

## Road Map Initiative

## Merging Data from Cook County Jail and the Homeless Management Information System: Preliminary Findings

### OVERVIEW

Municipalities across the country wrestle with how to help “high utilizers” of multiple sectors, namely homeless services, jails, and the emergency health system. News media as well as individual entities report that high utilizers use a disproportionate amount of resources. Policymakers and advocates have proposed and tried a range of strategies, but they often only address one aspect of the problem within a single system. When solutions do work, scarce resources prevent these strategies from being employed for everyone who needs them.

We know that a person’s health doesn’t come from any single system, and neither do available services. The Road Map Initiative seeks to examine and address the outcomes for people who use our systems most — not just a single system, but multiple systems.

This brief summarizes what we have learned about “cycling high users” (CHUs) — people who cycle at high rates between homeless services and Cook County Jail in Chicago. We followed CHUs over time to better understand their service use patterns, general characteristics, and common profiles, and list factors that help identify those at highest risk to target them for additional services and help end the cycling of high users across the criminal justice, homeless services, and health sectors in Chicago.

We analyzed data from the Homeless Management Information System (HMIS) and the Cook County Jail, with the support of the Cook County Sheriff’s Office and All Chicago. Merging data across sectors is providing unprecedented insights into the true scope of utilization, both the amount of CHUs and service utilization patterns.

### **The results detailed in this brief can help administrators of programs and services and direct service professionals in the following ways:**

#### ***Improve Outcomes***

By identifying factors that increase or decrease risk of cycling across these two systems, program administrators can identify appropriate strategies to prevent homelessness and protect against recidivism. Our analyses show that previous homelessness increases risk of future homelessness and previous jail bookings increase the likelihood of a future jail booking. By identifying characteristics and risk factors, we hope to help systems identify people who have high service needs in multiple sectors, prevent people from becoming high utilizers, and improve outcomes for vulnerable populations.

#### ***Target Services to CHUs***

By identifying common characteristics of CHUs, we hope to help program administrators and providers identify individuals for targeted referrals and services so that people get the right services at the right time.

#### ***Inform Allocation of Resources***

Our objective is to ensure that the systematic data analysis we conduct is accessible to decision makers to help inform policy and program decisions, leading to the strategic allocation of limited resources to best help end the cycling of CHUs.

## LINKING DATA TO DEFINE HIGH UTILIZATION

The Health Lab identified people who engaged in homeless services and spent time in Cook County Jail during a four-year study period (January 1, 2014 to December 31, 2017). Roughly 15,000 people encountered both sectors at least once (Figure 1).

Of this group, the Health Lab identified roughly 7,000 Cycling High Users (CHUs) with a pattern of “high use,” defined as four or more encounters with the jail OR homeless services sector during the four-year period. While CHUs on average spent more than three times the number of days in jail, shelter, or homeless outreach services than the typical detainee or homeless client, CHUs had four unique patterns of service use:

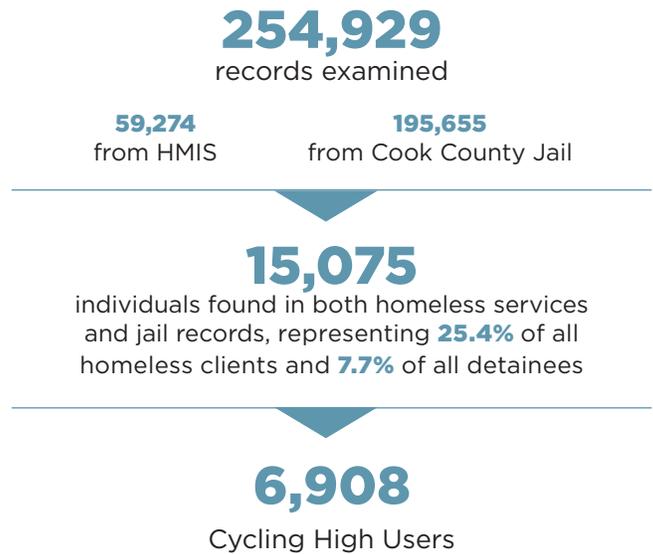


Fig. 1 – Numerical breakdown of homeless and detainee population

### 1 Combined Users (N=2,526)

Some CHUs were not cycling at high rates in either sector alone but did demonstrate “high use” combined across the two sectors.

