Ineffectiveness of Prison-Based Therapy: The Case for Community-Based Alternatives

Policy Report
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By Susan Sered[1], Erica Taft, and Cherry Russell

Executive Summary

Purpose and Scope: In light of imminent plans in Massachusetts to build a new women's prison that purports to be therapeutic, this report investigates recent scholarship on the effectiveness of mental health, trauma and substance use disorder treatment for women during incarceration.

Methodology: A literature review was conducted using articles drawn from the major social science and criminology databases and journals, from 2005 to the present.

Findings: Of the 200+ studies reviewed, few track long-term outcomes of therapeutic interventions carried out in prisons or jails. The small number of methodologically rigorous studies indicate that prisons and jails are not suitable sites for effective therapeutic interventions, based on the following findings:

- There is little evidence that mental health services in prison are of benefit to women after they are released (Liebman et al., 2014; Severson et al., 2020).
- There is little evidence that in-prison treatment ameliorates trauma symptoms (Yoon et al., 2017). This is particularly important given that most incarcerated women are survivors of significant trauma.
- Incarceration in and of itself often retraumatizes women and damages women's mental health (Owen, 2020).
- Intensive prison drug treatment is less effective than out-patient programs (Beletsky et al., 2018).
- People who are involuntarily committed to drug treatment are more than twice as likely to die by overdose after they are released as those who complete voluntary treatment (Massachusetts Department of Public Health, 2017).
- Drug overdose is the leading cause of death after release from prison, especially for women (Evans & Sullivan, 2015).

Recommendations: The evidence is too weak to recommend any specific prison-based programs as effective measures for improving the health and well-being of women. While therapeutic programs in prison may help alleviate some of the stresses of incarceration, the harms of prison are far greater than the benefits of in-prison programming for women. Given these findings, we recommend alternatives to incarceration that provide community-based practical assistance with the following:

- secure housing,
- support for family unification,
- facilitation of relationships within the wider community,
- accessible and culturally appropriate health and substance use services, including harm reduction programs (Calhoun et al., 2015; Tadros et al., 2019; Goshin & Byrne, 2011; Buhse & Schafer, n.d.), and
- restorative justice programs.

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Introduction

Authors' Expertise

Dr. Sered is Professor of Sociology and Criminal Justice at Suffolk University. Her research for the past three decades has focused on the health and well-being of women inmates, formerly incarcerated women, women in prostitution, elderly women, and women living with chronic illness.

Ms. Taft is a dual-degree Masters of Social Work/Juris Doctorate student at Boston College.

Ms. Russell is Visiting Scholar at the Center for Women's Health and Human Rights at Suffolk University. She holds a Masters of Social Work degree from Salem State University and a Bachelor of Science degree from the Massachusetts Institute of Technology.

This report presents a review of recent scholarship regarding effectiveness of mental health and substance use disorder programming for incarcerated women. The review is of particular urgency in light of plans in Massachusetts to build a new women's prison billed as setting "a higher standard for women's correctional centers," with a focus on "rehabilitation" and therapeutic services (Schoenberg, 2019; Division of Capital Asset Management and Maintenance Designer Selection Board, 2019, p. 5).

Throughout the United States being African American or Latina, poor, and/or insecurely housed is associated with elevated rates of incarceration for both women and men (deVuono-powell et al., 2015; Bishop et al., 2020). In comparison to men, women tend to be charged with fewer and less serious crimes, serve shorter sentences, are more likely to have been the primary caregivers for minor children before incarceration, and—of particular relevance to this report—are in significantly poorer health than their male counterparts (The Sentencing Project, 2020; Sawyer, 2018; Bronson et al., 2017).

The large majority of incarcerated women in the United States live with physical and mental health challenges, often in the wake of childhood abuse and/or later assault by intimate partners and strangers. Many struggle with substance use, and nearly all are involved in the institutional circuit of juvenile facilities, drug treatment centers, mental health programs, and homeless and battered women's shelters for many years before and after incarceration (Sered & Norton-Hawk, 2015).

