Helping Homeless Families

An Evaluation of the Homeless CalWORKs Families Project After Five Years

Summary of Outcomes

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This report presents the key observations and findings from the evaluation of the Homeless CalWORKs Families Project covering the period from January 2005 through January 2008.
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EXECUTIVE SUMMARY

The Homeless CalWORKs Families Project (HCFP) was authorized by the Los Angeles County Board of Supervisors in 2002. The HCFP is jointly administered by the Los Angeles County Department of Public Social Services, the Los Angeles County Department of Mental Health, and the joint City/County Los Angeles Homeless Services Authority. Approximately 400 families are served each year in six program sites in Los Angeles County. On average, participants spend about 13 months in the program. Goals include both finding permanent housing and making constructive use of the welfare-to-work provisions of CalWORKs. This report is the third evaluation of the program conducted by the California Institute for Mental Health.

MAJOR FINDINGS

- Research recently published about family homelessness supports two major conclusions:
  a. Most causes of family homelessness are economic and structural and not related to personal issues.
  b. The most helpful intervention is housing subsidies (low-income housing or housing vouchers like Section 8).

- Over the last three years of the evaluation, 32 percent of participants successfully completed the program and another 2 percent left due to full-time employment that made participation difficult. Neutral reasons, such as moving, accounted for 13 percent of departures. Forty percent left for reasons that indicate clients did not meet their goals (such as non-compliance with program requirements). The remaining 13 percent had multiple reasons or were unclassified.

- More than 85 percent of participants interviewed by CiMH research associates were very satisfied with the program.

- A mental health problem was an eligibility requirement. Staff judged that about three-quarters made positive changes in mental health status and 85 percent of interviewees said they had been helped. However, at discharge 30 percent were still functioning at quite a low level.

- At follow-up between 48 and 68 percent (depending on source of information) lived in long-term housing that they rented. Roughly half of the families in rental housing made use of a housing voucher. Those not in long-term rental housing were predominantly in transitional shelters, or living with family or friends. The HCFP is demonstrably successful in helping families find temporary shelter initially and more permanent housing over the long term.

- Follow-up data on participants who received a Section 8 voucher through the program in 2005–2006 showed that 90 percent were able to obtain a lease and have maintained their housing.

- Staff reported that only 12 percent of clients were working when they were admitted. At the final staff rating, about 20 percent were in school, training or working as a volunteer, and 13 percent were working full-time. Overall 53 percent were working or had some work-related activity. About 55 percent of client interviewees reported that they were working or going to school, while 9 percent were disabled.

- Earned income was reported by one third of interviewees, with an average of $922 per month; only 12 percent of all interviewees had earned income of $1,000 or more a month.

- Interviewees reported that only a small percentage of children did not receive needed medical care, but about 35 percent of those parents who said a child needed mental health care said it was not received. Food insecurity was reported by 25 to 35 percent of interviewees.

- Domestic abuse is a problem for at least 15 percent of interviewees — primarily threats by past partners. Staff judged that 40 percent of clients with domestic abuse problems had made positive change in their situation by the time of the last evaluation.

- Substance abuse was reported by staff for 10 percent of participants, and it was associated with leaving the program for negative reasons. Staff judged about one third of those with substance abuse problems showed positive change over the course of treatment.

Recommendations are presented on page 31.
BACKGROUND

The Los Angeles County Homeless CalWORKs Families Project has been in existence for five years.

In 2002, the Los Angeles County Board of Supervisors established and funded an interagency Homeless CalWORKs Families Project (HCFP) to address the needs of CalWORKs-eligible homeless families in which a parent has mental health problems. This evaluation covers project participants from January 2005 through January 2008. Two previous evaluation reports are available.1

Participants in the HCFP must meet the Los Angeles County Department of Public Social Services (DPSS) definition of homelessness.2 Participants must also be eligible for CalWORKs if not already receiving CalWORKs support. A parent must also have a diagnosable mental health disorder. Overall administrative direction for the project is provided by DPSS. The program is conducted at six mental health sites located throughout the county and administered by the Los Angeles County Department of Mental Health (DMH). Mental health staff, specialized eligibility and GAIN workers, and Los Angeles Homeless Services Authority (LAHSA)3 staff are co-located and collaborate to provide services at each site. The mental health agency at each site performs case management and treatment (counseling and/or medications) and is responsible for providing assistance in locating and obtaining permanent housing. There are approximately 350 participants at any given time.

The Homeless CalWORKs Families Project was designed in 2002 when relatively little information was available about the causes of family homelessness and models for serving homeless families. At the five-year mark, it is appropriate to view HCFP outcomes in the context of what is now known about serving homeless families.

Contrary to what many of us believe, family homelessness is common in the United States.

In 2005 three of the leading researchers in family homelessness concluded that as many as 600,000 families are homeless annually in the United States. Included in this estimate are 10 percent of the nation’s children who live in poverty — approximately 1.26 million children each year.4

“My son has asthma and we couldn’t stay living with my mom. They wouldn’t change the carpet and she was complaining, so we had to get out, although my husband wasn’t working.”

Approximately 16,000 family members are homeless in Los Angeles on a given night. Over the course of a year, the aggregate total may be as high as 120,000 family members.

The Greater Los Angeles Homeless Count for 2007 conducted by the Los Angeles Homeless Services Authority found that 16,648 family members were homeless on a given night in 2007. Approximately 15 percent of the homeless population is composed of children under 18 years of age. On any given night, at least 10,100 children are homeless and at least 7,998 are unsheltered. The projected number of families rendered homeless during the course of a year is a total of 12,887 separate families encompassing 34,383 persons.5 Homeless Count researchers acknowledge that this is a conservative estimate both because of a bias toward undercounting and because the HUD definition of homelessness that was used excludes many persons classified as homeless by DPSS, particularly families doubling up. The final Bringing LA Home report estimated 119,100 family members were homeless at least part of 2002.6

A high rate of homelessness occurs among Los Angeles families receiving CalWORKs.

A DPSS study published in May of 2005 found that 7 percent of CalWORKs cases (comprising 48,800 family members, half of whom were aided children) were homeless in the last quarter of 2004. The definition used was conservative, however, because a comparable number had declared themselves homeless but had not applied for special homeless assistance. The rate of use of CalWORKs-funded mental health, substance abuse and domestic violence services was twice as high among the homeless families as among non-homeless families.7
Causes for family homelessness are primarily economic.

It is important to recognize the broad structural trends affecting family homelessness in Los Angeles County as well as elsewhere.

- First causes. Family homelessness began to emerge in the early 1980s and was significant by 1990. The basic reason is the change in balance between the number of low-income households and low-income housing units. In 1970, the United States contained 9.7 million units renting for roughly 30 percent of the income of a poor family, which was 2.7 million more units than the number of families with a low income. By 1985, the number of low-rent units had declined by 1.8 million, and the number of persons with low incomes by then exceeded the number of low-rent units by 3.7 million.\(^8\) HUD’s most recent analysis of U.S. Census data indicates that 6.5 million low-income renter households that did not receive housing assistance in 2005 had “severe housing problems,” which means they either paid more than half of their income for rent and utilities or lived in severely substandard rental housing. This number increased by 20 percent between 2001 and 2005.

Los Angeles County included 2.3 low-income renter households for every affordable unit in 2001. The California Budget Project calculated that Los Angeles had, at that time, a shortage of 289,000 affordable units.\(^9\)

- Best predictors. In 2001 University of California researchers published a widely recognized analysis of the predictors of homelessness using both national and California data. The strongest predictor of homelessness was low vacancy rates. The proportion of income residents used for housing also had an effect.\(^10\) These factors had the greatest impact in analyses using CalWORKs permanent and temporary housing assistance data. In addition, counties with low per-capita income were associated with higher rates of homelessness among CalWORKs recipients.

- Lack of affordable housing combined with low average earnings increasingly affect homelessness in Los Angeles. More than 50 percent of Los Angeles households are renters (U.S. average is 33 percent). In 2001 in Los Angeles County, 50 percent of renters spent more than 30 percent of their income on housing; by 2007 this figure had increased to 56 percent. Among low-income Los Angeles County families in 2007, about 93 percent spent more than 30 percent of their income on rent.\(^11\) The $1,300 fair-market value for a two-bedroom apartment exceeds the maximum possible CalWORKs grant by $577.\(^12\) In part these data reflect the expensive housing market in Los Angeles County, but in part they reflect the fact that average earnings in Los Angeles in 2005 were only 83 percent of earnings statewide.\(^13\)

- Changes in welfare. Welfare is the nation’s safety net for poor families. Yet unadjusted inflation reduced the value of welfare payments nationally between 1970 and 2003 by 41 percent. And welfare reform resulted in a decline in the percentage of eligible persons using welfare from 86 percent to 48 percent between 1996 and 2006. Between January 1, 1998, and January 2006, the number of persons in Los Angeles County receiving cash aid through CalWORKs declined by 352,000 (48 percent compared to 36 percent in California); the number receiving General Relief dropped by 16,600 (21 percent); and the number receiving food stamps dropped by 120,000 (15 percent). Many leaving welfare are still poor: 54 percent of persons in an MDRC study of Los Angeles residents who had left welfare in 1998 still had incomes below the poverty level in 2001.\(^14\) Compared to public assistance statistics for other states, the number of California CalWORKs participants who receive housing vouchers is a very low proportion: 10 percent.\(^15\)

Less than 5 percent of cases of family homelessness are likely to be attributable to personal disabilities or problems, although such factors increase vulnerability to economic forces.

Just as it is common to underestimate the number of homeless families and ignore the larger economic factors causing family homelessness, the individual vulnerabilities of homeless families tend to be over-emphasized as a cause for their predicament. Twenty years of research has shown that personal vulnerabilities, such as mental health problems, substance abuse problems, domestic violence and illness do not cause family homelessness except in a relatively small percentage of cases.
A leading researcher, Dennis Culhane, used data from the shelter systems of three large metropolitan areas and the entire state of Massachusetts to develop an empirically based typology. He found that between 72 percent and 80 percent (depending on location) of family homeless shelter users had only one fairly brief episode. Between 17 percent and 21 percent had extended stays in shelters, and 2 percent to 8 percent had recurrent episodes. Previous psychiatric hospitalizations or substance abuse treatment in the small group of episodic families occurred at two to three times the rate in the extended-stay families, and double the rate in the brief one-time-stay families. In the episodic group, the proportion of families having either of the two conditions was as high as 40 percent. The vast majority of families quickly find housing (even if they have these problems). About half of the small number of families that have recurrent episodes of homelessness have these or other disabilities.\textsuperscript{16}

However, 24.7 of those who self-declared they had a mental health need were homeless in the same period.\textsuperscript{19} It is worth remembering that the vast majority of parents who become homeless do not have mental health problems and that among those who do these problems may contribute far less than economic factors.

**RECENT RESEARCH ON HELPING HOMELESS FAMILIES**

Since the initiation of the HCFP a number of studies have been published that test different ways of serving homeless families. We summarize this literature (and some earlier studies) below, paying particular attention to a well-done randomized control study of New York state programs serving persons very similar to those in the Homeless CalWORKs Families Project. Unfortunately, this New York study is an exception: very few of the studies on interventions have a control group of any sort, making it difficult to judge how much change is due to the intervention. Other significant methodological problems are evident with this literature as well, but certain broad outlines are clear.\textsuperscript{20} In general three main types of intervention for homeless families have been studied: housing subsidies alone, services alone, and subsidies plus services.

*Research findings are very clear that the most significant factor in creating stable residential situations for homeless families is rental assistance.*

Only a few of the major studies documenting this finding are described here, but there are many others.\textsuperscript{21}

- **Subsidies prevent homelessness.** Between 1999 and 2004 Congress provided housing vouchers to TANF recipients in an experimental program. The experiment included over 8,000 participants in six sites, including Los Angeles. Half of the participants were chosen randomly to receive the housing vouchers. Those receiving vouchers were significantly less likely to have been homeless during the 42-month study period and to have moved less frequently. In the year prior to the final follow-interview, 12 percent of those receiving vouchers had been homeless or living with family or friends compared to more than 25 percent of those not assigned vouchers (some of whom did obtain vouchers independently). As a side benefit, the children in vouchered families fared significantly better than children in

> "Both of my kids have disabilities and we were being supported by the children’s father. He ended up in jail and I had no means of support."

Supporting this conclusion, a CiMH analysis of data from a probability sample of Los Angeles women shows that homeless mothers accompanied by children have far fewer behavioral problems than those exhibited by single homeless women, by women whose children are grown, or by parents not accompanied by their children. However, longer duration of homelessness among the accompanied mothers was predicted both by behavioral problems (particularly substance abuse) and housing difficulties.\textsuperscript{17}

However, there is some evidence that homelessness in the CalWORKs population is more likely if there is serious substance use or, to a lesser extent, mental and physical health problems.\textsuperscript{18} In Los Angeles, The Economic Roundtable has found that 8.1% of all CalWORKs participants with a welfare-to-work plan were homeless during a one-year period.
control group families. Note that there were large regional variations, with Los Angeles having the lowest “lease-up” rate, presumably due to conditions summarized in the previous section.

