Provider Experiences with Prison Care and Aftercare for Women with Co-occurring Mental Health and Substance Use Disorders: Treatment, Resource, and Systems Integration Challenges

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Abstract

Incarcerated women with co-occurring mental health and substance use disorders (COD) face complex psychosocial challenges at community reentry. This study used qualitative methods to evaluate the perspectives of 14 prison and aftercare providers about service delivery challenges

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and treatment needs of reentering women with COD. Providers viewed the needs of women prisoners with COD as distinct from those of women with substance use alone and from men with COD. Providers described optimal aftercare for women with COD as including contact with the same provider before and after release, access to services within 24–72 hours after release, assistance with managing multiple social service agencies, assistance with relationship issues, and long-term follow-up. Providers also described larger service system and societal issues, including systems integration and ways in which a lack of prison and community aftercare resources impacted quality of care and reentry outcomes. Practice and policy implications are provided.

Introduction

More than three quarters of women in the criminal justice system with substance use disorders have co-occurring mental health problems (about 80%).[1] Treatment of co-occurring mental health and substance use disorders (COD) is complicated by the fact that most incarcerated women serve short sentences and quickly return to the community.[2] For example, there were approximately 111,000 women in state or federal prison in the USA on a given day in 2011[3] and 1.1 million women on probation or parole.[4] Better understanding on the service delivery needs of women with COD returning to the community from prison is of public health significance.

There is wide recognition of the need for more effective transition planning and linkages with aftercare and community care for female prisoners in general.[5–9] Lack of aftercare is a considerable barrier to positive mental health, substance use, and criminal justice outcomes for women with COD as they face the stresses of community reentry, contributing to a revolving door of COD illness and reincarceration.[8–11] Despite the clear recommendations for appropriate mental health and substance use aftercare for women leaving correctional facilities,[9–18] only 30–50% access mental health services,[15, 19, 20] and less than one third access substance abuse services after release.[15] Female offenders with COD have greater aftercare needs but are less likely than women with substance use disorder alone to complete substance use aftercare programs.[21, 22] The fragmented nature of the criminal justice and affiliated mental health and substance use service systems,[8, 9, 23–25] low rates of insurance coverage and Medicaid enrollment experienced by reentering women,[15, 26] and the complex psychiatric and psychosocial challenges and numerous barriers to care faced by women with COD[27, 28] complicate successful reentry and aftercare linkage for this population.

Until recently, little was known about service delivery for those with COD in the correctional system.[29] Recent surveys have begun to identify the characteristics of COD services currently offered for offenders in prison and in-prison aftercare,[29–31] including aftercare linkage success rates[19, 20] and systemic predictors of the availability of various COD services.[29] In addition, the Substance Abuse and Mental Health Services Administration (SAMHSA) has published guidelines about what constitutes good care for this population (e.g., in-prison and post-release access to substance use and mental health care, gender-specific services).[32] However, the best ways to achieve these general goals are still unclear,[9] given that most of the relatively sparse prison aftercare literature[9, 33–35] focuses on the treatment of either mental health or substance use (but not both together[10, 34–44]) and exclusively[40–43] or primarily[44] addresses men. More information is needed about how to best meet the treatment and aftercare needs of women with COD.

The current study is part of a line of research focused on developing behavioral services interventions for women prisoners with COD (particularly co-occurring major depressive and substance use disorders) who are approaching community release,[45–47] including a qualitative study interviewing reentering women with COD about their experiences, needs, and challenges.[45] To better understand needs and challenges encountered during the community transition process from a variety of positions, this study reports on qualitative interviews conducted with 14 prison and aftercare providers or administrators involved with treatment and reentry services for women with COD. Successful community reentry often involves contact with a large array of correctional

(i.e., prison mental health or substance use providers, discharge planners, reentry specialists, employment specialists, parole or probation officers) and community providers (mental health, substance use, housing, employment) and agencies. Therefore, providers from several different positions in the prison and aftercare community were interviewed to better understand relevant perspectives, including both individual and systemic issues and difficulties at junction points between services. To our knowledge, this is the first qualitative study examining provider's views on the needs of reentering women with COD.

Method

Participants and procedures

Participants were 14 individuals working with reentering women with COD within one state prison and aftercare system. Participants working for the Department of Corrections were identified using a modified form of snowball sampling, beginning with the first author's (JJ) contacts within the system and continuing until no new individuals were identified and all components of the department's organizational chart were represented. This approach resulted in a near-exhaustive sample of correctional employees working with incarcerated women around COD and reentry issues within the system. A few external service providers representing key aspects of reentry were also identified through this process. Participants included prison mental health and substance use disorder (SUD) counselors and program directors, prison administrators, discharge planners, gender-specific and mental health probation officers, individuals working at community housing and other agencies, and directors of various reentry services. Providers ranged in education from bachelor's to doctoral degrees. Eleven of the 14 providers were female. At least five worked in positions requiring a clinical license (such as licensed substance abuse counselors or MSWs). As is common in correctional departments,[23] the other nine providers interacting with reentering women with COD worked in positions that do not require licensure (e.g., reentry planners, parole officers, case managers, program directors, superintendent), so their licensure status is unknown. Eight of the 14 participants had 10 years or more of experience with women in criminal justice, and five had more than 20 years of experience; the system in which they worked releases 400–500 women per year.

Potential participants were contacted by the first author, who interviewed each individually to conduct informed consent procedures and interviews. A semi-structured interview protocol was used (see Table 1). There were no financial incentives for participation. The study followed ethical guidelines for research under Brown University's institutional ethics review board approval.

Qualitative analysis

Qualitative methods were chosen because they are well-suited to formative research and research designed to elucidate processes.[48, 49] Interviews were audio-recorded and transcribed verbatim. Open coding strategies[50] were used to review transcripts and generate a preliminary codebook which was iteratively refined until no new codes emerged. Using the codebook generated from the initial open coding (which results in emergence and naming of categories) and axial coding (where codes developed through open coding are related to one another) steps, all transcripts were submitted to a final selective coding process in which the codebook was validated against the data and data saturation verified.

