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- The benefits of intensive services have held over time; for some residents, they have grown stronger.
- While Demonstration participants report feeling physically and mentally healthier, poor health remains a big challenge.
- Reported outcomes for young children and teenagers changed little from 2007 to 2011.

# Improving the Lives of Public Housing's Most Vulnerable Families

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For decades, the Chicago Housing Authority's high-rise public housing towers epitomized the failures of federal social policy. Shoddy construction, management neglect, and vandalism made the physical conditions hazardous for residents and unsightly to passers-by. Physically and socially isolated from the rest of the city, the developments gradually became mired in the most destructive kind of poverty, with extreme levels of violent crime, gang activity, and drug trafficking. Most residents who had better options moved away, leaving behind a population composed primarily of extremely vulnerable families (Popkin et al. 2000; Cunningham, Popkin, and Burt 2005).

In 1999, the Chicago Housing Authority (CHA) launched its ambitious Plan for Transformation, hoping to transform its distressed properties into healthy, mixed-income communities that would provide better options for their residents (Vale and Graves 2010). As the Urban Institute's decade-long research on the transformation has documented, relocation proved one of the biggest challenges (Popkin 2010; Popkin, Levy, et al. 2010). At the Plan's outset, the CHA had little experience providing relocation counseling or social services to its residents, and it was trying to serve a large number of high-need families simultaneously. Early efforts to provide these services floundered, and the CHA became the focus of criticism and legal action from

resident leaders and their advocates. In response to these pressures, the CHA gradually improved its service system and began providing more effective case management and referral services (Popkin 2006). By the end of the decade, the Urban Institute was documenting surprisingly positive outcomes for relocated families, with many living in higher-quality housing in safer neighborhoods (Popkin, Levy, et al. 2010).

But even as services improved over time, they proved inadequate to meet the more complex needs of the CHA's most vulnerable residents, many of whom relied on the distressed developments as housing of last resort (Popkin 2010). These "hard to house" families faced numerous barriers to moving toward

**Incorporating intensive supportive services for the CHA's most vulnerable public housing residents produced additional health and employment gains for adults.**

self-sufficiency and sustaining stable housing, including serious physical and mental health problems, weak (or nonexistent) employment histories, limited work skills, very low literacy levels, drug and alcohol abuse, family members' criminal histories, and serious credit problems (Cunningham et al. 2005; Popkin et al. 2004; Popkin, Levy, and Buron 2009).

In response to this situation, the Urban Institute, the CHA, Heartland Human Care Services, and Housing Choice Partners launched the Chicago Family Case Management Demonstration in 2007. The Demonstration tested the feasibility of providing intensive case management and wraparound services to hard to house residents who had not qualified to move with a voucher or to a mixed-income development (for more information, see the description of the Long-Term Outcomes for CHA Residents study on page 10). After just two years, participants reported gains in health and employment, improved housing and neighborhood conditions, and reduced fear and anxiety; participants were faring significantly better than a comparable sample of CHA relocatees who had not received intensive services (Popkin, Theodos, et al. 2010). The Demonstration was less successful in improving the trajectories of children and youth, and the services had no effect on chronic illness or mortality rates. The additional costs for intensive services were relatively modest, suggesting it would be feasible to take this model to scale; further analyses suggested strategies for careful targeting to maximize cost-efficiency and impact (Theodos et al. 2012).

There were no guarantees that these improvements in residents' lives would be sustained, especially as the extra resources for intensive services ended. To assess the long-term sustainability of these results, we followed up with the Demonstration sample in 2011 as part of the Long-Term Outcomes for CHA Residents study. Demonstration participants

received intensive services through mid-2010; after that, many continued to receive services through CHA's FamilyWorks program, which operates in the agency's traditional public housing and mixed-income properties.<sup>1</sup> Four years after receiving Demonstration services, the benefits have held; for some residents, they have grown stronger with time. Further, Demonstration participants continue to fare better than the other relocatees who did not receive intensive services.

### Early Findings Show Positive Trends

By the time the Chicago Family Case Management Demonstration began in 2007, growing evidence suggested that using housing as a platform to improve outcomes like health and employment might be extremely challenging. Research on programs like HOPE VI and Moving to Opportunity (MTO), which aimed to improve assisted residents' social and economic outcomes, had instead largely documented the limits of what housing-focused interventions could achieve.<sup>2</sup>

