Community Case Management for Former Jail Inmates: Its Impacts on Rearrest, Drug Use, and HIV Risk

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ABSTRACT *Dramatically increasing incarceration rates in the United States have led to large concentrations of formerly imprisoned people in poverty-stricken urban areas. Therefore, identifying ways to help inmates who exhibit multiple, serious problems and who are at great risk of experiencing poor postrelease outcomes is especially important to urban communities, as well as to service providers and policymakers concerned about these communities. Our research provides evidence about the effectiveness of one strategy, called Health Link, which recruited adult women and adolescent men while they were incarcerated in a New York City jail and offered case management services during the especially challenging first year after release. About 1,400 participants who enrolled during a 3-year period were randomly assigned either to a group that was eligible for intensive discharge planning services and community-based case management services or to a group eligible for less-intensive discharge planning and no community-based services. We investigated whether the availability of these services reduced rates of drug use, HIV risk, and rearrest. Using data from interviews and hair analysis to measure impacts during a 1-year follow-up period after clients' release from jail, we detected increased participation in drug treatment programs and weak evidence for reduced drug use. However, we did not observe reductions in rearrest rates or in activities with high risk of HIV infection. We conclude that a well-executed case management program can make modest differences in a few short-term outcomes of former inmates. However, the intervention did not lead to the hoped-for changes across a range of outcomes that would clearly indicate greater success in community reintegration or improved health.*

KEYWORDS *Case management, Community reintegration, HIV, Inmate reentry, Rearrest, Substance abuse.*

INTRODUCTION

Poverty-stricken urban neighborhoods are beset by crime, substance abuse, and poor health. Because of the confluence of these problems, the criminal justice system (CJS) plays a large role in the lives of the residents as members of the community are incarcerated and subsequently released.¹ Efforts to improve the reintegration of former inmates into their communities have focused on men, who make up almost 90% of jail inmates.² Although adolescent males and adult females now constitute a growing proportion of the incarcerated population, few programs have been developed to address the needs of either group.^{3,4}

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Compared with many other groups, adolescent males and adult females who have been incarcerated are likely to have high rates of substance abuse, mental health problems, and HIV infection or risk behavior, coupled with low educational attainment and long criminal histories. At the time these people are released from jail, they may well be in greatest need of crisis intervention and counseling, substance abuse treatment, primary health care and mental health care, and supportive social services. Their numerous serious problems suggest that a comprehensive approach may be the most effective in helping them overcome the large challenges they face in making a healthy integration into the community.

METHODS

The Health Link Model

The Hunter College Center on AIDS, Drugs, and Community Health developed Health Link in response to community health problems and the difficulties specific to incarcerated women and adolescent males.⁴⁻⁶ The program was based on the premise that jails provide an efficient setting in which to establish relationships with inmates and that caseworkers can help former inmates obtain community support to address their health-related and other needs. Clients' intermediate goals included increased use of drug treatment and primary health care, engagement in supportive social networks, and enrollment in school or training. Key long-run program goals were reductions in drug use, rearrest rates and HIV risk behavior.

Health Link served adolescent males (aged 16–18 years) and adult females held in jails in New York City. Health Link staff recruited participants through presentations at jail orientation sessions, referrals from other service providers or correctional staff, and word of mouth among inmates. During voluntary group meetings, called *empowerment groups*, caseworkers sought to help clients identify personal problems, build peer support, and develop trusting caseworker–client relationships. These meetings were open to all inmates in the jails in which the empowerment group sessions were held. Individual counseling supplemented the group sessions.

Health Link's signature component was case management in the community after release, which was designed to reintroduce offenders into the community with the support and assistance that would regularize lifestyles and lower the risk of continued problem behavior. To be eligible for postrelease case management, potential clients had to do the following: (1) show a commitment to receiving services, (2) expect to be released to the community within 1 year, and (3) be able to receive services in the South Bronx or Harlem. A tailored set of services that would help address each client's problems, called a *discharge plan*, became the guide for Health Link services after release. In addition, during frequent meetings held shortly after release from jail and then less frequently throughout the subsequent year, caseworkers supported clients by making referrals to services that could help clients address their substance abuse, health, and other problems; conducting crisis intervention; and providing counseling.

