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# The American Guaranteed Income Studies: City of Los Angeles BIG:LEAP

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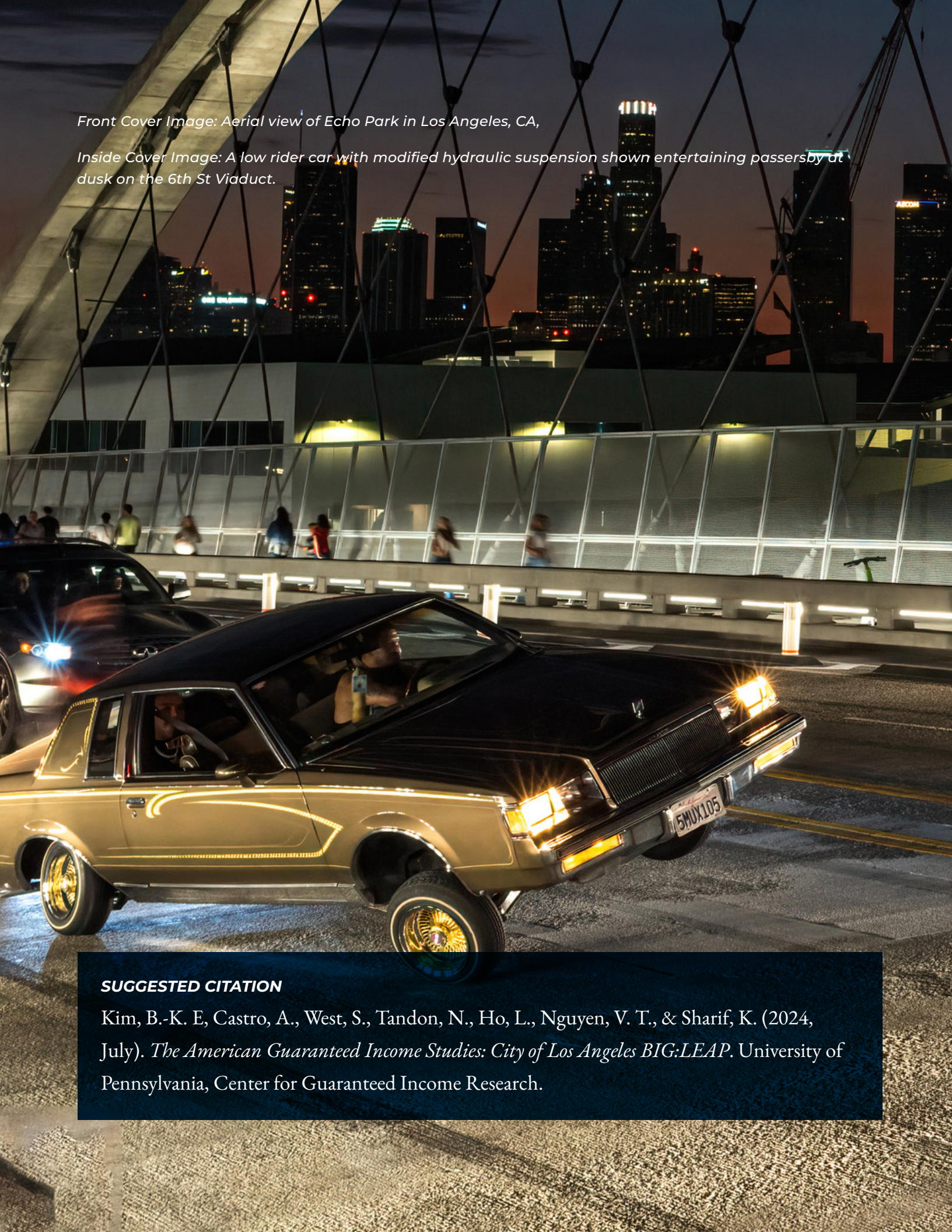
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Front Cover Image: Aerial view of Echo Park in Los Angeles, CA,

Inside Cover Image: A low rider car with modified hydraulic suspension shown entertaining passersby at dusk on the 6th St Viaduct.

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## Executive Summary

In October 2021, former Mayor Eric Garcetti announced the Basic Income Guaranteed: Los Angeles Economic Assistance Pilot (BIG:LEAP) program. Benefitting just over 3,200 households, the program provided \$1,000 per month in unconditional cash payments for 12 months to households living in deep poverty within the city of Los Angeles. To qualify, Angelenos were required to be at least 18 years old, have at least one dependent child within the household or be expecting a child, be negatively impacted by COVID-19, and fall below the federal poverty threshold. The program was implemented by the city's Community Investment for Families Department (CIFD), and supported by the general fund as well as investments from local council district leaders. Administrative costs were supported by the Mayor's Fund for Los Angeles and Mayors for a Guaranteed Income.

Announcing the program, Mayor Garcetti remarked:

***This program is a small but steady investment in a simple concept: when you provide resources to families that are struggling, it can give them the breathing room to realize goals that many of us are fortunate enough to take for granted: put food on the table and cover childcare with less stress, keep their children's focus on education, and pursue new opportunities with fewer worries about the day-to-day needs of their household.***

The Center for Guaranteed Income Research (CGIR), in partnership with the University of Southern California (USC) Suzanne Dworak-Peck School of Social Work and the University of California, Los Angeles (UCLA) Fielding School of Public Health, launched a mixed-methods randomized controlled trial (RCT) to test the impacts of guaranteed income (GI) on a battery of outcomes. The key research questions were: 1) How does GI affect participants' quality of life?; 2) What is the relationship between GI and participants' subjective sense of self?; and 3) How does GI affect participants' income, and through what mechanisms? Additional research questions, chosen by local community members and leaders included: 1) What is the relationship between GI and intimate partner violence?; 2) What is the relationship between GI and community interactions and safety?; and 3) How does GI affect engagement in child enrichment activities?

Applications for the program were open for 10 days, during which over 50,000 people applied. The sample of 3,202 people in treatment (receiving the GI) and 4,992 in control (not receiving the GI) earned, on average, approximately \$14,500 per year and had an average household size of four individuals. In 2021, the federal poverty guideline for a family of four was at or below \$26,500. With household incomes of just over half of the federal poverty guideline, BIG:LEAP participants were in

deep poverty—teetering on the edge of losing housing, struggling to pay bills, and having difficulty meeting their most basic needs in the midst of the public health and economic crisis brought on by the pandemic.

Despite perilous financial circumstances that had ripple effects on the health and well-being of participants and their families, BIG:LEAP participants experienced overwhelmingly positive outcomes with the infusion of unconditional cash. This landmark study, the largest to date that has concluded since the negative income tax experiments of the 1960s–1980s, demonstrated that GI participants were more likely to save for the future, improve their financial well-being, have sufficient food, reduce their housing cost burdens, reduce stress, maintain their physical health, leave abusive relationships and reduce experiences of intimate partner violence (IPV), support their children in after-school and enrichment activities, feel more secure and build community in their neighborhoods, enjoy a more harmonious home environment, feel that they matter in their community and to others, and take action toward their goals—in a single year and in the most unaffordable city in the country.

## KEY FINDINGS - AT A GLANCE

- » Financial Well-Being: The treatment group demonstrated a significantly increased ability to cover a \$400 emergency compared to the control group 6 months into BIG:LEAP
- » Food Security: The treatment group demonstrated a significant decrease in food insecurity and an increase in health-promoting behaviors. After 6 months, nearly 57% of the control group reported an inability to eat preferred foods, compared to about 43% of the treatment group.
- » Safety and Decision-Making: The treatment group reported reduced severity and frequency of IPV over the duration of BIG:LEAP. Narrative data captured how recipients used GI to prevent and exit IPV and homelessness. Recipients moved from establishing immediate safety in the first six months, to establishing proximate safety in months 6-9 and then establishing future safety in months, demonstrating active planning throughout the full course of the tight 12-month time frame.
- » Parenting: Treatment group parents were significantly more likely than control group parents to maintain their childrens' extracurricular activities like sports and after-school lessons across the duration of the pilot.
- » Community: Treatment group members were significantly more likely to report reduced fear of neighborhood violence and more positive interactions with neighbors across the duration of the pilot.
- » Employment: GI recipients were significantly more likely to secure full-time employment than to remain unemployed not looking for work, compared to control participants across the duration of the pilot.



# Acknowledgements

The City of Los Angeles, along with the Center for Guaranteed Income Research (CGIR), would like to acknowledge and thank former Mayor Michael Tubbs, Mayors for a Guaranteed Income, the families who participated in the study, and the numerous partners listed below.

Mayor Karen Bass

Mayor Eric Garcetti<sup>1</sup>

Brenda Shockley, Deputy Mayor of Economic Opportunity

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FamilySource Center Directors and Staff

BIG:LEAP participants



Founded by Michael D. Tubbs, MGI is a coalition of mayors advocating for a guaranteed income to lift all of our communities and build a more resilient, just America. Since launching in 2020, MGI has grown its ranks from 11 to over 125 mayors, supported the launch of 50-plus guaranteed income pilots across the country, and delivered more than \$250 million in direct, unconditional relief to everyday Americans. MGI has also launched two affiliates, Counties for a Guaranteed Income and United for a Guaranteed Income Action Fund. MGI's work has ensured that guaranteed income spreads from a single moment in Stockton, CA to a national movement—pushing the conversation forward in cities, state capitals, and Congress.

## Contributing Researchers

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<sup>1</sup> Author Note: Former Mayor Eric Garcetti is now the U.S. Ambassador to India.





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## Background

Beyond the entertainment industry, the beach, and the mirage Los Angeles (LA) holds in the public eye is a city densely packed with thriving neighborhoods, many functioning as islands unto themselves. From Boyle Heights, to Watts, to Koreatown, mutual aid, hustle culture, and a DIY mindset required to survive the nation's second largest city characterize the lives of Angelenos. This assemblage of communal investment, and by-whatever-means spatial negotiation surfaces in corners like The Smell, the city's ever-present car culture, and the land beneath Dodgers Stadium. LA history is replete with communities that form, and, at times, fall before the city's eyes. Long before the city sold it to the Brooklyn Dodgers in 1958, Chavez Ravine was the home of Mexican Americans crafting a semi-rural existence over generations only to be forcibly displaced through eminent domain. Initially, this forced displacement was committed under the auspices of a public housing development, which never happened, and later, on Black Friday, deputies kicked down doors and evicted the hold-outs, making way for bulldozers and Dodgers Stadium (Laslett, 2015). The dynamic interplay between a DIY mindset and mutual aid also surfaces in unexpected spaces nearly invisible to the outside world, like Waterdrop LA, a volunteer initiative formed during the pandemic that is still delivering 2,000+ gallons of clean water to Skid Row each Sunday, or the city workers quietly coalition-building behind the scenes and establishing BIG:LEAP. You find it in people like Lee, who encountered a mother of three unable to pay for groceries, pulled out her BIG:LEAP card and said, "you know what? I'll pay for that."

There is also an undeniable violence to this place, and at first blush it feels like it reflects precisely what the news would have you believe. But, the violence of LA is far more complex than petty crime, the mythical status of gang life or the legacy of Rodney King and police brutality. It reflects the structural violence found in societal arrangements and systems enacting harm on human beings by preventing them from meeting their basic needs (Galtung, 1969). It is structural violence burdening 24% of LA County households with food insecurity (de la Haye et al., 2023), and driving a 10% increase in homelessness among LA City residents specifically, leaving 46,260 Angelenos unhoused each night (LAHSA, 2023). Yet, beneath the visible struggles with poverty and violence, LA is a city filled with



hope, community, and resistance. Consider how the history of Boyle Heights, originally the Ellis Island of the West, provides America with a blueprint for multiracial neighborhoods experiencing structural violence. Although persistent redlining, racism, and segregation prevented Japanese, Armenian, Jewish, Chinese, African American, and Mexican families from living elsewhere in the early 20th century, this vibrant multiracial history tells “a different story, one of solidarity that helps inform the possibilities of a progressive, democratic culture in a city that tends to forget” (Sánchez, 2021, p. 5). Like the residents of Chavez Ravine who resisted losing their homes until the bitter end, this neighborhood has always been infused with the hopeful eye of activists and organizers. Jewish bakers formed a union in the 1920s; Dolores Huerta and Caesar Chavez launched the Chicano Movement and planned the United Farm Workers in the 1960s; 22,000 Latinx high school students staged a walkout demanding education equity in 1968 supported by their Black peers and cross-pollinated by the Civil Rights Movement (Sánchez, 2021). While it is easy to miss in a city filled with the false promise of individualistic success, the neighborhoods tell wildly different tales of interdependence, hope, and mutuality forged against the weight of structural violence.

LA has always been a place where people dream, and they hold onto that dream with a death grip, no matter the improbability of it, even when capitalism rips it away time and time again. At their core, dreams reflect hope, and even though hope implies risk and a foray into the unknown, a capacity for hope is intimately connected to possibility and economic mobility (Lybbert & Wydick, 2019). When you listen closely enough, you can hear the constant echo of a fight for hopefulness and the decision to dream big, permeating the lifeblood of LA’s communities as though the entire city is infused with it. In the places where you expect to hear despair, you hear a fight for survival, family, and one’s immediate community. From the Dunbar Hotel’s early days as the center of Black culture during the Great Migration to the BIG:LEAP participants who exited homelessness and IPV, Angelenos continue fighting and dreaming (Sweeting, 1992). Look past the fiction of Hollywood and tourists snapping selfies in front of a pink wall and you will find generous people thriving interdependently despite a housing crisis so severe your wealth cannot prevent you from being confronted with it, even when isolating yourself behind tinted windows on the 405.

Perhaps, it is then unsurprising that LA was remarkably early to the plate in allocating public funding and resources towards guaranteed income. As preliminary findings of the “third wave” of guaranteed income experimentation (Widerquist, 2019, p. 33), largely from Stockton Economic Empowerment Demonstration (Stockton, CA) and Magnolia Mother’s Trust (Jackson, MS), spread across mainstream media, the scientific community, and within offices of elected officials, the pandemic was threatening the livelihoods of many communities’ most vulnerable residents. City council members and the Garcetti administration took note of the promising early insights, and partnered with Mayors for a Guaranteed Income to establish the largest guaranteed income pilot in the country at the time of its launch. BIG:LEAP was funded through a reappropriation of funds from the city’s police budget, as well as additional investments from local council districts.

Prior to political support and funding allocations for BIG:LEAP, the Mayor’s Fund for Los Angeles set up the infrastructure of the Angeleno Card, a pre-paid, no-fee debit card that distributed one-time emergency cash payments to households residing in Los Angeles with an income below the federal poverty guideline, and that had experienced a job or income loss of at least 50% of their total annual



income (Mayor's Fund for Los Angeles, 2020). With funding from American Rescue Plan Act (ARPA) and some of the Council Offices' Reimagine LA funds, this disbursement mechanism was expanded in April 2021 to the Angeleno Connect card, a partnership with MoCaFi, Inc., that expanded access to critical community services as well as provided a pathway for BIG:LEAP payments (CIFD, 2021). Important to serving the diverse population of Los Angeles, the card connected residents regardless of documentation status or prior banking histories to safer financial products.

With the mechanism to provide monthly cash payments in place, community members and leaders grappled with targeting and eligibility criteria for BIG:LEAP. Profound financial need motivated BIG:LEAP to keep eligibility criteria as expansive as possible; use of general funds required that the city only include those living within the council districts of Los Angeles. Legal consent required that participants be at least 18 years old; caregiver status stemmed from the implementing CIFD's charge to serve families; and the poverty threshold guideline and requirement that individuals be impacted medically or financially by the pandemic ensured those most economically vulnerable were prioritized. Equitable access to apply for BIG:LEAP was prioritized by CIFD, evidenced by the nine languages in which the application was available, as well as in-person and over the phone assistance with the application completion. To mitigate any potential interactions with other benefits being reduced, CIFD leveraged existing waivers of TANF/CalWORKS and SNAP/CalFresh. Participants were also offered benefits counseling to ensure each understood potential impacts of GI receipt on other benefits like SSI/SSDI, housing vouchers, and MediCal.

Fast forward to the Spring of 2024, and the momentum started by BIG:LEAP is reflected in the numerous pilots and experiments with guaranteed income proliferating all over Southern California. While the public waits for those results, Yolanda reminds us that GI,

*"helps people get out of a bind. Whatever that bind is, it's gonna help them get out of it...and help their mental health because people die from stress. Some people have so much stress because they don't know how they're going to feed their family, pay their rent, and keep the lights on, and all that can kill people. This GI program is gonna help that. It helped me."*





## Context and Demographics

The City of Los Angeles (LA) covers an estimated 469.49 square miles of Los Angeles County (4,084 square miles) in Southern California, with a population of 3,820,914 residents (U.S. Census Bureau, 2022b). LA is one of 88 incorporated cities within the county (County of Los Angeles, n.d.). Women make up 50% of the city's population, which is quite racially diverse (U.S. Census Bureau, 2022c). Of the city's population, 48.1% are Hispanic/Latino, 41.2% are White,<sup>1</sup> 11.8% are Asian, 8.6% are Black/African American, 1.0% are American Indian/Alaska Native, and 12.7% identified as two or more races (U.S. Census Bureau, 2022b). The median household income in LA between 2018–2022 was \$76,244, slightly higher than the national median household income in 2022 of \$74,580 (Guzman & Kollar, 2023). In that same year, 16.6% of people in LA were living in poverty, more than the national poverty rate of 11.5% (Shrider & Creamer, 2023; U.S. Census Bureau, 2022b). The 2022 federal poverty threshold for a family of four with two children was \$29,678 (U.S. Census Bureau, 2023b).

LA is culturally and economically diverse, with plans that invest in areas such as conservation, land use, health, housing, mobility, safety, open space, noise, air quality, infrastructure systems, and public facilities. In a recent report, the LA Department of City Planning detailed its progress and plans for initiatives aimed at addressing homelessness and incentivizing affordable housing, along with re-centering key programs to further racial equity and strengthen the city's diversity (Department of City Planning Citywide Policy Division of Los Angeles, 2023). One initiative aims to improve its infrastructure: the Measure M Expenditure Plan secured \$120 billion for transportation investments over the next 40 years. Another, the city's Proposition HHH Supportive Housing Loan Program, assists over 34,000 homeless individuals and those at risk of homelessness throughout the city (City of Los Angeles, n.d.). Alongside the Getty Conservation Institute, the Department of City Planning launched a project to identify, protect, and celebrate LA's African American heritage, referred to as the Los Angeles African American Historic Places Project. LA is thus invested in its residents and continues to seek ways to improve its infrastructure and support its many communities.

The BIG:LEAP program consisted of a total sample size of 8,194 participants (3,202 randomized into the treatment group and 4,992 randomized into the control group). CIFD administered the program with the goal to break the cycle of intergenerational poverty (Guaranteed Income Pilots Dashboard, 2023). Eligibility to participate in this program required that participants be a resident of LA; 18 years or older with at least one dependent child younger than 18 or a student younger than 24, or be pregnant; and have an income at or below the federal poverty level. The program intervention began in January 2022 and ran through March 2023. A monthly stipend of \$1,000 was given to each participant in the treatment group for a 12-month period.

The sample was well-balanced across treatment and control groups (see participant demographics in Table 1 below). Approximately 98% of households in the treatment group and 97% of the control group had children, with both groups averaging two children per household. The average household size was about four in both the treatment group and control groups, and the average age of both sets

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<sup>1</sup> 28.1% are White alone and not Hispanic or Latino.



of participants was 37 years old. Approximately 66% of the control group and 65% of the treatment group reported being single, while 21% and 22% were married in the control and treatment groups, respectively. The remaining 13% in the each group were partnered or in a relationship. The treatment group was 80% female, while 77% of the control group were female. The proportion of women in the study sample was higher in comparison to the national rate of women receiving government assistance in 2021, where recipients of nutrition assistance benefits such as the Supplemental Nutrition Assistance Program (SNAP) and Women, Infants & Children Program (WIC) were approximately 65% female, and 55% female for cash assistance in the form of Supplemental Security Income (SSI) (King, 2022).

Approximately 46% of participants in the treatment group and 45% in the control group identified as either Hispanic, Latino, or of Spanish origin, which is comparable to LA's 48.1% Hispanic/Latino demographic. About 27% in both treatment and control groups identified as Black, which was much higher than the city's proportion of Black residents (8.6%); 15% in the treatment group and 14% in the control group identified as White. About 3% in the treatment group and 4% in the control group identified as Asian, while about 5% of participants identified as two or more races in the treatment group and 4% in the control group. Another 4% of participants in both treatment and control identified as Other. In the two groups, 67% primarily spoke English at home, while 29% of the treatment group and 28% of the control group used Spanish as their primary language. Roughly 5% in each group identified other languages as their primary language spoken at home; these included Armenian, Chinese, Farsi, Korean, Russian, Tagalog, Thai, Vietnamese, and others.



