APRIL 2023

Trauma-Informed Practice for Reentry Providers

Brief

Christopher Branson, PhD

Bureau of Justice Assistance
U.S. Department of Justice

CCETAC
Corrections & Community Engagement
Technical Assistance Center

AIR®
Advancing Evidence.
Improving Lives.

Trauma-Informed Practice for Reentry Providers

Childhood exposure to violence and other traumatic events is a "universal experience" among adults who are incarcerated (Wolff et al., 2014). Rates of post-traumatic stress disorder (PTSD) in this population are equivalent to those of military veterans and are associated with an increased risk for recidivism, substance use, aggression, and suicide. Involvement with the justice system itself may result in new traumatic experiences or harsh practices that exacerbate their psychological distress. The U.S. Department of Justice and other key stakeholders recommend using a trauma-informed approach across the criminal justice system to address the high rates of trauma and related impairment in individuals who are incarcerated and also for frontline professionals. This brief summarizes the latest trauma research, emphasizes the impact of trauma on returning individuals and programming designed to address their needs, outlines the key elements of a trauma-informed organization, and provides practical tips and resources for implementing this approach in reentry settings.

Part 1: Understanding Trauma and its Effects

Trauma: Definition and Prevalence

The International Classification of Diseases (ICD-11; World Health Organization [WHO], 2022) defines trauma as "an event or situation (either short- or long-lasting) of an extremely threatening or horrific nature." Traumatic events come in many forms, including but not limited to violence, psychological abuse, serious accidents, acute life-threatening illness, war/terrorism, and natural disasters. A person may experience trauma directly (e.g., physical or sexual assault), by witnessing threats or violence against others, or vicariously via exposure to the details of someone else's trauma (WHO, 2022). Similar variety is found in responses to traumatic events, which fall along a continuum in terms of both severity and duration (see table 1).

Table 1. Trauma-related responses and mental health disorders

Disorder	Description
Acute stress reactions	Behavioral, emotional, and physical responses that develop in the hours or days following a traumatic experience. Examples include anxiety, anger, rapid heartbeat, difficulty sleeping, and social withdrawal. These normal responses to trauma typically subside within days after the event or removal from the situation.
Post-traumatic stress disorder (PTSD)	Behavioral, emotional, and physical responses that last more than two weeks after the traumatic experience and cause significant problems in daily life. The core features are (1) re-experiencing the trauma via flashbacks or nightmares; (2) avoiding thinking about the event or any situations, places, or other things that are reminders of the event; and (3) constantly being on guard for potential threats (e.g., hypervigilance, heightened startle response).
Complex PTSD (C-PTSD)	A more severe form of PTSD associated with exposure to multiple or repetitive traumatic events (e.g., child abuse). Includes the symptoms of PTSD as well as (1) problems managing emotions (e.g., aggressive outbursts, emotional numbing, reckless behavior); (2) feeling diminished, defeated, or worthless accompanied by guilt or shame; and (3) problems sustaining relationships and feeling close to other people.

Note. See World Health Organization (2022) for more information.

Most people who experience a potentially traumatic event (PTE) do not develop lasting mental health problems, such as PTSD. In the general population, the lifetime prevalence of PTEs (greater than 80 percent) far exceeds the lifetime rates of PTSD (6 percent to 8 percent; Benjet et al., 2016; Goldstein et al., 2016; Schein et al., 2021). Multiple factors influence whether someone develops PTSD after a traumatic experience, including the timing, type, and number of PTEs (Liu et al., 2021; Tortella-Feliu et al., 2019). The risk for PTSD increases for those with histories of prior trauma, exposure in childhood, multiple or repetitive traumatic events (e.g., physical abuse), and traumas involving interpersonal violence (Briere et al., 2016; Kessler et al., 2017).

Long-Term Effects of Childhood Trauma

Traumatic experiences in early life can profoundly affect subsequent neurological and psychological development (De Bellis & Zisk, 2014; Dye, 2018; Perry, 2001; Putnam, 2006; Teicher & Samson, 2016). Difficulties in achieving early developmental tasks, such as attachment, trust, and self-regulation, contribute to difficulties in key areas of life, such as relationships and school success (table 2; Cook et al., 2005; Gregorowski & Seedat, 2013). Children raised by abusive or neglectful caregivers may develop a distrust of people in general, and authority figures in particular, thus impairing their ability to form positive relationships with others, including teachers and peers. PTSD symptoms, such as angry outbursts and emotional dysregulation, may lead to behavioral problems in school and peer rejection (Perfect et al., 2016). Intrusive flashbacks of past trauma or a hypervigilant focus on safety can hijack a student's attention away from important classroom instruction. Early delays in core academic skills, if unaddressed or misdiagnosed (e.g., attention deficit hyperactivity disorder, learning disorder), cause a child to fall further behind with each passing year (Cook et al., 2005).

Table 2. Children's development tasks at various age levels

Age Range	Major Developmental Tasks	How Trauma May Interfere
0–5 years	▪ Attachment/trust	▪ Problems forming trusting or positive relationships ▪ View authority figures negatively
6–12 years	▪ Regulate emotions and behavior (i.e., "use your words") ▪ Form friendships ▪ Learn to focus for long periods of time (i.e., for school/learning) ▪ Morality (i.e., sense of right and wrong)	▪ Aggressive or disruptive behavior ▪ Peer problems ▪ Learning disorders or school problems ▪ Distorted sense of right and wrong
13–18 years	▪ Develop stable identity ("Who and I?") ▪ Develop goals for the future/adulthood	▪ Develop negative identity ▪ Hang out with negative peers ▪ Difficulty forming long-term goals ▪ School problems earlier in life limit options and opportunities for the future.

As youth exposed to early trauma move through adolescence and into adulthood, they may be at increased risk for challenges that include PTSD and other mental health disorders, suicidality, and substance use disorders (Ford et al., 2012; De Ruiter et al., 2022; Zarse et al., 2019). Youth affected by trauma may begin to engage in behavior that is risky to their health and well-being to manage their trauma responses. Such "survival coping" may help them deal with the aftereffects of trauma but will likely cause problems in other aspects of their lives (table 3; Ford et al., 2009; Ford et al., 2010). Exposure to adverse childhood experiences, particularly those that are severe and chronic in nature, are linked to several antisocial or illegal behaviors, including substance use, violent behavior, gang involvement, carrying a weapon, and sexual offenses (Baglivio et al., 2015; Connolly, 2019; Farrington et al.,2016; Fox et al., 2015; Fitton et al., 2020).

Table 3. Survival coping strategies

Common survival coping strategies for justice-involved adults and youth
▪ Substance use to numb painful emotions or block intrusive memories of trauma (e.g., nightmares)
▪ Carrying a weapon or joining a gang for protection
▪ Preemptive aggression (i.e., "get them before they get me")
▪ Self-injurious behavior (e.g., cutting) to distract from painful thoughts and feelings
▪ Avoiding close relationships because of a general distrust of others

Rates and Impact of Trauma Among Justice-Involved Adults

Adults involved with the criminal justice system are disproportionately affected by trauma, with 90 percent to 99 percent of those incarcerated (both adolescents and adults) reporting histories of PTEs (Jäggi et al., 2016; Wolff et al., 2014). Compared with the general population, both youth and adults who are incarcerated are more likely to report multiple traumatic events, childhood exposure to trauma, and PTEs involving interpersonal violence (Malvaso et al., 2022). Up to 50 percent of youth and adults who are incarcerated have experienced four or more childhood traumatic events compared with approximately 12 percent of the general population (Baglivio et al., 2014). Marginalized groups that are overrepresented in the justice system (e.g., African Americans; Native Americans; lesbian, gay, bisexual, transgender, and questioning populations) also bear the weight of exposure to trauma associated with being part of a historically stigmatized, oppressed, and victimized group of people who are still experiencing the effects of experiences such as racism, discrimination, and prejudice (Mohatt et al., 2014).