A substantial body of literature documents the ways in which incarceration damages the health of women. Disruptions in relationships with healthcare providers, loss of family contact and social support, and barriers to housing and employment after incarceration all have deleterious consequences for women's well-being. Prison conditions including noise, crowding, lack of privacy, substandard diet, insufficient fresh

The State of the Scholarship: Inconsistencies, Confusion Regarding Outcomes, Publication Bias and Other Flaws

air, harassment and ongoing threats of violence and punishment are further associated with negative health impacts (Brinkley-Rubinstein, 2013; Owen, 2020; Harp & Oser, 2018). Women in prison face a greater likelihood of disciplinary action and more severe consequences for minor infractions than men (Shapiro & Pupovac, 2018). Incarcerated women harm themselves at substantially higher rates than women outside of prison (Dye, 2011), and in studies conducted in the U.K. women in prison were found to harm themselves at rates more than ten times higher than incarcerated men (Hawton et al., 2014).

The most comprehensive published study tracking long-term health impacts of incarceration on men and women was conducted in Sweden. Skogens et al. (2019) conducted a 30-year follow-up study of 1,163 men and women treated in residential care for drug problems in 1982–1983. Among the most important findings: Imprisonment was a strong predictor of mortality for women, but not for men. Women who had spent time in prison or jail died at significantly higher rates than women who had not been incarcerated prior to intake. Losing custody of children also constituted a risk factor for mortality among women, but not among men. And, perhaps most pertinent to this report in terms of treatment efficacy for women, "[Drug] treatment dropout was a significant risk factor for premature death among men, but not among women."

With these considerations in mind, this report investigates the state of recent scholarship regarding effectiveness of mental health and substance use treatment for women in a prison or prison-like facility.

Our review of over 200 studies (including ethnographic, quantitative, mixed-method and multi-site research, as well as meta-analyses) revealed a field plagued by significant methodological flaws.[2] Despite a fairly large corpus, nearly all studies in this realm are characterized by small sample size, barriers to access to research participants, self-selection bias, lack of control groups, low rates of participant retention, over-reliance on self-reporting, and—perhaps most problematic of all—lack of attention to disentangling individual behavior from the effects of criminal justice system policies and systemic racism (cf. Pelissier et al., 2007; Mosher & Phillips, 2006; Prendergast et al., 2003; King, 2017).

Few studies track outcomes of correctional or therapeutic interventions over extended periods of time (Skogens et al., 2019). We are struck by the Karlsson et al. (2015) study of a brief prison-based program for women exposed to sexual trauma. While participants indicated some improvement in their symptoms at the end of the program, the authors emphasize, "A final

limitation is that the measures that were used in this study were selected primarily based on brevity. This precluded analysis of changes in severity of PTSD symptoms following group treatment" (Karlsson et al., 2015, p. 613). In sum, the effects of this study are only limited to the short-term, and have no clear indications for long-term impacts of program participation.

In their meta-analysis of studies of effectiveness of continuing care for substance use disorders Blodgett et al. (2014) similarly notes, "A limitation of the published reports was that most presented findings from analyses based only on participants who were successfully followed-up. It is unclear how this study feature may have influenced the outcomes. Participants may drop-out and become lost to follow-up either because they are doing well and feel they no longer need formal treatment or, on the other end of the spectrum, because they have relapsed and cannot be located or do not want to reveal their condition to researchers or treatment staff" (p. 95). Even the studies that make vigorous efforts to follow up with all participants typically cannot find half or more of the participants. Thus, they have no idea what has happened to them or whether the half (or less) they

have managed to find are in any way representative of the full participant cohort. (Cf. Perry et al., 2019 and Werb et al., 2016 for similar observations. For discussions of publication bias favoring program effectiveness, see Mitchell et al., 2017 and Auty et al., 2017.)

