The Well-Being Development Model

A New Conceptual Framework to Guide Transitional Reentry Services for Individuals Releasing from Incarceration

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Abstract

The purpose of this article is to provide a new conceptual framework to support the development, design, implementation, and assessment of innovative reentry interventions designed to increase well-being among the millions of men and women who are released from prisons and jails each year. We propose the Well-Being Development Model (WBDM) as a new conceptual framework to guide the next generation of reentry service approaches. In contrast to prominent models guiding reentry services, the WBDM is articulated as a framework by which to increase incarcerated and formerly incarcerated individuals' capacity to reach their full human potential while simultaneously addressing the common problems and barriers that often compromise their best efforts to achieve success. In this paper, we propose that the WBDM has the potential to re-invent the way we perceive, respond to, and effectively support individuals who have experienced incarceration. First, we outline the history and context of reentry, explore the prominent conceptual foundation of existing reentry services, and establish the need for innovation in reentry service models. Then, we map each of the five key facilitators onto existing theoretical models derived from multiple disciplines and detail the WBDM propositions. Finally, we propose how data generated from interventions guided by the WBDM could be used by policy makers and advocates to redress observed structural and social disparities throughout the criminal justice system, allowing individuals to develop well-being while policymakers simultaneously promote public health and public safety and work toward racial and economic equity.

Keywords: Reentry, Well-Being, Formerly incarcerated individuals, Conceptual framework

Introduction

The United States is transitioning from an era of mass incarceration to an era of smart decarceration. Smart decarceration will have occurred when there is a state of effective, sustainable, and socially just criminal justice strategies that result in a substantially reduced criminal justice-involved population (Pettus-Davis & Epperson, 2014). One critical component of smart decarceration is to effectively support individuals during the transition from incarceration back to community settings (i.e., the reentry period) so that they experience long-term positive public health and public safety outcomes post-incarceration. To achieve this goal, a shift away from the prominent, deficits-oriented conceptual frameworks guiding current reentry practices is necessary. The purpose of this article is to provide a new conceptual framework to support the development, design, implementation, and assessment of innovative reentry interventions designed to increase well-being among the millions of men and women who are released from prisons and jails each year.

We propose the Well-Being Development Model (WBDM) as a new conceptual framework to guide the next generation of reentry service approaches. We focus on psychosocial well-being and define well-being as a state of satisfying and productive engagement with one's life and the realization of one's full psychological, social, and occupational potential (Carruthers & Hood, 2007; Harper Browne, Langford, Ahsan, & O'Connor, 2014). In contrast to prominent models guiding reentry services, the WBDM is articulated as a framework by which to increase incarcerated and formerly incarcerated individuals' capacity to reach their full human potential while simultaneously addressing the common problems and barriers that often compromise their best efforts to achieve success.

Well-being is of particular relevance for individuals leaving incarceration as the presence of well-being affords important protective factors in the face of stress and difficulty and well-being can be both achieved and increased despite adversity and social inequality (Ryff, 2016). For example, incarceration disproportionately affects men and women of color, who are incarcerated at rates two to eight times higher than their White peers (e.g, Mauer, 2011; Pettus, 2013; Travis, Western, & Redburn, 2014; Wacquant, 2009; Wehrman, 2010). Disproportionate incarceration rates amplify existing socio-economic disparities in communities of color and many negative social determinants of health including housing instability, poverty, discrimination, social exclusion, and lack of access to resources concentrate among racial and ethnic minorities (e.g., Braveman & Gottleib, 2014; Spivak & Monnat, 2013; Sykes & Pettit, 2014). These stark racial, social, and economic disparities among the population of individuals in prison and releasing from incarceration underscore why individual well-being development must be pursued while researchers and advocates work to identify and ameliorate these structural and social disparities.

The WBDM capitalizes on a growing research base in medicine, public health, psychology, sociology, education, occupational therapy, recreation and leisure studies, and social work (e.g., Boehm, Vie, & Kubzansky, 2012; Campbell, Converse, & Rodgers, 1976; Carruthers & Hood, 2007; Davidson & McEwen, 2012; Diener, Suh, Lucas, & Smith, 1999; Hood & Carruthers, 2007, 2016; Manderscheid et al., 2010; Ryff & Singer, 1996; Soutter, O'Steen, & Gilmore, 2014). Existing literature from these fields suggests that interventions designed to develop well-being differ from those designed to mitigate deficits; findings indicate that well-being interventions are effective among people who face a range of individual-level and structural-level barriers and who struggle to fully engage in the community due to these barriers

(Bolier et al., 2013; Davidson & McEwen, 2012; Gander, Proyer, Ruch, & Wyss, 2013; Sin & Lyubomirsky, 2009; Weiss, Westerhof, & Bohlmeijer, 2016). Well-being interventions have great potential for scaling because they can be delivered by non-clinicians and implemented over relative short timeframes (Boehm et al., 2012; Huppert, 2014; Weare & Nine, 2011). Further, evidence indicates that well-being is relatively stable over time, thus supporting the hypothesis that once well-being is enhanced, it will have more lasting effects than deficits-oriented reentry approaches (World Health Organization, 2010). Deficits-oriented approaches focus primarily on negative attributes such as character deficits, "criminal" cognitions, and avoidance behaviors (Taxman, Thanner, & Weisburd, 2006).

To create the WBDM, we synthesized theory, empirical research, and the practical experiences of a multidisciplinary team to describe the critical ingredients of well-being development. The WBDM is comprised of five malleable factors, here described as the five key facilitators of well-being development. The five key facilitators are: Healthy Thinking Patterns, Meaningful Work Trajectories, Effective Coping Strategies, Positive Social Engagement, and Positive Interpersonal Relationships. In this paper, we provide the origin and conceptual definitions of each of the five key facilitators and situate each key facilitator within the context of existing reentry and well-being theoretical literature.

In this paper, we propose that the WBDM has the potential to re-invent the way we perceive, respond to, and effectively support individuals who have experienced incarceration. First, we outline the history and context of reentry, explore the prominent conceptual foundation of existing reentry services, and establish the need for innovation in reentry service models. Then, we map each of the five key facilitators onto existing theoretical models derived from multiple disciplines and detail the WBDM propositions.

We are currently researching application of the WBDM in practice using a multisite randomized controlled trial of the 5-Key Model for Reentry which was developed using the WBDM as a conceptual framework (Pettus-Davis, Veeh, Renn, & Eikenberry, 2018). The phased multisite pilot trial is occurring across seven states with people releasing from one of 90 prisons and into one of 21 urban and rural counties. The baseline sample includes more than 3000 participants who will be followed for up to 15 months after they leave incarceration and return home. Reports on the progress of the research trial are released every three months from November 2018-June 2021. If warranted, the next phases of the research will include an effectiveness trial across additional states and sites.

Background

Correctional Practices and Growth of Incarceration

Approximately 2.2 million men and women are held in prisons and jails across the United States on any given day (Kaeble & Cowhig, 2018). More than 95% of these men and women will eventually be released back to their communities; approximately 626,000 people are released from state and federal prisons annually and in excess of eleven million people cycle through local jails each year (Carson, 2016). Since the creation of prisons, efforts have been undertaken to increase an individuals' opportunity to achieve a range of positive outcomes after their release from incarceration (Rothman, 1980). In the 1930s, an individual's post-release experience was primarily overseen by parole which provided supervision of formerly incarcerated adults in the community (Jonson & Cullen, 2015). Through World War II, the focus of parole was on the development of individuals' "moral fiber" through regular employment in the community (Jonson & Cullen, 2015, p. 519). In the late 1950's and into the 1960's, however, concern for the welfare of individuals with incarceration histories moved beyond a sole focus on employment

and pushed correctional agencies to develop treatment services aimed at rehabilitation, including formalizing and expanding the use of halfway houses to help individuals transition from prison back into their communities (Jonson & Cullen, 2015).

However, in the 1970's, a focus on the welfare of individuals with incarceration histories was superseded by a public safety narrative expressing misgivings about whether the treatment services offered to individuals during reentry were achieving public safety aims (Cullen, 2013; Martinson, 1974). This shift in focus towards law enforcement and punitive strategies as the primary means to achieve public safety ushered in a "law and order" model of corrections and parole that persisted into the late 1990s. This "law and order" era resulted in a 660% increase in incarceration rates. For example, in 1970, the incarceration rate in the United States was 96 people per 100,000 persons (Renshaw, 1982), but by 2016 the rate had increased to 670 per 100,000 (Kaeble & Cowhig, 2018). This exponential increase in incarceration, commonly referred to as mass incarceration, has been attributed to a constellation of factors, including punitive "tough-on-crime" policies like mandatory minimum sentencing and three-strikes laws, the increased criminalization of the drug trade and symptoms of behavioral health disorders, racially biased public policymaking, the collapse of the urban labor market for people of color, rising crime rates from the 1960s to the 1990s, and the expansion of post-release community supervision (Gottschalk, 2008; Phelps & Pager, 2016; Western, 2006).

Onset of "Reentry" as a Service Approach Due to Complex Needs of Incarcerated Individuals

The sheer volume of individuals releasing from incarceration skyrocketed by the early years of the 21st century, with over 12,000 individuals releasing from state and federal prisons and returning to communities each week by 2016 (Kaeble & Cowhig, 2018). Faced with a

rapidly expanding population of individuals returning home from incarceration, national momentum for a "reentry services" approach began during this same period. The "reentry" window was identified as a critical time for interventions designed to prevent future crime. Although a universal definition does not exist, most scholars conceptualize the reentry window as spanning the six months prior to release and lasting through at least the first year spent back in the community (e.g., Jonson & Cullen, 2015; Pettus-Davis, Renn, Lacasse, & Motley, 2018).

