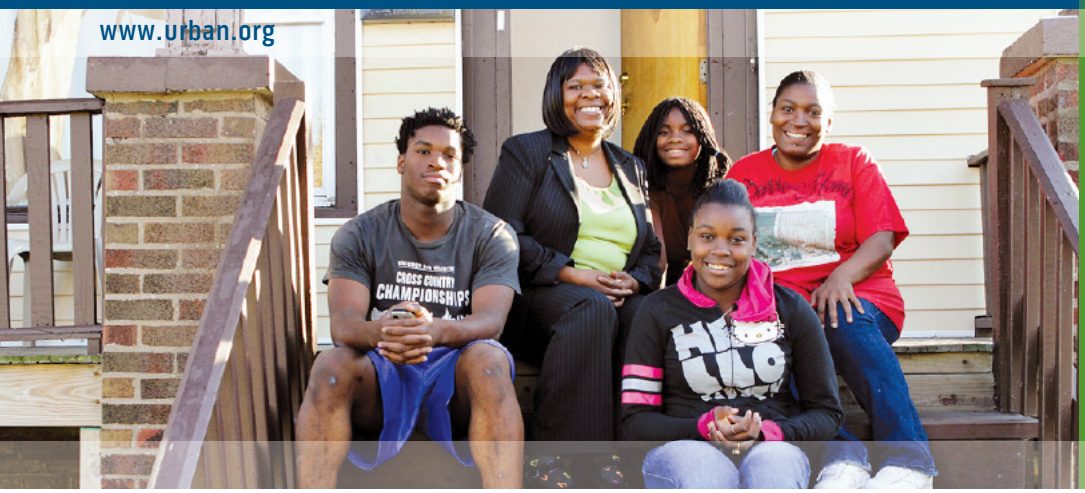
URBAN INSTITUTE

BRIEF # 03 DEC. 2010

Supporting Vulnerable Public Housing Families

www.urban.org



INSIDE THIS ISSUE

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

Tackling the Biggest Challenge

Intensive Case Management and CHA Residents' Health

Susan J. Popkin and Liza Getsinger

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

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

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

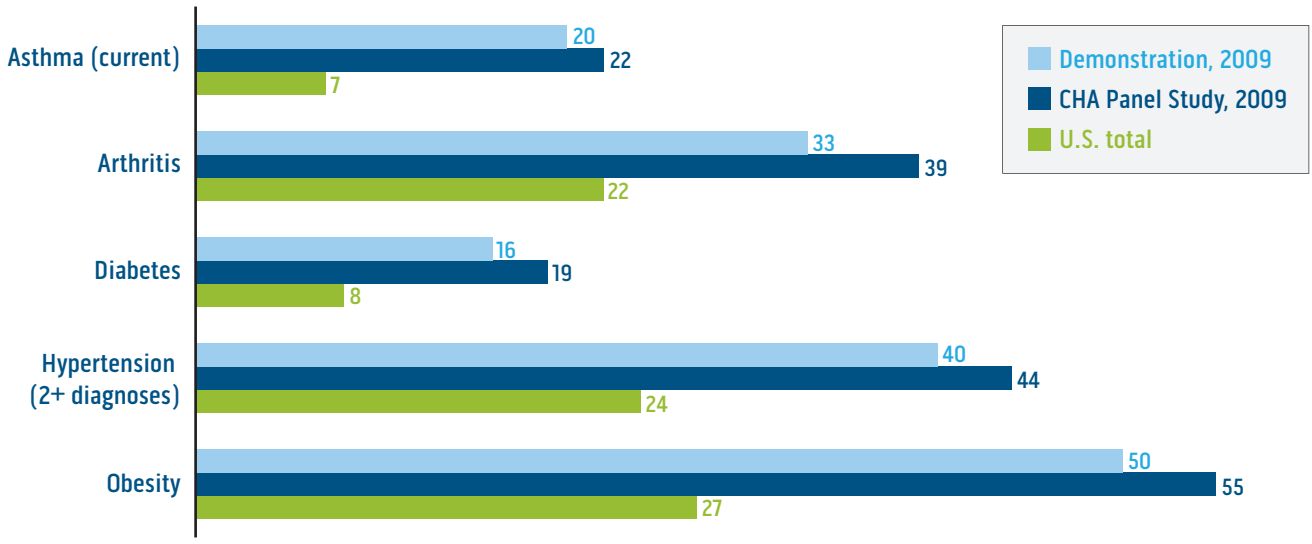
> Better housing in safer communities has not undone the damage that years of living in a dangerous environment has inflicted on CHA residents' health.

