The Role of Supportive Housing in Successful Reentry Outcomes for Disabled Prisoners

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Abstract

This article discusses the impact of a permanent supportive housing reentry program, Returning Home—Ohio, designed and implemented by the Ohio Department of Rehabilitation and Correction and a nonprofit housing advocacy agency. The program provided supportive housing to individuals who had behavioral health disabilities and who had histories of housing instability or were at risk for housing instability as they were released from 13 state prisons to five Ohio cities. Employing a quasi-experimental design with propensity score weights, the evaluation found that the supportive housing program was associated with recidivism reductions—as measured by rearrests and reincarcerations within 1 year of release. Additional analyses focused on the effects on rearrest outcomes of demographic characteristics and aspects of the supportive housing program received. Several demographic variables, including specific mental health disorders, were significantly associated with recidivism. This article discusses the implications of the findings, particularly for reentry and housing practitioners looking to implement similar programming.

Introduction

Various studies have documented the challenges individuals face in attempting to find stable and secure permanent housing on release from prison. Released prisoners have difficulty locating and affording available, independent housing in their communities for myriad reasons, including (1) incomes and work histories insufficient to rent and maintain independent housing, (2) formal policies inhibiting their ability to secure public housing, (3) long waiting lists for public housing, and (4) resistance by landlords to rent to them (see Fontaine and Biess, 2012; Roman and Travis, 2004, for a review). For these reasons, among others, incarceration places individuals at high risk of residential instability on release from prison or jail (Geller and Curtis, 2011)—leading a small share to enter emergency shelters immediately on release (Metraux, Roman, and Cho, 2008; Metraux

and Culhane, 2006, 2004). Residential instability, including homelessness and frequent moves, has also been documented in the months after release from prison, in part because the postrelease housing many former prisoners arrange before release is often only temporary (Visher and Farrell, 2005; Visher, Yahner, and La Vigne, 2010).

Most former prisoners live with family members or friends immediately upon release (La Vigne, Visher, and Castro, 2004; Visher, Baer, and Naser, 2006; Visher and Courtney, 2007; Visher, La Vigne, and Farrell, 2003), which may or may not be suitable to their longer term reentry plans or goals. Indeed, many of the family members with whom former prisoners live struggle with limited incomes and limited employment histories, and they occasionally have their own service needs and criminal justice issues with which to contend (Brooks et al., 2008; Fontaine, Gilchrist-Scott, and Denver, 2011; Visher and Courtney, 2006). Perhaps for these reasons, research shows that many former prisoners would prefer to have their own housing, believing that residential stability and housing will assist them in their reentry goals (Visher and Farrell, 2005). Recent research by Kirk (2012, 2009) suggests that individuals who move away from their former neighborhoods are more successful in refraining from future criminal activity, perhaps because these moves assist individuals in distancing themselves from their former criminogenic environments and networks.

Despite the volume of literature documenting the housing challenge for former prisoners and the potential for independent, permanent housing to reduce criminal activity, scant empirical evidence indicates that permanent housing, in and of itself, leads to better reentry outcomes. Housing theoretically could be used as a platform or pathway toward successful reentry outcomes—including reductions in recidivism, among other outcomes (Fontaine and Biess, 2012). Permanent supportive housing, in particular, could be an effective platform for a subset of individuals released from correctional institutions whom supportive housing models historically have targeted; that is, individuals with histories of or at risk for residential instability (homelessness), mental illnesses, and substance abuse disorders (Burt and Pearson, 2005).

The efficacy of permanent supportive housing for individuals with histories of residential instability and behavioral health issues has been well established in the literature. In particular, several meta-analyses and systematic reviews have concluded that supportive housing significantly improves a range of outcomes for the population with behavioral health issues. It is particularly effective in increasing residential stability, but it also leads to reductions in individuals' use of emergency shelters and emergency medical services and reductions in their length of stay in correctional institutions, such as prisons and jails (see Rog, 2004; Rogers, Kash-MacDonald, and Olschewski, 2009; Miller and Ngugi, 2009). This particular population—those affected by behavioral health issues and histories of residential instability—are disproportionately represented in the correctional population (James and Glaze, 2006; Mellow and Christian, 2008). In summary, it is evident that many of those released from correctional institutions are in need of and would benefit from permanent, independent housing. Permanent supportive housing is an evidence-based program for the population with histories of behavioral health issues and residential instability—a population that is, unfortunately, well represented in the population released from prison.

Using data from a multiyear evaluation, recently completed by the Urban Institute,[1] of the process, impact, and cost of a program called Returning Home—Ohio (RHO), this article adds to the extant literature in two primary ways. First, this article includes impact evaluation findings of a supportive housing program designed specifically for individuals released from state prison to the community. The findings demonstrate the ways in which (permanent supportive) housing can be a pathway toward successful reentry, focusing on rearrest and reincarceration outcomes. Second, because of the significant variation evident in the supportive housing program and in the population it served by design, the article includes findings on the relationship between some of the supportive housing components received and the population served to understand which were associated with recidivism. The first half of this study is notably grounded in the relatively robust empirical literature on the efficacy of permanent supportive housing models, whereas the second half is distinctly exploratory. Indeed, scant empirical literature "unbundles" what is most effective about supportive housing models (Osher and Steadman, 2007), and only limited evidence suggests who benefits the most (Rog, 2004; Rogers, Kash-MacDonald, and Olschewski, 2009).

This article begins with a further review of the literature on supportive housing and its role in reentry, providing context for the current study. After this review, it outlines the supportive housing program that was evaluated and highlights key aspects of the pilot program. The article then discusses the methods and data sources used to understand the effect of the pilot on recidivism and the relationship among participant characteristics, supportive housing, and recidivism. It then presents the findings for each component of the study in detail, including a summary of the main limitations of the findings. Finally, the article addresses the implications of the findings—particularly, for the field of reentry and housing practitioners and policymakers looking to implement similar programming for the reentry population.

Research Supporting the Efficacy of Supportive Housing for the Reentry Population

In general, supportive housing is the combination of affordable housing with supportive services that can include coordinated case management; health, mental health, and substance abuse treatment services; educational services; and vocational training and employment services. Supportive housing services are tailored by provider and intended to vary depending on participants' need of services and risk for residential instability (Rogers, Kash-MacDonald, and Olschewski, 2009). Supportive housing has been used to assist in the residential stability of the population at risk of homelessness and of those with histories of homelessness, mental health illnesses, or substance use illnesses (Burt and Pearson, 2005). Rates of housing retention have been high among various populations provided supportive housing, including those with severe mental illnesses, co-occurring mental illness and substance abuse diagnoses, and those who are chronically homeless (Martinez and Burt, 2006; Wong et al., 2006).

