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Research suggests that trauma is common among men reentering society after incarceration, and may complicate their ability to successfully transition back into their communities. Potential sources of trauma include experiences of sexual abuse and assault, physical abuse and assault, emotional abuse, neglect, domestic violence, community or school violence, traumatic grief or separation, removal from the home by the child welfare or justice systems, institutional racial and ethnic bias, discrimination and racism, or seclusion and restraint in the mental health system.

Although nationally representative data on trauma among men reentering society after incarceration are not available, previous research suggests trauma experiences are common and may occur before and/or during incarceration. For example, one study of incarcerated fathers found that nearly half had experienced physical violence by a family member.¹ Briere and colleagues² found that the prevalence of post-traumatic stress disorder (PTSD) in prison samples was 48 percent, compared with four percent in the general population, and that half of incarcerated men had a history of childhood sexual abuse. Violent victimization is also common among male prisoners during the incarceration experience itself,³ and research suggests that incarceration may trigger memories of past trauma as a result of practices like strip searches or witnessing violent victimization of others in the prison setting.⁴

Responsible Fatherhood programs provide group-based voluntary services that focus on parenting, economic stability, and healthy marriage and relationship services.

Many Responsible Fatherhood (RF) programs funded by the Office of Family Assistance (OFA) in the Administration for Children and Families (ACF) serve low-income fathers who have been incarcerated sometime in their lives and may have experienced trauma. For example, 72 percent of the 5,522 men in four programs studied in the Parents and Children Together (PACT) evaluation of OFA-funded Responsible Fatherhood programs reported having a criminal conviction.⁵ OFA also funds RF programs that focus exclusively on fathers who are in the reentry process through the Responsible Fatherhood Opportunities for Reentry and Mobility (ReFORM) programs. ReFORM programs and RF, collectively referred to as fatherhood programs, thus serve reentry populations and are positioned to support fathers who have experienced trauma.

A trauma-informed system of care is characterized by an organizational commitment to understanding and responding appropriately to signs of trauma, training staff in trauma awareness, creating an environment that is calm, safe, and empowering for all clients and staff, and assessing clients' need for clinical and other support services. The organization is part of a broader system that includes other agencies that also provide services and supports to individuals with a trauma history.

RF program staff interviewed for this project suggest that RF and ReFORM programs can create an environment that supports men in their recovery from trauma and successful achievement of fatherhood program goals by infusing their programming with the principles and elements of a trauma-informed system of care. **Trauma-informed system of care** is an umbrella term that encompasses both trauma-informed approaches to service delivery and trauma-specific services (Box 1). A **trauma-informed approach** refers to how organizations create the conditions necessary to foster

Trauma-informed system of care	
TRAUMA-INFORMED APPROACH	TRAUMA-SPECIFIC SERVICES
<p><i>A trauma-informed approach is embedded within the existing RF organization, its staff, and the RF services it provides. It does not require clinical training or intervention.</i></p>	<p><i>Trauma-specific services are for the subset of participants that may need direct clinical intervention for conditions arising from trauma, such as PTSD. RF organizations can refer clients in need of clinical treatment to other organizations in the community.</i></p>
Key elements	Key elements
<ol style="list-style-type: none"> 1. Organizational commitment to implementing principles of trauma-informed care 2. Staff training in trauma awareness and appropriate responses to signs of trauma 3. Foster healing and avoid further traumatization <ul style="list-style-type: none"> • Ensure psychological and physical safety of participants and staff • Facilitate development of trust • Facilitate peer support • Foster collaboration and mutuality • Empower participants by giving them voice, choice, and control • Avoid cultural, historical, and gender issues that could trigger trauma 	<ol style="list-style-type: none"> 1. Participant screening <ul style="list-style-type: none"> • Consider universal screening vs. only those with significant symptoms • Consider formal or informal assessment • Consider timing of the assessment— that is, after trust is established 2. Refer to clinical or other support services, as needed <ul style="list-style-type: none"> • In-house services, such as a therapist • Clinical and support services in the community • Consider gender and cultural appropriateness of intervention whether internal or external

healing and avoid re-traumatization during the normal course of service delivery. A trauma-informed approach does not require the use of clinically trained mental health professionals. *Trauma-specific services*, on the other hand, involve screening and referring program clients for clinical treatment for their trauma, if needed. Some RF or ReFORM clients may be in need of clinical treatment for trauma-related conditions, such as PTSD. Screening for need for trauma-specific services enables programs to identify these clients and refer them to organizations that can provide mental health services such as counseling.¹

The purpose of this brief is to describe how fatherhood programs serving men in reentry can implement a trauma-informed system of care. Most organizations begin the process by incorporating into their organization key elements of a trauma-informed approach. They also develop processes to assess and refer participants to trauma-specific services and other support services, as needed. While there is little information available about strategies for implementing a trauma-informed system of care for men at different stages of reentry, the principles of a trauma-informed system of care apply to any organization and client population served; the strategies used to implement the components may vary. Multiple sources of information (see Box 2) inform this brief and provide examples of how key elements of trauma-informed approaches have been and could be embedded in fatherhood programs. The brief also describes how fatherhood programs can and have included trauma-informed services for the subset of men who may need them, and presents a list of resources that may be useful to fatherhood programs that wish to implement or enhance their approach to trauma. The brief presents information we gathered from fatherhood programs that support fathers recently released from incarceration, not fathers currently incarcerated.

