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Jalisa Cruver

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## ABSTRACT

## Exploring Mental Health Services for Women Post Incarceration

By

Jalisa C. Cruver

December 8, 2016

**Background:** In recent years, the number of women incarcerated has increased at a rate higher than men. Drug and social policies related to employment, housing, education, welfare, mental health, and substance abuse treatment make it difficult for women to succeed once released from prison or jail. Women with co-occurring mental health and substance use disorders are a high-risk population for negative post-release outcomes. For the majority of prisoners experiencing psychological distress during incarceration, distress persists after release. Unfortunately, contact with mental health services in the community by ex-offenders is low. Further research is needed to understand the barriers to seeking these services.

**Aim:** Explore the social behavioral factors that contribute to mental health of women recently released from prison or jail by: (1) reviewing the current programs available for women who need mental health services after prison release, (2) synthesizing the peer-reviewed literature - evaluating the effectiveness of community reentry programs with a mental health service component and (3) identifying future research and policy needs to better address mental health needs of women post incarceration and reduce recidivism.

**Methods:** A literature review was conducted to assess the structure of current community reentry programs and evaluate the effectiveness of community reentry programs with mental health service components.

**Conclusion:** There is need for more gender specific mental health reentry programs for women. Men account for 90% of the incarcerated population, and as a result reentry programs are predominately created for men. Community reentry programs that focus on cognitive behavior theory rooted in the power of individual choice must also ensure that they prepare ex-offenders to deal with unexpected barriers to social services such as housing, employment, food stamps, and health insurance. There is need for more outcome evaluations of existing reentry programs and reentry programs that include tools that measure mental health outcomes during release.

Exploring Mental Health Services for Women Post Incarceration

by

Jalisa C. Cruver

B.A., GEORGIA STATE UNIVERSITY

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## APPROVAL PAGE

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Jalisa Cheri Cruver

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## Introduction

Women are the fastest growing population in the correctional system. Between 1977 and 2007, the rate of women incarcerated doubled that of men at 832% versus 416% (Flores & Pellico, 2011). Mandatory minimum sentencing of the 1990s contribute to the increase in female incarceration. The recent economic downturn has also led more women to resort to illegal activity (Flores & Pellico, 2011). More than half of incarcerated women are serving sentences from drug related charges. And while these are not often lengthy sentences, 58% of women are rearrested after release. Women of color are disproportionately represented in the incarceration population. Hispanic women are twice as likely and black women are four times more likely to be incarcerated than white women (Olphen, Eliason, Freudenberg, & Barnes, 2009). Most incarcerated women are low income before incarceration and over 75% are mothers (Flores & Pellico, 2011).

Surveys of federal and state inmates have identified rates of mental illness including depression, anxiety, and psychotic disorders are significantly higher than the general population. Depression was evident for 23.5 % of state prisoners and 29.7 % of jail inmates, compared to 7.9 % in the general population; mania disorders were present among 43.2 % of state prisoners and 54.5 % of jail inmates, compared to 1.8 % of the general population; and, psychotic disorders were experienced by 15.4 % of state prisoners and 23.9 % of jail inmates, compared to 3.1 % of the general population (Begun, Early, & Hodge, 2015).

Prison and jail inmates are being released early at exponential rates due to budget cuts and facility overcrowding. As of 2010, 708,677 sentenced prisoners were released from state and federal prisons, an increase of 20 percent since 2000 (Guerino, Harrison & Sabol, 2011).



There more than 9 million inmates released from jails, disproportionately to disadvantaged communities with limited or overwhelmed social resources (Hughes & Wilson, 2015). Returning ex-offenders with complex needs to communities with inadequate support is detrimental to both the individual and the community. Mortality rates among former prisoners are significantly higher than what would be expected in similar demographic groups (Binswanger, et al., 2011). The leading causes of death of those recently released from prison and jail are drug overdose, cardiovascular disease, homicide, suicide, motor vehicle accidents and cancer (Binswanger, et al., 2011).

Maintaining behavioral health and addiction services during the transition between incarceration and community reentry is a crucial factor in determining risk of recidivism (Begun, Early, & Hodge, 2015). The first 90 days after release are the most critical time of transition (Draine & Herman, 2007). It is important during this period to ensure that all services needed for successful reentry are initiated simultaneously. Receiving mental health treatment during reentry is associated with lower recidivism rates (Begun, Early, & Hodge, 2015). Unfortunately, several studies have discovered that individuals often experience a pattern of fragmented mental health services during community reentry. Prisoners with psychiatric disorders are often released with only a limited supply of medication, often running out before connection to mental health services in the community (Angell, Matthews, Barrenger, Watson, & Draine, 2014). One cause of this fragmentation is due to a loss of insurance during incarceration. In 90% of states, Medicare and Medicaid are revoked during incarceration (Flores & Pellico, 2011). Other barriers that prevent released prisoners from utilizing mental health services post incarceration include: inability to meet service costs insufficient numbers of public mental

health programs in the community, difficulty with getting an appointment with programs in community that are available, community-based programs being unable to adequately meet the needs of an ex-prisoner population, the double stigma of mental illness and ex-prisoner status (Binswanger, et al., 2011).

Needs for successful community reentry are different when comparing men and women. Approximately 73% of women prisoners have a mental health problem compared to 55% of men (Tripodi & Pettus-Davis, 2013). Incarcerated women are more likely than men to be diagnosed with a mental illness and experience higher rates of suicide (Begun, Early, & Hodge, 2015). Women in prison or jail also are more likely to be victims of physical and sexual trauma in childhood and adulthood. Many women prisoners who experience mental health and/or substance use problems are victims of childhood victimization (Tripodi & Pettus-Davis, 2013). A better understanding of victimization and subsequent mental health and behavioral problems for women prisoners allow for targeted and trauma focused interventions that could promote positive post-incarceration outcomes. The co-occurrence of mental health and substance use disorders is also more common among incarcerated women than men. Seventy-five percent of women prisoners who report mental health problems also meet the criteria for substance dependence compared to 56% of men (Tripodi & Pettus-Davis, 2013).

