THE IMPACT OF MECKFUSE ON RECIDIVISM AND HOMELESSNESS

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ABSTRACT

LAURA EMILY BARBER. The impact of MeckFUSE on recidivism and homelessness. (under the direction of DR. SHELLEY LISTWAN)

Every year, over 650,000 people, more than 10,000 every week, are released back into society from state and federal prisons. A lack of permanent housing is an important issue facing ex-inmates. The risks of parole violation and rearrests are higher for those who have no stable home upon release. The first response to homelessness has been shelters. Shelters are considered transitional in nature and lack the necessary support to assist offenders with their individual needs. Transitional housing programs have been tried as a substitute for shelters. However, temporary or transitional housing is not the stable answer to ending homelessness; projects that support permanent forms of housing can be more successful in fostering independence, especially for frequent users of the system. Frequent users are those with repeated episodes of both incarceration and homelessness who typically use other social services at higher levels, such as emergency rooms and substance abuse services. The Mecklenburg County FUSE project, or MeckFUSE, fosters independence for these frequent users while providing access to mental health and substance abuse treatment as well as medical care. This study looks at the demographic and individual characteristics of the MeckFUSE participants, the improvements they made, and the impact of the program on the participants' criminal behavior.

TABLE OF CONTENTS

LIST OF TABLES

INTRODUCTION

Each year in the United States, over 650,000 people are released back into society from state and federal prisons. Approximately two-thirds of those who are released will be rearrested within three years (Bahr, Harris, Fisher, & Armstrong, 2010). In addition, over 12 million people cycle through local jails every year. Offenders are more likely to recidivate if they are homeless, uneducated, unemployed, or have a history of drug use, alcohol use or mental illness (Harer, 1995). The majority of post-incarcerated offenders report that the difficulties getting and keeping a job, disagreements with family members, problems managing money, and periods of homelessness have contributed to their criminal justice involvement (Epperson, Wolff, Morgan, Fisher, Frueh, & Huening, 2011). In contrast, successful ex-inmates are not those who are employed but have support from family and friends and have higher levels of self efficacy (Bahr et al., 2010).

A lack of permanent housing is an important issue facing ex-inmates. Parole violations and rearrests increase for those that have no place to go when they are discharged (Gouvis Roman & Travis, 2004). This is a significant issue given statistics indicate that over 19% of those in state prisons and 9% of those in federal prisons report homelessness in the previous year (James & Glaze, 2006). Similarly, homelessness was 7.5 to 11.3 times more likely among jail inmates than the general population (Greenberg & Rosenheck, 2008). California reports that over 10% of the state's ex-inmates are homeless, but that number increases to 50% for large urban areas, like Los Angeles and San Francisco (Petersilia, 2003).

Problems with obtaining any type of permanent housing are vast for these released offenders. For example, a violent or drug-related criminal history can be grounds for denial of a housing application and termination of tenancy for public housing and section-8 housing. Government restrictions on subsidized housing make released offenders unable to obtain accommodation or even stay with family in subsidized housing because they risk eviction for all parties (Metraux, Caterina, & Cho, 2008). Financial disadvantages stemming from long-term unemployment, such as large debt or little savings, mean that many ex-inmates do not have the finances to lease apartments. Without a permanent address to provide to potential employers, many end up in a cycle that is difficult to break (Rodriquez & Brown, 2003).

Individual level risk factors such as age, substance abuse, and physical and mental health, can impact homelessness and successful return into society. For example, in terms of age, each year a person ages the associated shelter stay risk increases four percent, however, the risk of (re)incarceration decreases three percent (Metraux & Culhane, 2004). A reason for this finding may be that as people mature out of a criminal career, their susceptibility to homelessness increases due to a lack of available financial opportunities and declining physical health. In terms of substance abuse, approximately 75% of prisoners have a history of substance abuse (Petersilia, 2003); and substance use and homelessness are associated with "lower treatment retention, higher rates of post-treatment relapse, premature mortality, and longer periods of homelessness" (Palepu, Patterson, Moniruzzam, Frankish, & Somers, 2013, p. 30). Mental illness is also a significant risk factor for subsequent incarceration and is correlated with higher numbers of shelter stays and reincarcerations (Metraux & Culhane, 2004). One in six inmates

suffers from a mental disorder and yet less than a third receives help while in prison (Petersilia, 2003). As will be discussed in depth later, those who have issues with both substance abuse and mental illness have an increased risk of recidivism.

For those returning offenders who do not live with family or friends when released the housing options can be grouped into several categories. For example, Gouvis Roman and colleagues (2004) argue that "the housing options often include (1) community shelters; (2) community-based correctional housing facilities; (2) transitional (service-enriched) housing (non-corrections based and non-HUD funded); (3) federally subsidized and administered housing; (4) homeless assistance supportive housing, other service-enhanced housing, and special needs housing supported through the U.S. Department of Housing and Urban Development (HUD); or (5) the private market" (p. 5). These options are discussed in greater detail below.

As noted above, homeless ex-inmates that are released from jail or prison often have a variety of needs. Not surprisingly, homeless shelters are ill equipped to handle people with complex needs. They tend to be overcrowded and many are turned away without assistance (Gouvis Roman & Travis, 2004). There have been many attempts at providing housing programs to assist with offender needs. One example, Project Greenlight in New York, "systematically identified inmates needing housing, developed relationships with transitional housing resources in the community, and helped inmates develop a plan for where they would live upon release" (Rodriquez & Brown, 2003, p. 6). This project assisted newly released offenders with transitional housing services but often did not provide intensive treatment related to needs such as mental health or substance addiction

The current study examined a population of ex-inmates who were frequent users of both shelters and jails. Frequent users in the study are defined as those with repeated episodes of both incarceration and homelessness. The frequent users were enrolled in a program referred to as the Frequent User Systems Engagement (FUSE) program. The program is designed to provide permanent supportive housing and case management services to assist with needs such as driver's license paperwork, employment/education, and medical/medication management. The original program began in 2006 in New York where they found the program saved roughly $3,000 per person per year (Aidala, McAllister, Yomogida, & Shubert, 2013). The FUSE pilot program in Washington, D.C. was also launched to coordinate and improve services, break institutional cycling behavior, and ultimately, save money by reducing frequent use of city services (Gilchrist-Scott & Fontaine, 2012). The results of the Washington D.C. FUSE program were equally as promising.

The current study examines a FUSE program developed in Charlotte, North Carolina. The Mecklenburg County FUSE project, or MeckFUSE, is focused on serving those in the county who have a history of chronic shelter and jail usage. In order to qualify for the program, the client must have at least four incarceration episodes and four shelter stays within the last five years with the most recent of both occurring within the last year. The goal of MeckFUSE is to foster independence while providing access to medical, mental health and substance abuse treatment. The study will assess the population served by the MeckFUSE program to examine whether the program was effective in reducing the system burdens of homelessness and recidivism. Participant

demographics as well as his history of mental health, substance abuse, and social support will be discussed as well.

LITERATURE REVIEW

Re-entry to the community from jail or prison includes "all activities and programming conducted to prepare the ex-inmates to return safely to the community and to live as law-abiding citizens" (Petersilia, 2003, p. 3). It has been argued that prisoners should transition to the community slowly and in a closely supervised setting. The slow changeover can assist ex-offenders manage their post release issues in phases instead of having them deal with housing, employment, and relationships all at once (Petersilia, 2003). However, many ex-offenders are only given minimal resources and released. Finding appropriate housing and the finances for basic essentials, such as food and clothing, are left entirely up to the recently released offender (Petersilia, 2003).

Since 1973, the rates of imprisonment have grown from 110 prison inmates per 100,000 United States' residents to 478 per 100,000 (Petersilia, 2003). In addition, it is estimated that over 800,000 people will cycle through local jails per year (Wagner & Sakala, 2014) and in some states such as California, the jail population has reached epidemic levels. Given an estimated 93% of all inmates will eventually return to society (Petersilia, 2003), the successful reintegration of such a vast number of offenders from both jails and prisons is an important challenge.