Box 2. Data sources

- A review of the literature on trauma-informed approaches and an environmental scan of programs providing a trauma-informed system of care to fathers in reentry Dion et al. 2018⁵
- Discussions with five key experts on a trauma-informed system of care, training, and resources
- One-hour discussions about a trauma-informed system of care with the directors of six programs serving men in reentry (four of Substantive Abuse and Mental Health Services Administration (SAMHSA)'s offender reentry programs and two RF programs)
- In-depth information gathered from multiple levels of staff at five fatherhood programs about their approach to a trauma-informed system of care, including four selected ReFORM grantees and one RF grantee

IMPLEMENTING A TRAUMA-INFORMED APPROACH IN FATHERHOOD PROGRAMS SERVING MEN IN REENTRY

A trauma-informed approach is one aspect of a trauma-informed system of care that emphasizes the recognition of trauma in clients, and seeks to avoid retraumatization of clients. It refers to an organization-wide commitment that considers policies, procedures, and settings to infuse trauma-informed principles throughout the

Having organizational leadership on board with a trauma-informed approach is key: You have to have a champion—some entity or division for whom this work is the primary focus. It otherwise gets buried and watered down amidst other competing priorities.
—ReFORM grantee

organization and the development of robust partnerships with community-based organizations to further support fathers with a trauma history. In this section, we describe the key elements of a trauma-informed approach as they could be applied to fatherhood programs, beginning with (1) an organizational commitment to a trauma-informed system of care, (2) staff training in awareness of and appropriate response to trauma, and (3) practices to foster healing and avoid further traumatization. Throughout the section, we provide examples from the field to illustrate how particular programs have implemented the key principles of a trauma-informed approach.

1. Organizational commitment to trauma-informed approach

A trauma-informed approach may require a change in organizational culture. This change may focus on ways in which the organization and program staff can commit to creating favorable conditions for recovery from trauma within the standard services offered. Based on [SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach](#)⁶ and input from RF program staff, strategies for implementing a systemic, organizational commitment to a trauma-informed approach could include the following:

- **Leadership support.** Fatherhood programs emphasize that support by organizational leadership is key to becoming a trauma-informed organization. Strong leadership support can help embed a trauma-informed approach into the culture of fatherhood programs and send the message that attending to trauma during service delivery is a priority.
- **Designating a “champion.”** Some programs note that having a champion helps to prevent the attention on trauma from fading over time. A champion among direct care staff can (1) be a consistent advocate and resource for adopting a trauma-informed approach, (2) arrange staff trainings and refreshers, and (3) serve as a point of contact for internal and external efforts to align fatherhood programs with the principles of trauma-informed system of care.
- **Organizational assessments.** Organizations can conduct a self-assessment or ask a trauma consultant to assess the organization's current approach to trauma and make recommendations. Self-assessment instruments are available for programs that want to find out how they can develop or refine their approach to trauma. Such tools assess the extent to which an organization's administrative policies and practices are shaped by trauma-informed principles (see the Resources section of this brief for examples of such instruments).
- **Training all staff.** Experts recommend that training in awareness of and appropriate response to trauma should be organization-wide and ongoing. To build a trauma-informed workforce, experts suggest that staff in every part of the organization from front-desk staff to top-level administrators be trained regularly to recognize signs of trauma in program clients.

- **Formal policies regarding trauma.** Developing and implementing formal policies and guidance can help fatherhood programs institutionalize their trauma-informed approaches. One fatherhood program we spoke with developed an agency-wide written policy for staff use that defines trauma, gender differences in response to trauma, and trauma-informed practices. Another program is developing written guidance, based on [SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach](#), on recognizing and responding to trauma SAMHSA 2014b.⁶
- **Protecting staff.** Programs and trauma specialists note that an important part of an organizational commitment to addressing trauma is ensuring that staff are protected from the effects of direct or indirect trauma in the course of their work. Being trauma-informed extends to leadership and supervisors helping to prevent or address secondary or vicarious trauma among staff. One way program leadership can help prevent or address vicarious trauma is to refer staff to employee assistance programs (EAPs) and behavioral health services for formal support, if needed. Many programs also have policies that support staff well-being more generally, including paid time off that staff are encouraged to use, an emphasis on work-life balance, and providing opportunities for staff to socially connect with one another during and outside of work.