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

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

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

Figure 1. Chronic Illness (percent)



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

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

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

Demonstration Participants' Health Remained Stable Over Time

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

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

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

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

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

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

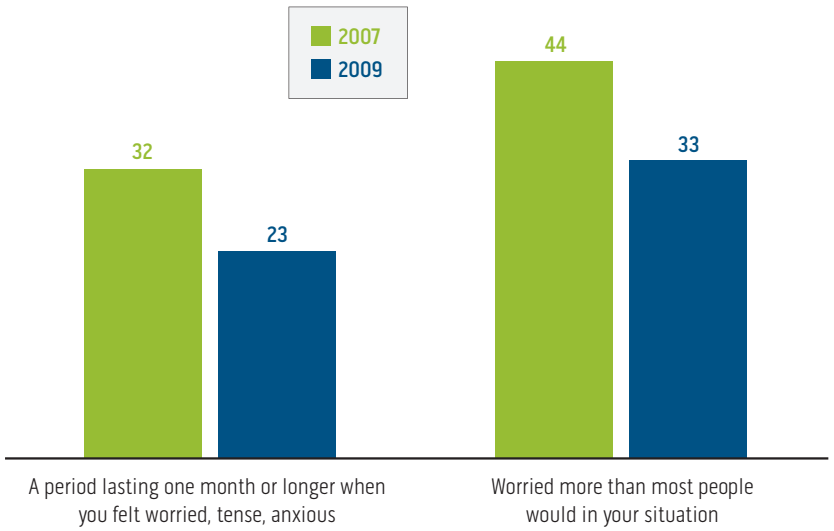
Rhonda's story illustrates how a combination of chronic health conditions can make it difficult to hold a job. When we interviewed Rhonda, a former Madden/Wells resident, in summer 2008, she described her struggles with substance abuse, depression, and severe hypertension. She had recently been fired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

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

Mental Health and Substance Abuse Remain Significant Challenges

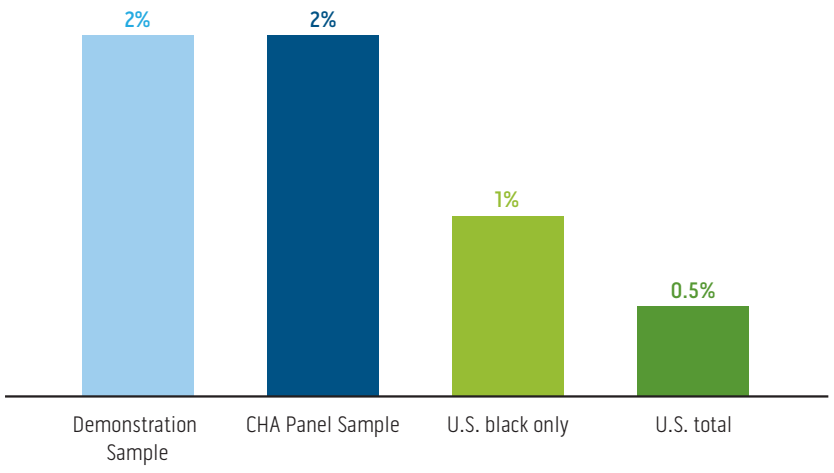
The original Demonstration service model did not include distinct mental health services. The plan was to have Heartland's case managers provide support through their more frequent contacts with clients and refer clients to external service providers as needed. However, as case managers began implementing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

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



Sources: 2007 and 2009 Demonstration samples.