[1] For more information about the housing pilot and evaluation, see Fontaine et al. (2012).

Studies and meta-analyses have consistently shown that supportive housing is effective, particularly in its ability to keep individuals residentially stable over time (Hurlburt, Hough, and Wood, 1996; Leff et al., 2009; Miller and Ngugi, 2009; Newman et al., 1996; Rog, 2004; Rogers, Kash-MacDonald, and Olschewski, 2009). Many supportive housing models are based on a "housing first" approach, an approach that emphasizes housing stabilization and harm reduction, wherein continued tenancy is not dependent on participation in services or maintaining abstinence (see NAEH, 2006; HUD-PD&R, 2007). As a result, the residential stability offered through supportive housing has also been associated with reductions in the use of and length of stay in other institutional settings, such as emergency treatment facilities, emergency hospitals, and correctional institutions (Rog, 2004; Rogers, Kash-MacDonald, and Olschewski, 2009). That is, individuals' use of other, often costly, public services declines after they become residentially stable in supportive housing (see Culhane, Metraux, and Hadley, 2002).

Very little research, however, has explored the specific aspects of the supportive housing that could be related to positive outcomes or the extent to which supportive housing is more effective than other housing models (for example, transitional housing or affordable housing models). The research demonstrates that supportive housing is more effective than no housing or nonmodel housing and that housing with more defined services may be more effective (Leff et al., 2009; Rog, 2004), but research on the components of effective supportive housing models is mostly missing in the literature. After their review of the extant literature at the time, Osher and Steadman (2007) argued that supportive housing has the potential to achieve significant behavioral health and public safety outcomes for the population with mental illnesses, yet no single model or package of services has emerged specifically for housing those with mental illnesses in the criminal justice system. Osher, Steadman, and Barr (2003) previously argued for the best-practice model called APIC (assessment, planning, identifying, and coordination), currently used for severely mentally ill patients in the community, to be expanded to that same population released from correctional institutions.

In addition to the different aspects of the service components, many aspects of the housing could be related to outcomes, including the characteristics of the specific housing unit, its affordability and quality, and its location (Fontaine and Biess, 2012). For the population returning from prison, the location of the housing unit may be critical if it offers returning prisoners greater access to employment opportunities, for example. On the other hand, as Kirk (2012, 2009) suggested, the location of the housing unit could be critical if it affords former prisoners the ability to distance themselves from former criminogenic networks.

Further, little is known on the effectiveness of supportive housing for the reentry population specifically. Although supportive housing has been found effective for the population with behavioral health disorders, and although a disproportionate number of individuals released from correctional institutions have behavioral health histories (James and Glaze, 2006), we know relatively little about supportive housing for those released directly from prisons and jails. A meta-analysis by the Washington State Institute for Public Policy concluded that the relative effect of housing and housing supports for the reentry population cannot yet be fully understood, given that housing and housing support services are commonly bundled with other services as part of more comprehensive reentry programs that typically serve a general population of formerly incarcerated people (Miller and Ngugi, 2009).

Housing theoretically could be a critical component of the reentry and reintegration process for formerly incarcerated people (Fontaine and Biess, 2012). For the population with or without behavioral health challenges, incarceration places individuals at immediate risk of residential instability on release (Geller and Curtis, 2011; Metraux and Culhane, 2006, 2004; Metraux, Roman, and Cho, 2008). Many former prisoners return to the community with only temporary housing arrangements (Visher and Farrell, 2005). For former prisoners, in particular, housing instability is a barrier to sustained employment and family reunification or support (Graffam et al., 2004; Roman and Travis, 2004), each of which has been associated with recidivism. Based on the literature, we expected that RHO would significantly reduce recidivism given the strong evidence base on supportive housing models and that RHO intentionally recruited the population expected to benefit most from supportive housing in the institutions. Furthermore, RHO included several hallmarks of successful reentry programming, including prerelease reentry planning and assessment of risk and needs, transitional services that continued from prison to the community, and the provision of services for an extended period of time (Petersilia, 2004; Visher and Travis, 2011).

Overview of the Permanent Supportive Housing Program

RHO was a joint venture of the Ohio prison system, the Ohio Department of Rehabilitation and Correction (ODRC), and a housing advocacy agency, the Corporation for Supportive Housing (CSH), whose mission is to support housing as a platform for vulnerable populations. The program was funded mostly by ODRC. ODRC and CSH planned and implemented the supportive housing pilot program—designed for individuals who had a disability, broadly defined, and who either had a history of, or were at risk for, homelessness on release—in 13 Ohio prisons in late 2006 and early 2007. The pilot provided prerelease reentry planning and postrelease housing and supports in five cities across the state with one of nine supportive housing providers associated with the pilot. One of the primary goals of the pilot was to reduce recidivism and residential instability under the logic that the provision of supportive housing to individuals as they were released from prison was a way to break costly cycles of system use and increase public safety and public health.

Whereas institutional staff determined eligibility for the pilot (disabilities and history of homelessness or risk of homelessness on release), the nine community-based providers associated with RHO made the final decision to enroll and house eligible prisoners after release. The RHO supportive housing providers varied—some had experience providing housing supports for the indigent population primarily, whereas others were more experienced working with individuals with severe mental illnesses or histories of trauma. Some providers had a history of employing a scattered-site housing model with private landlords, whereas others owned or managed a single affordable housing property where RHO participants were housed in units among non-RHO participants. The variation in the housing and support services offered was purposeful; ODRC and CSH recruited a diverse group of experienced housing providers to match the diverse eligible pilot population. Each provider managed its own implementation of supportive housing to its participants using the experience it had in implementing supportive housing before RHO.

Enrollment in the pilot proceeded in four steps: (1) prerelease identification by institutional staff in the 13 Ohio prisons; (2) prerelease referral to one of the housing providers associated with the pilot;

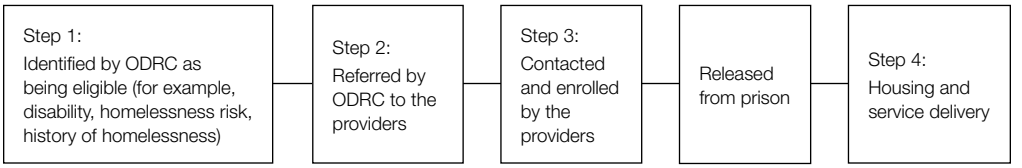
(3) prerelease contact and enrollment (in person or by teleconference) by one of the housing providers associated with the pilot—which included the development of a reentry plan that included postrelease housing and supportive services, as needed, for those accepted into the program by the provider; and (4) postrelease housing and supportive services with the provider in one of the five cities—either scattered-site housing with a private landlord or single-site housing managed or owned by one of the pilot-associated providers. Exhibit 1 shows the ideal pathway into the program through these four steps.