The fragmented U.S. healthcare system, absence of federal mortality data, state by state variation in reporting data, and lack of funding for long-term studies present enormous challenges to conducting research that follows participants for meaningful periods of time. As a consequence, even in the most rigorous studies, **effectiveness typically is measured by short-term (three- or six-month) follow-ups or even less robustly, by rates of program completion.** These measures shed little light on how various programs and policies impact the life trajectories of justice-involved women and men and preclude grappling with what kinds of outcomes are truly meaningful.

Following a comprehensive review of research examining the impact of federal, state, and local prison programming on post-release recidivism Byrne commented that while some programs show "modest" effects, "Unfortunately, there are too few high-quality evaluations available to offer any firm assessment regarding the impact of [U.S. Bureau of Prisons] programming on inmate success after release to the community" (Byrne, 2020, p. 4). Indeed, Byrne (2020) concludes, "[I]t appears that individuals will desist from crime upon release from prison based on a variety of individual and community level factors not directly related to the availability and/or quality of prison programming" (Byrne, 2020, p. 10).

The current state of the field may best be summed up by a 2020 study looking at women's mental health service utilization in prison. Severson et al. (2020) concludes that while mental health

services in prison can partially protect some women from some of the strains of being in prison,

Findings

there is **little evidence that these services are of much benefit after they leave prison**.

Prison-based trauma-informed[3] and gender-sensitive mental health programs

Incarcerated women are significantly more likely than incarcerated men to access mental health counseling and participate in clinical and non-clinical addiction treatment, including self-help groups. They are also more likely to be given psychotropic medications (Koons-Witt & Crittenden, 2019; see Auerhahn & Leonard, 2000 on overuse of psychiatric medication as "chemical restraints" for incarcerated women). However, there are few studies demonstrating significant effectiveness for any of these approaches. "Trauma and related mental health disorders are common among incarcerated women, but **empirically sound mental health interventions are lacking in prisons"** (Liebman et al., 2014, p. 894).

In the most comprehensive meta-analysis to date, Yoon et al. (2017) identified 37 high-quality randomized clinical trials (RCTs) measuring mental health outcomes of psychological therapies provided to prisoners. While some studies showed a moderately positive short-term effect, these effects were not sustained on follow-up at three and six months. Of particular relevance for women, **trauma symptoms proved consistently less amenable to treatment than did** other mental health problems such as depression or anxiety.

Trauma-informed therapeutic programs are designed to encourage clients (patients/participants) to acknowledge the extent of their trauma and to engage in a variety of practices aimed at promoting recovery and wellness. Some of the best-known programs include Seeking Safety (National Institute of Corrections, 2013), Helping Women Recover/Beyond Trauma (Covington, 1999/2008, 2003, cited in Swopes et al. 2017), Esuba (Roe-Sepowitz et al., 2014), and Beyond Violence (Covington, 2013). Professionals facilitating trauma-informed interventions are expected to recognize that treatment can retraumatize clients when authoritative or coercive methods are used. Ideally, trauma-informed treatment should take place in a warm, welcoming and uncrowded space that provides room for a "time-out" option.

These conditions are difficult to meet in a prison context (Muskett, 2014). "Most prisons are fear-inducing environments…. They are also antithetical to building a sense of autonomy and empowerment" (Jewkes et al., 2019, p. 3825). Loss of custody of children, lack of bodily privacy,

absence of control over whom one does or does not interact with, and limited freedom of movement, control over time, and personal space may in and of themselves cause trauma. Even when efforts are made to decorate common areas and limit the obvious presence of locks and bars, prisons are full of trauma-triggers such as unexpected noises, sounds of distress from other people, barked orders, pat-downs, strip searches, and looming threats of punishment for breaking any one of myriad rules. "For women with serious mental illnesses or other trauma symptoms," writes Owen, prison "can aggravate these symptoms, often escalating into destructive behavior and self-harm efforts" (Owen, 2020, para. 1).

