

Inclusive Public Housing: Services for the Hard to House

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INTRODUCTION

Twenty years ago, dilapidated, high-crime public housing developments populated by impoverished, female-headed households were a powerful symbol of the failures of U.S. social welfare policy. HOPE VI was a key element of a bold effort to transform these public housing communities and demonstrate that housing programs could produce good results for residents and communities. The program provided grants to housing authorities to replace their most distressed developments—those with high crime rates, serious physical decay, and obsolete structures—with new, mixed-income, mixed-tenure communities. In a departure from earlier efforts to “rehabilitate” public housing, HOPE VI sought to move beyond “bricks and mortar” and provided funding for supportive services for residents to help them move toward self-sufficiency and improve their life circumstances (Cisneros and Engdahl 2009; Popkin, Levy, and Buron 2009).

There is no question that HOPE VI has changed the face of public housing—hundreds of those dilapidated structures have been replaced with attractive new developments, and the program has sparked innovations in financing and management (Popkin et al. 2004; Kingsley 2009). However, the picture for residents appears more mixed. Evidence from the HOPE VI Panel Study, the most comprehensive study of resident outcomes, shows that many former residents have received Housing Choice Vouchers or moved into mixed-income developments, and now live in better housing in neighborhoods that are considerably less poor and distressed and provide safe environments for them and their children. Studies of individual HOPE VI sites show similar results (Popkin, Levy, and Buron 2009).

However, despite these generally positive findings about the impact on residents’ well-being, there are still real reasons for concern—many advocates point to the low rates of return to the new developments and the loss of hard units of public housing as a critical issue (Crowley 2009).

Of even greater concern, the program has not been a solution for the most vulnerable families—those “hard to house” families with multiple, complex problems that make them ineligible for mixed-income housing or unable to cope with the challenges of negotiating the private market with a Housing Choice Voucher. In many U.S. cities, public housing has served as the housing of last resort for decades, with the poorest and least desirable tenants warehoused in the worst developments. As these developments have been demolished, vulnerable families have often simply been moved from one distressed development to another, and with a concentration of extremely troubled families and a lack of adequate supportive services, these new developments have the potential to become even worse environments than those from where these families started.¹

Although bills reauthorizing HOPE VI were introduced in both the House and Senate in 2007, debate over resident relocation and displacement has delayed their passage (Crowley 2009). Congress has authorized the Obama administration’s new initiative, “Choice Neighborhoods,” that will build on the successes of HOPE VI, but broadens the scope of revitalization efforts beyond public housing to the surrounding community. If this new effort is to be more successful than its predecessor in improving the lives of the vulnerable families

¹ See Popkin, Levy and Buron (2009) for a comprehensive summary of the HOPE VI Panel Study and key findings.

that suffered the worst consequences of living in distressed public housing, it must incorporate strategies that effectively address their needs, specifically, by making targeted and intensive supportive services available to help these families succeed in housing (Popkin and Cunningham 2009). None of these solutions are simple, and all will require a long-term commitment to improving the quality of life for these households and ensuring better futures for their children (Popkin 2006).

The Chicago Family Case Management Demonstration provides an innovative model for serving the needs of the most vulnerable public and assisted housing families, those with high rates of physical and mental health problems, low levels of educational attainment, weak attachment to the labor force, and high levels of involvement in public systems (e.g., criminal justice, child welfare). The Demonstration, a partnership of the Urban Institute, the Chicago Housing Authority (CHA), Heartland Human Care Services (HHCS), and Housing Choice Partners, offered enhanced, wraparound supportive services to residents of two of CHA's remaining traditional public housing developments, the Ida B. Wells and Dearborn Homes.² The project is now in its third year, has achieved impressive engagement rates of nearly 90 percent, and has adapted its model from one that provides place-based services to one that serves residents after relocation in a variety of settings.³

² For a complete description of the Demonstration service model, see Susan J. Popkin, Brett Theodos, Caterina Roman, and Elizabeth Guernsey. 2008. *The Chicago Family Case Management Demonstration: Developing a New Model for Serving "Hard to House" Public Housing Residents*. Washington D.C.: The Urban Institute.

³ The Urban Institute is conducting a full evaluation of the Demonstration, including implementation,

In this report, we provide an overview of the Demonstration and its progress to date, and then focus on one of the major challenges for providers serving vulnerable families: identifying which clients require the full intensive services, and which would benefit from a different approach. The typology we have developed provides a template for delivering the wraparound services associated with supportive housing within public housing and assisted housing settings, including vouchers and units integrated into mixed-income developments.

INTENSIVE SERVICES: CHALLENGES IN SERVING THE MOST VULNERABLE

The Chicago Family Case Management Demonstration is taking place in the context of the CHA's ambitious efforts to transform its public housing. As in many cities, CHA housing had over the past several decades become the housing of last resort for the most impoverished households, leaving the CHA with a significant number of vulnerable families facing numerous, complex challenges that create barriers to their ability to move toward self-sufficiency or even maintain stable housing. For the CHA's most vulnerable families that are unable to qualify for or maintain a unit in a mixed-income development or a private apartment with a voucher, the transformation means yet another formidable challenge—and leaves them fearing the prospect of choosing between continuing to live in CHA's most distressed communities or potentially losing their assistance altogether.

impact, and cost-effectiveness. Final results from the evaluation will be available in late-2010.

The Chicago Family Case Management Demonstration is designed to meet the challenges of serving the most vulnerable residents, helping them to navigate the changes resulting from the CHA's Plan for Transformation. The Demonstration is also intended to benefit the CHA, as these families often represent management challenges in terms of lease noncompliance, nonpayment of rent, difficulty relocating, and criminal activities. The Demonstration serves residents who were living in two CHA developments—Wells/Madden Park and Dearborn Homes—in March 2007. It provides these families with a package of wraparound services, including intensive family case management; mental health and substance use counseling; enhanced relocation services; post-relocation support; workforce strategies for those who have barriers to employment; and financial literacy training. The primary goal of these services is to help these families maintain safe and stable housing—whether in traditional CHA public housing, in the private market with a voucher, or in new, mixed-income developments—as well as to improve family functioning and self-sufficiency.

As table 1 shows, the Demonstration enhances the CHA's standard service package in several key ways, particularly lowering case loads and allowing case managers to follow clients for up to three years post-relocation. We will be conducting a full cost-effectiveness analysis of the Demonstration in the coming months. In advance of that work, we developed annual cost estimates for the Demonstration services based on review of project budgets and

assumptions and then took an average cost per engaged household (i.e., households actually using the services). In developing these estimates, we consulted with the service providers, as well as with staff from the CHA. Our preliminary estimate for the average cost per household for the intensive case management services is \$3,800 per year. This figure includes: case manager and site manager salaries; a percentage of the project director salary; clinical social work staff; training and support for case managers; transportation costs; rent and other operating expenses. This figure does not include the costs for a slot in the Transitional Jobs program, including a three-month wage subsidy (roughly \$6,000 per enrolled client per year), nor the costs of the enhanced relocation counseling (approximately \$2,200 per relocated household). 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. We have also not included in the calculations the CHA's administrative time and costs for ancillary services such as slots in the Caritas drug treatment program (borne by state Medicaid funding) and in other GED or workforce programs.

Table 1. Features of the Chicago Family Case Management Demonstration

Service Feature	CHA Service Model at start of Demonstration^a	Demonstration Service Model
Case manager to client ratio	1 case manager for 55 residents	1 case manager for 25 residents
Frequency of contact	Once per month	Two to four visits per month
Contact with household	Leaseholder	Family
Length of time case managers remain with residents, even after they move	3 months	3 years
Engagement	50 percent ^b	86 percent ^b
Financial literacy training and matched savings program	Not available	Available
Clinical and substance use services	Referral to substance use counseling	On-site licensed clinical social worker; referral to substance use 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)	Enhanced 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

a. As discussed below, the CHA changed its service model to FamilyWorks, incorporating some of the lessons learned in the Demonstration.

b. Engagement levels at Dearborn Homes and Wells/Madden Park at the start of the Demonstration in 2007 and as of August 2009.

Since the Demonstration targets the entire population of the two CHA developments, the clients it serves have diverse needs, including older tenants who have aged in place; younger tenants struggling to stay connected to the labor market and care for young children; and tenants with substance use or mental illness challenges. This diversity presents a particular challenge for the staff, who must determine which clients require the most attention while sustaining high levels of engagement overall. In this report, we use data on residents participating

in the Demonstration to create a typology that sorts residents into groups according to key characteristics and level of need for supportive services. The typology could inform a new process for formalized assessment and screening of residents—including the development of more focused assessment tools—to target intensive supportive services more effectively.

Developing more effective assessment tools has implications beyond the current Demonstration. To develop people-focused

strategies that work for public housing residents and other vulnerable populations (e.g., families involved in the child welfare system, homeless families), we need better ways of understanding families' needs and targeting services. Not all families need intensive supportive services, and service needs are not static: they change depending on a number of factors related to mental health, economic, and personal circumstances.

