

OPRE Report # 2018-69

# **Trauma-Informed Approaches for Programs Serving Fathers in Re-Entry: A Review of the Literature and Environmental Scan**

**A Special Topics Study of the Parents  
and Children Together Evaluation**

July 2018



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Robin Dion, Lareina LaFlair, Melissa Azur, Michaela Morzuch, Angela D'Angelo

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Office of Planning, Research, and Evaluation

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330 C Street SW, 4th Floor

Washington, DC 20201

Project Officer: Seth Chamberlain (OPRE-COR)

Kathleen McCoy (OPRE/BSC – Project Monitor)

Contract Number: HHSP23320095642WC

Submitted by:

Mathematica Policy Research

1100 1st Street, NE

12th Floor

Washington, DC 20002-4221

Telephone: (202) 484-9220

Facsimile: (202) 863-1763

Project Director: Robin Dion

Reference Number: 06997.593



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## OVERVIEW

### Introduction

A large proportion of incarcerated persons in the U.S. are low-income men of color who are fathers. Evidence is growing that many such men have experienced trauma early in life, and that experiencing trauma may complicate their efforts to reconnect with and support their families after incarceration. This report explores trauma in the reentry population and how responsible fatherhood programs, including those funded by the Office of Family Assistance (OFA) in the Administration for Children and Families, can take a trauma-informed approach to the services they offer.

OFA provided support for fathers in 2015 through two funding streams that are part of the Healthy Marriage and Responsible Fatherhood (HMRF) discretionary grant program. OFA awarded grants to community-based organizations for services specifically tailored to the needs of fathers in the process of transitioning from incarceration to their families and communities, known as the Responsible Fatherhood Opportunities for Re-entry and Mobility (ReFORM) programs. OFA also awarded grants for programs that serve fathers without regard to incarceration status or history, known as the New Pathways for Fathers and Families (NPPF) programs, or more generally responsible fatherhood programs. Research suggests that many responsible fatherhood program participants have incarceration histories (Dion et al. forthcoming). Programs in both funding streams tend to focus on low-income fathers, and are required to offer services to promote responsible parenting, economic stability, and healthy marriage and relationship skills. Legislative authorization for HMRF programs was provided by the Claims Resolution Act of 2010.

### Primary research questions

1. What does the research literature suggest about the types and prevalence of traumatic experiences among fathers returning from incarceration? What are the potential consequences of these traumas for fathers' parenting, economic stability, and relationships?
2. What are the elements of a trauma-informed approach, and what can we learn from programs that are implementing such an approach with fathers returning from incarceration?
3. What evidence-based trauma-specific services are available to reentering fathers, and to what extent are they appropriate for men returning to the community after incarceration?

### Purpose

The purpose of this report is to document what is known about trauma among fathers reentering from incarceration, how fatherhood programs can foster healing and avoid exacerbating or re-traumatizing participants, and resources that may be available to help fatherhood programs become trauma-informed.

## Key findings and highlights

Fatherhood program participants are often low-income men of color who are re-entering or who have re-entered the community after incarceration (Dion et al. forthcoming). The research literature on trauma in this specific population is limited. However, we can approximate an understanding of the prevalence and experience of trauma in this population by drawing on studies of men generally, incarcerated men, low-income fathers, and low-income men of color. Although more systematic research is needed, the literature suggests that trauma is common in low-income fathers with incarceration histories. Unless addressed, trauma may complicate the efforts of responsible fatherhood programs to help men achieve positive outcomes.

Trauma-informed approaches to service delivery are more common in behavioral health settings than human services programs. However some examples show that human services programs, including those serving re-entering fathers, can implement trauma-informed care.

Key steps in taking a trauma-informed approach to fatherhood program services include:

- Make a systemic commitment to take a trauma-informed approach throughout the entire organization's policies, procedures, and settings
- Train all staff (including non-clinical staff) in the signs of trauma and how to appropriately respond to them
- Screen all program participants for signs of trauma
- Refer fathers in need of clinical treatment to gender and culturally appropriate services

Several models for delivering trauma-specific services have been developed, some of which must be delivered by mental health clinicians, while others can be delivered by case managers, peer specialists, or other nonclinical professionals (such as fatherhood program staff). Although this review did not identify any trauma-specific models designed specifically for recently incarcerated fathers, the report describes some models that are either designed for men, have been implemented in prison settings or with individuals who were recently incarcerated, or could potentially be adapted for fathers who were recently incarcerated.

Resources are available to assist programs interested in becoming trauma-informed, including training programs, organizational assessments, staff training, trauma screening instruments, and information about trauma-specific services. This report describes and provides contact information for several of these resources.

## Methods

This report is based on a review of the literature on trauma among incarcerated men, an environmental scan to identify programs that address trauma among fathers, and discussions with a subset of programs and key experts in the field of trauma-informed care.

## Glossary

- **Trauma-informed approaches** focus on the ways in which an organization reflects its understanding of trauma and responds by applying trauma-informed principles throughout all levels of its standard services and operations—from how staff interact with participants during service delivery to written policy and leadership support.
- **Trauma-specific services** are interventions to address trauma symptoms, such as clinical treatment for post-traumatic stress disorder. Such interventions can be group-based or individual-based. Often, but not always, they require delivery by a mental health professional.
- **Trauma-informed system of care** is considered an umbrella term that may encompass a trauma-informed approach, trauma-specific services, or both.

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## EXECUTIVE SUMMARY

A substantial proportion of individuals incarcerated in state and federal prisons are economically disadvantaged men of color who are fathers of minor children. About 90 percent of the prison and local jail population are men, with incarceration concentrated among young African American men who have not completed high school (Western and Pettit 2010). According to Bureau of Justice statistics, about 53 percent of the nation's incarcerated population were parents of children under age 18 in 2007, an increase of 79 percent since 1991 (Glaze and Maruschak 2010). Research suggests that the majority of men returning to their families and communities after incarceration face challenges in reconnecting as supportive and engaged parents, partners, and providers (Travis et al. 2001; Dion et al., forthcoming; Kubrin and Stewart 2006).

To address these and related issues, the Office of Family Assistance (OFA) in the Administration for Children and Families (ACF), U.S. Department of Health and Human Services provided support for fathers in 2015 through two funding streams that are part of the Healthy Marriage and Responsible Fatherhood (HMRF) discretionary grant program. OFA awarded grants to community-based organizations for services specifically tailored to the needs of fathers in the process of transitioning from incarceration to their families and communities, known as the Responsible Fatherhood Opportunities for Re-entry and Mobility (ReFORM) programs. OFA also awarded grants for programs that serve fathers without regard to incarceration status or history, known as the New Pathways for Fathers and Families (NPFF) programs, or more generally responsible fatherhood programs. Research suggests that many responsible fatherhood program participants have incarceration histories (Dion et al. forthcoming). Programs in both funding streams tend to focus on low-income fathers, and are required to offer services to promote responsible parenting, economic stability, and healthy marriage and relationship skills. Legislative authorization for HMRF programs was provided by the Claims Resolution Act of 2010.

The experiences of ReFORM grantees as well as research on NPFF programs suggest that many participants have experienced adverse childhood experiences (known as ACEs), which may complicate their efforts to reconnect with and support their families. The funding opportunity announcement (FOA) for the 2015 round of ReFORM grants explicitly recognized this challenge and indicated a special interest in applicants that take trauma into consideration when providing services. Borrowing from the successful integration of trauma-informed care in behavioral health settings, the grant announcement indicated interest in program designs that “take into consideration lessons emerging from related fields, including trauma or indicators of trauma, and how these experiences may influence the lives and behaviors of program participants.” The FOA also noted, however, that awardees would be prohibited from using ACF grant funds to directly provide behavioral or mental health treatment. The FOA noted that ACF is “particularly interested in applicants with a demonstrated ability to coordinate and integrate case planning and service delivery with appropriate providers within the community.”

## Report purpose and methodology

This report is based on a targeted review of the literature, an environmental scan of reentry programs, and discussions with key informants. It addresses three broad research questions:

1. What does the literature suggest about the types, correlates, and prevalence of traumatic experiences among fathers returning from incarceration? What are the potential consequences of these traumas for fathers' parenting, economic stability, and relationships?
2. What is a trauma-informed approach, and what can we learn from programs that are implementing such an approach to serving fathers returning from incarceration?
3. What evidence-based trauma-specific services are available, and to what extent are they appropriate for men returning to the community after incarceration?

In conducting the literature review, we used the search terms “trauma” and “men” and “incarceration” to identify and review 40 full-text journal articles and grey (unpublished) literature, such as project reports, white papers, and government reports, published between 2000 and 2016. About half of the articles described programs and interventions used to treat the effects of trauma among men recently returning from prison. Fourteen articles described the types, correlates, extent, and timing of traumatic experiences among men, and five articles described trauma-informed approaches to working with fathers recently returning from prison.

To assess the extent to which trauma-informed programs for justice-involved fathers exist (aside from ReFORM grantees), we conducted an environmental scan, identifying 41 programs that appeared to implement a trauma-informed approach or provide trauma-specific services. Based on their potential for providing useful information for fatherhood programs, we selected for further review six programs that serve recently incarcerated fathers, and held one-hour discussions with the program directors to better understand how the programs have implemented trauma-informed approaches and the facilitators and barriers to doing so.

To supplement the information gathered through the literature review and environmental scan, Mathematica and OPRE jointly identified five experts in trauma-informed approaches with whom we held one-hour telephone discussions. Discussions with these experts focused on (1) programs implementing trauma-informed approaches or delivering trauma-specific services for fathers recently released from prison; (2) facilitators of and barriers to successful implementation of trauma-informed approaches for fathers recently released from prison; and (3) trauma-informed programs or services that could be adapted to meet the needs of these fathers.

## Key findings

Taken together, the results of our study suggest several conclusions and implications for fatherhood programs serving men with incarceration experiences.

**Trauma in fathers who are re-entering society appears to be prevalent.** However, compared to what is known about trauma in women, children, and combat veterans, little information is available on the prevalence, experience, and impact of trauma among nonmilitary men, especially low-income men of color.

**Trauma may complicate the ability of men in fatherhood programs to achieve positive outcomes.** Past traumas, the incarceration experience itself, and the return to disadvantaged communities with few resources and job opportunities likely compound the difficulty these men experience in successfully re-entering the community.

**A key premise of a trauma-informed approach is that healing can occur through interaction with individuals who are sensitive to trauma but not necessarily trained therapists.** A trauma-informed approach suggests that healing and recovery can be facilitated through interaction with nonclinical staff, especially staff who have experienced and recovered from similar traumas. This is important because although some trauma survivors will receive trauma-specific services to address Post-Traumatic Stress Disorder (PTSD), many will not due to limited accessibility or resources.

**Implementing a trauma-informed approach at ReFORM and other fatherhood programs requires attention in several key areas:**

- *A systemic commitment across the entire organization to a trauma-informed approach.* A trauma-informed approach to services is about changing the organizational culture. Conducting an organizational assessment is an essential step to identifying ways that trauma-informed principles can be incorporated into policies, procedures, and settings.
- *Training all staff in the signs of trauma and how to appropriately respond to them.* Facilitating healing and taking care to not create additional harm can be promoted by training direct services staff to recognize and appropriately respond to signs of trauma.
- *Screening all participants for signs of trauma.* Trauma screening helps staff recognize the signs of trauma in their clients. Some fathers' responses to trauma may go beyond the help that a fatherhood program can provide. Trauma screening and assessment allows programs to identify fathers who may benefit from trauma-specific services.
- *Referring fathers in need of clinical treatment to appropriate services.* Some fathers will have PTSD or other disorders related to trauma exposure. Trauma-specific services vary in their suitability for use with men and people of various cultural backgrounds, their availability at the local level, and whether they can be provided by clinical or nonclinical staff.

**Several lessons can be drawn from programs that have begun to use a trauma-informed approach in serving men during re-entry.** Although this field is very young and our scan was not exhaustive, it suggests some general lessons:

- Trauma-informed principles can be embedded in a variety of program settings that serve justice-involved men.
- Organizations implementing trauma-informed principles in re-entry services should consider program structure, sequence, and activities.
- A trauma-informed approach to fatherhood services does not require clinical staff.
- Trauma-informed systems of care can be implemented in human services organizations that do not provide mental or behavioral health services.

Resources are becoming more available to assist programs interested in becoming trauma-informed, including organizational assessments, staff training, and information about trauma-specific services, some of which do not require delivery by a mental health clinician.

## 1. INTRODUCTION AND POLICY BACKGROUND

A substantial proportion of individuals in state and federal prisons are economically disadvantaged men of color who are fathers of minor children. Men comprise about 90 percent of the prison and local jail population, with incarceration concentrated among young African American men who have not completed high school (Western and Pettit 2010). According to Bureau of Justice statistics, about 53 percent of incarcerated individuals were parents of children under age 18 in 2007, an increase of 79 percent since 1991 (Glaze and Maruschak 2010). At least five million children have had a parent in prison or jail (Murphey and Cooper 2015), and children of parents who have been incarcerated are known to be at greater risk for developmental, health and mental health problems (Eddy and Poehlmann 2010; Jarjoura, DuBois, Slafter and Haight 2014; Murphey and Cooper 2015).