The Evaluation Design

The Evaluation of the Health Link Program assessed whether offering Health Link's community-based case management services to inmates who volunteered for them had an effect on the inmates' reintegration into their communities after release. The evaluation received approval from the City of New York Department of Health

Institutional Review Board and obtained informed consent from study participants. Eligible inmates who volunteered for discharge planning and community services were randomly assigned to the Jail-and-Community-Services (JC) group or to the Jail-Services-Only (J) group. JC group members were offered Health Link's intensive discharge planning and postrelease community case management services; J group members were offered less-intensive discharge planning services and were ineligible for Health Link's community case management services (but were encouraged to obtain services from other sources). A total of 1,416 women and adolescent males enrolled in the program and were randomly assigned between July 1997 and May 2000. Comparisons between the JC and J groups measure the marginal effects of the community-based services on client outcomes within an environment in which empowerment groups and discharge planning are available to everyone.

Health Link also tried to help clients indirectly by assisting community organizations that serve this population and by improving partnerships among public and private organizations.⁵ The evaluation did not examine these aspects of the program.

Data and Analysis

The analyses presented here used data from the following sources:

Intake Questionnaires These questionnaires, completed by clients and caseworkers at the time of enrollment in Health Link but before random assignment, covered clients' demographic and economic characteristics, criminal histories, substance use, sexual risk-taking behaviors, and other topics. Caseworkers used the information from this interview to target services to their clients' needs.

Caseworker Records Caseworkers completed logs of their one-on-one contacts with or on behalf of each client during and after incarceration. The analysis uses data covering 2 of the approximately 4 years during which study participants received services. Although these data collection and analysis efforts were not part of the original plans for the evaluation, they were added for a portion of the study period to provide insights into the interactions between the clients and their caseworkers.

Follow-up Interviews We conducted in-person interviews about 15 months after clients had been released from jail to obtain data on rearrests and related events, substance abuse, participation in drug treatment programs, sexual activity, and HIV risk. The interviews also asked about clients' interaction with Health Link. The response rate was 74%. At the time of the interview, 35% of the interviewed males and 29% of the interviewed females were incarcerated.

Chemical Analysis of Hair Samples Because self-reports of drug use are often unreliable,⁷ we asked each sample member to provide some hair for chemical analysis (incarceration facilities did not permit us to cut hair for use in the evaluation). Eighty percent of the sample interviewed in the community voluntarily provided a hair sample; most of the remaining 20% had hair too short to make testing feasible. The laboratory analysis detected metabolites indicating drug use during the 3 months preceding submission of the sample. Tests measured the presence of metabolites of cocaine, heroin, methadone, phencyclidine (PCP), and methamphetamine ("hard drugs"), and of marijuana. However, because the marijuana test requires more hair than do the tests for the other drugs, fewer samples produced results on marijuana use. Only 56% of the samples collected from the males, who

typically wore their hair short, yielded results for all 5 drugs, compared with 93% of those collected from the women.

We also collected administrative records on clients' CJS involvement, although the analyses of those data are not discussed here because the conclusions drawn from them are very similar to the conclusions based on the follow-up interviews.

Given the evaluation's random assignment design, simple differences in the mean outcomes of the JC and J groups would have provided unbiased estimates of Health Link's impacts. However, estimating impacts from multivariate models that control for other factors that affect the outcome measures can increase the precision of the estimated impacts and thereby improve the power of significance tests. In addition, the models can adjust for any random residual differences in the characteristics of J and JC group members as measured at the time of program intake. Therefore, the impact results presented here are based on two-tailed statistical tests of coefficients generated through ordinary least squares regressions. The 30 regressor variables that were included covered a range of demographic and economic characteristics, household and family characteristics, criminal and medical history, and sexual activity. The regressor variables were measured at the time clients enrolled; we did not include data on participation in the program in the regression models because doing so would bias the impact estimates.

