Helping Homeless Families in Los Angeles

Second Evaluation of the Homeless CalWORKs Families Project

Submitted by the California Institute for Mental Health
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A PDF copy of this report and a methodological appendix are available at **www.cimh.org/calworks**

EXECUTIVE SUMMARY

The Homeless CalWORKSs Families Project and what we can learn from it

Policymakers and administrators have taken steps to meet the needs of homeless parents with mental health problems. 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 the third phase of the project, which began in December 2004 and ended in June 2006.

Overall administrative direction for the project is provided by the Department of Public Social Services (DPSS). The program is provided at six sites located throughout the county. Services are provided for one to two years, based on individual need. Mental health staff, specialized eligibility and GAIN workers, and Los Angeles Homeless Services Authority (LAHSA) staff are co-located and collaborate to provide services at each site. The mental health agency at each site provides case management and treatment (counseling and/or medications) and is responsible for providing assistance in locating and obtaining permanent housing. During the 17-month study period, 50 Section 8 vouchers were dedicated to the 350 families participating in the HCFP. Expenditures per client served from the direct allocation from the Board of Supervisors averaged $11,000 (over an 18-month period).

At admission, 46% of participants had very serious functional impairment and 46% had moderate impairment due to psychiatric disorders. Except for the Skid Row program, participants had generally lived in the region of Los Angeles in which the program was located for several years. Before entering the HCFP, clients had been homeless from less than two months (28%) to over a year (44%). Relationship difficulties, job loss, and other economic setbacks were the main reasons for becoming homeless.

The evaluation covers a period of 9 to 17 months of service, depending on when participants entered the program. Data sources include mental health staff ratings, a research interview with participants, and Information System data from both Department of Mental Health (DMH) and DPSS. Information obtained in site visits provide a context for interpretation of the evaluation data.

Participation, satisfaction and mental health change

Overall, the program appears to work well for most participants.

- ❏ High percentages of both those who stayed and those who left early were satisfied with the services they received.
- ❏ Participants made positive changes in their mental health status:
  - Overall, staff judged 78% of HCFP participants to have made positive changes in their mental health status, and depressive symptoms were significantly ameliorated.
  - Eighty percent of participants who were interviewed reported positive change in their mental and emotional state, and 89% felt they had been helped at least "some" by the mental health services they received.
- ❏ Participants with the most severe problems were channeled to SSI. Staff reports indicated that by May 2006, 24 persons had applied for or received SSI due to mental disability.
- ❏ About 40% of the participants left the program early or were not actively engaged. As noted later, some of these clients found housing and therefore had a reduced need for services.

Housing and the limits of the service model

Nearly half the participants achieved the basic outcome for the project—long-term rental housing.

According to staff reports, participants living in long-term rental housing increased from 3% to 45%. However, at the end of the study period 6% were still living on the streets or in other places not intended for human habitation, 10% were still in emergency shelters, and 12% were in motels or hotels. The 35% of families "carried over" into the 2006-2007 project year may still succeed in finding housing.

Additional housing vouchers will be necessary to increase the percentage of those finding long-term rental housing.

- ❏ Interviewees reported a variety of reasons for not yet living in long-term rental housing—for the most part these reflect economic barriers such as having an income too low for available rental stock.

- About two-thirds of the participants who were in long-term housing by June 2006 were recipients of housing vouchers, but 15-20% of all HCFP participants found housing without vouchers. Most of those who lacked Section 8 housing vouchers experienced a variety of negative consequences. HCFP programs have turned to Shelter Plus Care vouchers, which are very restrictive and may be appropriate for only a small percentage of HCFP participants.

While shelters are important to the project, problems with the shelter system were also apparent.

- Most HCFP participants spend time in an emergency shelter or transitional shelter. About half of interviewees (48%) reported shelters had met their needs well, while about 20% were unhappy with the shelter environment, particularly with what they experienced as distrust and moral condemnation.
- Almost a third of interviewees reported being turned away from a shelter in the prior year.

Safety, particularly for children, remains a crucial issue for this population.

- Seventy percent of the participants were at least somewhat satisfied with where they lived. But less than 60% of the interviewees felt safe all the time in their living situation. Only 64% felt their children were safe all the time where they live.

Employment, work-activities, and income

- For homeless parents who can quickly re-enter the labor force, finding employment is likely to be the fastest way to also find housing. However, a range of personal obstacles face participants seeking work.
- The program provided limited assistance with child care problems; much more transportation assistance was provided.
- About 18% of participants received remedial education or vocational training.
- Findings suggest that specific supports for employment provided by the HCFP were useful.
- Staff judged that capacity to work increased for more than a quarter of the HCFP participants.
- DPSS data show a total of 31% of study participants worked during the study period.
- The percentage working in any month increased over 16 months from 10% to 19%.
- Monthly earned income in April 2006 averaged $954 for those who worked.

Child well-being

Many of the needs of the children in the families in the projects were addressed.

- Approximately 90% of the children in the program attended school regularly.
- Staff judged parenting capacities to have improved for over half of the parents.
- Eighty-three percent of the parents said their children "always" got the medical care they needed, and only 71% said they got the dental care they needed.

The mental health needs of the children are not being adequately addressed.

- Child's school, emotional, or health problems were identified by a quarter of the parents. Services for these children were by referral rather than by the HCFP.
- Only 33% of the parents said that their children got the mental health services that they felt they needed.

Some basic needs are not being met for a sizable minority of the children.

- Food insecurity occurred for about two-thirds of the HCFP interviewees in the two months prior to the interview. A much smaller percentage reported their children had actually gone hungry in this period.
- As noted above, nearly one-third of the children live in situations that are not considered safe by their parents.

Substance abuse and domestic violence

Substance abuse is sufficiently prevalent and problematic as to require additional services within the HCFP model.

- Staff suspect active substance abuse problems in up to half of the participants, even though participant-reported levels are much lower.

Substance abuse—by itself and as a contributing factor to emotional problems and to domestic violence—was linked to becoming homeless by about 4% of interviewees, while 7% received substance abuse services through CalWORKs.

- ❏ Program efforts have helped with these problems. Staff rated about half of the 42 persons (17%) whose substance use problem they knew about early on as having improved during the course of the study period.

Domestic violence is a problem for some participants, but the program appears to be helping.

- ❏ A history of abuse was reported by 80% of interviewees. Only a small number had been recently abused, but 15% reported feeling unsafe due to a prior partner.
- ❏ Domestic violence services were provided for 18% of the study participants through CalWORKs.
- ❏ During the study period, staff rated serious abuse as decreasing from 21 to 10 persons, and lesser abuse decreasing from 36 to 22 persons, but abuse may be a cause of early drop-outs.

Predicting housing success

- ❏ Receiving a housing subsidy (Section 8 or Shelter Plus Care) is the most important factor contributing to achieving long-term rental housing.
- ❏ Having a substance abuse problem or a recent criminal justice history makes it less likely that a participant will be able to leave temporary housing. Having a child living with relatives or having contact with child welfare services also reduces the chance of obtaining permanent housing. Participants who left the program early were more successful in obtaining permanent housing; most probably left the program because of their early success in finding housing.
- ❏ Staff are able to predict early on with considerable accuracy who will be successful in leaving temporary housing.

Taking action to meet the needs of homeless families

- ❏ For the Project to succeed, the Board of Supervisors must ensure that most HCFP participants receive housing subsidies. In 2005-2006 only 50 Section 8 vouchers were available for more than 350 families; in 2006-2007 there are no dedicated Section 8 vouchers for the project. It is not cost-effective to fund mental health and related services over months and even years while disregarding the basic need for housing income supplements.
- ❏ The Project Steering Committee should consider greatly reducing the size of the overloaded Downtown Mental Health program and assigning cases of families who had lived in other parts of the county to the agencies in those regions.
- ❏ The Project Steering Committee should consider making substance abuse an explicit focus of the program with a designated SA specialist at each site.
- ❏ DMH should ensure that mental health staff at each site include child/family therapists, so that all families can be offered mental health assessments for their children and co-located treatment if needed.

Summing up

The HCFP is an important program. It has addressed a critical population and done so with creative efforts by a highly committed interagency staff. Overall, the results in many domains are very positive. Results will improve markedly, though, if sufficient dedicated housing vouchers are provided.

CHAPTER I: THE HOMELESS CALWORKS FAMILIES PROJECT AND WHAT WE CAN LEARN FROM IT

Homeless families in Los Angeles County need help

Homeless family members make up about one-fifth of all homeless persons in Los Angeles County.

- *Homeless individuals:* Los Angeles County has the largest homeless population of any major metropolitan area: approximately 91,000 at any one time and an annual count of 224,000.[1]
- *Homeless families:* On any night, more than 7,500 families are homeless; approximately 20,000 parents and children.[2]

Many CalWORKs families are homeless or at risk of being homeless.

A recent study found a substantial portion of CalWORKs participants to be homeless: 7% (13,000 families) were homeless during a three-month period and an additional 12% were at risk of homelessness.[3]

CalWORKs participants with mental health problems are more likely to be homeless and are less successful than participants without mental health problems. When a parent has a mental health problem, providing help is more difficult.

CalWORKs participants with mental health problems are three times as likely as CalWORKs participants overall to become homeless.[4] In a 2006 survey, 17% of randomly selected current mental health CalWORKs supportive services clients reported that they had been homeless on the street or in a shelter in the past year. The California Institute for Mental Health (CiMH) estimates that as many as 3,450 parents with mental health problems are CalWORKs participants and have been homeless during a year.[5] In addition, CalWORKs mental health supportive services participants who were homeless during the year are more impaired than, and only half as likely to achieve employment as, other mental health supportive services clients.[6]

Policymakers and administrators have taken steps to meet the needs of homeless parents with mental health problems

The Los Angeles County Board of Supervisors established and funded an interagency Homeless Families Pilot Project to address the needs of CalWORKs-eligible homeless families in which a parent has mental health problems.

The board has funded the project in three phases.

- *Phase One (initial pilot):* In 2002 the board established an initial pilot project located in the Skid Row area to serve 26 homeless families that included a parent with mental health problems. Interagency partners included the Department of Public Social Services (DPSS), the lead agency, the Department of Mental Health (DMH), and the Los Angeles Homeless Services Authority (LAHSA).
- *Phase Two (two sites):* In September 2003, the board approved a resolution calling for two pilot projects—a continuation of the one in Skid Row and one in the San Gabriel Valley—to serve 20 clients each. The Skid Row project operates out of the Downtown Mental Health Clinic, and the San Gabriel Valley project is located at the PROTOTYPES clinic.
- *Phase Three (expansion to six sites):* The two existing sites were expanded and an additional four sites were added in the spring of 2005. The Skid Row site has 100 participants and each other site has 50 participants for a total of 350 families. Each supervisorial district contains one site. The funding for the project at these sites has been extended through June of 2007.

The service model has evolved over three years to maximize the benefit of collaborative effort.

