

# Conducting Surveys With the Formerly Incarcerated: What Works Best

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*This article examines the key features of a successful effort to collect data from people who have been incarcerated. The survey was part of the evaluation of Health Link, a program operated in Rikers Island Jail. We begin with a background of the Health Link program and its evaluation, then describe the survey procedures we employed and the key features that brought the data collection to a successful conclusion. We then compare these procedures with those of other data collection efforts with similar populations to identify key elements for success. In addition, we present a few caveats related to sample member program participation and the use of program staff as locators and interviewers.*

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## I. INTRODUCTION

Researchers have long been interested in studying the effects of prison-based programs on post-release outcomes for the formerly incarcerated. Collecting primary data is one of the best ways to determine how people are readjusting to life outside prison. However, this population is particularly difficult to locate and interview, with its homelessness and transience, drug addiction, reduced family and community ties, and suspicion of authorities and strangers. These factors all work against the survey techniques we typically use to locate and interview sample members. In this article we present the procedures we followed in the Evaluation of Health Link, a program for prisoners in New York City's Rikers Island Jail. We also highlight how other survey efforts with this population overlap in terms of their methods and response rates.

### A. Health Link Background

To respond to the problems of crime, violence, substance abuse, and homelessness in poor urban neighborhoods, and to the specific problems incarcerated adult women and adolescent men face in New York City, the Hunter College Center on AIDS, Drugs, and Community Health developed Health Link (see Freudenberg, Krauss, Ritas, Melly, & Minian, 2002). Health Link's goal was to promote the successful reintegration of former Rikers Island inmates into their communities. Health Link worked on four levels to help clients in New York City's South Bronx and Harlem by (a) providing direct services to incarcerated and formerly incarcerated clients, (b) assisting community organizations that serve this population, (c) establishing linkages between these organizations, and (d) strengthening linkages between community organizations and public agencies. Two premises underlay the Health Link client-level intervention. The first is that jails provide an efficient setting for recruiting and engaging clients in services, the second, that utilizing existing community services can help reduce problem behavior, such as criminal

activity and substance abuse. Thus, Health Link staff sought to reintroduce recruited offenders into the community with accessible local support and assistance that would reduce the risk of continued problem behavior and future incarceration.

Health Link staff provided guidance to incarcerated clients through group meetings and individual counseling sessions, but the signature component of Health Link was *case management in the community*. By meeting frequently with clients shortly after their release and then periodically over the subsequent year, caseworkers sought to provide a support structure, make referrals to service organizations, offer crisis intervention and counseling, and serve as advocates for clients. Clients' intermediate goals included increased use of drug treatment and primary health care, engagement in supportive social networks, and enrollment in school or job training. Key long-term program goals were reductions in drug use, HIV risk behavior, and re-arrest rates. Given Health Link's capacity, the program enrolled only a very small proportion of inmates who might have benefited from its services.

## B. Study Background

The Evaluation of the Health Link Program, funded by the Robert Wood Johnson Foundation (RWJF) and conducted by Mathematica Policy Research, Inc. (MPR), was designed to provide a rigorous assessment of the effects of making Health Link's community-based case management services available to former inmates of New York City's jail system. The evaluation utilized a design with random assignment of incarcerated inmates who volunteered and were eligible for services. Prior to random assignment, eligible inmates completed a baseline interview with a Health Link caseworker. We then randomly assigned them either to the Jail-and-Community-Services (JC) group or to the Jail-Services-Only (J) group. JC group members were eligible for Health Link's intensive case management services while incarcerated and for

up to a year after their initial release. J group members were eligible for some jail-based services but ineligible for Health Link's community case management services.

Study participants enrolled between July 1997 and May 2000. J and JC group sample sizes, slightly more than 700 each, included roughly equal numbers of adult women and adolescent men, for a total sample of 1,416.<sup>1</sup> During a one-year period after clients were released from jail, we measured the impacts of making caseworker assistance available. The primary source of data was an in-person follow-up survey conducted 12 months after the clients were released. The survey achieved a 74 percent response rate. A second source of data was a small lock of hair, obtained from consenting survey respondents in the community, with which to test for the presence of illicit drugs. All procedures used to collect data for the study were approved by the New York City Department of Public Health Institutional Review Board.