. Gender specific mental health reentry programs are necessary to address women's complex mental health concerns, specifically with effects of past trauma. Recent studies have found that 78% of incarcerated women report being physically or sexually abused prior to incarceration compared to only 15% of males reporting such abuse (Tripodi & Pettus-Davis,

2013). In addition to general barriers that prevent utilization of mental health services upon reentry, women encounter unique barriers to successful reintegration. Women who enter into the prison/jail system often have significant program needs such as histories of trauma and abuse, mental health issues, substance abuse, parenting issues, and relationship issues. Women are more likely than men to rely on substance-using family members and to return to unhealthy intimate relationships post incarceration (Flores & Pellico, 2011).

The primary aim of this research was to: (1) review current mental health programs available for women, (2) synthesize peer-reviewed literature –evaluating the effectiveness of community reentry programs with a mental health component (3) and identify future research and policy needs to better address mental health needs of women post incarceration and reduce recidivism.

### **Methods**

According to the Prisoner's Assistance Directory released in 2012, 27 states (including Washington D.C.) had a community reentry program that provided counseling or mental health treatment. Only 7 states had more than one specific program (American Civil Liberties Union, 2012). Using the Behavioral Health Treatment Services Locator on the official website for the Substance Abuse and Mental Health Services Administration (SAMHSA) the search was broadened to include existing mental health programs that accept referrals from ex-offenders. Using this tool, there is an increase in the number of services available, but there are still gaps in coverage for all ex-offenders. Figure 1 shows that out of 8,063 outpatient mental health facilities in the U.S., 1,668 facilities accept referrals from the court or judicial system (SAMHSA,

2016). There was no filter for specifically for ex-offenders, so it is assumed that this filter could still include persons that have never been incarcerated. For those leaving prison or jail, a common barrier to mental health services is affordability of services. To account for this commonality, the search was narrowed to only include programs that offer payment assistance or sliding fee scale payment options. There are 755 programs that offer sliding fee scale payment, 468 that offer payment assistance, and only 298 that offer both (SAMHSA, 2016). When looking where the affordable programs are concentrated in Figure 1, it is evident that there are places in the U.S. that have few services for low-income patients that receive referrals from the judicial system. Another pathway to reviewing outpatient services post incarceration is through insurance. The last row in Figure 1 shows that there are 1,551 outpatient mental health facilities that accept Medicaid insurance. For the purposes of this research, it is important to note that there was no filter to identify gender specific mental health programs. Typically, criminal justice agencies are responsible for providing reentry services for all women prisoners, including those with mental illness (Draine & Herman, 2007). The criteria for selecting reentry programs for the review were as follows: (1) a reentry program, community reentry program or outpatient mental service, (2) an affordable program- no cost, offers payment assistance, or accepts Medicaid or Social security insurance as most ex-offenders leaving prison or jail are uninsured and have low income, (3) program open to women or exclusively for women, (4) counseling or mental health services component to the program or service, (5) quantitative or qualitative outcome measures available at time of review. Three outcome measures were observed: (1) recidivism, (2) mental health improvements, and (3) access to mental health services after incarceration. There were two types of programs

identified: those that focused on connecting ex-offenders to existing mental health-related services and those that delivered new services to ex-offenders that aimed to address mental health issues.

### **Connecting Ex-Offenders to Existing Mental Health Services**

#### Engagement Processes: CTI vs. FACT

Ex-offenders attitudes toward mental health treatment reveal psychological barriers that effect service engagement. They described a fear of formal labeling, concerns about stigma, and distrust of authorities as major psychological barriers to seeking help (Angell, Matthews, Barrenger, Watson, & Draine, 2014). Programs serving people with mental illness during a high risk reentry period must incorporate strategies of service engagement to address these barriers and foster motivation to participate in treatment. Though differing in program structure, Critical Time Intervention (CTI) and Forensic Assertive Community Treatment (FACT) are community reentry programs that employ these engagement processes. Each program employs evidence-based treatment in an effort to mitigate the overrepresentation of people with mental illness in prison and jail.

CTI is a time-limited program designed to facilitate the transition from institution to community (Draine & Herman, 2007). The intervention focuses predominately on helping ex-offenders build linkages to treatment programs such as psychiatrists and therapists, but also community connections of families and housing programs (Angell, Matthews, Barrenger, Watson, & Draine, 2014). CTI uses case managers that advocate directly with social services on behalf of their clients as well as assist clients with problem solving strategies to help

themselves. In contrast, FACT is time-unlimited program adapted from an existing evidence-based treatment, Assertive Community Treatment (ACT). ACT is a case management program that uses a multi-disciplinary team to provide individualized comprehensive support to people with mental illness. The FACT program differs as it has a focus on preventing incarceration rather than hospitalization; there is more direct collaboration with criminal justice authorities; and often, the implicit threat of incarceration is used as leverage to promote compliance with treatment (Angell, Matthews, Barrenger, Watson, & Draine, 2014). The length of the program is unlimited to account for the need of ongoing support as ex-offenders continue to cope with chronic mental illness throughout life.