There is little precedent for providing intensive, wraparound services to vulnerable families in public or assisted housing. However, there is considerable evidence about the benefits of providing similar services to homeless families. In fact, the only thing that distinguishes homeless families from vulnerable public housing's tenants is that the former remain on a Public Housing Authority's wait list and the latter have received housing assistance. Like the residents in the Demonstration, homeless families have varying levels of need and face a range of different types of challenges and barriers. Those who work with homeless families are also attempting to develop new, more effective assessment tools that will allow providers to determine which families require the most intensive services, which will require only housing first and light services.

Currently, there are four primary housing models for serving homeless families: rapid rehousing, transitional housing, permanent supportive housing, and housing vouchers (Culhane and Metraux 2008; Bassuk et al. 2006; Burt 2006). These service enriched housing models provide a framework for integrating supportive services and housing (Caton, Wilkins and Anderson 2007; Locke, Khadduri, and O'Hara 2007; U.S. Department of Housing and Urban Development 1995). But some of these service models have been found more effective in generating resident gains than others.

Transitional housing—which has as its goal creating economic self-sufficiency through employment so individuals and families can maintain housing stability—has mixed evidence of success (Burt 2006; Locke, Khadduri, and O'Hara 2007). Many residents require an ongoing housing subsidy. For example, a recent evaluation of Washington State's Sound Families Initiative, a multiyear initiative aimed at increasing transitional housing units for homeless families, found that upon exiting the program, most families relied on public subsidies, such as the Housing Choice Voucher program and public housing units, to maintain permanent housing (Northwest Institute for Children and Families 2008).

A relatively new model for families with children, permanent supportive housing—which provides long-term housing and the support of case management services—appears to be an effective tool for providing housing stability for high need families (Bassuk et al. 2006). Supportive housing has demonstrated positive effects on families with children, increasing school attendance and parent and child mental health, and decreasing self-reported drug use (Nolan et al. 2005). Permanent support housing is costly, however, which makes developing effective targeting strategies essential.

DISTRESSED PUBLIC HOUSING IN CHICAGO

The CHA is now a decade into its ambitious Plan for Transformation, launched in 1999. The goal of the Plan is to replace the CHA's notorious high-rise developments with new mixed-income housing that reflects the current thinking on how best to provide affordable housing without creating new concentrations of poverty (Chicago Housing Authority 2000). By 2009, the CHA had demolished nearly all of its

high-rise developments and was constructing new mixed-income developments in their place. Thousands of CHA households were relocated with vouchers, either temporarily or permanently, but thousands more were living in the remaining traditional developments. Some of those residents were waiting for units to become available in the mixed-income developments, but a substantial number had failed to meet the mixed-income screening criteria and, for various reasons, had chosen not to or had been unable to make the transition to private market housing with a voucher.

In response to serious problems during the early phases of implementation—and because of pressure from advocates—the CHA gradually developed a resident services system to support residents through the relocation process. Over time, the system came to include relocation assistance—for example, help with locating apartments, information about a broad range of neighborhoods, and assistance with dealing with landlords—and case management, intended to help move residents toward self-sufficiency (Popkin 2010). Additionally, as the Plan for Transformation has moved forward, the CHA has contracted out the property management of its traditional public housing to private companies and has instituted stronger lease enforcement (BPI 2009).

At the start of the Demonstration, the families awaiting relocation faced three choices: meet the screening criteria to move into a mixed-income development, pass the conditions required for a voucher, or wait to move to another rehabilitated CHA development. Yet many residents could not meet the stricter criteria of either vouchers or mixed-income developments (see appendix A). Previous research on CHA residents has found that off those who did move, residents did not fare uniformly well—many vulnerable residents

could have benefited from extended support (Popkin, Levy, and Buron 2009; BPI 2009).

Over the past year, the CHA renamed its case management program for all CHA developments, including the Demonstration sites, FamilyWorks. As its name suggests, the revamped program is employment-focused but incorporates aspects of the Demonstration service package, including resources for clinical case management. In its most controversial reform, the CHA has rolled out a work requirement for residents. The CHA introduced a 20 hour a week work requirement in 2009 for all adults living in traditional public housing between the ages of 18 and 62; this requirement rises to 30 hours a week in 2010. Resident advocates were concerned that this requirement would generate a wave of evictions of the CHA's most troubled residents; it remains to be seen how aggressively the CHA will enforce these rules. The CHA does allow for exemptions to the requirement for those who are older than 62; single parents serving as the primary full-time caretaker for a child age one and under; and blind or disabled residents who certify they are unable to work. In addition, if residents do not meet the CHA work requirement they may be eligible for Safe Harbor, a six-month exemption to the work requirement for extenuating circumstances.⁴

⁴ Residents may be eligible to receive a Safe Harbor waiver if they are waiting for approval or an appeal of an application for SSI/SSDI; have a temporary medical condition; were separated from employment within the last 60 calendar days; are parents with children under age five and are participating in an active Department of Children and Family Services plan to reunify their family; were either the victim or the caregiver for a victim of domestic or sexual violence; attempted, but failed, to find adequate child care; or attempted but failed to find employment.

Study Sites

The Demonstration serves residents who lived in either Wells/Madden Park and Dearborn Homes as of March 2007. We selected these developments both because of the large numbers of vulnerable families in each site and because of differences between the sites that provide important contrasts for the research. While the Demonstration focused on just two developments, findings from the project will inform the broader discussion around providing services to public housing residents, especially for the hard to house.

Wells/Madden Park

The Wells/Madden Park community is located on the near South Side of the city, close to Lake Michigan on the east and to the sites of the former Robert Taylor and Stateway Gardens Homes on the west. The development, now empty, sits in the historic Bronzeville neighborhood, which has been undergoing rapid gentrification after many years of decline. There are expensive condominiums within blocks of the development, as well as a traditional CHA development (Lake Parc Place) and two new CHA mixed-income communities (Lake Park Crescent and Jazz on the Boulevard).

The Wells community, built between 1941 and 1970, was one of the CHA's largest public housing complexes. The site included approximately 3,000 public housing units in four developments: the Ida B. Wells Homes, a low-rise development first opened in 1941 to house black war workers; the Wells Extensions; Madden Homes; and the high-rise Darrow Homes (Bowly 1978). Wells became notorious in 1994 when two young boys pushed a 5-year-old out the window of a vacant apartment in one of the high-rises, reportedly because he refused to steal candy for them (Jones, Newman, and Isay 1997). The CHA received a \$35 million

HOPE VI grant in 2000 to convert the site into a mixed-income community as part of the Plan for Transformation.

The Wells community became increasingly troubled over the years. The HOPE VI Panel Study, discussed earlier, documented that by 2005, most of the residents remaining in Wells's few occupied buildings tended to be those who were hard to house, that is, long-term public housing residents with lower incomes, and poor physical and mental health (Popkin, Levy and Buron 2009). At the beginning of the Demonstration in 2007, fewer than 300 households remained on the site; the rest had relocated with vouchers, to a mixed-income development, or moved to other CHA developments. All of the residents were African American. By August 2008, the CHA made a series of decisions in response to rapidly deteriorating conditions that led the agency to accelerate the closing of the entire development. Much of the public housing on the site is now demolished and a new mixed-income community called Oakwood Shores is gradually rising in its place.

Dearborn Homes

The Dearborn Homes are located on State Street, about a mile south of the Loop. Immediately to the north sits the Harold Ickes Homes, another large, troubled CHA development, now slated for demolition. 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 now situated on the block between Dearborn and Ickes.

Dearborn was one of the CHA's first high-rises; the development opened in 1950 and was made up of 800 units in a mix of six- and nine-story buildings (Bowly 1978). Dearborn and Ickes were the northern anchor of the State

Street corridor, Chicago's notorious four-mile stretch of public housing high-rises that included the Robert Taylor Homes and Stateway Gardens. During the first phases of the Plan for Transformation, the CHA used both Dearborn and Ickes as "relocation resources"—replacement housing for residents from other developments that were being demolished who 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 two developments and a demoralized population of legal residents who were aware that they had been "left behind." In 2007, there were approximately 270 families still living in Dearborn; some were long-term residents, and the rest were recent transplants from other developments. All were African American. The development was split between competing gangs, with one group controlling the northern end (27th Street side) of the development, and another controlling the southern (29th Street side).

The housing authority received a small HOPE VI grant for rehabilitation in 2003 and later received additional HUD funds that allowed it to complete the revitalization of the entire development. As is the case with a small number of CHA developments (Trumbull Park, Lowden Homes, Altgeld Gardens, Wentworth Gardens), the development is slated to remain traditional public housing, rather than becoming mixed-income.⁵ By January 2010, the CHA rehabilitated and reopened half of the 16 buildings at Dearborn; the remainder should be completed within the next year. This

redevelopment activity meant that some Dearborn residents were relocated temporarily—some for a second time—during the course of the Demonstration.