While designing the evaluation, we realized the most challenging component would be conducting the 12-month follow-up survey. We expected that the formerly incarcerated population would be very transient and have fewer traditional community ties, which would make them more difficult to find after 12 months. Indeed, our survey data showed that of the female respondents, 16.3 percent were homeless, 19.0 percent were HIV-positive, and 18.8 percent had used crack cocaine in the 3 months prior to the follow-up interview. For both male and female respondents, 40.5 percent had further involvement with the criminal justice system in the 12 months before the follow-up interview (Needels, Burghardt, James-Burdumy, Stapulonis, & Kovac, 2004). Despite these challenges, we were able to achieve the 74 percent response rate, exceeding our original goal of 70 percent, through the use of sound survey

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<sup>1</sup> We chose these demographic groups because they have had large increases in their incarceration rates, even though they are a small proportion of the incarcerated population.

procedures, including collection of detailed contact information at baseline, interim locating and aggressive locating in the field, cooperation with New York jails and prisons, and the use of incentive payments.

### C. Survey Procedures

It is important that data collection efforts have procedures in place to maximize completion rates, comply with ethical standards for research on human subjects, minimize burden on sample members, and manage resources effectively. We designed the Health Link follow-up survey procedures with these needs in mind and modified them during the course of the study, both to reflect factors we learned along the way and to keep pace with the changing data collection environment.

Sample points were released for voluntary, in-person interviews 12 months after their incident release from Rikers Island.<sup>2</sup> Because of the time required to locate or persuade sample members to respond, the average follow-up period was 15 months post-release. We chose in-person interviewing over telephone interviewing because of the sensitive nature of the material being asked about (such as criminal activity, drug use, and health risk behavior), as well as our concern that these sample members would be harder than other low-income populations to reach by telephone. We used paper-and-pencil methodology to administer the survey.

Data collection took place between February 1999 and March 2002. We interviewed most sample members in the community, either in their homes or at a mutually agreeable location. Approximately one-third were back in jail or prison, in which case specially trained interviewers went into the facilities and followed institution-specific protocols (discussed later in this article).

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<sup>2</sup> “Incident release” refers to release from the spell of incarceration they were serving at the time of random selection into the study sample. Sample members’ average length of incarceration after study intake was 3 months.

Topics the interview covered included housing arrangements; involvement with family and the community; participation in employment, training, education, and income support programs; criminal activity and involvement in the criminal justice system; substance abuse and other health risk behaviors; participation in drug treatment programs; and health status, pregnancy, and use of health care services. The interview averaged nearly one hour, and while interviewers administered most of it, they gave sample members the option of self-administering the questions on drug use and health risk behavior. We offered self-administration because, although research shows that interview mode appears to affect self-reports of sensitive behaviors (and that a self-administered personal interview is better than an interviewer-administered one for eliciting responses), the U.S. Department of Labor estimates that 50 percent of adult inmates in U.S. prisons are illiterate (with a sixth-grade level as the standard for literacy) (Aquilino 1994; Newman, Lewis, & Beverstock 1993).

At the end of a community-based interview, we asked sample members to give a small lock of hair to be tested for illicit drugs. If the person consented, interviewers removed, from close to the scalp, a small lock of hair to send to a testing laboratory. While 94 percent of females interviewed in the community gave a hair sample, only 64 percent of the adolescent males did so. The lower rate for males was due to the shorter hairstyles that were fashionable among men during the data collection period. For many of the males in the study, this precluded their ability to provide an adequate sample for testing. For security reasons, taking hair samples was not an approved part of the protocol for interviews conducted in prison or jail.

