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FY 2020 Report to the Committees on Appropriations

Formerly Incarcerated Women and Reentry: Trends, Challenges, and Recommendations for Research and Policy

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EXECUTIVE SUMMARY

Female Involvement in the Justice System

Female arrest and imprisonment rates have increased more quickly than those of men in the justice system over the past five decades, resulting in substantial growth in the number of women returning from prisons and jails each year. The increase in justice-involved and incarcerated women is mainly attributable to several policy-level changes implemented in the 1980s and 1990s, including mandatory minimums for drug crimes, significant increases in female arrests for drug crimes, and growth in assault rates for females due to domestic violence mandatory arrest policies. Substance use is integral to understanding the involvement of women in the justice system, as many women are arrested either for drug-related crimes (e.g., possession, sale, or manufacturing) or instrumental property crimes designed to enable the acquisition of drugs. Research indicates that substance use and abuse among women in the justice system is often accompanied by one or more co-occurring psychiatric disorders; women in the criminal justice system are significantly more likely than the general population to suffer from a range of mental health disorders including depression, anxiety, borderline personality disorder, and especially post-traumatic stress disorder. Women in the justice system are also more likely than males to report both substance use and prior mental illness and to be diagnosed with co-occurring conditions.

While the total number of formerly incarcerated women is small compared to the total number of individuals returning from prison each year (12.5% of returning individuals in 2018, approximately 78,000 women), there are several reasons to offer reentry programming for these women. First, the majority of incarcerated females are parents to underage children and, unlike

most justice-involved men, have sole custody of these children and plan to resume their parenting role following release. The average incarcerated woman has about 2.3 children; thus, in a given year, almost 200,000 American children experience the incarceration and reentry of their primary caregiver. Moreover, some research suggests that females are more amenable to treatment and experience lower recidivism rates than men, even when enrolled in comparable programs. Justice-involved women are also more likely to suffer from co-occurring substance use and mental health disorders, putting them in the group at highest risk for recidivism and relapse and thus, most in need of treatment. Finally, while the number of women entering prisons and jails has grown significantly, a corresponding increase in programming has failed to materialize.

In light of documented gender differences in etiology, disease progression, motivation for treatment, and self-efficacy, practitioners and researchers have called for *gender-responsive* programming in reentry and rehabilitation. Gender-responsive programming is that which is based on assessment of each individual's risks and needs and considers the gender-specific variables of incarcerated women. In particular, programming that includes mental health components, supplementary services addressing female-specific topics, treatment for trauma, aftercare, child care, and parenting classes has been linked to reductions in relapse and increases in treatment retention following release.

Challenges to Female Reentry

Women reentering society from prison face both similar and unique challenges relative to their male counterparts. Compared to men, incarcerated women are more likely to be economically disadvantaged, be regular users of drugs, be victims of abuse and maltreatment,

suffer from mental illness or co-occurring substance use and mental health disorders, and be a parent to a minor child. Justice-involved women are typically lacking in job training, education, and employment skills; are at high risk for homelessness and housing insecurity; and are more likely to face familial and parenting challenges, be in poor physical health, and require mental health and substance use treatment services following release.

Based on review of published (peer-reviewed) and unpublished (grant reports) research studies, this report summarizes the extant literature on female reentry, identifies areas for future research, and offers recommendations for policy and practice regarding justice-involved women. After discussing the challenges faced by women returning from prison, the report summarizes reentry literature broadly and female reentry specifically and identifies gaps in the knowledge base.

Though the literature on what definitively works for female reentry remains in its infancy, programming that focuses on each of these challenges is a fruitful area for future program development and research. Prior studies with a mix of experimental and quasi-experimental research designs suggest that substance use treatment, therapeutic communities, interventions that bridge the institution and the community, and those that utilize cognitive behavioral therapy are most promising in significantly reducing recidivism and improving outcomes for formerly incarcerated women. What is less clear is if reentry programming related to mental health, housing and homelessness, family reunification, and employment services is able to significantly improve the criminal justice, social, health, and behavioral outcomes of justice-involved women.

Recommendations for Policy and Practice

Although the evidence base for reentry has increased over the past decade, there remain considerable issues related to research design and evaluation that impact the understanding of the phenomenon. Quasi-experimental designs are often more feasible for real-world settings such as jails and prisons, and the National Institute of Justice recommends using the most rigorous approaches to reducing spuriousness (such as propensity score matching and regression discontinuity designs). Researchers should commit to randomized controlled trials and other strong quasi-experimental approaches as opposed to the descriptive studies or single-sample before-after designs common in the reentry literature.

Research from criminology and criminal justice often focuses on limited measures of reentry success — such as recidivism, relapse, or revocation — and does not include outcomes such as treatment continuation, mental health symptomology, physical health, housing, and family-related issues. While it is reasonable that the criminal justice system is primarily concerned with recidivism, the outcomes mentioned here are intrinsically linked to the success of individuals during reentry, and each exerts influence on the overall likelihood of recidivism. Future research should expand the definition of reentry success and collect a wide range of data related to these extrajudicial outcomes.

Reentry programs also need to expand the types of services provided for returning individuals, particularly those related to post-release housing, transportation, and employment. Substance use treatment represents the core of most reentry programs, and while such treatment is of critical importance, it alone cannot solve the problems facing formerly incarcerated individuals. Recovery from substance use means little if an individual has no job, no

transportation to community-based treatment or work, and no secure housing. In fact, all of these are related to an increased risk for reentry failure. Similarly, future research needs to focus on the effectiveness and, especially, feasibility of programs designed to increase employment or provide stable housing after release.

Another key area where both practice and research should be expanded is medication-assisted treatment, particularly for opiate/opioid-dependent individuals involved in the criminal justice system. Medication-assisted treatment for heroin, opioid, and alcohol addiction has been a staple of the public health response to substance use for more than four decades but remains relatively uncommon in the criminal justice system (O'Brien & Cornish, 2006). One of the most effective treatment strategies involves the use of extended-release naltrexone for opioid, opiate, and alcohol use disorders. Prior research indicates that the use of naltrexone is related to successful outcomes for those under community supervision and thus may be an important strategy for the larger reentry movement.