- Overall administrative direction for the project is provided by DPSS, and includes an interagency steering committee to resolve problems.
- Services are provided for one to two years, based on individual need. Initial expectations that services could be completed in six months have proved to be unrealistic.
- Mental health staff, specialized eligibility and GAIN workers, and LAHSA staff collaborate to provide services at each site. To the extent

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

- ❏ The mental health agency provides both case management and treatment (counseling and/or medications).
- ❏ Housing specialists and case managers from the mental health agency provide active assistance in locating and obtaining permanent housing. During the 18-month study period, only 50 Section 8 vouchers were dedicated for the 350 families participating in the HCFP.
- ❏ LAHSA staff are responsible for finding short-term and transitional housing for families. LAHSA staff also provide transportation in vans to appointments and, as time allows, for other purposes.

Only some aspects of how to help homeless families are clear

Many questions remain—but results from the evaluation can help policymakers and administrators answer them.

At the request of the Board of Supervisors, the Department of Mental Health contracted with the California Institute for Mental Health (CiMH) to evaluate the Homeless CalWORKs Families Project.

A first report in August 2005 focused on the 40 participants of Phase Two.[7] The current report covers the period December 2004 through May 2006.

The results of the evaluation of Phase Three are intended to provide crucial information to policymakers and administrators so that they can improve Los Angeles County's ability to meet the needs of homeless family members. We present evidence to help policymakers and administrators:

- ❏ Continue to offer the kinds of help that have been proven effective with parents in the HCFP.
- ❏ Increase needed services to children in homeless families and to the minority of HCFP clients who need substance abuse or other specialized services.
- ❏ Understand the role of different kinds of housing resources in addressing homelessness for families.

CHAPTER II: THE CONTEXT FOR UNDERSTANDING HCFP OUTCOMES

HCFP participants must meet DPSS criteria for homelessness and need for mental health service as well as being eligible for CalWORKs.

Homelessness. Project eligibility is determined by a DPSS definition of homelessness (which can include families doubling up) but other definitions may be applied by related agencies, such as administrators of the Section 8 housing vouchers.

Mental health issues. The Homeless CalWORKs Families Pilot Project is intended to serve homeless CalWORKs-eligible parents who have mental health problems severe enough to constitute a barrier to finding housing and employment. However, these problems should not be so severe as to qualify for federal disability payments due to severe and persistent mental illness. Persons with a diagnosis of schizophrenia, for example, are likely to receive federal disability payments (SSI) and therefore not receive CalWORKs. All participants had to meet the usual criteria for CalWORKs mental health supportive services[8] clients, which includes having a diagnosable mental disorder.

CalWORKs. Not all participants were receiving CalWORKs when screened. For example, some may have been sanctioned. However, all participants had to be eligible for CalWORKs to enter the program and remain eligible throughout. DPSS staff members were diligent in helping clients become eligible and retain eligibility.

The evaluation covers a period of 9 to 17 months of service, depending on when participants began services.

Services were phased in over several months in the spring of 2005, with the full complement of 350 participants achieved in late summer. The time between admission and the end of the study period (May 31, 2006) was between 9 and 12 months for 26% of the participants, and over 12 months for 74% of the participants While the study period ended on May 31, 2006, not all the clients were terminated by that date. Approximately 40% of participants had already left the HCFP program prior to May 31, 2006. While project staff were asked to close as many of the remaining cases as possible by the end of June 2006 in order to make room for new families, approximately 35% of the 350 were "carried over" into the new funding period that started July 1, 2006.[9]

Participating families were diverse.

- Service participants were primarily single mothers with an average age of 35. (The 6% of the study participants who were male had an average age of 39.) The highest grade of school completed by 43% of the interviewees was between sixth and 11th grade. High school was completed by 31%, while 23% had some college, and 3% had graduated from college.
- The largest racial/ethnic group is Latino (37%), followed by African-American (31%), White (18%), and American Indian (2.5%).
- The number of CalWORKs-aided children in the families was one for 37% of participants, two for 29%, three for 20%, and four or more (up to eight) for 14% of families.
- At admission, 40% of participants were either entering CalWORKs or had received CalWORKs support for less than six months; 36% had received CalWORKs from six months to two years; and 24% had received it from two years to 16 years.
- Despite the presence of significant mental health issues, for 70% this was the first time they had received mental health services.

Out of an anticipated 350 families, 246 were designated study participants and signed informed consents. The sample is representative of all those served in the project through May 2006.[10] Information on study clients was obtained from both staff and from direct interviews with the clients.

- Mental health staff filled out information forms on individual clients at intake and at discharge (either at the time of discharge for the 40% of participants who left the project in May 2006 or before).
- A research interview was conducted by trained CiMH research associates in late April through June 2006. A total of 174, or 71% of study participants, were located and interviewed.[11]
- Other information is drawn from the Department of Mental Health Information System, and from DPSS project records.

Site visits provide a context for interpretation of the evaluation data.

CiMH evaluators spent a half day with each HCFP site in May 2005 and again in May 2006. We interviewed mental health case managers, therapists, and administrators; DPSS eligibility and GAIN workers; and LAHSA staff and administrators. DPSS administrators were in transition at the time and unavailable for interview.

An average of $11,000 (over an 18-month period) was expended per client served from the direct allocation from the Board of Supervisors.

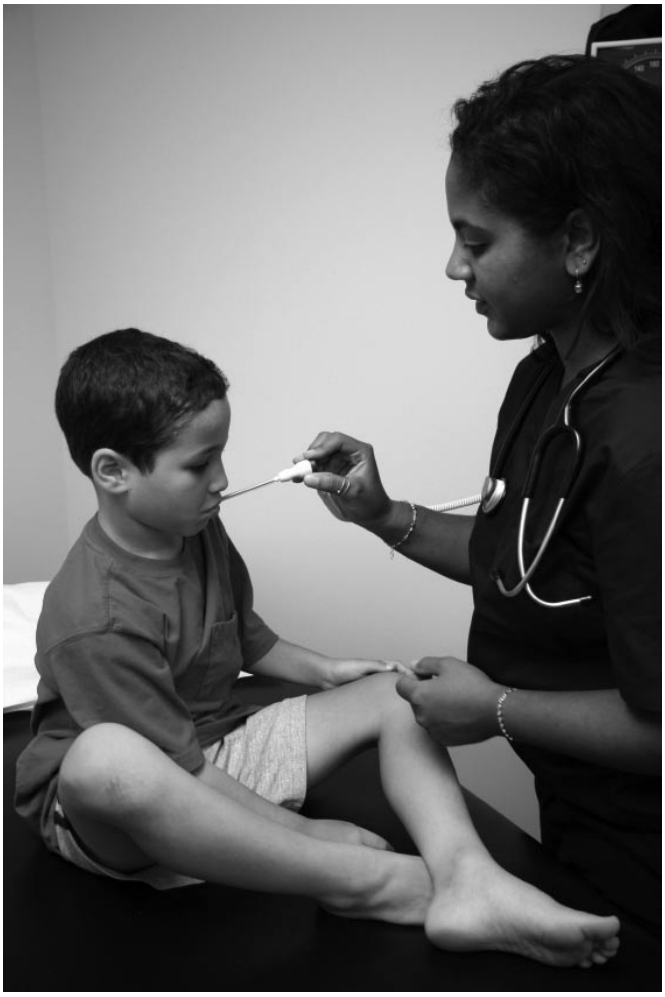
The Board of Supervisors allocated $6,543,119 to DMH and LAHSA over 18 months; of this amount $4,436,733 was actually expended. Through June of 2006, DPSS staff report 405 persons were served. Thus, the average cost per person for these direct costs (excluding other costs discussed below) is $10,955.

The main other cost of the project is mental health treatment services, which are part of the pre-existing supportive services allocation.

Mental health service costs for the study sample. Direct mental health treatment services (as opposed to case management and other non-treatment services) were billed to the CalWORKs supportive services allocation, not the project. Since the allocation is capped, the amount does not represent an additional cost to the county. Using Information System data from DMH, we calculated that the direct service costs for therapy and case management (all providers) for the 246 participants in our sample (which is only a subset of the total number of clients served with the funds expended, as shown above) was $1,716,211 for services between January 1, 2005, and June 13, 2006. The mean mental health service cost per study participant was thus $6,976.

DPSS costs. Project clients received cash aid, homeless assistance funds, and food stamps through DPSS, but most would have been eligible for these without project participation and are not included in the costs of the project. The only special service they received was a more intense involvement of eligibility and GAIN workers who were primarily dedicated to the project and had lower than usual case loads. We are unaware that DPSS actually hired additional staff, so any reductions in caseload are best conceived as an opportunity cost borne by DPSS.[12]

Other costs. The program had 50 Section 8 vouchers dedicated to HCFP clients. In addition, Shelter Plus Care vouchers were utilized for some participants. HCFP participants were, of course, eligible for these vouchers in any case but (given the disproportionate demand compared to supply) might not have been chosen if they had not been part of the program.



CHAPTER III:
PARTICIPATION, SATISFACTION, AND MENTAL HEALTH CHANGE

Program participation and satisfaction

While about 40% of the clients either did not engage with the program or left early, clients overall were quite satisfied with the services they received.

In April 2006, a total of 394 persons had been admitted and 161 (41%) had left the program. Both participants (in interviews) and staff identified moving, finding housing, and losing CalWORKs as primary reasons for leaving early. While some of these reasons suggest unavoidable withdrawal from services, we should be concerned that the ability of the project to achieve its housing and other goals is severely limited if clients do not remain engaged in the program.

Several measures indicate participants were in general highly satisfied with HCFP services. Overall, 62% were "very satisfied" with the program and an additional 25% were "somewhat satisfied." The 30 persons who were no longer enrolled were more likely to be at least somewhat dissatisfied (26%) than were those who were still enrolled (10%). (See Table 1 below.)

Table 1: Measures of Interviewee Satisfaction

	HCFP interviewees N=172
Reported being somewhat or very satisfied	87%
Treated with respect[+]	100%
Would recommend to a friend (Percent yes)	92%
Trust clinician work with most[++]	94%
Services in primary language	98%
Services available at convenient times	93%

[#]Number varies slightly by question.
[+]The respondents had options of "by all," "by some," and "by none." We have combined all and some.
[++] This is the percentage saying "yes" or "somewhat."

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

Staff descriptions of why some participants left early:

- ❑ *Client terminated after one year in the program; moved to Texas where she was able to find a job and a place to live.*
- ❑ *Client exited a substance abuse treatment facility and was arrested the following day. Client remains behind bars and DPSS terminated the case.*
- ❑ *Working full time and requested to be closed due to not having time to attend appointments.*
- ❑ *Client disappeared after a Department of Child and Family Services (DCFS) representative requested to meet with her concerning her child. Client refused services.*
- ❑ *Client stopped coming in for services. The client voluntarily gave son to mother for temporary custody.*

Participation in treatment. The core of treatment for most participants was counseling sessions with a therapist. It is important to note that participation in mental health treatment is a requirement of the program, but one that may have much less priority for clients than finding housing or employment. Overall, 17% of clients participated in virtually all sessions, and 35% participated in most sessions. Participation was sporadic or rare for 47% of the participants overall. Participation was sporadic or rare for a higher percentage of those who had left early (66% vs. 35% for those still enrolled).

