Homelessness, Crime, Mental Illness, and Substance Abuse: A Core Population with Multiple Social Service Needs

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ABSTRACT

This thesis identifies a Core Population of individuals who fall into three or more of the following categories: Mental Illness, Homelessness, Criminal Involvement, and Substance Abuse. This thesis is an attempt to learn more about this Core Population: Who is the Core Population? How is this group dealt with in our social service systems? Using Data from the Bureau of Justice Statistics and the Substance Abuse and Mental Health Services Administration, this Core Group is analyzed with regard to their demographic characteristics, biographies, and treatment history. Case studies illustrate the tragic biographies of individuals with multiple social service needs. This thesis examines the political, social, legal and systems barriers to treating this core group as its own category, addressing the needs of this challenging population in a logical and effective way. Finally, recommendations are made that aim to give this population a real chance to succeed rather than simply allowing them to bounce from one social service agency to another.

Thesis Supervisor: Langley Keyes
Title: Professor of Urban Studies and Planning

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Introduction

Homelessness, crime, substance abuse and mental illness are a set of problems everyone assumes go together. In many cases, it is an unfair stereotype to cast these four categories together. However, at times, the four are inextricably linked. What happens to individuals who are in several of these categories? They are being tracked and taken care of by many different systems. At any given time, they may be in prison, living on the streets or in a shelter, in rehab, or in our mental health systems. This thesis seeks to answer the following questions: Who are these people in multiple systems? What happens to them in these various systems? What are the barriers and opportunities to treating them in a systematic, effective way? In this thesis I identify a Core Group who fall into three or more of these four categories:

- Mental Illness
- Homelessness
- Criminal Involvement
- Substance Abuse

Case studies will illustrate the tragic biographies of this group. In addition, this thesis will analyze their demographic characteristics, their biographies, and their treatment histories. I also address the political, social, legal and systems barriers to treating this core group as its own category, addressing their needs in a logical and effective way. Finally, I make recommendations that aim to give this population a real chance to succeed rather than simply allowing them to bounce from program to program, from one social service agency to another.

Methodology

Four data sets from the Bureau of Justice Statistics and the Substance Abuse and Mental Health Services Administration were analyzed to learn more about the Core Group. These large data sets are the result of one-two hour questionnaires administered by federal agencies. Together, they comprise a total of 34,710 individuals, 7,623 of whom, 21.96% are in the Core Group. The data sets are:

- Survey of Inmates in State and Federal Prisons
- Survey of Adults on Probation
- Drug Abuse Treatment Outcomes Survey
- Services Research Outcomes Survey

In each data set, new variables were contrasted out of existing questionnaire items; each case was coded as to whether they were homeless, mentally ill, has a substance abuse problem, or had a criminal history. Each case was then given a score from 1-4 indicating how many

categories they fall into. Cases with a score of 3 or 4 are in the core group. Cases with a score of 1 or 2 are not in the Core Group. Cross-tabulations and mean comparisons were then conducted to compare the core group with the non-core group based on their demographic characteristics, biographic information, and treatment histories.

Findings

The Core Group members are:

- Between 21.96% of inmates, probationers, and clients in substance abuse treatment
- Not simply the older cohort of their non-core group counterparts in the criminal justice system or substance abuse treatment.
- Less likely than their non-core group counterparts to be married
- Less likely to be employed
- More likely to be white
- Less likely to have a high school diploma
- More likely to receive public benefits
- Characterized by a high prevalence of childhood physical and sexual abuse, as well as involvement in the youth services, foster care, and juvenile justice systems.
- The children of parents with a high incidence of mental illness, history of incarceration, and substance abuse.
- Only slightly less likely to have children.
- Far more likely to attempt suicide, use IV drugs, and overdose.
- Slightly younger when their substance abuse begins, but their substance abuse is much more intense from an early age, with more different drugs.
- More likely to have been in all types of treatment but once enrolled they do not stay as long.
- More likely to have been convicted of every type of crime.

Barriers & Strategies

It is difficult to garner public sympathy for this population. Advocates spend most of their time trying to make sure that these categories are not seen as related; that homeless people are not thought of as drug addicts, that the mentally ill are not thought of as violent, that substance abusers are not thought of as criminals. In the effort to present these categories as deserving of our sympathy, and "just like you and me," the core population is ignored for the good of the movement.

Social categories are powerful ways of framing social problems. By separating these four categories, the core group that falls into many of them is made invisible.

Legal strategies to protect civil liberties have been very successful in reducing stigma and promoting autonomy, especially among the mentally ill. However, they have reduced the service sector's ability to treat patients who

may not be able to judge their own best interests. Recently, advocates have been more active in using legal strategies to promote positive rights for this population, and use the law to require treatment rather than simply securing the right to refuse it.

Systems meant to help the core group most often get in their way. Three types of systems; emergency, case-management, and custodial systems are analyzed.

Two examples of initiatives that could serve as models for the core group are analyzed: The Consensus Project and the Juvenile Detention Alternatives Initiative.

Recommendations

Given what we have learned about the nature of the core population and the systems in which they are treated, recommendations should take the following concepts into account:

- Start early
- Jail diversion is essential
- The homeless system is a good place to start
- Plan for relapse, and emphasize harm reduction
- Focus on small fixes
- Avoid writing more reports for their own sake
- Plan for release and re-entry
- Reform the probation system

CHAPTER 1: INTRODUCTION

"Eventually, the fit between categories and reality becomes so weak that new categories emerge. The number of cases that do not fit the old categories increases so dramatically that people must use new categories simply to make themselves understood."[1]

"Darlene was referred to STOP because she was too tormented and overwhelmed by her disordered thinking. She was sent away because her thinking was too disordered to get there on time. You can't do any treatment unless you've got a patient. But you can't do any treatment unless you've got a program. In a fine balancing act, programs' needs for sanity are weighed against the insane lives of their clients. Poor judgment calls are inevitable. It's easy to look back and say that Darlene should have been invited to stay even though she'd arrived late, that she first be engaged in treatment and then requested to come on time. But such armchair psychology is a luxury denied to rehab counselors working on the front lines with some of the most difficult clients."[2]

Homelessness, crime, substance abuse and mental illness are a set of problems; everyone assumes they go together. In many cases, it is an unfair stereotype to cast these four categories together. However, at times, the four are inextricably linked. What happens to individuals who are in several of these categories? At any given time, some they may be in prison, living on the streets or in a shelter, in rehab, or in our mental health systems. They are being tracked and taken care of by many different systems. Who are the people in multiple systems? What happens to them in these various systems? In this thesis I identify a core population who are in three or more of these four categories:

- Mental Illness
- Homelessness
- Criminal Involvement
- Substance Abuse

Case studies illustrate the tragic biographies of this group. I analyze their demographic characteristics, their biographies, and their treatment histories. I address the political, social, legal and systems barriers to treating this core group as its own category, addressing their needs in a logical and effective way. Finally, recommendations for this population are proposed that give them a real chance to succeed rather than simply allowing them to bounce randomly from program to program.

Once an individual falls into two of these categories, a third and perhaps fourth are likely to follow. It is difficult to imagine a drug addicted, homeless schizophrenic who

[1] Kingdon 1995: p. 112
[2] Shavelson 2001: p. 52

has never been arrested. Similarly, it would not be surprising to find that a mentally ill substance abuser recently released from prison has become homeless. These four problems occurring together represent our worst fears about each category; they are a stereotype professionals try to avoid acknowledging. But this population does exist, and the social service world needs to address this unavoidable fact.

Each of these individual sectors has had to accommodate people who also fall into the other categories. There is not a comprehensive effort to coordinate services, to make sure people end up in the setting most appropriate for treatment, rehabilitation, public safety, and cost effectiveness. Research on each population shows that the co-occurrence of these problems or diagnoses exacerbates each issue from a clinical, cost, and public safety perspective.

Existing data and literature demonstrates that each of the four sectors are aware of this core population and their inability to serve these clients effectively. Each of the four sectors has extensive literature listing the others as 'risk factors' or special sub-populations that require specialized services. However, there has not been a comprehensive effort to view this population as its own category or examine the extent to which multiple issues co-occur. Each field acknowledges these four issues are risk factors for one another, and that the addition of each issue complicates the treatment and prevention of the other. But because the four worlds have such different cultures, goals, and spheres of influence, an outside analysis may be helpful in illuminating the extent to which these are in large part the same population of clients.

The research in each field is extensive and shows that these conditions exacerbate and reinforce one another. Social work, psychiatry and health services research examine how these four categories work together and attempt to design specific clinical interventions. This thesis is examines the political and institutional issues of treating these currently separate populations as a syndrome of problems that ought to be formally combined for the most efficient and positive result. Service provision should be aligned with the needs of these extremely challenging and costly clients.

There are, of course, legitimate reasons why these categories have emerged and why they remain stable despite evidence that these problem co-occur to such a large extent. Each field of research and practice has a different way of 'mapping' the problem. A medical doctor sees mental illness and increasingly, substance abuse, as medical conditions that if left untreated, are the causes of social problems such as crime or homelessness. Cure the patient's medical problems, and the social problems will no longer be an issue. Incarceration and homelessness

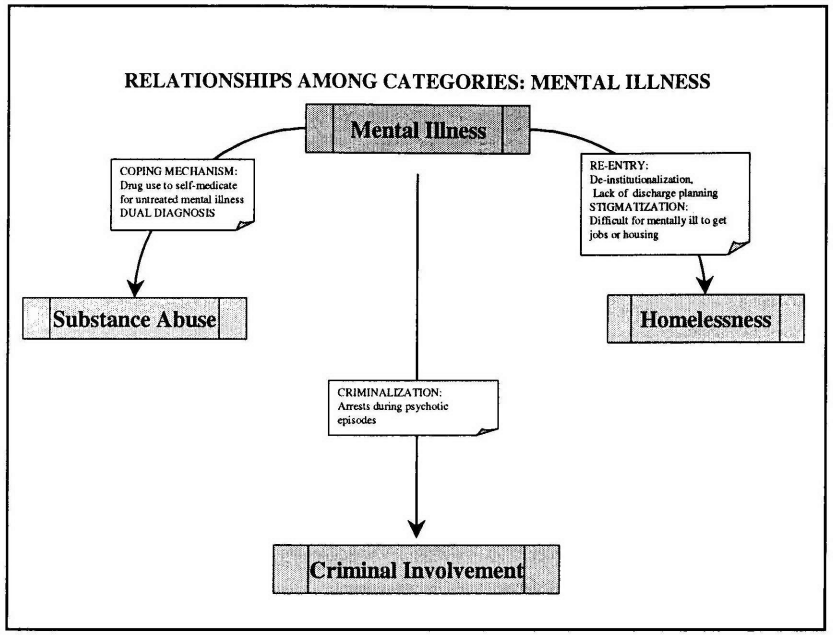
may also be viewed as exacerbating factors for mental illness and substance abuse, as these are such anti-therapeutic settings. Homelessness advocates may take another point of view, where substance abuse and mental illness are to some extent the result of homelessness: "Wouldn't you take drugs if you were living on the street? Wouldn't you be depressed? Wouldn't you lose touch with reality?", resorting to criminal behavior is a coping mechanism (think of theft, trespassing, burglary, loitering or panhandling), and effective mental health treatment is laughable until the system is able to get the client off the streets.

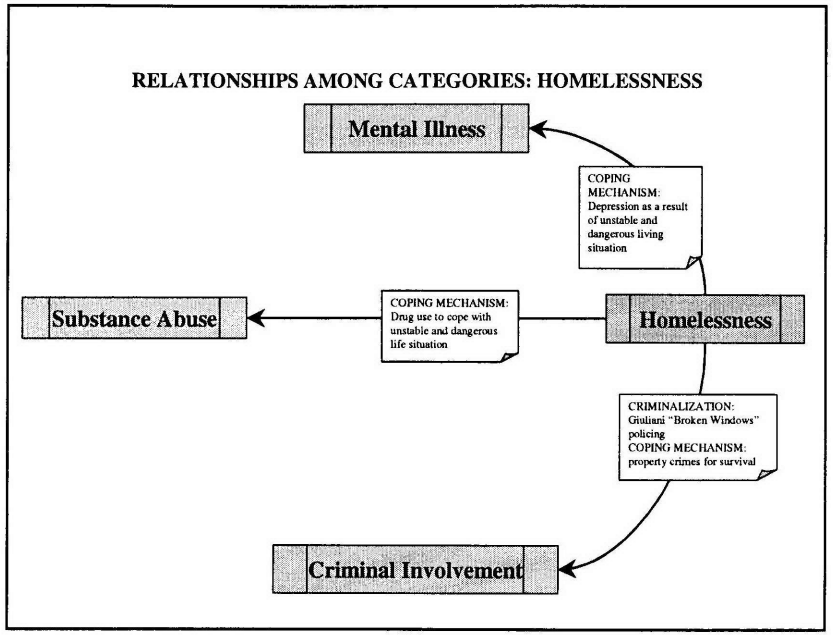
Such different conceptions of "the problem" are difficult to reconcile. But to a large extent, these various actors are all talking about the same group of people, and they recognize this. Even still, the population is not treated as a category in itself and is allowed to float among safety nets, prison, and the streets without a research agenda or treatment plan that takes into consideration the totality of their needs.

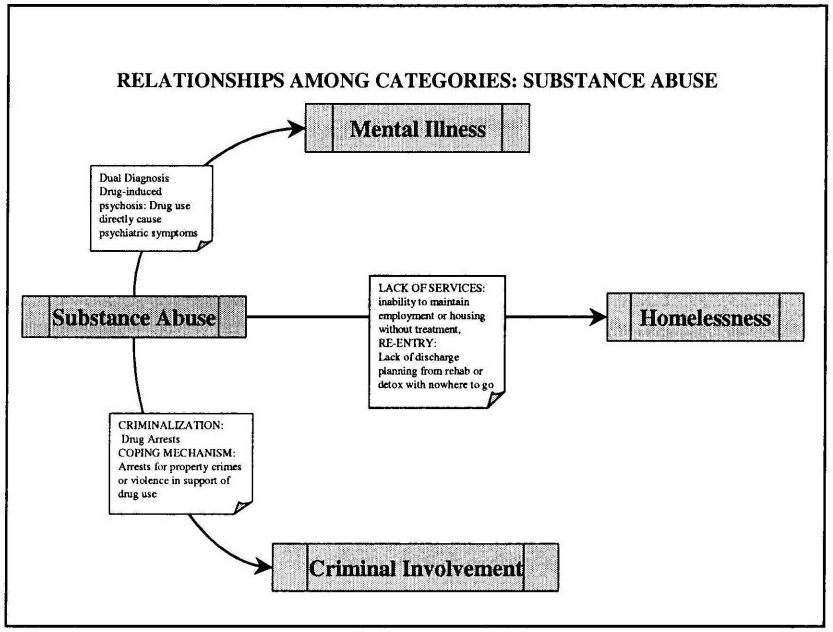
Stigma and public opinion also play a role in why this population is not identified and treated properly. It is not in the best interests of any group to draw attention to their most difficult clients. Mental health advocates have worked tirelessly to combat stigma and highlight the medical nature of mental illness while refuting the suspicion that mental illness is a matter of personal weakness. Focus on substance abuse or criminal activity among the mentally ill could be a setback to this advocacy.

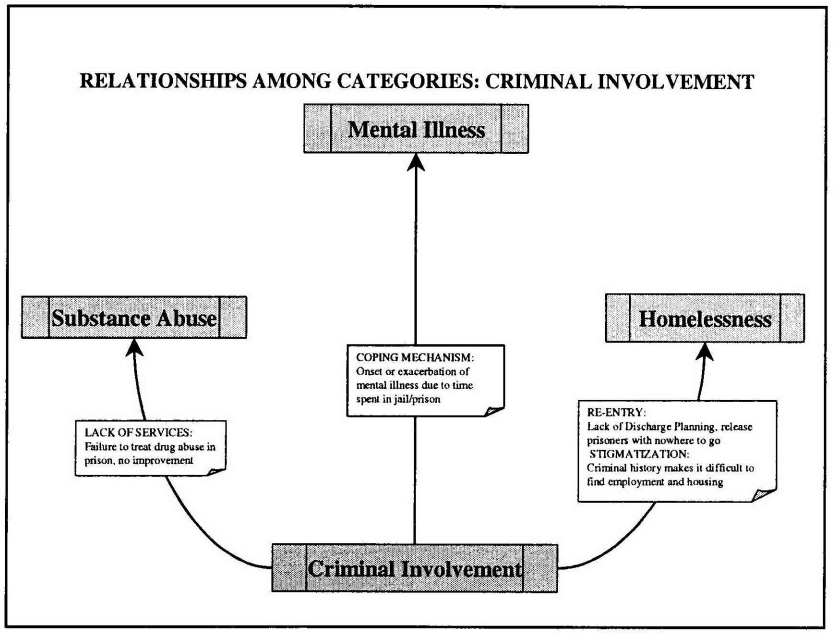
These four categories are inter-related in many different ways. The diagrams that follow show some of the common explanations for why these categories overlap and exacerbate one another.

Given that these four categories are inter-related, how many people fall into three or more of them? Have these individuals "fallen through the cracks"? What are the characteristics of this core population and how can social policy be crafted to help them? This thesis is an attempt to look at these four categories in a new way, and isolate the most difficult-to-treat cases in each, to see what this core population has in common, regardless of what system we happen to place them in at any given point in their lives.


RELATIONSHIPS AMONG CATEGORIES: MENTAL ILLNESS
Mental Illness
COPING MECHANISM:
Drug use to self-medicate for untreated mental illness
DUAL DIAGNOSIS
RE-ENTRY:
De-institutionalization,
Lack of discharge planning
STIGMATIZATION:
Difficult for mentally ill to get jobs or housing
Substance Abuse
Homelessness
CRIMINALIZATION:
Arrests during psychotic episodes
Criminal Involvement


RELATIONSHIPS AMONG CATEGORIES: HOMELESSNESS
Mental Illness
COPING MECHANISM:
Depression as a result of unstable and dangerous living situation
Substance Abuse
COPING MECHANISM:
Drug use to cope with unstable and dangerous life situation
Homelessness
CRIMINALIZATION:
Giuliani "Broken Windows" policing
COPING MECHANISM:
property crimes for survival
Criminal Involvement


RELATIONSHIPS AMONG CATEGORIES: SUBSTANCE ABUSE
Mental Illness
Dual Diagnosis
Drug-induced psychosis: Drug use directly cause psychiatric symptoms
Substance Abuse
LACK OF SERVICES:
inability to maintain employment or housing without treatment,
RE-ENTRY:
Lack of discharge planning from rehab or detox with nowhere to go
Homelessness
CRIMINALIZATION:
Drug Arrests
COPING MECHANISM:
Arrests for property crimes or violence in support of drug use
Criminal Involvement


RELATIONSHIPS AMONG CATEGORIES: CRIMINAL INVOLVEMENT
Mental Illness
Substance Abuse
COPING MECHANISM:
Onset or exacerbation of mental illness due to time spent in jail/prison
Homelessness
LACK OF SERVICES:
Failure to treat drug abuse in prison, no improvement
RE-ENTRY:
Lack of Discharge Planning, release prisoners with nowhere to go
STIGMATIZATION:
Criminal history makes it difficult to find employment and housing
Criminal Involvement

Methodology

As the literature review describes in detail, there are numerous studies that begin to hint at the overlap between the following four categories: homelessness, crime, mental illness, and substance abuse. Existing data analysis has not sufficiently explored the nature of the overlap.

Using data sets from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Bureau of Justice Statistics (BJS), I created new variables based on the existing questionnaire questions. Each case was recoded based on whether the individual fell into the following four categories:

- Homeless,
- Substance Abuse
- Criminal History, and
- Mental Illness

Four data sets are used in this thesis, two from substance abuse research and two from criminal justice research. This creates a balance between studies focused on crime and punishment and studies focused on treatment and social work. The four data sets are:

- Drug Abuse Treatment Outcomes Survey (DATOS)
- Services Research Outcomes Study (SROS)
- Survey of Inmates in State and Federal Prisons
- Survey of Adults on Probation

Each data set includes different questions on these topics, so they are not perfectly comparable, but every effort is made to keep these categories consistent across data sets. For example, some of the data sets asked whether the respondent was homeless at the time of the interview, while others asked if the respondent has been homeless during the past 12 months. This chapter contains a detailed description of how the 4 category variables were created for each data set.

From these four new variables, a 5th variable called "Score" was created; each case is scored from 1-4 based on how many of the above categories that case falls into. A variable called "Core" was created: cases who fall into 3 or 4 of the categories are in the Core Group, cases who fall into only 1 or 2 categories are not in the Core Group.

These new variables were used in three types of analysis:

Venn Diagrams are presented to show how the four categories overlap.

Cross-tabulations and mean comparisons are used to compare the core group with the non-core group in terms of basic demographic information, biographical information, and treatment history.

Case studies were compiled by choosing random individual cases from the core group and using the entire questionnaire to piece together the respondent's history as comprehensively as possible to form a qualitative picture of the life story of typical members of the core group. Cases from three data sets were chosen arbitrarily and compiled into biographies of the individuals.[3] Some data in the cases is missing or extremely general, and in this section I have reported only what is in the data sets without selectively editing or filling in any missing information. Assumptions, generalizations, and commentary are reserved for the discussion that follows all the cases. Some very rough estimates of the public cost of treating these individuals are also included.

