People Suck.
Build Around the Suck.

VOLUME 4

ADDICTION-RELATED HOMELESSNESS



JMAC

SIDE ANGLE WORKS

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Build Around the Suck.

Volume 4

Addiction-Related Homelessness

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Side Angle Works

First digital edition

Version 1.0

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A note on AI, authorship, and accountability

This manuscript was built with substantial assistance from OpenAI's ChatGPT and Codex. I used them as thinking partners and working tools: to challenge assumptions, compare drafts, organize research, surface counterarguments, trace sources, and sharpen language.

It would be dishonest to hide that collaboration. It would also be dishonest to hand responsibility for the work over to the tool. The questions, values, judgments, and final choices are mine. AI did not decide what matters, what is true, or what I am willing to stand behind. It can be useful, fast, persuasive, and wrong. Every claim still has to earn its place.

That is consistent with the argument of this book. If we want to understand an outcome, we have to make the choices, tools, and conditions that produced it visible—including those behind this manuscript. Tools and institutions should be built around predictable failure, including our own. I used AI to extend attention and expose blind spots, not to escape responsibility. I remain accountable for this manuscript and for any errors.

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How to read this book

Start with the question. You do not need to agree with my conclusion to follow how I got there.

Some passages describe what a source reports. Others compare explanations or propose a way a system could work. Those are different kinds of claims. A useful idea still needs testing; a result from one place does not automatically tell us what happens everywhere.

Ask what the evidence shows, what remains uncertain, and what would change the conclusion. The same questions apply to my work.

This volume stands on its own. The other books use different subjects to practice the same method: Outcome Anatomy.

Scope of this volume

This volume examines addiction-related homelessness and the continuity of support. It does not assume every person experiencing homelessness has an addiction or that every substance carries the same risks. Clinical examples retain their substance-specific limits. This book does not provide an individual diagnosis, treatment plan or eligibility determination.

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A WAY INTO THIS QUESTION

You can start here. The approach used in this book is called Outcome Anatomy: follow a result back through the choices, conditions, and relationships that helped produce it. When the same crisis keeps returning, the repeating path needs explaining too.

For addiction-related homelessness, that means following a person across the street, shelter, hospital, treatment, jail, and housing. What changed at each encounter? Was the next step usable? What progress survived, and what had to begin again? We will examine personal choices alongside addiction, capacity, rules, incentives, and the gaps between institutions. Neither choice nor circumstance gets to explain everything alone.

A completed service does not tell us whether life became safer or more stable afterward. We will test explanations against evidence, compare alternatives, and say what remains unknown. The aim is not a tidy story about deserving people or failing agencies. It is a clearer account of what keeps the cycle going—and what could give the person a better next move.

1. WHY THE REPEATING PATH BECAME THE QUESTION

First, narrow the question.

This volume is not about every person experiencing homelessness.

It is about homelessness where addiction materially affects the person's ability to obtain, maintain, or return to stable housing.

Addiction here means a persistent pattern of substance use that is difficult to control and continues despite significant harm or consequences.

That is not the same as all substance use.

It is not the same as intoxication.

And it is not a moral judgment.

Cause and effect can run both directions.

One possible pathway to examine is whether addiction contributed to housing loss.

Another is whether homelessness intensified substance use.

The two may form a feedback loop. Whether that happened for a particular person requires tracing their sequence and considering other explanations.

A person may move through hospital, detox, shelter, treatment, jail, the street, and back again.

If the person keeps arriving at the same crisis, that repeating path needs its own explanation. What keeps carrying them back?

If the same person repeatedly passes through institutions that each address one piece and their overall path barely changes, the analysis cannot stop at individual choice or individual program performance.

Outcome Anatomy follows that sequence: what each encounter changed, what carried forward, what fell away, and how the person arrived at the same crisis again.

Once the path matters, so does its design.

2. WHAT HELP IS SUPPOSED TO ACCOMPLISH

“Get people off the street” sounds like a clear objective.

So does “get them sober.”

Neither is sufficient by itself.

Start with survival and reduced harm. Then ask about stability, usable treatment and support, recovery, connection, and autonomy. We need room to recognize progress in each without pretending one improvement means everything is solved.

Those outcomes do not always arrive together.

A person may remain housed after relapse.

Return to treatment quickly after leaving.

Reduce overdose risk before achieving abstinence.

Rebuild relationships before employment.

Progress should not disappear because the final destination has not been reached.

That gives this volume a working definition:

SUCCESS MEANS THE PERSON'S PATH BECOMES SAFER, MORE STABLE, MORE DURABLE, AND INCREASINGLY UNDER THEIR OWN CONTROL.

Success is not perfection.

It is not a life with no reversal.

And service success is not automatically system success.

A detox program may complete its job.

A shelter may provide a safe night.

A hospital may stabilize the emergency.

The larger question is whether those interventions leave the person with a better next move than before.

3. THE NETWORK THAT CALLS ITSELF A SYSTEM

Addiction-related homelessness touches many institutions.

Hospitals.

EMS.

Shelters.

Detox.

Treatment providers.

Recovery housing.

Police.

Jails.

Courts.

Probation.

Housing agencies.

Landlords.

Benefit systems.

Outreach teams.

Families.

Each may perform a legitimate function.

That does not mean the network functions as a system.

Calling the network a system does not tell us whether someone can get through it. The connections have to make the next step usable.

A hospital can discharge appropriately.

A shelter can enforce reasonable rules.

A treatment provider can follow admission criteria.

A housing program can apply eligibility standards.

And the combined result can still be a person sleeping outside that night.

That creates two kinds of accountability.

Institutional accountability asks:

Did this organization perform its assigned function?

System accountability asks:

Did the parts work together well enough to produce a usable path?

Everyone can be accountable for a task while the person is left carrying everything between the tasks. That is the gap we need to follow.

When a person's outcome depends on several institutions acting together, we have to trace what happened between them—not infer success from each institution's account of its own work.

4. FOLLOW ONE HUMAN THROUGH IT

Organization charts hide the thing we need to see.

Follow one person instead. The subject of the inquiry is how their situation changed, not a diagnosis of their worth or a search for one person to blame.

Start at a crisis or intervention.

An overdose.

An arrest.

A shelter entry.

A hospital visit.

A request for treatment.

Then follow the path until one of three things happens:

Workable stability holds.

Responsibility genuinely transfers.

Or the same crisis cycle begins again.

“Stability” does not mean the life is solved.

It means the immediate crisis is interrupted and basic conditions hold long enough for the next decision to be made without the current emergency dictating everything.

At every transition, ask:

What happened?

What function was needed next?

Who was supposed to provide it?

Was it actually usable?

What was preserved?

What was lost?

What made the next step harder?

Where did the person disappear from view?

A referral may look like completion to the sender.

The person experiences whether the next door actually opened.