A team of trained coders (three to four for each transcript) independently analyzed and coded each transcript with attention to relapse triggers, recovery facilitators, and desired treatment factors. Passages that most accurately reflected an emerging concept were identified and code-reconciled to represent team consensus. Team consensus codes were entered into NVivo analysis software. Open coding was initially conducted on the specific concept level (e.g., role model or mentor support);

Table 1
Interview guide

1. How long have you been working with substance using incarcerated women?
2. What do you like about it?
3. What's difficult about it?
4. What do you think happens to women as they leave prison? Who do you think does well in terms of substance use, who doesn't, and why?
   - Does this differ at all for women with co-occurring mental health problems (such as major depressive disorder)? How?
5. When you see women who have relapsed to substances and have returned to prison, are there common themes? What usually happens to them?
   - Does this differ at all for women with co-occurring mental health problems (such as major depressive disorder)? How?
6. What aspects of substance use treatment for women in prison do you think are the most helpful?
   - Does this differ at all for women with co-occurring mental health problems (such as major depressive disorder)? How?
7. What aspects of substance use treatment after release from prison are the most helpful?
   - Does this differ at all for women with co-occurring mental health problems (such as major depressive disorder)? How?
8. Do you think that there is utility in treating co-occurring major depressive disorder while women are in prison, or that much of women's life problems will resolve if they stay clean and sober as they return to the community? Why?
9. If you could design your ideal treatment program for women in prison with co-occurring substance use and major depression, that could include both in-prison and post-prison components, what would you do? (Money is no object)
   - Does this differ from the program you would design for substance-using women in prison in general? How?

during axial coding, concepts were subsequently clustered into broader unified themes (e.g., support as a treatment recommendation theme). Themes are shown in Table 2. Given our interview outline, we anticipated responses in three general topic areas: the degree to which treatment needs of our target population were specific or general, post-release relapse triggers, and treatment needs. The fourth, unanticipated, general topic area described how individual and systemic service delivery challenges impacted providers' ability to assist reentering women prisoners with COD; providers strongly emphasized the importance of these larger context issues (see Table 2).

Results

Topic 1: Who are women prisoners with COD? How specific are their treatment needs?

They are a vulnerable population

Providers universally described incarcerated women with COD as vulnerable. They described the high level of morbidity in the weeks and months following community reentry and described prison as a place that tends to collect individuals who are psychosocially at risk, "those that are particularly fragile under particularly fragile circumstances, they will end up here." Providers cited poverty,

Table 2
Outline of topics and themes

Topic 1: Who are women prisoners with COD? How specific are their treatment needs?
Theme 1: They are a vulnerable population
Theme 2: Their needs differ from those of women with substance use disorder alone
Theme 3: Their needs differ from those of men
Topic 2: Substance use relapse triggers for depressed women leaving prison
Theme 1: Romantic relationships (using, violent, antisocial, or otherwise unhealthy)
Theme 2: It is difficult not to go back to old situations
Theme 3: Family upbringing
Theme 4: Trauma or exploitation
Theme 5: Lack of support
Theme 6: Difficult life events
Theme 7: Family responsibilities
Theme 8: Discontinuity of psychiatric medications
Theme 9: Antisocial peers and the allure of fast living
Theme 10: Predicting who will relapse
Topic 3: Provider recommendations for COD treatment for incarcerated/reentering women
Theme 1: Continuity of care (contact with the same provider before and after release, access to care within 24–72 h of release, catching slips, long-term follow-up)
Theme 2: Support (including sober support, role model or mentor support, and peer support or a sense of community)
Theme 3: Mental health treatment and mental health-savvy substance use treatment
Theme 4: Treatment addressing relationship and family issues
Theme 5: Empowerment and self-esteem
Theme 6: Realistic expectations for the difficulties of recovery/life skills
Emergent Topic: Systems-level barriers and challenges
Theme 1: The criminal justice system is dramatically under-resourced relative to mental health and substance use treatment needs
Theme 2: Importance and challenges of providing structural services such as housing, jobs, and education
Theme 3: "Jumping through hoops" is a deterrent to post-release mental health care
Theme 4: Need for coordination of services (e.g., case management or wraparound care)
Theme 5: Opportunities and challenges with incarceration as part of a care continuum
Theme 6: Opportunities and challenges with parole/probation as part of a care continuum
Theme 7: Sometimes it is difficult to engage women despite providers' best efforts

victimization, and lack of education and job skills as factors contributing to vulnerability, as well as fear and a self-esteem level "at the bottom of the barrel"; "they've been told their whole lives that they're nothing." However, providers also acknowledged the women's resiliency: "When you hear their stories you just say, 'how does she function at all? That she's survived all that is pretty remarkable.'"

The needs of women prisoners with COD differ from those of women with SUD alone

Most providers viewed the needs of women prisoners with COD as differing from those with SUD alone, indicating that women with co-occurring major depression and SUD seem to get

defeated more quickly than women with SUD alone when facing the challenges of reentry: "Any woman, even without depression would feel defeated at some point when they get out if they didn't have the support and all that, but if you add in depression…you will feel defeated that much quicker. You will feel worse about yourself within two days of getting out of here because you're already in that place." Another provider described the mechanism by which a relapse might occur more quickly for women with co-occurring major depression: "I think women who are depressed [are] more vulnerable and they have less skills and less tools and less people around them. It's like a vicious cycle that I don't even think they realize they're caught in. They're depressed so they isolate so they don't reach out for help so the triggers pretty much take over and then they self-medicate. With someone who is not depressed, they're not gonna tolerate abuse, they're gonna surround themselves with more positive people, they're gonna pick up the phone and say, 'Look. I need some help.' They're gonna go to the counselor and they're gonna say, 'I need to make an appointment.'" In particular, providers noted that women with co-occurring depression seem more likely to remain in abusive relationships: "Because of their depression it may make them think they need more of the security thing…. They stay in or go into relationships or situations where if they perhaps were not depressed, would not."