Results from a study comparing services of the two programs indicated that FACT was a more comprehensive program. In comparison, due to its short duration (90 days) and scarce financial resources, the CTI program was often unable to provide supplemental assistance after encountering problems with securing state/federal benefits for their clients to be used to pay for mental care post incarceration (Angell, Matthews, Barrenger, Watson, & Draine, 2014). In these instances, the FACT program was more effective in assisting clients because their model imbeds psychiatric services within their program versus a linkage to services. The study found that developing a relationship bond with the assigned client is essential to program engagement. Trust was pivotal between client and case managers as often ex-offenders have a mistrust in authorities based from negative past interactions in prison/jail or in the community. Another important aspect of this relationship was developing a non-hierarchical relationship between case managers and clients. By accepting phone calls after hours and adopting a casual, friendly demeanor with clients, trust was developed. Clients asserted that efforts of emotional

investment beyond the job role made them feel like 'more than a paycheck' (Angell, Matthews, Barrenger, Watson, & Draine, 2014). Another important engagement component of both programs was to connect case managers with clients prior to release from incarceration. In the FACT program, case managers were required to transport clients from prison to housing upon release. Advocating for clients in social systems was also a powerful engagement technique. After clients had exhausted personal efforts, case managers would follow up with phone calls or in-person meetings with social services representatives when clients experienced difficulty securing insurance (for mental health service payment), food stamps, housing, or job placement.

#### Oklahoma Collaborative Mental Health Reentry program

In 2007, the Oklahoma Department of Corrections (ODOC) and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) partnered to create the Oklahoma Collaborative Mental Health Reentry program (OCMHRP) (Bureau of Justice Assistance, 2013). The OCMHRP is designed for offenders with serious mental illness (schizophrenia, bi-polar disorder, depression). ODMHSAS case managers are assigned to a correctional facility where they implement individualized treatment plans for participants. The program also provided Reentry Intensive Care Coordination Teams (RICCTs) that meet with offenders during incarceration and continues to work with the participant after release for up to a year (Bureau of Justice Assistance, 2013). The RICCT staff are responsible for getting releases signed, setting up phone interviews, coordinating with ODOC Mental Health Services clinical staff who prepare the discharge summaries for ex-offenders (Morgan, 2011). The RICCT staff also follow up with individual to assist in securing Medicaid and Social Security Benefits.

Each team has contract with budgets to include flex funds for basic living needs and housing assistance if clients has issues securing housing. Through the RICCT, participants are also assigned peer support specialists that have experience with mental illness. Peer support specialists are required to make contact with their assigned client monthly and make themselves available to meet with or talk to their clients on the phone as needed. The program requires that peer support specialists completed 40 hours of training, have a high school diploma, obtain continuing education credits, openness to share demonstrated recovery from mental illness, signed employment verifications and Code of Ethics forms (Morgan, 2011).

Participants in the OCMHRP are recruited based on scores of a validated risk assessment. The assessment evaluated offenders with respect to their: need for community based mental health services, eligibility for benefits, job/life skills, educational needs, housing needs, post release supervision requirements, and criminogenic risk factors (Bureau of Justice Assistance, 2013). With scarce resources, the program has managed to serve over 400 participants and outcome surveys have found that the program has been moderately successful. Figures 2, 3, and 4 show some comparisons to baseline groups. For example, results suggest that the program resulted in a 6% decrease in inpatient hospitalizations, 34% increase in use of community outpatient services, 41% increase in Medicaid enrollment, 53% increase in Social Security Benefit enrollment, and a 41% decrease in recidivism rates in comparison to similar groups not in the program (Bureau of Justice Assistance, 2013).



## Delivering New Services to Address Mental Health Issues

### Moving On: Minnesota Reentry Program

Beginning in 2001, Moving On is one of a few gender-specific reentry programs designed for women. Initiated by the Minnesota Department of Corrections (MNDOC), Moving On is voluntary cognitive-behavior therapy (CBT) program that focuses on improving communication skills, building healthy relationships upon release, and constructively expressing emotions (Duwe & Clark, 2015). CBT is based on the assumption that delinquent behaviors are often defense mechanisms in response to conflict between the personality and the inner self (Kellett & Willging, 2011). The goal of this therapy is to promote positive decision making skills as a means to avoid situations that could lead to recidivism. The original structure of the program consisted of 26 sessions in which women participated in group and individual discussions with a counselor, self-assessments, writing exercises, and role-playing and modeling activities (Duwe & Clark, 2015). However in 2011, the program was reformatted into a mandatory program condensed from 12 weeks to 3 weeks and offered during prisoner intake as a part of orientation instead of towards the end of prison sentence. Due to time restrictions, certain aspects of the program were eliminated including role playing, skill building exercises and homework assignments. Because the program was now mandatory, the class size shifted from 5-10 participants to 40-50 participants (Duwe & Clark, 2015). In 2013, the MNDOC officials decided to return the program to its original format, except that now a risk assessment (Minnesota Screening Tool Assessing Recidivism Risk (MnSTARR)) would be used to determine participant eligibility similar to the collaborative mental health program in Oklahoma. Only prisoners with a high recidivism risk were open to participate in the program.

There have only been two outcome evaluations of the Moving On program. The first, conducted in 2010 compared 190 Moving On participants to 190 similar women on probation that did not participate in any CBT (Gehring, Van Voorhis, & Bell, 2011). The treatment and control groups were matched on many characteristics including: judicial district, race, age, risk assessment scores and probation start times (Gehring, Van Voorhis, & Bell, 2011). Outcome measures indicated whether the sample had been rearrested, convicted, incarcerated, or had a technical violation during 12, 18, 24, and 30 month follow-up periods following the participants' completion of Moving On. Study findings at different times of follow up indicate that Moving On participants had significantly lower rates of rearrests and convictions than the control group. As illustrated in Figure 5, differences in rearrest rates between the *Moving On* group and the comparison group were statistically significant at 18 months ( $p = .012$ ), and 24 months ( $p = .053$ ) (Gehring, Van Voorhis, & Bell, 2011). In Figure 6, conviction rates were also statistically significant at 18 months ( $p \leq .05$ ) and 24 months ( $p = .058$ ). Analysis for incarcerations indicated no difference between the Moving On participants and the comparison group. After 30 months, only 17.9 percent of the Moving On sample had been incarcerated and 16.3 percent of the comparison group had been sent to prison (Gehring, Van Voorhis, & Bell, 2011). Moving On participants did have significantly more technical violations than their matched probationers. By the end of the 30 month follow up period, 16.9 percent of the Moving On participants acquired a technical violation compared to only 3.7 percent matched comparison group (Gehring, Van Voorhis, & Bell, 2011).