Follow the path far enough and component-level success can look very different.

We need to know where the path begins, where we stop following it, and what remains unknown. Otherwise the result disappears into a stack of completed tasks.

5. WHERE THE INCENTIVES POINT

Institutions do not operate on mission statements alone.

Funding, liability, staffing, regulation, capacity, reimbursement, audits, performance measures, political pressure, and workload all affect what an institution can do and what it is rewarded for doing. We have to examine those pressures alongside its mission.

The useful question is:

WHAT DOES THIS INSTITUTION BECOME MORE LIKELY TO DO WHEN ITS INCENTIVES ARE WORKING EXACTLY AS DESIGNED?

A hospital may be organized around treating medical emergencies rather than providing ongoing housing.

A shelter has to protect residents and staff.

A treatment provider has limited beds.

A housing program may be measured on tenancy outcomes.

Police respond to visible public-order problems whether or not policing can solve addiction or housing.

Good people can compensate for bad incentives.

They cannot reliably cancel them.

And the actor making the decision may not bear the consequence.

A local rule can push risk toward another institution, another budget, another neighborhood, or the person themselves.

When mission and incentives conflict, test what the institution rewards in practice. A mission statement does not establish that its incentives support the mission.

6. FRONTLINE REALITY CHECK

“The service exists.” Good. What has to happen for this person to use it?

Do they know about it?

Qualify?

Reach it?

Arrive at the right time?

Complete intake?

Stay reachable?

Tolerate its conditions?

Is there capacity?

Frontline workers can identify gaps between the official process and the usable one.

Their experience does not automatically prove the explanation.

It tells us where to look.

When frontline workers keep repairing the same breakdown, ask:

Requirement — What is supposed to happen?

Reality — What actually happens?

Failure Point — Where does the ordinary path break?

Authority — Who can change it?

Workaround — How do competent people currently get around the break?

Recurrence — Is this unusual or routine?

Repair — What would make the workaround unnecessary?

Repeated unofficial repair is a useful place to look. It tells us someone keeps doing work the ordinary process leaves unfinished.

WHEN COMPETENT PEOPLE REPEATEDLY HAVE TO BREAK, BEND, BYPASS, OR PERSONALLY REPAIR THE NORMAL PROCESS TO MAKE IT WORK, STOP STUDYING THE WORKAROUND AND START STUDYING THE DESIGN.

7. THE PEOPLE HOLDING THE FRAGMENTS TOGETHER

Sometimes a person gets through because someone else keeps fixing what the ordinary process leaves unfinished. Consider these illustrative workarounds:

A case manager calls three extra providers. An outreach worker drives someone across town. A nurse finds a bed through a personal contact. A family member pays for a motel. A shelter employee bends a process just enough to keep the next step alive.

That work matters. It may be the reason the next step happens at all.

It can also make a weak process look more capable than it is. The gap disappears from view because somebody keeps reaching across it. That is GOOD-ACTOR MASKING.

We need to distinguish good judgment from dependence on someone's extra effort. An unusual case may need someone to adapt a process that ordinarily works. A routinely broken path may need personal time, money, transportation, relationships, credibility, or unofficial contacts just to become usable.

So ask what the person had to repair. Was their judgment useful because this case was unusual? Or was it necessary because the same part of the process keeps failing?

Once we know a workaround is recurring, someone needs to own the repair decision. What job is the workaround doing? Who has the authority to put that job into the process? What will happen while the gap remains?

If everyone knows about the workaround and nobody owns the repair, the design failure is already acknowledged. We just have not assigned anyone to deal with it.

If the person stops doing that extra work and the predictable problem returns, record the failure in the system. Do not let it disappear into another individual case that supposedly went wrong.

8. WHEN HELP RECREATES THE CONDITIONS OF CRISIS

Interventions can reduce one danger while creating another.

A shelter may enforce a rule and send someone back outside.

A treatment discharge may interrupt medication.

An arrest may remove a person from immediate public risk while costing housing or employment.

A housing move may separate someone from treatment or support.

That does not make the intervention wrong.

It means the intervention has a footprint.

When an intervention solves one problem, ask what else it changed:

Purpose — What problem was the intervention supposed to solve?

Necessity — What disruption was actually required?

Other Losses — What else changed?

Preservation — What could have remained intact?

Recovery — What will repair the disruption?

Then check the result.

Predictable harm caused by an intervention belongs in the analysis alongside its benefit.

Not every negative consequence is someone's fault.

But once a pattern becomes known, repeated collateral damage is no longer invisible.

The question is:

WHAT DID WE LEAVE STANDING, WHAT DID WE BREAK, AND WHO OWNS WHAT HAPPENS BECAUSE OF IT?

9. THE SPACE BETWEEN SYSTEMS

The most dangerous part of a fragmented system may be the gap between institutions.

A hospital refers to treatment.

A shelter refers to housing.

Jail gives discharge instructions.

Treatment gives a list of programs.

Everyone can truthfully say:

We referred them.

The referral tells us someone tried to connect the person. We still need to know whether the connection happened.

RESPONSIBILITY SHOULD NOT BE TREATED AS TRANSFERRED UNTIL THE NEXT NECESSARY FUNCTION ACTUALLY BECOMES USABLE.

Use a Transition Test:

Destination — Where is the person supposed to go?

Acceptance — Has the next actor actually agreed?

Timing — When does the next step become available?

Access — Can the person get there and use it?

Requirements — What must be completed first?

Continuity — Did records, medication, identification, benefits, contact information, and property travel?

Communication — Do the actors know what each other is doing?

Confirmation — Did the handoff actually happen?

Ownership — Who keeps the unresolved problem open until the handoff is complete?

Contingency — What happens if it does not?

A transition is not successful because the sending institution finished.

It is successful when the next necessary function becomes usable.

10. THE HOURS AFTER AN OVERDOSE

An overdose can create a brief opening.

It does not automatically create readiness.

The person may be frightened, sick, intoxicated, withdrawing, embarrassed, angry, or desperate to leave.

So the practical question is:

WHAT HAS TO BE TRUE OVER THE NEXT SEVERAL HOURS FOR A MEANINGFULLY SAFER NEXT MOVE?

What is the immediate risk? Where can the person go, and what happens during the wait? What medication, contacts, or other protection should stay intact? What do they choose? If that next step fails, what is the fallback, and how can they reconnect?

Treatment may be appropriate.

So may naloxone for opioid overdose, medication continuity, safer-use information, transportation, temporary shelter, a peer connection, or simply a usable way back into care.

A person refusing the entire treatment plan does not make every smaller harm-reduction step irrelevant.

The choice should not become:

Accept everything we want to offer or receive nothing useful.

And crisis should not become the only reliable admission ticket.

The hours after overdose do not need to solve the person's life.

They should improve the odds that the person is alive and able to make another decision tomorrow.