We also conducted tests of the sensitivity of our impact results to our model specification and found that none of the checks alter our main conclusions about the effectiveness of the availability of postrelease, community-based case management services on clients' outcomes. We examined unadjusted impacts and also varied the list of regressors to include alternate specifications of variables or different combinations of variables. For a subset of regressions when the dependent variable was binary, we investigated whether using a probit or logit maximum likelihood specification affected the impact estimates. In addition, for some dependent variables, we excluded outliers of the dependent variable when we suspected that extreme values of the variable may have been unduly influencing the impact estimates. Finally, we used multivariate methods to test whether impacts on related outcome measures were jointly equal to zero; doing so reduced the risk of incorrect interpretations, which can arise when a large number of outcomes is examined. Thus, our interpretations of impacts depend on the statistical significance of individual outcomes and related outcomes.

An extensive analysis of impacts for different subgroups of clients also was consistent with the conclusions that we draw from the analyses of the full sample of clients. We examined impacts for subgroups defined on the basis of their racial background, age, education level and school enrollment status, work history, family structure, criminal history characteristics, and reasons given for enrolling in the program. In some instances, however, the impact estimates were quite noisy because the sample sizes were small.

RESULTS

Clients' Preenrollment Characteristics

Health Link staff sought to enroll clients facing significant barriers to successful reintegration. Nearly 90% of the female clients reported drug use, 54% lacked high-school diplomas, 36% had been homeless during the preceding year, and nearly one fifth were HIV positive (Table 1). More than 90% of the adolescent males had not graduated from high school, 85% reported recent drug use, and 47% said that illegal activities were their primary source of income.

TABLE 1. Clients' characteristics at intake

	Females				Males			
	All (n = 704)	JC group (n = 352)	J group (n = 352)	Difference	All (n = 706)	JC group (n = 352)	J group (n = 354)	Difference
Age (years)	34.7	34.5	35.0	-0.5	17.3	17.3	17.3	0.0
No high-school diploma or GED (%)	54.4	55.7	53.1	2.6	92.6	92.9	92.4	0.5
Homeless or stayed in shelter or SRO in past year (%)	35.7	38.2	33.2	5.0	8.2	7.8	8.6	-0.8
Primary income source is illegal activities (%)	38.9	37.3	40.5	-3.2	47.2	43.3	51.2	-7.9*
Number of prior convictions	6.3	5.7	6.8	-1.1	1.4	1.5	1.4	0.1
Drug use in past 6 months (%)†	88.4	89.2	87.5	1.7	85.2	86.4	84.0	2.5
Received alcohol or substance abuse treatment in 12 months before incarceration (%)	47.7	42.9	52.6	-9.7*	11.1	12.3	10.0	2.3
At least one medical problem (%)‡	89.2	89.4	88.9	0.5	50.1	47.8	52.5	-4.6
HIV positive (%)§	17.0	18.0	16.0	2.0	0.0	0.0	0.0	0.0
Ever physically or sexually abused (%)	66.1	65.9	66.3	-0.4	17.4	16.6	18.1	-1.6
Number of vaginal or anal sex partners in 12 months before incarceration	6.7	5.9	7.5	-1.7	5.3	5.3	5.3	0.0
Used condom last time had vaginal or anal sex (%)	37.8	40.6	35.1	5.5	59.3	56.6	61.9	-5.4

GED, general educational development; J group, Jail-Services-Only group; JC group, Jail-and-Community-Services group; SRO, single-room occupancy.

* $P < .05$.

†Includes a list of nine drugs and any other drug.

‡Includes 23 physical or mental health problems.