Each year, about 636,000 people are released from state and federal prisons, while more than 11 million cycle through local jails (Wagner and Rabuy 2015). Research suggests that the majority of men returning to their families and communities after incarceration face challenges in reconnecting as supportive and engaged parents, partners, and providers. Incarceration can affect a man's relationship with his spouse or partner; research shows that those relationships are central to successful reintegration (Travis et al. 2001). Many men face barriers to steady and gainful employment as a result of their criminal records, which makes supporting themselves and their families difficult. Criminal justice backgrounds also function as a barrier to housing stability and may lead to homelessness, especially among fathers who are unmarried.

To address these and related issues, the Office of Family Assistance (OFA) in the Administration for Children and Families (ACF), U.S. Department of Health and Human Services provided support for fathers in 2015 through two funding streams that are part of the Healthy Marriage and Responsible Fatherhood (HMRF) discretionary grant program. OFA awarded grants to community-based organizations for services specifically tailored to the needs of fathers in the process of transitioning from incarceration to their families and communities, known as the Responsible Fatherhood Opportunities for Re-entry and Mobility (ReFORM) programs. OFA also awarded grants for programs that serve fathers without regard to incarceration status or history, known as the New Pathways for Fathers and Families (NPFF) programs, or more generally, responsible fatherhood programs. Research suggests that many responsible fatherhood program participants have incarceration histories (Dion et al. forthcoming).

Legislative authorization for HMRF programs is provided by the Claims Resolution Act of 2010, which allows funding for three specific responsible fatherhood activities:

- **Responsible parenting**, which includes skill-based parenting education; information about good parenting practices; counseling, mentoring, and mediation; and encouraging child support payments

- **Economic stability**, which includes such activities as job search, job training, subsidized employment, job retention, and career-advancing education
- **Healthy marriage**, which includes enhancing relationship skills; counseling, mentoring, and disseminating information about the benefits of marriage for children; education in avoiding aggressive behavior, domestic violence, and child abuse; marriage preparation programs; premarital counseling; marital inventories; skills-based marriage education; financial planning seminars; and divorce education and reduction programs

The experiences of ReFORM grantees as well as emerging research on other fatherhood programs that serve similar populations suggest that many participants who are re-entering society have experienced traumatic experiences early in life (also referred to as adverse childhood events, or ACEs), which may complicate their efforts to reconnect with and support their families. Experts generally agree that traumatic experiences are defined as “an event, or series of events, that causes moderate to severe stress reactions” and include sexual or physical abuse or assault; emotional abuse; neglect; domestic violence; community or school violence; traumatic grief or separation; and system-induced trauma, such as a forced removal from the home (National Child Traumatic Stress Network). Traumatic experiences can have a lasting negative effect on a person’s well-being and functioning (Huang et al. 2014).

Childhood traumatic experiences that have been documented among fatherhood program participants include child abuse or neglect; witnessing or being victims of family or community violence; early and repeated exposure to substance abuse; and parental death, abandonment, or incarceration (Comfort et al. 2016; Holcomb et al. 2015). These traumatic experiences may continue during adulthood in the form of toxic stress, such as racial discrimination and loss of friends and family members to early death (Dion et al., forthcoming). The effects of such traumatic experiences may limit fathers’ ability to participate in and benefit from the programs designed to help them during re-entry.

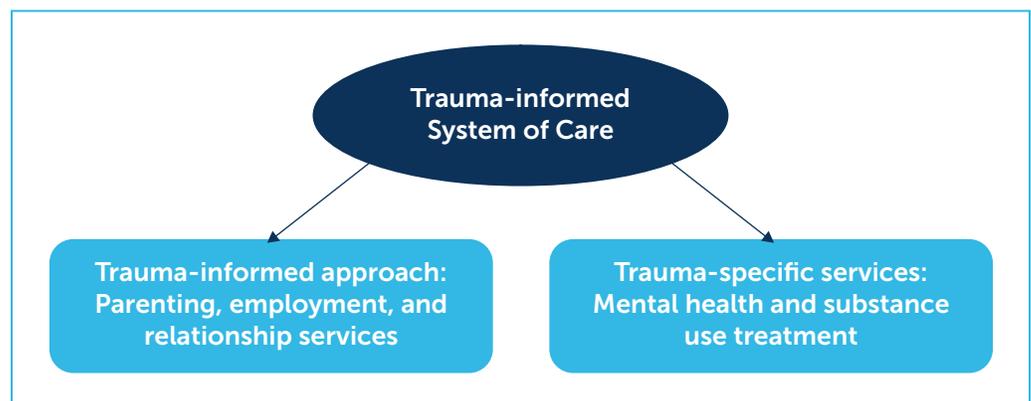
In the funding opportunity announcement (FOA) for the 2015 round of ReFORM grant applicants, ACF expressed a special interest in grant applicants who plan to provide services that are sensitive to the effects of trauma in participants. Borrowing from the successful application of trauma-informed care in behavioral health, the grant announcement indicated interest in program designs that “take into consideration lessons emerging from related fields, including trauma or indicators of trauma, and how these experiences may influence the lives and behaviors of program participants.” The FOA noted that although ReFORM grantees are not permitted to use ACF grant funds “to provide behavioral or mental health care or treatment related to trauma or early adverse experiences,” ACF hopes to increase fathers’ success in re-entry by incorporating “appropriate community-based trauma-informed supports.” ReFORM

grantees are encouraged to coordinate care planning with community organizations that do deliver trauma-specific services.

Strategies to recognize and address the effects of traumatic events have been implemented in other human services settings, such as employment services. ACF is interested in learning more about how ReFORM grantees can take a trauma-informed approach to the services they offer. However, the implementation of these approaches is still very new to the field. Furthermore, some confusion exists about the distinctions among the terms “trauma-informed approach,” “trauma-specific services,” and “trauma-informed care.” As shown in Figure 1.1, we define these terms following the approach by Huang and colleagues (2014):

- **Trauma-informed approaches** focus on organizational change—that is, the ways in which an organization reflects its understanding of trauma and responds by applying key trauma-informed principles throughout all levels of its standard services and operations, from policy and leadership to staff training and cross-sector collaboration.
- **Trauma-specific services** are interventions that are delivered to clients to directly address their traumas. These services typically include clinical treatment for such trauma-related conditions as post-traumatic stress disorder (PTSD). Such interventions can be group-based or individual-based. Often, but not always, they require delivery by a mental health professional.
- **Trauma-informed system of care** can be considered an umbrella term that may encompass a trauma-informed approach, trauma-specific services, or both.

**Figure 1.1. Trauma-informed care, approach, and specific services**



This report summarizes our findings from a targeted review of the literature, an environmental scan for relevant programs undertaking trauma-informed care, and interviews with key informants who are leading initiatives on trauma-informed approaches (see Appendix A for a discussion of our methods). The review, scan, and interviews focused on three broad research questions:

1. What does the literature suggest about the types and prevalence of traumatic experiences among fathers returning from incarceration? What are the potential consequences of these traumas for fathers' parenting, economic stability, and relationships?
2. What are the elements of a trauma-informed approach and what can we learn from programs that are implementing such an approach with fathers returning from incarceration?
3. What evidence-based trauma-specific services are available, and to what extent are they appropriate for men returning to the community after incarceration?

The remainder of this report describes our findings. Section 2 describes traumatic experiences among fathers in re-entry. Section 3 discusses the elements of a trauma-informed approach and how they might be applied to fatherhood programs. Section 4 highlights a selection of organizations that are undertaking a trauma-informed approach to serving men in re-entry. Section 5 focuses on trauma-specific services and their suitability for fathers returning from prison. Section 6 offers some conclusions and implications.

## 2. TRAUMA AMONG FATHERS IN RE-ENTRY

Fatherhood program participants are often low-income men of color who are re-entering the community after incarceration or were incarcerated in the past. The research literature on trauma in this specific population is limited. However, we can approximate an understanding of trauma in this population by drawing on studies of men generally, incarcerated men, low-income fathers, and low-income men of color. In this section, we describe what is known about the experience of trauma in men generally, the prevalence of childhood trauma in low-income men, traumatic experiences among adult incarcerated men, and the challenges these men face in re-entering society and in recovering from trauma.

### A. An emerging area of research

Although the topic of trauma has received increasing attention by researchers and service providers in the last decade, much of the literature on trauma focuses on women, children, and military veterans. Comparatively little information is available on the prevalence, experience, and impact of trauma among nonmilitary men, especially low-income men of color.

What we do know is that the types of trauma experienced and how trauma affects behaviors and relationships is often different for men than for women. Relative to girls, boys are more likely to report higher rates of witnessing a severe injury or murder; being threatened, held captive, or kidnapped; or experiencing physical assault (Schilling et al. 2007). Men are more likely to engage in substance use or aggression in response to trauma, whereas women may show more detachment and other symptoms of PTSD (Breslau et al. 2004; Olf et al. 2007; Tolin and Foa 2006). We also know that compared to women, men tend to underreport traumatic experiences, which further masks our understanding of their prevalence and effects (Holmes and Slap 1998; Lee et al. 2014).

The human services field has only recently recognized and taken steps to address the presence and impact of male victimization, intergenerational trauma, and the traumatic experiences faced by individuals involved in the criminal justice system. A recent series of expert panel meetings on trauma in men involved in the criminal justice system sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) indicated the need for an improved understanding of how men's socialization influences their response to violence, abuse, and other traumas (personal communication with Mary Blake, December 20, 2016). Differences in gender-role socialization are also thought to influence men's support-seeking behavior and perceived level of social support later in life, such that, relative to women, men tend to have less social support (Evans et al. 2013). Recognizing how trauma is experienced and expressed among men, particularly men of color, will be key to developing gender- and culturally-appropriate interventions and reducing service practices that may also be traumatizing.

## **B. Childhood trauma in low-income men**

Several studies suggest that childhood traumatic experiences are common in low-income men of color (Carlson and Shafer 2010; Gordon et al. 2011; Holcomb et al. 2015). The childhoods of low-income fathers are frequently characterized by poverty, a lack of resources, and parental absence or loss. In addition, abuse in childhood is more prevalent among low-income men than in the general population (Briere et al. 2016; Topitzes et al. 2016). In some studies, nearly one in five low-income men report experiencing some combination of physical, psychological, or sexual abuse before age 18 (Messina et al. 2007; Topitzes et al. 2016). Relative to the general population, low-income African American men report higher overall rates of childhood family dysfunction, including witnessing domestic violence, household substance use, parental separation and divorce, and incarceration of a family member (Topitzes et al. 2016). In a 2015 qualitative study of 86 fathers participating in responsible fatherhood programs, the majority of whom had been incarcerated, men described social isolation accompanying childhood parental abandonment or prolonged absence due to incarceration, divorce, or separation. Some men described the enduring impact of the sudden loss of a parent or family member (Holcomb et al. 2015).

## **C. Trauma in incarcerated men**

Although not all low-income men experience incarceration, and not all men who are incarcerated are fathers of color, childhood traumatic events are common among incarcerated men. Adverse experiences include, for example, child abuse, early exposure to parental substance abuse, and community violence. One study of 838 incarcerated fathers reported that 49.8 percent of men had experienced physical violence by a family member (Carlson and Shafer 2010). About half of men involved in the criminal justice system report a history of childhood sexual abuse (Briere et al. 2016; Johnson and James 2016), compared to only about 7 percent of men in the general population (Briere et al. 2016). Another study found that about half of incarcerated men reported growing up with at least one parent who abused drugs or alcohol (Messina et al. 2007). These fathers also tend to experience instability in the form of childhood community violence. In a study of trauma among individuals in state prisons, most men reported having lived in a violent neighborhood (Maschi et al. 2011).

Men can also experience trauma during incarceration. One study of mostly male, African Americans in prison reported that 84 percent witnessed someone being threatened by a weapon during incarceration (Maschi et al. 2011). In the same study, violent victimization, defined as physical or sexual assault, was commonly reported among incarcerated men. According to the U.S. Department of Justice, between 149,200 and 209,400 incidents of male and female sexual victimization occur annually in prisons, yet fewer than 10 percent of these incidents are reported to the authorities (Beck et al. 2013; Kubiak et al. 2016).

According to emerging literature on trauma during incarceration, people who have been incarcerated describe the distressing psychological effects of practices such as solitary confinement (Haney et al. 2001). In an essay, one man described his 15 months in solitary confinement as a harrowing experience of extreme deprivation, likened to “going to prison inside of a prison” (Deveaux 2013). Some investigations further note the risk for trauma related to strip searches and witnessing or experiencing violent victimization during incarceration (Maschi et al. 2011; Deveaux 2013). Although qualitative research suggests that incarceration may trigger memories of past trauma and that new instances of trauma may occur during incarceration, the lack of accurate data on victimization within correctional institutions makes it difficult to understand the impact of prison trauma post-release (de Viggiani 2006; Madera 2016).