Their needs differ from those of men

Most providers saw differences in the treatment and reentry needs of women and men prisoners with COD, describing women as more comfortable expressing their needs: "The male [prison] population's very closed…. Whereas the female [prison] population, we're certainly able to take more action because their disclosure's right there in your face and they'll say, 'Any help you can give me. Can you do something for me? Can I see the shrink?'" Providers indicated that relationship issues affect male and female prisoners differently with women more likely to struggle with dependency and "not putting themselves first…. Men seem to have a better sense of themselves: 'Well I'm not gonna. Hey, I'm getting life together. I'm not gonna hang around with that drug addict or whatever.'" Another said, "A lot of women sometimes come in here because they're with someone who's dealing drugs or using drugs and the person has a record and the woman doesn't, so she'll take the rap and come in. That's just one side of what goes on. Nine times out of ten when a man is arrested, the women stay by them. Nine times out of ten when the woman is arrested, the guy is gone." Given this difference, treatment with women "has to be much more relational" (i.e., focus much more on relationships). Providers further noted that women are more likely to have sole responsibility for their children after they are released, whereas men often have a female partner who has been caring for their children.

Topic 2: Substance use relapse triggers for depressed women leaving prison

Romantic relationships

Using relationships were seen as triggers: "Nine times out of ten, if a woman's going home to a family or a significant other that's drinking or drugging, she's going to relapse." Similarly, another provider said that women "follow the partner into whatever they're doing." Providers pointed out that "even if they get treatment in here, which is wonderful, their partner isn't receiving any treatment on the outside." Furthermore, women may believe that they are leaving prison to go to a drug-free, safe situation only to find out that the partner has been lying about his continued drug use and housing status. Women may also "think that, 'Oh, well he loves me enough. He's going to stop.'" Other kinds of relationships leading to relapse could be violent: "if there's a lot of violence in a home obviously the return, relapse happens a lot faster"; antisocial, "some of their biggest problems are…their boyfriends and the antisocial behavior of the boyfriend"; or otherwise

triggering, "the mindset of a lot of the women here is so kind of skewed that they don't even recognize or acknowledge that some of their relationships are abusive or really unhealthy and likely to contribute to relapse."

It is difficult not to go back to old situations

Several providers said that women relapsed when they went back to "the same lifestyle, the same circle of friends, the same environment, the same boyfriend." Another said, "If they go back to the same old same old, they're going to get the same old same old. Because I firmly believe that when these inmates leave, they really, truly intend to succeed." Providers also said that women return to prior situations because of lack of options: "The main things I hear from women coming back is lack of available housing, lack of financial support whether that's SSI's taking too long, they don't have a job and sort of a lack of resourcefulness. Rather than accessing a shelter or something they'll kind of go back to the old neighborhoods and the old behaviors pretty quickly." Finding services after release is more difficult that it is in prison, especially for depressed women: "When they're here, they roll out of bed, they walk down the hall and there's your class…[at home], they have to go out and find it."

Family upbringing

Providers see substance-free living as challenging for women who have never seen it modeled: "You've watched your mother and your grandmother smoke pot, shoot up in some families. You know, women who tell you, that was breakfast, they lined up the cocaine lines…. So where do you go from there?" Other providers noted that the women they work with are "less than motivated," but it is "almost not their fault" because "they didn't see it in their childhood;" "they just don't have a lot to draw on."

Trauma or exploitation

Providers saw women's current and past trauma histories as increasing their vulnerability to substance use relapse: "They make such compromises on their sobriety and their safety to get safe housing. Daddy, you know, sugar daddy* drives up and picks them up…. You say, this is going nowhere, but they needed a place to stay, and so this 60-year-old guy that you say, 'ugh, I wouldn't even want to be next to him in a grocery store,' picks them up because he is giving them a room and they just have to do a little something, and then you know where it's going to go [substance use], because you're already destroyed internally by having to do that."

Lack of support

Another common relapse trigger mentioned by providers was a "lack of relational support." For example, "A lot of times too, their family, they maybe were supportive the first three, four times that they came to prison but now they just cut them off which is kind of understandable. They're in a lot of pain too." This can be difficult for women: "You don't know where you're going. You have no support. Your family, I'm sure don't trust, and all the relationships and the damage and the shame. I'd go get high, too." Providers said that many women leave prison "wanting to do the right thing," but their "families have disconnected or their friends are negative supports anyway."

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*The term "sugar daddy" refers to a man (usually older) who financially supports a younger woman in exchange for sex and companionship.

Life events

Women with COD often face difficult life events after prison, which can lead to SUD relapse: "Some just have nobody…. You know it could be like they lose their job or they split up with their boyfriend or somebody dies or they have some traumatic event or some just realize they can't—like they go back to their kids and they realize they really can't pay rent and so they totally bottom out and come back to prison." Another stated, "I don't know how some of these women are walking and talking today, by some of the things that happened." Providers mentioned illness or death of children as particularly difficult events.

Family responsibilities

Family responsibilities were mentioned as a potential precipitant of post-release SUD relapse for women with COD: "Because everybody, it's all you—…as soon as they hit [the community], everybody—the men went from the family, the kids—everyone's pulling at them, pulling at them." Providers also noted that the difficulty reestablishing a parenting relationship with children or inability to regain rights to children after release can be a relapse trigger: "Have you observed that heartbreaking thing about they're dying to see their kids and I'm sure the kids are dying to see them, [but] when they come, the first thing they do is run to mom and kick her in the shins. You know, worse. Right? For having left."

