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FORMERLY INCARCERATED WOMEN AND REENTRY:

UPDATED TRENDS, CHALLENGES, AND RECOMMENDATIONS FOR RESEARCH AND POLICY

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Introduction

Reentry remains one of the most significant challenges facing the criminal justice system, as hundreds of thousands of people are released from prison each year, and even more from jail. While women continue to account for a small portion of those incarcerated, their representation in the criminal justice system has exponentially increased over the past several decades. Large numbers of women continue to be supervised on probation and parole and incarcerated in prisons and jails, facing formidable challenges during reentry, including employment, addiction, mental illness, housing, transportation, family reunification, childcare, parenting, and poor physical health. And while the numbers of women involved in the justice system have increased, a corresponding growth in gender-responsive programming has not manifested.

Originally, the Department of Justice (DOJ), Office of Justice Programs (OJP), National Institute of Justice (NIJ) provided this report on formerly incarcerated women and reentry, consonant with the House Report 116-101 (2020), and accompanying the Consolidated Appropriations Act, 2020 (P.L. 116–93; 2019). Specifically, that 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 reentry 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 original report was completed and delivered to Congress in 2021 (Ventura Miller, 2021). Since this time, new data and research has been released, providing an opportunity to update the original report. The purpose of the current effort is to provide additional information and resources.

This report describes the extant literature related to female offending, victimization, and reentry.[1] The report first 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 report then describes the challenges faced by incarcerated women and reviews the extant 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.

[1] 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 science staff and librarians.

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

Women's representation in the criminal justice system has increased exponentially over the past several decades (Council on Criminal Justice, 2024). Although men made up 90% of the population incarcerated in prisons and jails in 2022 (Buehler & Kluckow, 2024), the rate of female incarceration in the United States has increased more rapidly than the rate of male incarceration over time (Chesney-Lind & Pasko, 2013; Clark, 2019; Council on Criminal Justice, 2024). This is true even after COVID-related reductions in incarceration. Between 2020 and 2022, the rate of women held in prisons and jails increased 18% compared to 5% for men, although incarceration rates remain considerably lower overall than pre-pandemic levels (Buehler & Kluckow, 2024). Conversely, the rate of women supervised on probation or parole has decreased by 9% compared to 6% for men over the same period. Similar to males, available data also show that Black, Hispanic, and American Indian/Alaska Native women and girls were incarcerated in prisons at higher rates than white females in 2022 (Carson & Kluckow, 2023), although racial disparities in imprisonment have generally decreased since 2000 (Beck & Harrison, 2001; Sabol & Johnson, 2022). It is unclear how these disparities manifest by gender in jail or community supervision populations. As of 2022, one in 141 U.S. adult women — nearly 950,000 individuals — were under some form of correctional supervision (Buehler & Kluckow, 2024). Lastly, while arrest rates generally fell during the COVID-19 pandemic, women made up 26% of arrests in 2020, compared to 14% in 1980 (Council on Criminal Justice, 2024).

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 & Bartollas, 2014). Although national-level sentencing data disaggregated by gender is limited, as of 2022, based on the most serious offense included in the sentence, 46% of females incarcerated in state prisons for more than one year were sentenced for a violent offense, 25% for a drug offense, and 19% for a property offense (Carson & Kluckow, 2023).

Substance use disorders are 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). 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, Hoffman, & Nixon, 2014). Women are also more likely to use prescription drugs than illicit substances (Fattore, Melis, Fadda, & Fratta, 2014).

There are also significant differences between males and females involved in the justice system in terms of childhood and adult maltreatment and subsequent substance use and criminality (McClellan, Farabee, & Crouch, 1997). Maltreatment of justice-involved females actually increases in adulthood, while men's maltreatment decreases, resulting in an even greater disparity in victimization experiences between male and female individuals in prison. Abuse in childhood, then,

is a strong correlate of adult victimization, substance use, and criminality in females (Chesney-Lind & Pasko, 2013; Ireland & Widom, 1994; Smith & Thornberry, 1995). 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; Miller, Miller, & Barnes, 2016). Females convicted of crimes are significantly more likely to have severe substance use histories, family histories of drug use and dysfunction, and comorbid physical and psychological health problems, and to have experienced abuse as children (Ashley, Marsden, & Brady, 2003; Langan & Pelissier, 2001; Van Wormer & Bartollas, 2014). As of 2016, 58% of females in state prison met the criteria for a substance use disorder in the year prior to their admission, compared to 48% of males (Maruschak, Bronson, & Alper, 2021).

In addition to pronounced substance use concerns, 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, & Weilbaecher, 2007; Stanton, Kako, & Sawin, 2016). In 2016, 69% of females in state prison and 52% in federal prison reported a history of mental health problems, compared to 41% of men in state prison and 21% in federal prison (Maruschak et al., 2021). Other estimates suggest that nearly three-fourths of females in prison or jail in the United States have some form of mental illness, including post-traumatic stress disorder; substance use disorders; depression; anxiety; and dissociative, personality, or other mood disorders (Covington & Bloom, 2003; James & Glaze, 2006; Steadman, Osher, Robbins, Case, & Samuels, 2009).

Relatedly, justice-involved females often suffer from co-occurring substance use and mental health disorders (Abram, Teplin, McClelland, & Dulcan, 2003; Ditton, 1999; Greenfeld & Snell, 1999; Kajstura & Sawyer, 2023; Pew Charitable Trusts, 2023). 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, Prendergast, 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).

Justice-involved females are also victimized at a far higher rate than the general population. Females in prison have typically been victimized as children (Messina et al., 2014; Sacks et al., 2012) and often abused as adults (Heideman et al., 2014). Other common traumatic events in the lives of these women include familial addiction and violence (Few-Demo & Arditti, 2014); trading sex for money, drugs, or other basic needs (Hearn et al., 2015); separation from their children; and homelessness (Miller et al., 2016). According to Bureau of Justice Statistics (BJS) data, nearly six in 10 women in state prisons have experienced physical or sexual abuse in the past, more than one-third have been abused by an intimate partner, and about one-fourth have been abused by a family member (Greenfeld & Snell, 1999).