- **Subsidies allow homeless families to become stably housed.** A six-site federal program in the early 1990s in which all participants received a Section 8 voucher found 85 percent to be stably housed after 18 months. In the ensuing year three sites kept the percentage at 80 percent and three others dropped to 66 percent. Some analysis suggested serious domestic violence accounted for much of the later loss of housing. Participants also received an average of a little over an hour a month of case management services.22

"They sent the application for the Section 8 as quickly as possible in order to accelerate the process and so that we were not so long in the hotel." (Translated from Spanish.)

"The amount of money I make now is not enough. Housing is very expensive and I can’t afford it. I was working two jobs and my baby’s father came around and said I was a bad mom for working two jobs."

Shinn and colleagues conducted a five-year follow-up study with 266 sheltered families in New York City. At follow-up, receipt of subsidized housing was the fundamental predictor of housing stability among formerly homeless families. (Behavioral problems, demographics, and social relationships were also tested.) Families with subsidized housing were 21 times more likely to have been stably housed than those without. With regard to preventing a recurrence of homelessness, the authors conclude: “Housing subsidies are critical to ending homelessness among families.”

A two-year follow-up study in New York City found a return-to-shelter rate of only 7.5 percent among families receiving subsidized housing; among others it was far higher.23 A 2004 retrospective study of several study cohorts in New York City by the Vera Institute for Justice found that subsidies greatly reduce returns to shelters for families over as long as ten years.24 The authors conclude: “Subsidized housing provides the best protection against shelter return.”

- **Subsidies are not a panacea.** While the best predictor of housing stability for formerly homeless persons is receipt of a housing subsidy, some persons return to shelters even though they have a subsidy. And some persons who do not receive subsidies do achieve stable housing.

So far little research has been conducted to help determine who might not need a subsidy (though employment or an employed partner is predictive) or who will become homeless again even with a subsidy. In addition, tight housing market conditions and inadequate affordable housing stock reduced the effectiveness of vouchers. Nationally, the proportion of voucher holders able to use their voucher (the “success rate”) fell from 81 percent in the early 1990s to 69 percent in 2000.25

**The evidence that services — absent housing subsidies — can lead to permanent housing has very limited support.**

The Los Angeles HCFP was established as a service model targeting parents with mental health problems, and was initiated with the implicit premise that resolving personal problems would assist participants in finding and retaining housing. Only in the second year were housing vouchers added for the 40 participants. In the following two years only 50 vouchers were available for a group that exceeded 400 participants. While we will use data from the HCFP itself to examine the evidence that services are sufficient, it is useful to see whether other studies have found services alone to be sufficient in stabilizing housing.

- The major study addressing this question is The Center for Mental Health Services and Center for Substance Abuse Treatment Homeless Families Program, a five-year multi-site study initiated in 1999. Results have been published for only one New York state site, but the lead author summarized overall findings in 2007. Like the HCFP, the project was designed to meet the psychiatric, substance abuse, and/or trauma services needs of homeless women with children. Services were provided for nine months and included securing and maintaining housing, parenting skills, household and money management, and goal setting, in addition to
mental health and substance abuse treatment. The mix and method of providing the services differed by site. The evaluation has found that outcomes generally improved for those receiving these intensive and comprehensive services but did not differ from the outcomes of persons receiving “usual services” (which often meant no services). Both groups, however, encompassed a sub-group of persons with mental health problems who did not improve over time.

- Samuels has published results for one of these sites. This study is particularly important because it, unlike the other sites, used a randomized control group. The program also used an evidence-based approach called Critical Time Intervention.
  a. An important finding is that mental health distress is greatly elevated by homelessness itself but decreases over time with no intervention. Assessment during the period of homelessness will overestimate long-term mental health problems. If the HCFP is to target those with ongoing mental health problems, the mental health assessment must take place after an initial stabilization process.
  b. The percentage of families housed at 15 months was 68 percent for those receiving the experimental services and 65 percent for those receiving usual services, but the experimental group was less likely to be in permanent rather than transitional housing.
  c. “Readiness” criteria were unnecessary because members of both groups were housed and the investigators found “no impact of mental health or substance abuse or other challenges on housing.”
  d. With housing “held constant” statistically there were no other better or worse outcomes for the group receiving intensive and comprehensive services.

**Family supportive housing offers both rental support and services, often in a “housing first” model. These programs appear to be successful but it is still unclear which families need this level of support.**

Supportive housing is intended for homeless persons with multiple barriers to housing stability who are thought unable to maintain housing in the long term without significant support. Some type of rental assistance is provided. Often the apartments are in reh rehabbed buildings, managed by an agency separate from the one providing services. Tenants have a lease and can stay as long as they meet the conditions of the lease. Services are usually not required but are available on site. A variety of supportive housing projects exist for single persons. The great advantage of supportive housing (or integrated housing development as it is sometimes called) is that it increases the stock of affordable housing. For example, in San Francisco 2,500 new supportive housing units have been created since 2004.

In Los Angeles, as of 2007, an estimated 6,030 supportive housing units were available in 45 projects. About 600 new supportive housing units were brought on line between 2004 and 2007, and at least 2,200 are actively in development. However, Los Angeles is estimated to need another 14,000 supportive housing (or equivalent) units to serve the chronically homeless — a population that for the most part excludes families.

Supportive housing for single homeless persons, particularly those with serious mental disabilities, has been the subject of several well-designed studies with randomized control groups. It is a cost-effective approach for this population. For families the evidence is more limited: a number of demonstration projects have been evaluated but none involved a control group, and they have differed greatly in the housing provided, the services offered and the criteria for eligibility.

- In a direct parallel to the use of supportive housing for single individuals who are chronically homeless, family supportive housing has usually targeted those with repeated episodes of homelessness. In one study the average was four homeless episodes totaling 48 months without a home.

- Bassuk summarized the early findings from 13 family-supportive housing sites with a total of 453 units for families. However, at the end of one year, outcomes were available for only four programs. The percentage of families retained in housing for 12 months at the four sites was 94 percent, 95 percent, 71 percent, and 67 percent. Some left due to alcohol and other drugs, mental health problems or domestic violence. Others left voluntarily to get more housing choice, particularly if they had a Section 8 voucher available.
The evidence for supportive housing for families is still slim. In Los Angeles, the organization Beyond Shelter has used a variant of this model for families. It is an approach, though, that seems best suited for families that can be characterized as “chronically” homeless. And it, along with transitional housing, is well suited for parents who are trying to retain or regain custody of their children, since the child welfare system needs to be satisfied that parents are receiving services and making progress.

In summary, structural factors are responsible for most family homelessness; housing subsidies are the most effective way to combat it.

The need for extended services is one of the first findings to emerge from the HCFP. The initial service design was for six months. It rapidly became clear that 18 months to two years was a more realistic figure. This service pattern also increases the costs of the program per enrollee by up to four times the originally conceived amount.

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“It was difficult because I was really counting on it. I enrolled in my current program so I didn’t have to move so much. It was too difficult when you have school-aged children.”

“My biggest issue was we joined the program as a family — man, wife, kids — but the program splits families up by having so many rules for each area of the program that causes hardship and breaks families apart in all different directions. We should be considered a family unit.”
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**Services to homeless families can be helpful in achieving goals other than housing; in particular they can help children.**

Three important supplementary findings that we did not know five years ago have since emerged.

- First, distress and behavioral problems or symptoms of both parents and children are greatly elevated by being homeless but will decline without services over a few months if families are housed. The distress of children usually peaks at four months of homelessness.

- Second, services provided to homeless families that are housed can improve outcomes for the children. This was a finding in the study by Samuels (with regard to school outcomes and behavior problems) as well as in the San Francisco Family Permanent Supportive Housing initiative.

- Third, like other very poor families, homeless families exhibit substantial needs for services, which may be needed for two or more years.
Successful HCFP Participants Speak: A Current Client

B’s story:

Becoming homeless. I have one child and she’s 16. She is suffering from depression and goes to counseling. In 2004, I was in a car accident. As I was recuperating, I was in another car accident. I was going through the process of rehabilitating, and I just completely lost it. They said I had post-traumatic stress syndrome. Then I lost my apartment because I couldn’t keep up with the rent. I went over to apply for TANF, and I had no idea what to do. This was the first time that anything like this had happened to me. and at that point I was so emotionally drained and depressed that I couldn’t do anything but cry.

The program. The GAIN staff was very kind and referred me to the HCFP, and that’s when I started the process for seeing the counselor. We sat down and tried to figure out a plan. I was really slow moving and I couldn’t get out of bed. She would force me to come here twice a week so I would at least get up and make some type of progress. She’s very positive. I feel a lot better about myself and that I can do this. I’m still receiving counseling.

Housing. We applied (for a new housing project) and had to wait a good six months before it was completed. I never got a Section 8 voucher, but my housing is subsidized. It’s beautiful, brand new. I love it there. The people that run it are extremely nice and it’s very secure. The only downfall is that it’s so strict. This is a good place and there’s a lot of rules, so it’s like being in a shelter but I like it.

Career. In the meantime I was going to school and I completed my CNA certification for nursing. The CalWORKs (program) at the college really helps you. They go the extra mile when you’re not able to make it and they even gave me a job in the admissions office. They asked me to speak at one of their conferences. I told them no matter what you go through there’s always people there to support you; you just have to reach out and ask for the help. I really did not have a clue where to start, and these people just led me in the right direction. So now I’m going back to school for my LVN [certification] and hopefully will become a nurse.
**CHAPTER II: UNDERSTANDING HCFP OUTCOMES**

**PROGRAM CHARACTERISTICS**

**HCFP participants must meet DPSS criteria for homelessness.**

DPSS defines those homeless to include persons who lack a fixed nighttime residence, share a residence with family or friends, live in a shelter, reside in places not designed for sleeping quarters, or who receive an eviction notice. This definition is broader than that used by other administrative entities, such as HUD. Participants must also be eligible for CalWORKs if not already receiving CalWORKs support.

**The HCFP model is predicated on interagency collaboration.**

- Each of the six service sites has mental health staff, specialized eligibility and GAIN workers, and the LAHSA Emergency Response Team Program. Each agency has an administrative unit overseeing all six sites. Overall administrative direction is provided by DPSS, and includes an interagency steering committee to resolve problems.

- To the extent possible, staff from all three agencies are co-located at least part time at the mental health agency.

- Both case management and treatment (counseling and/or medications) are required components of services. These are provided by the mental health agency.

- DPSS staff help participants obtain cash aid, food stamps, Medi-Cal, child care, employment and educational resources as well as offering specific services to address homelessness, such as first and last month's rent.

- LAHSA staff provide emergency and transitional housing placement options for families along with providing transportation in vans to appointments and, as time allows, for other purposes.

LAHSA staff also assist with long-term housing and assists families in maintaining stability until they secure permanent housing.

- Housing specialists are part of the mental health agency staff, and provide active assistance in locating and obtaining permanent housing.

- Case managers help clients find and use Section 8 housing vouchers and other rent subsidies to the extent possible.

**The HCFP serves upwards of 400 participants in each year.**

According to DPSS records, 405 persons were served during the 18-month period ending June 30, 2006. The six HCFP sites admitted 264 new participants during 2006–2007, and 159 persons were held over from the previous year, so that a total of 423 persons were served in the year in which the current study cohort was enrolled.

**The Board of Supervisors approved $12.7 million for the HCFP between January 1, 2005 and December 30, 2007; of this amount $10.1 million was actually expended. There are substantial other costs but they are for services which would be available to any eligible CalWORKs participant.**
Funds for the project are from the CalWORKs Single Allocation provided by the state, but are specifically allocated to the HCFP by the Board. The funds approved by the Board cover case management and administrative costs for DMH and the costs of LAHSA’s services (administration, transportation, housing assistance). Funding for mental health treatment services comes from the existing allocation for CalWORKs supportive services, so these functions do not represent a marginal increase. The DPSS services and support (including cash aid, food stamps and Medi-Cal) are likewise available to CalWORKs participants and so do not constitute a marginal cost — although the HCFP caseloads are far smaller than usual. Vouchers are an additional cost. The costs per client per year just for the Board approved funds are estimated by CiMH to be over $8,000. If the other costs were included, the estimated costs would be double that amount.

The program has multiple goals, including improving mental health functioning and helping clients obtain education or employment. These improvements also have to be factored in when looking at the overall cost effectiveness of the HCFP, but they are more difficult to assess because they occur over a longer period of time and successful outcomes are less easily defined.

**THE EVALUATION SAMPLING AND DESIGN**

*The study sample is generally representative of all those admitted to the project between January 1, 2005, and June 30, 2007. The current cohort of study participants entered the study between July 1, 2006, and June 30, 2007. Services provided through January 2008 were evaluated.*

This report updates information on Round II participants, who enrolled between January 1, 2005, and September 2005. In the current phase of the evaluation (Round III), participants enrolled between July 1, 2006, and June 30, 2007. In Round III, a total of 314 persons were designated study participants who had signed informed consents; 73 of these had been held over from 2005–2006 because they had not found housing by June 30, 2006. The primary focus of this report is the Round III participants, but results for both Round II and Round III participants are presented when comparable data exists for both groups.