Discontinuity of psychiatric medications

Women were provided with 2 weeks of psychiatric medications at release. However, community follow-up appointments to refill prescriptions often did not take place. As a result, many women stopped taking medications shortly after reentry: "They come in really sick, really either dope sick or later we get them healthy, we get them regulated, we make sure their nutrition is up, their medical needs are addressed and they get on the proper meds and then they go out. If they're not able to substantiate their meds, then they're going to go to the nearest drug to self-medicate." Another said, "Those who seem to get on their meds tend to be able to handle things a little bit differently."

Antisocial peers and the allure of fast living

Another commonly mentioned precipitant for relapse for women was "antisocial associates" and peer groups: "There's a group of women for whom sobriety is just so boring. Drug, the culture, if you're, you've got some credibility in it, is exciting…you're never going to find life like that." Similarly, another said, "The street controls…[the women] like their money, and they like their drugs."

Predicting who will relapse

Many providers said they could not predict who would use substances after release from prison: "I have been 100% wrong every time." Others suggested that getting older, going back to supportive situations, distancing themselves from substance using or criminogenic peers, and having a feasible plan for post-release treatment are good prognostic indicators. A poor indicator is when women, typically the "young ones," insist that they are "going to do it their way" or think they can recover "on their own." However, providers emphasized that there is always an opportunity for women to recover, such as one woman who had "done multiple, multiple, multiple, multiple bids. Usually a pain in the ass. This time she did a really, really, really nice bid. She went

through the substance abuse [treatment]. She went upstairs to work release and seems to be more accepting."

Topic 3: Provider recommendations for COD treatment for incarcerated/reentering women

Continuity of care

Providers' primary suggestion for treatment for women with co-occurring disorders was to do everything possible to ensure continuity of care through the reentry period through: (1) contact with the same provider before and after release, (2) providing assistance in the critical period of 24–72 h after release, (3) catching slips before they escalated, and (4) offering long-term support.

Providers talked about the necessity of contact with the same provider before and after release in order to be able to help women best after release: "The key element would be the relationship—number one—a trusting relationship between the caseworker and the ex-offender, soon-to-be ex-offender, and then to go from there." This can take time: "I wish [the aftercare providers] could build the relationship a little more in [prison]. It's really using that relational model and having that person help advocate for them to make sure they're getting access to services in the first week or two" or even "pick them up at the gate." One of the key elements to building this relationship is having a reputation for keeping one's word and providing promised help: "Because you know what? Soon as you don't, they don't call you anymore." Providers said that in a perfect world, community treatment or case management relationships would begin 90–180 days before release from prison and would be continuous after release so women are "not handed off from person to person every three months."

Providers mentioned that women may face relapse triggers within minutes of walking out of the prison, including drugs in the car or bus ride home: "We find that the first 24 h upon release is critical." Another explained, "They have to get treatment fast. They have to…. They have to know that they have a support group" because "They just—they get defeated so quickly. So quickly and they feel that once their knocked down they're done, that's it." Providers said, "Help should be readily available in the first 24–72 h after release."

Many providers talked about a need for providers to have methods to "help women who had already slipped keep from sliding into full relapse and "not have to go all the way back here [prison]." As one said, "We're talking about creating some parameters for them, so they can bounce, so they can make a mistake—and somebody will catch them and throw them back up from falling, you know what I mean? Catch them, before they go into the vortex."

Providers said that many women prisoners with COD will need long-term community follow-up, recommending community treatment ranging from 6 months to 5 years. The level of suggested care ranged from outpatient three times per week with urine drug testing to residential care, but providers agreed that some kind of longer-term support was necessary: "It takes a good two to five years for their brain to get to some kind of place where they can function, really." When asked what one thing she would want policymakers to know, one provider said, "These are women with complex problems, way beyond substance abuse. But they will abuse [substances] if there isn't treatment for the other dynamics. They don't have any place else to go. If they can't get long-term follow-up, and I'm not talking about intensive individual, I'm talking about follow-up…case management. Oh my god! And pay for it! The six-month program is just a tickler." Another explained, "It's such a long, winding road out."

Support

Providers described many kinds of support as important, including sober support, role model or mentor support, and peer support or a sense of community.

Sober support Providers said reentering women with COD need the support of others who are sober and healthy. Providers said that some women say, "Oh, I can do it alone." "No one does it alone. You've got to build other relationships into your life." Providers said that women needed "someone to eyeball you every day," "someone living a conventional lifestyle," and "a couple of people in the community that want them to do well." Finding supportive people can be challenging because, "The devil you know is better than the angel you don't know." However, one provider summarized, "If they stick with the recovering people…. I think that's the strongest thing for women. I really do."

Role model or mentor support Providers spoke highly of a state program that matched trained female community mentors with reentering women: "Having a mentor is one of the best things… they need to have someone that's not authoritative, that will go and find them, like a friend, almost." The mentors accompanied women to treatment and case management meetings because women "can't always trust those people. They need to have their own personal advocate." Providers said that mentors had more time than clinicians to listen and help women sort out how they felt and what they wanted. One said, "It was her mentor that saved her…. All these clinicians and stuff, they put together these great plans, but unless you have somebody walking with this individual to get these things done, to keep this person focused, it's not going to happen. Because they're not strong enough to do all these different things."

Peer support/sense of community In addition to general sober support, providers discussed peer support. For example, "If you want to learn to be a woman with dignity and not to use substances or whatever, you have to be around people who are doing that. And I'm gonna tell you something. Your boyfriend—and he may not be using and may not be an addict—but he's a man. He'll never teach you how to be a woman not using drugs." Providers underscored the importance of a sense of community for reentering women with COD: "What I was trying to create also was a community of women that were successful that had left prison…so other people can join that and continue to survive."