Drug Abuse Treatment Outcomes Survey (DATOS)

The Drug Abuse Treatment Outcomes Survey (DATOS) is conducted by the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. The DATOS research was designed to study outcomes in substance abuse treatment programs nationwide. Four types of treatment settings were studied: Outpatient Treatment, Methadone, Short-Term Inpatient, and Long-Term Residential. Each participant was interviewed twice at intake into the treatment program, then twice more one-month and three-months later. Finally, a follow-up interview was conducted 12 months after initial intake into the program. This thesis uses only the data from the Intake # 1 interview.

A total of 10,010 clients were interviewed between 1991-1993 at substance abuse treatment programs across the nation.[4] Each interview lasted approximately 2 hours and included 1,289 variables.

DATOS Recoding Procedure

A DATOS case was recoded as "Homeless" if when asked what type of residence they lived in when they entered the program, the respondent answered "Homeless Shelter" or "On the Street (No Regular Place)."[5] DATOS does not include questions that address homelessness over the client's lifetime, so a history of homelessness is underestimated in this data set.

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[3] The SROS data did not include a significant amount of background information and so case studies were not compiled from SROS data. Cases were identified by selecting the first and last case in each data set that fell into each of the four categories.

[4] More information about DATOS research design, sampling, and survey administration including codebooks, raw data, and reports are available at www.datos.com and www.icpsr.umich.edu

[5] DATOS variable aa12: 9=Homeless Shelter, 10=Street (No Regular Place)

A DATOS case was recoded as "Mentally Ill" if they answered yes to any of the following questions[6]:

- Have you ever received payments for a psychiatric disability?
- Have you ever taken regular medication for emotional problems?
- Are you currently taking medication for emotional problems?
- Have you ever had overnight treatment for emotional problems?

Other questions in the DATOS survey relate to mental illness but were considered sufficient to classify a case as mentally ill. These variables include: was there ever a period of weeks when you felt depressed? Have you ever thought a lot about suicide? Have you ever attempted suicide? Are you very troubled by your mental/emotional problems right now? Have you ever had temper outbursts, hallucinations, or suspiciousness of other people not due to your drug use? In keeping with conventions in mental health literature, a suicide attempt does not by definition constitute a mental illness.

A DATOS case was recoded as "Criminal Involvement" if they answered yes to any of the following questions:[7]

- Type of residence when entered program = Jail/Prison/Juvenile Detention
- When admitted, on probation, on parole, awaiting trial, awaiting sentencing, serving a sentence, on bail awaiting trial, on bail awaiting sentencing, released/case pending, or other criminal justice status.
- Was admission required/suggested by the justice system?
- During treatment, drug testing by the criminal justice system?
- Arrested more than 3 times since age 18?
- Ever convicted of a felony?

This thesis uses arrests rather than the stricter standard of convictions to code clients as having criminal involvement. If an individual was arrested more than three times but has never been convicted or has never been to prison, they are classified as having criminal involvement. Such individuals have had multiple contacts with criminal justice officials, that is, they are not falling through the cracks, and they incur costs to public resources. Therefore arrests are considered in criminal history even where the offense has not been proven in a court of law. Individuals are excluded if they

[6] DATOS variables af9, af10, af11, and af12

[7] DATOS variable aa12: 6=Jail/Prison/Juvenile Detention, ac8, responses 1-9, aac9a, aac9d, ag6 Respondents were asked how many times they had been arrested, and if this value was greater than 3, the case was included in the recoded "Criminal Involvement" variable, ag13

were arrested as juveniles but never as an adult, or if they were arrested fewer than three times in their lifetime.

All DATOS cases are recoded as "Substance Abuse" by definition because they are all enrolled in substance abuse treatment. This includes individuals in treatment for alcohol abuse.

Services Research Outcomes Study (SROS)

SROS is research of the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, conducted by the National Opinion Research Center (NORC) at the University of Chicago. This data was designed to serve as a baseline cohort of individuals participating in substance abuse treatment in 1990, to provide a comparison in light of increased federal funding for substance abuse treatment in the 1990's.

The initial intake portion of the study included 3,407 individuals discharged from substance abuse treatment in 120 different facilities in 1989-1990. Each interview included 246 variables regarding demographic data, employment history, criminal history, substance abuse, and health issues.[8] Follow-up interviews and interviews with directors of the treatment facilities are also part of the SROS research but were not included in this thesis.

SROS Recoding Procedures

An SROS case was recoded as "Homeless" if the respondent stated that their living arrangement at admission is "No Stable Arrangement (Including Homeless, Shelters).[9] The SROS survey does not include questions that address homelessness over the client's lifetime, so a history of homelessness is very likely to be underestimated in this data set.

An SROS case was recoded as "Mentally Ill" if any of the following conditions were met:[10]

- Primary referral source to drug treatment was a community mental health center
- Client has a history of psychological disorders
- Client has a dual diagnosis of substance abuse disorder and another mental illness
- One of the client's three primary reasons for treatment services is dual diagnosis (substance abuse/mental illness)

[8] More information about SROS research design, sampling, and survey administration including codebooks, raw data, and reports are available at www.samhsa.org and www.icpsr.umich.edu

[9] SROS variable Q17 Living Arrangement at Admission, 1=No Stable Arrangement (include homeless, shelters)

[10] SROS variable Q5 Primary Referral Source 12=Community Mental Health Center, Q28, Q29, Q58_PRA, Q58_SECA, Q58_PRB, Q58_SECB, Q58_PRC, Q58_SECC, Q58_PRD, 18=Substance Abuse/Mental illness (Dual Diagnosis), Q79, Q33b: 14=Mental Illness

- The treatment center categorizes the client as dual diagnosis at discharge
- A medical diagnosis code of a mental illness is noted in the client's record

An SROS case was recoded as "Criminal Involvement" if any of the following conditions were met[11]:

- Client listed their primary referral source as the legal system, either voluntarily or under court order
- Client was charged with DWI/DUI prior to admission
- Client has other arrests prior to admission
- Client has a prison or jail record prior to admission
- Client is receiving treatment as a condition of probation or parole
- Client was discharged from the SROS treatment because he/she was incarcerated

All SROS cases are recoded as "Substance Abuse" by definition because they are enrolled in substance abuse treatment. This includes individuals in treatment for alcohol abuse.

[11] SROS variables: Q5 Primary Referral Source (9=Legal System (Court Order), 10=Legal System (Voluntary), 11= Legal System (Unspecified), Q22, Q23, Q24, Q25, Q58_REA and SROS Variable Q76 "Reason for Discharge"

Survey of Inmates in State and Federal Correctional Facilities, 1997

Since 1974, every 5-10 years the US Census Bureau conducts a survey of inmates in state correctional facilities. Federal prisoners were also surveyed, beginning in 1991. The study is funded by the United States Department of Justice, Bureau of Justice Statistics and the Federal Bureau of Prisons. A total of 18,326 inmates were asked 2,325 questions during a one-hour interview. Alphanumeric data that includes responses for open-ended questions is also part of the Inmates survey but was not included in this thesis.[12]

Inmates Recoding Procedure

Inmates cases are recoded as "Homeless" if respondents were living on the street or in a homeless shelter prior at the time of their arrest, or had been in a shelter or on the street in the 12 months prior to their arrest.[13]

Inmates cases are recoded as "Mentally Ill" if they meet any of the following conditions:[14]

- Sentence includes mandated psychiatric counseling

[12] More information about the Inmates Survey research design, sampling, and survey administration including codebooks, raw data and reports is available at www.icpsr.umich.edu/NACJD and www.ojp.usdoj.gov/bjs

[13] Inmates variables v1354 and v1355

[14] Inmates Variables: v515, v1322, v1794-1801

- Self-reported that that have a mental or emotional condition
- Ever taken medication prescribed by a doctor, been admitted to a mental hospital overnight, received counseling or therapy from a trained professional, or received any other mental health services because of a mental or emotional condition.
- Since admission to prison, have taken medication prescribed by a doctor, been admitted to a mental hospital overnight, received counseling or therapy from a trained professional, or received any other mental health services because of a mental or emotional condition.

Inmates cases are recoded as "Substance Abuse" if the respondent reports having used any of the following drugs regularly[15]: Heroin, Other Opiates (Darvon, Percodan, Methadone w/o Prescription), Methamphetamines, Other Amphetamines, Quaaludes, Barbiturates, Tranquilizers, Crack, Cocaine, PCP, LSD or other Hallucinogens, Marijuana, Inhalants, or Other Illegal Drugs.[16]

Inmates were also coded as substance abusers if they had not used illegal drugs regularly but abuse alcohol only. Alcohol Abuse is defined by using the CAGE score, a commonly used index to determine alcohol abuse.[17] The CAGE score is comprised of the following four questions:

- Have you ever felt you should cut down on your drinking?
- Has anyone ever annoyed you by criticizing your drinking?
- Have you ever felt bad of guilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?[18]

If the respondent answers "yes" to 3 or more of these questions, they are considered to have an alcohol problem.

If a respondent's sentence includes drug treatment, but the case does not meet any of the other criteria for substance abuse, it may be that the inmate is convicted of drug distribution and is required to undergo treatment because theirs is a 'drug charge' despite the fact that they do not themselves abuse any substance. Therefore this is not a sufficient condition to be classified as a substance abuser in this thesis.

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[15] In each of the data sets and in this study, "regularly" is defined as once a week or more for at least a month.

[16] Inmates variables v1593, v1597, v1601, v1605, v1609, v1613, v1617, v1621, v1625, v1629, v1633, v1637, v1641, and v1645

[17] CAGE is an acronym for the four questions that make up the test: C= "Cut Down", A= "Annoyed", G= "Guilty", E= "Eye-Opener"

[18] Inmates variables v1567-1570

All respondents in the Inmates survey are recoded as "Criminal Involvement" by definition because they are incarcerated.

Survey of Adults on Probation, 1995

The United States Census Bureau administers a survey on behalf of the United States Department of Justice, Bureau of Justice Statistics to collect individual-level data about adult probationers in the United States. A sample of 4,062 probationers is interviewed and their responses checked against official records.

Probation Recoding Procedure

Probation cases are recoded as "Homeless" if the respondent is currently living on the street or in a homeless shelter, or has done so in the past 12 months.[19] This variable does not include the "couch homeless;" individuals who have never been on the street or in a homeless shelter but who stay with family or friends because they have nowhere else to go.

Probation cases are recoded as "Substance Abuse" if the respondent has used any of the following substances regularly: Marijuana, Barbiturates, Quaaludes, Methamphetamines, Amphetamines, Crack, Cocaine, Heroin, Other Opiates including Methadone not by prescription, PCP, LSD or other Hallucinogens, or any other illegal drugs.[20] Alcohol abusers who do not us illegal drugs regularly are also included using the CAGE score described earlier.[21]

Probation cases are recoded as "Mentally Ill" if the respondent meets any of the following criteria: [22]

- Ever received services for an emotional or mental problem
- Ever been told by a mental health professional that they had a mental or emotional disorder.
- Because of a mental or emotional disorder, ever been admitted overnight to a treatment program, received family or group counseling, received individual counseling, or any other mental health services from a trained professional.

All respondents in the Probation survey are recoded as "Criminal Involvement" by definition because they are on probation.

Caveats

There are several reasons why this analysis may underestimate the proportion of individuals in the core

[19] Probationers variables sc0733, sc0717, sc0707

[20] Probationers variables MIJ89BBX, BRB89BBX, MTQ89BBX, MTP89BBX, AMP89BBX, CRK89BBX, COC89BBX, HER89BBX, OPI89BBX, PCP89BBX, LSD89BBX, ILG89BBX

[21] Probationers variables SC0860-SC0863

[22] Probationers variables SC1004, SC1005, SC1006, SC1008, SC1010, SC1012, SC1014

group. First, the data sets rely on self-reporting of drug use and mental illness, and some respondents may be reluctant to be completely truthful. Second, homelessness is underestimated because the data only includes homelessness just before treatment or incarceration in some data sets, and homelessness in the previous 12 months in other data sets. Individuals who have been homeless in the past, but never in the past 12 months will not be coded as homeless. Probationers have a much higher percentage of persons who fall into only one category, for reasons that were explored earlier.

It must be remembered that these individuals are not the most reliable reporters. They are being asked for detailed, sensitive information that they may not have the memory or the inclination to disclose accurately. In some cases they may be remembering incorrectly, in some cases they may be lying, and in some cases we may hope for their own sake that they aren't telling the truth. Some responses may be exaggerated and some may omit of sensitive facts. The survey instruments are ambitious and ask very detailed questions about long periods of time, and the exact months, years, number of incidents, specific charges, etc. may not always be precisely accurate. That said, in many cases these respondents have no reason to lie; they are already in prison or in rehab; and altering details of their lives serves no purpose. The most likely source of error in this data is simply that the questions are very specific and the level of detail is probably difficult to accurately recount.

CHAPTER 3: THE OVERLAP BETWEEN HOMELESSNESS, CRIME, SUBSTANCE ABUSE, AND MENTAL ILLNESS

After recoding the data, the data sets were analyzed in several different ways to show how the four categories overlap. For a fuller picture of how these groups overlap and interact, we asked the following questions:

- What percentage of individuals are in each of the four categories?
- How many categories do individuals fall into?
- What percentage of individuals in each data set fall into the core group, I.e., are in 3 or 4 of the categories?
- How do the four categories overlap with one another?

What Percentage of Individuals Fall into Each of the Four Categories?

We begin by looking at what percentage of people in each data set fall into each of the four categories. Among Inmates, 31.70% are mentally ill, 9.90% have been homeless in the past 12 months, and 69.90% have had a substance abuse problem in their lifetime. Among Probationers, 10.90% are mentally ill, 1.90% were been homeless in the past 12 months, and 25.30% have had a substance abuse problem in their lifetime. Of the SROS clients, 62.90% had a criminal history, 25.70% have had mental health problems, and 4.10% were homeless upon admission to the treatment program. Of the DATOS clients, 62.20% have a criminal history, 20.90% are mentally ill, and 4.40% were homeless upon admission to the program.

Table 1: Incidence of Homelessness, Mental Illness, Substance Abuse, and Criminal Involvement

	Criminal Justice		**Substance Abuse**	
	Inmates	Probation	SROS	DATOS
Criminal Involvement	100%	100%	62.90%	62.20%
Mentally Ill	31.70%	10.90%	25.70%	20.90%
Homeless	9.90%	1.90%	4.10%	4.40%
Substance Abuse	69.90%	25.30%	100%	100%
N=	18,326	4,062	2,222	10,100

The four data sets were very consistent, with the exception of the probation data, which had a substantially lower percentage of homelessness, mental illness, and substance abuse. Two factors contribute to the discrepancy. First, the criminal justice system is less likely to place on probation individuals who have nowhere to live, have active substance abuse problems, a serious mental illness, or a combination of these. Second, it is possible that individuals who are in the core group and placed on probation are more likely to abscond or be unable to fulfill the terms of their probation, and

therefore would not be included in the Probationers survey. Other studies have calculated such statistics as well, and the results in this thesis are similar to these other available sources of data. (See Table 2)

Table 2: Incidence of Homelessness, Mental Illness, Substance Abuse, and Criminal Involvement in Other Data Sets

	BSAS[23]	NSHAPC[24]	McCormack[25]	Long Island Shelter[26]	Jencks[27]
Categories					
Criminal Involvement	24.20%	54.00%	22.00%	77.08%	41.00%
Mentally Ill	28.20%	39.00%	39.00%	33.33%	33.00%
Homeless	20.50%	100.00%	100.00%	100.00%	100.00%
Substance Abuse	100.00%	26.00%	50.00%	75.00%	29.00%
n=	121,277	4,207	338	48	*N/A*

[23] Mass. Bureau of Substance Abuse Services Interview with Theresa Anderson, Director of Statistics and Research, February 28, 2003
[24] National Survey of Homeless Assistance Providers and Clients, Interagency Council on the Homeless 1999
[25] McCormack 1997
[26] Interview with John Christian, Social Services Administrator, Boston Public Health Commission, March 17, 2003
[27] Jencks 1994, p. 22

How Many Categories do Individuals Fall Into?

The data sets were used to calculate how many categories these individuals fall into. In all data sets except for Probationers, a clear pattern emerges. Roughly one quarter of cases fall into only one category, more than half fall into two categories, and the remaining cases fall into 3 or four categories, with only a small percentage in all four. (See Table 3)

Table 3: Distribution of SCORE in Each Data Set

	Criminal Justice		Substance Abuse	
Score (# of Categories)	Inmates	Probation	SROS	DATOS
1	21.80%	69.60%	24.70%	27.90%
2	49.00%	23.10%	58.40%	57.40%
3	24.90%	6.80%	16.40%	14.10%
4	4.20%	0.50%	0.60%	0.70%
N=	18,326	2,030	3,047	10,100

What Percentage of Individuals Fall Into the Core Group (3 or 4 Categories)?

In the Inmates data set, 29.10% of cases are in the core group. In the probationers data set, 7.30% of clients are in the core group, a much smaller percentage is due to reasons discussed earlier. Among DATOS clients, 16.90% are in the core group, and in the SROS study, 14.70% are in the core group. All together, 7,623 cases in four separate data sets are members of the core group. (See Table 4)

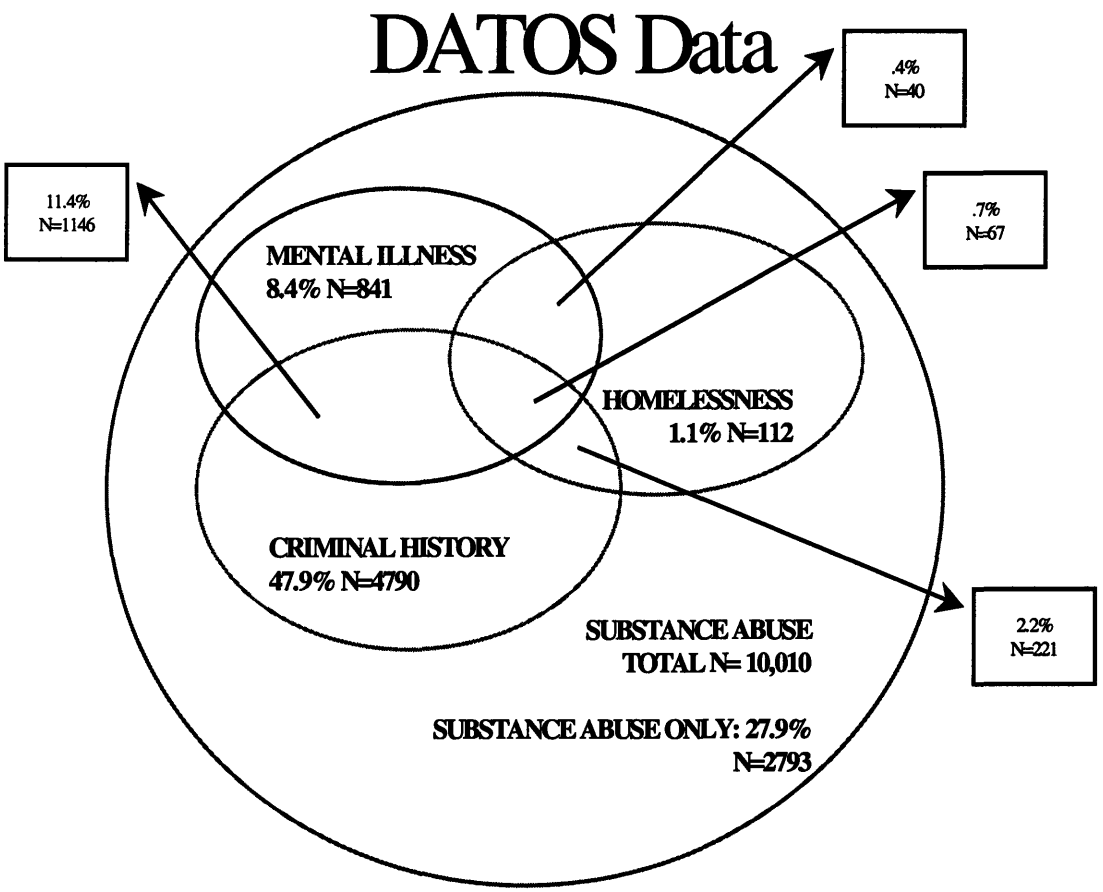
Table 4: Percentage of Cases in the Core Group (Three or Four Categories)

	Percent	Number
Inmates	29.10%	5,337
Probationers	7.30%	296
DATOS	16.90%	1,474
SROS	14.70%	516

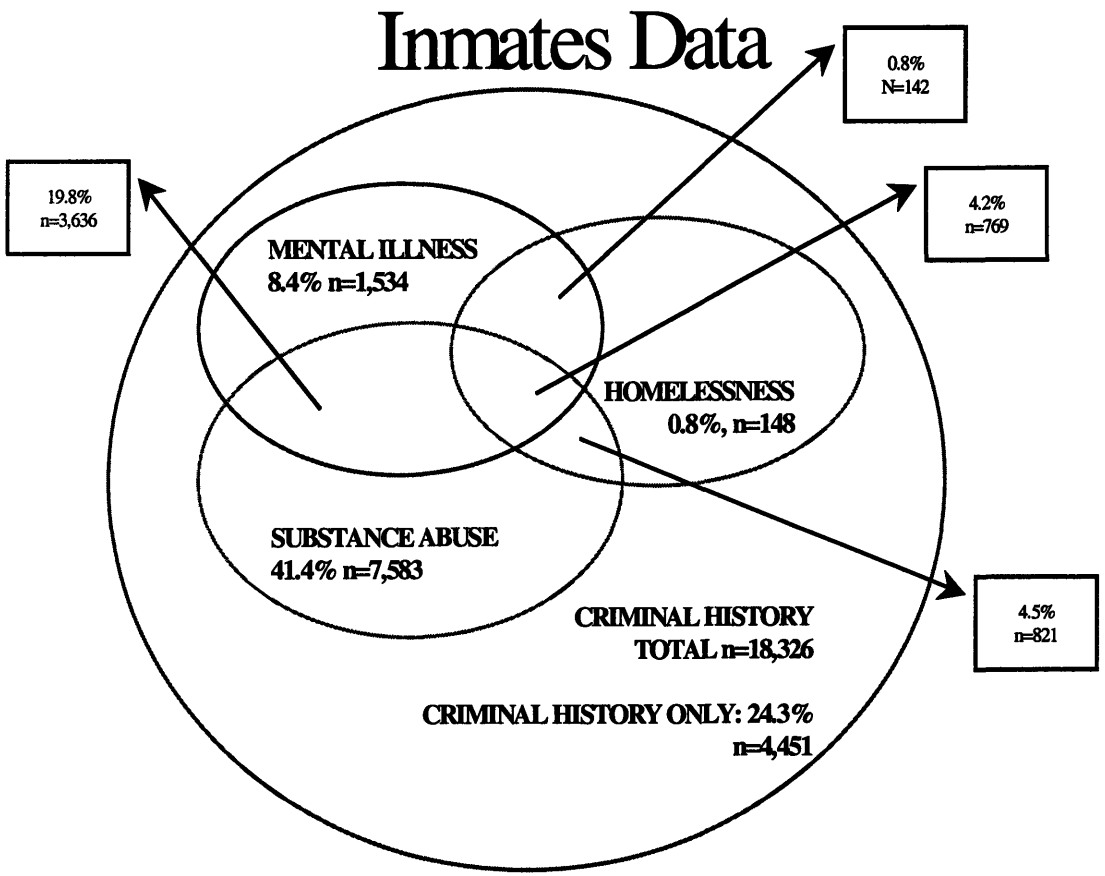
How Do the Categories Overlap?