This report presents information from 243 Round II participants plus 240 from Round III (with the 73 served in both Rounds counted in Round II). Altogether the participants define a representative sample of 483 persons who were admitted to the HCFP’s six sites between early 2005 and the end of 2007. In the Round III cohort 222 persons had already left the program when summary data was provided for them by staff, while 88 were still receiving services.

*Information on study clients was obtained from staff and from direct interviews with the clients as well as electronic databases.*

Information comes from a number of different sources. The number (N) in tables varies depending on the source of the data and, in some cases, the amount of missing information.

- Mental health staff filled out information forms on individual clients at intake and at discharge (or, for the 88 clients still receiving services, in January 2008).
- A research interview was conducted in Round II by trained CiMH research associates in the period April–July 2006. A comparable interview was conducted for Round III between November 2007 and early June 2008. In Round II a total 174 of 243, or 70 percent of study participants, were located and interviewed. In Round III, 208 interviews were completed, out of 308 attempted (67 percent). Unfortunately, 89 participants (29 percent) could not be located despite using multiple search methods. Six persons refused, and scheduling interviews with five others proved impossible. The interviewees are not equivalent to a random sample of participants. Interviewees include a higher proportion of current enrollees and a lower proportion of

---

**How did you come to be homeless?**

**Client 1:** “*My husband committed suicide, which led me to financial problems.*”

**Client 2:** “*The emotional stuff and I relapsed. And I’m self-sabotaging. I start judging where I’m at by judging where everybody else is. And around here I run into people [who are] not safe to be around.*”

**Client 3:** “*I was unemployed, using drugs, and the house I was renting sold, and I had no transportation to get around.*”
persons who left the program for negative reasons (e.g., noncompliance or dissatisfaction). A number of other comparisons — including reports of school attendance and child welfare placements — show that participants in the interview sample were functioning better than those not interviewed. Thus, the findings from the interviewed group are likely to be more positive than they would have been if all participants had been interviewed.

- Other information is drawn from the Los Angeles Department of Mental Health Information System. Unfortunately it was not possible to obtain matching DPSS data for this report; it will be presented in the next evaluation report.

- Finally, the Housing Authority of the County of Los Angeles provided de-identified data on HCFP applicants and participants in the Section 8 and Shelter Plus Care voucher programs.

**The design of the evaluation has two significant weaknesses.**

Strong evaluation designs include a comparison group; ideally, participants are randomly assigned to each study group. Instead, we must draw inferences from change during the course of the services or, when using MIS data, from a baseline period. There are many possible causes for change, and because of the “pre-post” design we are unable to say whether the changes we document are due to the program intervention or to other factors.

A second weakness is the lack of independent measurement of some variables. In particular, the study includes client interview data at the end of the study period but not interview data from the time participants were admitted or independent measures of child well-being.

**CLIENT AND SITE CHARACTERISTICS**

*Los Angeles County operates six HCFP sites, one in each Los Angeles County Supervisorial District.*

The initial pilot program in 2002–2003 was conducted at the Downtown Mental Health Clinic. In the second year of the project, a mental health contractor (Prototypes) added services in the San Gabriel Valley. In 2005 the county added four other sites: Shields for Families in South Central Los Angeles, the San Fernando Valley CMHC, Inc. in North Hollywood, Pacific Clinics in Norwalk, and ENKI in Covina.

**Most participants were females with an average age of 33. Depression was the most common diagnosis.**

Basic demographic characteristics of the Round II and Round III groups are shown below. Some 73 persons were “held over” from Round II to Round III; they are shown in the Round II data.

### TABLE 1: HCFP CLIENT CHARACTERISTICS AT ADMISSION, ROUND II AND ROUND III

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Round II (N=243)</th>
<th>Round III (N=233)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age</td>
<td>35</td>
<td>32</td>
</tr>
<tr>
<td>Female</td>
<td>93%</td>
<td>92%</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latino/a</td>
<td>40%</td>
<td>45%</td>
</tr>
<tr>
<td>African-American</td>
<td>34%</td>
<td>35%</td>
</tr>
<tr>
<td>White</td>
<td>20%</td>
<td>17%</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjustment disorder</td>
<td>21%</td>
<td>20%</td>
</tr>
<tr>
<td>Depressive disorder</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>8%</td>
<td>11%</td>
</tr>
<tr>
<td>Serious mental illness</td>
<td>7%</td>
<td>8%</td>
</tr>
</tbody>
</table>
Successful HCFP Participants Speak: A Graduate Who Found Hope

A’s story:

Becoming homeless. Well, I have a daughter and she’s 14. We were homeless because of financial difficulties. I was working a job that I didn’t like. I was renting a room but I barely made ends meet. I was also in school so I can better my life. I was just so stressed out. The people we stayed with, in their house, they weren’t very nice so I just moved out.

Housing. I was about to get counseling, and that is when I was referred to the HCFP. LAHSA brought me over here and they made an appointment with a shelter. When we went to the shelter it was hard. There were a lot of rules, my daughter is a teenager and she didn’t want to follow them. She did follow as best she could, but that stressed me out at the shelter. We did make it through. We were at the shelter 13 months — a long time. Thanks to this program I finally got this Section 8 voucher to move out of the shelter.

The program. I was very eager to come here because I saw some hope in my life. I’m like, how am I going to make it if I don’t get some help, because I was renting one room for years. You get a certain amount from welfare, you work part time, you try to go to school, it’s just, you barely make it. So, I was very grateful when I came here and very happy when I was told I qualified. (My counselor) said that if you do what we ask of you, you’re going to get your housing voucher, so I did my best. They worked with my schedule because I was going to school. They really work with you.

Mental health. Before I got here, I would say the emotional part was, what’s going to happen to us in the future? What’s going to happen to my daughter? Depression and a lot of stress. When I got here (HCFP) I saw the light at the end of the tunnel. I saw some hope.
CHAPTER III: SERVICE OUTCOMES

PARTICIPATION AND SATISFACTION

Participants spend an average of 13 months in the program, but the range is broad.

Initial expectations that services could be completed in six months have proved to be unrealistic. Although the official duration of services is currently one year, half of the participants have received services for longer than that. Once accepted in the program only 3 percent stay less than three months until discharged; 17 percent stay six months or less. A stay of six to 12 months is found for 51 percent; 22 percent stay between a year and 18 months; and 27 percent stay longer than 18 months.

“I want to thank the HCFP program for all the help they gave me, including my caseworkers, who were nice and very helpful to me and my family in a time of despair.”

“I wouldn’t have a home if it wasn’t for them.”

In Round III, less than a third of the 224 participants who had left the program by January 2008 had completed treatment or left because of employment; half left for reasons that might suggest failure to adequately help the participants.

Over the three years of the program encompassed by both cohorts, 32 percent left because of successfully completing the program and another 2 percent left due to full-time employment that made participation difficult. Neutral reasons, like moving, accounted for 13 percent of departures, 40 percent left for negative reasons, and the remainder are unclassified or have multiple reasons (see Table 2).

One way in which to gain some perspective on the third of clients completing the program is through comparing the 32 percent HCFP completion with the overall completion rate for the mental health component in CalWORKs welfare-to-work plans — which averages only 17 percent. These measures are not exactly the same as a completing the HCFP program includes finding permanent housing as well as mental health treatment, a more difficult task. But

<table>
<thead>
<tr>
<th>Reason left program</th>
<th>Discharged in Round II N=134 Percent</th>
<th>Discharged in Round III N=226 Percent</th>
<th>Total N=360 Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>POSITIVE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed the program</td>
<td>38.6</td>
<td>28.3</td>
<td>31.9</td>
</tr>
<tr>
<td>Employment</td>
<td>2.3</td>
<td>2.2</td>
<td>2.2</td>
</tr>
<tr>
<td>NEUTRAL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moved</td>
<td>9.8</td>
<td>7.5</td>
<td>8.3</td>
</tr>
<tr>
<td>Served elsewhere</td>
<td>2.3</td>
<td>5.3</td>
<td>4.2</td>
</tr>
<tr>
<td>NEGATIVE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lost eligibility</td>
<td>12.1</td>
<td>8.0</td>
<td>9.4</td>
</tr>
<tr>
<td>Dropped by program</td>
<td>18.9</td>
<td>26.5</td>
<td>23.6</td>
</tr>
<tr>
<td>Was dissatisfied</td>
<td>9.1</td>
<td>3.5</td>
<td>5.6</td>
</tr>
<tr>
<td>Jail</td>
<td>2.3</td>
<td>1.3</td>
<td>1.7</td>
</tr>
<tr>
<td>Multiple or other reasons</td>
<td>6.1</td>
<td>17.3</td>
<td>13.1</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
it does indicate that in comparison to the overall CalWORKs mental health program, achievement of goals is high.

Round III interviewees were generally satisfied with the HCFP program (85 percent), felt they were treated with respect (85 percent), trusted the staff person they worked with most often (92 percent), and would recommend the program to a friend (92 percent).

Those figures, for Round III, differ very little from those for Round II. In addition, 92 percent said the services were available at convenient times and 99 percent said services were available in their primary language. Only 28 percent had received mental health services previously.

MENTAL HEALTH: STATUS AND OUTCOMES

Staff judged that the participation rate for mental health treatment was “good” for a little more than half of the clients.

Although the percentages in each category shifted somewhat between the two rounds, participation in mental health treatment was good or very good for about 52 percent and poor or minimal for the remainder.

Overall, staff judged almost three quarters of HCFP participants to have made positive changes in their mental health status. However, global mental health ratings at discharge showed that 30 percent still were functioning at quite a low level.

Relatively few participants made either strong positive change (13 percent) or regressed (4 percent) in their mental health status. About 60 percent made some positive change, and a fifth were rated by staff as unchanged (see Table 3).

Scores reflecting global level of functioning increased from admission to discharge.

The GAF scale is used by clinicians to rate clients from 0 to 100 on several dimensions of functioning — from symptoms to relationships to employment. Persons given a rating of 40 or less have impairments in multiple functional areas, psychotic symptoms, or presence of danger to self or others. Ratings of 41 to 50 indicate serious symptoms or impairment, and those with ratings of 51 to 60 have moderate symptoms or impairment. Ratings over 60 indicate mild symptoms and some impairment in daily activities.

For each person, the GAF score at discharge in Round III was compared with the GAF score at time of admission. These comparisons showed quite strong statistically significant positive change — from a mean of 51.3 at admission to a mean of 55.2 at discharge. Those who had the lowest scores at admission (40 or under) made the biggest gains (mean increase of 14.4). See Table 4 for details.

### TABLE 3: POSITIVE AND NEGATIVE CHANGE ON MENTAL HEALTH SYMPTOMS (ROUNDS II AND III)

<table>
<thead>
<tr>
<th>Change in mental health problems</th>
<th>Round II</th>
<th>Round III</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=155</td>
<td>N=306*</td>
<td>N=461</td>
</tr>
<tr>
<td>Percent</td>
<td>Percent</td>
<td>Percent</td>
<td>Percent</td>
</tr>
<tr>
<td>Strong positive</td>
<td>12.3</td>
<td>13.4</td>
<td>13.0</td>
</tr>
<tr>
<td>Some positive</td>
<td>54.8</td>
<td>60.8</td>
<td>58.8</td>
</tr>
<tr>
<td>No change</td>
<td>18.7</td>
<td>18.3</td>
<td>18.4</td>
</tr>
<tr>
<td>Negative change</td>
<td>3.9</td>
<td>3.9</td>
<td>3.9</td>
</tr>
<tr>
<td>Could not judge</td>
<td>10.3</td>
<td>3.6</td>
<td>5.9</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Includes 73 held-over participants
Recall that participants indicated a wide range of positive and negative reasons for leaving. Among those with positive reasons for leaving, the exit GAF score was an average of 61; for those with neutral reasons it was 56; for those with negative reasons, the average score was 52. Among those who scored 40 or less on the GAF at discharge, 80 percent had a negative reason for leaving; and among those with scores between 41 and 50 on the exit GAF, 65 percent left for negative reasons.

**TABLE 4: GAF SCORES AT ADMISSION AND DISCHARGE (ROUND III)**

<table>
<thead>
<tr>
<th></th>
<th>Admission N=185</th>
<th>Discharge N=185</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent</td>
<td>Percent</td>
</tr>
<tr>
<td>40 or under</td>
<td>11.9</td>
<td>8.6</td>
</tr>
<tr>
<td>41-50</td>
<td>30.8</td>
<td>23.2</td>
</tr>
<tr>
<td>51-60</td>
<td>42.7</td>
<td>38.4</td>
</tr>
<tr>
<td>Over 60</td>
<td>14.6</td>
<td>29.7</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Eighty-five percent of interviewees believed their mental health services had helped with emotional or mental health problems.

