

The Helping Former Prisoners Reenter Society: The Health Link Project

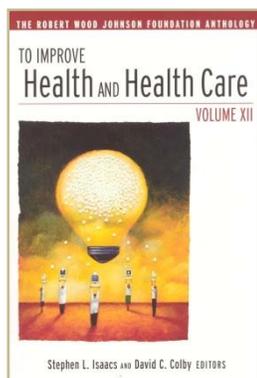


Robert Wood Johnson Foundation

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Editors' Introduction

More than two million people are currently serving time in America's prisons. Over half a million are released back into the community every year.¹ Many inmates have addiction or mental health disorders, or both; according to one study, over 60 percent of offenders tested at the time of arrest admitted to using or were found to have been using at least one illicit drug. Recidivism rates are high, with 67 to 90 percent being arrested in the three-to-five-year period following release.² The revolving door of arrest, imprisonment, release to the community, and re-arrest has spawned interest in prisoner-reentry programs—programs that provide services to inmates when they are in prison and after they are released to help them integrate back into society.

In this chapter, Will Bunch, a journalist with the *Philadelphia Daily News*, looks at Health Link, an early prisoner-reentry program that ran between 1992 and 2002 and was funded by the Robert Wood Johnson Foundation. The program tested the idea of caseworkers helping recently released inmates with job, educational, health, housing, and other social services. It was evaluated by means of a study whereby roughly half of the released inmates were provided these case management services and half were not, and at the end of a year, the two groups were compared for rates of recidivism and drug use, among other outcomes.

Evaluations of prisoner-reentry programs have generally shown them to be ineffective or to have produced mixed results—hardly surprising given the extremely challenging circumstances in which these programs operate. For example, an examination of job training and placement programs for former inmates by the Campbell Collaboration found “little or only modest effects . . . for reducing the recidivism of ex-offenders.”³ An analysis conducted by National Institute of Justice of reentry programs for women inmates reported mixed results.⁴

Health Link was no exception. The evaluation found that the group of ex-inmates receiving case management services did no better than the group not receiving services in terms of recidivism, drug use, employment, and sexual activity linked to HIV/AIDS (unprotected sex, multiple partners). It did, however, find that the group receiving case management services had increased rates of participation in drug treatment programs, young men receiving services had a greater likelihood of receiving a high school diploma or GED degree, and women receiving services were more likely to

have gotten gynecological services.

As Bunch notes in his conclusion, even though Health Link itself had mixed results, the project turned out to be an influential one. Not only was it an early effort but it made a serious attempt to determine those approaches that worked and those that didn't. It helped focus attention on the importance of providing social services for inmates returning to the community and provided a framework that others could adapt to their own circumstances. Prisoner-reentry programs are now quite common. A review of such programs conducted by the Urban Institute for the Annie E. Casey Foundation listed more than 160 programs.⁵ The federal government has taken the problem seriously, with programs such as the Prisoner Reentry Initiative (originally named the Serious and Violent Offender Reentry Initiative) and the Young Offender Reentry Program. State and local governments and foundations have also developed and supported these programs.

The Health Link project and its evaluation raise important questions. One of these is determining the appropriate assessment measure. The Health Link evaluation looked at how the intervention group (those who received post-release case management in the community) compared with the control group (those who did not) and found that it had been ineffective in reaching the key goals of reducing recidivism and drug abuse among the population being studied. The Health Link caseworkers and administrators looked to a different measure: individuals in the most dire circumstances who were helped, and the chapter contains interviews with former inmates whose lives were turned around because of Health Link.

Another question has to do with the ethics of random trials in this context. Evaluators argue that it is ethical to divide people into treatment and control groups, just as in medical research having a control group is considered the best and most ethical way to determine whether a particular drug works or not. Caseworkers felt that it was unethical to offer some people services and to withhold those same services from others who also needed them. That some caseworkers refused to withhold services from those in the control group when asked for help illustrates the bind they were placed in.⁶

A third question is the extent to which a foundation specializing in health and health care can reasonably expect to develop programs that will change the behavior of those entangled in the criminal justice system—a system with complex societal roots and consequences. Related to that is

the question of how a foundation should tap and utilize knowledge in a field—whether it be criminal justice, education, or housing—that it has entered but that is not within the normal expertise of its program staff.