11. TREATMENT IS NOT ONE THING

“Treatment” sounds singular.

It is not.

It can mean detox, medication, residential care, outpatient treatment, peer support, recovery housing, psychiatric care, primary care, harm reduction, case management, or mutual aid.

These functions are not interchangeable.

The useful question is not:

Is treatment available?

It is:

WHAT FUNCTION DOES THIS PERSON NEED NOW?

Separate four layers:

Stabilization — getting through the immediate medical or psychiatric danger.

Treatment — addressing the substance-use disorder itself.

Recovery support — helping gains survive outside the clinical setting.

Life infrastructure — housing, transportation, income, communication, healthcare, and other conditions that make the rest usable.

A person may receive excellent treatment and still lose housing.

Receive housing and still lack treatment.

Complete detox and still have no safe next step.

The presence of treatment is not proof that the right treatment existed at the right time or that the surrounding conditions allowed it to work.

That distinction matters at a familiar front door: detox. What it can do and what has to happen afterward are different questions.

12. DETOX IS A DOORWAY, NOT A DESTINATION

Detox can be important, sometimes lifesaving.

It can stabilize withdrawal, manage acute medical risk, and create a temporary interruption in use.

It does not by itself resolve addiction.

The transition out matters.

Opioid tolerance may be lower after a period without use.

The person may still have no housing.

Medication may need continuity.

The next program may have a wait.

Transportation may fail.

Before discharge, ask:

Clinical Continuity — What care still has to continue?

Destination — Where does the person go next?

Timing — Is the next step available when discharge happens?

Risk — What changes because tolerance, medication, or circumstances changed?

Access — Can the person actually reach the next service?

Connection — Has the next actor accepted the handoff?

Fallback — What happens if the plan fails?

Reentry — Can the person reconnect without another crisis?

A completed detox stay is an output.

A safer transition is the outcome.

Repeated return from overdose to detox and back to the same conditions is not proof that detox was useless.

That pattern warrants investigating what stabilization and the transition afterward failed to address.

Detox can open the door.

The question is whether there is anything usable on the other side.

Evidence note: For opioid use disorder, CDC guidance recommends treatment with medication and warns against detoxification alone because of the risk of resumed opioid use, overdose and death. That guidance concerns opioids; care for other substance use disorders requires its own evidence.

Chapter references →

13. JAIL AS THE DEFAULT TREATMENT BED

Jail is not treatment.

But in fragmented systems it can become the most dependable place where someone has a bed, schedule, supervision, meals, and temporary separation from the street.

That is a disturbing form of reliability.

CUSTODY CAN CREATE STRUCTURE WITHOUT CREATING RECOVERY.

Legitimate criminal consequences still matter.

Public safety still matters.

The question is what unnecessary losses occur around incarceration and release.

Does medication continue?

Is treatment connected before release?

Where will the person sleep?

Do they have identification?

Benefits?

Transportation?

A working phone?

What legal requirements begin immediately?

Release is a high-risk transition because multiple functions can restart at once.

Before release, check medication, destination, treatment, and the legal requirements that start next. Will identification and benefits be available? Can the person travel and stay in contact? What risks remain, what is the fallback, and how can they reconnect if the plan breaks?

The criminal-justice system should not become the most reliable treatment infrastructure simply because every other doorway is optional, full, or disconnected.

A locked door can create temporary structure.

It cannot substitute for a usable path after release.

Evidence note: A study published in 2007 followed people released from Washington state prisons during 1999–2003. Death risk was especially high in the first two weeks after release, with overdose a major concern. This supports treating release as a serious transition. It does not provide a current risk estimate for every jail or prison, or prove that any one missing support caused the deaths. The checklist above is a proposed safeguard to evaluate.

Chapter references →

14. THE SHELTER DOOR

Shelters live inside a real tension.

They need to remain accessible to people in crisis.

They also have to protect residents, staff, property, and basic function.

Low barrier does not mean no boundary.

The useful question is:

Which standards are necessary for safety and function, and which mainly screen out the people most likely to need shelter?

For any shelter rule, ask:

Purpose — What is the rule trying to protect?

Necessity — Is the rule required for that purpose?

Fit — Does the consequence match the behavior?

Alternative — What happens if the person cannot meet the condition?

Continuity — What progress disappears at exit?

Repeat Pattern — Does the same rule repeatedly push the same type of person back outside?

A shelter with strict conditions may serve a population capable of meeting them.

That is not automatically a flaw.

But the system should describe the population honestly.

A legitimate shelter rule can still create a larger systems question when the predictable result is that people with the greatest instability remain outside.

The shelter has to protect the people inside.

The larger system still has to account for what happens outside the door.

15. THE FAMILY BOUNDARY

Families can become an informal safety net where formal support ends. Consider these examples:

A mother provides housing after treatment.

A sister drives to appointments.

A parent pays for a motel.

A spouse manages medication.

A relative keeps trying after every discharge.

That labor can make services look cheaper and transitions look more successful than they really are.

That is the Hidden Family Subsidy.

But families have limits too.

Children in the home matter.

Safety matters.

Money matters.

Exhaustion matters.

A family boundary is not automatically abandonment.

When a family reaches its limit, ask:

Safety — Who is at risk?

Capacity — What can the family realistically sustain?

Function — What missing system role is the family currently performing?

Limit — What is the family no longer willing or able to do?

Consequence — What happens when that support stops?

Alternative — Who carries the function next?

Responsibility — What belongs to the person, the family, and the formal system?

Families can be partners. Love does not make their time, money, housing, or patience unlimited. If the formal plan depends on those resources, name the dependence and ask what happens when the family cannot carry it.

16. A KEY IS NOT A HOUSING SYSTEM

Getting housed is an important event.

It is not the same thing as becoming stably housed.

A key changes the environment.

It does not automatically change addiction, health, routines, relationships, income, medication, transportation, or the skills needed to maintain a tenancy.

PLACEMENT IS AN EVENT. STABILITY IS A PROCESS.

Can the person afford the tenancy? Are support and treatment usable? Can daily routines hold, and what puts the lease at risk? Who is around them? What happens in a crisis, and how do they reconnect with help afterward?

A person can be successfully placed and still be one bad week away from eviction.

Treat housing as a condition that helps life hold together. Getting the key does not tell us which other supports are still doing necessary work. Check before closing them.

The real test is whether the key remains usable long enough for life to rebuild around it.

17. RECOVERY HOUSING

Recovery housing can organize daily life around:

structure,

peer accountability,

routine,

community,

and an environment organized around recovery.

That structure can also be fragile.

A return to use, rule violation, or safety incident may trigger different responses under different programs' policies. Read the actual policy rather than assuming that every program requires the same response.

Those events should be separated.

RELAPSE IS A RETURN TO USE.

A PROGRAM VIOLATION IS A CONFLICT WITH A RULE.