Table 1: Participant Demographics

TREATMENT		CONTROL
3,202	<b>SAMPLE SIZE</b>	4,992
37	<b>AVERAGE AGE of PARTICIPANT (YEARS)</b>	37
<b>GENDER (%)</b>		
80%	Female	77%
20%	Male	22%
0%	Other	0%
<b>CHILDREN IN HOUSEHOLD (%)</b>		
98%	Yes	97%
2%	Currently pregnant	3%
2	<b>AVERAGE NUMBER of CHILDREN IN HOUSEHOLD</b>	2
4	Average HH Size	4
3	Median HH Size	3
<b>ETHNICITY (%)</b>		
46%	Hispanic or Latino or Spanish Origin	45%
27%	Black	27%
15%	White	14%
5%	Two or more races	4%
4%	Other race	4%
3%	Asian	4%
0%	American Indian and Alaska Native	1%
0%	Native Hawaiian and other Pacific Islands	0%
<b>MARITAL STATUS (%)</b>		
65%	Single	66%
22%	Married	21%
13%	Partnered/In relationship	13%
<b>PRIMARY LANGUAGE AT HOME (%)</b>		
67%	English	67%
29%	Spanish	28%
5%	Other	5%
<b>EDUCATION (%)</b>		
29%	High school diploma	30%
20%	High school (10th–12th grade)	22%
13%	Trade or technical school	11%
8%	Middle school (6th–9th grade)	8%
7%	Associate’s degree (2-year college degree)	7%
6%	Bachelor’s degree (4-year college degree)	6%



TREATMENT		CONTROL
3,202	<b>SAMPLE SIZE</b>	4,992
<b>EDUCATION (%)</b>		
6%	GED (diploma equivalency test)	6%
4%	Elementary school (through grade 5)	5%
3%	No formal education	4%
2%	Other post-graduate degree	1%
1%	Some college	1%
1%	Other education choice not listed	1%
<b>ANNUAL INCOME (IN \$)</b>		
\$14,273	Mean	\$14,476
\$15,336	Median	\$15,357

About 29% of the treatment group and 30% of the control group had received a high school diploma, while 20% of the treatment group and 22% of the control group had attended high school (grades 10–12) but did not graduate. About 6% of both groups obtained a GED as their highest form of education. An estimated 13% in the treatment group and 11% in the control group attended trade or technical schools, and 8% of both treatment and control groups attended middle school (grades 6–9). Those who attended elementary school (through grade 5) comprised 4% of the treatment group and 5% of the control group. Those having no formal education consisted of 3% of the treatment group and 4% of the control group. There were fewer participants who had attained a college degree. Those earning some college credits consisted of 1% of both treatment and control. In both treatment and control groups, approximately 7% had completed an Associate’s degree and 6% had received a Bachelor’s degree. Those obtaining other post-graduate degrees consisted of 2% of the treatment group and 1% of the control group.

About 71% of the treatment group and 69% of the control group were beneficiaries of SNAP/CalFresh, and 24% in treatment and 23% in control groups received benefits from WIC, with another 6% in both groups receiving benefits from SSI. The average reported annual household income for the treatment group was \$14,273, while it was \$14,476 for the control group. The median reported annual household income was \$15,336 in the treatment group and \$15,357 in the control group.

## Theoretical Framework and Methods

All research methods used in this study were approved by the Institutional Review Board of the University of Pennsylvania (Penn), UCLA, and USC. This research rests on a theoretical framework which posits that experiences of chronic scarcity reduce cognitive capacity, increase financial fragility, and curtail an individual's ability to cope with stressors (Mani et al., 2013; Shah et al., 2021). In turn, material hardship creates a scarcity mindset that negatively impacts physical and mental health, undermines goal setting, curtails hope, and locks people in the present (West et al., 2023). When scarcity traps an individual, their cognitive capacity is inescapably dedicated to their finances, leaving little to no cognitive bandwidth or resources for finding pathways out. Therefore, unconditional cash provides a pathway for eliminating scarcity and smoothing income volatility, which then creates space for alternative ways of being and decision-making (West & Castro, 2023; West et al., 2023). This sequence of change requires recurring, predictable amounts of cash over time versus one-time or short-term cash transfers that alleviate material hardship but are not associated with changes in well-being. Finally, given the City of Los Angeles' interest in testing the relationship between unconditional cash and community violence, safety, and intimate partner violence (IPV), this design also draws on literature theorizing how a basic income can have an emancipatory impact on women lacking the means to exit unsafe relationships and living conditions (Gonalons-Pons & Calnitsky, 2022; Miller et al., 2023). While data from the 1970s income experiment demonstrated reductions in community violence and IPV associated with unconditional cash (Calnitsky & Gonalons-Pons, 2021; Gonalons-Pons & Calnitsky, 2022), this study is the first RCT in the current "third wave" of experimentation with GI in the US examining questions on community violence and IPV (Widerquist, 2019, p. 31).

Per the analytic plan (ABT Associates, 2023), the primary research questions are as follows:

1. How does GI affect participants' quality of life?
2. What is the relationship between GI and participants' subjective sense of self?
3. How does GI affect participants' income, and through what mechanisms?
4. How does the implementation of GI inform the existing safety net?

This research rests on a parallel mixed-methods design (QUANT + QUAL), which means that data collection and analysis occur independently within the quantitative and qualitative strands and are not integrated into meta-inferences until within-strand analysis is complete (Tashakkori et al., 2020). Parallel designs also provide the option of including analogous sub-strand questions that can be integrated into the primary design. Since LA was specifically interested in how GI interacts with community violence and IPV, additional sub-questions were added as follows:

- » What is the relationship between GI and intimate partner violence?
- » What is the relationship between GI and community interactions and safety?
- » How does GI affect engagement in child enrichment activities?



LA invited all eligible residents to apply for the GI program as well as the accompanying research study. To promote accessibility for the application and to ensure a fair and legitimate selection process, LA contracted with CGIR and USC to oversee both processes. CGIR used Qualtrics to collect informed consent and the Baseline survey, notifying participants of the voluntary nature and purpose of the study as well as the confidentiality of the data collected. The application was offered in English and eight additional languages to promote equitable access. At the close of the application period, over 100,000 people completed the pre-screening, and more than 50,000 participants completed the application, indicating an enormous need in the community for cash support and a baseline level of trust. CGIR thoroughly reviewed all applications and removed any duplicates to ensure that each applicant had an equal chance of being selected to participate. CGIR then used a random selection and assignment method to allocate the treatment and control group participants. During the notification and onboarding process, treatment group participants received benefits counseling to identify any impacts of the cash transfers on their receipt of public benefits. In sum, the application and selection processes were carefully designed to promote transparency, accessibility, fairness, and justice.

## QUANTITATIVE METHODOLOGY

**Study Design and Participant Selection:** The RCT conducted in LA evaluated the impact of a guaranteed monthly income of \$1,000 over a 12-month period. From a pool of over 50,000 applicants, 3,202 participants were selected to receive the GI. Individuals selected for participation had to meet five basic criteria: 1) reside in the City of Los Angeles; 2) be 18 years of age or older; 3) have at least one dependent child younger than 18 or a student younger than 24, or be pregnant; 4) have an income level at or below the federal poverty line; and 5) have experienced economic and/or medical hardship related to COVID-19.

Quota sampling was used to determine the number of available treatment and control group participants by council district. Per the city's directive, the first step of quota sampling was to allocate available slots by the proportion of eligible residents in each district that account for the city's overall poverty rate. As shown in the table and map below (Figure 1), Council District 1 contained 9.8% of Angelenos living in poverty (rather than having a 9.8% poverty rate itself). Supported by the city's general fund, this led to allocation of more slots to districts with a greater number of lower-income Angelenos. In step two, Council Districts 6, 8, 9, and 10 invested discretionary funding to provide additional slots. Thus, for each \$12,000 (\$1,000 per month x 12 months) of additional funding provided by a council district, one additional slot was allocated to that council district. Post-hoc, several districts had difficulties meeting enrollment targets. Where those slots remained open, they were re-allocated to the districts that invested additional funding. Figure 1 shows the allocations by council district.

Of the selected participants, 3,202 were randomly assigned to the treatment group to receive the monthly cash transfer starting in January 2022, while 4,992 were randomly assigned to the control group. Data collection occurred at four intervals (Waves): Baseline (Wave 1), prior to randomization or notification of group assignment (December 2021–April 2022); 6 months (Wave 2) (August 2022); 12 months (Wave 3) (February 2023); and post-intervention at 18 months (Wave 4) (August 2023). Participants were compensated for completing surveys. The detailed information on response rates to surveys is provided in Appendix C.

Figure 1. Final Program Slots by LA Council District

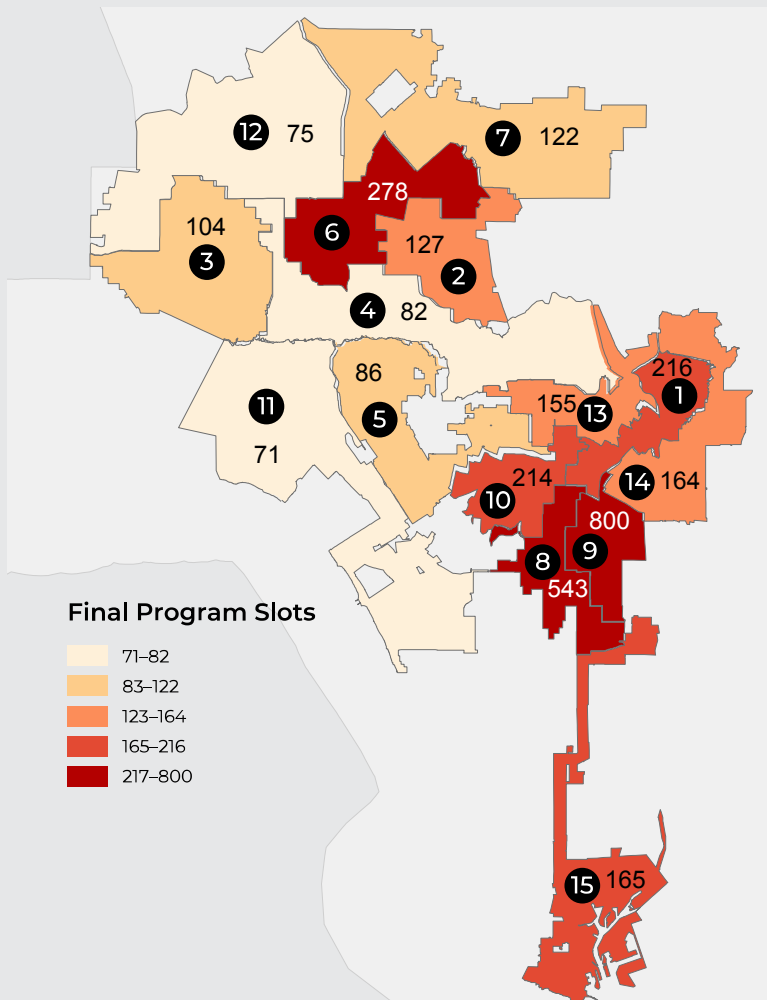


Figure 1 is a choropleth map, displaying the number of final program slots allocated per LA City Council District. Numbers circled in black represent City Council Districts, and numbers with plain text represent the final number of program slots. Final program slots were determined by Council District poverty rate, and general and discretionary GBI funding for each respective council district. Council Districts that struggled to meet their original program enrollment had their slots consolidated into other Districts to meet the total participant goal.

**Data Analysis:** A standardized approach was used for outlier management, employing the winsorization method. The study utilized Multiple Imputation by Chained Equations (MICE) (Azur et al., 2011) for missing data, a method effective in complex datasets with significant data gaps. MICE involves multiple iterations with varying random seeds to ensure diverse and robust imputation. Imputations were conducted on key outcome variables and selected demographics. The process included checks for the distribution, plausibility, and convergence diagnostics to validate the imputed data’s accuracy and reliability; this led to the creation of multiple datasets, forming the basis for further analysis. By generating multiple datasets, each with a slightly different imputation for the missing value, MICE accounts for the uncertainty of the imputation process. Datasets were analyzed separately and then pooled together, producing results that are statistically valid and unbiased. This methodology also ensures that the standard errors of the estimates are correctly computed, thereby reinforcing the accuracy and reliability of subsequent statistical inferences.



Due to successfully establishing Baseline equivalence between the treatment and control groups, the study's analysis was streamlined. Post-imputation, a comprehensive analysis was conducted to evaluate the GI's impact, using validated measures. Basic inferential statistics (i.e.,  $\chi^2$ -tests, t-tests) were used to assess the difference in prevalence and means between treatment and control groups. Regression analyses (linear, logistic, or multinomial logistic regression, depending on the outcome) were also conducted to estimate mean difference comparisons between treatment and control groups at each time point (Baseline, 6-month, 12-month, and 18-month), adjusting for Baseline values. Finally, given the nested nature of the study design, two-level multilevel models were used to account for variation between individuals (level 1) and council districts (level 2). Random intercept models were estimated to examine differences in the mean level of each outcome of interest for treatment and control groups, controlling for the Baseline measure. This report provides estimates from basic inferential statistics and regression analyses. Full adjusted means for both treatment and control groups based on multilevel analyses—while minimally different from adjusted means based on regression analyses—are provided in the Appendices.

## QUALITATIVE METHODOLOGY

Semi-structured interviews were conducted at two time-intervals with the same group of participants. The first round occurred at the midpoint of the disbursement period and the second 4 months after the final GI payment. The first-round interview guide was informed by the theoretical framework noted prior and included prompts on health, well-being, care work responsibilities, neighborhood safety, values, finances, and relationships. Thirty-five recipients were recruited to participate in the first set of interviews, which lasted 1.5–2.5 hours depending on how participants answered the questions. One participant canceled, yielding a sample of 34. All interviews were compensated with a \$50 Target gift card and were digitally recorded and professionally transcribed verbatim. Participants chose their own fake names and locations for the interview, with the majority occurring in public parks.

The second-round interview guide was primarily focused on decision-making trajectories as the pilot neared its conclusion, as well as an oral history component focused on the antecedents for hope, mattering, and belonging. The positive psychology literature is anchored in what Seligman (2002) terms the “three pillars” for hope (p. 3), which include positive subjective experiences, positive individual traits, and positive social institutions. However, less research in positive psychology has focused on the antecedents of hope, which include the settings, milieus, and sociological contexts that foster conditions for hope (Baker et al., 2021) and are key ingredients for economic mobility (Castro et al., 2021; Lybbert & Wydick, 2018). After analyzing the first-round interviews, it was clear that an unexpected level of change was occurring for the GI recipients, but it was not clear why some participants were ready and able to act on their goals so quickly. Thus, based on the positive psychology and economic development literature noted prior, an oral history approach was taken in the second round of interviews to understand hope's antecedents along with beliefs around finances, parenting, community-building, relationships, and well-being. The same participants were recruited for the second-round interviews; 25 responded and three canceled at the last minute, yielding a sample of 22 respondents. Interviews were compensated and recorded in the same manner as the first round.

Structured, recursive memo-writing occurred throughout each stage of data-collection and analysis using a “thick description” format which laid the groundwork for thematic mapping at the end of analysis (Ponterotto, 2006, p. 358). All coding occurred in Dedoose by human beings without the use of AI and involved blending a thematic analysis approach for semantic-level coding and a grounded theory approach for latent coding<sup>2</sup> (Braun & Clark, 2012; Charmaz, 2014). The semantic level included values coding and process coding to understand decision-making and strategies around finances, parenting, health behaviors, relationships, and community. The latent level included focus and theoretical coding based on the theoretical framework to understand agency, family history, antecedents, structural vulnerability, and care work (Saldaña, 2021).



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2 A full description of this blended analytic approach is documented in ABT Associates (2023).



# Findings

## 1. The Impact of Guaranteed Income on Quality of Life

At the start of the intervention, most of the treatment and control group members were living in either poverty or deep poverty in one of the most expensive housing markets in the country. When pandemic-era policies, like the Child Tax Credit, expired in 2021, poverty in California rose from 11% in 2021 to 16.4% in 2022, with more pronounced impacts on children and households of color (U.S. Census Bureau, 2023b). The official poverty threshold in the US in 2022 was \$20,172 for a household with two adults and one child, with 11.5% of the population, or 37.9 million Americans, living in poverty (Shrider & Creamer, 2023; U.S. Census Bureau, 2023b), and 5.5% of U.S. inhabitants living in deep poverty. Deep poverty is defined by the U.S. Census Bureau as a household whose cash income is less than 50% of the poverty threshold. The average annual income at Baseline for both the treatment (=\$14,273) and control (=\$14,476) groups hovered around the deep poverty threshold depending upon how many children were in the household. This indicates a high degree of economic precarity where a single financial shock can quickly place a household dangerously close to eviction or homelessness. Unstable employment with unpredictable hours and wages are a primary driver of deep poverty, rather than complete lack of connection to the labor market (Institute for Research on Poverty, 2017). Against this stark financial backdrop, and with only one year of guaranteed income, participants in the treatment group demonstrated a statistically significant increase in savings, a statistically significant decrease in food insecurity, and an emerging increase in financial well-being.

### Financial Stability and Well-Being

The degree of financial vulnerability with which participants entered BIG:LEAP introduced a unique pressure not yet documented in the *American Guaranteed Income Studies*. Although participants described a sense of immediate relief with the first payment, they simultaneously described an infusion of stress from 1) knowing that the GI would only last 12 months, leaving them with a very brief window to create a financial floor, and 2) a sense that this was their one and only shot at stability in an extremely unaffordable city. In other words, while the GI alleviated the anxiety associated with living with chronic scarcity, the tight timeline also introduced a motivating pressure to act on financial goals as quickly as possible. Recipients immediately prioritized savings, with many describing a capacity to act on long-held savings goals either for the first time or for the first time since the start of the pandemic, even with the pressures of inflation. Mikey, a small business owner, father, and Japanese immigrant, articulated the experiences of many participants when he said that his family “used this money for a better life” after “worrying about payments 24/7,” but then carefully juxtaposed the anxiety he associated with material hardship against the motivation introduced by GI. In Mikey’s words, the first is “living the nightmare,” where one is constantly asking, “what is your life meaning?” whereas the latter was “just a little distress and a little pressure.” This undercurrent of external motivation nested within narratives of lessened anxiety and a higher quality of life abounded throughout the narrative

data and points to the ways that severe financial distress in the context of a shorter GI intervention can manifest differently than longer-term interventions.

Table 2: Trends in Household Savings

SAVINGS (\$)	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
<200	83.42%	83.71%	79.29%	80.83%	81.95%	79.75%	84.63%	81.95%
200–500	8.84%	9.21%	15.37%	16.77%	12.62%	16.81%	10.77%	14.86%
>500	7.75%	7.07%	5.34%	2.40%	5.43%	3.45%	4.59%	3.19%

GI recipients reported double the rate of savings of more than \$500 than the control group starting at 6 months after the first payment (5.3% vs 2.4%;  $B=.84, p<.001$ ) and continued to maintain significantly higher rates at 12 months (5.4% vs. 3.5%;  $B=.40, p<.01$ ) and 18 months (4.6% vs. 3.2%;  $B=.29, p<.05$ ). These differences were statistically significant.

Table 3: Household’s Ability to Cover \$400 Emergency Expense (in %)

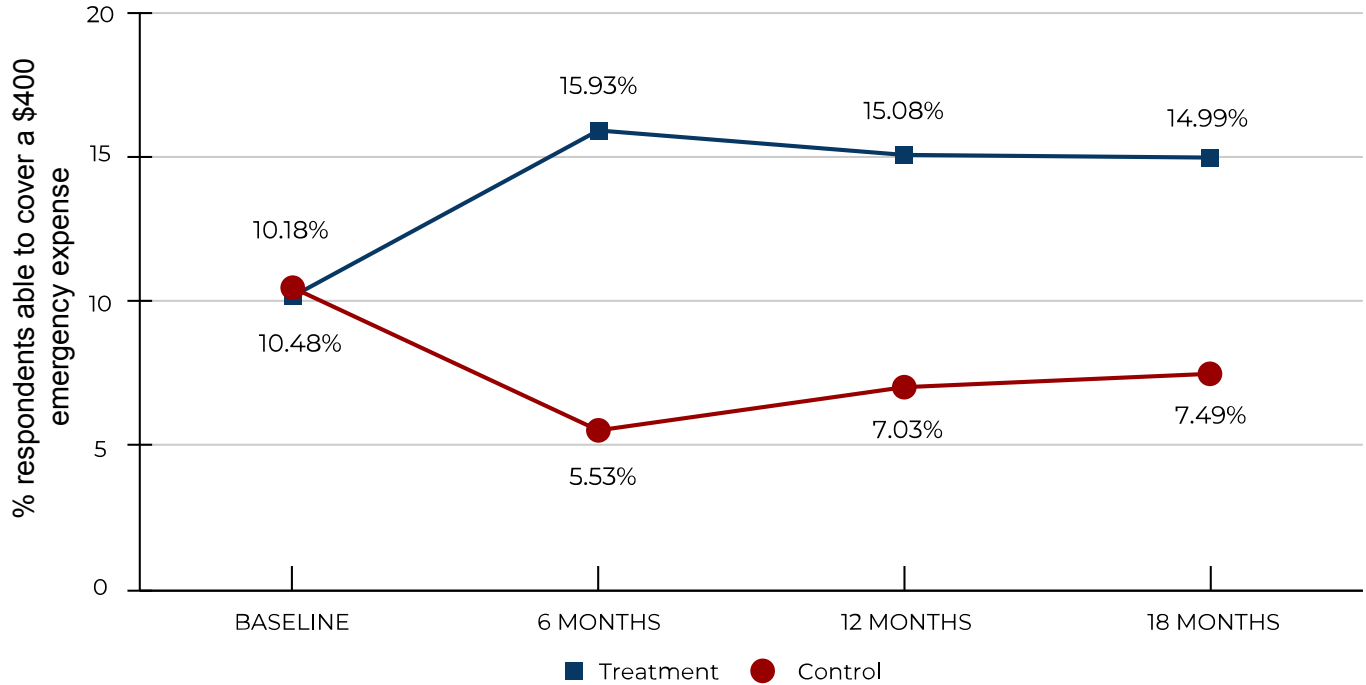
	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
No	89.82	89.52	84.07	94.47	84.92	92.97	85.01	92.51
Yes	10.18	10.48	15.93	5.53	15.08	7.03	14.99	7.49

The household’s ability to cover a \$400 emergency expense using cash or a credit card paid in full improved significantly for the treatment group during and after the cash disbursement period. At Baseline, about 10% of both treatment and control groups reported that they were able to cover a \$400 emergency expense using cash or a credit card paid off in full. At 6 months, this rate increased to 15.9% for the treatment group but dropped to 5.5% for the control group ( $B=1.28, p<.001$ ). Through the Endline (18 months), this rate was maintained at about 15% for the treatment group, ending at a significantly higher rate than the control group (7.5%) ( $B=.84, p<.001$ ).