Among youth who have been incarcerated, exposure to traumatic events during incarceration (both direct and witnessed) is thought to be highly common. In one study, nearly all youth reported some type of abuse (for example, physical or sexual violence, denial of food, or solitary confinement) during incarceration (Dierkhising et al. 2014). Youths’ exposure to prison trauma is associated with increased levels of anxiety, depression, and PTSD (Boxer et al. 2009; Dierkhising et al. 2014).

#### **D. Challenges for fathers in re-entry**

Fathers returning to their communities after incarceration face multiple challenges to successful re-entry, including dangerous neighborhoods, lack of social support, the effect of their criminal records on employment and housing opportunities, the effects of their absence on children and partners, and frequently, substance use disorders that co-occur with mental health conditions related to trauma. Having a history of traumatic experiences may exacerbate these already difficult challenges.

**Neighborhood and community factors.** Men returning to disadvantaged neighborhoods face barriers that may impede their re-entry. Concentrated disadvantage at the community level can exacerbate existing psychological problems due, in part, to an absence of social ties and support (Diez Roux 2001; Kim 2010; Mair et al. 2010; Sampson et al. 1997). Social networks can provide both emotional support and connections to resources, such as information about job opportunities. However, some evidence suggests that the average size of the social networks of formerly incarcerated fathers is small compared to national norms, with most of these fathers reporting 5 or fewer connections to family or friends compared to the national average of 23 connections (D’Angelo et al. 2016). In addition, disadvantaged neighborhoods tend to have fewer people who are employed, thus residents have fewer people in their social networks that they can rely on for job referrals (Kubrin and Stewart 2006). Undoubtedly, many fathers will return to their communities with pre-existing mental health problems and in need of social support and appropriate services.

Neighborhood disadvantage also may confer risk for recidivism through several mechanisms, including the social context. Recidivism is high for previously incarcerated individuals who return to the same or similar neighborhoods and social networks that led them to incarceration in the first place (Kubrin and Stewart 2006). In one analysis of previously incarcerated men, researchers in Oregon found that neighborhood socioeconomic status predicted new arrests 12 months post-release—even after accounting for race and ethnicity, gender, and age (Kubrin and Stewart 2006). Yet in a similar study with male racial minority offenders in Pennsylvania, neighborhood concentrated disadvantage was not associated with repeated incarceration. The authors suggested that cognitive factors, including decision-making skills, may play a role instead (Stahler et al. 2013). These findings highlight the need for consideration of both neighborhood context and other determinants during re-entry.

**Effect of criminal records on employment and housing.** Having a felony criminal record threatens the chance of securing stable employment and housing. Among the many factors affecting employability, numerous studies have shown that having a criminal record is a barrier to obtaining a job (Holcomb et al. 2015; Mong and Roscigno 2010; Topitzes et al. 2016; van der Geest 2016). Past felonies severely limit employment opportunities even for those who are actively engaged in employment and training services, particularly for African American and Latino men who may also experience racial discrimination (Holcomb et al. 2015; Swisher and Waller 2008). Economic difficulty can, in turn, lead to an inability to provide financial support for children and families, and may lead to homelessness (Holcomb et al. 2015). One study of formerly incarcerated parents found that nearly half of fathers had experienced homelessness (Carlson and Shafer 2010). When fathers do secure employment, low wages and child support arrears (which can accumulate during incarceration) often contribute to fathers' financial hardships. These interrelated factors, in turn, affect fathers' abilities to maintain stable housing, which can then limit their opportunities to be involved with their nonresidential children (Holcomb et al. 2015). Children of incarcerated parents face greater financial, material, and housing instability than children of parents who are not incarcerated (Geller et al. 2009, 2011).

**Effect of absence on relationships with children and partners.** Extended absences due to incarceration can damage relationships with children and partners. The prolonged physical separation between fathers and their families often strains these connections (Secret 2012). Interviews with incarcerated fathers and their families confirm that while families can be a source of social and structural support during re-entry, meeting men's needs for emotional connection and practical support can be overwhelming, especially for couples who complete multiple cycles of incarceration and re-entry (Comfort et al. 2016). Partners in intimate relationships are forced to adapt to changing expectations about the relationship's future during each stage of re-entry; parent-child relationships are equally strained during lengthy absences.

Parenting children during incarceration is challenging at best, given fathers' limited access to their children. Roy and Dyson (2005) found that fathers sometimes fear being replaced or cut off from their children, especially if mothers and children physically relocate. They also found that transitioning back into the role of a present parent is challenging for many fathers who were previously incarcerated. Fathers face difficulty reunifying with children after an extended absence, particularly if mothers become involved with new partners during the incarceration period (Roy and Dyson 2005). When co-parenting relationships were positive, fathers had greater involvement in their children's lives.

**Co-occurring substance abuse disorders.** In addition to possible trauma-related mental health conditions such as PTSD, men returning from prison often struggle with co-occurring substance use disorders. Criminal justice-involved men, particularly those with a history of trauma, experience significant alcohol and drug problems that often persist during the re-entry process (Carlson et al. 2010). Early exposure to substance use and violence may have contributed to the fathers' own struggles with drug and alcohol in adulthood (Holcomb et al. 2015). One study of incarcerated parents found that more than two-thirds of fathers experienced drug or alcohol addiction at some point in their lives (Carlson and Shafer 2010). Although 67 percent and 79 percent of trauma-exposed, incarcerated fathers reported an alcohol or a drug problem, respectively, fewer than one-fourth acknowledged a need for substance use disorder treatment (Carlson et al. 2010). These data suggest a significant unmet need for substance abuse services among incarcerated fathers.

The prevalence of trauma among incarcerated men, and among low-income men in general suggests the need for trauma-informed care for fathers reentering from incarceration. The challenges incarcerated fathers face in re-integration can only complicate their recovery from trauma and further underscores the need for trauma-informed care.

### 3. ELEMENTS OF A TRAUMA-INFORMED APPROACH

This section describes the elements of a trauma-informed approach that could be adopted by fatherhood programs. As described in Section 1, a trauma-informed approach refers to how an organization reflects its understanding of trauma and responds by applying key trauma-related principles throughout its various levels of operations. Trauma-informed care may also include screening and referral to trauma-specific services, but these are distinct concepts. Trauma-specific services are client-focused, often clinical interventions for trauma survivors designed to address the individual response to trauma exposure (such as treatment for PTSD), while a trauma-informed approach involves how staff delivering other services (such as parenting, employment, or relationship education) adjust their interactions and procedures to create opportunities for healing and to avoid additional trauma to participants.

#### A. Trauma-informed approaches require organizational change

SAMHSA's concept paper (Huang et al. 2014) introduces a general framework for trauma-informed care and offers principles and guidance on developing a trauma-informed approach, which could be helpful to programs that provide services to criminal justice-involved populations. The framework views programs as trauma-informed if they (1) realize the prevalence of trauma among participants; (2) recognize the impact of trauma in their population; (3) respond by implementing principles of trauma-informed system of care; and (4) resist additional trauma by emphasizing physical and psychological safety for both survivors and staff. These basic assumptions serve as a foundation for understanding what trauma is, how it manifests, how to avoid additional trauma, and how organizational leadership and direct care staff can benefit from adopting a trauma-informed approach. The SAMHSA framework focuses on six key principles of a trauma-informed approach, as shown in Box 3.1.

#### Box 3.1. Principles of Trauma-Informed Approaches

SAMHSA developed a framework for trauma-informed care, identifying six core principles of a trauma-informed approach (Huang et al. 2014).

1. **Safety:** Ensuring physical and emotional safety for participants and staff in program activities and settings
2. **Trustworthiness and transparency:** Enhancing the ability of participants to trust staff through the establishment of expectations and boundaries
3. **Peer support:** Building trust and rapport among participants with like experiences in group settings
4. **Collaboration and mutuality:** Leveling staff-participant power differences to make healing more likely
5. **Empowerment, voice, and choice:** Giving participants choice and control whenever possible
6. **Cultural, historical, and gender issues:** Moving past cultural stereotypes and biases and incorporating processes that respond to individuals' cultural needs

Because trauma-related issues can be made better or worse by how individuals are approached in service programs, a fully trauma-informed organization reflects these principles throughout its operations and culture. SAMHSA suggests 10 domains of implementation that can reflect an organization's awareness of trauma (Box 3.2).

Other proponents of trauma-informed care have built upon SAMHSA's framework to provide additional suggestions for implementation. For example, the Campaign for Trauma-Informed Policy and Practice added a public health framework, with an emphasis on an intergenerational, life course approach (Bloom 2016). The National Center for Trauma-Informed Care further built upon the framework to add a focus on elimination of coercive practices such as seclusion and restraint (Huang et al. 2014). Research organizations including the Center for Health Care Strategies and the American Institutes for Research have also added to the model by proposing strategies for integrating trauma-informed care across service sectors (DeCandia et al. 2014; Menschner and Maul 2016).

**Box 3.2. Ten Areas for Implementing the Principles of a Trauma-Informed Approach**

1. Governance and leadership
2. Policy
3. Physical environment
4. Engagement and involvement
5. Cross-sector collaboration
6. Screening, assessment, and treatment services
7. Training and workforce development
8. Progress monitoring and quality assurance
9. Financing
10. Evaluation

Although the frameworks differ slightly, they all suggest that trauma-informed principles can and should be implemented throughout a program's operations. Each principle can be implemented in multiple domains, but may not be needed in every domain. For example, the principle of safety can be reflected in written policies regarding participants' confidentiality and privacy and also within the physical setting by ensuring that rooms are soundproof. Trustworthiness and transparency can be shown by staff clearly explaining expectations for attendance and by following up on participants' requests or questions. The principle of peer support can be implemented by offering group-based settings instead of or in addition to individual-level services. The principle of collaboration and mutuality can be implemented by training staff to approach participants as equals. The principle of empowerment, voice, and choice can be embraced by engaging participants in their own service planning. The principle of cultural, historical, and gender issues can be reflected in the choice of tools used to assess participants for trauma.

On a practical level, applying SAMHSA's guidance for a trauma-informed approach to ReFORM grantee services and other fatherhood programs would suggest developing

a systemic commitment to recognizing and addressing trauma in two main ways: creating the conditions that promote healing and recovery from trauma within existing fatherhood services, and systematically screening fathers for symptoms of trauma exposure and referring them to agencies that provide clinical treatment when needed. ReFORM grantees could also partner with agencies that are already funded to provide trauma services.

### **B. Systemic commitment to a trauma-informed approach**

The main objectives of ReFORM grantee programs and similar programs are to improve fathers' parenting, economic stability, and marriage or relationships. Yet, these efforts may be undermined by the effects of trauma among participants. To successfully infuse fatherhood services with awareness and knowledge about trauma, existing frameworks suggest that a systemic commitment to this goal is necessary. Organizations can foster the adoption of trauma-informed practices within their fatherhood services by taking the following steps:

**Develop an understanding of trauma and how programs can promote or delay recovery.** As a first step, fatherhood programs can receive training and technical assistance to become familiar with what trauma is, how it is manifested, how people can be traumatized again, how to assess for trauma, and what supports or delays recovery from trauma. A range of organizations (described in Section 3, Section E below) can provide this information through brief or longer training sessions. Resources such as trauma-informed assessments are also available and can be recommended by trauma consultants.

**Show leadership support for implementing a trauma-informed approach.** Strong leadership support can help embed trauma-informed practices into the culture of fatherhood programs. Organization and program leaders can find ways to convey to staff the importance of attending to trauma while still maintaining a commitment to the primary mission. To aid in this goal, organizations may want to identify a champion who can arrange training, be a consistent advocate for other staff to adopt a trauma-informed approach, and serve as a point of contact for internal and external efforts to align fatherhood programs with the principles of trauma-informed care.

**Revise policies and procedures to take trauma into account.** An important way that leaders can demonstrate their commitment to becoming a trauma-informed organization is to ensure that written and unwritten policies and procedures reflect an awareness and sensitivity to the issue of trauma and the principles of a trauma-informed approach. For example, procedures can specify how staff should protect participants' privacy, demonstrate trustworthiness, and empower participants by giving them choices in service delivery. Written policies can also specify how to screen participants for trauma and make appropriate referrals to behavioral health treatment when needed.