§New York requires a specific consent form be signed before information on HIV status can be transferred from one organization to another. Because intake interviews during early sample enrollment did not include this form, we could not include this information for some sample members. For these estimates, we assumed that the sample for whom we had HIV information was a random sample of all clients.

Random assignment was implemented successfully. With two exceptions, the JC and J groups, for each gender, were similar on most characteristics. The exceptions were that JC females were less likely than J females to have participated in drug or alcohol treatment during the 12 months preceding incarceration, and JC males were less likely than J males to have relied on illegal activity as their primary income source.

Health Link Participation

To confirm that Health Link provided JC clients with services that could reasonably be expected to improve the clients' outcomes, and that the services differed from those of the J group, we examined both differences in the services the two groups received while incarcerated and the JC group's level of contact with caseworkers after release (detailed data not shown). Ninety-one percent of JC females and 84% of JC males reported having completed discharge plans, which were intended to prepare clients for release into the community. These rates are 5 and 8 percentage points higher than the rates for J females and males, respectively. Caseworkers also had contact with most JC clients after their release from jail. About 60% of JC clients in each gender group reported meeting with their caseworkers after release. About half of female JC clients (51%) and two fifths of male JC clients (42%) reported having contact with their caseworkers at least 6 months after their release, and about a third of each gender group (36% of females and 29% of males) reported maintaining contact for most or all of the 12-month eligibility period. In contrast, J clients were not eligible for postrelease services.

Despite sustained contact, however, caseworkers were able to devote only a limited number of hours to each JC client. To get a rough measure of the average time spent with clients, we used information recorded in the caseworkers' contact logs to calculate the average number of hours of work with or on behalf of clients after release. Caseworkers recorded an average of about 6.5 hours of contact during the 12-month period immediately after release, either directly with each female client or with a friend, family member, or service provider on behalf of the client. They recorded an average of 9.5 hours for their male clients. Although these averages mask substantial variation among individual clients, the figures underscore the challenges of delivering case management services to former inmates. Caseworkers also sought to connect clients to other community services, but data on the time spent in these leveraged services are not available.

Criminal Justice System Involvement

One of Health Link's key goals was to reduce rearrest rates, as incarceration can lead to increased risks of poor health and inadequate receipt of health care.^{4,8} We identified two categories of CJS events: (1) those because of arrests that occurred before enrollment in Health Link and (2) those because of arrests or parole violations occurring after release from jail. Health Link was unlikely to have influenced CJS outcomes for preenrollment arrests. (To preserve the benefits of the random assignment design, we retained all clients in the analysis, including those who were transferred to another incarceration facility because of arrests that occurred before enrollment.)

JC and J clients reported similar incarceration rates because of preenrollment CJS events (Table 2). They were about equally likely to have been transferred from jail to another incarceration facility or to have been incarcerated for the duration of

TABLE 2. Criminal justice system (CJS) events during the follow-up period

	Females			Males		
	JC group (n = 247)	J group (n = 264)	Impact	JC group (n = 268)	J group (n = 269)	Impact
Incarceration resulting from events before intake						
Transferred from jail to other incarceration facility (%)	11.7	13.1	-1.4	9.6	10.7	-1.1
Incarcerated for entire follow-up period owing to preintake CJS event (%)	5.9	8.0	-2.2	7.9	9.9	-2.0
Months of incarceration that began with transfer from jail	1.2	1.4	-0.1	1.4	1.7	-0.3
Events resulting from activity after release from jail (%)						
Arrested	39.0	35.3	3.7	41.6	45.9	-4.3
Had serious arrest charge*	1.0	4.1	-3.1†	15.8	15.0	0.7
Had drug charge‡	19.5	18.4	1.1	17.6	20.3	-2.7
Convicted on at least one charge	27.1	20.3	6.8§	23.6	19.1	4.5
Sentenced to incarceration	21.4	15.5	5.9	22.0	18.1	4.0
Served incarcerated time	35.5	32.6	2.9	38.5	42.7	-4.2

J group, Jail-Services-Only group; JC group, Jail-and-Community-Services group.