In order to fully explore how these categories overlap, it is necessary to look at which categories overlap more frequently than others. To do this, Venn Diagrams were constructed for each data set.

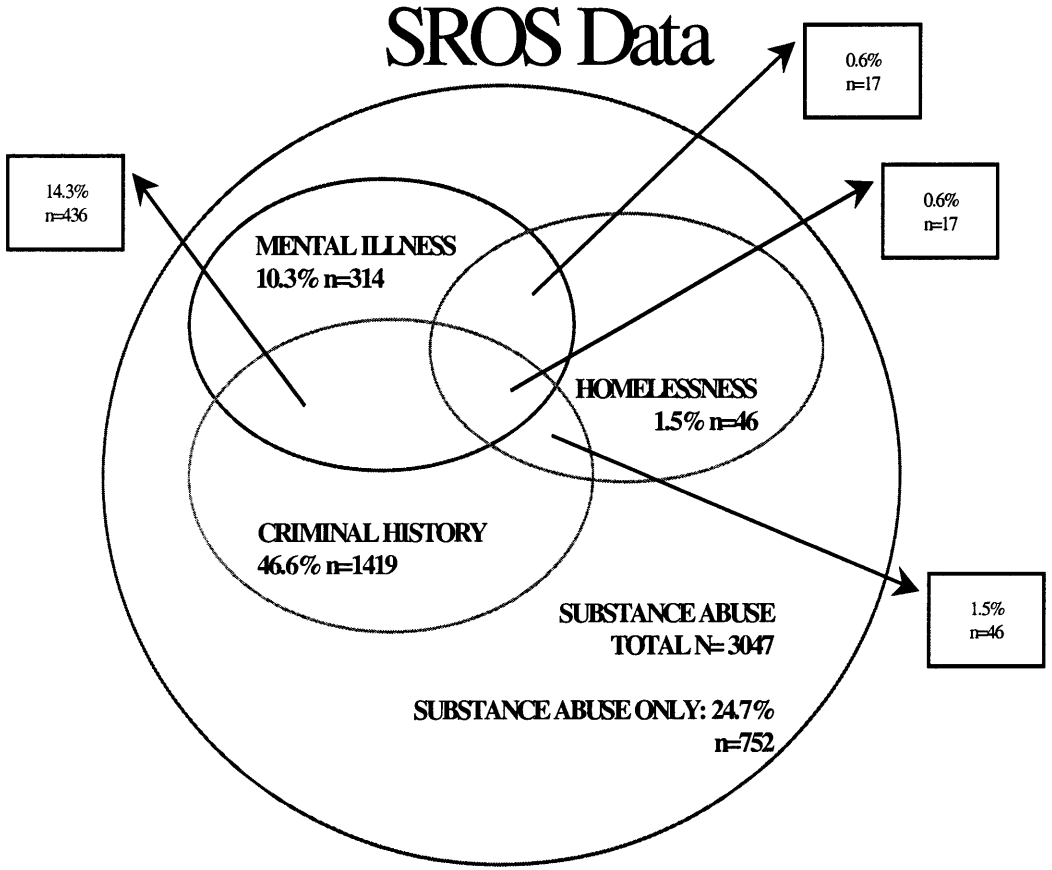
The data used in this thesis indicates that the largest subset in the core group is made up of individuals who are mentally ill, substance abusers, and have a criminal history. However, because data sets from all four categories were not available, and because, as was discussed in the methodology, homelessness is underestimated in the data sets that were used, it is inappropriate to draw conclusions at this time about the distribution of the core group, or which categories overlap more than others.



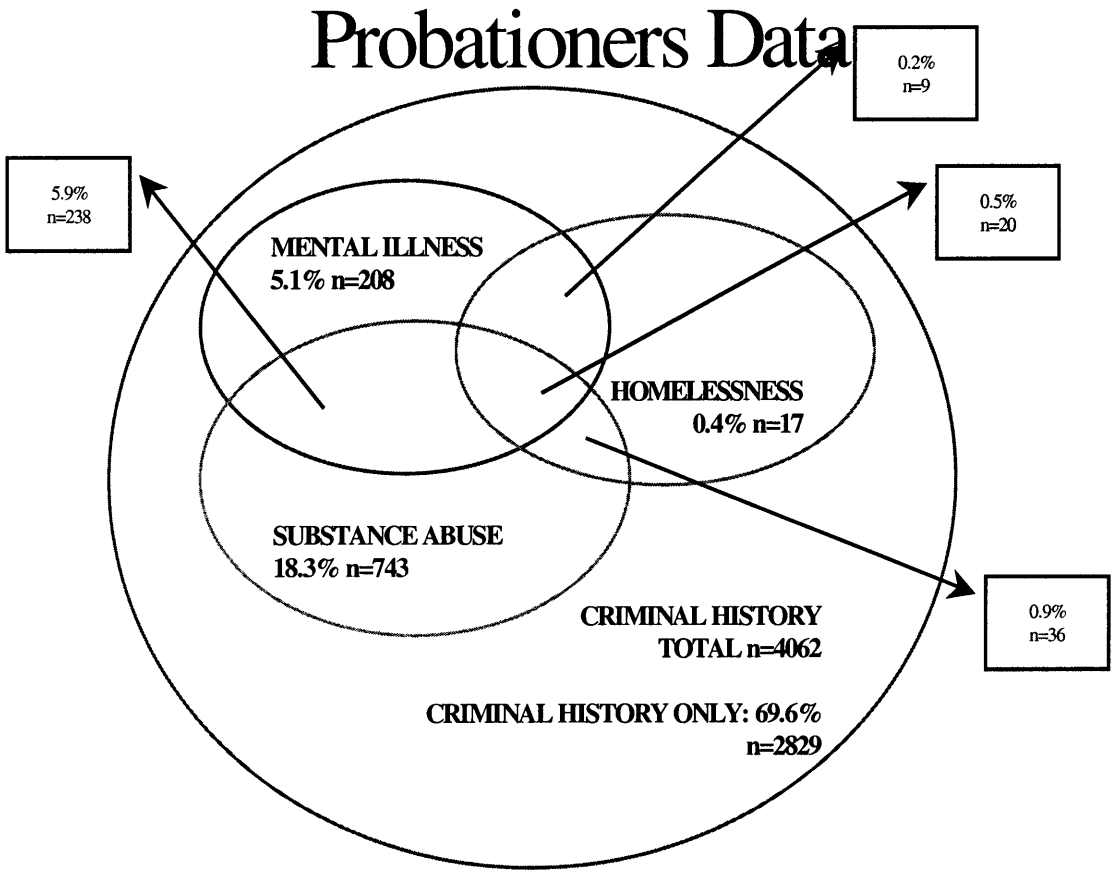
DATOS Data Summary	
Categories	
Criminal Involvement	62.20%
Mentally Ill	20.90%
Homeless	4.40%
Substance Abuse	100.00%
n=	10,100
Core Group	
%	16.90%
n=	1,474
Score (# of Categories)	
1	27.90%
2	57.40%
3	14.10%
4	0.70%
n=	10,100



Inmates Data Summary	
Categories	
Criminal Involvement	100.00%
Mentally Ill	31.70%
Homeless	9.90%
Substance Abuse	69.90%
n=	18,326
Core Group	
%	29.10%
n=	5,337
Score (# of Categories)	
1	21.80%
2	49.00%
3	24.90%
4	4.20%
n=	18,326



SROS Data Summary	
Categories	
Criminal Involvement	62.90%
Mentally Ill	25.70%
Homeless	4.10%
Substance Abuse	100.00%
n=	2,222
Core Group	
%	14.70%
n=	516
Score (# of Categories)	
1	24.70%
2	58.40%
3	16.40%
4	0.60%
n=	3,047



Probation Data Summary	
Categories	
Criminal Involvement	100.00%
Mentally Ill	10.90%
Homeless	1.90%
Substance Abuse	25.30%
n=	4,062
Core Group	
%	7.30%
n=	296
Score (# of Categories)	
1	69.60%
2	23.10%
3	6.80%
4	0.50%
n=	4,062

"Judge Hoover offered his perspective. He described Valerie's initial contact with the criminal justice system and the consequences of having to give up her son, Marcos, to foster care. He also described her encounters with a local hospital, the police department, the county jail, the district attorney's office, the public defenders' office, and the court, each of which created separate files on Valerie's situation. To demonstrate the impersonal nature of the system, Hoover dramatically placed a new file on the podium for every agency Valerie encountered. Pointing to the stack of filed, Hoover argued: 'This is what Valerie looks like to many people in the criminal justice system...This doesn't make any sense. All we do is make up files. Who is this person? And why in the world are we prepared to spend so much money on her every two or three months when something bizarre happens in her life? Maybe we ought to deal with her personally.'"[28]

Before turning to statistics, six biographies are included. This is truly a case where quantitative research, in its quest for objectivity, does an injustice to its subjects. Life in the core group is unimaginable. Lost in the social service system, these men and women have been subjected to every possible neglect and abuse. Our society has responded largely by shuffling them from place to place, in and out of jail.

That is not to say that no money has been spent in an effort to keep them from harming themselves and others; indeed, thousands of public dollars each year are spent keeping these individuals alive. Later in this chapter we turn to the issue of costs of treating the core group.

These stories are real: perhaps they shall make the statistics that follow more compelling, and the recommendations more urgent.

Case 1: Richard H.

Source: DATOS Survey Case #49, Interview Conducted April-June 1992

Richard H.[29] is a 24-year old white male. He has just enrolled in a methadone maintenance program. He is here voluntarily. His family suggested that he seek treatment but he enrolled in this program himself. He currently lives in a homeless shelter. He has never been married.

Both Richard's father and mother had drug problems, which were never treated, and his mother was hospitalized for mental health problems.

[28] Nolan 2001: p. 121

[29] All names are invented; the data sets contained no identifying information to protect confidentiality

Richard was 11 years old the first time he got drunk. At this age he also started getting into trouble at school. At age 12 Richard was drinking at least once a month and was using marijuana regularly.

Richard skipped school regularly as early as age 13. He had difficulty getting along with teachers, but he was never expelled, never repeated a grade, his marks were always above average, and he graduated from high school.

He suffered from severe anxiety at this age, and was eventually was prescribed numerous different sedatives and tranquilizers to aid his anxiety. He was 13 the first time he tried cocaine and hallucinogens.

At 14, Richard tried heroin for the first time. He began to use hallucinogens regularly and taking opiates daily. At age 15, Richard tried cocaine, amphetamines, methamphetamines, and illegal methadone. He began to take cocaine and amphetamines every day. He went to a short-term detox program for the first time. He has tried short-term detox 11 times since.

Richard tried crack once at age 16 but has never used it regularly. At 16 he began using heroin regularly. At this age he had his first inpatient stay in a psychiatric hospital. Since then he has tried numerous treatment programs for his mental illness, including medication, three inpatient stays at private psychiatric hospitals, one at a public psychiatric hospital, and two appointments at a community mental health center. He has never regularly attended outpatient treatment.

At age 17, alcohol became more of a problem for Richard. On several occasions, he had 23 drinks in one day, and by 18 or 19 he had 16 drinks per day until he went to rehab at age 21. He only drinks hard liquor, never beer or wine.

At age 18 Richard's belongings were repossessed because of bad debts. Around this time he had a $4.25/hour factory job for nearly six months. He got along well with his co-workers but not very well with his supervisors. His drug use led to Richard being fired. This is the longest he has ever held a legitimate job.

At age 21, he attempted suicide for the third time. He was also arrested for drug possession at this time and went to a rehab program that included methadone maintenance, which has significantly reduced his drinking and for a time he stopped using marijuana, heroin, and amphetamines. He has not resumed use of marijuana of amphetamines since this treatment episode.

Richard has overdosed 14 times in his lifetime. He injects cocaine, heroin, and amphetamines. He estimates that he has shared needles with a stranger three times, and

has never cleaned old needles when he uses them to inject drugs.

He was arrested twice prior to age 18. As an adult, Richard has been arrested and convicted of larceny, burglary, forgery, possession of stolen goods, and drug possession. He has never been convicted of a violent crime or any other felony crime.

Eight Months ago, Richard was released from prison for purchase/possession of stolen goods. Two months later he entered a detox program for heroin and cocaine. He was suicidal and spent 90 days in a public psychiatric hospital. He was released two months ago and now lives in a homeless shelter. He attends Narcotics Anonymous and Alcoholics Anonymous meetings. Richard has spent 13 weeks of the past year in a restricted setting, either in jail or a restricted psychiatric facility.

In the past 12 months Richard received $3,800 in Supplemental Security Insurance, and $20,000 from illegal activities including larceny and drug dealing. He has major financial problems and knows this is a result of his drug use.

These days, he takes cocaine once a month but injects heroin two to three times daily. He also takes other opiates besides heroin daily and takes tranquilizers four times a day. He recognizes that his drug use increase his chance of injury and health problems, create problems with his family and the police. Richard believes that his cocaine use contributes to his mental health problems but heroin does not.

Medicaid will pay for all of Richard's treatment. He wants to enter treatment to get off drugs and because he cannot financially support his habit any longer. He will walk from the homeless shelter to the clinic to get his methadone every day and thinks he has a good chance of quitting drugs this time, or at least cutting down.

Case 2: Kevin T.

Source: DATOS Survey Case #9,900, Interview Conducted October-December 1992

Kevin T. is a 37-year old white male. He is enrolled in a residential drug treatment program. He was referred to the program by the probation department, who will send him to jail if he fails a drug test or quits the program. He was married once, but legally separated after less than a year. He was living in a homeless shelter when he entered the program but still says he would have preferred outpatient treatment.

As a child, he always got bad grades, and his teachers felt he could have worked harder. Kevin never repeated a

grade, but was suspended many times starting at age twelve, and was finally expelled in ninth grade. Later he received a GED.

When Kevin was growing up, his father had problems with alcohol. His father was never in any type of treatment for alcoholism but was hospitalized for his mental illness. The first time Kevin drank alcohol regularly and the first time he got drunk was at age 12. The most he has ever had to drink is 30 drinks in one day. The first time he drank this much was at age 13, and he was 14 the first time he drank more than five drinks every day for a week. His alcohol problems continued throughout his life, and seven years ago when he was still drinking more than 25 drinks a day, he was prescribed antabuse, a maintenance drug for alcohol withdrawal.

At age 12 Kevin was using marijuana regularly and had tried heroin. At age 13 he was using heroin daily and also experimented with cocaine. By age 14 he was also using cocaine daily. At age 15, he began using hallucinogens and opiates daily and injecting tranquilizers on a regular basis. He also tried illegal methadone at this age. Kevin has never used crack, amphetamines, or PCP, and has only tried inhalants once or twice.

Kevin was arrested four times prior to his 18th birthday, and first sent to juvenile court at 16, where he was sent to rehab for the first time. He has spent just over a year in juvenile jail.

The first time Kevin had treatment for drug abuse was when he was 16 years old. In his life he has been in 25 different drug treatment programs, and has quit many times. He has been in short-term (one-week) detox programs ten times. He has been in 28-day programs ten times for a total for 40 weeks, in methadone maintenance three times for a total of 156 weeks. Once, when he was 20 years old, he was in a residential program for three weeks before he quit in June 1986. Two years ago he attended a few Narcotics Anonymous meetings.

He has injected cocaine, heroin, tranquilizers, and other opiates. He has shared needles regularly (over 99 times in his life), and at least ten times with people he knows to be HIV-positive. He always cleans needles with water when he is sharing, and sometimes he cleans them with bleach.

At age twenty Kevin began experiencing severe anxiety, and became depressed at age 25. He has attempted suicide three times, most recently six months ago. He has had and continues to have hallucinations that he does not believe are related to his drug use. He has spent an estimated 500 nights in overnight mental health treatment in his lifetime, and in the past year he spent 60 days in a public psychiatric hospital, the tenth time he

has stayed overnight at such a facility. He has been through a lot of outpatient treatment, over 1,000 visits in his lifetime. He has been prescribed anti-depressants in the past. He is very troubled by his mental health problems, and believes they are a direct result of his drug use.

Kevin has spent close to five years in jail or prison since he turned 18. He has been arrested between 11-49 times in his life for non-traffic violations. Most of these arrests were for drug possession, but he has also been arrested for driving while intoxicated, forgery and fraud, larceny, and robbery. He has never been arrested for a violent crime or for drug dealing. He has had 100-199 traffic tickets in his life, and his driver's license has been revoked. He turns to a legal aid attorney when he has legal problems.

He has quit many jobs and been fired more than once. Two and a half years ago he had a $400 per week construction job. He got along very poorly with his co-workers and supervisors, and after six months of work he quit.

Kevin stopped taking hallucinogens and smoking marijuana more than 12 years ago, and about one year ago he stopped using illegal methadone and opiates other than heroin. He continues to take heroin, cocaine, and tranquilizers. He used these drugs together more or less daily.

In the past year, he was in jail for receiving stolen goods for 6 months. Kevin also overdosed once this year, the third time he overdosed in his life.

He has had no legitimate jobs in the past 12 months and is not interested in working because of his disability and his drug problems. He received $3,000 in Supplemental Security Income this year, and steals an additional $50,000.

Kevin has no health insurance.

Kevin has been arrested twice in the past year, for drug possession and larceny. He lives alone at a homeless shelter. He attends outpatient weekly mental health treatments. He smokes between 16 and 25 cigarettes per day.

He has been drunk almost every day this year and has on average 24 drinks a day. He does not think treatment for his alcoholism is important and is not bothered by his drinking.

Kevin injects heroin and cocaine every day, sometimes several times a day. He has been using these drugs for over 20 years. Excluding alcohol, his drug habit costs

him $300 per day. He is very bothered by financial problems, and wants counseling for these problems.

Kevin thinks he has a good chance of reducing his drug use or quitting.

Case 3: Jennifer B.

Source: Inmates Survey Case #18,315, Interview Conducted July 31, 1997

Jennifer B. is a 37-year old white female living in a medium security state prison in the western United States. She is five-foot five-inches, and weighs 138 pounds. She was born in Germany, but is now a US citizen.

She grew up living with her mother and three brothers, none of whom have ever been incarcerated. She was 13 years old when she started using drugs and engaging in other illegal activities. She was arrested only once before her 18th birthday for a minor crime.[30] She finished ninth grade and then dropped out of school. Before she turned 18, she had been raped multiple times. The rapist was an adult.

In 1981 when she was 22, she worked in sales. This was the last time she held a legitimate job for more than two consecutive weeks. This is also the year her first child, now 16 years old, was born.