Mental health treatment and mental health savvy substance use treatment

Providers viewed mental health treatment both in prison and after release as an essential part of recovery for women with COD. One said, "Get her some kind of help for the mental health…it would put her in a better place to deal with a lot [of things]." Another described it this way: "They're depressed. If they're depressed they want to get high. Why? Drugs make you feel good…. Life is painful. It's painful now." In particular, providers emphasized the need for mental health treatment for depression, post-traumatic stress disorder, "grief and loss," and "living life without drugs." This would start with "a psych eval, a needs assessment," and continue with treatment plans and coordination among prison mental health providers, discharge planners, and probation. Providers said that mental health treatment is important because mental health problems can interfere with women's ability to function well enough to focus on substance use education or treatment and because "I don't think their depression will go away just by stopping drug use. They need to be treated at the same time, right with each other."

Another commonly mentioned issue was that the prison substance use treatment programs did not always address COD issues optimally. One SUD treatment provider noted, "This is just a substance abuse program. We don't really do mental health stuff." Other providers expressed desired for prison SUD treatment for women with COD to be less "confrontational," less focused on women admitting they have a substance use problem and on "denial," and more understanding of "the emotional component that leads to the drinking."

Treatment addressing relationship and family issues

Providers wanted treatment to address relationship issues and healthy boundaries: "I hear lots of kind of relational aggression type behaviors [in prison], lots of abusive things in here and private sessions. I hear a lot of people complaining that so and so is touching me inappropriately. Is going through my things, is, and there's just this complete lack of boundaries or accountability." Many also wished they could do more family therapy, while women are incarcerated.

Empowerment and self-esteem

In addition to empowering women by providing them with education, resources, and support, providers wanted to help women increase their "self-esteem and self-image." Providers wanted women to learn to value themselves and their own well-being, despite past victimization. They tried to do this by forming groups of women to help each other by bringing in an "empowerment coach" to help women change their thinking or by reframing women's street survival skills as pro-social assets: "You can remember how to manipulate A, B, and C. Let's use these powers for good!"

Realistic expectations for the difficulties of recovery/life skills

Providers said that "sometimes the substance abuse treatment creates unrealistic expectations," and sometimes, women think that once they decide to recover, things should be easy. Providers said that both providers and women should have a clear sense of how much footwork, perseverance, and effort is required for successful reentry and dual recovery and that women needed to be prepared to persevere through challenges and setbacks: "I think it's one thing to sit in prison and make a plan. It's another thing to step out that door and really see what it's like." Providers also said that women needed education about and practice using life skills such as goal setting, planning, and backup planning (e.g., "What do you do if you might have to miss work?" and "How to function in the real world"). Another was more specific: "Teach them just something basic like how to keep notes about phone calls, how to date things and who did you call, what did you, what was the number, who'd you speak with, what the message because most of these women are going to interact with a million social service agencies." One provider suggested a stepped release model so that the prison could coach women in these tasks as they transitioned their care to the community.

Emergent topic area: systems-level barriers and challenges

Although we asked about COD treatment techniques and approaches, providers frequently discussed systems-level issues and barriers impacting care, such as lack of resources for appropriate care, emphasizing the importance of these larger context issues.

The criminal justice system is dramatically under-resourced relative to mental health and substance use treatment needs

Providers nearly universally felt they lacked the resources to provide the care women need. One stated, "My problem in mental health is I don't have enough resources to provide them counseling and psychoeducation in addition to medication management. I could use a lot more. Oftentimes we're just treating crises, we had gotten away from that somewhat but now I'm having staffing problems so we're back to more crisis management." Providers expressed a desire for more professional resources related to trauma and boundaries, treatment aimed at victims rather than just perpetrators of partner violence, anger management for women, more vocational training and work-release programs for women, and a mental health day treatment unit for women. In contrast

to this diversity of desired treatment, one provider noted that many of the classes offered to women were spiritual in nature because they were no-cost; community volunteers come in to teach them. Providers wanted the classes "that we need…the anger management. The right domestic violence…. You are in for domestic [assault] and your biggest need is to learn how to manage your anger and the only thing I can offer you is why don't you see [the social worker] once a month? And work on that. Okay well, I'm here for three months. Okay so you'll see [the social worker] three times. It's better than nothing. But how is that going to impact her at all? It's not."

Because the prison budget did not allow them to hire more people trained to provide psychotherapy (such as MSWs), prison mental health and substance use services primarily offered psychoeducation rather than psychotherapy. Providers viewed the effects of psychoeducation alone as limited and felt that existing psychoeducation programs did not provide women enough opportunities to explore feelings, work on cognitive restructuring, and learn coping skills: "Our trauma classes are…just basically education level and don't dig down. [Women] wish they had a trauma 2 class," and "I've got plenty of women who can teach me substance abuse education. But they can't stop [using]." To remedy this problem, one provider said that in a perfect world, she/he would "find grant money and get programs and I would try—I would get more social workers. Are you kidding me? We should probably have three in each building. Why shouldn't you be getting therapy every week?" As one treatment director explained, "We don't have enough resources…. I mean it's so hard, it's—and this is just a fault of, it's a societal issue. Prisons are being asked to do stuff that they're not really set up to do."

Providers also said that a lack of resources for discharge planning within the facility and for community-based aftercare outside the facility negatively impacted community reentry. They explained that good discharge planning is essential for successful reentry and said that individualized treatment plans are important because "what works for one woman doesn't work for another woman." However, creating an individualized aftercare plan could be challenging because it takes time and assumes that real options exist. In contrast, providers described limited availability of appropriate community care and substantial competition for state-funded aftercare slots: "Historically, we had residential treatment or we've had outpatient…. It didn't really matter what your need was you just got put into what was available and that still happens to some degree." In addition, a chronic shortage of discharge planners meant that many women did not receive any discharge planning at all and were released without clear housing or treatment plans.

Importance and challenges of providing structural services such as housing, jobs, and education

There was strong, nearly universal agreement that women with COD need access to "safe and secure housing," jobs, and a way to pay for health care at community reentry. They explained, "You can't get to counseling or get to work if you don't have a place to live." Providers also mentioned "education," "employment skills," or a "marketable trade" as very important because "without employment they don't have insurance."