Because evidence suggests women tend to experience unique trajectories leading to involvement in the justice system (Blanchette & Brown, 2006; Fattore et al., 2014; Hall et al., 2004; Leverentz, 2014; Richie, 1996), theoretical frameworks known as gendered pathways have been developed specifically to understand female criminality. These gendered pathways include three models: 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 justice-involved women are disproportionally more 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 three 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.

Reentry

Incarceration rates increased exponentially between the 1970s and early 2000s (Kang-Brown, Hinds, Heiss, & Lu, 2018), with the rate of individuals incarcerated in prisons and jails peaking at a rate of 1 in 100 U.S. adult residents in 2006, 2007, and 2008 (Glaze & Herberman, 2013). This increase, combined with high recidivism rates,[2] prompted efforts to reduce incarceration and prevent individuals from recycling through the system. One remedy to prison overpopulation has been state-level legislation transferring supervision of persons convicted of lower-level felony offenses from prisons to community corrections, where treatment is increasingly now delivered.[3] However, since more than 90% of people in prison are eventually released back into the community with multiple needs for transitional services germane to their offending, reentry has emerged as a way to reduce recidivism, address mental health and addiction among individuals in prison, and increase public safety through reductions in new crimes (Petersilia, 1999, 2001; Travis, 2004, 2005; Travis & Visher, 2005).

Reentry is the process by which a person in correctional confinement prepares for release and transitions back into the community (NIJ, 2023b, 2024). Reentry is not monolithic; instead of a singular policy, program, or approach, reentry programming includes a wide range of modalities to improve social, health, and behavioral outcomes following release. Reentry programs are designed to address multifaceted and interrelated post-release needs related to substance use, mental illness, employment, housing, health challenges, and educational attainment, though the vast majority of programs feature substance use treatment as a core component (Sugie & Turney, 2017). The focus on substance use treatment in reentry is especially salient for females, who are more likely than males to be diagnosed with a substance use disorder, use drugs regularly, and use more serious drugs such as heroin and cocaine.

History of the Reentry Movement

The history of the reentry movement is in many ways the history of rehabilitative efforts in the criminal justice system more broadly. Though reentry was not a common term until the late 1990s, early efforts at reducing recidivism among persons returning from prison existed within the framework of rehabilitation. Rehabilitation efforts in the criminal justice system are traceable to the late 19th century, when alcohol was viewed as a problem that contributed to crime and general lawlessness (Weinman, 2011). Individuals with alcoholism were sent to asylums, jails, and other carceral settings, and in the early 20th century, state legislatures passed laws leading to the legal commitment of "inebriates" (White, 1998). In 1914, New York became the first state to allow for the civil commitment and compulsory treatment of people convicted for drug offenses (Hafemeister & Amirshahi, 1992), and during the 1930s, Congress legislated the creation of "narcotics farms" where heroin users received the first semblance of mandated drug treatment in the criminal justice

[2] BJS data indicate that two-thirds (66%) of individuals released from prison are rearrested within three years, 77% within six years, 81% within nine years, and 43% in the first year alone (Antenangeli & Durose, 2021).

[3] In an effort to reduce state prison populations, the Ohio Legislature passed House Bill 86 (2011), which transferred custody of persons convicted of lower-level felony offenses to local jails and placed an emphasis on reentry planning for all individuals in custody who were not serving either a death sentence or life without parole.

system (Inciardi, 1988). Federal funding for substance use treatment increased significantly in the 1970s, with an 800% increase in federal spending between 1969 and 1973 (Massing, 1998). This was reversed in the 1980s, when two-thirds of all drug budgets were devoted to enforcement rather than treatment. Although the 1980s and 1990s were generally defined by get-tough policies and the larger war on drugs, at the same time, efforts aimed at the expansion of treatment transpired at the federal level as well.

The federal Residential Substance Abuse Treatment (RSAT) program, under the Violent Crime Control and Law Enforcement Act of 1994, increased in-prison substance use treatment during the late 1990s. RSAT provided funding to all states and territories for residential treatment in correctional facilities, with several eligibility requirements including: (1) the duration of participation is between six and 12 months; (2) the residential treatment facility is physically distinct and set apart from the general correctional population; (3) the program focuses on substance use disorders; (4) the program incorporates the development of behavioral, cognitive, social, and vocational skills; and (5) the program implements reliable drug testing, most commonly urinalysis, for participants. RSAT programming was widespread, with all 50 states, five territories, and the District of Columbia implementing at least one RSAT program by the early 2000s (Bureau of Justice Assistance [BJA], 2005).[4]

The passage of the Second Chance Act (SCA) in 2008 advanced the rehabilitation and reentry movement by appropriating millions of dollars for reentry funding across a number of program areas (Council of State Governments, 2013). The SCA authorized multiple federal grant-funding streams to implement demonstration projects, family-based treatment, mentoring initiatives, and programs specifically targeting individuals with co-occurring substance use and mental health disorders. Programs funded under the SCA provide several services to persons convicted of crimes, including expunging criminal records, increasing actuarial screening and assessment to inform individualized treatment planning, and delivering reentry services to individuals at medium and high risk of reoffending. The SCA articulated a number of goals, including enhancing public safety, expunging criminal records, providing services to individuals at high risk of reoffending, reducing correctional costs, and offering opportunities for establishing the effectiveness of reentry and rehabilitation approaches. The SCA Grant Program funds eight separate project types, all intended to increase the likelihood of reentry success among people who have spent time in prison: demonstration projects for the implementation of reentry initiatives for juveniles or adults; mentoring programs for juveniles or adults; family-based substance use treatment programs for parents who are incarcerated; reentry courts; programs for people with co-occurring substance use and mental health disorders; state departments of corrections; probation-specific programming; and training programs for technological careers.[5]

In 2018, SCA was reauthorized as part of the First Step Act (NIJ, 2022). The reauthorization directed NIJ to evaluate the effectiveness of grants funded by the Department of Justice that can support reentry and reduce recidivism.[6] As of 2022, NIJ awarded $17 million for evaluations of SCA projects.