We asked sample members to sign informed-consent or agreement-to-participate forms before being interviewed and again before donating a hair sample.<sup>3</sup> The field interviewer read the form aloud to ensure that the sample member understood the stipulations and his or her rights. To ensure strict confidentiality of the data, we obtained from the Department of Health and Human Services a “certificate of confidentiality” that protected the data from subpoena by law enforcement agencies. In addition, the sample member’s name was not attached either to the 12-month interview or to the hair sample; rather, we coded each interview and hair sample with a unique identification number. Finally, we kept 12-month interviews in a locked facility and later destroyed them. To avoid the possibility that either the hair or the results of the assay could be used in court, MPR staff and the contractor who performed the hair assay deliberately made sure *not* to maintain a chain of custody.<sup>4</sup>

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<sup>3</sup> To gain assent from adolescent males (those under age 18), we administered agreement-to-participate forms.

<sup>4</sup> Typically a chain of custody is used in court to maintain the integrity of the sample and test result by verifying each entity that had access to the sample from the point of collection to the point of analysis.

## II. KEY ELEMENTS FOR SUCCESS

In this section we review the components of the Health Link data collection effort and discuss the techniques employed for successfully completing the survey, especially those for locating sample members. The key components proved to be collecting contact information at baseline, employing diverse locating techniques, obtaining cooperation with prisons and jails in the study area, offering adequate incentives, and using locally based field interviewers. While we achieved a 74 percent response rate for the Health Link 12-month follow-up survey, the overwhelming reason for nonresponse was the inability to locate sample members. Table 1 shows the final disposition of the 12-month follow-up sample. We were unable to locate fully 14.5 percent of sample members, while only 2.8 percent refused to participate.

Table 1  
Final Disposition of Cases

Case Disposition	Number (Percent)
Complete	1,048 (74.0)
Cannot locate	205 (14.5)
Refusal	40 (2.8)
Moved out of area	38 (2.7)
Incarcerated, denied access	30 (2.1)
Partial + unusable completes	25 (1.8)
Multiple attempts, case retired	20 (1.4)
Deceased	10 (0.7)
<b>Total</b>	<b>1,416 (100)</b>

Source: Evaluation of the Health Link Program, Mathematica Policy Research, Inc.



## A. Contact Information at Baseline

Once an inmate expressed interest in Health Link, a Health Link caseworker would secure informed consent (or an agreement to participate from an adolescent male) and then ask the client to complete the contact information form providing the names, addresses, and telephone numbers of people who would know how to contact the client over the next year. This information was critical to the success of the 12-month follow-up effort. The form requested the names of no less than three, and preferably four, friends or relatives who normally did not live with the sample member. Caseworkers were trained to encourage clients to provide as much of an address or telephone number as they could, even if they did not know the complete information. Clients were also encouraged to list out-of-state contacts, since they can be just as useful as local ones. In addition, during the baseline interview caseworkers asked sample members for any nicknames they were known by, their typical “hangouts,” and their dates of birth, social security numbers (SSNs), and New York State Identification (NYSID) numbers. This information shaped the foundation for follow-up locating efforts.

## B. Locating Techniques

### *1. Interim Locating at 3 and 7 Months Post-release*

To maintain up-to-date locating information for the 12-month interview, the data collection design initially called for interim mail and telephone contacts at 3 and 7 months after release from Rikers Island. Interim locating helped establish a history of contacts and leads so we would be in a better position to locate sample members when it was time for their 12-month follow-up interviews. A tracking database stored release dates for all sample-members to facilitate the interim locating and ensure the release of sample points for their 12-month follow-up observation on schedule.