The columns labeled "Impact" contain the regression-adjusted impacts of being randomly assigned to the JC group compared to the J group; that is, the columns indicate the percentage point differences in outcomes that are attributable to having access to Health Link's intensive discharge planning and postrelease community-based case management services.

*Includes murder or assault, robbery, and burglary.

† $P < .05$.

‡Includes drug-law violations related to drug sales or drug possession.

§ $P < .10$.

the follow-up period. The two groups' months incarcerated as a result of events occurring before release from jail also were similar.

Health Link did not reduce new CJS involvement. About 40% of each gender group reported a rearrest. The only statistically significant impacts on key CJS measures were that JC women reported fewer arrests for serious charges and a *higher* conviction rate—possibly because the less serious charges were more likely than the more serious ones to be resolved quickly, before the follow-up interviews were conducted.

Drug Treatment and Drug Use

Encouraging clients who needed drug treatment to enter treatment programs was a major focus of the caseworkers' efforts. Health Link increased participation in such programs, especially by women (Table 3). JC women were more likely than J women to participate in drug treatment programs, including the ones that provided services other than detoxification. This outcome is important, as detoxification programs typically are less effective than other types at reducing drug use.^{9,10} Although JC males were not significantly more likely to participate in any treatment, they were more likely than J males to attend long-term residential programs.

Health Link had weak beneficial impacts on drug use. Interview self-reports and hair test data suggest that JC women were less likely than J women to use marijuana. However, we did not find any data suggesting that the program reduced women's use of hard drugs. Self-reported drug use measures point toward lower use among JC males than among J males, a result primarily of reductions in marijuana use. Hair tests also suggest that the males' cocaine/crack use declined. At the same time and for both gender groups, however, physical and social problems resulting from drug use—such as blackouts, seizures, and homelessness—were unaffected.

Behaviors Affecting HIV Risk

The risk of contracting or transmitting HIV increases with having multiple sex partners, using drugs while having sex, and having sexual contact without protective barriers.^{11,12} Caseworkers used education and counseling to try to change their clients' HIV risk behaviors.

Despite caseworkers' efforts, however, we did not detect reductions in clients' self-reported behaviors associated with risk of HIV infection (Table 4). The distribution and average number of sex partners were unaffected, and the frequency of unprotected sex did not fall. In fact, JC women reported more unprotected sex than did J women, a finding that holds true even when women with very high frequencies of sexual encounters are excluded from the analysis. We caution, however, that the interpretation of impacts on HIV risk using measures of sexual activity or the number of sexual partners is difficult because most sample members have either 1 or 0 sexual partners. Other measures of behavior that are likely to increase HIV infection risk, such as using drugs while having sex or exchanging sex for drugs or money, also are relatively rare. Although the estimates are noisy, no systematic pattern of *reductions* in these other risky behaviors is evident, a finding that provides support for the view that Health Link was not effective in reducing the HIV infection risk.

DISCUSSION

The Health Link model was based on three assumptions: (1) jail inmates have unmet needs for drug treatment, health care, and support services; (2) an advocate