Other evidence-based strategies for medication-assisted treatment include methadone maintenance regimens and buprenorphine, both of which are FDA-approved for the treatment of opioid use disorder, but are infrequently used by the criminal justice system or reentry programs specifically to treat substance use disorders. Co-occurring psychiatric disorders can similarly be treated with medication for anxiety, major depression, and bipolar disorder, among others. Incarcerated and detained individuals are more likely to receive medication for diagnosed mental health disorders than they are to receive medication-assisted treatment for substance use, however, this varies across facilities and jurisdictions.

Despite the shortcomings of the reentry literature, there have nevertheless been efforts to identify the most effective reentry practices (i.e., those that reduce recidivism or improve reentry outcomes). Overall, programs that feature a continuum of care beginning during incarceration and continuing after release are best suited to assisting individuals in a successful transition to the community. Reentry programs should commence at least several months prior to expected release and should involve community in-reach. Optimal interventions begin with actuarial screening and assessment using validated instruments and continue with individualized approaches that target criminogenic risks and needs in programs that are implemented with high levels of service fidelity. Successful reentry programs also provide critical aftercare and case management components that allow returning persons to continue to receive services in the community and maintain connectivity to treatment that began during incarceration. For incarcerated women, gender-informed programming can produce better outcomes than gender-neutral programming.

With this report, and based on the empirical reentry literature, the following nine recommendations for improving policy and practice related to female reentry are offered. They are:

- Use of gender-responsive programming for female reentry;
- Use of integrated treatment for co-occurring mental health and substance use disorders;
- Use of therapeutic communities for in-prison reentry programs;
- Aftercare as a requisite program component;
- Increased use of medication-assisted treatment;
- Use of peer recovery support services;

- Increased employment, skills, and job training for justice-involved women;
- Housing assistance; and
- Family-focused reentry programming.

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1. INTRODUCTION

The Department of Justice (DOJ), Office of Justice Programs (OJP), National Institute of Justice (NIJ) provides this report on formerly incarcerated women and reentry, consonant with the House Report 116-101 accompanying the Consolidated Appropriations Act, 2020 (P.L. 116-93). Specifically, this report's language states:

> *The Committee is concerned about the many challenges faced by formerly incarcerated individuals —particularly women, who make up the fastest growing incarcerated population in the country—as they reintegrate into their communities. Accordingly, the Committee directs the Department of Justice to conduct a study on the most common challenges faced by formerly incarcerated women (unemployment, underemployment, family reunification, job training and skills development re-entry programing, access to stable housing, mental health and substance abuse services) and provide its findings and recommendations on ways to better mitigate recidivism of formerly incarcerated women…*

The report describes the extant literature related to female offending, victimization, and reentry.[1] The report's first chapter examines the extent and nature of women's involvement in the justice system, with a focus on gender-specific pathways to crime, and female reentry and rehabilitation. The second chapter describes current trends in female reentry. The third chapter describes the challenges faced by incarcerated women, and the fourth chapter reviews the extant

[1] The quantitative data included in this report are drawn from the Bureau of Justice Statistics' Arrest Data Tool and Corrections Statistical Analysis Tool; a review of the reentry and rehabilitation literature was executed using online search tools including Google Scholar, PubMed, Criminal Justice Abstracts, and Social Science Abstracts, and with input from National Institute of Justice staff.

literature related to the effectiveness of reentry programming for women. Finally, the report concludes with suggestions for future research, along with specific recommendations for policy and practice.

Extent, Nature, and Antecedents of Female Involvement in the Justice System

Arrest and incarceration rates of women increased exponentially over the past five decades, and although the vast majority of individuals involved in the criminal justice system remain male, the rate of female incarceration in the United States has increased more rapidly than the rate of male incarceration (Chesney-Lind & Pasko, 2013; Guerino, Harrison, & Sabol, 2011; Snell, 1992). The increase in justice-involved women (and consequently incarcerated women) is mainly attributable to several policy-level changes implemented in the 1980s and 1990s, including mandatory minimums for drug crimes, significant increases in female arrests for drug crimes, and growth in assault rates for females due to mandatory arrest policies for domestic violence (Bloom, Owen, & Covington, 2004; Blumstein & Beck, 1999; Chesney-Lind & Pasko, 2013; Mauer & Huling, 1995; Richie, 1996; Van Wormer & Batollas, 2007).

Substance misuse is integral to understanding the involvement of women in the justice system, as many women are arrested either for drug-related crimes (e.g., possession, sale, or manufacturing), or instrumental property crimes designed to enable the acquisition of drugs. Men and women experience different pathways to crime and addiction as well as alternative trajectories of drug use (Hall, Prendergast, Wellisch, Patten, & Cao, 2004; Hser, Anglin, & Booth, 1987; Richie, 1996). Women's drug use and associated criminal behavior are more likely to occur within interpersonal relationships and are strongly associated with the behavior of romantic partners (Chesney-Lind & Shelden, 2014; Fleming, White, & Catalano, 2010; Richie,

1996). Evidence indicates that men often initiate women into various forms of crime and delinquency (Magnusson, 1992; Steffensmeier & Allan, 1996; Warr, 2002). Histories of childhood maltreatment and abuse, co-occurring psychiatric disorders, familial dysfunction, and negative self-concept are also more common among justice-involved women compared to men (Brady, Grice, Dustan, & Randall, 1993; Merikangas & Stevens, 1998).

Substance use among justice-involved women is often accompanied by one or more co-occurring psychiatric disorders, as women in the criminal justice system are more likely than the general population to suffer from a number of mental health disorders, including depression, anxiety, borderline personality disorder, and especially post-traumatic stress disorder (Peters, Strozier, Murrin, & Kearns, 1997; Salina, Lesondak, Razzano, & Weilbacher, 2007; Stanton et al., 2016). Similarly, justice-involved women are more likely than male counterparts to report both substance use and prior mental illness and to be diagnosed with co-occurring conditions (Ditton, 1999; Greenfeld & Snell, 1999). Diagnosis of co-occurring substance use and mental health disorders has significant implications for reentry, as both conditions are predictive of higher recidivism and relapse rates (Grella, Greenwell, Pendergrast, Sacks, & Melnick, 2008; McNiel, Binder, & Robinson, 2005). Individuals with co-occurring disorders experience worse treatment outcomes than those with one disorder (Messina, Burdon, Hagopian, & Prendergast, 2006) and, compared to the general population, those with co-occurring disorders are at higher risk of incarceration overall (Rock, 2001).

More so than for men, female involvement in the justice system and substance use are often preceded by traumatic life events such as physical and sexual violence, family disruption, loss of a loved one, or accidents (Grella, 1997; Nelson-Zlupko, Kauffman, & Dore, 1995; H.