> *Many of our clients (if not all), have experienced trauma, and it affects their perception of programming and accepting assistance in the programs.*
>
> *—Reentry Program Coordinator*

Trauma exposure, particularly during childhood, increases the risk for contact with the justice system in adolescence and adulthood (Graf et al., 2021). For example, childhood trauma is associated with arrest,

recidivism, and incarceration (Graf et al., 2021; Testa et al., 2022; Yohros, 2022). Using data from the National Longitudinal Study of Adolescent to Adult Health, Testa et al. (2022) found that experiencing four or more childhood traumatic events was significantly associated with arrest, incarceration, and multiple incarcerations in young adulthood (ages 24–32) and middle adulthood (ages 33–43).

Reported rates of PTSD in adults who are incarcerated adults are four to five times higher than in the general population (Fovet et al., 2023). A meta-analysis of studies in prison settings estimated lifetime PTSD prevalence rates of 27 percent for male prisoners and 50 percent for female prisoners in the United States (Baranyi et al., 2018). Trauma and PTSD are both associated with an array of co-occurring problems in studies of adults under correctional or community supervision. Research shows that offenders with multiple adverse childhood experiences (four or more) and/or PTSD are more likely to report co-occurring depression, substance use disorders, suicidal thoughts, and violent behavior compared with offenders without PTSD (Baranyi et al., 2018; Malvaso et al., 2022; Bowen et al., 2018). Moreover, trauma and PTSD are linked to worse legal outcomes, such as recidivism and incarceration (Baranyi et al., 2018; Marshall et al., 2020; Sadeh & McNiel, 2015).

Trauma Resulting From Justice System Involvement

Research shows that adult offenders frequently experience new traumatic events as a result of their contact with the criminal justice system itself, and incarceration specifically (i.e., systemic trauma; see table 4). This includes directly experiencing or witnessing violence and harsh or coercive disciplinary practices (e.g., solitary confinement, physical restraint) that may exacerbate their psychological distress.

> *The research reflects what I have consistently observed over my 17 years working in both community and facility settings. We see the behaviors of substance use, acting out violently, and gang involvement, and on the surface these behaviors in themselves appear to be the barrier to programming, treatment, and change. In truth, the underlying trauma repeatedly experienced by these individuals is the true barrier to achieving positive behavior change. We cannot fully achieve the benefits of programming if we don't also address the element of trauma.*
>
> *—Programs Director, Department of Corrections*

Table 4. Potential sources of systemic trauma in criminal justice

Potentially traumatic events	Harsh or coercive practices
▪ Stop and frisk police searches ▪ Physical or sexual victimization by other inmates ▪ Physical or sexual victimization by correctional staff ▪ Witnessing violence in prison ▪ Solitary confinement for extended periods	▪ Physical restraint ▪ Pat downs and strip searches ▪ Being observed by staff during urine toxicology testing ▪ Handcuffs, shackling ▪ Use of threats or coercion to ensure compliance (e.g., threats of re-incarceration by parole officer)

Across studies, between 13 percent and 40 percent of men and women who are incarcerated report experiencing some form of trauma during incarceration, including high rates of physical or sexual victimization by correctional staff or other individuals who are incarcerated, as well as witnessing such acts (Teasdale et al. 2015; Wolff et al. 2007, 2009).

Exposure to PTE during incarceration—physical or sexual victimization, solitary confinement, and coercion—are significantly associated with post-release PTSD outcomes and an increased risk for recidivism (Liu et al., 2021; Piper & Berle, 2019).

Trauma and Resilience

Research has identified several factors that promote healing from traumatic stress and resilience against future PTEs. Resiliency factors include social support (peers, family, coworkers), stable employment or school connectedness, coping skills, and spirituality or religious faith (Southwick et al., 2014; Yule et al., 2019).

> *We have found that while the justice-involved individuals we serve have often undergone significant trauma, they demonstrate a tremendous amount of resilience as well. We work to facilitate this as much as possible by providing and/or referring clients to trauma-specific treatments to learn healthy coping strategies such as recognizing and managing triggers and emotional regulation; assisting clients in developing positive natural supports; and linking them to employment and educational opportunities.*
>
> *—Reentry Services Director*

Parole officers, case managers, and other frontline providers in the reentry field can use case planning and service referrals to help clients build on these factors. Examples include the following:

- Referrals to trauma-specific treatments can help clients learn strategies for coping with PTSD and other trauma-related problems.
- Social support—mentoring, peers (e.g., advocates, navigators), and other existing sources of support embedded in the community (i.e., supports that clients can access even after court involvement ends)
- Linkages to opportunities for employment, vocational training, or continuing education
- Spirituality and religious faith—helping clients find or reconnect with their local faith community

Vicarious Trauma in Criminal Justice Professionals

Frontline professionals throughout the criminal justice system are routinely exposed to potentially traumatic events in the line of duty. Elevated rates of work-related victimization (threats, physical assault) have been found among parole and probation officers (Lowry, 2000). Many justice system professionals also frequently experience secondary exposure to the details of traumatic events experienced by the victims of violent crimes and/or offenders with histories of trauma (Brobst, 2014; Severson & Pettus-Davis, 2013). Studies report elevated rates of PTSD across disciplines in the criminal justice system, including parole officers, mental health providers, attorneys, court professionals, and clerical staff in community corrections (Denhof & Spinaris, 2013).

Among criminal justice professionals, PTSD is associated with an increased risk for health problems, impaired job performance, and turnover (Denhof & Spinaris, 2013; Spinaris et al., 2012). The effects of trauma on the workforce only increase the risk for engaging in practices that retraumatize people involved with the criminal justice system, further perpetuating systemic traumas that cause additional harm. Building a resilient workforce is essential to

success across justice settings and involves applying what we know about resilience in the face of trauma to staff as well as clients.

> *It is crucial to support our staff who are working with justice involved individuals, as they are prone to experiencing vicarious trauma.*
>
> *—Reentry Services Director*

Part 2: Adopting a Trauma-Informed Approach in Justice Settings

Trauma-Informed Criminal Justice

The U.S. Department of Justice and other key stakeholders have called for criminal justice systems in this country to adopt a trauma-informed approach to combat the prevalent and pernicious effects of trauma on individuals who are involved in the justice system and correctional and reentry staff (Branson et al., 2017; International Association of Chiefs of Police, 2019, pp. 23–24; Pettus, 2023). A trauma-informed system "uses principles of safety, trust, empowerment, choice, and collaboration to enhance engagement, build self-regulation and resilience skills, and avoid re-traumatization of criminal justice clients" (Levenson et al., 2022, p. 483). The Substance Abuse and Mental Health Service Administration (SAMHSA, 2014) identified four key assumptions (the four "R's") for a trauma-informed organization or service system:

- **Realize** the widespread impact of trauma.
- **Recognize** the signs and symptoms of trauma in clients, families, and staff.
- **Respond** by fully integrating knowledge about trauma into policies, procedures, and practices.
- Seek to **resist** retraumatization.