The failure rates among those re-entering the community from prisons and jails are high. Ex-inmates are often mandated to find and maintain employment, stay free of drugs, as well as report regularly to their parole officer. They are also unable to leave the state or own a firearm (Bahr et al., 2010). Violating any of these conditions could result in reincarceration. In fact, in 2012, eight percent of admissions to federal prison were offenders who were returning for violating the circumstances of their parole release

(Carson & Golinelli, 2013). One study found that approximately two-thirds of those who are released from jails and prisons are rearrested within three years and three-fourths will be rearrested within five years (Durose, Cooper, & Snyder, 2014). Most rearrests occur within the first six months of release (Petersilia, 2000) and this number is especially high for African-American populations (Carson & Gollinelli, 2014).

A lack of permanent housing is a risk factor for recidivism. In fact, studies suggest that up to 50% of the homeless population has a history of incarceration (Metraux & Culhanem 2006). Yet the literature on recidivism and the literature homelessness is often siloed given the academic focus often neglects one for the other. As a result, the complexity of those with long histories of arrest and homelessness is not fully understood. The following sections will go more in depth into examining the issue of housing and other risk factors that intersect to increase the chances of reincarceration and chronic homelessness.

Homelessness and the Criminal Justice System

The Stewart B. McKinney Homeless Assistance Act defines a person as homeless if the "individual lacks a fixed, regular, and adequate nighttime residence" and includes people who sleep in "a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings" as well as those who reside in community shelters (Burt, 2003, p. 2-3). Housing and Urban Development (HUD) estimates that in January 2006, 759,101 individuals were homeless. Of those, 331,000 (44%) were unsheltered and one-fifth met the federal definition for chronic homelessness (Rickards, McGraw, Araki, Casey, High, Hombs, & Raysor, 2010). The National Alliance to End Homelessness's point-in-time counts estimate that currently over

500,000 Americans are homeless on any given night and an estimated 1.6 million people access homeless shelters each year (Henry, Cortes, Shivji, & Buck, 2014).

Federally subsidized and administered housing often include three main groups: Housing Choice Voucher Program (or Section 8), Federal Public Housing Program, and a variety of privately owned federally subsidized programs. These programs are scarce in availability and have many regulations that restrict occupancy. About a third of eligible families actually gain access to these facilities. The public housing authority can deny admission or terminate a lease based on a history of substance use or criminal behavior. Supportive housing is housing that is permanent and contains social service provision and funding. Service-enhanced housing is either transitional or phased-permanent housing. In transitional housing, residents do not have a lease. Phase-permanent housing includes month-to-month agreements that are not leases. These are short-term options and clients with a criminal record are even less likely to be eligible for these services.

The final route is to obtain housing in the private market. Those who owned homes before incarceration are likely to have lost them due to neglect of mortgages while incarcerated (Gouvis Roman & Travis, 2004). Recently released ex-offenders normally do not have the finances to move into private housing, such as an apartment, which usually requires two months' rent as well as a security deposit. Even when people can afford private housing, they may be passed over during the required background or work history checks (Petersilia, 2003). And since certain federal and state policies often keep felons from accessing public housing, many ex-offenders are faced with living in shelters, with friends of acquaintances for short periods of time, or in low-cost hotels located in high risk communities (Lutze et al., 2014, p. 472).

For those who are homeless, the options for housing vary by length of stay, level of support, and type of assistance. Types of housing can be permanent, transitional, short-term (temporary), or emergency. Permanent housing has no time limits and is meant to be long-term. Transitional housing has a time limit that often includes stays of up to 24 months. Short-term or temporary housing is intended to last for 30 to 90 days whereas emergency shelters provide overnight stays. Type of assistance for housing can include affordable housing, tenant-based subsidized housing, project-based subsidized housing, and homeless prevention. Affordable housing refers to properties that provide below-market rents for low-income people, including low-income housing, disabled housing, and senior housing. Tenant-based subsidized housing provides a voucher to be able to choose a community and lease from a private landlord. This includes section 8 housing choice voucher, rapid re-housing, and tenant based rental assistance. Project-based subsidized housing requires one to living in a housing unit at a property that is subsidized, including section 8 public housing and homeless project-based units. Homeless prevention housing provides assistance for those who have their own accommodation, but need assistance to prevent them from becoming homeless. This includes ESG homeless prevention and temporary financial aid programs. While these are housing options for those who are homeless, they might not necessarily take in returning offenders due to criminal background checks (Homebase for Housing, 2015).

While many housing options exist for those who are chronically homeless, those who are re-entering the community from prison may be ineligible or not targeted. For re-entering inmates, community-based correctional housing options include halfway houses or community reentry centers that try to be the "halfway" step between prison and the

community, but these can be very expensive and have little research supporting their effectiveness. Transitional housing is funded by private organizations and charities that charge a fee for residents to live there and are subject to increases. This type of housing is difficult to successfully implement and develop with funding being the main barrier.

A substantial proportion of the jail population identified as homeless as well (McNiel, Binder, & Robinson, 2005). Greenberg and Rosenheck (2008) found that 15.3% of the jail population was homeless and that "recent homelessness was 7.5 to 11.3 times more common among jail inmates than in the general population" (p. 170). Homelessness and incarceration appear "to increase the risk of each other and these factors seem to be mediated by mental illness and substance abuse" (Greenberg & Rosenheck, 2008a, p. 171). McNiels and colleagues (2005) argue, "jails are de facto assuming responsibility for a population whose needs span multiple service delivery systems" (McNiel et al, 2005, p. 840).

Other factors can also contribute to the fact that adult state and federal prisoners have a homeless rate that is four to six times higher than the general population (Greenberg & Rosenheck, 2008). For example, compared to ex-inmates who have stable housing, homeless ex-inmates are more likely to have histories of trauma, poor health, and poverty (Greenberg & Rosenheck, 2008). Given the complexity of this relationship, the next section will discuss the factors that increase the likelihood that an individual will remain homeless and at risk of criminal behavior. The factors that put an individual at risk for recidivism are similar to the risk factors for homelessness. However, the homeless population is not always involved in the criminal justice system. This is an important distinction to consider when discussing homelessness in general. However, for

the scope of this study the literature summarized below provides a perspective of the population that falls into both categories.

Individual & Structural Risk Factors

Both structural and individual factors contribute to homelessness and criminal behavior. To define, structural factors are "larger societal trends and changes that affect broad segments of a population", including changes in land use, employment opportunities, and quality or relevance of public education (Burt, 2003, p. 2). Individual factors are the "conditions and circumstances that make particular people particularly vulnerable to homelessness" (Burt, 2003, p. 2). These include mental, developmental, or physical disabilities, illiteracy, and addictions and situational factors such as poverty, domestic violence, or family dysfunction (Burt, 2003).

Approximately 124,000 homeless people are chronically homeless (Henry et al., 2014). The Department of Housing and Urban Development's defines a chronically homeless individual as "someone who has experienced homelessness for a year or longer, or who has experienced at least four episodes of homelessness in the last three years and has a (physical or mental) disability" (Henry et al., 2014, p. 2). This chronic homeless population tends to be frequent users of emergency services, jails, and shelters (Henry et al., 2014). The population tends to be mostly male (about 77 to 86%), middle-aged (ages 35 to 54), and disabled (83 to 87%) (Burt, 2003) and between one fourth and one third of homeless persons have current severe psychiatric conditions with 50% of those individuals have comorbidity with a substance use disorder (Rickards et al., 2010). Homelessness aggravates health conditions like respiratory disorders, cardiovascular disease, ulcers, frostbite, hypothermia, skin diseases, diabetes, liver disease, dental

disease, seizures, cancer, HIV/AIDS, cognitive impairments, and traumatic injuries (Rickards et al., 2010).

Age. Age and its' impact on homelessness and recidivism is more complex. Older ex-inmates are the least likely of any group to be reincarcerated upon reentry (Blevins & Blowers, 2014). In fact, "recidivism rates were inversely related to age at release; the older the person, the lower the rate of recidivism – 56.6% of those 25 years of age or younger recidivated compared to 15.3% of those 55 years of age or older" (Harer, 1995, p. 98). There are some key differences between the reentering population and those who are chronically homeless. For example, older ex-inmates are less likely to be reincarcerated but are at an increased risk for shelter stays. Each year of increased age is associated with a 4% increase in shelter stay risk and 3% decreased risk of incarceration (Metraux & Culhane, 2004). However, inmates who are released at older ages are more likely to tax the system given they do have higher rates of chronic medical issues and a bigger risk of post-release death (Culhane, Kane, & Johnston, 2013; Williams, McGuire, Baillargeon, Cenzer, & Kushel, 2010). Pre-release health care planning is vital for older prisoners, especially since most states terminate government assistance, like Medicaid, Medicare, and Social Security Disability, during incarceration and reinstatement of these programs can take up to three months after release (Williams et al., 2010).