**Structure service delivery in ways that foster healing and recovery.** Several studies have documented the success of group-based, peer-led community building sessions in creating safe, supportive environments to heal from trauma (Fallot et al. 2011; Slattery et al. 2013). Research on fatherhood programs serving low-income, primarily African American, fathers living in urban areas has shown that participants overwhelmingly value the opportunity to discuss their issues in settings that include other men like themselves (Holcomb et al. 2015; Miller and Knox 2001; Zaveri and Baumgartner 2016). Although intensive treatment for PTSD may be needed for some individuals, researchers suggest that peer-group settings may be more useful than individual therapy in helping men process difficult experiences (Fallot and Harris 2002; Wolff et al. 2015). More research is needed to confirm that peer-group settings are the most useful strategy for other populations such as low-income fathers from other cultural backgrounds. For example, during a site visit one fatherhood program in rural Appalachia has described a strong cultural taboo against men talking about their personal issues even in a small group; it is seen as not masculine.

**Train staff on how to recognize and appropriately respond to signs of trauma in participants.** Nonclinical fatherhood program staff are in a unique position to foster healing and recovery from trauma, but they can unintentionally worsen its effects or further traumatize participants if they are not trained properly. Staff can be trained to increase their awareness of trauma and their ability to recognize trauma symptoms, as well as to develop skills for avoiding potentially harmful interactions. Training can focus on developing an understanding of how to apply the principles of trauma-informed care when engaging program participants. For example, training can enhance staff skills for encouraging open and honest communication. As described in more detail below, these positive, supportive interactions between participants and program staff can promote psychological safety and facilitate recovery from the effects of trauma.

### **C. The role of fatherhood program staff**

Although OFA-funded fatherhood programs are not permitted to use grant funds authorized under the Claims Resolution Act of 2010 to provide mental health treatment, a great deal can be done to promote trauma recovery as part of existing nonclinical services. Staff delivering these services can facilitate healing in at least two ways suggested by the research literature: by promoting nonjudgmental daily interactions and by avoiding the exacerbation of trauma.

**Promoting nonjudgmental daily interactions.** Staff in programs that serve fathers who are re-entering their communities are likely to be the first responders with respect to the impact of trauma exposure. Thus, they are well positioned to either promote or delay recovery. Compassionate, nonjudgmental interactions with fathers who have suffered trauma can set the stage for recovery and healing according to SAMHSA's model.

Research has shown that an enhanced understanding of how men respond to trauma can induce compassion, particularly among male program staff (Miller and Najavits 2012). Educating staff to detect the signs of trauma in the specific population of recently incarcerated fathers is essential because how trauma is manifested in this population may differ from others. Because trauma interferes with the ability to self-regulate, trauma in men may manifest itself as aggression, substance abuse, moodiness, or other behaviors that may be misunderstood (Agaibi and Wilson 2005; Ford et al. 2012).

**Avoiding the exacerbation of trauma.** Staff can be trained to avoid and resist inadvertently worsening trauma symptoms. Staff who are unable to recognize the signs of trauma in men may react to disruptive behavior unfairly or with punishment—for example, with hostility or threats to drop them from further services. Such punishments are unlikely to be helpful for trauma survivors and could traumatize them further or delay their recovery.

Through training, staff can develop an awareness of the manifestations of trauma in men and learn to respond appropriately. Training in communication techniques that promote safety and avoid punishment may be helpful. Verbal communication techniques that de-escalate conflict can be effective in responding to trauma and in creating a safe environment (Miller and Najavits 2012). Programs can also train staff in ways that engage participants with empathy and compassionate care as well as that avoid triggers that may activate a trauma response.

#### **D. Screening to identify need for treatment**

Because of the prevalence of traumatic experiences among low-income fathers who are re-entering the community from prison, trauma-informed programs screen applicants for the effects of trauma exposure. Simple and easy-to-use tools are available that can be employed by nonclinical staff to conduct this screening. For example, Brewin and colleagues (2002) developed a 10-item screener for symptoms of PTSD that has been validated and frequently used in a wide variety of settings. In choosing a screening tool, fatherhood programs should consider its gender and cultural appropriateness by checking national registries (for example, SAMHSA's National Registry of Evidence-Based Programs and Practices) for the populations in which the particular tool has been used.

The main purpose of screening is to identify individuals who may need further clinical assessment and treatment for PTSD and other mental health problems associated with trauma exposure such as a depression. Some fatherhood programs retain a clinician on staff to provide in-house mental health treatment, typically as an individual-based service (funded by non-ACF sources). According to some fatherhood practitioners, however, this is not always feasible because of the cost or because the organization does not see mental health treatment as part of its mission.

Most programs refer fathers who are in need of treatment to mental health services that are available in the community. However, researchers report multiple challenges in making this process work effectively. First, fathers may not follow through on the referral for a variety of reasons, such as having no health insurance or concerns about stigma. Second, available treatment may not be gender or culturally appropriate. Third, treatment may not be grounded in evidence-based practices. Section 5 explores currently available trauma-specific treatment and its challenges.

Efforts are currently under way to identify ways to more effectively refer low-income male survivors of trauma to appropriate treatment. Researchers at the Institute for Child and Family Well-Being at the University of Wisconsin–Milwaukee are conducting a study to examine the effectiveness of connecting low-income men in transitional jobs programs to health and mental health services that can address trauma. The enhanced model helps participants: (1) obtain health insurance coverage; (2) establish services with a primary care physician; and (3) complete a trauma screening and brief intervention protocol, which is followed by a referral to mental health services if needed. The researchers hypothesize that enhanced services will result in improved physical or behavioral health, as well as gains in long-term employment and yearly income. A report on the pilot test of this screening and referral process is forthcoming in the journal *Social Practice and Addictions* (personal communication with Dr. Dimitri Topitzes, February 23, 2017).

### **E. Training and resources to help programs become trauma-informed**

As the field of trauma-informed care develops, resources and training are increasingly available. Public and private agencies offer assistance and training for a variety of organizations to help them become trauma-informed. In addition, self-assessment instruments are becoming available for use by programs that want to determine the extent to which they are trauma-informed.

For more information about TREM and M-TREM training, contact Community Connections at 202-608-4788 or email [lbeyer@ccdc1.org](mailto:lbeyer@ccdc1.org)

**Community Connections.** Community Connections (CC) is a nonprofit organization that provides consultation and training to various types of human service providers who are interested in creating cultures of trauma-informed care. CC's approach uses a tool to focus on how the key principles of safety, trustworthiness, choice, collaboration, and empowerment can be implemented within a program, as well as how an understanding of the effects of trauma and the paths to healing and recovery can be reflected throughout all aspects of a program's service delivery and settings. CC also provides training in trauma-specific services. Led by Maxine Harris, CC developed the Trauma Recovery and Empowerment Model (TREM) group intervention for women in the 1990s, an evidence-based model that has been widely adopted in the field. Building on this effort, CC clinicians, led by Roger Fallot, created a version of the intervention specifically for men in 2005, called M-TREM (described in more detail in Section 5). CC is currently conducting a rigorous evaluation of M-TREM's effectiveness.

For more information about trauma-informed trainings for criminal justice professionals and trauma trainers, contact SAMHSA's GAINS Center at 1-800-311-4246

For more information about technical assistance products developed by the NCMHJJ, call 866-962-6455 or email [ncmhjj@prainc.com](mailto:ncmhjj@prainc.com)

For more information on trauma training and technical assistance provided by NCTIC, call 1-866-254-4819 or email [NCTIC@NASMHPD.org](mailto:NCTIC@NASMHPD.org)

For more information on NASMHPD's training and technical assistance to state mental health agencies, submit your request to SAMHSA's TA tracker at <https://tatracker.treatment.org/loginaspx>

**Policy Research Associates.** Policy Research Associates (PRA) is an organization that seeks to create positive social change for vulnerable populations, including persons involved in the juvenile or criminal justice systems, as well as for adults and youths who have co-occurring substance use disorders. PRA provides trauma-related technical assistance and training for federal agencies such as SAMHSA, the Health Resources and Services Administration, and the Office of Justice Programs. PRA leads SAMHSA's GAINS Center for Behavioral Health and Justice Transformation and the National Center for Mental Health and Juvenile Justice (NCMHJJ). These centers aim to improve services and treatment for adults and youths with behavioral health problems who come into contact with the criminal justice system. The GAINS Center provides technical assistance and training for prison staff and leads initiatives such as the Behavioral Health Treatment Court Collaborative. Through its trainings, the GAINS Center's mission is to create a trauma-informed criminal justice system workforce by promoting evidence-based trauma treatments. The National Center for Mental Health and Juvenile Justice provides technical assistance on trauma screening, assessment, and treatment in juvenile justice settings and on the development of trauma-informed diversion programs. The center is currently developing a trauma-informed decision protocol for juvenile justice practitioners.

**National Association of State Mental Health Program Directors.** As a nonprofit organization representing state mental health commissioners and directors and their agencies, the National Association of State Mental Health Program Directors (NASMHPD) provides guidance for state mental health agency interests, including state mental health planning, service delivery, and evaluation. NASMHPD offers consultation, training, and technical assistance on an array of topics, including understanding the impact of trauma and the need for trauma-informed care. NASMHPD also directs SAMHSA's National Center for Trauma-Informed Care (NCTIC). Through NCTIC, the organization provides technical assistance and consultation to support programs that are committed to implementing trauma-informed approaches. NCTIC staff provided intensive training for two of SAMHSA's five-year grantee programs to facilitate re-entry: (1) the Offender Re-entry Program (ORP) and (2) the Resiliency in Communities After Stress and Trauma (ReCAST) program. These five-year grants assist awardees in serving marginalized, at-risk populations that are in need of trauma-informed behavioral health supports. Although NASMHPD has worked with organizations serving incarcerated men, it has not yet worked with programs that have a fatherhood focus.

**Drexel University (Sanctuary Model).** Developed by Dr. Sandra Bloom of Drexel University, the Sanctuary Model® is a trauma-focused organizational change model designed to promote a healing care environment in which both staff and patients are empowered decision makers (Bloom and Sreedhar 2008). This model was first

For more information about the Sanctuary Model® submit your request to <http://sanctuaryweb.com/ContactUs.aspx>

To obtain a sample copy of the ARTIC scale, email [artic@kingberg.org](mailto:artic@kingberg.org)

To purchase the ARTIC scale and supporting materials, complete this form [http://traumaticstressinstitute.org/wp-admin/admin-ajax.php?action=frm\\_forms\\_preview&form=r3xfv4](http://traumaticstressinstitute.org/wp-admin/admin-ajax.php?action=frm_forms_preview&form=r3xfv4)

implemented in acute psychiatric settings to treat childhood trauma but is expanding to other service organizations, including residential treatment centers, school settings, domestic violence shelters, and drug and alcohol treatment centers. The Sanctuary Model's focus on organizational and cultural change makes it a promising model for fatherhood programs, though it would likely need some adaptation to be suitable for low-income men returning from prison.

**Self-assessments.** New self-assessment instruments are available for organizations to determine the extent to which they are taking a trauma-informed approach. One such instrument is the Attitudes Related to Trauma-Informed Care (ARTIC) scale (Baker et al. 2016). Based on research showing that staff attitudes are important drivers of successful implementation, this 45-item measure assesses service provider attitudes that are relevant to trauma-informed care. The domains measured include an understanding of problem behavior and symptoms, responses to problem behavior and symptoms, on-the-job behavior, personal support of trauma-informed care, and system-wide support for trauma-informed care.

## 4. TRAUMA-INFORMED PROGRAMS SERVING JUSTICE-INVOLVED MEN

Federal and other agencies are increasingly calling for a trauma-informed approach in the health and human service programs they support. Although this approach is more common in the child welfare field, other fields are beginning to realize the important role of trauma in program participants' lives. The latter is the case for programs that serve men in re-entry. Such programs include those whose primary goals are to improve employment outcomes, address substance use disorders, promote father involvement, and prevent recidivism. Early lessons learned by these programs in implementing a trauma-informed approach for serving recently incarcerated men and fathers may be useful for ReFORM and other grantees and programs that serve similar populations.

To assess the existence of trauma-informed re-entry programs from which we might glean useful lessons, we conducted a brief environmental scan.<sup>1</sup> First, we drew on information from the literature and from talking with a range of experts to identify a set of programs that appeared to be taking a trauma-informed approach. Next, we identified publicly available information describing these programs. Finally, for a subset of these programs, we held one-hour telephone discussions with their directors (see Appendix A for more information on our methods). Our search and review included organizations and services for fathers with past criminal justice system involvement, incarcerated men, male trauma survivors, and individuals transitioning to re-entry. These programs offer services either before release, after release, or both. This scan was limited in scope and not intended to be an exhaustive review. In some cases, the descriptions of the programs relied only on publicly available information, which may be out of date or incomplete.<sup>2</sup>

Taken together, our analysis of the group of programs we identified suggests that while interest is great, programs for men who are re-entering society are just beginning to discover how to implement trauma-informed approaches. Some are further along in their thinking and implementation than others. A few incorporate an understanding of trauma throughout most of their service delivery and systems; others do so in only some implementation domains but not others. In general, helping programs develop a better understanding of trauma-informed approaches and how they can be implemented at all points in re-entry services appears to be needed.