Prior to the SCA, the federal government appropriated more than $100 million to fund the large-scale Serious and Violent Offender Reentry Initiative (SVORI), which provided resources to all 50 states to implement programs designed to reduce recidivism among individuals at high risk for recidivism (Lattimore & Visher, 2009). In 2005, the Reintegration of Ex-Offenders (RExO) project began as a joint initiative of the U.S. Department of Labor's Employment and Training

[4] State-level RSAT evaluations have been a mix of experimental, quasi-experimental, and descriptive assessments that examined a range of social and behavioral outcomes, and their results generally indicated success in improving participant outcomes (BJA, 2005; Hiller, Knight, & Simpson, 1999; Inciardi, Martin, & Butzin, 2004; Knight, Simpson, & Hiller, 1999; Prendergast, Hall, Wexler, Melnick, & Cao, 2004). Evaluations revealed that individuals who completed treatment were less likely to be rearrested or placed in a higher custody level than those who did not (BJA, 2005). BJA (2005) also reported that programs increased participants' self-esteem and self-efficacy while reducing their levels of anxiety, depression, risk-taking, and hostility.

[5] Juvenile programs are administered through the Office of Juvenile Justice and Delinquency Prevention, and adult programs are administered through the Bureau of Justice Assistance.

[6] As a result of First Step Act reforms, nearly 30,000 people were granted expedited release (i.e., under compassionate release, home confinement, or retroactively) from federal prison between 2019 and early 2023; however, it is unclear how that has impacted the female rate of imprisonment (Nellis and Komar, 2023; Office of the Attorney General, 2023). Of the 4,560 individuals compassionately released, 11% were female.

Administration, the U.S. Department of Justice, and several other federal agencies. The programs funded under RExO primarily provided three types of services: mentoring, which most often took the form of group mentoring; employment services, including work readiness training, job training, job placement, job clubs, transitional employment, and post-placement follow-up; and case management and supportive services (Wiegand & Sussell, 2016). These federal efforts, combined with largely bipartisan and public support for rehabilitation and reentry, have resulted in the implementation and assessment of a considerable number of initiatives over the past decade.[7]

Female Reentry and Rehabilitation

Available data indicate that 1.9 million women are released from prison and jails each year (Sawyer, 2019). And while these numbers are dwarfed by the number of men returning from correctional facilities each year, there are many reasons to offer reentry programming for these women. Importantly, the majority of incarcerated females are parents to minor children — an estimated 58% of women in prison and 80% of women in jail (Bryant, 2021; Maruschak & Bronson, 2021) — and research shows many hope to reunite with their children after release (Cobinna & Bender, 2012; La Vigne, Brooks, & Shollenberger, 2009). 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; Pelissier, Camp, Gaes, Saylor, & Rhodes, 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).

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; Cobbina & Bender, 2012; La Vigne et al., 2009; 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 (Blanchette & Brown, 2006; Bloom et al., 2004; Haywood et al., 2000). 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, 2014). These differences, in turn, may necessitate alterations to reentry programs' design and focus, 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 rates 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 to be predictive of treatment initiation and retention, while self-efficacy has been linked to lower levels of relapse (Burling, Reilly, Moltzen, & Ziff, 1989; de Leon & Jainchill,

[7] SCA programs, SVORI, and RExO have been evaluated using a mix of descriptive, quasi-experimental, and experimental designs across multiple studies. These evaluations are discussed in the following chapter.

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 (Blanchette & Brown, 2006; Bloom et al., 2004; Haywood et al., 2000; Messina, Wish, & Nemes, 2000; Pelissier & Jones, 2006). In particular, programming that includes mental health components, supplementary services addressing female-specific topics, treatment for trauma, childcare, 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).

Trends in Female Reentry

Recidivism

High rates of recidivism continue to plague the criminal justice system for justice-involved men and women alike. BJS data indicate that two-thirds (66%) of returning individuals are rearrested within three years, 77% within six years, and 81% within nine years; 43% are rearrested in the first year alone (Antenangeli & Durose, 2021). Women are less likely to be arrested within the first year following release compared to men (34% versus 43%), though this differential narrows in subsequent years such that 74% of women were arrested within nine years (82% 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 (Garcia & Ritter, 2012; Langan & Pelissier, 2001; McClellan et al., 1997; Raeder, 2005; Scott, Dennis, & Lurigio, 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 (Blanchette & Brown, 2006; Bloom et al., 2004; Fretz, Erickson, & Mims, 2007; Stuart & McCoy, 2023). 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 is 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).[8] 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.

[8] 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; and Trejbalová & Salisbury, 2020).

Reentry Challenges Faced by Formerly Incarcerated Women

Job Training, Education, and Unemployment

The challenges faced by 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 (Miller-Roenigk et al., 2023; 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 (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 a mental health disorder, a 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. Further, returning women face practical hardships in relation to finding and keeping employment, such as transportation difficulties or inability to obtain childcare (Roddy, 2023).

Factors largely outside of the control of returning women are also 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 formerly incarcerated individuals 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 — such as the restrictions on employment for formerly incarcerated individuals that are common in many states and jurisdictions — similarly impact women's employment chances. 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 & Denq, 1996); qualitative research indicates past convictions may be especially impactful for Black women as a barrier to employment (Sanders, Hoskins, & Morash, 2023). 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 that 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 desistance, 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, Erkanli, Keeler, Costello, & Angold, 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, McHale, Strozier, & Pietsch, 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, 2004). 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, such as 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 who 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, Hanlon, & Eichner, 2018).