Finally, this chapter and the chapter on reducing alcohol and substance abuse among Native Americans living on the Lakota Sioux reservations in South Dakota⁶ raise a question of how a foundation should go about dealing with intractable or nearly intractable situations and what results it is reasonable to expect. These may be exactly the situations where foundations' resources can be most beneficial. On the other hand, these situations may be ones that foundations should avoid (or enter with low expectations), at least until greater attention is given to addressing some of the underlying social, psychological, and economic roots of the problems.

*Will Bunch interviewed case workers who told him that they were serving all former inmates, whether or not they were in the control group. Marian Bass, who oversaw the evaluation at the Robert Wood Johnson Foundation, and John Burghardt, who managed the evaluation for Mathematica, deny that caseworkers, on a large scale, subverted the rule that no follow-up services be provided to the control group except in the expected rare instance when a desperate client contacted Health Link for emergency help.

Notes

1. Johnson Listwan, S. "How to Prevent Prisoner Re-entry Programs from Failing: Insights from Evidence-Based Corrections." *Federal Probation*, 2006, 70.
(http://www.uscourts.gov/fedprob/December_2006/prevent.htm)
2. Nolan, C. (Advisor to the Administrator, Substance Abuse and Mental Health Services Administration). Testimony before the Senate Subcommittee on Corrections and Rehabilitation, September 21, 2006.
3. Visher, C., and others. "Systematic Review of Non-Custodial Employment Programs: Impact on Recidivism Rates of Ex-Offenders." *Campbell Collaboration Reviews of Interventions and Policy Evaluations*, 2006.
4. National Institute of Justice. "Reentry Programs for Women Inmates." *NIJ Journal*, July 2005, 252.
5. Solomon, A. and others. *Outside the Walls: A National Snapshot of Community-based Prisoner Reentry Programs*. Annie E. Casey Foundation, 2004.
6. See Chapter Six in this volume.

In the late 1980s and early 1990s, New York City’s most frayed neighborhoods were under assault from the twin scourges of widely available drugs—especially the powerful form of cocaine known as crack—and a rising rate of HIV infection spread by contaminated needles and unprotected sex. Crack arrived in already troubled neighborhoods such as Harlem and the South Bronx in the mid-1980s and exacerbated existing social problems and created new ones, including an increase in robberies, violent crime, and the use of weapons. The murder rate in New York City peaked in 1990, when there were 2,262 killings—roughly five times as many as there are today. Many people were caught up in drug sweeps or arrested for criminal activity; according to one study, the number of prisoners sent to New York City’s main jail at Rikers Island nearly tripled during the 1980s.

During this time, Nicholas Freudenberg, Distinguished Professor of Urban Public Health at Hunter College in New York City, and some of his colleagues were working in the South Bronx and East Harlem tackling a related problem—the growing number of inner-city residents infected with HIV, the virus that causes AIDS. Although the deadly virus—unknown at the start of the 1980s—was initially linked largely to the gay community, by the end of the decade this plague had spread through the inner city with a vengeance, and according to one published report, by 1990 one in every ten adults in East Harlem was thought to be infected with HIV, one of the highest rates in the nation.¹

Freudenberg was then heading the Hunter College Center on AIDS, Drugs, and Community Health. As he and his team struggled to organize programs for those at risk of HIV infection, particularly drug abusers and the homeless in the low-income neighborhoods of New York City such as East Harlem and the South Bronx, seemingly engaged clients would suddenly disappear. “They would be attending sessions or workshops or coming for food, and then they’d be gone for a while,” Freudenberg recalled. “And what we found out is that often, they had been arrested and were in jail—often for something to do with drug use, but also for the whole range of reasons why people are arrested.”

The vast majority of people at risk of HIV infection or already infected who were incarcerated were destined for Rikers Island—a sprawling complex consisting of ten separate jails, all located on a landfill-expanded island in New York City’s East River between the Bronx and Queens. Like other

urban jails across the nation, Rikers is host to an array of offenders serving shorter sentences for lesser crimes or parole violations and suspects awaiting trial on more serious charges.

Not only did the Rikers population surge during the crack crisis of the 1980s and 1990s, but the facility was also beset by violence—with occasional riots, such as one in 1990 that flared for a day and a half, injuring twenty-nine people; that same year, more than 2,500 violent incidents were reported. The rate of HIV-infected inmates also soared; Freudenberg said the Rikers zip code had the highest rate of HIV infection in the nation, with more than one in four of the women inmates and close to one in five of male inmates infected. Yet at the dawn of the 1990s, neither the New York City Department of Correction nor the main health provider at Rikers, Montefiore Medical Center, offered systematic HIV prevention or treatment services.