In tandem with trauma-informed therapy, gender-sensitive programming—in use since the mid-2000s—typically incorporates cognitive behavioral therapy with a variety of relational approaches that recognize so-called gendered "pathways" to "female offending." Looking at studies conducted both within and outside the United States, Kruttschnitt, Joosen and Bijleveld (2019) argue that pathways theories typically emphasize victimization, weakness and trauma and tend to underestimate or even ignore the reality that finances (especially debt), current relationships and substance use may be the most salient causes of women's incarceration. Particularly problematic in light of the over-representation of women of color, poor women and sexual minorities in prisons, pathways theories rarely consider the full range of women's identities and the diverse structural factors that shape and constrain their lives.

On the one hand, gender-sensitive and trauma-informed approaches acknowledge that incarcerated women are likely to experience abuse of various sorts both within and outside of prison. On the other hand, ideas about female pathways may echo 19th century ideas of female proclivity to hysteria—theories that served to treat women's legitimate concerns as nothing more than expressions of feminine psychopathology. In light of that history, some contemporary scholars challenge the unilateral power of doctors and psychotherapists to decide what constitutes a legitimate trauma and what kinds of reactions should be considered pathological (McDonald, 2018).[4] Indeed, Morash (2010) argues that gender-responsive programs may actually serve to reinforce gender stereotypes by emphasizing problematic mental health, parenting and intimate relationships rather than vocational training.

There have been few high-quality studies of gender-sensitive prison-based programs. Many studies are plagued by selection bias (women volunteer for the program) and retention challenges. A meta-analysis of studies published between 2000 and 2013 identified **reduced recidivism rates for women who participated in gender-informed correctional interventions**. However, "**analyses did reveal relatively large amounts of unexplained variability across studies**. Ideally, it would have been possible to identify moderators that could have explained large components of that variance. However, studies varied considerably in the information that was reported," making this level of analysis impossible (Gobeil et al., 2016, p. 318).

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Though limited in that no follow-up measures were included, Swopes et al. (2017) carried out a comparatively rigorous evaluation of a four-month integrated trauma and gender-sensitive treatment program, Helping Women Recover/Beyond Trauma (HWR/BT), supplemented with additional modules on domestic violence, relapse prevention, and a 12-step program. Self-report measures were collected from 95 incarcerated women who participated in the integrated treatment program and 56 matched women in a control sample. **No differences were observed for posttraumatic stress disorder (PTSD) symptoms and substance-related self-efficacy, depression, dissociation, tension reduction, or anxious arousal**. The authors conclude, "The…findings are consistent with many previous studies of integrated trauma-focused treatments for PTSD-SUD that have failed to find a unique advantage over comparison groups" (p. 15; see also Messina et al., 2010).

While not looking specifically at gender-sensitive services, in interviews with 383 men and women regarding their perceptions of the help they receive from prison staff, Trammell et al. (2018) found men more likely to report that staff members help them gain real-world job and educational skills. Women, in contrast, more often reported that staff members urge them to see and acknowledge the error of their ways, and push them to self-improve while in prison. Qualitative research by Pollack (2012) and Hackett (2013) further critique the emphasis upon individual pathology and pathology in gender-responsive programs. This emphasis, they suggest, actively suppresses discussions of the socio-economic power imbalances that draw women into cycles of abuse and incarceration. In short, **not only are women less likely to receive practical preparation for post-prison success on the job market, they also are inculcated with a sense that they are personally flawed**—a feeling often associated with subordinate social and cultural status (cf. Hoskins & Cobbina, 2020).

Prison-based drug treatment programs

There is little evidence for the effectiveness of prison-based substance abuse treatment. Mitchell et al. (2017) note that, **"Methodologically rigorous assessments of the impact of [drug treatment during] incarceration on drug offenders are lacking, as are assessments that examine the potential for incarceration effects to vary by the race, ethnicity, gender, or age of individuals"[5]** (p. 5). **Drug overdose is the leading cause of death after release from prison, and this risk is significantly higher among women compared to men** (Evans & Sullivan, 2015).