In addition to parental responsibilities and concerns, the quality of familial relationships after release from prison may be important for reintegration. Negative familial relationships have been associated with decreased life satisfaction for women post-release (Kashy & Morash, 2022; Helfgott & Gunnison, 2023) and reincarceration may be less likely when women have helpful families (La Vigne et al., 2009).

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. Compared to the general public, formerly incarcerated men are roughly 9 times as likely to be homeless while formerly incarcerated women are nearly 13 times as likely to be homeless (Couloute, 2018). Data from a variety of sources suggest that 50% to 70% of the homeless population has previously experienced incarceration (Burt, Aron, & Lee, 2001; Cho, 2004; La Vigne et al., 2009) and about 10% of incarcerated individuals are homeless at the time of their arrest (Hughes, Wilson, & Beck, 2001).

Homelessness among formerly incarcerated individuals 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 being released directly to shelters (Hombs, 2002). Homelessness among formerly incarcerated individuals 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 & Culhane, 2004, 2006). Data also reveal that the strongest predictor of shelter use following release from prison is shelter use prior to entry.

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 formerly incarcerated individuals from accessing the public housing that may be the only practical economic choice for them (Roman & Travis, 2006) and they may not have the resources required to secure housing in the private sector. Often the only 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 — referred to as marginal housing — 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 (Couloute, 2018; Fontaine & Biess, 2012; La Vigne et al., 2009; Metraux & Culhane, 2004, 2006). Past research suggests that many women stay with friends and relatives upon release from prison, and they tend to move more often than returning males in the first 8 to 10 months (La Vigne et al., 2009). However, it is unclear whether these situations are ideal or the most suitable option, and whether that would impact a returning person's success (Fontaine and Biess, 2012).

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, Rosky, & Hamilton, 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, Tyler, & Wright, 2010; Lutze et al., 2014). Indeed, many justice-involved women report engaging in prostitution or other forms of crime in exchange for temporary accommodations. Unsafe housing, and housing that becomes unsafe, has also been associated with lower life satisfaction for women on probation and parole (Kashy & Morash, 2022). 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; Tripodi, Bledsoe, Kim, & Bender, 2011; Van Olphen, Eliason, Freudenberg, & Barnes, 2009), even though a higher frequency of movement within the first year after release is linked to an increased risk for recidivism (Roman & Travis, 2006; Steiner, Makarios, Travis, & Meade, 2012). 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, Burrus, Finigan, Sanders, & Allen, 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, Malone, & Collins, 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.

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; 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 by the challenges of reentry. Research shows that although female facilities often try to address trauma, they struggle with being fully trauma responsive (Willison et al., 2020).

Despite the great need for aftercare services during reentry, released women generally have difficulty accessing psychological treatment services (Colbert, Sekula, Zoucha, & Cohen, 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 programming, such as 12-step recovery meetings, integrated mental

health counseling, and discharge planning (Colbert et al., 2013; McDonald & Arlinghaus, 2014; Stanton et al., 2016). A recent meta-analysis of programs for women with substance use disorder found that transitional programs, those that are gender-responsive, those that use individualized case management, and those that target co-occurring mental health and substance use disorders are most effective at reducing recidivism and substance use (Edwards et al., 2022).

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 childcare, and difficulties scheduling appointments are all common barriers for returning women (Stanton et al., 2016). Additionally, effective mental health and substance use services may differ depending on demographic characteristics, such as race or ethnicity, although research is lacking. For example, a 2023 study on women in jail found that white women were more likely than women of color to have previous mental health treatment and to be currently medicated in relation to a mental health diagnosis (Hicks, Putans, Comartin, Burgess-Proctor, & Kubiak, 2023).

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 outpatient treatment for the larger community. Through community in-reach prior to release, appointments and information can be made or transmitted, providing the incarcerated person 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 substance use disorders following release (Normile et al., 2018). Moreover, the Medicaid Reentry Act (H.R. 955) currently pending before Congress would enable coverage for individuals in prison 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 use 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 (La Vigne et al., 2009). Individuals in the justice system tend to be unhealthy and are more likely to suffer from chronic diseases compared to the general population (Hammett, Roberts, & Kennedy, 2001; Mallik-Kane & Visher, 2008; La Vigne et al., 2009).

The incarcerated population is overwhelmingly poor and many are members of racial or ethnic minority groups, with inadequate prior access to health care, all of which makes poor health outcomes following release more likely (Conklin, Lincoln, & Tuthill, 2000). Incarcerated women have likewise reported that healthcare in some prisons is not adequate or timely, with limited access to preventative services and an insufficient number of caregivers (Wennerstrom et al., 2021). Estimates indicate that about one in four incarcerated individuals have a history of intravenous drug use and, relatedly, the prevalence of HIV/AIDS and other infectious diseases (e.g., hepatitis, tuberculosis) is much higher among the incarcerated population (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 their 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: 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 certain state and local policies that prohibit formerly incarcerated individuals from accessing Medicaid (Garfield, Damico, Stephens, & Rouhani, 2016; Grodensky 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).

Given these significant and interrelated challenges, recommendations have been offered to improve issues related to physical and mental health during reentry (Hammett et al., 2001). First, correctional facilities should improve programs for discharge planning, community linkages, and continuity of care. While the majority of individuals returning to the community from prison or jail may receive referrals for physical and mental health problems, they are far less likely to actually have an appointment made prior to release. The likelihood that continuity of care is realized in the community depends on both referrals and appointments being secured prior to release from prison. Assisting individuals with their transportation needs also makes it more likely that appointments can be kept, as lack of reliable transportation is commonly cited by persons who have been released from prison as a main reason why treatment is not continued in the community. Reentry programs benefit from collaborations with community health agencies and service providers, as they ensure pre-release community in-reach. Pre-release facilities closer to the home communities provide a place where these linkages can be set up and thus increase the likelihood that continuity of care will be realized.