Health and social needs. Due to the lack of treatment services available during and after incarceration, individuals leaving incarceration demonstrate a multitude of unmet needs at a greater prevalence than members of the general public (Fazel & Seewald, 2012; Jonson & Cullen, 2015). Trauma exposure is nearly universal, with up to 98% of incarcerated men and women reporting having experienced at least one traumatic event including child abuse, physical attack, intimate partner violence, rape or sexual violence, witnessing a murder, or having a family member or loved one killed (Jäggi, Mezuk, Watkins, & Jackson, 2016; Katz, Willis, & Joseph, 2014; Kennedy, Tripodi, & Pettus-Davis, 2013; Kennedy, Tripodi, Pettus-Davis, & Ayers, 2016; Morrison, Pettus-Davis, Renn, Veeh, & Weatherly, 2018; Tripodi, Onifade, & Pettus-Davis, 2014; Tripodi & Pettus-Davis, 2013; Wolff & Shi, 2012; Wolff, Shi, & Siegel, 2009).

Experiences of trauma are also often compounded by negative social determinants of health including poverty, discrimination, and social exclusion, as incarcerated individuals are disproportionately drawn from poor communities which lack resources and opportunities. For some, compounded individual, family, and community trauma exposure translates into chronic stress reactions and acute psychological distress (Golder, Engstrom, Hall, Higgins, & Logan, 2015; Krieger, Kosheleva, Waterman, Chen, & Koenen, 2011; Turney, Kissane, & Edin, 2013).

In fact, more than half of state and federal inmates and 64% of jail inmates are diagnosed with a mental health disorder; these rates are higher among incarcerated women when compared to incarcerated men (73% compared to 55%; Bronson & Berzofsky, 2017; Epperson et al., 2014; James & Glaze, 2006). The prevalence of serious mental illness is estimated at nearly 15% - more than double the rate of serious mental illness in the general population (National Institute of Mental Health, 2019). Nearly three-quarters of incarcerated men and women are diagnosed with substance use disorders (Bronson, Stroop, Zimmer, & Berzofsky, 2017; Califano, 2010). Comorbid disorders are also common, with 24-34% of women and 12-15% of men of jail inmates being diagnosed with co-occurring serious mental health and substance use disorders (Mir et al., 2015; Substance Abuse and Mental Health Services Administration, 2015). Additionally, nearly three-quarters of state prisoners and more than three-quarters of jail inmates who had a recent (past 12 months) history of any mental health problem also met diagnostic criteria for substance dependence or abuse (James & Glaze, 2006).

Further, results from meta-analyses suggest that 46-60% of adults incarcerated in prisons and jails have also sustained a head injury where they lost consciousness or a traumatic brain injury (Centers for Disease Control, n.d.; Durand et al., 2017; Farrer, Frost, & Hedges, 2013; Shiroma, Ferguson, & Pickelsimer, 2012), compared to a general prevalence of 8.5% among the general public (Silver, Kramer, Greenwald, & Weissman, 2001). Having a head injury or a traumatic brain injury significantly increases risk for substance use disorders and a range of mental health diagnoses, although varied measurement of these constructs makes it difficult to conduct cross-sample comparisons (Ray, Sapp, & Kincaid, 2014; Schofield et al., 2006; Slaughter, Fann, & Ehde, 2003; Walker, Hiller, Staton, & Leukefeld, 2003; Young et al., 2018).

Additionally, some incarcerated men and women also struggle with low educational attainment and limited employment histories. One third of incarcerated adults do not have a high school diploma or a GED at the time of their admission to prison (Rampey et al., 2016) and rates of full-time employment in the months prior to incarceration are estimated at just under 50% (Looney & Turner, 2018). For some, educational attainment and employment intersect with community-level opportunities, as individuals from poor communities (whether urban or rural) with limited infrastructure are over-represented in prisons and jails (Lopez-Aguado, 2016; Miller, 2014).

Further, housing instability is a common factor for individuals releasing from incarceration. Formerly incarcerated adults experience homelessness at a rate nearly seven times higher than the general public, with each incarceration event exponentially increasing the risk for homelessness (Couloute, 2018). Housing also intersects with poverty, discrimination, and social exclusion as incarcerated and formerly incarcerated individuals often live in communities with limited affordable housing options and may not have family members with whom they can live after release from incarceration (Draine, Salzer, Culhane, & Hadley, 2002; McKernan, 2017).

The incarceration experience itself further strains interpersonal relationships between formerly incarcerated individuals and their family members and loved ones. Although research shows that most individuals have social support from loved ones immediately upon their release from incarceration (Pettus-Davis, 2014; Pettus-Davis, Scheyett, Hailey, Golin, & Wohl, 2009; Pettus-Davis, Scheyett, & Lewis, 2014; Scheyett & Pettus-Davis, 2013), social support tends to deteriorate soon after due to the stress and strain related to reentry (Pettus-Davis, Eggleston, Doherty, Veeh, & Drymon, 2017).

Contemporary Reentry Services Approach and Limitations

At their inception, reentry service approaches emphasized the importance of continuity of care to comprehensively address formerly incarcerated individuals interconnected needs and to reduce recidivism. Continuity of care was defined as a multi-component services approach that should begin during incarceration (within the prison setting) and extend into the community after release (Seiter & Kadela, 2003). Scholars and practitioners posited that reentry services needed to include some programming for some or all of the following areas: coping skills, life skills, cognitive behavioral therapy, job readiness training, education assistance, employment assistance, and referrals to other services like substance use disorder treatment or community mental health centers (Travis, 2005).

To develop and disseminate reentry services, the federal government launched a series of funding initiatives in the early 2000's, including the Prisoner Reentry Initiative (PRI), the Serious and Violent Offender Reentry Initiative (SVORI), and the Second Chance Act (Bureau of Justice Assistance, 2018; Visher, Lattimore, Barrick, & Tueller, 2017). Combined, these initiatives poured approximately $700 million dollars into establishing reentry programming in all 50 states (Bureau of Justice Assistance, 2018; National Institute of Justice, 2012; United States Department of Labor, 2007). Unfortunately, the reentry services models developed from these federal initiatives have not been associated with decreased recidivism for program participants (Straight Talk on Evidence, 2018). In fact, many program evaluations report no difference in rates of recidivism when comparing individuals who received services versus those who had not, others show that individuals who received services had higher rates of recidivism when compared to controls, and the rest detail only limited treatment effects (Bouffard & Bergeron, 2006; Duwe, 2012; Grommon, Davidson, & Bynum, 2013; Jacobs & Western, 2007;

Lattimore, 2020; Lattimore & Visher, 2009; Roman, Brooks, Lagerson, Chalfin, & Tereshchenko, 2007; Veeh, Severson, & Lee, 2017; Wilson & Davis, 2006). A meta-analysis of 53 reentry services program evaluations from across the United States found the average reduction in recidivism to be only six percent (Ndrecka, 2014). In other words, based on a benchmark recidivism rate of 50%, participation in existing reentry program models, on average, would reduce the recidivism rate to 47%, while a comparable group of individuals not in a reentry program would return to prison at a rate of 53%. Unfortunately, as of 2018, national data indicate that more than three quarters of the individuals released from prisons and jails will recidivate within the first three years after release, further suggesting that extant programs are neither meeting individual needs nor reducing recidivism (Alper, Durose, & Markman, 2018).

The societal context in which reentry services occur in the United States explains some of the limited success of reentry initiatives. High incarceration rates have disproportionately impacted already marginalized communities including Black, Hispanic, and Native American communities, people with problematic substance use histories and mental health disorders, and people in poverty (Nkansah-Amankra, Agbanu, & Miller, 2013; Sakala, 2014; Sampson & Loeffler, 2010). Pervasive structural inequalities create a cycle whereby it is difficult for members of marginalized groups to access community-level employment and educational opportunities (Western & Muller, 2013). These inequalities also make them more likely to make contact with the criminal justice system and to have worse outcomes within the criminal justice system when compared to peers with similar charges and criminal histories who do not have a marginalized identity (Miller, 2014). Individuals drawn from these marginalized communities are more likely to be incarcerated, and the experience of incarceration then deepens existing disparities (Bobo & Thompson, 2010).

Further, evidence suggests that incarceration itself is criminogenic, and contributes to a range of negative outcomes including increased criminal offending (Cochran, Mears, & Bales, 2014; Cullen, Jonson, & Nagin, 2011; Harding, Morenoff, Nguyen, & Bushway, 2017; Nagin, Cullen, & Jonson, 2009) and the exacerbation of physical illness, problematic substance use, and mental health disorder symptoms (Brinkley-Rubinstein, 2013; Harner & Riley, 2013; Massoglia & Pridemore, 2015). After release from incarceration, existing public policies and pervasive stigma limit opportunities for those with a criminal record, as a range of policies control where formerly incarcerated individuals can live and work, whether they can vote or access educational institutions, and how they engage in interpersonal relationships and community activities (Pettus-Davis, Epperson, & Grier, 2017). In many cases, these restrictions either limit formerly incarcerated individuals' opportunities for years after release from incarceration or permanently separate them from full community participation. Reentry services, however, work only at the individual level and were not designed to redress structural inequalities or reverse the public policies that ban access to everyday citizenry for formerly incarcerated individuals (i.e., the collateral consequences of incarceration). Instead, nearly all reentry services focus on the immediate needs of individuals who are releasing from incarceration. They target problematic individual behaviors (e.g., problematic substance use or lack of job seeking) and characteristics (e.g., homelessness or unemployment) and provide limited focus on individual skill-building, which fails to consider the full context of the reentry experience.