However, providers also described many challenges in trying to help women obtain these services. Barriers to employment included lack of confidence or impatience: "A lot of these women don't think they can work. They think that just because they haven't had a job before that they don't have skills; they don't have the ability to do it. Just their thought of, 'Well, I have felonies'… blocks them off from even trying." Providers described some women as less than interested in the entry-level jobs available to them, especially given how easily they made large sums of money illegally: "The toughest thing is getting these women motivated to work. They'll come up with 100 excuses why they won't work at McDonalds or why they won't work at a subway shop." Another noted, "That step by step thing is hard," but that pressure from the courts to look for work can help women become more motivated.

Providers also described challenges providing housing services. Many women were discharged from prison to a homeless shelter, but many women with addiction would rather live in the street than in the shelter because of drug traffic in the shelter. The prison did partner with a community agency that would help women get into housing. However, that agency described a struggle between wanting to place women directly into housing at release versus needing to establish post-release commitment to recovery before providing apartments: "We get people, they come in, they say all the right things. They want all these services. We house them, we never see them again. They're in permanent housing. Now they do what they want. The landlord's calling us up, 'You got to do this and we need them out.'…. It's difficult. It costs thousands of dollars to remove people out of the apartments, and then there's a breakdown in the relationships with the landlords, and they don't want to rent to us. You've got to balance all these things in helping them maintain their housing." Other providers agreed that access to housing and employment is important but will not be an entire solution if women are surrounded by antisocial associates and/or are not attending treatment. One provider described a woman she had placed in a new apartment: "She is smoking crack and she's smashed her windows out. She hasn't unpacked anything." Another said that pimps have said, "Thank you for getting her a place, getting her food stamps, GPA and all that. We appreciate that but [she's] still with me."

A final barrier to helping women access basic needs such as housing, employment, and food described by providers was a lack of trust in institutions: "They don't believe that people are really there to help." One provider explained that unlike other populations of low-income women, "I would have to sometimes talk to [the women in prison] about you should get food stamps and you should do this and they don't want anything to do with benefits because they don't want anything to do with authority." Similarly, "Not only did they not trust the people that raised them, people around them, but they don't trust systems."

"Jumping through hoops" is a deterrent to post-release mental health care

There was a strong consensus about the need for aftercare for women, but providers described a mismatch between women's expectations and resources and the steps required to engage with the public mental health service delivery system. Providers said that women sometimes "left [prison] with the intention of going to outpatient counseling [but] they often don't follow through with it" or saw the effort required to engage in aftercare as a "hassle." As one provider described, "[In prison] they have all of this support right at their fingertips, I mean literally steps away from where they're sleeping…. Peer support, counseling support. The mental health worker on the wing is right down the hall…[then] when they leave, it's like, nothing. 'Whaddya mean I gotta call and make an appointment? Whaddya mean I gotta wait three weeks?' 'No I don't have insurance.' Yeah. Then, what are they doing in that three weeks? Do you really think they're sitting quietly and reading books?" Another explained how missing one appointment can challenge a woman's treatment episode: "So someone like this didn't show up okay?…and then they call back and they have to wait or they owe $30.00 and they can't come back. So then it's like this person is struggling, teetering on going back to drugs. And it's like they're screwed because they can't get their mental health appointment and they have to go through hoops."

Need for coordination of services (such as case management or wraparound care)

Because accessing one kind of service, let alone many, during reentry could be overwhelming for women, providers consistently described a need for someone to coordinate treatment, housing, job training, and other services: "Case management matters. Somebody who really kind of is looking at all the stuff they need. I think they all have multiple needs and they all need to be case managed. They all need somebody who is coordinating it." An additional way to provide this

support was "Transitional housing, step-down supportive apartments, where somebody does check in every day….Who eyeballs them and says, 'okay, how was your day?'" "Everything needs to be in one spot for them at first…everything under one roof would be excellent, if you ask me. Then as time goes by and as they get better then maybe they're more independent." Another said that her perfect program would be to buy a city block and provide substance use treatment, mental health treatment, supported housing, job training, parenting classes, education, and medical care on-site to reduce barriers to accessing these services.

Opportunities and challenges with incarceration as part of a care continuum

Providers recognized that the prison system has become a de facto service delivery system for many poor, disenfranchised individuals. Even though providers wished that more women would be diverted to treatment programs instead of coming to prison, they saw prison as a potential teachable moment, with few distractions, where people are sober and in a "healthier mental and physical state" than they would be "on the street": "It's great to start that work with them in [prison]…. They're vulnerable. They are more honest with you and they're more honest with themselves. Once they get out, they have to turn into a different person" to survive in often tough environments. However, in addition to other challenges with prison as a care delivery system, providers said that women's short sentences (often a few months) limited time to address dual recovery and psychosocial challenges: "Some of these women have been using for 14 years. You think six months is enough? That's only the tip of the iceberg," and "You're not gonna undo 20 years of trauma in six sessions." Another described wanting to divert women with under a year to serve because "they're not there long enough to really intervene…. It's not a long enough period of sobriety, it's not long enough to build any kind of system for them out there."

Opportunities and challenges with parole and probation as part of a care continuum

Providers saw community corrections (i.e., probation and parole) as an "opportunity to intervene" because "I don't think really they should have a choice [about post-release treatment], because they don't want to choose anything that's uncomfortable and change is uncomfortable." Probation or parole officers tried to help women attend aftercare by requiring women make their legally mandated reporting visits at treatment facilities or locations of other needed services. However, they wished for more options for sanctions other than a dichotomous choice to send the woman home or back to prison, especially tools for helping women analyze slips and avoid them in the future: "We just punish and we don't say, 'what have we learned from that?'" For example, providers wished for the option to reincarcerate women for shorter lengths of time (a weekend, a few weeks) to "dry out, stabilize, come back out" and liked an existing specialized caseload that required women with positive urine drug screens to make more frequent parole visits where "I can eyeball you and say, 'are you using today? What did you do? Where did you go?'"