These results contrast with national trends showing decreased ability to cover a \$400 emergency expense. In 2019, 68% of households could cover this expense using cash or its equivalent (FRS, 2023b). This rate dropped down to 63% by 2022 (FRS, 2023a). Of the 37% who could not cover a \$400 emergency expense completely, most would pay using a credit card and carry a balance and 13% said they would be unable to pay the expense by any means (compared to 11% in 2021) (FRS, 2023a). Nationally, covering such an expense is even harder for families with children. According to the 2022 Survey of Household Economics and Decisionmaking (SHED), only 43% of U.S. families with children below the age of 18 could cover a \$400 emergency expense with cash or its equivalent, a 7% decline compared to 2021 (Board of Governors of the Federal Reserve System [FRS], 2023a).



Figure 2. Trends in Household’s Ability to Cover \$400 Emergency Expense (in %)

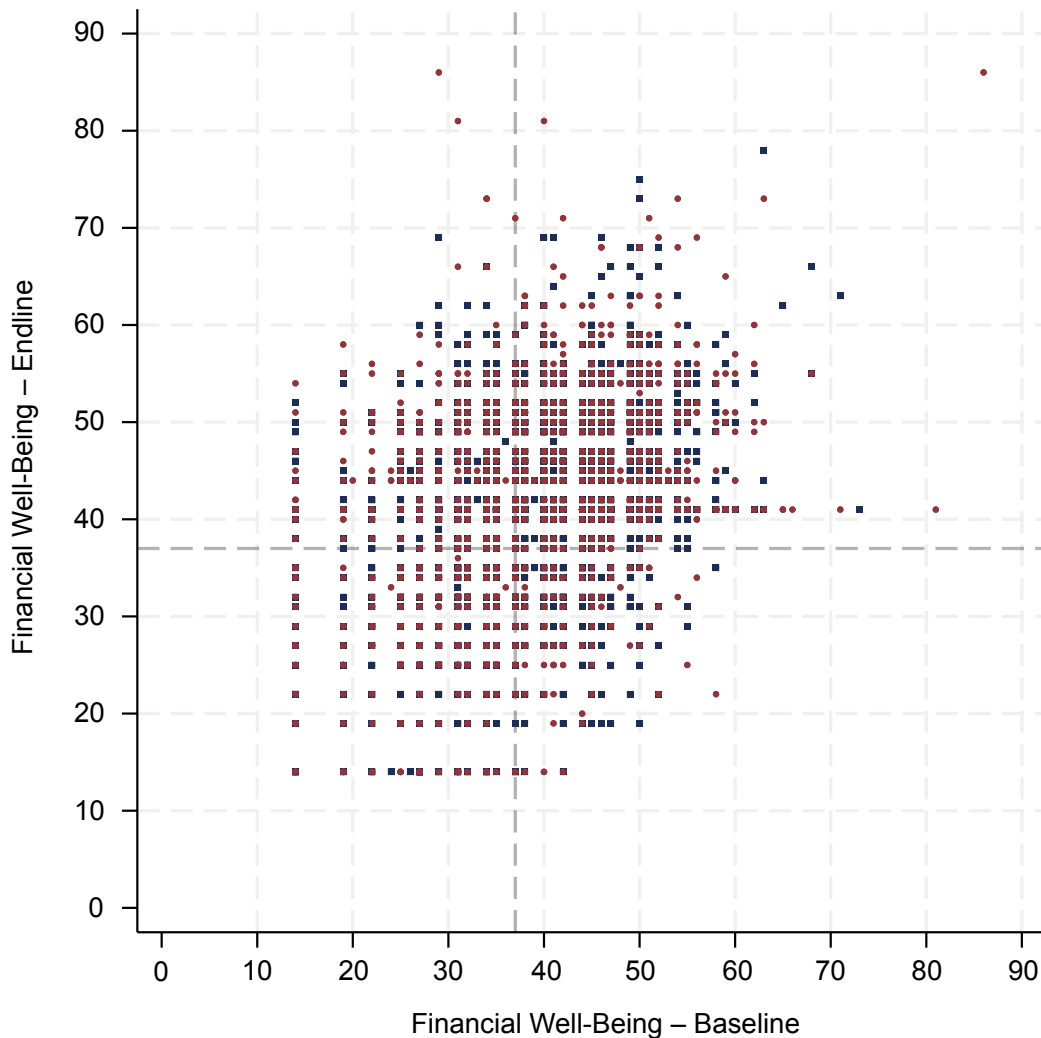


Despite barely making ends meet, GI participants reported an increasing sense of financial well-being over the study period, per the Consumer Financial Protection Bureau's (CFPB) Financial Well-Being Scale (CFPB, 2015). The scores across all time points, however, were in the Medium-Low strata of the scale (38–49). Most individuals in this range tend to have recurrent material hardships, little savings, and trouble covering unexpected emergency expenses. Although reporting lower household income than control participants, GI participants still reported better financial well-being while cash disbursements were being made. At the 6-month and 12-month marks, GI recipients reported significantly higher levels of financial well-being than control participants (6 months:  $M=40.29$  vs.  $M=39.88$ ;  $Mdiff=0.51$ , 95% CI [0.24, 0.78],  $p<0.001$ ; 12 months:  $M=40.54$  vs.  $M=40.21$ ;  $Mdiff=0.44$ , 95% CI [0.14, 0.74],  $p<0.01$ ), but at 18 months, control participants reported slightly higher levels of financial well-being than the treatment group ( $M=40.65$  vs.  $M=41.14$ ;  $Mdiff=-0.35$ , 95% CI [-0.67, -0.04],  $p<0.05$ ).

Table 4: CFPB Financial Well-Being Scale Scores

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	38.26	38.75	40.29	39.88	40.54	40.21	40.65	41.14
Median	38	40	40	40	40	40	41	41

Figure 3: Financial Well-Being: Baseline vs. Endline Comparison



## Food Security

The U.S. Department of Agriculture estimated that 17 million U.S. households, or 12.8% of all households, experienced food insecurity in 2022 (Rabbitt et al., 2023). With poverty as one of the leading causes of food insecurity in Los Angeles County, there is a correlation between income loss and food insecurity (Los Angeles County Department of Public Health [LACDPH], 2018). Over one-quarter of Los Angeles County households, or 516,000 households, with incomes less than 300% of the federal poverty line (FPL) experienced food insecurity in 2018 (LACDPH, 2021). While high, this rate was in fact an improvement from the rate of 31% in 2011 (de la Haye et al., 2023). Following the pandemic, 24% of households in Los Angeles County experienced food insecurity in 2022. Additionally, food insecurity among low-income (<300% FPL) county residents was worse in 2023 (44%) than during the pandemic (42%) in 2020.



Across both treatment and control groups, participants experienced high levels of food insecurity, with well over half of the participants reporting that they worried about not having enough food in the past 4 weeks (Figure 4). While these concerns were similarly reported across treatment and control participants at Baseline (approximately 65%), significantly fewer treatment participants reported worry at 6 months (about 55% for treatment vs. 59% for control;  $B=-.21, p<.001$ ) and at 12 months (52% for treatment vs. 55% for control;  $B=-.14, p<.01$ ). More GI participants reported worry at 18 months (59% treatment vs. 58% control;  $B=.08, p=.10$ ), but the difference was not statistically significant.

Figure 4: Affirmative Responses to the Question, “In the past 4 weeks, did you worry that your household would not have enough food?”

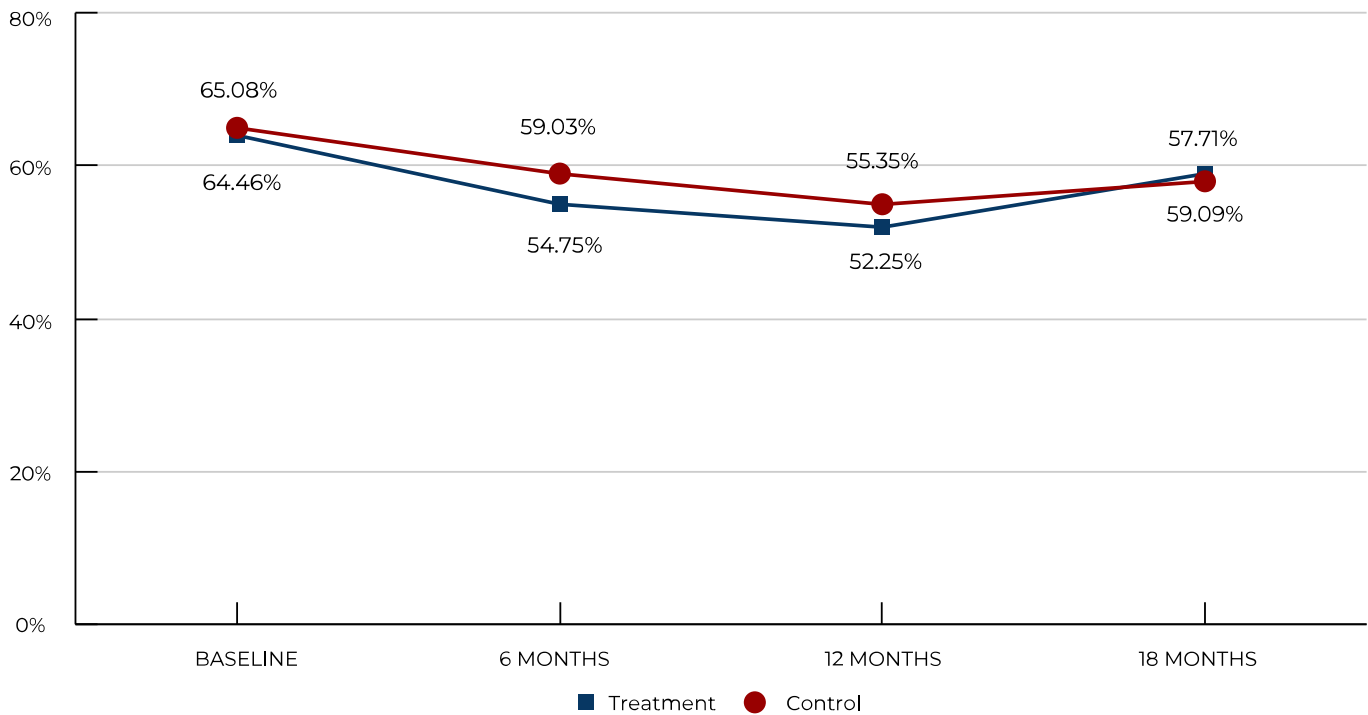


Table 5: Trends in Food Insecurity—Household Food Insufficiency

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
No	35.54%	34.92%	45.25%	40.97%	47.75%	44.65%	40.91%	42.29%
Yes	64.46%	65.08%	54.75%	59.03%	52.25%	55.35%	59.09%	57.71%

Over the course of the study period, GI participants experienced less food insecurity than control participants, albeit with still high levels of food insecurity across both groups. We asked three questions specific to food insecurity in the past 4 weeks, including about participants not being able to eat the kinds of food they preferred (Figure 5), eating food they really did not want to eat (Figure 6), and eating

less food due to lack of food (Figure 7). At Baseline, 50% of treatment participants (vs. 49% control) reported that they were not able to eat the kinds of food they preferred due to lack of resources. At 6 months after the first cash disbursement, 43% of treatment participants (vs. 57% control;  $B=-.78, p<.001$ ) reported not being able to eat preferred foods. At 12 months, 45% of treatment participants (vs. 52% control;  $B=-.37, p<.001$ ) reported not being able to eat preferred foods. By 18 months, 52% of treatment participants (vs. 55% control;  $B=-.20, p<.001$ ) reported not being able to eat preferred foods. These differences were statistically significant. Similarly, fewer treatment participants reported eating food that they really did not want to eat because of a lack of resources. At Baseline, 47% of treatment participants (vs. 46% control) reported they ate unwanted food. At 6 months, 43% of treatment participants (vs. 55% control;  $B=-.69, p<.001$ ) and at 12 months, 44% of treatment participants (vs. 51% control;  $B=-.39, p<.001$ ) reported eating food they really did not want to eat. Six months after the cash disbursement ended (at 18 months), the treatment participants continued to report significantly lower rates of eating unwanted food than control participants (50% vs. 54%;  $B=-.19, p<.001$ ). Moreover, the treatment group was significantly less likely to report having to eat less because of lack of food than control participants during the study period. At Baseline, 30% of treatment participants (vs. 32% control) reported eating less because there was not enough food. At the 6-month mark, 34% of treatment participants (vs. 50% control;  $B=-.82, p<.001$ ) reported eating less; at the 12-month mark, 35% of treatment participants (vs. 48% control;  $B=-.65, p<.001$ ); and at the 18-month mark, 42% of treatment participants (vs. 50% control;  $B=-.36, p<.001$ ) reported eating less because of lack of food. These differences were also statistically significant.

Table 6: Trends in Food Insecurity—Inability to Eat Preferred Foods

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
No	49.75%	50.78%	56.78%	43.07%	54.62%	48.20%	48.38%	45.11%
Yes	50.25%	49.22%	43.22%	56.93%	45.38%	51.80%	51.62%	54.89%

Table 7: Trends in Food Insecurity—Having to Eat Unwanted Foods

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
No	53.22%	53.63%	57.21%	44.87%	56.12%	49.30%	49.56%	46.21%
Yes	46.78%	46.37%	42.79%	55.13%	43.88%	50.70%	50.44%	53.79%

Table 8: Trends in Food Insecurity—Having to Eat Less Food

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
No	69.55%	67.83%	66.11%	50.38%	64.83%	52.14%	58.00%	50.26%
Yes	30.45%	32.17%	33.89%	49.62%	35.17%	47.86%	42.00%	49.74%



Figure 5: Affirmative Responses to the Question, “In the past 4 weeks, were you or any household member not able to eat the kinds of foods you preferred because of a lack of resources?”

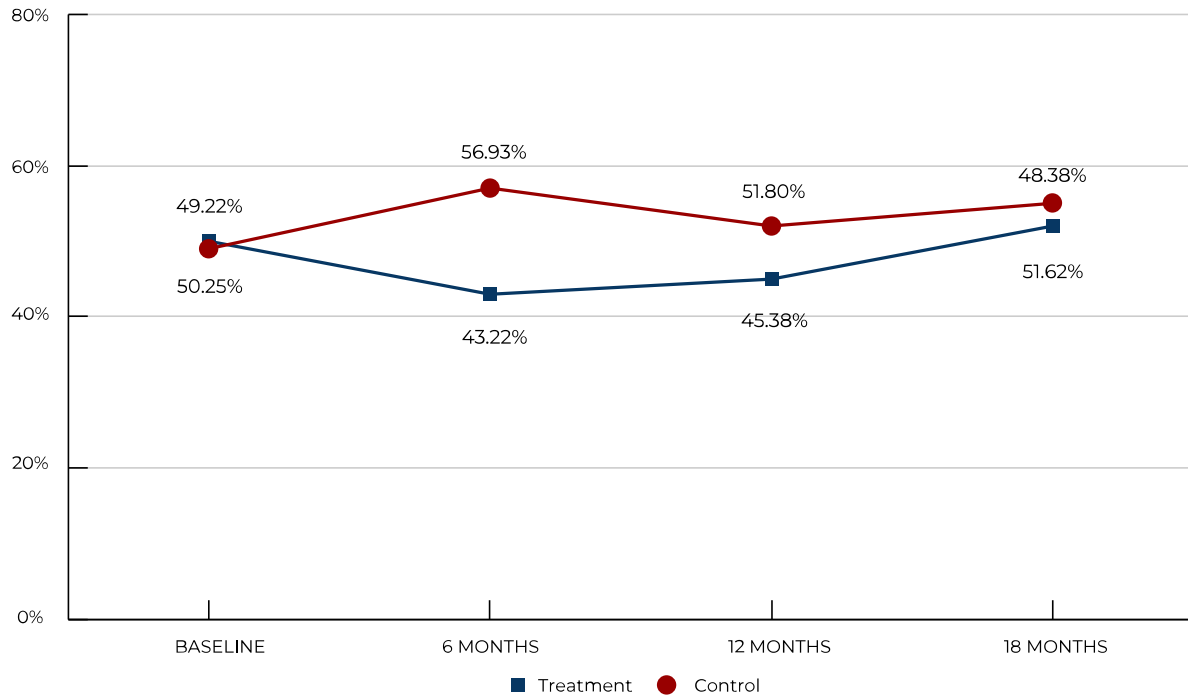


Figure 6: Affirmative Responses to the Question, “In the past 4 weeks, did you or any household member have to eat some foods that you really did not want to eat because of a lack of resources to obtain other types of food?”

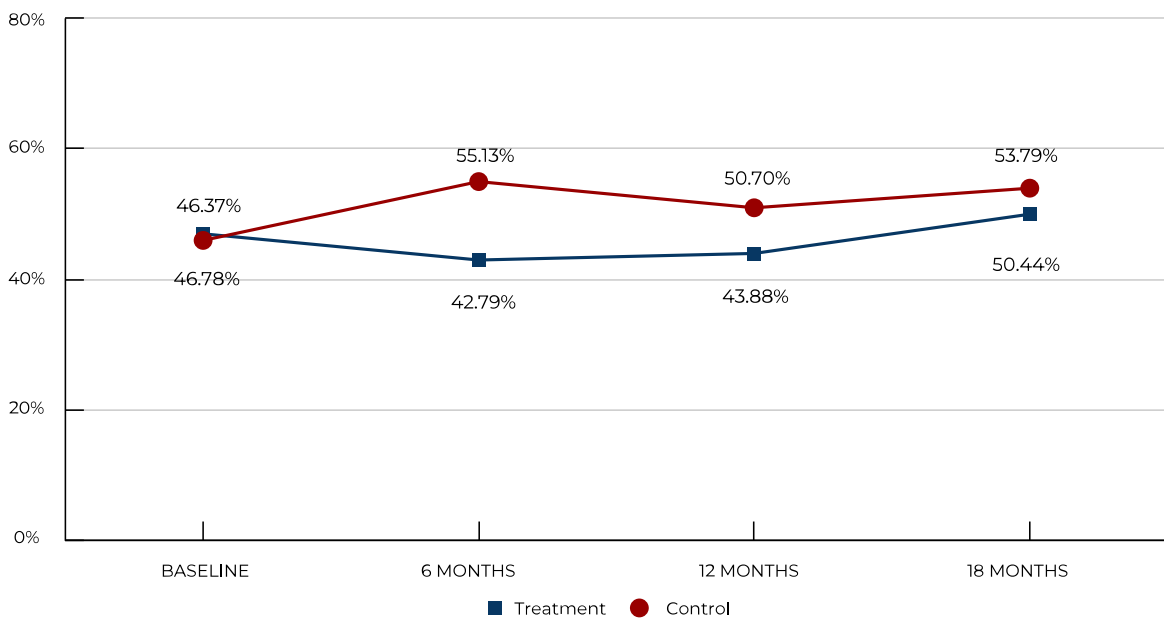
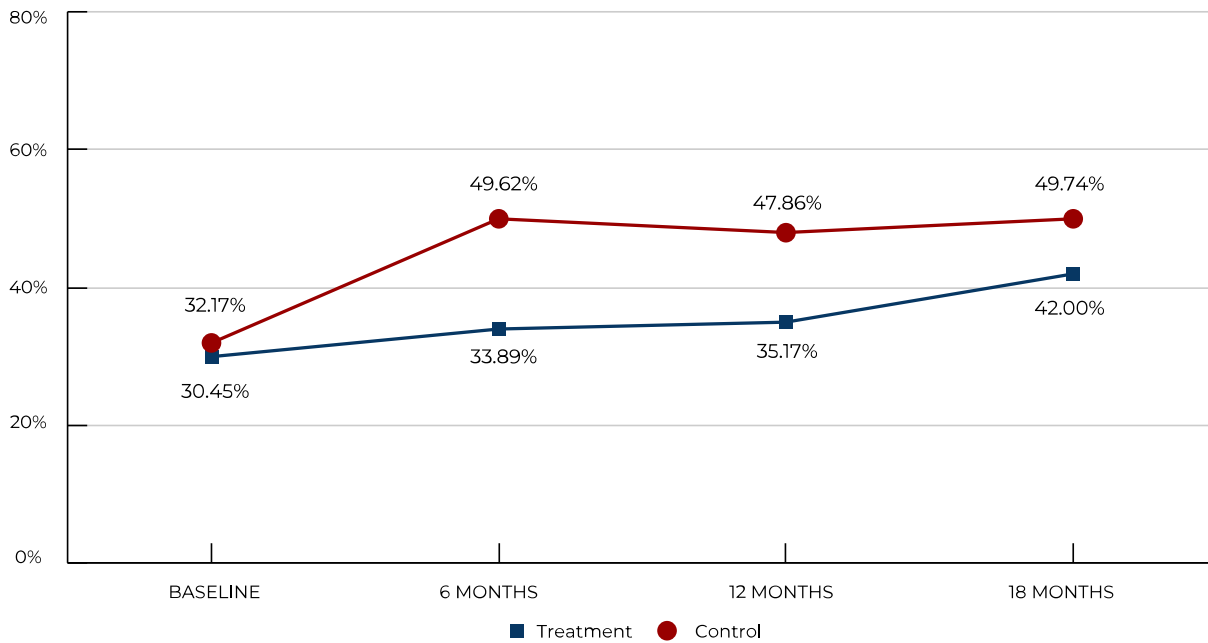


Figure 7: Affirmative Responses to the Question, “In the past 4 weeks, did you or any other household member have to eat less in a day because there was not enough food?”