Freudenberg approached Montefiore and the city administration about launching an AIDS prevention program based at Rikers. He teamed with Beth Richie, an instructor in community health education at Hunter, who was actively working with female victims of domestic violence in East Harlem. “We found a number of women involved in violent relationships who were in jail—not in a shelter or a rape crisis center or a hospital emergency room, where they might get the services they need,” recalls Richie, who went on to chair the Department of African American Studies at the University of Illinois at Chicago and is now associate dean of the College of Liberal Arts and Sciences there.

The initial female inmate programs at Rikers developed by Freudenberg and Richie, in cooperation with Montefiore officials and funded by the American Foundation for AIDS Research (AmfAR), began to highlight themes that would later become central to a Robert Wood Johnson Foundation program known as Health Link, which involved not just counseling but empowerment sessions. “We focused on issues of power, both in intimate relationships and social institutions. We tried to help women make decisions that were in their best interest, for example, how to use protection or have access to abortion or HIV information, and we helped them link up to community-based services,” Richie recalled.

But after a couple of years of developing these initial programs, Richie and Freudenberg came to realize that inmates were in danger of losing these newfound life skills and self-empowerment once

they hit their old neighborhoods, where friends, lovers, spouses, and other family members often pulled them right back into their old environment and social conditions: poverty, drugs, joblessness, homelessness, and the like.

“We wanted to talk to women, once they got out, about what was happening in their lives, and we found two things,” Freudenberg recalled. “One was that we couldn’t find a lot of them—that even though they’d given us contact information, either their lives were so chaotic and troubled because of the difficulty of finding housing, drug use, or their family situation, or the good intentions of the changes they had said they wanted to make in their drug use, in their relationships, were overwhelmed by the life experiences once they got out. Even though their insights and motivations had changed at Rikers, the circumstances on the outside hadn’t changed.”

Indeed, the Hunter College team working on health programs at Rikers learned that there were other problems in connecting just-released inmates to much-needed services; most had seen the state terminate their Medicaid benefits when they were incarcerated, making it difficult, if not impossible, to receive proper treatment for AIDS or tuberculosis or mental health issues in the days immediately after their release. In the early 1990s, as the Hunter researchers were looking to expand their Rikers program, Freudenberg had also developed a relationship with the Robert Wood Johnson Foundation when he was asked to join with some University of Michigan researchers to evaluate the Foundation’s national AIDS programs. He told Foundation officials of his idea for the program that would become Health Link, and they were receptive.

Health Link Takes Shape

The concept that Freudenberg and his colleagues presented to the Foundation was to motivate jail inmates through empowerment sessions at Rikers Island, to develop a plan for action when they were discharged back to the community, and then to work with them aggressively on the outside with drug treatment and remedial school or job training before they could relapse into bad habits of drug abuse and crime.

“We were ambivalent about focusing on the prison and jail population for a couple of reasons,” recalled Marjorie Gutman, a program officer with the Foundation, who had worked with Freudenberg on an earlier AIDS project and who became the program officer for Health Link until

she left the Foundation in late 1997. “In general, it would be more difficult, and it was not an attractive area.” On the other hand, she noted that some of the Foundation trustees believed that programs targeting drug abuse should try to reach what she called “the hardest of the hardest hit.” There was arguably no better place in the United States for such an effort than Rikers Island, where as many as 80 percent of the 125,000 inmates who cycled through the jail complex every year tested positive for drugs.

In October 1991, the Foundation agreed to fund Health Link on a trial basis, which ultimately led to ten years of support for the project. Between 1992 and 2002, the Foundation paid out just over \$12.25 million to finance Health Link. The second half of that effort was tied to an evaluation aimed at showing whether Health Link was successful in reaching its goals, which included reducing recidivism, drug use, criminal activity, and unsafe sex.

The Health Link model was based on three assumptions: (1) many inmates have unmet needs for health care, education, and support services; (2) former inmates need an advocate to help them become productive members of their communities; and (3) time in jail is an opportune time to establish relationships with inmates who will need support and guidance when they return to the community. It worked this way: the Hunter team and its case managers would seek to recruit inmates to take part in the empowerment sessions at Rikers, and develop protocols, or release plans, for those interested in receiving social services upon their release. The case managers would follow up with the Health Link participants for one year to ensure that they continued receiving community services, even though in some cases that required tracking down clients and getting them interested in the program again.