Jennifer's drug and alcohol abuse use has resulted in trouble at school, arrests, physical fights, and car accidents. In her lifetime she has tried all of the following drugs at least once: Heroin, Other Opiates, Methamphetamines, Other Amphetamines, Barbiturates, Tranquilizers, Crack, Cocaine, PCP, LSD, Marijuana, & Inhalants. She has never taken Quaaludes. Crack, powder Cocaine, and Marijuana are her drugs of choice. She has injected cocaine in the past and has shared needles. She is HIV-negative.

She has had treatment for her substance abuse on many occasions and of many different types; both inpatient and outpatient, as well as peer and professional counseling. She has never taken methadone or any other maintenance drug by prescription.

Jennifer has a mental condition for which she has sought help on several occasions in the past and has received medication and counseling. Because of her mental health problem and her low skill level, she has not worked or

[30] This category includes such offenses as a traffic crime, disorderly conduct or public drunkenness

looked for work in some time. Instead she as supported herself through welfare and illegal activities.[31]

She has been physically abused on more than one occasion, sometimes with a knife. This abuse has left her with bruises and swelling and her teeth have been knocked out. The perpetrators were multiple adults known to her, including a boyfriend.

Jennifer has never been married

She has never been armed while committing a crime, and she has never owned a gun.

In 1984, at the age of 25, Jennifer was placed on probation for driving while intoxicated and possession/use of crack cocaine.

In 1987, at age 28, she was sent to jail for drug possession. She served eight months and five days in a state prison and was released to probation in 1988. During her stay in prison she received her GED.

In 1993, while she was on probation Jennifer was re-arrested for larceny, prostitution and a drug offense. She went to jail for five months and released to probation. This was the year her second child was born. Neither of her children has ever lived with her; one lives with other family and one is in state agency custody.

In 1997, Jennifer was intermittently homeless but by June was living in an apartment with a friend on welfare. She was using crack and drinking heavily at this time. She was not working and all of her income (less than $200 per month) was obtained through illegal activities.

On June 27, 1997, while still on probation, Jennifer failed to report to her probation officer and was arrested, charged with the violation of probation and incarcerated for her current sentence. At the time of her arrest she had been drinking for more than 24 hours.

She was assigned a state-appointed attorney who she did not meet until she had spent more than a week in jail. She only spoke to her attorney on one occasion. No plea bargain agreement was reached prior to trial. Her trial was one month after her arrest. She pled guilty, and the month spent in jail was applied towards her sentence.

She is receiving substance abuse counseling and mental health counseling in prison, but does not participate in any other activities. Yesterday she watched television for an hour and a half.

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[31] Because we know she was later arrested for prostitution, she may have been supporting her self in this manner for any number of years.

She lives in an open dorm with 40 other women in a medium security facility. She spent 23 hours in that room yesterday.

The prison is less than 50 miles from her home. She is allowed to receive phone calls and visits in prison, but she hasn't had any in the past month. She has never received a visit, call or letter from either of her children.

She feels 'somewhat safe' in the jail, although in her opinion the streets are safer. At the time of her interview she had served seven months of a five-year sentence. She expects to be released at some point but does not know whether she has a set release date.

Case 4: Sarah G.

Source: Inmates Survey Case Study #67, Interview Conducted August 7, 1997

Sarah G. is a 32-year old white female. She is 5 feet tall, 135 pounds. She lives in a minimum-security federal prison in the northeast.

She grew up with her alcoholic mother, because her father was incarcerated. She has nine siblings. As a child, her mother and a brother physically abused her on more than one occasion. Her family was on welfare when she was growing up, and at age 12 she began shoplifting and doing drugs with her friends.

At age 16 she started drinking. Her alcohol abuse was severe; she has at some point had more than 12 drinks in one day, by the time she was 19 years old she was drinking nearly every day.

At one time or another, Sarah has been a regular user of all of the following substances: opiates other than heroin, amphetamines, barbiturates, cocaine, hallucinogens, marijuana & alcohol. She has tried Quaaludes, tranquilizers, and inhalants but never on a regular basis. She never tried crack or heroin, and she has never used a needle to inject drugs.

In 1984, she was living in 'a place not meant for human habitation' with a friend (not her husband) and had been in a shelter or on the street in that year. She had never been arrested, and had finished 11th grade and then dropped out of school. She was not receiving any type of public benefits, and was making $1,000-$1,199 per month at her full-time job as a dancer.

One evening in March 1984, Sarah, then age 19, was arrested for the murder of her husband. She had been drinking heavily that night but was not under the influence of any other drugs at the time of the offense. During the month prior to her arrest, however, she had been using cocaine, hallucinogens, and marijuana daily.

The murder did not occur in the place where she lived, but she is not specific about where exactly this was. Her husband (the victim) was white, 18-24 years old, and was under the influence of both alcohol and drugs at the time he was murdered. Sarah says he never abused her in any way.

The court assigned her a public defender to whom she has only spoken twice. The first time they spoke was more than a week after her arrest. She spent 18 months in jail before her trial was over, where she pled not guilty and was convicted by a jury. The judge sentenced her to 99 years in prison. The judge applied the 18 months she had already spent behind bars to her sentence.

She is now 32 years old and has been in prison for 11 years. She says her daughter is 9 years old, was not living with her at the time of her offense and never calls or visits.

During her incarceration, Sarah has received her GED, participated in group therapy, drug and alcohol counseling, arts and crafts, like skills, and religious activities. She is enrolled in college classes and vocational training. She has never been given a day pass or work furlough. She has never been written up for breaking prison rules.

In the past month, Sarah has received only one phone call and no visits. The prison she lives in is over 500 miles from where she lived at the time of her offense. She spends 38 hours per week working maintenance around the prison; for this work she is paid 44 cents an hour. In the past week, she spent 18 hours in religious activities. Yesterday she watched television for 2 1/2 hours and spent 2 hours reading.

She says she feels safe in prison; just as safe as she felt where she lived before her incarceration. She is scheduled for released from prison in 2058, when she will be 93 years old.

Case 5: Michael R.

Source: Probation Survey Case #2,852, Interview Conducted June 15, 1995

Michael. R is a 23-year old Mexican-American male from San Antonio, Texas. His is 5 foot 8, and weighs 232 pounds. He has never married and he has never finished high school. He left school after 11th grade. In August 1984, he was arrested for breaking and entering and was first reported to probation. He was 11 years old.

He has been arrested ten times since age the age of 11, for such crimes as petty larceny, juvenile offenses,[32] burglary, public drunkenness, drug trafficking, and possession. He has never been charged with any weapons violation or violent crime of any type. He has never been charged with driving while intoxicated. He has spent time in a juvenile facility 15 times, and has never spent time in an adult jail or prison.

When Michael was not in a juvenile detention facility, he lived with his mother, six sisters, and two brothers. His mother abused alcohol. Several of his siblings have been incarcerated. Michael was physically abused by one of his parents and another family members growing up, but he reports no history of sexual abuse.

When Michael was 17 years old, his first child was born. When he was 19 his second child was born. The children are now four and six and do not live with their father.

Michael started drinking heavily at age 12. His CAGE score is four out of four; he has felt that he should cut down on his drinking, he is annoyed because people criticize his drinking, he sometimes feels guilty about his alcohol consumption, and he has in the past had a drink first thing in the morning to steady his nerves or battle a hangover. He drinks almost daily at this time. By his own admission, Michael's drinking has caused him to lose jobs, get into car accidents, get into arguments as well as physical fights, and has resulted in his arrest. He was drunk when he committed the burglary that led to his probation.

In addition to his alcohol abuse, Michael uses marijuana and cocaine daily and takes LSD approximately once a week. He has tried Methamphetamines, crack, and barbiturates but does not use these drugs on a regular basis. He has never tried Heroin or PCP. Michael has used needles to inject cocaine, but has had an HIV-test and he tested negative.

Since his first arrest at age 11, Michael has been in numerous treatment programs for his drug and alcohol abuse and mental health problems: He has been to outpatient and inpatient treatment; detox and AA meetings; a private physician and a public community mental health center; He has spoken with his clergyman and taken prescription medications; He has stayed overnight at a psychiatric facility.; He has been to a boot camp program. He needs to maintain clean drug tests as a condition of his probation.

Michael spent three months in a vocational training program that he completed successfully. He spent two months taking college classes but then quit. He has

[32] This classification includes alcohol possession by a minor, runaway, truant and juvenile public order offenses.

voluntarily completed an estimated 200 hours of community service.

He has been homeless in the past 12 months, and stayed with friends because he had nowhere else to go. For the past three years he has been working as a laborer and earned between $7,500-$9,999 last year. He has no health insurance. Three months ago he found an apartment to share with a friend and he is now paying $250 a month in rent.

Last year, Michael was arrested, as an adult this time, for public drunkenness, was assigned a public defender and pled guilty. He was released to house arrest while awaiting trial and served no time; his probation was reinstated for five years and with new conditions.

As a condition of his probation, Michael is required to pay court costs, fines, drug testing fees, and a public defender fee. His sentence requires that he pay $60 per month. In the last 12 months he made four payments and missed the remaining eight. He has not been taken to court for nonpayment.

Michael has only met his probation officer once, when he was reprimanded for violating the terms of his probation and discussed his financial problems with his probation officer. The meeting lasted for five minutes. Michael has had no other contact, by phone, by mail, or in person, with the probation department.

Case 6: Ted L.

Source: Probation Survey Case #221, Interview Conducted June 14th, 1995

Ted L. is a white male from Poughkeepsie, New York, born February 17, 1973. He is 22 years old, five foot 11 and weighs 175 pounds. At the time of this interview in June 1995, he is on probation. He is a US citizen, and has never married. He started college but dropped out during his freshman year.

Ted lived with an alcoholic father growing up, and has three brothers and three sisters. No one in the family has ever served time in jail or prison. As a child, he was physically abused by his father on more than one occasion. He has drunk alcohol before, but drinks only very occasionally. He has tried LSD, but does not use it regularly. He has tried crack, and was using it once a month in the period leading up to his arrest. He was smoking marijuana every day in the month before his arrest, and continues to smoke it every day. He has never tried cocaine, heroin, amphetamines, Methamphetamines, PCP, barbiturates or any other illegal drug. Ted has never injected any drug, and he has never had an HIV test.

In July 1994, when he was 21 years old, Ted stopped working as a security guard for unknown reasons. Three months later he was arrested for a weapons offense[33] and destruction of property.[34] He was later also charged with escape from custody.[35] Ted says he was not armed at the time of the escape. This was his first arrest. This was also the summer Ted's only child was born. Ted does not live with his child, and he says he is not required to provide support payments for the child.

Ted was released on bail bond and assigned a public defender. He pled guilty in January 1995, served three months and 26 days, and then sentenced to five years on probation. In order to comply with his probation, Ted is prohibited from possessing a firearm. He is also required to enroll in vocational training, undergo drug testing, attend psychiatric counseling, and pay $2,000 in probation fees. He has not paid any of this money and has not been taken to court for nonpayment. He concedes that he has lost jobs, gotten into arguments and physical fights, and gotten arrested as a result of his drug use, and he tests positive for drugs every time he meets with his probation officer.

These days, Ted is not looking for work because of his medical issues, but receives welfare as well as some financial assistance from family and friends. He earned less than $1,000 in the past 12 months. Ted receives Medicaid. He stayed with friends when he was initially released from prison, but for the past three months he has lived in a homeless shelter.

The first time he reported to probation was in February 1995, and has seen his probation office a total of four times. In his meeting today Ted spoke with his probation officer for two minutes. They discussed making sure he was meeting the conditions of his probation, attending school, and his health issues.

Discussion

One may have predicted a high prevalence of childhood physical abuse and drug problems among this population, but the very early age and ferocity of drug abuse is more startling than aggregated statistics can convey. The early adolescent behaviors of these individuals are no doubt aggravated by the substance abuse and criminal activity of many of their parents. These individuals could hardly be expected to develop into mature, healthy law-abiding adults. While there may be many resilient individuals who experience tumultuous

[33] This charge category includes such offenses as possession of an illegal firearm, brandishing a weapon, or threatening someone with a weapon

[34] This charge category includes such offenses as criminal damage to property, malicious mischief, and vandalism.

[35] This charge category includes escape from custody, escape from jail or prison, attempt to escape, aggravated escape, aiding an escape, and harboring a fugitive.

childhoods and grow into reasonably well-functioning adults, there is almost no one in the core group that did not have multiple difficulties themselves and in their families growing up.

Richard H. Richard H. has had numerous problems, and has been know to authorities and service providers from a very young age. He has been a drug user for almost half of his life. He has attempted suicide numerous times, and takes multiple drugs. He supports himself with illegal activities, and it is likely that he does not have any job skills or any substantial employment history. His is not a case that has slipped through the cracks; he has been in every type of treatment program imaginable.

Richard has used intravenous drugs in the past and is at high risk of contracting HIV unless his substance abuse is brought under control.

He has required an enormous amount of public resources, with no apparent coordination among the various sectors that have tried to help or punish him. It is not clear how much Richard is monitored when he is released from each of these programs, but it doesn't seem like there has been a successful method of making sure he doesn't end up back in the same place.

The positive side of Richard's story is that he is relatively young. He also does not have any children so has not continued the cycle of physical abuse and drug abuse one more generation as of yet.

Kevin T. Kevin T.'s life could be a picture of where Richard will be in 15 years if no solution can be found to address his multiple problems. Kevin is 37 years old. He is required to be in treatment as a condition of his probation. At age 12 he had 30 drinks in one day and developed multiple drug addictions between the ages of 12 and 14. He was arrested numerous times and has been in rehab numerous times. He shares needles regularly, often with people he knows to be HIV-positive, and has been lucky to escape contracting HIV himself. He is not violent, but steals for drug money and to support himself, in the amount of $50,000 in the last year alone.

Kevin has been in the core group, bouncing among social service systems, for over 20 years. As a 12–year-old child of abuse and alcoholism, we may have felt a responsibility towards him, and we may have been able to improve his chances. 25 years later, this sympathy has worn out and Kevin is relegated to an ineffective probation system and a cycle of drug treatment and relapse with no long-term coordinated service plan. After 25 years, haven't we learned not to simply throw him in jail for a few months after he is arrested for drug possession?

Jennifer B. Jennifer is a prostitute with two children, and is the victim of domestic violence and rape. She is sentenced to be in jail for 5 years. If she is not given drug treatment, job training, and psychological counseling for her trauma while in prison, there is little reason to believe her life will be any different post-incarceration. Jennifer's children may not be any better off that she is.

Sarah G. Sarah's parents abused drugs, abused her, and had criminal histories. If we had taken her out of this home at an early age, would she have fared better? Sarah is a true case of falling through the cracks. We didn't even try to help her. At age 19 she was a drug addict living on the street. She claims she did not kill her husband in a drunken haze, but she probably could not come up with a better explanation. She has two daughters she never sees. We gave her no substantial legal representation, and we locked her up and threw away the key. Sarah's life in prison is dominated by religious activity. The role of religion in rehabilitation is beyond the scope of this thesis, but anecdotally religion plays a major role, and many success stories in this population involve religious faith.

Michael R. Also abused by his alcoholic parents, Michael began bouncing from treatment to punishment and back as a juvenile. Not having resolved his problems, his continues this pattern into early adulthood. He has been through lots of treatment programs, but we have not done a good job of harm reduction in such cases. The probation office is keeping track of whether he has paid his court fees (which he is not likely to do) but is not in a position to monitor him closely, make referrals or provide any guidance.

Ted L. While Ted was abused by an alcoholic father growing up, he had no personal history of childhood substance abuse, mental illness or juvenile delinquency. The survey does not address his mental health diagnosis directly, but it seems likely that his sudden decline indicates the onset of a serious mental illness such as bipolar disorder or schizophrenia. Ted went to college but quickly dropped out. Then, all in one summer in his early 20's, Ted lost his job and was arrested for a weapons charge and escaping custody, perhaps during a psychiatric crisis. He uses marijuana daily and has experimented with other drugs but has not developed problems with them.

Ted was first sent to jail and then to probation. He is required to undergo drug treatment and psychiatric counseling as a condition of his treatment, but his visits with his probation officer are rare and his positive drug tests are dutifully recorded, but result in no consequences or counseling.

Ted's homelessness reflects a commonly cited situation; upon release from prison, Ted had a plan and a place to

stay. But he soon became too much for his hosts and moved to a shelter three months later. Re-entry plans and housing counseling that stop at the prison gate will commonly release people to housing situations that are unstable.[36]

Ted is the classic case of criminalizing mental illness instead of treating it. If he is in fact bipolar or schizophrenic, we will not be able to cure him. But with the appropriate treatment we can stop Ted from costing us a lot more money, doing more drugs, and becoming more violent and increasingly mentally ill.

[36] CRJ 2001b: p. 6

Costs of Treating and Warehousing the Core Group

The cost of social services is treated elsewhere in more depth; this section will simply summarize the costs of treatment and incarceration for this population and roughly estimate an annual cost of treating an individual in the core group.

The following is a sample of cost estimates for the public systems whose resources go to treating and warehousing the core group:

Substance Abuse:[37]

Detox:	$194/day
Residential:	$66/day
Intensive Outpatient:	$33/day
Standard Outpatient:	$15/day

Prison Costs:

Federal Prison:	$21,926 per year[38]
	$60/day
State Prison:	$28,195/year[39]
	$77/day

[37] CSAT 2001

[38] Federal Register August 11, 1999 (Vol 64, No. 154) Annual Determination of Average Cost of Incarceration

[39] CSAT 2001

CSH Ny/Ny Cost Study:[40]

Dept. of Homeless Services:	$86/day
Office of Mental Health:	$437/day
Health & Hospitals Corporation:	$755/day
Medicaid-Inpatient:	$657/day
Medicaid- Outpatient Visit:	$84/day
Veteran's Administration:	$467/day
Dept. of Correctional Services:	$79/day
Dept. of Corrections:	$129/day

Foster Care:[41]

Age 0-5:

$14.92/day + $107 Quarterly Clothing Allowance

$5,874/year

Age 6-12:

$15.97/day + $181 Quarterly Clothing Allowance

$6,553/year

Age 13+:

$17.16/day + $282 Quarterly Clothing Allowance

$7,391/year

By themselves, these impartial numbers do not tell us much. Let us see how these costs translate into the lives of one of our case studies, Richard H.:

[40] CSH 2001

[41] State of Massachusetts data; for more information about the Foster Case System, See C. Simmons DUSP MCP Thesis 2003

In one year, Richard received payments from SSI, overdosed once (we will assume he was taken to the emergency room), went to detox once (we will assume one week-detox, which is standard), spent 90 days in a psychiatric hospital, and 60 days in a homeless shelter, and 120 days in prison.

According to the above cost estimates, here is a cost breakdown of one year in Richard's life:

SSI (1 year):	$ 3,800
Emergency Room (1 night):	$ 755
Detox (7 days):	$ 1,358
State Prison (120 days):	$ 9,240
Homeless Shelter (60 days) :	$ 5,160
Psychiatric Hospital (90 days):	$39,330
RICHARD H. total public spending/year:	**$59,643**
RICHARD H. total public spending/day:	**$163**

This does not account for the amount Medicaid is spending on his methadone treatment right now, or the $20,000 he stole to support his addiction. Unlike many individuals in the core group, Richard does not have children so there is no state expenditure for taking care of them while he is unable to do so.

Lack of funding is always a problem in social services, but in the case of this core group, there is no shortage of money spent. The challenge instead is to spend money in a more targeted and efficient manner. In fact, the core group's service utilization rates are so much higher that they may be causing long waiting periods for others. In Massachusetts, more than 25% of detox clients are also homeless and 40% of individuals who have been to detox four or more times in one year are homeless.[42] If we could stabilize these individuals for longer periods of time, the waiting period for detox services would be much shorter and the resources better-utilized.

[42] Interview with Theresa Anderson, Director of Research and Statistics, BSAS February 28, 2003

CHAPTER 5: WHO IS THE CORE GROUP?
DEMOGRAPHIC AND BIOGRAPHIC CHARACTERISTICS

Introduction

Now we have seen that these four categories overlap considerably and many individuals fall into three or four categories. We have met some of the individuals in the core group and heard their stories. We can now proceed to answer the following questions: What are the characteristics of the core group? How is this group different from clients who are in 'only one or two categories? How does this differ from expectations or assumptions one may have about the homeless, substance abusers, prison inmates, or mentally ill persons? The core group is analyzed with respect to demographic and biographical characteristics; their drug habits, treatment history and criminal background are examined in detail. Now that the core group has a human face, we can analyze its characteristics more rigorously, in the hope that we can uncover some specific points of intervention.

Age

- **Individuals in the Core Group are not older than their non-Core Group counterparts.**

The average age in the Core Group across the four data sets ranges from 30-36, while the average age for those not in the core group is between 32-38. Probationers and DATOS clients in the core group are slightly older than their non-core group counterparts. Inmates and SROS clients are slightly younger than their non-core group counterparts.

This finding is slightly surprising. Intuitively, the older you are, the more time in your life you have had to experiment with drugs, lose your housing, commit crimes and get caught, and see your mental condition worsen. Thus you might expect that older clients would be more likely to fall into 3 or 4 of these categories.