Given that the Demonstration intentionally targeted high-need CHA families who had failed to qualify for mixed-income housing or vouchers, there was ample reason to expect that even high-quality, intensive services might have only modest effects. However, early findings were unexpectedly encouraging. Between 2007 and 2009, self-reported employment increased significantly despite the extremely tough labor market. Further, Demonstration residents' health statuses remained stable or improved, in contrast to residents in the Panel Study, whose health steadily declined over time (Popkin and Getsinger 2010; Popkin, Theodos, et al. 2010). These health improvements were associated with service use and behavior changes, such as seeing a mental health counselor and reducing substance abuse.<sup>3</sup> Health *declines* were associated with factors more difficult to change in

the short term, like having a chronic illness and poor mental health in 2007.<sup>4</sup>

Children whose families participated in the Demonstration have not fared as well historically. Although the Demonstration took a family-oriented approach, no services or case managers were provided to children and youth. In 2009, these children were still experiencing high levels of distress and exhibiting behavioral problems and delinquency (Popkin and Getsinger 2010; Popkin, Theodos, et al. 2010).

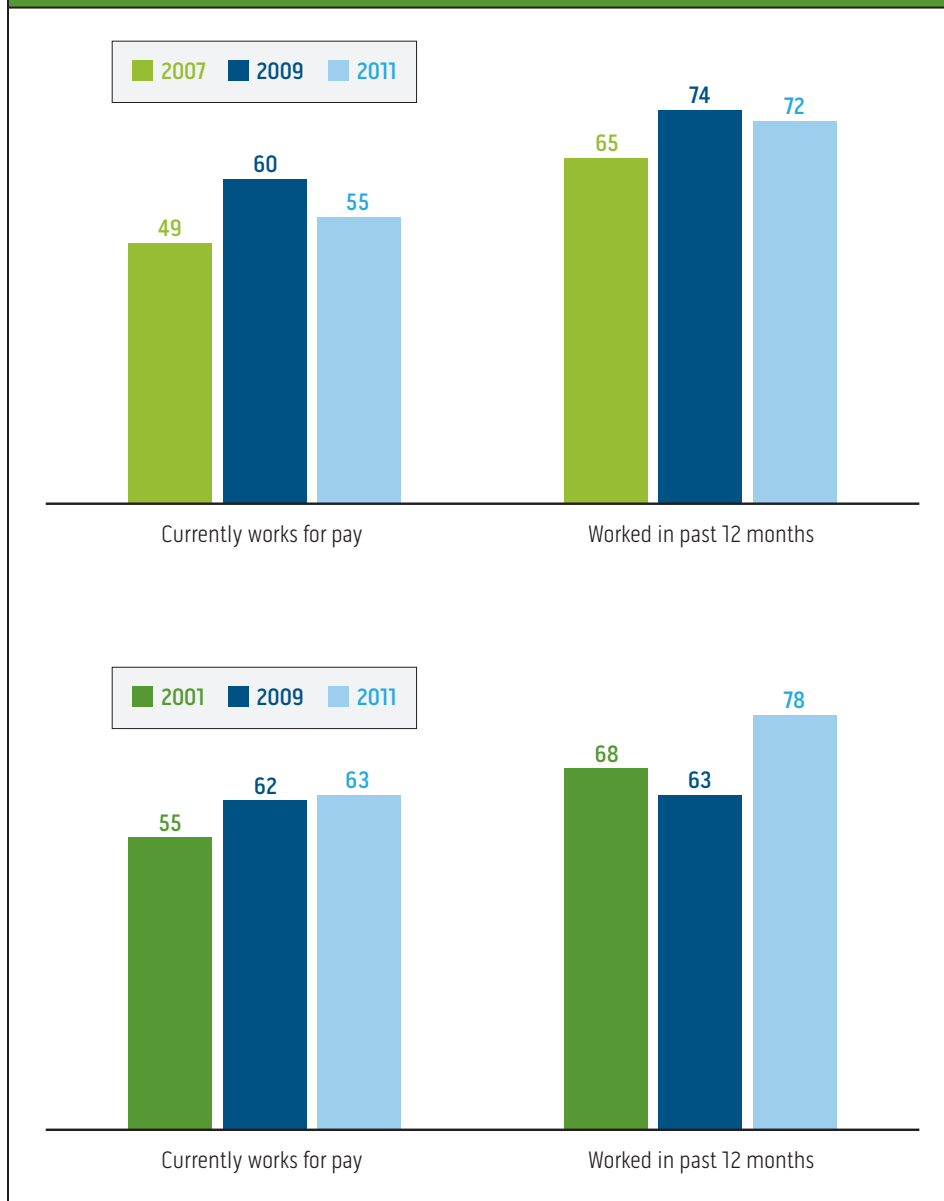
### Employment Gains Continue in 2011

Public housing residents face numerous barriers to employment, including low educational attainment, poor mental and physical health, limited access to social networks that facilitate job access, and physical isolation from opportunity (Turney et al. 2006). Although recent efforts to transform public housing have sought to address these barriers and improve self-sufficiency (Popkin et al. 2004; Turner, Popkin, and Rawlings 2008), they have not affected employment outcomes (Briggs, Popkin, and Goering 2010; Levy 2010; Levy and Woolley 2007).<sup>5</sup>