“We combined what people called a psychosocial intervention with meeting basic needs,” Freudenberg said of the model. “So the psychosocial would be counseling—looking to strengthen motivation, giving people some understanding of the roots of their drug problem. And the basic needs part was that we were helping to get people housing, job training, health care, and drug treatment. A lot of programs have done one or the other; we saw that if we were going to make a difference, we would have to address both.”

In its later phase—between 1997 and 2002—the project underwent an evaluation. All inmates were

to participate in the empowerment sessions at Rikers. Upon their release, half of them would receive follow-up services from caseworkers, while the other half served as a control group. The follow-up was to take place among the former inmates released in the South Bronx and Harlem. Thus, Health Link would be evaluated along the lines of a clinical drug trial; a portion of the population would receive intensive services—in this instance, case management—and a portion would not, and the two would be compared to see if the intervention made a difference.

While the bulk of the inmates at Rikers were adult males, the organizers of Health Link decided to aim the program at female inmates and at young men aged sixteen to eighteen. Freudenberg explained that these were the two groups that social workers believed could benefit the most from this intervention strategy. “Women had really been at the center of the crack epidemic, and the impact of the crack epidemic and HIV on women resonated throughout the whole community,” Freudenberg said. The male teenagers, he added, were less likely to be addicted to drugs or to be homeless than their adult counterparts, so the Health Link organizers believed early intervention could make a greater difference.

Health Link in Practice

In practice, the obstacles to Health Link loomed large. Inside Rikers, the caseworkers had to deal with a city bureaucracy that was more oriented toward keeping order in the violence-prone facility than toward rehabilitation, and was skeptical of the academic social workers. With the frequent unrest at Rikers, there were lockdowns or other measures that sometimes wasted half a day. “Because we were guests in the Department of Correction’s house, we had to live by their rules,” Freudenberg said. Furthermore, Health Link had to deal with a shifting political landscape; the administration of Mayor David Dinkins had been more supportive of jail-based rehabilitation programs, according to the Health Link officials, than the administration of Mayor Rudolph Giuliani, who took office in 1994.

Yet roadblocks at the jail were not as great as the difficulties in keeping up with clients after they were released back to Harlem or the South Bronx. Within Rikers, the inmates were quite literally a captive audience who often welcomed the empowerment sessions as a break in their routine, but back in their neighborhoods they faced a culture that had been heavily warped by the drug trade and other social ills, and often friends and family members were the ones luring them back to old habits.

Stanley Richards, the chief operating officer at the Fortune Society, a nonprofit organization in New York City that works to ease prisoner reentry and promote alternatives to incarceration and that oversaw Health Link’s case management services between 1997 and March 1999, described a typical circumstance that a caseworker encountered. “We had a situation where one of our young folks went home, and he was really trying to stop smoking weed,” Richards recalled, describing an approach called “harm reduction” that involved gradually reducing drug use. “He came in and said, ‘Look, I’m having a really hard time, because my father and everybody in my house is smoking weed, and how am I supposed to deal with that?’” Richards said that the caseworker tried to place the client in a residential treatment program, but was not successful, so she instead worked with him to negotiate with family members not to use drugs around him.

Inside Rikers, the empowerment groups focused on concrete issues of substance abuse and violence in relationships as well as broader topics around decision-making and self-esteem. Richards—who himself had been incarcerated before his career in social work—said that getting the male teenagers to talk proved a little more difficult. “When you had sixteen- or seventeen- or eighteen-year-olds, you are not going to have conversation, so you had to have it be active,” he recalled. “So we had a lot of role plays, a lot of edgy conversations about the reality.”

For some of the more socially isolated female inmates, however, the chance to talk to and hear a supportive voice in group sessions—especially since so many had just learned of their HIV infections—was a valuable lifeline. In 1992, Phyllis Anderson, then a forty-three-year-old career bookkeeper caught up in the crack epidemic, was sentenced to eight months at Rikers for an attempted burglary; one of the clinicians from Montefiore informed Anderson that she had tested positive for the virus that causes AIDS. “She said, ‘Remember when you took the test for HIV, and remember how we discussed that it could be positive,’” Anderson recalled nearly sixteen years later. “She said, ‘You tested positive for HIV.’ But that was OK. Then she said that in a year I would be dead.”