One of the few randomized, large-scale and prospective studies of this issue in the United States used an experimental design to explore the effects on reincarceration rate of a prison-based therapeutic community compared to outpatient group counseling, over a 3-year follow-up period (n = 604). **Intensive prison treatment was not found to be more effective than outpatient counseling** (Welsh et al., 2014). In a second study, Welsh and Zajac (2013) looked at four-year

follow-up post-release outcomes (reincarceration, rearrest, and drug relapse) for men/women/people who participated in intensive therapeutic community drug treatment programs at five prisons (n = 555). **The intensive treatment did not show any significant impact on rearrest, reincarceration or drug relapse rates** (see also Prendergast et al., 2011 and Butzin et al., 2002 for similar findings).

One of the few studies focusing on women, Messina et al. (2006), compared six- and 12-month return-to-custody data for 171 participants in an intensive therapeutic community drug treatment program and 145 non-treated women in the general population at the Central California Women's Facility. **Findings showed no differences between the drug treatment group and the no-treatment comparison group with regard to six- and 12-month return-to-custody rates. In contrast, success on parole was associated with participation in community-based aftercare, suggesting that program participation outside of prison walls may be more effective.**

A number of factors likely militate against effectiveness of prison-based drug treatment. First, especially for women, incarceration is short-term whereas effective substance-use treatment is long-term. Second, the prison environment itself creates added stress which may lead some people to seek psychotropic substances—both prescribed and illicit. Third, prisons tend to be averse to medication-assisted treatment (MAT), despite the scientific consensus that MAT is likely the most effective treatment modality (Beletsky et al., 2018). And finally, evidence suggests that coerced drug treatment in any setting lacks effectiveness.

Involuntary drug treatment programs

Compulsory treatment in inpatient facilities is by definition coercive and therefore worth considering alongside studies of prisons. Reviewing studies assessing the outcomes of compulsory treatment in terms of drug use and formal measures of recidivism, Werb et al. (2016) found that a third of studies reported no significant impacts of compulsory treatment compared with control interventions that were not compulsory, a third observed negative impacts of compulsory treatment, and a third observed positive impacts. They concluded, **"Evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms"** (Werb et al., 2016, p.1).

In a review of studies of court-mandated drug treatment, Pilarinos et al. (2018) found that **forced treatment not only did not improve outcomes for substance use, but actually leads to higher levels of mental duress** associated with compulsory admission to treatment; persistent **homelessness** associated with community treatment orders; higher rates of **relapse** associated with compulsory admission to treatment; and increased risk of **overdose** among adults after discharge from mandated treatment. In Massachusetts, **people who**

were involuntarily committed were more than twice as likely to experience a fatal overdose as those who completed voluntary treatment (Massachusetts Department of Public Health, 2017).

Few studies look specifically at women's experiences. One exception is the Scott et al. (2017) Chicago study of intensive recovery management checkups. Interestingly, recovery management checkups were found to be associated with significant increases in participation in substance use treatment and significant reductions in substance use and HIV risk behaviors **during periods when women were not on probation**. However, recovery management checkups had **no benefits when women were on probation**—suggesting that **this otherwise high-quality program lost efficacy when carried out under circumstances of coercion.**

Recommendations

In contrast to treatment programs in prison, community-based alternatives to incarceration may be cost-effective means to keep women out of prison in the first place (Marsh & Fox, 2008; Bales & Piquero, 2012; Robertson et al., 2020; van Wormer & Persson, 2010; Tadros et al., 2019; Harris & Gilhuly, 2017). This is a rapidly evolving field, and across the country there are numerous models for alternatives to incarceration. Unfortunately, evaluations of these alternatives share the same deficits as evaluations of prison-based programming: lack of long-term follow-up, self-selection of participants, problematic definitions of success, etc. For this reason, **we cannot recommend specific programs at this time**.