Demonstration services, notably the intensive Transitional Jobs program, contributed to employment gains in 2009. But the Demonstration's conclusion in mid-2010, coupled with Heartland stopping intensive services and CHA scaling back Transitional Jobs as the citywide Opportunity Chicago program wound down (Parkes et al. 2012), raised some concern that these employment gains might be tenuous and fade by the time of the four-year follow-up (Theodos and Parilla 2010).

Although employment among all working-age (under age 62) Demonstration participants in 2011 has not changed significantly since 2007 (55 percent versus 49 percent), those that relocated to CHA's rehabilitated traditional public housing increased their employment modestly (figure 1). Participants like Kim (see text box on page 4) were the most likely to be

**Figure 1. Employment Rates for Demonstration and Panel Study Participants, 2001/2007 to 2011**



employed, possibly because they were subject to the CHA's work requirement, which requires all able-bodied public housing residents to work or be engaged in employment-related activities for 20 hours a week.<sup>6</sup> Whatever the reason, employment rates among traditional public housing residents were particularly high: 51 percent of working-age indi-

viduals reported current employment, up 18 percentage points from 2007. Approximately 70 percent reported being employed in the last year, a 25 percentage-point increase from 2007.

Employment also did not change for Panel Study respondents over time; 63 percent of working-age respondents reported being employed in 2011, statistically insignificant

from the 55 percent rate reported in 2001. However, about three-quarters of respondents (78 percent) reported working in the last year, a statistically significant increase from the 63 percent reported in 2009.

Another factor that may have contributed to the small increases in employment in the Demonstration sample is improved physical and mental health, especially among those who relocated to traditional public housing. Over the past 10 years of tracking HOPE VI Panel residents, we consistently find a strong association between poor health and low employment rates. In 2009, as in previous rounds of the survey, poor health remained strongly linked to lower rates of employment. Among respondents reporting poor overall mental health, 89 percent were not working; of those reporting depression, 59 percent were not working. Sixty-seven percent of respondents who reported two or more mobility limitations were not employed (Levy 2010).

### Demonstration Participants Report Substantial Health Improvements

One of the most encouraging findings from our earlier research on Demonstration participants was that their physical health seemed to stabilize—particularly surprising given that research on HOPE VI relocatees had consistently found worsening outcomes over time (Manjarrez, Popkin, and Guernsey 2007; Popkin and Getsinger 2010; Popkin and Price 2010). This trend continued in 2011. Demonstration participants are now significantly more likely to report good health than they were in 2007. In 2007, 53 percent rated their health as fair or poor; by 2009, this figure had decreased slightly to 48 percent; and by 2011, it had decreased an additional 10 percentage points to 38 percent (figure 2). In contrast, the health of Panel Study respondents has deteriorated steadily, from 36 percent reporting poor or fair health in 2001 to 48 percent in 2011. Although Panel Study respondents reported

health levels similar to Demonstration participants in 2009, they now, as a group, report worse health outcomes.

While these gains for Demonstration participants are very encouraging, these residents are still three times as likely to report fair/poor health than the general adult population and even more likely than other poor adults (28 percent of whom report poor health).<sup>7</sup> It is also worth noting that Demonstration participants still report severe difficulty carrying out three or more basic activities of daily living, such as climbing stairs or walking four blocks, in 2011 as in 2009 (40 versus 39 percent); the same share of Panel Study respondents reported similar difficulties (40 percent).<sup>8</sup>

### Demonstration Participants' Mental Health Has Improved Dramatically

The Chicago Family Case Management Demonstration was designed to target mental health; in fact, Heartland increased clinical services as the depth of residents' challenges became more clear. Services included regular contact with case managers (as often as once or twice a week), "wellness counselors" who provided clinical mental health services on site, substance abuse counseling, and a psychiatrist who held office hours at the two Heartland offices (Popkin and Getsinger 2010). In 2009, we found some indicators of improved mental health, especially statistically significant reductions in worry and anxiety, but no improvements in clinical depression rates.

Consistent with the gains in physical health and employment, Demonstration respondents' mental health has continued to improve. Since 2007, Demonstration participants have experienced significant reductions in worry and anxiety, with the proportion reporting "worrying more than others" decreasing dramatically between 2009 and 2011 (figure 2). Even more striking, Demonstration participants were increasingly less

### Kim's Story

Kim and her two daughters moved to Wentworth Gardens Homes in late 2007. Around the time of her move, Kim was diagnosed with an aneurysm and hospitalized for three weeks. When we first met her in 2008, Kim was struggling, and reluctant to talk to us about her experience.