A SAFETY VIOLATION IS BEHAVIOR THAT CREATES MEANINGFUL DANGER.

They can overlap.

They are not synonyms. SAMHSA's 2023 guidance recommends written policies explaining responses to return to use and supports residents' access to prescribed medications, including medications for opioid use disorder. Taking medication as prescribed should not be confused with returning to illicit use. These are best-practice recommendations, not proof that every recovery home follows them.

That gives us a rule:

Recovery response should address relapse.

Program accountability should address rule violations.

Safety intervention should address danger.

When something goes wrong, describe the event and the risk it creates. What is the response meant to accomplish, and does it fit what happened? Separate recovery support, program accountability, and safety intervention. Then ask what should continue, what the fallback is, how reentry works, and which unrelated gains can survive.

There is also an Exit-Day Problem.

A resident can follow every rule, work, save money, and reach the end of the program while market housing is still unavailable.

The program succeeded internally.

The transition may still fail.

If the system knows when structured support ends, it knows when the next structure must be ready.

A planned exit should not become a cliff.

Chapter references →

18. WORK, INCOME, AND THE STABILITY TRAP

Employment is often treated as a simple marker of progress.

But work sits inside at least three different kinds of stability.

Work stability asks whether the person can obtain and keep employment.

Can they get there?

Can life reliably support the schedule?

Is there backup when transportation or health fails?

Benefit stability asks how income-based public assistance changes when earnings rise.

How will housing support, food assistance, health coverage, cash assistance, or disability-related benefits change, and which transition protections apply? For example, qualifying SSI recipients may retain Medicaid under Section 1619(b) after earnings end their SSI cash payment. Check the person's actual eligibility and program rules rather than assuming all support ends together.

Support stability asks whether non-benefit services and relationships remain compatible with work until their functions are genuinely replaced.

Treatment.

Case management.

Peer support.

Transportation services.

Medication management.

Childcare.

Family help.

Flexible supervision.

These are different problems.

They need different fixes.

A person can become work-stable while a benefit change creates a financial cliff. The Atlanta Fed's benefits-cliff tools model how earnings, taxes, benefits, and basic expenses interact for particular households and places. The result depends on the programs and rules involved; not every benefit ends abruptly or makes work financially worse.

Or gain income while a new schedule makes treatment and transportation unusable.

INDEPENDENCE IS NOT CREATED BY REMOVING SUPPORT.

It grows when necessary functions can be carried reliably by the person, chosen relationships, or dependable services, with less unnecessary control over their life.

Ask three questions:

Can the person keep the work?

Can financial assistance adjust without crisis?

Can necessary supports change without disappearing before their functions are replaced?

Chapter references →

19. THE LANDLORD GATE

A person can be ready for housing and still be unable to enter the housing market.

Those are different things.

Housing readiness asks:

Can this person live safely and sustainably in housing?

Market readiness asks:

Will someone rent to them?

The landlord gate may include:

application fees,

deposits,

income requirements,

credit,

eviction history,

criminal records,

rental references,

utility debt,

employment verification.

Landlords have legitimate risk.

Especially small landlords who may be unable to absorb a failed tenancy.

So screening is not automatically unfair.

But screening can become identity when past instability never loses weight.

For a housing screen, ask:

Purpose — What risk is the screen trying to predict?

Relevance — Does the information actually predict that risk?

Age — How old is the event?

Change — What evidence shows circumstances are different now?

Fit — Does the consequence match the actual risk?

Mitigation — Can deposit support, guarantees, services, or another tool reduce the risk?

Transparency — Does the applicant know why they were denied?

Correction — Can errors be fixed?

Path Forward — Is there any way to become eligible later?

If public policy wants private landlords to absorb unusual public-policy risk, that risk should be located honestly.

Housing readiness and market access are separate problems.

A working housing system has to solve both.

20. THE FIRST NINETY DAYS HOUSED

Newly housed is not the same thing as durably housed.

The first months can reveal problems that homelessness itself was hiding.

Budgeting.

Household routine.

Treatment continuity.

Transportation.

Lease expectations.

Isolation.

Neighbors.

Guests.

Social environment.

Crisis response.

Support during this period should not become surveillance.

Privacy and autonomy matter.

The question is what functions are temporarily necessary for the tenancy to stabilize, and when those functions can step down.

Ninety days is a reminder to look at the transition, not a universal deadline. Status can change faster than life reorganizes.

A person can move from “homeless” to “housed” in one afternoon.

The routines, health, income, recovery, and relationships that make housing durable may take much longer.

Early support should therefore have an exit condition.

It becomes lighter as stability becomes more transferable.

The goal is not to recreate institutional control inside the home.

It is to give the tenancy enough margin to survive ordinary trouble.

21. THE OVERDOSE BEHIND A LOCKED DOOR

Housing can provide stability and protection from exposure.

It does not erase overdose risk.

The person’s overdose risk still needs its own assessment.

A person may now be using alone.

A period without opioid use can lower tolerance. Returning to a previously used dose can then increase overdose risk.

Medication may have been interrupted.

The drug supply may have changed.

Fewer people may be present to notice a crisis.

That is not an argument that housing is dangerous.

Privacy is valuable.

A home can provide shelter and safety without resolving every health risk.

The point is to assess the risks that remain or change, rather than infer them from housing status alone.

HOUSING CHANGES RISK. IT DOES NOT ERASE IT.

Ask:

Risk — What is different now?

Opioid tolerance — Has recent abstinence changed overdose vulnerability?

Naloxone — Is it available and does anyone know how to use it?

Connection — Who notices if the person disappears?

Treatment — Is care still usable?

Isolation — Has privacy become dangerous isolation?

Choice — What voluntary supports does the person want?

The answer is not to rebuild institutional control inside the home.

It is to stop treating “housed” as if it describes the whole human condition.

A locked door should protect privacy.

It should not become the point where the system stops looking simply because the crisis is less visible.

Evidence note: Housing with continuing support can improve stability. Overdose risk can still remain after a person is housed. These are different outcomes, and both matter. The studies reviewed here do not establish that housing increases mortality or that privacy itself causes overdose.

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22. THE NEIGHBORHOOD BOUNDARY

Homelessness and addiction happen in shared space.

That means other people become stakeholders too.

Residents.

Businesses.

Families.

Workers.

Wheelchair users.

Transit riders.

People using parks and libraries.

Their burdens are real.

PUBLIC PROBLEMS CREATE PUBLIC STAKEHOLDERS.

But visibility reduction is not automatically problem reduction.

Move an encampment and the sidewalk may improve.

That matters.

If the people simply move one block away, the underlying problem may not have changed.

Ignoring legitimate public burdens creates another risk.

Residents who feel dismissed may broaden frustration from specific behaviors to entire groups of people.

That is the Ignored-Burden Feedback Loop.