Ensuring adherence to treatment regimens is also commonly identified as a means to improve the health of individuals returning to the community. This begins during incarceration, when correctional facilities are presumably able to ensure that medications, treatment sessions, and medical appointments are maintained. The challenge, however, is after release. One meaningful step correctional departments and reentry programs can take is to enable adequate discharge planning and community linkages as part of a larger reentry plan. Relatedly, however, exclusions from or delayed enrollment in benefits programs (e.g., Medicaid) also hinder adherence to treatment, as do lapses in prescription medications in the time immediately following release. Delays in accessing benefits and coverage are common; it is therefore important to include benefits acquisition as part of discharge planning. State and local policies that prevent otherwise eligible returning individuals from receiving government-subsidized health care (e.g., Medicaid) have led to a situation in which this lack of health insurance makes reentry failure more likely.

Transitional and permanent housing for returning individuals is a serious need among all persons who have been incarcerated, but especially those dealing with physical and mental health issues. Stable housing, however, can be the most difficult resource to provide. Without stable housing, maintaining a treatment regimen is more difficult, which risks worsening chronic health conditions. Of course, housing is limited in many of the communities to which the majority of individuals are released, long waits exist for receiving subsidized housing, and some states and localities have taken steps to prohibit those with criminal records from living in public housing (as with the denial of health insurance discussed above).

Previous Research

What Works in Reentry?

Reentry encompasses a number of programmatic elements and efforts designed to address the numerous, multifaceted, and interrelated issues faced by individuals returning from prison. Reentry programs most often focus on the provision of substance use disorder treatment, but they may also include intervention elements aimed at mental health, job training and employment readiness, and housing insecurity. Overall, prior research is largely inconsistent regarding the effectiveness of reentry programs, both gender-responsive and not, in part because of differences among programs and target populations, but also due to related research-design limitations (Lattimore & Visher, 2009; Petersilia, 2001; Roman et al., 2007; Seiter & Kadela, 2003; Weisburd, Farrington, & Gill, 2016; Wilson & Davis, 2006; Wright et al., 2014). Historically, reentry program evaluations have rarely employed randomized controlled trials or rigorous quasi-experimental designs with appropriate techniques (e.g., propensity score matching, regression discontinuity) to causally link specific program elements with observed performance measures (e.g., recidivism, relapse). Evaluations seldom include process and implementation components to document program fidelity; most studies simply assume that modalities are delivered as intended in terms of dosage, exposure, and quality, and that outcomes are driven by programming (Miller & Miller, 2015).

Despite these shortcomings, the number of evaluations of reentry programs published over the past decade has increased commensurate with the expansion of treatment programming due to reentry initiatives such as the Serious and Violent Offender Reentry Initiative (SVORI) and the Second Chance Act (SCA).[9] However, several of these evaluations reveal inconsistent results both within and across sites.

A multisite evaluation of SVORI programs found that participants experienced favorable life maintenance outcomes in areas such as housing and employment, but did not experience the intended reductions in recidivism (reincarceration and self-reported offending) (Lattimore & Visher, 2009). Assessments of individual sites were similarly inconsistent: Kansas SVORI participants had a higher risk for failed urinalysis, return to prison, and fewer days to arrest (Severson, Bruns, Veeh, & Lee, 2011), while Boston SVORI participants had significantly lower recidivism rates (Braga, Piehl, & Hureau, 2009). The multisite SVORI evaluation also examined the effectiveness of reentry services by type to determine the most salient program components. This evaluation found that case management, anger management, and educational programs were associated with lower recidivism, while life skills assistance, reentry classes, and employment services were associated with a shorter time to arrest (Visher, Lattimore, Barrick, & Tueller, 2017).

Other large-scale reentry evaluation initiatives have also produced mixed results. New York's Project Greenlight reported worse recidivism rates for participants than for controls (Wilson & Davis, 2006). The Maryland Reentry Partnership Initiative failed to reduce reoffending among program participants (Roman et al., 2007). And a series of reentry initiatives at Rikers Island in New York City realized varying levels of success (Freudenberg, Daniels, Crum, Perkins, & Richie, 2005; Glowa-Kollisch et al., 2014; White, Saunders, Fisher, & Mellow, 2012).

During the past decade, several experimental evaluations have been conducted to examine the effect of various types of reentry programs on a range of criminal justice and related outcomes (Clark, 2015; Cook, Kang, Braga, Ludwig, & O'Brien, 2015; D'Amico & Kim, 2018; Duwe, 2013; Farabee, Zhang, & Wright, 2014; Jacobs, 2012; McNeely, 2018; Redcross, Bloom, Azurdia, Zweig, & Pindus, 2009; Redcross, Millenky, Rudd, & Levshin, 2012; Wiegand, Sussell, Valentine, & Henderson, 2015). As with earlier, less rigorous evaluations of reentry programs, the results were largely inconsistent across studies and outcomes. D'Amico and Kim (2018), for example, assessed the impact of seven SCA demonstration

[9] As of 2023, NIJ has awarded over $60 million to projects studying reentry, including over $17 million for evaluations of SCA projects such as reentry initiatives administered by the Federal Bureau of Prisons (NIJ, 2022; NIJ, 2023a).

projects using a randomized controlled trial and found that those in the program group were no less likely to be rearrested, reconvicted, or reincarcerated at 30 months, nor did they have fewer total days incarcerated. Program group members actually had a greater total number of rearrests and reconvictions (which the authors hypothesized might be due to enhanced case management that caught more offenses) but also had better longer-term employment and earnings.