A trauma-informed approach is understood as a universal approach, provided by all, for all. Although the field has yet to establish an agreed-on definition of the specific practices and policies that comprise a trauma-informed approach (Branson et al., 2017; Guevara et al., 2021), multiple areas of relative consensus include physical and psychological safety for clients and staff, staff training in trauma-informed care (TIC), trauma-specific mental health services, and collaboration with other service providers or systems that work with clients (Auty et al., 2022; Branson et al., 2017; Levenson & Willis, 2019; SAMHSA, 2014). See table 5 for a snapshot of the core domains of TIC and related practices that are common across systems, including the justice system.

> *Having more partner organizations across the board in the justice system and reentry-based programs being appropriately trained to Trauma-Informed Care approaches and making appropriate referrals for trauma treatment/assessments would be greatly beneficial in raising the success rate of individuals involved in the justice system.*
>
> *—Reentry Program Coordinator*

In the past 20 years, a small but growing body of research has evaluated the effectiveness of implementing a trauma-informed approach (Bendall et al., 2021; Fernández et al., 2023). Most of the available evidence on the impact of TIC comes from studies in mental health, child welfare, school, juvenile justice, and healthcare organizations, with relatively few studies in the adult justice system, and even fewer in the field of reentry (Fernández et al., 2023; Purtle, 2020; Pettus, 2023). For example, a systematic review of research on the effectiveness of TIC organizational interventions identified

23 studies, none of which were conducted in criminal justice settings (Purtle, 2020). Evidence on the effectiveness of TIC in criminal justice is largely limited to studies showing that trauma-focused mental health treatment reduces PTSD symptoms among adult offenders (Malik et al., 2021; Messina, 2022; Messina & Schepps, 2021). Further research and implementation guidance is needed adopt a comprehensive trauma-informed approach across the continuum of corrections and reentry programming and environments (Pettus, 2023).

Research on TIC in other service settings shows promise for improving outcomes of relevance to the criminal justice system, including in the area of trauma-responsive reentry (Pettus, 2023). In secure juvenile justice facilities, implementation of TIC has reduced client aggression toward staff in secure settings, youth disciplinary infractions, and youth mental health symptoms (Baetz et al., 2022; Elwyn et al., 2015; Ford & Hawke, 2012; Marrow et al., 2012). Studies in multiple service systems (e.g., juvenile justice, child welfare, mental health, substance abuse treatment) report improvements in staff perceptions of workplace safety, organizational climate, and organizational support as well as staff burnout and turnover (Baetz et al., 2022; Elwyn et al., 2015; Fernández et al., 2023; Hales et al., 2019).

Table 5. Core domains of a trauma-informed organization

Domain of TIC	Description	Specific practices and policies
Physical & psychological safety for clients	Establishing a sense of safety is the foundation of healing from trauma and is an essential ingredient for helping clients feel comfortable when engaging with providers.	▪ Client-centered treatment planning (“voice and choice”) ▪ Consistency in programming and staffing ▪ Reduce or eliminate harsh or coercive practices (e.g., shackling, mechanical restraints)
Physical & psychological safety for staff	Staff must feel safe to create a safe environment for clients. Perceptions of workplace safety are higher for justice system staff who feel supported by the organization and those who report that their organization was taking steps to address work-related trauma (Baetz et al., 2022).	▪ Staff education on sources, signs, and impact of work-related traumatic stress ▪ Opportunities to provide feedback to leadership and share safety concerns ▪ Organizational strategies to support staff exposed to trauma (e.g., debriefing after workplace crises, referrals to trauma-focused mental health services, peer support groups)
Staff training	Staff throughout the organization should receive training to increase their knowledge and skill in working with clients affected by trauma.	▪ Training on impact of traumatic stress, principles of TIC, and specific trauma-informed skills (e.g., de-escalation) ▪ Ongoing coaching or supervision to promote staff mastery of new skills
Trauma-specific mental health services	Adults on parole report high rates of trauma exposure and related problems. Accordingly, a trauma-informed organization or justice system should ensure that clients are routinely screened or assessed for trauma-related problems and referred to interventions designed to address such issues (i.e., trauma-specific treatment).	▪ Universal screening of clients’ trauma-related problems (e.g., PTSD) and comprehensive trauma-informed mental health assessments for clients who screen positive ▪ Evidence-based, trauma-specific treatment widely available and accessible to clients ▪ Develop trauma-informed safety plans (triggers, warning signs, coping strategies) for all clients affected by trauma

Domain of TIC	Description	Specific practices and policies
Cross-system collaboration and coordination of care	Adults reentering the community often are mandated to work with multiple providers and service systems (e.g., parole, mental health, vocational training). Coordination of care among involved providers can help avoid redundancy in services (e.g., undergoing multiple trauma screenings) and promote sharing of vital information to improve client outcomes.	▪ Multidisciplinary treatment teams ▪ Establish information sharing protocols ▪ Joint TIC training with other service systems or providers that serve the reentry population

Source: Branson et al. (2017); Brennen et al. (2019); Levenson et al. (2019); SAMHSA (2014).

Becoming Trauma-Informed: Tips for Providers

Building a shared understanding and common language related to the body's response to stress and traumatic stress among staff and clients is central to adopting a trauma-informed approach. Without an awareness of how trauma responses may manifest, staff risk misunderstanding and mislabeling client behaviors, further perpetuating harm. This section describes three practical yet effective trauma-informed practices that reentry agencies can easily adopt in a variety of settings.

> *In order to create a trauma-informed approach, all staff must be involved and trained to accurately identify trauma responses and to implement practical trauma-informed skills. Too often, I have seen the opposite, which leads to escalated aggressive behavior, uses of force, injury, and overall backwards progress. One mishandled incident that only lasts several minutes can destroy months' worth of skill building, evidence-based interventions, and programming.*
>
> *—Programs Director, Department of Corrections*

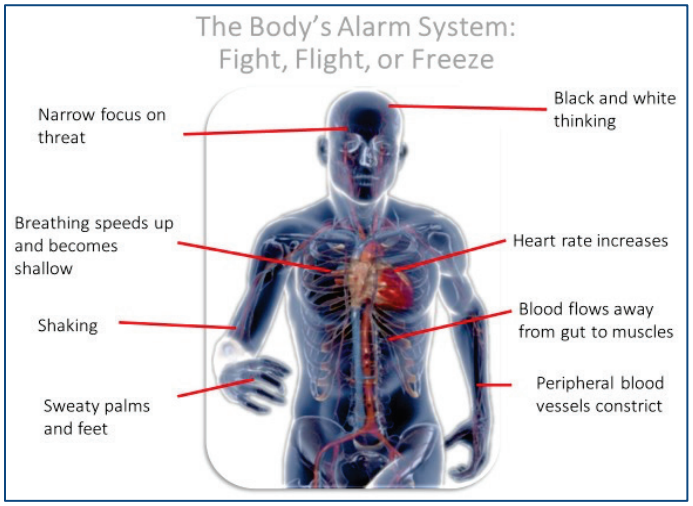
These practical skills have been taught to probation/parole officers, drug treatment court case managers, defense attorneys, court officers, and bachelor-level staff in diversion programs. Moreover, providers benefit from applying these skills to understand their own stress responses and manage the impact of work-related trauma on their health and well-being. The core skills identified here may be incorporated into new hire training and annual or ongoing refresher trainings with staff and incorporated into regular discussions in supervisory and team meetings related to how these skills are applied in daily practice with clients and among staff.