In 2011, Kim is healthy and employed. Kim credits the change to regular meetings with her FamilyWorks case manager and the CHA's employment services. She says the thing that has changed most about her life is her improved job prospects:

I'm in the FamilyWorks program, and we have job trainings.... they actually help you find a job if you go... They assign you a case manager.... She worked good, closely, she comes, pays visits or send letters for me to come and to see her if she [knows] about jobs or any type of activity that's going on... [Your experience] all depend on your case manager. That's why I was thinking about [living at Wells] permanently, because it's hard to find a job. [And] I wasn't going to try to get an apartment and pay light and gas [if] I knew I wasn't able to.... [But eventually] I took a class for my sanitation license and passed the test. Finally, I'm hired permanently. I just heard back from my case manager a week ago.

Kim's daughters are enrolled in a vocational school, where Annie, the elder, is preparing to receive her cosmetology license. Meanwhile, Annie does hair to earn additional income for her family. She and her sister are heavily involved in the FamilyWorks program and worked at a camp over the summer.

likely to report symptoms of depression in 2011 (11 percent) than in 2007 (17 percent).<sup>9</sup>

The reduction in depression is greatest among participants who relocated to traditional public housing. Nicole's story (see page 5) illustrates how Demonstration services addressed deep trauma and substance abuse and helped some participants move toward greater stability and even self-sufficiency. Neighborhood improvements may also have helped improve mental health among Demonstration residents, as previous research findings suggest that crime, and fear of crime, is linked to higher levels of anxiety (Roman and Knight 2010).

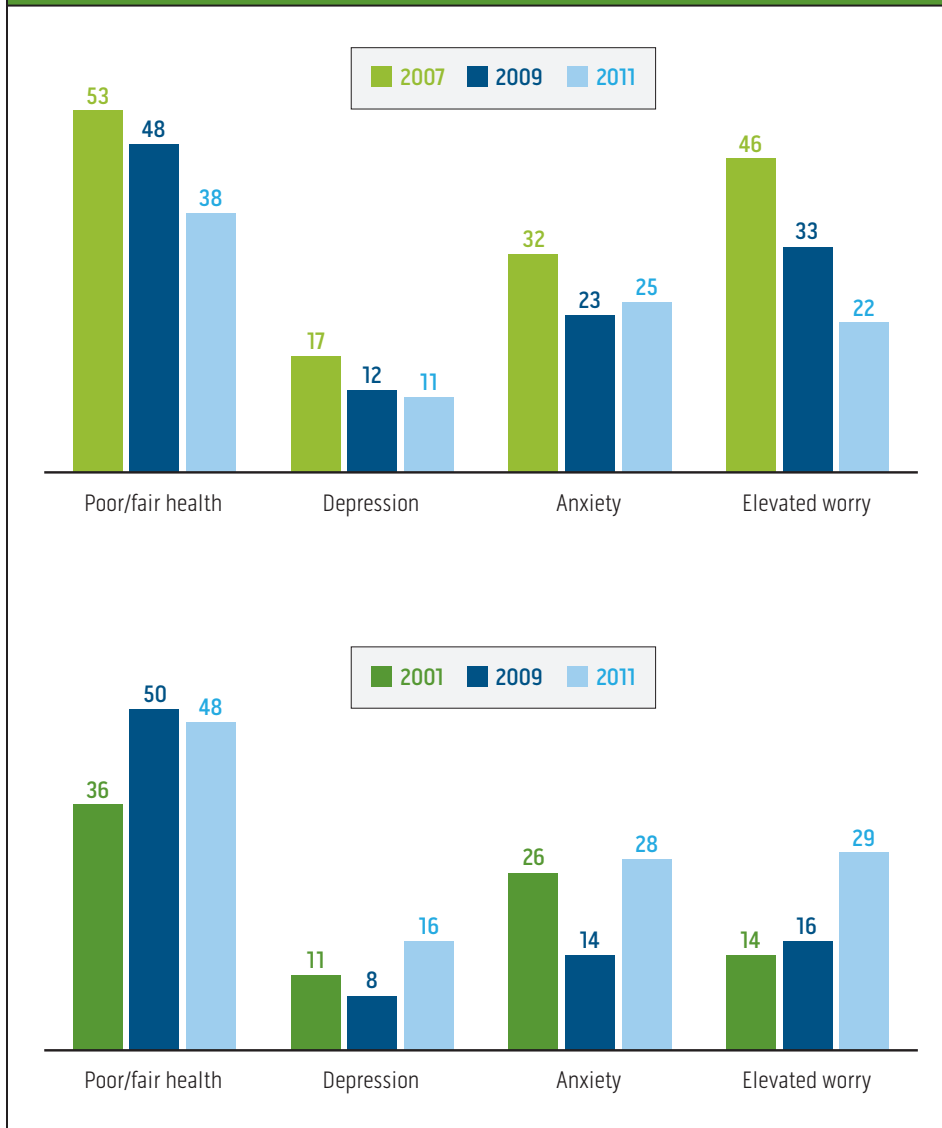
In contrast, the mental health of Panel Study respondents has deteriorated over time, with respondents in 2011 reporting higher levels of depression and worry than they did in 2001 (figure 2). It is particularly interesting to note that this increase in