Miller et al., 2016). Men and women also differ in multiple aspects of drug use, including initiation, relapse, and drug choice. Women become immersed in serious drug use faster than men (Bloom, Owen, Covington, & Raeder, 2003; Lewis, Hoffman, & Nixon, 2014; Fattore et al., 2014) and experience more rapid progression through drug use milestones including initial use, regular use, and chronic use (Lewis et al., 2014). Women are also more likely to abuse prescription drugs than illicit substances (Fattore, Melis, Fadda, & Fratta, 2014).

Because evidence suggests women tend to experience unique trajectories leading to substance use disorders and involvement in the justice system (Blanchette & Brown, 2006; Fattore et al., 2014; Hall et al., 2004; Richie, 1996), theoretical frameworks known as *gendered pathways* were developed specifically to understand female criminality. These gendered pathways include three models: the childhood victimization pathway, relational pathway, and social and human capital pathway (Salisbury & Van Voorhis, 2009). The childhood victimization pathway occurs when women are subject to victimization as children, which then contributes to the development of co-occurring mental health and substance use disorders. Evidence supports a link between victimization and involvement in the justice system, as women are disproportionally likely to have suffered from physical or sexual abuse as children relative to justice-involved men. Justice-involved women are similarly more likely to suffer from co-occurring disorders than are men. The relational pathway describes dysfunctional adult relationships that lead to poor self-efficacy, persistent mental illness, and increased substance use. There is also considerable evidence to support this model, with interpersonal relationships playing a significant role in women's substance use and criminal behavior. Finally, the social and human capital pathway is one in which educational deficits and dysfunctional familial relations

contribute to poor self-efficacy, employment issues, and financial problems leading to substance use and criminal behavior. These pathways are not necessarily mutually exclusive; justice-involved women may suffer from a combination of educational deficits, unemployment, dysfunctional familial relationships (including with intimate partners), abuse, trauma, and socioeconomic disadvantage.

Female Reentry and Rehabilitation

Although women represented only about 12.5% of returning persons in 2018, this translates to approximately 78,000 women reentering society each year, or more than 200 every day. And while these numbers are dwarfed by the number of men returning from prison each year, there are many reasons to offer reentry programming for these women. Importantly, the majority of incarcerated females are parents to underage children (Glaze & Maruschak, 2008; Mumola, 2000) and, unlike most justice-involved men, have sole custody of these children and plan to resume their parenting role following release. The average incarcerated woman has about 2.3 children; thus, in a given year, almost 200,000 American children experience the incarceration and reentry of their primary caregiver. Moreover, some research suggests that females are more amenable to treatment and experience lower recidivism rates than men, even when enrolled in comparable programs (Langan & Levin, 2002; Pelissier et al., 2001, 2003; Rhodes et al., 2001). Justice-involved women are also more likely to suffer from co-occurring substance use and mental health disorders, putting them in the group at highest risk for recidivism and relapse (Ashley et al., 2003) and thus most in need of treatment. Finally, while the number of women entering prisons and jails has grown significantly, a corresponding increase in programming has not materialized (Haywood, Kravitz, Goldman, & Freeman, 2000).

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Reentry and rehabilitative programming have largely focused on interventions for incarcerated men (Blanchette & Brown, 2006; Haywood et al., 2000). For the most part, programs and risk assessment instruments have been designed for justice-involved men, with little attention to gender-specific factors that uniquely impact the reentry experiences of returning women (Blanchette & Brown, 2006; Bloom, 2003; Smith & Manchak, 2015; Van Voorhis & Presser, 2001). The available evidence suggests that findings from evaluations of men's reentry programs may not necessarily be generalizable to justice-involved women (Haywood et al., 2000; Blanchette & Brown, 2006; Bloom et al., 2004). There are well-documented differences between justice-involved women and men related to factors such as substance use histories, family histories of substance use and dysfunction, comorbid physical and mental health problems, and victimization history (Ashley et al., 2003; Langan & Pelissier, 2001; Van Wormer & Bartollas, 2007). These differences, in turn, may necessitate alterations to reentry programs' design and focuses, as gender-specific variables play a role in women's recidivism outcomes (Blanchette & Brown, 2006; Haywood et al., 2000; Messina et al., 2006; Smith & Manchak, 2015). Compared to incarcerated men, incarcerated women experience different, gendered pathways to substance use, crime, and desistance; as a result, reentry programming should address these specific risks and needs (e.g., for trauma-informed care, parenting issues, and social support).

A number of studies provide evidence that women tend to recidivate at lower levels than men (Ney, 2016; Pelissier et al., 2003), suggesting that they may be more amenable to treatment, and particularly to approaches rooted in cognitive behavioral modalities. Past research demonstrates that gender differences exist in theoretically relevant elements of cognitive

behavioral therapy models such as motivation, coping style, and self-efficacy (Skutle, 1999; Pelissier & Jones, 2006). This is especially noteworthy since many, if not most, reentry programs utilize some form of cognitive behavioral therapy as their primary approach (see Wright et al., 2014, and Spjeldnes & Goodkind, 2009, for reviews of the types of modalities employed by reentry programs). Motivation has been found predictive of treatment initiation and retention, while self-efficacy has been linked to lower levels of relapse (Burling, Reilly, Moltzen, & Ziff, 1989; deLeon & Jainchill, 1986; Simpson & Joe, 1993; Stephens, Wertz, & Roffman, 1993). Women report a higher recognition of problematic substance use and are more likely to report use of coping skills such as social support, accepting responsibility, and escapism (Pelissier & Jones, 2006).

Given the documented gender differences in etiology, disease progression, motivation for treatment, and self-efficacy, practitioners and researchers have called for *gender-responsive* programming in reentry and rehabilitation (Haywood et al., 2000; Blanchette & Brown, 2006; Bloom et al., 2004; Messina et al., 2000; Pelissier & Jones, 2006). In particular, programming that includes mental health components, supplementary services addressing female-specific topics, treatment for trauma, child care, and parenting classes has been linked to reductions in relapse and increases in treatment retention following release (Ashley et al., 2003; Pelissier & Jones, 2006; Pelissier, Motivans, & Rounds-Bryant, 2005). Similarly, aftercare services can play an important role in reentry outcomes for justice-involved women (Scott & Dennis, 2012).