## Emotional Well-Being

Across the duration of the study, both the treatment and control participants reported high stress levels, as measured by the four-item Perceived Stress Scale (Cohen et al., 1983; Cohen & Williamson, 1988), above the threshold score of 6. GI recipients reported significantly lower levels of stress at 6 months (M=7.63 vs. M=7.78; Mdiff=-0.16, 95% CI [-0.24, -0.07],  $p<0.001$ ) and 12 months (M=7.78 vs. M=7.80; Mdiff=-0.03, 95% CI [-0.12, 0.06],  $p=0.545$ ), but significantly higher levels at 18 months (M=7.91 vs. M=7.75; Mdiff=0.16, 95% CI [0.07, 0.25],  $p<0.001$ ).

Table 9: Perceived Stress Scale

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	8.07	8.04	7.63	7.78	7.78	7.80	7.91	7.75
Median	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00

Using the Kessler Psychological Distress Scale (Kessler et al., 2003), similar patterns were detected in levels of psychological distress. Scores on this scale totaling less than 20 indicate that a person is likely to be mentally well; scores between 20–24 suggest a person is likely to have a mild mental health disorder; 25–29 are likely to indicate a moderate mental health disorder; and those scoring 30 or



higher are likely to have a severe mental health disorder. Across all observations, participants in both the treatment and control groups scored within the range indicating a mild mental health disorder, like anxiety or depression. Some small variations occurred over time, however. While GI recipients reported comparable levels of psychological distress as control participants at 6 months (M=21.77 vs. M=21.73; Mdiff=0.15, 95% CI [-0.11, 0.41],  $p=0.246$ ), at 12 months (M=22.24 vs. M=21.69; Mdiff=0.65, 95% CI [0.38, 0.93],  $p<0.001$ ) and 18 months (M=22.84 vs. M=21.80; Mdiff=1.14, 95% CI [0.85, 1.43],  $p<0.001$ ) the treatment group members' scores were statistically higher. Regardless, the clinical significance was unchanged across all time points.

Table 10: Trends in Psychological Distress—Kessler Psychological Distress Scale

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	23.50	23.71	21.77	21.73	22.24	21.69	22.84	21.80
Median	22.00	22.00	20.00	21.00	21.00	21.00	21.00	21.00



## CASE STUDY

## When Health Needs, Financial Stress, and Cash Collide

Aldy grew up in and out of South Central's foster care system while his family battled homelessness. Now a married father of three, he describes himself as "very family oriented, because I didn't have it growing up." Aldy was born with spina bifida, and, alongside physical limitations, his need for routine medical care, combined with a lack of stable access to providers and treatments due to insurance gaps, makes finding viable work that much harder. After losing his job in the pandemic, financial stress and anxiety mounted, with him constantly worrying, "How much time do I have? How many days before I have to pay this bill? How many days do I have before I have to do this? You know, it was time, time, time. Everything was always time." Aldy's health has significantly impacted his economic mobility, self-image, and relationships, making him anxious about his status "as a male role model," saying, "a lot of things fall upon me to be the protector, and the provider for the family." For Aldy, the GI alleviated some of this by helping meet his family's needs at a time when forces beyond his control curtailed his ability to do so. BIG:LEAP also offered him a path to mobility by enabling him to resume pursuit of a Bachelor's degree in electronics. Still, the cost of living and providing for his family meant the GI left little discretionary funds:

When it got there, basically, the money was already spent before it was even in my account. Like, I already knew this had to go to rent; this had to go to life insurance, to car insurance; this had to go for the kids, this had to go here... Once that [payment] hits, automatically, everything was withdrawn, and gone that same day.

Though every penny was already spoken for, the financial breathing room provided by BIG:LEAP improved his mental health. Prior to the pilot he described,

[getting] panic attacks in the daytime, in the middle of the night... like, I was having panic attacks at random times of the day. I would end up at the hospital twice a month because of panic attacks. After [I started receiving] the income, I was getting panic attacks, maybe, once a week, at night, when I had no control over them when I was asleep... So they came down, and I believe a lot of it was



because I had a lot of stuff removed off my shoulders with that extra money. I knew most of it had to do with bills and being able to provide for the family, and that money really helped out a lot.

The impacts of the GI extended to his relationships with his family:

My personal life with my wife and kids got a lot better. There was less arguing, and less pointing blame to where money would be coming from next... We weren't in debt with family members on either side. We were able to show up more to family dinners and gatherings... Since we didn't have no stress about rent or bills, really, and not having to know if our kids are gonna have something in their stomachs, like, really takes a lot off of both of our shoulders, to the point where we were able to communicate more about normal things like school, "this is how my day went," instead of like, "oh, what are we gonna do, what just happened? What's gonna go wrong next?"

For Aldy, the GI decreased financial burdens and reduced his anxiety, allowing him to reallocate energy and time to things he wanted and valued, such as time with his family or completing higher education. The GI provided him with opportunities he needed to tend to his physical health, mental health, family, and career.

## Physical Functioning

To assess health and well-being of participants, surveys asked for self-ratings on their general health (i.e., In general, your health is 100=excellent, 75=very good, 50=good, 25=fair, 0=poor), physical functioning (e.g., Does your health now limit you in lifting or carrying groceries?), and role limitations due to physical health (e.g., Have you cut down the amount of time you spend on work or other activities as a result of your physical health?) from the 36-Item Short-Form Health Survey (SFHS) (RAND, n.d.). Across the study period, control participants reported better general health than treatment participants (6 months: M=60.70 vs. M=63.49; Mdiff=-2.56, 95% CI [-3.17, -1.95],  $p<0.001$ ; 12 months: M=58.89 vs. M=61.26; Mdiff=-2.15, 95% CI [-2.79, -1.51],  $p<0.001$ ; 18 months: M=59.07 vs. M=61.76; Mdiff=-2.49, 95% CI [-3.16, -1.82],  $p<0.001$ ). However, most people were generally healthy according to the 36-Item SFHS, where the population level scores of "generally healthy" average 56.66 (SD=21.11) (RAND, n.d.). Similar trends emerged for physical functioning and role limitations due to physical health. Control participants reported better physical functioning (6 months: M=72.99 vs. M=74.39; Mdiff=-1.45, 95% CI [-2.23, -0.66],  $p<0.001$ ; 12 months: M=73.68 vs. M=74.11; Mdiff=-0.47, 95% CI [-1.29, 0.35],  $p=0.260$ ; 18 months: M=72.13 vs. M=74.06; Mdiff=-1.97, 95% CI [-2.82, -1.12],  $p<0.001$ ) and fewer role limitations due to physical health (6 months: M=61.25 vs. M=64.71; Mdiff=-3.46, 95% CI [-4.67, -2.25],  $p<0.001$ ; 12 months: M=61.54 vs. M=66.15; Mdiff=-4.61, 95% CI [-5.89, -3.33],  $p<0.001$ ; 18 months: M=60.51 vs. M=65.77; Mdiff=-5.27, 95% CI [-6.58,



-3.96],  $p < 0.001$ ) than treatment participants. Similar to findings on perceived stress and psychological health, these statistically significant effects do not suggest clinically significant differences between groups.

Table 11: 36-Item Short Form Health Survey—General Health

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	57.24	57.68	60.70	63.49	58.89	61.26	59.07	61.76
Median	60.00	60.00	65.00	65.00	60.00	60.00	60.00	60.00

Table 12: 36-Item Short Form Health Survey—Physical Functioning

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	69.14	69.01	72.99	74.39	73.68	74.11	72.13	74.06
Median	75.00	75.00	77.50	75.00	80.00	75.00	77.50	75.00

Table 13: 36-Item Short Form Health Survey—Role Limitations Due to Physical Health

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	52.67	52.67	61.25	64.71	61.54	66.15	60.51	65.77
Median	50.00	50.00	75.00	68.75	75.00	68.75	75.00	68.75

## Healthy Behaviors, Care Work, and Weathering

On the surface, participants in BIG:LEAP appeared relatively healthy, but this masked the healthy behaviors that GI facilitated and the cumulative toll unpaid care work and health trouble elsewhere in their family networks were having on female participants in particular. Unpaid care work references household activities such as childcare, cleaning, shopping, cooking, eldercare, caring for ill family members, and the invisible mental burden of managing the schedule and emotional needs of an entire family. These unpaid tasks are necessary for the economy to function, and society typically assigns them to women (Castro et al., 2024). In turn, the burden of unpaid care work undermines women’s ability to secure financial stability and can erode their health over time. The impact of these stressors are magnified for women of color, who also live with the cellular and physiological impacts of chronic stress created by racism and marginalization, termed “weathering” (Geronimus, 2023, p. 10). Living with the repetitive activation of a stress response for years due to weathering lowers life expectancy, is associated with the onset of chronic diseases earlier in the lifespan, is experienced

more acutely by Black Americans, and is not explained by the disproportionate number of Black Americans living in poverty (Geronimus et al., 2006). Women of color who are the center of financially fragile networks experience both the toll of unpaid care work and the impact of weathering more acutely than their male counterparts when failures elsewhere in the market or holes in the safety net cascade through the women's social ties. In other words, their bodies and bank accounts absorb the costs of care work and the impact of weathering over time. While the process of weathering occurs throughout the lifespan, the onset of detectability typically does not begin until age 35 (Geronimus et al., 2006). The average age of the treatment group was just 37, placing them at the early end of this spectrum. While the quantitative data do indicate a generally healthy sample, the narrative data divulge looming health issues which participants directly associated with the burden of care work and chronic material hardship.

## WEATHERING

*Weathering is a process that encompasses the physiological effects of living in marginalized communities that bear the brunt of racial, ethnic, religious, and class discrimination ... weathering afflicts human bodies all the way down to the cellular level as they grow, develop, and age in a racist, classist society.... Weathering is about hopeful, hardworking, responsible, skilled, and resilient people dying from the physical toll of constant stress on their bodies, paying with their health because they live in a rigged, degrading, and exploitative system. (Geronimus, 2023, p. 11)*

Further, during the first-round interviews, all participants were asked the single-item self-rated health screener, "In general, would you say that your health is excellent, very good, good, fair or poor?" followed by a series of probes to describe what prompted that rating (Ware & Sherbourne, 1992). Out of the 34 participants interviewed, 2 chose excellent, 3 very good, 9 good, 12 fair, 4 poor, and 2 skipped the question. Participants attributed these ratings to the mental health impact of the pandemic, back pain, work-related injuries, the constant stress of material hardship, the stress and physical burden of caring for aging and ill family members, the 24/7 toll of parenting, chronic health conditions they only treated intermittently, giving birth during the pandemic, and an inability to remain consistent with prioritizing their health due to lack of time and resources. They also recounted health histories of anxiety, depression, diabetes, severe food insecurity, hypertension, asthma, and high cholesterol, all of which they attributed to stress, lack of finances, and prior experiences with homelessness.

In many cases, even though the majority reported access to medical insurance and positive encounters with primary care, it was the surrounding time scarcity, inflexible or erratic work schedules, and lack of childcare caused by chronic financial hardship that prevented them from managing their health in the ways they desired. Several participants were able to use the GI to seek physical therapy and other treatment modalities to address chronic back pain and injuries that previously kept them out of work. This more nuanced picture of the participants' health also included a drive to pursue well-being in a range of areas either not captured by the quantitative measures or that reflected the start

of healthier behaviors the GI facilitated which participants may have ceased or titrated due to the 12-month duration of the payments.

In addition to using the GI for acquiring healthier food options and increasing the amount of fruits and vegetables in their diets, participants also attributed the space, time, and funds the GI afforded with increasing healthy behaviors. This included increasing the quality and duration of their sleep, resuming necessary medication, exercising more, having the time to choose walking over driving or public transit, and prioritizing their mental health by seeking therapy for themselves and their children. Like several participants, Jasmine felt that the GI facilitated behavioral changes that translated into a healthier weight and feeling differently in her body through expanding her access to food choices and affording her much-desired time for exercise. Before the GI, she described her health as limiting her ability to work and keep up at home, saying:

*Before I was more tired. My back would hurt more. Like, just, like, your body would hurt more and be more sore, like it was just harder. I've actually lost a lot of weight and I feel like I'm just faster. I'm lighter. I feel like I have more energy throughout my day... Before I went home and slept. Now, I could actually be home for a while.*

Participants were well aware of the toll material hardship was taking on their bodies and felt motivated to prioritize their health and well-being while participating in BIG:LEAP. Nelli, who struggled with hypertension for years, credited having more money for healthy food and the brain-space GI created with assisting her in finally “remembering to take my medicine every day... And [now] the doctors are like amazed.” Danny describes that she now takes “multivitamins ... and stays active, like walking, I know it will make you healthy so that’s what I do and eating healthy, like vegetables,” all steps she did not have the funds or time to take advantage of prior to receiving the GI.

The GI also introduced proactive behaviors for managing mental health and recovering from past trauma, particularly intimate partner violence (IPV).<sup>3</sup> This included resuming or starting therapy for the first time along with seeking mental health care for their children who had experienced living environments characterized by violence. Others, like Michelle, who experienced depression and social isolation, described the GI as accelerating the work they were doing in therapy by spilling over into small but consistent mindset shifts over time.

*I'm able to spend a lot more quality time with friends and loved ones. Before I received the money, I was shutting myself out from a lot of loved ones because I just had like, “Oh my god, I owe money and I have to pay these bills!” and it just wasn't a time I wanted to necessarily be, like, out with friends or family. Everything just looks a lot more positive. I'm able to look at things in a more positive way just because I have control of my time. I just feel I have this sense of, like, there's nothing I can't do now...*

*Recently I've been trying to take a little bit more time for me. I've had some issues with*

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<sup>3</sup> A full recounting of fundings related to IPV begins on page 39.



*meals before, not necessarily eating what I needed to eat because of mental illness. [But] I have learned to kind of manage my eating habits, my exercise habits, a little better than I have before. I've gotten into this mentality that however I'm feeling, I should still be able to accomplish one to two tasks a day ... I still kind of push myself to, you know, do small tasks. Maybe not the productivity I would have on like a good health day, but that's fine. Emotionally, it's been a hard year. I'm slowly getting better... another weight has been lifted.*

The relative speed at which participants prioritized healthier food and lifestyle choices when receiving the GI is indicative of a similar dynamic that, at times, is seen in financial literacy programming and literature, which often assume a lack of knowledge or specific behaviors rather than a lack of cash keeping households mired in poverty. However, financial literacy interventions for lower-income households only explain less than .01% of financial behaviors, prompting difficult questions for policymakers and non-profits who recommend allocating funds and resources for financial literacy programming (Fernandes et al., 2014). When it comes to health, a similar lack of health literacy or lack of rational action is also assumed by policymakers and clinicians at times, but these narrative data tell a counter-story—one where participants remain clear-eyed about the impact of the economy on their bodies and health while having distinct health goals that the market prevents them from acting on.



## 2. Change and Decision-Making in a 12-Month Pilot

As the largest 12-month guaranteed income RCT to date, BIG:LEAP offers a unique window into the degree of change and decision-making possible with one year of cash disbursements. For participants situated on the brink of deep poverty, the GI activated a decision-making trajectory that accelerated people against the spiral of poverty. The findings indicate that the duration and context of this pilot overlapped with changes that rest on shifts in subjective sense of self that spillover into community context and acts of reciprocity. More specifically, participants moved sequentially from alleviating material hardship (months 1–6), to an active goal-setting phase (months 6–9) and then shoring up resources in anticipation of material hardship resuming when the GI concluded (months 9–12). Within this trajectory, there is a distinct pattern and hierarchy of needs in how participants utilized the GI to prevent their households from falling deeper into poverty. First, they established immediate safety for their households by securing housing and necessary material resources, preventing homelessness, and getting themselves and their children out of dangerous relationships, housing arrangements, or settings characterized by IPV. Second, they established proximate safety and security for their children and community across three domains: enrolling their children in enrichment activities, alleviating the material hardship of others through acts of reciprocity and mutual aid, and engaging or re-engaging with their neighborhoods. Finally, when and if funds allowed, participants engaged in the proactive and preventative health and well-being behaviors detailed above along with shoring up resources to establish safety in the future. This included participants taking active steps to heal from past trauma associated with poverty, homelessness, and/or IPV.



## Months 1–6 | Alleviating Material Hardship and Establishing Immediate Safety

In the first 6 months of the pilot, GI recipients worked to establish immediate safety for themselves and their children, alleviating material hardship through meeting basic needs, securing housing, and moving themselves and their children out of housing arrangements where they were exposed to IPV, community violence, or emotionally unsafe relationships. Unlike the remainder of the *American Guaranteed Income Studies* to date, the acute pressures of the LA housing market forced families to prioritize securing their housing first. Participants in other sites rarely focused on housing costs until several months into the pilot, but the looming threat of eviction and past experiences with homelessness meant offsetting housing costs carried equivalent urgency to securing food and establishing physical safety from violent or threatening contexts.

### **ESTABLISHING IMMEDIATE SAFETY: HOUSING**

In October 2021, approximately 63% of the nearly 1.4 million households in LA rented their homes for an average rental price of \$2,557 per month (U.S. Census Bureau, 2022a; U.S. Census Bureau, 2022d; Zillow Economic Research, 2024). This is reflected in the housing arrangements of BIG:LEAP participants, where upwards of 70% of households (about 73% for treatment group and 70% for control group) rented their primary residence. Soaring housing prices coupled with reduced affordable housing supply keeps homeownership out of reach for many lower-income families. These conditions also force families into crowded housing arrangements, with multiple households residing in a single-family dwelling. Often termed “doubling up,” LA has the second highest rate of this phenomenon in the nation (Zhu et al., 2021). In the BIG:LEAP sample, “doubling up” may be a subset of the renter and living with friends and family subcategories (see Table 14).

In 2022, nearly 42,000 individuals were without housing in LA, reflecting an over 60% increase since 2015 (Los Angeles Homeless Services Authority, n.d.). In both treatment and control groups, the rate of individuals experiencing homelessness was consistent through the end of cash disbursements, though a change of methodology for constructing this variable caused the appearance of a sharp increase in this attribute at Endline.<sup>4</sup> A consistently higher rate of individuals in the control group than in the treatment group categorized their housing status as “Other” at all time points.

LA’s complex housing dynamics, which create instability for lower-income families, are also due in part to a lack of housing supply. In the first quarter of 2020, the Los Angeles metropolitan area had low vacancy rates for renters (2.3%) and homeowners (1.1%), with expensive housing being a key contributing factor (U.S. Census Bureau, 2023b). The city continues to drive investment into development and

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4 The definition of homelessness in this research synthesizes the Department of Housing and Urban Development (HUD) and McKinney-Vento standards, focusing on individuals, especially children and youths, lacking stable nighttime residences and living in temporary, inadequate conditions, or facing ongoing housing instability, as outlined by federal guidelines (National Center for Homeless Education, n.d.; U.S. Department of Housing and Urban Development, n.d.). In the Baseline, 6-month, and 12-months surveys, rates of homelessness were calculated based on extracting write-in responses from “Other housing status.” In Wave 4 of the survey, the additional standalone category of “Homeless” was added, to which the observed increase is attributable.



preservation of affordable housing units, yet development of units for lower-income households was less than half of the intended target from 2013–2021 (California Department of Housing and Community Development, 2023). Notably, as reported in 2022, Los Angeles County has a shortage of 499,430 affordable homes for the lowest-income renters (County of Los Angeles Homeless Initiative, 2022), which may largely be attributed to corporate investors purchasing large shares of the housing supply (Joint Center for Housing Studies of Harvard University [JCHS], 2023a). The persistent lack of affordable housing means households must spend an unsustainable portion of their monthly income to cover housing expenses, known as housing cost burden. Specifically, HUD defines households that spend more than 30% of their income on housing costs as housing cost burdened; this suggests that cost-burdened households may subsequently struggle to afford other necessities, like food, clothing, and transportation (HUD, 2017).

Table 14: Trends in Housing Status

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Renter	72.70%	70.29%	75.08%	71.63%	75.36%	72.22%	76.01%	72.78%
Homeowner	2.56%	2.48%	2.47%	2.80%	2.65%	3.04%	2.56%	3.10%
Rent-to-own	0.25%	0.24%	0.41%	0.28%	0.31%	0.30%	0.69%	0.24%
Living in a Public Housing Authority building	4.59%	4.39%	4.18%	4.05%	3.97%	4.03%	3.56%	3.91%
Living with friends or family	15.12%	16.59%	13.49%	15.36%	13.15%	14.98%	10.06%	13.36%
Other housing status	3.62%	4.31%	2.78%	4.15%	2.72%	3.75%	2.22%	3.41%
Homeless	1.16%	1.70%	1.59%	1.72%	1.84%	1.68%	4.90%	3.21%

In 2021, 57% of renters and 46% of all households in the Los Angeles metropolitan area were housing cost burdened (JCHS, 2023b), spending 30 to 50% of their monthly income on housing expenses. According to an article by the JCHS, the percentage of U.S. households that are cost-burdened has increased since 2019, with renters being more likely than homeowners to be cost-burdened or severely cost-burdened (spending more than 50% of their income on housing). It is estimated that close to one-third of all households in the US are currently housing cost burdened (Whitney, 2024). In 2022, an estimated 1,710,553 renter households in Los Angeles County on average spent 33.8% of their income on housing costs (Cromwell, 2022). The burden is driven by not only insufficient incomes, but also by increasing housing costs. Based on the HUD Rental Affordability Index,<sup>5</sup> renter affordability has declined since 2018 in the Los Angeles metropolitan (Westside) area because the median income grew at a slower pace relative to the median rent (HUD, Office of Policy Development and Research, 2020).