depression followed a *decline* in depression between 2001 and 2009.

Multivariate analyses indicate that reported symptoms of depression are associated with receiving services and supports. Family support,<sup>10</sup> attendance at counseling sessions, respondent's age, overall health, and employment are all associated with lower levels of depression symptoms for respondents in both the Demonstration and Panel samples. On the other hand, worry and anxiety are more a factor of respondents' living conditions.<sup>11</sup>

Taken together, these results suggest that the supports Demonstration participants received may have also contributed to their reduced depression symptoms. In contrast, reported worry may be more a response to improved housing and neighborhood conditions rather than a change in personal circumstances; respondents in both samples who

**Figure 2. Health Outcomes for Demonstration and Panel Study Participants, 2001/2007 to 2011**



reported higher levels of neighborhood collective efficacy and fewer housing problems were less likely to have also reported worrying in the past year.

**Chronic Disease and Mortality Remain Major Concerns**

As Carl’s story (see page 6) illustrates, despite improvements in self-reported health and mental health, poor health remains one of the

biggest challenges for CHA’s residents, many of whom will not be helped simply by case management or support from the CHA’s service providers.<sup>12</sup> About half of all respondents in both samples reported having an illness that requires regular ongoing care in 2011; for the Panel Study sample, this represents a significant increase since 2001. Reported rates of chronic illness are high across the entire Long-Term Outcomes popu-

**Nicole’s Story**

Nicole is a recovering heroin user living in Dearborn Homes. She has used the Demonstration services not only to work on her addiction, but also to address the underlying childhood trauma and grief that led her to it. Her case manager, who visits frequently, has helped her get into detox, although Nicole’s struggle with the drug is ongoing. Nicole’s case manager also helped her find a job working part time in food services, which has allowed Nicole to be more self-sufficient.

In addition to her case manager, with whom Nicole describes a close and positive relationship, she sees her three adult children and grandchildren frequently. Nicole does not socialize with her neighbors often, but still feels that the improved neighborhood after rehabilitation has affected her quality of life. She reports a cleaner and safer building and neighborhood where she can walk around without being harassed.

lation; just over half reported having been diagnosed with hypertension, more than a third reported having arthritis, a fifth reported having been diagnosed with diabetes, and nearly a tenth reported having had a heart attack. Three-quarters of the respondents were overweight, and about half were obese. A substantial proportion of both groups reported being regular smokers—37 percent of Panel Study respondents and 50 percent of those in the Demonstration—figures that far exceed the national average (19 percent), the average for African Americans (21 percent), and the average for adults living below the poverty level (29 percent).<sup>13</sup>

Mortality rates for both samples remain shockingly high. Between 2007 and 2011, 6 percent of the Demonstration sample died, a



rate twice that of the general population (3 percent) and 50 percent higher than the rate for African American women (4 percent).<sup>14</sup> The death rate for the Panel Study remained at its 2009 high of 14 percent, approximately 75 percent higher than the rate for members of the general population (8 percent) and about 40 percent higher than the rate for African American women (10 percent).<sup>15</sup>

### Limited Access to Regular Health Care

Demonstration residents face challenges accessing regular health care, a factor that may contribute to their high rates of poor health and debility. In 2011, just 28 percent of Demonstration participants who had a regular place to receive care used a doctor's office; this figure is very low compared to the proportion of all Americans (76 percent) or even low-income adults nationally (58 percent) who consider a doctor's office their usual place of health care (Schiller et al. 2012). Instead of seeing a doctor, most Demonstration participants rely on hospital outpatient clinics (41 percent). About 42 percent of Panel Study respondents who had a place to receive care reported using a doctor's office or private clinic; 35 percent used hospital outpatient clinics as their place to receive routine medical care. Panel Sample respondents were somewhat more likely to report having seen a doctor in the past year than Demonstration participants (86 percent compared with 75 percent).