- **Skill 1. Teach Clients About the Body's Alarm System.** Every human has a built-in threat detection system in their brain, also known as the "body's alarm system" (Ford, 2017). In the context of everyday stressors, such as running late for an appointment or rush-hour traffic, the alarm (i.e., the amygdala) communicates with the parts of the brain that control decision making and that store memories of similar experiences. This communication allows for calm decision making to deal with the stressor. However, this is not the case when faced with a traumatic stressor.

  When the alarm detects a potentially life-threatening situation, it sets off a series of mental and physical changes that prepare us for survival, referred to as "fight-flight-freeze" (figure 1). This fight or flight response includes the release of adrenaline and

increased blood flow to major muscle groups needed for self-defense or escape (Ford, 2017). Attention becomes narrowly focused on the threat, and decision making is instinctual. Communication between the alarm and other parts of the brain breaks down; an immediate reaction is essential, and there is no time for careful planning.

Figure 1. The body's alarm system



Source: Adapted from Marrow et al. (2012).

After a traumatic experience, the alarm system may be triggered by reminders of the trauma rather than actual danger. These false alarms feel real despite the absence of any immediate threat. Trauma survivors often respond to false alarms with some form of fight, flight, or freeze—which is helpful in life-threatening situations but likely to cause problems in daily life. For example, a person who was verbally abused as a child may be triggered by criticism at work and respond in a way that gets them fired. Teaching staff how to talk to clients about the body's alarm system and false alarms is a first step toward helping them learn to manage these responses. See table 6 for a summary of key concepts to teach staff to use with clients.

Table 6. Key concepts related to the stress response and trauma

Term	Definition
The body's alarm system	The alarm system, activated by the amygdala, promotes survival by detecting danger and preparing us to survive such situations.
Fight, flight, or freeze	In a life-threatening situation, the alarm will prepare us to survive by defending ourselves (fight) or escaping (flight). One may dissociate or become stuck like a deer in headlights (freeze) when overwhelmed or if escape and self-defense are impossible.
False alarms	When the body's alarm is activated by a reminder of a past trauma rather than an actual threat.
Trigger	Any trauma reminder that activates a false alarm. Reminders or triggers include people, places, sights, sounds, physical sensations, thoughts, and emotions.

- **Skill 2: Help Clients Learn to Spot False Alarms.** Once staff educate clients about false alarms, staff can assist clients in learning how to recognize when they experience one. Warning signs may include physical sensations (fidgety, rapid heartbeat, upset stomach), emotions (anger, fear, anxiety), and thoughts ("I need to get out of here"). In the midst of a false alarm, behaviors often are some variations of fight (become loud or aggressive to frighten off potential threats), flight (leave the room, withdraw socially, use drugs to escape mentally), or freeze (space out). Staff can regularly ask clients about recent false alarms and have them recount what they felt physically and emotionally, their thoughts, and what they did in the situation. The goal is for clients to notice a false alarm as early as possible because it will make it easier to reset their alarm (see skill 3).

> *Knowing and understanding the triggers and signs of trauma effects in justice involved clients as well as justice involved professionals aids to mitigate any further traumas and stress. If a justice involved professional is not seeing the signs in their clients, it will make it harder to work with them and create possible goal oriented solutions with clients if they are experiencing effects from trauma.*
>
> *—Reentry Program Coordinator*

- **Skill 3: Support Clients in Learning Their Triggers.** Once clients start to recognize their false alarms, the next step is learning their most common triggers. This information can help clients make plans to either avoid certain triggers (if possible) or cope with them. Staff can help clients identify the triggers that cause the most problems in their daily life, particularly those related to their reentry plans (e.g., parole office, courts, workplace, treatment programs). Anticipating potential triggers ahead of time allows staff to help clients plan for and practice how they can manage potentially triggering scenarios that may arise at work, at home, or in the community. See table 7 for a list of common triggers for adults involved in the justice system, as well as for criminal justice professionals.

Becoming Trauma-Informed: Tips for Organizations

Integrating a trauma-informed approach to reentry requires planning, resources, commitment, and time. The following tips come from the literature and the author's experience with real-world TIC implementation projects:

- **Form a TIC Workgroup.** Identify a team of staff members who can support efforts to adopt a trauma-informed approach. This team has primary responsibility for maintaining the momentum for trauma-informed organizational change. It is important to get representation from all major disciplines in the organization (e.g., parole officers, mental health, substance use, placement staff) and to ensure that line staff are well represented on the workgroup, along with people who have authority to make recommended changes.

Table 7. Common triggers for adults on parole and criminal justice professionals

Common triggers for adults on parole		Common triggers for criminal justice professionals
▪ Authority figures ▪ Feeling insulted or disrespected ▪ Criticism ▪ Feeling ignored ▪ Perceived lack of control over a situation ▪ Loud voices, yelling ▪ Court appearances ▪ Crowded waiting rooms ▪ Being touched	▪ Being stared at ▪ Uniformed law enforcement ▪ Being asked personal questions ▪ Being searched, pat downs ▪ Handcuffs or shackles ▪ Physical restraint ▪ Being observed during urine toxicology testing ▪ Threats of parole violations or re-incarceration	▪ Feeling unsupported or let down by coworkers or leadership ▪ Client becomes loud or verbally aggressive ▪ Place where trauma happened (i.e., work assignment, gym, dorm) ▪ Feeling under pressure because of short staffing or high workload ▪ Lack of voice ▪ Working overtime or working through a significant staff shortage

Our Trauma Committee meets monthly and is continuously working to ensure that we have created a service system that is responsible to our clients' past experiences and challenges related to trauma and other adverse experiences.

Reentry Services Director

When considering workgroup size, ensure a large enough group to withstand the loss of staff, while also keeping numbers manageable for the team. Agencies may wish to break into subgroups that each focus on the implementation of a particular practice or policy (e.g., crisis response team, staff training, trauma screening, treatment referrals). As agencies create their workgroups, they should consider if they have internal staff with the capacity to help guide this effort or whether it would be useful to have an external consultant with expertise in trauma-informed care to support their change efforts.

- **Conduct a Needs Assessment.** Agencies invested in adopting a trauma-informed approach take time to examine current practice as it relates to a trauma-informed approach. Agency assessment tools often are designed based on particular areas of focus or domains (see table 5), such as the following: (1) the types of training that staff have had related to trauma and trauma-informed practice; (2) ways that the agency supports clients' physical and emotional safety; (3) how client voice and choice are integrated into service delivery; and (4) what types of policies and procedures are in place that support a trauma-informed approach. The goal of an assessment process is to identify areas of strength and need as it relates to trauma-informed practice. Results should guide implementation plan.

There are a variety of methods for assessing organizational trauma-informed practice. (See Additional Resources section for examples of assessment tools that can be used or adapted.) Some assessment tools include specific strategies and require agency staff to determine the extent to which they integrate those strategies, whereas other assessments are based on a series of reflection questions for agencies to consider as they relate to trauma-informed practice. Throughout the assessment process, it is important to gather information from multiple perspectives, and the voices of clients and frontline staff should be central to the assessment process. Oftentimes, management will have a different perspective on program practice compared with line staff, and it is necessary to ensure a 360-degree assessment of programming. Examples of assessment tools that can be used or adapted to support this process are included at the end of this brief.