Mental health status

Measures of mental health status at both intake and discharge suggest a population with significant mental health issues.

At admission, 46% had very serious functional impairment and 46% had moderate impairment due to psychiatric disorders.

At admission, clinicians recorded (as part of the assessment) a summary score of functional impairment due to mental disorder. These scores are only available for 183 persons, though we believe this to be a representative group. Table 2 contains a summary of the scores and their meaning.[13]

Table 2: Global Assessment of Functioning Scale Ratings at Admission

GAF Score	Cases	Percent
0—40: Extremely low functioning	19	10.4
41—50: Serious symptoms	65	35.5
51—60: Moderate symptoms	84	45.9
61—70: Some mild symptoms or some difficulty in social, occupational, or school functioning	15	8.2
71—100: Few if any symptoms	0	0.0
Total	183	100.0

A second measure correlated with level of functioning is psychiatric diagnosis. The largest diagnostic category assigned at intake was depressive disorders (58% including dysthymic disorders). The second-largest category was adjustment disorders (21%) followed by anxiety disorders, including post-traumatic stress disorder (12%). Serious and persistent mental illness (bipolar disorder and schizophrenia spectrum disorders) comprised 7% of the cases. Only 3% had "situational" problems (V codes).

In May 2006, the mental health symptom score on the SF-12 instrument showed participants to be below the 25th percentile of Americans overall.

The average SF-12 mental health score among American females is 49.3, while scores for HCFP female interviewees averaged 41.7—higher scores indicate better mental health.[14] For men, the national norm is 50.7 and the 12 HCFP male participants averaged 36.2. Mean scores for both men and women in the HCFP are below the 25th national percentile.

In addition to severity overall, it is instructive to see how mental health scores correlate with other important variables in the study. Mental health scores are significantly better for those who were no longer enrolled than those still enrolled in May 2006.[15] Lower mental health scores (more impairment) were also correlated with increasing age.[16] Interviewees who had a spouse or partner showed significantly less impairment—whether or not the partner lived with the interviewee did not matter. However, type of residence, admit diagnosis, race, and number of children were not correlated with the mental health scores in May 2006.[17]

Staff reported that by May 2006, a total of 24 persons had applied for or received SSI due to mental disability.

At intake, staff reported that 23 persons had applied for SSI (disability income due to mental illness) or were anticipated to do so shortly. At discharge (or in May of 2006) this figure had increased only to 24. Apparently, the HCFP included about 10% of participants with mental health problems that so seriously impaired functioning that employment was unlikely.[18] Twelve of those identified at intake, however, were not listed as having received SSI at discharge; and 10 of those identified as getting SSI at discharge were not identified at intake. Thus, it appears the HCFP mental health staff helped sort out this option for the most seriously functionally impaired clients.[19]

Mental health outcomes and perceived help

Overall, staff judged 78% of HCFP participants to have made positive changes in their mental health status, and depressive symptoms were significantly ameliorated.

On ratings of change in mental health status, those still enrolled in May 2006 were judged to have made significantly more positive change than those who left early (87% vs. 63%).[20] Very similar amounts of change were rated regarding improvements in capacity to handle daily life demands; again, more positive change was found for those still enrolled in May.

Staff-rated changes in depressive symptoms from admit until discharge (or May 2006) on a depression scale (the MADRS) show significant improvement, particularly for those with a diagnosis of depressive disorder or severe mental illness.[21] The positive change was less marked for those who remained in the program as of May 2006.[22]

Eighty percent of participants who were interviewed reported positive change in their mental and emotional state, and 89% said they had been helped at least "some" by the mental health services they received.

Interviewees in May 2006 were asked, "Compared to how you were feeling one year ago, how is your mental and emotional state?"[23] As shown in Table 3, 46% of interviewees overall said that their mental and emotional feelings had gotten "a lot better," while another 34% reported they were "somewhat better."

Among those who left the program early, 20% said their mental and emotional state was *worse* than at intake into the program. Although the figures in the table favor those who were still linked to the program in May 2006 (compare the 2nd to the 3rd column), the difference is not statistically significant.[24]

A second question asked, "Did the services you received help with your emotional or mental health problems?" Overall, 61% reported getting a lot of help, with another 28% getting "some" help (total 89%). Differences between reports of those still enrolled and those who left early are pronounced and statistically significant[25]. (See Table 4 below.)

About 35% of the interviewees reported receiving and being helped by psychiatric medications.

Of 173 interviewees answering these questions 92 or slightly more than half (53%) of interviewees said they were prescribed medicines for emotional or mental health problems. As might be expected, participants with low GAF scores at admit were significantly more likely to report being prescribed psychiatric medication.

Two-thirds (66%) of those prescribed medications perceived that they were helped by the medications. Unfortunately, only 61% of those prescribed a medication said they took it regularly.

Table 3: Interviewee perception of changes in mental health status between admission to the program and May 2006

	Linked to Program N=134	Left Early N=30	Combined N=164
A lot better	48%	37%	46%
Somewhat better	35%	30%	34%
About the same	7%	13%	8%
Worse	10%	20%	12%
Total	100%	100%	100%

Table 4: Interviewee perception of help received for mental health issues

Help received	Linked to Program N=135	Left Early N=30	Combined N=165
A lot	66%	37%	61%
Some	25%	40%	28%
Little or not at all	1%	7%	2%
Made worse	3%	6%	4%
Reported no MH problem	4%	10%	5%
Total	100%	100%	100%

CHAPTER IV: HOUSING AND THE LIMITS OF THE SERVICE MODEL

The fundamental goal of the HCFP is to find long-term housing for participating families. In this section, we describe the living situation at intake and causes of homelessness and contrast these to the living situation in May 2006 and, for those who are not in long-term housing, reasons for not yet having achieved their housing goal. In addition, we present information about use of Section 8 and other housing vouchers, the housing services participants received, and interviewee experiences with the shelter system.

Homelessness

The projects largely served clients who were long-term residents in their areas prior to becoming homeless.

As shown in Table 5, while 25% of study participants were served at the Downtown Mental Health Clinic, only 6% had lived there prior to becoming homeless. As a rule, participants had lived in the region from between four and 13 years prior to becoming homeless. Those coming from East Los Angeles and the San Gabriel Valley had the longest residence in the region.

Time homeless prior to entering the HCFP varied greatly from less than two months (28%) to more than a year (44%).

Research interview respondents were asked how long they had been homeless prior to enrolling in the HCFP. Twenty-eight percent of the respondents had been homeless for two months or less, 16% had been homeless between two and six months, and 13% had been homeless between six and 12 months. A very high 44% had been homeless for more than a year,[26] indicating that this population of CalWORKs participants experienced considerably more severe homelessness than is common among CalWORKs participants who become homeless.

Relationship difficulties, job loss and other economic setbacks were the main reasons for becoming homeless.

Table 6 shows staff assessments of why the clients were homeless. The most frequent reason is domestic violence followed by eviction. Alcohol and drugs or mental health problems were cited in only 6% of the cases.

Client descriptions of reasons for becoming homeless for the most part echo those reported by staff. The clients could choose several possible reasons, so the figures in Table 7 total more than 100%. Clients were most likely to stress job-related problems that led to income loss (34%). Domestic violence and separation or divorce were mentioned by 25% and 17%, respectively. Higher percentages than in the staff reports mentioned drugs and alcohol (12%), and mental health (17%).

Table 5: Region in which interviewees lived prior to becoming homeless

Region	N	Percentage	Mean years lived in the region*
Downtown	11	6%	3.8
South Central	24	14%	6.9
East LA	23	13%	12.9
West Side	6	4%	3.7
San Gabriel Valley	32	19%	12.7
San Fernando Valley	25	15%	7.3
Hollywood	6	4%	4.6
Long Beach	2	1%	4.0
Other LA	29	17%	7.3
Out of county	13	8%	2.3
Total	171	100%	8.3

*N is 165 for years lived in the region

Table 6: Narrative statement by staff of reason client became homeless, coded into categories

Reasons	Percentage N=235
Domestic violence (include child abuse by partner)	18%
Evicted due to not paying rent/or lost housing because could not afford rent	14%
Could no longer stay with family or friends client was staying with	12%
Evicted for some other reason	8%
The housing went away (torn down, sold, health violations, etc)	9%
Lost job or hours got cut back, or partner lost job/hours	8%
Drug or alcohol problem	4%
Separated from partner or boyfriend/girlfriend	8%
Lost or reduced welfare or other benefits (even if temporary)	2%
Landlord raised rent	2%
Released from jail, a rehab agency or hospital, foster care with no place to go	2%
Mental health problems left client unable to cope	2%
Health problems caused financial strain	1%
Other	10%

Clients respond to: "Why did you become homeless?"

- *I couldn't keep job at time because I had emotional issues. I had lost my father and grandmother. I messed up my credit and had been on drugs and alcohol.*
- *They raised my rent at the last place to $1,300 and we could only afford $900.*
- *I got kicked out of the place I was living. My boyfriend got in a fight with the person we lived with, so he kicked us out.*
- *I was the resident manager. When the owner passed away, the family didn't want to take over apartment. The new owners came one day and gave me a 30-day notice. I didn't have enough money for an apartment.*
- *I was in a domestic violence relationship. He didn't want to work and didn't want to let me work.*

Shelters

Most HCFP participants spend time in an emergency shelter or transitional shelter, although almost a third of interviewees reported being turned away from a shelter in the prior year.

Seventy-two percent of interviewees (124) had lived in an emergency or transitional shelter during the time they were part of the HCFP. But reflective of a general shortage of beds to serve families, 29% of the interviewed families reported they had been turned away from a shelter in the last 12 months due to lack of capacity or restrictive rules.[27]

About half of interviewees (48%) reported shelters had met their needs well, while about 20% were unhappy with the shelter environment, particularly with what they experienced as distrust and moral condemnation by shelter staff.

Forty-eight percent of the interviewees said that the emergency or transitional shelter met their needs "Very well;" 28% said "Somewhat;" 11% said "Not very well;" and 12% said "Very poorly."

One of the most significant issues for about half of the parents was that living in shelters entailed inability to keep their children in the same schools.

Table 7: Reasons for becoming homeless described by clients during May 2006 research interview (multiple responses were possible)

Reasons	Percentage N=163
Unemployed/lost job/laid off	34%
Evicted	29%
Domestic violence	25%
Conflict with friends/family where living	21%
Alcohol or drug use	12%
Mental health issues	17%
Divorce/separation	17%
Housing went away (rent raised, landlord changed)	12%
Financial problems/credit	9%
Illness or medical problem	7%
Moved to LA with no place to live	1%
Other reasons	2%

One major problem cited by staff is that shelters are often located far from where the family has been living, often in entirely different regions of the county. Living at considerable distances can result in difficulty keeping children in the schools in which they are established. Of the 103 interviewees using shelters who had school-age children, 54 (52%) said they were able to maintain their children in the same school; 46% could not. For 2% of interviewees, some but not all children were able to continue in their same school. About the same percentage (52%) said they had been able to maintain other contacts where they had lived before, while 47% said they had not.