Data Collection

This report is primarily based on the baseline survey of residents in the two developments in that took place in Spring 2007 as the Demonstration was getting under way. The baseline survey covered several domains, including housing conditions, financial hardship, experiences with case management, neighborhood conditions, crime and victimization, mental and physical health, employment, and public assistance. If the head of household had children, interviewers asked questions about a younger and older child's behavior, school performance, and health. All households living in Wells/Madden Park and Dearborn Homes as of March 2007 were eligible for the Demonstration services. Whether or not residents participated in the expanded services, we attempted to conduct a baseline survey. In all, we succeeded in completing interviews with 344 residents (153 from Dearborn Homes and 191 from Wells/Madden Park). The response rate for the survey was 76.6 percent. The follow up survey will occur in 2009, approximately two years after the roll out of the Demonstration.

Additional information on residents comes from CHA administrative records and case manager reporting. Important information includes whether residents chose to engage in the Demonstration services, whether they were referred for additional services, and their relocation history. The research team also conducted in-depth qualitative interviews with case managers and project staff twice during the Demonstration. Finally, to complement the survey, Urban Institute staff conducted 30 interviews with residents over the course of two

⁵ The decision to rehabilitate some developments and retain them as traditional public housing has been controversial. See BPI 2009.

weeks in summer 2008 (21 adult interviews and nine adolescent interviews). For a complete discussion of the baseline survey and other data collection efforts, see appendix B.

UNDERSTANDING RESIDENT NEEDS

The Demonstration changed the existing Service Connector model and case managers' jobs in several important ways. Prior to its introduction, case managers had high caseloads and little time to meet with residents—generally seeing clients just once per month, and often those meetings consisted of having the resident sign off on a form that reported their progress toward meeting the goals of their “Family Action Plan.” Because of these high caseloads, case managers were only able to deal with clients who actively sought them out; they had little time to go out into the development and find people who were unresponsive; as a result, the proportion of residents engaged in services hovered around 50 percent.

The Demonstration allowed service providers to dramatically lower caseloads—to about half of the standard load for Service Connector providers—offer new training, and introduce a family-centered service model (see table 1). The site managers reassigned clients and restructured responsibilities, for example, moving clients identified as active substance users to a case manager with clinical expertise in these issues. With these changes, case managers now had to focus on outreach to clients on their caseload who previously had not engaged in services, going out into the development and knocking on doors. And they had to meet more often with all of their clients, seeing them weekly and spending time reviewing issues and attempting to engage other family members. Case managers focused their services on helping

the family meet its goals for eligibility for new mixed-income developments or housing choice vouchers (e.g., utility debt, housekeeping, drug tests, children in school, work requirements). By these measures, the Demonstration has achieved important intermediate outcomes. Engagement rose from less than 50 percent of residents before the start of the Demonstration to nearly 90 percent of residents as of summer 2009. Staff met with residents an average of three to four times per month, up from just once per month before the Demonstration. Further, and perhaps most significant, case managers had to adapt rapidly from an on-site model to one where they were relocated residents living in a variety of settings around the city, including those who moved to live in the private market with vouchers, in other traditional public housing developments, and even in mixed-income housing.

Beyond the changes in the service model, case managers report that the work itself was much more challenging. In conducting outreach to residents who had resisted services, 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 users who were so in debt to drug dealers that the dealers had taken over their apartments. In meeting more frequently, case managers reported they often found that the more they “unpacked” the families' situations, the more serious the problems they uncovered. The increased emotional burden proved very challenging for case managers, and one of the first adjustments to the Demonstration service model was adding

clinical groups for staff to review cases and get support (Popkin et al. 2008).

In addition to the stress of dealing with more intense needs, case managers also found it challenging to deliver the same level of service regardless of the clients' needs. It became clear that they needed to "triage," that is, decide which clients really needed their intensive focus. For some residents who were basically stable and doing well, a weekly check-in proved bothersome, eroding hard-won trust. In contrast, other residents really needed daily meetings to ensure that they were taking medication, following through on substance use rehabilitation, or successfully navigating a web of other systems and providers. Site supervisors and the program director met regularly with staff to help them navigate these challenges and figure out an approach that would help them adjust to residents' needs while still meeting the requirements of the Demonstration.

It was clear, however, that the case managers would benefit from an assessment tool that could help them to target services more effectively and make decisions about allocating their time and resources. The problem of targeting is a challenge for serving other vulnerable populations, most notably homeless families (Culhane and Metraux 2008; Northwest Institute for Children and Families 2008). However, despite the need, there has been relatively little focus on developing and testing assessment tools, and many practitioners engaged in serving those at risk for homelessness continue to call for research that would help inform this critical need.

To help meet the need for a better assessment strategy for the Demonstration, we used the baseline data from our resident survey to develop a "typology" that would identify groups of residents with different sets of needs and strengths. This work builds on an earlier analysis

we conducted that drew on the HOPE VI Panel Study, and used survey data to develop a definition of hard to house residents. This earlier research grouped households into five groups based on some of their characteristics, i.e. family size, grand families, in order to offer a basic estimate of the proportion of residents who might need different housing and or service options than most HOPE VI relocation programs provide (Popkin, Cunningham and Burt 2005). However, this research described the full resident population of the targeted developments, and did not specifically focus on the most vulnerable. Further, the HOPE VI Panel Study survey lacked the detail on resident needs required for developing a full typology.

This new analysis expands this earlier work, using sophisticated analytical techniques to identify groups of residents with similar profiles and service needs. We used a mixed method approach, relying on both quantitative and qualitative information. We began with an analytic technique called cluster analysis—a strategy for grouping residents who are similar along a number of key characteristics.⁶ For this analysis, we relied on information about each resident's (or head of household's) housing, physical and mental health, self-efficacy, education, employment and income, public assistance, criminal activity, and demographic characteristics. We used qualitative information gathered from the qualitative service provider and resident interviews to inform which parameters to include in the cluster definitions,

⁶ Grouping similar residents also requires distinguishing between dissimilar residents, and in that sense, cluster analysis can be said to create maximum differences between groups. Mathematically, cluster analysis works by measuring the distance between individual observations on a range of indicators and the center of groups of observations. See appendix b for an explanation of the technique and parameters used.

and then again in selecting and naming the groups. For a complete description of our methods in identifying groups of residents and the underlying data sources see appendix B.

Resident Typology

The cluster analysis identified three distinct types of residents with distinct sets of challenges. We have labeled these groups “striving,” “aging and distressed,” and “high risk.” While this research focuses on the important differences between these groups, it is worth first noting that they are alike in a way that may account for why all were still living in some of the CHA’s most distressed properties long after the Plan for Transformation was under way: all are extremely long-term residents, having lived in CHA housing for more than 25 years on average. Below, we briefly describe the characteristics of each group, and then present our findings on how they differ along a number of key domains, including health and connection to the labor market

Striving

This group of residents is the least vulnerable of the three. They are generally connected to the labor market, even if they cycle in and out of low-wage jobs, and most have a high school diploma. Younger than the other groups of residents, their average age is 42.

More than half have children living in their home (61 percent). More than three-fourths are female-headed homes (78 percent). But the most striking difference between striving and other residents is that they are in significantly better mental and physical health. Many striving residents receive food stamps, but few report using TANF and SSI. Although their incomes are higher than those of other residents, they report high rates of material hardship, particularly paying utilities and affording food. Eighty-four percent of strivers report meeting with their case manager at least once or twice a month—the same as the share of high risk residents, but more than the aging and distressed group (75 percent). Nearly 40 percent of residents in the Demonstration sample fall into this group.



Striving and Struggling to Make Ends Meet

Sharon, a woman in her late 40s is proud of the challenges she and her family have overcome. Sharon has lived in public housing most of her life, growing up on the South Side of Chicago and with her mother and siblings. She had her first child when she was a senior in high school but managed to stay in school and receive her diploma; she now has five children ranging in age from 15 to 32. After high school, Sharon got married and moved into her own apartment in Wells/Madden; she is still married, although her husband does currently not live with her. Three of Sharon's daughters have graduated from high school and are now adults with their own homes.

Although Sharon has tried to provide a stable life for her children, she has faced many challenges, including struggles with drugs and alcohol. She has held a series of part-time jobs, but often found it difficult to earn enough money to balance the bills and child care. She has held her current job for a number of years, but worries about making ends meet and would like to find another part-time job to increase her income.

When Wells/Madden closed, Sharon opted to take a voucher and is now living in a newly rehabilitated house on the South Side. Although it was her long-time home, she was glad to leave Wells behind; she had become increasingly concerned about the violence and drug trafficking and worried about her 16-year-old daughter, who frequently got into fights with other girls. Although the family's new home is far from friends, it is within walking distance of Sharon's part-time job. Her daughters are happy and are attending a new school close by and making friends; Sharon has had more difficulty adapting to the new community and, even though she believes the move was good for her family, still has concerns about drug trafficking and crime.