- **Start With a Focus on Staff Safety and Wellness.** Staff levels of safety and well-being directly influence the success of any organizational change effort.

For many years I think the trauma experienced by corrections staff, both directly and indirectly, has been overlooked. It was something no one talked about, no one wanted to admit to. As we find ourselves in the middle of the worst staffing crisis I have ever seen, it is something that can no longer be ignored if we want to continue not only operating, but also providing the most effective services we can to the population we work with.

—Programs Director, Department of Corrections

Organizations with low ratings of staff safety often struggle with high rates of staff absenteeism and turnover. These are major barriers to implementing a trauma-informed approach and can result in wasted resources (e.g., trained staff leave the agency). Thus, agencies should start their trauma-informed efforts with a focus on staff. It is important to get a sense of staff members' current experience working in the program, including a sense of physical safety and emotional safety (e.g., level of support, supervision, resources, training, trust in managers and colleagues) before spending their (often limited) resources on more extensive staff training. Fortunately, organizations can take many steps to improve staff safety for little or no cost (see table 8). These efforts reflect an essential dimension of trauma-informed practice.

Table 8. Organizational strategies to promote staff resilience and wellness

Category	Description	How it helps	Examples
Debriefing protocol	Protocol for checking in with staff and clients following a traumatic event in the workplace	▪ Staff desire support/acknowledgement from leadership in times of crisis ▪ Reminds staff of available supports ▪ Reduces stigma around help-seeking ▪ Increases access to treatment and support for staff in distress	▪ Critical Incident Stress Management (CISM) Team ▪ Training supervisors or line staff to conduct debriefings
Staff training	Training to provide staff with tools for working with clients affected by trauma and managing their own work-related trauma/stress	▪ Increases staff knowledge of the impact of trauma on clients and core principles of TIC ▪ Enhances staff's ability to engage clients, foster a safe environment, and deescalate potential crises ▪ Increases awareness of the signs of work-related PTSD ▪ Teaches staff skills to cope with workplace trauma	▪ Existing manualized training curriculums include *Think Trauma* and *T-Care*
Peer support	Providing opportunities for staff to seek support from fellow professionals within the system	▪ Social support is one of the strongest predictors of resilience after workplace trauma exposure. ▪ Increased trust and support among coworkers contributes to positive culture in facility.	▪ Onsite peer support groups ▪ Peer-run 1-800 hotline for staff ▪ Mentoring programs for new staff
Supervisor support	Training supervisors to check in with staff/provide support around issues of trauma, stress, and wellness	▪ Few jurisdictions train supervisors in strategies for supporting staff ▪ Social support predicts resilience ▪ Supervisor support reduces risk of PTSD	▪ Develop training curriculum for supervisors ▪ Monthly meetings for supervisors to receive peer support and exchange ideas for supporting line staff
Staff forums	Establish regular meetings or surveys to solicit staff concerns and feedback	▪ Trauma involves a loss of control. Thus, "voice and choice" is a key principle of TIC for staff. ▪ Line staff can often identify problems (and solutions) long before leadership.	▪ Town Hall meetings or "Listening tour" by leadership ▪ Periodic anonymous staff surveys
Staff recognition	Recognizing staff successes and efforts	▪ Staff recognition is important for countering the trauma and stress of the job (e.g., sudden death of client or coworker, client re-arrested for serious crime), which can lead staff to question their effectiveness or competence ▪ Recognizing and celebrating staff can help increase employees' connection to the organization	▪ Staff Spotlight articles for agency intranet or newsletter ▪ Employee-of-the-Month award ▪ "Compliment box" ▪ Acknowledgment of staff work anniversaries

- **Provide Continuous Staff Training and Support.** A key aspect of promoting staff support and resilience is staff training to provide staff with the tools they need to help clients affected by trauma and to manage their own stress responses. All frontline staff who interact with clients, along with their supervisors, should participate in TIC training. Training should go beyond "Trauma 101" and offer practical knowledge and skills for working with trauma survivors, such as those described in this brief. Ideally, the trainer will have prior experience working with the justice system.

> *We make certain that all levels of staff have training and understanding of the impact of trauma on those we serve as well as coworkers. We are also constantly evaluating and reevaluating our processes to ensure that we have created a responsive and positive work environment for staff. This includes a peer-led support group that meets bimonthly.*
>
> *—Reentry Services Director*

Initial training should be supplemented with regular opportunities for coaching or supervision to help staff master new skills. Research shows that attending a single workshop without follow-up leads to gains in knowledge but not skill in using evidence-based practices (Beidas et al., 2016). Initial training should be supplemented with regular opportunities for coaching or supervision to help staff master new skills. Team meetings and one-on-one supervision offer smaller settings for conveying and clarifying information and skills and enable staff members to continuously apply trauma concepts to real-life work situations and discuss and practice specific ways of responding to different scenarios.

Conclusion

Exposure to traumatic experiences is extraordinarily common among people involved in the justice system and can have profound effects on many aspects of daily life and functioning. Increased awareness and understanding of the prevalence and impact of trauma has prompted the call for a trauma-informed approach across justice settings. Adopting a trauma-informed approach ensures that all staff have the knowledge and skills needed to understand and best serve clients exposed to trauma prior to incarceration and to avoid unintentionally causing additional harm. Integrating a trauma-informed approach requires a sustained, concerted effort to cultivate a shared understanding of trauma and healing and to align organizational policies, culture, and practice to foster optimal conditions for safety, support, and success for all.

Additional Resources

Some of the following resources were developed for use in other service systems (e.g., juvenile justice) but can easily adapted for use by agencies that serve adults.

Trauma-Informed Organizational Assessment Measures

- Branson, C. E. (2017). *Trauma-informed juvenile justice organizational self-assessment*. https://cbransonconsulting.com/
- American Institutes for Research. (2015). *Trauma-informed organizational capacity scale.* https://www.air.org/resource/trauma-informed-organizational-capacity-scale
- College of Behavioral and Community Sciences. (2010). *Creating trauma-informed care environments: An organizational self-assessment*. University of South Florida. https://www.hca.wa.gov/assets/program/trauma-informed-care-organization-self-assessment-university-south-florida.pdf
- Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-informed organizational toolkit for homeless services*. https://www.air.org/sites/default/files/2021-06/Trauma-Informed_Organizational_Toolkit_0.pdf

PTSD Symptom Screening and Assessment Measures

- Department of Veterans Affairs, Adult PTSD self-report measures: https://www.ptsd.va.gov/professional/assessment/adult-sr/index.asp
- Department of Veterans Affairs, PTSD screening instruments: https://www.ptsd.va.gov/professional/assessment/screens/index.asp
- PTSD Checklist for *DSM-5* (PCL-5): https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp
- International Trauma Questionnaire: https://www.traumameasuresglobal.com/itq
- Global Psychotrauma Screen: https://gps.global-psychotrauma.net/home?lang=en_us

Staff Training

- GAINS Center for Behavioral Health and Justice Transformation: *How being trauma-informed improves criminal justice system responses*: https://www.samhsa.gov/gains-center/contact-gains-center and https://www.prainc.com/wp-content/uploads/2016/07/HBTIICJR-2016JMHD.pdf
- Advance Trauma Solutions, *Trauma-informed care*: https://www.atspro.org/targetcurricula
- National Child Traumatic Stress Network (Marrow et al., 2020): *Think trauma: A training for working with justice-involved youth* (2nd ed.): https://www.nctsn.org/resources/think-trauma-training-working-justice-involved-youth-2nd-edition