Unfortunately the reentry programs that support older prisoners to find employment or housing are typically reserved only for veterans despite rates of chronic health problems and mental illness being similar between veterans and non-veterans (Williams et al., 2010). While older inmates do receive their prescribed medications during imprisonment, it is normal to be released with only a short supply of medication or

none at all, meaning that many go without proper medication for long periods of time after release (Blevins & Blowers, 2014). An important issue for policymakers is that they "understand the difficulties that many older ex-prisoners will face when attempting to obtain healthcare in the community and implement policies that will help ease the transition into the community" (Blevins & Blowers, 2014, p. 18). This influx of older ex-inmates who are also homeless causes additional financial burdens on emergency services and health care institutions.

Race. Race is an individual characteristic that affects homelessness rates. "Many Afro-Americans in inner cities are vulnerable to social problems such as homelessness" (Belcher, 2015, p. 42). Belcher (2015) goes on to discuss how this lifetime of poverty for many Afro-Americans is due to "decades of social isolation" that "have created a closed opportunity structure" (p. 42). Due to these blocked opportunities, African Americans have to rely on the welfare system far more than white Americans which puts them at increased vulnerability to homelessness (Belcher, 2015) and recidivism. A link between race and severe and persistent homelessness is also reflected in inadequate inner city school systems. "Reform of the inner city education system and a more equitably based economic development effort are directly linked to serious efforts to solve the problem of severe and persistent poverty, which is a catalyst for homelessness" (Belcher, 2015, p. 47).

African Americans are at increased risk for poverty and subsequently incarceration. The growth in the incarceration rate was disproportionately felt among minority populations, including both Hispanic and African American men and women. While the issue is complex, the same issues regarding poverty, blocked opportunities and

isolation that were noted above are salient for understanding race and its impact on incarceration.

Mental Illness. Approximately one in five inmates reports having a mental illness, including schizophrenia/psychosis, major depression, bipolar disorder, and post-traumatic stress disorder (Petersilia, 2000). The occurrence of these disorders is more common among inmates than in the overall United State's population (Hammett, Roberts, & Kennedy, 2001, p. 391). Homelessness within jail populations has also been linked to mental health and substance abuse issues. For example, twenty-two percent of homeless individuals in the San Francisco County Jail had a psychiatric diagnosis and close to 18% had a substance-related disorder compared to roughly 16% and 12% of the non-homeless population, respectively (McNiel et al., 2005). While "having a mental illness places an individual at heightened risk of become homeless…being homeless contributes to and exacerbates one's mental illness" (Slate et al., 2013, p. 79). Those with mental illness report higher pre-prison homelessness rates as well as higher rates of homelessness after incarceration (Mallik-Kane & Visher, 2008). Approximately 15% of those with mental illness are homeless in a given year compared to 1% of the general population (Slate et al., 2013).

People with mental illness who are released into the community are also more prone to stop taking medication or unable to afford the medication in the first place (Petersilia, 2003). Opportunities that "provide interventions in correctional facilities and in preparation for inmates' return to the community" need to be seized or "the public health, as well as the health of releases and their families will suffer and the public will continue to bear the cost of hospitalization, reliance on emergency room treatment, (and)

reincarceration" (Hammett et al., 2001, p. 392). At least 80% of offenders returning to incarceration have a chronic physical, mental, and/or substance abuse problem; over 40% of men and 70% of women were likely to have a mental illness. Other reports indicate that 25% of those returning may have an undiagnosed mental illness (Slate et al., 2013).

Very few individuals receive the types of services needed. In 2000, about one in eight state prisoners, or 79 percent of those mentally ill, received counseling services or therapy. Unfortunately, the medication and counseling that begins in prison is often not continued once they are released (Petersilia, 2003). Only about one-third of ex-offenders with mental illness receive any discharge planning services (Slate et al., 2013). Roughly 75% of probation programs do not have specialized programs for those with a mental illness (Petersilia, 2003). As argued by Slate and colleagues (2013), "discharge protocols that fail to provide a network of support for released offenders with mental illness can only result in the continued recycling of person with mental illnesses through the criminal justice system and needless suffering for these individuals and society" (p. 448).

Mental illness is also highly correlated with substance abuse. Approximately 39% of alcoholics and 53% of drug addicts had a dual diagnosis with mental illness, and this rate is even higher in jails where up to 75% of inmates have co-occurring disorders at intake (Slate et al., 2013). Mental illness and substance abuse are both "clearly associated with a greater risk of homelessness among jail inmates" (Greenberg & Rosenheck, 2008b, p. 13). Offenders with co-occurring disorders, or comorbidity, are those with a concurrent DSM-IV Axis I major mental health or substance abuse disorder. However, it also includes those with two co-existing mental health, substance use, or personality disorders. Comorbid offenders represent one of the most challenging groups within the

criminal justice system because their needs are multifaceted (Chandler, Peters, Field, & Juliano-Bult, 2004). Mental illness disrupts an individual's self-care and, in turn, their relationships with their social support network (Slate et al., 2013). As discussed next, substance abuse issues only exacerbate this disruption of self-care.

Substance Abuse. Another key factor in whether or not an ex-offender successfully reintegrates is whether they are addicted to drugs (Bahr et al., 2010). Over half of those in state and federal prisons admit to using drugs in the month before their offense, and approximately 20 to 30 percent used drugs at the time of their offense (Mumola & Karberg, 2007). Also, about two-thirds of men and women report active substance abuse in the six months before their incarceration (Mallik-Kane & Visher, 2008). Forty-five percent of federal prisoners and fifty-three percent of state prisoners meet the criteria for drug dependence and abuse according to the DSM-IV (Mumola & Karberg, 2007). Released offenders with substance abuse problems are more likely to live with people who pose a risk to their reentry. One-third of men and one-half of women with substance abuse problems were living with former prisoners or individuals with a substance abuse issue as well (Mallik-Kane & Visher, 2008). Offenders who participate in a substance abuse treatment are less likely to return to prison than those who do not (Bahr et al., 2010). However, fewer than five percent of all prison inmates received substance abuse treatment (Petersilia, 2003), and these substance abuse treatment rates fall further after release (Mallik-Kane & Visher, 2008).

Ex-offenders with a pre-prison substance abuse problem had poorer outcomes with regard to housing, employment, and recidivism. Also, this group is more likely to participate in criminal activity following release and more likely to be reincarcerated than

other returning prisoners (Mallik-Kane & Visher, 2008). Individuals who use illegal drugs become "involved in a variety of crimes, such as possession of an illegal substance, possession with intent to distribute, possession of drug paraphernalia, selling of drugs, writing bad checks, and various types of theft and fraud" (Bahr et al., 2010, p. 685). Substance use negatively affects health and family relationships and increases the risk of homelessness (Fries, Fedock, & Kubiak, 2014; Mallik-Kane & Visher, 2008).

Substance abuse disorders also increase the risk for adult first-time homelessness (Thompson et al., 2013). Drug use not only precedes onset of homelessness but is "independently associated with homelessness" (Shelton et al., 2009, p. 470). One policy that has increased the risk of homelessness among substance abusers is the Public Law 104-121 of 1996 which ended Supplemental Security Income (SSI) benefits to "individuals disabled primarily by a substance-use disorder" (Thompson, Wall, Greenstein, Grant, & Hasin, 2013, p. 285). Another is the Housing Opportunity Extension Act of 1996 that compels public housing organizations to allow their leases to evict tenants or guests who engage in a drug-related crime (Thompson et al., 2013). Many housing programs require sobriety before placement can occur. However, there is little to no evidence that making clients seek substance abuse treatment or be sober pre-housing helps their ability to maintain or obtain housing (Tsemberis, Gulcur, & Nakae, 2004). Stable housing should be available on the front end for substance abusers in order to decrease reincarceration and homelessness while helping these ex-offenders get the help with substance use that they need.