Anderson was crushed. “I was alone when I got my diagnosis, and I didn’t tell anybody,” she recalled. “I walked back to my dorm at Rikers in tears.” Now divorced and with no children, Anderson said that when she learned about Health Link empowerment groups a short time later, she

was happy to have “a safe place” to talk to about her diagnosis with other people. Before her release from Rikers, she became something of an inmate activist, even organizing an offshoot for the HIV-infected called Positive Group Linkage and creating a buddy system so that women would not go alone for HIV testing or learn their diagnosis alone, as she had.

But in the long run the close tie that Anderson forged at Rikers with her Health Link caseworker, Gloria Jean Jenkinson, may have proved even more meaningful. Initially, Jenkinson and Health Link helped to connect Anderson with a treatment program then known as Stand Up Harlem, which offered her a place to live and a full-time job. She was the program’s first client to become a salaried employee. Eventually, the former bookkeeper became a counselor working on HIV issues and running a jail outreach program that actually brought her back into Rikers, but now as a case manager. And Anderson’s Health Link counselor continued to work with her.

“I had some issues, and she connected me to a therapist who helped me resolve some stuff from my past,” Anderson recalled. Health Link’s Jenkinson also provided moral support in those initial days when she was still worried about her HIV diagnosis, although over time it turned out that Anderson’s T-cell count was so high she never required medication. “Gloria always told me to never give up hope,” said Anderson, who has stayed in touch with her former caseworker over the years. Today she works to educate young people and adults about the risks of HIV infection.

The Evaluation

By 1996, officials at the Robert Wood Johnson Foundation came to believe that a thorough evaluation of Health Link was critical to showing whether the strategy employed by the project was a workable one that ought to be replicated in communities across the country.

It quickly became obvious, however, that there was no clear roadmap for how to conduct a scientific evaluation of a program such as Health Link, and the debate over how one might be carried out exposed a divide between the research orientation of the evaluation community and the perspective of the social workers on the ground in New York. On the one hand, evaluators argued that placing people in randomized control groups, one of which would receive services and one of which wouldn’t, was the best way to find out what works and what doesn’t—much as medical researchers test a new drug by providing it to some sick people and not to others and then comparing the results

between the two groups. On the other hand, caseworkers and social workers voiced more concern about individuals than about data. They argued that it was unethical to deny the program's services to any willing inmate at Rikers for the purpose of creating a control group. An initial compromise proposed in the mid-1990s by Abt Associates, of Cambridge, Massachusetts, tried to solve the problem by comparing outcomes for Health Link clients with outcomes for a group of similar inmates selected from elsewhere. But that proposal was rejected for funding by the National Institute on Drug Abuse.

After several failed attempts to develop an appropriate research design, the Foundation called upon Mathematica Policy Research, an evaluation firm with headquarters in Princeton, New Jersey, to devise a plan to evaluate Health Link, with the assistance of some of the experts serving on the program's technical advisory committee. Between July 1997 and May 2000, Mathematica carried out an evaluation of approximately one thousand Rikers Island inmates, who were divided into two groups. The first group received empowerment training and discharge counseling plus case management services in the community for a year after release. The second group received less intensive discharge services and limited follow-up case management. The former inmates participating in the program were interviewed, on average, fifteen months after their release. In addition, hair samples were collected, with the clients' permission, and tested for traces of drugs. The comparisons between the two groups were to reflect the effect of case-management services on outcomes—most important, on recidivism and drug use.

Although the Mathematica evaluation indicates that the intervention group received more case management services in the community than the control group, interviews with case managers suggest that at least some caseworkers, who were never comfortable with the evaluation process, did not follow the instructions to deny services to the ex-inmates who were in the control group. JoAnne Page, the president and chief executive officer of the Fortune Society, said that it was simply not in the nature of New York's social workers to discard a willing client who had volunteered for the jail empowerment groups. "I think that taking a group of people in desperate need of services and saying that you get a full meal and you get a crumb—the kind of staff you're looking for aren't going to do that," Page said.

Charles Watts, one of the Fortune Society caseworkers who worked on Health Link in the late 1990s,

said he intentionally tried to circumvent the walls that were erected for the evaluation (that is, no post-release outreach to members of the control group). “After I became a case manager, I struggled with that issue,” Watts said. “I did everything I could to circumvent it, to counteract it. Because it was a difficult situation to just give someone a discharge plan and a referral and no support in the community with helping them translate that discharge plan into a community service plan, when we were dealing with adolescents.”