<sup>5</sup> HUD developed a rental affordability index that measures whether a typical renter household has enough income to qualify for a lease on a typical rental home at the national level (HUD, 2016).

Table 15: Trends in Housing Cost Burden

COST BURDEN (%)	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
<30	13.52%	13.04%	16.27%	16.23%	17.02%	17.77%	17.58%	19.65%
30–50	14.46%	14.42%	17.55%	17.29%	16.11%	18.65%	15.90%	19.89%
51–70	15.02%	15.85%	17.71%	19.21%	18.55%	20.87%	17.83%	24.48%
>70	57.00%	56.69%	48.47%	47.28%	48.31%	42.71%	48.69%	35.98%

Housing cost burden was extremely high for both treatment and control participants across the study, with nearly half of participants spending upward of 70% of their monthly income on housing expenses. At Baseline, about 87% in each group were housing cost burdened, paying housing costs in excess of 30% of their monthly income. While the percentage of housing cost burdened participants reduced for both treatment and control groups, at the Endline (18 months), 82% of the treatment participants and 80% of the control participants were still housing cost burdened. The slightly lower rate of housing cost burden among control participants is consistent with the higher household income they reported.

Despite these extreme burdens, both groups displayed a positive shift in perceptions of home quality, suggesting that they felt their current homes were better than their prior ones from Baseline to 6 months after the GI payments ceased. Over time, fewer people in both groups also reported they felt their current home was worse than the last.

Table 16: Comparative Analysis of Home Quality Between Treatment and Control Groups

HOME QUALITY	BASELINE		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL
About the same	49.06%	49.86%	47.25%	47.62%
Better home	34.60%	33.55%	38.19%	38.68%
Worse home	16.33%	16.59%	14.55%	13.70%

**WHEN THE SAFETY NET FINALLY CATCHES YOU: PREVENTING HOMELESSNESS**

Persistent housing strain and fear of eviction were present across the entire narrative dataset. Participant decision-making around financial matters and GI revolved around either managing the cost of housing in LA, trying to rebuild credit after prior experiences with eviction, rebounding from prior experiences with homelessness, managing escalating rental costs, or moving in with family or friends to save on housing costs. While this may seem intuitive, the degree to which BIG:LEAP participants were preoccupied with the cost of housing as a matter of establishing immediate safety and survival is

unique to this location in comparison to the other sites included in the *American Guaranteed Income Studies*.<sup>6</sup> The cost of housing, past experiences with eviction and homelessness, and looming fears surrounding housing saturated decision-making and produced a constant drumbeat of stress. To a person, all interview participants credited the GI with assisting them in offsetting rental costs and most in preventing homelessness, along with noting that “paying the rent first” is the guiding North Star in every household budget.

Unlike many other housing interventions, which require a lengthy waitlist, application process, an eviction, or current experience with homelessness to access services, the GI functioned in this dataset as a preventive measure against homelessness that finally caught Angelenos, like Seven, who have been falling through the safety net since birth.

Seven is a formerly homeless father and LA native who was raised in foster care, group homes, and residential facilities. Seven “never had parents,” and echoed others when saying,

***[BIG:LEAP] saved my life really ...  
I'd probably be living on the streets. I probably would have had my kids  
taken ... it gave me a sense of security instead of always wondering if I'm  
gonna be able to get money for the next meal.***

He went on to share that beyond housing, he was able to participate in a community fundraiser, buy his child a costume and take them trick-or-treating, and buy the supplies necessary for continuing his small design business, which suffered serious declines during the pandemic. For Seven, like many of the fathers interviewed, the GI restored his sense of humanity and masculinity because it provided him with an enhanced capacity to act as a provider for his family. He also noted that his decrease in stress translated to not only the ability to “get my children clothes and stuff like that so that they weren't embarrassed at school,” but meant he was more emotionally available for them and able to “partake in the events at school.”

Participants also credit the GI with keeping them from needing to access other housing services, preventing complete financial exhaustion due to the rising cost of rent, and serving as a buffer that could tide them over while waiting for other housing support to arrive. In cases where family members were eligible for other pandemic-related interventions such as the Child Tax Credit or expanded unemployment insurance, participants took savvy measures to combine the GI payment with these other programs to maintain housing for their families. The GI also provided them with a degree of safety and flexibility about whom they chose to live with versus feeling forced to remain in unsafe housing situations, neighborhoods, or relationships.

The advantage of GI is that it is fungible, flexible, and efficiently delivered, which created space for moms like Lisa to ride out the notoriously long waiting list for Section 8 housing. In her case, the GI arrived a few months before she finally made it off the waiting list, and without it, she likely would

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<sup>6</sup> As of summer 2024, CGIR is conducting 36 GI experiments across the continental US and thus far, the cost of housing and fear of homelessness is more acute in LA than in the other sites. This includes New York, NY.



have returned to homelessness with her autistic son in tow. In her words, BIG:LEAP gave her “a sense of security because it was something that I didn’t have for a long time, just knowing I have a place to lay my head with my children.” Now, rather than living on the streets she is “across the street from a park” in a community where she says her “neighbors are awesome... I’ve been able to just make friends with people.”

### **ESTABLISHING IMMEDIATE SAFETY: PREVENTING, ESCAPING, AND HEALING FROM IPV**

The second way GI functioned to establish immediate safety was by providing a material avenue for escaping or healing from IPV and unsafe relationships. IPV includes sexual violence, stalking, physical violence, psychological aggression, and is concomitant with financial abuse and control of reproductive/sexual health (Centers for Disease Control and Prevention, 2022). Consequently, the experience of IPV and associated economic conditions generate a revolving cycle whereby poverty increases IPV risk factors and violence increases the risk of poverty (U.N. Women & Social Development Direct, 2020). These dire economic consequences extend beyond household-level impact, with the annual cost of IPV exceeding \$8.3 billion in the US and victims cumulatively losing 80 million days of paid work annually (Rothman et al., 2007). This dynamic is not unique to LA or the US and represents a global public health problem primarily impacting women. Approximately 27% of women who are over 15 years of age have experienced IPV, which is associated with significant impacts on physical and mental health including anxiety, depression, suicidality, reproductive issues, sexually transmitted disease, physical injuries, and death (Sardinha et al., 2022). Pre-pandemic, approximately 20% of women over the age of 18 in Los Angeles County reported experiencing physical and/or sexual violence from an intimate partner over their lifespan (LACDPH, 2018), with more than one in 10 women reporting IPV while pregnant (Los Angeles County Domestic Violence Council, 2020).

BIG:LEAP represents one of the first studies conducting an epidemiological assessment of IPV using a self-reported survey in lieu of administrative records such as crime reports and emergency room visits. Although administrative records are ordinarily relied on to establish the prevalence of IPV, they only capture incidents when victims seek medical care or report their experiences to law enforcement, thereby undercounting IPV. The COVID-19 lockdowns prompted widespread concern by advocates and policymakers that incidences of IPV would increase under stay-at-home orders, when women and children were isolated with abusive partners and separated from social institutions and relationships where they could seek help (Babalola et al., 2022; Sardinha et al., 2022). The pandemic also created a prolonged economic shock, with the most acute impact on those already living at or below the poverty line. Given that financial stress is well-established in the literature as being associated with IPV risk (Gelles, 1997; Matjasko et al., 2013), it has long been theorized that unconditional cash provided directly to women instead of to the household may decrease the incidence of IPV (Calnitsky & Gonalons-Pons, 2021; Miller et al., 2023). In this RCT, the quantitative and qualitative data both indicate that providing recurring unconditional cash in the form of a GI reduced or prevented the incidence of IPV in the treatment group. It also simultaneously created avenues for healing, as women like Linda, a single mother in her 30s, were able to combine the GI with other, pre-existing social services. In her words, she was able “to recover from abuse... I could never say enough ‘thank you’s... I’m able to be a more happy, healthy person for my child.”

In this study, over half of the study participants—56% of treatment and 55% of control participants—reported experiencing IPV at some point in their lifetime. Table 17 below provides rates of different types of IPV experienced by participants in the past 12 months, among those who reported ever experiencing IPV. Over 50% of participants—both treatment and control—who reported ever experiencing IPV at Baseline indicated that they had suffered psychological abuse by intimate partners in the past 12 months. The rate was 30% for physical abuse. This is substantially higher than the 20% who reported experiencing IPV county-wide before the pandemic (LACDPH, 2018). While it is likely indicative of increases in IPV associated with the financial pressures of the pandemic, deep poverty, and isolation during stay-at-home orders,<sup>7</sup> it is not possible to know conclusively from this dataset. Over the study period, treatment participants reported lower IPV total scores than control participants.<sup>8</sup>

At Baseline, IPV total scores for treatment and control participants were not significantly different ( $M=17.46$  vs.  $M=20.40$ ;  $M_{diff}=-2.94$ , 95% CI  $[-7.42, 1.54]$ ,  $p=0.197$ ). Similarly, no statistically significant difference was found across all subcategories of IPV at Baseline. Overall, GI recipients reported lower levels of total IPV scores than control participants at 6-month ( $B=-7.04$ ,  $p=.053$ ) and 12-month follow ups ( $B=-5.40$ ,  $p=.172$ ), but the difference was not statistically significant. At the 18-month follow-up, however, the treatment group reported significantly lower levels of total IPV scores than control participants ( $B=-7.97$ ,  $p<.05$ ). These trends were consistent for some subcategories of IPV. Treatment participants, compared to control participants, reported lower levels of psychological abuse, sexual abuse, and coercive control across each time point, but the difference was not statistically significant. Similar to the total IPV scores, the treatment group reported lower levels of physical abuse than control participants at 6-month ( $B=-2.44$ ,  $p=.051$ ) and 12-month follow-ups ( $B=-1.02$ ,  $p=.426$ ), but the difference was not statistically significant. At 18 months, GI recipients reported significantly lower levels of physical abuse than the control group ( $B=-2.90$ ,  $p<.05$ ). Finally, 6 months following the first cash disbursement, treatment participants reported significantly lower levels of financial abuse ( $B=-.54$ ,  $p<.05$ ) than control participants. While GI recipients continued to report lower levels of financial abuse at 12-month and 18-month follow-ups, the difference was not statistically significant.

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7 During stay-at-home orders in LA, there was a 3.4% increase in mean domestic violence calls, but these reverted to baseline when stay-at-home orders were lifted (Babalola et al., 2022).

8 This study utilized the Composite Abuse Scale (CAS R-SF), a 15-item scale designed to capture a respondent's experience of IPV with a particular emphasis on the frequency of experiences (Ford-Gilboe et al., 2016). Participants were asked whether they had experienced any of the 15 IPV items (e.g., My partner(s) shook, pushed, grabbed, or threw me). If they responded yes, they were asked to indicate how often it happened in the past 12 months (e.g., Not in the past 12 months, Once, A few times, Monthly, Weekly, Daily/Almost Daily). Total scores ranging from 0 to 75 were computed by calculating the mean frequency of all abuse items and multiplying this score by 15, where there were responses for at least 11 of the 15 items (~70%). Scores for the psychological abuse (range: 0 to 30), physical abuse (range: 0 to 25), and sexual abuse (range: 0 to 10) subscales were calculated in the same manner.

Table 17: Composite Abuse Scale—Total Score (0 - 75)<sup>9</sup>

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	17.46	20.40	11.32	21.90	12.19	20.34	15.19	20.36
Std. Dev.	22.93	23.95	18.60	24.11	21.06	25.97	23.38	24.22

Table 18: Composite Abuse Scale—Psychological Abuse Subscale Score (0–30)

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	8.20	9.44	7.37	9.21	7.47	8.17	7.76	8.62
Std. Dev.	9.55	9.45	8.87	9.22	9.22	9.38	9.52	9.62

Table 19: Composite Abuse Scale—Physical Abuse Subscale Score (0–25)

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	4.93	5.50	2.85	6.18	3.48	5.56	4.69	5.91
Std. Dev.	7.34	7.52	5.71	7.83	6.73	8.32	7.68	7.87

Table 20: Composite Abuse Scale—Sexual Abuse Subscale Score (0–10)

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	1.72	1.99	1.09	2.02	1.23	2.48	1.74	2.17
Std. Dev.	2.70	2.91	2.24	3.03	3.44	3.44	2.91	3.12

9 Accounting for those who did not respond to the survey wave and those who did not respond to the IPV-specific questions, survey items regarding IPV had missingness rates ranging from 0–97%. Despite the high level of missingness, the descriptive statistics and analyses reported on IPV data here are based on raw data instead of multiply imputed data using machine learning techniques. We have done this for two main reasons: 1) While scholars disagree on the percent of missingness as the main consideration for multiple imputation methods and, in fact, caution against relying on existing data with large missingness (Austin & van Buuren, 2022; Madley-Dowd et al., 2019), we wanted to ensure the results are understandable to the general public given the sensitive nature of the topic; and 2) Consistent with a study examining machine learning algorithms to address missing data in IPV research that found simulated predictions of IPV incidence rates to be higher than the rates from the original dataset, we also found a similar trend where imputed IPV incidence rates were higher than the original dataset. This is mainly due to machine learning techniques accounting for biased non-responses that would undercount actual IPV incidence (Chen et al., 2023). We are confident in the sophisticated approach we took with MICE; however, considering the general reader of this report, we have opted to present imputed results using data based on MICE in Appendix B instead.



Table 21: Prevalence of IPV Subtypes in the Past 12 months (Not Including Never or Not in the Past 12 Months)—Raw Data

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Psychological Abuse	53	55	50	58	47	52	49	52
Physical Abuse	29	30	23	33	24	27	24	29
Sexual Abuse	11	11	11	13	9	13	11	14
Coercive Control	12	11	10	12	10	11	11	13
Financial Abuse	14	15	11	16	11	14	12	16

Consistent with data from the 1970s Mincome experiments, which showed reductions in crime that included IPV (Calnitsky & Gonalons-Pons, 2021; Gonalons-Pons & Calnitsky, 2022), participants described leveraging the cash to escape living situations where IPV was prevalent, to avoid returning to an abusive environment in order to secure housing or transportation for work, to avoid seeking housing in a domestic violence shelter, or to supplement services they were receiving for experiences with IPV. In other words, the disbursements were being used to either prevent returning to an unsafe relationship or housing arrangement, to heal from the physical and emotional impact of violence, and/or to escape an unsafe relationship altogether. However, also consistent with the literature (Gonalons-Pons & Calnitsky, 2022), the infusion of GI into a relationship with a high degree of financial stress and risk of IPV can prompt either a healthier relationship due to reductions in financial stress or provide the partner experiencing abuse with the means to leave and heal.

Healing took place physically and emotionally, with multiple women like Crystal describing the ability to recover from diagnoses of “PTSD from my DV” through prioritizing therapy for themselves and their children. Meanwhile, others noted physical changes like healing from injuries, recovering from the physical impact of constant stress, and for one mother, being able to afford restorative surgery after a disfiguring experience with IPV. Others, like Sara, a single mother and college student, described remaining in an unsafe living arrangement and “toxic relationship” out of necessity when she lacked the transportation needed for work and classes. For Sara, leaving her abusive partner meant losing transportation, which would snowball into losing her employment and being forced back onto the streets or into a shelter without income. Once enrolled in BIG:LEAP, she immediately prioritized combining the GI with the “little bit of money I had saved up from working [in a fast food chain]” to purchase a used car which allowed her to leave the unsafe situation without losing her job or stopping coursework. For others, like Lici, the GI simultaneously prevented her and her children from experiencing more violence while also facilitating her exit from homelessness.

## CASE STUDY

## "A Ray of Hope": Exiting Homelessness and IPV

Lici is a single mother to two teenagers; her story is one of migration, self-preservation, and adaptability. As she nears 50, she still supports her family despite gradually declining health that has impacted her employment, going from working two jobs to working only part-time in a restaurant. She left an abusive relationship just prior to BIG:LEAP and was moving with her children from shelter to shelter, in hiding until the GI afforded her a chance to secure housing. In her words:

*It was very complicated for me to get out of domestic violence and start with nothing. Because I left—we left without anything. Only the clothes we were wearing... and seeing the change now is very significant. We were going from shelter to shelter... When I lived in the shelter, I saw the news that this program was going to be launched... So it was like a ray of hope and I was dreaming with my eyes open. And there was no door that I wouldn't knock on. I knocked on all the doors, many told me "no," many, many. They told me, "No, you don't qualify, no, not this, not that." And it was devastating for me when I received a "no." But I always tried... When I received that news... I mean, they just told me, "You qualify."*

*Wow. And it was like heaven opened for me, right? I couldn't believe it... I had nothing... I was wearing all second-hand items they gave us in the shelter. Everything that people didn't need anymore, I would pick it up. It was a treasure to me. When I received the card, the first thing I did, I'm sorry, I get emotional. I know that for some people, it is easy go to a grocery store and buy food. And I couldn't do that. When I received it [the GI] the first thing I did, I went to buy food for my children... And that burden that I felt that didn't let me breathe, it was like that burden that I carried on my back was taken away from me. I let it go. I wasn't going to worry about buying food anymore. I could live on the street, but my children can't. And to leave a golden cage, with a man who, according to him, gave me everything. But it was actually martyrdom to endure that, just to have food. And sometimes I thought, oh, I shouldn't have left. I should have stayed there, but if I had stayed there, my children would have been left without a mother. And now... Now I think it was the best thing I could have done. To have left that place.*



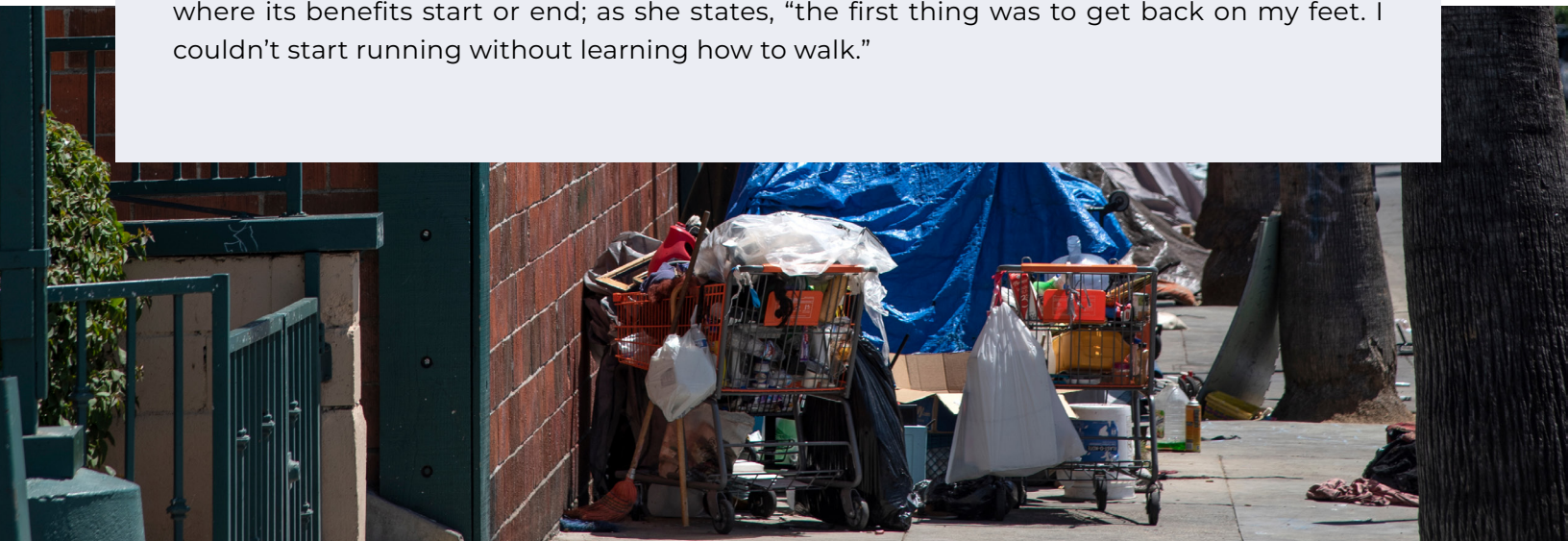
After several months of payments, Lici was finally able to leave the shelter system and move into an apartment with her children. She still fears eviction, but for now, says:

*This program is giving me so much. It's giving me the opportunity to give my children memories with me. Because I don't know how long I'm going to live. But they are going to remember. At least this year, their mom was with them. We now have time to live together as a family. And that was a privilege that I didn't have. With this program, I have that privilege. And that doesn't have a price. It's not worth a thousand dollars. It's invaluable that a mother has time with her children. And her children have time with their mother.*

Though she had additional goals that she could not meet in the year-long duration of the pilot—finding new work as a nanny or in eldercare, saving up for a car, and taking English courses—BIG:LEAP gave her something she had not thought she would have: time with her children after working “myself to death to give them, not the best, because I couldn't give them the best, but give them what my children needed.” Lici compared the pilot to a dream, one she yearned to not wake up from. Yet even 3 months post-pilot and the end of the GI, Lici's hope remained unshakeable, fortified by her experiences in the pilot:

*I'm a victim of domestic violence. I left my home, I abandoned everything, but thank God we are safe. We lived in shelters.... It's a process that required a lot of work, but I'm seeing the fruits of it. We are in the process of recovery. We are still working on that every day, with PTSD, and other problems that arose in the process, but I have faith and I'm confident that everything will work out fine. ... BIG:LEAP program was a miracle to me. Honestly. To you, it's a project, I don't know, I mean, it's a project, someone invented it, let's see how it works and so on. But to me, it was a miracle.*

Lici's experiences underscore that GI's financial impacts—though invaluable—are neither where its benefits start or end; as she states, “the first thing was to get back on my feet. I couldn't start running without learning how to walk.”