In practice, however, significant variation occurred, and RHO participants had three primary pathways into the program. Among the RHO participants, 45 percent had the ideal pathway to housing—that is, they were identified by the prison as eligible, referred to a provider, and subsequently enrolled into the pilot before release. The remainder of RHO participants (55 percent) followed a less than ideal pathway into the program. Some (18 percent) were identified and referred prerelease but enrolled into the program by the provider after release. Others (17 percent) were identified, referred, and enrolled after release. The remaining 20 percent did not fall into any of these primary pathways due to missing provider data, out of order pathways (for example, contact and enrollment occurred before ODRC referral), or inconsistent dates of provider enrollment (for example, contact and enrollment occurred at different dates). Additional variation was evident in the actual receipt of supportive housing in the community. For some individuals, housing occurred immediately upon their release from the institution, whereas others were in the community for several weeks or months before receiving supportive housing. The variation in the pathways to housing was due to (1) inherent challenges in facilitating the reentry process before release, (2) the type and availability of housing offered by the community-based providers, and (3) the number of stakeholders involved in the identification and enrollment process. Prerelease recruitment was a critical goal for this pilot because the months immediately after release are known to be critical periods for the reentry population generally (Langan and Levin, 2002)—particularly for a population that has a history of, and is at risk for, residential instability.

Despite the variability in the pathways into the program, over a period of approximately 2 years, the program housed more than 100 individuals in the community. In addition to receiving the housing, individuals received a host of supportive services in the community, including mental health services, such as medication and therapy; substance abuse services, such as Alcoholics Anonymous; and other supportive services offered by the providers directly or through referrals to other agencies. Unfortunately, the evaluation was able to collect only limited systematic information on the providers' services across all the pilot participants to understand the direct effect of

Exhibit 1

Ideal Pathway Into the RHO Program



ODRC = Ohio Department of Rehabilitation and Correction. RHO = Returning Home—Ohio.

Source: Urban Institute analysis of discussions with stakeholders from ODRC, the Corporation for Supportive Housing, and the RHO supportive housing providers

provider services on outcomes. Further, the provision of services was guided primarily by whether the individual needed more (or fewer) services, and only one provider required services as a condition of program enrollment. As shown in the following section, the population recruited into RHO also varied on the program eligibility criteria and other demographics, suggesting that a range of different service options was needed.

Because of the variation found in the pathways into the program and the variation in the housing offered (single or scattered-site housing providers), a secondary goal of the study was to identify whether these two core objective measures of the program were related to outcomes. As mentioned, the moment of release is a critical period and the variation in the pathways to the RHO program theoretically could be related to outcomes. For example, individuals who experienced the ideal pathway received additional provider services given their prerelease enrollment as compared to those who did not experience prerelease enrollment. The different housing models the providers employed are also a rough proxy for the different services to which individuals were exposed. For example, the single-site housing models used in the RHO program had onsite staff who could monitor RHO (and other) residents, whereas RHO participants in the scattered-site housing models had more independence. In another example, the scattered-site housing providers needed approval from private landlords to house individuals—which would have been easier to receive for some participants rather than others. The single-site housing providers, however, did not have to overcome this additional barrier.

Therefore, after exploring the program's overall impact on recidivism, the study focuses on what characteristics of the treatment group were related to recidivism and whether pathways into the program and housing type were related to recidivism. The variation in the eligible population, provider experiences, and services required ODRC, CSH, and the providers to work collaboratively to identify and match the "right" population of eligible prisoners to the "right" provider.[2] Although the variation evidenced in RHO is a reflection of the variety built into supportive housing programs more generally, it provided an opportunity to explore whether that variety was related to outcomes.

Methods—Sample, Data Collection, and Analysis Strategy

Using a quasi-experimental design, the impact evaluation focused on a prospective cohort of prisoners released from the pilot prisons during the pilot's implementation period (2007 to 2009). The evaluation compared individuals receiving supportive housing through the pilot with a contemporaneous cohort of individuals released from the target prisons deemed eligible for the pilot but not housed. The pilot offered fewer units than could house the number of individuals assumed to be eligible. The study requested consents from every individual interested in the pilot program and collected data from only those individuals from whom the research team received signed consents.[3] Enrollment into the study yielded a total sample of 244 individuals, 121 of whom were provided housing

[2] More information is available in the full report on the process evaluation of the program (Fontaine et al., 2012).

[3] Participation in the research study was not a condition of participation in the program. Therefore, the findings are limited to the sample from which the Urban Institute received a signed consent. Our analyses suggest that very few individuals served by the pilot did not consent to participate in the study.

through the pilot. Data were collected from ODRC for 239 of the 244 consenting individuals, including 121 RHO participants (treatment) and 118 comparison group participants. In addition to collecting data on individuals' basic demographic characteristics, including age, race/ethnicity, and gender, data on time served in instant incarceration (*time served*), ODRC incarceration histories (*previous incarcerations*), security level and release risk as classified by ODRC (*security level and release risk level*), homelessness status at arrest (*recent homelessness*), primary disability classifications and diagnoses (*mental health or alcohol or drug abuse*), medical status (*medical status*), and postrelease supervision status (*postrelease supervision*).

Enrollment in the study took 2 years for several reasons, chiefly the initial implementation challenges that slowed enrollment into the RHO program. Comparison group enrollment was skewed toward the latter months of the study enrollment period. Funding constraints required us to focus only on 1-year outcomes. We collected information on 1-year rearrest incidents for any crime, including felonies and misdemeanors, and 1-year reincarceration incidents for any reason, including community supervision violations and new crimes. Exhibit 2 shows select demographic, incarceration, and program characteristics of the individuals in the sample, including those housed and not housed by the pilot, based on data collected from ODRC.

As shown in exhibit 2, there were significant differences in the sample groups with respect to their racial /ethnic breakdown, prison security level, and alcohol or drug abuse disability. Statistically nonsignificant, yet notable percentage differences were observed between the two groups on their time served in prison[4] and the percentage who were recently homeless. Taken together, the differences in these demographic, incarceration, and program characteristics suggest that the treatment group may have been at a slightly greater risk of rearrest and reincarceration upon release than the comparison group. Exhibit 2 shows, however, that the 1-year rearrest and reincarceration outcomes are significantly different on two of the six recidivism measures estimated—with the treatment group having better outcomes. The comparison group had a higher rate of total rearrests and rearrests for misdemeanors. Although the comparison group was also reincarcerated at a higher rate than the treatment group, tests of statistical differences for total reincarcerations, new crimes, and technical violations between the two groups was not significant at or below the .10 level of significance.

