IN FOCUS

Incarceration & Homelessness: A Revolving Door of Risk

A Quarterly Research Review of the National HCH Council: Vol. 2, Issue 2 **Nov. 2013**

The November issue of *In Focus* provides a synthesis of recent literature on the connections between incarceration and homelessness in the United States. The relationship between these topics is an intricate one, as both are risk factors for the other. Some homeless sub-populations are at increased risk for incarceration, including those with mental health issues, youth, and veterans without stable housing. Considerations for these special populations, as well as the health impact of incarceration; the role of housing first, jail inreach, and re-entry programs; and additional policy implications, will be discussed in this publication.

Rates of Incarceration and Homelessness

Incarceration and homelessness are mutual risk factors for each other.[1, 2] Study currency and methodologies vary, but researchers generally estimate that 25-50% of the homeless population has a history of incarceration.[3-5] Compared to adults in the general population, a greater percentage of inmates have been previously homeless (5% of general population versus 15% of incarcerated population with history of homelessness), illustrating that homelessness often precipitates incarceration.[2, 6, 7] Greenberg and Rosenheck found that homelessness was 7.5 to 11.3 times more prevalent among jail inmates than the general population.[2] Exiting homelessness is daunting regardless of one's criminal record. However, individuals with past incarceration face even greater barriers to exiting homelessness due to stigmatization, policies barring them from most federal housing assistance programs, and challenges finding employment due to their criminal records.[4] To meet basic necessities amidst these barriers, previously incarcerated individuals sometimes engage in criminal activities to get by, perpetuating the cycle of homelessness, re-arrest, and incarceration.

History of homelessness is
7.5 to 11.3
times more prevalent among inmates than the general population

Incarceration of Special Populations

Individuals without stable housing are already at greater risk for incarceration than the general population. However, sub-groups within the homeless population—namely individuals with mental health issues, veterans, and youth—have even more widespread incarceration histories.

Mental health issues are prevalent among incarcerated populations. Nearly one million adults with a serious mental illness are booked into jails annually,[8] and many of these individuals have histories of homelessness. Severe mental illness is prevalent among the homeless population and is associated with increased risk of criminal justice system involvement.[2] A study of 6,953 jail inmates found that individuals with homelessness in the year prior to incarceration had symptom clusters associated with mania, depression, psychosis, and substance use at 10-22% higher rates than inmates without prior homelessness.[2] Constantine et al.[9] completed a longitudinal study of 3,769 arrestees and jail inmates with serious mental illness and found that being male, being homeless, not having outpatient mental health treatment, and having an involuntary psychiatric evaluation were independently associated with significantly increased odds of misdemeanor arrests and a longer period of incarceration. The most common diagnoses among this population were major depression, bipolar I disorder, and psychotic disorders; 67% had a substance use disorder diagnosis.

Runaway/homeless youth (RHY) is another sub-population that experiences high rates of incarceration. An estimated 20-30% of unstably housed young people have arrest histories, equating to about 150,000 entering the criminal justice system annually.[10, 11] A cluster analysis of unstably housed youth identified four typological groups based on their use of homeless services: 1) basic survival service use, 2) multiple service use, 3) incarceration experience, and 4) minimal service use.[12] Youth in the group with incarceration experience had high histories of abuse, running away, and risky behavior on the streets in comparison to the other groups. Two-thirds of the previously incarcerated group had been kicked out of their housing compared to less than half of youth in the other three groups. Finally, the previously incarcerated youth were the lowest utilizers of homeless services despite their traumatic histories and high needs.

The unstably housed veteran population also experiences disparate rates of incarceration compared to the general homeless population.[4] Veterans who served during 1973-1980 are especially vulnerable, as they are overrepresented in both the homeless and prison populations.[4, 13-15] In a study of 14,557 veterans in the U.S. Department of Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) program—which provides rental assistance, case management, and clinical services to unstably housed veterans—66% reported incarceration histories.[4] Before entering HUD-VASH, veterans with incarceration histories displayed greater psychiatric symptoms, received more substance abuse diagnoses, and were more likely to be chronically homeless than unstably housed veterans without prior incarceration. Additionally, having served in the Vietnam Theater of operations was associated with a greater history of incarceration, while service in Iraq/Afghanistan was associated with a reduced history of incarceration, demonstrating the diversity among unstably housed veteran cohorts. In a study of previously incarcerated veterans in the Health Care for Re-Entry Veterans Program, 30% were homeless.[6] Among incarcerated veterans who were homeless, three-fourths were episodically or chronically homeless and all reported significantly more mental health problems, more substance abuse, more arrests, and a greater likelihood of incarceration for non-violent offenses than previously incarcerated veterans with stable housing.