To assist readers in identifying programs most similar to their own, we group the program description into five categories:

1. Employment-focused re-entry programs
2. Re-entry programs focused on substance abuse recovery
3. Responsible fatherhood programs serving previously incarcerated men
4. Court-based programs focused on re-entry
5. Community-wide initiatives focused on trauma

## A. Employment-focused re-entry programs

The U.S. Department of Labor provides funding for several grant programs, including the Re-entry Demonstration Project, the Re-entry Employment Opportunities program (formerly the Reintegration Ex-Offender's Program), and the Training to Work program. Although a trauma-informed approach was not specified in its funding opportunities announcement, the Dannon Project is one example of a Labor Department grantee that is taking a trauma-informed approach in re-entry services and career readiness training for nonviolent, previously incarcerated persons who are reintegrating into the community.

### THE DANNON PROJECT

- Conduct an organizational assessment related to trauma
- Develop a training guide on trauma-informed care and integration of trauma principles in service delivery
- Revise program policies and procedures to reflect awareness of trauma
- Create trauma-informed staff training
- Begin services prerelease for nonviolent male and female offenders

**The Dannon Project.** To reduce recidivism and ease re-entry to the community, the Dannon Project begins preparing offenders for transition about six months before their release (by focusing on such areas as housing, employment, health care, and social connections) and provides continued supports after their release. As described in a recent webinar sponsored by the Office of Family Assistance, the Dannon Project made a conscious decision to take a trauma-informed approach to its services, especially in its case management and referrals. It began developing its trauma-informed approach by first conducting an organizational assessment of its policies, procedures, and practices as they related to trauma. It then developed a training guide on trauma-informed care and integration of trauma-informed principles in client services; revised its program policies, procedures, and forms to reflect trauma-informed needs; and created trauma-informed training for staff to embed trauma-informed care into service delivery.

## B. Re-entry programs focused on recovery from substance use

The Offender Re-Entry Program (ORP) from SAMHSA provides grants for programs to expand or enhance substance use disorder treatment and related recovery and re-entry services for individuals who are returning to their communities and families after incarceration. The grant solicitation specifically emphasizes that grant applicants should include a trauma-informed approach to their services. Funded programs focus on providing transition supports from incarceration to community-based substance abuse treatment and re-entry services. Re-entry transition is expected to begin in the correctional facility prior to release. Below, we highlight four ORP grantees: (1) the Re-Entering the Albany Community Through Treatment (REACT) program at the Addictions Care Center of Albany, New York; (2) the Montgomery County Offender Re-entry Program (MCORP) in Ohio; (3) the Prince George's County Offender Re-entry Program (PGCORP) in Maryland; and (4) the Living Free program at the Connecticut Mental Health Center (CMHC) in New Haven. We also describe a multisite, recovery-focused, re-entry program in Florida that is sponsored by Bridges International.

**REACT**

- Focus on adult offenders with substance abuse issues who are re-entering the community
- Conduct needs assessment and, if needed, trauma and mental health screenings
- Provide services to clients with (1) substance abuse issues only or (2) co-occurring substance use and mental health problems (using the Seeking Safety curriculum)
- Deliver ongoing staff training on the principles of a trauma-informed approach

**Albany, New York: REACT.** The REACT program provides screening, education, case management, and integrated treatment for men and women with substance abuse issues who are re-entering the community. Program referrals typically come from parole officers, probation officers, the drug court, or the correctional facility. Participation in the REACT program may be mandated as a condition of release. Intake coordinators first conduct a needs assessment. If the screening indicates further assessment is needed, the participant completes the Modified Mini-Screen, a tool for identifying PTSD, anxiety, and depressive disorders. Based on the results, the intake coordinator may recommend further assessments with the organization's on-site psychiatrist. Case managers also administer SAMHSA's Government Performance and Reporting Act instrument, which includes questions about whether the client has ever experienced any traumatic event (specific examples are provided).

The REACT program offers two tracks of services: (1) one for clients with substance abuse disorders only and (2) one for those with co-occurring substance use and mental health problems, including PTSD. The co-occurring track includes the group-based, trauma-specific service Seeking Safety, an evidence-based curriculum that can be used with men to treat trauma and co-occurring substance use disorders. Additional services in this track may include cognitive behavioral therapy and motivational interviewing to build and reinforce positive behaviors. The REACT program has trained its clinical counselors and halfway house staff in the principles of a trauma-informed approach and has implemented these principles in several domains. Staff were taught how to approach and appropriately work with clients who have had traumatic experiences. To help establish an emotionally safe group setting, participants are asked to sign a pledge to respect others' privacy. The program builds trustworthiness by clearly establishing rules and expectations and ensuring consistency in staffing. Although some participants are mandated to receive substance abuse treatment, clients are given the choice of deciding which other services they would like to receive. To ensure the psychological safety of staff, the program provides ongoing training to address potential emotional entanglement with clients and offers an employee assistance program. Staff are encouraged to attend Al-Anon meetings, which are support groups designed to help family members and close friends of an addicted person cope. Therapists are also available to help staff who are experiencing burnout or compassion fatigue.

**MCORP**

- Coordinate with a community correctional facility to provide services before and after release
- Serve participants who have been arrested for an alcohol- or drug-related offense or have screened positive for drug use
- Provide prerelease services that include health screenings and education workshops on substance use and healthy lifestyles
- Provide support and coordination services to help re-entry

**Montgomery County, Ohio: MCORP.** The MCORP provides prerelease and post-release services to residents of a community-based correctional facility who have been arrested for or screened positive for alcohol or drug use and who were referred by judges or probation officers. The MCORP provides prerelease health screening and an education group on alcohol and substance use, HIV and sexually transmitted diseases, and violence prevention, as well as a group on healthy lifestyles. After release, the MCORP strives to serve as a bridge between incarceration and re-entry. Post-release services include a mental health screening using the Patient Health Questionnaire, the

Satisfaction with Life Scale, and several substance abuse assessments. The MCORP coordinates client care and treatment post-release and provides resources to help clients secure housing and employment.

MCCORP implements some elements of trauma-informed care. It provided several trauma-related trainings to all staff. Several years ago, they participated in a two-day training on trauma-informed care, which was sponsored by SAMHSA. In the past year, they also received training by the Urban Minority Alcoholism and Drug Abuse Outreach Program, which included trauma-related topics. MCORP staff continue to receive additional training on trauma-informed care through regular webinars. To avoid triggering or traumatizing clients further, staff use language that reflects trauma-informed principles. For example, they are careful to avoid using references to violence in their language. Staff work to make clients feel comfortable and safe during assessments that may include sensitive questions. One of the providers they refer clients to uses TREM, an evidence-based, trauma-specific service.

#### PGCORP

- Provide services before and after release to participants with substance abuse issues or mental health needs, including the trauma-specific service M-TREM
- Behavioral health specialists use the TAP to screen participants, which includes questions to identify potential trauma
- Assign a recovery coach before release, who provides support and coordination services after release

**Prince George's County, Maryland: PGCORP.** Similar to the REACT and MCORP programs, the PGCORP begins working with potential participants who have a history of substance abuse or mental health needs while they are incarcerated and provides ongoing support after they are released to facilitate their transition and re-entry to the community. All participants complete a screening, the Treatment Assistance Protocol (TAP), to which the PGCORP added several questions to assess trauma. (The TAP is used agency-wide by certified addiction counselors and licensed professional counselors to inform care and is not specific to the PGCORP.)

To address trauma in men prior to re-entry and after release, the program provides M-TREM, a 24-session, trauma-specific service provided in a group setting. The curriculum focuses on messages, emotions, and relationships; trauma recovery; and recovery skills. The PGCORP initially only provided M-TREM in the prison setting. However, staff found that individuals were often released before they could finish the program and there were no community-based providers available to help them complete it. To address this problem, the PGCORP arranged for county behavioral health clinics to be trained to provide M-TREM in the community setting after release. As might be expected of a trauma-specific service, facilitators of the M-TREM groups implement several trauma-informed principles, including allowing participants to develop their own rules for the group (empowerment), taking a nonjudgmental attitude (safety), and using recovery coaches to develop rapport with offenders prior to release (trustworthiness). Post-release services also include helping participants obtain identification, health insurance, transportation, and jobs.

**LIVING FREE**

- Provide post-release services to participants with substance abuse or mental health problems
- Conduct “in-reach” at prisons to recruit participants
- Prior to release, participants visit the clinic to meet clinicians and the psychiatrist and to complete screenings
- Participants participate in individual counseling
- All staff are trained in trauma-informed care

**New Haven, Connecticut: Living Free.** The Living Free program, which is sponsored by the CMHC and the Yale University School of Medicine, coordinates and provides addiction, mental health, physical health, and other services for men who are re-entering the community. The program is client-centered and takes an individualized approach to care. Services include addiction treatment, evidence-based behavioral health and pharmacological treatments, and identification and treatment of co-occurring psychiatric and physical health problems.

To foster trust, the program begins working with individuals a few months prior to release from incarceration to introduce the program and its goals and to build rapport with prospective participants. (The Department of Corrections is able to identify potential participants based on the program’s eligibility criteria). Closer to release, corrections staff escort participants to the program’s community-based facility to meet with clinicians and a psychiatrist and to complete screenings (including a PTSD checklist and a trauma assessment). Program staff noted that they close the clinic to all other patients at this time as a way of ensuring the physical and psychological safety of the participant. “We want to make them as comfortable as possible. We meet them at the vehicle, in a wheelchair, and cover them so no one can see they are handcuffed.” This prerelease procedure can help support clients as they prepare for their re-entry to the community and increase the likelihood that they will follow up with services after release.

All program staff are trained in trauma- and gender-informed care; some participate in weekly seminars, including a three-week seminar on PTSD that was held in spring 2017. All staff, from the receptionist to supervisors, are trained to be nonjudgmental in their interactions with clients and to enhance collaboration by mitigating the power differential between staff and clients. Participants exercise choice because the program is not mandated. They collaborate in their treatment through client-centered, one-on-one counseling. Clients are empowered through client-led peer support groups. Trustworthiness is further enhanced in several ways. First, program staff participate in weekly case reviews to provide consistency in treatment. Second, peer mentors with prior addiction or incarceration experience provide wraparound services for clients after their release. Staff safety is further ensured in post-release services by always having supervisory staff on-site in the event that a client becomes combative, by encouraging staff to take time off, and by providing individual staff supervision. Trauma-specific services include individual counseling and cognitive behavioral therapy. The program is considering adding a male-specific trauma group.

### BROWARD COUNTY AND TURNING POINT PROGRAMS

- Provide a trauma-sensitive therapeutic community for men
- Offer continuity of services and supports from prerelease to post-release
- Provide peer led and driven services
- Deliver skill development to address emotions that may arise from trauma

**Bridges International.** Other programs provide re-entry services focused on substance abuse recovery that seek to be trauma-informed. Bridges International, a multisite provider of re-entry programming in the state of Florida, receives funding from a variety of sources to provide a continuum of care focused on substance abuse recovery for individuals who are transitioning from incarceration. Services range from residential substance abuse treatment to community re-entry services to transitional housing. According to its website, local programs ground their core services in 10 concepts of a trauma-sensitive therapeutic community, which was developed with a licensed mental health counselor. These services, which are peer-led and peer-driven, attempt to instill a sense of trust and empowerment through ownership, responsibility, direction, and decision making skills. One location, the Broward County Treatment Center/Community Release Center provides a trauma-sensitive therapeutic community that includes substance abuse treatment for men with a remaining sentence of 24 months to 36 months. Clinical services are peer-led and peer-driven and encourage men to become active participants in their recovery. Treatment plans are multidisciplinary and customized to respond to individual needs. Once participants complete the transition re-entry program, they become eligible for the Community Release Center.

Prerelease services at another location, the Turning Point Bridge Community Release Center, are also described as being grounded in concepts that support a trauma-sensitive therapeutic community. These services also use peer-led and peer-driven approaches. In Turning Point's post-release program, the men work at jobs in the daytime and engage in treatment in the evenings. Substance abuse treatment and accompanying services focus on problem solving, critical thinking, conflict resolution, and recovery maintenance skills. The men pay room and board, make any court-ordered payments, and start to build personal savings accounts.

### C. Fatherhood-focused programs for previously incarcerated men

#### FATHERS' SUPPORT CENTER

- Provide annual training in trauma for all staff
- Practice to recognize trauma and avoid additional trauma are built in to service delivery
- Conduct formal screening for effects of trauma, using an established tool
- Provide referral to either in-house therapist or community-based mental health service provider, who also provides re-entry services

**Fathers' Support Center (FSC).** With Training to Work, Pathways to Responsible Fatherhood, and Offender Re-entry Program (ORP) grants,<sup>3</sup> FSC provides a range of services to men and fathers with incarceration histories who are re-entering society. FSC first became trauma-informed as a result of its ORP grant. For the last five years, the organization has brought in experts to conduct a multiday annual training for all staff that focuses on recognizing and responding appropriately to trauma.