Some positive and negative client comments on shelters:

- *After entering in there, they provided transitional housing for me and my son and they helped me with everything they said, like first months rent, furniture I needed and all the household items.*
- *It kept the family together. Made us feel comfortable. Didn't make us feel like we are homeless because we want to be.*
- *The home provided was very good; we had everything we needed. Bathroom, kitchen, our own place. But staff was not very understanding about our emotional needs, making it very difficult to focus on moving forward as far as school, work, looking for a place. No compassion. No understanding.*
- *They don't care about anything but getting the participation fee. They give a list of things they can do for you when you enter the program but they don't do anything.*
- *I felt all the time that they didn't trust me and that the rules were very strict and they put me down. Emotionally I was hurt a lot by the workers.*
- *Other residents were smoking and stealing your clothing. You had to take all your belongings with you to the bathroom.*

Housing outcomes

The basic outcome of the HCFP was the increase of participants in long-term rental housing from 3% to 45%-53% (depending on the data source).

At the time of admission to the HCFP, 59% of families were living in temporary programs[28] for the homeless; at discharge this was reduced to 28%. The percentage in long-term rental arrangements at intake was 3%; this increased to 45% at discharge[29]. About 20% lived with friends or relatives; this remained fairly constant. (See Table 8.)

Table 8: Where participants were living at the time they were assessed to be in the program *and* in May 2006: staff report

Living situation at intake or at discharge, or in May 2006 if still enrolled	Intake Percentage N=241	Follow-up* Percentage N=221[30]
A vouchered hotel, motel or SRO	20%	<1%
Transitional homeless shelter	19%	11%
Emergency homeless shelter	19%	10%
Rented room in a hotel, motel or SRO	10%	12%
With relatives (not parents)	7%	10%
On the streets	7%	5%
With friends	6%	3%
With parents	6%	5%
Rented house or apartment	3%	45%
In domestic violence shelter	2%	<1%
Encampment or place that is not intended for human habitation	<1%	<1%
Other	<1%	4%

*May, 2006 or discharge, if earlier than May.

Of concern were those who were still on the streets or in temporary housing at time of discharge—6% were still living on the streets or in other places not intended for human habitation, 10% were still in emergency shelters, and 12% were in motels or hotels.

Information on housing from the May 2006 client interviews allows for comparisons between those who left the program early and those who did not. The percentage in long-term rental housing in May 2006 was higher for those who had left the program early, suggesting that some may have left the program early because they achieved their housing goal. Also a higher percentage of those who left the program early were living with relatives, indicating they may have been able to re-establish ties with families.

Nearly half of those still enrolled in May (35% of all participants) were carried over into the new project starting July 1, 2006. Of those carried over, 29% were still in temporary shelters, 32% were in transitional shelters and 26% were in rented housing (compared to 72% of those not carried over).

Interviewees reported a variety of reasons for not yet living in long-term rental housing—for the most part, these are economic barriers such as having an income too low for available rental stock.

Interviewees who were not yet housed were asked what barriers they perceived to finding permanent housing. As shown in Table 9, the major barriers fall into three major categories. The first is financial: participants focus on the lack of affordable housing, lack of a housing voucher, lack of an adequate income, or lack of move-in resources. The second has to do with participant history: bad credit an eviction record and a criminal justice history constitute problems for many. Finally, smaller numbers have current mental health, substance abuse, or domestic violence problems.

Seventy percent of the participants were at least somewhat satisfied with where they lived.

Finding long-term housing was a goal for each project participant. Interviewees were asked how satisfied they are with their current housing and how satisfied they were with the help in finding housing that they received from the HCFP (including the mental health agency, DPSS, and LAHSA staff). Answers to both questions are shown in Table 10.

While only 71% of interviewees are very or somewhat satisfied with their actual living situation, 82% were very or somewhat satisfied with the help provided by HCFP staff. Not surprisingly, satisfaction with housing help was correlated with the type of housing the respondents lived in at the time of the interview.

Less than 60% of the interviewees felt safe all the time in their living situation, and only 64% felt their children were safe all the time where they live.

Table 9: Obstacles to finding permanent housing: views of research interview respondents

Reason	Percentage mentioning each reason* N=74
Can't afford rent	62%
No job or earnings	34%
Bad credit	33%
Low-income housing not available	28%
Moving costs are too high (deposits)	24%
Eviction record	23%
Lack of a housing voucher	20%
Mental health problem	14%
Domestic violence	10%
Transportation	6%
Substance abuse	6%
Criminal justice history	5%
Too many demands from shelters, DPSS and other agencies	5%
I am not interested in permanent housing	1%
Some other reason	23%

*Multiple answers possible, so responses sum to over 100%

Table 10: Interviewee satisfaction with current housing (May 2006) and housing help received from HCFP

Satisfaction level	Satisfaction with current housing N=173	Satisfaction with housing help received N=173
Very satisfied	40.0%	57.2%
Somewhat satisfied	31.2%	24.9%
Somewhat dissatisfied	15.6%	8.7%
Very dissatisfied	13.2%	9.2%
Total	100.0%	100%

Interviewees were asked how safe they feel and how safe they believe their children are. "Safety" was described as "taking into account things like gangs, drug dealing, street fights and crime."

Although not shown in Table 11, living with friends or relatives was rated safest for both children (75% safe all the time) and the interviewee (70% safe all the time). Least safe was temporary housing such as emergency shelters (safe almost all the time child was 50%; adult was 41%).

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

As seen in Table 12, staff reported over half of the participants at intake had virtually no support from family, another quarter had some support, and 18% had moderate to significant support. By discharge or May 2006, 50% of the 225 participants rated both times had improved support from family, 31% had not changed, and 19% had *less* support from family.

The importance of family support is shown in the fact that for seven of the 12 persons whom staff rated as homeless at discharge or in May 2006, family support was reduced from that at intake. In contrast,

Table 11: Interviewee judgments of the safety of where they live

How often safe?	Percentage Feel Kids Safe N=169	Percentage Safe Themselves N=171
Almost all the time	64%	57%
Some of the time	29%	29%
Very little of the time	7%	14%
Total	100%	100%

Table 12: Family support for participant at intake

Amount of family support	Intake Percentage N=242	Discharge Percentage N=229
A significant amount of support	2%	10%
A moderate amount of support	16%	17%
Some support but not a lot	24%	37%
Minimal support	41%	30%
Client has no support network	17%	7%
Total	100%	100%

for 21 of the 35 persons living with family or friends, support from family had increased.

Housing assistance

Although critical to achieving the goals of the project, the financial housing assistance provided to participants was severely limited.

As noted above, 72% of interviewees spent time in an emergency or transitional shelter using DPSS support. Using state guidelines, DPSS also provides temporary and "permanent" cash housing assistance on a once-in-a-lifetime basis (unless an exemption is met). Temporary assistance is to help families obtain shelter from hotels, motels or short-term rentals; the amount is based on the number of family members. It can be for up to 16 consecutive nights. "Permanent" assistance is to pay the move-in costs for long-term housing, including last month's rent security deposit, cleaning fees, utility deposit (but not first month's rent). This fund can also be used to pay up to two months of owed rent to avoid eviction. (See Table 13.)

A total of 48% of the participants received temporary cash homeless assistance during the 16 study months, and a total of 5% received the "permanent" assistance. DPSS data on the amounts of cash provided do not distinguish these two types of assistance. The average amount of temporary and/or "permanent" cash aid provided each of the 124 persons who received some assistance was $962 (range $265 to $6,532).

Most of the participants who were in long-term housing by June 2006 were recipients of housing vouchers, but some found housing without vouchers.

Unlike the second year of the project, not all pilot participants were guaranteed a Section 8 voucher if they qualified for one; only 50 county vouchers were designated for the 350 year-three participants. A few other city Section 8 certificates were obtained, and about 15 Shelter Plus Care vouchers were granted in addition to Section 8 vouchers. Providers offered the available vouchers to eligible clients on a first-come first-served basis.

DPSS reported that as of early June 2006, 44 persons had been granted a Section 8 voucher, and four persons had a Section 8 voucher pending (together comprising 19.5% of all study participants). Additionally, 15 Shelter Plus Care were pending or received for a total of 63 likely to have a voucher.[31] This means that of the 101 persons staff reported to be in long-term rental housing by June 2006, at least 38 persons were able to find rental housing without a voucher.[32]

Table 13: Percentage receiving DPSS temporary and long-term cash assistance, by study month

Month	Total with data	Percent receiving temporary help	Percent receiving "permanent" help
Jan-05	212	5.7	0.0
Feb-05	215	7.0	0.5
Mar-05	221	9.1	0.5
Apr-05	227	6.2	0.0
May-05	233	7.3	0.9
Jun-05	230	6.5	0.0
Jul-05	235	5.5	0.0
Aug-05	237	3.4	0.0
Sep-05	235	3.4	1.3
Oct-05	233	0.9	0.0
Nov-05	230	5.2	0.0
Dec-05	227	1.8	0.9
Jan-06	225	0.4	0.0
Feb-06	226	1.8	0.4
Mar-06	221	2.3	0.9
Apr-06	212	2.8	0.5

Most of those who lacked Section 8 housing vouchers experienced a variety of negative consequences.

For participants who did not get a Section 8 voucher, mental health agency staff were asked to report "how the lack of a section 8 voucher affected this family." The most common consequence (33% of those staff rated) was that after many months a significant number of families were still without long-term housing. A variety of other consequences for housing, most negative, were listed, including doubling up, eviction, multiple moves and moving out of the county. About 17% had employment- or income-related consequences. For the majority of these, the effect was financial hardship, but a few were motivated by not having a voucher to find a job. A total of 18% had personal or family effects, such as loss of custody of a child, poor school attendance, and exacerbated mental health symptoms for parents and children. A total of 19% had minimal or no effects on the family of not getting a voucher.

HCFP programs have turned to Shelter Plus Care vouchers, but they are very restrictive and may be appropriate for only a small percentage of HCFP participants.

One negative consequence of the shortage of Section 8 vouchers and low-income housing is that case managers have felt pushed to use Shelter Plus Care rental assistance. This program is intended for persons with severe and persistent mental illness, a category only a small percentage of the HCFP clients fit. Aside from using resources intended for another population, these vouchers carry with them the requirement that clients continue to receive case management or other clinical services monthly for as long as the voucher is valid, which is at least five years. Shelter Plus Care participants are required to have an income source (which is usually SSI); however, the program's objective is gainful employment and self sufficiency at the end of the five-year period. Shelter Plus Care is an option for some clients whose criminal record would disqualify them from receiving Section 8 subsidy. HCFP staff have found it difficult to get clinics to agree to provide the necessary long-term services in the area where clients decide to use their Shelter Plus Care voucher.