2. TRENDS IN FEMALE REENTRY

Recidivism

High rates of recidivism continue to plague the criminal justice system for justice-involved men and women alike (Alper, Durose, & Markman, 2018). Bureau of Justice Statistics (BJS) data indicate that more than two-thirds (68%) of returning individuals are rearrested within three years, 79% within six years, and 83% within nine years; 44% are rearrested in the first year alone (Alper, Durose, & Markman, 2018). Women are less likely to be arrested within the first year following release compared to men (35% versus 45%), though this differential narrows in subsequent years such that 77% of women were arrested within nine years (84.2% of men were arrested within nine years). Other data similarly confirm that women tend to recidivate at lower levels than their male counterparts (Ney, 2016; Pelissier et al., 2003).

Gender-Responsive Reentry Programming

Women reentering society from prison face both similar and unique challenges relative to incarcerated men. Incarcerated women are more likely to be economically disadvantaged, be regular users of drugs, be victims of abuse and maltreatment, suffer from mental illness or co-occurring disorders, and be a parent to a minor child (Langan & Pelissier, 2001; Garcia & Ritter, 2012; McClellan et al., 1997; Raeder, 2005; Scott et al., 2015). Historically, however, most interventions have been aimed at incarcerated men, and even risk assessment instruments were designed for justice-involved men, with little attention to gender-specific factors (Bloom, 2003; Smith & Manchak, 2015; Van Voorhis & Presser, 2001). As a result, calls have been made for gender-responsive programming for justice-involved women (Fretz et al., 2007; Blanchette & Brown, 2006; Bloom et al., 2004). Gender-responsive programming is designed to account for

the unique challenges faced by incarcerated women while capitalizing on some of the characteristics that make them more amenable to rehabilitation.

Gender-responsive programming is based on an assessment of each individual's risks and needs and considers gender-specific variables particular to incarcerated women. Gender-responsive programming entails incorporation of relevant treatment targets for justice-involved women, such as parent-child relationships, familial reunification, substance use, and mental and physical health needs (Fretz et al., 2007). In particular, the use of cognitive behavioral therapy, all-female group sessions, and mutual support groups are recommended in programming for women involved in the criminal justice system. Like all justice-involved individuals, women require adequate screening and assessment for recidivism risk, criminogenic needs, and responsivity to treatment. However, some research has suggested that risk assessment instruments designed for men may not be as valid for women (Hardyman & Van Voorhis, 2004). Consequently, a number of female-specific classification instruments have been developed, such as the Gender Informed Needs Assessment (GINA), the COMPAS for Women, the Service Planning Instrument for Women (SPIn-W), and the Women's Risk and Needs Assessment (WRNA).[2] Utilizing a gender-informed instrument, combined with additional screening and assessment for trauma and other signs of psychological distress, is the first step in developing an individualized treatment plan that accounts for women's risks and needs.

[2] To date, there are no peer-reviewed, published assessments of the GINA, COMPAS for Women, or SPIn-W. The WRNA is the only validated, peer-reviewed risk/needs assessment developed for justice-involved women (see Wright, Van Voorhis, Salisbury, & Bauman, 2012; Trejbalova & Salisbury, 2020).

3. REENTRY CHALLENGES FACED BY FORMERLY INCARCERATED WOMEN

Job Training, Education, and Unemployment

The challenges faced by returning women during reentry are considerable. A primary challenge is stable employment, which has been associated with reintegration in nonexperimental studies (Finn, 1999; Sampson & Laub, 1995; Uggen, 1999) and is linked to positive economic outcomes, improved health, increased social functioning, and self-efficacy (Parsons & Warner-Robbins, 2002; Richie, 2001). Stable employment acts on and interacts with other risk factors more likely to be present in women reentering society, such as mental health and substance use disorders, low educational attainment, and few marketable job skills.

Prior research has identified four groups of factors associated with employment outcomes: personal, relational, structural, and institutional factors (Visher & Travis, 2003). First, the personal characteristics of many reentering women are a considerable barrier to finding and retaining legitimate employment. Incarcerated women typically possess limited educational attainment, few skills, and spotty work histories and are more likely to experience mental health disorder, substance use disorder, or both. Education is identified as one of the most salient variables predicting successful employment, which is problematic in that the majority of incarcerated women lack a high school diploma. Incarcerated women also tend to lack marketable skills for employment as well as the prosocial attitudes necessary for legitimate work (Hardesty, Hardwick, & Thompson, 1993). Many justice-involved women have limited work histories and resumes, and some report that they are able to earn more money through illegitimate means than through legal employment (Uggen & Kruttshnicht, 1998). High rates of substance use and mental health disorders among incarcerated women also serve as a significant

barrier to women achieving the level of social functioning necessary to maintain stable employment (Blitz, 2006).

Women are also impeded to a greater extent than men by relational factors including family status, dysfunctional family relationships, and custody of children, all of which impact their likelihood of employment success. Factors largely outside of the control of returning women also are associated with employment outcomes, such as the state of the economy and labor market, legal restrictions on employment, and the social stigma of a criminal conviction. When the overall economy is doing poorly, job prospects for the formerly incarcerated are even bleaker (Harrison & Schehr, 2004). Poor economic conditions are magnified in the disadvantaged communities from which justice-involved individuals may hail and into which most reenter after incarceration, further reducing the likelihood of obtaining stable employment.

Structural and institutional factors similarly impact women's employment chances, such as restrictions on employment for formerly incarcerated individuals that are common in many states and jurisdictions. For example, formerly incarcerated individuals are often banned from employment in health care and child care. Since women occupy the majority of positions in these two areas, formerly incarcerated women are barred from two professions in which women typically dominate, thus exacerbating the difficulty of securing stable employment. Additionally, because considerable stigma attaches to those with criminal convictions, many employers are reluctant to hire previously incarcerated women (Albright & Deng, 1996). Because of the significance attached to stable employment in terms of facilitating successful reintegration, some reentry efforts are designed to address these deficiencies, particularly those which can be addressed through education or employment skills training.

Recently, scholars have attempted to place the issue of reentry employment within a larger theoretical discussion of models of justice-involved individual desistence, such as process and identity models. Bushway (2020) argues that employment services may be effective only for those already committed to a change in social identity, of which labor market participation is a consequence, not an antecedent.