Interim locating took place centrally from MPR's data collection facility in New Jersey, and consisted of the following:

- Checks for re-incarceration at Rikers Island via the automated Rikers Island phone line
- Checks for incarceration at the DOCS facilities via their Web page
- For sample members not incarcerated, contacts by telephone and/or mail, depending on the quality of our phone number or address information. If contact was by mail, we requested that the sample member call our toll-free number to update address and phone information. We offered sample members \$5 if they called in to update their contact information
- If we could not contact sample members by mail or phone, we tried to reach people that they had listed at intake or at other times as people who would know how to locate them

Sample members' NYSID numbers were particularly helpful in verifying re-incarceration at Rikers Island and the state prison facilities. Unlike surveys of other populations, SSNs were not helpful for locating this population; many of the adolescent males either did not know their SSNs or were reluctant to provide them. Also, the usefulness of SSNs as locating tools derives from the fact that they can be used to check national databases. However, many of these databases are based largely upon credit histories, which for this population are spotty at best. As each case became due for its 12-month interview, we conducted another round of locating before assigning the case to a field interviewer.

As shown in Table 2, we were able to locate 72 percent of our sample members at 3 months: 40 percent in a community setting and 32 percent in Rikers Island or another jail or prison. At 7 months, we located 59 percent of the sample members: 33 percent in the community and 26 percent at Rikers Island or another jail or prison. At the 12-month point, prior to sending cases to the field, we located 73 percent: 38 percent in the community and 35 percent in Rikers Island or another jail or prison. The lower percentage located at 7 months is due in large part to a

change in procedure roughly one year after data collection started. In particular, we decided to stop making phone calls and mailing letters to sample members or their contacts at the 7-month point. We judged that it was efficient to limit the 7-month locating in this way and invest more effort in the 12-month locating. We did, however, continue at 7 months to check Rikers through its toll-free line and DOCS through its Web site, since those sources were both useful and cost-effective.

Table 2  
Interim Searching Results  
(Percentage)

	3 Months	7 Months	12 Months
Located in community	40	33	38
Located in Rikers/another jail or prison/other facility	32	26	35
<b>Total</b>	<b>72</b>	<b>59</b>	<b>73</b>

<sup>a</sup>The 7-month locating rate is based on roughly one-quarter of the full sample or 370 cases.

Source: Evaluation of the Health Link Program, Mathematica Policy Research, Inc.

### *2. Locating at 12 Months Post-release*

Though the primary challenge to community interviewing was the ability to locate sample members, there were a number of other significant difficulties. Gaining the trust of sample members' friends and relatives was a time-intensive task. It could take several visits to a home before someone trusted an interviewer enough to provide information on the sample member. Female sample members tended to be more difficult to locate than the adolescent males. Often the females were estranged from their families and children and generally disconnected from traditional community ties. Locating male sample members was less of a problem, because they typically kept in touch with the mothers and grandmothers they listed as contacts. However, they

were more likely to break appointments and thereby require additional follow-up efforts for making contact and conducting an interview.

### C. Cooperation With Prisons and Jails

Approximately one-third of our sample members were re-incarcerated at the time of their 12-month interview. By obtaining consent from the DOCS and the City of New York Department of Correction (DOC) to meet with and interview these sample members, we were able to boost our overall response rate significantly. As shown in Table 3, our completion rate for incarcerated sample members was roughly 82 percent; it was 71 percent for sample members in the community. Ironically, locating and interviewing incarcerated sample members was much easier than for sample members in the community, primarily as a result of the easily accessible information on the DOCS Web site and the Rikers Island phone line. The downside to interviewing incarcerated sample members was that we were unable to collect a hair sample from them. In addition, we were unable to interview some incarcerated sample members, such as those who were in isolation, in transit from one facility to another, or in court on the day of their scheduled interview. Sometimes we were able to interview them at a later time.

Table 3  
Completion Rates for Community and Jail/Prison Cases

	N (by Location)	Completions	Completion Rate
Community	1,004	712	71%
Jail/prison	412	336	82%
<b>Total</b>	<b>1,416</b>	<b>1,048</b>	<b>74%</b>

Source: Evaluation of the Health Link Program, Mathematica Policy Research, Inc.