Scholars attribute several factors to the limited effectiveness of reentry services. These include having no uniform approach to reentry services nor fidelity assessments, working primarily to address "avoidance" goals (e.g., avoiding problematic peers, avoiding having too much free time, and avoiding triggering people or places) as a proxy for reducing risk for future

criminal behavior, and focusing on the misspecified primary outcome of recidivism (Jonson & Cullen, 2015; Lattimore, 2020; Petersilia, 2009; Taxman, 2020; Visher & Travis, 2011). Therefore, it is difficult to identify a promising treatment model for reentry services as no two existing programs are exactly the same and the specification of outcomes is fluid. For example, some reentry services provide extensive employment services in-house and refer participants out to receive substance use disorder treatment, mental health treatment, or other needed community services. Other reentry models focus solely on housing or religious education (e.g., Bible study), and yet others provide psychoeducation and cognitive-behavioral therapy. In fact, the descriptor "reentry services" has become so widely adopted that even those models that do not offer any semblance of continuity of care (the signature approach of reentry services) refer to themselves as delivering reentry services simply because some of their clients have a history of arrest or incarceration.

To date, no singular definition or set of definitions of successful reentry have been proposed. When reentry services practitioners and researchers report outcomes other than recidivism to report on program impacts, those outcomes flow from the primary focus of the reentry services model and are as varied as the models themselves (e.g., employment, education, problematic substance use, mental health symptoms, trauma symptoms, or housing; Jonson & Cullen, 2015). Within reentry programs, one client's needs may look very different from another client's needs. Therefore, condition-specific outcomes do not equally apply for all clients of reentry services (e.g., employment needs, housing needs, or alleviating trauma symptoms), which makes identifying a universal metric of individual success or program effectiveness difficult. Program-specific outcomes, therefore, are as imprecise an indicator of success as recidivism and using program-specific outcomes also makes it difficult to both compare

effectiveness across reentry services models and to identify best practices. Consistent, universal outcomes are needed, and these outcomes must be flexible enough to reflect changes which occur as a result of receiving reentry services despite the presenting characteristics of any given participant (e.g., for participants who have substance use disorders as well as participants who do not have substance use disorders but have different reentry support needs).

Further, to date, the reentry services field has almost solely relied on the primary outcome of recidivism to determine a reentry program's effectiveness at rehabilitating an individual who has released from prison. Although recidivism is treated as both an individual-level outcome and a proxy for program effectiveness in the literature, recidivism more often describes the interaction of criminal justice system-level factors than individual actions (Lattimore, 2020; Pettus-Davis & Kennedy, 2020b). Individuals return to incarceration for myriad reasons beyond the commission of new crimes such as the inability to pay fines and fees, having a positive drug screen, not meeting the conditions of post-release supervision (e.g., not finding or securing employment; Pettus-Davis & Kennedy, 2020b). Recidivism as an outcome has also been heavily critiqued as no singular definition of recidivism exists (Lattimore, 2020; Petersilia, 2009; Severson, Veeh, Bruns, & Lee, 2012; Taxman, 2020). In official statistics and academic research, recidivism may be defined as subsequent law enforcement contact (despite the reason for that contact), re-arrest (even when charges are dropped), re-incarceration in a local jail or prison (due to legal warrants for arrest issued prior to incarceration, violation of the terms of release, or the commission of a new crime), or re-incarceration in a federal or state prison due to a new conviction. Estimates suggest that up to a third of prison admissions are driven by technical violations after release (e.g., CSG Justice Center, 2019; Glaze & Bonczar, 2008; Maruschak & Bonczar, 2012; Pew Trusts, 2019). There are vast differences between these

definitions and most definitions of recidivism fail to distinguish between criminal behavior, the decision making of law enforcement officers/probation and parole officers/other criminal justice system agents, and the range of structural factors that result in a formerly incarcerated individual returning to prison or jail. However it is defined, recidivism is simply an imprecise indicator of individual success or treatment effectiveness. Regardless, in the absence of a uniform definition of successful reentry, it is nearly impossible to compare effectiveness across several reentry services models.

Predominant Conceptual Framework Guiding Reentry Efforts

The principles of the Risk-Need-Responsivity model (RNR; Andrews & Bonta, 2016; Andrews, Zinger, Hoge, & Bonta, 1990) guide most 21st century correctional programming, including assessment, in-prison correctional rehabilitation interventions, and reentry services. The RNR model surfaced out of an effort of several researchers from the “Canadian School” who began to challenge Martinson’s (1974) assertion that “nothing works” in correctional services using meta-analytic statistical methods (Smith, Gendreau, & Swartz, 2009). After identifying more than 370 studies of juvenile and adult offenders, lead scholars Don Andrews and James Bonta demonstrated that programs with a human service component significantly reduced criminal behavior when compared to programs which focused solely on supervision and punishment (Andrews & Bonta, 2016; Andrews et al., 1990). These empirical findings provided support for the creation of a new theoretical model to guide screening, assessment, and targeted service referral - the RNR model. The RNR model was adopted by the criminal justice system in the mid-1990s and remains the dominant correctional paradigm to this day.

The RNR model identifies the “Central Eight” criminogenic risk/need factors (Andrews & Bonta, 2016). Criminogenic factors, in this model, are defined as factors that contribute to

criminal behavior and that can be altered or ameliorated through direct intervention. Although incarcerated individuals may have many tangible and social needs, needs that are not hypothesized by the developers as associated with criminal behavior are not addressed in this model. *Criminal history* is the only static, or unchangeable risk factor; the remaining seven dynamic (or changeable) criminogenic factors are: *Poor school/work history*, *Procriminal attitudes*, *Antisocial personality pattern*, *Substance abuse*, *Social supports for cri*me, *Limited Leisure and recreational activities*, and *Poor family/marital relationships*. Each risk/need factor is defined in terms of identifiers (how to recognize the presence of the factor) and intervention goals (how to intervene to reduce the impact of the factor; Bonta & Andrews, 2007). For example, the presence of an antisocial personality pattern is indicated by impulsivity, adventurous pleasure seeking, and being restlessly aggressive and irritable; intervention goals include avoiding such behaviors and anger management. Procriminal attitudes are indicated by rationalizations for crime and negative attitudes toward the law; intervention goals are to counter rationalizations with psychoeducation around prosocial attitudes. Risk and need are supposed to be assessed using a standardized risk assessment measure.

In addition to identifying risk/need factors, the three principles of the model – risk, need, and responsivity – guide intervention. The **Risk** principle suggests that program intensity should match the individual's risk level such that high-risk individuals receive the most intensive services and minimal or low-risk individuals receive the least intensive services (or no services at all). The **Need** principle examines the individual-level factors related to criminal behavior, including cognitions, behavior, and both tangible (i.e., education, employment, and housing) and social needs. Finally, the **Responsivity** principle indicates that an individual's skills and abilities

should be matched when appropriate interventions are identified to ensure a good fit (Bonta & Andrews, 2007).

Since publishing their first meta-analysis investigating "what works" in correctional rehabilitation, Andrews, Bonta, and other members of their group have published additional meta analyses to identify how using the RNR model principles decreases recidivism for special groups of formerly incarcerated individuals. For example, Bonta, Law, and Hanson (1998) reviewed 64 unique samples to assess whether clinical factors or the RNR Central Eight risk/need factors were stronger predictors of general and violent recidivism for formerly incarcerated individuals diagnosed with mental disorders. Results indicated that criminal history variables had a small predictive effect on recidivism ($Zr = 0.12$), and that clinical variables had the smallest effect sizes ($Zr = -.02$). Further, using a similar methodology, Bonta, Blais, and Wilson (2014) reviewed 96 unique samples and found that the Central Eight risk/need factors predicted both general and violent recidivism, and that clinical variables, apart from antisocial personality disorder, did not predict either outcome. All domain categories within the Central Eight predicted general recidivism, with small to moderate effect sizes ($d = .28$-$.51$) and violent recidivism, with small to moderate effect sizes ($d = .16$-$.50$). Specifically, they found that individuals with a diagnosis of antisocial personality disorder were significantly more likely to be re-incarcerated for a violent crime when compared to individuals with any other clinical diagnosis (e.g., mood disorder, schizophrenia; $\chi 2$ [1, $N = 7{,}045$, $k = 17$] $= 62.53$, $p < .001$).

Bonta, Blais, and Wilson (2014) replicated this finding in an updated review, noting that having any mental disorder was not predictive of violent recidivism [$d = -.16$, 95% Confidence Interval (CI): -.40, .09], although having an antisocial personality disorder was a moderate predictor of violent recidivism ($d = .66$, 95% CI: .52, .80). In a meta-analysis of 26 unique

studies of RNR-based correctional treatment, Dowden and Andrews (1999a) found that RNR treatment was associated with significantly decreased recidivism when it was implemented among samples of predominantly or exclusively women (ή= .14; SD = .24). Specifically, the recidivism rate for treatment group members was 43% compared to 57% among controls. Hanson, Bourgon, Helmus, and Hodgson (2009) examined the impact of RNR programming on sexual recidivism among individuals convicted of sexual crimes. They included 22 unique samples in their meta-analysis and found that sexual recidivism among individuals who received RNR-based correctional programming was lower than sexual recidivism among controls in 17 of the 22 studies. The random-effects weighted mean across all 22 studies was .66 (95% CI: .49-.89). Adherence to all three RNR principles had a mean effect size of .30 on recidivism compared to programs which did not adhere to any principle, which showed increased recidivism ($\Phi = -.06$; Andrews & Bonta, 2010).