References

Auty, K. M., Liebling, A., Schliehe, A., & Crewe, B. (2022). What is trauma-informed practice? Towards operationalisation of the concept in two prisons for women. *Criminology & Criminal Justice.* Advance online publication. https://doi.org/10.1177/17488958221094980

Baglivio, M. T., Epps, N., Swartz, K., Sayedul Huq, M., Sheer, A., & Hardt, N. S. (2014). The prevalence of adverse childhood experiences (ACE) in the lives of juvenile offenders. *Journal of Juvenile Justice, 3*(2). https://www.prisonpolicy.org/scans/Prevalence_of_ACE.pdf

Baglivio, M. T., Wolff, K. T., Piquero, A. R., & Epps, N. (2015). The relationship between adverse childhood experiences (ACE) and juvenile offending trajectories in a juvenile offender sample. *Journal of Criminal Justice, 43*(3), 229–241. https://doi.org/10.1016/j.jcrimjus.2015.04.012

Baranyi, G., Cassidy, M., Fazel, S., Priebe, S., & Mundt, A. P. (2018). Prevalence of posttraumatic stress disorder in prisoners. *Epidemiologic Reviews*, *40*(1), 134–145. https://doi.org/10.1093/epirev/mxx015

Baetz, C. L., Surko, M., Bart, A., Guo, F., Alexander, A., McCann, A., Havens, J., & Horwitz, S. M. (2022). The role of trauma-informed practices and individual factors on perceptions of safety among staff in secure juvenile detention settings. *Journal of Crime and Justice*. Advance online publication. https://doi.org/10.1080/0735648X.2022.2148960

Beidas, R. S., Stewart, R. E., Adams, D. R., Fernandez, T., Lustbader, S., Powell, B. J., Aarons, G. A., Hoagwood, K. E., Evans, A. C., Hurford, M. O., Rubin, R., Hadley, T., Mandell, D. S., & Barg, F. K. (2016). A multi-level examination of stakeholder perspectives of implementation of evidence-based practices in a large urban publicly-funded mental health system. *Administration and Policy in Mental Health and Mental Health Services Research*, *43*(6), 893–908. https://doi.org/10.1007/s10488-015-0705-2

Bendall, S., Eastwood, O., Cox, G., Farrelly-Rosch, A., Nicoll, H., Peters, W., Bailey, A. P., McGorry, P. D., & Scanlan, F. (2021). A systematic review and synthesis of trauma-informed care within outpatient and counseling health settings for young people. *Child Maltreatment*, *26*(3), 313–324. https://doi.org/10.1177/1077559520927468

Benjet, C., Bromet, E., Karam, E., Kessler, R., McLaughlin, K., Ruscio, A., Shahly, V., Stein, D. J., Petukhova, M., Hill, E., Alonso, J., Atwoli, L., Bunting, B., Bruffaerts, R., Caldas-de-Almeida, J. M., de Girolamo, G., Florescu, S., Gureje, O., Huang, Y., Lepine, J. P., . . . Koenen, K. (2016). The epidemiology of traumatic event exposure worldwide: Results from the World Mental Health Survey Consortium. *Psychological Medicine, 46*(2), 327–343. https://doi.org/10.1017/S0033291715001981

Bowen, K., Jarrett, M., Stahl, D., Forrester, A., & Valmaggia, L. (2018). The relationship between exposure to adverse life events in childhood and adolescent years and subsequent adult psychopathology in 49,163 adult prisoners: A systematic review. *Personality and Individual Differences, 131*, 74–92. https://doi.org/10.1016/j.paid.2018.04.023

Branson, C. E., Baetz, C. L., Horwitz, S. M., & Hoagwood, K. E. (2017). Trauma-informed juvenile justice systems: A systematic review of definitions and core components. *Psychological Trauma: Theory, Research, Practice, and Policy*, *9*(6), 635–646. https://doi.org/10.1037/tra0000255

Brennen, J., Guarino, K., Axelrod, J., & Gonsoulin, S. (2019). *Building a multi-system trauma-informed collaborative: A guide for adopting a cross-system, trauma-informed approach among child-serving agencies and their partners*. Chapin Hall at the University of Chicago & American Institutes for Research. https://www.air.org/sites/default/files/2021-10/Multi-System-Trauma-Informed-Care-MSTIC-Guide-FINAL-6.16.20.pdf

Briere, J., Agee, E., & Dietrich, A. (2016). Cumulative trauma and current posttraumatic stress disorder status in general population and inmate samples. *Psychological Trauma: Theory, Research, Practice, and Policy, 8*(4), 439–446. https://doi.org/10.1037/tra0000107

Brobst, J. (2014). The impact of secondary traumatic stress among family attorneys working with trauma-exposed clients: Implications for practice and professional responsibility. *Journal of Health & Biomedical Law*, *10*(1), 1–54. https://ssrn.com/abstract=2466814

Connolly, E. J. (2019). Further evaluating the relationship between adverse childhood experiences, antisocial behavior, and violent victimization: A sibling-comparison analysis. *Youth Violence and Juvenile Justice*, *18*(1), 3–23. https://doi.org/10.1177/1541204019833145

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E., & van der Kolk, B. J. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35*(5), 390–398. https://doi.org/10.3928/00485713-20050501-05

De Bellis, M. D., & Zisk, A. (2014). The biological effects of childhood trauma. *Child and Adolescent Psychiatric Clinics, 23*(2), 185–222. https://doi.org/10.1016/j.chc.2014.01.002

Denhof, M. D., & Spinaris, C. G. (2013). *Depression, PTSD, and comorbidity in United States corrections professionals: Prevalence and impact on health*. Desert Waters Correctional Outreach. https://desertwaters.com/wp-content/uploads/2021/03/Comorbidity_Study_09-03-131.pdf

De Ruiter, C., Burghart, M., De Silva, R., Griesbeck Garcia, S., Mian, U., Walshe, E., & Zouharova, V. (2022). A meta-analysis of childhood maltreatment in relation to psychopathic traits. *PLoS One*, *17*(8), Article e0272704. https://doi.org/10.1371/journal.pone.0272704

Dye, H. (2018) The impact and long-term effects of childhood trauma, *Journal of Human Behavior in the Social Environment*, *28*(3), 381–392. https://doi.org/10.1080/10911359.2018.1435328

Elwyn, L.J., Esaki, N., & Smith, C.A. (2015). Safety at a girls secure juvenile justice facility. *Therapeutic Communities: The International Journal of Therapeutic Communities*, *36*(4), 209–218. https://doi.org/10.1108/TC-11-2014-0038

Farrington, D., Ttofi, M., & Piquero, A. (2016). Risk, promotive, and protective factors in youth offending: Results from the Cambridge study in delinquent development. *Journal of Criminal Justice, 45*, 63–70. https://doi.org/10.1016/j.jcrimjus.2016.02.014

Fernández, V., Gausereide-Corral, M., Valiente, C., & Sánchez-Iglesias, I. (2023). Effectiveness of trauma-informed care interventions at the organizational level: A systematic review. *Psychological Services*. Advance online publication. https://doi.org/10.1037/ser0000737

Fitton, L., Yu, R., & Fazel, S. (2020). Childhood maltreatment and violent outcomes: A systematic review and meta-analysis of prospective studies. *Trauma, Violence, & Abuse*, *21*(4), 754–768. https://doi.org/10.1177/1524838018795269