Aging and Distressed

In contrast to the striving group, aging and distressed residents are extremely troubled, with serious health challenges and little connection to the labor market. They are the oldest group, with an average age of 57. This group has a higher share of single residents, and includes more men than the other groups (32 percent). A quarter of aging and distressed residents care for children, often their grandchildren.⁷ Most are in extremely poor health, with strikingly high levels of depression, anxiety, and physical ailment, such as cardiovascular disease, asthma, arthritis, diabetes, and severe mobility impairments; many report receiving SSI. Less than half of this group has a high school diploma or GED, and

most have not worked in decades. From the qualitative interviews with residents and service providers, we learned that substance use is a struggle for many in this group. For these residents, achieving economic self-sufficiency is an unattainable goal; in addition to their fragile health status, most are truly disconnected from the labor market and the world outside public housing. Their profile is similar to older individuals in the homeless system, the key difference being that these residents have managed to rely on public housing as housing of last resort. This group is the least likely to report meeting with their case manager at least once a month. Over one in five residents in our sample is aging and distressed.

⁷ So called 'grandfamilies' are nontraditional households such as custodial grandparents or persons caring for related foster children. This phenomenon is growing in other public housing environments as well (Smith and Ferryman 2006).

***Aging and Distressed with a Disabled Child
in the Home***

Martin, a 65 year-old man, and his 15-year-old developmentally delayed son, Andrew, relocated from Wells/Madden 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 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.

High Risk

High risk residents share characteristics with both striving and aging and distressed residents. Like the striving group, they generally are younger, most have children in their household, and meet frequently with their case manager. While not yet as frail as the aging and distressed, they already have serious physical and mental health challenges, with high rates of poor health, obesity, depression, anxiety, and substance use. Their employment levels are low, though twice that of aging and distressed residents; most receive public assistance (SSI, food stamps, and TANF). The high risk group—mostly families—is overwhelmingly female headed (95 percent female). They have the largest households of the three groups, averaging 3.5 people and 64 percent have children.⁸

At 48, their average age is older than strivers, but younger than aging and distressed residents. These families are especially vulnerable; they are at risk of becoming as troubled as the aging and distressed group, but with the right support, may be able to make gains. Forty percent of all residents in our sample fall into the high risk group.

⁸ Household size has clear implications for housing choice. Large families often have difficulty using vouchers to find stable, high quality housing. Public housing has long been one of the few reliable sources of large, affordable apartments. Using criteria established by HUD, we estimate the number of bedrooms required by each household on the basis of the roster collected during the baseline survey. Twenty-eight percent of high risk households require four-bedroom units or more. Fewer aging and distressed and striving households require this many bedrooms (8 percent each).

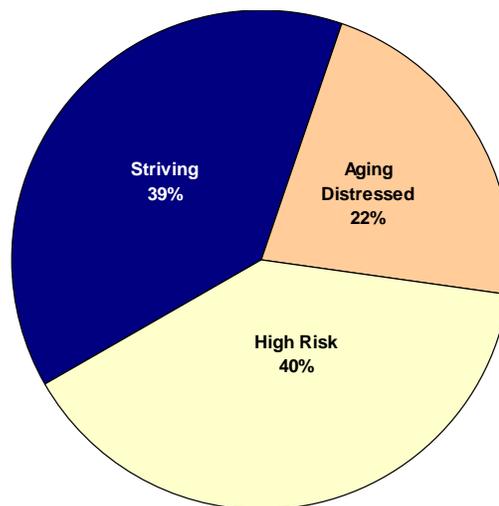
High Risk and Struggling to Retain Custody of Her Children

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, step-father, and three siblings on the South Side of Chicago. Jasmine had a troubled childhood, and says her parents were both 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 says that 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 gotten worse, 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.

Figure 1. Resident Typology



Source: Baseline survey of residents in Chicago Family Case Management Demonstration

Physical and mental health

The HOPE VI Panel Study research documented the shockingly poor health status of residents of distressed public housing residents. The Panel Study tracked residents from five developments across the nation where redevelopment began in 2000. In 2005, 41 percent rated their health as “fair” or “poor,” a much higher rate than for the general population or even for black women, a group with higher-

than average rates of poor health.⁹ HOPE VI Panel Study respondents also reported high rates of chronic, debilitating conditions like asthma, obesity, diabetes, and hypertension (Manjarrez, Popkin, and Guernsey 2007; Popkin, Levy and Buron 2009). Further, these residents were often debilitated by their illnesses; health problems were the main reason that they were unable to work (Levy and Woolley 2007).

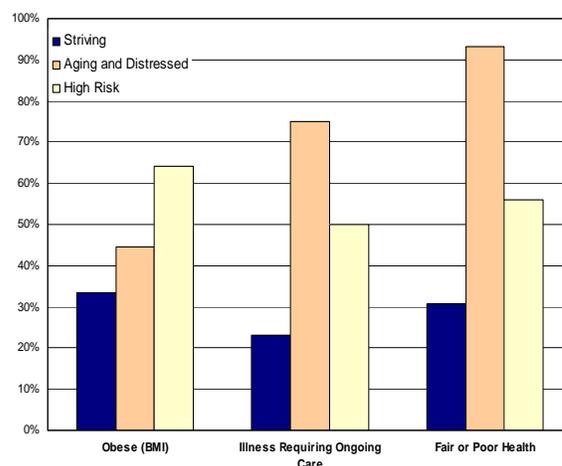
Even given this context, the prevalence of serious health problems in the Chicago Family Case Management Demonstration sample is striking. It is clear that one of the ways in which this population is particularly vulnerable is their extremely poor health. While the population as a whole is in poor health, there is substantial variation among the three groups. Aging and distressed respondents are by far the worst off: a shocking *93 percent* of residents in this category rate their health as fair or poor—more than twice as high as the figure for the HOPE VI Panel study (figure 2). By nearly every measure, respondents in the aging and distressed group are in worse health than other

respondents: three out of four have an illness requiring ongoing care; a third have asthma; and more than two-thirds have hypertension. By comparison, 23 percent of HOPE VI Panel Study respondents had asthma and 39 percent reported being diagnosed with hypertension (Manjarrez, Popkin, and Guernsey 2007) Almost half—45 percent—of respondents in the aging and distressed group are obese (body mass index of 30 or greater), and another 27 percent are overweight. Not surprisingly, given their poor health overall, many (58 percent) report severe difficulty with physical mobility—tasks like being able to walk three blocks, climb a flight of 10 stairs without resting, or stand on their feet for two hours.

Respondents in the high risk group are nearly as badly off, and in many ways seem simply a younger version of the extremely troubled residents in the aging and distressed group. Just over half rate their health fair or poor, and about the same proportion report having an illness requiring ongoing care (figure 2). Twenty-seven percent have asthma, and 53 percent report that they have been diagnosed with hypertension.

⁹ Many health problems vary significantly by gender and race, and because over 88 percent of the adults in the HOPE VI Panel Study are women and 90 percent are black, the HOPE VI Panel study used a sample of black women nationally as the comparison group. The national data cited in this testimony are published by the U.S. Department of Health and Human Services, calculated from the National Health Interview Survey in 2005. National Health Interview Survey data are broken down by sex and race, but not further by poverty status. Nationally, approximately one-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 of the relatively better economic well-being of the national population of black women compared with the HOPE VI sample. However, even limiting the comparisons to similar gender, race, and age groups, adults in the HOPE VI study experience health problems more often than other demographically similar groups.

Figure 2: Physical Health for Residents, by Group



Source: Baseline survey of residents in Chicago Family Case Management Demonstration

Residents in the high risk group report the highest rates of obesity: two-thirds of high risk residents are obese and another 17 percent are overweight (body mass index from 25 to under 30). (By comparison, 48 percent of HOPE VI Panel Study respondents were obese (Manjarrez, Popkin, and Guernsey 2007). Even though they are on average 15 years younger than the aging and distressed group, 39 percent of high risk respondents already report severe difficulty with mobility.

In contrast, respondents who fall into in the striving group are in far better health than those who fall into the aging and distressed and high risk categories. A comparatively low 31 percent rate their health fair or poor—although this figure is still high relative to the general population (Manjarrez, Popkin, and Guernsey 2007). Less than a quarter say they have an illness that requires ongoing care, under 20 percent have been diagnosed with asthma, and less than one-third have been told by a doctor that they have hypertension. Those in the striving cluster are also much less likely to be obese than other respondents in the sample: only one-third of strivers are obese, a rate that is similar to the national average for black women and *half* of the figure for the high risk group. And, being in better health overall, just 5 percent of respondents in this group report severe difficulty with mobility.