The second outcome evaluation of the Moving On program was conducted in 2014. Researchers compared recidivism rates between (1) Moving on participants pre-2011( before

the program was abbreviated), (2) Moving On participants between the years 2011-2013, and (3) a control group that did not participate in any CBT intervention (Duwe & Clark, 2015). The purpose of the evaluation was to measure the effect of eliminating evidence-based components of the program on recidivism rates. Similar to the 2010 study, recidivism was measured using rearrest, reconviction, new offense reincarceration, and technical violation rates. Using a retrospective, quasi-experimental design the study yielded 216 pre-2011 participants, 864 2011-2013 participants, and comparison pool of 3,021 inmates for control groups. Researchers used propensity score matching to control for selection bias and established comparison groups (Duwe & Clark, 2015). The researchers used Cox survival analysis, controlling for several covariates including: age at release, length of prison stay, suicidal tendencies, prison visitation, and education level. Cox regression models were generated across all three comparison groups to determine the effects of Moving On and program abbreviation on recidivism. Illustrated in Figure 7, the results in the first comparison indicate that when controlling for covariates, participating in Moving On prior to 2011 significantly reduced two of the four recidivism measures, lowering the risk of reoffending by 31 percent for rearrest and 33 percent for reconviction (Duwe & Clark, 2015). In the second comparison (2011-2013 Moving On participants vs. control group), the results indicated that Moving On participation did not have a significant effect on any of the four recidivism measures. The hazard ratio was positive for rearrests, reconvictions and new offense reincarcerations. The third comparison (pre-2011 versus 2011-2013 Moving On participants) results indicated the hazard of reoffense was 44 percent lower for rearrest and 47 percent lower for reconviction (Duwe & Clark, 2015). The hazard ratio was in the negative direction for

new offense reincarceration, it was in the positive direction for technical violations but neither were statistically significant (Duwe & Clark, 2015). The results of the study indicated that abbreviating the program had an effect on recidivism rates.

#### Community Wise: New Jersey Reentry Program

The Community Wise program was developed in 2010 by the Newark Community Collaborative Board using community based participatory research. The framework of the program is based on Paulo Freire's critical consciousness theory. The primary goals of the program are to reduce psychosocial distress, substance abuse, risky health behaviors, and reoffending. The Community Wise program aims to empower participants to combat oppression in distressed communities by developing critical analysis skills and creating social change projects. The program is delivered in two phases. In phase 1, participants engage in critical dialogue when prompted with historical illustrations related to substance abuse and incarceration in the United States (Windsor, Jemal, & Benoit, 2014). During phase II, participants develop personal goals and engage in social change projects. The projects are focused on challenges participants identify in their community. Examples include writing letters to elected officials, participating in fund raising events, and civic activities such as park cleaning (Windsor, Jemal, & Benoit, 2014).

A pilot test of the program was conducted to evaluate the program for future implementation. There were quantitative and qualitative measures used to evaluate program effectiveness. Critical consciousness, reoffending, health risk behaviors, substance use, and mental health were all measured quantitatively by clinicians using respective risk assessments

and tests. Three focus groups were used for the qualitative evaluation. The study sample included 26 participants that completed the program; 16 men and 10 women (Windsor, Jemal, & Benoit, 2014). Participants were divided into three groups; two were gender specific and one was not gender specific. The results indicated that women had the lowest scores on some mental health outcome measures at baseline compared to men (Windsor, Jemal, & Benoit, 2014). Women had significantly higher PTSD, anxiety and physical aggression scores at baseline. At the conclusion of the intervention critical consciousness increased for the women's only groups but decreased for the mixed gender group and son change in the men's group. For all groups, psychological distress, PTSD symptom severity and reoffending were reduced (Windsor, Jemal, & Benoit, 2014).

### **Future Recommendations**

#### Program Recommendations

Women are being incarcerated and released from prison at exponential rates. Studies have documented that incarcerated women suffer from mental illness more than men. There are not enough reentry programs that are gender-specific or that address mental health issues upon release from prison. Cognitive behavior therapy is more successful at reducing recidivism when it is coupled with a plan to address barriers to environmental stability after release from prison or jail. A program recommendation would be ensuring that women leaving prison are prepared to combat structural changes to their lives and also maintain healthy relationship with their families. There is a need for more reentry programs constructed using evidence based research. It is important that programs are modified with changes beneficial to the participants.

In the Moving On reentry program for example, abbreviating the program had an effect of recidivism measures. When compared to a control group receiving no therapy, the participants in the pre-2011 extended program reduced rearrests and reconvictions. The participants in the abbreviated program did not reduce arrests or reconvictions when compared to a control group receiving no therapy. Including a mental health outcome measurement tool in a reentry program is another recommendation. An example of an evidence based mental health outcome measurement tool is the Daily Living Activities- 20 (DLA-20). This tool measures improvements in mental functioning in the community using 20 everyday tasks (Presmanes, 2011). This functional assessment takes less than 10 minutes to complete and is administered by a person close to the client, such as a case manager. This tool is recommended because it is provided for free after completed webinar training provided by MTM Services and the National Council (Presmanes, 2011). Most reentry programs solely focus on reducing recidivism and often this is the only outcome used to measure program effectiveness. Women are more likely to experience trauma proceeding incarceration and are also at higher risk to incur difficulty readjusting to parenting and staying away from unhealthy intimate relationships once released from incarceration. An opportunity to conduct this qualitative analysis could be during follow up periods assessing recidivism.

