sample.
* Difference between Demonstration and Panel Study is significant at the $p < .05$ level.

exhibiting high rates of health and behavior problems. There was little change in children's well-being from baseline to follow-up, so we focus primarily on the data from the 2009 survey, comparing it with data from the 2005 CHA Panel Study and national figures.[2]

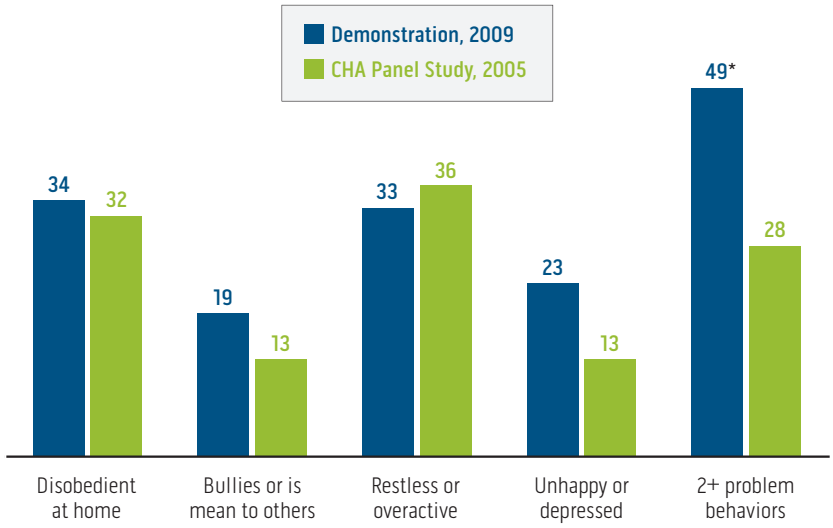
At follow-up, Demonstration participants reported that their children were suffering from poor health at rates far higher than national averages: approximately 72 percent of parents rated their child's health as excellent or very good, compared with 84 percent of parents nationally.[3] Demonstration participants reported that their children were suffering from a range of serious health conditions, some at rates higher than even those for children in the CHA Panel Study (figure 2).

According to parental reports, almost all children in the Demonstration sample (95 percent) attended school in the 2008–09 school year, and nearly two-thirds of parents reported that their children were not highly engaged in school.[4] Additionally, Demonstration parents reported that nearly a third of older youth had been suspended from school. Even more worrying, the children are exhibiting high levels of behavior problems,[5] an indicator of poor mental health; about half of parents reported that their children were exhibiting two or more problem behaviors. This statistic is particularly alarming compared with the 2005 CHA Panel Study, where less than a third of children exhibited this level of problem behaviors. Nearly one in four parents said that their child was often or sometimes unhappy, sad, or depressed, and nearly one in five said that their children were mean to or bullied others. Although the individual measures of problem behavior do not vary between the two surveys, children in the Demonstration are more likely to exhibit several behaviors (figure 3).

Another alarming indicator of distress is that, according to parent reports, 22 percent of boys in the Demonstration follow-up sample had been arrested, and 19 percent had been incarcerated, compared with 6 and 4 percent, respectively, for girls (figure 4). Nine percent of all children age 14 and older exhibited two or more delinquent behaviors.[6] In comparison, 7 percent of children in the 2005 CHA Panel Study exhibited two or more delinquent behaviors, and 14 percent of boys had been arrested.[7]

Our interviews with adolescents revealed some of the traumatic experiences and stresses that underlie these alarming statistics.

Figure 3. School Engagement and Behavior (percent)



Sources: 2005 Chicago Panel sample and 2009 Demonstration sample.
* Difference between Demonstration and Panel Study is significant at the $p < .05$ level.

Violence was a common theme in the lives of these youth. One girl spoke of a close family member being raped, while another discussed the recent murder of her father; many others discussed getting into fights. In many circumstances, youth felt it necessary to resort to fighting to protect themselves and their friends. Kenneth, a 14-year-old boy who grew up in Wells, describes the violence in his neighborhood:

> *I be fighting 'cause some people, like, they be hating. And mostly all my life, I had to fight because some people was hating me. You know, one time, there was a dude he was hating on me and 'cause he wanted to steal my shoes. And I didn't want him going around stealing my shoes. Then, we's on the front of my building, we started fighting. Dunno, happens a lot.*

Vulnerable Families, Vulnerable Children

We developed a typology based on baseline characteristics that categorizes the head-of-household Demonstration participants into three groups: "strivers," younger residents who mostly have high school degrees and are connected to the labor force; "aging and distressed," who suffer from high rates of mental and physical illness, lack high school degrees, and have little work experience; and "high risk," younger residents already showing high rates of chronic illness and labor force disconnection (Theodos et al. 2010). For our analysis, we combined the aging and distressed families and the high-risk families because the risk characteristics for these families look very similar, and relatively few children lived in aging and distressed families. Similar to the adults in our sample, the children vary in

A Family Overwhelmed by Challenges

Annette is a 30-year-old woman struggling to raise her three children as well as two other girls she has taken in. Annette was a troubled child, frequently getting into fights and being arrested. She speaks of the many traumas she faced, including the death of her best friend and emotional and physical abuse from her alcoholic mother. Annette dropped out of school at 16 and had her first baby at 18.