Table 5: Average Age of Core Group Members

	Not Core Group	Core Group	Total
Inmates %	37.71	36.96	37.53
n=	70	23	93
Probationers %	32.35	33.04	32.31
n=	3,729	296	4,025
DATOS %	32.29	33.28	32.52
n=	8,533	1,474	10,007
SROS %	32.03	30.53	31.77
n=	2,451	512	2,963

Marital Status

- **Individuals in the Core Group are less likely to be married and more likely to be divorced.**

That members of the Core Group are less likely to be married and more likely to be divorced is intuitive. Core group members are also more likely to have never married. The percentage of core group members who have married is higher than may have been anticipated.

Table 6: Marital Status of Core Group Members

	Not Core Group	Core Group	Total
Married			
Inmates	21.00%	15.90%	19.50%
Probationers	30.00%	16.00%	28.10%
DATOS	20.30%	15.20%	19.50%
SROS	24.10%	19.80%	23.40%
Divorced/Separated			
Inmates	24.50%	29.60%	26.00%
Probationers	22.70%	33.70%	24.20%
DATOS	20.40%	26.00%	21.30%
SROS	28.20%	29.90%	28.50%
Never Married			
Inmates	52.10%	52.00%	52.10%
Probationers	46.10%	49.00%	46.50%
DATOS	45.30%	45.90%	45.40%
SROS	24.60%	27.30%	25.10%
n=			
Inmates	12,961	5,333	18,294
Probationers	1,864	294	2,158
DATOS	8,514	1,469	9,983
SROS	2,417	499	2,916

Race and Ethnicity

- **Individuals in the Core Group are more likely to be White, and less likely to be African-American or Latino.**

According to the 2000 Census, the United States population is 75.1% White, 12.3% Black, 3.6% Asian, and 12.5% Hispanic/Latino.

In these four data sets, the Asian population is significantly under-represented, and was never more than 2% of the cases in any data set, regardless of their core group status. Table 7 shows a breakdown of race and ethnicity in the core group.

Table 7: Race and Ethnicity of Core Group Members

	Not Core Group	Core Group	Total
White/Caucasian			
US Census 2000			75.1%
Inmates	46.40%	52.70%	48.20%
n=	5,999	2,807	8,806
Probationers	65.30%	77.70%	66.30%
n=	2,305	230	2,535
DATOS	45.40%	51.80%	46.30%
N=	3,819	751	4,570
SROS	66.30%	76.40%	68.10%
N=	1,557	381	1,938
Black/African-American			
US Census 2000			12.3%
Inmates	48.00%	40.80%	45.90%
N=	6,209	2,171	8,380
Probationers	28.80%	18.90%	28.00%
N=	1,016	56	1,072
DATOS	49.40%	43.30%	48.50%
N=	4,156	628	4,784
SROS	31.10%	19.40%	29.00%
N=	730	97	847
Hispanic/Latino			
US Census 2000			12.5%
Inmates	19.70%	13.80%	18.00%
N=	2,561	736	3,297
Probationers	16.90%	8.60%	15.80%
N=	326	25	351
DATOS	12.80%	10.70%	12.50%
N=	1,089	157	1,246
SROS	16.70%	7.90%	15.20%
N=	236	22	258

The Latino population is somewhat over-represented in the non-core group, while the Latino population is slightly under-represented in the core group.

The African-American population is vastly over-represented in all datasets. African-Americans make up just over 12% of the US population as a whole, but make up 30-50% of the criminal justice and substance abuse data sets. In the core group, this discrepancy is much smaller.

This finding can be framed in two ways. It could be argued that while minorities are over-represented when it comes to substance abuse and incarceration, the misfortune of one individual falling into many of these categories does not discriminate, and the core group is more representative of the racial and ethnic makeup of the nation as a whole. Interpreted in this way, the discrimination that is so pervasive in the social service and criminal justice system is no longer as strong when dealing with individuals with so many co-occurring problems. While the criminal justice system and the rest of our society is plagued with racism, the core group is equal-opportunity.

Alternatively, this data could mean that the nation does not treat substance abuse or crime among the white population seriously until the individual has a lengthy history of numerous social problems. Interpreted in this way, the racial and ethnic makeup of the core group reflects persisting discrimination.

Special Populations: Gender, HIV Status, and Veterans

➢ The data is inconclusive with regard to Gender, HIV Status and Veteran Status

The data sets vary as to the gender, veteran status and HIV status of the core group. This may indicate that there is no difference between the core group and those not in the core group with respect to these issues. It is also possible that these groups are treated in programs not represented in these data sets.

Individuals who are HIV-positive (See Table 9) or veterans of the US U.S. Armed Forces (See Table 10) may also find it easier to get access to appropriate treatment in programs that are specifically designed and funded for these subgroups.

Table 9: Percentage of the Core Group that Served in the Armed Forces

	Not Core Group	Core Group	Total
Inmates	11.40%	11.90%	11.50%
N=	1,475	635	2,110
Probationers	14.30%	17.20%	14.80%
N=	249	51	300
DATOS	12.70%	14.70%	13.00%
N=	1,082	216	1,298

Table 10: HIV in the Core Group

	Not Core Group	Core Group	Total
Inmates	1.50%	3.90%	2.20%
n=	121	139	260
Probationers	0.90%	0.90%	0.90%
n=	8	2	10
SROS	23.70%	6.90%	20.40%
n=	57	4	61

Women may be treated in a separate service system for domestic violence survivors, or for families with children. Women are under-represented regardless of their core group status. (See Table 11) However, with the rate of incarceration among women rising, this disparity may be diminishing.

Table 11: Women in the Core Group

	Not Core Group	Core Group	Total
Inmates	17.90%	27.60%	20.70%
n=	2,324	1,472	3,796
Probationers	21.10%	26.00%	21.40%
n=	791	77	868
DATOS	34.00%	34.40%	34.00%
n=	2,901	507	3,408
SROS	28.30%	23.30%	27.40%
N=	713	120	833

Education

The level of education is not substantially different between the core and non-core group members. (See Table 12) The core group is slightly less likely to have finished high school, but is more likely to have a GED. Longer periods of incarceration may contribute to a higher proportion of GED's among the core group. Perhaps because it is a measurable and attainable goal, the prison system seems to be extremely focused on offering GED classes while other types of services and therapy are not as common in prisons and jails.

Table 12: Education

		Not Core	Core	Total
DATOS				
GED or High School Graduate	%	64.30%	60.47%	63.74%
	N=	5,373	866	6,239
Inmates				
Do You Have A GED?	%	41.18%	43.52%	41.91%
	N=	3,262	1,564	4,826
SROS				
GED or High School Graduate	%	26.30%	21.78%	25.48%
	N=	1,313	248	1,561
Probation				
GED or Equivalency Certificate	%	24.40%	31.60%	25.50%
	N=	754	136	890

Work & Public Benefits

Employment

- **A Significant Portion of the Core Group is Employed**

In all data sets a large proportion of the core group is employed, or was employed immediately prior to their incarceration. 57.27% of inmates, 27.62% of SROS clients, and 64.60% of Probationers in the core group are employed. (See Table 13) The probationers have the highest rate of employment among core group members. This could be because the core group is unlikely to be released to probation unless they can show that they are stable and employed, or that employment may be a condition of their probation. SROS clients are the least likely to be employed.

Table 13: Employment

	Not Core	Core	Total
Inmates			
Received Income From A Job %	64.70%	54.27%	61.64%
n=	8,295	2,892	11,187
SROS			
Employed (Full or Part Time) %	39.54%	27.62%	37.53%
n=	908	129	1,037
Probation			
Are You Currently Employed? %	76.80%	64.60%	74.90%
n=	845	158	1,003

- **Core Group members are less likely to be employed than the non-core group.**

In Inmates, SROS, and Probation Data, the Core Group is considerably less likely to be employed than the non-core group. Among Inmates, 54.27% of the core group is employed compared to 64.70% of the non-core group. Among SROS clients, 27.52% of core group clients are employed compared to 39.54% of non-core group members. Probationers show the highest employment rates: 64.60% of core group members and 76.80% of non-core group members are employed. (See Table 13)

Income & Sources of Income

- **Core group members are poorer than non-core group members.**

The Core Group has less income, but their income is drawn from multiple sources, especially public programs. The core group is far more likely to earn less than $10,000 per year than their non-core group counterparts, and less likely to earn more than $20,000 per year. (See Tables 14 and 15)

Table 14: Last 12 Months Personal Income (Probation)

	Not Core	Core	Total
>$9,999	47.00%	63.80%	49.50%
$10,000-$19,999	30.90%	22.00%	29.50%
$20,000+	22.30%	14.20%	21.00%
n=	1,658	282	1,940

Table 15: Last 12 Months Personal Income (Inmates)

	Not Core	Core	Total
>$9,588	39.93%	50.50%	43.06%
$9,589-$23,988	35.75%	29.96%	34.04%
$23,989+	24.32%	19.55%	22.91%
N=	11,032	4,640	15,672

- **The core group is far more likely to receive income from public sources.**

Both inmates and probationers who are Core group members are more likely to receive all types of public benefits, including welfare, educational assistance, social security, and SSI. The discrepancies between core and non-core group members are far greater among probationers than among inmates; core group probationers are 4.6 times as likely to receive welfare, while core group inmates are only 1.4 times as likely to receive welfare. Probationers are 4.6 times as likely to receive educational assistance while inmates are only very slightly more likely to receive it. (See Table 16)

It may be that the probation department is effective in connecting disabled and disadvantaged clients such as those in the core group with public benefits. After all, the Inmates data is for the 12-month period to incarceration, and respondents may not have had any criminal justice oversight during that time. So this discrepancy may reflect the criminal justice system's inadvertent role in bringing people 'into the system' and connecting them with benefits and services, albeit only after they have broken the law and become so-called burdens to society.

Alternately, individuals may be more likely to be released to probation if they are able to support themselves, but core group members with a disability are allowed to

circumvent this preference. Finally, eligibility requirements may include mandates, preferences or loosened requirements for individuals who are disabled or homeless.[43] For example, in many states Medicaid eligibility takes disability status into account, and SSI is specifically targeted to those who cannot work because they are disabled.

Most importantly, we can see once again that the core group is not 'falling through the cracks', and is known to multiple public agencies. Welfare departments, the Social Security Administration, and Probation Offices all have files on these individuals, and all keep track of their whereabouts, their income, and other information. Each of these departments screens these individuals, keeps records, and maintains at least nominal contact in one way or another.

- **The core group is more likely to have financial support from their family and friends.**

There is a common assumption that the core group is made up of individuals who have lost contact with their families and have no social support network. Despite this, core group inmates much more likely to receive assistance from family or friends, and core group probationers are almost 3 times as likely to receive assistance from their family. (See Table 16)

Table 16: Income Sources Past 12 Months[44]

		Not Core	Core	Total
Inmates				
Public Assistance or Welfare	%	26.57%	38.77%	30.00%
	n=	2,782	1,589	4,371
Educational Assistance	%	1.10%	1.27%	1.15%
	n=	141	68	209
Family or Friends	%	16.68%	22.61%	18.42%
	n=	2,140	1,206	3,346
Social Security	%	5.00%	7.27%	5.63%
	n=	601	340	941
SSI	%	1.91%	4.08%	2.52%
	n=	230	191	421
Illegal Sources	%	24.45%	30.14%	26.12%
	n=	3,115	1,600	4,715
Probation				
Welfare	%	6.61%	30.74%	8.37%
	n=	37	8	45
Educational Assistance	%	1.17%	5.41%	1.48%
	n=	44	16	60
Family	%	7.73%	20.95%	8.69%
	n=	291	62	353

[43] This may be counteracted by the fact that some public benefits make turn away individuals with criminal histories, especially those with drug charges.

[44] These categories are not mutually exclusive. Many respondents are counted in several of these income source categories

Health Insurance

- **Individuals in the core group are slightly more likely to have health insurance if they are in substance abuse treatment, and much less likely to have health insurance if they are on probation.**

The DATOS data shows that the core group is slightly more likely to have health insurance, and more than half of DATOS clients in both the core group and non-core group have health insurance. (See Table 17) This makes sense because many of the substance abuse treatment programs included in the DATOS study may have required health insurance or have limited slots available for non-funded clients. Furthermore, substance abuse programs may have resources to enroll their clients in public health insurance programs as part of their services.

Core group members on probation are almost twice as likely to have no health insurance as non-core group probationers. (See Table 17) This is yet another revealing statistic about the failings of the probation system, and one that shows the value of analyzing this problem as one of a population who is being treated in many different sectors. There is no reason why they should be provided health insurance if dealt with in one system (i.e., substance abuse) and not have health insurance if they so happen to be on probation. The probation department knows if a client is required to undergo treatment or counseling as a condition for their probation, and if they are disabled and therefore unable to work. In short, the probation officer will be aware that the client is in need of healthcare, and yet this group is far less likely to have health insurance on probation.

Table 17: Health Insurance

DATOS	Not Core	Core	Total
Not Insured	49.00%	46.80%	48.70%
N=	4,135	683	9,891
Probation			
Employer or Private	17.29%	27.37%	18.96%
N=	689	81	770
Military	0.93%	3.04%	1.08%
N=	35	9	44
Medicare	1.22%	6.76%	1.62%
N=	46	20	66
Medicaid	4.51%	27.36%	6.18%
N=	170	81	251
Other	1.09%	1.69%	1.13%
N=	41	5	46
Not Insured	20.37%	39.86%	22.53%
N=	797	118	915
All Public Sources	6.66%	37.16%	8.88%
N=	251	110	361

Parents and Children in the Core Group

A parent history of incarceration, mental illness, or substance abuse can lead to reproduction of these factors in future generations.[45] Each of these factors tends to reproduce itself among children, and have a greater prevalence among the core group than the non-core group.

Parent History of Incarceration

Criminally involved members of the core group are more than 1.5 times as likely to have parents who had been incarcerated as those in the non-core group. (See Table 18 and 19) However, the proportion of core group members whose parents had also been incarcerated is only 21.5%-23.1%. There is a stronger association with the incarceration of siblings, girlfriends and boyfriend. (See Table 19) It could be argued from this finding that criminal activity has a stronger association with the lifestyle of one's peers than that of one's parents. However, the data may also reflect the sharp increase of the incarceration rate in the past 20-25 years. The next generation of inmates and probationers are likely to have much higher rate of parental incarceration.

Table 18: Parent History of Incarceration (Probation)

Any Parents Ever Serve Jail Time?			
	Not Core	**Core**	**Total**
	11.56%	21.50%	13.00%
n=	1721	293	2014

Table 19: Family History of Incarceration (Inmates)

Family Served Time in Jail or Prison			
	Not Core Group	**Core Group**	**Total**
Parents/Stepparents	14.45%	23.10%	16.98%
n=	1,837	1,217	3,054
Other Family	36.45%	45.52%	39.12%
n=	4,637	2,405	7,042
Girlfriend	13.53%	23.65%	16.19%
n=	295	184	479
Boyfriend	52.33%	61.51%	56.38%
n=	202	187	389

[45] None of the data sets contained questions about the experience of homelessness during childhood or among the family members of the respondents.

Parent History of Substance Abuse

Parental substance abuse is a more common factor than a parent history of incarceration, but the distinction between the core group and the non-core group is weaker. Still, among probationers, 35.87% of the non-core group and 54.72% of the core group have parents with substance abuse problems. (see Table 20) Among DATOS clients, 64.89% of the non-core group and 69.97% of the core group have parents with substance abuse problems. (See Table 21) The core group's parents are more likely to have abused illegal drugs or drugs as well as alcohol, but less likely to have abused alcohol only. Substance abusing parents of core group members are also slightly more likely never to have received treatment for their substance abuse. (See Table 21)

Table 20: Parent History of Substance Abuse (Probation)

	Not Core	Core	Total
Yes	35.87%	54.72%	74.90%
No	9.90%	45.27%	12.48%
Missing	54.22%	0.00%	12.62%
n=	3766	296	4062
If Yes, Was it Alcohol, Drugs, Or Both?			
Alcohol	84.87%	76.38%	82.64%
Drugs	1.96%	2.36%	2.07%
Both	13.17%	21.25%	15.29%
n=	357	127	484

Table 21: Family History of Substance Abuse (DATOS)

DATOS Family with Drug Problem			
	Not Core	**Core**	**Total**
Any Relative	64.89%	69.97%	65.64%
N=	5,324	988	6,312
Mother	15.84%	21.37%	16.65%
N=	1,352	315	1,667
Received Treatment?	24.14%	20.73%	23.50%
N=	310	62	372
Type of Problem			
Alcohol	63.1%	56.7%	61.90%
Drug	13.6%	14.0%	13.70%
Both	23.25%	29.29%	24.40%
N=	1,350	314	1,664
Father	28.13%	34.67%	29.09%
N=	2,401	511	2,912
Received Treatment?	23.24%	22.54%	23.20%
N=	524	108	632
Type of Problem			
Alcohol	77.2%	75.5%	76.86%
Drug	6.5%	5.7%	6.33%
Both	16.37%	18.82%	16.80%
N=	2,412	510	2,922

Parent History of Mental Illness

Parental History of Mental Illness is less prevalent among the core group than a history of drug use, but more prevalent than a history of incarceration. The core group is also significantly more likely to have relatives with mental illness than non-core group members. (See Table 22)

The siblings and fathers of core group members are more likely to have been hospitalized, while the mothers are slightly less likely to have been hospitalized. This could be a result of the minimal mental health treatment of women in past decades, or the fact that mothers who needed to stay home and raise the family were not available for treatment. It is important to remember here that hospitalization could be an indicator of a more severe mental illness that could bode badly for the children, or it could indicate a stronger ability and willingness on the part of the family to seek treatment and a reduced exposure on the children to severe mental illness.

Table 22: Family History of Mental illness (DATOS)

	Not Core	Core	Total
Any Relative	24.4%	40.2%	26.69%
n=	2,029	578	2,607
Mother	9.4%	16.8%	10.51%
n=	804	248	1,052
If Yes, Hospitalized?	55.8%	54.8%	55.57%
n=	438	131	569
Father	4.2%	7.2%	4.62%
n=	356	105	462
If Yes, Hospitalized?	43.2%	51.5%	45.12%
n=	146	53	199
Brother/Sister	9.7%	17.2%	10.84%
n=	832	253	1,085
If Yes, Hospitalized?	62.3%	70.7%	64.27%
n=	506	174	680

Parent History and Impact on the Core Group

Parental incarceration has the smallest presence in the core group, mental illness slightly more, and substance abuse the highest. While mental illness has a hereditary component, it does not follow that children of mental illness develop multiple social problems. While parental criminal involvement contributes significantly to criminal activity in children, it does not make the children more likely to be members of the core group. That is to say, parental incarceration leads to high rates of incarceration among the children, but it does not much increase the child's chances of ending up in three or more of these categories.

Parental substance abuse, however, seems to be an indicator of core group membership among children. This information should be used to devise effective social service policies for at-risk children. It may be, however, that substance abuse itself does not lead to core group membership among children. Rather, substance abuse is linked with incarceration because behaviors correlated with drug use such as theft and vagrancy are illegal, and drugs themselves are illegal. Substance abuse could be self-medication for mental illness. Therefore it is these linkages that lead to multiple social problems among children of substance abusers.

The Core Group as Parents

- **Individuals in the Core Group are only slightly less likely to have children than those not in the Core Group.**

In all data sets, a large percentage of cases have children. The core group is only slightly less likely to have children than individuals not in the core group. (See Table 23) This finding, combined with the fact that many in the core group had a family history of substance abuse, mental illness, incarceration, and physical or sexual abuse, indicates a generational cycle that has an enormous impact, on today's social service systems and on future generations. Many of these children do not live with their core group parents and are taken care of either by family members or by the state.

Table 23: Percentage of Core Group with Children

	Not Core Group	Core Group	Total
Inmates	71.00%	67.50%	70.00%
n=	9,113	3,596	12,709
Probationers	52.10%	55.30%	52.60%
n=	638	131	769
SROS	67.50%	61.70%	66.50%
n=	1,325	261	1,587

Childhood Experiences

Physical & Sexual Abuse

Individuals in the core group are approximately 3.5 times as likely to have been physically or sexually abused as children, usually both. (See Table 24) They are significantly more likely to have been the victims of every type of violence as children or as adults. (See Table 25) Childhood abuse is among the largest discrepancies between individuals who fall into the core group and those who do not.

Learning more about increasing and fostering resiliency among survivors of abuse could be a key aspect of preventing people from falling into the core group. Youth services must focus not only on removing the child from the dangerous situation, but also providing the therapy and supports that will increase the chances that the child will recover successfully. Youth services are structured differently in each state, but in general terms, they do not focus on preventing the long-term consequences of abuse. Instead, they are focused on the more immediate problem of alternative placement in a case where the parents are abusive. Typically, abuse in itself is not enough to ensure that a youth receives psychological counseling; only after the child begins to exhibit negative behaviors does the social service system attempt to provide them with counseling. If these behaviors get worse and the child is repeatedly breaking the law or behaving violently, the system begins to behave more like the adult criminal justice system (in many cases the child is literally transferred to its custody) and focuses more on punishment and public safety than rehabilitation and social supports. A pre-emptive focus on providing support for all victims of childhood physical and sexual abuse could be a major first step in reducing the number of people who end up in the core group.