When asked if the services provided helped with emotional or mental health problems, 55 percent said they “helped a lot,” 29 percent said they helped “some,” 10 percent said they did not help or made things worse, and 5 percent reported they did not have emotional or mental health problems. The change in staff-rated GAF scores from admission until discharge for these participants corresponded well with client reports. Clients who said they were helped a lot improved an average of 4.8 points; those who said they were helped somewhat improved by an average of 3.7 points. Those who said treatment made their problems worse had a slightly lower discharge than admit score (-.33). These associations between GAF score changes and client reports of being helped were statistically significant.

Interviewees were also asked how their mental and emotional feelings (depression, being stressed out, inability to sleep or sleeping too much, being very worried, excessive irritability, or struggles to get going each day) had changed in the previous year. “A lot better” was reported by 45 percent of Round III participants, and “somewhat better” by another 33 percent of participants; 13 percent reported no change; and 8 percent reported feeling worse than a year before. The percentage of interviewees saying their mental health was at least somewhat better varied somewhat, depending on program status. Those still in treatment were most positive (90 percent); those who left for positive reasons were next (84 percent); but even those leaving for negative reasons, such as noncompliance with the program, were predominantly positive (66 percent).

**Staff rated parenting capacities as exhibiting improvements.**

Staff were given a detailed set of criteria for rating parenting to ensure consistency. At intake, 67 percent were rated as “good” or better, and fewer than 4 percent were judged to be “deficient or unsafe” (which meant CPS reports were filed). However, about a quarter of parents were rated as “inconsistent” in parenting.

Between admission and the final evaluation in Round III, some movement was evident between categories, and the overall percentages improved a small amount among persons rated both at admission and discharge (with “can’t judge” excluded); 72 percent were rated as “very good” or “good” at intake, a figure that changed to 79 percent at the final evaluation. Of eight parents rated “deficient or unsafe” at intake, four were rated “good” at the final evaluation; however, the ratings of two parents declined from “good” to “deficient or unsafe.”

**HOUSING: STATUS AND OUTCOMES**

According to staff, approximately 70 percent of Round III participants had a history of housing instability in the prior three years.

Only 6 percent of participants had a “very stable” housing history, while 30 percent had a “very unstable” history. Twenty-one percent of participants had been homeless over a year. Participants had lived in the region in which they were served an average of 8.4 years.

Staff were asked which of 15 potential barriers to housing clients had at admission. While 25 persons had no perceived barriers, a third had two or three, another third had four or five, and 15 percent had six to ten. The barrier that is most common (83 percent) is the inability to afford rent — a powerful argument for housing subsidies.
**LAHSA is the agency charged with providing emergency housing while participants are working on securing permanent housing.**

- LAHSA’s HCFP Team of 20 full-time staff serves approximately 350 CalWORKs families at any given time, placing clients in emergency housing, transitional shelters, and a variety of other programs using DPSS 120-day emergency shelter funds and other funding sources. In addition to finding housing, LAHSA’s HCFP Team guides CalWORKs clients in learning life skills, advocates for CalWORKs children at their schools and with their parents, and provides transportation to important appointments. In addition to providing transportation to mental health and DPSS appointments, LAHSA’s HCFP Team maintains a network of emergency housing options for participants, provides critical emergency services that aid families in gaining stability, provides other emergency housing placements, and can extend the family’s emergency and transitional housing stay until permanent housing is found.

> “The biggest help I had was LAHSA. They provided me with a voucher for the hotel and drove me to the appointment.”

- As part of its larger responsibilities, LAHSA maintains agreements with several providers who serve only HCFP participants. LAHSA staff screen the clients for these agencies and in some cases provide funding. If permanent housing is not found within 120 days, LAHSA helps to locate limited Los Angeles County funds to be used to extend the family’s stay until such housing is found.

**The most significant resource for the HCFP is LA Family Housing’s Comunidad Cesar Chavez Emergency Shelter (Chavez House), a LAHSA-funded emergency housing program that serves only HCFP families.**

Chavez House has 26 apartments, 17 of which are under contract with LAHSA for the HCFP. It is one of several buildings owned and operated by Los Angeles Family Housing. Participants are screened by LAHSA, which pays a rate of $50.05 per day per family to cover the costs of services as well as housing. Funding for Chavez House is provided through CalWORKs and Los Angeles County General Fund (Supervisor Gloria Molina). Los Angeles Family Housing also maintains a transitional housing facility, and Chavez clients may have some priority getting into it. HCFP participants from any part of the county are eligible.

The comprehensive Chavez House services include helping clients apply for Section 8 vouchers, which occurs soon after admission; case management; employment services; child care or child watch; assistance finding permanent housing; life skills training; and transportation. In some cases, however, these services duplicate or are at odds with services from the HCFP mental health agencies. The facility can accommodate families with older boys, two parent families, and large families (of up to 11 members). The facility is attractive and includes a garden maintained by residents.

Between July 1, 2007, and May 15, 2008, the program served 76 families, of whom 39 moved into permanent housing and 16 moved into transitional housing. The program follows up for at least six months with families who relocated to permanent housing; so far, none have been evicted.

**Other shelters, particularly transitional shelters, provide resources in addition to housing.**

Services available at some shelters include parenting and other support groups, assistance with housing and employment, assistance saving money for first- and last-month deposit, and services for children.

**Many shelter resources are in short supply.**

- Emergency shelters are lacking or in very short supply in many parts of the county, including those served by Prototypes, ENKI, Pacific Clinics, and San Fernando Valley MHC Inc. Some new resources are being planned in some of these areas.

- There is an overall dearth of transitional shelter placements in the county.

- Funding for shelters is often inadequate, particularly if the 120-day DPSS allocation has been depleted. This insufficiency results in numerous problems for parents and their children, who may be shuttled from one shelter to another as a result. The challenge posed for LAHSA’s HCFP staff is to access emergency and
transitional housing for HCFP families and help families stay in emergency housing until they gain permanent housing.

- The county lacks adequate shelter resources for families with boys over the age of 12, for families headed by a single father, for two-parent families, and for families who are exiting from domestic violence shelters.

**Many families are satisfied with their stay in shelters, but for a minority of participants shelters involve significant problems.**

Most HCFP participants spend time in an emergency shelter or transitional shelter, although almost a third of interviewees in Round II and 22 percent in Round III reported being turned away from a shelter in the prior year because the shelter didn’t take families, teenagers or single fathers, or required occupants to be married, or because the number of children in the family exceeded the shelter’s maximum permissible limit.

Over half of interviewees in both rounds reported that shelters had met their needs “very well,” about a quarter said they did “somewhat,” 11 percent said “not very well,” and 6 percent said “very poorly.” In Round III most of the families who said their needs were not met well complained of clearly substandard conditions (cockroaches, fleas, bad food, code violations), unhelpful staff, or financial exploitation. In some cases clients reported that a shelter to which they were referred had since been closed. One interviewee said: “I am concerned about safety for children — places we were sent to aren’t family-oriented.”

One of the most significant issues for about half of the parents was that living in shelters sometimes prevented them from keeping their children in the same schools. In each round, this disruption was reported by 54 percent of interviewees. About 60 percent of parents (in each round) reported that they

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**TABLE 5: MOST RECENT LIVING SITUATION KNOWN TO STAFF FOR ROUND II AND ROUND III PARTICIPANTS**

<table>
<thead>
<tr>
<th>Living situation</th>
<th>Discharged in Round II N=137 Percent</th>
<th>Discharged in Round III N=226 Percent</th>
<th>Still in Program January 2008 N=82 Percent</th>
<th>Round II &amp; III Total N=445 Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless</td>
<td>2.9</td>
<td>2.2</td>
<td>1.2</td>
<td>2.2</td>
</tr>
<tr>
<td>Emergency shelter</td>
<td>5.8</td>
<td>4.9</td>
<td>1.2</td>
<td>4.5</td>
</tr>
<tr>
<td>Transitional shelter</td>
<td>4.4</td>
<td>8.0</td>
<td>32.9</td>
<td>11.5</td>
</tr>
<tr>
<td>Rented room</td>
<td>5.1</td>
<td>5.3</td>
<td>3.7</td>
<td>4.9</td>
</tr>
<tr>
<td>House/apartment</td>
<td>31.4</td>
<td>24.8</td>
<td>7.3</td>
<td>23.6</td>
</tr>
<tr>
<td>House/apartment with voucher</td>
<td>20.4</td>
<td>23.5</td>
<td>31.7</td>
<td>24.0</td>
</tr>
<tr>
<td>With parents</td>
<td>5.1</td>
<td>6.2</td>
<td>4.9</td>
<td>5.6</td>
</tr>
<tr>
<td>With other relatives</td>
<td>11.7</td>
<td>11.1</td>
<td>3.7</td>
<td>9.9</td>
</tr>
<tr>
<td>With friends</td>
<td>7.3</td>
<td>5.8</td>
<td>3.7</td>
<td>5.8</td>
</tr>
<tr>
<td>Other</td>
<td>5.8</td>
<td>6.2</td>
<td>7.3</td>
<td>6.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
were able to maintain contacts with people at places in which they previously had lived.

**The basic outcome of the HCFP was an increase of participants in long-term rental housing to between 48 percent and 68 percent, depending on the data source (see Table 5).**

**Staff rating.** A total of 363 ratings were available for client living status at the time of leaving the program. A little over 49 percent were living in rented apartments or houses; 23 percent were using a voucher. The second biggest category was family and friends (23.4 percent), with 11.8 percent still in shelters and 2.5 percent still on the street, in encampments or living where humans are not intended to live.

The program is clearly successful for the vast majority of participants in keeping them from being literally homeless or living in emergency shelters. Half of those who left had achieved their goal of living in a rental apartment or house, and about half of these had rental subsidies so they could be reasonably assured of continuing to have affordable housing. The remainder of those discharged were still living in less permanent situations, typically with family and friends.

**Information from interviews with clients provides a more up-to-date picture of housing situations: living situations were better than at discharge for 27 percent of interviewees, including those who had left for negative reasons.**

Interviews were conducted between November 2007 and early June 2008. Staff ratings of client situations occurred at discharge, which in some cases took place 18 months or more before the interviews with clients. In virtually all cases, the interview data is more recent. However, it is less complete than staff ratings because only 67 percent were available to be interviewed.

The housing situation for interviewees was significantly better than for persons at discharge; at the time of Round III interviews 68 percent were in rental housing (25 percent with a voucher); 13 percent were with family or friends; and nearly 12 percent were in transitional shelters. Since only 48 percent of the interviewees were in rental housing at discharge, a significant gain in renting seemingly occurs after program participation ends.

We attempted to verify this finding by comparing the housing situation at discharge and the housing situation at interview only for those for whom an interview was completed in Round III. For 27 percent of interviewees (excluding those living in “other” situations, which are not readily classifiable) the living situation of persons assessed at discharge or the final evaluation improved by the time of the interview.

**TABLE 6: LIVING SITUATION OF INTERVIEWEES (MOST RECENT INFORMATION)**

<table>
<thead>
<tr>
<th>Living situation</th>
<th>Round III (N=201) Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary shelter or homeless</td>
<td>3.5</td>
</tr>
<tr>
<td>Reliant on family/friends/others</td>
<td>12.9</td>
</tr>
<tr>
<td>Transitional shelter</td>
<td>11.9</td>
</tr>
<tr>
<td>Rented housing</td>
<td>43.3</td>
</tr>
<tr>
<td>Rented with voucher</td>
<td>25.4</td>
</tr>
<tr>
<td>Other</td>
<td>3.0</td>
</tr>
</tbody>
</table>

In many cases, improvement in living situation took place without a voucher and after discharge. In fact, of the 53 families who improved their living situation, 23 (39 percent) had left the program for negative reasons. *Thus, it seems completing the program is not necessary for participants to improve their situation, though they may be using tools developed while they were program participants.*

In fact, one striking trend that emerges from the comments by clients is that finding housing appeared to solve their problems in many cases. And it is also striking how often program requirements (time limit, having to live in a shelter, getting to the program site) were cited by clients as having been a cause of difficulties.

**Lack of affordable housing and lack of earnings were the most frequently cited reasons for inability to find rental housing.**

Ninety-seven interviewees explained why they were not living in rental housing. The largest percentages in both rounds and overall indicated they were unable to afford the rent, and closely related was lack of earnings from a job or other source. Two personal barriers listed were bad credit and a record of eviction. Lack of affordable housing, lack of a rental subsidy and the high costs of moving (first and last
In each round over 50 percent said mental health services were helpful.

**Family support improved during the course of the project, which provides increased opportunities for assistance when homelessness threatens.**

Support from families and friends increased over time, so that while 59.4 percent had minimal support or none at admission, at final assessment this figure had declined to 35.1 percent.