Figure 3. Annualized Mortality Rate in Demonstration and Comparison Populations



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

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

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

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

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

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

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

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

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

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

Mortality Rates Are Shockingly High

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

Jasmine's Story

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

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

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

Policy Implications

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

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

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

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

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

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

Notes

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

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

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

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

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

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

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

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

References

Buron, Larry, and Susan J. Popkin. 2010. "After Wells: Where Are the Residents Now?" *CHA Families and the Plan for Transformation* Brief 1. Washington, DC: The Urban Institute.

Levy, Diane K., and Mark Woolley. 2007. "Relocation Is Not Enough: Employment Barriers among HOPE VI Families." *HOPE VI: Where Do We Go from Here?* Brief 6. Washington, DC: The Urban Institute.

Lindberg, Ruth A., Edmond D. Shenassa, Dolores Acevedo-Garcia, Susan J. Popkin, Andrés Villaveces, and Rebecca L. Morley. 2010. "Housing Interventions at the Neighborhood Level and Health: A Review of the Evidence." *Journal of Public Health Management and Practice* 16(5): 44–52.

Manjarrez, Carlos A., Susan J. Popkin, and Elizabeth Guernsey. 2007. "Poor Health: Adding Insult to Injury for HOPE VI Families." *HOPE VI: Where Do We Go from Here?* Brief 5. Washington, DC: The Urban Institute.

Miranda, Jeanne, Joyce Y. Chung, Bonnie L. Green, Janice Krupnick, Juned Siddique, Dennise A. Revicki, and Tom Belin. 2003. "Treating Depression in Predominantly Low-Income Young Minority Women: A Randomized Controlled Trial." *Journal of the American Medical Association* 290(1): 57–63

Popkin, Susan J. 2010. "A Glass Half Empty? New Evidence from the HOPE VI Panel Study." *Housing Policy Debate* 20(1): 43–63.

Popkin, Susan J., and David J. Price. 2010. "Escaping the Hidden War: Safety Is the Biggest Gain for Chicago Housing Authority Families." *CHA Families and the Plan for Transformation* Brief 2. Washington, DC: The Urban Institute.

Popkin, Susan J., Diane K. Levy, and Larry Buron. 2009. "Has HOPE VI Transformed Residents' Lives? New Evidence from the HOPE VI Panel Study." *Housing Studies* 24(4): 477–502.

Popkin, Susan J., Brett Theodos, Liza Getsinger, and Joe Parilla. 2010. "An Overview of the Chicago Family Case Management Demonstration." *Supporting Vulnerable Public Housing Families* Brief 1. Washington, DC: The Urban Institute.

Popkin, Susan J., 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 Families." Washington, DC: The Urban Institute.

Popkin, Susan J., Diane K. Levy, Laura E. Harris, Jennifer Comey, Mary K. Cunningham, and Larry Buron 2002. *HOPE VI Panel Study: Baseline Report.* Washington, DC: The Urban Institute.

Price, David, and Susan J. Popkin. 2010. "The Health Crisis for CHA Families." *CHA Families and the Plan for Transformation* Brief 5. Washington, DC: The Urban Institute.

Roman, Caterina G., and Carly Knight. 2010. "An Examination of the Social and Physical Environment of Public Housing Residents in Two Chicago Developments in Transition." Washington, DC: The Urban Institute.

Theodos, Brett, and Joe Parilla. 2010. "Relocating Vulnerable Public Housing Families." *Supporting Vulnerable Public Housing Families* Brief 5. Washington, DC: The Urban Institute.

Vale, Lawrence J., and Erin Graves. 2010. *The Chicago Housing Authority's Plan for Transformation: What Does the Research Show So Far?* Cambridge, MA: Department of Urban Studies and Planning, Massachusetts Institute of Technology.

URBAN INSTITUTE

Chicago Family Case Management Demonstration

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

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

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

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

About the Authors

Susan J. Popkin is the director of the Urban Institute's Program on Neighborhoods and Youth Development and a senior fellow in the Metropolitan Housing and Communities Policy Center.

Liza Getsinger is a research associate in the Urban Institute's Metropolitan Housing and Communities Policy Center.

Cover photograph © 2010 by Shauna Bittle.

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

URBAN INSTITUTE
2100 M Street, NW
Washington, DC 20037-1231
(202) 833-7200
paffairs@urban.org www.urban.org