## Months 6–9 | Goal-Setting and Establishing Proximate Safety

Once participants established immediate safety in the early months of the pilot, they began establishing proximate safety and engaging in goal setting at the study's mid-point. As material hardship lifted, the GI functioned as an accelerant in decision-making, with participants acting quickly knowing that only 6 months of disbursements remained. Parents primarily invested in enrichment activities and mental health care for their children, but also began engaging differently in their neighborhoods and social networks through mutual aid and acts of reciprocity. The capacity for change at this juncture rested on the material support that the GI facilitated and on subjective shifts in sense of self introduced by unconditional cash. While material support took the obvious form of suddenly having the capacity for sharing resources and paying for enrichment activities, it also introduced a shift in meaning-making whereby participants felt they mattered to society and their community, spent more time engaging positively with their family and neighbors, and had a greater capacity for hope and a stronger sense of agency.

### ENRICHMENT ACTIVITIES AND COMMUNITY ENGAGEMENT

Far more GI recipients reported that their children participated in enrichment activities, such as sports, lessons, and clubs, than control participants. At Baseline, approximately 44% of the treatment group (vs. 40% control) had their children in at least one enrichment activity. The rates for treatment participants remained relatively stable across the study period (43% at 6 months, 40% at 12 months, and 41% at 18 months), while the rates dropped for control participants (30% at 6 months, 26% at 12 months, and 27% at 18 months). At 6 months, the effects were significant for both sports ( $B = .41, p < .001$ ) and lessons ( $B = .88, p < .001$ ). This significance persisted at 12 months (sports:  $B = .47, p < .001$ ; lessons:  $B = .75, p < .001$ ), as well as at 18 months (sports:  $B = .51, p < .001$ ; lessons:  $B = .77, p < .001$ ). This trend was consistent across all enrichment activities, both paid and unpaid.

Table 22: Trends in Child Participation in Enrichment Activities by Type

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Sports	25.89%	25.18%	29.58%	24.42%	27.42%	20.89%	29.54%	21.96%
After-school lessons	21.36%	19.19%	21.64%	10.40%	21.61%	11.58%	21.39%	11.24%
Clubs/Organizations	21.96%	20.45%	21.17%	22.48%	22.61%	19.27%	20.89%	12.24%

Table 23: Trends in Any Child Enrichment Activities

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Yes	43.54%	40.44%	42.60%	29.53%	40.10%	26.22%	40.60%	26.98%
No	56.46%	59.56%	57.40%	70.47%	59.90%	73.78%	59.40%	73.02%

Table 24: Confusion, Hubbub, and Order Scale—Total Score

TIME PERIOD	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	29.53	29.51	29.21	30.18	29.87	30.11	30.62	30.84
Median	29.00	29.00	29.00	30.00	30.00	31.00	31.00	31.00

The study additionally employed the Confusion, Hubbub, and Order Scale (CHAOS) (Matheny et al., 1995) as a determinant of home environment; this approach offered insights into the indirect factors that may influence mental health and perceived stress. More specifically, the CHAOS scale assesses the level of disorganization, confusion, instability, and disorder in a home, which all impact the home environment and child development. Treatment participants reported significantly lower levels of household stress and disorder at 6 months (M=29.21 vs. M=30.18; Mdiff=-0.99, 95% CI [-1.19, -0.78],  $p < 0.001$ ) than did control participants, and again at 12 months (M=29.87 vs. M=30.11; Mdiff=-0.25, 95% CI [-0.47, -0.03],  $p < 0.05$ ). While still lower at 18 months (M=30.62 vs. M=30.84; Mdiff=-0.23, 95% CI [-0.46, 0.00],  $p = 0.05$ ), the differences were not statistically significant.

### TIME FOR CHILDREN AND PARENTING

Enrichment extended beyond activities outside of the home and included participants describing more time for engaging in relationships, parenting, and community once basic needs were met and time scarcity lifted. In Seven’s words, BIG:LEAP “made his family closer because we get to go do things to bond.” Although the CHAOS scale was not statistically different between treatment and control groups, the narrative data supported the lower levels of household stress and disorder found among the treatment group at the 6- and 12-month marks. Fathers like Aldy described having newfound time for being with family; Aldy remarked that he could finally take his children to “parks, or to the beach, every here and there, on days that I normally wouldn’t be able to do any of this. I was able to just spend a lot—a lot more quality time with the family.”

Meanwhile, parents directly attributed positive shifts in their children’s academic performance, coping skills, and behavior to spending more time with their children. After Amira was able to catch up on back rent, she immediately leveraged the GI for a job that kept her “closer to her son” by working from home. In turn, she was then able to give more attention to her son, who struggled from the pandemic’s effects on his education: he “got disconnected... so when he returned to school, he also had problems with how to get along.” In her words,

Financial scarcity creates time scarcity when low-income people are forced to work excessive and unpredictable hours to make ends meet and/or contend with the administrative burdens imposed by the safety net. This traps people in the present, eliminates pathways out of poverty, undermines healthy relationships and leaves no bandwidth for applying to new jobs or opportunities (West & Castro, 2023).

*it gave me time to be with my son. I haven't neglected him, and I've also seen progress in, in him, in school... In his behavior, he improved, and also academically. Because he was, like, depressed, violent too, he would get upset very, very quickly.*

Like other parents, she also established proximate safety for him by seeking behavioral health help, and it paid dividends by the end of the pilot when “the psychologist gave me the letter... finished... he had completed his therapy well.”

**NEIGHBORHOOD CONTEXT**

In assessing the neighborhood in which participants lived, subsections of the Neighborhood Environment for Children Rating Scale covering worries about victimization and interactions with neighbors were used (Coulton et al., 1996). In this section, participants were asked to rate on a scale from 1 to 10 the degree to which: 1) Neighbors positively engaged with one another and 2) Participants worried about harm to property, self, and others in the neighborhood. The scale score was calculated by adding the score for each of the individual items and dividing the sum by the number of nonmissing items for that individual. Scores ranged from 0 to 10, with higher scores on the interaction subsection indicating more positive neighborhood interaction, and higher scores on the victimization subsection indicating more worry about harm to property, self, and others in the neighborhood. Overall, GI recipients reported an increasing trend of engaging positively with their neighbors across the study period. At Baseline, levels of positive engagements with neighbors were not different between treatment and control participants ( $t=-1.31, p=.19$ ). Compared to the control group, the treatment group reported significantly more positive engagement with neighbors at 6 months ( $B=.20, p<.001$ ), 12 months ( $B=.23, p<.001$ ), and 18 months ( $B=.23, p<.001$ ), during and beyond cash disbursement. Consistent with this finding, treatment participants were significantly less likely to perceive safety issues than control participants at 6 months ( $B=-.63, p<.001$ ), 12 months ( $B=-.60, p<.001$ ), and 18 months ( $B=-.60, p<.001$ ), even though treatment participants were significantly more likely to worry about safety at Baseline ( $t=-2.50, p<.05$ ).

Table 25: Neighborhood Environment for Children Rating Scale—Interaction Subscale Overall Score

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	3.63	3.56	3.81	3.58	3.79	3.53	3.86	3.60
Std. Dev.	2.19	2.19	1.96	1.51	2.08	1.58	2.06	1.58

Table 26: Neighborhood Environment for Children Rating Scale—Victimization Subscale Overall Score

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	6.09	5.94	6.40	6.98	6.15	6.70	6.17	6.72
Std. Dev.	2.51	2.60	2.11	1.47	2.21	1.57	2.24	1.71



Figure 8: Average Score for the Neighborhood Interaction Items for Each Group at Each Point in the Study

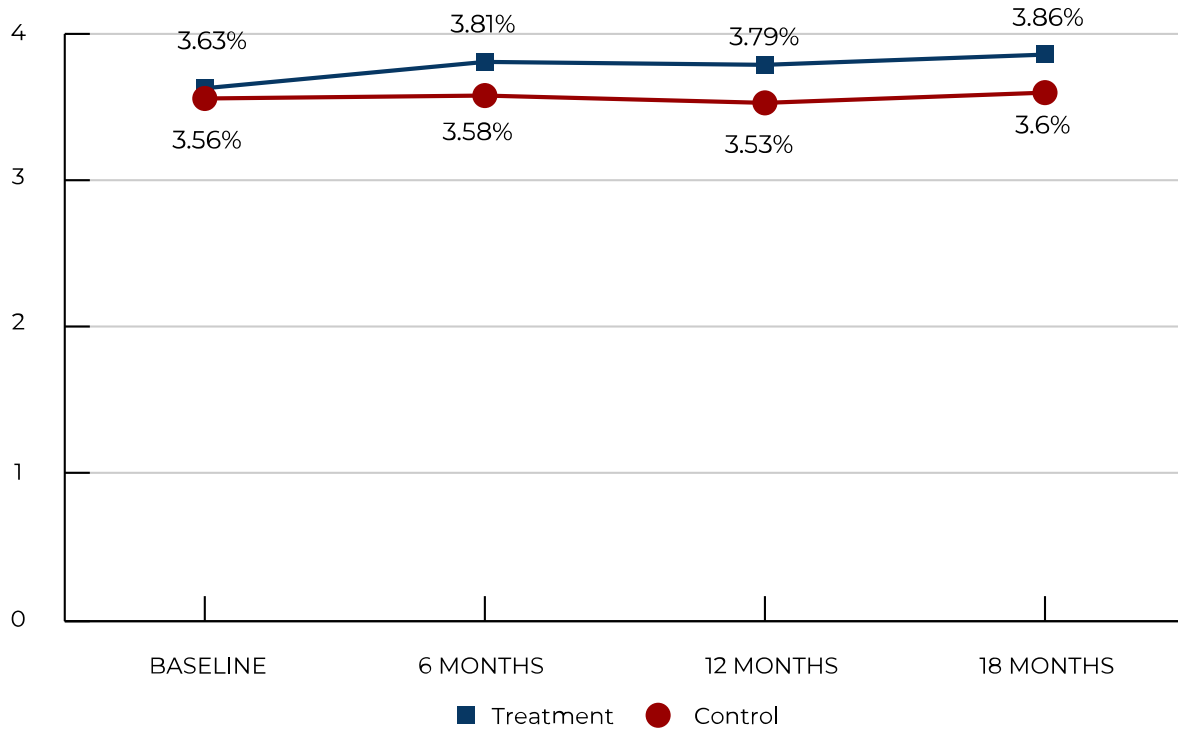
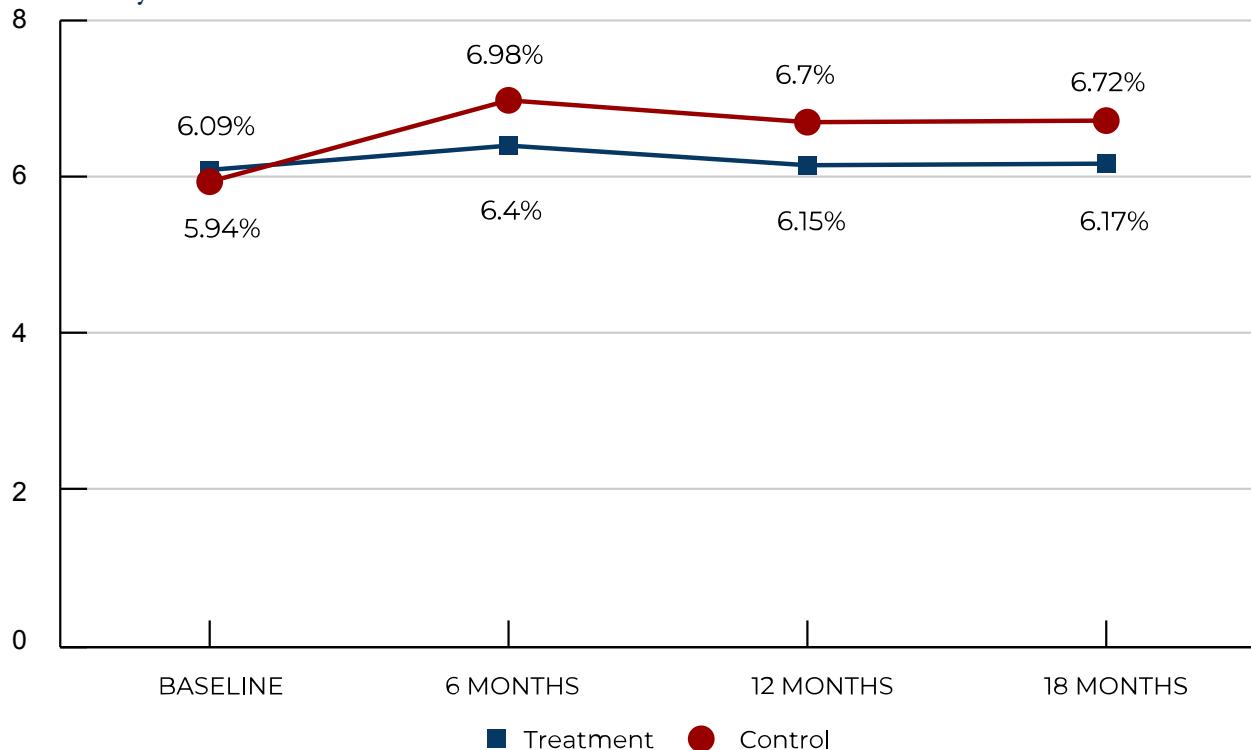


Figure 9: Average Score for the Neighborhood Victimization Items for Each Group at Each Point in the Study



## **MATTERING, HOPE, AND AGENCY**

An emerging trend in economic development and mobility literature is wrestling with the question of why some people experiencing hardship fall into despair when others in similar circumstances cling to possibility. In the words of Lybbert & Wydick (2018, p. 718), “hope is not for the omnipotent,” and its presence is indicative of uncertainty about what may pass tomorrow or the next day. In the context of extreme financial risk, which infuses daily life with anxiety and uncertain outcomes, the capacity for hope is associated with the instruments necessary for upward mobility and the wherewithal to respond to opportunity when it presents itself (Baker et al., 2021; Castro et al., 2021; Lybbert & Wydick, 2018). Hope encompasses three elements: the ability to set goals, the ability to visualize a pathway for achieving them, and a sense of agency that one is able to move along that pathway in the face of uncertainty (Snyder et al., 1991). A sense of mattering, which references the degree to which you as a human being matter to society and institutions with power and control over your life, also facilitates the conditions for hope (Baker et al., 2021). This does not mean that people trapped in poverty or inequality are responsible for clawing their way towards hope and mattering through individualistic grit. Instead, it points towards the structural antecedents for hope which include positive social connections, supportive relationships, and community connection that—despite inequality—affirm one’s humanity in the face of structural constraints and vulnerability (Castro et al., 2021). People experiencing marginalization receive an opposite message from the market, which dictates that worth is tied to one’s economic output. When unconditional cash is infused into this dynamic, it reminds people of their dignity outside of capitalism while providing them with material ways to set and act on goals necessary for hope, mattering, and community.

## **SENSE OF SELF**

The Mattering Index (Elliott et al., 2004) assesses how individuals perceive their value in the eyes of those around them, encompassing three dimensions: Awareness, Importance, and Reliance. Awareness refers to how people believe others perceive them, Importance refers to how people believe that others are emotionally invested in them, and Reliance refers to how much individuals feel others can rely on them. While small in magnitude, GI recipients reported significantly higher levels of Awareness and Reliance at 6 months (Awareness:  $M=30.11$  vs.  $M=29.54$ ;  $M_{diff}=0.60$ , 95% CI [0.42, 0.77],  $p<0.001$ ; Reliance:  $M=21.63$  vs.  $M=21.42$ ;  $M_{diff}=0.19$ , 95% CI [0.06, 0.33],  $p<0.01$ ), 12 months (Awareness:  $M=29.92$  vs.  $M=29.66$ ;  $M_{diff}=0.29$ , 95% CI [0.11, 0.47],  $p<0.01$ ; Reliance:  $M=21.77$  vs.  $M=21.57$ ;  $M_{diff}=0.18$ , 95% CI [0.03, 0.33],  $p<0.05$ ), and 18 months (Awareness:  $M=29.63$  vs.  $M=29.25$ ;  $M_{diff}=0.39$ , 95% CI [0.20, 0.59],  $p<0.001$ ; Reliance:  $M=21.56$  vs.  $M=21.36$ ;  $M_{diff}=0.18$ , 95% CI [0.03, 0.33],  $p<0.05$ ) than control participants. This suggests that treatment group members had a more positive outlook on how they were perceived by others, as well as a greater sense that people could depend on them. Treatment group members also reported significantly higher levels of Importance at 6 months ( $M=35.44$  vs.  $M=35.16$ ;  $M_{diff}=0.26$ , 95% CI [0.07, 0.45],  $p<0.01$ ) and 12 months ( $M=35.51$  vs.  $M=35.24$ ;  $M_{diff}=0.25$ , 95% CI [0.05, 0.45],  $p<0.05$ ) than control participants, though the effect was not statistically significant at the final observation. These findings suggest that GI receipt was positively associated with an improved perception of others’ emotional investments in treatment group members.

The concept of mattering is critical to overall psychological health and well-being, as the sense of one’s mattering to other people is “double edged in that mattering is highly protective but feelings of not mattering are deleterious, especially among people who have been marginalized and mistreated” (Flett, 2022, p. 3).

Table 27: The Mattering Index—Awareness

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	30.28	30.33	30.11	29.54	29.92	29.66	29.63	29.25
Median	30.00	31.00	31.00	31.00	30.00	30.00	30.00	30.00

Table 28: The Mattering Index—Importance

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	35.61	35.58	35.44	35.16	35.51	35.24	35.13	35.05
Median	36.00	36.00	35.00	35.00	35.00	35.00	35.00	35.00

Table 29: The Mattering Index—Reliance

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	21.50	21.47	21.63	21.42	21.77	21.57	21.56	21.36
Median	21.00	21.00	22.00	21.00	22.00	22.00	21.00	21.00

Questions using the Adult Hope Scale (Snyder et al., 1991), a frequently used measure to detect a person’s state of planning and action to meet goals, were asked at each time point. Overall, both treatment and control groups scored within the Hopeful range, or the lowest range of 40 to 48, compared to Moderately Hopeful range of 48 to 56 and High Hope range of greater than 56. The scale contains two subscales—Agency, or a person’s goal-directed energy, and Pathways, the extent to which a respondent is planning to reach their goals. Overall, treatment group participants reported significantly higher scores of overall hope at 6 months after the initial cash disbursement than control participants (M=44.15 vs. M=43.25; Mdiff=.65, 95% CI [0.37, 0.92],  $p<0.001$ ). Yet, this trend reversed at the one-year mark, where control group members had significantly higher scores of overall hope (M=43.54 vs. M=43.62; Mdiff=-0.32, 95% CI [-0.63, -0.02],  $p<0.05$ ). The overall level of hope was not significantly different between treatment and control at 18 months (M=43.03 vs. M=42.91; Mdiff=-0.12, 95% CI [-0.44, 0.21],  $p=0.479$ ).

On the subscale of Agency, significantly higher scores were reported by GI recipients at 6 months (M=21.36 vs. M=21.09; Mdiff=0.15, 95% CI [0.00, 0.30],  $p<0.05$ ). At 12 and 18 months, the control group



trended toward significantly greater agency scores (12 months: M=21.13 vs. M=21.32; Mdiff=-0.31, 95% CI [-0.47, -0.14],  $p < 0.001$ ; 18 months: M=20.93 vs. M=21.04; Mdiff=-0.21, 95% CI [-0.39, -0.04],  $p < 0.05$ ). For the Pathway subscale, the treatment group reported significantly higher scores at 6 months (M=22.79 vs. M=22.17; Mdiff=0.51, 95% CI [0.36, 0.67],  $p < 0.001$ ). This trend of higher scores continued through the 12-month and 18-month marks, but the difference was not statistically significant (12 months: M=22.41 vs. M=22.30; Mdiff=0.00, 95% CI [-0.17, 0.17],  $p = 0.985$ ; 18 months: M=22.09 vs. M=21.88; Mdiff=0.11, 95% CI [-0.07, 0.29],  $p = 0.222$ ).

Taken together, these findings suggest that GI recipients had greater goal-directed energy and actions or agency at the 6-month mark, though only their goal-directed actions persisted differentially from the control group after the cessation of GI payments. Conversely, the control group had a greater likelihood of engaging in goal-setting and planning, yet their ability to take steps toward those goals did not outpace the treatment group until the 18-month mark.