To prove his point, Watts cited one of the Rikers inmates who was randomly assigned to the control group yet continues to meet with his original caseworkers at the Fortune Society, a twenty-four-year-old man named Parcell Leibert. Leibert was just sixteen when he was sent to Rikers for dealing drugs on the streets of Harlem. When Leibert was at Rikers, Watts and another caseworker practically leaped at the chance to work with him. “We really tried to get in as many face-to-face encounters as we could,” Watts said. And they continued to work with him after he was released—even after he had been sent to state prison for six years and then released.

In the end, the evaluation found no significant difference between the two study groups in the major areas that Health Link hoped to affect.² In terms of recidivism, approximately 40 percent of both the groups receiving case management and the groups that didn’t were arrested or charged and approximately 20 percent were sentenced to prison, jail, or a detention home. In terms of drug use, roughly 40 percent of the women and 15 percent of the young men tested positive for cocaine or crack cocaine, again with no significant differences among the intervention group and the control group. Nor did the project reduce the amount of unprotected sex or other behaviors that put the former inmates at risk for HIV/AIDS.

The evaluators did, however, find some benefits for those who received post-prison case management, such as a higher rate of participation in drug-treatment programs, more male teenagers earning high school diplomas or GED degrees (thus opening the door to gainful employment), and increased use of gynecological services for women (thereby leading to increased disease prevention and earlier detection of diseases).

A Case Worker and Client Perspective

Despite the evaluation results showing that Health Link did not affect either drug use or recidivism,

those involved in carrying out the project say that the evaluation doesn't tell the whole story of the program at Rikers and that it was not the last word of what was accomplished. The caseworkers most closely involved with Health Link define success with a more hardened view shaped by the deep despair of New York City's drug and HIV/AIDS crises of the 1990s. Their view of Health Link focuses not so much on data as on people, and so in gauging both the success and the potential of Health Link and programs like it, they cite personal success stories like that of Kim Barber, a woman who peddled crack cocaine on Manhattan's West 119th Street a little more than a decade ago.

"There used to be drug buildings everywhere," said Barber, now acting as a kind of tour guide. Pointing at one renovated building, she said, "This used to be a hotel, and baby! . . ." Her voice trailed off.

What went on there, Barber was asked.

"What didn't go on there?" she responded. In this gentrifying neighborhood, where Barber's last crash pad with an ex-boyfriend now sits above a patisserie selling cappuccino and chocolate truffles, it's hard to imagine a flourishing narcotics trade not so long ago. But it is even harder to imagine Barber—now forty-two years old, short and stylish in designer jeans and a down parka—so caught up in that world.

Yet back in 1993, when Barber was six-months pregnant with her fifth child, she was arrested for dealing drugs right there on 119th Street—and received the devastating news that she was HIV-positive as well. But even then, as she cycled in and out of jail cells, she found her drug habit almost impossible to break. In October 1997, Barber was picked up on a parole violation and sent to Rikers Island, for what would prove to be her final stay. During Barber's five months at Rikers in late 1997 and early 1998, the Health Link workers enticed her to join regular empowerment sessions. Barber forged a connection at Rikers with her caseworker, Guadalupe Aleman, who helped her plan for her release with practical matters such as making sure she had the right paperwork, like her birth certificate and Social Security card, to deal with the city bureaucracy, with the promise that she would continue to work with Barber on the outside.

On the winter morning that Barber was released, she had nowhere to go but her boyfriend's

apartment overlooking 119th Street, but this time she managed to resist the lure of the street. Instead, she continued to trek weekly to the South Bronx to see Aleman, who successfully pushed to get Barber into the Jericho Project, supportive housing for the formerly homeless in the South Bronx. She started working, first at the Fortune Society, then for another social services program, and enrolled in a program to get her high school diploma and college degree at the same time.

Today Barber is some ten years and thirty blocks removed from her career as a crack dealer, planning to go for a master's degree, and living with her fifteen-year-old daughter in a clean but cluttered apartment on 149th Street that's decorated with self-help poems and certificates from the programs that she has successfully completed. "I just reached a point where I said I can't do this anymore—the cops are getting younger and I'm getting older," she said with a laugh.

Reflecting on Health Link

One reason that the success stories of individual clients such as Kim Barber, Phyllis Anderson, and Parcell Leibert resonate so much with the people who worked on or supported Health Link is that the broader short-term effects of the program, as measured by the evaluation, were negligible. Several social scientists and advocates who are familiar either with Health Link or with the evaluation say they wish more scientific evidence had been collected as to why the program fell short for so many of its clients. These experts say they suspect that it was largely the severity of the social crisis in New York City's worst neighborhoods in the 1990s, combined with a failure to provide intensive enough services—or "dosage" in the social service vernacular—to overcome such steep obstacles.