Moving Beyond Risk and Need to Well-Being Development

The introduction and dissemination of the RNR model came at a critical time in correctional history. The RNR model provided the field with a much-needed framework to help usher in a renewed focus on rehabilitation and simultaneously offered principles and measurable program objectives for practitioners to pursue. Although developed primarily on the risks and needs of juvenile offenders, the RNR model guided future researchers toward specific risks and needs upon which to ground research questions and assess intervention outcomes. However, whether due to implementation challenges or limitations in the model itself, the RNR model as the predominant framework is not producing dramatic results. For example, the mean effect size (r) for RNR model-adherent correctional treatment programs conducted outside of the laboratory setting is only 0.15 ($k = 10$), suggesting that something integral to success is missing (Andrews

& Bonta, 2016). Below, we describe several limitations with the RNR model and respond to those limitations in pursuit of a new conceptual framework, the WBDM.

First, the deficits-oriented nature of the RNR model and, by extension, the vast majority of existing in-prison intervention and reentry services, leaves little opportunity for individuals to enact deep or lasting changes in their lives and ignores all other markers of psychosocial wellness and human potential. Likewise, a focus on individual-level deficits and criminogenic risk ignores how negative social determinants - poverty, discrimination, social exclusion, and beleaguered communities - intersect with crime and potentially further alienate already marginalized individuals from personal growth. Second, a growing body of research is examining racial and economic disparities in risk assessment tools (Larson et al., 2016; Mayson, 2019). Researchers hypothesize that disparities are present because many of the variables in the risk assessment tools (e.g., education, employment, income, housing, and criminal history) are experienced differently along racial and economic lines (Van Eijk, 2017). Disparities in assignment to higher risk levels is problematic because individuals categorized as high-risk are more likely to receive the most punitive and invasive interventions. Further problematic is that the science on the predictive validity of risk assessment tools indicates that their ability to accurately predict future crime is weak (DiBenedetto, 2019). Irrespective of racial and economic disparities, legal scholars and judges are reviewing assessment tools for fairness in determining prospective criminal justice interventions based on experiences unrelated to the offense (Eckhouse et al., 2019). Thus, the risk factors identified by the RNR model may unintentionally reproduce the racial disparities and racial disproportionality identified at every level of the criminal justice system. Third, being charged and convicted of a crime activates a range of other collateral consequences which constrain individuals' ability to fully participate in society

(Pettus-Davis et al., 2017). These collateral consequences intersect with individual-level risk and need in a way that is not fully articulated in risk/need assessments or in how the RNR model measures individual-level success. For example, history of a felony conviction and prison record makes securing employment, particularly living wage employment, particularly complicated (Pettus-Davis et al., 2017). Yet, in the RNR model, low employment heightens risk scores.

Given the limitations of the RNR model, we looked to other disciplines and fields of research for guidance on the development of a new conceptual framework designed to address existing theoretical and programmatic gaps, provide universal outcomes, and move away from a focus on recidivism as the hallmark of the success for individuals and/or reentry service approaches. Our goal was to develop a guiding conceptual framework for reentry services to create space for individuals to engage with a real change process, expand their human potential, and build well-being.

Formation of the Well-Being Development Model

Our development of the WBDM was based upon a comprehensive examination of myriad extant definitions of well-being as a construct, existing empirically supported theory, and on a deep understanding of the context of the reentry environment. The team informing the WBDM was comprised of formerly incarcerated individuals, researchers, and corrections and reentry practitioners. Most researchers on the team also had extensive practitioner work experience prior to becoming faculty members. Taken together, the WBDM synthesizes many lines of practical/applied experience and conceptual and scientific inquiry to depict the reentry period as a time for individuals to realize their potential, experience meaningful connections with others, manage external demands, capitalize on opportunity, and pursue overall positive self-regard and self-direction. The WBDM focuses on psychosocial well-being and defines well-being as a state

of satisfying, and productive engagement with one's life and the realization of one's full psychological, social, and occupational potential (Hood & Carruthers, 2007; Harper Browne et al., 2014).

Origins of the Well-Being Development Model

In 1948, the World Health Organization revised its definition of health, marking a general departure from a focus on ailment and toward well-being. The revised definition indicated that health is more than the absence of illness, but rather a state of "complete physical, mental, and social well-being" (Carruthers & Hood, 2007; Harper Browne et al., 2014). The shift sparked decades of empirical research on quality of life, well-being, and a multitude of related conceptual constructs. Most major disciplines soon developed well-being related conceptual orientations including medicine, public health, psychology, sociology, education, occupational therapy, recreation and leisure studies, and social work (e.g., Boehm et al., Campbell et al., 1976; Carruthers & Hood, 2007; Davidson & McEwen, 2012; Diener et al., 1999; Hood & Carruthers, 2007, 2016; Manderscheid et al., 2010; Ryff & Singer, 1996; Soutter et al., 2014). For example, the term "positive psychology" was coined by Abraham Maslow in 1954 and under Martin Seligman's leadership of the American Psychological Association (beginning in 1996), positive psychology became an official field of study (Seligman & Csikszentmihalyi, 2000). This research was paired with theoretically grounded and empirically-validated measures of well-being, quality of life, and hope, allowing for researchers and practitioners to develop interventions to increase these constructs in individuals' lives and to see how these social indicators varied across age, racial and ethnic identity, and socio-economic groups (Manderscheid et al., 2010). In the 21st century, much of mental healthcare and prevention has

shifted from treating or preventing mental health complaints to enhancing positive aspects of mental health with the goal of developing and promoting well-being (Weiss et al., 2016).

Well-being represents a paradigm shift, however, not just for medical or other clinical fields, but also for child welfare and education. Since the early 2000s, the child welfare system has increasingly turned toward well-being (Harper Browne, 2016). Likewise, following the introduction of the Global School Health Initiative in 1995 (World Health Organization, n.d.), the education sector has begun to conceptualize student well-being in broad terms, seeking for ways to maximize the development of well-being in educational settings (Soutter et al., 2014). The well-being orientation across various disciplines eventually began to guide policy strategies and community-level intervention approaches. As the United States transitioned into the 21st century, research, human service, and even federal policy shifts were seen in interventions with child-welfare involved youth and families (Harper Browne, 2016), elderly adults residing in nursing home facilities (Reinhardt, Boerner, & Horowitz, 2006), and individuals seeking life coaching in the community (Seligman, 2011). Interventions were delivered in a range of settings including clinical settings, residential settings, homes, schools, and athletics departments.

The empirical support for well-being development-based interventions is mushrooming. Well-being based interventions have been found to increase survival times by 18 months of women with breast cancer in randomized controlled trials that included 10 year follow up data collection (Spiegel et al., 1989). Davidson and McEwen (2012) identify growing evidence that well-being interventions produce plasticity-related changes in the brain and also support a range of behavioral outcomes. In a meta-analysis of 27 studies (Weiss et al., 2016), moderate effects on primary outcomes were identified immediately after the intervention. At follow up between two to 10 months, a small effect was still identified (d = .44 and .22, respectively). Samples in the

studies include employees, health professionals, and other non-clinical populations; elderly adults diagnosed with depression and elderly adults in a variety of living situations; adults diagnosed with a range of mental health disorders, adults experiencing psychological distress, and adults in rural South Africa; undergraduate and middle school students; and, individuals suffering from chronic pain. A meta-analysis of 51 positive psychology interventions targeting well-being with nearly 4,300 individuals also found small to moderate effects on well-being (mean $r = .29$) as well as symptoms of depression (mean $r = .31$; Sin & Lyubomirsky, 2009). Similarly, in a meta-analysis of 39 studies of positive psychology interventions (i.e., self-help, group, and individual) conducted with more than 6,000 individuals, Bolier and colleagues (2013) detected small to moderate effects on subjective well-being (mean $r = .34$), psychological well-being (mean $r = .20$) and symptoms of depression (mean $r = .23$). A randomized controlled trial of internet-based well-being interventions similarly found significant positive effects on the primary outcomes of happiness ($F = 30.4$) and depression ($F = 41.5$) in eight of the nine interventions included in analyses (Gander et al., 2013).

Thus, well-being has been proposed and explored as a guiding conceptual framework for years in almost every other human service setting and discipline with the exception of reentry services and well-being-oriented interventions have promising empirical support. Therefore, we pulled from extant theoretical literature and identified three psychosocial conceptual frameworks of well-being that were developed from, and applied in, a range of non-criminal justice disciplines and settings: a) Psychological Well-Being Model, b) Seligman's PERMA Model, and c) Leisure and Well-Being Model. We also identified a fourth conceptual framework that demarks the first shift toward well-being in correctional rehabilitative practice – the Good Lives Model – which was largely geared toward the reentry of individuals charged with sexual crimes.

Building across each of the conceptual frameworks (including the prominent RNR model), we propose five key facilitators of well-being development and defined each key facilitator using the extant empirical and theoretical literature (described below).