In addition to the significant differences between the treatment and comparison groups on some of the demographic, incarceration, and program-eligibility variables, additional statistical tests confirmed that several demographic variables were associated with group assignment. A logistic regression predicting assignment into the treatment group showed that race/ethnicity, primary disability, recent homelessness, and security level increased the probability that an individual was placed into the treatment group.[5] Therefore, we used inverse propensity score weights in our regression models, given that the potentially biased process used to select program participants could be related to outcomes—as evidenced by the regression model predicting group assignment and discussions with stakeholders on how participants were enrolled into the program.

[4] The *time served* variable is notably short, particularly for RHO participants. This short time is because several RHO participants were recruited into the program while serving a sentence for a postrelease violation. Furthermore, stakeholders from ODRC indicated that RHO was used as a viable way to house individuals deemed "hard to house."

[5] Results are available from the author on request.

Exhibit 2

Select Demographic, Incarceration, and Program Characteristics and 1-Year Recidivism Outcomes of Sample Groups

	Treatment—RHO Participant	Comparison	Significance Level
Male (percent)	76.9	78.8	—
White (percent)	40.5	60.2	.01
Age at release (years)	41.6	42.4	—
Time served (days)	907.4	1,289.7	—
Previous incarcerations	1.8	1.6	—
Security level[a]	2.61	2.43	.05
Release risk level[b]	1.18	1.18	—
Postrelease supervision (percent)	50.4	53.0	—
Recent homelessness (percent)	23.1	14.9	—
Primary disability—MH (percent)	62.8	65.4	—
Primary disability—AOD (percent)	31.4	20.6	.01
Medical status[c]	1.62	1.50	—
Any rearrest (percent)	27.3	37.3	.05
Rearrest—felony (percent)	18.2	17.8	—
Rearrest—misdemeanor (percent)	18.2	27.1	.05
Any reincarceration (percent)	6.6	11.0	—
Reincarceration—new crime (percent)	5.8	8.5	—
Reincarceration—technical violation (percent)	0.8	2.5	—

AOD = alcohol or other drug use. MH = mental health. RHO = Returning Home—Ohio.

[a] Security level ranges from 1 to 5, from low- to high-security level.

[b] Release risk level ranges from -1 to 8, from low or basic risk to high or intensive risk.

[c] Medical status ranges from 1 to 4, from regular checkups to intensive care required.

Notes: Various statistical tests of differences in the means of the treatment group and the comparison group tested whether the differences were significantly different from 0: $p < .10$, $p < .05$, and $p < .01$. Valid N = 121 treatment-group participants, 118 comparison-group participants.

Source: Urban Institute analysis of data from the Ohio Department of Rehabilitation and Correction

Findings—Impact of RHO on Recidivism

Exhibit 3 shows the three weighted logistic regression models on any rearrest (within 1 year) and three weighted logistic regression models on any reincarceration (within 1 year). All the models for the logistic regression of any rearrest and any reincarceration include the propensity weights and covariates. The final models (model 1.3 and 2.3) that have the propensity weights and the most covariates show that placement into the treatment group is associated with statistically significant recidivism reductions. We decided to include the weights and the covariates, or doubly robust models, to reduce bias to the greatest extent possible. Although including covariates and propensity weights in regression models trades precision in the estimates for reduced error, we preferred to use the doubly robust models to get the best sense of the impact of RHO on recidivism (see Funk et al., 2011). In addition, correlations of all the covariates in the final models (model 1.3 and 2.3) were not heavily collinear,[6] which suggests that each final model provides the least biased estimate of the impact of the program on outcomes.

[6] Results are available from the author on request.

Exhibit 3

Logistic Regression of Any Rearrest or Reincarceration Within 1 Year After Release (1 of 2)

	Any Rearrest Within 1 Year After Release (model number)			Any Reincarceration Within 1 Year After Release (model number)		
	1.1	1.2	1.3	2.1	2.2	2.3
RHO treatment	– 0.660**	– 0.809**	– 0.852***	– 0.611	– 0.907	– 1.404*
	(0.295)	(0.316)	(0.322)	(0.510)	(0.605)	(0.724)
Age at release	– 0.023	– 0.028	– 0.039**	– 0.007	– 0.013	– 0.012
	(0.018)	(0.021)	(0.021)	(0.028)	(0.035)	(0.043)
Race/ethnicity—White	– 0.015	– 0.189	– 0.183	– 0.906*	– 1.181*	– 1.114
	(0.298)	(0.342)	(0.352)	(0.535)	(0.673)	(0.765)
Gender—male	0.123	0.122	– 0.361	0.649	0.715	0.073
	(0.374)	(0.404)	(0.441)	(0.781)	(0.878)	(1.043)
MH disability	0.187	0.042	0.167	0.228	0.111	0.073
	(0.620)	(0.633)	(0.719)	(0.963)	(1.094)	(1.405)
AOD disability	0.107	– 0.160	– 0.341	– 1.129	– 1.027	– 1.475
	(0.630)	(0.669)	(0.672)	(1.127)	(1.247)	(1.439)
Primary disability—MH and primary disability—AOD	– 0.119	– 0.039	0.005	0.906	0.580	1.533
	(0.723)	(0.770)	(0.781)	(1.253)	(1.403)	(1.681)
Security level	0.231	0.306	0.212	0.623*	0.530	0.526
	(0.210)	(0.248)	(0.260)	(0.342)	(0.424)	(0.523)
Recent homelessness	—	0.411	0.023	—	1.260	0.979
		(0.476)	(0.464)		(0.800)	(0.863)
Previous incarcerations	—	0.312***	0.386***	—	0.222	0.353**
		(0.096)	(0.098)		(0.146)	(0.166)
Time served	—	< 0.000	—	—	< 0.000	—
		(< 0.000)			(< 0.000)	
Postrelease supervision	—	0.169	0.003	—	0.861	0.487
		(0.369)	(0.366)		(0.677)	(0.740)
Release risk level	—	– 0.375	– 0.249	—	1.573**	1.789***
		(0.443)	(0.444)		(0.617)	(0.692)
Medical status	—	—	– 0.402	—	—	1.293*
			(0.337)			(0.725)
Psychotic MH disorder	—	—	– 0.852*	—	—	– 0.243
			(0.469)			(0.794)
Substance use MH disorder	—	—	0.531	—	—	0.010
			(0.434)			(0.930)
Personality MH disorder	—	—	0.529	—	—	0.775
			(0.433)			(0.812)
Mood MH disorder	—	—	– 0.327	—	—	1.014
			(0.395)			(0.757)
Anxiety MH disorder	—	—	– 0.147	—	—	– 2.723***
			(0.369)			(1.001)

Exhibit 3

Logistic Regression of Any Rearrest or Reincarceration Within 1 Year After Release (2 of 2)

	Any Rearrest Within 1 Year After Release (model number)			Any Reincarceration Within 1 Year After Release (model number)		
	1.1	1.2	1.3	2.1	2.2	2.3
Other MH disorder	—	—	0.273	—	—	1.040
			(0.649)			(1.063)
AIC	290.45	274.93	286.55	137.08	124.26	122.02
N	223	223	223	223	223	223

AIC = Aikaka Information Criteria. AOD = alcohol or other drug use. MH = mental health. RHO = Returning Home—Ohio.