Duwe (2013) examined the Minnesota Department of Corrections' reentry program using a randomized controlled trial and reported relatively modest reductions in hazard ratios for four of the five recidivism measures included in the outcome analysis. (New offense incarceration was the only recidivism measure that was not reduced significantly.) The study also estimated that the program produced a net benefit of about $4,300 per participant, or $1.8 million overall. Clark (2015) and McNeeley (2018) evaluated a different Minnesota reentry program. During the first phase of the evaluation, at one to two years after release, Clark (2015) reported participants were 43% less likely to be reconvicted and 28% less likely to have their parole revoked for technical violations than were members of the control group. The second phase of the evaluation showed that program participation significantly reduced the risk of rearrest but had no effect on the other measures of recidivism (McNeely, 2018). These results provided limited support for the program, since its effectiveness appeared to decline over time. The program also reduced costs; however, the estimated benefits were not found to be particularly robust.

Many of these recent evaluations have estimated the impact of employment-focused reentry programming such as New York City's Center for Employment Opportunities (Redcross et al., 2009, 2012), the Transitional Jobs Reentry Demonstration (Jacobs, 2012; Redcross et al., 2010), the Reintegration of Ex-Offenders Program (Wiegand et al., 2015), and California's STRIVE program (Farabee et al., 2014), among others (Cook et al., 2015; Jacobs, 2012).

Redcross and colleagues (2009, 2012) reported that the Center for Employment Opportunities increased employment early during the follow-up period, mainly due to jobs provided by the program, though this effect diminished over time. Program participants were, however, less likely than the control group to be arrested, reconvicted, or reincarcerated, particularly those participants who enrolled in the program within three months following release (Redcross et al., 2012). A cost-benefit analysis of the Center for Employment Opportunities indicated that the program's financial benefits outweighed its costs for taxpayers, victims, and participants. Evaluation of the Transitional Jobs Reentry Demonstration similarly found a limited positive impact on employment during the first months of follow-up, but the program did not exert consistent impacts on recidivism (Jacobs, 2012; Redcross et al., 2010).

A recent evaluation of the Reintegration of Ex-Offenders (RExO) Program (Wiegand et al., 2015) related null findings across a range of outcomes, including a lack of positive impact on recidivism or labor market outcomes — what the study authors referred to as "a disappointing picture of the impact of RExO" (page ES 4). Similarly, Farabee and his colleagues (2014) reported no significant impacts of employment-focused reentry programming on employment, recidivism, or residential stability. Underwhelming findings were also reported by Cook et al. (2015) on the ability of a Wisconsin reentry program to increase employment and earnings and decrease recidivism.

Employment-based reentry programs appear reasonable for a number of reasons. First, economic and opportunity theories of criminal offending predict those with legitimate opportunities for economic success have little incentive to live a life of crime; social bond theory predicts those with normative social bonds will similarly be avoidant of behaviors that risk their families, reputations, and careers. Early research on reentry and rehabilitation suggested that job training, employment assistance, and work release programs could improve outcomes post-release (Seiter & Kadela, 2003; Turner & Petersilia, 1996; Witte, 1977). However, the more recent studies discussed above failed to demonstrate the efficacy of these types of approaches. Some scholars have argued that desistance (i.e., refraining from additional crime) cannot be realized until justice-involved individuals internally commit to a change in social identity, irrespective of the services they are being provided. 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. If this hypothesis is valid, employment programs (or any reentry efforts) may be most effective for those who are willing participants, not coerced.

In addition to the focus on individuals returning from prison, a growing body of evidence on jail-based reentry has been produced over the past decade (Lurigio, 2016; Miller & Miller, 2010, 2015; Miller, Miller, & Barnes, 2015; Osher, 2006, 2007; Osher, Steadman, & Barr, 2002; Solomon, Osborne, LoBuglio, Mellow, & Mukamal, 2008; Ward & Merlo, 2016). Promising or effective strategies for jail reentry include the use of integrated services (i.e., concurrently addressing both mental illness and substance use disorders) for individuals suffering from co-occurring disorders (Osher, 2006, 2007; Osher et al., 2002), the Community Reinforcement and Training Model (Miller et al., 2015), Moral Reconation Therapy (Miller & Miller, 2010, 2015), case management (Miller et al., 2016; Miller et al., 2019), and mental health treatment that begins during incarceration and is concluded post-release in community settings (Gordon, Barnes, & Van Benschoten, 2006; Lamberti et al., 2001). Jail reentry programs are often designed to address the needs of justice-involved individuals with co-occurring disorders, who are overrepresented in the nation's jails even more so than in prisons.

Targeting those with co-occurring disorders makes sense, because these individuals are at high risk for recidivism; have educational and employment deficits, limited social support systems, and limited aftercare provision (Osher et al., 2002); and are most in need of treatment interventions (Miller & Miller, 2017; Peters, LaVasseur, & Chandler, 2004; Skeem, Nicholson, & Kregg, 2008). Since the 1990s, there has been a consistent call to integrate treatment for mental illness and substance use disorders (Drake et al., 1998; Mueser, 2003; Peters, Wexler, & Lurigio, 2015), though the criminal justice system has only recently focused attention on this recommendation. Integrated approaches to treatment of co-occurring disorders take several forms, including multidisciplinary case management teams, dual-disorder group interventions, assertive outreach, and motivational interviewing (Drake et al., 1998). Integrated approaches to co-occurring disorders have fared well in experimental and quasi-experimental studies, especially when they include assertive outreach (Drake, O'Neal, & Wallach, 2008). A review of 45 psychosocial interventions for co-occurring disorders identified several approaches that produce positive results for substance use disorders, including group counseling, contingency management, and residential dual-diagnosis programs.