All program staff can be trained to do the following:

- Increase their awareness of trauma
 - Improve their ability to recognize trauma symptoms
 - Understand how to apply the principles of a trauma-informed system of care when engaging program clients
 - Develop skills for avoiding potentially harmful interactions
 - Recognize and address their own trauma
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2. Staff training in awareness of and appropriate response to trauma

A trauma-informed approach does not necessarily mean adding new services or adding content or material to existing services. Building a trauma-informed workforce *does* require training staff on how to recognize and appropriately respond to signs of trauma among program clients within the course of normal program operations. Nonclinical RF and ReFORM program staff are uniquely positioned to foster healing and recovery from trauma, but without training, they can unintentionally worsen its effects or further traumatize clients. Although the specific content and approach to training varies, training in trauma-informed approaches typically focuses on what trauma is, how it manifests, how people can be re-traumatized, and what supports or delays recovery from trauma. Trauma-informed system of care experts recommend that initial staff training include a basic understanding of trauma and should be supplemented by ongoing training opportunities, including those that recognize the role of trauma among both staff and program clients. RF and ReFORM programs, funded by the OFA, can use program funds to build staff awareness of trauma and its impact on clients and staff, and can partner with or refer clients to organizations that provide mental health services when needed.

Initial staff training on trauma can lay the foundation for trauma awareness.

Several programs offer general trauma training for nonclinical staff at all levels of the organization. For example, the SAMHSA-funded National Center on Trauma-Informed Care conducted a day-long training event for two fatherhood programs, focusing on “Trauma 101”—that is, the key principles of a trauma-informed approach and how they can be implemented. Other fatherhood programs have contracted with trauma consultants from local universities and community organizations to train their

staff. Trauma training and technical assistance designed specifically for criminal justice professionals is also available. A sampling of training resources can be found in the Resource section of this brief.

RF program staff suggest that for long-term organizational change, staff have ongoing formal or informal training to process and apply the information. Staff turnover presents a challenge in maintaining trauma awareness, and among long-term employees, the focus on trauma may be forgotten amid competing priorities. To address these issues, some programs train specific employees to be “in-house” trainers. The trainer’s role is to conduct regular refresher trainings, facilitate staff buy-in, and address specific issues that may arise. For example, two programs we spoke with created dedicated staff positions charged with overseeing trauma-informed initiatives and training. A third program regularly invites experts from the field to discuss trauma-related topics, and staff share their experiences applying trauma-informed concepts with one another at staff meetings and retreats. Both approaches emphasize continual learning and skill building (see Box 3). To help staff apply the information, at least two of the fatherhood programs we spoke with provide feedback to workshop facilitators

Box 3. Examples of approaches to building capacity and training staff on trauma

ORGANIZATION 1

- **Goal: Strengthen capacity to provide trauma-informed care in a large, multisite program**
 - Contracted with a university-based trauma specialist to train all staff on how to recognize and address trauma
 - Designated program managers to oversee nonclinical staff’s trauma-informed approach
 - Identified a community partner to provide ongoing staff training every six months
 - Encouraged staff to participate in local workshops and conferences on a trauma-informed system of care
 - Used non-ACF funds to hire an in-house therapist to provide trauma-specific services

ORGANIZATION 2

- **Goal: Build internal organizational capacity to focus on a trauma-informed system of care within a smaller program**
 - Hired a trauma specialist to provide initial and ongoing in-house training for nonclinical staff
 - Trauma specialist also provided trauma-specific services to clients (using non-ACF funding)

ORGANIZATION 3

- **Goal: Enhance gender-responsive and trauma-informed care for fathers pre- and post-release**
 - Created a dedicated position to provide staff training and oversee a trauma-informed system of care
 - Trained Department of Corrections (DOC) staff to take a more trauma-informed approach to fathers and identify those who need trauma-specific services
 - Clinicians funded by DOC provided trauma-specific services

by directly observing their performance. In light of the potentially retraumatizing experience of incarceration itself, one ReFORM program has worked with its state Department of Corrections to train prison staff in trauma-informed principles.

Training that provides staff with personal learning and growth as related to their own trauma can ultimately benefit program clients. Many staff at fatherhood programs have experienced trauma themselves. One program we spoke with indicated that training sessions that gave staff opportunities to apply information to their own experiences better prepared them to respond to clients who have experienced trauma. To help staff avoid burnout, vicarious trauma, and compassion fatigue, another program emphasizes the importance of self-care, taking time off, and communicating with supervisors; that program also designed a “respite room” for staff to use as needed.

3. Practices to foster healing and avoid retraumatization

There are six key principles that can establish the conditions that facilitate healing and avoid retraumatization of fatherhood program clients.⁷ Here we provide examples of how fatherhood programs can, and in some cases have, implemented these principles within standard fatherhood services.