**p < .10. **p < .05. ***p < .01.*

Notes: Each column reports selected coefficients from a logistic regression that includes inverse propensity score weights. The treatment coefficient is the expected change in the odds of any rearrest or reincarceration from being placed in the treatment group as opposed to being placed in the comparison group. Positive values indicate that the treatment group is more likely to be rearrested or reincarcerated than the comparison group; negative values indicate that the treatment group is less likely to be rearrested or reincarcerated than the comparison group.

Source: Urban Institute analysis of data from the Ohio Department of Rehabilitation and Correction

According to the final models, 1.3 and 2.3, receipt of supportive housing through the RHO program was associated with a reduced probability of rearrest and reincarceration. Specifically, RHO participants were 40 percent less likely to be rearrested within 1 year and 61 percent less likely to be reincarcerated within 1 year compared with the rates for the comparison group. A logistic regression on the felony rearrests (within 1 year) and misdemeanor rearrests (within 1 year), which similarly included the propensity weights and all the covariates, showed that RHO participants were significantly less likely to be rearrested for misdemeanors only (43 percent less likely). The logistic regression showed that RHO participation was not associated with significant reductions in felony rearrests. Models estimating the impact of RHO participation on reincarceration rates for new crimes did not show a significant effect for the RHO treatment variable and models estimating RHO's effect on technical violations was not estimated given the few observations.[7]

In addition to the significant impact of RHO participation on rearrests, rearrest outcomes were also significantly associated with some of the covariates. Specifically, being younger, having more previous incarcerations, and having no diagnosis of a psychotic disorder were associated with a significantly greater likelihood of rearrest within 1 year of release from prison (exhibit 3, column 1.3). Regarding the reincarceration model, in addition to RHO participation, previous incarcerations, release risk, medical status, and anxiety disorder diagnosis were significantly associated with reincarceration outcomes. Specifically, having more previous incarcerations, a higher release risk, a lower medical status (denotes receiving less medical care in prison), and no diagnosis of an anxiety disorder were associated with a significantly greater likelihood of reincarceration within 1 year of release. The significant relationship between release risk and reincarceration is notable, given that this variable is ODRC's measure of an inmate's likelihood of reincarceration (exhibit 3, column 2.3).

[7] Results are available from the author on request.

Aside from the significant findings of program effects that have implications for the reentry housing field (discussed in a subsequent section), the findings of RHO's impact on recidivism is notable for two methodological reasons. First, given the 1-year followup period, the study may have underestimated the program's full benefits. Recall that several RHO participants were not housed with the program until several weeks (or months) after their release from prison, and others were not contacted by the program at all until weeks or months after their release from prison. Although every RHO participant received housing in the 1-year followup period, RHO demonstrated significant impact given the small dosage (of housing) that some participants actually received. Second, as discussed in the review of the housing program, significant variation was built into the program by design. The program participants varied (on homelessness and disability), and the housing support services varied, including the participants' pathway into the program. Some of the variation was likely related to better (or worse) outcomes, yet, the impact evaluation includes the entire cohort of RHO participants, including those with better (or worse) outcomes. Stated differently, bias in the RHO treatment variable that is not modeled in the logistic regressions just described. Therefore, to explore whether some participant characteristics and program components were related to better (or worse) outcomes, the second half of this study focuses exclusively on the treatment group.

First, we explored whether the treatment group that was rearrested was significantly different from the treatment group that was not rearrested. The decision to focus only on rearrests was because of the few observed reincarcerations among the treatment group during the study period. Next, we explored whether program eligibility criteria were related to the two core program components outlined—pathway into the program and scattered-site housing provider. Last, we explored whether all these measures were related to rearrest outcomes.

Findings—Effect of Demographics and Program Components on Recidivism

Despite the relatively small sample of program participants with full data (N = 118), several significant differences were observed between the not-rearrested group and the rearrested group. As displayed in exhibit 4, the group rearrested 1 year after release comprised significantly more males, more non-Whites, and more of those with more previous incarcerations. In addition, the rearrested group also comprised significantly more individuals who had served less time in their most recent incarceration and were not under postrelease supervision. Regarding the program-specific eligibility criteria, exhibit 4 shows that the group that was rearrested comprised significantly fewer individuals who were homeless at arrest (of the instant incarceration that got them into RHO) and fewer who had mental illness as their primary disability. The rearrested group had significantly lower medical statuses (meaning they were receiving fewer medical services in prison). The rearrested group also comprised significantly more individuals diagnosed with a substance abuse mental health or personality disorder. Taken together, the significant differences between the group on homelessness at arrest and disabilities may be an indication that the RHO program is working well for those for whom supportive housing has been shown to be most effective. Finally, of the two variables related to the program services, the rearrested group comprised fewer individuals who experienced the ideal pathway into the program (the variable is marginally significant)—that is, fewer individuals whose pathway into RHO included prerelease identification by ODRC and prerelease enrollment by a provider.