Family Reunification and Parental Issues

The majority of justice-involved women are the primary caregivers to underage children, and the typical incarcerated woman has 2.3 children (Greenfeld & Snell, 1999). Most women also plan on residing with their children and resuming parental responsibilities following release from prison (Hagan & Dinovitzer, 1999). Separation from their children is identified as the most damaging aspect of women's imprisonment (Covington & Bloom, 2003); women who are able to maintain familial and other social relationships during and after incarceration are less likely to recidivate (Petersilia, 2001). Unfortunately, many mothers are geographically distanced from their children during incarceration and are unable to maintain this critical contact (Hagan & Dinovitzer, 1999). Many women report seeing their children either once or twice per year during incarceration, or not at all (Arditti & Few, 2006). For those who do experience family visitation, interactions are too short or infrequent, and reports about children having to endure exceedingly long wait times to see their mothers are common. Moreover, a considerable body of research has now established the proximate and long-term deleterious impact that parental incarceration (and especially maternal incarceration) has on the offspring of incarcerated individuals. These effects include: economic disadvantage, social stigma, low educational attainment, and their own increased likelihood of imprisonment (Miller & Barnes, 2015; Phillips et al., 2006).

Reentering women with children commonly experience maternal distress, defined as depression, physiological malaise, and unhappiness (Arendell, 2000). Maternal distress is predictive of a range of negative familial, social, and economic outcomes, such as parenting difficulties and unemployment. Reentering mothers also commonly suffer from volatile or violent interpersonal relationships with their significant others, or the fathers of their children. These relationships are often linked with women's histories of substance use, thus affecting more than just this relational aspect of their reentry experience (Arditti & Few, 2008). Prior substance use and fear of relapse are also linked to maternal distress associated with their parental role.

The majority of incarcerated women with children lived with those children prior to incarceration and the custody and care of children can be among the most daunting and distressing realities associated with imprisonment. Only 10% of children with incarcerated parents live in the foster care system; the remaining 90% (Eddy & Reid, 2001) with custodial uncertainty are particularly vulnerable to emotional and adjustment problems. Since the majority of children with incarcerated mothers (75%) also have criminally involved fathers (Phillips et al., 2006), most fathers are not viable options for custody (Cecil et al., 2008). Instead, it is family kin groups that typically provide care in the event of maternal absence. In particular, maternal grandmothers enable contact between children and their mothers during periods of incarceration (Cecil et al., 2008), which often exceeds the contact between children and their fathers (Johnston & Carlin, 2007). These kinship ties and contact during the period of imprisonment are critical to what happens to these women's families following their release from prison.

The quality of these relational ties varies from cooperative alliances, to ambivalence, to resentment. However, research is clear that children's outcomes are best when co-parenting

arrangements are based on cooperative collaboration. When mothers and custodial family members agree to co-parent a child during incarceration, the potential for family reunification following release is increased (Arditti & Few, 2006, 2008; Arendell, 2000; Cecil et al., 2008; Clone & DeHart, 2014; Few-Demo & Arditti, 2014). As a result, policies that enable and ease the difficulties associated with familial visitation during incarceration are integral to ensuring sustained contact between mothers and their children. Reentry programming that includes attention to these family reunification and custody issues can assist incarcerated mothers in this crucial aspect of reintegration.

Women who are pregnant during incarceration and reentry face especially formidable challenges relative to those who are not, including substance use disorders, financial hardship, insurance barriers, interpersonal violence, sex work, and legal problems, including with child protection agencies (Morse et al., 2019). Recently incarcerated women are significantly more likely to experience unintended pregnancies (Finer & Zolna, 2016) and more likely to report worse perinatal health behaviors (Dumont et al., 2014). Reentry planning that proactively links pregnant women (or those that already have children) with physical and mental health resources, including those provided by Medicaid, can be instrumental in ensuring a continuum of care for these women (Normile et al., 2018).

Housing and Homelessness

Homelessness and residential instability are among the most significant challenges facing formerly incarcerated individuals (Gunnison & Helfgott, 2011) and this is particularly true for formerly incarcerated women. Data from a variety of sources suggest that 50%-70% of the homeless population has experienced incarceration previously (Cho, 2004; Burt et al., 2001) and

about 10% of incarcerated individuals are homeless at the time of their arrest (Hughes et al., 2001). Homelessness among the formerly incarcerated varies by location, with an estimated 70% of all homeless persons in California also having current or prior involvement in the criminal justice system (California Health Policy Strategies, 2018) and about 10% of individuals incarcerated in Massachusetts released directly to shelters (Hombs, 2002). Homelessness among the formerly incarcerated is also strongly correlated with mental illness, which is problematic for justice-involved women who are far more likely to suffer from mental illness or co-occurring disorders (Metraux & Cullane, 2004, 2006). Data also reveal that the strongest predictor of shelter use following release from prison is shelter use prior to entry (Metraux & Cullane, 2004, 2006).

Because the majority of incarcerated women were unemployed or underemployed prior to their incarceration, many are already housing insecure before imprisonment. They also tend to return to communities where there is a shortage of affordable housing (Clear, 2007; Kirk, 2012). Structural barriers also create difficulties for returning women, as federal and state policies often prohibit the formerly incarcerated from accessing the public housing that may be the only practical economic choice for these individuals (Roman & Travis, 2006) and the formerly incarcerated may not have the resources required to secure housing in the private sector. Often the best option a returning individual has depends entirely on the benevolence, goodwill, and resources of family members. Mental illness, substance use, and co-occurring disorders often make steady employment difficult for formerly incarcerated individuals, impacting their ability to afford permanent housing. As a result, many justice-involved persons face homelessness or homeless-adjacent realities, such as living in temporary shelters, staying with friends and family

for short periods of time, or living in low-cost hotels in disadvantaged and high-risk communities (Fontaine & Biess, 2012; Metraux & Cullane, 2004, 2006).

Safe and stable housing is the foundation with which returning persons engage the process of reentry, as it provides a sense of security and social and psychological refuge from external threats (Lutze et al., 2014; Shaw, 2004). Residential stability provides a base from which to order one's day, from seeking employment to maintaining substance use recovery and treatment regimens. Homelessness, on the other hand, offers permanent instability, exposure to victimization, increased social stigma, ready access to drugs and alcohol, and "shadow work" that exists outside of the legitimate economy, such as theft, panhandling, prostitution, and drug dealing (Lee et al., 2010; Lutze et al., 2014). Indeed, many justice-involved women report engaging in prostitution or other forms of crime in exchange for temporary accommodations. Consequently, homelessness and housing instability generate social contexts and situations that place the individuals at greater risk for recidivism and relapse (Roman & Travis, 2006).