The households in the Demonstration are among the most vulnerable in the CHA's population; they were among those who had been unable to move into better housing options as other families relocated. When the Demonstration started, these residents were living in extremely dangerous and stressful conditions. In 2007, both Wells/Madden Park and Dearborn Homes had active, open drug markets, and serious problems with gang violence. At the baseline, more than 50 percent

of residents reported that shootings and violence were a big problem in their community, 77 percent reported big problems with drug dealing, and 60 percent reported that gangs were a big problem (Popkin et al. 2008). Our research suggests that these dangerous conditions had serious implications for residents' well-being; we found clear linkages between residents' perceptions of safety and their mental health (Roman et al. 2008).¹⁰ Underscoring the linkages between safety and well-being, our analysis shows that residents in the aging and distressed group, the most troubled of the three groups of residents, had much higher levels of fear of crime than other residents. At baseline, they reported feeling very unsafe at three times the rate of those in the striving group (figure 3).¹¹

Our baseline survey included measures of depression and anxiety, and we looked at differences across the three clusters (figure 3). Again, the HOPE VI Panel Study serves as a point of comparison—that study found that 14 percent of respondents overall were suffering from depression, a rate twice as high as that of black women nationally (Manjarrez, Popkin, and Guernsey 2007). The prevalence of depression and anxiety is higher yet for respondents in the Demonstration. The aging and distressed cluster is by far the most severely affected: an astonishing one-third of these respondents are

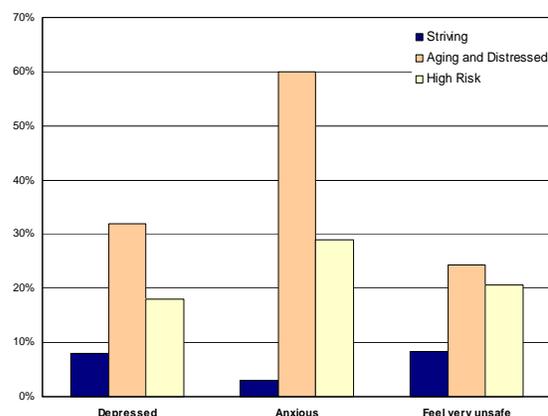
¹⁰ Other research on public housing relocatees supports this finding; findings from the HOPE VI Panel Study and the Moving to Opportunity Demonstration both show that adult women and girls who moved from public housing to neighborhoods that were lower poverty and lower crime reported reductions in anxiety and depression (Popkin, Buron and Levy 2009).

¹¹ We asked residents how safe they feel when alone outside their apartment building at night.

depressed¹² and 60 percent suffer from anxiety.¹³ Case managers reported several instances of uncontrolled schizophrenia and that many—perhaps most—residents in the two developments had experienced trauma and had symptoms of post traumatic stress disorder (PTSD).

Respondents in the high risk group look more like the HOPE VI Panel Study sample, with just under 20 percent scoring as depressed and about 30 percent reporting anxiety—again, it is important to remember that this figure is far higher than that for the general population. In contrast, as figure 3 shows, respondents in the striving group are much better off, with just 8 percent scoring as depressed and 3 percent reporting anxiety.

Figure 3: Mental Health for Residents, by Group



Source: Baseline survey of residents in Chicago Family Case Management Demonstration

Employment and Income

Many of the residents in the two developments face numerous, complex challenges that create barriers to their ability to move toward self-sufficiency and remain stably employed. These residents have weak (or nonexistent) employment histories, limited work skills, and very low literacy levels. A comparison with results of The HOPE VI Panel Study again reveals that residents in the Demonstration were more disadvantaged and disconnected. Just under half (48 percent) of working-age Panel Study respondents were employed – a figure that remained constant across all three survey waves (Levy and Woolley 2007). That compares with a little more than a third (34 percent) of working-age residents in the Demonstration who are employed. The Panel Study found that severely challenged physical mobility and depression were the leading barriers to work—and residents in the Demonstration are in even worse health, so the lower rates of employment are not surprising. As described above, the CHA restructured its resident services program across all public housing developments, placing a greater emphasis on work requirements and

¹² This scale is a modified version of the CIDI-12, or Composite International Diagnostic Interview instrument. The series includes two types of screener questions that assess the degree of depression and the length of time it has lasted. The index is then created by summing how many of the five items (the standard CIDI-12 has seven items) respondents reported feeling for a large share of the past two weeks. If a respondent scores three or higher, their score indicates a major depressive episode.

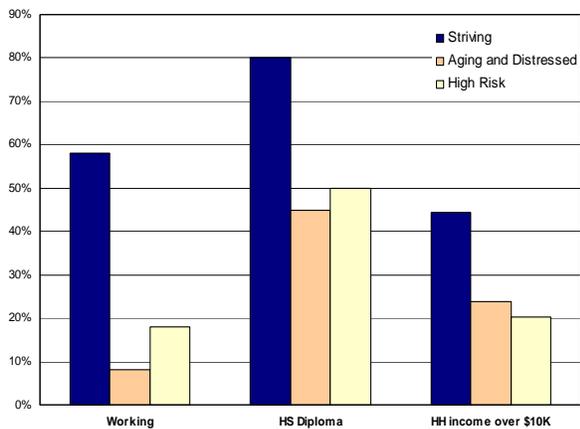
¹³ We assessed anxiety based on responses to a series of questions called the Mental Health Inventory five-item scale (MHI-5), a shorter version of the 38-item Mental Health Inventory. This scale assesses mental health on four dimensions: anxiety, depression, loss of behavioral or emotional control, and psychological well-being. The five questions ask how often respondents have experienced the following mental states during the past month: nervous, “calm and peaceful,” “downhearted and blue,” happy, and “so down in the dumps that nothing could cheer you up.” Respondents are considered to have poor mental health if they fall in the lowest quintile for a national sample (Ehrle and Moore 1999).



supports. The findings from the Demonstration highlight both the importance of increasing employment and self-sufficiency and also the enormous challenge of doing so. They also raise questions about whether the CHA will have to develop different strategies for residents in poor health.

While the overall employment situation for Demonstration participants is striking, we again see highly divergent circumstances for the different groups of residents. Aging and distressed residents are the worst off; even those of working age are almost entirely absent from the labor force (figure 4). In addition to poor mental and physical health, this group faces serious barriers to employment due to low literacy and numeracy levels. Case managers report that many are reading below the 5th grade level and over half did not graduate from high school or get a GED. As a result, their incomes are extremely low (only one in four earns above \$10,000 per year). Many receive public assistance (figure 5). More than half receive food stamps and nearly half receive SSI for themselves or someone in their household. Use of TANF, at 7 percent, is lower.

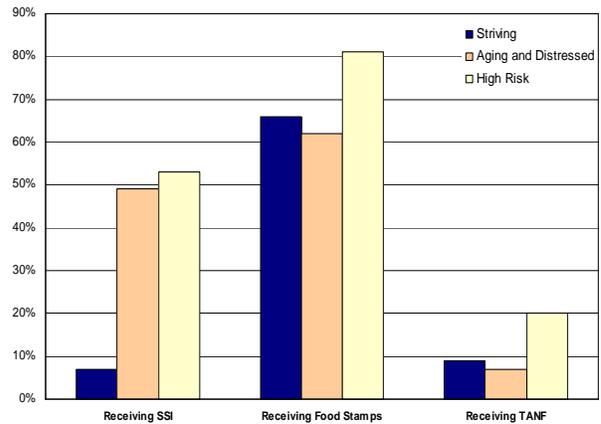
Figure 4. Employment, Education, and Earnings for Residents, by Group



Source: Baseline survey of residents in Chicago Family Case Management Demonstration

Many high risk residents are on the margins of the labor force. Just 18 percent are working, but unlike aging and distressed residents, they have not been out of work for as long; the median length of time out of the labor force is three years. And many are taking care of young children. These factors raise hopes that given the right work supports—for example a transitional jobs program—the high risk group may be able to transition into (or maintain) stable employment. They are slightly better educated, but have slightly lower incomes than aging and distressed residents (figure 4). Public assistance receipts them are the highest: four out of five receive food stamps, one in five use TANF, and just over half receive SSI (figure 5).

Figure 5. Public Assistance for Residents, by Group



Source: Baseline survey of residents in Chicago Family Case Management Demonstration

While still low income (54 percent earn under \$10,000 a year), striving residents look more like other low-income families with housing assistance. Over half are working—strikingly divergent from the other groups but similar to the HOPE VI Panel Study results. But striving residents generally work for low pay; their median hourly wage is \$10.00. Fifty-six percent take home less than \$10,000 a year (figure 4). Strivers are Eighty percent have graduated high school or have a GED. Given

their existing employment levels and high school graduation, this group may benefit from increased training and skill-building opportunities. Many striving residents receive food stamps (66 percent), but very few receive SSI or TANF (7 and 9 percent, respectively).

TARGETING SERVICES EFFECTIVELY

The striking differences among the three groups of residents in the study population suggest a need for a range of service approaches and a strategy for identifying those most likely to need—and benefit from—an intensive case management model. Clearly, the *striving* group is very different from the other two: they have their high school diplomas; they are connected to the labor market, even if they cycle in and out of low-wage jobs; and, most significantly, they are in relatively good mental and physical health. Case managers in the Demonstration have commented that this group is often the most difficult to engage in the intensive services, both because they are often uninterested or simply unavailable during the workday. Although they are long-term public housing residents, very few of these residents are interested in staying in traditional public housing: at baseline, nearly two-thirds (60 percent) said they wanted a voucher and another 25 percent indicated that they hoped to move to a mixed-income development. There is considerable evidence from our other research on HOPE VI relocation in Chicago and other cities that residents who move with vouchers or to mixed-income end up in better housing in dramatically safer neighborhoods, and report lower levels of anxiety (Buron, Levy and Gallagher 2007; Popkin, Levy and Buron 2009). Our qualitative interviews with striving residents like Sharon, profiled above, suggest that

Demonstration participants will likely experience the same gains.