Staff describe deleterious effects of not getting a Section 8 voucher:

- ❑ *Client has spent a long time living in a motel with her girls and has been unable to move out of the motel despite full-time employment.*
- ❑ *Client has been struggling to pay her bills, buy food and pay for gas even with full-time employment; client is extremely stressed out.*
- ❑ *Client felt forced to relocate her family to another state because she could not afford to pay rent in this area.*
- ❑ *Client has eight children and has had to live in a two-bedroom apartment because that's all she can afford.*
- ❑ *Client's three children remain in mother's custody. Client's youngest child is in client's custody.*
- ❑ *Client has been living in temporary housing/shelter with her children for extended period of time. Begins her day at 3:30 a.m. due to distance from her school and children's schools.*

CHAPTER V: EMPLOYMENT, WORK-ACTIVITIES, AND INCOME

Workforce readiness

Helping clients find employment is an integral part of the program. For homeless parents who can quickly re-enter the labor force, finding employment is likely to be the fastest way to also find housing. But many participants face daunting obstacles to employment.

The difficulty of obtaining a Section 8 certificate plus the attendant difficulties of finding housing once a voucher is obtained means that obtaining reasonably well-paying employment is a surer route to housing. It is important, therefore, to assess the likelihood of the project participants being able to obtain such employment and to assess how much change occurred in this area during the course of the project.

Many participants had few skills and little work history, along with multiple barriers to working. At intake, staff judged capacity to work to be "very good" or "good" for 31%, with 34% rated as "OK" and 22% as "poor" or "very poor."

A range of obstacles faced participants seeking work.

- *Poor work history.* Nearly two-thirds (65%) of the participants had not worked in more than a year, and 9% had never worked.
- *Mental health issues.* Approximately 30% of interviewees who were not working said mental health problems were a major difficulty in working at least half-time. For another 28% mental health issues were a small problem.[33]
- *Poor physical health* was a clear barrier to employment for about 10% of the participants, but may affect many others. Based on scores on the physical health scale of the SF-12 (which are associated with known disability levels), 23% of the HCFP interviewees have a better than 50% chance of not working due to health impairments, and another 20% have at least a 25% chance of not working due to health impairments.
- *Generational welfare.* Welfare over two generations can be a significant risk factor for moving off welfare by employment. Growing up in a family receiving public support "most of the time" was reported by 20% of the interviewees.
- *Illness or disability of a child.* A child's illness or developmental or behavioral problems was deemed by staff to constitute a barrier to the participant's employment for 13 participants (6% of cases). Sixteen, or 28%, of the interviewees responding to the question said that at some time in the past year they had to quit a job, school or training activity in order to care for a child; and 21 or 36%, said that they were unable to take a job, start school or a training activity because of the need to care for a child.
- *Interviewee learning disability.* Thirty-six interviewees reported they had been referred for learning disability testing.[34] Of the 36 referred for more testing, seven had a learning disability, 15 did not, seven were still being tested, and seven did not know the results for sure. Only two of the seven with a confirmed disability reported actually receiving services, and services were part of the client's welfare-to-work plan for only one client.
- *Criminal justice contacts and history.* At intake, staff report that 25 persons (10% of the study sample) had a criminal justice history of some sort, including 11 persons who had been arrested and 12 who had spent time in jail during the prior year.[35] Twelve persons had been convicted of a felony in the past, and nine of these were drug related. During the course of the project, five persons were arrested and spent time in jail. A total of 23 of the 243 were known to have had some criminal justice contact during the study period for issues such as child support, domestic violence, acts of their child, littering, and traffic violations.
- *Problems with child care.* Ten percent of interviewees said in the prior six months they had quit or been fired from a job due to problems with child care; 22% said they had often been late for, or absent from, work, school or a training program; and 25% said problems with child care had kept them from looking for work, taking a job, or participating in training or school. In all, 30% reported one or more of these problems due to child care difficulties.
- *Problems with transportation.* Quitting or being fired due to transportation problems in the prior two months was reported by 8% of interviewees; being often late or absent was reported by 24%. Lack of transportation kept 21% from looking

for work or participating in training or school. Overall, 29% of the 174 interviewees reported some sort of employment-related negative consequence due to transportation problems in the prior two months.

- *Other practical barriers listed by interviewees.* Persons who did not work or said they were disabled or in school were asked to say whether particular barriers to employment affected them (other than those discussed already). "No work clothes" and "health problems" were the most frequently mentioned issues; but "no permanent address" and "domestic violence" affected at least a quarter. A quarter also said they were not interested in working at the time.

Program assistance

The program provided only limited assistance with child care problems, and the CalWORKs contribution was minimal.

According to interviewees, help with child care was provided by the HCFP to 63 persons (36% of the interviewees). Of these, 21 (one-third) were among those who said they had problems with child care. However, 32 (60%) of those having problems with child care reported they did not receive help with child care. Those interviewees who said they had received help with child care were asked how satisfied they were with it. Overall 76% were very satisfied and 11% were somewhat satisfied.

Only 26 (11%) of the 239 persons with DPSS data received child care from DPSS. (See Table 14 for month-by-month data.) Those who did receive help through DPSS got it in 10 to 16 of the 16 months. It is unclear why some received assistance and others did not. Certainly most of those working would need child care (some children might be old enough to care for themselves). Yet, DPSS data show, for example, in May 2006 only 10 of 40 persons working (25%) received child care assistance through CalWORKs.

More assistance was provided by the project for transportation.

Overall, nearly three-quarters (74%) had to rely on public transportation; 56% had no drivers license and another 18% had a license but no access to a car. The need for transportation assistance was viewed as a fundamental barrier in the design of the project.

As a result, LAHSA staff provided transportation to mental health appointments and to shelters in a van as part of the project. Some assistance in looking for appropriate rentals was also provided. For managing all the transportation needs of persons simultaneously seeking housing and employment (or school or training) this was a necessary but cumbersome approach.

Table 14: Number and percentage receiving DPSS transportation or child care assistance, by study month

Month	Total with data	Percent receiving transportation help	Percent receiving child care help
Jan-05	212	21%	10%
Feb-05	215	26%	11%
Mar-05	221	37%	10%
Apr-05	227	51%	10%
May-05	233	64%	11%
Jun-05	230	69%	11%
Jul-05	235	70%	11%
Aug-05	237	75%	11%
Sep-05	235	76%	11%
Oct-05	233	76%	11%
Nov-05	230	77%	11%
Dec-05	227	76%	11%
Jan-06	225	74%	12%
Feb-06	226	72%	12%
Mar-06	221	71%	11%
Apr-06	212	67%	11%

DPSS data (Table 14) show that as many as 76% received transportation assistance in one month. Overall, 90% received DPSS help, which closely matches interviewee reports.

Overall, 88% of interviewees reported receiving transportation assistance. Of the 152 who did, 44 were among those who reported experiencing transportation-related problems; six others who reported problems said they did not receive assistance with transportation. Of those who did receive assistance, 75% overall were "very satisfied" and 21% were "somewhat satisfied" with the assistance they got.

Thus, few participants who experienced problems were not provided help (only six), and 90% of those who experienced problems

were at least somewhat satisfied with the help they received. These figures indicate very high rates of satisfaction, but also raise concern that 30% of participants were nonetheless experiencing job-related transportation problems.

About a quarter of study participants received remedial education or vocational training through CalWORKs.

A total of 23 (9.6%) of 239 participants had remedial education recorded on their welfare-to-work plan. Vocational training or job skills training was listed for 44 persons (18.4%).

Findings suggest that specific job support provided by the HCFP was useful.

Staff indicated (on the discharge summaries) that they had provided specific supports to 155 of the 226 participants (69%) to help them prepare for, find or maintain employment. This varied from trouble-shooting with a participant's employer, to referral to the STEP program or other employment services, to requiring the participant to enroll in a computer class, to taking a participant to the school she was enrolling in, to stress management around balancing work and home responsibilities, to helping client get a birth certificate needed to enroll in school, to assisting with car repairs so the client could look for a job.

We have some evidence from staff that the assistance provided was helpful because the average number of hours worked per week at discharge (all clients not just those working) was significantly greater for those who received help than those who did not (13.7 hours vs. 9.1 hours). Those who received specific help also had a statistically significant higher monthly income at discharge (mean of $875 vs. $753).

Work-related outcomes

Staff judged that capacity to work increased for more than a quarter of the HCFP participants.

At discharge, staff rated change since intake in the capacity to look for, find or retain a job. Change was rated for 205 participants, with 25% judged to have made strong positive changes, 42% to have made some positive change, 27% to have stayed the same, and 5% to have changed for the worse.

A total of 24% of interviewees worked part- or full-time in May 2006.

Table 15 shows all categories of work reported by interviewees. Full-time work was reported by 14%, part-time work by 10% and student status by 13%.

Table 15: Interviewee report of workforce status, May 2006

Workforce status	N	Percentage
Working full time	24	14%
Working part time	17	10%
Student	23	13%
Laid off	1	<1%
Looking for work	40	24%
Unemployed, not looking	28	16%
Disabled	12	7%
Not in labor force	25	15%
Total	170	100%

Staff describe work readiness of some clients:

- *Client's capacity to work has increased because client is close to receiving a GED. Also client has gained self confidence.*
- *I believe that client can get a full-time job. She has permanent housing. This was her barrier to getting a full-time job.*
- *Capacity to work increased because completed truck-driving school; gained a skill and confidence.*
- *Capacity to work has not changed, but her ability to secure and maintain employment have improved due to being more focused and resolution of DV issues.*
- *Client has had an increase in medical problems. Client has gone on two job interviews in which she was offered the job but could not take it due to health issues.*
- *The client has become more dependent on the system and less motivated to work.*
- *The client now has six children. Her husband was deported to Mexico. I think client may not be ready to work now.*
- *Client continues to have same issues as before. She is homeless, has health issues, and family relatives have passed away. Client is not ready to work.*

Table 16: Type of exemption in each study month

Month	Total with DPSS data	Pregnant or caretaker	Single parent working at least 32 hours a week	Disabled
Jan-05	212	12.7%	1.4%	1.9%
Feb-05	215	14.0%	0.9%	1.9%
Mar-05	221	13.1%	1.8%	2.7%
Apr-05	227	13.2%	2.2%	3.1%
May-05	233	12.9%	2.2%	2.6%
Jun-05	230	13.9%	3.0%	2.2%
Jul-05	235	12.8%	3.8%	3.0%
Aug-05	237	13.1%	3.4%	3.8%
Sep-05	235	11.9%	3.4%	4.3%
Oct-05	233	12.9%	3.0%	3.9%
Nov-05	230	10.4%	3.5%	5.7%
Dec-05	227	9.7%	3.5%	4.0%
Jan-06	225	9.3%	4.4%	3.6%
Feb-06	226	9.3%	5.3%	3.5%
Mar-06	221	7.7%	5.4%	3.6%
Apr-06	212	8.0%	5.2%	3.3%

Exemptions from work-related requirements were primarily due to caretaking responsibilities.

One important category related to employment is clients who are "exempted" from work and other welfare-to-work requirements—who we would not expect to be working. Table 16 shows the major categories of exemption month by month during the study period.