### *1. Interviews at New York State DOCS*

Researchers must follow strict rules and procedures if they want to include DOCS inmates as part of a research study. Researchers must direct all interviewing or data acquisition requests to the DOCS research department, which has developed specific, clear conventions on what is allowed and required. For the interviewing portion of the Health Link study, DOCS did not permit us to take hair samples (because of security concerns regarding the use of scissors) or to offer the \$25 incentive payment to the interviewee. We modified our questionnaire, procedures, and interview-consent and agreement-to-participate forms to reflect DOCS requirements.

To schedule interviews, we submitted the names of inmates to a representative of the DOCS research department three weeks in advance of our requested interview date. The DOCS staff asked that we check our information against its Web page to verify that the inmate was still incarcerated and to confirm the facility. Our contact person at DOCS would then give our interview requests to the warden at each facility, along with information on which inmates we gained clearance to interview and which declined to be interviewed or, because of disciplinary action, could not be interviewed. The interviewers never experienced problems with obtaining clearance upon arriving at DOCS facilities.

### *2. Interviews at Rikers Island*

To negotiate our follow-up data collection at Rikers Island, we identified an assistant commissioner at DOC who was willing to work with us and facilitate our interviews. Again, safety concerns prevented us from taking hair samples, but here we were granted permission to deposit the \$25 incentive payment in an inmate's commissary account. Although we tried different approaches to depositing the money, the most successful was to have an interviewer make the deposit shortly after the interview (or during a subsequent trip to Rikers). Unlike the DOCS, Rikers Island did not have an established process for dealing with research organizations.

Consequently, we experienced difficulty in establishing interviewing schedules and consistent procedures at Rikers. One problem was gaining clearances, both at the bridge that leads to the island and at the main security building. In several instances, we thought an interviewer had clearance to the island, but he or she arrived and discovered that no one had informed the officers on duty. Over time, we were able to resolve these problems with the commissioner's office. An interviewer was usually able to conduct two interviews during a day-long visit to Rikers Island. Interviewers often had long waits after being cleared through security, because of the geography of the island (housing units are spread out and accessible only by a DOC bus) and because of frequent security lockdowns.

#### D. Use of Incentives

Studies often provide incentives to encourage sample members to participate. There is a vast literature on incentives and survey participation; most studies indicate that incentive payments boost response rates, especially among low-income populations (Singer & Kulka, 2002). The difficulty lies in determining the most cost-effective amount and type of incentive for the population to be interviewed. For our 12-month follow-up survey, we gave sample members a \$25 check for meeting with our interviewer (and, we hoped, for completing the survey).<sup>5</sup> In addition, sample members who provided a hair sample received another \$25. Therefore, respondents could potentially receive a total of \$50 for taking part in the survey and donating a hair sample. This incentive seemed sufficient for what we were asking of sample members (an hour in-person interview and removal of a lock of hair) without being excessive. We initially considered other forms of payment, such as gift certificates or phone cards, but rejected these

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<sup>5</sup> The IRB required that we pay sample members for meeting with us whether or not they agreed to be interviewed.

options as less enticing to sample members, since they restricted the incentive to certain stores or types of use.

Sample members responded favorably to the incentive amount. We initially paid respondents with a check, an approach we thought would minimize the risk to interviewers of carrying cash in high-crime communities, but soon discovered that this method was not well received. Respondents complained that they had no checking accounts and had to pay high fees at check-cashing agencies, thereby receiving a considerably reduced incentive. We then modified procedures so that interviewers brought cash with them to interviews so they could offer it if the sample member was averse to receiving a check. When dispensing cash, we asked respondents to sign a form indicating their receipt of cash for the interview and, if applicable, for the hair sample as well. This method did not pose undue safety concerns for the interviewers, as we had initially anticipated.

#### E. Field Interviewers

We hired and trained a group of New York City residents to conduct community locating and interviewing. We chose interviewers who were familiar with the local neighborhoods and would feel comfortable walking the streets and interacting with sample members, their families, and their friends. We chose not to hire people who were working in or had recently worked in the criminal justice field (such as probation officers or police officers), since we did not want to intimidate sample members. We also did not engage Health Link caseworkers during the process of locating sample members, since they could potentially bias the study by their involvement with the program. When assigning cases, we also matched interviewers and sample members by gender because of the sensitive questions on high-risk behaviors.