Psychological and physical safety. Psychological safety and physical safety are fundamental requisites for personal growth and healing. A range of policies, procedures, settings, and interactions can affect clients’ safety, both real and perceived. Safety can be reflected in written policies regarding clients’ confidentiality and privacy, and also within the physical setting. For example, the fatherhood programs we visited noted the following strategies to establish emotionally and physically safe environments (both inside and outside correctional facilities):

- **Confidentiality.** Fatherhood program services are often provided within a group setting. Group facilitators work to establish clear rules to promote confidentiality within the group setting, formally (such as signing a statement) or informally, followed by regular reminders of this rule. Several programs noted that facilitators repeatedly emphasize “what happens in group stays in group.” Such confidentiality should also be assured during any individual-level services.
- **Program setting.** Programs may address structural characteristics of the building in which they are located to emphasize client safety, such as removing or modifying aspects of the physical environment that may be disturbing to clients. For example, one program whose facility was formerly a bank removed the teller bars after realizing their potential traumatic impact as reminders of the prison experience. Mindful of thin walls, staff use a white noise machine to ensure rooms are private and soundproof.
- **Building security.** Programs emphasize the importance of security procedures for protecting physical safety and addressing major disruptions by clients, while at the same time treating clients with respect, even if they are removed because of

We have a good understanding that these folks have a past [traumatic] history, and we have to keep that in the front of our minds.
—ReFORM grantee

disruptive behavior or rule violations. Another program, located in a high-crime neighborhood, conducts tours of the service facility for new clients to demonstrate the building's safety and security features.

Trust. Enhancing the ability of clients to trust staff and one another is fundamental and necessary for establishing a healing environment. In most programs, staff recognize that trust among both clients and staff is built over time, and management of expectations facilitates its development. Programs and organizations can employ a variety of strategies to develop trust:

There is shame . . . [clients] don't want to talk about painful experiences. They have a lot of issues with trust, and haven't had a lot of people in their lives to trust. It takes time for them to tell their story. You have to be present and listen. If that environment is safe, and they feel safe, you can see people start to share.

—ReFORM grantee

- **Use of facilitators with lived experience.** Many fatherhood programs find that group facilitators play a crucial role in the development of trust with fathers. Programs find it useful to employ facilitators who were once incarcerated themselves and have succeeded in reentry, because these people are more likely to understand clients' experiences and challenges.
- **Clear communication.** Programs believe that clear, early, and regular communication about rules and expectations helps establish trust. Some ask fathers to sign a document or pledge at orientation confirming their understanding of program hours, content, code of conduct, and other policies.
- **Follow-through.** Programs can demonstrate their trustworthiness by ensuring that they always follow through on what they say they will or will not do. Programs emphasize that it is essential for staff to be consistent in following up on clients' requests or questions.

Peer support. Fatherhood programs are especially suited to facilitate peer support because many services are provided in a group setting. Fathers thus have the opportunity to receive social and emotional support from their peers during parenting workshops and other services as well as through staff-delivered, individual-level services.

- **Opportunities to share.** At one fatherhood program, men are invited to begin each session by sharing what interactions they have had with their children or partner since the last time the group met. This sharing inevitably leads to the recognition that fathers are not alone in their struggles. Other programs provide similar opportunities for peer support. Although fathers are expected to share personal experiences only to the extent they are comfortable, fathers at most programs welcome the opportunity, especially after the first few weeks. Giving emotional support and receiving it from others who are in similar circumstances can be powerful in helping men process difficult experiences.
- **Cultural differences.** Some settings and cultural differences may limit the extent of peer support. Several studies of primarily urban African American men have cited the group setting as a key feature in clients' positive reactions to fatherhood programs.^{8,9} The group experience normalizes men's experiences because they see

that they are not alone in their struggles. In contrast, at one fatherhood program located in a rural, predominantly white area, staff indicated that men in jail felt particularly vulnerable and were reluctant to share any background that may make them appear weak. Staff described a strong cultural taboo against men talking about their personal issues even in a small group setting after release. Programs that serve members of tribal communities may want to incorporate tribal beliefs around healing and recovery. Programs' service delivery and format may have to be adapted to make programs culturally sensitive for the fathers in their care.

Collaboration and mutuality. Healing is more likely when the power differential between staff and clients is leveled. When staff approach clients as equals, clients are more likely to feel respected. Programs emphasized several practices that enhanced power-sharing between staff and clients:

The majority of staff in this program have been incarcerated. Participants can see staff as role models in terms of how their lives have changed.
—ReFORM grantee

- **Staff sharing.** To foster an even balance of power between staff and clients, staff who have experienced challenges similar to those of clients may selectively share these experiences with clients. Many RF programs employ staff with a personal or family history of incarceration, which facilitates trust between staff and clients and provides fathers with positive role models with similar backgrounds. Staff may choose to share their personal history or experiences with clients as long as this sharing is intended solely for the benefit of the clients. Organizations may want to provide staff with ongoing guidance regarding the type of personal information appropriate to share with clients.
- **Service planning.** Collaboration can be embraced by engaging clients in their service planning. Case managers and social workers often strive to take a collaborative, client-driven approach to developing individual service plans. They encourage fathers to identify their own goals, and they work to support the fathers' goals. Case managers and social workers also work with fathers to coordinate service planning with partner organizations such as behavioral health, child welfare, and housing.
- **Motivational interviewing.** Staff use motivational interviewing techniques to establish a partnership with the father that is supportive and collaborative rather than punitive or judgmental. For example, staff do not offer advice or prescribe solutions but, instead, act as partners in helping fathers identify their goals and objectives.

Empowerment, voice, and choice. Giving fathers who have been incarcerated choice and control whenever possible may help empower them to recognize and deal with their traumatic experiences.