Overall, 37% of the participants were exempt at some time in the study period, with 23% exempt due to pregnancy, having a very young child, or being caretaker for a disabled person, 8% due to working 32 hours or more a week, and 8% due to being disabled.

Welfare-to-work requirements may also not apply if participants are sanctioned. During the study period, a total of 33 (14%) of 239 study participants were "deregistered" from GAIN with a notation that they were sanctioned.

Earned income increased over time and in April 2006 averaged almost $1,000 a month for the 19% of participants who had worked in the month.

As shown in Table 17, the percentage working increased from 10% in the first month to 19% in the last study month. Earnings per person for those

Table 17: Percentage working and average earnings in each study month

Month	Total with DPSS data in month	Number working	Percent working [36]	Average earnings
Jan-05	212	21	9.9%	$542
Feb-05	215	16	7.4%	$564
Mar-05	221	22	10.0%	$597
Apr-05	227	21	9.3%	$623
May-05	233	21	9.0%	$902
Jun-05	230	25	10.9%	$749
Jul-05	235	24	10.2%	$910
Aug-05	237	28	11.8%	$831
Sep-05	235	28	11.9%	$945
Oct-05	233	34	14.6%	$906
Nov-05	230	31	13.5%	$939
Dec-05	227	32	14.1%	$1,147
Jan-06	225	37	16.4%	$997
Feb-06	226	37	16.4%	$939
Mar-06	221	37	16.7%	$1,140
Apr-06	212	40	18.9%	$954

working, however, almost doubled from an average of $542 to an average of $954 (and were even higher in March).

A total of 31% of the participants were shown in DPSS data to have worked during the study months. (The actual total is somewhat higher because a few participants left CalWORKs when they got well-paying jobs and do not show up in these data.)

Total income was from a variety of sources and averaged about $900 a month.

Interviewees were asked to describe the amount of income they received in the prior 30 days from a large variety of sources, including employment, SSI or SSDI, unemployment insurance, CalWORKs, General Relief, child support, the Department of Veteran's Affairs, and from friends and relatives. In addition to employment income, 19 persons reported getting sums of between $50 and $1,000 from family or friends. Twenty-two persons received child support; it was $100 or less for 15 persons. Eighteen people reported getting SSI benefits. Three persons listed GAIN transportation funds, four persons indicated a working spouse or partner, one person received Social Security benefits, one person listed a Pell grant, one person received workers compensation, one person's husband received SSI and Social Security, one person listed a small VA payment, and one person received work-study payments.

Table 18 shows total income for the 169 interviewees who listed their sources of income in May 2006. Income of less than $580 per month was reported by 17% of the interviewees (the mean in this category was $419). On the other end of the scale, 20% had income between $1,221 and $2,522 (mean of $1,597). Overall, the mean income was $900 per month. Because we asked about such detailed categories and included support from friends and relatives, we think this information is reasonably valid.

Table 18: Interviewee total income for month

Income	N	Percentage	Mean income in this category
$100-580	28	17%	$419
$581-720	35	21%	$614
$721-860	36	21%	$783
$861-1,220	36	21%	$1,013
$1,221-2,522	34	20%	$1,597
Total	169	100%	$900

CHAPTER VI: CHILD WELL-BEING

Status of children in the HCFP

Because homelessness frequently has negative consequences for children[37] it is important to understand whether and how the project affected the well-being of children in the HCFP families.

Approximately 90% of the children in the program attended school regularly.

As noted above, school attendance was made difficult by the fact that shelters were often far from where the family had been living. While school districts are required, under the McKinney Act, to provide transportation to homeless children, their commitment to this varies. At intake, staff reported all children in 83% of families were believed to attend school regularly; this was 87% at discharge or in May 2006.

In about a quarter of the families, parents told staff that a child had school, emotional, or health problems.

At discharge or in May 2006, staff were asked whether clients had identified any significant problems with any of their children. A total of 66 parents had identified problems with a child or children to staff. The largest categories were school-related problems (17 cases) and behavior problems (11 cases); mental health, medical and developmental problems were also reported.

Food insecurity occurred for about two-thirds of the HCFP interviewees in the two months prior to the interview.

Worries about food running out affected two-thirds of the interviewees in the two months prior to the interview. Strategies parents used included cutting the size of meals or skipping meals (34%) and using a food bank (28%). Twenty-one persons (13%) said, "There was a time when my children were hungry because I just could not afford to buy food." Fifteen of 21 persons saying "yes" to this question reported it occurred more than one day a month in the prior two months. The vast majority of those reporting their children had been hungry (80%) were currently enrolled in the program, not those who left early.

Staff rated parenting capacities as having improved for over half of the parents.

Staff rated their perception of client parenting abilities at admission and at discharge (or in May 2006). Table 19 shows little change toward more positive parenting categories for the 187 parents rated at both times.

Table 19: Mental health staff ratings of participant parenting ability at intake and discharge

Percentage at intake N=187	Percentage at discharge N=187	Rating
20%	14%	Very good
52%	64%	Good
24%	18%	Inconsistent
3%	<1%	Deficient
<1%	4%	Unsafe
7%	0%	Can't judge

Client reports of reasons for food insecurity:

- ❑ *Where we are staying you can't cook, so we had to spend more money to purchase food out. Made us run out of funds faster.*
- ❑ *My food stamps would run out. DPSS cut my food stamps. Fifty dollars doesn't go very far at the grocery store.*
- ❑ *I don't get food stamps until the 10th. All my money goes towards rent and bills. I have trouble getting food while waiting for food stamps.*
- ❑ *Transportation, getting the food and bringing it back. Sometimes the food pantries are closed or don't have enough food or you don't live in their area so they won't give the food to you.*
- ❑ *Used food stamps to give to people that let me stay. I was homeless and they took advantage. I bought them groceries then they make an excuse and threw me out.*
- ❑ *Well I only get $181/month from food stamps. That covers about two weeks. That leaves me with about $200 that I need to pay for with my own cash. Then I have to pay bills, too. That leaves me with little money left.*

Child-related services

While 83% of interviewees said their children got needed medical care, only 33% said they got needed mental health care.

Interviewee reports of service receipt. We asked interviewees how often in the past three months the child had gotten care they needed for medical problems, for emotional or behavioral problems, and for dental care. The numbers in the tables vary because parents could say the question did not apply to their children.

As shown in Table 20, receipt of medical care appears to be very high, but receipt of dental care is less so—a persistent problem among poor Californians with Medi-Cal. Of most concern is the large percentage of families in which a child who apparently needed mental health services, or at least an assessment, did not get these services.

Staff reports of mental health treatment and referrals. Staff reported children in 27 families (out of 246) were seen by agency mental health clinicians. In addition to these small numbers provided treatment directly, staff reported that children in 80 of 246 families were referred to services, either by the project or a related agency such as a shelter. For the 48 cases referred by HCFP, 39% followed through and got services, 40% did not follow through on the referral, and staff were uncertain in 21% of the cases. Thus in both parent and staff reports lack of assessment and treatment for mental health problems is a significant problem.

Some HCFP participants reported receiving assistance in obtaining child support, but 28 parents received no child support (despite a child support order) and received no HCFP assistance with securing child support.

Fifty-three of the interviewees said their oldest child was covered by a child support order.[38] In the past 12 months 19% reported receiving the full amount, 30% a partial amount, and 51% no payments.

A total of 21 persons reported getting help from HCFP in obtaining child support. Eleven of these were "very satisfied" with the help they received, and 10 were "somewhat satisfied." However, of the 29 cases in which none of the child support was paid, only one reported getting help from HCFP. GAIN staff may need to be more systematic in discovering the need for child support assistance.

A small number of children were placed out-of-home by child welfare services during the study period. The minority of interviewees who received assistance regarding child custody (and other legal issues) were very satisfied with the assistance provided.

Client involvement with child welfare services. Staff reported that in 16 cases a child had been placed out of the home by child welfare services (in two cases this was with a relative). Of these 16 cases, 10 occurred during the study period. During the same time, one was restored and reunification plans existed for seven families. A number of other children lived away from the parent as well: two were in residential treatment, six lived with the other parent, and 10 were living with relatives.

Assistance with legal issues. Interviewees were asked specifically whether they received help from the HCFP regarding child custody, child welfare, or other legal problems. Overall, 21 of the 174 interviewees (12%) reported getting help with these issues. Of these, 90% said they were "very satisfied" with the help they received, and the remaining 10% were "somewhat satisfied."

Table 20: Children received needed medical care

Got needed care…	Medical care past 3 months N=143	Mental health care past 3 months N=85	Dental care past year N=164
Always	83%	33%	71%
Sometimes	16%	24%	15%
Never	1%	44%	14%
Total	100%	100%	100%

CHAPTER VII: SUBSTANCE ABUSE AND DOMESTIC VIOLENCE

Substance abuse

Substance abuse—by itself and as a contributing factor to emotional problems and to domestic violence—contributes to homelessness for a small percentage of HCFP participants.

The Beyond Shelter survey of family homeless shelters found substance use to be a primary cause of homelessness for 5% of families; it was listed as a cause by 4% of HCFP interviewees. The effects of substance use and abuse go beyond causing homelessness, however. HCFP staff report that participants with substance abuse problems have great difficulty in meeting program requirements and being successful.

Although up to 15% of interviewees described themselves and their partners as recovering substance abusers, only about 2% admitted to active substance abuse.

As a summary measure of the role of alcohol and drugs in the lives of participants (and their partners) we asked interviewees to classify themselves among the categories in Table 21.

Only 2% of interviewees said they were currently an alcoholic or drug addict or that they were a problem drinker or drug user, but partners were more likely to be characterized this way. Much higher percentages (8% to 15%) characterize persons in recovery from alcoholism or drug addiction—both HCFP participants and their partners.[39] A significant percentage of participants (26%) said they have an occasional problem with drinking, and 20% said they use drugs in a social way.

Attendance in the prior two months at an AA or NA meeting was reported by 29 persons out of 174; seven persons said they currently have a 12-step sponsor. Four persons said they had been unable, in the past year, to get desired treatment for alcohol or drug problems.

A DPSS GAIN service component for substance abuse was opened for 7% of the participants.

Just as participants were receiving mental health services through GAIN, some also received substance abuse services. A total of 18 persons, or 7.5% of the 239 persons with DPSS data had substance abuse treatment as part of their welfare-to-work plan.

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

According to staff ratings,[40] four of eight who were abusing alcohol at intake were abstinent at discharge, while one had progressed to being dependent on alcohol. Of the four with dependence at intake, one was unchanged, two were now abstinent, and one was not rated.

Ten of the 13 persons abusing drugs at intake had reduced use or were abstinent at the discharge rating. Four of the 11 persons judged to be dependent on drugs at intake reduced use or were abstinent, two were still dependent, and four were not rated at discharge.