We provided interviewers a two-day training that covered such topics as the study background, locating techniques, question-by-question review of the survey instrument, practice administering the instrument, and instructions and practice on how to take a hair sample.

Using local interviewers was very important to the success of the study. Interviewers spent many hours per case, knocking on doors or calling relatives and friends, searching local hangouts, talking with neighbors, and checking local rehabilitation centers, as well as making appointments with and interviewing sample members. Interviewers were comfortable working in the neighborhoods and knew how to get around and interact with residents. Interviewers were also tenacious: they worked all leads and followed all clues. Some interviewers carried cards containing their name and number and gave them out to family and friends. All interviewers carried magnets with our study's name and a toll-free number and gave them to family and friends to pass on to sample members. These items helped to engender trust between interviewers and sample members.

We hired a separate group of interviewers and trained them to conduct interviews with sample members in prisons or jails. The training for these staff focused on learning about each facility's protocols and rules, the logistics of travel to and from facilities, how to interact with prison staff, and how to administer the survey in a prison or jail setting.



### III. TECHNIQUES USED IN OTHER SURVEYS

Most studies to date on incarcerated or formerly incarcerated persons have relied on analysis of secondary data such as probation, parole, prison, and jail records. This may be a result of the challenge and expense of collecting primary data or of a lack of the specialized skills needed for such research. However, several other surveys have been conducted with this population, most achieving response rates similar to those of the Health Link survey. In this section, we examine the key components of successful data collection efforts by comparing the techniques other surveys used to those the Health Link survey employed. Was the Health Link survey experience unique? What techniques did other surveys use? How did the techniques contribute to the surveys' outcomes? We attempt to tie the experience of these surveys together in order to present readers with a "best practices" approach to conducting primary data collection with this population.

In 2001, the Urban Institute began a four-state longitudinal study called "Returning Home: Understanding the Challenges of Prisoner Reentry" (see Visher, LaVigne, & Farrell, 2003; Visher, Kachnowski, LaVigne, & Travis, 2004; Visher, LaVigne, & Travis, 2004). To date, a pilot study has been conducted in Maryland, and data collection is under way in Illinois, Texas, and Ohio. This study enrolls participants in prison and then conducts three in-person follow-up interviews at 1 to 2, 4 to 6, and 10 to 12 months post-release. These surveys collect, at the pre-release interview, contact information similar to what Health Link collected at baseline. Having three follow-up waves should facilitate high response rates, since interviewers will be making frequent contact with sample members and collateral contacts and will thereby maintain up-to-date contact information. The study began with a \$25 incentive for each follow-up interview, then increased the amount to \$50 (C. Visher, personal communication, September 15, 2004). In

Illinois,<sup>6</sup> a state using the \$25 incentive, the 1- to 2-month post-release group achieved a 75 percent response rate. The importance of cooperation with prisons and jails is borne out here as well. During the early follow-up interviews in Illinois, the study did not have access to the state prison system and was unable to complete interviews with sample members incarcerated there. Having this access would have boosted the first follow-up response rate of 75 percent. Finally, similar to Health Link's use of the DOCS Web site and Rikers Island phone line, this study had access to an automated parole location system in Illinois (C. Visher, personal communication, April 8, 2004).

Another Urban Institute study, "Opportunity to Succeed," was a multi-site study of prison and jail aftercare projects (Rossman, Sridharan, Gouvis, Buck, & Morely, 1999). Participants were randomly assigned either to a treatment group that received Opportunity to Succeed services or to a control group that did not. The random assignment and baseline interview took place either in the jail or prison or shortly after release. A follow-up interview was conducted 12 months after baseline. The surveys achieved an 86 percent response rate at baseline and 72 percent at follow-up. As in the Health Link Evaluation, detailed contact information was collected at baseline. In addition to the sample member's SSN, date of birth, race and sex, the baseline survey collected the names and relationships of people who were living with the sample member (if not incarcerated), those who lived with the sample member prior to the incarceration, and those with whom the sample member expected to be living with upon release. The survey also collected the name and contact information for one person who the sample member knew would be able to reach him or her in 12 months. An incentive of \$15 was offered for baseline and

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<sup>6</sup> At this writing, Illinois is the only state with response rate data.