#### Policy Recommendations

The SAMHSA maps indicate that there are vast areas where there are no programs that offer payment assistance. Women leaving prison are often low income and predominately mothers. This leaves little to no funds for personal mental care. There are also very few mental health community reentry programs for ex-offenders in the U.S. The SAMHSA maps also

indicate that there are several programs that offer outpatient mental health services to Medicaid recipients. The Affordable Care Act expanded coverage to include most individuals in the prison/jail system. States made the individual choice to accept the Medicaid changes. Figure 8 shows the states with programs to enroll most prisoners or some prisoners like those with disabilities or mental illness (Marshall Project, 2016). It is recommended to increase enrollment to prisoners in the states that have expanded Medicaid. The enrollment would be initiated during the last 90 days of incarceration by parole officers or prison official responsible for other reentry services such as housing placement. Studies in Florida and Washington found that released inmates with serious mental illness who were enrolled in Medicaid at prison/ jail release were more likely to access community mental health and substance abuse services than those without Medicaid (Gates, Artiga, & Rudowitz, 2014) These studies also found that 2 months after release, Medicaid enrollees had 16% fewer detentions and stayed out of jail longer than those who were not enrolled (Gates, Artiga, & Rudowitz, 2014). It is also recommended that correctional facilities connect eligible inmates with Medicaid coverage if provided by the state. This may prove difficult with prison/jail budget and employee constraints, but there are currently correctional systems successfully employing this strategy. Cook County Health and Hospital System (CCHHS) partnered with Cook County Sheriff's Office (CCSO) and a non-profit organization, Treatment Alternatives for Safe Communities (TASC), to screen detainees entering Cook County Jail for eligibility for CountyCare, the county's Medicaid expansion program. As of April 2014, over 3,800 people received coverage and there is a 94% approval rate for applications submitted (Gates, Artiga, & Rudowitz, 2014). The Connections Correctional Health Care Services in Delaware also provides

connections to services. The system brings providers into the facilities so the inmate can also connect to coverage before release. On average the Connections program works with about 7,000 prisoners per day (Gates, Artiga, & Rudowitz, 2014).

### Research Recommendations

There is a need for more research evaluating program effectiveness. Evaluations provide important information on how program structure, content, and length have significant impact at improving the mental health of women post incarceration and reducing recidivism. Further research is need evaluating reentry programs using both mental health outcomes and recidivism outcomes. The Oklahoma Mental Health Reentry Program has documented success in reducing recidivism and mental illness outpatient costs. Amending this program to also include a tool to measure mental health outcomes such as the DLA-20, would be useful in reentry program evaluation research. There is a need for research regarding gender specific recidivism strategies. Do men and women experience similar pathways to reoffending? Also with the recent Affordable Care Act Medicaid expansion, more research is needed to document the changes in coverage for eligible women post-incarceration.

### **Conclusion**

In recent years, the number of women incarcerated has increased at a rate higher than men. Men account for 90% of the incarcerated population, and as a result reentry programs are predominately created for men. Women leaving prison are more likely than men to be victims of trauma or abuse prior to incarceration, primary care givers to children post incarceration and involved in an unhealthy intimate relationship prior to and post incarceration. There is a need



for more gender specific mental health reentry programs tailored to women. It is important that reentry programs that focus on the power of individual choice must also ensure that they prepare ex-offenders to deal with unexpected barriers to social services such as housing, employment, food stamps, and health insurance. Since the Affordable Care Act expanded Medicaid provisions, more women with mental illness leaving prison/jail qualify for insurance to supplement mental health service costs. Finally, there is a need for more outcome evaluations of existing reentry programs and reentry programs that include tools that measure mental health outcomes during release.

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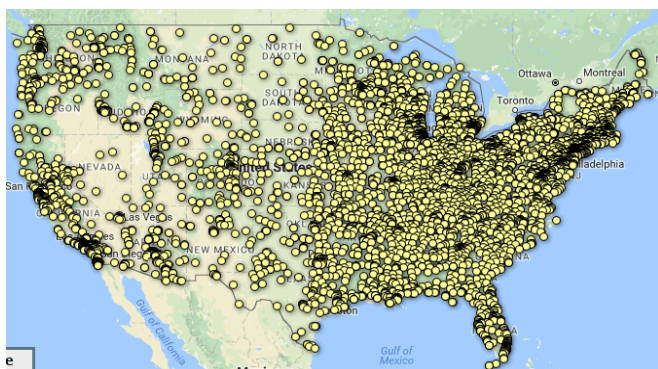
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## Appendix

### Figures

Figure 1 SAMHSA Behavioral Health Locator Maps



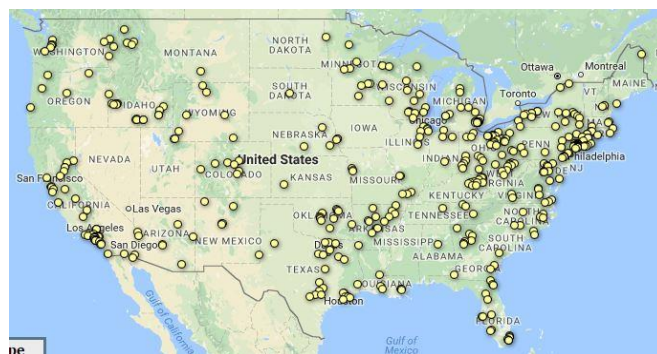
Outpatient Mental Health Facilities in the continental U.S., 2016



Outpatient Mental Health Facilities in continental U.S. that receive referrals from court/judicial system, 2016