However, while striving residents are likely to benefit considerably from relocation, simply helping them to move will not ensure their long-term stability. Although they are better off on many indicators, these striving residents are also very long-term public housing residents with little experience in dealing with landlords or the stresses of living in the private market. Indeed, evidence from the Demonstration baseline survey shows that striving residents were nearly twice as likely as those in the high risk group to report difficulty in paying their rent while they were still living in public housing, suggesting they may continue to experience trouble after relocation. Likewise, other research on HOPE VI relocatees also shows that private market movers report experiencing significant hardship, especially difficulty paying utility bills and affording food (Buron, Levy, and Gallagher 2007; Popkin, Levy, and Buron 2009). Striving families will continue to need “light-touch” support to ensure that they are able to maintain the gains they made in leaving distressed public housing including:

- Long-term follow up, with monthly visits from a case manager for the first year, and quarterly contact for at least two years.
- Access to employment services, including transitional jobs, job search assistance, job training, and education.
- Financial literacy, particularly budgeting and saving.
- Second mover counseling to help striving families make subsequent moves to communities that will offer greater opportunities for themselves and their children.



Striving to Protect her Son

Tanya and her 11-year old son Jaylen hope to move into one of CHA's new mixed-income developments. Tanya was not raised in public housing; she grew up with both her parents and 10 siblings in a house on Chicago's South Side. Tanya got pregnant at 16, but still finished high school. She married the father of her child, but left her husband after he became abusive. She remarried and had her second child (Jaylen), but has been separated from her husband for 11 years because he uses drugs and is in and out of prison.

Tanya has been living in Dearborn for 11 years. She worries about the drug use and gang violence, especially because of the dangers for her son. She sees herself as different from many other public housing residents, since she is employed as a crossing guard and does not use drugs. She gives her neighbors food when she can, but she also tries to keep Jaylen from interacting with people in her building, because she thinks they will have a negative influence on him and bully him.

Tanya suffers from several health problems; she is partially blind and has heart problems, acid reflux, migraines, and a bladder problem. Luckily, her job provides health insurance. Still, Tanya struggles to make ends meet and sometimes has to go to food banks and, on occasion, asks family members for help.

Tanya is very protective of her son. She maintains a strict curfew, and does not allow Jaylen to go outside alone. She pays close attention to his school performance, and doles out rewards or punishments based on his grades. Jaylen has been doing well: he works hard in school, stays out of trouble, and plays sports with his friends. Jaylen says he appreciates how hard his mom works to give him a good life, and thinks that he and his mom have "made it."

In contrast, *aging and distressed* residents have very different service needs. As figures 3 and 4 show, they face stark physical and mental health challenges. Nearly all of them (93 percent) rate their health as "fair or poor," indicating an extreme level of vulnerability. As a point of comparison, 65 percent of residents 65 and older in the five-site HOPE VI Panel Study reported fair or poor health, as did 58 percent of those aged 45 to 64; these figures for the Panel study respondents were already twice as high as for black women nationally—and black women as a group are in poorer health than average (Manjarrez, Popkin and Guernsey 2007). Further, aging and distressed residents were twice as likely to report anxiety and depression as HOPE VI Panel Study respondents, which means they are experiencing these problems at a rate *more than four times* that for black women nationally.

For these residents, achieving self-sufficiency is an unattainable goal; in addition to their fragile health status, most have not worked in decades and are truly disconnected from the labor market and the world outside public housing. A better approach for these extremely vulnerable residents is to focus on "harm reduction," helping them remain stable and avoid becoming either homeless or ending up in nursing homes—and their children from ending up in the child welfare system. Appropriate strategies for the aging and distressed include the following:

- An assisted living model which provides sufficient care (meals, housekeeping, activities, health care, case management) to help frail and mentally unstable residents remain in the community. To accommodate the needs of the public housing population, this service would need to be available to residents who are under age 60, but have enough physical and mental health



- challenges to fall into the aging and distressed group.
- Permanent supportive housing that provides the same service package as assisted living for those who have custody of children or grandchildren, and adds parenting support, child care, and after school services for youth.

High risk residents share characteristics with both striving and aging and distressed residents. Like the striving group, they generally are younger and have children in their household. And, like the striving group, at baseline, the vast majority of these residents indicated that they did not want to remain in traditional public housing. While not yet as frail as the aging and distressed, they already have serious physical and mental health challenges, with high rates of poor health, depression, anxiety, and substance use.

Notably, they are the group most likely to report being obese, which places them at risk for other serious health problems like hypertension and diabetes. With their multiple challenges, high risk families are the group for whom intensive case management models are most likely to pay off in terms of keeping them out of the homelessness, child welfare, and criminal

justice systems, providing stable environments for their children; assisting them to achieve their housing goals (vouchers or mixed-income developments), and helping them move toward self-sufficiency.

These families need the type of services that the Chicago Family Case Management Demonstration provides, including:

- Permanent family supportive housing that provides services on-site such as health care, mental health services, and substance use counseling; educational and literacy services; transitional jobs and other employment and training services; financial literacy; parenting support; child care; after school services.
- “Integrated” supportive housing—small numbers of permanent family supportive housing units incorporated into mixed-income developments, with case management and services provided on site.
- Vouchers with “Wraparound Services”—case managers go into the community to provide the same package of services delivered in permanent family supportive housing to voucher holders.

In her 40s and Already Physically Old

Rhonda, a woman in her mid-40s, is working to overcome many challenges in her life. She moved from Wells/Madden Park to her current public housing apartment about a year ago. Rhonda was born in public housing, and had a troubled adolescence; when she was a teenager, she was sexually abused. She has been drinking and doing drugs since she was in high school. Although she says she is now trying to get sober, she admits to not being able to see her 6-year-old son because of her history of drug addiction. One of the major barriers to her recovery is the fact that Rhonda is the primary caretaker for her alcoholic and mentally ill sister, who lives in an apartment in the same building. Rhonda herself is very depressed, and says that she often turns to drinking to cope with stress of caring for her sister.

Rhonda also suffers from serious physical health problems—far worse than most people in their 40s. She has asthma, hypertension, and emphysema, and is a long-time smoker. She does not have health insurance and cannot afford dental work. Her substance use problems have caused memory loss; she often loses track of what she is saying or cannot retrieve words when she is speaking. Rhonda is currently unemployed; she says she lost her job at McDonald’s because of her frequent absences and hospitalizations. Rhonda worries that her health conditions and worsening depression will make it almost impossible to find a new job.



High Risk and 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 and 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 she is trying to separate from him.

Annette's 12-year-old son, Tim, is also very troubled. He says he has behavior problems in school and fears being hurt or killed in his neighborhood. Although Tim was happy to leave Wells/Madden Park, 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 like mildew and a basement that floods regularly. She has almost no furniture in her house.

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

- Incorporating best practices like the
- "incentives model" from Project Match's "Pathways to Rewards" program in Chicago that helps families move toward self-sufficiency through providing rewards for achievements like paying their rent on time, getting their children to school, and volunteering (Herr and Wagner 2009).¹⁴

INFORMING THE NEXT GENERATION OF PUBLIC HOUSING REFORM

Many policymakers and scholars regard the HOPE VI Program as one of the nation's most successful urban redevelopment programs (c.f. Katz 2009; Cisneros 2009). But despite its very real accomplishments, the HOPE VI program's record in meeting the needs of the original residents who endured the worst consequences of the failures of public housing is mixed. While many ended up relocating with vouchers to better housing in safer neighborhoods or moving into the new developments, too many others were simply relocated to other, traditional public housing. The residents who ended up in these developments were disproportionately the most vulnerable—those who had been most damaged by the distressed environment and were least able to cope with the challenges of relocation.

With its proposed "Choice Neighborhoods" initiative, the Obama administration has the opportunity to build on the experiences of nearly two decades of experience with HOPE VI. HUD Secretary Shaun Donovan recently stated that "There is no

¹⁴ The Demonstration uses the "incentives" model for its Get Paid to Save financial literacy program, but that is targeted primarily at residents in the striving group.



excuse, any longer, if there ever was, to fail to house and support every family now living in a distressed or assisted housing project.” Incorporating intensive case management and permanent supportive housing for the most vulnerable into Choice Neighborhoods and any other comprehensive redevelopment efforts is one way to ensure that these initiatives truly meet the needs of these public housing families.

The early findings from the Demonstration show that it is feasible to provide intensive services in the context of public and assisted housing. Our typology suggests a

strategy for targeting services in order to make providing intensive services more feasible, even with limited resources. In our final report, we will look at the trajectories of each of the three groups and estimate the costs of providing services. However, to benefit both public housing service providers and those who work with the homeless, the next step should be to develop and test an assessment tool from this research. Once tested, such a tool could be easily adapted for a range of service providers working with vulnerable families, including those working as part of HOPE VI or Choice Neighborhoods Initiatives.