FSC's ORP program begins services before fathers are released from prison. The Missouri Department of Corrections first conducts prerelease assessments to identify eligible participants. FSC then administers the GAIN assessment tool (a biopsychosocial assessment that supports clinical diagnosis, treatment planning, and program planning) to fathers selected for the program. Based on the screening results, FSC coordinates with Preferred Family Health (PFH), a local provider, for further assessment and treatment services, if needed. PFH provides integrated recovery

services specifically for adults returning to St. Louis, Missouri, after incarceration—including substance abuse and mental health treatment, job readiness, skills training, and employment placement and retention services. Services include group counseling, one-on-one therapy, and medication-assisted treatment. Fathers who successfully complete treatment through the ORP are eligible to participate in FSC’s fatherhood program.

FSC’s six-week fatherhood program sponsored by ACF incorporates workshop practices that provide men with opportunities to discuss traumatic experiences with their peers in a safe group setting. For example, one session is devoted to facilitating an open discussion among fathers of what their lives have been like. As part of this session, fathers often end up sharing personal stories about past trauma. In turn, the fathers receive support, encouragement, and acceptance from their peers and group facilitators, who like themselves have experienced trauma and incarceration in the past. FSC also conducts a formal assessment of all fathers entering the program, for mental health conditions such as PTSD, depression, and anxiety. Depending upon which program they are in, fathers in need of treatment may be referred to a local partner organization for mental health services or to an in-house therapist, who is funded through community foundations.

#### SEEDCO

- Provide peer support
- Offer long-term commitment to fathers
- Deliver trauma-informed case management

#### **Structured Employment Economic Development Corporation (SEEDCO).**

SEEDCO is a nonprofit national workforce development program that operates Strong Fathers, Stronger Families (SFSF), an ACF-funded Pathways to Responsible Fatherhood program. Although the SFSF is not exclusively for fathers re-entering the community after incarceration, many program participants have incarceration histories. The SFSF has not yet taken systematic steps to become trauma-informed, but incorporates some key trauma-informed principles, such as safety. For example, its case management staff are experienced in working with fathers with a history of criminal justice involvement and difficult backgrounds. They tailor their approach based on the needs of the client. Services incorporate peer support; staff take a nonjudgmental approach to their interactions with clients; and the program maintains a commitment to continue working with fathers over a long period, throughout their ups and downs. However, program leaders have been cautious about focusing on trauma too much because the SFSF is not a mental health, substance abuse, or re-entry program and because fathers do not come to their program for these needs. Program staff have not been trained to recognize and respond to trauma, nor does the program’s needs assessment specifically screen for trauma. The program has struggled to identify appropriate community-based providers of trauma-specific services as well as sufficient funding to employ an in-house therapist or licensed clinical social worker to work with fathers who have trauma histories.

## D. Court-based behavioral health treatment re-entry programs

SAMHSA launched the Behavioral Health Court Treatment Collaborative (BHCTC) to address the behavioral health needs of adults involved in the criminal justice system by coordinating efforts between courts, criminal justice agencies, and community-based providers of treatment or recovery support services. Programming includes expanded access to critical mental health, substance use, and trauma-specific treatment services and recovery support. SAMHSA awarded 17 four-year grants for initiatives in 2014; public information about the two court collaboratives summarized below suggest that both take a trauma-informed approach.

### BHCTC INITIATIVE: TENNESSEE

- Focus on adult offenders re-entering the community
- Provide trauma-informed care in mental health and substance use counseling to address co-occurring disorders

**E-Recovery Project of Tennessee.** This project provides services for criminal justice-involved adults with behavioral health conditions in six rural Appalachian counties. Focused on adults in re-entry, E-Recovery expands access to integrated services for co-occurring disorders, trauma-informed care, and recovery supports, while expanding diversion opportunities and training. The expected outcomes include improvements in mental health, reduced substance use and abuse, and reduced recidivism among the target population.

### BHCTC INITIATIVE: LAKE COUNTY

- Target offenders with substance use disorders or mental illnesses
- Integrate a trauma-informed approach into existing TIM courts
- Serve as alternatives to incarceration and focus on re-entry

**Lake County, Illinois, Behavioral Health Court.** This SAMHSA grantee expects to enhance the 19th Judicial Circuit's Therapeutic Intensive Monitoring (TIM) Courts and to implement specific strategies that include a trauma-informed approach. These problem-solving courts consist of the TIM Drug Court, TIM Mental Health Court, and the TIM Veterans Treatment and Assistance Court. These courts are intended to serve as an alternative to incarceration, but are also focused on re-entry. They serve a target population of individuals with substance use disorders or mental illnesses. They expect to improve the target population's mental health, reduce substance use and abuse, and reduce recidivism.

### ReCAST PROGRAMS

- Target high-risk youths and families in communities that have experienced civil unrest and associated trauma
- Train first responders, educators, clergy, and health and human service providers in trauma-informed approaches
- Identify individuals who have experienced trauma and link them to trauma-informed behavioral health services
- Provide peer-led and peer-driven support for youths and families

## E. Community-wide initiatives focused on trauma

### SAMHSA's Resiliency in Communities After Stress and Trauma (ReCAST)

**program.** The purpose of ReCAST is to promote resilience and equity in communities that have faced civil unrest through the implementation of evidence-based violence prevention, community youth engagement programs, and linkages to trauma-informed behavioral health services. Currently being implemented in eight cities, the grant program requires that communities (1) identify and implement trauma-informed behavioral health services; (2) provide training in trauma-informed approaches to first responders, educators, clergy, and health and human service providers; and (3) provide peer support for high-risk youths and families.

## 5. TRAUMA-SPECIFIC SERVICES

With the trauma field rapidly evolving in recent years, there are now several models for delivering trauma-specific services to support individuals with trauma histories. Some of these services must be delivered by mental health clinicians, while others can be delivered by case managers, peer specialists, or other nonclinical professionals who provide services and supports to individuals with trauma histories. Although we did not identify any trauma-specific services designed specifically for recently incarcerated fathers, we did identify some services that were either designed for men, have been implemented in prison settings or with individuals who were recently incarcerated, or could potentially be adapted for fathers who were recently incarcerated. The extent to which these services have been evaluated varies.

### A. Non-clinical trauma-specific services

From the programs' websites, we identified four models for delivering trauma-specific services that may not require the involvement of a mental health clinician and could therefore be implemented by nonclinical fatherhood program staff. All four service models can be delivered as group interventions; some of them can also be delivered to individual participants. Two of the models are flexible in allowing the provider to pick and choose the components they will deliver. The other two are more structured and designed to be implemented in a specific way.

#### SELECTED SEEKING SAFETY TOPICS

- Asking for help
- Setting boundaries
- Healthy relationships
- Self-care
- Getting support
- Community resources
- Detaching from emotional pain
- Substance use
- PTSD
- Coping with triggers
- Red and green flags
- Recovery thinking
- Creating meaning

**Seeking Safety.** Currently implemented by one ReFORM grantee, Seeking Safety is an evidence-based counseling model for men and women with histories of trauma or substance use (see <http://www.treatment-innovations.org/seeking-safety.html>). It is a flexible model that can be used with groups or individuals. It can be delivered in any type of setting and by any provider, including peer specialists. The model has been implemented with criminal justice populations, veterans, and individuals with behavioral health problems. Its primary goal is to help participants achieve safety in their relationships, thoughts, feelings, and actions. The program has 25 modules that address cognitive, behavioral, and case management domains. Providers can choose which modules to address and can deliver them in any order.

#### SELECTED ATRIUM TOPICS

- Anxiety problems
- Self-harm
- Anger
- Sexuality
- Self-expression
- Physical health
- Sleep problems
- Spirituality
- Relationship challenges
- Self-care

**Addictions and Trauma Recovery Integration Model (ATRIUM).** This model is designed for survivors and perpetrators of physical or sexual abuse or violence, individuals with addictive behaviors, and individuals with serious mental health conditions (<http://www.dustyjmillier.com/books/addictions-trauma-recovery/>). It can be delivered by professionals or peers. ATRIUM addresses the physical, mental, and spiritual impact of trauma through psychoeducation, interpersonal skills training, and activities such as meditation and self-expression. It has 12 sessions that cover three phases of treatment (Center for Substance Abuse Treatment 2014). In the first phase, the provider gathers client history, provides psychoeducation about trauma, and

assesses the client's strengths. In the second phase, the provider addresses the trauma symptoms and encourages the client to use community resources and supports. In the third phase, the provider challenges "old beliefs" about the trauma and supports the client in replacing those beliefs with more appropriate ones. ATRIUM has been implemented in several settings, including behavioral health agencies, prisons, and peer-support groups. Although the program is not specifically designed for men, it has been delivered to groups of men. To our knowledge, ATRIUM does not include explicit modules on fatherhood.

#### SELECTED SELF TOPICS

- Effects of and responses to trauma
- Physical, emotional, psychological, and moral safety
- Boundaries
- Trust
- Negative self-talk and coping strategies
- Disconnecting from intrusive thoughts
- Coping skills and stress management
- Conflict resolution
- Addictive behavior
- Loss
- Behavior change and empowerment
- Recovery

**Safety, Emotions, Loss, and Future (SELF).** SELF is a group-based psychoeducational program that was designed as part of an organizational change model for implementing trauma-informed approaches (<http://www.sanctuaryweb.com/Products/SELFGROUPCurriculum.aspx>). SELF includes 37 lessons that focus on safety, emotions, loss, and the future. The program is flexible, allowing group facilitators to select and present the sessions in any order and adjust the length of time spent on a given topic, depending upon the needs of the group. Although the curriculum itself does not appear to be specific to men or fathers, the developers describe it as addressing universal issues that span all ages, genders, races, and religions. They also note that adaptations to the model are available; however, it is unclear from publicly available documents the type of adaptations that programs can make. The program's website does not specify whether the program can be delivered by any trained individual or is intended to be delivered by a behavioral health specialist.

**Helping Men Recover.** This model is a group-based, trauma-informed program to treat addictions in men (<http://stephaniecovington.com/helping-men-recover-a-program-for-treating-addiction1.php>). It is a structured program with 18 modules that address self, relationships, sexuality, and spirituality. The modules incorporate information on the social messages men receive and the ways in which "male socialization" impacts recovery, relationships, and trauma and abuse. The relationship module includes sessions on fathers and mothers, which are relevant for fatherhood program participants. Helping Men Recover is designed to be delivered in prisons and other settings, including outpatient, residential, and community-based settings. The groups meet one or two times a week for 90 minutes; the program typically lasts two to four months. Helping Men Recover can be delivered by an experienced licensed addictions specialist or an individual with a bachelor's degree in the human services field.

### **B. Trauma-specific services requiring delivery by a mental health specialist**

Although OFA-funded fatherhood programs are not permitted to use grant funds authorized under the Claims Resolution Act of 2010 to provide mental health treatment, they can do so using other funding streams or by referring participants

to partner organizations that do provide treatment. In this section, we describe one trauma-specific service for trauma survivors and five services that specifically address PTSD.

#### SELECTED M-TREM TOPICS

- Male messages
- Emotions: Anger, fear, hurt, shame, hope
- Understanding trauma and trauma behavior
- Abuse: Physical, sexual, emotional
- Family relationships
- Communication skills
- Problem solving skills
- Goal setting and empowerment

**M-TREM.** This model is a group intervention designed to support men who are trauma survivors (<https://www.samhsa.gov/nctic/trauma-interventions>). M-TREM is a male-focused adaptation of the TREM program, which is considered an evidence-based model for addressing trauma (Fallot et al. 2011; Wolff et al. 2015). M-TREM is delivered by two co-leaders: (1) a clinician and (2) a support specialist, such as a bachelor's degree-level professional, certified addictions counselor, or peer-support specialist (personal communication with Lori Beyer, Community Connections on December 14, 2016). For example, M-TREM may be delivered by a social worker and an addictions specialist. M-TREM, which was recently redesigned, now includes 18 sessions that focus on empowerment, trauma education, and skill building. The first sessions focus on the social messages or stereotypes that men receive from society. In the next sessions, facilitators discuss violence as a way to segue into discussions of trauma and abuse. The skill-building sessions, which include role-playing, help men develop communication skills, problem-solving skills, and healthy coping strategies.

**Prolonged Exposure (PE) Therapy and Cognitive Processing Therapy (CPT).** These two therapies are the predominant treatments for PTSD and the treatments for which the evidence is strongest (IOM 2008, 2014). They are both provided in individual therapy sessions. Some evidence indicates that CPT is also effective in group formats (Sloan and Beck 2016). PE and CPT have similar treatment elements, including education about trauma and trauma responses; the use of cognitive behavioral techniques, such as questioning black-and-white thinking; and the use of homework as a way to reinforce the treatment. In PE, the client is “exposed” to the traumatic event through detailed retelling of the traumatic event and gradual exposure to people, places, or objects that remind the client of the event (Foa et al. 2007). In CPT, the client writes about the traumatic event, discusses negative thoughts about it, and learns more adaptive ways of thinking about it (Resick et al. 2010; Resick and Schnicke 1993).