Employment. After release, finding and keeping employment is significantly associated with successful reintegration while decreasing an ex-offender's chance of

recidivism. While two-thirds of ex-prisoners report having employment before incarceration, most offenders have difficulty finding a job afterwards (Visher & Kachnowski, 2007). About 75% of ex-offenders remain unemployed up to a year after release (Pager, 2007). "Congress, various states, and some courts have supported the principle that steps should be taken to integrate ex-offenders back into society, the vast majority of laws legalize employment discrimination based on conviction or arrest records" (Harris & Keller, 2005, p. 11).

Barriers to post-release employment may be both direct and indirect. Direct barriers are those that are in the various statutes and occupational guidelines, such as public employment positions, which require employers to eliminate candidates with criminal convictions or certain arrest records (Harris & Keller, 2005). Indirect barriers involve the inability to obtain proper documentation for employment. Many offenders and those who are chronically homeless do not have access to their Social Security card, driver's license, or birth certificate (Petersilia, 2003). Many times, these individuals seek jobs on the "spot market" where they are only given temporary or seasonal work instead of permanent employment due to their perceived untrustworthiness (Petersilia, 2003).

Another obstruction to finding employment is the personal bias of employers to hire ex-offenders or homeless. Over 40 percent of employers stated they would "probably not" or "definitely not" be willing to hire someone with a criminal record, and only 20% indicated that they would definitely or probably hire a person with a criminal record. About 35% stated that it depends on the nature of the crime and applicant (Holzer, Raphael, and Stoll, 2007). For those who answered "probably not" or "definitely not", only seven percent hired an ex-offender, 36 % of those willing hired an ex-offender and

24% for those employers who said it depended (Holzer, Raphael, and Stoll, 2007). In another study, 50% of employers were reluctant to consider a competent candidate based merely on the presence of a criminal record (Pager, 2007). The stigma of a criminal record is enough to prevent many employers from hiring or even consider hiring an ex-offender. As noted earlier, employment opportunities are also limited among those who are homeless who lack a phone or address to provide to potential employers.

Social Support. The burden of reentry and housing often falls upon families and communities where ex-offenders with family support are more successful (Pager, 2007). Strong ties between ex-offenders, their families, and close friends "appear to have a positive impact on post-release success" (Visher & Travis, 2003, p. 99). According to Bahr et al (2010), friends are a "significant predictor of parole success" but a lack of social support can decrease psychological wellbeing (Listwan, Colvin, Hanley, & Flannery, 2010). Those who participated in enjoyable activities with friends were more likely to succeed during parole periods whereas those who failed reported fewer friends and increased loneliness (Bahr et al., 2010). Also, those who reported having a partner, being married, being close to parents, and having frequent contact with family members were associated with parole success (Bahr et al., 2010).

While many returning ex-prisoners may have assistance from family members, these family influences can still be negative. Criminal convictions, addiction problems, a history of homelessness can be common (Mallik-Kane & Visher, 2008). Families with higher levels of conflict are positively related to an ex-offender's post-release drug use and criminal activity (Mowen & Visher, 2015). While "family and community supports will always represent an important part of the reentry process, it is

unlikely that these informal resources alone can effectively absorb the steady influx of returning prisoners" (Pager, 2007, p. 25). Those with chronic homeless histories have often damaged family relationships with their repeated calls for housing.

Those who lack support systems often rely on social systems for their support. However, the cost can be quite high given medical treatment, interventions, and emergency shelter expenses quickly add up. Also, the homeless regularly access the more costly services in health care, such as longer hospital stays and more frequent hospital admissions (Cost of Homelessness, 2015). One study found that "the average cost of additional days per discharge ($2,414) among the homeless nearly equaled the annual public-assistance rent allowance for a single person in New York City ($2,580)" (Salit, Kuhn, Hartz, Vu, & Mosso, 1998). According to a different study, every homeless individual costs the taxpayers approximately $14,480 per year largely for overnight stays in jail (Cost of Homelessness, 2015).

Systems Impacts

The chronically homeless drain the resources of hospitals, emergency rooms, substance abuse services, jails and prisons, veterans' services, and other social agencies (Burt, 2003). In Philadelphia about 20 percent of chronic homeless individuals who incurred the highest costs for services accounted for 60 percent of the total service costs of about $7,455 per person per year or approximately a total of 20 million dollars (Poulin, Maguire, Metraux, & Culhane, 2010). And these numbers are underestimation for chronic homelessness because they do not include the cost associated with police, courts, emergency services, and general health care (Poulin et al., 2010). Ending chronic homelessness means assisting people who have one or more severe disabilities, including

physical and mental disorders as well as substance or alcohol abuse (Burt, 2003). Traditional shelters have difficulties meeting these needs of the chronically homeless (Lincoln, Plachta-Elliot, & Espejo, 2009), and jails are underequipped to handle the complex needs these individuals possess.

One-half of men and two-thirds of women returning from prison reported having been diagnosed with a chronic physical health condition like high blood pressure, hepatitis, asthma, high cholesterol, and arthritis at the time of release (Mallik-Kane & Visher, 2008). Ex-inmates with physical health conditions are less likely to have stable housing a month before release (Mallik-Kane & Visher, 2008). Homelessness is associated with a higher incidence of acute and chronic health problems as well as premature mortality since many homeless individuals are exposed to weather, infections, drugs, and violence while receiving no to little health care (Henwood , Cabassa, Craig, & Padgett, 2013). These types of conditions require long term management and available treatment may not meet the needs of the returning ex-offender. As would be expected those with these histories are not well served in jails or shelters. Many only receive "acute, episodic care" in the year following release (Mallik-Kane & Visher, 2008, p. 30). However, while the U.S. government has made a specific program for those with HIV to find housing more easily, there are not currently any similar programs for other specific illnesses (Hammett, Roberts, & Kennedy, 2001).

Permanent supportive housing can improve a homeless individual's physical health by reducing his or her exposure to weather elements, infections, and violence (Henwood et al., 2013). Physical and mental illness not only makes it even more essential for releasees to have stable and safe housing that will be conducive to medication

adherence and attention to appointments and other details of care (Hammett et al., 2001, p. 401). Research has shown that services that affect the risks for homelessness alone are not effective. Thus, it is suggested to approach with a combination method of permanent supportive housing and targeted prevention (Burt, 2003). This perspective will inform the discussion for why the MeckFUSE program was ultimately created.

Responses to Homelessness

Stable housing is necessary for successful reentry from either jail or prison as it provides consistency and control for day-to-day activities (Lutze et al., 2014). In fact, "housing should optimally provide a foundation for health (a bed, refrigerator, heat, electricity), and the physical space needed to engage in healthy behaviors" (Henwood et al., 2013, p. 189). Also, a permanent address increases the likelihood of reporting to parole officers, seeking medical care, and consistently taking proper medication as well as increase the likelihood of obtaining a job or public benefits (Blevins & Blowers, 2014). By providing secure housing upon release the exposure to deviant peers, violation of public order laws, and deconstructive activities is the reduced (Lutze et al., 2014). Research has shown that permanent supportive housing and services for ex-offenders, such as Reentry Housing Pilot Program in Washington State, reduces new convictions, revocations, and reincarceration (Lutze et al., 2014).

Housing First.

The first permanent supportive housing program for the chronically homeless was Pathways' Housing First model. When Housing First was introduced in 1992, it was the first departure from the standard homelessness intervention services, specifically for those with psychiatric and substance use disorders (Greenwood, Stefancic, & Tsemberis, 2013). Housing First programs typically include assessment-

based targeting of services, assistance in locating rental properties on the private market as well as lease negotiation, housing financial assistance (security deposit, one month's rent, or long-term subsidy), a nonexistent time limit, and a case manager to coordinate services (National Alliance, 2006). Housing First is a pathway for the homeless and mentally ill to reduce their contact with the court system by increasing both public safety and public health (Somers, Rezansoff, Moniruzzaman, Palepu, & Patterson, 2013). The aim is to help families and chronically homeless individuals by providing quick access to sustainable permanent housing (National Alliance, 2006).