Outpatient Mental Health Facilities that offer sliding fee scale payment, 2016



Outpatient Mental Health Facilities that offer payment assistance, 2016



Outpatient Mental Health Facilities that accept Medicaid, 2016

Figure 2 Oklahoma Collaborative Mental Health Reentry Program Baseline Comparison 1

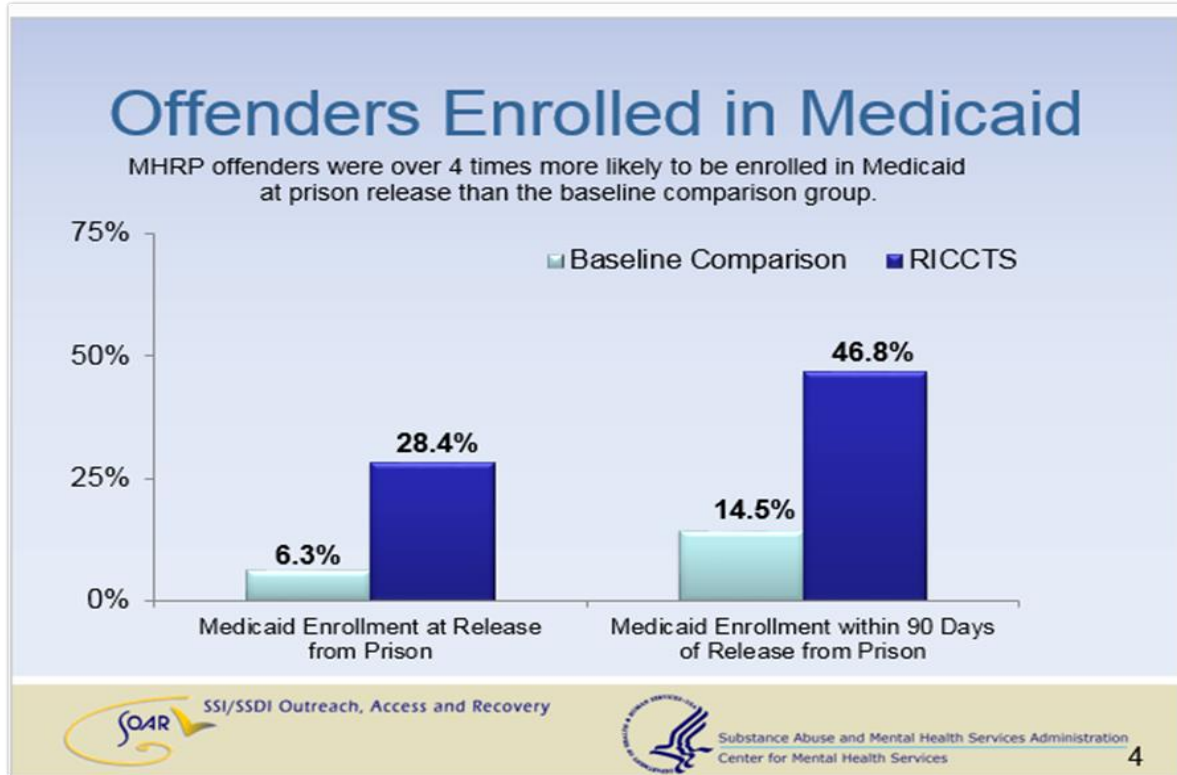


Figure 3 Oklahoma Collaborative Mental Health Reentry Program Baseline Comparison 2

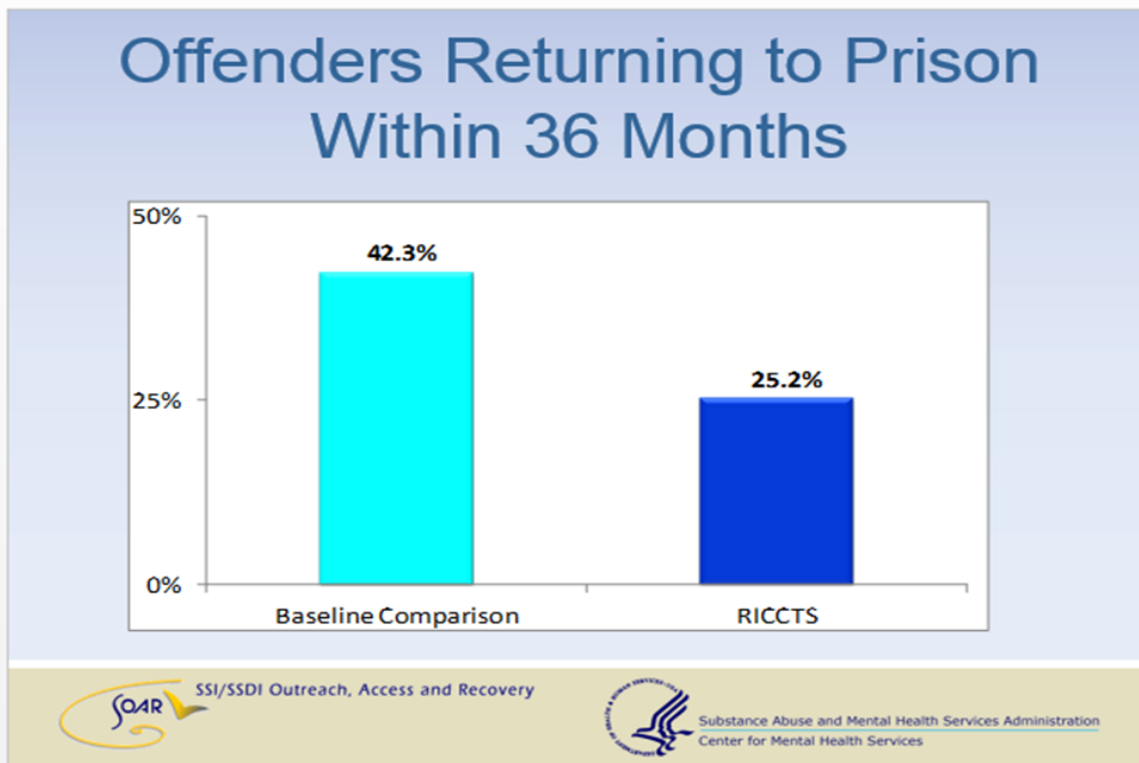


Figure 4 Oklahoma Collaborative Mental Health Reentry Program Baseline Comparison 3