TABLE 3. Drug treatment participation during the follow-up period

	Females			Males		
	JC group (n = 247)	J group (n = 264)	Impact	JC group (n = 268)	J group (n = 269)	Impact
Participation in drug or alcohol treatment program						
Participated in at least one program (%)	66.0	56.6	9.4*	16.5	13.5	3.0
Participated in program other than detox program (%)	64.4	53.3	11.2*	16.0	13.6	2.4
Participated in residential program of 30 days or more (%)	34.1	31.7	2.3	12.8	7.5	5.3†
Currently receiving treatment (%)	36.1	36.4	-0.3	10.0	7.0	3.0
Drug and alcohol use in past 3 months						
Self-reported use of drug (%)						
Any drugs	40.4	37.8	2.6	49.4	57.1	-7.7†
Any hard drugs	35.5	31.6	3.9	5.1	5.4	-0.3
Marijuana	14.5	18.6	-4.1	48.8	55.1	-6.4
Cocaine/crack hair test results (%)						
Negative hair test	26.4	29.1	-2.7	23.7	16.9	6.8†
Positive hair test	39.2	37.6	1.7	13.6	18.1	-4.5
Unable to test hair sample	1.1	0.8	0.3	5.1	5.7	-0.6
Could not obtain hair sample	33.3	32.5	0.7	57.7	59.3	-1.6
Marijuana hair test results (%)						
Negative hair test	41.2	36.5	4.7	5.7	5.1	0.7
Positive hair test	20.1	26.9	-6.8†	16.7	18.6	-1.9
Unable to test hair sample	5.4	4.1	1.3	19.9	17.0	2.8
Could not obtain hair sample	33.3	32.5	0.7	57.7	59.3	-1.6
Number of physical problems due to alcohol or drug use‡	0.3	0.3	0.1	0.1	0.2	-0.1
Number of social problems due to alcohol or drug use§	0.7	0.7	0.0	0.2	0.3	-0.1

J group, Jail-Services-Only group; JC group, Jail-and-Community-Services group.

The columns labeled "Impact" contain the regression-adjusted impacts of being randomly assigned to the JC group compared to the J group; that is, the columns indicate the percentage point differences in outcomes that are attributable to having access to Health Link's intensive discharge planning and postrelease community-based case management services.

* $P < .05$.

† $P < .10$.

‡Includes nine categories of problems: blackouts; seizures; overdoses; hearing voices; seeing things; shakes, tremors, or delirium tremens; vomiting; becoming violent; or other physical problems.

§Includes nine categories of problems: missing work, missing school, fighting with others, problems in one's family, financial problems, homelessness, being arrested, being rejected by friends, and other social problems.

TABLE 4. HIV risk behavior in past 30 days

	Females			Males		
	JC group (n = 247)	J group (n = 264)	Impact	JC group (n = 268)	J group (n = 269)	Impact
Number of sex partners						
0	51.1	50.6	0.5	36.9	38.8	-1.9
1	42.3	43.3	-0.9	41.3	40.2	1.2
2 or 3	3.3	4.0	-0.6	16.8	13.2	3.6
4 or more	3.2	2.1	1.1	5.0	7.9	-2.8
Mean	1.2	0.8	0.5	1.2	1.3	-0.1
Number of times had unprotected anal or vaginal sex*	2.7	0.8	1.8†	3.4	3.7	-0.3
Number of times used drugs or alcohol while having sex‡						
0	86.1	88.9	-2.8	96.7	95.4	1.4
1	4.0	2.6	1.4	0.8	1.1	-0.3
2 or 3	1.7	4.5	-2.8	0.9	1.0	-0.1
4 or more	8.1	4.0	4.2§	1.6	2.5	-1.0
Mean	1.6	0.5	1.1†	0.1	0.3	-0.1
Gave sex to get money or drugs (%)‡	6.4	2.4	4.0†	0.6	1.0	-0.4
Gave money or drugs to have sex (%)‡	1.4	1.8	-0.4	0.3	0.5	-0.3

TABLE 4. Continued

	Females			Males		
	JC group (n = 247)	J group (n = 264)	Impact	JC group (n = 268)	J group (n = 269)	Impact
Had sex with a regular partner (%)‡						
Who injected drugs	1.9	1.5	0.4	0.0¶	0.8	-0.9
Who had multiple sex partners in past year	6.1	10.3	-4.3§	2.0	3.8	-1.9
Whose HIV/AIDS status was unknown	0.2	3.8	-3.6**	0.0	0.4	-0.4
Had sex with any other person (%)‡						
Who injected drugs	0.0¶	0.5	-0.6	0.0	0.0	0.0
Who had multiple sex partners in past year	1.9	2.7	-0.8		2.4	0.5
Whose HIV/AIDS status was unknown	1.0	0.7	0.3	0.0	0.0	0.0

J group, Jail-Services-Only group; JC group, Jail-and-Community-Services group.