Sometimes it is difficult to engage women despite providers' best efforts

Providers were invested in improving care for the women they served and expressed frustration at the limitations of the system and of existing treatments but also acknowledged that they "can't force women" or "make them interested if they're not." One prison provider explained, "I remember when I first got here and I'm walking down the halls and trying to ask people what they wanted and I'd get all these programs and then I'm chasing them all to do the programs and to sign up and then they don't even show up. I'm like 'you guys complain all the time that there's nothing to do and then I get you guys programs and you don't even go.'" An aftercare planner described a similar experience: "You can do hours and hours of work for aftercare for someone and then have

them walk out into the lobby, say 'I'm going [somewhere else]' and say goodbye." Another summed up, "I mean unfortunately some people I just lose my mind with. Because there's only so many times I can tell you. And I almost sense it. I can almost see the defeat in their eyes and I sense it that they're just—they're not ready."

Discussion

Providers described reentering women prisoners with COD (major depressive disorder in particular) as a high-risk, vulnerable population. They viewed women prisoners with COD as having needs that differed from women with SUD alone (e.g., fewer emotional resources to cope with problems) and from men with COD (e.g., more open to providers but also more relationally vulnerable). Findings are consistent with prior quantitative studies indicating that drug-involved female prisoners are vulnerable in many ways. In particular, they have poorer vocational skills, lower education, higher levels of depression and other co-occurring mental health disorders, and poorer health and are more likely to have drug-involved spouses, friends, and family members relative to drug-involved male prisoners.[39, 51–53] Furthermore, female prisoners are more likely than males to report that the main reason that they used drugs was to alleviate emotional or physical pain (as opposed to "enjoying it").[51] Providers in this study were clear that reentry is difficult for women with COD, especially given these contextual challenges. Providers identified many triggers for women's relapse to substances after prison release, including problematic or using relationships, trauma or exploitation, lack of social support, and few emotional and practical resources for addressing challenges or difficult life events that occur during the reentry period.

Providers were particularly concerned about women's tendency to be in unhealthy relationships to try to meet their emotional or practical needs. Consequently, providers wanted treatment options that could provide women information and skills to develop healthy relationships as well as the sense of self and practical resources to avoid exploitative ones. Providers also mentioned several different ways for women to build a network of sober supports to help them with dual recovery and reentry. Providers' concern about the supportiveness versus exploitativeness of women's relationships is consistent with gender-specific theories of substance use which highlight the importance of empowering relationships for women.[54]

Given these contextual challenges, providers were clear that continuity of care and a high level of support are essential for reentering women with COD. This included the ability for women to have relationships with at least one helping professional that began in prison and extended into the community, the need for emergency help that women could access in the first 24–72 h after release, and the opportunity for long-term follow-up. Providers also discussed the need for support to help women manage multiple problems and contacts with numerous social service agencies. Providers had many ideas about the form this support could take, including wraparound services, case management, supportive housing with on-site professional services, mentors, coaching with basic life skills, or reentry specialists who worked with probation officers; the overarching need was for someone to check in with women frequently (even daily) and to be available to listen to their concerns and to accompany or coach them through procuring needed services and resources.

Agreement among providers on the need for continuity of care, the salience of relationship issues, and the need for someone to be available to help women manage the complexities of reentry was striking. In addition, there was good agreement between relapse triggers and treatment needs described by providers and those described in a companion study examining the perspectives of women prisoners with COD.[45] Both providers and women identified relationship and mental health factors as triggers for substance use after release from prison. In fact, when presented with a similar list of more than 20 potential relapse triggers, both providers and women identified the same most common trigger item: "being with the wrong people." Both identified a need for comprehensive services that would address mental health, substance use, family, and housing/employment issues

and identified similar barriers to the successful use of these services. Specifically, both said that access to services can be spotty and confusing (both used the language *jumping through hoops*) and both saw a need for a single, identified, familiar person who could help women access and manage a confusing array of service needs. In addition, providers and women described the need for sober supports, including professional, practical, and emotional support, as critical for successful mental health and substance use recovery during community reentry. Both identified access to housing and employment as important. Finally, providers and women described a need to help women build motivation and confidence to make needed changes and to work on self-esteem and self-care.

As a psychology-based team, we designed qualitative interview questions to gather information about the most helpful behavioral treatment techniques, but providers' responses overwhelmingly focused on system capacity issues described in the emergent fourth topic area (see Table 2), especially lack of resources to provide adequate mental health and substance abuse treatment. This emphasis on systems' capacity problems is consistent with a recent review which suggested that systemic issues including (a) inadequate discharge treatment programs and discharge planning services during incarceration, (b) an insufficient number of public mental healthcare programs in the community, and (c) community mental health treatment programs that are not directed to the treatment needs of returning prisoners or are unwilling to provide services for them likely play a role in prison aftercare service linkage failures.[35] A recent model of prisoner reentry for individuals with mental illness framed these interactions of service systems as part of a larger social context.[55] This model explains reentry as a social welfare issue that involves resources for the family and the community as well as for the individual, suggesting that reentering individuals' needs and risks is more accurately understood in the context of a community's willingness and ability to accommodate them.[55]