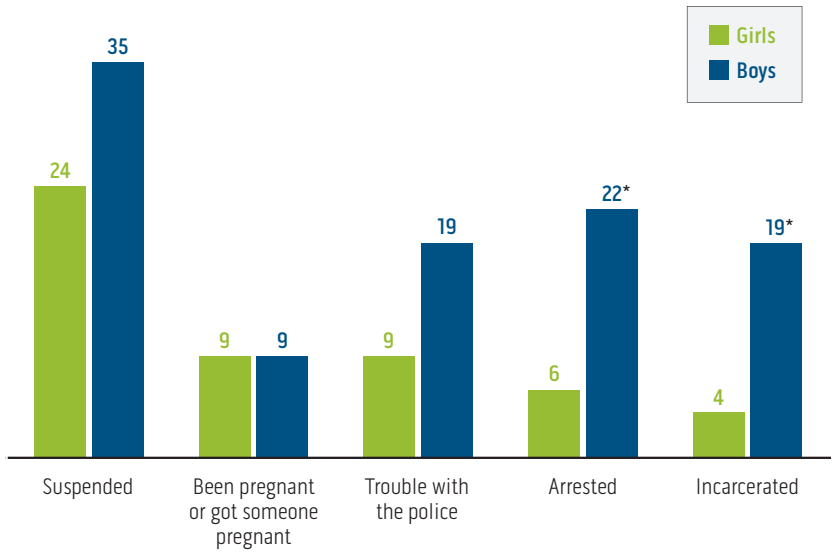
Annette's adult life has been equally difficult. She says she feels overwhelmed by the challenge of caring for her children and often feels depressed and even suicidal, though she has refused to go into counseling. Annette has also faced major traumas, including being shot four times and the recent murder of her son's good friend. She drinks and smokes marijuana frequently, describes screaming at her children when she gets angry, and thinks about taking revenge on the woman who shot her. Her boyfriend, who is her children's father, is a drug dealer and abuses her; she says is trying to separate from him.

Annette's 12-year-old son, Robert, is also very troubled. He says he has behavior problems in school and fears being hurt or killed in his neighborhood. Although Robert was happy to leave Madden/Wells, he feels isolated and vulnerable in the new neighborhood, far removed from familiar social networks and friends.

Annette is having difficulty making the transition to the private market. She recently lost her job because of a conflict with her supervisor and is behind on her utility payments. Because two of her children are not officially part of her household, her house is too small and she says she has serious maintenance problems, such as mildew and a basement that floods regularly. She has almost no furniture in her house.

Annette says this about her life: "It's like, I'm struggling too hard. It's like, some, I try to make this right, something go wrong. It just don't never go right. But then when I think I'm doing good, something else going bad."

Figure 4. Delinquent Behavior (percent)



Source: 2009 Demonstration sample.

* Difference between boys and girls is significant at the $p < .05$ level.

their levels of distress. The children whose parents are higher functioning—more likely to work and have a high school education, and less likely to be experiencing mental and physical health issues—are doing better. Meanwhile, the children living in the most distressed households—children whose parents are substance abusers, suffer from serious mental and physical health challenges, and are not connected to the labor market—are suffering the most.

As figure 5 shows, children living in high-risk households are only half as likely to be engaged in school as children whose parents are strivers, and nearly twice as likely to exhibit two or more problem behaviors. Children living in high-risk families are also more likely to be overweight and have a health condition.

Annette and Robert's story illustrates how parental problems place youth at risk. Annette suffers from depression and has a history of abuse and violent aggression; Robert, her 12-year-old son, already suffers from depression and thinks about harming himself and others (see sidebar on page 5).