**Eye Movement Desensitization and Reprocessing (EMDR).** EMDR is an effective psychotherapy used to treat PTSD (IOM 2008, 2014). Although it has traditionally been delivered in individual therapy sessions, some studies are investigating the therapy's effectiveness in group settings. EMDR is grounded in the theory that PTSD is a result of traumatic memories that have been inadequately processed. In EMDR, the client first learns techniques to manage emotional distress. He then thinks about the traumatic event or an aspect of the traumatic event while focusing on a back-and-forth movement or sound made by the therapist. (For example, the therapist may move his or her finger back and forth.) The client continues to focus on the movement until his distress decreases, and then processes the experience with the therapist.

**TARGET'S STEPS TO  
MANAGE STRESS  
REACTIONS**

1. Focus to reduce anxiety and increase alertness
2. Recognize specific triggers
3. Identify feelings
4. Evaluate main thoughts
5. Define personal goals
6. Identify successful step toward goal
7. Make a contribution

**Trauma Affect Regulation: Guidelines for Education and Therapy (TARGET).**

TARGET is a 12-session, group- or individual-based psychotherapy designed to prevent and treat PTSD. The program teaches skills for managing problems that result from high stress, explains the difference between normal and extreme stress, and teaches seven steps to manage extreme stress reactions. The program can be delivered by clinicians, case managers, rehabilitation specialists, and teachers (<http://www.advancedtrauma.com/Services.html>; <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=145>). It has been adapted for recently incarcerated men and women.

## 6. SUMMARY AND KEY STEPS FOR PROGRAMS

This report explored what is known about trauma among fathers in re-entry and how programs serving them may provide trauma-informed care. In this section, we summarize some of the key points and lessons, and suggest key steps for implementing trauma-informed care with justice-involved men in ReFORM or other fatherhood programs.

**Trauma in fathers who are re-entering society appears to be prevalent.** We began by exploring the types and prevalence of trauma experiences among previously incarcerated men and the potential consequences for their parenting, economic stability, and relationships after release. Although traumatic events in childhood are thought to be prevalent in this population based on qualitative research and community samples, more research is needed. Compared to what is known about trauma in women, children, and combat veterans, little information is available on the prevalence, experience, and impact of trauma among nonmilitary men, especially low-income men of color.

**Trauma may complicate the ability of men in fatherhood programs to achieve positive outcomes.** Trauma likely contributes to the struggles that many fathers re-entering the community experience. Past traumas likely compound the difficulty these men typically experience with becoming economically stable and reconnecting in positive ways with their partners and children. These struggles may be compounded by the incarceration experience itself and the return to disadvantaged communities that have few resources and job opportunities.

**A trauma-informed approach focuses on organizational change.** It systematically integrates trauma-informed principles throughout program operations and service delivery, ensuring that participants and staff experience safety, trustworthiness, empowerment, peer support, and collaboration. These principles are implemented within and across multiple domains of implementation such as policies, settings, and participant-staff interactions.

**A key premise of a trauma-informed approach is that healing can occur through interaction with individuals who are sensitive to trauma but not necessarily trained therapists.** Programs that take a trauma-informed approach seek to avoid worsening the effects of past traumas or further traumatizing clients. Just as importantly, a trauma-informed approach suggests that healing and recovery can be facilitated through interaction with nonclinical staff, especially staff who have experienced and recovered from similar traumas. This is important because although some trauma survivors will receive trauma-specific services to address PTSD, many will not due to limited resources. Facilitating healing and taking care to not create additional harm can be promoted by training staff to recognize and appropriately

respond to signs of trauma and by implementing trauma-informed principles throughout service delivery activities and settings.

**Our scan of programs serving justice-involved men showed that implementation of trauma-informed principles is feasible in a wide range of program types and settings.** These include programs that focus on employment, re-entry, prevention of recidivism, substance use recovery or mental health treatment, fatherhood, behavioral health courts, and community-wide initiatives. It also revealed that a trauma-informed approach to fatherhood services does not require clinical staff, and suggests that such an approach can improve client engagement and participation.

**The information collected and analyzed for this study suggest the following key steps to implementing a trauma-informed approach at ReFORM and other fatherhood programs:**

- *Create a systemic commitment across the entire organization to a trauma-informed approach.* The trauma-informed approach to services is, in many ways, about changing the organizational culture. Conducting an organizational assessment is a key step in identifying needed changes to policies, procedures, and settings.
- *Train all staff in the signs of trauma and how to appropriately respond to them.* The premise of a trauma-informed approach is that healing can occur through interaction with individuals who are sensitive to trauma but not necessarily trained therapists. The majority of service delivery in ReFORM and other fatherhood programs occurs through group-based, facilitator-led parenting workshops, employment readiness services, and relationship education led by nonclinicians. For this reason, training only case managers or clinical staff in trauma is likely to be insufficient.
- *Screen all participants for trauma-related mental health conditions.* Although programs may take the position that all participants have experienced trauma, some fathers' responses to trauma may go beyond the help that a fatherhood program can provide. Some will develop mental health conditions such as PTSD. Systematic screening allows programs to identify fathers with such conditions who may need clinical treatment. Simple, brief and well-validated screening tools are available for use by nonclinicians to identify and refer fathers who exceed a specified threshold of symptoms.
- *Refer fathers in need of clinical treatment to appropriate services.* Some fathers will have disorders related to trauma exposure. Trauma-specific services vary in their suitability for use with men and people of various cultural backgrounds, their availability at the local level, and whether they can be provided by clinical or nonclinical staff.

- Some evidence-based treatments are available for trauma and PTSD, such as PE, CPT, and TREM, although they are not necessarily accessible in every community. Some of these treatments have not been tested with men, particularly low-income fathers who have involvement with the criminal justice system.
- Two group-based clinical treatments, M-TREM and Helping Men Recover, have been designed or adapted specifically for men and could prove useful for participants of fatherhood programs, if available in these fathers' communities.
- Group-based services that do not require clinical staff to deliver—such as, Seeking Safety, ATRIUM, Helping Men Recover, and SELF—are promising options for trauma-specific services that can be implemented by ReFORM and fatherhood programs.

Resources are becoming more available to assist programs interested in becoming trauma-informed, including organizational assessments, staff training, and information about trauma-specific services, including those that do not require delivery by a mental health clinician.

## REFERENCES

- Agaibi, C.E., and J.P. Wilson. "Trauma, PTSD, and Resilience: A Review of the Literature." *Trauma, Violence & Abuse*, vol. 6, no. 3, 2005, pp. 195–216.
- American Psychiatric Association. "Trauma- and Stressor-Related Disorders." In *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Washington, DC: American Psychiatric Association, 2013, Available at <http://dx.doi.org/10.1176/appi.books.9780890425596.dsm07>.
- Baker, Courtney N., Steven M. Brown, Patricia D. Wilcox, Stacy Overstreet, and Prerna Arora. "Development and Psychometric Evaluation of the Attitudes Related to Trauma-Informed Care (ARTIC) Scale." *School Mental Health*, vol. 8, no. 1, 2016, pp. 61–76.
- Beck, Allen J., Marcus Berzofsky, Rachel Caspar, and Christopher Krebs. "Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12." Washington, DC: U.S. Bureau of Justice Statistics, 2013.
- Black, M., K. Basile, M. Breiding, S. Smith, M. Walters, M. Merrick, and M. Stevens. "National Intimate Partner and Sexual Violence Survey, 2010 Summary Report (NISVS, 2010)." Atlanta, GA: National Center for Injury Prevention and Control and Centers for Disease Control and Prevention, 2010.
- Bloom, Sandra L. "Advancing a National Cradle-to-Grave-to-Cradle Public Health Agenda." *Journal of Trauma & Dissociation*, vol. 17, no. 4, 2016, pp. 383–396.
- Bloom, Sandra L., and Sarah Y. Sreedhar. "The Sanctuary Model of Trauma-Informed Organizational Change." *Reclaiming Children and Youth*, vol. 17, no. 3, 2008, pp. 48–53.
- Boxer, Paul, Keesha Middlemass, and Tahlia Delorenzo. "Exposure to Violent Crime During Incarceration: Effects on Psychological Adjustment Following Release." *Criminal Justice and Behavior*, vol. 36, no. 8, 2009, pp. 793–807.
- Breslau, N., E.L. Peterson, L.M. Poisson, L.R. Schultz, and V.C. Lucia. "Estimating Post-Traumatic Stress Disorder in the Community: Lifetime Perspective and the Impact of Typical Traumatic Events." *Psychological Medicine*, vol. 34, no. 5, 2004, pp. 889–898.
- Brewin, C.R., S. Rose, B. Andrews, P. Tata, C. McEvedy, S. Turner, and E.B. Foa. "A Brief Screening Instrument for Post-Traumatic Stress Disorder." *British Journal of Psychiatry*, vol. 181, 2002, pp. 158–162.
- Briere, J., L.A. Madni, and N. Godbout. "Recent Suicidality in the General Population: Multivariate Association with Childhood Maltreatment and Adult Victimization." *Journal of Interpersonal Violence*, vol. 31, no. 18, 2016, pp. 3063–3079.

- Carlson, Bonnie E., and Michael S. Shafer. "Traumatic Histories and Stressful Life Events of Incarcerated Parents: Childhood and Adult Trauma Histories." *The Prison Journal*, vol. 90, no. 4, 2010, pp. 475–493.
- Carlson, Bonnie E., Michael S. Shafer, and David E. Duffee. "Traumatic Histories and Stressful Life Events of Incarcerated Parents II: Gender and Ethnic Differences in Substance Abuse and Service Needs." *The Prison Journal*, vol. 90, no. 4, 2010, pp. 494–515.
- Center for Substance Abuse Treatment. "Trauma-Informed Care in Behavioral Health Services." Treatment Improvement Protocol (TIP) Series, No. 57. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
- Comfort, M., T. McKay, J. Landwehr, E. Kennedy, C. Lindquist, and A. Bir. "Parenting and Partnership When Fathers Return from Prison: Findings from Qualitative Analysis." ASPE Research Brief. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services, 2016.
- D'Angelo, Angela Valdovinos, Emily Knas, Pamela Holcomb, and Kathryn Edin. "The Role of Social Networks Among Low-Income Fathers: Findings from the PACT Evaluation." OPRE Report Number 2016-60. Washington, DC: Office of Planning, Research & Evaluation, Administration for Children & Families, U.S. Department of Health & Human Services, 2016.
- DeCandia, C.J., K. Guarino, and R. Clervil. "Trauma-Informed Care and Trauma-Specific Services: A Comprehensive Approach to Trauma Intervention." Washington, DC: American Institutes for Research, 2014.
- DeVeaux, Mika'il. "The Trauma of the Incarceration Experience." *Harvard CivilRights-Civil Liberties Law Review*, vol. 48, 2013, pp. 257–277.
- De Viggiani, Nick. "Surviving Prison: Exploring Prison Social Life as a Determinant of Health." *International Journal of Prisoner Health*, vol. 2, no. 2, 2006, pp. 71–89.
- Dierkhising, Carly B., Andrea Lane, and Misaki N. Natsuaki. "Victims Behind Bars: A Preliminary Study of Abuse During Juvenile Incarceration and Post-Release Social and Emotional Functioning." *Psychology, Public Policy, and Law*, vol. 20, no. 2, 2014, pp. 181–190.
- Diez Roux, A.V. "Investigating Neighborhood and Area Effects on Health." *American Journal of Public Health*, vol. 91, no. 11, 2001, pp. 1783–1789.

Dion, Robin, Pamela Holcomb, Heather Zaveri, Angela D'Angelo, Elizabeth Clary, Daniel Friend, and Scott Baumgartner. "Bringing it all Together: How Did Responsible Fatherhood Programs in PACT Address Participants' Needs and How Did Fathers Respond?" Draft report submitted to Office of Research, Planning and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Washington, DC: Mathematica Policy Research, May 2017.

Eddy, J.M., and J. Poehlmann (eds.). *Children of Incarcerated Parents*. Washington, DC: Urban Institute Press, 2010.

Evans, Sarah E., Anne L. Steel, and David DiLillo. "Child Maltreatment Severity and Adult Trauma Symptoms: Does Perceived Social Support Play a Buffering Role?" *Child Abuse & Neglect*, vol. 37, no. 11, 2013, pp. 934–943.

Fallot, R., and M. Harris. "The Trauma Recovery and Empowerment Model (TREM)." *Community Mental Health Journal*, vol. 38, no. 6, pp. 475–485.