Conceptual Building Blocks for the Well-Being Development Model

In this section, we provide an overview of each well-being oriented conceptual framework that informed the WBDM including their propositions, assumptions, and highlighted empirical support: Psychological Well-Being Model, Seligman's PERMA Model, Leisure and Well-Being Model, and the Good Lives Model. Because the RNR model was discussed at length previously in this paper, we do not revisit the RNR model in this section. We took several steps as we sifted through extant theoretical models for well-being. First, we identified the universe of empirically driven theoretical models. Then we narrowed in on theoretical models that specified measurable constructs. As we further narrowed our model selection, we prioritized theoretical models that could be applied to a wide range of populations. In our final selection, we selected those models that articulated constructs that were anchored in well-being and aligned with the constructs of RNR. See Table 1 to view how existing constructs overlay with the five key facilitators of well-being development that comprise the WBDM.

TABLE 1 - *How the WBDM maps onto existing theoretical constructs*

THE WELL BEING DEVELOPMENT MODEL	RISK-NEEDS-RESPONSIVITY	THE PERMA MODEL	PSYCHOLOGICAL WELL-BEING MODEL	LEISURE AND WELL-BEING MODEL	THE GOOD LIVES MODEL
Healthy Thinking Patterns	Criminogenic thinking patterns, Antisocial personality patterns	Positive emotions	Self-acceptance, Personal growth, Purpose in life		Inner peace, Creativity, Knowledge
Meaningful Work Trajectories	Low employment/ Low education	Meaning in life, Achievement		Occupational well-being	Excellence in work
Effective Coping Strategies	Substance abuse		Environmental mastery, Autonomy		Spirituality, Life
Positive Social Engagement	Associations with others who engage in crime, Lack of prosocial leisure activities	Engagement		First medial leisure outcome	Excellence in play, Excellence in agency, Pleasure
Positive Relationships	Poor family and other relationships	Relationships	Positive relations	Second medial leisure outcome	Relatedness, Community

The Psychological Well-Being Model.

Model Overview: The six-factor model of Psychological Well-Being is grounded on early sociological and psychological examinations of what it means to be psychologically well (Ryff, 1989; 1995). This model posits that the realization of personal potential is conceptually distinct from the pursuit of happiness and satisfaction (Ryff & Singer, 1996). Specifically, Ryff (1989) situates the Psychological Well-Being Model in Eudaimonic well-being, which is about the

realization of personal potential in contrast to Hedonic well-being, which addresses experiences of happiness and satisfaction.

Propositions and Assumptions: The Psychological Well-Being Model emphasizes moving beyond reductionist medical or biological descriptions of well-being and helping individuals explore how they define a good life (Ryff & Singer, 2008). The model synthesizes the philosophy of Aristotle and John Stuart Mill with the humanistic psychology of Maslow and Jung and defines well-being as a multidimensional construct that spans all aspects of an individuals' life (Ryff & Singer, 1996). The focus on a good life and "living virtuously" broadens well-being beyond notions of feeling good or happy (Ryff, 1989). The model conceptually defines well-being on six domains: *Self-acceptance*, *Personal growth*, *Purpose in life*, *Positive relations with others*, *Environmental mastery*, and *Autonomy* (Ryff & Keyes, 1995). These six dimensions of well-being build individuals' capacity to see and accept their own strengths and weaknesses, have positive feelings about their lives thus far, and pursue a state of continued development and growth, using talents and potential to have close connections with others, manage demands of daily life, and have strength to follow personal conviction.

The PERMA Model.

Model Overview: The PERMA model is a well-known model of the Positive Psychology movement which scientifically examines the factors that make life worth living (Seligman & Csikszentmihalyi, 2000). The PERMA model was designed by Martin Seligman with five essential elements of psychological well-being and happiness, described by the mnemonic PERMA: *Positive emotions*, *Engagement*, *Relationships*, *Meaning*, and *Accomplishment* (Seligman, 2011). The PERMA model increases individuals' engagement with the five essential elements to help them build a life of fulfillment, happiness, and meaning. The PERMA model

can also be applied to organizations, agencies, and institutions and used to develop programs to help employees or clients develop the cognitive and emotional tools needed to flourish.

Propositions and Assumptions: The five essential elements to psychological well-being help individuals to focus on positivity and successes over the inevitable challenges and mistakes of life. This positive outlook on life combats depression symptoms, leads individuals to identify more creative solutions to problems, and to have better productivity at work and in life. One of the foundational goals of the PERMA Model is to center enjoyment on intellectual stimulation rather than the satisfaction of physical needs, which helps individuals to cultivate meaning (Seligman, 2011). Creating a meaningful life is about increasing engagement and becoming fully immersed in the moment. Immersive engagement, whether playing a sport or an instrument or creating through art or music is integral to building and expanding intelligence, skills, and emotional capacities. Relationships and social connections, in the PERMA model, are important for well-being as connection to other people – friends, family, intimate partners, and members of one's community – are key to building a life worth living. A meaningful life is achieved when individuals become a part of something larger than the self; meaning is foundational for providing individuals with a reason for living well. Individuals who can perceive the impact of the work they do report greater life satisfaction and happiness. Individuals who feel connected and engaged in their lives and are able to cultivate meaning are likely to work toward their goals to create a sense of fulfillment and achievement (Positive Psychology Center, n.d.).

The Leisure and Well-Being Model.

Model Overview: The Leisure and Well-Being Model provides an intervention development framework to increase well-being development for people with various disabilities through increased leisure activities (Carruthers & Hood, 2007; Hood & Carruthers, 2007). The

overarching goals of the model are to increase individuals' capacities related to living well while simultaneously addressing existing challenges and limitations to well-being (Hood & Carruthers, 2007).

Propositions and Assumptions: Leisure is identified as an integral component of a "life well-lived," as leisure is capable of generating positive emotion and self-efficacy (Carruthers & Hood, 2007). Hood and Carruthers (2007) note that at the most fundamental level, the absence of problems does not automatically translate into healthy thinking patterns and positive affect but personal growth can be achieved through leisure exploration. Leisure is an integral component of a life and is a vehicle for generating positive emotion, developing resources, and cultivating strengths to achieve well-being. The Leisure and Well-Being Model is composed of proximal, medial, and distal goals. The proximal goals are about experiencing and deriving pleasure from leisure experiences (Hood & Carruthers, 2007). Proximal goals are achieved by developing a range of individual (i.e., cognitive, psychological, and physical) and community (social and environmental) resources. The medial goals are achieved via the proximal goals: by identifying leisure activities that support well-being. Medial goals develop the interpersonal and external capacity and resources to support well-being, social connectedness and satisfaction, and engagement with one's community (Hood & Carruthers, 2016). The distal goals of the model are thought of all those goals that directly increase positive emotion, cultivate the expression of strengths and capacities, and develop and achieve well-being (Carruthers & Hood, 2007; Hood & Carruthers, 2007, 2016).

The overarching assumption of the Leisure and Well-Being Model is that individual well-being is developed by engaging in meaningful recreational activities with other people in their communities. Leisure activities serve as the vehicle for individuals to develop strengths and

capacity, experience social connectedness, and enjoy themselves in an immersive and meaningful activity. Practitioners help individuals to identify and access leisure and recreational activities, experience them fully, and expand their social networks through community engagement.

The Good Lives Model.

Model Overview: The Good Lives Model (GLM) is a strengths-based framework for correctional rehabilitation (Laws & Ward, 2011; Ward & Maruna, 2007). While originally developed for individuals convicted of sexual crimes, the GLM is a general rehabilitation theory that can be used with all justice-involved individuals, regardless of crime type (Ward, 2010). Although the GLM developers agree that RNR is a useful and effective theory for rehabilitation (Willis & Ward, 2013), they note that program participants may not respond positively to the negative orientation of some of the RNR language, argued to counteract with programming goals (Ward, Yates, and Willis, 2012). Thus, GLM developers hypothesize that if correctional rehabilitation is focused on an individual's valued goals to achieve their "good life," then those individuals will stay motivated and engaged in the rehabilitation process (Levenson, Prescott & D'Amora, 2010).

Propositions and Assumptions: GLM theory frames the motivation for criminal behavior as an individual's attempt to achieve a valued goal or outcome. These valued goals and outcomes are defined as primary goods - each of which have "intrinsic value" and "represent fundamental purposes and ultimate ends of human behavior" (Ward & Maruna, 2007, p.113). Evidence from psychological, biological, and anthropological research have identified at least 11 types of primary goods (Aspinwall & Staudinger, 2003; Cummins, 1996; Deci & Ryan, 2000). The 11 types of primary goods are: *Life* (defined as both healthy living and functioning), *Knowledge*

(feeling well informed about things one deems important), *Excellence in play* (leisure and recreational activities), *Excellence in work* (working towards mastery), *Excellence in agency* (having autonomy, power, and the ability to direct oneself), *Inner peace* (freedom from stress and emotional turmoil), *Relatedness* (relationships with friends, family, and intimate partners), *Community* (defined as a connection to wider social groups), *Spirituality* (defined broadly as finding meaning and purpose in life), *Pleasure* (or, feeling good in the here and now), and *Creativity* (being able to express oneself).

Primary goods are achieved by an individual through concrete actions called secondary or instrumental goods (Ward, Vess, Collie, & Gannon, 2006). The relationship between primary goods and secondary goods is fundamental to GLM because it is hypothesized that the use of maladaptive secondary goods in pursuit of a primary good is what leads to criminal behavior (Ward & Maruna, 2007). There are two main routes to criminal behavior according to the GLM: direct and indirect. The direct route is when an individual uses criminal means to attain a primary good (Ward & Maruna, 2007). In contrast, the indirect route is when the use of a particularly secondary good "creates a ripple effect in the person's personal circumstances" that increases the likelihood for criminal behavior (Ward & Maruna, 2007, p.123). In sum, GLM posits that by identifying an individual's valued goals to achieve their self-defined good life, the practitioner can work in partnership with the participant to identify pro-social and adaptive secondary goods to achieve their valued life goals (Ward & Maruna, 2007).