Table 30: The Adult Hope Scale—Agency

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	21.24	21.02	21.36	21.09	21.13	21.32	20.93	21.04
Median	22.00	21.00	22.00	21.00	22.00	22.00	21.00	21.00

Table 31: The Adult Hope Scale—Pathway

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	22.51	22.28	22.79	22.17	22.41	22.30	22.09	21.88
Median	23.00	23.00	23.00	23.00	23.00	23.00	23.00	22.00

Table 32: The Adult Hope Scale—Total Score

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	43.75	43.30	44.15	43.25	43.54	43.62	43.03	42.91
Median	44.00	44.00	45.00	44.00	44.00	44.00	44.00	43.00

**SENSE OF SELF, MUTUAL AID, AND RECIPROCITY**

As scarcity lifted and immediate safety was established, participants began experiencing the aforementioned shifts in their sense of self, which laid the groundwork for acts of reciprocity and mutual aid that are emblematic of community and belonging in LA’s storied neighborhoods. Despite its brevity, the BIG:LEAP pilot pointed towards an emerging understanding of how the infusion of cash provided avenues for people to draw on changes in sense of self and their positive social connections

while building new ties through generosity. These acts served the dual purpose of pooling resources across networks while restoring GI recipients' humanity by enabling them to give in ways they could not previously. This included meeting the needs of elderly and ailing family members, and sharing food, clothing, time, resources, and money even when their own financial stability remained uncertain. Veronica gave an entire month's disbursement to a neighbor who was a street vendor, and lost their livelihood due to a transmission fire. Lisa stocked up on sweatpants that she delivered to those experiencing homelessness in her community before she used the GI to buy herself and her children beds after sleeping on the floor for over a year. Lee encountered a woman in a Walmart check-out line staring down public embarrassment when she was unable to pay the full cost of groceries. But, instead of avoiding eye contact, Lee stepped up:

*She had three kids with her. I looked at her cart and I said, "You know what? I'll pay for that." And she was like "Wait, what?" I was like, "Yeah, I'll pay for you."*

*It wasn't much, but I was like, "If I got blessed on something, I could bless you." ... And I just felt good helping... I was like "Ma'am, don't even worry about it," because, just hopefully one day, when that's me and my kids, someone will feel the same, will do the same. And trust me, people have done it all the time for me and my kids. It felt good... she said thank you over 1,000 times walking to the parking lot, and I was just grateful. I put it on my BIG:LEAP card.*

These acts may feel small but are indicative of what cash can do when unfettered from the demands of low-wage work and a public discourse tying dignity to economic production instead of humanity.

## CASE STUDY

## Antecedents for Hope: Radical Generosity and Belonging in Boyle Heights

Veronica is a mother to four, grandmother to five, a former foster-mother to many, and head of a household of eight. Born and raised in Boyle Heights, Veronica is a social worker and avid volunteer in urban development projects, fundraising, and restorative justice efforts. Her life reflects deep commitment to community saying, “my family comes first but my community comes second and so wherever I can be of help, that’s where I make my time.... I don’t want to ever leave Boyle Heights. I love it here.” Her life story stretches through decades of LA history, as she watched the crack and HIV/AIDS epidemics decimate the housing project she was raised in, but she was adamant in relaying the joy, community, and love she felt as a child even when “we would see so many of our friends die.” She credits the positive influences she had in those spaces as protective factors that carried her well into adulthood, saying that beyond her parents she also had “amazing mentors growing up. They kept me from becoming part of the statistics... accessibility to drugs, gangs, illegal activity was 5 ft away from my front yard.” As a teenager she found belonging in her church, with neighbors, and in the city’s recreational park programs by playing “in every sport and dance class... and the director there, she took them [neighborhood kids] under her wings and we saw her like a mom... she wanted us to succeed and make it out.” Perhaps unsurprisingly, this included being an early member of Father Greg’s historic Homeboy Industries and watching a wrecking ball eviscerate the housing project she called home, splintering social ties in the name of redevelopment. Being raised in a place marked by death and trauma but also joy and belonging shaped her life trajectory and how she approached GI years later.

In 2020, Veronica fell seriously ill with COVID-19, requiring intubation. Despite battling for her life, bills and financial pressures were at the top of her mind: “I remember when the doctor came in and he was talking to me about being intubated, my landlord texted me, ‘Hey, are you gonna be able to pay the rent this month?’” Though she survived intubation, she continued to have debilitating long-term symptoms. These new challenges brought their own stress; she required the use of an oxygen tank for 6 months, and her health prevented her from working for a year, leading to dual financial crises of unemployment and mounting medical debt.



When Veronica received the GI, she immediately focused on her medical debt, “it was a blessing for me, um, that I was able to use it for those things which were the biggest things that weighed heavy on me when I was going through my COVID experience.” The impact of the GI extended beyond paying down debt. Importantly for Veronica, who believes that helping others is something “you shouldn't even think about, you should just do it,” BIG:LEAP also increased her capacity to support her community:

*I've even blessed other people. One time there was a family who—their transmission went out, and they're street vendors, and they're very good friends of mine and I just saw how much they were struggling, and stressing out of how to fix their car, because that's how they make money to survive. And, so, I offered to give them that month's income [the GI], so that they can pay for their transmission. I would never have been able to do that on my own—on my own income.*

Through Veronica, BIG:LEAP's impact on Boyle Heights extended concretely into the community, as the above example illustrates. But by easing Veronica's financial stress, and thereby providing her with more emotional space and time capacity, GI has allowed her to be able to continue making room for the community she loves. While recovering, Veronica made and delivered care kits to anyone in her community who needed one, saying:

*It's what we're supposed to do, help our neighbors and help one another and I think through the pandemic, we saw how people who didn't agree maybe on other occasions, we all agreed that we had to help each other in order to survive this and we saw it and it was beautiful.*

The care Veronica shows her community is present even when her own needs are not met. To her, reciprocity is something that can take many forms, and there is more than a personal return on investment to be gained when it comes to keeping her community afloat.

*I won't pay my rent to help someone else pay the rent if they're being evicted. That's just the kind of person that I am. Um, and then I'll worry about, you know, how I'm gonna—I'll figure it out, I always do. But that's just, you know, that's just how I was raised.*

## Months 9–12 | Anticipating Material Hardship and Establishing Future Safety

Unlike pejorative assumptions that people in poverty are wasteful and lack financial management skills, BIG:LEAP participants were clear-eyed about carefully planning around the short duration of the pilot and approached the remaining disbursements by anticipating the potential for material hardship and establishing future safety. This included stocking up on basic needs and future clothing sizes for their children, investing in their family networks, and engaging in the preventive health behaviors noted prior. When emails were sent reminding participants the program would be ending soon, mothers like Maria started buying items,

*that I know I need for the future which is my soaps, my towel, my shampoos, and almost all the things that get used up, toilet paper, dish soap, things we need in the house... like rice, beans, everything to supply me... help is going to end... I prepared myself by paying in advance. I paid for the electricity. I still have an electricity credit. I gave the gas in advance, I paid my bills in advance... So, I anticipated all that. Secure first everything for the house.... So that's what I did, took precautions.*

Others moved beyond the basics and reorientated their relationship with waged labor to better suit family life. Once parents secured proximate safety at the midpoint, many described starting to leverage the GI to apply for jobs closer to home or with hours more conducive to parenting and getting their children to bed on a more predictable schedule. Similar to the findings in Stockton (West & Castro, 2023), the infusion of cash and time created a material and immaterial buffer that allowed GI recipients to reduce their hours at one job in order to apply for another. Crucial for LA, this often involved investing in purchasing a car to get to work, which is necessary in many areas of the city.

It also created a financial cushion that permitted some parents of younger children and those with special needs to trade higher-paying jobs for ones that paid less but offered other supports like benefits, a shorter or less-expensive commute, and predictable hours that are more conducive to parenting and unpaid care work. Participants described taking these steps in anticipation of the future and trying to reorient the structure of their homes and finances so they would have a “healthier family life than at the beginning [of BIG:LEAP].” Others with small businesses and side hustles used the final payments to stock up on items or services necessary to keep their business moving once the GI payments ceased.

The attempts to establish future safety carried mixed results and for some were curtailed by the limits of the safety net and the “benefits cliff” (Dinan et al., 2007, p. 1). The benefits cliff, or cliff effect, references predetermined thresholds set by policymakers where any increase in household income beyond those eligibility criteria can prompt benefits loss, pushing recipients further into poverty. People living near the poverty line are often forced to skip raises or better employment if the amount of money they would earn is not enough to replace the loss in benefits, keeping them trapped in poverty. Although many BIG:LEAP participants were living well below the poverty line and not in

danger of making too much money to suddenly prompt the loss of housing or food support, some did choose to forego better employment with stronger benefits because it would mean losing a crucial benefit at approximately the same time BIG:LEAP ended. This dynamic forced people like Nelli to make constant calculations about which work hours to take on and what opportunities must be left behind. Nelli, like others, skipped promotion when it would not replace her benefits and GI, saying:

*I don't know if I can lose my SNAP benefits tomorrow. If I make too many hours tomorrow, I'm gonna have to report monthly ... I'm losing that benefit and I know I can't pass, I can't work too much because I'm gonna lose that benefit. And that's steady income of my SNAP benefit is \$287. I'd rather work less hours and guarantee that \$287, because I don't know what next month is going to bring and if I lose those hours that I'm grabbing.*

The U.S. Census Bureau reports that the civilian labor force (i.e., individuals aged 16 and older not institutionalized or on active military duty, either employed or unemployed) in LA between 2018–2022 was at 66.5% of the total population, and among females, 60.7% (U.S. Census Bureau, 2022b). Of the civilian labor force, 61.9% were employed in 2020, 58.9% in 2021, and 52.6% in 2022. Prior to the COVID-19 pandemic, the annual unemployment rate<sup>10</sup> in LA was 4.5% (approximately 94,500 unemployed) in 2019, which rose to an annual rate of 12.3% (252,100) in 2020. Annually, unemployment has continued to drop to 8.9% (183,100) in 2021, then 5.1% (104,200) in 2022, with a slight increase to 5.3% (108,500) in 2023. Within the specific context of the study, peak unemployment in LA reached 19.1% during May 2020, when an estimated 370,300 individuals were unemployed. In December 2021 when the study period started, the city's unemployment rate was 6.1% (125,500). At Wave 2 (August 2022), the unemployment rate declined to 4.8% (99,000) but increased to 5.2% (108,200) at Wave 3 (February 2023), and continued to increase through Wave 4 (August 2023), reaching 6.0% (123,100) (California Employment Development Department, 2024).

Participants in the treatment and control groups reported consistently increasing trends of full-time employment over the study period, starting at 7% for treatment and 9% for control at Baseline and ending at 18% for both groups at 18 months, after the final cash disbursement. Unemployment rates (i.e., those not working but actively looking for work) started at 33% for both groups and showed a decreasing trend over the study period, ending at 18% for the treatment group and 10% for the control group. However, across each time point, GI recipients were more likely to secure full-time employment than to remain unemployed not looking for work, compared to control participants (6 months:  $B=.33, p<.05$ ; 12 months:  $B=.35, p<.05$ ; 18 months:  $B=.35, p<.05$ ). This trend also extended to part-time employment. The treatment group was more likely to secure part-time employment than to remain unemployed and not looking for work, compared to the control group (6 months:  $B=.65, p<.001$ ; 12 months:  $B=.76, p<.001$ ; 18 months:  $B=.51, p<.001$ ). Consistent with the qualitative findings indicating the heavy caretaking role GI recipients took on, quantitative data suggest treatment participants were more likely to be a caregiver or a stay-at-home parent than to remain unemployed and not

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<sup>10</sup> The unemployment rate represents the number of unemployed as a percentage of the labor force. Labor force data are restricted to people 16 years of age and older, who currently reside in 1 of the 50 states or the District of Columbia, who do not reside in institutions (e.g., penal and mental facilities, homes for the aged), and who are not on active duty in the Armed Forces (U.S. Bureau of Labor Statistics, 2024).



looking for work, compared to control participants (6 months:  $B=.62, p<.001$ ; 12 months:  $B=.57, p<.001$ ; 18 months:  $B=.36, p<.05$ ). Other employment categories were less consistent across each time point. GI recipients were more likely to be in retirement or experiencing disability than to remain unemployed and not looking for work compared to control participants at 6 months and 12 months, but not at 18 months (6 months:  $B=.34, p<.05$ ; 12 months:  $B=.36, p<.05$ ; 18 months:  $B=.18, p=.228$ ). Moreover, treatment participants were more likely to own a business (be self-employed) than to remain unemployed and not looking for work compared to control participants at 12 months only (6 months:  $B=.14, p=.286$ ; 12 months:  $B=.32, p<.05$ ; 18 months:  $B=.09, p=.550$ ). Likewise, treatment group participants were more likely to be full-time students than to remain unemployed and not looking for work compared to control participants at 6 months only (6 months:  $B=.34, p<.05$ ; 12 months:  $B=.18, p=.258$ ; 18 months:  $B=-.002, p=.991$ ). No statistically significant differences were found between control and treatment groups in terms of being gig workers in comparison to remaining unemployed and not searching for work. Finally, while unemployment rates remained higher for treatment participants than control participants, GI recipients continued to search for jobs more proactively than control participants. Specifically, the treatment group was significantly more likely to be looking for work than not looking for work while unemployed, compared to control participants (6 months:  $B=1.02, p<.001$ ; 12 months:  $B=1.13, p<.001$ ; 18 months:  $B=.89, p<.001$ ).

Table 33: Trends in Employment (in %)

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Employed full-time	7	9	13	16	15	18	18	18
Employed part-time or seasonal	16	17	15	12	16	13	16	14
Stay-at-home parent or caregiver	22	20	19	15	16	15	16	16
Business owner/ Self-employed	7	8	10	13	11	14	11	14
Gig worker	3	2	6	11	6	10	5	9
Retired/Disabled	7	6	9	10	8	9	8	9
Full-time student	3	2	6	7	5	7	5	6
Unemployed looking for work	33	33	18	10	19	10	18	10
Unemployed not looking for work	2	2	3	5	3	4	3	4

## CASE STUDY

## Exiting Homelessness: The Drive of Entrepreneurship

Ashley, a 33-year-old entrepreneur, was born and raised in LA and has lived in neighborhoods across the region, including Compton, West LA, Paramount, Palmdale, Carson, and Pomona. She describes herself as an opportunist, saying, “I have hustle, I’ll donate plasma,” and signs up for any and every paid opportunity she can find, including studies, to supplement her income. Currently, she is working on her personal brand, in an effort to build a following as an influencer, and pursuing multiple side gigs. She describes her goals with high energy and a twinkle in her eye—apartments in high rises, new cars, stability. Ashley understands her goals take hard work and says, “I’m willing to do whatever it takes” to make her business succeed and stay out of homelessness. To that end, she leveraged the GI to continue selling beauty products she makes through Amazon, explaining: “It was just something that I saw a need for and I felt like I could fulfill.” Ashley registered for an LLC and secured product placement with a local organic food store. In a stroke of luck, pandemic shortages for other products meant hers “flew out the shelves during COVID.” Ashley attributes her drive to her experiences with financial instability and homelessness. She has been unhoused at multiple points in her adult life, having been “on Skid Row, in that area, sleeping out the missions.” While in this vulnerable state, she had also had altercations—self-defense—lead to multiple jail sentences, for as long as 6 months at a time. Despite her resilience, these experiences left Ashley with scars, ruined her credit, and created persistent struggles with housing insecurity. Before the GI, she and her daughter were “going from Airbnb to Airbnb ... and that’s expensive. Daily, we were paying anywhere from, like, \$50 to \$150 for Airbnb ... and BIG:LEAP helped a lot... So yeah, I still was homeless, so that helped a lot.” Ashley also struggles with her mental health, especially her anxiety, but the GI also provided her a sense of agency. Ashley recalled telling her grandmother about being selected: “Wow, Grandma, I really got it. I’m able to pay my car note. I’m able to do a little helping if you need.” For Ashley, the GI freed her from homelessness and served as a reminder that financial security means having more time and freedom to care for the people she loves: “if I have more control over my time, I would just be wanting to take my daughter out to have fun. That’s my goal.”

### 3. How Implementation of GI Informs the Existing Safety Net

#### Leveraging Pre-Existing Programs and Benefits

Designing unconditional cash programs in the US historically revolves around an enduring debate about whether or not GI should work alongside the safety net or replace means-tested benefits (Baker et al., 2020). Supporters of replacing the safety net with cash, an idea espoused by Andrew Yang when running for President, base their case on Milton Friedman's proposal for the Seattle/Denver Income Maintenance experiments (SIME/DIME) in the 1970s, where the logic rested on replacing benefits with a negative income tax (Christophersen, 1983). This approach was expected to improve efficiency, lower costs, and increase work incentives, but participants in SIME/DIME refused to sign up for the program until they were assured they would not lose their benefits, foreshadowing the ethical dilemmas of the present (Baker et al., 2020; Christophersen, 1983). In contrast, most current GI programs follow the Stockton model, where unconditional cash is designed to work alongside the safety net rather than replace it (Baker et al., 2020). The logic rests on mitigating the potential for pushing people further into poverty when GI is not enough to offset the combined loss of public insurance, housing supports, subsidized childcare, CalFresh, and myriad other benefits. Put another way:

*Imagine, if you will, a scenario in which the US provides an unconditional cash transfer of \$1,000 per month per adult over the life course. A young adult in the Northeast with a full-time job with benefits and no dependents could see increases in liquidity and reductions in debt. A young adult in the Southwest with three dependents working full-time and receiving various safety net services could see their benefits actually decrease or disappear as a result of the additional income. The net gain for one may be the full \$1,000, yet the net gain for another may only be \$200 (Castro & West, 2022, p. 642).*

BIG:LEAP's design mirrored Stockton's, with LA taking extensive steps to mitigate the risk of benefits loss for participants when they were enrolled into the treatment group. Its design also represents the final puzzle piece in understanding how an unexpected amount of change was possible over only 12 months. Participants leveraged the GI alongside existing public benefits such as CalFresh, housing supports, WIC, and expanded unemployment insurance while also frequenting other social programs throughout the city that provided housing and utility assistance, after-school programming, IPV services, and mental health support. In other words, participants' strategies for using the GI to alter their trajectory often included availing themselves of other programs whenever feasible—just as those in the control group did. The GI acted, essentially, as a super-vitamin, shoring up the gaps

that traditional safety net services could not sufficiently cover. According to the narrative data, this was particularly key for those battling significant food insecurity, housing insecurity, homelessness, and experiences with IPV. For example, Lici, whose case study was described above, would not have escaped homelessness and IPV without simultaneously availing herself of GI and the city’s domestic violence services. The GI alone would likely not have been enough for many of the interviewees to experience the level of change they described.

The narrative data also demonstrated a second trend for those who were experiencing poverty but were relatively more stable than those receiving a multiplicity of benefits with overlapping systems involvement. For the second group, the size of smaller benefits like WIC and CalFresh failed to outweigh the time costs, transportation costs, and administrative burdens associated with maintaining them. In these instances, participants would forgo these benefits in order to spend more time at home or avoid an extremely long commute on public transportation or an expensive Uber ride to recertify their paperwork. While preliminary, these trends provide promising insights into GI implementation and design.

### GI’s Effect on Legal System Involvement

Across the study period for both treatment and control participants, little change was reported in terms of legal involvement. At Baseline, about 11.4% in the treatment group and 11.7% in the control group reported ever having been convicted of a crime. For GI recipients, this number remained the same at the 6- and 12-month marks at 11.4%, and slightly increased at 18 months, reaching approximately 11.5%. The difference in conviction rates between control and treatment participants were not significantly different across all time points (6 months:  $B=-.008, p=.952$ ; 12 months:  $B=-.008, p=.947$ ; 18 months:  $B=-.09, p=.433$ ). This trend was consistent with those who reported ever having been incarcerated, which included any type of short- or long-term jail and prison stays in adult or juvenile facilities. Of note, a higher percentage of participants reported incarceration than crime conviction because some individuals may have been arrested and temporarily detained in jail awaiting trial or bail without having been convicted of a crime. At Baseline, 13.3% of treatment participants (vs. 13.48% for control) reported ever having been incarcerated, and this figure remained consistent across the study period, with a small increase for control participants to 13.8% at 18 months. The difference in incarceration rates between control and treatment participants were not significantly different across all time points (6 months:  $B=-.02, p=.865$ ; 12 months:  $B=-.05, p=.708$ ; 18 months:  $B=-.06, p=.592$ ).

Table 34: Trends in Conviction (in %)

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
No, I have never been convicted of a crime	88.63	88.32	88.63	88.30	88.63	88.22	88.51	88.02
Yes, I have been convicted of a crime	11.37	11.68	11.37	11.70	11.37	11.78	11.49	11.98



Table 35: Trends in Incarceration (in %)

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
No, I have never been incarcerated	86.70	86.52	86.70	86.52	86.70	86.52	86.70	86.20
Yes, I have been incarcerated	13.30	13.48	13.30	13.48	13.30	13.48	13.30	13.80

## Limitations

This landmark study provides important insights into the impacts of GI on recipients’ quality of life. However, the findings should be interpreted with several limitations. First, the intervention and study were conducted during the COVID-19 pandemic; given the profound impacts of the pandemic on individual and community well-being, the findings should be considered within that context. Second, the study was conducted from a random quota sample of individuals who applied for and met the eligibility criteria for BIG:LEAP. The findings should not be generalized to a total population, but do provide information about the effects of GI for those meeting study criteria in LA. Finally, attrition rates were addressed by the use of MICE, with the exception of IPV and incarceration variables. While the MICE method is recognized for its robustness in handling missing data, it is important to acknowledge that no imputation technique, including MICE, is entirely free from some degree of uncertainty. Despite rigorous checks and validations, the imputed data may not perfectly represent the true underlying patterns. This inherent limitation of imputation should be considered when interpreting the results. As noted in the IPV section, some items regarding IPV experiences had high levels of missingness. Given the highly sensitive nature of the topic and extreme caution it deserves when reporting out, we decided to provide both the raw data and the imputed data. Neither is free of limitation since underreporting of IPV is well-documented in the literature. By presenting both, we wanted to provide the readers the opportunity to understand the findings on IPV in the way most sensible to them.