Ford, J. (2017, September 28). *Introduction to the trauma affect regulation TARGET model.* [PowerPoint slides]. University of Connecticut. https://pcit.ucdavis.edu/wp-content/uploads/2012/08/Workshop16_PCIT-2017-Summit-Keynote-A-Developmental-Trauma-Approach-to-Helping...Resilience.pdf

Ford, J. D., Chapman, J. C., Connor, D. F., & Cruise, K. C. (2012). Complex trauma and aggression in secure juvenile justice settings. *Criminal Justice & Behavior*, *39*(5), 695–724. https://doi.org/10.1177/0093854812436957

Ford, J. D., Chapman, J., Mack, M., & Pearson, G. (2009). Pathway from traumatic child victimization to delinquency: Implications for juvenile and permanency court proceedings and decisions. *Juvenile and Family Court Journal*, *57*(1), 13–26. https://doi.org/10.1111/j.1755-6988.2006.tb00111.x

Ford, J. D., Elhai, J. D., Connor, D. F., & Frueh, B. C. (2010). Poly-victimization and risk of posttraumatic, depressive, and substance use disorders and involvement in delinquency in a national sample of adolescents. *Journal of Adolescent Health*, *46*(6), 545–552. https://doi.org/10.1016/j.jadohealth.2009.11.212

Ford, J. D., & Hawke, J. (2012). Trauma affect regulation psychoeducation group and milieu intervention outcomes in juvenile detention facilities. *Journal of Aggression, Maltreatment & Trauma, 21*(4), 365–384. https://doi.org/10.1080/10926771.2012.673538

Fovet, T., Wathelet, M., Amad, A., Horn, M., Belet, B., Roelandt, J.-L., Thomas, P., Vaiva, G., & D'Hondt, F. (2023). PTSD in prison settings: The need for direct comparisons with the general population. *Psychological Medicine, 53*(2), 597–599. https://doi.org/10.1017/S0033291721000507

Fox, B. H., Perez, N., Cass, E., Baglivio, M. T., & Epps, N. (2015). Trauma changes everything: Examining the relationship between adverse childhood experiences and serious, violent and chronic juvenile offenders. *Child Abuse & Neglect*, *46*, 163–173. https://doi.org/10.1016/j.chiabu.2015.01.011

Goldstein, R. B., Smith, S. M., Chou, S. P., Saha, T. D., Jung, J., Zhang, H., Pickering, R. P., Ruan, W. J., Huang, B., & Grant, B. F. (2016). The epidemiology of DSM-5 posttraumatic stress disorder in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions-III. *Social Psychiatry and Psychiatric Epidemiology*, *51*(8), 1137–1148. https://doi.org/10.1007/s00127-016-1208-5

Graf, G. H. J., Chihuri, S., Blow, M., & Li, G. (2021). Adverse childhood experiences and justice system contact: A systematic review. *Pediatrics, 147*(1), Article e2020021030. https://doi.org/10.1542/peds.2020-021030

Gregorowski, C., & Seedat, S. (2013). Addressing childhood trauma in a developmental context. *Journal of Child & Adolescent Mental Health*, *25*(2), 105–118. https://doi.org/10.2989/17280583.2013.795154

Guevara, A. M. M., Johnson, S. L., Elam, K., Rivas, T., Berendzen, H., & Gal-Szabo, D. E. (2021). What does it mean to be trauma-informed? A multi-system perspective from practitioners serving the community. *Journal of Child and Family Studies*, *30*, 2860–2876. https://doi.org/10.1007/s10826-021-02094-z

Hales, T. W., Green, S. A., Bissonette, S., Warden, A., Diebold, J., Koury, S. P., & Nochajski, T. H. (2019). Trauma-informed care outcome study. *Research on Social Work Practice*, *29*(5), 529–539. https://doi.org/10.1177/1049731518766618

International Association of Chiefs of Police. (2019). *2019 resolutions*. https://www.theiacp.org/resolutions

Jäggi, L. J., Mezuk, B., Watkins, D. C., & Jackson, J. S. (2016). The relationship between trauma, arrest, and incarceration history among Black Americans: Findings from the National Survey of American Life. *Society and Mental Health*, *6*(3), 187–206. https://doi.org/10.1177/2156869316641730

Kessler, R. C., Aguilar-Gaxiola, S., Alonso, J., Benjet, C., Bromet, E. J., Cardoso, G., Degenhardt, L., de Girolamo, G., Dinolova, R. V., Ferry, F., Florescu, S., Gureje, O., Haro, J. M., Huang, Y., Karam, E. G., Kawakami, N., Lee, S., Lepine, J.-P., Levinson, D., Navarro-Mateu, F., . . . Koenen, K. C. (2017). Trauma and PTSD in the WHO world mental health surveys. *European Journal of Psychotraumatology*, *8*(sup5), Article 1353383. https://doi.org/10.1080/20008198.2017.1353383

Levenson, J. S., & Willis, G. M. (2019). Implementing trauma-informed care in correctional treatment and supervision. *Journal of Aggression, Maltreatment & Trauma*, *28*(4), 481–501. https://doi.org/10.1080/10926771.2018.1531959

Levenson, J., Prescott, D. S., & Willis, G. M. (2022). Trauma-informed treatment practices in criminal justice settings. In E. Jeglic & C. Calkins (Eds.), *Handbook of issues in criminal justice reform in the United States* (pp. 483–502). Springer. https://doi.org/10.1007/978-3-030-77565-0

Liu, H., Li, T. W., Liang, L., & Hou, W. K. (2021). Trauma exposure and mental health of prisoners and ex-prisoners: A systematic review and meta-analysis. *Clinical Psychology Review*, *89*, Article 102069. https://doi.org/10.1016/j.cpr.2021.102069

Lowry, K. D. (2000). United States probation/pretrial officers' concerns about victimization and officer safety training. *Federal Probation, 64*(1)*,* 51–55. https://www.uscourts.gov/sites/default/files/64_1_9_0.pdf

Malik, N., Facer-Irwin, E., Dickson, H., Bird, A., & MacManus, D. (2021). The effectiveness of trauma-focused interventions in prison settings: A systematic review and meta-analysis. *Trauma, Violence, & Abuse*. Advance online publication. https://doi.org/10.1177/15248380211043890

Malvaso, C. G., Cale, J., Whitten, T., Day, A., Singh, S., Hackett, L., Delfabbro, P. H., & Ross, S. (2022). Associations between adverse childhood experiences and trauma among young people who offend: A systematic literature review. *Trauma, Violence, & Abuse*, *23*(5), 1677–1694. https://doi.org/10.1177/15248380211013132

Marrow, M., Benamati, J., Decker, K., Griffin, D., & Lott, D. A. (2012). *Think trauma: A training for staff in juvenile justice residential settings*. National Center for Child Traumatic Stress.