Well-Being Development Model and Reentry

After a thorough review of each of the theories described in detail above, we sifted out the major constructs of each of the theories and aligned them with the RNR model theoretical constructs. We choose to take this approach because RNR has been the predominant model in

reentry for at least two decades and has an empirical base that we felt needed to be acknowledged. After aligning the RNR constructs with the other four well-being oriented theoretical models, we proposed five constructs that reconceptualized the RNR Central Eight risk/need factors as facets of well-being while simultaneously responding to the reentry context. We refer to each of the five proposed constructs as “key facilitators of well-being development” or otherwise the 5 Key Facilitators of the WBDM. See Table 2 for a definition of each of the five proposed key facilitators of well-being.

TABLE 2 - *The five key facilitators of well-being development*

CONSTRUCT	DEFINITION
Healthy Thinking Patterns	Adaptive mental actions or processes, the presence of empathy, and the acceptance or internalization of values and norms that promote pro-social behavior. • Pro-social behavior is defined as actions that are intended to benefit another individual, groups of individuals, or society as a whole.
Meaningful Work Trajectories	Compatibility between an individual's goals and abilities and the demands of that individual's occupation is sustainable. • Compatibility is defined as a state in which two things are able to exist or occur together without problems or conflict. • Occupation is defined as obligation(s) / job paid or unpaid. • Sustainable is defined as able to be maintained or kept going, as an action or process.
Effective Coping Strategies	Adaptive behavioral and psychological efforts taken to manage and reduce internal/external stressors in ways that are not harmful in the short or long-term. • Effort is defined as work done by the mind or body. • Stressor is defined as demands that cause mental tension.
Positive Social Engagement	When an individual is engaged in social experiences organized for beneficial social purposes that directly or indirectly involve others, engaged in during discretionary time, and experienced as enjoyable. • Beneficial social purpose means the intention of an activity is to promote greater societal good. • Discretionary time is defined as time free from obligations, work, and daily living tasks (e.g., housework). • Indirectly involving others is defined as individuals co-located in a common physical space.
Positive Interpersonal Relationships	An association between two people that occurs in person and can range in duration from brief to enduring within formal or informal social contexts. The relationship is reliable, mutually beneficial, and enhances psychological well-being. • Formal social context is defined as paid or unpaid work settings, healthcare/treatment settings, and social service settings. • Informal social context is defined as all settings outside of paid or unpaid work, healthcare/treatment, and social services. • Reliable is defined as a relationship that promotes honesty and trust. • Mutually beneficial is defined as a relationship that supplies the needed level of honesty and trust for all people involved.

Constructs representative of each of the five key facilitators of the WBDM are conceptually and empirically linked to well-being development in extant literature from a range of disciplines and among a wide range of study samples. Below we review the related empirical literature for each of the five key facilitators of well-being development.

Healthy Thinking Patterns.

Healthy Thinking Patterns are adaptive mental actions or processes, the presence of empathy, and the acceptance or internalization of values and norms that promote pro-social behavior. Healthy Thinking Patterns may be crucial to the development of well-being among individuals leaving incarceration as the process of incarceration is isolating, frightening, and often dehumanizing. Individuals are not in control of making decisions about their lives, empathy is often interpreted as a form of risk and vulnerability, and opportunities to engage in pro-social behavior are constrained (Haney, 2002). Incarceration can instill and reinforce rigid thinking patterns and mute pro-social adaptive thought processes (Haney, 2002). Strengthening Healthy Thinking Patterns allows individuals leaving incarceration to develop and improve problem solving and communication styles, refine their decision-making skills while thinking about and caring for others in that process.

Several studies identify a link between Healthy Thinking Patterns and well-being, noting that a focus on the development of understanding one's thought process has a direct impact on psychological well-being (Kelley, 2011). In college students, Healthy Thinking Patterns like empathy and adaptive cognitions predict perceived well-being, with healthier thinking patterns being associated with increased self-reported well-being (Fredrickson & Joiner, 2002; Wei, Liao, Ku, & Shaffer, 2011). Longitudinal research with general population samples across the lifespan shows that empathy improves multiple dimensions of well-being. For example, Gruhn et al.

(2008) followed individuals aged 10 to 87 years over 12 years and found that increased self-reported empathy predicted personal growth ($r = 0.51$, $p < .01$), life satisfaction ($r = 0.16$, $p < .05$), and positive relations with others ($r = 0.50$, $p<.01$) - all critical facets of the well-being construct. Likewise, adaptive cognitions, a key facet of Healthy Thinking Patterns, were also found to protect against daily stress ($B = -0.16$, $p < .001$) in a large representative sample of 1,035 participants in Switzerland (Gloster, Meyer, & Lieb, 2017). Healthy Thinking Patterns are likely critical to the management of the stress and anxiety of reentry as well as managing mental health and substance use disorders experienced by many with incarceration histories (Weiss et al., 2016).

Meaningful Work Trajectories.

Meaningful Work Trajectories are defined as the compatibility between an individual's goals and abilities and the demands of that individual's occupation is sustainable. The Meaningful Work Trajectories key facilitator goes beyond traditional dichotomous employment outcomes to describe the complex interaction of an individual and their current and future work providing a far more sensitive indicator of individual and program progress related to employment. Occupations, in this context, describe any work that is paid or unpaid as a means to accommodate a broad range of activities engaged in to fulfill an internal or community need performed within or outside of the home, regardless of wherever these activities are exchanged for pay. For example, individuals with some disabilities may be unable to sustain paid work, but they may engage in unpaid, work-like activities that fulfill a similar purpose in their lives. Alternatively, some individuals may be able to care for their children at home while another family member works for pay. At the heart of this key facilitator is the notion of compatibility. When compatibility is achieved, then meaningful work takes on a sustained trajectory, where an

individual is able to maintain employment because it provides for the tangible needs of their lives while allowing them to deepen their sense of self and continue to grow as a person. Seeking and achieving Meaningful Work Trajectories helps move individuals in the reentry period toward a sense of personal empowerment, draws on their talents without creating unreasonable expectations or unintended burnout and frustration, and promotes employment sustainability as individuals engage in meaningful work, rather than accepting any available job.

The relationship between Meaningful Work Trajectories and well-being has yet to be explored in a criminal justice population but has been explored among samples of individuals who have similar complex needs. In a study with individuals with psychiatric disabilities, the quality of match between the individual's capacities and the environmental opportunities and demands significantly impacted overall well-being (Eklund, Leufstadius, & Bejerholm, 2009). Increased levels of education and higher occupational status are strongly correlated with well-being in a range of samples (Ryff & Keyes, 1995). For example, in a national survey of more than 3,000 middle-aged adults in the United States, engaging in meaningful work, even when that work was unpaid was associated with enhanced well-being ($B = 0.04$, $p < .05$; Son & Wilson, 2012).

The fit between an individuals' goals, skills, abilities and preferred advancement and their work environment appears to strongly predict well-being among workers (Lin, Yu, & Yi, 2014; Wu, Luksyte, & Parker, 2015; Yang, Che, & Spector, 2008). In a meta-analysis of 223 studies, Bowling, Eschleman, and Wang (2010) found that positive assessments of the work environment (or, job satisfaction) was linked to perceived well-being ($r = .40$, $p < .05$). Among the longitudinal studies examined, the authors note that the causal relationship from well-being to job satisfaction was significantly stronger than the causal relationship from job satisfaction to

well-being. This suggests that meaningful work is an extension of well-being, and functions as both a predictor and an outcome of well-being. Likewise, pursuing and attaining goals and having a strong sense of self-perceived workforce success also significantly predicts well-being (r = .22-.44, p < .05) in longitudinal studies (e.g., Wiese, Freund, & Baltes, 2002). In a meta-analysis of 85 studies and more than 20,000 study participants across North American, European, Australian, and Asian samples, Klug and Maier (2015) found that the relationships between self-perceived workforce success and well-being were retained (ρ = .43).

Effective Coping Strategies.

Effective Coping Strategies are defined as adaptive behavioral and psychological efforts taken to manage and reduce internal/external stressors in ways that are not harmful in the short- or long-term. Upon re-entering communities, individuals must navigate relationships with loved ones, identify a stable living situation, secure employment, and participate in services or treatment. This time of reentry is often compounded by the unique life experiences of individuals with incarceration histories that include disproportionate rates of trauma and poverty (Covin, 2012; Morrison et al., 2018; Pettus-Davis, Renn, et al., 2018). These factors may lead to chronic stress post-incarceration, which increases the likelihood for problematic behaviors such as problematic substance use, impulsivity, and re-engagement in crime (Bennett, Holloway, & Farrington, 2008; Dowden & Brown, 2002; Wilson & Wood, 2014). Developing and strengthening Effective Coping Strategies allows individuals to respond to stress, disappointment, anger, and periods of crisis using positive social supports and other healthy coping skills rather than reacting to these situations using violence, drugs, or alcohol or other negative or avoidant coping strategies (Lazarus & Folkman, 1984; Taylor & Stanton, 2007). Although Effective Coping Strategies may vary greatly among individuals and situations, all

individuals engage in some form (e.g. positive, negative, avoidant) of coping (Lazarus & Folkman, 1984; Taylor & Stanton, 2007). Further, Effective Coping Strategies are a key ingredient in almost all evidence driven treatments for problematic substance use and mental health disorders (Adan, Antunez, & Navarro, 2017).