Health Impact of Incarceration

In addition to contributing to risk of homelessness, incarceration can also have significant effects on health. Brinkley-Rubinstein and Turner developed a model depicting the intersections of incarceration and health, including risk factors associated with incarceration and proximal predictors of health (see figure 1).[16] In a National Institute of Health manuscript, Dumont et al. describe incarceration as a public health epidemic.[17] Although previously thought to be a protective health influence, incarceration is actually a health risk based on the surge in mortality following release.[17] Overcrowded conditions, high-risk sexual behaviors, and shared needles for drug use and tattoos create ideal conditions for infectious disease outbreaks, although incarceration has even

Source: Brinkley-Rubenstein, L., & Turner, W.L. (2013). Health impact of incarceration on HIV-positive African American males: A qualitative exploration. AIDS Patient Care and STDs, 27(8), 450-458.

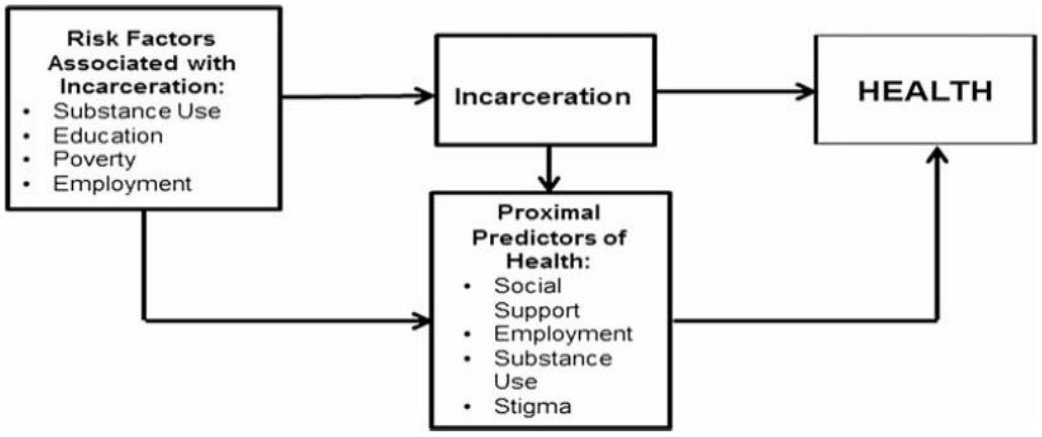

FIG. 1. The hypothesized impact of incarceration on health.

greater adverse effects on addiction and mental illness following release.[17] While the criminal justice system provides a steady source of health care during incarceration, continuity of care is disrupted upon release, particularly for those returning to unstable housing situations. Sudden discontinuation of medications and services, paired with lack of access to services, puts previously incarcerated individuals at risk to cycle among the streets, shelters, emergency rooms, and criminal justice system.[18] In addition to health challenges upon release, previous incarceration can even increase the risk of adult physical and sexual victimization among women.[19]

Re-Entry Programs Targeting the Homeless Population

With high rates of recidivism on top of the deleterious circumstances faced by those without stable housing, several programs have been implemented with much success. These programs connect formerly incarcerated individuals with stable housing, clinical, and support services to break the cycle of recidivism. An overview of these programs and supporting outcome data is presented below.

Jail Inreach

Jail inreach programs build relationships with inmates at risk of homelessness prior to their release, laying the groundwork for continuity of care. Healthcare for the Homeless-Houston operates a Jail Inreach Project that provides intensive medical case management to individuals with behavioral health diagnoses.[18, 20] Eligibility for the program is contingent upon: 1) being incarcerated in the Harris County Jail, 2) having a behavioral health diagnosis(es), 3) expecting to be homeless upon release, and 4) being a "frequent flyer," meaning high arrest rates and utilization of mental health services while incarcerated. Since 2009, the program has worked with over 492 individuals, 22% of which experienced multiple encounters resulting from re-arrest and incarceration. Of first-encounter clients, 56% had successful linkage to services after release, 5% declined services, 11% were transferred to another correctional facility, and 29% did not follow through with the program upon release.[20] The project attributes its success to developing patient-centered release plans with clients and promoting daytime release so that services are immediately accessible, often with case managers accompanying clients directly to the clinic.[18] Immediate linkage reduces missed first appointments and overall loss of clients, reducing arrest rates, number of days in jail, and costs of incarceration to the community.[18]