*365+ combined days in shelter, outreach, and jail OR 4+ combined stays in shelter or jail*

### 2 Extreme Users (N=363)

A very small number (approximately 400) of CHUs had a high number of encounters in both sectors, spending 455 days on average in the two systems over the four-year period.

*Individual meets “high user” criteria for both jail and homelessness*

### 3 High Users of Homeless Services (N=1,176)

Some CHUs were more frequently engaged with the homeless services sector but were only in the jail one or two times.

*5+ shelter stays or 3+ stays and 120+ days or 365+ days in shelter and/or street outreach*

### 4 High Users of Jail (N=2,843)

Other CHUs returned to the jail many times, but experienced homelessness infrequently.

*4+ jail stays or 3+ stays and 365+ days*

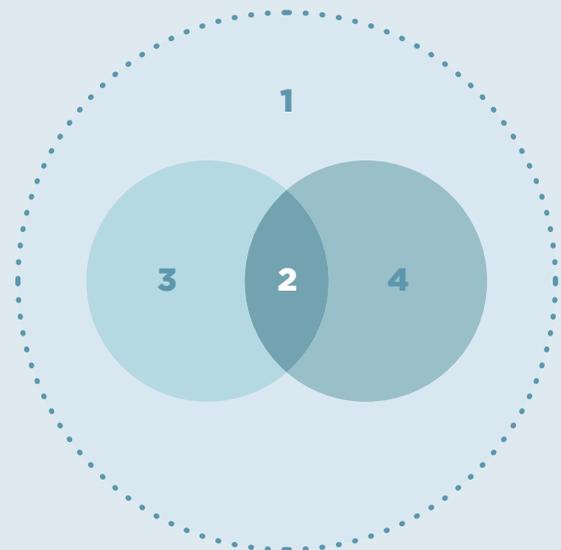


Fig. 2 – Patterns of service use; every Cycling High User (N=6,908) had at least four encounters with the jail and homeless services sector in the four-year study period (1.1.2014-12.31.2017).

## CYCLING HIGH USER GENERAL CHARACTERISTICS

As an overall population, CHUs:

- Are predominantly male (82%) and African American (79%)
- Generally present to the homeless services sector as single individuals, although there were still almost 700 CHUs who accessed services as part of a family
- Are most commonly booked in the jail for “crimes of survival” (e.g. retail theft and trespassing) and drug possession

### *Behavioral Health Challenges among CHUs*

CHUs have higher rates of self-reported or observed behavioral health conditions than average detainees. While in Cook County Jail, detainees receive additional services if they have an “alert” designating specific medical or behavioral health needs. These operational “alerts” inform the type of care they receive. While an “alert” does not serve as a formal medical or mental health diagnosis, it does reflect the need for different levels of services or placements for a detainee’s care. Psychological needs are designated by “P-alerts” and medical needs are designated by “M-alerts.” “Alerts” are accompanied by a numerical rating ranging from 2-4, with a higher rating indicating a more intensive need. For example, a P2 alert indicates a low-level mental health need, while a P4 alert requires an institutional level of mental health care.

Compared to jail detainees who never accessed homeless services, CHUs are four times more likely to have received an operational psychological alert (“P-alert”) while in the jail and are six times more likely to have received a P4 alert, thus requiring institutionalized care. CHUs are also four times more likely to have received detox treatment upon arrival to the jail and three times more likely to have received operational medical alerts (“M-alert”).