So separate status from behavior.

Sleeping outside is not the same as threatening someone.

Addiction is not the same as public drug use.

Visible poverty is not the same as blocking an accessible walkway.

Homelessness is not property damage.

The diagnostic challenge is to hold two truths at once:

People experiencing homelessness retain dignity and need usable pathways.

People sharing public space are entitled to reasonable safety and function.

This chapter does not solve that boundary yet.

It makes the collision visible before we try.

23. THE FRONTLINE BURDEN

Unresolved upstream problems eventually land somewhere.

Police.

Emergency departments.

Libraries.

Shelters.

Transit workers.

EMS.

Outreach teams.

Store employees.

Families.

That can happen because these are the people physically present when the crisis becomes visible.

Not because they are equipped to solve the underlying problem.

The burden has landed on the frontline actor.

THE PLACE WHERE A PROBLEM BECOMES VISIBLE IS NOT NECESSARILY THE PLACE WHERE IT SHOULD BE SOLVED.

When that keeps happening, ask:

Original Problem — What is actually unresolved?

Frontline Function — What can this actor legitimately do?

Mismatch — What are they being asked to solve that lies outside that function?

Recurrence — How often does it return?

Transfer — Where should the problem go next?

Authority — Who can actually resolve it?

Feedback — Does the recurring burden travel backward as information?

The last point matters.

If police respond to the same person repeatedly, or a library repeatedly manages crises that belong elsewhere, the pattern should become upstream evidence.

Otherwise every institution sees activity.

Nobody sees the whole system.

Some places become the default destination because someone is there and cannot simply close the door. That does not give them the capacity to solve what keeps arriving.

A functioning system loops that burden back toward the parts capable of changing the conditions that created it.

24. THE DATA MIRAGE

Beds used, encounters completed, referrals made, detox stays finished, people housed, arrests avoided. These are numbers an institution can report. What do they tell us about the person afterward?

Those numbers matter.

They do not automatically describe what happened to the person's life over time.

Separate:

Activity — what happened.

Output — the immediate result.

Outcome — what changed for the person, including gains, losses, and progress preserved through a setback.

Durable outcome — what still held later.

Administrative status is not the same as human status.

“Housed” does not tell us whether the tenancy lasted.

“Treatment completed” does not tell us whether recovery support existed afterward.

“Referred” does not tell us whether the next service became usable.

Use the Denominator Check.

Who entered?

Who disappeared?

Who never qualified?

Who was never reachable?

Who is missing from the success rate entirely?

Follow the starting condition through the intervention, its immediate result, and the next transition. Did the next step happen? Did the improvement hold? Record what was lost and what we still do not know.

Unknown should remain unknown.

IF EVERY INSTITUTION MEASURES ONLY THE MOMENT IT TOUCHES THE PERSON, NOBODY MAY BE MEASURING THE LIFE MOVING BETWEEN THEM.

If we cannot distinguish activity from durable progress, we will eventually reward the wrong thing.

25. THE EXIT PROBLEM

Consider a possible failure in stepping support down:

Support produces stability.

Then visible stability becomes the reason to remove the support that was producing it.

Housing support ends.

Case management closes.

Transportation disappears.

Treatment steps down.

A program reaches its time limit.

If the person destabilizes, that does not by itself establish that their progress was unreal—or that removing support was the sole cause.

The system can mistake support-produced stability for independence.

The better question is:

WHAT FUNCTION IS THE SUPPORT PERFORMING, AND HAS THAT FUNCTION ACTUALLY TRANSFERRED?

That is Transferable Stability. Before stepping a support down, check whether the person or another dependable structure can carry its function. Looking stable while the support does the work does not settle that question.

Reduce support gradually where possible.

Watch what happens.

Restore it if the function fails to transfer.

Test stability against ordinary trouble.

A missed paycheck.

A bad week.

A relapse.

A broken phone.

A transportation problem.

If one routine setback collapses everything, stability may still be externally held.

The goal is durable stability with as much meaningful autonomy as possible.

Some supports can become lighter. Others may remain necessary. The test is whether their functions remain reliable and the person retains as much control as those needs allow.

26. DESIGNING THE SAFETY NET FOR FAILURE

Recovery can include setbacks.

A useful design test is whether the system can respond to a setback without discarding unrelated progress.

One setback can trigger a cascade:

Relapse.

Program discharge.

Housing loss.

Medication interruption.

Missed appointments.

Benefits problems.

Arrest.

Another crisis.

The problem is not that consequences exist.

The problem is how far one failure is allowed to travel.

That gives us Progress Preservation.

A setback should change what actually needs to change without automatically destroying unrelated gains.

It also reveals the cost of restarting from zero.

After a crisis, a person may have to restore lost identification, medication access, provider connections, housing applications, eligibility, relationships, or trust. Identify which functions actually broke and why; do not assume every crisis erased them all.

Rebuilding can require time, effort, and money. The added cost must be measured rather than assumed to rise after every crisis.

The Recovery Ratchet is the design principle we propose:

PROGRESS CAN MOVE BACKWARD WHEN NECESSARY, BUT IT SHOULD RESIST RETURNING ALL THE WAY TO ZERO.

That requires four things:

Separation — distinguish the failed function from everything else.

Preservation — keep unrelated progress intact.

Reentry — make return easier than full restart.

Escalation — increase support when repeated failure shows the ordinary pathway is not enough.

The hardest test is simple:

Does the system still work when the person behaves like someone with the condition the system exists to address?

27. THE COORDINATION MYTH

A hospital faxes a referral. A shelter provides a list. A case manager leaves a voicemail.

Everyone sent the message. Can the person take the next step?

Their appointments, requirements, transportation, medication, and destination may still conflict. Communication tells another actor what we are doing. Coordination means changing what we are doing because the other actor exists.

Consider a person required to attend treatment in the morning and a probation meeting at the same time. Housing intake needs documents they cannot retrieve without missing treatment.

Each requirement may make sense on its own. The person still cannot be in two places at once.

Now they have to connect the institutions themselves: carry the information, remember the requirements, reconcile the schedules, explain the conflicting rules, and find a way through.

That is what this book calls the Human API. The person becomes the connection the institutions failed to build.

Use four tests:

Visibility — Can the actors see the relevant parts of the person's path?

Compatibility — Do their requirements work together or conflict?

Closure — Does a handoff actually finish, or has someone only sent a message?

Escalation — Who can act when the ordinary process cannot resolve the conflict?

Then give the arrangement an ordinary test. Would it still work if the unusually capable coordinator took two weeks off?

If everything falls apart, we have learned where the coordination lives. The person is doing work the process has not learned to carry.

28. THE MISSING OWNER

Fragmented systems are full of assigned tasks.

They are much worse at owning outcomes that exist between those tasks.

That creates the Missing Owner.