AHCH Re-Entry Program

The Re-Entry Collaborative (REC), facilitated by the Albuquerque Health Care for the Homeless (AHCH), uses an integrated primary care and social services treatment model to assist with the re-entry of homeless individuals released in the past 90 days with opiate dependency.[21] The program seeks to reduce the human suffering of opiate-addicted individuals without stable housing while also reducing societal damage and system costs of recidivism and overdose deaths. REC is a collaborative among the New Mexico Department of Health, Bernalillo County Substance Abuse Treatment Services, the New Mexico Department of Corrections, and the University of New Mexico Health Sciences Center (Project ECHO). The treatment model includes: 1) opiate replacement therapy using Suboxone, 2) care coordination, 3) stages of change and motivational interviewing for risk reduction, 4) Housing First philosophy, 5) trauma-informed care, and 6) a collaborative model for Systems Integration and Enhancement. REC has produced positive outcomes, including decreased drug use, associated risky/unhealthy behaviors, and mood disorders. Additionally, arrests decreased by 3% over the first six months and 11% after the first 12 months.

Supportive Housing and the Housing First Approach

The Housing First approach, which provides permanent supportive housing without sobriety or treatment requirements, has demonstrated its efficacy among the general homeless population. However, a building body of research has also revealed the model's success in preventing future incarceration and creating housing stability for those with histories of incarceration.

A study of unstably housed adults with medical illnesses and high prior acute care utilization found that the group engaged in Housing First had greater reductions in hospital admissions and jail bookings than the comparison group.[22] Additionally, a study of 95 chronically homeless individuals with severe alcohol problems found that the number of months of Housing First exposure predicted significant decreases in jail days and bookings compared to their incarceration histories in the past two years.[23] Of note, 91.3% of the participants' prior convictions were misdemeanors.

Exposure to
Housing First
predicted significant decreases in jail days and bookings

The supportive housing approach used by the HUD-VASH program has also demonstrated its effectiveness among those with incarceration histories. HUD-VASH does not exclude veterans with past criminal offenses from its permanent supportive housing and clinical services. Tejani et al. completed a study of 14,557 veterans in the HUD-VASH program and found that history of incarceration did not impede therapeutic alliance or housing success. The previously incarcerated population was equally successful at obtaining housing even though it had a higher incidence of chronic homelessness, substance abuse, and alcohol abuse/dependence prior to entering the program.[4]

Conclusion

The mutual risk between homelessness and incarceration necessitates greater attention from clinicians, administrators, researchers, and policymakers. In particular, special considerations should be made for the homeless population subsets at an even greater risk: youth, veterans, and those with mental health issues. A number of effective approaches exist to break the cycle of homelessness and recidivism. Supportive housing/Housing First, jail inreach, and integrated treatment for opiate-dependent individuals are three evidence-based examples. For a policy perspective on the topic, see the National HCH Council's Policy Statement on "Criminal Justice, Homelessness & Health" at http://www.nhchc.org/wp-content/uploads/2011/09/Criminal-Justice-2012.pdf.

References

1. Metraux S, Roman CG, Cho RS. Incarceration and Homelessness. In: 2007 National Symposium on Homelessness; 2008.
2. Greenberg GA, Rosenheck RA. Jail incarceration, homelessness, and mental health: a national study. Psychiatr Serv 2008;59(2):170-7.
3. Metraux S, Culhane DP. Recent incarceration history among a sheltered homeless population. Crime and Delinquency 2006;52(3):504-517.
4. Tejani N, Rosenheck R, Tsai J, Kasprow W, McGuire JF. Incarceration Histories of Homeless Veterans and Progression Through a National Supported Housing Program. Community Ment Health J 2013.
5. Burt MR, Aron LY, Douglas T, Valente J, Lee E, Iwen B. Homelessness: Programs and the people they serve. Findings of the national survey of homeless assistance providers and clients. Washington, D.C.: Urban Institute; 1999.
6. Tsai J, Rosenheck RA, Kasprow WJ, McGuire JF. Homelessness in a National Sample of Incarcerated Veterans in State and Federal Prisons. Adm Policy Ment Health 2013.
7. Greenberg GA, Rosenheck RA. Mental health correlates of past homelessness in the National Comorbidity Study Replication. Journal of Health Care for the Poor and Underserved 2010;21(4):1234-1249.
8. Morrissey JP, Cuddeback GS, Cuellar AE, Steadman HJ. The role of Medicaid enrollment and outpatient service use in jail recidivism among persons with severe mental illness. Psychiatr Serv 2007;58(6):794-801.
9. Constantine R, Andel R, Petrila J, Becker M, Robst J, Teague G, et al. Characteristics and experiences of adults with a serious mental illness who were involved in the criminal justice system. Psychiatr Serv 2010;61(5):451-7.