Exhibit 4

Differences in 1-Year Rearrest Outcomes, by RHO Participants' Demographic, Incarceration, and Program Characteristics

	Not Rearrested	Rearrested	Significance Level
Male (percent)	74.4	87.5	.10
White (percent)	47.7	25.0	.05
Age at release (years)	41.6	41.8	—
Time served (days)	1,051.3	358.1	.05
Previous incarcerations (percent)	1.17	3.42	.01
Security level (percent)[a]	2.61	2.68	—
Release risk level (percent)[b]	1.15	1.23	—
Postrelease supervision (percent)	58.1	28.1	.01
Recent homelessness (percent)	27.9	9.38	.01
Disability[c]—MH (percent)	70.9	56.3	.10
Disability[c]—AOD (percent)	72.1	71.8	—
Medical status[d]	1.55	1.34	.05
Psychotic MH diagnosis[e] (percent)	26.7	31.3	—
Substance use MH diagnosis[e] (percent)	45.3	62.5	.05
Personality MH diagnosis[e] (percent)	15.1	37.5	.01
Mood disorder MH diagnosis[e] (percent)	47.7	43.8	—
Anxiety MH diagnosis[e] (percent)	36.0	25.0	—
Other MH diagnosis[e,f] (percent)	5.81	12.50	—
Ideal pathway to program (percent)	50.6	37.5	.10
Scattered-site housing provider (percent)	51.2	43.8	—

AOD = alcohol or other drug use. MH = mental health. RHO = Returning Home—Ohio.

[a] Security level ranges from 1 to 5, from low- to high-security level.

[b] Release risk level ranges from -1 to 8, from low or basic risk to high or intensive risk.

[c] Disability could be primary or secondary.

[d] Medical status ranges from 1 to 4, from regular checkups to intensive care required.

[e] Psychotic, substance use, personality, mood, and anxiety disorders are Axis I or Axis II MH classifications.

[f] Other MH diagnosis includes mental retardation and developmental disabilities and attention deficit hyperactive disorder, among others.

Notes: Various statistical tests of differences in the means of the treatment group and the comparison group tested whether the differences were significantly different from 0: $p < .10$; $p < .05$; $p < 0.01$. N = 118 (treatment group/RHO participants only).

Source: Urban Institute analysis of data from the Ohio Department of Rehabilitation and Correction

Given the findings of significant differences between the not-rearrested and arrested groups along several program-specific variables (for example, homelessness, disability, and ideal pathway), we analyzed several two-way interactions using chi-square tests to further explore their relationship to recidivism. Exhibit 5 shows the interaction between the ideal pathway and recent homelessness, mental health disability, and alcohol or drug use disability and its relationship to rearrests. Exhibit 6 similarly shows the interaction between scattered-site housing provider and the same three demographics and its relationship to rearrests. Of the six interactions estimated, only one is statistically significant: the interaction between recent homelessness and ideal pathway. None of the interactions between scattered-site housing provider and homelessness or disability were significant at or below the .10 level of significance. A relationship appears to exist between recent homelessness and ideal pathway; the distribution of rearrests along the continuum of these two variables is significantly different from the distribution that would be expected if there was no

Exhibit 5

Interaction Between Select Eligibility Criteria, Ideal Program Pathway, and Recidivism

Recent Homelessness* + Ideal Pathway			
	Not Arrested	**Arrested**	**Total**
0: not homeless, not ideal pathway.	31	19	50
	(62.0%)	(38.0%)	
1: not homeless, ideal pathway.	30	10	40
	(75.0%)	(25.0%)	
2: homeless, not ideal pathway.	11	1	12
	(91.7%)	(8.3%)	
3: homeless, ideal pathway.	13	2	15
	(86.7%)	(13.3%)	
Total	85	32	117
MH Disability + Ideal Pathway			
	Not Arrested	**Arrested**	**Total**
0: no MH disability, not ideal pathway.	12	9	21
	(57.1%)	(42.9%)	
1: no MH disability, ideal pathway.	13	5	18
	(72.2%)	(27.8%)	
2: MH disability, not ideal pathway.	30	11	41
	(73.2%)	(26.8%)	
3: MH disability, ideal pathway.	30	7	37
	(81.1%)	(18.9%)	
Total	85	32	117
AOD Disability + Ideal Pathway			
	Not Arrested	**Arrested**	**Total**
0: no AOD disability, not ideal pathway.	12	6	18
	(66.7%)	(33.3%)	
1: no AOD disability, ideal pathway.	12	3	15
	(80.0%)	(20.0%)	
2: AOD disability, not ideal pathway.	30	14	44
	(68.2%)	(31.8%)	
3: AOD disability, ideal pathway.	31	9	40
	(77.5%)	(22.5%)	
Total	85	32	117

AOD = alcohol or other drug use. MH = mental health.

** p = .10.*

Note: Chi-square significance testing tested whether the observed distribution differed from the expected distribution of no relationship between eligibility criteria, ideal pathway, and rearrest. Numbers in parentheses indicate the percentage of the total that fell into each group.

Source: Urban Institute analysis of data from the Ohio Department of Rehabilitation and Correction and the Returning Home—Ohio housing providers

significant relationship between these variables. The significant interaction suggests that the ideal pathway into the program may have been particularly beneficial to individuals with recent homeless experiences.

The lack of significance for the other two-way interactions indicates that entering the program through the ideal pathway does not appear particularly beneficial, in terms of rearrest outcomes,

Exhibit 6

Relationship Between Select Eligibility Criteria, Scattered-Site Housing Provider, and Recidivism

Recent Homelessness + Scattered-Site Provider			
	Not Arrested	**Arrested**	**Total**
0: not homeless, not scattered-site provider.	36 (69.2%)	16 (30.8%)	52
1: not homeless, scattered-site provider.	26 (66.7%)	13 (33.3%)	39
2: homeless, not scattered-site provider.	6 (75.0%)	2 (25.0%)	8
3: homeless, scattered-site provider.	18 (94.7%)	1 (5.3%)	19
Total	86	32	118
MH Disability + Scattered-Site Provider			
	Not Arrested	**Arrested**	**Total**
0: no MH disability, not scattered-site provider.	15 (60.0%)	10 (40.0%)	25
1: no MH disability, scattered-site provider.	10 (71.4%)	4 (28.6%)	14
2: MH disability, not scattered-site provider.	27 (77.1%)	8 (22.9%)	35
3: MH disability, scattered-site provider.	34 (77.3%)	10 (22.7%)	44
Total	86	32	118
AOD Disability + Scattered-Site Provider			
	Not Arrested	**Arrested**	**Total**
0: no AOD disability, not scattered-site provider.	11 (73.3%)	4 (26.7%)	15
1: no AOD disability, scattered-site provider.	13 (72.2%)	5 (27.8%)	18
2: AOD disability, not scattered-site provider.	31 (68.9%)	14 (31.1%)	45
3: AOD disability, scattered-site provider.	31 (77.5%)	9 (22.5%)	40
Total	86	32	118

AOD = alcohol or other drug use. MH = mental health.

Note: Chi-square significance testing tested whether the observed distribution differed from the expected distribution of no relationship between eligibility criteria, scattered-site housing provider, and rearrest. Numbers in parentheses indicate the percentage of the total that fell into each group.