Task Accountability asks:

Did you do your part?

Outcome Accountability asks:

Did the next necessary thing actually happen?

The missing owner is not someone who personally provides every service.

The role has five functions:

See the whole path.

Keep the unresolved problem open.

Convene the necessary actors.

Force escalation when the ordinary path cannot resolve it.

Close the loop.

NO UNRESOLVED CROSS-SYSTEM FAILURE SHOULD BE ALLOWED TO BECOME OWNERLESS.

Ownership also needs authority.

A case manager who can see the problem but cannot compel a response may become a witness rather than an owner.

The owner needs clearly defined authority over the resolution process, even if not over every participating agency. Define what they can require, which information they need, and how decisions can be challenged. Test the role under someone we distrust. Ownership means responsibility for a usable response and an honest account of any gap—not unlimited power or a guarantee of outcomes beyond anyone's control.

And ownership needs a clock.

Risk determines urgency.

Near misses count too.

A useful ownership record is simple:

What happened?

Who owns the next action?

What happens next?

By when?

What is the escalation path?

Who verifies closure?

What changed so the same problem is less likely to recur?

The point is not to create another coordinator title.

It is to ensure that when every institution says, “That is not our part,” someone can still say:

IT IS MINE NOW.

29. THE ACCOUNTABILITY TRAP

Metrics change behavior.

That is not corruption.

It is adaptation.

Reward treatment completion and organizations may work harder to help people complete.

They may also become more selective about who they admit.

Reward stable housing and providers may improve support.

They may also avoid people most likely to lose housing.

That creates a measurement trap:

A MEASURE INTENDED TO IMPROVE PERFORMANCE CAN CHANGE WHO GETS SERVED, WHAT GETS DOCUMENTED, AND WHICH RISKS ORGANIZATIONS ARE WILLING TO ACCEPT.

Difficult cases can become penalties.

The Recovery Ratchet can even be punished if the metric values only clean endpoints rather than preserved progress.

A person who relapses but remains housed may look like failure under one measure and meaningful progress under another.

Use the Denominator Check again.

Who was admitted?

Who was screened out?

Who was discharged?

Who disappeared before being counted?

Look at who can get in and how difficult their needs are, then follow progress, what survives a setback, and what holds later. Include dropout, early exit, other effects, and whether the system repaired a recurring problem. A clean endpoint cannot tell us all of that.

Then run a metric version of the Hostile Actor Test:

How could a rational organization improve this number without improving the thing we actually care about?

Once a distorted metric is known, leaving it unchanged becomes a design decision.

A system that learns how to win the metric while losing the person has not become accountable.

It has become better at hiding failure.

30. THE HARD CASE

Every system eventually reaches a case it does not know how to handle well.

Not because the person is less worthy of help, but because their needs do not fit neatly inside the pathways available.

Relapse, shelter exits, hospital visits, arrests, and housing loss may all be part of the history. Several agencies may already know the person. Several approaches may already have been tried.

Eventually someone says:

We already tried that.

That is the hard case.

The difficulty is how complex needs, real behavior, and legitimate institutional limits interact. We have to examine that arrangement without treating the person as a problem to dispose of.

Individually reasonable limits can accumulate into an Exclusion Stack.

Consider a person with opioid addiction, diabetes, intermittent psychiatric symptoms, and a recent eviction.

Recovery housing will not admit active use.

A low-barrier shelter can accept the use but not the medical needs.

Residential treatment wants medical stabilization first.

The hospital stabilizes the immediate problem but does not see an inpatient need.

Supportive housing might fit, but no unit exists.

Every individual decision can make sense while the combined result still leaves the person stranded.

The hospital should not become a shelter.

The shelter should not become a hospital.

The treatment provider should not manage risk outside its capacity.

Those limits can remain legitimate.

But the combined result still has to belong somewhere.

A referral is not a transfer.

Responsibility changes hands when the next actor actually accepts the next function.

Until then, someone has to keep the thread from breaking.

If no workable option exists, record the capacity gap honestly.

Do not disguise it as:

Noncompliant.

Too complex.

Failed placement.

Nothing else we can do.

The Hard-Case Test is not a test of the person.

It is a test of the system:

AS NEEDS BECOME MORE COMPLEX, DOES THE AVAILABLE RESPONSE BECOME MORE CAPABLE—OR DOES COMPLEXITY SIMPLY CLOSE MORE OPTIONS?

The hard case is where we learn whether the system can keep working after ordinary answers run out.

31. THE PUBLIC BOUNDARY

A person experiencing homelessness still has rights.

So does everyone else using the same public space.

A sidewalk belongs to the person sleeping there.

It also belongs to the wheelchair user trying to pass.

A park belongs to the person with nowhere else to go.

It also belongs to the family trying to use it.

A library can be refuge.

It still has to function as a library.

The question is:

WHAT HAPPENS WHEN ONE PERSON'S SURVIVAL NEEDS BEGIN INTERFERING WITH ANOTHER PERSON'S REASONABLE USE OF SHARED SPACE?

Communities can reasonably restrict violence, obstruction, dangerous fires, harassment, property damage, and conduct that prevents shared spaces from remaining shared.

But enforcement creates another question:

Then what?

Movement is not resolution.

REMOVING A PROBLEM FROM ONE LOCATION DOES NOT NECESSARILY REDUCE THE UNDERLYING PROBLEM. IT MAY ONLY CHANGE WHERE THE PROBLEM APPEARS.

Public-order interventions therefore need two outcomes.

Did the shared space become safer and more usable?

What happened to the people affected?

Both outcomes matter.

The Recovery Ratchet applies here too. Address the conduct without unnecessarily destroying identification, medication, treatment contact, housing progress, or other unrelated gains.

And distinguish status from behavior.

Homelessness is a condition.

Blocking an accessible sidewalk is behavior.

Addiction is a condition.

Threatening someone is behavior.

Rules should target the conduct creating the conflict as directly as possible.

A competent system has to account for both public use and the human consequences of enforcement.

The deeper question is:

WHAT HAD TO GO UNRESOLVED UPSTREAM FOR SHARED PUBLIC SPACE TO BECOME THE PLACE WHERE EVERY COMPETING NEED FINALLY COLLIDED?

32. THE COERCION BOUNDARY

Autonomy is easy to defend when someone is making choices we understand.

The harder question comes when they are not.

A person repeatedly overdoses.

Refuses shelter.

Leaves treatment.

Rejects medication.

Returns to the same dangerous environment.

At some point the system has to ask:

WHEN, IF EVER, IS IT JUSTIFIED TO OVERRIDE THE PERSON'S REFUSAL?

The first distinction is essential.

BAD JUDGMENT IS NOT THE SAME THING AS INCAPACITY.

Adults are allowed to make terrible decisions.

A person can understand the danger, understand the alternatives, and still choose something everyone else thinks is irrational.