Striving for Stable Work and a Safe Neighborhood

Cristina, is a 25-year old woman who has four young children. She grew up in public housing and says that in high school, she hung out with a “bad crowd,” but eventually got “tired of that lifestyle.” She got pregnant at 18, and her daughter was premature. But her daughter pulled through, and so did Cristina: she finished high school and has remained more or less steadily employed throughout her daughter’s childhood. The father of Cristina’s first two children recently finished a seven-year term in prison, but now comes to visit often. Cristina now lives with the father of her second two children.

Though Cristina’s life has been far from easy, she has managed to maintain a reasonable degree of stability for herself and her children. Cristina became concerned about the drug trafficking and violence in Dearborn, as well as the physical decay and opted to relocate with a voucher. She now lives in an apartment on a quiet block where she can walk to get her groceries.

Cristina has also sustained a number of healthy relationships. She is close to her mother, aunt, and two friends, and describes frequent get-togethers with their kids. Cristina has dealt with a number of stressors, including recently losing her job and having difficulty finding a new one, but says her family and friends have helped her through (both emotionally and financially). She is actively pursuing employment, and completed the Transitional Jobs program and is in frequent contact with her case manager. Cristina says that her family sustains her through it all, and that her greatest source of pride is her children.

APPENDIX A: RESIDENCY CRITERIA FOR HOUSING CHOICE VOUCHERS, MIXED- INCOME DEVELOPMENTS, AND TRADITIONAL AND SENIOR CHA DEVELOPMENTS

As the CHA demolished or rehabilitated buildings at Wells/Madden Park and Dearborn Homes, residents who wanted to keep a housing subsidy had three or four options, depending on their age: moving with a Housing Choice Voucher into a private apartment or home, relocating to one of the CHA's new mixed-income developments, or moving to another traditional public housing or senior public housing development. Residents, along with the CHA, work to select housing that fits the preferences of each individual and family.

Prior to moving into either a private apartment or house with a voucher, or into a mixed-income development, residents must first meet a set of established criteria that differ depending on the type of assistance. For families and individuals that do not meet the criteria for these alternatives it often means a move to other distressed public housing. This section describes the criteria that residents must meet in order to be deemed eligible for either a HCV or a mixed-income development, as well as for traditional and senior CHA developments.

Housing Choice Voucher Criteria

Using a HCV (formerly the Section 8 program), residents of Wells/Madden Park and Dearborn Homes rent a private apartment or home. Under the program, recipients must pay between 30 and 40 percent of their income each month in rent. Residents may select from any eligible properties in the Chicago area or

beyond, though most choose to remain within the city itself. To be eligible, a property must pass an inspection and its rent cannot exceed Fair Market Rent (FMR) payment standards published by HUD. In most jurisdictions, FMRs are set at the 40th percentile of rents in the market area, however in Chicago it is set at the 50th percentile. FMR levels also take into account the size and number of bedrooms within a given unit (CHA 2009a).

Residents must meet several requirements in order to qualify for a voucher, including factors relating to, income, citizenship, utility payments, and criminal activity and background. HUD establishes base eligibility criteria, which the CHA expands. Table 2 lists selected criteria that individuals and families must meet to qualify for and maintain a HCV.



Table 2. Requirements for CHA residents to receive a HCV

- Incomes not exceeding 80 percent of area median income
- U.S. citizens, U.S. nationals, or noncitizens with eligible immigration status
- Current with utility bills or be current in a repayment plan, and must have connected utility in head of household’s name
- No one in household evicted from federally-assisted housing for criminal drug activity in the past 3 years (unless the person has completed a drug rehabilitation program or is no longer living in the household)
- No one in household uses illegal drugs or has used illegal drugs in the past six months
- No one in household is a registered sex offender or has ever been convicted of child molestation
- A criminal background check for each adult in the household showing no involvement in the past five years in drug-related criminal activity, violent criminal activity, or criminal activity that threatens other residents, property, or CHA staff.

softening, the CHA is having more difficulty filling unit within these developments. The impacts of these markets changes are yet fully understood, but could affect the composition of tenants within these developments. In some cases, residents who leave public housing with vouchers rent in mixed-income developments from private owners (and may be counted toward the share of units that are affordable rather than the share that are public housing).

Criteria for mixed-income developments are generally stricter than those for HCVs. They often involve screening for credit history, child care arrangements, bankruptcy, criminal and financial background checks, and tenant history. Specific criteria for varies by site; their enforcement is at the discretion of the property management. There is a formal process by which a rejected applicant can challenge the property manager’s decision. Below are selected move-in criteria for three different Chicago mixed-income developments: Oakwood Shores, Jazz on the Boulevard and Lake Park Crescent. All three are located on the near South Side of Chicago and received residents from the Demonstration.

Mixed-Income Developments

Mixed-income developments are partnerships between the CHA, private developers, and a property manager. These developments are built on the site of the demolished public housing development once occupied. Mixed-income developments are typically structured to include one-third of the units for public housing residents, one-third affordable rental units, and the final third are market rate sales. In a difficult economy, and with the housing market

Table 3. Move-in Requirements for Three Mixed-Income Developments

	Oakwood Shores	Jazz on the Boulevard	Lake Park Crescent
Bankruptcy	None	No bankruptcy in the past 4 years	No bankruptcy in the past 4 years
Financial Standing & Credit	An acceptable history of meeting financial obligations	No delinquent debts over \$1,000	No delinquent debts over \$1,000
Residential history	5 years of landlord verification; no negative landlord history in the past 2 years; no debt to CHA	No landlord judgments and no negative landlord history in the past 2 years	No landlord judgments in the past 3 years
Employment	For 30 hours a week, all members of household over 18 must work, attend an economic self-sufficiency program, or attend a regular education program (e.g. GED classes, secondary or post-secondary education, or English proficiency or literacy classes). Exceptions allowed for an adult who elects to stay home to care for young children; residents age 62 or older; blind or disabled residents; or residents who are the primary caretaker of a blind or disabled person.		
Child Care	Children over 6 enrolled in school unless evidence of high school graduation or GED.	Children over 6 enrolled in school and adequate day care or supervision provided to children under 10 years old	Children over 6 enrolled in school and adequate day care or supervision provided to children under 10 years old
Background Check	5 year criminal background check for all household members 18 and older	10 year criminal and credit background checks conducted for all household members 18 or older	10 year criminal and credit background checks conducted for all household members 18 or older
Criminal Activity	<ul style="list-style-type: none"> • No one in household can be evicted from federally-assisted housing for criminal drug activity in the past 3 years (unless the person has completed a drug rehabilitation program or is no longer living in the household) • No household member currently using illegal drugs • No one in household is a registered sex offender or has ever been convicted of child molestation • No household member convicted in past three years of violent crimes to persons or property or of gang activity. 		
Drug Testing	Annual drug screening for all household members 18 and over	Annual drug screening for all household members 18 and over	Drug screening for all household members 17 and over at initial application
Home Visit	Home visit as part of the screening process: <ul style="list-style-type: none"> • No health or safety hazards that contributes to infestation, or damage to the unit caused by household • Number of occupants must match with the information given on the application 	Home visit as part of the screening process: <ul style="list-style-type: none"> • No health or safety hazards that contributes to infestation, or damage to the unit caused by household 	Home visit as part of the screening process
Max Income	No more than 60% of the area median income		
Utilities	Able to obtain utilities and all outstanding utility charges paid before occupancy	No delinquencies to any utility provider	No delinquencies to any utility provider
Case Management	Households must engage in a case management plan and attend housing readiness training		



Criteria for Traditional and Senior Public Housing

For residents who chose to remain in traditional public housing, the CHA has more flexible eligibility requirements than for moving into a mixed-income development or out with a housing choice voucher. When determining eligibility, the CHA will consider an applicant's past performance in meeting financial obligations, especially payment of rent. Also applicants, coapplicants, and all members of the applicant's household age 18 to 61 are subject to the CHA Work Requirement. Applicants are not eligible for safe-harbor status. Below are selected reasons why the CHA could deny a potential applicant (CHA 2009b):

The CHA can deny applications if

- Applicants have been evicted from the CHA or any other subsidized housing program within the last two years from the date of the eviction for nonpayment of rent will have his/her application denied. For three years from the date of eviction, if any household member has been evicted from any federally-assisted housing for drug-related criminal activity.
- Applicants owe funds to the CHA or any other housing authority for any program that the CHA or another housing authority will be denied. In addition, applicants who owe funds or judgment debts to any utility company or cannot obtain utility connections will be denied.
- Any household member is currently engaging in illegal use of a drug and that there is reasonable cause to believe that a household member's illegal use or pattern of illegal use of a drug or alcohol may threaten the health, safety, or right to peaceful enjoyment of the premises by other residents;
- Any household member has ever been convicted of any of the following criminal

activities: drug-related criminal activity for the manufacture or production of methamphetamine on the premises of any federally-assisted housing, arson, child molestation, any member of the household is subject to a lifetime or any registration requirement under a state sex offender registration program, including the ten-year Illinois State Sex Offender Registration Act; or an applicant or household member has a criminal history in the past three years that involves crimes of violence to persons or property as documented by police arrest and/or conviction documentation.