Of all the areas to be addressed for reentering females, stable housing is perhaps the least likely to be a component of typical reentry programs (Scroggins & Malley, 2010; Spjeldnes & Goodkind, 2009; Tripoldi et al., 2011; Van Olphen et al., 2009), even though a higher frequency of movement within the first year after release is linked to an increased risk for recidivism (Steiner et al., 2012; Roman & Travis, 2006). There is a small body of nonexperimental evidence suggesting that the provision of housing, combined with other reentry services, may be able to reduce recidivism (Lutze et al., 2014; Miller & Ngugi, 2009). Halfway houses are also effective at reducing recidivism if they target and are responsive to the appropriate populations (Seiter & Kadela, 2003). Providing housing to individuals with substance use disorders is also associated

with lower rates of drug use (Worcel et al., 2009). Prior research indicates that supportive housing programs are beneficial to chronically homeless individuals with histories of incarceration (Tsai & Rosenheck, 2012) and that criminal history itself is not predictive of housing failure (Malone, 2009). Moreover, stable housing reduces time spent in jail (Clifasefi et al., 2013) and has been shown to significantly reduce new convictions and readmissions to prisons (Lutze et al., 2014). Homelessness, conversely, increases the risk for rearrest, reconviction, and reincarceration (Lutze et al., 2014).

Mental Health and Substance Use Services

Justice-involved women are more likely than their male counterparts to suffer from mental illness, substance use disorders, or co-occurring substance use and mental health disorders. These issues are interrelated and often present in a reciprocal fashion. For example, many women report using drugs during the first year following release because of negative emotional and mental health symptoms (Arditti & Few, 2008; H. Miller et al., 2016). This tendency to self-medicate is exacerbated by the limited aftercare treatment available to many returning persons. Many returning women have experienced significant trauma and abuse in their lives, making long-term psychological problems more likely. Further, the prison experience itself can be traumatic for women whose existing mental illness is then compounded with the challenges of reentry.

Despite the great need for aftercare services during reentry, released women generally have difficulty accessing psychological treatment services (Colbert et al., 2013; McDonald & Arlinghaus, 2014). While some women are court-ordered to receive treatment, this is more likely to come in the form of substance use treatment than mental health counseling, in spite of these

issues often being interrelated and ideally addressed though an integrated treatment framework that accounts for the presence of co-occurring disorders and provides interventions accordingly (Osher, 2006).

Both incarcerated and formerly incarcerated women often acknowledge their need for treatment in the areas of substance use and mental illness and articulate their desire for programing, such as 12-step recovery meetings, integrated mental health counseling, and discharge planning (Colbert et al., 2013; McDonald & Arlinghaus, 2014; Stanton et al., 2016). Despite the aspiration of many women to maintain recovery from substance use and seek out psychological counseling, research indicates that there are significant barriers to the successful maintenance of aftercare treatment. Transportation needs, health insurance coverage, availability of adequate child care, and difficulties scheduling appointments are all common barriers for returning women (Stanton et al., 2016). Research also suggests that reentry programs can increase women's access to post-release treatment services, ideally through implementation of a reentry plan that is developed prior to release from prison. Reentry programs can benefit from partnerships with local community health organizations (e.g., behavioral health agencies) primarily tasked with providing out-patient treatment for the larger community. Through community in-reach prior to release, appointments and information can be made or transmitted, providing the incarcerated with some predictability for their release, also referred to as a "warm hand-off" (Knight et al., 2021; Miller & Miller, 2010). Effective post-release planning can be critical for reentry success, particularly in the realms of substance use and mental health. Some states (e.g., Pennsylvania, Texas) have made efforts to connect reentering women with services through pre-release enrollment in Medicaid which provides insurance coverage for those with

SUD following release (Normile et al., 2018). Moreover, the Medicaid Reentry Act (H.R. 955) is pending before the Congress which would enable coverage for imprisoned individuals beginning 30 days prior to release. Passage of this bill has the potential to greatly reduce the burden posed by lack of health insurance for reentering women, particularly for substance abuse and mental health treatment services. Women's mental health following release has many implications for their reintegration more broadly. Generally, women with mental illness have more difficulty securing both employment and job training, which has further implications for their overall social and economic well-being and that of their children.

Health Challenges

In addition to mental health conditions, many justice-involved women also have serious physical health conditions. Individuals in the justice system tend to be unhealthy and are more likely to suffer from chronic diseases compared to the general population (Hammett et al., 2001; Mallik-Kane & Visher, 2008). The incarcerated population is overwhelmingly poor and minority, with inadequate prior access to health care, all of which makes poor health outcomes following release more likely (Conklin et al., 2000). Estimates indicate that about 1 in 4 incarcerated individuals have a history of IV drug use and, relatedly, the prevalence of HIV/AIDS, asthma, and other infectious diseases (e.g., hepatitis, tuberculosis) is much higher among the incarcerated (CASA, 1998; Hammett et al., 2001). Data indicate that two-thirds of incarcerated women have been diagnosed with a chronic physical health condition, including: asthma; high blood pressure; hepatitis; back pain; and arthritis (Mallik-Kane & Visher, 2008). Formerly incarcerated women are significantly more likely than male counterparts to report ailments such as arthritis, asthma, back pain, and chronic lung disease. Evidence also suggests

links among physical health, mental health, and substance use in women reentering society, as one-third of those with physical health conditions also have a mental health condition, and more than two-thirds of reentering women report pre-incarceration substance use.

Although returning individuals are more likely to suffer from a range of physical health problems, they are unlikely to have health insurance or linkages to community-based care following release (Hammett et al., 2001). Even those who receive treatment for chronic health problems while incarcerated are less likely to receive care once released and often remain uninsured for months following release (Mallik-Kane & Visher, 2008). Lack of health insurance is often a function of some state and local policies that prohibit the formerly incarcerated from accessing Medicaid (Garfield & Damico, 2017; Grodensky, Rosen, Blue, et al., 2018; Rosen, Grodensky, & Holley, 2016). Research also suggests that returning persons with physical health conditions are less likely to have housing lined up prior to release, are more likely to have trouble maintaining housing, and move more often than those without these conditions. About one-third of returning individuals report that their physical illness is a barrier to work, and people in this group experience less employment success than those without chronic conditions. There is also some evidence that women with chronic health conditions are more likely to recidivate than those in better health (Mallik-Kane & Visher, 2008; Hammett et al., 2001).