Research from the MTO demonstration found that those who received vouchers were more likely to have health insurance and less likely to report not receiving care than those in the control group who remained in public housing (Ludwig et al. 2012). In the CHA's case, the remaining public housing developments are in relatively isolated, primarily residential areas that have few services and amenities and, in some cases, limited access to public transportation. All these factors may limit residents' access to care.

### ... Except for Youth

As highlighted by Hailey and Gallagher (2013), the benefits of the Demonstration have not extended to youth and children; they are no better off than children in the Panel Study sample whose parents did not receive services (Gallagher 2010; Popkin and Getsinger 2010). Reported outcomes for young children and teenagers in the 2011 Demonstration sample have changed little since 2007; in some instances, they have gotten worse. In 2011, more parents reported that their young children (age 0–12) had two or more problem behaviors (48 percent) and that their teenagers (age 13–17) were engaged in two or more delinquent behaviors (19 percent) than parents of these same age groups in 2009 (23 and 7 percent, respectively). Young adults (age 18 or older) whose families participated in the Demonstration also had high rates of engaging in delinquent behaviors: 28 percent had been in trouble with police, 24 percent had been arrested, and 17 percent had been in jail or incarcerated.

Surprisingly, this rise in delinquency and problem behavior is accompanied by a small increase in school engagement. Parents in the Demonstration reported that about half their young (56 percent) and teenage (47 percent) children are highly engaged in school, an increase from 2009 when 38 percent of young children and 32 percent of teenagers were highly engaged in school. Still, these youth are faring poorly overall as they transition to adulthood. About a third of young adults in the Demonstration sample are neither in school nor employed and are at high risk for negative outcomes like criminal justice involvement.

As with the Demonstration sample, parents in the Panel Study reported high levels of distress among children and youth. More teenagers in 2011 were engaging in two or more problem behaviors (61 percent) and two or more delinquent behaviors (19 percent) than

### Carl's Story

Carl, who is in his mid-60s, moved from Dearborn in 2007 after his doctor recommended that he find a home with fewer stairs. Carl has many health problems. Diagnosed with lung cancer in 2003, he is receiving chemotherapy and radiation at the University of Chicago Hospital. He had a tumor removed in summer 2011. Carl has also reported suffering from diabetes and congestive heart failure.

Carl's poor health has prevented him from working for the past 20 years. He spent most of his working life as a welder or with his father's trucking business. Carl now receives disability payments, in addition to Social Security and Medicaid.

Carl had his first child at 18; he now has five adult children that live in the Chicago area. His youngest child, Harry, began living with Carl following Harry's mother's death in 2006. In 2011, Harry was 18 and preparing to leave for college. Harry has his own health challenges: he has a developmental disorder and is overweight. Father and son are close. During our interviews, Carl spoke candidly about his worries about his son's health.

CHA's services are not enough to address the complex health challenges Carl and his son are facing, and Carl reports little contact with his case manager. During our interviews, he commented that, "[Heartland] does a well-being check when the weather is real hot. But other than that, I don't [have contact]."

teenagers in 2009 (37 and 7 percent, respectively). The share of teenagers who had been in trouble with the police increased notably (from 4 percent in 2009 to 19 percent in 2011). At the same time, parents of teenagers are now more likely to report that their teenagers display five or more positive behaviors (54 percent in 2011, compared with 28 percent in 2009). Delinquent behavior among young adults was comparable to 2009, with about 20 percent reported to have been in trouble with the police, 14 percent have been arrested, and 7 percent have been in jail or incarcerated. Education outcomes were also concerning. Less than a quarter of teenagers (19 percent) were highly engaged in school, and, like the young adults in the 2009 sample, only a quarter of young adults in the 2011 sample were currently employed. One in three was detached from both school and employment.

### Policy Implications

The CHA's ambitious Plan for Transformation necessitated relocating thousands of vulnerable families. Although the conditions residents were living in at the outset were deplorable, the relocation was involuntary and was a major disruption to their lives. Many residents were extremely vulnerable, suffering from serious mental and physical health problems that could be exacerbated by major stress. The CHA had little experience in providing effective relocation services and even less in providing wraparound case management that could help stabilize residents' lives and help them move toward self-sufficiency. Given these circumstances, there were reasons for serious concern about how residents would fare and whether they might end up even worse off as a result of relocation.