The emerging literature on justice-involved individuals with co-occurring disorders does offer some insight into the most effective types of programming for this population. Case management, integrated programs, and community-based residential treatment have resulted in the reduction of both psychiatric symptoms and substance use disorders (Chandler, Peters, Field, & Juliano-Bult, 2004). Therapeutic communities are also promising for individuals with co-occurring disorders, particularly when they continue taking part in those communities following release (Sacks, Sacks, McKendrick, Banks, & Stommel, 2004; Sacks et al., 2008). Evidence also supports family-based and individual therapy (Santisteban et al., 2015) and specialized supervision teams (Skeem & Manchak, 2008) for individuals with co-occurring disorders. Woodhouse and colleagues (2016) more recently conducted a systematic review of studies that examined the effectiveness of interventions for these individuals and found that neither case management, motivational interviewing, and cognitive skills nor interpersonal psychotherapy were linked to significant reductions in drug use or recidivism.

What Works for Incarcerated Females?

Because most reentry programs are designed for males, prior research has noted the need for gender-responsive programming (Haywood et al., 2000; Blanchette & Brown, 2006; Bloom et al., 2004; Fleming et al., 2021; La Vigne et al., 2009; Messina et al., 2000; Pelissier & Jones, 2006). Specifically, interventions designed for females that include mental health components, treatment for trauma, childcare, and parenting classes are associated with reductions in relapse and increases in treatment retention following release back to the community (Ashley et al., 2003; Pelissier & Jones, 2006; Pelissier et al., 2005). Aftercare services also play an important role in reentry outcomes for females, including return to treatment, continuity of care, and post-release abstinence from drugs and alcohol (Scott & Dennis, 2012).

Gender-responsive case management has emerged as a promising strategy for female reentry. For example, Collaborative Case Work with Women (CCW-W) — previously known as the Women Offender Case Management Model (WOCMM) — is a case management model designed specifically for women in the criminal justice system, developed by the National Institute of Corrections (NIC) and Orbis partners (Fleming et al., 2021). CCW-W is designed to provide coordinated, uninterrupted services that begin at sentencing and continue through community reentry and supervision. This is consistent with the principle of community in-reach, where reentry programming begins during incarceration by bringing in community partners for the provision of treatment services and for the purposes of reentry planning. (Miller & Miller, 2010). This planning and treatment provision prior to release increases the likelihood that reentry plans will be developed and adhered to and that critical aftercare is continued in the community following release. Preliminary empirical evidence suggests women who participate in case management based on the CCW-W model experience lower rates of recidivism compared to those on standard probation, although these studies are mostly descriptive in nature (Van Dieten, 2015).

Although reentry efforts are often focused on prisons, where individuals are typically convicted and incarcerated for periods over one year, engaging in reentry programming during incarceration in jail is also crucial for success. Local jails incarcerate people for shorter terms — often days or weeks — and the majority are unconvicted and held pretrial (Zeng, 2023), both of which can make delivering effective reentry programming difficult. Jails tend to lack this type of programming when compared to prisons, and there is a resulting lack of research on effective strategies for the jail population (Rodda & Beichner, 2017; Roddy, 2023; Yasunaga, 2001). However, women released from jail experience similar hardships to women returning from prison, including a lack of housing or employment, mental health or substance abuse issues, and childcare concerns.

While a number of narrative or qualitative reviews of female reentry programs delivered in prisons and jails have been published, the remainder of this chapter reports specifically on the results from a series of meta-analyses (Dowden & Andrews, 1999; Gobeil, Blanchette, & Stewart, 2016; Tripodi et al., 2011). Meta-analysis is a statistical approach that improves on traditional methods of narrative review by systematically aggregating information and quantifying its impact (Gobeil et al., 2016). Meta-analysis has several well-documented advantages, including increased statistical power, examination of intervening factors, and increased generalizability of results. In short, meta-analysis allows us to understand not only which factors impact reentry, but to what degree.

Prior to Gobeil and colleagues' more recent study (2016), two other meta-analyses were conducted on correctional programs for females (Dowden & Andrews, 1999; Tripodi et al., 2011). Dowden and Andrews' (1999) analysis was conducted well before the push for gender-responsive programming; the 16 studies included in their assessment took place in the 1980s and 1990s, and many focused on juveniles or youth, as opposed to adult women. Only programs that were evaluated using either experimental or quasi-experimental designs were included in the analysis. Dowden and Andrews concluded that programs designed using the Risk-Needs-Responsivity model were able to reduce recidivism among men and women alike, and to a similar degree. Tripodi and colleagues (2011) examined the findings from six U.S. studies using either experimental or quasi-experimental designs published between 1988 and 2008 that focused on interventions delivered to women in adult correctional facilities. The results indicated that substance use treatment exerts an appreciable effect on reducing recidivism for women returning from prison; women who participated in treatment had 45% lower odds of reoffending.

Building on these meta-analyses, Gobeil and colleagues (2016) sought to assess the effectiveness of gender-responsive programming in particular, as well as to identify which other intervention characteristics are associated with reentry success. A total of 37 studies were included in their analysis, and more than 75% of these reported lower recidivism rates for program participants compared to control groups. The meta-analysis similarly confirmed a statistically significant reduction in recidivism for those in the intervention/treatment groups. Interventions focused on substance use had

significantly larger effects, as did programs that employed therapeutic communities. Programs that were fully gender-informed had smaller effects than those that were partially or not gender-informed, though the difference was not statistically significant. Interventions offered in an institution or those that bridged the institution and the community were also more effective than those administered in the community alone. When only experimental designs were included in the meta-analysis (excluding quasi-experiments), the effect size for gender-informed interventions was significantly and considerably greater than that for gender-neutral programs. Cognitive behavioral approaches also had a more significant impact than other approaches.