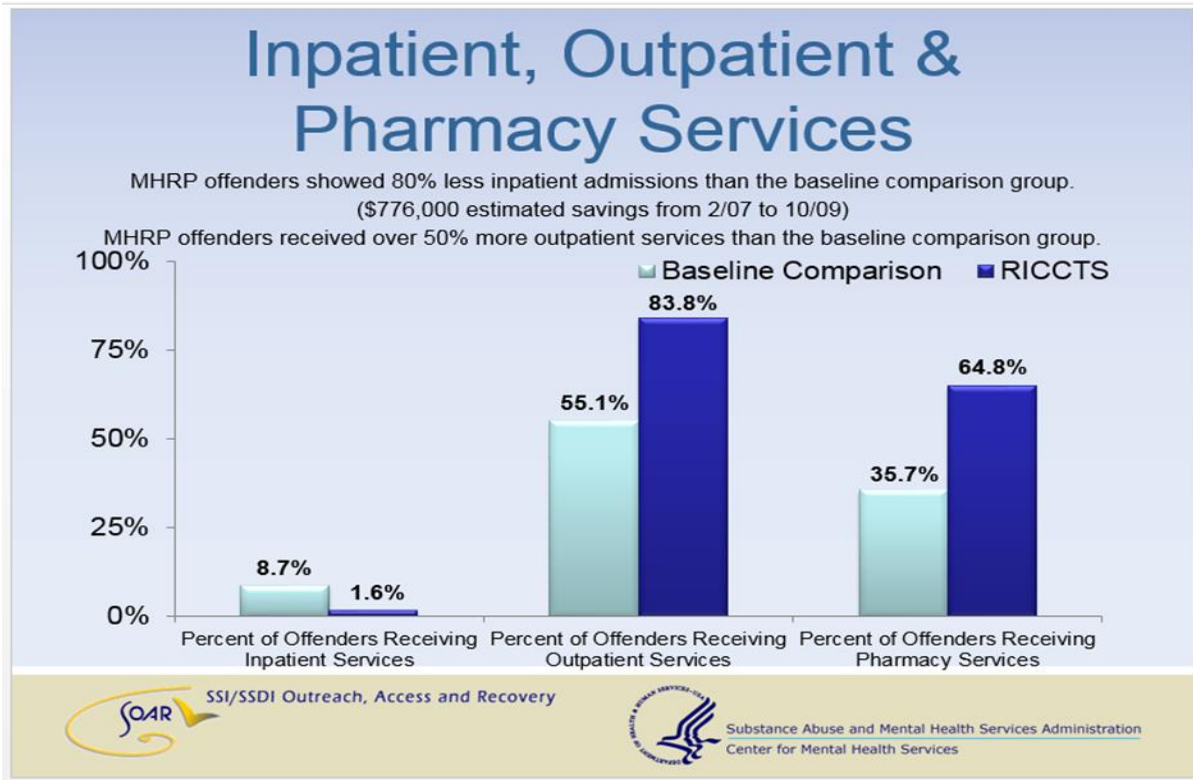


Figure 5 2010 Moving On Evaluation: Rearrests

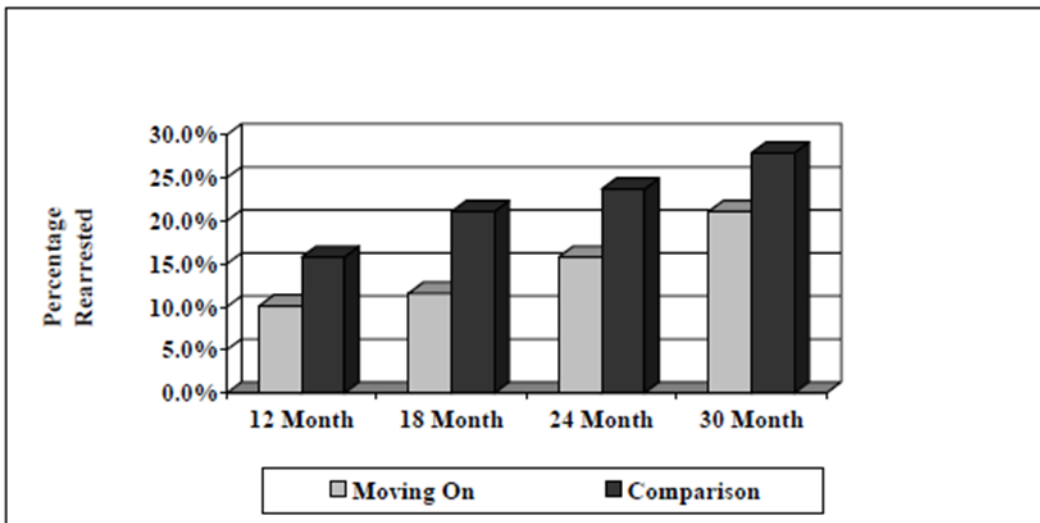




Figure 6 2010 Moving On Evaluation: Reconvictions

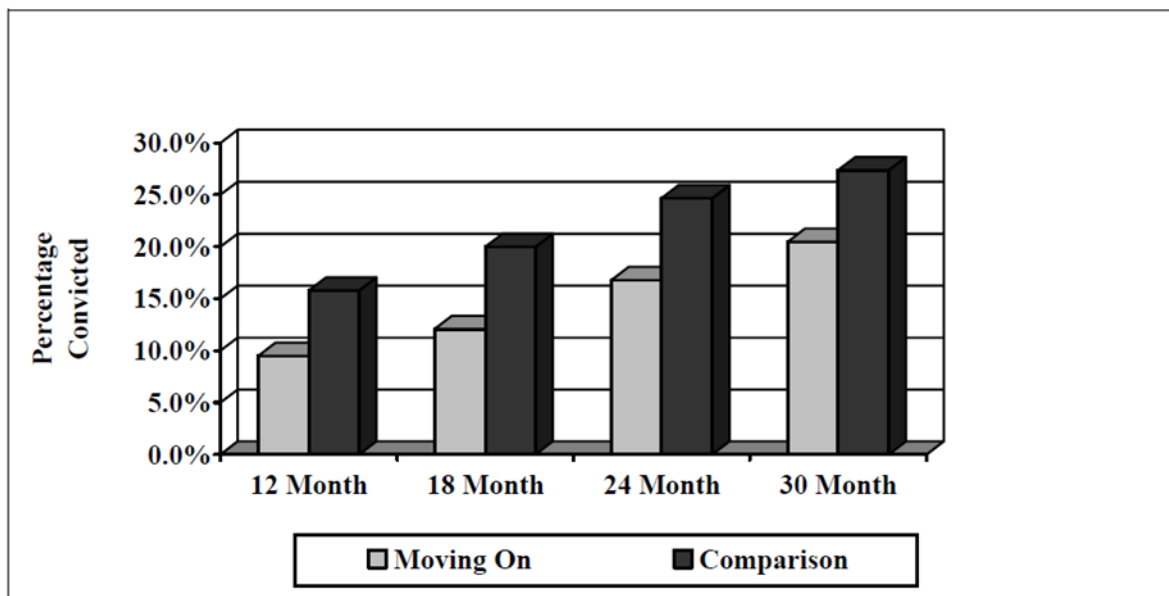


Figure 7 2014 Moving On Evaluation Cox Regression Models

Table 5. Cox Regression Models: Impact of Moving On Program Participation on the Hazard of First Recidivism Event

Predictors	Hazard Ratios by Comparisons and Type of Recidivism											
	Rearrest			Reconviction			New Offense Reincarceration			Technical Violation Revocation		
	1	2	3	1	2	3	1	2	3	1	2	3
Moving On (pre-2011)	0.695**		0.562**	0.671*		0.527**	0.828		0.666	0.945		1.299
Moving On (2011-2013)		1.125			1.026			1.232			0.874	
Propensity Score			1.126			1.283			2.291			0.869
Age at Release (years)	0.970**	0.980**	0.987	0.971**	0.980**	0.993	0.971*	0.961**	0.991	0.980	0.980**	1.001
Length of Stay (Months)	0.992	0.966**	0.987	0.992	0.970**	0.989	0.995	0.984	0.990	0.992	0.987	0.986
Prison Discipline Convictions	1.007	1.018**	1.014**	1.012*	1.012**	1.017**	1.009	1.014*	1.004	1.009*	1.021**	1.013*
Suicidal Tendencies	1.480**	1.119	1.085	1.219	1.029	1.109	1.467	1.461**	1.304	2.440**	1.762**	1.390
Visited in Prison	0.676*	0.882	0.644*	0.535**	0.980	0.498**	0.587*	0.792	0.570	0.905	0.566**	0.421**
Earned Secondary Degree in Prison	1.116	0.998	1.016	0.931	0.939	0.668	0.975	0.895	0.651	0.683	0.635	0.882
Earned Post-Sec. Degree in Prison	0.855	0.659	0.899	0.765	0.667	0.486	1.206	0.697	0.580	0.566	0.865	0.937