Source: Urban Institute analysis of data from the Ohio Department of Rehabilitation and Correction and the Returning Home—Ohio housing providers

for individuals with mental health and alcohol and other drug disabilities. This lack of significance alternatively suggests that, although the ideal pathway appears to be beneficial for the entire RHO group (as evidenced in exhibit 4), its benefits were independent of the mental health or alcohol and drug disability status of those in the program. The nonsignificant findings on any of the interactions between disability or recent homelessness and scattered-site housing provider also seem to

suggest that those served by a scattered-site housing provider with either a mental health disability, alcohol or other drug disability, or recent homelessness did not experience significantly different outcomes than those served by the single-site housing providers. Notable, however, are the relatively few observations within each of these interactions; therefore, the lack of significant findings could be the result of the small sample size.

A logistic regression estimating the effect of RHO participants' demographic characteristics and core program components received is estimated in exhibit 7. Several different models were estimated with different covariates to reduce collinearity in the estimates and to determine the best fit to the data. Specifically, release risk was highly correlated to security level and previous incarcerations. Different covariates were significant in different models, but several variables appear to have a robust relationship to rearrest outcomes among RHO participants. Previous incarceration is notably significant in every model estimated with this variable—RHO participants with more previous incarcerations were significantly more likely to be rearrested than those with fewer previous incarcerations. When this variable is removed, other covariates become significant, suggesting that this variable—although not highly collinear with any other variable except release risk—has much explanatory power in the data. According to the Aikaka Information Criteria, wherein lower numbers imply better goodness of fit, model 1.4 and model 1.5 appear to be the best fit for the data (both include the previous incarcerations variable). Postprediction analyses show that these two models also reduce classification error by more than one-half. It is notable that neither of these models includes the two core program component variables: scattered-site housing provider and ideal pathway. Models 1.4 and 1.5 show that certain mental health disorders are significantly related to recidivism. Substance abuse mental health disorder and personality mental health disorder are each associated with a significantly greater probability of rearrests in the data, whereas psychotic disorder and anxiety disorder (in one of these two models) are each associated with a significantly lower probability of rearrests. Lower medical status is also associated with a significantly lower probability of rearrests in one of the two best fitting models. The significance of the independent mental health diagnoses variables is evident with or without the inclusion of the alcohol or other drug disability and mental health disability variables (these results are not shown).

Exhibit 7

Logistic Regression of Any Rearrest Within 1 Year After Release Among RHO Participants (1 of 2)

	(1.1)	(1.2)	(1.3)	(1.4)	(1.5)	(1.6)	(1.7)	(1.8)
Age at release	– 0.010	– 0.012	– 0.018	0.030	0.026	– 0.045	– 0.024	0.012
	(0.026)	(0.026)	(0.035)	(0.044)	(0.045)	(0.040)	(0.043)	(0.048)
Race/ethnicity—White	– 0.996**	– 1.061**	– 0.801	– 0.836	– 0.798	– 1.151*	– 0.793	– 1.718
	(0.490)	(0.482)	(0.580)	(0.720)	(0.729)	(0.691)	(0.730)	(0.736)
Gender—male	1.031	0.882	1.399*	0.519	0.331	1.249	0.515	0.699
	(0.653)	(0.634)	(0.789)	(1.061)	(1.007)	(0.968)	(1.071)	(1.090)
MH disability	– 2.479*	– 0.667	– 1.070	– 2.407	– 2.315	– 2.769*	– 2.380	– 2.248
	(1.288)	(0.474)	(1.467)	(1.926)	(1.935)	(1.599)	(1.908)	(1.908)
AOD disability	– 1.965	– 0.255	– 1.232	– 2.362	– 2.514	– 2.040	– 2.337	– 2.410
	(1.253)	(0.517)	(1.380)	(1.658)	(1.629)	(1.392)	(1.635)	(1.683)

Exhibit 7

Logistic Regression of Any Rearrest Within 1 Year After Release Among RHO Participants (2 of 2)

	(1.1)	(1.2)	(1.3)	(1.4)	(1.5)	(1.6)	(1.7)	(1.8)
MH and AOD disability	2.181 (1.340)	—	1.130 (1.589)	2.893 (2.011)	2.986 (1.992)	2.582 (1.735)	2.840 (1.991)	– 2.838 (2.022)
Security level	0.097 (0.323)	0.124 (0.316)	0.154 (0.457)	—	– 0.219 (0.572)	0.185 (0.497)	– 0.223 (0.562)	– 0.269 (0.563)
Recent homelessness	—	—	– 0.413 (0.840)	– 0.601 (1.071)	– 0.610 (1.111)	– 0.720 (0.977)	– 0.482 (1.120)	– 0.547 (1.129)
Previous incarcerations	—	—	0.464*** (0.155)	0.510*** (0.196)	0.584*** (0.189)	—	0.531** (0.208)	0.526** (0.214)
Time served	—	—	– 0.002 (0.001)	– 0.001 (< 0.001)	– 0.001 (0.001)	– 0.001** (< 0.001)	– 0.001 (0.001)	– 0.002 (0.001)
Postrelease supervision	—	—	– 0.742 (0.636)	– 1.109 (0.764)	– 0.937 (0.751)	– 1.442** (0.716)	– 1.051 (0.779)	– 1.079 (0.792)
Release risk level	—	—	0.126 (0.847)	0.521 (1.065)	—	1.744* (0.921)	0.563 (1.087)	0.599 (1.137)
Medical status	—	—	—	– 1.142 (0.726)	– 1.226* (0.701)	– 0.698 (0.657)	– 1.135 (0.724)	– 1.205 (0.761)
Psychotic MH disorder	—	—	—	– 1.178 (1.076)	– 1.242 (1.108)	– 1.110 (0.885)	– 1.212 (1.092)	– 1.168 (1.083)
Substance use MH disorder	—	—	—	2.288** (1.124)	2.172** (1.100)	2.440** (1.035)	2.287** (1.130)	2.056* (1.129)
Personality MH disorder	—	—	—	1.791* (0.978)	1.890* (1.024)	1.868** (0.900)	1.908* (1.038)	1.870* (1.078)
Mood MH disorder	—	—	—	– 1.310 (0.965)	– 1.354 (0.971)	– 0.969 (0.846)	– 1.338 (0.967)	– 1.067 (1.008)
Anxiety MH disorder	—	—	—	– 1.422 (0.899)	– 1.478* (0.893)	– 1.508* (0.821)	– 1.416 (0.895)	– 1.326 (0.895)
Other MH disorder	—	—	—	1.084 (1.342)	1.021 (1.341)	1.240 (1.156)	1.022 (1.319)	– 1.785 (1.640)
Ideal pathway into program	—	—	—	—	—	—	—	0.258 (0.748)
Scattered-site housing provider	—	—	—	—	—	—	—	– 0.129 (0.751)
AIC	138.67	139.41	117.90	110.87	110.91	119.06	112.64	115.73
Correctly classified (percent)	75.00	74.14	83.62	86.21	86.09	86.96	85.22	85.09
N	116	116	116	116	115	115	115	114

AIC = Aikaka Information Criteria. AOD = alcohol or other drug use. MH = mental health. RHO = Returning Home—Ohio.