Collectively, these meta-analyses suggest that programs that focus on substance use, use therapeutic communities and cognitive behavioral therapy, and employ gender-responsive programming are most successful in significantly reducing recidivism and improving outcomes for females who have returned to the community from prison. While these studies provide the strongest findings based on the meta-analytic approach, it should be noted that they do not consider differential impacts for women with varying demographic characteristics, such as race or ethnicity, despite research showing the importance of considering both gender and culture in programming (Covington & Bloom, 2003).

Exhibit 1 presents a summary of the reentry programs and practices designed for justice-involved females currently rated as promising by CrimeSolutions.[10] A rating of promising indicates there is some evidence that a program produces the intended outcome. Programs that are not for reentry per se but are rather single-approach rehabilitative initiatives are not included, nor are reentry programs targeting males or juveniles. In exhibit 1, a reentry program or practice is regarded as a system of continuous care that begins in custody and continues following release. Considerably fewer programs and practices meet these criteria than are listed under a general search for "reentry" on CrimeSolutions; out of 120 rated reentry programs, only five met the criteria for inclusion.

[10] CrimeSolutions (CrimeSolutions.ojp.gov) is an online resource for helping practitioners and policymakers understand what works in justice-related programs and practices. Its purpose is to assist in practical decision-making and program implementation by gathering information on justice-related programs and practices and reviewing evaluation and meta-analysis research against standard criteria.

Exhibit 1. Female Reentry Programs Rated Promising by CrimeSolutions

Program	CrimeSolutions Rating	Description and Outcomes	Number of Studies
Forever Free	Promising	The first comprehensive, in-prison, residential substance use disorder treatment program designed for incarcerated women. The intervention group reported fewer arrests during parole, less drug use, and more employment at follow-up than the comparison group. https://crimesolutions.ojp.gov/ratedprograms/40	One quasi-experiment
Gender-Specific Drug Treatment Court	Promising	A drug court program that provides treatment services to women on probation to reduce their risk of reoffending. The program gives preference to women who have higher need and risk profiles, are mothers, and have substance use problems. At the two-year follow-up, women in the treatment group were statistically significantly less likely to have a new conviction, compared with similar women on probation who did not participate in the program. https://crimesolutions.ojp.gov/ratedprograms/747	One quasi-experiment
Moving On	Promising	A curriculum-based, gender-responsive intervention created to address the different cognitive-behavioral needs of incarcerated women. The program was shown to significantly reduce recidivism as measured by rearrests and reconvictions, but it did not have a significant impact on reincarcerations for a new offense or technical violation revocations. https://crimesolutions.ojp.gov/ratedprograms/476	One quasi-experiment
"Seeking Safety" for Incarcerated Women	Promising	A manualized cognitive-behavioral intervention for incarcerated women with co-occurring post-traumatic stress disorder (PTSD) and substance use disorders. Evaluation results suggest that the program significantly reduced PTSD and depression scores in program participants. https://crimesolutions.ojp.gov/ratedprograms/424	One quasi-experiment

Source: CrimeSolutions.ojp.gov

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. Notably, rigorous evaluations of programs designed for women are lacking. 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.

In addition to quantitative analyses, continued incorporation of qualitative research is important to understand mechanisms between observed relationships and disparities in experiences. Mixed-methods data collection approaches that include both quantitative and qualitative research techniques may be better suited to adequately capture 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. Applying a racial equity lens to reentry program evaluations is especially important as formal measures of recidivism cannot account for social contexts such as implicit bias or concentrated disadvantage (Lindquist, 2021).

While research from criminology and criminal justice often focuses on limited measures of reentry success — such as recidivism, relapse, or revocation — other important reentry outcomes can be measured and evaluated, such as treatment continuation, mental health symptomology, physical health, housing, and family-related issues. Although 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, collect a wide range of data related to these extrajudicial outcomes, and use a racial equity lens when appropriate.

Accordingly, reentry programming should incorporate culturally responsive strategies that consider variations in client characteristics and intersecting identities, and how those variations impact service needs and reentry experiences (Sheppard, Hassoun Ayoub, & Pecos Melton, 2021). Results from a handful of studies suggest that culturally responsive programs may be more effective than traditional programming in reducing recidivism and improving program engagement; however, more rigorous research is needed.

Reentry programs also need to expand the types of services provided for returning individuals, particularly those related to post-release housing, transportation, and employment. The likelihood of success in employment and other outcomes may be limited if someone is not stably housed. 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 limited in the criminal justice system (Homans, Allen, & Mazariegos, 2023; 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; as the nation's largest public health system, utilizing MAT within the criminal justice 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 U.S. Food and Drug Administration for the treatment of heroin use in 1984 and alcohol use in 1995 (Greenstein, Arndt, McLellan, O'Brien, & Evans, 1984; O'Brien, Greenstein, Mintz, & Woody, 1975; 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, Lundy, Stringer, Gallop, & Gastfriend, 2015), though only one of these studies addressed the effectiveness of the newer extended-release naltrexone, signaling the need for additional evaluation. This prior research indicates that the use of naltrexone correlates with 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 approved by the U.S. Food and Drug Administration 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 use disorders; 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 and justice-involved girls, gender-informed programming can produce better outcomes than gender-neutral programming.

Recommendations for Policy and Practice

Although the bulk of reentry research focuses on men, studies related to female reentry have produced several important findings with implications for improving policy and practice for this group.

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, childcare, 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. Culturally responsive programming elements beyond gender should also be considered.

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 rearrest 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 handoffs), 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 incarcerated persons with substance use disorder, mental illness, or both, and especially for those with opioid 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 (SAMHSA) identifies peer support workers 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 (SAMHSA, 2018). 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 workers, clinicians) (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 individuals 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 on which formerly incarcerated individuals 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 funding necessary for providing housing assistance. An increase in funding, along with a corresponding increase in research, is needed to 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 to 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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