Girls Appear Especially Vulnerable to Distress

Although boys within the larger sample appear more troubled than girls, the story is different when comparing children living only in high-risk families. Then, girls living in high-risk families appear particularly vulnerable: 71 percent of girls in high-risk households exhibit two or more problem behaviors, compared with 50 percent of boys. These findings are similar to research on adolescent outcomes from MTO and the HOPE VI Panel Study, which suggests that girls growing up in high-poverty communities may face gender-specific stresses, including harassment and the pressure for sexual activity (Popkin, Leventhal, et al. 2010). Briana, a 13-year-old former Dearborn resident, talks about how she deals with harassment in her neighborhood:

> *Ever since that boy told me he was going to rape me, I have a feeling that [I had less] protection, and [I had to keep] my protection built up. And like every time I walk to the stores, it be more men than women. So, I try to like, like, like—I try to like wear more baggy clothes than tight. And also my cousin who died 'cause somebody raped her.… Or if I'm walking by myself I'll—I'll like have my fists balled up like this so no one touch me.*

Implications for Policy

Findings from the Chicago Family Case Management Demonstration paint a shocking picture of at-risk children and youth living in extremely troubled households. These children have endured years of living in violent and chaotic environments; in many cases, their parents were so distressed—suffering from mental and physical illness, struggling with substance abuse, dealing with histories of trauma—that they were unable to shield their children from the worst effects of the stresses surrounding them. The situation of these children represents a profound crisis; without effective intervention, too many of them will face the same—or worse—struggles as their parents. Finding solutions will not be simple, and the costs are likely to be high. But the costs of failing to act will be much higher, both for the CHA—in management problems and instability in its developments—and for society.

- **Experiment with intensive service models that focus explicitly on youth.** The Demonstration service model successfully engaged vulnerable CHA families in intensive case

management services, with important benefits for families in improved quality of life and for adult participants in stable health and improved employment. However, while the Demonstration used a family-focused model, it does not seem to have successfully reached youth. The CHA and other housing authorities should consider testing a modified service model that includes strategies to engage youth and offers evidence-based interventions to serve their needs. This new, youth-focused demonstration should also employ the typology we have developed to try to target the neediest families with intensive services.

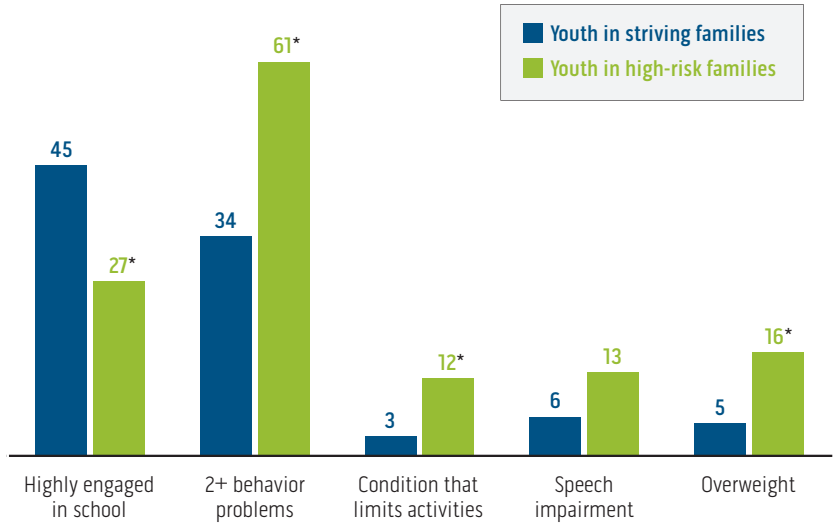
- **Provide clinical mental health services on site for children and families; make services accessible for voucher holders.** Children within the CHA are particularly vulnerable and suffering from high levels of distress. The CHA should make continuing to provide clinical services through its FamilyWorks resident services program a priority, with a greater emphasis on addressing the challenges of children within the household. FamilyWorks currently only serves residents in the CHA's traditional public housing communities, and many of the CHA's vulnerable families are now voucher holders; meeting their needs is more challenging and will require a new approach to service provision.

- **Incorporate youth engagement into management strategies for public housing and mixed-income developments.** Making youth engagement part of a basic management strategy could benefit both youth and property managers. If youth are engaged in positive activities, they are less likely to cause serious problems like vandalism or fighting that create challenges for property management. Further, youth outreach workers can identify problems early on and attempt to intervene to avert more severe problems. The Housing Authority of Portland has developed a youth engagement strategy for its properties that could serve as a model for other housing agencies.

- **Partner with neighborhood schools that serve public housing families.** The CHA and other housing agencies should consider partnering with local schools, especially as part of HOPE VI or Choice Neighborhood redevelopment initiatives. Investing in high-quality schools will not only attract higher-income households to the community, but will also provide important resources for public housing residents.

- **Develop partnerships to create comprehensive place-based initiatives.** The best current thinking suggests that the most effective way to improve outcomes for youth from distressed, high-poverty communities is to offer linked, comprehensive services that serve children and families from "cradle to college" (Harlem Children's Zone 2009). The CHA and other housing authorities should consider partnering with local Promise Neighborhood initiatives, to leverage funding from the federal Choice Neighborhoods initiative and be able to provide these comprehensive services to vulnerable public housing residents. ▪

Figure 5. Older Child School Engagement, Behavior, and Health, by Cluster (percent)



Source: 2009 Demonstration sample.
* Difference between youth in striving and high-risk families is significant at the $p<.05$ level.