Preliminary studies, however, consistently show that **successful programs provide practical assistance with housing and other challenges, set realistic expectations for participants, avoid using threats of punishment to obtain compliance, and refrain from sending participants to prison because of drug use** (Illinois Criminal Justice Information Authority, 2020; Kroner et al., 2016). In light of social, racial and economic patterns of criminalization and incarceration in the United States, it makes sense that positive outcomes are associated with secure housing, support for family unification, facilitation of relationships within the wider community, and accessible and culturally appropriate health and substance use services, including harm reduction (Calhoun et al., 2015; Tadros et al., 2019; Goshin & Byrne, 2011; Buhse & Schaffer, n.d.).

Some alternatives to incarceration embrace harm reduction principles. Harm reduction programs and policies seek to minimize negative health, social, and legal impacts associated with drug use, sex work, and other potentially dangerous activities and situations. Harm reduction acknowledges both individual and community health and well-being, making these approaches especially appropriate for women caring for children and other family members. Examples of harm reduction programs include needle exchanges, housing that does not require residents to abstain from drugs or alcohol, overdose prevention and reversal, and provision of resources to facilitate safe sex.

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There is **strong evidence supporting harm reduction strategies** in relation to illicit drug use (Ritter & Cameron, 2006). We particularly note the Wright et al. (2012) assessment of a comprehensive harm reduction program for substance-using pregnant women in Hawaii. Positive outcomes included decreased rates of preterm births and dramatically increased rates of women retaining custody of their children. Wright et al. conclude that "[a] comprehensive harm reduction model of perinatal care for substance-using women without mandating abstinence, provides exceptional birth outcomes and can be implemented with limited resources" (Wright et al., 2012, p. 2).

Restorative justice programs are another promising avenue. These programs invite all parties involved in a crime (or other situations of abuse or bullying) to join a mediated discussion intended to lead to mutual agreement on steps to repair the harm done. Restorative justice programs in schools and in sexual assault cases show strong track records both in terms of reducing future offenses and in terms of victim satisfaction (Karp, 2015; Koss, 2013). Preliminary evidence also suggests that restorative justice programs in the criminal legal system yield lower rates of future arrests, enhanced community cohesion, and positive outcomes in terms of personal well-being. Scholars evaluating restorative justice initiatives express optimism that "**restorative justice is a promising alternative to conventional criminal justice practices**" (Beckett & Kartman, 2016, p. 18; Bonta et al., 2002).

Finally, there is solid evidence going back at least to the early 1990s showing that **individuals are more successful in overcoming root causes of incarceration when their families remain intact** (Stark, 1992). Family-focused models are more successful in treating substance use among parents (Calhoun et al., 2015), and community-based family therapy is more accessible, more practical, and likely more effective than prison-based therapy (van Wormer & Persson, 2010; Tadros et al., 2019). One such program, the Washington State Parenting Sentencing Alternatives, allows parents of minor children to replace prison sentences with community custody, or to be released on electronic home monitoring for the last 12 months of a prison sentence. In 2017, 474 parents had successfully completed the program, with only 8% returning to prison on a new felony charge following completion (Washington State Department of Corrections, 2017).

In New York, programs emphasizing family outcomes while incorporating treatment of root causes to incarceration are underway. The JusticeHome program serves women charged with a felony that carries a minimum of a six-month sentence (Buhse & Schaffer, n.d.). On average, women are involved with JusticeHome for nine months, during which they work with case managers to devise and carry-out a self-directed change plan including mental health counseling, substance use treatment, life skills development, or parenting classes, depending on need. Women are allowed to stay in their home with their family, increasing their chances of success in treatment (Tadros et al., 2019) and mitigating the effects of justice-system involvement on their children. Preliminary evaluation shows relatively positive outcomes: less than 20% of participants rearrested, at

approximately 10% of the cost it would take to imprison them (M. Goodman, personal communication, Dec. 10, 2020; Women's Prison Association, 2020).