4. CONCLUSIONS, DISCUSSION, AND RECOMMENDATIONS

Limits of Extant Literature and Suggestions for Future Research

Although the evidence base for reentry has increased over the past decade, there remain considerable issues related to research design and evaluation that impact our understanding of the phenomenon. There are far too few randomized controlled trials within the reentry literature and even fewer that feature mixed-methodological implementation, process, and outcome phases. Quasi-experimental designs are often more feasible for real-world settings such as jails and prisons, and therefore researchers should strive to employ the most rigorous approaches to reducing spuriousness, such as propensity score matching and regression discontinuity designs. Researchers should commit to randomized controlled trials and other strong quasi-experimental approaches as opposed to the descriptive studies or single-sample before-after designs common in the reentry literature.

Research from criminology and criminal justice often focuses on limited measures of reentry success — such as recidivism, relapse, or revocation — and does not include outcomes such as treatment continuation, mental health symptomology, physical health, housing, and family-related issues. While it is reasonable that the criminal justice system is primarily concerned with recidivism, the outcomes mentioned here are intrinsically linked to success during reentry, and each exerts influence on the overall likelihood of recidivism. Future research should expand the definition of reentry success and collect a wide range of data related to these extrajudicial outcomes. Mixed-methods data collection approaches that include both quantitative and qualitative research techniques may be better suited to adequately capturing the experiences of reentering persons than single approaches alone (i.e., a randomized controlled trial). Meta-

analysis should also be employed, as it has several well-documented advantages including increased statistical power, examination of intervening factors, and increased generalizability of results.

Reentry programs also need to expand the types of services provided for returning individuals, particularly those related to post-release housing, transportation, and employment. Substance use treatment represents the core of most reentry programs, and while such treatment is of critical importance, it alone cannot solve the problems facing returning persons. Recovery from substance use means little if an individual is without a job, transportation to community-based treatment or work, and secure housing. In fact, all of these are related to an increased risk for reentry failure. Similarly, future research needs to focus on the effectiveness and, especially, feasibility of programs designed to increase employment or provide stable housing after release.

Another key area where both practice and research should be expanded is medication-assisted treatment (MAT), particularly for opiate/opioid-dependent individuals involved in the criminal justice system. Medication-assisted treatment for heroin, opioid, and alcohol addiction has been a staple of the public health response to substance use for more than four decades but remains relatively uncommon in the criminal justice system (O'Brien & Cornish, 2006). Given the staggering growth in opioid use disorder and death over the past two decades, medication-assisted treatment is an important public health measure that can be implemented to address this epidemic. Opioid overdose deaths have increased almost every year since 1999, with more than 400,000 Americans losing their lives to opioid use disorder since 2000. According to 2019 data from the Centers for Disease Control and Prevention, 130 Americans die each day from fatal drug overdoses, including from prescription and illicit opioids; MAT within the criminal justice

system, as the nation's largest public health system, has the potential to disrupt these increasing numbers for those in contact with the justice system.

One of the most effective treatment strategies involves the use of extended-release naltrexone for opioid, opiate, and alcohol use disorders. This treatment was first developed by the National Institute on Drug Abuse in the 1970s and approved by the Food and Drug Administration for the treatment of heroin use in 1984 and alcohol use in 1995 (O'Brien, Greenstein, Mintz, & Woody, 1975; Greenstein, Arndt, McLellan, O'Brien, & Evans, 1984; Volpicelli, Alterman, Hayashida, & O'Brien, 1992). Earlier versions of naltrexone, a medication that targets opioid receptors in the brain, were administered orally, typically once or twice weekly; the more recent sustained-release version is given through injection, and a single dose can last up to 28 days. A small number of studies have examined the use of naltrexone in people under correctional supervision (Cornish et al., 1997; Coviello et al., 2012; Crits-Cristoph et al., 2015), though only one of these studies addressed the effectiveness of the newer extended-release naltrexone, signaling the need for additional evaluation. Prior research indicates that the use of naltrexone is related to successful outcomes for those under community supervision and thus may be an important strategy for the larger reentry movement.

Other evidence-based strategies for medication-assisted treatment include methadone maintenance regimens and buprenorphine, both of which are FDA-approved for the treatment of opioid use disorder, but are infrequently used by the criminal justice system or reentry programs specifically to treat opioid use disorder. Co-occurring psychiatric disorders can similarly be treated with medication for anxiety, major depression, and bipolar disorder, among others. Incarcerated and detained individuals are more likely to receive medication for diagnosed mental

health disorders than they are to receive medication-assisted treatment for drug abuse, however, this varies across facilities and jurisdictions.

Despite the shortcomings of the reentry literature, there have nevertheless been efforts to identify the most effective reentry practices (i.e., those that reduce recidivism or improve reentry outcomes). Overall, programs that feature a continuum of care beginning during incarceration and continuing after release are best suited to assisting returning persons in a successful transition to the community. Reentry programs should commence at least several months prior to expected release and should involve community in-reach. Optimal interventions begin with actuarial screening and assessment using validated instruments and continue with individualized approaches that target criminogenic risks and needs in programs that are implemented with high levels of service fidelity. Successful reentry programs also provide critical aftercare and case management components that allow returning individuals to continue to receive services in the community and maintain connectivity to treatment that began during incarceration. For incarcerated women, gender-informed programming can produce better outcomes than gender-neutral programming.

Recommendations for Policy and Practice

The following nine recommendations are offered for improving policy and practice related to female reentry.

Recommendation 1: Gender-Responsive Reentry

Reentry scholars have long called for gender-responsive reentry programming that pays attention to the particular and unique needs of incarcerated women. Programming that includes mental health components, supplementary services addressing female-specific topics, treatment

for trauma, child care, and parenting classes has been linked to reductions in relapse and increases in treatment retention following release. Reentry programs aimed at women should utilize actuarial screening instruments for substance use disorders, psychiatric disorders, and criminogenic risk that have been designed specifically for women, as well as implementing various programming elements that are gender informed.