- **Client feedback.** Programs recommend providing opportunities for client feedback on program experiences both throughout the program and at the program's conclusion.

Our starting point is nonjudgment: 'I don't know your life or your experiences.'

—ReFORM grantee

- **Voluntary services.** Staff remind fathers that enrollment in a fatherhood program is voluntary, and that the fathers control how and what they want to participate in and share. Staff emphasize that the choice to participate is a positive sign of fathers' growth.
- **Nonjudgmental approach.** Universally, programs emphasize the importance of approaching fathers nonjudgmentally and validating their experiences.
- **Celebration.** Programs often celebrate fathers' successes, even if small and incremental, to help fathers feel empowered and raise their self-esteem.

Cultural, historical, and gender issues. To promote culturally responsive care, SAMHSA's principles of Trauma-Informed Care TIC call for programs to strive to avoid stereotypes and biases, which may have played a role in clients' past traumas. Approaches that work with one population may not transfer immediately to the population of low-income men who have been incarcerated. Recognizing how trauma is experienced and expressed among men is key to developing gender-appropriate, culturally appropriate interventions and reducing service practices that may lead to further trauma.

- **Gender differences.** Research suggests that the manifestations of trauma are not the same for men and women.^{10,11,12} For example, men are more likely to engage in aggression or substance use, whereas women may show more detachment and withdrawal. Differences in gender-role socialization may also influence men's support-seeking behavior with the result that men may have less social support than women.
- **Incarcerated men.** Men who have been incarcerated are more likely to have specific types of trauma than men in the general population.^{2,13} For example, about half of incarcerated men report a history of childhood sexual abuse. Men also often experience violent victimization and trauma during incarceration itself.³
- **Men of color or low income.** Men of color and men with a low income are more likely than their white and higher-income counterparts to have experienced toxic stress such as racial prejudice or discrimination and/or poverty.^{14,15,16} The cumulative effects of traumatic experiences may represent an additional challenge for these fathers.

IMPLEMENTING TRAUMA-SPECIFIC SERVICES AS PART OF FATHERHOOD PROGRAMS SERVING MEN IN REENTRY

While practices to foster healing and avoid further traumatization may be valuable for all program clients, some fathers may need more support that specifically addresses their trauma. Trauma-specific services are for those program clients who need direct clinical intervention. In this section, we describe approaches to identify program clients who may need clinical intervention, the ways in which programs may connect clients to clinical services, and trauma-specific services that can be delivered by nonclinical staff in fatherhood programs. As noted earlier, ACF-funded fatherhood programs cannot use ACF funds to provide behavioral or mental health care or treatment related

[Trauma] is so prevalent around here, that even when you ask if someone has had trauma, the answer is 'who hasn't?'
—ReFORM Grantee

to trauma or early adverse experiences.

Client screening

While most fatherhood programs serving men in reentry believe that trauma experiences are nearly universal among their clients, screening can identify those who may need further diagnostic assessment, and potentially clinical intervention, for trauma-related disorders. It is important to recognize that screening tools such as the Trauma Screening Questionnaire identify whether a client has experienced a traumatic event, but unlike screeners for PTSD or depression, may not identify whether a client needs further assessment for mental health problems.

SAMPLE SCREENING TOOLS

- Trauma Screening Questionnaire
 - Beck Anxiety Inventory
 - Short form of the PTSD Checklist
 - Primary Care—PTSD screen
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Simple and easy-to-use screening tools are available and suitable for use by

nonclinical fatherhood program staff. For example, a well-validated 10-item screener for symptoms of PTSD has been used in a wide variety of settings. Short tools like the Beck Anxiety Inventory screen not only for PTSD but also depression and anxiety—conditions that frequently co-occur with PTSD. A list of screening and assessment tools is in the Resources section of this brief.

Currently, fatherhood programs serving men in reentry vary in their approaches to client screening. The ReFORM and RF programs we examined tend to assume that all fathers have had traumatic experiences. However, only some programs currently use screening to help identify a subset of clients who may be experiencing trauma-related disorders, such as depression or anxiety disorders, which require clinical treatment. Such programs systematically screen all fathers for trauma-related conditions so that they can refer those in need for further clinical assessment and, potentially, intervention. For example, some screen fathers for trauma as part of a psychosocial assessment at program enrollment or within the first few weeks of the program, using formal assessment tools such as a PTSD screener. In other programs, staff use a global instrument that screens all fathers on multiple factors (including suicidal or homicidal thoughts, trauma, and substance use) or an instrument whose main focus is not trauma but includes some trauma-related questions (for example, a substance abuse assessment). Some of the programs we spoke with currently screen only fathers they suspect may need clinical services, and others take an informal approach to screening. The drawbacks to these approaches are that to be successful, they require staff to have good clinical judgment, and that they are unlikely to identify all the fathers who may need clinical intervention.

Fatherhood programs are likely to benefit from seeking the assistance of a trauma training provider or specialist in making decisions about screening, including who to screen, how to screen, and when to screen program clients. A trauma specialist can also provide guidance on tools that are the most gender-appropriate and culturally appropriate for the program's target population, as well as advise whether the tools can be administered by nonclinical staff or require a clinician.