### *Rates of federally-qualifying disabilities among CHUs*

Compared to homeless services clients who did not enter the jail during the study period, CHUs are 24% less likely to be receiving SSI or SSDI, which is considered to be a proxy for having a federally-qualifying disability. Not receiving SSI or SSDI may mean that an individual does not meet the federal disability standard or that they have not attempted or successfully applied to meet the federal disability standard.

## COMMON PROFILES OF CYCLING HIGH USERS

The Health Lab also identified common profiles of CHUs using a statistical technique called “cluster analysis.” This approach allows us to see which characteristics are commonly seen together among different types of CHUs. We chose to look at characteristics that have implications for the type of care from which distinct CHUs may benefit, including proxies for behavioral health challenges, family status, types of criminal charges, and age. We found three common profiles of CHUs with distinct characteristics:



Older people with multiple vulnerabilities

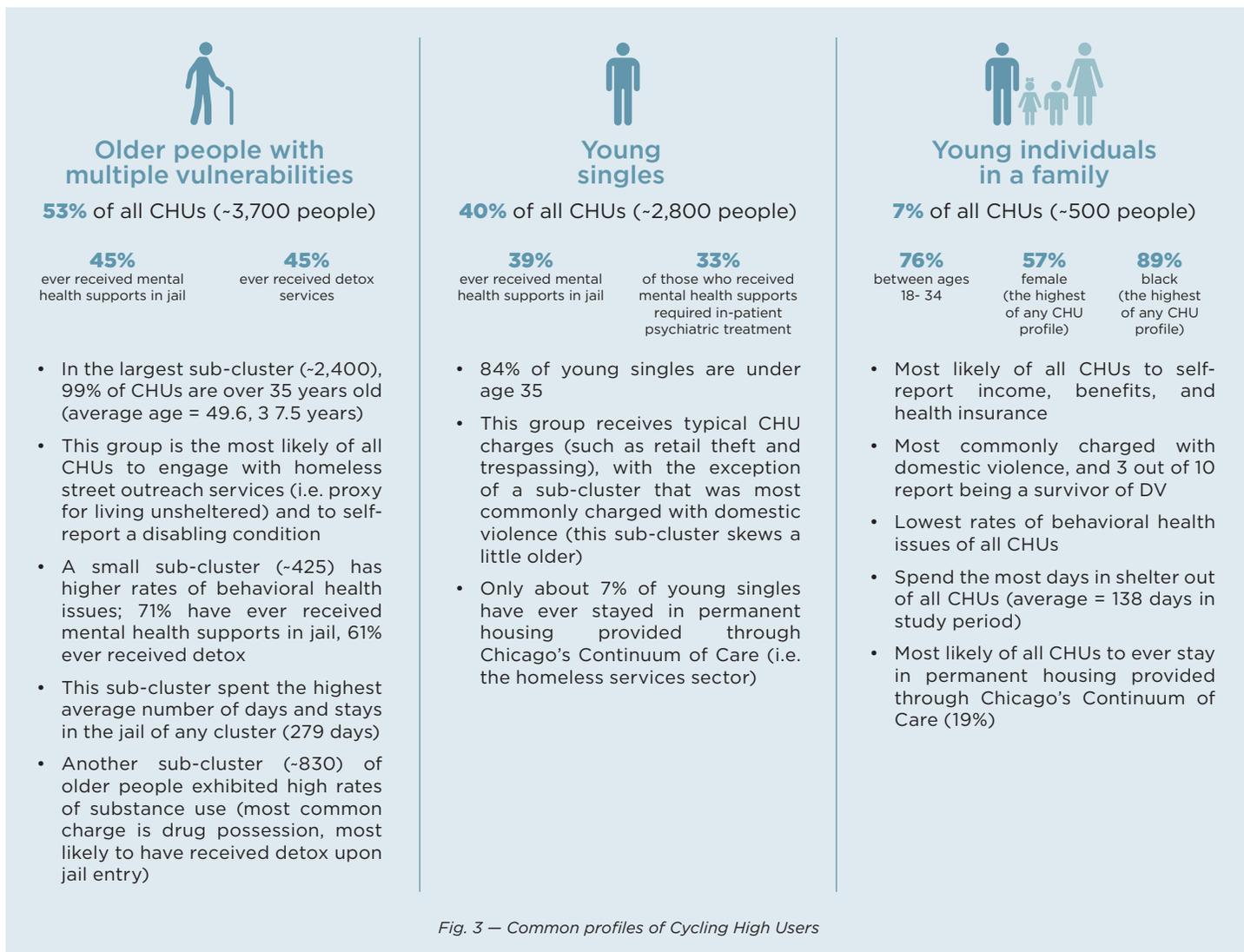


Young singles



Young individuals in a family

Each of these profiles is described in more detail below (Figure 3). It is important to note that these are not the only clusters present among CHUs. In fact, some of these profiles showed “sub-clusters” within them with slightly distinctive characteristics. This information should be taken as a general resource to help guide care, but all decisions should be made on a case-by-case basis by trained professionals.



## RISK FACTORS AND PROTECTIVE FACTORS FOR INCARCERATION AND HOMELESSNESS

Being able to determine whether people are more likely to first encounter the jail or access homeless services in the Continuum of Care (CoC) (i.e. homeless services sector) remains a challenge. In our study period, 60% of individuals entered the jail prior to accessing CoC services (either shelter or street outreach). However, this finding may be because people simply spend more time in jail than they do in shelter or outreach. Individuals who encountered both the jail and homeless service systems spent an average of 60% of their combined service days during the study period in jail and the remaining 40% in shelter or outreach.