10. Ferguson KM, Bender K, Thompson SJ, Xie B, Pollio D. Exploration of Arrest Activity among Homeless Young Adults in Four U.S. Cities. Social Work Research 2012;36(3):233-238.
11. Whitbeck LB. Mental health and emerging adulthood among homeless young people. New York: Psychology Press; 2009.
12. Kort-Butler LA, Tyler KA. A cluster analysis of service utilization and incarceration among homeless youth. Soc Sci Res 2012;41(3):612-23.
13. Gamache G, Rosenheck R, Tessler R. The proportion of veterans among homeless men: a decade later. Soc Psychiatry Psychiatr Epidemiol 2001;36(10):481-5.
14. Greenberg GA, Rosenheck R. Risk of Incarceration among Male Veterans and Non-Veterans: Are Veterans of the All Volunteer Force at Greater Risk? Armed Force and Society 2007;33:337-350.
15. McGuire J. Closing a front door to homelessness among veterans. J Prim Prev 2007;28(3-4):389-400.
16. Brinkley-Rubinstein L, Turner WL. Health Impact of Incarceration on HIV-Positive African American Males: A Qualitative Exploration. AIDS Patient Care STDS 2013;27(8):450-8.
17. Dumont DM, Brockmann B, Dickman S, Alexander N, Rich JD. Public health and the epidemic of incarceration. Annu Rev Public Health 2012;33:325-39.
18. Brown CA, Hickey JS, Buck DS. Shaping the Jail Inreach Project: program evaluation as a quality improvement measure to inform programmatic decision making and improve outcomes. J Health Care Poor Underserved 2013;24(2):435-43.
19. Hudson AL, Wright K, Bhattacharya D, Sinha K, Nyamathi A, Marfisee M. Correlates of Adult Assault among Homeless Women. Journal of Health Care for the Poor and Underserved 2010;21(4):1250-1262.
20. Buck DS, Brown CA, Hickey JS. The Jail Inreach Project: linking homeless inmates who have mental illness with community health services. Psychiatr Serv 2011;62(2):120-2.
21. Homeless AHCft. Albuquerque Health Care for the Homeless: Re-Entry Collaborative (REC) Fact Sheet. In. Albuquerque, NM; 2013.
22. Srebnik D, Connor T, Sylla L. A pilot study of the impact of housing first-supported housing for intensive users of medical hospitalization and sobering services. Am J Public Health 2013;103(2):316-21.
23. Clifasefi SL, Malone DK, Collins SE. Exposure to project-based Housing First is associated with reduced jail time and bookings. Int J Drug Policy 2013;24(4):291-6.

DISCLAIMER

This publication was made possible by grant number U30CS09746 from the Health Resources & Services Administration, Bureau of Primary Health Care. Its contents are solely the responsibility of the author and do not necessarily represent the official views of the Health Resources & Services Administration.

Suggested citation: National Health Care for the Homeless Council. (November 2013). Incarceration & Homelessness: A Revolving Door of Risk. *In Focus: A Quarterly Research Review of the National HCH Council, 2*:2. [Author: Sarah Knopf-Amelung, Research Associate] Nashville, TN: Available at: www.nhchc.org.

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

P.O. Box 60427, Nashville, TN 37207 | (615) 226-2292

For more research on incarceration and homelessness, contact Sarah Knopf-Amelung, Research Associate, at sknopf@nhchc.org. For more information about our Research and Evaluation team and other projects at the National HCH Council, contact Dr. Darlene Jenkins at djenkins@nhchc.org.