**Most of the participants who were in long-term housing had been recipients of housing vouchers, but some found housing without vouchers.**

As described in Chapter I, strong evidence shows that housing subsidies are the critical ingredient in helping families find and retain permanent housing. Housing vouchers for participants were very limited for much of the study period, but increased starting in July 2007. In Round I (2003–04), only 50 Section 8 vouchers were allocated to the HCFP for over 400 participants; a few participants also accessed Shelter Plus Care vouchers designed for persons with ongoing serious mental health problems. The January 2007 CiMH evaluation report on the HCFP Round II recommended strongly that housing vouchers should be made available to all participants. In April of 2007 the DMH Homeless and Housing Division and the City of Los Angeles Housing Authority allocated the HCFP 100 Section 8 vouchers; another 100 were allocated in July 2007. In July the HCFP began processing applications for these vouchers. While many of the persons in the Round III study cohort were thus eligible for Section 8 vouchers, 45 had already left the program without having such access. Some vouchers were available, however, to participants through other programs. These include the Shelter Plus Care vouchers as well as some Section 8 vouchers allocated to individual providers and, in a few cases, through Chavez House (26 vouchers) and Beyond Shelter — programs sometimes used by HCFP participants.

A total of 238 persons among 473 study participants received a voucher at some time in the three-year study period; 158 vouchers were Section 8s, and 80 were Shelter Plus Care participants.

A total of 46 percent of the participants in Round III lived in a rented house or apartment at the final staff rating. Among those with no voucher, 24 percent lived in rented apartments or houses, compared to 67

---

**Reasons participants are not in permanent rental housing:**

“Even though I have a section 8 voucher, that will expire at [the] end of [the] month. My credit is an issue. I haven’t gotten help with my credit and low income, [which] have made me turned down.”

“I have not really been looking since I have been living with my daughter for about a year. I might look again when my son gets older.”

month’s rent, and need for furniture) are also cited.

Much smaller percentages of interviewees cite alcohol or drugs, domestic violence, mental health or a criminal justice record. A strikingly lower percentage of persons in Round III cited prior evictions, bad credit, lack of affordable housing or lack of a subsidy. We don’t know why this would be unless program admission requirements changed, and persons with some of these barriers were less likely to participate.

In addition we asked: “Specifically, we would like to know whether emotional or mental health problems are a barrier to finding permanent housing.” A third of the persons who were having difficulty finding rental housing said mental health was not a barrier, and another 10 percent denied having a mental health problem. Twenty-four percent said their mental health problem was a major barrier and 34 percent said it was a minor barrier.

**A majority of interviewees reported being very satisfied with the housing assistance they received from HCFP staff.**

Interviewees were also asked: “How satisfied are you with the help in finding housing you received from the Homeless CalWORKs Families Project, including the mental health agency, DPSS and LAHSA staff?”

Clients still enrolled in HCFP were much more likely to say they were very satisfied (75 percent) than were those who were no longer enrolled (55 percent). Among current enrollees only 1.7 percent were very dissatisfied, but 18 percent of those no longer enrolled were very dissatisfied.

We asked interviewees who did live in rented apartments what had been most helpful in enabling them to move there. Consistent with the greater availability of Section 8 vouchers, a higher percentage in Round III listed the vouchers as helpful; likewise, in Round II persons were more likely to get Shelter Plus Care vouchers, which were also listed as helpful.
percent of those who had received a voucher. Some 13 persons had received a voucher but had not yet been able to find housing at a place that would accept it; consequently, the category of those having received a voucher but not having permanent housing will decline, and the percentage of participants in permanent housing will increase proportionately to 75 percent.

Data pertaining to the initial 50 Section 8 vouchers that were allocated to the project show recipients to be successful in retaining rental housing. In 2005–06, about 85 percent (62 out of 73 HCFP participants) who were assisted in applying for housing vouchers were successful. Of the 62 persons granted a voucher, 56 (90 percent) obtained a lease and have maintained their housing; one person was unable to find a suitable apartment before the voucher expired; and five vouchers were terminated.

Data available from Housing Authority of the County of Los Angeles, which donated 50 Section 8 vouchers and administered 12 Shelter Plus vouchers for the 2005–06 cohort show that 85 percent of applicants are successful. Of the 11 who were unsuccessful, six failed to complete the application and the remainder were ineligible, particularly due to the criminal background check.

The time required from application until a lease was signed was considerable. Only seven completed the lease within three months, and more than six months (up to 14 months) elapsed for 47 others.

One person was granted a voucher but was unable to find an apartment and get it approved within the permitted time frame. Once having a lease, 56 maintained it (three of these relocated) while five left the vouchered housing — in three cases because of “tenant violation” or “non-compliance.”

We found no relationship between the limited demographic variables we obtained (race/ethnicity, number of children, single- or two-parent family) and maintaining the lease. This “success rate” of 90 percent compares very favorably with the previously mentioned nationwide 69 percent “lease-up” rate.

In 2007, the source of renter income was updated by the Housing Authority. CalWORKs was the sole source for 56 percent of renter participants, and it contributed to the income of another 28 percent. Only two persons were supported solely by wages, and three others reported wages plus other income. Other sources include SSA, SSI, alimony, child support, general relief, disability and adoption support. Thus, attaining affordable housing in 2005 or 2006 did not contribute substantially to achieving the CalWORKs goal of economic independence through employment.

WORK AND SCHOOL: STATUS AND OUTCOMES

For homeless parents who can quickly re-enter the labor force, finding employment is likely to be the fastest way to also find housing. While many participants have little history of employment, few skills, or face other daunting obstacles to employment, it appears a majority do or could work.

In general, employment provides more income than welfare. However, because of a generous CalWORKs allowance for earned income, persons who work as well as getting CalWORKs, and also receive Medi-Cal and food stamps, can for a time maximize their purchasing power. At admission, about 15 percent of HCFP participants worked some — slightly higher during Round III. Only 3 percent worked full-time (see Table 7).

### Table 7: Work Status at Admission (Both Rounds)

<table>
<thead>
<tr>
<th>Hours per week</th>
<th>Round II N=237</th>
<th>Round III N=216</th>
<th>Total N=453</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent</td>
<td>Percent</td>
<td>Percent</td>
</tr>
<tr>
<td>Not working</td>
<td>89.9</td>
<td>81.9</td>
<td>86.1</td>
</tr>
<tr>
<td>Less than 21 hours</td>
<td>6.3</td>
<td>8.3</td>
<td>7.3</td>
</tr>
<tr>
<td>21–31 hours</td>
<td>1.7</td>
<td>2.3</td>
<td>2.0</td>
</tr>
<tr>
<td>32 hours and over</td>
<td>2.1</td>
<td>3.2</td>
<td>2.6</td>
</tr>
<tr>
<td>Not sure</td>
<td>0</td>
<td>4.2</td>
<td>2.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
Successful HCFP Participants Speak: A Graduate with a Large Family

L’s story:

**Becoming homeless.** I was pregnant at the time I moved to Los Angeles and I had diabetes. My health condition was out of control and I didn’t have anybody to take care of my family. I had to stay in the hospital, in and out until I had the baby and stayed for almost nine months. I am the mother of nine children. Their dad is in their lives as well. Finally I received help from a program where they put the kids into a shelter but before we went into the shelter we were staying on the street.

**Mental health.** Everything was going on at the same time until I was introduced to the HCFP where they gave me therapy and tried to get me back on my feet. It wasn’t easy for me to adjust to the program because I had to stabilize the children first, make sure that all of the kids were in school; that was the first step and then to get mental health [services]. It was complicated because I had elementary children, I had high school children, I had babies and I had to get help for everybody.

**Career.** The HCFP was great and I’m glad that I was a part of it. They asked me what I wanted and I told them I wanted to go to school. I went back to school and I love it. I wish that more programs would be out there to better serve the people. That program, while you go to school, they support all the way, no matter what. Whether you have housing or not, they continue on supporting and making sure you get where you want to go. I’m majoring in child development. Just recently I wrote an essay to the head of the community college and I was surprised at the outcome: I was the winner. My children are all doing good. My oldest daughter will be graduating from college next week. I have one son who is getting ready for the American Olympic team. I have a son who is into cross country running and will be graduating this year and going to college. One older daughter went to community college. I do have special needs children. That’s something that’s a real challenge.

**Housing.** I did receive a Section 8 voucher within six months after being in the program. Whenever we looked for houses it was like a turndown because my family was really large. Finally, we found a home and we stayed in it almost a year. I ran into a situation where the owners fell out and had to go through court procedures, and I had to move out of the house. So now we are staying in motel to motel. They gave me an extension on the voucher. We are waiting on another house to move into now, but it’s been really hard because no one wants to rent to a large family.

**The program.** This was my first time being homeless. I paid taxes and I did all these things, but it was hard to get the help that I really needed. It wasn’t a whole lot but it gave me a push. It gave me the opportunity to feel good again in my lifetime. I’m still struggling with my health, but from being at this program I feel a whole lot better. I’m still making baby steps and I’m just thankful to be a part of the CalWORKs program. I just say, put your all in it, and never let any circumstances get to you. Whatever you do in your lifetime, you go through ups and downs, and you have to remember the children first.
**Employment history.** Employment history is generally the best predictor of employment while on CalWORKS. Overall about 12 percent of the sample had a three-year history of stable full-time employment, 15 percent had worked part time, 32 percent had only occasional or sporadic employment, and 40 percent had little or no employment. Thus, based on work history, the likelihood that employment will contribute toward obtaining adequate rental housing is low for at least 70 percent of the participants (see Table 8).

**Capacity to work.** Staff also rated the capacity of participants to become employed. Judgments took into account work skills, attitudes and beliefs, available supports (friends, family, child care, transportation), and impairment due to symptoms. While fewer than 15 percent of participants were rated as “very good,” only about 30 percent were rated “poor” or “very poor.” Well over half were rated as having good or acceptable capacities for employment. These ratings are substantially higher than found in the regular CalWORKs mental health program, where in our most recent random survey (in 2006) 52 percent were rated as “poor” or “very poor.”

**Staff judged that capacity to work increased for more than half of the HCFP participants.**

At final assessment staff rated change since intake in the capacity to look for, find or retain a job. **Strong positive change** was found for more than 15 percent of participants, and **some positive change** for 44 percent overall. **Negative change** was uncommon, but no change occurred for about a quarter of participants (see Table 9).

**Staff ratings show about half of participants are not working or involved in school or other work activities at the time of the final evaluation.**

**Staff ratings.** At the final staff rating in Round II, 55 percent of participants were not working at all. At the final rating in Round III, 47 percent were not working and had no work-related activities, but 20 percent were in training or school, or working as a volunteer (information not captured in Round II). In Round II, 21 percent worked full-time (32 or more hours a week) at the final evaluation, in contrast to 13 per-

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**TABLE 8: EMPLOYMENT HISTORY AT ADMISSION (BOTH ROUNDS)**

<table>
<thead>
<tr>
<th>Degree of employment</th>
<th>Round II N=237</th>
<th>Round III N=209</th>
<th>Total N=446</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primarily stable full-time</td>
<td>13.1%</td>
<td>10.0%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Primarily part-time employment</td>
<td>13.1%</td>
<td>18.2%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Sporadic or occasional</td>
<td>30.8%</td>
<td>34.4%</td>
<td>32.5%</td>
</tr>
<tr>
<td>Little or no employment</td>
<td>43.0%</td>
<td>37.3%</td>
<td>40.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

**TABLE 9: CHANGE IN CAPACITY TO FIND AND KEEP EMPLOYMENT (ROUND II AND ROUND III)**

<table>
<thead>
<tr>
<th>Degree of change</th>
<th>Round II N=153</th>
<th>Round III N=297*</th>
<th>Total N=450</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong positive</td>
<td>20.3%</td>
<td>16.5%</td>
<td>17.8%</td>
</tr>
<tr>
<td>Some positive</td>
<td>35.9%</td>
<td>48.8%</td>
<td>44.4%</td>
</tr>
<tr>
<td>No change</td>
<td>28.1%</td>
<td>23.2%</td>
<td>24.9%</td>
</tr>
<tr>
<td>Negative change</td>
<td>4.6%</td>
<td>8.4%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Can’t judge</td>
<td>11.1%</td>
<td>3.0%</td>
<td>5.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

* Includes 73 held over from 2005–06
cent in Round III. Similarly, more people in Round II than Round III worked part time (24 percent vs. 18 percent). A few persons were exempt or between jobs.

**Round III interviewees reported somewhat higher labor force participation than did staff.**

Interviewees were asked about their current labor market status. No statistically significant difference emerged between Round II and Round III, but a distinction was evident between the participants still enrolled in the program and those no longer enrolled. Persons in Round III who had left the program were less likely to be students (18 percent vs. 37 percent), more likely to be looking for work (19 percent vs. 5 percent) and also more likely to be “not working” (10 percent vs. 2 percent). The percentage working full-time was the same in each group (19 percent). The percentages working part time were close (11 percent vs. 14 percent), as were the percentages of disabled (10 percent vs. 7 percent). Thus, 55 percent of interviewees in Round III were working or going to school. Recall, though, that the sample of persons interviewed appears to be biased toward better-functioning participants (see Table 10).