Problem-focused coping is positively associated with well-being in a range of settings and samples (e.g., Mayordomo, Viguer, Sales, Satorres, & Meléndez, 2016). In a large, nationally representative sample of nearly 40,000 Canadians, effective coping was positively correlated with overall health and well-being (Meng & D'Arcy, 2016). These relationships held in a meta-analysis of 34 studies on the association of various types of coping and physical and psychological outcomes (Penley, Tomaka, & Wiebe, 2002) as well as in studies of college students, employees, and physical rehabilitation patients (Cheng, Lau, & Chan, 2014; Greenglass & Fiksenbaum, 2009). Effective coping strategies not only promote well-being, but they also help to protect against negative psychological symptoms in samples of college students ($r = -0.24$, $p = 0.017$; Gustems-Carnicer & Calderón, 2013) and cancer patients ($r = -.40$, $p < .01$; Boehmer, Luszczynska, & Schwarzer, 2007). Further, in gender analysis, when gender is the moderator, the positive relationship between problem-focused, effective coping and well-being holds true for both men and women (Gattino, Rollero, & De Piccoli, 2015).

This key facilitator reflects the RNR model's criminogenic risk/need factor of substance abuse - problematic substance use histories are common among individuals with incarceration histories and problematic substance use is likely a negative coping skill used after release (Bronson et al., 2017). Effective Coping Strategies reflects the GLM basic human goods of Spirituality and Life, which encourage individuals to deepen their own connection to their lives and environments. Finally, the Psychological Well-Being Model's dimensions of Environmental

mastery and Autonomy are embedded within this key facilitator, as individuals learn to activate effective coping to manage stress and solve problems and avoid engaging in behaviors likely to put themselves, their loved ones, or their community at risk.

The relationship between Effective Coping Strategies and well-being has previously been examined among incarcerated individuals. Overarchingly, results indicate that as Effective Coping Strategies increase, physical and psychological well-being also increases. For example, for many incarcerated individuals, experiencing optimism and being able to appropriately manage negative emotions like guilt, shame, and sadness are linked to both psychological and physical well-being (Van Harreveld, Van der Pligt, Claassen, & Van Dijk, 2007). Development of effective coping appears to be especially needed for incarcerated women, who arrive at prisons and jails with few coping resources and high levels of depression (Keaveny, 1999). Among incarcerated Australian men, positive coping styles had stronger relationships with well-being ($R^2 = .27$, $p < .001$) than incarceration-related variables like length of the current sentence ($R^2 = .08$, $p < .01$; Gullone, Jones, & Cummins, 2000). Further, in an intervention study conducted in the UK with 172 incarcerated men, Shuker and Newton (2008) found that a therapeutic community designed to improve coping, decrease substance use, and reduce criminogenic risk significantly improved psychological well-being (change correlation range -.400 - .639; $p < .01$). Likewise, participation in a drug court program in New South Wales also increased pre- to post-test mean scores on dimensions of physical well-being (pre-test $M = 60.1$, post-test $M = 75.8$, $p < .01$) and psychological well-being (pre-test $M = 53.8$, post-test $M = 73.1$, $p < .01$) for drug-using individuals with multiple prior arrests and incarcerations (Freeman, 2003). The use of Effective Coping Strategies in times of stress, day-to-day hassles, and in

problem-solving promotes well-being of all individuals with or without impairments, major life changes, or behavioral health diagnoses (Lazarus & Folkman, 1984; Taylor & Stanton, 2007).

Positive Social Engagement.

Positive Social Engagement is defined as social experiences organized for beneficial social purposes that directly or indirectly involve others, engaged in during discretionary time, and experienced as enjoyable. Although social engagement with friends and family are enjoyable, the Positive Social Engagement construct goes one step beyond to underscore the importance of social engagement pursued for beneficial social purposes. This means that the explicit intention of Positive Social Engagement is to promote greater societal good and to foster connection within the community (e.g., creating art, using public spaces like parks or libraries, playing or coaching sports). This type of engagement may directly involve other people or groups or may be more indirect, such as when individuals are co-located in a common physical space (e.g., community festival). Although there are many home-based or solitary forms of engagement one can enjoy alone or with friends and family that decrease the risk of engaging in criminal behavior (e.g., watching movies or playing video games), Positive Social Engagement is about connecting oneself and their family to the larger community and participating in the social world. Moreover, this facilitator acknowledges that some people choose to self-isolate after incarceration to protect themselves from what they believe to be bad influences. However, there is a tipping point with self-isolation when isolation can lead to negative experiences (Audet, McGowan, Wallston, & Kipp, 2013). As such, Positive Social Engagement encourages activities which reduce isolation (Lubben, Gironda, Sabbath, Kong, & Johnson, 2015), combat the stigma of incarceration (Brayne, 2014; Goffman, 2009), engage individuals as an accepted member of

their community (Maruna, Lebel, Mitchell, & Naples, 2004), and build positive social capital through informal social networks (Budde & Schene, 2004; Sampson & Laub, 1993).

This key facilitator reflects the RNR model's criminogenic risk/need factor - lack of prosocial recreational activities. Positive Social Engagement is reflective of the GLM basic human goods of Excellence in play, Excellence in agency, and Pleasure, and the PERMA Model's essential element of Engagement, all of which catalyze individuals to explore pleasure through recreation, leisure, and human connection. Finally, Positive Social Engagement maps onto the first medial leisure outcome in the Leisure and Well-Being Model, which is to identify leisure activities that support well-being and increase the value of those activities among individuals. According to the Leisure and Well-Being model, the more an individual values leisure activity as a part of their recovery from behavioral health disorders, the more likely they are to engage in and benefit from these social activities.

Increased participation in and satisfaction with leisure activities, especially those performed with a social group, are positively associated with increased material and emotional well-being among adolescents ($\beta = .21$, $p < .01$; Staempfli, 2007), adults ($\beta = .29$, $p < .001$; Pressman et al., 2009), and older adults (Koopman-Boyden & Reid, 2009; Kuo, Chew, & Hooi, 2007). Further, in a meta-analysis involving 37 effect sizes and more than 11,000 study participants, the relationship between leisure engagement and subjective well-being was mediated by an individuals' satisfaction with their leisure activities (Kuykendall, Tay, & Ng, 2015). Among adults diagnosed with schizophrenia or other psychotic disorders, leisure activity significantly moderates the relationship between negative symptomatology and well-being ($t = 2.45$, $p = 0.015$; Mausbach, Cardenas, Goldman, & Patterson, 2007). Research on interventions designed to enhance leisure experiences similarly find that positive social

engagement in leisure activities improves well-being. The frequency and diversity in positive social engagement activities like leisure, is more strongly associated with well-being than the amount of time spent engaged in activities (Kuykendall et al., 2015). Although there has been substantially less research in this area for incarcerated individuals, Positive Social Engagement has been connected to well-being among individuals involved in the criminal justice system. For example, Cooper and Berwick (2001) note that interpersonal relationships and social activities (e.g., having friends prior to incarceration and playing a sport on a community team) increased self-reported well-being for incarcerated boys and men serving life sentences in Ireland.

Positive Interpersonal Relationships.

Positive Interpersonal Relationships are defined as reliable, mutually beneficial relationships between two people that range from brief to enduring in duration within formal or informal social contexts. The focus of Positive Relationships is on face-to-face relationships between people who share a formal (e.g., paid or unpaid work, treatment, or other social service settings) or informal (e.g., family or neighborhood) connection. Further, Positive Interpersonal Relationships are reliable in that they promote honesty and trust, even when these relationships are very brief. Not all of an individual's relationships will meet this threshold, even when the relationships are healthy and do not result in negative influences. Positive Interpersonal Relationships are meant to identify relationships which foster connection and have the capacity to enact transformation - of the individual, their family, their community, or the social structures with which they interact. For example, Positive Interpersonal Relationships may help individuals heal from trauma, reduce stigma in a community, or promote engagement with social structures (e.g., hospitals and schools) often regarded with fear and distrust among individuals in the reentry period (Goffman, 2015).

Positive Relationships have been identified as a critical protective factor by a range of disciplines addressing varied life experiences including health management, behavioral health, stress management, caretaking, and well-being (Cohen, Underwood, & Gottlieb, 2000; Sarason & Sarason, 2009). This key facilitator reflects the RNR model's criminogenic risk/need factors of Poor family/marital relationships and the GLM basic human goods of Relatedness and Community. Likewise, the PERMA Model's essential element of Relationships and the Psychological Well-Being Model's dimension of Positive relations are also embedded in the Positive Relationships construct. Finally, Positive relationships map onto the second medial leisure outcome in the Leisure and Well-being Model, which is to develop the interpersonal and external capacity and resources to support well-being, social connectedness and satisfaction, and engagement with one's community. Essentially, the model contends that interpersonal relationships are key to positively reinforcing engagement in one's community to manage and cope with symptoms related to various cognitive or physical ailments.