Senior housing has all the same rules as traditional public housing but also has age restrictions. Senior housing provides current and potential residents age 62 and up with housing geared toward the specific needs of an aging population. Senior services offered to residents vary by development and residents' specific needs. These [[Q: or Preference units?]]units are first given to seniors 62 year of age and older. The CHA may lower the age restriction at senior housing developments based on occupancy rates (but not below 55).

APPENDIX B: DATA AND METHODS

Data

This section describes the data used to inform our analyses.

Baseline Survey of Residents

The Survey Research Laboratory (SRL) at the University of Illinois—Chicago conducted a baseline survey of residents for this Demonstration. The baseline survey collected residents' experiences, attitudes, and opinions across several domains including: housing conditions, financial hardship, experiences with case management, neighborhood conditions, crime and victimization, mental and physical health, employment, and public assistance. If children were present in the home, SRL asked the respondent about the child's behavior, school performance, and health. SRL asked about a randomly selected younger child (defined as less than 6 years old) and a randomly selected older child (defined as ages 6 through 17).

SRL attempted to survey all residents living in Wells/Madden Park and Dearborn Homes as of March 15, 2007; residents were eligible to participate in the research regardless of whether they engaged in the Demonstration services. Data collection ran from June through October 2007. Using paper questionnaires, the interviews were in-person, usually lasting from 45 to 60 minutes. Respondents received a \$15 gift card to Jewel, a local grocery store, at the completion of the survey.

SRL attempted ten contacts with households before characterizing them as non-respondents. When contacting a household, SRL asked to interview the leaseholder. If the

leaseholder was repeatedly not available, SRL interviewed another adult present in the household. SRL completed 344 interviews—153 interviews from Dearborn Homes and 191 from Wells/Madden Park. The response rate (the proportion of the eligible respondents who completed the interviews) for the survey was 76.6 percent. The refusal rate (the proportion of the eligible respondents who either refused to complete an interview or who broke off an interview) was 9.1 percent.

To ensure the quality of the data collected, SRL validated the work of all the interviewers. Validation consisted of reviewer at SRL telephoning a respondent who completed a survey and again asking four to six questions from the beginning, middle, and end of the questionnaire. The reviewer then compared these responses to the original survey questionnaire. SRL checked 45 surveys in this manner; all validated successfully.

Qualitative Interviews with Residents

Urban Institute researchers conducted in-depth qualitative interviews with households over the course of two weeks in August 2008. The purpose of the interviews was to provide greater context on the residents' perceptions of their current and former housing and neighborhoods, the prospect or experience of moving into a mixed-income development or a private apartment with a HCV, as well as their family dynamics, health status, employment, access to services, and long-term goals. Researchers also asked residents about their childhood and adolescence—including their education, family, and housing backgrounds. This information was a key support in shaping and validating our findings from the cluster analysis (described below). All of the resident profiles in this report were drawn from these interviews.

Urban Institute researchers drew a random, stratified sample of 24 households from the baseline survey respondents. We stratified residents by their housing development at baseline (Wells/Madden Park or Dearborn Homes) and family type (households with adolescents, seniors, and all other households) to ensure proportional representation of these groups. Researchers conducted 30 interviews with 21 households (21 adults and nine adolescents). Of the 21 households, five had a senior as the head of household and 11 had children. Due to the closing of Wells/Madden Park that same month and the rehabilitation of Dearborn Homes, several residents had moved between the baseline survey and these interviews. Of the interviewed households, nine lived in a private home with a voucher, six were still living in Dearborn Homes, and six households lived in another CHA public housing development. Interviews typically lasted 60 to 90 minutes; residents received \$45 at their completion.

Qualitative Interviews with Service Providers

To assess the Chicago Family Case Management Demonstration and gain greater insights into the lives of residents, staff from the Urban Institute and SRL conducted three rounds of semi-structured and focus group interviews with all service providers and supervisors participating in the Demonstration. These interviews focused on activities and services implemented, barriers and obstacles to program implementation, and community contextual factors. Directly informing this research, we queried case managers on the types of services that were effective and ineffective for different residents—using this information to refine our understanding of the groups of residents emerging from the cluster analysis and also to

inform our recommendations for targeting services. In total, staff conducted 54 semi-structured interviews and three focus groups with service providers. Interviews typically lasted for 45 minutes. Service providers were not compensated for their time.

Engagement Data

Heartland collects monthly data on the households that are on their caseload (those households that lived in Dearborn Homes and Wells/Madden Park on March 15, 2007). The data include information on whether the head of household engaged with the services, the number of times the case manager met with the client during the month, his or her relocation status, and information on whether anyone in the family enrolled in Transitional Jobs or “Get Paid to Save.” Heartland provides these data to UI monthly.

Methods

We used a mixed method approach to identify mutually exclusive groups of residents and their service needs. In order to differentiate public housing residents’ barriers and needs, we began with an analytic technique called cluster analysis. Cluster analysis is a strategy for grouping residents who are similar along a number of key characteristics. Grouping similar residents also requires distinguishing between dissimilar residents, and in that sense, cluster analysis can be said to create maximum differences between groups. This does not mean that every resident in a given group is exactly the same in every respect, but they are more similar to other residents in the same cluster than to households in other clusters.

Mathematically, cluster analysis works by measuring the distance between individual

observations and the center of groups of observations for a number of variables. Cases with shorter distances on the set of variables are grouped together. A number of algorithms are available for clustering; for this analysis, we use a non-hierarchical cluster technique known as k-means that relies on Euclidean distances. We chose this approach because it is suitable for variables that are continuous or categorical—and our survey results contain both. After standardizing the input variables using the Jaccard coefficient, we conducted this analysis using the FASTCLUS procedure in SAS. We determined the number of clusters by examining statistical criteria, evaluating how the clusters differed on each variable used in the analysis, and vetting these results with our findings from the in-depth resident and service provider interviews.¹⁵ We then assigned labels to each of the clusters, which makes it easier to communicate about them and apply the resident typology in practice.

Clustering methods allow many factors to be taken into account at once, reducing a complicated set of differences among households and to a minimum number of groups. For this analysis, we relied on information about each resident's (or household's) housing, physical and mental health, education and employment, public assistance, criminal activity, and demographic characteristics. We used qualitative information gathered from the service provider and resident interviews to inform which parameters to include in the cluster definitions. For a complete description of the indicators included in this analysis and their construction see table 4.

Cluster analysis is open for interpretation at several points. Its strength lies in synthesizing large amounts of complex information into discrete and understandable groups. As with any classification technique, the clusters we present may oversimplify important differences between residents. Further, clustering results are sensitive to the variables that are included in the analysis. For this reason, we relied on statistical tests to ensure that highly-correlated variables were not included as these can skew results. We also relied on the qualitative interviews with residents and service providers to inform which the fields we included. To ensure the robustness of our findings, we ran the clustering technique through several iterations replacing, removing, or adding other variables. We consistently arrived at the three groups of residents described here, with minor variations.

¹⁵ The number of clusters was determined by looking for the maximum value of the pseudo-F statistic and the minimum of the R^2 (Finch 2005).

Table 4. Variables Used to Define Clusters of Residents and their Definitions

Variable Label	Variable Description
Demographic	
Age	Age of Respondent (head of household)
Gender	Gender of Respondent
Housing	
Years in CHA	Number of years respondent has lived in CHA housing
Threatened with eviction	Respondent threatened with eviction in the past 12 months
Number of bedrooms	Number of bedrooms household requires based on CHA and HUD standards
Physical health and substance use	
Overall health	Self-ranked health of respondent (excellent, very good, fair, poor)
Body Mass Index	Body Mass Index of respondent
Current smoker	Respondent is a current smoker, following the CDC's National Health Interview Survey classification (smoke cigarettes every day or some days in the past month)
Regular drinker	Respondent is a regular drinker (consumed more than 12 drinks per month)
Regular marijuana user	Respondent is a regular marijuana user (used marijuana 12 or more times in the past year)
Used illegal drugs (other than marijuana)	Respondent used illegal drugs other than marijuana in the past year
Mental Health, Self-efficacy, Support	
Depression scale	Composite International Diagnostic Interview Depression Scale
Anxiety score	Anxiety Index/5-Item Mental Health Inventory (MHI-5)
Self-efficacy	Respondent's assessment of his/her self-efficacy using the New General Self Efficacy Scale
Family support	Respondent's assessment of his/her family support using the Social Support Survey Family Support Scale
Education, Employment, Income	
HS graduate	Respondent complete high school or received a GED (yes, no)
Currently works for pay	Respondent is currently employed in a part-time or full-time paid position
Household income	Total household income (<\$5,000, \$5,000 - \$9,999, \$10,000 - \$14,999, ..., \$40,000 or more)
Public assistance	
Receive SSI	Respondent and/or someone in the household receives Supplemental Security Income
Criminal Activity	
Anyone in household convicted	Whether anyone in living in respondent's household ever been convicted of a criminal offense
Anyone in household served a year or more in prison	Whether anyone in respondent's family or household is currently serving or has ever served more than a year of time in a state or federal prison

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