Capacity asks whether the person can understand relevant information, appreciate how risk applies to them, compare realistic options, and communicate a choice.

Capacity can fluctuate.

Intoxication, withdrawal, psychiatric crisis, or medical illness may change it temporarily.

That gives us Constrained Agency:

A PERSON CAN RETAIN MEANINGFUL AGENCY WHILE ADDICTION, ILLNESS, OR CIRCUMSTANCE MAKES SOME CHOICES SUBSTANTIALLY HARDER AND LESS RELIABLE.

Coercion exists on a gradient:

Information.

Persuasion.

Repeated offers.

Structured conditions.

Court supervision.

Emergency holds.

Compulsory treatment.

Detention.

Use the least coercive intervention capable of managing the demonstrated risk.

Can the person make this decision? What risk or conduct justifies acting? Are less restrictive alternatives actually usable? What evidence supports the intervention, how long should it last, and who reviews it? Then what happens when the restriction ends?

A legal order does not create a treatment bed.

A compulsory hold does not create housing.

Authority without capacity can produce more coercion without producing more treatment.

The Restoration Principle is simple:

THE PURPOSE OF JUSTIFIED COERCION SHOULD BE TO RESTORE SAFETY AND MEANINGFUL AUTONOMY, NOT TO REPLACE AUTONOMY INDEFINITELY.

When the system overrides an adult's refusal, it should have to prove why the restriction is necessary—and keep proving it for as long as the restriction lasts.

33. THE RECOVERY DEFINITION

Recovery sounds simple until we try to measure it.

Does it mean abstinence?

Stable housing?

No overdoses?

Employment?

Medication adherence?

No arrests?

Rebuilt relationships?

More autonomy?

Those are different outcomes.

And the definition matters because systems eventually optimize whatever they decide recovery is.

One definition is usually too small.

A person can stop using drugs and remain homeless, isolated, medically unstable, and miserable.

Another can continue occasional use while remaining housed, working, avoiding overdose, and rebuilding relationships.

A binary label loses too much information.

Recovery is better understood as a direction over time:

RECOVERY IS SUSTAINED MOVEMENT TOWARD GREATER SAFETY, HEALTH, STABILITY, CONNECTION, AND AUTONOMY WHILE SUBSTANCE USE EXERTS LESS CONTROL OVER THE PERSON'S LIFE.

Relapse should affect that path.

It should not automatically erase it.

Progress has memory.

Recovery can be measured across substance use, health, housing, daily functioning, relationships, legal stability, income, autonomy, and durability.

Those domains may move in different directions.

Support is not the opposite of autonomy.

Unnecessary control is.

And motivation should not become another shortcut.

Instead of asking:

Is this person motivated?

Ask:

Toward what, under what conditions, and what makes that choice sustainable?

We should not require people with addiction to become exceptional humans before declaring their lives are improving.

The better question is:

IS ADDICTION TAKING LESS FROM THIS PERSON'S LIFE, AND DOES THE PERSON HAVE MORE ABILITY TO DECIDE WHAT HAPPENS NEXT?

If the answer keeps becoming yes, that is recovery.

34. WHAT SUCCESS COSTS

Successful intervention can look expensive.

Housing.

Treatment.

Case management.

Medication.

Transportation.

Peer support.

Psychiatric care.

All of it has a visible price.

Failure is harder to see because the bill arrives in pieces.

Emergency rooms.

Ambulances.

Jail.

Police.

Shelters.

Detox.

Court.

Cleanup.

Repeated intake.

Repeated crisis.

The comparison is rarely expensive intervention versus zero.

It is expensive intervention versus the cost of what will probably happen without it.

Declining to spend money does not necessarily eliminate the cost.

It may move the cost somewhere else—or into another budget.

That creates a basic accounting problem:

AN INTERVENTION CAN BE FINANCIALLY UNATTRACTIVE TO THE INSTITUTION PAYING FOR IT WHILE STILL BEING ECONOMICALLY VALUABLE TO THE SYSTEM AS A WHOLE.

Timing makes this worse.

Prevention costs money now.

Benefits may appear later in another budget, administration, agency, or fiscal year.

The Recovery Ratchet changes the accounting too.

A cheap intervention repeated ten times may be more expensive than a more intensive intervention that produces stability once.

But honest cost accounting cuts both ways.

Not every humane intervention saves money.

Some cost more and still produce better lives.

So distinguish actual savings, avoided future costs, freed capacity, and improved human outcomes.

KNOW WHAT SUCCESS COSTS. KNOW WHAT FAILURE COSTS. COMPARE THEM HONESTLY.

The cheapest program is not always the cheapest system.

35. THE EVIDENCE PROBLEM

“Evidence-based” sounds reassuring.

It should.

But the phrase can compress a lot of uncertainty.

A treatment has evidence.

For whom?

Compared with what?

Under what conditions?

For which outcome?

For how long?

Evidence does not travel perfectly.

A program that works in one city may perform differently in another.

A pilot may depend on unusually skilled staff, generous funding, or participants easier to recruit and retain.

Evidence tells us what happened under studied conditions.

Policy still has to decide how far those findings can reasonably travel.

The problem gets worse when evidence is compressed into:

This works.

This does not work.

Research proves.

Who was studied, and compared with whom? What changed, by how much, and for how long? Who dropped out or left early? What explains the result, and which conditions may matter elsewhere? Keep the tradeoffs and uncertainty visible, and ask what new evidence would change the conclusion.

The Recovery Ratchet adds another question:

Did the intervention preserve progress when something later went wrong?

A person may relapse but remain housed.

Miss treatment but reconnect quickly.

Lose a job without losing medication, benefits, and every other support.

Those are meaningful outcomes.

Lived experience belongs here too.

Experience generates questions.

Evidence helps test them.

And sometimes the honest answer is:

We do not know yet.

“Evidence-based” should not end the conversation.

It should make the conversation more precise.

WHAT EXACTLY DOES THE EVIDENCE SAY—AND WHAT ARE WE ADDING WHEN WE TURN IT INTO POLICY?

36. THE REFORM GRAVEYARD

Systems are full of reforms that once looked promising.

Pilot programs.

Task forces.

Special grants.

New coordinators.

Innovative partnerships.

For a while, they work.

Then the grant ends.

The champion leaves.

Staff turn over.

Leadership changes.

The old workflow returns.

A REFORM CAN BE EFFECTIVE WITHOUT BEING DURABLE.

A pilot may succeed because unusually capable people are holding it together.

If the reform survives only while the right champion is in the room, the institution has not really learned it.

Reform can also fail because it becomes an extra layer on top of everything already there.

New forms. New meetings. New reporting. Nothing old disappears.

Eventually staff run the original process and the reform simultaneously.

When capacity tightens, the extra layer goes first.

So ask:

What old process does this replace?

What permanent function does it create?