Fallot, Roger D., Gregory J. McHugo, Maxine Harris, and Haiyi Xie. "The Trauma Recovery and Empowerment Model: A Quasi-Experimental Effectiveness Study." *Journal of Dual Diagnosis*, vol. 7, no. 1-2, 2011, pp. 74–89.

Foa, E.B., E. Hembree, and B.O. Rothbaum. *Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences, Therapist Guide*. New York: Oxford University Press, 2007.

Ford, Julian D., John Chapman, Daniel F. Connor, and Keith R. Cruise. "Complex Trauma and Aggression in Secure Juvenile Justice Settings." *Criminal Justice and Behavior*, vol. 39, no. 6, 2012, pp. 694–724.

Friend, Daniel, Jeffrey Max, Pamela Holcomb, Kathryn Edin, and Robin Dion. "Fathers' Views of Co-Parenting Relationships: Findings from the PACT Evaluation." OPRE report 2016-60. Washington, DC: Office of Planning, Research & Evaluation, Administration for Children & Families, U.S. Department of Health & Human Services, 2016.

Geller, Amanda, Irwin Garfinkel, Carey E. Cooper, and Ronald B. Mincy. "Parental Incarceration and Child Well-Being: Implications for Urban Families." *Social Science Quarterly*, vol. 90, no. 5, 2009, pp. 1186–1202.

Geller, Amanda, Irwin Garfinkel, and Bruce Western. "Paternal Incarceration and Support for Children in Fragile Families." *Demography*, vol. 48, no. 1, 2011, pp. 25–47.

Glaze, Lauren E., and Laura M. Maruschak. "Bureau of Justice Statistics Special Report, Parents in Prison and Their Minor Children." Washington, DC: Bureau of Justice Statistics, March 30, 2010.

Gordon, Derrick M., Derek Iwamoto, Natasha D. Watkins, Trace Kershaw, Diana Mason, and Anthony Judkins. "Promoting Responsible Fatherhood Programming: Factors Affecting Low-Income Fathers' Involvement in Child Protection Services and Court-Restricted Access to their Children." *Journal of Poverty*, vol. 15, no. 2, 2011, pp. 184–205.

Haney, Craig. "The Psychological Impact of Incarceration: Implications for Post-Prison Adjustment." From Prison to Home: The Effect of Incarceration and Reentry on Children, Families, and Communities. Washington, DC: Office of the Assistant Secretary of Planning and Evaluation, U.S. Department of Health and Human Services, December 2001. Available at <https://aspe.hhs.gov/basic-report/psychological-impact-incarceration-implications-post-prison-adjustment>. Accessed May 22, 2017.

Holcomb, Pamela, Kathryn Edin, Jeffrey Max, Alford Young, Jr., Angela Valdovinos D'Angelo, Daniel Friend, Elizabeth Clary, and Waldo E. Johnson, Jr. "In Their Own Voices: The Hopes and Struggles of Responsible Fatherhood Program Participants in the Parents and Children Together Evaluation." OPRE Report Number 2015-67. Washington, DC: Office of Planning, Research & Evaluation, Administration for Children & Families, U.S. Department of Health & Human Services, 2015.

Holmes, William C., and Gail B. Slap. "Sexual Abuse of Boys: Definition, Prevalence, Correlates, Sequelae, and Management." *JAMA*, vol. 280, no. 21, 1998, pp. 1855–1862.

Huang, Larke N., Rebecca Flatow, Tenly Biggs, Sara Afayee, Kelley Smith, Thomas Clark, and Mary Blake. "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach." HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Institute of Medicine. *Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence*. Washington, DC: The National Academies Press, 2008.

Institute of Medicine. *Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations: Final Assessment*. Washington, DC: The National Academies Press, 2014.

Jarjoura, G. Roger, David L. DuBois, Rebecca J. Shlafer, and Konrad A. Haight. "Mentoring Children of Incarcerated Parents." Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, 2014.

Johnson, Emmanuel J., and Christine James. "Effects of Child Abuse and Neglect on Adult Survivors." *Early Childhood Development and Care*, vol. 186, no. 186, March 22, 2016, pp. 1836–1845.

- Kim, Joongbaeck. "Neighborhood Disadvantage and Mental Health: The Role of Neighborhood Disorder and Social Relationships." *Social Science Research*, vol. 39, no. 2, 2010, pp. 260-271.
- Kubiak, S.P., H. Brenner, D. Bybee, R. Campbell, and G. Fedock. "Reporting Sexual Victimization During Incarceration: Using Ecological Theory as a Framework to Inform and Guide Future Research." *Trauma, Violence & Abuse*, 2016, pp. 1-13, epub ahead of print.
- Kubrin, Charis E., and Eric Stewart. "Predicting Who Reoffends: The Neglected Role of Neighborhood Context in Recidivism Studies." *Criminology*, vol. 44, no. 1, 2006, pp. 165-197.
- Lee, Chioun, Vera Tsenkova, and Deborah Carr. "Childhood Trauma and Metabolic Syndrome in Men and Women." *Social Science & Medicine*, vol. 105, 2014, pp. 122-130.
- Liu, Young, Janet B. Croft, Daniel P. Chapman, Geraldine S. Perry, Kurt J. Greenlund, Guixiang Zhao, and Valerie J. Edwards. "Relationship between Adverse Childhood Experiences and Unemployment among Adults from Five U.S. States." *Social Psychiatry and Psychiatric Epidemiology*, vol. 48, no. 3, 2013, pp. 357-369.
- Madera, Johanna E. *The Cumulative Impact of Trauma Exposure and Recidivism After Incarceration Among Black Men*. New York: CUNY Academic Works, 2016.
- Mair, Christina, Ana V.D. Roux, and Jeffrey D. Morenoff. "Neighborhood Stressors and Social Support as Predictors of Depressive Symptoms in the Chicago Community Adult Health Study." *Health & Place*, vol. 16, no. 5, 2010, pp. 811-819.
- Maschi, Tina, Sandy Gibson, Kristen M. Zgoba, and Keith Morgen. "Trauma and Life Event Stressors Among Young and Older Adult Prisoners." *Journal of Correctional Health Care*, vol. 17, no. 2, 2011, pp. 160-172.
- Menschner, C., and A. Maul. *Key Ingredients for Successful Trauma-Informed Care Implementation*. Trenton, NJ: Center for Health Care Strategies, 2016.
- Messina, Nena, Christine Grella, William Burdon, and Michael Prendergast. "Childhood Adverse Events and Current Traumatic Distress: A Comparison of Men and Women Drug-Dependent Prisoners." *Criminal Justice and Behavior*, vol. 34, no. 11, 2007, pp. 1385-1401.
- Miller, Cynthia, and Virginia Knox. *The Challenge of Helping Low-Income Fathers Support Their Children: Final Lessons from Parents Fair Share*. New York: MDRC, 2001.
- Miller, Niki A., and Lisa M. Najavits. "Creating Trauma-Informed Correctional Care: A Balance of Goals and Environment." *European Journal of Psychotraumatology*, vol. 3, no. 1, 2012.

- Mong, Sherry N., and Vincent J. Roscigno. "African American Men and the Experience of Employment Discrimination." *Qualitative Sociology*, vol. 33, no. 1, 2010, pp. 1–21.
- Morenoff, Jeffrey D., and Robert J. Sampson. "Violent Crime and Spatial Dynamics of Neighborhood Transition: Chicago, 1970–1990." *Social Forces*, 1997, vol. 76, no. 1, pp. 31–64.
- Murphey, David and P. Mae Cooper. "Parents Behind Bars: What Happens to Their Children?" Washington, DC: Child Trends, October 2015.
- National Child Traumatic Stress Network. "Types of Traumatic Stress." Available at <http://www.nctsn.org/trauma-types>. Accessed May 22, 2017.
- Olf, Miranda, Willie Langeland, Nel Draijer, and Berthold P. Gersons. "Gender Differences in Posttraumatic Stress Disorder." *Psychological Bulletin*, vol. 133, no. 2, 2007, p. 183–204.
- Resick, P.A., C.M. Monson, and K.M. Chard. *Cognitive Processing Therapy: Veteran/Military Version*. Washington, DC: Department of Veterans' Affairs, 2010.
- Resick, P., and M. Schnicke. *Cognitive Processing Therapy for Rape Victims: A Treatment Manual (Interpersonal Violence: The Practice Series)*. Newbury Park, CA: SAGE Publications, 1993.
- Roy, K.M., and O.L. Dyson. "Gatekeeping in Context: Babymama Drama and the Involvement of Incarcerated Fathers." *Fathering*, vol. 3, 2005, pp. 267–288.
- Sampson, R.J., S.W. Raudenbush, and F. Earls. "Neighbourhoods and Violent Crime: A Multilevel Study of Collective Efficacy." *Science*, vol. 277, issue 5328, 1997, pp. 918–924.
- Secret, Mary. "Incarcerated Fathers: Exploring the Dimensions and Prevalence of Parenting Capacity of Non-Violent Offenders." *Fathering*, vol. 10, no. 2, 2012, pp. 159–177.
- Schilling, Elizabeth, Robert H. Aseltine, Jr., and Susan Gore. "Adverse Childhood Experiences and Mental Health in Young Adults: A Longitudinal Survey." *BMC Public Health*, vol. 7, no. 30, 2007, pp. 1–10.
- Slattery, Michelle, Mallory T. Dugger, Theodore A. Lamb, and Laura Williams. "Catch, Treat, and Release: Veteran Treatment Courts Address the Challenges of Returning Home." *Substance Use & Misuse*, vol. 48, no. 10, 2013, pp. 922–932.
- Sloan, D., and J. Beck. "Group Treatment for PTSD." *PTSD Research Quarterly*, vol. 27, no. 2, 2016, pp. 1–9. Available at <https://www.ptsd.va.gov/professional/newsletters/research-quarterly/V27N2.pdf>. Accessed February 28, 2017.

Stahler, G.J., J. Mennis, S. Beleko, W.N. Welsh, M.L. Hiller, and G. Zajac. "Predicting Recidivism for Released State Prison Offenders: Examining the Influence of Individual and Neighborhood Characteristics and Spatial Contagion on the Likelihood of Reincarceration." *Criminal Justice Behavior*, vol. 40, no. 6, 2013, pp. 690–711.

Swisher, Raymond R., and Maureen R. Waller. "Confining Fatherhood: Incarceration and Paternal Involvement Among Nonresident White, African American, and Latino Fathers." *Journal of Family Issues*, vol. 29, no. 8, 2008, pp. 1067–1088.

Tolin, David F., and Edna B. Foa. "Sex Differences in Trauma and Posttraumatic Stress Disorder: A Quantitative Review of 25 Years of Research." *Psychological Bulletin*, vol. 132, no. 6, 2006, p. 959–992.

Topitzes, James, David J. Pate, Nathan D. Berman, and Christopher Medina-Kirchner. "Adverse Childhood Experiences, Health, and Employment: A Study of Men Seeking Job Services." *Child Abuse & Neglect*, vol. 61, 2016, pp. 23–34.

Travis, Jeremy, Amy L. Soloman, and Michelle Waul. "From Prison to Home: The Dimensions and Consequences of Prisoner Re-Entry." Washington, DC: The Urban Institute, June 2001.

van der Geest, Victor R., Catrien C. Bijleveld, Arjan A. Blokland, and Daniel S. Nagin. "The Effects of Incarceration on Longitudinal Trajectories of Employment: A Follow-Up in High-Risk Youth from Ages 23 to 32." *Crime & Delinquency*, vol. 62, no. 1, 2016, pp. 107–140.

Wagner, Peter, and Bernadette Rabuy. "Mass Incarceration: The Whole Pie 2015." Northampton, MA: Prison Policy Initiative, 2015.

Western, Bruce, and Becky Pettit. "Incarceration and Social Inequality." *Daedalus*, vol. 139, no. 3, summer 2010, pp. 8–19.

Wolff, N., J. Huening, J. Shi, B.C. Frueh, D.R. Hoover, and G. McHugo. "Implementation and Effectiveness of Integrated Trauma and Addiction Treatment for Incarcerated Men." *Journal of Anxiety Disorders*, vol. 30, 2015, pp. 66–80.

Zaveri, Heather, and Scott Baumgartner. "Parents and Children Together: Design and Implementation of Two Healthy Marriage Programs." OPRE Report Number 2016-63. Washington, DC: Office of Planning, Research & Evaluation, Administration for Children & Families, U.S. Department of Health & Human Services, 2016.

**ENDNOTES**

- <sup>1</sup> We did not include ReFORM grantees in this scan; information about these grantees will be discussed in a forthcoming brief for program practitioners.
- <sup>2</sup> For six programs, we conducted one-hour conversations to supplement the information that was gleaned by examining publicly available sources. These programs included the four SAMHSA offender re-entry programs and the two ACF responsible fatherhood programs described in this section.
- <sup>3</sup> FSC's ORP is a collaboration between FSC, the Missouri Department of Corrections, and Preferred Family Health.