Positive relationships are a critical component for generating positive emotions and developing well-being (Diener et al., 1999; Fredrickson, 2001; Fredrickson, Tugade, Waugh, & Larkin, 2003; Shankar, Rafnsson, & Steptoe, 2015). The social support that individuals receive through their interpersonal relationships, especially those relationships between parent and child, intimate partners, family members, and close friends is one of the most robust correlates of well-being across sample, population, and study design (Lyubomirsky, King, & Diener, 2005; Ramsey & Gentzler, 2015). Social support has been associated with increased self-esteem and positive emotions, positive coping skills, as well as physical and mental health, creating an upward spiral of emotional and physical well-being (Fredrickson & Joiner, 2002). For example, in a longitudinal study of 7,500 older adults, support from spouses, children, and friends

significantly predicted increased well-being over the 8-year follow-up period ($\beta = .21$, $p < .001$; Chopik, 2017). Likewise, in a cross-sectional survey of nearly 275,000 adults, having strong family relationships exerted a static influence on both health ($R\chi 2 = -5.00$, $p = .03$) and well-being ($R\chi 2 = -6.41$, $p = .01$) across the lifespan, while having strong friendships was related to better functioning overall ($R\chi 2 = 9.33$, $p = .002$) Chopik, 2017). Additionally, the relationship between positive interpersonal relationships also extends beyond family and close friends and into weaker social relationships among acquaintances, suggesting that even social interactions with the more peripheral members of our social networks contribute to individuals' well-being (Sandstrom & Dunn, 2014).

The impact of interpersonal relationships remains when examined among samples of individuals diagnosed with life-threatening or chronic illness. In a study of 175 cancer patients, having strong social support at one and six months after tumor removal surgery was statistically associated with well-being ($\beta = .19$, $p < .05$; Boehmer et al., 2007). Likewise, increased self-reported perceptions of positive social support was associated with increased well-being among 570 elderly adults adapting to chronic vision impairments (Reinhardt et al., 2006). To overcome barriers to treatment engagement, such as transportation, practitioners are increasingly looking to technology to augment human-to-human interactions (Pettus-Davis & Kennedy, 2019). As such, researchers have begun to examine the connections between positive relationships fostered using technology and social media platforms and well-being. Although the strength of the relationships varied, using social media platforms was related to social support and psychological well-being ($r = 0.16$, $p < .01$) and talking on the telephone was a strong predictor of social support and well-being for individuals aged 35 and older ($r = 0.08$, $p < .05$; Chan, 2018). However, for many of

the younger members of the sample, some technology and social media platform use was associated more negative emotions and increased feelings of entrapment.

In summary, the five key facilitators of well-being development are a guide for the next generation of reentry programs. Strong theoretical and empirical support for these five key facilitators as central mechanisms of action indicate that targeting the key facilitators will achieve the long-term goals of promoting overall individual well-being and community stability among individuals with incarceration histories.

Implications for Research, Policy, and Practice

Ryff and Singer (1996) argue compellingly that the route for an individual's recovery from a disorder is likely not about simply ridding oneself of negative risk factors or unhealthy behaviors, but rather is more likely about promoting and facilitating protective factors and positive behaviors that can be drawn upon in the face of adversity. We propose the WBDM as a new conceptual framework to guide the next generation of reentry service approaches focused on the promotion of protective factors and positive behaviors among individuals leaving incarceration and returning home. Extant evidence supports well-being-based interventions for individuals across varied populations, diseases, and disorders as effective – especially in the face of adversity. We hope that interventions developed using the WBDM as a theoretical orientation will increase incarcerated and formerly incarcerated individuals' capacity to reach their full human potential while simultaneously addressing the common problems and barriers that often compromise their best efforts to achieve success. Although many other fields have shifted from a focus on individual deficits and individual risk toward well-being, reentry has lagged behind. The field of reentry is well-suited to focus on well-being, re-inventing the way we perceive, respond to, and effectively support individuals who have experienced incarceration.

Since 2008, the United States federal government has launched several initiatives designed to promote well-being-oriented outcomes among children and families including educational success, child health and social-emotional development and connection and support to a child's family (e.g., the Fostering Connections to Success and Increasing Adoptions Act of 2008, the Child and Family Services Improvement and Innovation Act of 2011, and Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services of 2012). With the passage of the First Step Act (2018), there is now opportunity to shift reentry services approached to also focus on well-being. The First Step Act calls for the use of evidence-driven services and assessment approaches to promote success in reentry. One critical next step is to develop a Well-Being Oriented Agenda for Reentry Services to detail how such success could be achieved. The WBDM may provide guidance for such an agenda. A re-orientation toward achieving individual well-being can be adopted within the reentry context and, if it proves successful, this orientation can be infused throughout all phases and facets of the entire criminal justice system. This might include increasing the use of deflection programs within law enforcement settings, expanding diversion practices in both prosecution and court settings, implementing well-being-oriented programs within incarceration settings, and designing programs to help individuals develop and enhance well-being as they leave incarceration and return home during the reentry period.

We propose the five key facilitators of well-being development articulated in the WBDM as a new framework for reentry practice. The five key facilitators provide standardization in intermediate outcomes for assessing program impact on key mechanisms of action that universally affect all individuals releasing from incarceration despite their presenting characteristics or life histories. Theoretical explorations and empirical evidence suggest that if an

individual performs well on each of the five key facilitators, then they will likely develop or enhance overall well-being. Overall well-being, in turn, will likely improve community stability (e.g., housing stability, employment, coping, family and social support, and community engagement), helping individuals with incarceration histories to thrive in their communities and break the cycle of incarceration, release, and re-incarceration that all but defines the reentry period. The WBDM is grounded upon other existing frameworks that have been shown to improve outcomes among a range of individuals facing myriad challenges in their lives and communities. Further, the WBDM provides five standardized program targets for intervention developers and practitioners to apply when working with a range of individuals leaving incarceration, each of whom have varied needs. The intermediate outcomes (i.e., the five key facilitators for well-being development) and long-term outcomes (i.e., community stability and overall well-being) advance research and practice by facilitating assessment of individual success and program effectiveness while also allowing for analysis across multiple reentry services programs offered in a range of settings and contexts. As more researchers and practitioners adopt this framework, data generated by interventions grounded upon the WBDM can be used to further examine the validity of the model.

Although existing theoretical and empirical data suggests the WBDM is valid, further subjecting the model to empirical investigation is important and warranted. Examining the effectiveness of well-being-oriented reentry services interventions may also undercover critical intervention gaps that, when addressed, will increase the impact of programming efforts on individuals' progress through each of the five key facilitators of well-being development. One of the most promising uses of the WBDM and well-being-oriented reentry services interventions is shifting away from a sole focus on recidivism as a proxy for individual success during the

reentry period. The five key facilitators of well-being development, as consistent intermediate indicators of success, will help the field to identify differential responses by subgroup for each key. For example, using the five key facilitators for well-being development may show age or gender (or any number of other characteristics) as significant independent variables or moderators. Perhaps those releasing from incarceration who are younger than 22 need more (or less) support when compared to those releasing who are age 65 or older to achieve Meaningful Work Trajectories and Positive Interpersonal Relationships? Perhaps men and women experience Positive Social Engagement differently as they leave incarceration and return home. Any number of explorations will help researchers and practitioners to tailor well-being-oriented reentry services interventions to meet the needs of the individuals with whom they work.

As mentioned above in the introduction, we are currently testing a well-being-oriented reentry services intervention called the 5-Key Model for Reentry with individuals leaving incarceration in seven states across the nation (Pettus-Davis & Kennedy, 2020a; Pettus-Davis, Veeh, et al., 2018). To develop this comprehensive reentry services program, we identified a package of evidence-based interventions used with criminal justice-involved and other marginalized populations that collectively addressed each of the five key facilitators of well-being development. The 5-Key Model is comprised of several interventions for each key facilitator. These interventions were selected based on their effectiveness when used with criminal justice system-involved or other populations with similar needs and their relevance to the population of individuals leaving incarceration and returning home. Interventions were selected to ensure that all individuals would receive an assessed and work with a practitioner and receive an intervention appropriate to their needs to support progress on each key facilitator. Great care was taken not to over-program individuals with low needs (Pettus-Davis, Veeh, et al.,

2018). Each participant's progress through the five key facilitators is guided by the use of a validated assessment tool called the Reentry Well-Being Assessment Tool (Veeh, Renn, & Pettus-Davis, 2018). Using a standardized decision-making assessment tool allows us to monitor an individual's progress on each of the five key facilitators during their reentry program participation. We pair this assessment package with both the clinical judgment of our practitioners and with direct participant input to determine whether program dosage should increase or decrease around a given key facilitator.

The Reentry Well-Being Assessment Tool established benchmark score ranges on each of the five key facilitators using existing research on criminal justice-involved and non-criminal justice involved samples. Future research on assessment tools developed using the WBDM framework should also explore critical differences between those actively engaged in reentry services when compared to those who are not engaged in services. This will allow for more comprehensive understanding of individuals' functioning on each of the five key facilitators during their reentry transition and provide data for targeted benchmarking among individuals who have experienced incarceration and interacted with reentry services programs. Additionally, multisite trials and research-practitioner partnerships are needed to facilitate the adoption and testing of innovative well-being-oriented interventions using the WBDM. For example, we refined the 5-Key Model during a multisite pilot and feasibility test and are currently testing the effectiveness of the model with the goal of examining efficacy and working towards national scaling.

In conclusion, the WBDM is an innovative conceptual framework designed to shift the reentry landscape to focus on well-being and to guide the next generation of reentry services approaches for individuals releasing from incarceration. The WBDM represents individuals who

have experienced incarceration as capable and deserving of reentry services programs that engage them as active participants in the building or rebuilding of their lives rather than as passive or incapable people for whom the risk for crime must be controlled. Our hope is that the WBDM offers researchers, practitioners, and policymakers a framework that identifies positive outcomes upon which to assess an individual and program's success and allows the field to move beyond the flawed recidivism construct. The WBDM has the potential to demonstrate the range of factors, and associated needed resources, that drive observed structural and social disparities throughout the criminal justice system, allowing individuals to develop well-being while policymakers simultaneously promote public health and public safety and work toward racial and economic equity.

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