Who performs that function after the pilot?

What pays for it?

What happens when the original champions leave?

Institutional memory has to be built into the system.

If a lesson matters, build it into policy, funding, training, workflow, data, authority, and accountability.

PEOPLE NEED A RECOVERY RATCHET. INSTITUTIONS NEED ONE TOO.

The goal is not program permanence.

It is learning permanence.

If a reform does not work, stop it and preserve what was learned.

If it works, move the useful function out of the pilot and into ordinary operations.

The real durability test is:

Can this improvement survive becoming boring?

37. WHAT ADDICTION-RELATED HOMELESSNESS ADDED TO OUTCOME ANATOMY

Child welfare showed that explaining an outcome requires examining what intervention itself changed, especially when one side holds far more power than the other.

Addiction-related homelessness adds another difficulty: we cannot explain the path honestly by choosing either individual responsibility or surrounding conditions and ignoring the other.

A person can have meaningful choices while facing conditions that make some choices much harder. We need to know how both shaped the path.

That is Constrained Agency:

A PERSON CAN REMAIN RESPONSIBLE FOR CHOICES MADE INSIDE CONDITIONS THEY DID NOT FULLY CHOOSE AND CANNOT EASILY OVERCOME.

Without agency, compassion can turn into treating adults as if their choices do not matter.

Without context, responsibility can become abandonment.

This volume also sharpened the distinction between observing stability and explaining what produces it.

The question is not only:

Is the person stable?

It is:

What is producing the stability, and will it survive when conditions change?

That is Transferable Stability.

Then came the Recovery Ratchet:

FAILURE SHOULD MOVE SOMEONE BACKWARD ONLY AS FAR AS THE FAILURE ACTUALLY REQUIRES.

Preserve what still works.

Preserve progress unrelated to the setback.

Preserve the ability to restart.

And that principle eventually had to apply to institutions too.

Tracing the path exposed another question about ownership:

Who keeps the next necessary function from becoming unassigned?

A referral is not enough.

Someone has to know whether the next function was accepted.

It also added a design rule:

DESIGN FOR THE PREDICTABLE LIMITATIONS OF THE POPULATION THE SYSTEM EXISTS TO SERVE.

Addiction treatment should expect relapse.

Homelessness services should expect unstable phones, transportation, identification, schedules, and housing histories.

Behavioral-health systems should expect symptoms.

A system should not require people to stop exhibiting the condition it exists to address before they become easy enough to serve.

The broader question is:

WHEN EVERY INDIVIDUAL DECISION MAKES SENSE, WHAT EXPLAINS THE COMBINED RESULT?

Human beings have agency.

Human beings have constraints.

Institutions have limits.

Systems still have outcomes.

A useful explanation has to show how all four interact over time. A useful design has to work within that reality.

38. WHAT THE SYSTEM OWES THE PERSON

The system cannot promise recovery.

It cannot promise sobriety.

It cannot promise stable housing, employment, reconciliation, or a life without relapse.

Human beings are too complicated for guarantees like that.

But limits on outcomes do not erase obligations.

The question is:

WHAT DOES THE SYSTEM OWE THE PERSON LIVING INSIDE IT?

It owes reality.

An honest description of the problem, options, risks, and limits.

It owes usable choice.

Not theoretical options. Choices a person can realistically access and act on.

It owes consequences that fit the problem.

One failure should not automatically trigger every possible consequence.

It owes continuity.

Preserve medication, housing, records, benefits, identification, relationships, and progress that do not need to disappear.

It owes reentry.

Relapse, treatment exit, housing loss, or another bad decision should not require catastrophe before help becomes available again.

It owes intervention before catastrophe.

It owes capacity before coercion.

Before taking away autonomy, make sure the less restrictive alternative actually exists.

It owes limits that make sense.

Other residents, workers, families, neighbors, and public space matter too.

Compassion does not require pretending harmful behavior has no consequences.

It owes accountability without erasure.

People remain responsible for choices and harms. Consequences should address the problem without unnecessarily destroying everything else that has been built.

It owes protection from complexity.

A person should not need to become the unpaid interface between institutions that cannot coordinate themselves.

It owes a continuous handoff.

A referral is not enough.

Someone should keep the thread until the next necessary function is actually accepted.

It owes an honest response to the hard case.

When ordinary programs cannot serve someone safely or effectively, the capacity gap should become visible rather than being converted into “this person cannot be helped.”

It owes an honest account of the evidence.

Use what we know, say what we do not, and change the answer when better information appears.

It owes learning.

The same preventable problem should not need to harm another person before the institution remembers what it already discovered.

It owes honest accounting.

Count intervention.

Count crisis.

Count where costs move.

It owes progress preservation.

The Recovery Ratchet may be the clearest rule this volume found:

A SETBACK SHOULD MOVE SOMEONE BACKWARD ONLY AS FAR AS THE SETBACK ACTUALLY REQUIRES.

Adults retain agency too.

The person can reasonably be expected, where capable, to participate, communicate honestly, respect other people, follow legitimate rules, take responsibility for harm, and make reasonable effort toward chosen goals.

But the system should not demand:

Perfect sobriety before housing.

Perfect organization before services.

Perfect compliance before another chance.

Crisis before attention.

Gratitude for inadequate help.

Or the ability to navigate complexity professionals themselves struggle to navigate.

Most of all, it should not demand:

BECOME EASY BEFORE YOU BECOME WORTHY OF HELP.

Neither the person nor the system will be perfect. The obligations still stand. Make the choices usable, keep consequences connected to the problem, preserve what still works, and provide a way back before another catastrophe.

Respect the limits other people need. Show the evidence, count the costs honestly, and carry what the institutions learn into the next case. When something goes wrong, the person should still have a next step.

Because the principle underneath this entire series still holds:

DO NOT DESIGN A SYSTEM THAT REQUIRES EXCEPTIONAL PEOPLE TO OVERCOME ITS INCENTIVES.

People recovering from addiction already have enough to overcome.

The system should not become one more thing to overcome.

Author’s note: These are proposed standards for continuity, accountability and dignity. Whether a particular design delivers them requires evaluation against realistic alternatives.

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About the author

JMAC is the writing name of Brian Phillips, an independent systems researcher and writer building Side Angle Works.

Before this work, he spent years in professional kitchens. That experience still shapes his approach: understand the whole operation, find the bottlenecks, work with the resources available, and account for real human behavior.

Through Outcome Anatomy, he examines how choices, conditions, incentives, rules and resources combine to produce results.

Teaching people to ask better questions.
Team Human.

Corrections and contact

A correction is useful. If you find an error, a missing explanation, or evidence that changes the picture, include the volume, chapter and passage so I can find it.

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Other volumes in the series

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- Volume 4: Addiction-Related Homelessness

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If help keeps arriving, why does the same crisis keep returning?

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