\$25 for follow-up survey participation (S. Rossman, personal communication, September 13, 2004).

As in the Health Link Evaluation, in which case managers implemented random assignment and baseline interviews, case managers, probation/parole officers, or facility staff cooperated with the Opportunity to Succeed baseline survey by obtaining informed consent and implementing random assignment. At follow-up, both Health Link and Opportunity to Succeed used specially trained interviewers to locate and interview sample members.

One MPR study, the National Evaluation of the Welfare to Work Grants program, included a site that was dedicated to ex-offenders who were noncustodial parents (Fraker, Levy, Olsen, & Stapulonis, 2004). The evaluation included a baseline interview at program intake, plus 12- and 24-month follow-up interviews. We collected contact information at baseline for the participant and for three friends or relatives who would know how to reach the participant. The follow-up interviews used telephone with in-person (cell phone) follow-up methods, and offered respondents \$20 for participation. The 12-month follow-up achieved a 70 percent response rate and the 24-month follow-up 69 percent. We did not obtain permission to conduct interviews in the state prison system, but we did gain access to city jails. Had we solicited and gained permission to conduct interviews from the state prison system, the response rates for the follow-up waves would likely have increased by a few percentage points.

A study that had less success is the 1995 Survey of Adults on Probation, touted as the first national survey of adults on probation (Mumola & Bonczar, 1998). To maximize response rates, the project enlisted probation office personnel to make the initial contact with the sampled probationers, to schedule the in-person interview to coincide with their regularly scheduled office visits to the extent possible, and to follow up as needed to encourage participation. No incentive payment is documented in the literature. The survey achieved a 50 percent response

rate. While probation officers presumably had current contact information for the probationers, they may not have had the time required to follow up appropriately. Staff in most of the human services carry heavy caseloads, and agencies are traditionally understaffed.

Careful consideration should be taken when using case managers or facility staff in follow-up interviewing. First, program staff have a vested interest in the success of the program and are less likely to be unbiased data collectors. Second, program staff will probably stay in touch only with those sample members who participate in the program, losing track of those who drop out. When there is a treatment and a control group, the disparity becomes more problematic, since control group members never have contact with program staff. Further, program staff often do not have the time, resources, or specialized skills to locate this population. While using program staff may seem like an economical way to conduct primary data collection, the practice could engender biased data and/or skewed response rates when there are treatment and control groups.

#### IV. CONCLUSION

With thorough data collection techniques, it is possible to conduct primary data collection with formerly incarcerated people and achieve high response rates. An effective methodology for this population requires the collection of detailed contact information; tenacious locating and follow-up methods for tracking people, collaboration with local prisons and jails to gain access to sample members who have been re-incarcerated, adequate monetary incentives to encourage participation, and specially trained local field staff. Since the target population is highly mobile and may have concrete reasons for avoiding detection, obtaining high response rates is likely to require more time and resources than would surveys of other populations.

Program participation by sample members is an additional factor that can influence the success of a survey effort. All but one of the studies cited in Section 3 of this article involved sample members who were participants in a program of some kind. Enrolling in and attending a program can increase sample members' interest in participating in a survey about that program and thus lead to higher response rates. The one study that achieved a much lower response rate than the others lacked the involvement of sample members in a program. Similarly, if a control group is involved, those sample members may react negatively to a study associated with a program to which they were denied admittance. To compensate may require greater efforts on the part of interviewing staff to avoid skewed response rates. A final caveat when interviewing program participants is to avoid using program staff for locating and interviewing purposes. This can produce biased results or skewed response rates by treatment and control groups. It is preferable to hire and train a separate group of local field staff who have little or no vested interest in the program or its participants.

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