Marshall, K., Abate, A., & Venata, A. (2020). Posttraumatic stress symptoms and recidivism in serious juvenile offenders: Testing the mediating role of future orientation. *Journal of Child and Adolescent Trauma, 13*(1), 33–43. https://doi.org/10.1007/s40653-018-0234-8

Messina, N. (2022). Evaluation of a peer-facilitated trauma intervention for incarcerated men. *Criminal Justice and Behavior*, *49*(10), 1399–1417. https://doi.org/10.1177/00938548221093280

Messina, N. P., & Schepps, M. (2021). Opening the proverbial 'can of worms' on trauma-specific treatment in prison: The association of adverse childhood experiences to treatment outcomes. *Clinical Psychology & Psychotherapy*, *28*(5), 1210–1221. https://doi.org/10.1002/cpp.2568

Mohatt, N. V., Thompson, A. B., Thai, N. D., & Tebes, J. K. (2014). Historical trauma as public narrative: A conceptual review of how history impacts present-day health. *Social Science & Medicine, 106,* 128–136. https://doi.org/10.1016/j.socscimed.2014.01.043

Perfect, M. M., Turley, M. R., Carlson, J. S., Yohanna, J., & Saint Gilles, M. P. (2016). School-related outcomes of traumatic event exposure and traumatic stress symptoms in students: A systematic review of research from 1990 to 2015. *School Mental Health: A Multidisciplinary Research and Practice Journal*, *8*(1), 7–43. https://doi.org/10.1007/s12310-016-9175-2

Perry, B. D. (2001). The neurodevelopmental impact of violence in childhood. In D. Schetky & E. Benedek (Eds.), *Textbook of child and adolescent forensic psychiatry* (pp. 221–238). American Psychiatric Press.

Pettus, C. A. (2023). Trauma and prospects for reentry. *Annual Review of Criminology, 6,* 423–446. https://doi.org/10.1146/annurev-criminol-041122-111300

Piper, A., & Berle, D. (2019). The association between trauma experienced during incarceration and PTSD outcomes: A systematic review and meta-analysis. *The Journal of Forensic Psychiatry & Psychology*, *30*(5), 854–875. https://doi.org/10.1080/14789949.2019.1639788

Purtle, J. (2020). Systematic review of evaluations of trauma-informed organizational interventions that include staff trainings. *Trauma, Violence, & Abuse*, *21*(4), 725–740. https://doi.org/10.1177/1524838018791304

Putnam, F. (2006). The impact of trauma on child development. *Juvenile and Family Court Journal, 57*(1), 1–11.

Sadeh, N., & McNiel, D. E. (2015). Posttraumatic stress disorder increases risk of criminal recidivism among justice-involved persons with mental disorders. *Criminal Justice and Behavior, 42*(6), 573–586. https://doi.org/10.1177/0093854814556880

Schein, J., Houle, C., Urganus, A., Cloutier, M., Patterson-Lomba, O., Wang, Y., King, S., Levinson, W., Guérin, A., Lefebvre, P., & Davis, L. L. (2021). Prevalence of post-traumatic stress disorder in the United States: A systematic literature review. *Current Medical Research and Opinion*, *37*(12), 2151–2161. https://doi.org/10.1080/03007995.2021.1978417

Severson, M., & Pettus-Davis, C. (2013). Parole officers' experiences of the symptoms of secondary trauma in the supervision of sex offenders. *International Journal of Offender Therapy and Comparative Criminology*, *57*(1), 5–24. http://doi.org/10.1177/0306624X11422696

Southwick, S. M., Bonanno, G. A., Masten, A. S., Panter-Brick, C., & Yehuda, R. (2014). Resilience definitions, theory, and challenges: Interdisciplinary perspectives. *European Journal of Psychotraumatology, 5*(1), Article 25338. https://doi.org/10.3402/ejpt.v5.25338

Spinaris, C. G., Denhof, M. D., & Kellaway, J. A. (2012). *Posttraumatic stress disorder in United States corrections professionals: Prevalence and impact on health and functioning*. Desert Waters Correctional Outreach. https://web.archive.org/web/20170806063832/http:/desertwaters.com/wp-content/uploads/2013/09/PTSD_Prev_in_Corrections_09-03-131.pdf

Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach* (HHS Publication No. [SMA] 14-4884). https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf

Teasdale, B., Daigle, L., Hawk, S., & Daquin, J. (2015). Violent victimization in the prison context: An examination of the gendered contexts of prison. *International Journal of Offender Therapy and Comparative Criminology*. *60*(9), 995–1015. https://doi.org/10.1177/0306624X15572351

Teicher, M. H., & Samson, J. A. (2016). Annual research review: Enduring neurobiological effects of childhood abuse and neglect. *Journal of Child Psychology and Psychiatry*, *57*(3), 241–266. https://doi.org/10.1111/jcpp.12507

Testa, A., Jackson, D. B., Ganson, K. T., & Nagata, J. M. (2022). Adverse childhood experiences and criminal justice contact in adulthood. *Academic Pediatrics*, *22*(6), 972–980. https://doi.org/10.1016/j.acap.2021.10.011

Tortella-Feliu, M., Fullana, M. A., Pérez-Vigil, A., Torres, X., Chamorro, J., Littarelli, S. A., Solanes, A., Ramella-Cravaro, V., Vilar, A., González-Parra, J. A., Andero, R., Reichenberg, A., Mataix-Cols, D., Vieta, E., Fusar-Poli, P., Ioannidis, J. P. A., Stein, M. B., Radua, J., & de la Cruz, L. F. (2019). Risk factors for posttraumatic stress disorder: An umbrella review of systematic reviews and meta-analyses. *Neuroscience & Biobehavioral Reviews, 107,* 154–165. https://doi.org/10.1016/j.neubiorev.2019.09.013

Wolff, N., Huening J., Shi, J., & Frueh, B. C. (2014). Trauma exposure and posttraumatic stress disorder among incarcerated men*. Journal of Urban Health, 91*(4), 707–719. https://doi.org/10.1007/s11524-014-9871-x

Wolff, N., Shi, J., Blitz, C. L., & Siegel, J. (2007). Understanding sexual victimization inside prisons: Factor that predict risk. *Criminology & Public Policy, 6*(3), 535–564. https://doi.org/10.1111/j.1745-9133.2007.00452.x

Wolff, N., Shi, J., & Siegel, J. A. (2009). Patterns of victimization among male and female inmates: Evidence of an enduring legacy. *Violence and Victims, 24*(4), 469–484. https://doi.org/10.1891/0886-6708.24.4.469

World Health Organization. (2022*). International classification of diseases for mortality and morbidity statistics* (ICD-11). https://icd.who.int/en/

Yohros, A. (2022). Examining the relationship between adverse childhood experiences and juvenile recidivism: A systematic review and meta-analysis. *Trauma, Violence, & Abuse*. Advance online publication. https://doi.org/10.1177/15248380211073846

Yule, K., Houston, J., & Grych, J. (2019). Resilience in children exposed to violence: A meta-analysis of protective factors across ecological contexts. *Clinical Child and Family Psychology Review, 22*, 406–431. https://doi.org/10.1007/s10567-019-00293-1

Zarse, E. M., Neff, M. R., Yoder, R., Hulvershorn, L., Chambers, J. E., & Chambers, R. A. (2019). The adverse childhood experiences questionnaire: Two decades of research on childhood trauma as a primary cause of adult mental illness, addiction, and medical diseases. *Cogent Medicine*, *6*(1), Article 1581447. https://doi.org/10.1080/2331205X.2019.1581447

AIR®
Advancing Evidence.
Improving Lives.

For more information, please contact
Simon Gonsoulin • sgonsoulin@air.org
Michelle Perry • mperry@air.org
or visit us at https://www.air.org

This document was prepared under Cooperative Agreement Number 2020-CZ-BX-K002 from the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the SMART Office. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

.

20566_03/23