Another complexity highlighted in our findings and echoed in others is the issue of how much responsibility for change is borne by the women themselves, how much is borne by the individuals and systems that seek to serve them, and how much is related to larger societal issues such as poverty and discrimination. Providers in this study assigned responsibility to all three, recognizing that they *can't force women* or *make them interested if they're not*, but that (a) practical barriers can make successful reentry next to impossible and that (b) a lifetime of victimization and lack of access to resources can leave women without the confidence or skills to actively manage new opportunities when they are provided. Qualitative studies which have interviewed general populations of reentering women (not women selected for COD) have described how the identical, overwhelming problems facing women prior to prison greet them at release.[56, 57] These studies have documented how the demands of the parole and probation systems, housing, employment, treatment and recovery, taking care of their children, and protecting themselves from victimization can be mutually exclusive and harrowing, especially without reliable transportation or money.[56, 57] For example, many programs for partner violence victims will not help women with addiction or criminal records.[56] Similar to providers' perceptions in this study that prison treatment sometimes creates unrealistic expectations for the difficulties of recovery, one study found that in-prison programming emphasizing that women's future and choices were up to them alone did not accurately reflect women's realities and led some to blame themselves for their inability to access services in communities that did not have services.[57] This programming emphasized the danger of returning to old social networks in which drug and alcohol misuse was common; however, many women had few other options for survival.[57] In contrast, the capabilities approach described by Kellett[57] asserts that because of structural inequalities, including class, ethnicity, race, disability, gender, and sexual oppression, providing resources to individuals do not necessarily bring differently situated individuals up to an equal level of capability to function.[58, 59] Therefore, the ability of women to function requires not only individual freedom to act but also a supportive social, cultural, and political environment that affects the capacity to act.[57, 60]

Strengths of this study include description of provider experiences and perspectives on the treatment of a high-risk and understudied population. Understanding day-to-day provider's needs and challenges can guide intervention development and implementation/dissemination efforts by providing information about the likely acceptability of new interventions or delivery methods. In addition, because providers work with a broad range of incarcerated women, they are able to identify facilitators and barriers to care on individual and system levels, issues with gaps between services, issues affecting quality of care, and struggles to provide services to a complex population.[50, 61–63] Finally, the study's qualitative approach provides a rich description of provider's views on how behavioral health and criminal justice policies affect this vulnerable population. However, the study has limitations. The sample is small ($n=14$ individual qualitative interviews). Participants came from one state system, and it is unclear how their views translate to other areas of the country. Nevertheless, the study provides an initial understanding on the complex treatment needs of incarcerated women with COD and presents potential solutions to effectively address these challenges.

Implications for Behavioral Health

Results of this analysis, integrated with the existing literature, have implications for treatment approaches for reentering women with COD as well as for criminal justice and community service system policy approaches to justice-involved individuals.

The following are implications at the treatment level:

- Relationship problems and depressed mood are triggers for substance use relapse after release. Substance use and mental health issues are intertwined. Both should be treated.
- Relationships with providers (including parole and probation officers) matter.[45, 46, 64–66] Be validating and respectful.
- Relationships with other matters.[45] Treatment should address relationship issues, including violent or conflictual relationships and worry about children. Strategies for improving women's access to and familiarity with specific positive, sober social supports in the community before reentry are needed. These may include mentors, sponsors, recovery coaches, or conducting in-prison family therapy with estranged family members. Getting partners and family members into treatment is a plus.
- Continuity of care is important. This includes contact with the same provider before and after release, access to services within 24–72 h after release, a nonpunitive method for helping women with slips before they become full-blown relapses, and long-term follow-up. None of these suggestions are typical for the current service delivery system.
- Many women need a single, identified person to actively help them coordinate multiple services (e.g., mental health, substance use, housing, job training),[45] especially since accessing community treatment can be challenging.
- As providers, have respect for the difficulties of reentry, especially in the context of COD and partner violence. Prepare women for these difficulties. Be thoughtful about the balance between helping women take responsibility where they can and providing them with concrete assistance to overcome structural and other barriers.

The following are implications at the policy level:

- Prison and jail mental health and substance use treatment are under-resourced, as are discharge planning and affiliated community mental health and substance use treatment.[26, 67, 68] More resources are needed. This issue is complex,[69] but possibilities include the following:
  - Advocate for more resources.[68] Consider ways to help voters and legislators understand the degree to which prisoner health is community health, given how many people are incarcerated in the USA, how many are nonviolent, and how quickly they return to their communities.

- Compare the costs and cost-effectiveness of incarceration, diversion, community supervision, and related prison and community mental health and substance use treatments on a societal level, recognizing that reducing costs in one system may increase costs in others.[69] Examine the advantages, disadvantages, and overall cost-effectiveness of "service extenders" such as community volunteers and bachelor's level providers of psychoeducation, relative to more highly trained treatment providers. Disseminate results to policy-makers.
- Examine ways to better allocate existing public safety and public health resources (e.g., among community treatment, incarceration, diversion, reentry) to improve public safety and public health.[35, 68] This may mean the following: (1) more people in community treatment and fewer people incarcerated and/or (2) better treatment and service matching. Some initial efforts have produced excellent, cost-informed policy analyses and recommendations;[26, 67] put these into action.

- Integrate efforts of the mental health, substance use, and criminal justice (including prison, jail, parole, and probation) systems,[26, 68, 70] including services for women who are victims of partner violence.[56]
- Find ways to incentivize outpatient community behavioral health systems to be easier and quicker for reentering women to access and more flexible and responsive in providing care as needed, especially in the first month of reentry. Having more community providers who are willing to treat justice-involved individuals and are knowledgeable in reentry issues would be helpful.

In summary, providers we interviewed were invested in improving care for the women they served. They were optimistic about women's ability to recover but acknowledged that women face daunting personal, interpersonal, service access, and societal barriers to maintenance of COD recovery and successful reentry. All thought that existing treatments, service delivery systems, and the structure of the criminal justice system itself could be improved to better meet the needs of justice-involved women with COD. In particular, they described a need for more treatment resources both in prison and in the community and more system integration. Given that one third of women imprisoned in the world are imprisoned in the USA[71] and that almost all will rejoin communities[2] that take on the costs of their untreated behavioral health conditions, a thoughtful, integrated approach to treatment and to resource allocation is needed.

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