## Discussion

In Los Angeles, a city of extreme wealth and extreme poverty, the opportunities for upward economic mobility can seem out of reach. BIG:LEAP, the largest GI program at its time of launch, represented a bold and significant investment to provide economic security and a solid foundation for mobility to a diverse group of caregivers with children. For families largely led by women of color, GI payments of \$1,000 per month for one year nearly doubled their annual household income.

GI’s theory of change rests upon alleviating the material hardship that causes stress in the mind and body, a necessary preoccupation with day-to-day survival, and structurally limited opportunities for positive change. When that material hardship is lessened, individuals and families can access faculties within themselves and their communities that allow for better futures to be explored and obstacles to be overcome (West et al., 2023). While recipients had rational anxiety about the relatively short duration

of the program and what could be accomplished in only one year, the results were remarkable.

Compared to the control group, GI recipients were more likely to save for the future, improve their financial well-being, have sufficient food, reduce their housing cost burden, seek out and attain employment prospects that coalesced with their caregiving responsibilities, reduce stress, maintain their physical health, leave abusive relationships and reduce experiences of IPV, support their children in after-school and enrichment activities, feel more secure and build community in their neighborhoods, enjoy a more harmonious home environment, feel that they matter in their community and to others, and take action toward their goals—in a single year and in the most unaffordable city in the country. Importantly, some of these positive outcomes reverted after BIG:LEAP concluded. Participants were still saving money but were more stressed and reported lower financial well-being than control group members. Housing cost burden remained high, and treatment group members felt less able to plan for the future, though they were still taking steps toward their goals.

As the country, led by individual municipalities and innovative state leaders, moves toward shoring up the porous social safety net, GI appears to be an effective strategy to promote overall health and well-being. And, as poverty is a key driver of healthcare, safety, and educational costs, appropriations for unconditional cash programs like BIG:LEAP may represent a positive return on investment. In California, fiscal year 2021–2022 brought a \$35M allocation from the state's general fund to support GI programs for young people aging out of foster care, as well as expectant parents. Across the state, over 12,000 individuals were slated to receive over \$180M in GI programs in 2023 (Kuang, 2023). While the results of this study, like any other, face limited generalizability across context and populations, the findings suggest other programs could be a critical and commonsense investment to support families and communities.

# Center for Guaranteed Income Research

The Center for Guaranteed Income Research (CGIR) was established in 2020 at the University of Pennsylvania School of Social Policy & Practice with the aim of developing a shared body of knowledge on unconditional cash transfers.

At CGIR, distinguished academics and professionals in this field lead pilot guaranteed income programs and oversee the planning and implementation of research initiatives. CGIR is led by two Founding Directors: Dr. Amy Castro, Associate Professor of Social Policy & Practice at the University of Pennsylvania, and Dr. Stacia West, who holds a faculty fellowship at the University of Pennsylvania in addition to her primary role as an Associate Professor at the College of Social Work at the University of Tennessee-Knoxville.

CGIR conducts applied cash transfer studies and pilot designs that contribute to the empirical scholarship on cash, economic mobility, poverty, and narrative change. Our investigations build upon existing literature on cash transfers and incorporate evaluation practices and lessons learned from our previous research on guaranteed income and the gender and racial wealth gap.

All of our research is grounded in Durr's (1993) fundamental question: "What influences policy sentiment?" With this in mind, we are committed to conducting public science that challenges prevailing narratives surrounding poverty, deservedness, and economic mobility, utilizing diverse approaches such as multi-site ethnography, politically-driven sampling, and data visualization.

Our dashboards, created in partnership with Stanford Basic Income Lab, feature filters at the pilot level, allowing individuals to access and compare information while obtaining detailed insight into our investigations.

**Please direct all inquiries  
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# Appendix A

Table 36. Comparative Analysis of Select Outcome Measures: Treatment vs. Control Groups

OUTCOME	TREATMENT GROUP ADJUSTED MEAN	CONTROL GROUP ADJUSTED MEAN	MEAN DIFFERENCE	95% LOWER CI	95% UPPER CI	STANDARD ERROR	P - VALUE	RELATIVE IMPACT
<b>FINANCIAL WELL-BEING</b>								
Baseline	38.27	38.75	[-0.48]*	-0.89	-0.08	0.21	0.02	
6 months	40.35	39.84	[0.51]***	0.24	0.78	0.14	0.00	1.32%
12 months	40.61	40.17	[0.44]**	0.14	0.74	0.15	0.00	1.14%
18 months	40.73	41.08	[-0.35]*	-0.67	-0.04	0.16	0.03	-0.90%
<b>PERCEIVED STRESS LEVELS</b>								
Baseline	8.07	8.04	0.02	-0.11	0.16	0.07	0.74	
6 months	7.63	7.79	[-0.16]***	-0.24	-0.07	0.04	0.00	-1.99%
12 months	7.77	7.80	-0.03	-0.12	0.06	0.05	0.54	-0.37%
18 months	7.91	7.75	[0.16]***	0.07	0.25	0.05	0.00	1.99%
<b>KESSLER PSYCHOLOGICAL DISTRESS</b>								
Baseline	23.50	23.71	-0.20	-0.66	0.25	0.23	0.38	
6 months	21.84	21.68	0.15	-0.11	0.41	0.13	0.25	0.63%
12 months	22.30	21.65	[0.65]***	0.38	0.93	0.14	0.00	2.74%
18 months	22.90	21.76	[1.14]***	0.85	1.43	0.15	0.00	4.81%
<b>CHAOS</b>								
Baseline	29.53	29.51	0.03	-0.31	0.36	0.17	0.88	
6 months	29.20	30.19	[-0.99]***	-1.19	-0.78	0.10	0.00	-3.35%
12 months	29.86	30.11	[-0.25]*	-0.47	-0.03	0.11	0.03	-0.85%
18 months	30.62	30.85	-0.23	-0.46	0.00	0.12	0.05	-0.78%



OUTCOME	TREATMENT GROUP ADJUSTED MEAN	CONTROL GROUP ADJUSTED MEAN	MEAN DIFFERENCE	95% LOWER CI	95% UPPER CI	STANDARD ERROR	P - VALUE	RELATIVE IMPACT
<b>AVERAGE GENERAL HEALTH</b>								
Baseline	57.24	57.68	-0.46	-1.52	0.61	0.55	0.40	
6 months	60.84	63.40	[-2.56]***	-3.17	-1.95	0.31	0.00	-4.44%
12 months	59.02	61.17	[-2.15]***	-2.79	-1.51	0.32	0.00	-3.73%
18 months	59.19	61.68	[-2.49]***	-3.16	-1.82	0.34	0.00	-4.32%
<b>SF-36 PHYSICAL FUNCTIONING</b>								
Baseline	69.14	69.01	0.13	-1.10	1.36	0.63	0.84	
6 months	72.96	74.41	[-1.43]***	-2.22	-0.65	0.40	0.00	-2.07%
12 months	73.65	74.12	-0.46	-1.28	0.36	0.42	0.26	-0.67%
18 months	72.11	74.08	[-1.96]***	-2.81	-1.11	0.44	0.00	-2.84%
<b>SF-36 ROLE LIMITATIONS DUE TO PHYSICAL HEALTH</b>								
Baseline	52.67	52.67	0.00	-1.87	1.86	0.95	1.00	
6 months	61.25	64.71	[-3.46]***	-4.67	-2.25	0.62	0.00	-6.57%
12 months	61.54	66.15	[-4.61]***	-5.89	-3.34	0.65	0.00	-8.75%
18 months	60.51	65.77	[-5.27]***	-6.58	-3.96	0.67	0.00	-10.01%
<b>ADULT HOPE - AGENCY</b>								
Baseline	21.24	21.02	0.22	-0.03	0.48	0.13	0.09	
6 months	21.29	21.13	[0.15]*	0.00	0.30	0.08	0.05	0.71%
12 months	21.06	21.36	[-0.31]***	-0.47	-0.14	0.08	0.00	-1.47%
18 months	20.87	21.08	[-0.21]*	-0.39	-0.04	0.09	0.02	-1.00%
<b>ADULT HOPE - PATHWAY</b>								
Baseline	22.51	22.28	0.23	-0.01	0.47	0.13	0.07	
6 months	22.72	22.21	[0.51]***	0.36	0.67	0.08	0.00	2.29%
12 months	22.34	22.34	0.00	-0.17	0.17	0.09	0.99	0.00%
18 months	22.03	21.92	0.11	-0.07	0.29	0.09	0.22	0.49%

OUTCOME	TREATMENT GROUP ADJUSTED MEAN	CONTROL GROUP ADJUSTED MEAN	MEAN DIFFERENCE	95% LOWER CI	95% UPPER CI	STANDARD ERROR	P - VALUE	RELATIVE IMPACT
<b>ADULT HOPE - TOTAL</b>								
Baseline	43.75	43.00	0.46	0.00	0.91	0.23	0.05	
6 months	44.00	43.35	[0.65]***	0.37	0.92	0.14	0.00	1.51%
12 months	43.39	43.71	[-0.33]*	-0.63	-0.02	0.15	0.04	-0.77%
18 months	42.89	43.00	-0.12	-0.44	0.21	0.17	0.48	-0.28%
<b>ADULT MATTERING - AWARENESS</b>								
Baseline	30.28	30.33	-0.05	-0.32	0.22	0.14	0.72	
6 months	30.13	29.53	[0.60]***	0.43	0.77	0.09	0.00	1.98%
12 months	29.94	29.65	[0.29]**	0.11	0.48	0.09	0.00	0.96%
18 months	29.64	29.25	[0.39]***	0.20	0.58	0.10	0.00	1.29%
<b>ADULT MATTERING - IMPORTANCE</b>								
Baseline	35.61	35.58	0.03	-0.26	0.33	0.15	0.83	
6 months	35.43	35.17	[0.26]**	0.08	0.45	0.10	0.01	0.73%
12 months	35.50	35.24	[0.25]*	0.06	0.45	0.10	0.01	0.70%
18 months	35.12	35.05	0.07	-0.14	0.27	0.10	0.52	0.20%
<b>ADULT MATTERING - RELIANCE</b>								
Baseline	21.50	21.47	0.04	-0.18	0.25	0.11	0.74	
6 months	21.62	21.43	[0.19]**	0.06	0.33	0.07	0.01	0.88%
12 months	21.76	21.58	[0.18]*	0.03	0.33	0.08	0.02	0.84%
18 months	21.55	21.37	[0.18]*	0.03	0.33	0.08	0.02	0.84%
<b>ANNUAL HH INCOME</b>								
Baseline	\$15,336.11	\$15,356.48	-4.11	-372.35	364.14	187.88	0.98	
6 months	\$17,787.56	\$17,743.00	46.32	-218.26	310.89	134.99	0.73	0.30%
12 months	\$18,719.25	\$19,214.65	[-488.88]**	-809.68	-168.07	163.68	0.00	-3.18%
18 months	\$18,728.37	\$20,735.48	[-2002.83]***	-2336.08	-1669.59	170.02	0.00	-13.04%

OUTCOME	TREATMENT GROUP ADJUSTED MEAN	CONTROL GROUP ADJUSTED MEAN	MEAN DIFFERENCE	95% LOWER CI	95% UPPER CI	STANDARD ERROR	P - VALUE	RELATIVE IMPACT
<b>HOUSING COST BURDEN</b>								
Baseline	103.17	105.30	-2.11	-7.69	3.47	2.85	0.46	
6 months	82.97	77.72	[5.31]***	2.39	8.24	1.49	0.00	5.04%
12 months	83.90	74.93	[9.02]***	5.38	12.67	1.86	0.00	8.57%
18 months	87.83	69.90	[17.94]***	14.14	21.73	1.93	0.00	17.04%

Footnotes:

**Baseline Mean:** Adjusted average score prior to any intervention

**6/12/18 month Mean:** Adjusted average score at the respective time mark

**Mean Difference:** The Mean difference between the treatment and control groups

**Standard Error:** Indicates the precision of the impact estimates

**95% CI Lower/Upper:** Bounds of the 95% confidence interval for the impact estimate

**Relative Impact:** Percentage change in the treatment group compared to the control.

**\* Indicates statistical significance:** \*  $p < 0.05$ , \*\*  $p < 0.01$ , \*\*\*  $p < 0.001$

# Appendix B

## IPV Results Using Data Based on MICE

In this study, approximately one in three study participants - 32% of treatment and 30% of control participants - reported ever experiencing intimate partner violence in their lifetime. The table below provides different types of IPV rates experienced by participants in the past 12 months, among those who reported ever experiencing IPV. Over 50% of participants in both treatment and control who had reported ever experiencing IPV at Baseline indicated that they experienced psychological abuse from intimate partners in the past 12 months. The rate is at 30% for physical abuse. This is substantially higher than the 20% who reported experiencing it county-wide before the pandemic (LACDPH, 2018). While it is likely indicative of increases in IPV associated with the financial pressures of the pandemic, deep poverty, and isolation during stay-at-home orders, it is not possible to know conclusively from this dataset. At Baseline, IPV total scores for treatment and control participants were not significantly different (M=15.21 vs. M=16.60; Mdiff=-3.34, 95% CI [-7.78, 1.11],  $p=0.141$ ). Similarly, no statistically significant difference was found across all subcategories of IPV at Baseline. At each time point, treatment participants reported significantly lower levels of total IPV scores than control participants (6 months:  $B=-10.31, p<.001$ ; 12 months:  $B=-7.95, p<.001$ ; 18 months:  $B=-8.17, p<.001$ ). These trends were consistent across all subcategories of IPV. Treatment participants, compared to control participants, reported lower levels of psychological abuse (6 months:  $B=-2.19, p<.001$ ; 12 months:  $B=-2.37, p<.001$ ; 18 months:  $B=-3.07, p<.001$ ), but the difference was statistically significant at 6 months ( $B=-.50, p<.01$ ) and 12 months ( $B=-.56, p<.001$ ). Finally, treatment participants reported lower levels of financial abuse across all time points, but the difference was statistically significant at 6 months ( $B=-.56, p<.001$ ) and 18 months ( $B=-.38, p<.01$ ).

Table 37. Prevalence of IPV Subtypes in the Past 12 Months

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Psychological abuse	53.03%	56.07%	77.79%	86.03%	79.19%	86.70%	82.23%	86.04%
Physical abuse	29.65%	30.28%	53.28%	58.15%	55.01%	58.58%	59.81%	59.14%
Sexual abuse	11.64%	11.87%	21.62%	23.94%	22.88%	25.37%	27.58%	26.07%
Coercive control	11.74%	11.41%	18.98%	22.28%	19.05%	22.55%	23.64%	23.09%
Financial abuse	13.80%	15.11%	21.79%	25.78%	23.57%	25.01%	27.01%	26.40%



Table 38. Composite Abuse Scale - Total Score (0 - 75)

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	15.21	16.6	30.06	37.31	31.15	37.39	33.21	37.24
Std. Dev.	18.03	18.67	20.45	18.9	20.9	19.18	20.17	19.24

Table 39. Composite Abuse Scale - Psychological Abuse Subscale Score (0 - 30)

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	6.93	7.44	12.15	14.91	12.74	15.06	13.28	14.93
Std. Dev.	8.03	8.12	8.65	8.20	8.94	8.24	8.65	8.39

Table 40. Composite Abuse Scale - Physical Abuse Subscale Score (0 - 25)

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	4.12	4.44	9.46	12.50	9.70	12.06	10.58	11.80
Std. Dev.	5.87	5.97	8.00	7.52	8.04	7.55	7.97	7.55

Table 41. Composite Abuse Scale - Sexual Abuse Subscale Score (0 - 10)

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	1.59	1.97	3.37	4.62	3.65	4.74	4.11	4.64
Std. Dev.	2.50	2.84	3.42	3.16	3.55	3.26	3.40	3.32

Table 42. Composite Abuse Scale - Coercive Control Score (0 - 5)

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	0.96	1.16	1.84	2.48	1.81	2.4	2.14	2.28
Std. Dev.	1.35	1.58	1.93	1.89	1.93	1.91	1.97	1.92

Table 43. Composite Abuse Scale - Financial Abuse Score (0 - 5)

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	1.16	1.33	1.91	2.53	2.04	2.39	2.26	2.56
Std. Dev.	1.58	1.66	1.92	1.84	1.97	1.02	1.96	1.95

# Appendix C

Table 44. Neighborhood Environment for Children Rating Scale

Participants were asked to rate the following statements on a scale of 1 to 10, with 1 being "Mostly False" and 10 being "Mostly True".

***“When the weather is nice, the people living in my neighborhood visit with one another outside.”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	3.74	3.57	3.84	3.47	3.77	3.47	3.94	3.59
Std. Dev.	3.05	3.00	2.59	1.86	2.67	1.94	2.66	1.98

***“The people in my neighborhood visit with one another in their homes.”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	3.12	2.98	3.29	3.05	3.27	3.03	3.33	2.99
Std. Dev.	2.72	3.00	2.34	1.71	2.45	1.80	2.44	1.87

***“The people in my neighborhood loan things to one another.”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	2.72	2.64	2.93	2.78	3.08	2.82	3.16	2.91
Std. Dev.	2.44	2.00	2.16	1.58	2.35	1.69	2.33	1.78

***“The people in my neighborhood make sure other’s homes are safe when someone is away.”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	4.00	3.97	4.26	4.03	4.29	3.97	4.23	4.01
Std. Dev.	3.10	3.16	2.68	2.03	2.78	2.04	2.70	2.04

***“On Halloween, most of the children living in my neighborhood go trick-or-treating in my neighborhood.”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	4.56	4.65	4.73	4.57	4.53	4.35	4.63	4.50
Std. Dev.	3.28	3.32	2.81	2.09	2.87	2.14	2.82	2.18

Participants were asked to rate how much they worried about the following situations on a scale of 1 to 10, with 1 being "not at all worried" and 10 being "very worried".

***“Having property damaged”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	5.29	5.06	5.54	6.06	5.49	5.92	5.55	5.98
Std. Dev.	3.28	3.31	2.65	1.83	2.73	1.93	2.76	2.05

***“Having property stolen”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	5.86	5.68	6.23	6.76	6.08	6.56	6.08	6.59
Std. Dev.	3.35	3.39	2.72	1.90	2.82	2.00	2.83	2.12

***“Walking alone during the day”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	4.63	4.58	4.97	5.45	5.05	5.45	5.04	5.50
Std. Dev.	3.15	3.17	2.59	1.81	2.68	1.95	2.71	2.01

***“Walking alone after dark”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	6.91	6.69	7.12	7.65	6.85	7.37	6.77	7.29
Std. Dev.	3.22	3.29	2.66	1.88	2.78	2.03	2.79	2.13

***“Letting children go outside alone during the day”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	6.39	6.26	6.69	7.17	6.35	6.86	6.28	6.82
Std. Dev.	3.26	3.31	2.63	1.82	2.76	1.96	2.78	2.10

***“Letting children go outside alone after dark”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	8.15	7.95	8.29	8.58	7.94	8.33	7.78	8.24
Std. Dev.	2.90	3.07	2.42	1.76	2.66	1.92	2.71	2.09



***“Being robbed during the day”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	5.63	5.54	6.10	6.70	5.80	6.39	5.83	6.44
Std. Dev.	3.27	3.30	2.67	2.87	2.78	1.99	2.77	2.11

***“Being robbed at night”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	7.39	7.26	7.67	8.20	7.34	7.93	7.26	7.81
Std. Dev.	3.11	3.24	2.59	1.81	2.76	1.96	2.75	2.16

***“Being raped”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	5.74	5.60	6.05	6.70	5.77	6.38	5.88	6.47
Std. Dev.	3.61	3.65	2.96	2.00	3.01	2.13	2.98	2.28

***“Being mugged or beaten up”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	6.29	6.15	6.69	7.42	6.28	6.93	6.34	7.00
Std. Dev.	3.44	3.52	2.84	1.94	2.94	2.07	2.93	2.23

***“Having a child sexually abused by a stranger”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	6.09	5.96	6.49	7.24	6.18	6.83	6.28	6.92
Std. Dev.	3.66	3.68	2.97	2.03	3.04	2.11	3.00	2.24

***“Having a child sexually abused by someone they know”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	4.85	4.78	5.10	5.66	4.97	5.51	5.08	5.53
Std. Dev.	3.78	3.75	3.01	2.12	3.06	2.16	3.04	2.29

***“Having children kidnapped”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	6.13	5.96	6.46	7.18	6.09	6.73	6.21	6.92
Std. Dev.	3.66	3.70	2.99	2.07	3.07	2.14	3.02	2.24

***“Being murdered”***

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Mean	5.91	5.76	6.22	6.90	5.90	6.60	6.00	6.59
Std. Dev.	3.70	3.70	2.98	2.08	3.11	2.17	3.06	2.32

## Appendix D

Table 45. Participant Attrition Over the Study Period

TIME PERIOD	TREATMENT	CONTROL	OVERALL ATTRITION	DIFFERENTIAL ATTRITION
Baseline	3,202	4,992		
6-month	1,951	1,135	62.34%	-38.19%
12-month	2,244	1,452	54.89%	-40.99%
18-month	2,332	1,760	50.06%	-37.57%