Our ten-year study of CHA families shows that most residents are better off overall as a result of the Plan for Transformation; they live in higher-quality housing in neighborhoods

that are generally safer and offer a better quality of life for them and their children (Popkin et al. 2013; Buron, Hayes, and Hailey 2013). However, incorporating intensive supportive services for the most vulnerable public housing residents produces additional gains. Our findings indicate positive outcomes on a range of adult health and employment-related outcomes that are key to improving family stability. The CHA's investments in its remaining traditional developments—rehabilitation and improved management and security—have made them better places to live. The agency's FamilyWorks program and work requirement may be providing the ongoing support that is sustaining the benefits of intensive case management for the Demonstration participants who now live there. In the long run, these investments could pay off in higher rents and lower management costs for the housing authority, as well as reduced costs for the health, child welfare, and criminal justice systems. In sum, the findings from this analysis make a strong case for housing authorities to go beyond improved management to use their housing as a platform for supportive services that can truly improve residents' lives.

Despite the generally good news, two important cautionary notes point to the need for more services and better partnerships across systems. First, poor health and high mortality remain serious problems for Chicago's public housing residents. Truly improving this situation will require intensive coordination with the health care system as well as creative use of public health interventions such as the With Every Heart Beat Is Life program that is now widely used in public housing (National Institutes of Health 2008). Second, the CHA's services have not led to better outcomes for children and youth (Hailey and Gallagher 2013). To truly change the trajectory for CHA's families, the agency will need new and innovative approaches such as

two-generation models that address the needs of both adults and children (Mosle and Patel 2012; Popkin et al. 2012).

With the Chicago Family Case Management Demonstration, the CHA has shown itself an innovator in the field, willing to invest in new strategies that have the potential for long-term payoffs. To really address the problems of deep poverty and distress, the CHA and other housing authorities will have to continue to be willing to experiment with new models of incorporating services into their housing.

### Acknowledgments

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## Notes

1. For more information, see [http://www.thecha.org/pages/case\\_management\\_familyworks\\_/31.php](http://www.thecha.org/pages/case_management_familyworks_/31.php) and [http://www.thecha.org/pages/plans\\_reports\\_policies/40.php](http://www.thecha.org/pages/plans_reports_policies/40.php).
2. The five-site HOPE VI Panel Study found residents living in better housing in safer neighborhoods but no impact on employment, education, or health (Popkin et al. 2009). Research on MTO also showed important gains in housing and neighborhood quality (Comey, Popkin, and Franks 2012; Orr et al. 2003; Sanbonmatsu et al. 2011).
3. Twenty-four percent of respondents reported health improvements between 2007 and 2009; multivariate analyses indicate that these improvements are associated with lower substance abuse levels (not being a regular drinker) and seeing a mental health counselor. In 2009, 15 percent of Demonstration participants reported attending group or one-on-one counseling.
4. Nine percent of respondents reported worse health in 2009 than in 2007; multivariate analyses showed that these declines were associated with having a chronic illness and poor mental health at (Popkin and Getsinger 2010).
5. In contrast, initiatives that specifically provide employment services to public housing residents appear to improve employment outcomes. For example, the U.S. Department of Housing and Urban Development's (HUD) Jobs-Plus program, which sought to connect public housing residents to employment through employment services, rent incentives, and community support for work, led to marked gains in resident employment and earnings when properly implemented (Bloom, Riccio, and Verma 2005). Project Match, a Chicago-based workforce development program that offered comprehensive employment services, increased earnings for some program participants by 105 percent over 10 years (Herr and Wagner 2008).
6. Public housing residents living in new mixed-income housing communities are also subject to work requirements, while voucher holders were still exempt as of 2011. For details of the work requirements, see the FY 2009 Admissions and Continued Occupancy Policy (ACOP) and the Minimum Tenant Selection Plan for Mixed-Income/Mixed-Finance Communities at [http://www.thecha.org/pages/plans\\_reports\\_policies/40.php](http://www.thecha.org/pages/plans_reports_policies/40.php).
7. Per the 2010 National Health Interview Survey (NHIS), age-adjusted summary health statistics for U.S. adults.