Referral to clinical services

Once program staff have identified clients who may need further assessment or clinical

services, they then refer the client to either an in-house or an “outside” mental health service provider. The availability and accessibility of trauma-specific services varies across communities. In addition, trauma-specific services for men, especially men who have been incarcerated, may be particularly limited. Programs may want to consider these challenges in deciding whether to secure funding for an in-house provider or develop a close relationship with a clinical treatment organization in the community that is willing to serve referred fathers. Both approaches to delivering trauma-specific services have advantages and disadvantages.

Referrals to in-house clinical treatment. Using non-ACF funding, some fatherhood programs have developed the internal capacity to provide in-house clinical treatment for at least some clients.

- According to one fatherhood program, the availability of in-house services reduces stigma and logistical barriers to clients accessing services. Program staff are better able to see the benefit of mental health services and feel more comfortable in referring program clients to them.
- Another potential advantage is that the in-house provider will become specialized over time in the trauma-related needs of the special population of fathers reentering the community after incarceration.
- Despite the benefit of in-house clinical staff, the need for alternative sources of program funding for clinical services—ACF funding cannot be used for clinical mental health treatment—may pose a significant challenge to programs that want to provide trauma-specific services.

Referrals to external services. Because of limited internal capacity or funding to deliver mental health services in-house, most of the fatherhood programs we spoke with partner with community-based organizations to provide trauma-specific services when needed. The partnerships may be informal or may be established through written memoranda of understanding. The partnerships allow case managers, program facilitators, or social workers to refer clients in need of clinical services to a mental health service provider in the community who has capacity and has agreed to provide appropriate services. Programs with such partnerships indicate that the referral process and follow-up works best when the fatherhood program and community provider have clearly developed expectations and mutual trust; staff at one program said they refer clients only to providers known to them.

Trauma-informed programs strive to select a partner agency that takes an evidence-informed approach to working with trauma survivors, using such models as the Men’s Trauma Recovery and Empowerment Model (M-TREM), Prolonged Exposure Therapy, or Cognitive Processing Therapy. These models and others are described more fully in the Resources section of this brief. Regardless of the approach used, fatherhood programs may also want to consider the agency’s specific experience working with low-income men coming out of correctional institutions.

SELECTED EVIDENCE-BASED TRAUMA-SPECIFIC SERVICES

- Men’s Trauma Recovery and Empowerment Model
 - Prolonged Exposure Therapy
 - Cognitive Processing Therapy
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**SELECTED
NONCLINICAL TRAUMA-
SPECIFIC SERVICES**

- Seeking Safety
 - Addictions and Trauma Recovery Integration Model (ATRIUM)
 - SELF (Safety, Emotions, Loss, and Future)
 - Helping Men Recover
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Referral to nonclinical trauma-specific services

While several clinical treatments are known to successfully help people who have experienced trauma, other models for delivering trauma-specific services may not require delivery by a mental health clinician and, therefore, could be implemented by nonclinical fatherhood program staff. Services such as Seeking Safety or Helping Men Recover, for example, take the form of a group-based workshop with multiple sessions covering a range of topics (see the Resource section of this brief for more specific information). Generally, the trauma-specific services that do not require delivery by a mental health clinician focus on supporting individuals with a trauma history while the services that require a mental health clinician generally focus on treating individuals with PTSD. These nonclinical trauma-specific services have several advantages.

- Each can be delivered as a group-based psychoeducational program, similar to fatherhood/parenting workshops.
- They generally cover a range of topics, including the effects of and responses to trauma, asking for help, coping with triggers, dealing with anger and relationship challenges, negative self-talk, disconnecting from intrusive thoughts, addictive behavior, recovery thinking, and self-care. These topics are complementary to standard fatherhood program curricula.
- Some models, such as SELF (Safety, Emotions, Loss, and Future), are flexible and allow the facilitator to pick and choose the most relevant topics and components to deliver, the order in which to present the material, and the amount of time to spend on the material.

In addition to providing referrals to non-clinical trauma-specific services, fatherhood programs may also provide referrals to and coordinate services with other support services such as housing, child welfare, and probation. The development of robust partnerships with these types of agencies will facilitate the delivery of care to participating fathers.

RESOURCES FOR FATHERHOOD PROGRAMS IMPLEMENTING A TRAUMA-INFORMED SYSTEM OF CARE

A variety of resources and tools are available to assist programs that want to implement a trauma-informed system of care. These include organizational assessment tools, staff training resources, screening and assessment tools, and information about trauma-specific services, including those that require delivery by a mental health clinician and others that do not. The type of staff member best positioned to use each tool will vary across organizations. Each organization should assess the skills, experiences, and interests of their staff to determine who, for example, should complete an organizational assessment or conduct a screening. We provide a sample of available resources below.