There is a large body of research on the lasting effects of childhood abuse. Abuse is clearly a risk factor for later substance abuse, criminal activity, and homelessness, and the relationships here intuitive, numerous, and well-documented. The key finding in this thesis is that childhood abuse has a massive effect on the number of problems you are likely to have as an adult.

Table 24: Physical and Sexual Abuse (Probation)

	Not Core	Core	Total
Ever Been Physically or Sexually Abused?			
%	11.57%	40.20%	15.75%
N=	1729	296	2025
(If Yes) Which was it?			
Physically Only	48.60%	35.40%	43.71%
Sexually Only	20.63%	18.58%	19.86%
Both	30.69%	45.13%	36.09%
N=	189	113	302

Table 25: Victimization in the Core Group (Inmates)

	Not Core Group	Core Group	Total
Ever Been Shot At with a Gun	39.93%	52.01%	43.48%
n=	5,112	2,770	7,882
Anyone Ever Use a Knife Against You?	36.72%	56.31%	42.48%
n=	4,702	3,002	7,706
Anyone Ever Hit You with a Fist?	46.67%	61.88%	50.32%
n=	5,242	2,195	7,437
Anyone Ever Beat You Up?	31.70%	48.31%	35.69%
n=	3,560	1,713	5,273
Choked You?	15.59%	29.17%	18.85%
n=	1,751	1,034	2,785
Used a Weapon Against You?	40.32%	54.26%	43.67%
n=	4,530	1,925	6,455
Ever Physically Injured?	70.60%	80.94%	74.20%
n=	5,917	3,627	9,544
Sexual Contact Against Your Will?	6.55%	22.97%	11.37%
n=	837	1,217	2,054

Foster Care, Welfare, & Public Housing

Core group members are almost twice as likely to have been in foster care or juvenile institutions of some kind as children. (See Table 26 and 27) They are more likely to have been in both a foster home and an institution. We can interpret this to mean that the core group had more chaotic and unstable lives as children. Or, we can go one step further and argue that in the simplest terms, foster care is designed to make up for the failings of the parents, while juvenile institutional settings are designed to treat the problems of children themselves. So the core group is made up of troubled children who had troubled parents that were unable to care for them. Growing up in foster care can also leave grown children without a support system to lean on if they face trouble after their 18th birthday. This can be the factor that causes individuals to go from one category to three or four.[46] This is also a confounding factor with child abuse; so it is not foster care that puts you in the core group, but rather the circumstances that led to your foster care placement that is a risk factor.[47]

The core group is also more likely to have grown up on welfare or in public housing. (See Table 27) This is not a function of welfare or public housing in itself, but simply a proxy for poverty and the inability of poor families to get the assistance they need to prevent their troubled children from becoming extremely troubled adults. This is also an indication, yet again, of the extremely high level of government involvement throughout the lives of core group members. Some branch of government has recorded every detail of these people's lives, and funded numerous ineffective attempts at recovery.

Table 26: Ever Lived in a Foster Home? (Probation)

	Not Core	Core	Total
Yes	43.31%	82.43%	46.18%
No	2.55%	16.89%	3.59%
Missing	54.14%	0.68%	50.22%
n=	3,766	296	4,062

[46] For more comprehensive treatment of the process of aging out of foster care, see the MIT DUSP MCP Thesis 2003 by Catherine Simmons.

[47] Despite public perception that that there is an unusually high incidence of child abuse by foster parents, this is probably more a factor of increased scrutiny, increased reporting, and increased media sensationalism than of actual higher level of abuse.

Table 27: Foster Care & Juvenile Institutions (Inmates)

Inmates			
	Not Core Group	**Core Group**	**Total**
While Growing Up Did You Ever Live in a Foster Home or Institution?			
	8.52%	19.57%	11.73%
n=	1,083	1,018	2,101
A Foster Home, Agency/Institution, or Both?			
Foster Home Only	42.47%	38.64%	40.61%
Agency/Institution Only	47.86%	46.64%	47.27%
Both	9.67%	14.72%	12.11%
n=	1,076	1,012	2,088
While Growing Up:			
Did Parents Receive Welfare?	30.99%	40.81%	33.87%
n=	3,893	2,125	6,018
Did You Ever Live in Public Housing?	15.72%	20.71%	17.18%
n=	2,003	1,091	3,094

Dangerous Behaviors & Crises

Suicide Attempts

Members of the Core group are almost three times as likely to have attempted suicide at some point in their lives. (See Table 28) The mean number of suicide attempts is only slightly higher for the core group.

Table 28: Suicide Attempts (DATOS)

		Not Core	Core	Total
Suicide Attempted Ever?		16.26%	46.36%	20.72%
	N=	1,367	677	2,044
Mean # of Attempts		2.41	2.92	2.58
	N=	1,367	676	2,043

Intravenous Drug Use, Sharing Needles, & Overdoses

Core group members who are substance abusers are almost twice as likely to have overdosed at some point in their lives. (See Table 29) The mean number of overdoses is higher: the average individual in the core group has overdosed close to four times in his or her lifetime. The core group is one 1.5 times as likely to use needles to inject drugs. (See Table 29) It is not clear whether the core group mental illness or substance abuse is more severe, but the core group is much more susceptible to the life-threatening harms associated with untreated substance abuse and mental illness.

Table 29: Overdose and IV Drug Use (DATOS)

		Not Core	Core	Total
Overdosed		19.20%	37.40%	21.90%
	n=	1,632	549	2,181
Mean # of Overdoses		3.06	3.99	3.30
	n=	1,637	546	2,183
Used Needles		24.01%	34.01%	25.50%
	n=	2,028	496	2,524

This thesis deals only with those individuals who have survived their numerous brushes with death. Overdose, suicide, violence, and HIV have claimed the lives of many others.

Substance Use & Treatment

- **The core group experimented with drugs at a slightly younger age than the non-core group.**

The core group first tried almost every type of drug slightly earlier than their non-core group counterparts.[48] (See Table 30) The SROS data shows a wider age gap than the DATOS data. Considering the marked differences between the core and then on-core group in challenging and tragic childhood experiences, one might have expected a wider discrepancy in the age at which the core group tried drugs for the first time. Both SROS and DATOS data show virtually the same pattern in the order of experimentation with drugs that does not vary based on membership in the core group. The first drug is inevitably alcohol, then inhalants or marijuana, then LSD, and then amphetamines. Then in the early 20's come the first experiences with sedatives, cocaine, crack, and heroin. There is some evidence that this may be changing and that heroin, cocaine and crack are becoming more available to adolescents at a younger age.

Table 30: Mean Age First Tried Drugs

		Not Core Group	Core Group	TOTAL
Alcohol	DATOS	13.91	13.50	13.85
	SROS	15.10	13.90	14.87
Inhalants	DATOS	14.54	14.33	14.49
	SROS	16.39	14.37	15.89
Marijuana	DATOS	15.07	14.49	14.98
	SROS	15.92	15.27	15.78
LSD/Other Hallucinogens	DATOS	17.16	16.82	17.09
PCP	DATOS	18.96	18.94	18.96
LSD/PCP	SROS	17.55	17.52	17.54
Other Hallucinogens	SROS	17.40	18.03	17.60
Amphetaminies/Stimulants	DATOS	19.02	18.76	18.97
Methampthetamines	SROS	17.93	17.62	17.84
Sedatives/Tranquilizers	DATOS	19.85	18.90	19.66
Benzodiazepines	SROS	21.62	22.40	21.79
Other Sedatives/Hypnotics	SROS	20.41	19.00	20.20
Cocaine	DATOS	22.15	21.77	22.09
	SROS	21.95	20.47	21.67
Crack	DATOS	19.62	21.13	19.85
	SROS	20.09	22.53	23.80
Heroin	DATOS	21.11	20.35	20.98
	SROS	20.35	20.76	20.40

48 There is one significant exception: the core group tried crack on average almost a year and a half after their non-core group counterparts in the DATOS data, and almost two and a half years later in the SROS data.

- **The core group is more likely to have tried any given drug at least once.**

While the core group was only slightly younger when they began experimenting with drugs, the core group is more likely to have tried any given drug at least once. (See Table 31) They are almost twice as likely to have tried inhalants or Methamphetamines. They are also far more likely to have tried barbiturates, amphetamines, PCP or LSD, and other hallucinogens. In the core group, 99.2% have tried alcohol, 94.7% have tried marijuana, and 85.4% have tried cocaine. More than half of the core group has tried crack, heroin or other opiates, Benzodiazepines, Methamphetamines, PCP, LSD or other hallucinogens.

Table 31: Ever Tried Drugs (SROS)

	Not Core Group	Core Group	Total
Cocaine	80.9%	85.4%	81.7%
Crack	49.5%	55.3%	50.5%
Heroin	59.0%	56.7%	58.7%
Illegal Methadone	14.3%	18.4%	15.0%
Other Opiates	41.4%	52.9%	43.5%
Barbiturates	29.2%	38.2%	30.9%
Benzodiazepines	45.1%	56.0%	47.1%
Other Sedatives/Hypnotics	27.9%	29.5%	28.2%
Methamphetamines	36.3%	63.5%	41.7%
Other Amphetamines	35.4%	49.7%	38.2%
Marijuana	85.4%	94.7%	87.2%
PCP/LSD	45.7%	66.1%	49.8%
Other Hallucinogens	29.1%	51.9%	33.6%
Inhalants	17.5%	31.2%	19.9%
Over-the Counter Drugs	19.8%	23.8%	20.4%
Alcohol	97.4%	99.2%	97.8%

- **The Core Group is more likely to abuse multiple drugs and is more indiscriminate about which drugs they take.**

While the core group begins experimenting with drugs only slightly earlier than the non-core group, (See Table 30) their substance abuse is more indiscriminate and more intense than the non-core group. They are far more likely to have tried any given drug at least once (See Table 31), and they develop problems with multiple drugs. There is no significant variation in which drugs they abuse (See Table 33), but the core group is far more likely to abuse multiple drugs in addition to alcohol (See Table 34). They are less likely to have a single problem drug or abuse alcohol only. The core group is also less likely to abuse multiple drugs without alcohol. The core group is far more likely to use three or more drugs per week, while the non-core group is more focused on their drug of choice (See Table 32).

Table 32: # of Drugs Used Weekly (DATOS)

	Not Core Group	Core Group	Total
Mean	1.77	1.98	1.80
0-2 Drug used per week	77.20%	69.90%	76.14%
3 or More Drugs per week	22.80%	30.10%	23.86%
n=	8,536	1,474	10,010

Table 33: Primary Problem Drug (DATOS)

	Not Core Group	Core Group	Total
No Favorite Drug	6.5%	4.1%	6.1%
Alcohol	11.9%	16.5%	12.5%
Marijuana	3.0%	3.5%	3.0%
Hallucinogen	1.6%	1.3%	1.6%
Cocaine/Crack	52.2%	52.2%	52.2%
Heroin	19.1%	16.3%	18.7%
Narcotics/Other Opiates	2.3%	1.9%	2.2%
Sedatives/Tranquilizers	0.8%	1.3%	0.9%
Amphetamines/Stimulants	2.5%	2.6%	2.5%
Inhalants	0.1%	0.1%	0.1%
Other	0.2%	0.1%	0.2%
N=	8,324	1,447	9,771

Table 34: Principal Treatment Focus (SROS)

	Not Core Group	Core Group	Total
Single Drug (excluding alcohol)	19.55%	10.10%	17.90%
Polydrug Abuse (excuding alcohol)	8.50%	6.29%	8.10%
Alcohol Abuse Only	31.26%	25.79%	30.30%
Alcohol+Other Drugs	37.80%	53.88%	40.60%
Other	2.89%	3.98%	3.10%
n=	2246	477	2723

➢ **The core group has been in drug treatment much more often than the non-core group.**

There is anecdotal evidence, especially regarding dual-diagnosis clients, which argues that clients with multiple problems are excluded from treatment because they do not fit the placement criteria of the programs. Clients with mental illness as well as a substance abuse problem are not considered appropriate for treatment in either type of program, and therefore are left without help entirely. The data shows that while they may never have been in treatment programs appropriate for their needs, they have in fact been in treatment over and over again, more than twice as many times as the non-core group (See Table 35 and 36).

However, while core group members have been in treatment more times, they do not stay as long. The total number of weeks in any given treatment is shorter for the core group than for non-core group members. (See Table 36) This may indicate resistance to treatment, or that the core group is repeatedly placed in programs that are inappropriate for them, and they are either moved, asked to leave, or drop out.

Table 35: Substance Abuse Treatment History (SROS)

	Not Core Group	Core Group	Total
Mean Number of Hospitalizations Year Prior	0.22	0.36	0.25
Mean Number of Treatment Episodes	2.52	3.20	2.65
Mean # of Years Over Which Treatment Occurred	6.23	8.13	6.69

Table 36: Substance Abuse Treatment History (DATOS)

	Not Core Group	Core Group	Total
Alcohol Treatment			
# of Weeks	17.40	24.15	18.97
# of Admissions	0.85	2.09	1.14
28-Day			
# of Weeks	7.32	9.20	7.70
# of Admissions	1.74	2.30	1.86
Methadone			
# of Weeks	148.37	138.83	146.53
# of Admissions	2.22	2.37	2.24
Outpatient			
# of Weeks	20.29	19.52	20.15
# of Admissions	1.45	2.00	1.55
Short-Term Detox			
# of Weeks	4.96	8.92	5.71
# of Admissions	2.61	3.90	2.85

Criminal History

- **The core group is far more likely to be convicted for minor offenses, and more likely to be incarcerated for such minor offenses.**

The core group is almost three times as likely to be convicted of vagrancy, more than twice as likely to be convicted of loitering, and more likely to be convicted to public drunkenness, disorderly conduct, or minor traffic crimes (See Table 37). The core group is also more likely to be incarcerated for these offenses; 53.63% of core group had been incarcerated for minor crimes compared to 47.13% of individuals not in the core group.

These figures have several possible explanations. First, there are those who believe that our society criminalizes mental illness and homelessness, and that public displays of either are specifically targeted by police in broken-windows style crackdowns. Alternately, the core group may be legitimately more likely to commit such offenses and to commit them repeatedly. Third, this group, especially the homeless among them, may have nothing to go home to, and no resources to be bailed out of jail after arrest, and the criminal justice system is more likely to prosecute such offenders.

The concern is that jail or prison is not a good environment to recover from substance abuse and mental illness, and that racking up still longer criminal records (with little or no benefit to public safety) will make recovery still more complicated. Incarcerating people with so many problems for such minor crimes does not address the issue, exacerbates the problem, and provides no benefit to society except for the immediate removal of objectionable people from the streets. When an individual is arrested for a minor offense, it is the perfect time for jail diversion programs to intervene and treatment to begin.

Table 37: Minor Offenses (Inmates)

	Not Core Group	Core Group	Total
Ever Convicted of...			
Vagrancy?	0.77%	2.19%	1.22%
N=	77	103	180
Public Drunkenness?	9.37%	13.51%	10.69%
N=	936	634	1,570
Loitering?	2.60%	5.29%	3.46%
N=	260	248	508
Disorderly Conduct?	10.01%	16.20%	11.99%
N=	999	760	1,759
Minor Traffic Crimes?[49]	15.31%	18.49%	16.33%
N=	1,529	868	2,397
Ever Serve Time for These Offenses?	47.13%	53.63%	49.67%
n=	1,266	924	2,190

[49] Not counting convictions for DUI/DWI

- **Members of the core group have been arrested and incarcerated more times than the non-core group.**

The core group has been arrested and incarcerated more times than the non-core group. The core group has been arrested an average of 6.69 times in their lifetime, while the non-core group is arrested an average of 4.14 times. The core group has been incarcerated an average of 3.27 times compared to 2.44 times for the non-core group (See Table 38).

Table 38: Criminal Justice Systems Contacts (Inmates)

	Not Core Group	Core Group	Total
Mean # of Arrests	4.14	6.69	4.88
n=	12,536	5,130	17,666
Mean # of Incarcerations	2.44	3.27	2.72
n=	6,273	3,150	9,423

Inmates in the Core Group are more likely to be incarcerated multiple times. They are less likely to have only one prior sentence, and almost twice as likely to have 6 or more prior sentences (See Table 39).

Table 39: Number of Sentences to Jail/Prison (Inmates)

	Not Core Group	Core Group	Total
0 prior sentences	33.25%	20.74%	29.61%
n=	4,280	1,095	5,375
1 prior sentence	17.21%	14.73%	16.49%
n=	2,216	778	2,994
2-5 prior sentences	37.16%	40.32%	38.08%
n=	4,784	2,129	6,913
6+ prior sentences	12.39%	24.21%	15.82%
n=	1,594	1,278	2,872

- **Members of the Core group were first arrested at an earlier age, and had many more arrests as juveniles than non-core group members.**

The core group has more of a criminal history as adults, and almost twice the number of arrests as juveniles. A core group member was arrested as a juvenile 5.42 times on average while a non-core group member was only arrested an average of 2.59 times (See Table 40). Here is further evidence that the problems of this core group originated at a young age, and perhaps that the best intervention would target minors before they had been arrested 5 times.

Table 40: Number of Juvenile Arrests (Probation)

	Not Core Group	Core Group	Total
Probation			
Mean # of Times Arrested as a Juvenile	2.59	5.42	3.20
n=	353	97	450

- **The Core Group is more likely to have been convicted of almost every type of crime, and to have been convicted more times.**

The core group is more likely to have been convicted of almost every type of crime, including both violent and non-violent offenses (See Table 41). They have also been convicted more times than the non-core group. They are twice as likely to be convicted of fraud than non-core group members. The core group is almost twice as likely to be convicted of public order offenses such as prostitution or disorderly conduct. The only exception is DUI/DWI, for which the core group is less likely to be convicted. Because of their low job skills, their vulnerability, and their increased drug use, it is possible that the core group commits more crimes more frequently. It is also possible that the core group may be less skillful at getting away with crime than the non-core group, and the statistics may reflect a higher rate of arrest rather than a higher rate of criminal activity itself.

Table 41: Criminal History by Type of Offense (Probation)

	Not Core Group	Core Group	Total
Ever Convicted of Robbery?	4.80%	8.30%	5.50%
N=	26	11	37
If Yes, Means # of Times	1.17	1.27	1.21
N=	23	11	34
Sexual Assault	3.10%	3.80%	3.30%
N=	17	5	22
If Yes, Mean # of Times	1.08	1.40	1.17
N=	13	5	18
Other Assault	14.00%	26.90%	16.50%
N=	76	36	112
If Yes, Mean # of Times:	1.49	1.59	1.52
N=	68	34	102
Burglary	14.80%	22.40%	16.30%
N=	80	30	110
If Yes, Mean # of Times:	1.87	1.59	1.79
N=	75	27	102
Larceny/Auto Theft	16.70%	21.40%	17.60%
N=	90	28	118
If Yes, Mean # of Times:	1.68	1.78	1.70
N=	88	27	115
Fraud/Bad Checks	9.10%	19.10%	11.00%
N=	49	25	74
If Yes, Mean # of Times:	1.44	2.32	1.73
N=	45	22	67
Drug Trafficking	5.40%	7.60%	5.80%
N=	29	10	39
If Yes, Mean # of Times:	1.22	1.43	1.26
N=	27	7	34
Drug Possession	20.10%	29.50%	22.00%
N=	109	39	148
If Yes, Mean # of Times:	1.35	4.33	2.07
N=	103	33	136

	Not Core Group	Core Group	Total
Ever Convicted of DUI/DWI?	41.90%	38.90%	41.30%
N=	226	51	227
If Yes, Mean # of Times:	1.95	1.76	1.91
N=	220	50	270
Weapons Violations	6.90%	9.20%	7.40%
N=	37	12	49
If Yes, Mean # of Times:	1.30	1.09	1.25
N=	33	11	44
Other Property Offenses	14.60%	20.60%	15.80%
N=	79	27	106
If Yes, Mean # of Times:	1.77	1.19	1.62
N=	74	26	100
Other Public Order Offenses	10.20%	23.70%	12.80%
N=	55	31	86
If Yes, Mean # of Times:	1.84	2.86	2.22
N=	49	29	78
Probation/Parole Violations	15.20%	22.10%	16.50%
N=	82	29	111
If Yes, Mean # of Times:	1.36	1.31	1.35
N=	75	29	104

"If you have four fingers on one hand, that's not a problem, that's a situation. Conditions become problems when we come to believe that we should do something about them."[50]

These statistics have shown that it is not the rare case that falls into three or more of these categories. This thesis examines over 7,500 individuals who have a debilitating combination of criminal history, substance abuse, mental illness, and homelessness. It is difficult to say which problem came first, and it is impossible to try and address one without coming up against the others. There is much we do not know about this population and how they move through the systems; we do know that they tend to have chaotic childhoods, indiscriminate drug habits, and impressive rap sheets.

At the outset of this research, it seemed logical that there could be three ways our systems deal with such clients: First, we could let them bounce around among the services, jails, shelters, and streets. Second, we could let them fall through the cracks, loosing touch with reality, their families, and civil society. Third, we could lock them up and throw away the key; as many people have argued, we allowed jails to take the place of mental hospitals after de-institutionalization. Without hope of rehabilitation, we could simply warehouse these people far away from the rest of us.