Notes

1. Our sample includes 75 younger children and 142 older children. The median age of younger children is 4½; ages range from 2 to 7. The analysis in this brief is centered on the older children in our sample. The median age of older children is 14½; ages range from 8 to 20.

2. We use the 2005 CHA Panel sample instead of the 2009 sample (as in the other briefs) because the average age of the children in the 2005 sample is comparable to that in the 2009 demonstration follow-up.

3. National data taken from the 2007 National Survey of Children's Health, available at Child and Adolescent Health Measurement Initiative, "National Survey of Children's Health Data Resource Center," http://www.nschdata.org.

4. Developed in 1996 by Jim Connell and Lisa J. Bridges at the Institute for Research and Reform in Education in California, this measure attempts to assess the level of child's interest and willingness to do their schoolwork. Each head of household was asked four questions about whether the child cares about doing well in school, only works on homework when forced to, does just enough homework to get by, or always does his or her homework. The answers were scored on a scale from 1 to 4, where 1 means none of the time and 4 means all of the time (answers to the negative items were scored in reverse). We measure the proportion of children with a high level of school engagement, which is equivalent to a scale score of 15 or more.

5. Items for the problem behaviors scale were taken from the Behavior Problems Index. The heads of households were asked to indicate how often the children exhibited any one of the seven specific negative behaviors: trouble getting along with teachers; being disobedient at school; being disobedient at home; spending time with kids who get in trouble; bullying or being cruel or mean; feeling restless or overly active; and being unhappy, sad, or depressed. The answers ranged from often and sometimes true to not true. We measure the proportion of children whose parents reported that they demonstrated two or more of these behaviors often or sometimes over the previous three months.

6. Respondents were asked if over the previous year their children had been involved in any of the following nine activities: being suspended or expelled from school, going to a juvenile court, having a problem with alcohol or drugs, getting into trouble with the police, doing something illegal for money, getting pregnant or getting someone else pregnant, being in a gang, being arrested, and being in jail or incarcerated. We measure the proportion of children involved in two or more of these behaviors.

7. The differences among the 2005 CHA Panel and the Demonstration boys subsample on measures of delinquent behavior are not significant because the sample size is too small to properly test the significance levels.

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Chicago Family Case Management Demonstration

The Chicago Family Case Management Demonstration was a partnership of the Urban Institute, the Chicago Housing Authority (CHA), Heartland Human Care Services, and Housing Choice Partners, intended to test the feasibility of providing wraparound supportive services for vulnerable public housing families. The demonstration ran from March 2007 to March 2010, targeting approximately 475 households from the CHA's Dearborn Homes and Madden/Wells developments with intensive case-management services, transitional jobs, financial literacy training, and relocation counseling.

The Urban Institute evaluated the Chicago Family Case Management demonstration to inform implementation and track outcomes for participants over time. In spring 2007, we conducted a baseline resident survey (n = 331, response rate 77 percent). The survey asked about a range of domains, including housing and neighborhood conditions, service use, mental and physical health, employment and economic hardship, and children's health and behavior. We conducted a follow-up survey (n = 287, response rate 90 percent) in summer 2009, approximately two years after the rollout of the demonstration. The largest source of attrition between 2007 and 2009 was mortality; we were able to locate, if not survey, nearly all original sample members.

To complement the survey, Urban Institute staff conducted 30 qualitative in-depth interviews (21 adults and 9 adolescents) with participants in summer 2008. We also gathered information from CHA administrative records and case manager reports, including whether residents chose to engage in the demonstration services, whether participants were referred for additional services, and their relocation history. In addition, we assembled secondary data on neighborhood poverty, unemployment, crime, race and other characteristics that we received from the Metro Chicago Information Center. Finally, we conducted a process study to assess the efficacy and cost of the demonstration's implementation. We conducted in-depth qualitative interviews with case managers, project staff, relocation providers, and CHA administrators, monitored service implementation weekly, and met regularly with Heartland and Housing Choice Partners leadership and CHA staff. We also thoroughly analyzed the costs associated with the intensive services.

The principal investigator for the Chicago Family Case Management Demonstration is Susan J. Popkin, Ph.D., director of the Urban Institute's Program on Neighborhoods and Youth Development. Funding for the demonstration was provided by the John D. and Catherine T. MacArthur Foundation, the Annie E. Casey Foundation, the Rockefeller Foundation, the Partnership for New Communities, JPMorgan Chase, and the Chicago Housing Authority.

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