Christy Visser, a leading authority on prisoner reentry programs at the Washington, D.C.-based Urban Institute and professor of sociology and criminal justice at the University of Delaware, said that she believed that Health Link "tried to take on the worst of the worst" in dealing with teens and mostly drug-addicted females from Harlem and the South Bronx. "Especially with the young males—they are the hardest group to address because of the peer pressure and because of their psychology, because they're not ready to make the lifestyle changes that Health Link sought to inspire." What's more, Visser added, these younger inmates were often harder to reach because of their broken families when they returned home. She said more recent research on prisoner-release programs shows that clients who are in their thirties or older are more optimistic about their ability to stay out of jail and turn away from drugs for good upon release.

Ironically, the issues that proved so challenging in developing the evaluation of Health Link—how to determine success and over how long a period of time—remain controversial among the experts on prisoner reentry programs. To this day, some experts believe that the evaluation design that finally emerged may have masked a larger truth: that any intervention with such a disadvantaged population—even the limited empowerment sessions and discharge planning work with the control group—might have yielded positive results for both sets of inmates. “There could be what we call a treatment-treatment outcome,” said Mark Lipsey, director of the Center for Evaluation Research and Methodology at Vanderbilt University. “In other words, maybe it had an effect on both groups, and that’s why you didn’t see a difference.”

JoAnne Page of the Fortune Society said she felt that a one-year or eighteen-month study might be too short a time to gauge the impact of the jail empowerment efforts and the initial intervention. “It’s like the seeds that you plant—they come up, but they take time,” she noted. “And so the quick-fix idea of whether a program works or not, I think it’s the wrong template. I’d like to see a study of Health Link clients over a span of five or ten years, because I think that’s how you measure the impact.” The Urban Institute’s Visher agreed, noting that some released inmates faced so many issues with housing, jobs, health care, and the like that you may only see “incremental progress” in just one year.

However, some experts say that a probable reason that Health Link had such a high failure rate—particularly the 40 percent re-arrest rate for clients—may be a case of too few services over too short a period of time. Jeff Mellow, an associate professor at City University of New York’s John Jay College of Criminal Justice, who has studied the City’s reentry programs, said that intensive services and counseling need to last much longer to have much impact.

“The longer they”—former inmates—“are out, the more problems that arise,” said Mellow, who studied extensive data on released prisoners for a Foundation-funded report entitled *Mapping the Innovation in Correctional Health Care Service Delivery in New York City*.³ He said that since the era of Health Link, officials had placed a greater emphasis on solutions that were tailored to the overwhelming and overlapping problems of the ex-inmate population. For example, he mentioned a pilot program in Washington, D.C., with health clinics that will see recently discharged inmates

immediately, because keeping future appointments is so difficult for patients who are often in crisis. So while Health Link may have been innovative in its broad concept of linking Rikers' inmates to service providers back in their neighborhoods, Mellow said, it probably needed to be even more intensive to make sure they actually showed up at the places where they could get help.

However, despite its immediate and often frustrating failings, most experts believe that the experience of Health Link made a positive contribution to policymakers' understanding of the problems facing urban jail inmates reentering society—mainly because it was so far ahead of the curve. The Urban Institute's Visher said that on the federal level, the Justice Department did not seriously begin to study local jail reentry issues until around 1999 or 2000, at least seven years after the Foundation began funding Health Link.

Today the problem is even more significant than it was when Health Link began. The U. S. Department of Justice has reported that the number of inmates leaving prison or jail and returning to their neighborhoods nearly quadrupled, from fewer than 170,000 annually in 1980 to more than 650,000 currently, the logical consequence of rising arrest rates, longer sentences, and the construction of new facilities during the 1980s and 1990s.

“There's a big need for this,” said Robinson Hollister, professor of economics at Swarthmore College in suburban Philadelphia, who served on the technical advisory committee for the evaluation of Health Link. He believes that despite the disappointing outcomes, the body of data that was developed through Health Link was invaluable for the next generation of prisoner reentry programs.

Indeed, when officials talk about the later impact of the Health Link experiment, they point to some down-to-earth, practical lessons that were learned, as well as the broader significance that it was one of the first large-scale programs to address the issue within jails and in the community.