This thesis found that the great majority of the core group is in the first category; they bounce around among many service systems. The case studies include one exception to this rule: Sarah G. had only minimal contact with social service agencies and no criminal history when one day at age 19, a homeless mentally ill drug addict, she was arrested for murder and sentenced to life in prison. Sarah truly had fallen through the cracks, and when our system finally caught up with her, it was deemed to late and the criminal justice system locked her up and threw away the key.

All other case studies and all the statistics we have seen point to the fact that contrary to the common belief that these individuals have 'fallen through the cracks." On the contrary, they are very much known to all types of criminal justice authorities, social service agencies, and public benefits systems. They have lengthy histories of multiple types of treatment, and yet are discharged with no hope of maintaining sobriety, sanity, housing, or work. These individuals have undergone treatment time and time again to no avail. What solution can be found to

[50] Kindgon 1995: p. 109

provide an opportunity for this group to put their lives back together? At the very least, how can we deal with them efficiently until they are ready to change, or until their history, behavior, and their bad luck get the best of them once and for all?

The statistics in this thesis are not based on original data; they are gleaned from data sets collected by federal agencies and analyzed by numerous academics and policymakers. Front-line social service workers, emergency room doctors, and police officers have all seen this core group up close, time and time again. Our homeless shelters, jails, detox clinics, and emergency rooms are filled with this core population. In short, it is not news that these four categories-- homelessness, crime, substance abuse, and mental illness-- overlap. That this core population of extremely troubled and difficult individuals exists and cycles through our public systems is not news either. If such individuals are neither rare nor hidden, then what are the barriers to making the changes that will allow this population to be dealt with more systematically, efficiently and effectively?

The individuals working in these social service and criminal justice systems are not for the most part ignorant or uncaring; there are substantial structural barriers to solving this problem and treating this population. There are, however, also some effective strategies, both small and large that could go a long way in improving how these overlapping systems deal with this core population.

This chapter outlines the political, social, legal and administrative barriers to treating this core population effectively and suggests some initial points of entry to address this problem.

Political Barriers & Strategies: Willie Horton & Taxing Our Sympathy

"Problems are not self-evident by the indicators. They need a little push to get the attention of people in and around government."[51]

Politicians are in the business of getting elected: they want your vote and your financial contribution. Homeless, substance abusing, mentally ill criminals are nonexistent in the political system; they do not vote, they especially do not donate money to political candidates.[52] Political attention for this population must be grounded in placing their interests on the national agenda in some other way. The sympathy (or fear) of voters must be roused to put this issue on the national agenda. This is

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[51] Kingdon 1995: p. 94

[52] Indeed, in many jurisdictions, to be convicted of a felony is to give up your right to vote for life.

called a "conscience constituency" as opposed to a "beneficiary constituency."[53]

This may happen by playing on the voter's fear that he will someday fall into this category himself. A voter can imagine himself getting old, or fears getting cancer, or worry that his child could be the next kidnapping victim, and therefore supports costly initiative to improve the lot of those victimized by such misfortune. But it is difficult to get voters to empathize with the core group. Though mental health advocates have made progress in medicalizing (and therefore democratizing) mental illness, if you have not developed a serious mental illness by the time you are 35, you are unlikely to develop one.[54] It is even harder to imagine oneself becoming homeless, or addicted to drugs, or going to jail if such experiences have not been a part of your life experience. Therefore the fear of falling into this group oneself is unlikely to be the basis for public sympathy for this group.

Personal experiences with mental illness and substance abuse do have some residual political currency, however. Tipper Gore planned for her term as first lady to be based on raising the profile of mental health issues and openly referred to her personal experiences with mental illness. Gore is not the only first lady to have made mental health a personal and political cause; Betty Ford and Rosalynn Carter also brought mental illness and substance abuse to the fore front through their advocacy and personal experiences. Several US Senators have immediate family members with severe mental illness, which they have parlayed into raising the profile of the financial and insurance coverage issues of mental health treatment.[55] We have now de-stigmatized substance abuse to the point where the president of the United States is a recovering addict, stating openly on television: "I believe in forgiveness, because I have needed it."[56] Such personal/political experiences have not been fully utilized by advocates to lobby for increased services and publicize the possibility of recovery. In other fields, this is a long-standing strategy: "Lobbyists for biomedical research know the disease of the day, know which congressman's mother died of it and which one's wife has the disease, and they play on it."[57] Mental Health and Substance Abuse treatment advocates should focus on sending the message that treatment works; that treatment is the difference between one cocaine addict who becomes the President of the United States and another who goes to jail for breaking and entering.

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53 Rosenthal 2000: p. 119

54 Interview with Prof. Robert Blendon, Harvard University, Kennedy School of Government, March 10, 2003

55 New York Times September 15, 2002 "Then Politics is Personal" by Deborah Sontag

56 May 3, 2000 George W. Bush, Republican Nomination acceptance speech

57 Kingdon 1995: p. 96

No private citizen or elected official has affected the public's perception and response to convicts more than Willie Horton. Since that tragic incident in 1987, the public and politicians risk aversion towards criminals has reached a peak. Services for ex-offenders, jail diversion, and re-entry programs have all suffered because of the fear of releasing criminals into the community. Still, people continue to be released from prison or jail in record numbers. The fear of another politically charged incident such as was caused by Willie Horton frames every effort to monitor offenders in the community or provide services to returning prisoners as "soft on crime" and therefore creating a threat to public safety. The negative impact of one single incident on public policy has been immeasurable. Any political strategy to address the needs of the core population described will have to both confront and attempt to avoid this problem.

Utilitarian arguments are another political strategy that can be used to convince the public to fund services for these unsympathetic groups. Two major arguments are used: one appeals to a fear of crime and the discomfort of walking past drug addicts and homeless people on the street, the other deals with the financial costs to taxpayers of treating these individuals. One Drug Court Judge refers to her program as a "taxpayer factory."[58]

Homelessness and hunger have political currency that has not been fully exhausted.[59] Despite the fact that the public cannot always empathize with these conditions, there is a powerful sense of moral responsibility. Providing for these basic needs is the very minimum safety net, and it bothers people when we cannot provide them for everyone. Unfortunately, this often leads to the creation or emergency-based services, but does not extend to more comprehensive long-term programs. The pity for the hungry and homeless goes so far as to establish soup kitchens and emergency shelters; it has not been utilized to create sufficient job training programs and supportive housing.

As we have seen, three types of political strategies can be used to improve the lot of the core population. Utilitarian arguments focus on reduction in tax spending or crime. Conscience-based arguments play on people's sympathy for. Empathy-based arguments require the public to believe: "but for the grace of god there go I." Politicians must position their policies so that they do not look soft on crime or forgiving of vice, but demonstrate that these policies benefit everyone. These recommendations are not simple feats, but there is progress that can be made.

[58] Nolan 2001: p. 59

[59] Interview with Prof. Robert Blendon, Harvard University, Kennedy School of Government, March 10, 2003

Social Barriers & Strategies: Defining Social Problems & the Boundaries of Sympathy

"National Coalition for the Homeless, tiring of the effort to 're-present' homeless people in an appealing light to reporters, once suggested that perhaps we should focus attention on 'homeless blonde white girls with AIDS who are Vietnam veterans'"[60]

As the previous section showed, services for this core population depends in large part upon the public feeling that this group is deserving of our help. Unfortunately, this leads each of the four sectors to "strategize within the boundaries of political possibility set up by public labeling."[61] Joel Best's analysis of the emergence of new crimes is a useful theoretical template for this thesis. Best, writing about new crimes, argues that in order for a 'new' crime to be institutionalized as a social problem, it must be adopted by an organization outside the media that will keep the issue alive beyond the initial discovery of the problem by the media and the public.[62] "Existing movements make efficient owners of new crime problems; they already have leaders, members, budgets, offices, contacts with reporters and legislators, and other resources needed to mount effective campaigns to change social policy."[63]

For this core population, there is no such infrastructure to make sure the problem is at the forefront of national discourse. If anything, the existence of this population hinders the efforts of activists who would prefer that we think of these categories as mutually exclusive. Mental health advocates spend a lot of time trying to combat stereotypes about the mentally ill: that they are violent, threat they are on drugs, that they are the cause of their own illness. The public face of the mental health system is: these people are just like you and me, except they have an illness. Sympathy for the mentally ill rests on the ability to see yourself or your loved ones in their place. Drawing attention to the problem of the core population jeopardizes the gains of the mental health advocacy movement, and threatens to reinforce the stereotypes that the movement has fought so hard against.

The homeless system also has this problem. A person without a roof over their head is an inherently sympathetic figure. That is, so long as they are blameless. "Despite all evidence that mental illness and substance abuse play a big role in homelessness, some knowledgeable people still insist that the homeless are mostly people 'just like you and me' who happened to be

[60] Blasi 2001: p. 15
[61] Rosenthal 2000: p. 119
[62] Best 1999: p. 46
[63] Best 1999: p. 64

down on their luck."[64] The homelessness advocacy movement, like its counterpart in mental health, is committed to presenting their clients as deserving of society's help. A nuclear family whose life has been turned upside down by a house fire or a breadwinner having an accident, is the perfect cover story; a mentally ill, drug-addicted single man with a criminal history is not. "In their desire to attack the undeserving image of homeless people- and by implication, personal fault explanations of homelessness- advocates have tried to minimize or deny any characteristics of any homeless people that might interfere with the idea that "they're just like you and me.""[65] Increasingly, this strategy has backfired. It seems that everybody equates homelessness with mental illness, substance abuse, crime, and even violence. This is expressed in our social discourse when a family who truly is victim to a house fire is described as "temporarily homeless"[66] to distinguish it from the bad type of homeless that is, presumably, permanent.

Homelessness has also often been positioned as an economic problem; market capitalism leads to a housing and job market that allows people to fall out to bottom. By using the problem of homelessness as an argument against market capitalism, the homeless who would remain so even if they had money for housing are made invisible.

To arouse political and public support for the core population, one needs to arouse sympathy and avoid controversy. A good strategy to accomplish this is to focus on innocent victims and frame the story as a melodrama of innocents and monsters.[67] "Framed as a clear-cut moral principle, standing up for victims runs the politicians little risk. After all, there is rarely vocal opposition; there are no organized lobbies of victimizers."[68] Unfortunately, it is difficult to frame the core population as innocent victims. To do so is too upsetting to a conception of personal responsibility and the American Way. The core population creates conflicting perceptions of victim and criminal, disability and personal weakness, the sympathetic poor and the pathological underclass. This does not fit well into the melodramatic narrative. "As long as we remain focused on victims, disagreement vanishes... once we start identifying victimizers, we are back in the messy, divisive business of trying to both understand and blame deviants. As long as we can stay focused on victims, we can hope to mobilize consensus."[69]

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[64] Jencks 1994: p. 46
[65] Rosenthal 2000: p. 120
[66] Boston Globe December 27, 2002 "Apartment Fire Leaves More than 100 Temporarily Homeless)

[67] Best 1999: p. 89
[68] Best 1999: p. 122
[69] Best 1999: p. 140

This is exactly what we have done with this core population; we focus on aspects of their lives that can easily be framed to arouse sympathy. Why focus on innocent victims? We can all agree that we feel sorry for them. But when we get to the causes of deviance and who bears responsibility for the social conditions that give rise to it, the consensus breaks down. There is nothing here to "declare war" upon. Thus we can feed the hungry, pity battered women and children, and house the homeless. We build emergency shelters, but cannot provide continuums of care for an individual's lifelong struggle with poverty, mental illness, and addiction.

Controversy over what is cause and what is effect, what is a matter for personal responsibility and what is a structural societal problem is not played out only in the realm of public opinion. Each of the four categories has its own set of institutions, theories, and methods that are based on a different worldview about how the four categories are related to one another. The medical profession sees its role in treating disease and addiction; criminal justice officials protect public safety and punish offenders; social workers attempt to treat a person in a more holistic fashion, accessing services and addressing a set of problems with the resources available. There are still other variations among all the professionals who come into contact with the core population in terms of authority, jurisdiction, treatment style, and professional worldview. We now turn to the systemic and structural barriers to integrating services for the core population and some potential strategies to achieve such integration.

Legal Barriers & Strategies: The Right to Starve & the Limits of Civil Liberties

Legal strategies for this population originate in equal protection and civil liberties law. Enormous legal pressure has been brought to bear to ensure the rights of the mentally ill, indeed all patients, to refuse treatment and to be protected from involuntary commitment except under extraordinary circumstances.[70] However, some have argued that this strategy has backfired. It puts into place vital civil liberties but does not increase access to treatment. "Civil libertarians impermissibly failed to provide tangible solutions by focusing far more heavily on obtaining liberty for patients than on seeking services for them. Their advocacy has resulted in what essentially amounts to a right to starve on the streets and to be effectively cut off from any from of treatment or assistance."[71] Suppose, for example, that our case study, Jennifer H had refused treatment for her drug abuse, her post-traumatic stress. The legal system made it difficult or impossible to remove her from her parent's home as a child. The legal system is paralyzed, having provided

[70] Usually when the patient is a danger to himself or others or has committed a crime. This includes the right of the state to quarantine carriers of infectious diseases.

[71] Hodulik 2001: p. 1074

only negative rights for this family, then at age 19 Jennifer kills someone and only then is the system obligated to act. Only then is the system able to act to protect her and the public.

This is not to say that involuntary commitment should be commonplace or that the right to refuse treatment has done more harm than good, although some would make that argument. It is important to understand the possibilities and limitations of legal interventions for this population.

Limiting the rights of the mentally ill on the grounds that they are too confused to know their own interests or to respect the rights of other has led to many abuses. But the fact that a principle is often abused does not mean it is wrong. ... For the civil liberties lawyer who led the fight against involuntary commitment, all this was irrelevant. They thought individual autonomy so important that they could hardly imagine patients who would be better off when other people told them what to do... Legally, it is now impossible to lock people up forever simply because they were both psychotic and violent at some time in the past. If they are no longer psychotic today- they are entitled to another chance. The fact that people with histories of schizophrenia and violence tend to have relapses... does not have a comfortable place in American legal thinking.[72]

This final thought is perhaps the crux of the problem: relapse and medical uncertainty have no place in our legal system. The Drug Court (and the emerging Mental Health Court based on the same model) is hailed as a solution to this clash of cultures and procedures: sanctions in the interest of recovery, an "application of the disease model to the adjudicative process,"[73] "just treatment" versus "mere punishment."[74] By all accounts, this model is working. But the drug court model exchanges an offer of treatment with an extension of the court's authority over the personal life of offenders, and in many ways removes the legal barriers that protect a conventional offender from the state.[75]

Despite these concerns, civil rights law has made enormous progress, at least on paper, in securing equal rights for the mentally ill, and the courts are beginning to protect positive rights to treatment as well as negative rights to refuse treatment and to be protected from intrusion. In some cases these rights are being applied not only to the mentally ill, but to offenders as well. The US Supreme Court's Olmsted decision[76] argues that unnecessary institutionalization of disabled persons is discrimination under the Americans with Disabilities Act. This decision has been interpreted as a court mandate for

[72] Jencks 1994: p. 30

[73] Nolan 2001: p. 132
[74] Nolan 2001: p. 193
[75] Site Visit, Roxbury Drug Court, Judge Anderson; March 5, 2003
[76] Olmsted vc. LC, US Supreme Court 1999

supportive housing where it is the most appropriate form of treatment and institutionalization is more restrictive than necessary. In New York State, a lawsuit is has been settled that requires mentally ill inmates released from prison to benefit from the law requiring the state to release the patient with a treatment plan in place. "[New York] State law requires that arrangements be made for continuing treatment of mentally ill patients before they are released form psychiatric hospitals and other treatment programs. But the city argues that inmates are not covered by this law."[77] The court has required the state to provide treatment until the resolution of the case, and indications are that the state will lose the suit and be required to provide ongoing treatment to mentally ill inmates post-release.

In Massachusetts, state law prohibits state-funded agencies or programs from hiring ex-offenders who have been convicted of certain serious crimes. Rather than allowing the agency to discriminate on this basis based on its best judgment, or requiring extra explanation, the statute categorically excludes this class of people from working for any state-funded program forevermore. This hits the social service world particularly hard. The best person to work as a substance abuse counselor or a homeless shelter is often the one who has been in that situation himself. Under this law, a conviction in a 'former life' prevents people from being employed where they can do their best work, and it denies the currently homeless or addicted from getting the advice of those who are best positioned to understand and help them.

A class-action lawsuit recently made some progress in unraveling this legal perversity, but it did not create meaningful changes.[78] The revised law now allows an ex-offender to provide a letter from a corrections officer stating that the individual is rehabilitated and poses no risk in the workplace. Unfortunately, because of the liability this would subject the probation office to, probation department and other corrections officials are not allowed to issue letters making judgments upon the risk posed by any individual formerly in their care. Psychiatrists commonly offer such assessments, but the high cost (approximately $1,500) is prohibitive for most offenders seeking employment.

Civil liberties law has erected critical boundaries around the rights of the mentally ill. It has also reduced the ability of the healthcare professions to mandate treatment, even in cases where an individual is clinically and legally unable to make decisions for themselves. Recent cases point to the possibility of using legal mechanisms to secure positive rights to treatment.

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[77] Day 2001

[78] Interview with John Christian, March 17, 2003

System Barriers & Strategies:

"The first consequence of system fragmentation is policy fragmentation."[79]

For the Core Group, a fragmented social service system has led to fragmented and ineffective care, especially to those individuals who make their home in more than one social service system. The following section will overview some of the barriers to system integration, and examine some fragments of policy that may go a long way towards improving some portion of those who spend their lives bouncing around the systems.

The case studies and statistics in this thesis have demonstrated that the Core Group spends its time bouncing around the system. This is a major drain on social service resources and a major impediment to rehabilitation. This section analyzes the structure of the multiple systems the core group finds itself in and the barriers these systems present to the rehabilitation or stabilization of the core group. Administrative and system barriers can deter or prevent progress, and many of the simplest social policies lie in simply adjusting the systems within which we attempt to treat these individuals.

[79] Kingdon 1995: p. 119

While fragmentation of services is treated as pariah in social services literature, there are many reasonable explanations for why the social services system behaves the way it does. At the same time, a solution to this problem is likely to be found in incremental changes to the ways we allow people to move from one part of the system to another. A major reason why the systems have a difficult time working together is that they serve very different purposes.

There are different types of systems that "make files" on core group members. Emergency systems, place-based warehousing or custodial systems, and holistic, person-based case management systems each make up one piece of this puzzle. Some of these systems are designed to punish and some are designed to save. Some are very visible and some are, literally, behind walls. All are complicated, highly regulated, and poorly funded.

Emergency Systems

Emergency systems include emergency rooms, homeless shelters, police and 911, and detox centers. Such systems are highly standardized to ensure the fastest response for the greatest number of people. For police, this can mean getting someone who is disturbing the neighbors off the street as quickly as possible. For an emergency room, it means arriving at the scene as quickly as possible to stabilize the patient and release him. For a homeless shelter it means providing as many beds as possible. It is

outside the scope of such systems to spend a lot of energy considering next steps; their performance is (and should be) evaluated based on efficiency and speed. There is no time or money to spare in lengthy interventions and specialized services. There is no premium placed on effective discharge planning.

This is partly as it should be. Police should not be expected to act as therapists, and detox clinics should aim to provide services to the largest possible number of addicts. Emergency systems should not behave less like emergency systems. But what might improve the lot of the core group is to make a more seamless transition from these emergency systems to ongoing treatment. Efforts are already underway to improve police response to mentally ill victims or offenders.[80] Making the leap from emergency to long-term ongoing services is difficult. For the core group the situation is still more complicated, because there may be no perfect placement for persons with overlapping needs.

There are, however, small changes that can be made to make emergency services lead to a more long-term solution for the core population and for all users. Providing cross-training to staff, promoting accurate documentation of multiple contacts, and making connections (not simply referrals) to ease the transition from emergency services to longer-term ongoing treatment. These connections may include interventions as simple as providing transportation from one program to another, more intense coordination such as reserved slots or beds, or a continuum model such as assigning the same caseworkers to clients across treatment systems.

Case Management Systems

Unlike emergency systems, case management systems are planned to be holistic, flexible and responsive to an individual client's needs. Youth Services, Foster Care, Parole and Probation Offices are examples of such systems, as well as some public mental health care systems that combine treatment with case management.

Such systems are intended to tailor their services to the individual client, but the reality often falls short of this. Clients are classified and re-shuffled. The easiest clients are skimmed to the top, while the quiet ones are left alone, and the worst clients often receive the least effective services. Waiting lists, paperwork, and perverse incentives abound.

Probation emerges here as a particularly ineffective intervention. As we learned in the case studies, Probation officers spend minimal time with clients; they seem poorly positioned to advocate for their clients, and seem unable to set effective conditions of probation or enforce them. The goal for case-management systems is

[80] Consensus Project 2002, Teplin 2000

that they should manage their cases rather than simply document them.