To help clinicians in the jail and homeless services sector identify people at highest risk of cycling between the sectors, the Health Lab conducted an analysis to identify characteristics associated with a person's likelihood of experiencing homelessness after being released by the jail, or conversely, the risk of spending time in the jail after engaging in homeless services (Figure 4). These characteristics can help target people for referrals and/or additional services, with the goal of decreasing the total number of people who end up becoming CHUs.



The average CoC client experiencing literal homelessness has an **18.6%** likelihood of entering Cook County Jail within 18 months of engaging in homeless services.



Factors associated with an **increased** likelihood of jail entry

Highest increase  
↑  
↓  
Lowest increase

**Prior jail bookings**

Previously booked in last 18 months

**Young age**

Age 18-44, as compared to 45+; each year younger is associated with an increased risk

**Evidence of disabilities**

Receiving SSI or SSDI (self-reported disabling condition, not significant for ages 18-24)

**Prior homelessness**

Previously homeless in last 18 months

Factors associated with an **decreased** likelihood of jail entry

Highest decrease  
↑  
↓  
Lowest decrease

**Protective markers**

- Living in permanent housing in the last 18 months (if age 18-24) or transitional housing (if 25 or older)
- Has income (if 25 or older)

**Demographics**

As compared to male, single, and African American

- Female
- In a family with kids
- White (if 25 or older)
- Hispanic (if 25 or older)



The average person leaving the jail has a **3.8%** of engaging in homeless services in Chicago's Continuum of Care (CoC) within 18 months of discharge.



Factors associated with an **increased** likelihood of homelessness

Highest increase  
←

→  
Lowest increase

**Previous experiences with homelessness**

Engaged in CoC services while homeless in the 18 months prior to jail entry, and especially in the month prior

**Received mental health services while in jail**

Ever received a P4, P3, or P2 alert

**Previous jail stays**

**Older age**  
Age 45-64 at release

**Type of charge for current booking**

Retail theft, property theft, or trespassing charge

**Evidence of substance use**

Possession charge or has ever required detox at entry

Fig. 4 — Characteristics of people at highest risk of cycling between sectors

We thank you for your ongoing support and engagement with the Road Map Initiative. The involvement of provider organizations, policymakers, and other stakeholders is incredibly valuable to bringing this work to life and for ensuring that it is useful to those serving people who cycle through the emergency health, homeless services, and justice systems.

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