Organizational assessment and implementation tools

Organizational assessment tools are used to assess an organization's readiness to implement a trauma-informed system of care or to identify areas where an existing trauma-informed system of care may be strengthened. Some self-assessment instruments are now available for use by programs and organizations; alternatively,

Box 4. A guide to implementing a trauma-informed system of care

A comprehensive and practical guide for practitioners interested in implementing trauma-informed care is available from SAMHSA. Topics include:

- What is trauma and why does it matter
- Trauma awareness
- Understanding the impact of trauma
- Screening and assessment
- Making referrals to treatment
- Trauma-specific services

an external consultant can conduct the assessment. Several of the following resources, all of which are designed to help organizations develop or reevaluate their approach to trauma-informed system of care, are cited in both [SAMHSA's Trauma-Informed Care in Behavioral Health Services treatment improvement protocol](#) (TIP 57)⁷ (see Box 4). Others were identified by ReFORM grantees that have used them. Although the organizational assessment tools below were not designed specifically to assess fatherhood programs or organizations that run fatherhood programs, they can be applied or adapted to such settings. The tools can be used to help programs assess how their policies, procedures, and practices relate to trauma and determine the next steps they will take in developing or improving a trauma-informed system of care and infusing trauma-informed principles into their programs (Table 1).

Table 1. Organizational assessment and implementation tools

Tool name	Description
Creating Cultures of Trauma-Informed Care: A Self-Assessment and Planning Protocol ¹⁷	<ul style="list-style-type: none"> • The protocol and accompanying self-assessment scale provide guidelines for agencies or programs that want to make their service systems trauma-informed. This tool is for administrators, providers, and clients to use in the development, implementation, evaluation, and ongoing monitoring of trauma-informed programs.
The Trauma Toolkit: A Resource for Service Organizations and Providers to Deliver Services That are Trauma-Informed ¹⁸	<ul style="list-style-type: none"> • This toolkit aims to (1) provide knowledge to service providers working with adults who have experienced or been affected by trauma, and (2) help service providers and organizations work from a trauma-informed perspective and develop trauma-informed relationships that cultivate safety, trust, and compassion. It includes a checklist that organizations can use as a guideline for implementing trauma-informed practice; the checklist was developed as a starting point for the ongoing process of becoming a trauma-informed system or organization.
Creating Trauma-Informed Care Environments: Organizational Self-Assessment for Trauma-Informed Care Practices in Youth Residential Settings ¹⁹	<ul style="list-style-type: none"> • Developed by the University of South Florida College of Behavioral and Community Sciences, this tool is designed for staff or key stakeholders who are either newly implementing or already practicing the principles of a trauma-informed system of care. The assessment helps organizations (1) identify existing components of a trauma-informed system of care that need further assessment or strengthening, (2) plan for implementation, (3) collect data, and (4) track progress.
Trauma-Informed Organizational Toolkit for Homeless Services ²⁰	<ul style="list-style-type: none"> • Developed with funding from the Daniels Fund, SAMHSA, and the W. K. Kellogg Foundation, this toolkit is used to examine an organization's current practices and steps toward becoming trauma-informed. The assessment is intended to be completed by all organization staff, including direct care staff, supervisors, case managers, clinicians, administrators, and support staff (for example, office support, maintenance, and kitchen staff).
Attitudes Related to Trauma-Informed Care (ARTIC) scale ²¹	<ul style="list-style-type: none"> • Based on research showing that staff attitudes are important drivers of successful implementation, this 45-item scale assesses service provider attitudes relevant to a trauma-informed system of care. The domains measured include understanding of problem behavior and symptoms, responses to problem behavior and symptoms, on-the-job behavior, personal support of a trauma-informed system of care, and system-wide support for trauma-informed system of care.

Training resources

A key premise of a trauma-informed approach is that healing can occur through interaction with people who are sensitive to trauma, including those who are not 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 regarding trauma is likely to be insufficient; training nonclinical staff is also important in creating a trauma-informed culture. Several publicly and privately funded organizations offer assistance and training to help programs become trauma informed. Table 2 provides an overview of such resources.

Client screening and assessment tools

Trauma screening and assessment help programs identify trauma and its effects on fathers so that appropriate services can be provided. Although fatherhood programs may take the position that all clients have experienced trauma and thus screening is unnecessary, some fathers' responses to trauma may go beyond the help that a fatherhood program can provide. [SAMHSA's Trauma-Informed Care in Behavioral Health Services](#) treatment improvement protocol⁷ presents factors to consider in selecting assessment tools, such as the purpose of the assessment, the population being assessed, and the quality of the instrument. Table 3 provides examples of screening and assessment tools, including selected instruments described in SAMHSA's document.⁶ Some RF program staff suggest that programs should look for tools that are culturally and gender sensitive.

Trauma-specific services

With the rapid evolution of the trauma field in recent years, several models for delivering trauma-specific services to support individuals with trauma histories have become available. Mental health clinicians are needed to deliver some of these services, whereas trained case managers, peer specialists, or other nonclinical professionals who provide services and supports to individuals with trauma histories can deliver others.

Trauma-specific services vary in their suitability for use with men and people of various cultural backgrounds. Although we did not find 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. Table 4 provides an overview of these services. The extent to which these services have been evaluated for effectiveness varies.