Housing First was considered a fundamental and profound transformation in homelessness policy for many reasons. First, it changed the order in which homeless adults received housing and services. Under this program, housing was viewed as a human right, not a reward for being sober or completing treatment. Second, this program moved the choices of housing and services from experts to consumers by letting them have the right to choose their housing as well as type, sequence, and intensity of the services they receive. Third, Housing First applied a harm reduction approach to psychiatric and substance abuse treatment. And fourth, it utilized research and evidence-based practices by focusing on rates of homelessness, housing stability, choice, psychiatric symptoms, substance use, and cost-effectiveness in order to deliver services (Greenwood et al., 2013).

Housing First programs have been found to be effective all over the country with different types of chronically homeless individuals. Housing First has achieved residential stability in homeless adults who have mental illnesses, even those with substance abuse disorders (Palepu et al., 2013). This program has also lowered

reoffending rates and reconviction of previously homeless individuals with a current mental disorder (Somers et al., 2013). Regardless of diagnostic criteria, Housing First promoted reduced offending and the ability to obtain and maintain stable housing from baseline to the two-year follow-up (Somers et al., 2013; Tsemberis et al., 2004).

Project Greenlight. As noted earlier, Project Greenlight is another example of a supportive housing program. Project Greenlight was an "innovative, short-term, prison-based reentry program" (Wilson & Davis, 2006). This 8-week reentry program took place at the Queensboro Correctional Facility in New York. This program was created when staff realized that there were a significant number of offenders who would be homeless upon release. They decided to systematically assign and match willing participants to existing, available housing resources (Rodriquez & Brown, 2003). Greenlight aimed to "improve post-release outcomes by (1) incorporating an intensive multimodal treatment regimen during incarceration and (2) providing links to families, community-based service providers, and parole officers after release" (Wilson & Davis, 2006, p. 307).

Project Greenlight addressed issues like employment, education, substance abuse, family issues, and constructive leisure time in a learning environment. Those who participated attended mandatory workshops that concentrated on job readiness, practical skills, and cognitive-behavioral tools. The participants were given volunteer opportunities with on-site job developers, a family counselor, and a community coordinator. This required close partnership with community based organizations as well as the inmates' families to increase support on the outside (Rodriquez & Brown, 2003).

Project Greenlight was able to secure housing for 63% of those who requested assistance (Rodriquez & Brown, 2003). But there was no actual follow-up in the

community so rates of success are not fully understood (Wilson & Davis, 2006). However, this project did provide an honest look at an assumption about ex-offenders released to homelessness in terms of the issues that exist with finding and keeping stable housing, including mental illness, employment, and substance abuse. The staff assumed that men who would request their assistance would be truly homeless. They learned that many of those who volunteered had families who had available housing, but the ex-inmates were barred from living with them because of certain restrictive laws (Rodriquez & Brown, 2003). The findings of this project suggest that while short-term programs seem attractive due to low cost and the ability to handle a large number, they are unable to address the numerous needs of ex-offenders.

FUSE. Instability in housing and homelessness and risk for incarceration are interrelated. The Frequent User Systems Engagement model, or FUSE, came about in order to address this cyclical risk (Aidala et al., 2013). The FUSE project contains similar philosophies and approaches to Housing First. FUSE targets high-frequency system users and establishes "permanent supportive housing as a key component of reentry services for persons with recurring experiences of homelessness and criminal justice involvement" that will increase "life outcomes, more efficiently utilize public resources, and likely create cost avoidance in publicly funded crisis care systems, including emergency medical, mental health, and addiction services" (Aidala et al., 2013, p. 5). The program has been shown to successfully reduce cycling between public systems, days spent in jail, and the use of crisis health services which in turn reduces the costs for government and society as a whole (Aidala et al., 2013). Frequent users are those with documented repeated episodes of incarceration and homelessness. About three-fourths of frequent

users have been incarcerated for drug related charges, mostly possession. Repeated incarcerations are often associated with low-level misdemeanor charges, such as theft of services, quality of life, and probation or parole violations (Aidala et al., 2013).

The findings for the FUSE initiative in New York suggest significantly reduced costs of public services while maintaining a high rate of housed individuals. Aidala and colleagues (2013) found that after the first twelve months of participating, 91% of those in treatment groups were in stable housing while only 28% of the control group were stably housed. After the first 24 months, 86% of the treatment group was in stable housing compared to only 42%. Reported recent use of hard drugs was cut in half, and current alcohol and substance use reports are one-third less for participants. The treatment group spent 146.7 days less in shelters than the comparison group, a reduction of 70%. Also, the treatment group had 19.2 fewer days spent in jail, a reduction of 40%. The comparison group spent an average of 8.04 days hospitalized for psychiatric reasons, 4.4 more days than the treatment group. The treatment group scored lower on psychological stress scales and higher on current family and social support. In terms of finances, this intervention reduced the annual costs of inpatient and crisis medical/behavioral services by $7,308 per individual, and it reduced shelter and jail costs by $8,372 per person (Aidala et al., 2013).

Due to the success in New York, the FUSE initiative was implemented in Washington, D.C. This program was launched in the capitol to "coordinate and improve services for frequent users in DC, to break institutional cycling behavior among program participants, and ultimately, to generate cost savings to the city through reduced systems use" (Gilchrist-Scott & Fontaine, 2012, p. 1). The qualifications for participation in the

D.C. FUSE program was three or more jail stays in the last three years, three or more shelter episodes or more than one year of continuous shelter use in the last three years, and a serious and persistent mental health diagnosis. Based on the records, 55% of the participants had a mood disorder, 49% had a schizophrenic disorder, and about 15% had post-traumatic stress disorder (PTSD). And roughly 66% of those with a mental health diagnosis had a comorbid substance abuse issue, including dependence on alcohol, cocaine, and cannabis. The average cost savings of D.C. Fuse initiative was $2,691 per individual per year. This is due to the average 19-day decrease in jail use and an estimated 14-day decrease of shelter use. These savings do not include the reduced use of emergency health and psychiatric service use that would cause these savings to rise (Gilchrist-Scott & Fontaine, 2012).

The question that remains is whether the homelessness initiatives that involve those with long jail histories are as likely to be effective in reducing criminal behavior. In order to be effective in reducing criminal behavior, programs need to be attentive to offering services designed to target other important criminogenic needs, especially substance use, criminal thinking patterns, and antisocial peer networks.

The literature on effective interventions with offending populations is relatively clear. To be effective in reducing recidivism, services should be matched to the ex-offender's core criminogenic issues at the dosage and duration that will produce sustained change. Ex-offender's risk and needs should be assessed in order to implement the best type and duration of service delivery (Listwan et al., 2010). Development of meaningful programs can increase skill training, coping, and social support networks. The question

that remains is whether the FUSE intervention can be effective both in terms of housing outcomes as well as criminal justice outcomes.

This study will examine the population served by the MeckFUSE program implemented in Mecklenburg County (Charlotte, NC). Given the literature noted above, it seems important to examine the individuals served by the program and whether it was effective in reducing the system burdens among participants. As such, the following questions will be examined:

(1) Who was ultimately selected for the MeckFUSE program?

(2) Do participants selected for the program have similar individual and structural risk factors compared to those who are chronically homeless and/or re-entering the community?

(3) Did the outcomes among the MeckFUSE participants improve compared to their prior arrest rate?

METHODS

Site Description

The MeckFUSE, initiative is a multi-agency program focused on increasing housing stability for high-risk individuals while reducing recidivism (Listwan & Deziel, 2015). The focus of this program is to get individuals housed as quickly as possible without time limits or contingencies. The model advocates for wraparound services that includes medication management. The impetus for the project came from a 2012 study on the Mecklenburg County jail population, which found that many chronic offenders who were arrested and jailed more than four times in a year were mentally ill and homeless. This group accounted for more than 21,000 shelter beds and a cost of $2.5 million over a four-year period (Listwan & Deziel, 2015). Building off of the Housing First initiatives, the FUSE model attempts to target this chronic offender population by widening the community resources available while having the potential "to break the costly cycle of incarceration, homelessness, and emergency service utilization common to high risk and needs individuals" (Listwan & Deziel, 2015, p. 9). Targeting a population with complex needs requires the coordination of many agencies. As such, the organization involved in the planning of the MeckFUSE program included the Office of Criminal Justice Services, the Public Defender's office, Urban Ministry Center, the Men's Shelter of Charlotte, the Salvation Army Center of Hope for Women and Children, Provided Services Organization, Social Services, Legal Services of Southern Piedmont, McLeod Center, A Place to Live Again, the Veteran's Administration, Carolinas Health Care, Charlotte Mecklenburg Police Department, and the Hoskins Park Ministries (Listwan & Deziel, 2015).