Entered Chemical Dependency TX	0.839	1.187	0.724	0.858	1.197	0.591	0.616	1.045	0.630	1.158	0.573**	1.085
Entered EMPLOY Program	0.931	0.849	1.041	0.835	0.783	1.213	0.608	0.625	0.586	0.418	0.745	0.487
Entered Work Release Program	0.964	0.628**	0.631*	1.003	0.501**	0.523*	0.831	0.492**	0.619	1.718*	1.250	1.146
Entered CIP	0.981	0.513**	0.625	0.834	0.322**	0.432	0.616	0.535	0.236	1.775	2.197**	1.473
Placed on ISR	1.081	0.638	0.798	0.634	0.768	0.464	0.740	0.808	0.508	2.858**	1.076	1.997*
Discharge	2.320*	0.931	1.839	2.823*	1.205	3.261	3.173*	2.225	4.294			
Supervised Release Revocations	1.149	1.002	1.664**	1.335*	1.027	1.561*	1.253	1.063	1.346			
New Offense Reincarcerations										0.683	0.852	0.623
N	430	1,720	432	430	1,720	432	430	1,720	432	422	1,709	429

\*\*  $p < .01$ \*  $p < .05$ 

Comparison #1: Pre-2011 Moving On vs. contemporaneous comparison group

Comparison #2: 2011-2013 Moving On vs. historical comparison group

Comparison #3: Pre-2011 Moving On vs. 2011-2013 Moving On

Figure 8 Affordable Care Act Medicaid Expansion Map

## Where Inmates In State Prison Can Get Help With Medicaid Upon Release

In states that expanded Medicaid, almost all exiting prisoners qualify for coverage. But some of these states only enroll select groups of prisoners, like those with disabilities. Others don't have any programs to enroll exiting inmates. In states that did not expand Medicaid, some still offer enrollment programs for select groups of prisoners that qualify.

States with programs to enroll: ■ Most prisoners ■ Some prisoners ■ No prisoners