**Total income for interviewees was from a variety of sources, and averaged about $925 a month.**

Round III interviewees reported income from a variety of sources, including employment, entitlements, unemployment insurance, general relief, child support and the U.S. Department of Veterans Affairs. Income averaged $925 a month (with no significant difference between rounds), but exhibited substantial range, with almost 20 percent of interviewees reporting a monthly income of less than $580 and a quarter with an income of over $1,220. The portion of the $925 per month that came from employment was $289. These figures are probably somewhat higher than for the entire sample, as the sampling was tilted toward the better-functioning participants.

**Earned income was reported by one third of interviewees.**

Interviewees. One third of the interviewees had income from employment. There was no difference statistically between the persons currently enrolled and those who had left the program, or between Round II and Round III. The average monthly earned income was $922 for those working. Only 12 percent of all interviewees had earned income of $1,000 or more a month (see Table 11).

TABLE 10: ROUND III LABOR FORCE STATUS OF INTERVIEWEES, BY WHETHER STILL IN THE PROGRAM OR NOT

<table>
<thead>
<tr>
<th>Work status</th>
<th>Currently in program</th>
<th>No longer in program</th>
<th>Combined N=203</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=57  Percent</td>
<td>N=146  Percent</td>
<td>Percent</td>
</tr>
<tr>
<td>Student</td>
<td>36.8</td>
<td>18.5</td>
<td>23.6</td>
</tr>
<tr>
<td>Full-time employment</td>
<td>19.3</td>
<td>19.2</td>
<td>19.2</td>
</tr>
<tr>
<td>Looking for work</td>
<td>5.3</td>
<td>19.2</td>
<td>15.3</td>
</tr>
<tr>
<td>Unemployed and not looking</td>
<td>12.3</td>
<td>12.3</td>
<td>12.3</td>
</tr>
<tr>
<td>Part-time employment</td>
<td>14.0</td>
<td>11.0</td>
<td>11.8</td>
</tr>
<tr>
<td>Disabled</td>
<td>7.0</td>
<td>9.6</td>
<td>8.9</td>
</tr>
<tr>
<td>Not working, other reason</td>
<td>1.8</td>
<td>10.3</td>
<td>7.9</td>
</tr>
<tr>
<td>Laid off</td>
<td>3.5</td>
<td>0</td>
<td>1.0</td>
</tr>
</tbody>
</table>

**TABLE 11: ROUND III INTERVIEWEE-REPORTED MONTHLY INCOME**

<table>
<thead>
<tr>
<th>Total monthly income</th>
<th>N=314  Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100–580</td>
<td>18.8</td>
</tr>
<tr>
<td>$581–720</td>
<td>19.7</td>
</tr>
<tr>
<td>$721–860</td>
<td>17.8</td>
</tr>
<tr>
<td>$861–1220</td>
<td>19.1</td>
</tr>
<tr>
<td>$1,221–2,522</td>
<td>24.5</td>
</tr>
</tbody>
</table>
CHILD WELL-BEING: STATUS AND OUTCOMES

Approximately three-fourths of the school-aged children in the program attended school regularly.

Staff reported that at admission, two-thirds of the school aged children attended school regularly, 16 percent were less regular and about 8 percent were irregular in attendance. (This question was not asked the same way in Round II.) At discharge the Round III figures show: 77 percent attended school 4–5 times a week, 15 percent attended most weeks but less than four days a week, and 8 percent attended sporadically. (Note that staff were unable to judge school attendance for 16 percent of school-aged children in the program.)

In the interview sample (combining both rounds), all except eight of the 426 children in these families were enrolled in school if they were 5 years of age or older. Among those enrolled, 95 percent were reported to attend regularly, 4 percent sporadically, and 1 percent not at all. Taking into account both non-enrollment and less-than-regular attendance, only 7 percent do not attend regularly. The difference between this 93 percent figure and the 77 percent reported by staff appears to be related to two factors. First, the interview information is very detailed; it is unlikely that staff inquired at the same level of detail (substantiated by the 16 percent who said they could not judge). Second, the interview sample is biased toward the more successful clients. If we look at the staff ratings for those interviewed in comparison to those who were not, the interview sample is shown as having 81 percent regular attendance as opposed to 67 percent for the participants we were unable to interview. So the true figure for regular attendance likely is somewhere between the 77 percent and 93 percent figures.

About 14 percent of the parents told staff that at least one child had school, emotional or health problems.

In Round III staff were asked: “At the time of admission, did any of the client’s children have significant physical health, mental health or developmental problems that may affect the client’s ability to find employment?” (This question was more comprehensive than a similar one asked in Round II.) Of 213 responses, 14 percent reported such a problem, 69 percent reported children did not have such problems, and in 17 percent of the cases staff were unable to judge.

Reason getting medical/dental care was difficult:

“With medical and dental, the insurance plans kept changing. We had to wait to get the cards in the mail for coverage.”

“Transportation is my problem because the dental office and doctor’s office is pretty far. And financially because I have to take all of them with me and I have to pay for all of them, so it’s financial too.”

“I’m looking for a dentist who will provide service for her. I haven’t been able to find one.”
in shelters on children (5 families), concerns about gang influence on children (2 children), and children affected by domestic violence (one family).

**Referrals for services of children in the family increased from Round II to Round III, but interviewees reported that some children did not get needed care.**

In Round II, 21 percent of the final assessment forms filled out by staff reported a child in the family was referred by HCFP staff to a specialized program outside the HCFP agency for a mental health, developmental or other problem. In Round III, 27 percent received such a referral.

Parental follow-up on the referral increased from Round II to Round III: from 29 percent to 41 percent. (In Round III, another 18 percent “partially” followed-up.)

Other children were referred to outside programs for medical care. In Round II, 15 percent of the forms reported a child received a referral for medical care, developmental care, or other needed care. In Round III, the percentage was 31 percent.

**Reason for food insecurity:**

“Food is our issue. When we came into transitional housing, they cut our food stamps in half. Before we were making ends meet, but now we’re not. My daughter and I both have specialized diet so we can’t just eat the food that’s offered.”

“I don’t get enough food stamps and my daughter is Type 1 diabetic and doesn’t always get special dietary food. I have to buy cheap food and eat cheaply. I don’t buy meat or fruits and vegetables. I have no transportation to the store so only get what I can carry home.”

“I only get $208 in food stamps and I have a 265 lb., six-foot-two-inch, 17-year-old [son]. He eats a lot and food runs out quick. Luckily there’s a food bank three blocks away so we get food once a month.”

Interviewees in Round III reported their children usually got needed medical care in the prior three months (79 percent said **always**, 16 percent said **sometimes** and 5 percent said **never** but the fact that fewer than 100 percent had consistent access to medical care is of concern because all children should have been covered by Medi-Cal (unless they had withdrawn from Med-Cal since leaving the HCFP). For dental care the comparable figures were 70 percent, 15 percent and 15 percent. There were few differences between Round II and Round III on these measures.

A third question investigated the parents’ view of how often during the past three months children had received the specialized care they needed for emotional or behavioral problems. More than half of the parents said such treatment was not relevant to their children, but 40 percent of Round III parents said it was relevant. Of these 80 respondents, 50 percent said their child or children received the needed care **always**, 15 percent said **sometimes**, and 35 percent said **never**. Although the numbers are small, the percentages in which the interviewees said children never got needed care ranged from 0 percent to 55 percent at the six service sites.

**Some HCFP Round III interviewees reported getting assistance with obtaining child support, but some parents said they were given no child support (despite a child support order) and received no HCFP assistance with securing child support.**

Under CalWORKs, county agencies are charged with obtaining child support orders if appropriate and enforcing them when they exist. In Round III a somewhat higher percentage of interviewees reported that their oldest child had a child support order than in Round II (38 percent compared to 28 percent). However, 53 percent of these reported that they received no child support in Round III (45 percent in Round II). Only half of those receiving any child support reported getting the full amount.

In the Round III interviews, 15 percent of families reported that HCFP helped them obtain child support that was owed. Of these, 90 percent were at least somewhat satisfied with the help they received. However, 35 persons in Round III who had a support order received neither child support nor assistance from the HCFP. This finding does not necessarily suggest the HCFP was remiss, but does indicate that even with a court order a significant proportion of parents don’t receive the support for their children to which they are entitled.

**A small number of children were placed out-of-home by child welfare services during the study period.**

According to staff reports, at admission 5 percent of the families had children who had been placed out of home. In the three-year study period, 20 families had a child removed (4.3 percent), six families had a child restored and 12 families had an official reunification plan.
Interviewees in 7.5 percent of the families said that at least one child was placed elsewhere by child welfare services at the time of the interview.

A large majority of interviewees who received assistance regarding child custody (and other legal issues) were very satisfied with the assistance provided.

In Round III, 28 families (14 percent of interviewees) received assistance regarding child custody, child welfare or other legal problems. Two thirds of them said they were “very satisfied” with the help they received, and another 29 percent were “somewhat satisfied.” Only 7 percent said they were dissatisfied.

Interviewees reported substantial “food insecurity,” and 10 percent reported that a child had gone hungry in the prior 60 days.

Twenty-four percent of interviewees in both rounds (with very little difference between rounds) reported that the statement “the food I bought just didn’t last, and I didn’t have money to get more” was often true for them during the prior 60 days. “Cutting the size of meals or skipping them altogether” was reported by 33 percent. “Using a food bank in the past 60 days” was reported by 25 percent. Ten percent said that “there was a time in the past 60 days when my children were hungry because I could not afford to buy food.” However, going hungry occurred for more than four days in a 60-day span for only two families. Interviewees who had been discharged were more likely to report food insecurity. For example, children being hungry was reported by 12 percent of those no longer in the program and 4 percent of those in the program. Food insecurity of this magnitude or greater is common among recipients of CalWORKs and families living in poverty.

DOMESTIC ABUSE: STATUS AND OUTCOMES

Twenty percent of Round III participants were judged by staff to experience domestic abuse from past partners during the time they were enrolled, and 10 percent from current partners. Moderate to extreme abuse was experienced by 14 percent.

Significant (moderate, serious or extreme abuse) during the HCFP Round III study period occurred for a total of 42 of 308 persons (13.6 percent), as described by staff on a standardized scale. Twelve persons (3.9 percent) said they were abused by a current partner; 36 participants (11.7 percent) were abused by a past partner; and six (2 percent) had both past and current abusers.

Interview respondents. Trauma due to physical, sexual or emotional abuse, rape, or other violence is extremely common in this population. In Round II, 79 percent of respondents reported one or more of these traumatic events in the course of their lives, and in Round III it was 83 percent.

In Round III, only three persons (1 percent of respondents) said they felt unsafe in their current relationship. However, 41 persons (13 percent of respondents) said a partner from a previous relationship was making them feel unsafe. Fifteen persons (4.8 percent of the respondents) had been hit, kicked, punched, otherwise hurt or sexually assaulted in the prior two months — only one of these by a current partner, six by a past partner, and six by an unrelated person.

**TABLE 12: ACTIONS TAKEN TO DEAL WITH DOMESTIC ABUSE SITUATION (ROUND III)**

<table>
<thead>
<tr>
<th>Action</th>
<th>Current partner N=37 Percent</th>
<th>Ex-partner N=68 Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Went to a DV agency</td>
<td>13.5</td>
<td>13.2</td>
</tr>
<tr>
<td>DV shelter</td>
<td>8.11</td>
<td>5.9</td>
</tr>
<tr>
<td>Got a restraining order</td>
<td>10.8</td>
<td>7.35</td>
</tr>
<tr>
<td>Moved</td>
<td>18.9</td>
<td>23.5</td>
</tr>
<tr>
<td>Moved to secret location</td>
<td>8.1</td>
<td>5.9</td>
</tr>
<tr>
<td>No formal help</td>
<td>62.1</td>
<td>55.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Moving was the most common action taken to deal with situations of abuse.

Staff in Round III reported that participants who experienced domestic violence took various evasive and corrective actions. Of those, moving was most common (reported by 27 percent who experienced abuse from a current partner and by 29 percent of those with abuse from an ex-partner). About 20 percent went to a DV agency or shelter. Over half, however, sought no formal help (see Table 12).

Interviewees. Past physical and sexual abuse was extremely common. In Round II, 79 percent of interviewees reported trauma during their lives due to physical, sexual, emotional abuse, rape or other violence; in Round III the figure was 83 percent. Nearly half of the respondents reported child physical abuse, and almost that percentage experienced child sexual abuse. Adult physical and emotional abuse was reported by three fourths, with adult sexual abuse by one third. Three fifths had also witnessed or been the victim of other violence. There were no significant differences between rounds.

Eighty-seven Round III respondents reported some level of recent family abuse or trauma; of these, 71 percent said they talked to someone about the abuse or asked for help. The most common action was talking to a counselor (92 percent did), followed by talking to a friend (42 percent did), talking to the police (25 percent did) or talking to someone at a domestic violence shelter (15 percent). But approximately 10 percent had gone to court and 10 percent had talked to a physician. Twenty-nine persons said they were separated from the person who was abusive.