Conclusion

Our review of the scholarly literature raises a number of concerns regarding the Commonwealth's plan to build or renovate a new prison for women.

First, we have identified serious gaps in knowledge regarding outcomes of various types of involuntary and prison-based mental health and substance use programs, especially for women. Leading scholars fail to identify more than a handful of methodologically sound studies that track outcomes over substantial periods of time.

Second, the literature lacks clarity regarding desired outcomes. Some studies assess program success based on a psychological survey or participant self-evaluation at the end of the program period without any follow-up regarding post-incarceration experiences. Other studies measure rates of recidivism, new incarcerations, new arrests or parole violations—all of which may reflect policing practices as much if not more than changes in women's behavior. **We could not identify any studies that evaluate program impact in terms of variables such as post-incarceration employment, health or family reunification**.

Third, the literature emphasizes the **likelihood of further traumatization in prison**, especially for women. More broadly, carceral punishment runs counter to efforts to build self-esteem, personal autonomy and healthy relationships.

Fourth, there is some evidence that therapeutic programs in prison may help alleviate some of the stresses of incarceration. However, recent high-quality studies indicate **no lasting therapeutic benefits accrue to women from trauma-informed and gender-sensitive treatment during incarceration**.

Fifth, studies indicate **better outcomes with community-based outpatient drug treatment** than prison-based treatment. Coerced treatment in general is found to be less effective than voluntary treatment and is often actually harmful.

Taken together, the scholarly literature indicates that prisons are poorly suited to provide therapeutic programming for women. Focus on treatment in prison does not address the poverty, insecure housing, violence and powerlessness that likely were the cause of incarceration from the start. To the contrary, the simple fact of being in prison—regardless of how good the prison

programming is—disrupts family relationships, ongoing medical care and stable housing women need to build safe and secure lives for themselves and their families (Smoyer et al., 2020).

While the scholarship is preliminary, early evaluations back the implementation of community-based solutions that emphasize secure housing, support for families, harm reduction, and restorative justice.

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Endnotes

[1] Department of Sociology and Criminal Justice, Suffolk University, ssered@suffolk.edu

[2] For this review, we searched the major social science and criminology databases (Academic Search Complete, Academic OneFile, JSTOR, EBSCOHost) using combinations of keywords including "effectiveness OR efficacy OR outcomes," "prison-based," "therapeutic," "substance abuse," "substance use," "drug treatment," "mental health," "women," "gender," "gender-sensitive," "trauma-informed," "involuntary treatment," "residential treatment" and "incarceration." In addition, we searched within the following journals: *Journal of Health and Justice*, *Journal of Experimental Criminology*, *Prison Journal*, *Affilia*, *International Journal of Offender Therapy and Comparative Criminology*, and *Journal of Offender Rehabilitation*. We initially limited the search criteria to post-2010. Due to a paucity of high-quality studies, we then expanded the criteria to post-2005.

[3] We focus in this paper on trauma-informed **therapeutic treatment programs.** This **does not include the broader field of trauma-informed policies and practices that create environments which assure respect, safety and dignity for incarcerated women, visitors and staff** (Owen, Wells & Pollock, 2017).

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[4] In previous work we argue that hyper focus on the particular individual's response to trauma draws attention away from forms of structural violence that give rise to suffering, puts the onus on the individual to heal rather than on powerful social actors to change (Sered & Norton-Hawk, 2015), and "creates a fundamental assumption that a rape or sexual battery is an isolated traumatic event" rather than a consequence of structural inequalities (Bumiller, 2008, p. 91-92).

[5] Tripodi et al. (2011)'s review of recidivism and well-being outcomes of various interventions shows greater variability in study results, possibly due to the inclusion of studies that did not use control groups, lack of differentiation between voluntary and involuntary program participation, and the absence of a methodological rating scale to rate the rigor of each study. Even with these reservations, it remains interesting to note that they found more positive outcomes in the recidivism measure than in the well-being measure.