** p < .10. ** p < .05. *** p < .01.*

Note: Each column reports selected coefficients and standard errors, in parentheses, from a logistic regression. The coefficient is the expected change in the log odds of any rearrest.

Limitations

Before discussing the conclusions and implications of the findings, a few limitations of the data and analyses are worth mention. First, the evaluation used a quasi-experimental design to determine whether supportive housing was related to recidivism reductions. Although the evaluation used propensity weighting methods to reduce the selection bias, other variables (unmeasurable in this dataset) could be related to RHO participation and outcomes, such as motivation, readiness to change, or aptitude. Several stakeholders were involved in the program's identification and enrollment process, including individuals with experience with the prisoners (ODRC), deep knowledge about the supportive housing service (providers), or both. Although no reason exists to believe the program served only certain types of prisoners it believed could be unequivocally successful in the program, quite a bit of discretion (and bias) was built into the enrollment process for the program. Future research on supportive housing programs for the reentry population that randomizes selection into the program may yield different results.

Second, the study had a relatively short followup period. Recall that several program participants were not enrolled into the program and did not receive housing until weeks or months after their release from prison. Some of those rearrested may have been rearrested before they were placed into supportive housing—meaning, the program benefit being assessed is contact with the program or provider. Therefore, the findings presented herein can be generalized only to this relatively short period (1 year). Additional research that extends the followup period to 2 or 3 years may yield different results. It could be that a program like RHO has significant short-term effects that attenuate over time, particularly if individuals' criminogenic needs are unmet by the program, or it could be that a program like RHO has even greater long-term effects when participants receive more of the housing services and experience greater residential stability.

Third, the evaluation had very limited data on service use as part of the supportive housing. Although the two core program components we measured might have been related to outcomes theoretically, and the lack of significant findings may have been related to the small sample, indeed, there are far more measurable services that may have a relationship to recidivism. As mentioned previously, these services could include the affordability, quality, and location of the housing and the myriad services offered through the housing (for example, treatment and referrals). The evaluation had limited data on the exact services offered to participants. Further, a more robust estimation of the effect of the services would require greater information on participants' needs for those services. Recall that service receipt as a part of supportive housing is determined by risks and needs. We simply did not have the data required to understand the effect of specific services on outcomes, moderated by risks and needs; also, the sample size would likely have been insufficient to model this effect with much precision.

Conclusions and Implications

Despite the study limitations, the program was associated with significant reductions in recidivism, which translates into significant public safety benefits for the communities in which these individuals live. Not to overstate the importance of one study, but the findings have considerable implications

for the reentry housing field given the paucity of empirical information on the utility of permanent supportive housing for the reentry population directly (see Lutze, Rosky, and Falconer, 2011). Most importantly, the RHO program demonstrated that supportive housing is beneficial to the reentry population. RHO participants were recruited directly from correctional institutions and the intention was to provide prerelease reentry planning that led to a relatively seamless, coordinated transition from prison to the community, one of the critical elements of successful reentry programming (Petersilia, 2004; Visher and Travis, 2011). The program sought to identify and enroll those individuals most appropriate for supportive housing and did so across 13 institutions.

The program also demonstrated how a partnership between a correctional agency and community-based providers can be effective. CSH and ODRC recruited experienced professionals, the majority of whom they had histories of working with, and trained them to work with the reentry population and correctional institutions directly. CSH provided constant training and oversight. ODRC allowed providers prerelease access to, and information about, the prisoners so they could ascertain their appropriateness for their specific housing program. The providers were willing to reach into prisons to recruit and enroll participants. Although the program experienced some early implementation issues because of the nascent partnership and the number of partners involved, it is evidence of a partnership that worked well. The significant variation in the services offered and participants recruited demonstrates the success of the partnership. It is apparent that the mix of providers with different service experiences and histories recruited by ODRC and CSH had the right mix of experiences to support and serve the varied population that the prisons referred to them. The success of RHO demonstrated the importance of partnerships between correctional agencies and community-based providers to facilitate successful reentry.

The program further demonstrated the strength of the partnership given the significant overall impact findings and the lack of support for the program pathway and scattered-site provider variables. Although the lack of significant findings may be because of limited data, it may also suggest that the program partners effectively matched the "right" people to the "right" provider. For example, the providers may have departed from the ideal pathway for those individuals they believed to be at lower risk of recidivism, or the scattered-site housing providers may have enrolled only those individuals they believed could be more independent. Indeed, the stakeholder interviews collected through the process evaluation revealed that some providers thought those referred were too mentally ill, whereas others thought those referred weren't disabled enough to benefit from their program. It is unlikely that these sentiments were about the overall effectiveness of supportive housing for the reentry population rather than the effectiveness of their own supportive housing program for a group of individuals with particular characteristics. By matching the "right" people to the "right" provider, the program demonstrates the utility of having a large network or pool of community-based providers with various experiences and histories with which correctional departments can work.

Finally, although the overall program was effective, this study does show that some participant characteristics were significantly related to recidivism. Specifically, the finding that those with a substance abuse (mental health) or personality disorder diagnosis had worse outcomes than those without these diagnoses may reveal something about RHO or about individuals with these characteristics. Unfortunately, the current study does not provide sufficient data to explore this issue in great detail. RHO may not have recruited providers with strong experiences working with these

two subsets of the mentally ill population and, therefore, the increase in the probability of rearrests among this population is an indication that they were underserved or not well served by the program. Or, this finding may demonstrate that individuals with these two histories are particularly hard to serve or hard to house. The combination of certain mental health diagnoses with recent criminal justice contact may be indicative of a particularly high-risk population.

At this time, however, given that RHO was successful overall and served prisoners with disabilities broadly defined is support for permanent supportive housing becoming a routine part of reentry programming—at least, for the population with behavioral health disabilities and residential instability. This study provides empirical evidence that permanent supportive housing may be a platform toward successful reentry outcomes for this population. Given the substantial numbers of this population in prisons across the country, the provision of supportive housing for this subset of the reentry population could translate into significant future cost savings for state correctional institutions.

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