The columns labeled "Impact" contain the regression-adjusted impacts of being randomly assigned to the JC group compared to the J group; that is, the columns indicate the percentage point differences in outcomes that are attributable to having access to Health Link's intensive discharge planning and postrelease community-based case management services.

*Created using the frequency of having sex without a barrier (always, almost always, some of the time, and never) and the number of times of sex. Excluding outliers does not significantly affect results.

‡P < .05.

§Includes sexual intercourse, oral sex, and anal sex.

§P < .10.

¶The regression-adjusted estimate was -0.1. The unadjusted percentage was 0.0.

**P < .01.

can help former inmates benefit from community-based services; and (3) jails are opportune settings in which to establish relationships with clients to help them reintegrate into the community.⁵ Health Link's clients exhibited characteristics that spurred the development of this model. Many had low education levels, previous incarcerations, and serious health problems, including drug use and HIV infection.

We detected beneficial program impacts in some areas, such as increased drug treatment participation. We also detected impacts on drug use, but the evidence was weak. Even if Health Link reduced clients' drug use, however, we did not observe improvement in areas that might be affected by this outcome, such as physical and social problems resulting from drug use or participation in activities that could lead to HIV infection.¹³ The high rates of rearrest and reincarceration that were experienced by both J and JC group members, and for which no program impacts were found, are likely to have had strong influences on the prevalence of these other outcomes that we observed. Despite extensive examination, we were unable to identify a pattern that indicated a more comprehensive set of beneficial impacts for any subgroup of clients.

These results underscore how difficult it is to influence outcomes of former inmates who exhibit multiple, serious problems through a case management intervention. Health Link's effects are similar to those found in other studies of case management programs for criminally active or drug-using clients.¹⁴⁻¹⁹ The evidence has shown that these types of programs increase participation in drug treatment, but it shows less consistently that they reduce drug use. There is little evidence that case management programs influence risky sexual behaviors or recidivism.

Why are Health Link's impacts limited? One possibility is that the program was not sufficiently well implemented to provide a valid test. The process of enrolling clients and serving them while they were incarcerated was difficult, given that access to inmates was often limited and contingent upon agreements with and safety regulations at the correctional facilities. It is our assessment, however, that the program was implemented according to its model, albeit at a lower intensity of postrelease contact with clients than had been planned.

A second possibility is that the increment in support that Health Link staff could provide through intensive discharge planning and community-based case management was insufficient to result in changes in most outcomes when compared with the more limited discharge planning services that J clients received through Health Link's caseworkers. JC group members received an average of 12-14 more hours of case management services than did J group members. Those hours were expected to generate support and use of services that would improve outcomes. One interpretation of our findings is that the people who volunteered for Health Link and who continued to want assistance from their caseworkers as they faced the temptations, pressures, and challenges of being back in the community would have been able to access services without assistance. A few hours of contact per month, even with a good caseworker, may be insufficient to make a difference in long-term prospects in an environment in which some J group members also had access to services and in which other clients were reincarcerated and unable to benefit from community-based services. The observed impacts may imply that the moral support and advice that caseworkers were able to offer were insufficient to move appreciable numbers of clients onto a positive track that they would not have followed on their own or with the support available from other sources. Our design did not enable us to test for differences between JC group members' outcomes and outcomes of a group of inmates who were similar but ineligible for Health Link's discharge planning services.

We conclude that while a well-executed case management program can make modest differences in a few short-term outcomes of former inmates, this one did not change the life course or basic health status of most of its clients.

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