Not surprisingly, the approach taken by Health Link and variations on it are being studied and in some cases adopted by other large and midsized cities. Freudenberg noted that around the time that the Robert Wood Johnson Foundation's funding for Health Link expired, in 2002, the New York City Department of Correction began supporting a nearly identical successor program, this time working with the more hard-core population of adult male inmates. Also, his unit at Hunter College

received funding from 2002 through 2007 from the National Institute of Drug Abuse for a project called REAL MEN (Returning Educated African-American and Latino and Low-Income Men to Enriched Neighborhoods), which follows the Health Link model but with a more compressed intervention time and a strong focus on concepts of masculinity and racial and ethnic pride.

Perhaps more important, after Health Link ended, a collaborative effort that includes not only key New York City officials from several agencies but also experts and advocates from some forty outside groups—including Health Link veterans Freudenberg and Page—began to look at more comprehensive and ambitious approaches to discharge planning and services to reentering inmates.

“One of the lessons was that this is a huge problem that has so many aspects—that it’s not health only or addiction only or housing only or work only,” explained Kathleen Coughlin, deputy commissioner for programs and discharge planning services for the New York City Department of Correction. Coughlin heads a public-private team effort that is called the Discharge Planning Collaborative, and the chief program it oversees is the Rikers Island Discharge Initiative, known as RIDE.

The RIDE initiative has tackled many of the problems that Health Link caseworkers identified at Rikers. One of them was the practice of releasing inmates back into the community in the middle of the night, alone. Today the RIDE program connects inmates about to be discharged with social service providers, who are allowed to bring their vans into the Rikers compound in the early morning, so that there is a seamless transition from the jail to aid programs on the outside. The innovation is one of several that has led officials from Philadelphia, Baltimore, and other cities to send teams to Rikers to study its reentry programs.

“Everything that we’re doing now is built upon those lessons learned” from the Health Link experience, Coughlin said. She added that the education process was ongoing. In recent years, some discharged inmates were bused directly to a job site where they were paid at the end of the first day so that they would not start life on the outside flat broke. Coughlin said officials have instituted a new reentry-jobs program more focused on keeping just-released inmates working for a longer period of time. Operators with New York City’s 311 city service phone system are also specifically trained to help people with reentry-related issues.

“We have a level of access that I have never seen before,” said the Fortune Society’s Page. In particular, she noted that city officials recently allowed Fortune to establish an office at the main Rikers Island control building, which had been a goal of Health Link.

In the last couple of years, a major focus has been the issue that prompted the creation of Health Link in the first place: access to better health care. In 2007, armed with hard data that he collected from the Health Link project, Freudenberg and other city advocates successfully lobbied state lawmakers in Albany for a new law that makes it much easier for released inmates to resume Medicaid coverage. After the program was enacted, New York City corrections officials—with funding from the Robin Hood Foundation—opened offices at Rikers for both male and female inmates to enroll as many as possible for government health coverage. Said the City’s Coughlin, “We want people covered as soon as possible, because if they wait forty-five days, we’re likely to see them back in jail before that benefit kicks in.”

Freudenberg said that he had concluded that lobbying government for broader policy changes for ex-inmates was a more effective strategy than the one-to-one work that Health Link specialized in. “I’ve become increasingly skeptical of programs as the solution to reentry issues,” he said. “I don’t think that any set of services by itself is going to dramatically change outcomes if they aren’t matched with policy change that creates a supportive environment that lets people succeed when they get out.”

Yet the concept that Health Link pioneered—bringing social services and empowerment training into the jail setting and linking former prisoners with caseworkers in the community and with health and social services—is becoming an entrenched practice. What’s more, because of New York City’s broad influence as the nation’s largest municipal jail system, the conversation that Health Link helped to launch about discharge planning and the broader issues of reentry is now an integral part of the national discussion about criminal justice and inner-city social welfare.

Notes

1. Woodard, C. "AIDS Trouble Spots Many; Study Suggests 10% Infected in Some Neighborhoods," *New York Newsday*, April 25, 1990.
2. Mathematica Policy Research, *The Evaluation of Health Link: Summary Report*, August 2003.
3. Mellow, J., and others. *Mapping the Innovation in Correctional Health Care Service Delivery in New York City*. New York: Criminal Justice Research and Evaluation Center, John Jay College of Criminal Justice, Spring 2008.
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