Recommendation 2: Integrated Treatment for Co-Occurring Disorders

Integrated treatment of mental illness and substance use disorder is common practice in public health, although the criminal justice system has only recently focused attention on this recommendation. Evidence-based, integrated approaches that have fared well in experimental and quasi-experimental studies include multidisciplinary case management teams, dual-disorder group interventions, assertive outreach, motivational interviewing, group counseling, contingency management, and residential dual-diagnosis programs. Reentry programs must screen the incarcerated for substance use disorders, mental illness, and chronic health conditions that may impact their recovery and reintegration and design individualized treatment plans that concurrently address these interrelated issues.

Recommendation 3: Therapeutic Communities

Therapeutic communities are a participatory, group-based approach to substance use intervention where individuals work through recovery while living together in residential settings. While therapeutic communities are not limited to the criminal justice system, they are particularly suited to prisons given the group living arrangements in these facilities. Prior studies using experimental and quasi-experimental designs indicate that therapeutic communities significantly reduce the likelihood of re-arrest and reconviction among participants following

release, even in the long term (Knight et al., 1999; Prendergast et al., 2004; Sacks et al., 2004, 2008, 2012; Wexler et al., 1999). Therapeutic communities were especially popular during the 1980s and 1990s but appear to have fallen out of favor overall in reentry programming. This is unfortunate, as therapeutic communities that include cognitive behavioral treatment and adequate aftercare following release are best suited to accommodating the prison context while offering the greatest likelihood for behavioral change following release. Today's reentry efforts can be improved by returning to the therapeutic communities model for incarcerated women.

Recommendation 4: Focus on Aftercare

Reentry programs that provide adequate aftercare are consistently linked with more positive outcomes for both males and females. At the same time, aftercare is the component that is most often missing from an otherwise successful program design. While most reentry programs focus on the provision of services during incarceration, there is a great need to devote equal effort and resources to what happens following release. Newly funded or implemented programs should be designed so that treatment begins at least 90 days prior to release and continues for a period under community supervision. Linkages to community health providers for treating substance use, mental health, and physical health needs should be made prior to release (i.e., community in-reach and warm hand-offs), and case management should be maintained while under community supervision after release. Case management that begins during incarceration and continues after release can enable a better continuum of care for returning persons.

Recommendation 5: Medication-Assisted Treatment

The National Institute of Drug Abuse has long advocated for the provision of treatment services to justice-involved populations. Its 13 "Principles of Drug Abuse Treatment for Criminal Justice Populations" (2020) mirror the principles of substance use treatment generally, but with a particular focus on the legal and systemic realities that impact justice-involved individuals. The first of these principles is that substance use disorder is a brain disease that affects behavior by altering the brain's anatomy and chemistry. This understanding is largely at odds with how the criminal justice system treats people with substance use disorders as a matter of legal practice (i.e., with incarceration). However, by combining treatment with carceral punishment in an attempt to strike a balance between deterrence and rehabilitation, the system may not fully embrace all of the tools available. Medication-assisted treatment is one such tool. For the incarcerated with substance use disorder, mental illness, or both, and especially for those with opioid use or alcohol use disorder, medication-assisted treatment presents a viable option for the criminal justice system to reduce recidivism and relapse using an established public health framework.

Recommendation 6: Peer Recovery Support

The use of peers to facilitate recovery and provide social support during reentry is another area where female reentry in particular can be improved. A peer recovery specialist is an individual who uses their lived experience and skills learned in training to help others achieve and maintain recovery and wellness from mental health or substance use disorders. The Substance Abuse and Mental Health Services Administration identifies peer specialists as bringing unique strengths and qualities to integrated care teams, such as personal experience with

recovery, insight into the experience of stigma, and being in a unique position to establish trust, particularly among those who have experienced trauma. The use of peers to enhance outcomes across a wide range of populations and problem areas has been demonstrated through several randomized controlled trials, and nonexperimental evidence also supports the use of peers in recovery, as clients report greater satisfaction with these individuals compared to traditional counseling personnel (e.g., social worker, clinician) (Cook, 2011).

The use of peer recovery specialists may be particularly salient for female reentry for several reasons. First, prior evidence suggests that women, on average, have stronger social bonds, feel more strongly about their interpersonal relationships, and view themselves through the lens of these relationships. Peer recovery specialists, then, can capitalize on these qualities and develop personal relationships with returning persons that serve as a form of social support during recovery. Peer specialists may also develop social networks between themselves and the formerly incarcerated with whom they work, expanding the community networks of formerly incarcerated women in a given area. Enhanced social networks may then enable formerly incarcerated women to form a sense of shared community and enhanced social capital. Furthermore, peer specialists have been particularly successful at improving trust with victims of trauma, a group overrepresented among incarcerated women.

Recommendation 7: Employment and Skills Training

Justice-involved women suffer from low socioeconomic status, limited job skills, and spotty employment histories, making post-release employment a considerable challenge for most reentering women. Most employment and skills training programs have been aimed at justice-involved men, without a corresponding interest in how to train incarcerated women in a

marketable trade. There is no good reason, however, that incarcerated women cannot be trained in the same areas and professions available more regularly to incarcerated men. Reentry programs should expand their offerings so that programmatic elements reflect the full range of risks and needs, including for employment. Since there are few incarcerated women without deficits in employment, education, or skills, employment programming may be more relevant for a greater number of reentering women than even substance use treatment.

Recommendation 8: Housing Assistance

Returning persons, especially females, experience homelessness and housing insecurity at a rate far higher than the general population. The importance of stable housing in reentry success cannot be overstated, as safe and stable housing is the foundation with which the formerly incarcerated engage the process of reentry. Stable housing provides a base from which to order one's day, from seeking employment to maintaining recovery from substance use and a continuum of care. Unfortunately, housing assistance is expensive and thus included infrequently in reentry programs. As with employment assistance, most reentry initiatives currently lack the resources necessary for providing housing assistance. Additional resources, along with a corresponding increase in research, would expand the provision of housing services for formerly incarcerated women, particularly those who have custody of their minor children.

Recommendation 9: Maintaining Family Bonds

There are numerous advantages to maintaining social and familial bonds during periods of incarceration, both for parents and their children. First, the loss of their children is often described as the most damaging or traumatizing aspect of women's incarceration. Women who maintain contact with their children and families are less likely report depression while

incarcerated and more likely to realize family reunification following release. The effects of parental incarceration, especially maternal incarceration, are well documented but may be mitigated if correctional departments and reentry programs increase the amount of contact women have with their children and families during incarceration. Reentry programs should also offer specific program elements that allow women to interact with their children on a regular basis while in prison (e.g., family-based therapy), along with parenting classes when appropriate.

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