Custodial Systems

There are two main types of custodial, or warehousing systems: prisons and mental hospitals. There are two main challenges for these systems: First, one must decide when a jail or mental hospital is appropriate and just. Second, once an individual is placed in a restricted setting, there must be a well-planned release procedure that provides a supported transition. These two concepts are related: many of the intended benefits of putting a person in a restricted setting are compromised when the period of confinement is not used for rehabilitation and intensive transition planning is not available.

Categorical Funding, Cost and Efficiency

One reason why these systems are unable to effectively support one another when they have clients in common is that their public funding is expressly categorical. A substance abuse treatment center receives a grant to open a detox center, and that is how that money needs to be spent. There is little room in the world of government funding for inspired cooperation and impromptu re-organization. Pilot programs can rarely be attempted on an ad hoc basis. Cost savings are a major argument for coordinating between systems, but here too the incentives are backwards:

"Generating more financial support for this fragmented system is very challenging politically. [Studies] have provided some evidence needed to demonstrate that such an improved service continuum could generate overall savings to society, through reduced prevalence of expensive illnesses and through reduced crime. However, it is important to point out that investments by one sector (eg a local public health system) could result in saving to another sector (eg federal and state Medicaid and prison system budgets). A broad multi-sector coalition is probably needed to achieve the kind of support needed for expanded services."[81]

Under these circumstances, it is difficult even to assess the cost-saving potential of programs that would benefit the core group:

"Linking identified returning prisoners who have serious mental health problems with community-based intensive case management programs is... difficult, but is likely to improve mental health symptoms and consequently, perhaps, prevent future crimes and incarceration. Unfortunately, cost-effectiveness studies have not yet taken such a relationship into account, so it is not possible to estimate whether such programs would reduce rates of return to prison."[82]

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[81] Howell, Greifinger, & Sommers 2002: p. 18
[82] Howell, Greifinger, & Sommers 2002: p. 13

Attempts at System Coordination: The Consensus Project and Juvenile Detention Alternatives Initiative

System coordination is a longstanding goal and a difficult one to achieve. There are examples, however, of programs that have attempted to bring together stakeholders from all sectors to discuss common clients and forge ahead to find common solutions. Now that all the barriers and tragedies have been fully explored, there are examples of successful collaboration in spite of the many roadblocks. A brief overview of two such projects- The Criminal Justice/Mental Health Consensus Project[83] and the Juvenile Detention Alternatives Initiative[84] – can serve as models and as inspirations.

The Consensus Project

The Mental Health/Criminal Justice Consensus Project is a project of the Council of State Governments. A broad coalition of mental health and criminal justice practitioners developed a set of 46 specific policy recommendations that "reflect a consensus among seemingly conflicting viewpoints".[85] Recommendations include ideas for all point along the continuum when mental health case and the criminal justice system collide. It addresses law enforcement contacts, pre-trial and sentencing, incarceration and re-entry, professional training, and measuring and evaluating outcomes. Best practices from across the country care highlighted and barriers to implementation are addressed.

The driving philosophy of this project is that practitioners are best positioned to make recommendations, and that despite the conflicts among the systems there are many things that everyone could agree upon, and a consensus must be reached before policymakers are able to promote and enact changes.

The project promotes a "no wrong door" approach. Rather than treating everyone according to which facility they land in first, an individual with multiple problems should be afforded appropriate treatment whether his first point of contact with 'the system" is a police officer or a physician. The report suggests specific policies that could help make this possible.

Juvenile Detention Alternatives Initiative

The Juvenile Detention Alternatives Initiative (JDAI) has the same animating force as the Consensus Project, and has taken this promise even further. Funded by the Annie E. Casey Foundation, JDAI's aim is to care for children and adolescents in the social service and juvenile justice system systematically, fairly, and effectively. The issues are very similar to systems for adults: "In many ways, the juvenile justice system is not truly a system; it operates as a set of independent agencies with separate

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[83] Consensus Project 2002, www.consensusproject.org
[84] Casey 2002, www.aecf.org/initiatives/juvenile
[85] Consensus Project 2002: p. iii

budgets, separate policymaking authority and little history of cooperation. JDAI seeks to get agencies to function more effectively as a system, to confer, share information, develop policies across agencies and to hold each other accountable."[86]

The first three steps in this process are clearly set out and closely resemble the Consensus Project: 1. Collaboration; 2. Consensus on Authorized Purposes; 3. Capacity Building. So far, this process is very analogous to the Consensus Project.

4. Information Systems and Data Use. JDAI recommends merging information systems so that all agencies have access to relevant information. This is where JDAI moves beyond the research-and-conferences stage, beyond the Consensus Project, and makes some real progress in practice. JDAI has pilot sites Cook County, & Multnomah County, Illinois.

5. Objective Screening Instrument. "With a clear sense of purpose, better information, and the power of a shared reform agenda, sites can begin transformation at the practice level"[87] A common risk assessment instrument is designed so that all agencies have a common understanding of which youths belong in which program.

For the Core Group, new admissions techniques would be a major step forward in making sure they receive the combination of services they need.

Once all agencies are working in concert, better, more tailored programming is much easier to envision. The next three steps consist of substantive policy and program changes:
6. Alternatives to Detention
7. Case Processing Efficiencies
8. Facility Conditions

The ninth and final step of the JDAI experiment is ongoing outcome measurement, assessment, and reform.

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[86] Casey 2002: p. 1
[87] Casey 2002: p. 2

The Core Group presents a difficult set of challenges. The systems in which they so often find themselves sometimes make no more sense that the clients who bounce around between them. Based on what we have learned about the Core Group, how can we begin to approach this problem systematically, effectively, and efficiently? Can we do this with a modicum of compassion as well? Several opportunities emerge as the most promising:

- **Start early.** The core population has a history of child abuse. They are raised by parents struggling with incarceration, mental illness, and substance abuse. Their substance abuse becomes severe very early. They are very likely to have come into contact with the foster care of juvenile justice system, and these systems may be the best time and place to intervene.
- **Jail Diversion is essential.** This population is often incarcerated simply because there is place else to put them, and often for minor crimes that are a direct result of their lack of effective treatment. This is an expensive and ineffective alternative to real treatment.
- **The Homeless System may be a good place to start.** Of the four systems, the homeless system is most accustomed to dealing with multiple social problems, has a therapeutic rather than punitive focus, and is often the last resort for those individuals in the core population who are not incarcerated. Without completely re-structuring the social service system, and if we do not catch these individuals before they grow to adulthood, this is the sector most likely to target programs to the core population.
- **Small Fixes.** Small changes in programs and how they communicate with each other have the greatest chance of success. We may not know exactly what works with this population, but we know what is not working. Provide transportation from one program to another rather than merely referring clients from one place to another; Train law enforcement to deal with mentally ill patients; make effective plans for discharge from hospitals and jails; loosen eligibility criteria so as not to filter out the core group.
- **Plan for Relapse & Promote Harm Reduction.** This is not a population that can be 'fixed' in one sitting by one perfect program. The issues are complicated and many. Substance Abuse and many types of mental illness are relapsing and chronic, and yet so many of our programs define success as permanent recovery or abstinence. Harm Reduction

should be the goal of any program designed for the core population.

- **Plan for Release & Re-Entry.** The core group moves from system to system more frequently than other clients. Therefore they are more affected by the lack of release planning in our custodial and treatment systems. The Core Group is defined by its inability to maintain sobriety, healthcare, legal employment, and housing as they move from system to system. Meaningful re-entry planning can make a world of difference for this group.
- **Avoid Reports For Their Own Sake.** As has been pointed out several times in this report, this phenomenon is not a surprise to practitioners in any of these sectors. It is not a surprise to policy-makers or researchers or the core group themselves. Forgive me my hypocrisy, but this problem is well-documented, and too often the only response is to document it further. The time is now.
- **Reform the Probation System.** As a legal mechanism to send offenders back to jail when they exhibit risk factors for recidivism, probation is working quite well. As an attempt to monitor offenders in the community and guide them with the threat of jail towards a law-abiding life, for the most part it is a miserable failure. Perhaps it is time to retain the former objective, but not play at the latter.

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APPENDIX: LITERATURE REVIEW

Literature in the fields of law and criminal justice, homelessness, substance abuse, and mental health has examined a slice of this topic. Each of these sectors defines the others as risk factors, or as a barrier to effective treatment or rehabilitation. But sector-specific studies seek to isolate individual characteristics of the core group and do not make an attempt to re-draw the boundaries of the social service and criminal justice sectors. Here I will review the literature on each sector, category, or sub-population. This thesis as a whole will seek to demonstrate how the research of the four sectors, while performed in isolation from one another, can if taken together argue for the existence of a core population that cannot be served adequately by any narrowly defined service or sanctions system. In reading literature from all four fields, each of these researchers is talking about *the same clients* and these individuals are being bounced between the silos of the government interventions without stabilizing or improving. These clients float among the various systems, tend to be the most severe cases in each category, and do not stabilize or improve.

Homelessness

In the 1970's and 80's, homelessness emerged as a social problem. Many scholars have attempted to characterize and categorize the homeless population. Langley Keyes[88] views the 'homeless problem' as a category that combines people who are homeless for rather different reasons. He argues that the homeless are defined according to their lack of housing, but that this category can be subdivided into groups based on the different interventions they require to achieve housing and thus shed their homeless status. Keyes identifies three subgroups or types of homelessness: economic, situational and chronic homeless. The *economic* homeless are households who lack only the financial resources to achieve and maintain housing. *Situational* homeless are homeless because of a dangerous situation in their lives and not solely due to lack of financial resources. This category includes victims of domestic violence and child abuse as well as adolescent runaways. Keyes' third category is *chronic* homelessness. The chronic homeless are those who "because of substance abuse or mental illness are unable to find a stable niche in the housing market...The deinstitutionalized (or if they are young enough, never institutionalized) mentally ill are the homeless for whom there is universal recognition that housing is not enough."[89] This thesis will concern primarily this last category, where multiple service need have left

[88] Keyes 1990
[89] Keyes 1990, p. 406

unanswered the question of just what needs beyond lack of housing must be met to stabilize and serve these individuals. I will also argue that many of the situational homeless, the victims of domestic violence or child abuse, are likely to fall into the core group (is, become chronic homeless) without appropriate services.

Other analyses of homelessness as a phenomenon divide the homeless population in various other ways, but scholars agree that the category 'homelessness' is valid because the homeless share a lack of shelter. There is also consensus that providing shelter is not the solution for the entire population we now define by their lack thereof. The social construction of this category has had important ramifications for policy-makers and advocates as well as public opinion.[90] In *Frame Reflection*, Schon and Rein examine the roots of the homelessness category in Massachusetts and national politics in the early 1980's. They argue that homelessness could have been subsumed under political coalitions that had come together to lobby for affordable housing, or welfare reform, but for various political and social reasons these coalitions were unattractive and undependable, and instead a new category was born. The "scandal of homelessness" looked capitalized upon "a new politics of compassion and shame- compassion for the plight of the dispossessed and shame at the inhumanity of national and local policies toward them."[91] Homelessness, though it was an eclectic category and perhaps an artificial one, was adopted by the Dukakis administration and a coalition of service providers as a political platform that could garner the greatest public support and broadest organizational coalition.

Rosenthal takes up the emergence of this category and examines later efforts by advocates and the media to portray the homeless in different ways to the general public.[92] He combines theories of public discourse as dividing recipients of charity or public services as "deserving" or "undeserving" and pairs these views with political intervention based on structural versus individual causes of homelessness, respectively. This dichotomy is overlaid with categorizations similar to Keyes' need-based categories of homelessness, and Rosenthal creates three categories of homelessness as seen through public opinion and media coverage: Lackers, Slackers, and Unwilling Victims. Rosenthal's 'slackers' are viewed as incompetent through their own fault; they are 'undeserving' homeless because their inability to retain shelter is a result of personal failures, laziness and irresponsibility. Thus these homeless are needy but undeserving of sympathy or help. Drug addiction, Rosenthal argues, is sometimes considered a

[90] Keyes 1990, Rein & Schon 1994, Rosenthal 2000

[91] Rein & Schon 1994, p. 132

[92] Rosenthal 2000

personal failure and sometimes an unfortunate circumstance. 'Lackers' are those homeless who through no fault of their own are burdened with individual characteristics that result in homelessness. Children and persons with physical or mental illness fall into this category; they require our aid, deserve our help, and require our stewardship. Lackers are blameless but still incompetent to provide for themselves. Finally, unwilling victims are those homeless who are caught in the crossfire of structural rather than personal factors such as lack of affordable housing, gentrification, de-industrialization, and unemployment. These homeless are competent, but are victims of forces larger than themselves, and deserve society's aid and compassion as well as "a share in decisions concerning their fate."[93] Rosenthal goes on to explain how these three formulations of homelessness are manipulated to create public opinion and policy and how homeless advocates juggle these competing conceptions of homelessness to gain resources, assemble political coalitions, and advocate for their cause.

Research institutes and homelessness trade associations have published applied research on the nature of the homeless population, and have confirmed the division of the homeless population among various categories. Nationwide research as well as analysis of specific local populations attempts to characterize the homeless and investigate patterns of service use, personal characteristics, and needs.[94]

In 1997, the McCormack Institute's Center for Social Policy Research conducted a survey of emergency shelter users in Boston. The McCormack study interviewed a sample of homeless shelter users throughout Boston on a single night in 1997, in an attempt to answer three general questions: "Who currently uses Boston's emergency shelter system? Where have they come from? What are their service needs?"[95] Typical for such studies as we shall see in this review, McCormack publishes statistics about homelessness co-occurring with substance abuse, criminal history, and mental illness, but does not discuss in detail the extent to which these sub-populations overlap with one another. Theses statistics are described in detail in Chapter 4.

Christopher Jencks's seminal work "The Homeless" synthesizes homelessness research from the 1980's and analyzes, one by one, explanations for homelessness.[96] Jencks unpacks and tests various explanations for homelessness: deinstitutionalization, lack of housing, breakdown of traditional family structure, and the crack

[93] Rosenthal 2000, p. 114

[94] McCormack 1997; Jencks 1994; Corporation for Supportive Housing 2001; Urban Institute 2001; May 2000

[95] McCormack 1997, p. 4

[96] Jencks 1994

epidemic. Once again, each of the four 'diagnoses' plays a major part, but the overlap among them is not addressed.

Substance Abuse

Substance Abuse literature dealing with the homeless, mentally ill, or incarcerated populations tends to concern innovations in dual diagnosis treatment, or treatment for individuals with a mental health diagnosis in addition to substance use disorder (SUD). The high incidence of dual diagnosis is well established in the medical community and the latest research takes the form of program evaluations of dual diagnosis programs[97] or inquiries into characteristics of clients who respond particularly well or badly to such interventions.[98]

Another source for substance abuse treatment programs are journalistic, biographical accounts of addicts' experiences in the treatment system. In Hooked, Lonny Shavelson followed five addicts as they made their way through addiction and treatment and sometimes back again.[99] This piece unearths the implementation problems faced by substance abuse service providers and the barriers to effective treatment.

[97] Minkoff et al 1999
[98] Drake et al 2000
[99] Shavelosn 2001

Mental Health

Mental Health advocates have made tremendous advances in raising awareness, reducing stigma, and bringing mental health issues into the public eye as a medical problem.[100] However, Mental Health service providers are acutely aware of the most vulnerable among their clients and have taken steps to reorganize and in Massachusetts, the Department of Mental Health houses a division of housing and homelessness, a forensic transition team to assist incarcerated clients in making the transition back to the community.[101]

Criminal Justice:
Characteristics of the Incarcerated Population and Current Interventions

Criminal justice policy research regarding substance abuse, homelessness and mental illness can be divided into three main themes; appropriate case disposition, managing the prison population, and re-entry planning to reduce recidivism. The criminal justice system is concerned almost exclusively with persons in its custody, so research is limited to focus primarily on the needs of the criminal justice system rather than the needs of the currently or formerly incarcerated. The war on drugs has prisons stretched beyond capacity and the system has had to re-examine their goals and case processing to

[100] NAMI 2001
[101] DMH 2001a, DMH 2001b

accommodate and manage this new population of low-level drug offenders. Public safety and financial concerns are the basis for the majority of criminal justice research on homelessness, substance abuse, and mental illness. The research attempts to illuminate promising practices to stop the 'revolving door' of the prison and use criminal justice resources more effectively.

In case disposition for offenders with substance abuse or mental health problems, the greatest momentum in the past several years has been in the drug court movement. James Nolan analyzes the emergence of drug courts according to a social movements model and focuses on the story-telling and political positioning drug court activists and drug court judges in particular have had to engage in order to balance those who would accuse them of being soft on crime with their natural allies in the therapeutic world.[102] Nolan examines how the drug court movement attempts to juggle its therapeutic and punitive roles in the public sphere and how a coalition of varied actors have learned to work together in common discourse and with shared goals.

It has been suggested that the increasingly popular drug court model would benefit the mentally ill population as it offers a more flexible range of judicial solutions based on a individual needs.[103] The drug court model is based on the fact that there is effective treatment available for substance abuse, without which jail or prison is nothing but a revolving door for drug offenders. Individualized attention, court-sanctioned treatment, and a regard for the offender's progress and lifestyle merge sanctions and social services.

The Soros Foundation's Open Society Institute advocates for diverting mentally ill offenders away from the criminal justice system and calculates that "approximately 670,000 mentally ill people are admitted to US jails each year. This is nearly eight times the number of patients admitted to state mental hospitals.[104] Diversion programs such as those modeled after drug courts can provide mentally ill offenders with the supportive service they need in the community and ensure that these offenders are placed in the most appropriate setting.

Hodulik takes up the criminalization of the homeless mentally ill under Mayor Rudolph Giuliani in New York.[105] The criminalization of homelessness through increased enforcement of vagrancy and anti-panhandling laws is condemned but no legal solution to providing treatment for this population has been proposed.

[102] Nolan 2001

[103] Hodulik 2001, Soros 1996, Bazelon 2001
[104] Soros 1996, p. 1
[105] Hodulik 2001

Hodulik believes a drug court model for the homeless mentally ill can balance civil liberties concerns with treatment and public safety goals. This research illustrates an evolving debate about the civil right to refuse treatment versus providing effecting services for treatment-resistant mentally ill.

The Bazelon Center for Mental Health Law lobbied the Clinton Administration for a demonstration program for mental health courts analogous to the drug courts demonstration to test the results of targeted, treatment-oriented jail diversion for the mentally ill.[106] A bill authorizing the demonstration was passed but the initiative was never funded by congress. Still, these efforts continue and considerable research ahs been performed to examine the nature of the mentally ill in the criminal justice system. Bazelon has found that mentally ill prisoners have a higher recidivism rate than the general incarcerated population, are more likely to have been homeless, are more likely to have been under the influence of alcohol or drugs at the time of their arrest.[107] Again we see a recognition that these populations overlap considerably, but each discipline views the core group with multiple issues through their own lens and sees the other factors only as special risks and exacerbating factors.

[106] Bazelon 2001b
[107] Bazelon 2001 c, Bazelon 2001d

The US Department of Justice has surveyed incarcerated populations and found high rates of substance abuse and mental illness.[108] These data sets, the Survey of Inmates and the Survey of Probationers, are used in this thesis to identify and analyze the core group. In 1997, the Bureau of Justice Statistics found that 57% of state prisoners and 45% of federal prisoners had used illegal drugs in the month before their offense, and 57% of federal prisoners reported that they had at one times used illegal drugs regularly.[109] Mental illness statistics are also quite high; over 16% of state prisoners and over 7% of federal prisoners are estimated to be mentally ill.[110] These inmates were more likely to have been arrested for a violent crime; 52.9% compared to 46.1% of other inmates. Mentally ill inmates are also more likely to report having been homeless within 12 months prior to their arrest, 20.1% as compared to 8.8% of other inmates.[111] While the Department of Justice contends that 'nearly all' State adults confinement facilities screen inmates for mental health problems,[112] only 60% of state prison inmates who are mentally ill receive treatment. It is precisely such reports that inspired this thesis; data is collected about mental illness, homelessness, crime, and substance abuse, but the overlap between these

[108] USDOJ 1999a, USDOJ 1999c, USDOJ 2001
[109] USDOJ 1999a
[110] USDOJ 1999c
[111] USDOJ 1999c
[112] USDOJ 2001

categories is not fully explored. Thankfully these data sets are available to researchers.

At the back door of the criminal justice system, re-entry planning is increasingly the focus of criminal justice and social service research.[113] Community Resources for Justice in Boston has done research about the importance of re-entry planning in general[114] and housing for returning prisoners as a key component of the re-entry process.[115] These reports attempt to balance a slant towards the rights or returning prisoners who have 'done their time' with a look at public safety and fiscal efficiency of releasing prisoners with nothing in the way of services, supervision, or prospects

The US Department of Justice has funded research and evaluations on re-entry programs, primarily job training programs, and the successful interventions, almost without exception, are those that account for chronic homelessness, mental illness and substance abuse among their clients.[116] Another model for integrating services from various sectors is the case management team, where an interdisciplinary team spans boundaries to ensure continuity of care and reduce recidivism.[117]

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[113] MassInc 2001, Urban 2001
[114] CRJ 2001a
[115] CRJ 2001b, CSJ 2001c
[116] USDOJ 1998a, USDOJ 1998b
[117] USDOJ 1998b