The inclusion criteria for the intervention includes the following: (1) four of more jail stays in the last five years, with one stay in the last 12 months; (2) four or more homeless shelter admission in the last five years, with one stay in the last 12 months; (3) current homeless status; (4) the ability to independently live and manage individual housing; (5) legal U.S. residency; and (6) a mental health or behavioral health problem. Registered state sex offenders, those convicted of arson, and those convicted of manufacturing methamphetamine were excluded. Those individuals with a violent history were considered on a case-by-case basis.

Recruitment for the project was coordinated through the Mecklenburg County jail and the local shelters. A list of potential clients was generated utilizing data from both of these systems (n= 193). Of the initial 193 eligible clients identified for this program, 156 were men and 37 were women. For men, the average age was 44, and 73% were African American, the average number of shelter episodes was 14, and the average number of jail episodes was 12. For women, the average age was 37, 72% were African American, and the average number of shelter episodes was 7, and the average number of jail episodes was 10 (Listwan & Deziel, 2015). Planning for this pilot began in June 2012 and the first five clients were housed in August 2013. The target number of participants was 45. Each participant has their own living space and did not share housing with other MeckFUSE clients.

Sample

Face-to-face, voluntary interviews were conducted with 42 MeckFUSE participants. The study included 42 clients rather than 45 because 2 clients could not be interviewed before dropping out of the program and one client declined participation

(response rate 95.5%). The interviews were guided by a standardized interview questionnaire. As shown in Table 1, of the 42 individuals who completed the interview, the majority were aged 50 or older (57%), with a range of 25 years to 61 years old. Thirty-six were male and 6 were female. In terms of race, 78.6% identified as African-American, most being non-Hispanic (92.9%).

Table 1: Demographics of MeckFUSE participants

Age	Frequency	Percent
29 and below	2	4.8
30 – 39	4	9.5
40 to 49	13	31.0
50 to 59	20	47.6
60 and above	3	7.1
Mean Age = 48		
Gender		
Male	36	85.7
Female	6	14.3
Race		
Caucasian	6	14.3
African-American	33	78.6
American Indian	1	2.4
Other	2	4.8

Dependent Variable

The dependent variable in this study is arrest. Recidivism is defined as any arrest that occurred post program entry (0 = no, 1 = yes). Outcome data available included the offense date, offenses' description, group (violent, property, public order, etc.), and type (misdemeanor or felony). New charges ranged from second-degree trespass and open container violations to uttering forged instruments and assault with a deadly weapon. Recidivism data were collected by Mecklenburg County in March 2015 via the

Mecklenburg County Criminal Justice Data Warehouse. The data warehouse pulls arrest information from the Mecklenburg County Arrest Processing Center, the Mecklenburg County Court System, and the Mecklenburg County Jail. This data are refreshed on a daily basis and allows county staff to access detailed charge, arrest, disposition, and jail booking and release data. Recidivism data were collected for each person from the point of program entry (e.g., August 2013-September 2014) to March 2015. The follow-up period for the current sample is an average of 13 months (range 5 months – 18 months).

Independent & Control Variables

Given the lengthy arrest history among participants and that every client had been arrested and jailed within the 12 months prior to program acceptance, the rate of recidivism is important. The factors that predict recidivism, however, remain to be explored for FUSE participants. This study controls for a number of client characteristics known to be associated with recidivism. Prior research has shown a relationship between comorbidity of mental illness and substance abuse, age, employment, and housing with how successful re-entry can be. Ex-offenders are more likely to recidivate if they are homeless, uneducated, impoverished, unemployed, mentally ill, or have a history of substance abuse (Harer, 1995). Following these trends, the expected result is that those who have a mental illness, substance abuse issue, or are unemployed will be more likely to fail out of the program, and those who are older will be more likely to succeed by continuing their stable housing as well as not committing new crimes.

The independent variables examined include mental illness, substance abuse, employment, social support, and criminal history. Participants were asked during face to face interviews if they had been diagnosed with a mental illness (1=yes; 0 = no) if they

responded affirmatively then the diagnoses were listed. There were follow-up questions regarding medication, institutionalization, and counseling. Past and present substance abuse was measured similarly with yes or no questions regarding addictions to drugs and alcohol (1 = yes, 0 = no). If the participant stated they had or have a substance abuse issue, the type of substance and frequency of use were documented. Employment was self-report on whether or not the participant currently had a job (1 = yes, 0 = no) and history of employment, including difficulties in finding work, if they had been fired from a job, and if they had been employed at least once for a full 12 months. Social support was measured through the Social Support Questionnaire which is a 12-item survey regarding participants' reliability and satisfaction with outside relationships. Criminal history was also self-report starting with juvenile criminal history and going into current status. Participants were asked if they were arrested as a juvenile, adult, or in the last six months. Incarcerations in jail and prisons were also recorded via self-report.

Risk of recidivism was measured through the Level of Service Inventory-Revised (LSI-R). The LSI-R is a 54-item quantitative survey that measures offender's attributes and their situations to predict recidivism. It contains scales for criminal history, education, employment, finances, family and marital status, housing, leisure, relationships, substance abuse issues, emotions, and attitudes/orientations. The LSI-R is useful for decision making about probation appointment, and assessing treatment progress. Failure or success in the program was measured by whether or not the participant was still housed at the end of year one (1 = yes, success, 0 = no, failure).

Statistical Analysis

The analysis proceeded in two stages. First, bivariate statistics were used to describe the sample and assess its comparability of those arrested versus those not arrested. Chi-square was used to test for differences on categorical variables and independent sample *t*-tests were used for continuous variables. Logistic regression is employed as a means to assess the impact of client characteristics on recidivism.

RESULTS

As shown in Table 2, the education and job history of the individuals in FUSE are as expected. One-third had a high school/GED level of education and about 14% had "some college" or higher. In terms of employment, 76.2% of the participants were currently unemployed at the first interview date. Financial support was determined at the time the participant was first contacted by a FUSE caseworker. None were currently married and half had children, but no children were currently residing with any clients.

Table 2: Education, employment, and background

Highest Education	Frequency	Percent
<9th Grade	3	7.1
10th Grade	7	16.7
11th Grade	7	16.7
HS Diploma/GED	14	33.3
Some College	5	11.9
2-Year Degree	1	2.4
Currently Employed		
No	32	76.2
Yes	10	23.8
Financial Support		
Regular Job	4	9.5
Odd Jobs for Pay	12	28.6
Government Benefits	1	2.4
Family/Friend Support	1	2.4
Selling Items on Street	3	7.1
Stipend Work	1	2.4
SSI/SSDI	5	11.9
Other	4	9.5
No Financial Support	10	23.8

Marital Status		
Married	0	0.0
Single	29	69.0
Divorced	8	19.0
Separated	5	11.9
Children		
Yes, 1	9	21.4
Yes, 2	7	16.7
Yes, 3 or more	5	11.9
No	21	50.0
Contact with Children		
Yes	17	81.0
No	4	19.0

Mental Illness

As illustrated in Table 3, almost 43% of the participants reported being diagnosed with a mental illness. Of the 17 diagnosed with a mental illness, the most common disorders were bipolar (33.3%), schizophrenia (22.2%), Post-Traumatic Stress Disorder (22.2%), and depression (16.7%). Many participants (35%) had more than one concurrent diagnosed disorder. Approximately half of the participants reported that they were currently taking their prescribed medication. Reasons given for not taking medication included not being able to access medical services/doctor, cost, side-affects, or just not wanting to take it.