About 40 percent of participants experiencing domestic abuse were able to make positive changes.

Domestic violence was considered relevant by staff for 21 percent of the clients. Of these, 19 percent made strong positive change, 24 percent made some positive change in their situation, 11 percent had negative change and the remainder did not change. Differences between Round II and III were not significant (see Table 13).

Only about 5 percent of participants had a domestic violence CalWORKs waiver, a low proportion of those reporting serious abuse.

In Round III, 18 participants (6 percent) had a domestic violence waiver at discharge or final evaluation; in Round II it was 5 percent. These figures are slightly lower than the percentage having a waiver due to domestic violence at admission, presumably due to favorable resolution of the domestic violence situation.

When Round III participants with moderate to extreme abuse at final assessment were compared with those having a waiver, only seven of 39 persons had a waiver; limiting the analysis to those with

<table>
<thead>
<tr>
<th>Change in domestic abuse situation</th>
<th>Round II N=</th>
<th>Round III N=</th>
<th>Total N=</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent</td>
<td>Percent</td>
<td>Percent</td>
</tr>
<tr>
<td>Strong positive</td>
<td>5.1</td>
<td>4.1</td>
<td>4.5</td>
</tr>
<tr>
<td>Some positive</td>
<td>4.4</td>
<td>5.9</td>
<td>5.4</td>
</tr>
<tr>
<td>No change</td>
<td>7.4</td>
<td>12.1</td>
<td>10.6</td>
</tr>
<tr>
<td>Negative change</td>
<td>4.4</td>
<td>1.0</td>
<td>2.1</td>
</tr>
<tr>
<td>Not applicable</td>
<td>57.4</td>
<td>69.3</td>
<td>65.5</td>
</tr>
<tr>
<td>Cannot judge</td>
<td>21.3</td>
<td>7.6</td>
<td>12.0</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
serious or extreme abuse, only four had a waiver while 18 did not. There could be many reasons for this, including client choice.

SUBSTANCE ABUSE OUTCOMES

Substance abuse — by itself and as a contributing factor to emotional problems and to domestic violence — affects homelessness for only a small percentage of HCFP participants, but clearly interferes with successful completion of the program.

Ten percent of the participants in the two cohorts combined were judged by staff to abuse or be dependent on alcohol or other drugs at admission. This percentage varied significantly by site, from as low as 2 percent to as high as 17 percent.

Reliable comparisons of substance use at intake and discharge are available only for Round III. Of those who were rated both times (254 persons; 16 percent were not rated at intake), 227 were abstinent or rated as having minor use at both rounds (89 percent). Twenty-one persons who had been abusing achieved abstinence versus six who went from abstinence to abuse. In addition, six persons who had a substance abuse or dependence problem at discharge in Round III were not rated at admit. Seemingly there was positive change, but it was small.

Substance abuse or dependence was a strong predictor of negative reasons for leaving the program: Of the 33 persons with abuse or dependence listed at either intake or discharge, 69 percent expressed negative reasons for leaving the program (vs. 32 percent for those without a substance abuse issue).

Round III interviewees reported very little current substance abuse or dependence, but a substantial proportion of them were in recovery.

- Heavy drinking: 15 percent of interviewees answered questions in such a way as to indicate they are “heavy drinkers.” Two people, asked to categorize themselves, said they were “an alcoholic.” Eight percent, or 25 persons, said they are recovering alcoholics.

- Drug use: 27 persons (8.6 percent) reporting illicit use of a drug during the previous 60 days. Two persons, asked to categorize themselves, said they were a “drug addict.” However, 41 (13 percent) reported being a recovering drug addict.

- Substance use interference with work or school or home: Only three persons said substance use in the prior two months had interfered with their functioning. None said they had lost a job or had job problems due to substance use. An employment drug test was reported by 60 persons, and 56 said they passed it.

Fourteen percent of interviewees reported 12-step attendance for past problems.

Fourteen percent of the Round III interviewees reported attending a self-help group like AA or NA in the prior two months, and 7 percent said they currently had a 12-step sponsor.

Staff rated one third of the persons whose substance abuse problem they knew about as having improved during the course of the study period.

“Substance abuse” and “substance dependence” are DSM IV defined disorders. But persons can have problems with use of alcohol or drugs without fitting the diagnostic criteria. Based on the number whose use of alcohol or drugs was rated by case managers (as opposed to being rated not applicable), at least 34 percent of participants in both rounds were known to have or have had a substance use problem of some magnitude; two-thirds of these participants, however, had not been given formal diagnoses of “abuse” or “dependence.” This percentage varied significantly by site: three sites reported 11 percent with a substance use problem; the others reported 28 percent, 32 percent or 45 percent.

Staff at some sites attempt to treat substance abuse themselves, while others refer. A total of 17 percent of participants were referred for substance abuse treatment. While 37 percent of these left the program for noncompliance, 25 percent left because they completed the program successfully.

As judged by case managers, there was “some positive change” in 31 (33 percent) of the persons having some degree of problems with substance use, “no change” in 37 (39 percent) and “negative change” in 27 (28 percent).
Successful HCFP Participants Speak: A Graduate Who Survived Domestic Abuse

K’s story

Becoming homeless. I have two kids, [ages] 11 and 8. This is my first time being homeless. I was in a domestic violence shelter for 22 months before coming to this program. If I became homeless from losing a job I could respect that a little more than getting beat up and being homeless, you know. Emotionally it was just like a roller coaster.

Mental health. When I was in the domestic violence shelter you had to go through GAIN. GAIN required me to go to mental health [services]. I started going and about my third meeting they said there’s a program that would be good for you, but it’s a year’s commitment. Not even a week later, I was getting a call from one of the people at the HCFP program to meet. You have a meeting with the team and then they contact you back. They work on it really fast. I was having mental issues and they were telling me you have post traumatic stress disorder and there was a lot going on with the blues and stuff and the domestic violence and trying to be with the kids and trying to explain to them. If I didn’t get the help I got, who knows what kind of mental status I’d have now?

Housing. They said they would help get me into an apartment. After getting into this program I got my voucher in April or May and moved out of the shelter in September. Now, I’m doing really good.

Career. I was going to school before I started in this program. I was taking medical assistant [training] in school and I finished last May. I’m a phlebotomist right now. I’m glad, you know. I’m working and the kids are in a school that they like. All the mental issues that I had, it’s gone.

The program. I’ve always done things by myself. Even having a partner, it was by myself. Now I have this whole team and a whole network of people behind me, so it was cool. They are not doing it for a paycheck. They actually care. It’s not just a team; it’s a team for me.
CHAPTER IV: POLICY ISSUES AND RECOMMENDATIONS

The information in the report can be used to clarify several important policy issues raised either by report analyses or the new family homelessness literature. Our recommendations draw on visits to each site and the literature as well as the empirical findings.

HOUSING ISSUES

How important are rental subsidies to the HCFP program?

The primary goals of the HCFP are helping participants find permanent housing and become prepared to participate in the labor market. While neither goal is more important than the other (they reinforce each other), finding permanent housing is temporally primary. If the program cannot assist participants with permanent housing, it also risks high dropout rates among dissatisfied participants — negating both goals. What is the evidence that absent housing vouchers, the program is successful in helping participants move into permanent housing?

Although not planned, the history of the program provides a natural experiment. During the period January 2005–July 2007, only 50 dedicated vouchers were available for the roughly 700 program participants in that time. During fiscal year 2006–2007 no dedicated vouchers were available, although vouchers were available through some other sources. In contrast, starting in July 2007 virtually all program participants who met eligibility standards could have applied for and received a voucher. What is the difference in the rate of those attaining rental housing in the period with few vouchers compared to the period with a relatively large number? The study cohort for Round III included both periods. The rate in this cohort of persons in rental housing after discharge was 29 percent if the family did not have a voucher, compared to a rate of 69 percent of those who did receive a voucher. The latter rate will increase because many of those receiving a voucher are still looking for housing in which to use it. In fact, our follow-up study of the persons receiving vouchers in the 2005–2006 year showed that 90 percent of those who received a voucher were able to use it and still maintained voucher-subsidized rental housing two years later.

Note that, as described in Chapter I, other studies also have failed to show that services alone are an effective intervention for family homelessness, while many studies show that housing subsidies are effective.

Recommendation 1

It is critically important for the Los Angeles County Board of Supervisors and the agencies involved in the HCFP program to take all necessary actions in order to retain the existing HACLA (Housing Authority of the City of Los Angeles) vouchers and obtain 200 more for the next year.

Could changes in policy and practice help make the HCFP services less disruptive for families?

The increase in Section 8 vouchers has made the process of finding permanent housing for many project families more feasible. However, some requirements that accompany these vouchers — and the HACLA vouchers in particular — significantly impede the ability of these families to succeed in the programs.

- Section 8 vouchers require applicants to live in a shelter (or at least not with family or friend or where perceived to be paying rent) in order to qualify for the voucher. When families exhaust their 120–day maximum limit for shelter stays, they often have to “bounce” from placement to placement, with each successive relocation often short-term and typically requiring changes of schools for the children. In addition, applications for vouchers also may be delayed by these moves. Despite the serious consequences of exhausting the 120 days, the program does not do everything it can to obtain a voucher and permanent housing within the 120-day period. (With the HACLA vouchers that seems now to be a reasonable goal, though in the past it was not.) In fact, although the requirement of a waiting period has been reduced over time, the program still requires participants to wait 30 days before applying for a voucher. In some cases delayed DMH assessments also contribute families expending some of their 120 days before a voucher application is submitted. We recognize, however, that not all families come to the program having all 120 days still available.

- Participants in Covina, San Gabriel and near Pacific Clinics (and to some extent North
Hollywood) are highly likely to have support systems in their region; they want to live near where they do currently and want their children to be able to attend their neighborhood school. The location of shelters and the Section 8 requirement that applicants live in a shelter force families to move from where they want to live and where they get services. Additionally, if they get a voucher from the city, they must establish their permanent housing in the city of Los Angeles (for at least one year). Both the shelter locations and the requirements to live in the city of Los Angeles also cause many children to change schools, sometimes two or more times.

“\textbf{The program is in Covina and I am in L.A. It was hard for me to make appointments due to the fact that my car went out; it was harder for me with my school and the children’s school. I couldn’t spend two hours on the bus.} ”

“They need to allow kids stability by staying at the same schools not constantly moving. They need better resources and stuff. I did [a] better job of gathering resources. They need to help people who are homeless but not in the shelters. They wanted me and my kids to move to a shelter in South Central before helping us!”

**Recommendation 2**

- The Steering Committee should set an overall program goal of obtaining permanent housing within 120 days, and enact policies and practices that support this goal. While that desirable outcome may not always be attainable, all efforts should be made to try to achieve it.

- HCFP administrators should consider the possibility of making HCFP services much more available in or near the shelters where people actually stay, thus cutting down on the burden of transportation for participants.

**SERVICE NEEDS**

The recommendations above regarding vouchers and organization of housing services apply to all or most participants. Numerous service needs are limited to a subgroup of participants. In some cases we believe services should be added; in others, existing services might be reorganized into separate “paths” to better serve participants with differing reasons for being homeless and differing mental health needs.

*Should the HCFP model explicitly include services for children?*

A number of findings and results from the literature stand out:

- Several studies, including the randomized controlled study of Samuels, indicate that children are beneficiaries of programs like the HCFP. This may be due in part to the improved parenting skills reported by staff in the HCFP.

- At least 40 percent of families have reported service needs of their children to staff, with 24 percent reporting a need for mental health services. Staff reported referrals for 21 percent.

- Interviewees reported that children did not always get needed medical and dental care, and that children experienced a substantial amount of food insecurity (10 percent of families reported a child who had been hungry in the prior 60 days).

- Some HCFP sites are able easily and quickly to provide services for children within their own agencies; others have great difficulty arranging referrals. In, general mental health programs bifurcate services to children and adults, and family-oriented services are not common.
Recommendation 3

The HCFP is conceived as an intervention for parents. We recommend making the well-being of children an explicit focus as well. Specifically, because children in families who experience homelessness often undergo trauma and are at high risk for emotional problems, HCFP should ensure ready availability of assessment and treatment for children with mental health needs at all sites. Difficulties that interviewees report in their efforts to obtain medical and dental services also should become an explicit focus for HCFP case management interventions.

Does the HCFP model need to explicitly include domestic violence services?

Domestic abuse plays several important roles for HCFP participants. In the first instance, it is a cause of homelessness. Staff cited abuse as a reason for being homeless in 7 percent of participant families, but 27 percent of interviewees cited domestic abuse as a reason for homelessness. Abuse was the most commonly cited reason among interviewees, and was cited two and a half times more often than were mental health problems.

Also, domestic violence was an ongoing issue for many participants. Twenty percent of Round III participants were judged by staff to experience domestic abuse from past partners during the time they were enrolled, and 10 percent from current partners. Moderate to extreme abuse was experienced by 14 percent. Among interviewees, 13 percent reported a past partner was making them feel unsafe. Fewer than a fourth of Round III participants with serious or extreme abuse (judged by staff) had a CalWORKs domestic violence waiver.