Table 21: Interviewees' categorization of alcohol and drugs in their lives

	Alcohol Percentage N=173	Drugs Percentage N=171
An alcoholic/drug addict	1%	1%
A recovering alcoholic/drug addict	8%	15%
A problem drinker/drug user	1%	1%
A recovering problem drinker/drug user	2%	1%
An occasional problem with drinking but not a problem drinker/not a problem drug user	26%	2%
A social drinker/drug user	22%	20%
A non-drinker/drug user, although I used to drink/use drugs	40%	59%
A non-drinker/drug user and have never been one	1%	1%

At discharge (or the rating made in May 2006) staff were asked to rate how much change had been made by those who had a substance abuse problem at intake. Of 42 persons they rated (indicating substance abuse at intake), nine had "strong positive change," nine had "some positive change," 16 had "no change," and eight had "negative change."[41]

Family violence

Most of the women had a history of some family abuse; and while only a few were currently in an abusive relationship, 15% reported feeling unsafe due to a prior partner.

Interviewee reports on domestic abuse. As noted above, domestic violence was a significant precipitant of homelessness among HCFP participants and was listed by many as a barrier to employment.

Past abuse was very common: a total of 80% of the interview respondents reported they had experienced (at least one of) physical, sexual, or severe emotional abuse as a child or adult or had witnessed or been the victim of other violence; many experienced multiple types of abuse. Current abuse was not common: only three persons of the 75 with a current partner said they had "often" been emotionally abused in the past two months, and 10 persons said "sometimes." Three persons said they feel unsafe in their present relationship. One person said she had been "hit, kicked, punched or otherwise hurt" by her current partner.

Safety issues from previous relationships affected many: 26, or 15% of the interviewees, said a past partner was making them feel unsafe; three persons had been "hit, kicked, punched or otherwise hurt" and one had been sexually assaulted by a previous partner within the two months prior to the interview.

A domestic violence service was part of the welfare-to-work plan for 18% of participants.

Of the 229 study participants for whom DPSS data is available, 43 or 17.9% had a domestic violence service as part of their welfare-to-work plan at some point in the study period.

Staff rated domestic violence situations as improving, overall. During the study period, staff rated serious abuse as decreasing from 21 to 10 persons and lesser abuse decreasing from 36 to 22 persons, but abuse may be a cause of early drop-outs.

Staff ratings of domestic violence at intake and discharge were available for 198 persons. There are overall substantial changes for the better: no abuse increased from 141 to 166, serious abuse decreased from 21 to 10, and lesser abuse decreased from 36 to 22 persons.

Confirmation of these positive changes is found in the reduction of participants who had a restraining order against a partner to seven at discharge vs. 22 at intake, as well as the reduction of participants having a CalWORKs domestic violence waiver to eight at discharge from 20 at intake. These figures are not quite so clear as they seem due to attrition. For example, of the 22 persons at intake with a restraining order, only 14 were rated at discharge; five still had restraining orders and nine did not. We don't know about the other eight persons who left the program and were not rated at discharge. Similarly, 12 of the 20 persons with a DV waiver at intake left the program early and were not rated.

Thus, while results are positive for participants rated both times, the relatively high rate of attrition among those with domestic abuse suggests that the abuse may be related to leaving the program early.

Client descriptions of current domestic violence situations:

- ❏ *I get panic attacks when I think I see my ex. I'm afraid he's going to find me or someone will tell him where I'm at.*
- ❏ *My husband is very abusive. He's not physical, just verbal abusive and talks down to me. We're getting marriage counseling. We've been married for eight years, together for 10. It's been a lot of tension now that we've been separated this past eight months. He's living at his mom's. Once we find an apartment, things will go better, hopefully.*
- ❏ *It bothers me a lot. A year ago his father showed up at my son's work, deeply traumatizing my son. I feel he endangers our lives. We don't want him to know where we are.*
- ❏ *I need help but he also does meth and doesn't want to do anything to stop it. He's very, very possessive—more than I have seen in my life.*
- ❏ *I am depressed from all the mental abuse. I guess all of the trauma made me insecure. I don't trust people and I am paranoid of being by myself.*
- ❏ *The abuse happened with a past relationship. I have a restraining order. He is still going to my relatives' homes looking for me.*
- ❏ *It's emotionally draining. It's stressful and then I lose weight. I'm always looking over my shoulder.*

CHAPTER VIII: PREDICTING HOUSING SUCCESS

Determining who will be successful in finding housing is complex, but analysis of factors potentially influencing success yields some clues.

It would be useful for both policy and program planning to understand what factors account for some HCFP clients successfully obtaining permanent rental housing vs. those who remain in temporary housing. Using multiple regression, a statistical tool used for "holding constant" the effect of all other factors while looking at the effects of each factor individually,[42] we explored the influence of various potential contributors to success in finding housing. The major factors considered included the following:

- *Human capital attributes:* having less than a high school degree, a poor work history, having a two-parent rather than single-parent family, and the number of minor children in the home.
- *Affiliation with family and friends:* nature of relationship with a spouse or partner; nature of relationship to other family and friends; and having children living with relatives.
- *Personal problems:* drug abuse, serious mental health problems, and criminal justice history.
- *Program participation:* the degree to which parents participate in the HCFP, attend therapy, and stay enrolled over time.
- Staff predictions at intake of housing success.

Certain personal problems—criminal justice involvement and substance abuse—played a significant role in whether or not participants remained in temporary housing.

The extent to which participants indicated they had criminal justice history within the prior year and substance abuse (self or staff rated) were predictive of housing status. Having a recent criminal justice history increases the odds of being in temporary housing versus rental housing by 167%, holding other factors constant. Having a substance abuse problem during the study period increases the odds of being in temporary housing rather than with family or friends by 236% and the odds of being in temporary housing rather than in rental housing by 148%, other factors being equal.

But not all the personal problems studied had an impact. Neither the presence of mental health problems that interfered with client functioning, scores on the MADRS depression test, nor learning disability were predictive of housing status in May 2006.

Apparent problems associated with parenting appear to negatively affect the success of obtaining permanent housing.

Having any relationship during the study period with child welfare services (even non-confirmed complaints) increases the odds of being in temporary rather than rental housing by 288%, holding other factors constant. If children were staying with relatives, the odds that the parent was living in temporary housing were 430% higher than the odds that they were living in rental housing.[43]

Active participation in HCFP did not predict the success of leaving temporary housing except paradoxically for the lowest users, who were more successful.

Staff judgments of how regularly vs. irregularly clients participated in therapy, client dissatisfaction with the program, or whether clients were still enrolled in May of 2006 were not predictive of housing success.

Lower levels of service were associated with greater success in leaving temporary housing. The odds of being in temporary housing rather than living with family or friends were decreased by 95% for the 14 parents who had less than 20 hours of case management or therapy time; the odds of living in temporary rather than rental housing were decreased by 91%. Thus paradoxically, low amounts of HCFP mental health service are associated with better outcomes. Table 22 shows the basic frequencies.[44]

A subset of parents very quickly found housing and did not continue to participate in the program. People who left early (got little service) were much more successful than those who got more service at leaving temporary housing. Thus, while it appears that the program was not helpful; in fact, these families appear to have had less need of the program.

For the 22 parents who were dropped by the HCFP, very similar results are found. The odds of being in temporary rather than housing with family or friends are 98% lower and 91% lower than being in rental housing.

Table 22: Type of housing in May 2006, by high and low mental health service receipt

Type of housing in May 2006	More than 20 hours N=57	Less than 20 hours N=90
Temporary housing	36%	7%
Living with family or friends	12%	36%
Long-term rental housing	52%	57%
Total	100%	100%

Other factors were hypothesized to predict success in housing status but did not.

None of the human capital factors made a difference in housing success; we conclude that while these may be important in finding well-paying employment, they are not important in a housing assistance model like the HCFP. None of the relationship factors nor the time homeless appeared to impact housing success.

Staff were able to predict who would leave temporary housing with considerable accuracy.

Because they can incorporate all of the factors mentioned above, plus intangibles that we did not measure, staff predictions should be highly accurate. Table 23 shows the basic predictive ability of staff (unaffected by other causal relations).

Results support including substance abuse as an explicit focus of the HCFP.

What can we learn from this analysis about how the program model should be structured? Mental health problems did not appear as a significant barrier to rental housing, but we believe that this arises from the fact that those with greater mental health needs received more assistance. Substance abuse was a barrier to leaving temporary housing; however, and this fact suggests more resources need to be available to help participants with their substance use patterns.

The same factors are statistically significant predictors when receipt of a housing subsidy is also held constant.

Table 23: Type of housing in May 2006, by staff prediction

Type of housing in May 2006	Predict high success N=57	Predict moderate success N=90	Predict low success N=24
Temporary housing	23%	39%	37%
Living with family or friends	14%	11%	25%
Long-term rental housing	63%	50%	37%
Total	100%	100%	100%

There is definitely a trend for the staff predictions to be correct.[45] Of those predicted to have good success, 63% were in long-term rental housing in May 2006, vs. 50% if moderate success was predicted, and 37% if low success was predicted.

The factor was predictive in a limited way in the multivariate analysis as well. Predictions of low or moderate success were not statistically significant, but prediction of high success was. The odds that someone predicted by staff to be "highly likely" to obtain long-term rental housing (rather than temporary housing) was 148% in favor of rental housing.

In the model discussed above, we did not include obtaining a Section 8 or other rental subsidy as a factor. Since we know that is important, we wanted to know what *other* factors predict housing success. However, we did rerun the statistical model with receipt of a Section 8 or Shelter Plus Care included as a predictor. While the other predictors discussed above continued to be statistically significant when housing vouchers were held constant, receipt of a voucher was, as expected, a strong predictor of having left temporary housing, second only to staff predictions of housing success at intake.

CHAPTER VIIII:
TAKING ACTION TO MEET THE NEEDS OF HOMELESS FAMILIES

Policymakers

For the project to succeed, the Board of Supervisors must ensure that most HCFP participants have housing subsidies.

Results show that about one-fourth of study participants found long-term rental housing using the very limited number of Section 8 vouchers available (50 were designated for the HCFP) and Shelter Plus Care vouchers. Between 15% and 20% of participants were able to find long-term rental housing using other means (including finding employment). Most of the 55% who did not find long-term rental housing during the study period suffered a variety of negative consequences, and their chances for finding housing in the next few months are not good.

In July, a new cohort of clients began being served. ZERO Section 8 vouchers are earmarked for this additional group of 350. Thus, 35% of last year's clients, plus all of this year's clients, must try to find housing without Section 8 vouchers. If last year's results continue to apply, no more than one in five of these families will be successful in the next 18 months at enormous cost in dollars and frustration for families and staff.

From a policy-perspective, it is not cost-effective to fund mental health and related services over months and even years while disregarding the basic need for housing income supplements.

Administrators

Project administrators should consider greatly reducing the Downtown Mental Health caseloads and assigning the cases of families who have lived in other parts of the county to the agencies in those regions.

Most families get placed in shelters outside of downtown and thus need to be transported back to downtown for their mental health services. Ultimately the goal is for families to relocate in their old regions or in some region other than downtown. So it makes sense that they see service providers where they intend to live rather than transporting them back to the Skid Row area to receive services.

The Project Steering Committee should consider making substance abuse an explicit focus of the program and having a designated SA specialist at each site.