Table 3: Mental health

Diagnosis	Frequency	Percent
Bipolar	6	35.3
Schizophrenia	4	23.5
PTSD	4	23.5
Depression	3	17.6
Dual-Diagnosis	6	35.3
Prescribed Medication		
Yes	9	52.9

No	8	47.1
Medication Usage		
Yes	4	44.4
No	5	55.6
Psychiatric Institution (Lifetime)		
No	32	76.2
Yes	9	21.4
Committed By		
Myself	3	33.3
Someone Else	6	66.7

Substance Use

As seen in Table 4, 90% of the participants had a history of drug or alcohol addiction with 43% having a history of problems with both. Those with a history of drug addiction most commonly used cocaine or crack cocaine (60%) or marijuana (28%). However, only 24% of the participants identified as still struggling with these past alcohol and drug addictions. When asked about drug and alcohol addiction of their social support, 21.4% reported having family members and 42.9% reported having regular contact with friends that have substance abuse and alcohol problems.

Table 4: Substance and alcohol use

History of Addiction	Frequency	Percent
Yes, Drugs	6	14.3
Yes, Alcohol	14	33.3
Yes, Both	18	42.9
Neither/None	4	9.5
Present Use		
Yes, Drugs	1	2.4
Yes, Alcohol	9	21.4
Yes, Both	0	0.0
Neither/None	31	73.8
Family Members' Addiction		
Yes, either drugs or alcohol	9	21.4

Yes, both	1	2.4
No	31	73.8
Don't Know	1	2.4
Friends' Addiction		
Yes	18	42.9
No	23	54.8
Refused	1	2.4

Criminal History

In terms of criminal history, 42% were arrested before age 18 with the mean age of 13.8 years (see Table 5). Almost all (97.6%) have an adult conviction with a mean number of 13 convictions. Fifteen of the participants had been arrested within the last six months. Over three-fourths (76.2%), or 32 participants, of the MeckFUSE project were considered at moderate risk for recidivism, 26.7% were low to low risk, and 7.1% were high risk. While all had jail experience, a majority (57%) also had prior prison experience.

Table 5:
LSI-R score category & criminal history

LSI-R Score Ranges	Frequency	Percent
14-23 [low risk]	7	26.7
24-33 [moderate risk]	32	76.2
34-40 [high risk]	3	7.1
Mean = 27.5		
Criminal History		
Arrested before age 18	18	42.0%
Prior prison	24	57.1%
Mean age of arrest =	13.8	
Arrested within last six months	15	35.7%
Mean number of convictions =	13	

Housing

With regards to prior housing, Table 6 illustrates that 93% of the participants had been homeless for twelve months or longer at the time of the first interview. The average time of homelessness was 10.8 years with a range from 1 to 35 years. Five (11.9%) participants had lived in a foster home while 6 (14.3%) had lived in a group home. Thirty-seven (88.1%) participants have never owned a home while 24 (57.1%) have never been a leaseholder for an apartment. When first contacted by a MeckFUSE caseworker, 50% of the participants indicated that they were living on the street, 33% were in homeless shelters, and 9.5% were in jail or prison. Other options included having a room at a hotel, drug treatment center, halfway house, hospital, or having a regular apartment/house with a monthly lease/mortgage (Listwan & Deziel, 2015). The majority of participants had at least one person to rely on in terms of social support. The average number of people was 4. See Table 7 for references to the social support questionnaire.

Table 6: Living situation		
At First FUSE Contact	Frequency	Percent
Street or Public Place	21	50.0
Shelter	14	33.3
Temporary Housing Program	1	2.4
Hotel	1	2.4
Jail/Prison	4	9.5
Friend's Apartment – Temporary	1	2.4
Previous 6 Months		
Street or Public Place	29	69.0
Shelter	21	50.0
Temporary Housing Program	2	4.8
Hotel	8	19.0
Drug Treatment	3	7.1
Jail/Prison	9	21.4
Hospital	3	7.1
Friend or Family's Apartment - Temporary	13	31.0
Foster Home		
Yes	5	11.9
No	37	88.1
Group Home		
Yes	6	14.3
No	36	85.7
Owned a Home		
Yes	5	11.9
No	37	88.1
Leaseholder on an Apartment		
Yes	18	42.9
No	24	57.1
Currently Assist with Rent		
Yes	12	28.6
No	30	71.4

Table 7: Social support questionnaire		
SSQ – Dependable for Help		
None	11	26.2
One	4	9.5
Two	8	19.0
Three or more	18	43.9
SSQ – Dependable for Relaxation		
None	15	35.7
One	8	19.0
Two	8	19.0
Three or more	9	22.5
SSQ – Accepts You Totally		
None	8	19.0
One	8	19.0
Two	9	21.4
Three or more	14	35.9
SSQ – Count On No Matter What		
None	7	16.7
One	6	14.3
Two	12	28.6
Three or more	14	35.9
SSQ – Count On When Sad		
None	10	23.8
One	5	11.9
Two	10	23.8
Three or more	14	35.9
SSQ – Count On When Upset		
None	14	33.3
One	7	16.7
Two	8	19.0
Three or more	9	23.7
SSQ Mean	4	

Table 8: Outcomes

	Frequency	Percent
Retention Rate	32	76.2%
Arrest Rate	15	35.7%
Charge Offense Description		
Obtain Property Under False Pretense	2	3.0%
Assault on a Female	2	3.0%
Assault on Police Officer	1	1.5%
AWDW and/or Serious Injury	2	3.0%
Breaking or Entering (M)	1	1.5%
Communicating Threats	2	3.0%
Disorderly Conduct	1	1.5%
DV Protective Order Viol (M)	1	1.5%
False Imprisonment	1	1.5%
Felony Larceny	1	1.5%
Financial Card Fraud/Theft	2	3.0%
Intoxicated and Disruptive	1	1.5%
Misdemeanor Larceny	5	7.7%
Poss/Cons Beer/Wine Public Street	4	6.2%
Possess Drug Paraphernalia	5	7.7%
Possess Illicit Substance	2	3.0%
PWITSD Illicit Substance	3	4.6%
Possess Stolen Goods	1	1.5%
Resisting Public Officer	3	4.6%
Second Degree Trespass	10	15.4%
Shoplifting/Concealment of Goods	6	9.2%
Simple Assault	2	3.0%
Solicit Alms/Beg for Money	4	6.2%
Uttering Forged Instrument	2	3.0%
Mean # of arrests	4.3	

Outcomes

The MeckFUSE program had a high retention rate of 76%, however, 35.7% (14 males and 1 female) of the sample recidivated by engaging in a new criminal activity. See table 8 for a breakdown of the new arrest charge offense types. The most common new charge was second-degree trespass (n = 10). Other charges that had more than one occurrence are shoplifting, possession of drug paraphernalia, and misdemeanor larceny. The average number of arrests was 4.3.

Table 9 shows the profile of those who were arrested. Of the 15 that were arrested, 4 were white and 11 were non-white. Eight had less than a high school diploma and 7 had a high school diploma or GED. Only 4 were employed at the time of the offense. Approximately 13 had a history of drug and/or alcohol addiction and 3 currently had an addiction to alcohol. Twelve of the fifteen had been in jail within the last six months. Over half of the sample (8) had a diagnosed mental illness. About 60% were between the ages of 50 and 59. In terms of LSI-R scores and the 15 new arrests, 1 had a low risk (22), 12 had a medium risk (25-33), and 2 had a high risk (34 and 35).

Participants were followed for an average of 13 months ranging from 5 months to 18 months. The average time from the interview date to first arrest was 205.4 days ranging from 0 days (charge on same day as interview) to 475 days. A total of 15 participants were arrested over the follow up period. The average number of arrests were 4 but ranged from one new arrest to twelve. A total of 11 felonies were committed between 7 different participants. The felony charges included uttering forged instruments, obtaining property under false pretense, and possession of cocaine. The other eight participants only had misdemeanor charges. These new offenses ranged from property

and public order offenses to possession of controlled substances or drug paraphernalia. There was only one new arrest charge classified as violent (Assault with a Deadly Weapon).