About 40 percent of participants experiencing domestic violence were able to make positive changes, but 11 percent had negative change and about half did not change — leaving considerable room for greater positive change.

Recommendation 4

Given the substantial role played by domestic violence in the lives of many participants, HCFP staff should be qualified to address many domestic abuse issues as part of the program. We recommend that each site should have at least one staff member who has completed a state-approved 40-hour domestic violence certificate program, and preferably that when possible, the agency should seek staff job applicants who have worked as domestic violence counselors.

Should the HCFP model explicitly include substance abuse services?

Relatively high prevalence of substance abuse problems (including maintaining recovery), negative consequences of substance abuse for HCFP goals, and limited capacity of HCFP programs to help with substance abuse are documented in the report.

- **Prevalence**: Although staff rated only 10 percent of participants as exhibiting substance abuse or dependence, 30 percent had some sort of problem with alcohol or drugs. Interviewees did not report many current problems, but 8 percent were recovering alcoholics and 13 percent recovering drug addicts; 14 percent said they attend 12-step meetings.

- **Consequences**: 69 percent of those participants whom staff identified as having abuse or dependence left HCFP for negative reasons (vs. 32 percent for those without abuse or dependence).

- **Effectiveness**: At the final evaluation, case managers determined that the condition of 67 percent of participants with alcohol or drug problems remained unchanged or deteriorated.

Recommendation 5

Allocation of at least one HCFP staff member at each site with substance abuse training and certification would be desirable. The Los Angeles Department of Mental Health has recently concluded an agreement with the Los Angeles Department of Public Health (Alcohol and Drug Program Administration) that will incorporate a part-time substance abuse specialist into each HCFP site. This is a very constructive action.

Does the HCFP, as it currently exists, provide the best practices for serving homeless CalWORKs participants with moderate to severe mental health problems?

A wide range of functional impairment is associated with mental health issues among HCFP participants. The more serious problems may need enhanced services.

- **Prevalence**: A relatively small percentage of HCFP participants have serious and persistent mental illness (8 percent) or are clearly functionally
disabled by their psychiatric disorder (14–29 percent). Some of these participants apply for SSI, but most do not, and as many as half of those applying for SSI are rejected.

- **Effectiveness:** Recall that participants express a wide range of positive and negative reasons for leaving. Among those with positive reasons for leaving, the exit GAF score was an average of 61; for those with neutral reasons it was 56; for those with negative reasons, 52. Among those who scored less than 40 on the GAF, 80 percent had a negative reason for leaving; and among those with scores between 41 and 50, about 65 percent left for negative reasons.

The finding above used staff ratings at time of discharge. The SF-12 mental health scale was administered to interviewees and produces the same finding: The highest mental health score is found in those still in the program, followed by those who left for positive reasons, then by those leaving for neutral reasons, and finally by those leaving for negative reasons. The score of the latter group (mean of 37.7) is roughly equivalent to scores of clinically depressed outpatients in the SF-12 reference group. Similarly, the lowest SF-12 mental health scores for interviewees are found among participants with minimal treatment participation (as rated by staff).

These findings parallel the conclusion of Samuels, noted above, that a relatively small subgroup of persons with serious mental health problems were not helped by assignment to receive services.

**Recommendation 6**

HCFP administrators should consider a separate path for the 15–30 percent of individuals who have serious functional impairment due to mental health problems, or who have co-occurring substance abuse or domestic violence and thus need integrated treatment. These persons might start individual therapy and/or medications immediately, and a long-term treatment program would be expected. Individual consideration of how mental health and substance abuse/domestic violence status affect both housing and employment would be a focus from the beginning. Introduction of GAIN activities might be delayed for this group. These persons probably will need special attention to help them stay in treatment rather than dropping out.

**Does the HCFP program need to provide mental health treatment services for most HCFP participants?**

A number of findings raise the question of whether mental health treatment (individual or group therapy or medications) is a necessary component of services for most participants. This issue concerns only treatment, not the mental health case management services and life skills development services provided by mental health staff.

- The previously cited Samuels study — in which a treatment group and a randomized control group that received no mental health services showed the same reduction in symptoms — suggests that for many persons most symptoms are due to the trauma of homelessness itself and are greatly reduced when housing is found. In the first CiMH evaluation report on the HCFP we found: “Positive change on SF-12 mental health status was associated with having a place of one’s own at follow-up. Thus, the data are consistent with the hypothesis that positive change in mental health status results from having permanent housing.”

- In support of this idea, many HCFP participants choose to stop mental health services once they are in permanent housing, which the interviews suggest is due to the participants’ belief that they do not need those services.

- The percentage of participants receiving at least one individual therapy visit per month varies dramatically by site. The site with the lowest individual therapy rate is also the site with the highest rate of participants finding permanent housing. Other factors are involved, but individual therapy clearly is not a necessary component of services for all.

- The HCFP is designed for persons with mental health problems that are barriers to finding housing. Both clients and staff answered questions regarding the extent to which that premise was true. Clients: only nine of 203 interviewees cited mental health status as a reason for being homeless; only 15 persons (7 percent) said mental health status was a major barrier to getting housing (another 37 said it was a minor barrier). Staff: At intake, staff cited mental health as a reason for becoming homeless for 14 percent, and said it was a barrier to finding housing for 35 percent. Thus, the
diagnosed mental health condition of a majority of participants is not viewed by staff or clients as a barrier to housing success.

**Recommendation 7**

HCFP administrators should consider developing a path for persons whose symptoms are believed to be due to situational stress — symptoms that can be expected to decline substantially when housing is found. The focus for this group would be addressing barriers to housing and obtaining a voucher and housing quickly. Daily living skills and money management as well as case management, rather than therapy, would be the focus. After finding housing, participants would continue to be offered mental health support, and some who had not used individual therapy or medications might find doing so desirable at that point. GAIN activities would be a focus from the beginning. A non-stigmatizing name for the services — like “Families in Transition” — would help attract and retain this group of persons who rightly feel they are not defined by their emotional distress or their homelessness.

A subgroup of these participants consists of families who were functioning quite well and had a significant work history prior to finding themselves homeless. Twelve percent of HCFP participants entering in 2006–2007 (and probably higher now) had a three-year history of stable work before becoming homeless. It may be possible to use the DPSS 24-month rent subsidies for these persons rather than Section 8 vouchers while focusing just on regaining employment. This expectation could be identified and communicated to these families early in the program.

**PROGRAM ELIGIBILITY**

*Given that the HCFP is an intensive program in an environment of limited resources, what criteria should be used for determining eligibility for the program?*

Thousands of homeless families participate in CalWORKs each year. A significant proportion have mental health problems. In the first CiMH evaluation we used a variety of data sources to estimate that as many as 3,450 adult family members with mental health problems are CalWORKs participants who have been homeless during a year. HCFP clearly does not have sufficient resources to serve all of these families. What should determine the choice about which families to admit?

- One possibility is to focus resources on those families whose homelessness is more severe. As noted in Chapter 1, this is the approach of supportive housing (in which services are available at the housing site). DPSS data suggest that about a quarter of homeless CalWORKs families have been homeless more than once during the past three years, and about a quarter have been homeless for more than three months. Some types of families, in addition to having a mental health problem, have particular difficulty finding housing — very large families, those with domestic violence victims, and those headed by single fathers, for example.

- A second possibility is to focus resources on people with serious mental health problems, which will clearly be a barrier to housing and welfare-to-work success. As noted above, this group probably comprises 15 percent to 30 percent of current HCFP participants.

- During the past 18 months the program has moved toward giving priority to persons who are believed willing and able to utilize the welfare-to-work elements of the program. That is, there is an emphasis throughout five of the six programs on screening for persons who will comply with welfare-to-work requirements, and in four of the programs, there is a strong focus on working with participants around education.

**Recommendation 8**

The findings in this report do not specifically lead to policy recommendations about eligibility criteria. Indeed, inherent conflicts arise among the three possibilities laid out here as — based on our findings — persons with the greatest housing or mental health needs are unlikely to be those most capable of succeeding in welfare-to-work activities. One option would be to continue to serve all three groups but have separate “tracks” for the different subpopulations, with somewhat different service constellations and different goals and expectations.
Many of the affordable housing units, though, are out of commission at any given time, and a substantial portion are occupied by persons with incomes over the threshold used in the analysis for low income. Shinn, M. (2002). “Homelessness: What Is a Psychologist to Do?” in, A Quarter Century of Community Psychology: Readings from the American Journal of Community Psychology: (Ed) Tracey A. Revenson, Springer.


California Budget Project. (2000). Housing Matters for CalWORKs Families. No more recent data is available from the California Department of Social Services.


California Budget Project. (2000). Housing Matters for CalWORKs Families. No more recent data is available from the California Department of Social Services.


13 Personal communication from Dan Flaming, Economic Roundtable. The definition of homelessness used is the “indicator” or “flag” entered into the DPSS GAIN data system when homelessness is reported.


28 In our first study of the HCFP we reported that CalWORKs participants receiving mental health services through CalWORKs supportive services had a more severe picture if they had been homeless in the year. At that time we interpreted this causally in terms of greater severity leading to homelessness. These new findings make it equally likely that the period of homelessness exacerbated the mental health distress.

29 The diagnostic pattern in these homeless parents looks strikingly like that in the HCFP.

30 For example, in December 2007 LAHSA announced it had received an additional $37 million for supportive housing projects. Only 22 of 207 units will be for single-parent families with a history of substance abuse.

31 http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2005/12/21/BAGOIGBB611.DTL


36 As of May 2008, however, implementation of the housing first model by Beyond Shelter had encountered multiple difficulties due both to a lack of available permanent housing for participants and to the more intense than expected service needs of clients. (Information from Downtown Mental Health Center staff who share some clients with Beyond Shelter.)


40 The percentage of interviews completed was lowest in Downtown (54 percent) and Shields (56 percent), the areas with greatest poverty. Completion was highest at San Fernando Valley CMHC (79 percent) with Prototypes (70 percent), ENKI (60 percent), Pacific Clinics (72 percent) rounding out the distribution.
In May of 2006, 91 Round II participants had left the program. Of the other 140, 73 were held over to Round III. We asked staff to update the reasons for discharge for those who were not held over but had not been discharged as of May 2006; we received a total of 57 updates out of a possible 68. Nine participants from Round II were still receiving services at Downtown Mental Health Center in March of 2008.

This item is missing a substantial amount of data. For example, in Round III of 226 persons discharged, only 197 had a discharge GAF assigned. We believe that case managers, who fill out the final assessment, are sometimes uncomfortable assigning GAF scores themselves and do not, as requested, ask the clinicians to provide them.

In May of 2006 the housing situation was known for 231 Round II participants, 91 of whom had left the program already. Of the other 140, 73 were held over to Round III. We asked staff to update the living situation at discharge for those who were not held over but had not been discharged as of May 2006; we received a total of 57 updates out of a possible 68. A very few participants from Round II were still receiving services at Downtown Mental Health Center.


This is a low estimate because we only asked the question about the oldest child.

Food insecurity with hunger ranged from 22% to 31% among former CalWORKs participants receiving various forms of housing assistance in 1998. Verma, N. and Henra, R. (1998) Comparing Outcomes for Los Angeles County’s HUD-Assisted and Unassisted CalWORKs Leavers. Available at: http://eric.ed.gov:80/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/1a/d6/67.pdf. Among poor persons who reported past homelessness, 57% reported food insecurity compared to 23% of those who had not been homeless during the previous five years. Among CalWORKs participants 32% reported food insecurity. Among those at 300% of poverty or less, 10% had food insecurity and hunger. LA Health at a Glance, (2001). Available at: http://publichealth.lacounty.gov/ha/reports/factsheets/fdsecure/foodinsecur.pdf

Although the rate was considerably higher among women, 59 percent of men also reported one or more of these traumatic events. Because only 7 percent of respondents are men, this affects the overall percentage little.

The finding is "also consistent with the possibility that the causal sequence starts with responding to treatment, which then leads to better mental health status. That, in turn, leads to obtaining permanent housing." Both quotations are from, Chandler, D., Meisel, J., and Jordan, P. (2005). Homeless Families Pilot Project Evaluation: Submitted to the Los Angeles County Department of Mental Health. Sacramento: California Institute for Mental Health, 2125 19th Street, 2nd Floor, Sacramento, CA 95818. Available at www.cimh.org/calworks.aspx.
The California Institute for Mental Health is a non-profit public interest corporation established for the purpose of promoting excellence in mental health. CiMH is dedicated to a vision of “a community and mental health service system which provides recovery and full social integration for persons with psychiatric disabilities; sustains and supports families and children; and promotes mental health wellness.” Based in Sacramento, CiMH has launched numerous public policy projects to inform and provide policy research and options to both policy makers and providers. CiMH also provides technical assistance, training services, and the Cathie Wright Technical Assistance Center under contract to the California State Department of Mental Health.

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