8. Questions from the NHIS were used to assess difficulty with activities of daily living. Respondents were asked how difficult it was to do the following unassisted: (a) walk a quarter of a mile; (b) walk up 10 steps without resting; (c) stand or be on their feet for about 2 hours; (d) sit for about 2 hours; (e) stoop, bend, or kneel; (f) reach up over their head; or (g) lift or carry something as heavy as 10 pounds. The responses were scaled from 0 (not at all difficult) to 4 (can't do at all).
9. Depression is measured using the short form of the Composite International Diagnostic Interview (CIDI-SF), a fully structured interview designed to be administered by lay interviewers who are not necessarily licensed clinicians. For this study, we eliminate two of the seven questions used to develop the CIDI-SF scale in order to compare depression accurately across waves. Our 5-item scale is correlated with the 7-item scale at  $r = 0.99$ .
10. The vast majority of respondents responded affirmatively to questions about the level of support provided by family members, including feeling close to their families, wanting their families in their life, considering themselves a source of support for their families, and having someone to "love [them] and make [them] feel wanted." Respondents also described having someone in their family whom they could talk to about problems, and who could provide financial support or assist with finding housing or a job.
11. The model tested how 11 factors affected depression (CIDI-SF, 7 questions): sample, housing assistance type, age, neighborhood cohesion, neighborhood violence, number of moves, number of housing problems, family support, counseling session attendance, self-rated health, and employment. The following factors significantly predicted depression in the full LTO sample: voucher status, younger age, lack of family support, attendance at a counseling session, poor health, and unemployment. Results were similar when Panel Study participants were compared to Demonstration participants.
12. Although the percentage of participants who report having an illness requiring ongoing care increased from 2007 to 2011, changes were not significant.
13. "Adult Cigarette Smoking in the United States: Current Estimate," Centers for Disease Control and Prevention, [http://www.cdc.gov/tobacco/data\\_statistics/fact\\_sheets/adult\\_data/cig\\_smoking/](http://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/) (last updated March 14, 2012).

14. The mortality rate for the general population is calculated by determining the probability that each respondent would survive based on averages for people of their age and sex using a 2005 National Vital Statistics Reports life table. Attrition analysis revealed that Demonstration respondents who died were also more likely to have had an illness requiring ongoing care and an inability to work due to health problems and/or a disability that prevents work. They were also more likely to have been older and/or obese, to have drunk regularly, and to have had multiple health problems. Those who died in the Demonstration sample did not differ from those still living in self-reported health, anxiety, or depression.
15. Attrition analysis revealed that Panel Study respondents who died were also more likely to have reported poor health and/or multiple health problems; having diabetes and other chronic illnesses; and being unable to work due to physical health or disability. In addition to being older, these individuals were more likely to experience anxiety and food insecurity; live in worse housing; and engage in unhealthy behaviors, such as smoking and drinking.

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## Long-Term Outcomes for CHA Residents

The Long-Term Outcomes for CHA Residents study builds on two major Urban Institute research initiatives that examined the effects of the Chicago Housing Authority's (CHA) Plan for Transformation on resident well-being:

- **The Chicago Panel Study** (The Panel Study), funded by the John D. and Catherine T. MacArthur Foundation, was a follow-up to the five-site HOPE VI Panel Study, which examined resident outcomes from 2001 to 2005. In Chicago, the Panel Study tracked residents from the CHA's Ida B. Wells Homes/Wells Extension and Madden Park Homes who relocated between 2001 and 2008. Researchers surveyed a random sample of 198 resident heads of household in 2001; follow-up waves were conducted with 174 residents in 2003, 165 residents in 2005, and 136 residents in 2009. A high mortality rate contributed to the sizable attrition between 2001 and 2009. The Urban Institute conducted in-depth, qualitative interviews with select residents to better understand the lives and challenges of these individuals and families.
- **The Chicago Family Case Management Demonstration Evaluation** (The Demonstration)—a partnership between the Urban Institute, the CHA, Heartland Human Care Services, and Housing Choice Partners—tested the feasibility of providing intensive case-management services, transitional jobs, financial literacy training, and relocation counseling to vulnerable public housing families. The demonstration ran from March 2007 to March 2010 and targeted approximately 475 households from the CHA's Dearborn Homes and Madden/Wells developments. Researchers administered resident surveys to the universe population in these sites: 331 residents in 2007 (response rate 77 percent) and 287 residents in 2009. Again, mortality contributed greatly to study attrition. In-depth interviews and an analysis of CHA administrative records, case manager reports, and publicly available data helped researchers contextualize survey findings. A supplemental process study, which relied primarily on in-depth administrative interviews, weekly service implementation monitoring, and regular meetings with project partners, assessed the efficacy and cost of the Demonstration's implementation. The Demonstration was funded by the John D. and Catherine T. MacArthur Foundation, the Annie E. Casey Foundation, the Rockefeller Foundation, the Partnership for New Communities, JPMorgan Chase, and the Chicago Housing Authority.

The Long-Term Outcomes study consists of 10- and 4-year follow-up surveys, respectively, and in-depth interviews with Panel Study and Demonstration participants. In summer and fall 2011, researchers surveyed 106 Panel Study respondents and 251 Demonstration respondents; 24 respondents were represented in both samples. Researchers supplemented this work with 31 in-depth, qualitative interviews with adults and youth. Administrative data specific to clients and to their neighborhood enriched the analysis. The principal investigator for the study is Susan J. Popkin, Ph.D., director of the Urban Institute's Program on Neighborhoods and Youth Development. Funding for this research was provided by the MacArthur Foundation and the Chicago Housing Authority.

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