Table 9:
Results: bivariate crosstabs

	Arrested Yes	%	Arrested No	%
Retained in MeckFUSE				
Yes	10	31.3	22	68.7
No	5	50.0	5	50.0
Race				
White	4	66.7	2	33.3
Non-white	11	30.6	25	69.4
Age				
29 and below	1	50.0	1	50.0
30 – 39	2	50.0	2	50.0
40 - 49	3	23.1	10	76.9
50 – 59	9	45.0	11	55.0
60 and above	0	0.0	3	0.0
Mean Age = 48				
Mental Illness				
Yes	7	29.2	17	70.8
No	8	44.4	10	55.6
LSI-R Total				
Low	1	14.3	6	85.7
Medium	13	39.4	20	60.6
High	2	66.7	1	33.3

Multivariate Model

Given the sample size, the multivariate model predicting arrest includes five key variables: program retention, race, age, mental illness, and LSI-R score. While clients

are not automatically removed from the program for criminal behavior, its relationship remains important. As noted in the literature review, age is a predominate risk factor, however, complex with the current sample given the relationship between homelessness and age. Mental illness is not a strong predictor of criminal behavior, however it can exacerbate the client's self care and adherence to program requirements. The LSI-R score includes criminal history, education, employment, financial stability, peers, family, and criminal attitudes. As noted earlier studies suggest it is highly predictive of recidivism.

Table 10: Results:
multivariate model predicting arrest

Variable	B	S.E.	Wald	df	Significance
Program Failure	.548	.817	.451	1	.502
Race	-.909	1.047	.755	1	.385
Mental Illness	-.104	.822	.016	1	.899
Age	.011	.044	.068	1	.795
LSI-R Total	.138	.114	1.456	1	.227

*p < .05

CONCLUSION

This study set out to investigate (1) the demographic profile of those selected for the MeckFUSE program; (2) the individual and structural risk factors present among participants; and (3) the preliminary arrest outcomes among program participants. This section will discuss each of these research questions individually.

Who was ultimately selected for the MeckFUSE program? This is important given there is very little research on the types of clients that are or should be served by the FUSE programs. Those selected for the MeckFUSE program were mostly male, non-white, and between the ages of 40 and 59 (n=33). Drawing from the literature discussed, this is typical of the chronic homeless population, which is roughly 77 to 86% male and middle-aged (ages 35 to 54), and disproportionately African American (Henry et al., 2014). It is also typical of the incarcerated population, which is 93% male and disproportionately African American.

The second research question further explores the population served by the program and asks whether participants selected for the program have similar individual and structural risk factors compared to those who are chronically homeless and/or re-entering the community. The study found that the MeckFUSE participants are similar to those found to be chronically homeless and/or re-entering the community. For example, the majority of the participants had at least a HS diploma or GED but were not employed. The rate of mental illness was higher than found in the general population. The most common disorders were bipolar, depression, anxiety, PTSD, and schizoaffective disorders. Moreover, eight of those re-arrested had a self-reported mental illness. As found in those re-entering the community, a majority had a history of drug or alcohol

addiction. Of those re-arrested, 13 had either a reported history of addiction to drugs, alcohol, or both while only 2 stated they did not have a history. Although the majority was found to either have a high school diploma or GED. Of those who recidivated, 8 had less than a high school education and 7 had a high school diploma or GED equivalent. The majority were unemployed, however, those employed often occupied low paying jobs. Because of this, current employment may not act as insulator from criminal activity.

The third question explored whether the outcomes among the MeckFUSE participants improve compared to their prior arrest rate? This is important to examine given that every person targeted for this intervention has been arrested multiple times. While comparison group data (e.g., those who did not receive the intervention) are not yet available, examining just the participants can tell us what impact the program is having during the pilot phase. The program was able to retain roughly 76% of the clients during their first year of operation. The retention rate is similar to what other FUSE programs nationally have been able to accomplish. These participants had a high rate of arrests prior to MeckFUSE with four arrests within the last five years, one of which was within the last 12 months. The current recidivism rate of 35% illustrates that MeckFUSE was able to reduce new criminal activity among the participants.While no risk factors were found to be statistically significant in the bivariate or multivariate models, the overall findings illustrate that MeckFUSE is having some measurable success.

An important limitation to consider is the reliance on self-report for some of the independent variables. Current mental health, substance abuse, criminal history, and other risk factors information came strictly from the participants. Those who are homeless and dually diagnosed tend to have a high rate of inconsistency due to memory errors, social

desirability concerns, and intentional misrepresentation (Tsemberis et al., 2004). Self-report data "poses reliability issues, and will often lack the precision that is possible with administrative data in gauging the extent and costs of services use. Thus, it will often be used when administrative data is not available, or to supplement administrative data" (Metraux & Culhane, 2010, p.39). The results of this study may have been more pronounced through the use of official reports regarding medical and mental health history as well as criminal history, education, and employment.

Another limitation facing the MeckFUSE study is the small sample size. Only 15 people were rearrested. As such, the analysis was limited in the number of variables that could be included in the multivariate model. For example, employment was excluded because such few numbers of clients were employed. Gender was excluded because there was only one female arrested, education was excluded because the LSI-R totals account for grade completed, and the Social Support Questionnaire was left out because there were so few people with no reported social support.

DISCUSSION

Previous studies find that frequent users of public health system are often a high-risk population that can be difficult to treat. Prevention and intervention strategies to relieve the risks of homelessness and recidivism need to be targeted towards these frequent users. While obtaining housing is not the only step these ex-offenders need help with, it is one of the most important steps to stabilizing their return. A Housing First philosophy grounded in permanent housing options can be an important addition to the re-entry literature that suggests that a slow transition helps ex-offenders manage their post release issues (Petersilia, 2003).

The FUSE model is based on a belief that supplying permanent housing with lead to significant cost savings. This makes sense given previous research. For example, while the target population for FUSE is only a portion of the overall homeless population, they use fifty percent or more of the available shelter beds and account for half of the resources in emergency responses to homelessness (Burt, 2003). The previous FUSE programs were able to address this cost savings issue. The New York study found that they were able to save over $7,000 in medical costs and $8,000 in shelter and jail costs per individual participant (Aidala et al., 2013). The Washington D.C. study found that they saved over $3,000 per individual on just decreases in jail usage and shelter use alone (Gilchrist-Scott & Fontaine, 2012).

MeckFUSE is partly a jail intervention, but the majority had prior prison experience. Perhaps, even applying the MeckFUSE perspective to those coming from prison would yield more significant results. Statistics indicate that over 19% of those in state prisons and about 9% of those in federal prisons report being homeless in the

previous year (James & Glaze, 2006). A higher population provides a better source of investigation.

The foundation of the Housing First philosophy is that people have a right to housing and permanent housing should not be contingent upon compliance with non-housing related conditions (e.g., sober living). MeckFUSE utilizes this Housing First approach to homelessness where housing is the first and most important step in reducing the impacts of chronic homelessness. However, it is important to remember that the target population for the FUSE initiatives are chronically homeless populations that also tend to have higher rates of mental illness and substance abuse and are frequent users jails (Henry et al., 2014). MeckFUSE may see more improvement in recidivism if substance abuse issues are directly addressed as well. Individuals who use illegal drugs become "involved in a variety of crimes, such as possession of an illegal substance, possession with intent to distribute, possession of drug paraphernalia, selling of drugs, writing bad checks, and various types of theft and fraud" (Bahr et al., 2010, p. 685). These types of related crimes, possession, distribution, and various fraud crimes, were some of those committed by this population.

Prior research shows that the risk factors discussed this study are similar for both chronic homelessness and recidivism. What remains less clear is whether taking a harm reduction approach that does not require individuals to participate in treatment is likely to have a long term effect on recidivism. Specialized training for those who work with homeless ex-offenders is another area that should be examined. While harm reduction strategies have their benefits, future research should examine how to blend the effectiveness of mandatory treatment services with harm reduction techniques. Perhaps,

having cross-trained individuals who deal with both facets of homelessness and incarceration would promote better success in lowering rates of both.

There are important policy implications of this study given Charlotte is a midsized, southeastern city whereas previous FUSE research focuses on New York and D.C., which are significant larger in size and population. The study illustrates that the MeckFUSE program was able to target a similar population and the preliminary results show that it appears to be an effective way of providing permanent supportive housing. And while not part of the current study, the MeckFUSE program also helped the county develop a multidisciplinary team that continues to develop other initiatives to end homelessness in the area. The potential success of MeckFUSE will be better understood in a few years once the final outcome study is completed. The final outcome study will be able to examine recidivism data as well as cost-savings information for emergency services, jails, and shelters.

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