Staff at all sites say that they suspect unreported substance abuse is a problem for up to half of the families. This is usually alcohol or marijuana, not harder drugs, but it can interfere with functioning. Clients do not report use for fear of losing their children or getting kicked out of shelters and because they do not feel it interferes with their functioning. Some staff members report that families in which SA is an issue do not do well in this program when the issue is not addressed. LAHSA reports some families who must move from shelter to shelter due to violating alcohol and drug rules.

DMH should ensure that mental health staff at each site include child/family therapists, so that all families can be offered mental health assessments for their children and co-located treatment if needed.

Mental health staff at the sites estimate that as many as 50% of the families have children with behavioral problems. While some HCFP interventions, such as parenting counseling or classes, address these issues teams should have a greater capacity to assess children in the family for mental health problems and provide child and family therapy as needed.

HCFP GAIN staff need to be more systematic in discovering the need for child support assistance.

Of the 29 cases in our study group in which a child support order existed but none of the child support was paid, only one person reported getting help from HCFP staff.

Each mental health agency should have one or more "dedicated" therapists.

In at least one site, clients were accepted whose therapist was in a different agency—causing coordination problems. In another site, as many as five different therapists see clients. In another site, getting access to a therapist has been difficult. We recommend that the therapist(s) be fully integrated into the service team rather than an adjunct function as has occurred in some sites.

Each mental health agency should have one or more "dedicated" housing specialists.

The site with the most proactive housing specialist helped 71% of participants find long-term rental housing. In other sites, this percentage was as low as 21%. While differences in regional resources and client characteristics affect these results, we think a dedicated housing specialist (not just case management) will pay off.

ENDNOTES

1 Applied Survey Research. (2006). 2005 Greater Los Angeles Homeless Count. Los Angeles: Sponsored by the Los Angeles Homeless Services Authority. 452 S. Spring Street, 12th Floor. Los Angeles, CA 90013.

2 Ibid.

3 In our view, these are conservative estimates. See: Bono, M., Toros, H., Mehrtash, F., & Moreno, M. (May 2005). CalWORKs Homeless Families. Retrieved May 19, 2005, 2005, from http://www.ladpss.org/dpss/REQAD/pdf/cw_homeless_families_2005.pdf

4 The Economic Roundtable found 24% of persons with a mental health supportive service in their welfare-to-work plan had a homeless flag in their record. (Personal communication from Dan Flaming, President.)

5 The methodology for reaching this number is described in: Chandler, D., Meisel, J., & 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.

6 Ibid.

7 Ibid.

8 The California Legislature established special treatment services for CalWORKs participants with mental health issues. Funding is through the CalWORKs allocation but services are provided by county Department of Mental Health providers. The treatment services of the HCFP project are provided under this provision.

9 These are estimates based on our study sample rather than data for the entire project.

10 Downtown and PROTOTYPES clients who were carried over from the prior year were not included, and to match the other sites only the first 50 of Downtown's 100 clients were included. A total of 283 project participants, thus, was intended to comprise the study sample. In the event, a total of 255 participants signed consent forms, but attrition reduced the sample to 246—87% of the intended size. An appendix on methodology, available at www.cimh.org/calworks, contains measures of how representative our sample is.

11 Overall, those interviewed are similar to those not interviewed in reasons for attrition and in employment patterns and GAF admit scores but differ in the percent leaving the program early, education level, age, diagnosis, amount of services received, and housing status. It is likely that the group interviewed is somewhat better educated, less impaired by their mental health symptoms, more likely to stay in the program, and more likely to have obtained positive outcomes through the program than those not interviewed.

12 There may in fact be no marginal cost at all if workloads were simply rearranged in order to provide lower caseloads for HCFP staff. Whether work was reallocated in DPSS offices to accommodate the reduced caseloads for staff serving HCFP clients is not known and might constitute a "cost" of a different kind—one borne by other workers and other clients. For our purposes, we estimate the HCFP Project opportunity cost is approximately $382,949 staffing cost per year. We calculate six eligibility workers at $2,688.55 per month (Eligibility Worker II, minimum based on "Class and Salary" listings on http://dhr.lacounty.info/) is equal to $193,576, and six GAIN services workers at $2,630.18 per month is equal to $189,373, for an annual total of $382,949.

13 DMH Information System data was drawn from different systems due to ongoing changes in the IS system. GAF scores were available only on the largest group. However, we tested the representativeness of this group by comparing the MADRS depression scores for it with all other clients; scores were very similar.

14 Ware, J. E., Jr., Kosinski, M., & Keller, S. D. (1995). *SF-12: How to Score the SF-12 Physical and Mental Health Summary Scales:* The Health Institute, New England Medical Center, Boston, MA. Ware, J. E., Jr. (1994). *SF-36 Physical and Mental Health Summary Scales: A User's Manual* (4th ed.). Boston: The Health Institute, New England Medical Center.

15 A mean of 40 for enrollees vs. 45 for early leavers: P= 0.0696

16 A regression of mental health scores on age was statistically significant at P=0.003. For example, scores for persons over the age of 45 averaged 37.9.

17 This is an interesting finding because in last year's study of Phase II symptom scores were correlated with type of housing. See page 10-11: Chandler, D., Meisel, J., & 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.

18 As noted above, the admission Global Assessment of Functioning rating for about 10% of clients was below 40, a score consistent with the need for disability income.

19 SSI income was reported by 18 interviewees out of 174 in May of 2006.

20 Pearson chi2(1) = 16.0022 p = 0.000

21 Average change for depressive disorders is .90 (p=0.000), for severe and persistent disorders it is 1.29 (p=0.001); for anxiety and other disorders it is .20 (p=0.122).

22 Average change for those still enrolled was .49 (significant at p=0.000); for those leaving early it was .95 (significant at p=0.000). The difference in amount of change for the two groups is significant (p=0.023).

23 Mental and emotional feelings were defined as being depressed, stressed out, unable to sleep or sleeping too much, being very anxious or worried or very irritable, or not being able to get yourself going each day.

24 p= 0.253

25 p=0.029

26 The DPSS study by Michael Bono and colleagues published in 2005 found 84% were homeless less than a year. Bono, M., H. Toros, et al. (2005, May 2005).

CalWORKs Homeless Families. Retrieved May 19, 2005, 2005, from http://www.ladpss.org/dpss/REQAD/pdf/cw_homeless_families_2005.pdf.

27 According to a new Beyond Shelter study, emergency and transitional shelters that serve families can provide for only about a quarter of the nightly population of homeless families. The Beyond Shelter study reports 37% of family shelters limit age of boys, 42% limit two-parent families, 42% require several months of sobriety and 23% do not accept those with mental disorders or who are taking psychiatric medications, and 12% do not accept persons with recent domestic violence.

28 We include vouchered hotel or motel, emergency homeless shelter, domestic violence shelter, rented room in a hotel, and living on the streets or a place not designed for human habitation. Other arrangements may also have been very tentative, e.g. living with friends.

29 DPSS staff compiled a tabulation of living situation as of the end of May). They had data on only 162 of the 243 participants in the study. The percentages in long-term rental housing and transitional housing, respectively, were 56% and 14%. Two percent were in jail and 12% in an emergency shelter. So these percentages are quite similar to staff ratings. Of the 174 persons interviewed, 43% were in rental housing, 14% reliant on family or friends, 17% in transitional housing, and 16% in temporary housing such as emergency shelters.

30 The living situation at discharge or in May 2006 for 22 participants could not be rated by staff because it was unknown. In addition, ratings for non-enrolled clients were made in some cases many months before May 2006 (at the time participants left the program).

31 Mental health staff reports differ somewhat. According to mental health staff reports, 97 persons were helped to apply for a Section 8 or other voucher. Of these, 59 were granted a voucher and of those with a voucher, 46 found an apartment and were using the voucher as of May 2006.

32 The 38 persons comprise 15% of the 246 who consented to be in the study. However, since only 192 persons were described by staff, there could be some others staff do not know about who achieved long-term rental housing. The actual percentage of those able to find rental housing without a voucher probably varies between 15% and 20%.

33 Those persons saying mental health reasons were a big problem in working had an average SF-12 mental health score of 28 (very impaired), vs. those saying it was a small problem (38), or not a problem (49).

34 This may be a low estimate of the potential number of participants with a learning disability. GAIN does not systematically screen for learning disabilities, which, if they exist, can be expected to affect job and promotion chances. We embedded in the interview a 13-item screening instrument developed and tested in the state of Washington CalWORKs program in order to estimate the percentage of interviewees likely to have learning disabilities. We found 47 persons who met the cutoff score indicating a need for a referral for a full learning disability assessment. Fifteen of these had been identified by staff and referred for an assessment, the others had not.

35 This is an area in which staff expressed uncertainty, so rates could be higher. To illustrate: in only 164 cases of 243 was information about arrest in the previous year included, and staff reported there were 16 persons they were unsure about.

36 The percentage working according to interviewees is higher than that shown in DPSS MIS data. This may reflect that the data refer to a somewhat different group of persons or, since the rate of those employed increased slowly in the DPSS data, (from11% to 17% of over the 16 months) it may just reflect an increase in those working in May over those working in April—or both. Finally, it may reflect the fact that some persons were able to leave welfare (so their income in not in the DPSS data) due to employment income.

37 Zima, B. T., Bussing, R., Forness, S. R., & Benjamin, B. (1997). Sheltered homeless children: their eligibility and unmet need for special education evaluations. *Am J Public Health,* 87(2), 236-240; Zima, B. T., Bussing, R., Bystritsky, M., Widawski, M. H., Belin, T. R., & Benjamin, B. (1999). Psychosocial stressors among sheltered homeless children: relationship to behavior problems and depressive symptoms. *Am J Orthopsychiatry,* 69(1), 127-133.

38 Since 29 of these parents had at least three children, presumably the number of children with a child support order is larger than 53.

39 We asked a number of other questions to get at substance abuse. On the basis of these questions, a total of four persons (2.2% of interviewees) would probably meet the definition of drug abuse or dependence.

40 Agency staff used the Alcohol Use Scale and the Drug Use Scale—standard rating instruments (particularly for those with both mental health and substance use disorders)—at intake and discharge (or in May 2006 for those still enrolled). Each subject was rated as abstinent, using alcohol or drugs but not to a point where it interfered with functioning, "abuse" of alcohol or drugs defined in terms of interference with functioning, and "dependence," as defined in the Diagnostic Standard Manual IV. More persons had known drug problems (24) than had known alcohol problems (12).

41 The wording here is "substance abuse problems" rather than "abuse" or "dependence," which may explain why somewhat more persons are rated at discharge than were judged to have abuse or dependence at intake.

42 We used multinomial logistic regression, with the omitted category being Temporary Housing. That is, we compared the effect of each predictor contrasting first family/friend housing with temporary housing, then rental housing with temporary housing.

43 Statistical tools frequently use odds rather than proportions. Odds of 1 in 2 is equal to a .5 proportion.

44 $P \leq 0.01$

45 $p \leq 0.09$