Table 2. Training resources

Organization	Description	Available training	Contact
Community Connections	<ul style="list-style-type: none"> Provides consultation and training for organizations interested in creating a culture of trauma-informed care 	<ul style="list-style-type: none"> Uses a tool to focus on how the principles of safety, trustworthiness, choice, collaboration, and empowerment can be implemented within a program/organization Provides training in trauma-specific services, specifically TREM and M-TREM 	<p>(202) 546-1512 info@cccdc1.org</p>
Policy Research Associates	<ul style="list-style-type: none"> Provides trauma-related technical assistance and training for federal agencies such as SAMHSA, HRSA, and OJP Leads SAMHSA's GAINS Center for Behavioral Health and Justice Transformation and the NCMHJJ 	<ul style="list-style-type: none"> The GAINS Center provides technical assistance and training for criminal justice professionals (police officers, corrections personnel, court personnel) to help them become trauma informed NCMHJJ provides technical assistance on trauma screening, assessment, and treatment in juvenile justice settings and on the development of trauma-informed diversion programs 	<p>PRA: (518) 439-7415 pra@prainc.com</p> <p>For technical assistance products: (866) 962-6455 ncmhjj@prainc.com</p> <p>For trauma-informed trainings for criminal justice professionals and trauma trainers: Contact the GAINS Center at (800) 311-4246</p>
SAMHSA's National Center for Trauma-Informed Care (NCTIC)	<ul style="list-style-type: none"> NCTIC provides on-site training and technical assistance to develop and improve trauma-informed environments across the spectrum of public health programs 	<ul style="list-style-type: none"> Offers consultation, training, and technical assistance on understanding the impact of trauma and the need for trauma-informed care 	<p>For information on trauma training and technical assistance provided by NCTIC: (866) 254-4819 NCTIC@NASMHPD.org</p>
Drexel University (Sanctuary Model®)	<ul style="list-style-type: none"> Developed by Dr. Sandra Bloom, the Sanctuary Model® is a trauma-informed and evidence-supported approach to creating and sustaining organizational change 	<ul style="list-style-type: none"> Focuses on organizational and cultural change designed to promote a healing environment in which both staff and patients are empowered decision makers 	<p>Submit request for information at http://sanctuaryweb.com/ContactUs.aspx</p>

Source: Dion et al.⁵

Notes: TREM = Trauma Recovery and Empowerment Model; M-TREM = Men's Trauma Recovery and Empowerment Model. TREM is an evidence-based group intervention model for women that has been widely adopted in the field. Clinicians at Community Connections created a version of TREM for men in 2005. NCMHJJ = National Center for Mental Health and Juvenile Justice; OJP = Office of Justice Programs; HRSA = Health Resources and Services Administration.

Table 3. Trauma screening and assessment tools

Title	Description	Qualification to administer	Completion time	Contact
Abbreviated PTSD Checklist	<ul style="list-style-type: none"> • 6-item self-report • Assesses PTSD symptoms • Respond on scale from “not at all” to “extremely” • Score ≥ 14 suggests need for structured assessment 	None specified	5–10 minutes	Ariel Lang, Ph.D. Phone: (619) 400-5173 ajlang@ucsd.edu
Primary Care PTSD Screen for DSM-5	<ul style="list-style-type: none"> • 5-item self-report • Assesses PTSD symptoms • Yes/no format • Score ≥ 3 suggests need for structured assessment 	None specified	5–10 minutes	U.S. Department of Veterans Affairs National Center for PTSD. The screen is available here
Beck Anxiety Inventory—Primary Care	<ul style="list-style-type: none"> • 7-item self-report • Screens for anxiety, depression, and PTSD • Respond on scale from “not at all” to “severely” • Score ≥ 5 suggests need for structured assessment 	None specified	5–10 minutes	Pearson Education, Inc. Phone: (800) 627-7271
Trauma Assessment for Adults—Self Report ²²	<ul style="list-style-type: none"> • 17-item self-report • Assesses 14 life events • Yes/no format 	None specified	10–15 minutes	Heidi Resnick, Ph.D. resnickh@musc.edu
Trauma History Questionnaire ²³	<ul style="list-style-type: none"> • 24-item self-report • Assesses trauma events in three areas (crime, general disaster and trauma, and unwanted physical and sexual experiences) • Yes/no format 	Contact Dr. Green	5–15 minutes	Bonnie L. Green, Ph.D. bgreen01@georgetown.edu
Traumatic Stress Schedule ^{24,25}	<ul style="list-style-type: none"> • 10 items with 12 probes • Semistructured 	Can be administered by lay interviewer with training	5–30 minutes	Fran Norris, Ph.D. Fran.Norris@dartmouth.edu
Trauma History Screen ^{26,27}	<ul style="list-style-type: none"> • 14-item self-report • Yes/no format; number of times an event occurred; scales for duration and level of distress 	Can be administered by lay interviewer with training	2–5 minutes	Eve Carlson, Ph.D. eve.carlson@med.va.gov
Traumatic Events Questionnaire ²⁸	<ul style="list-style-type: none"> • 11-item self-report • Yes/no format; frequency experienced; age at time of event; and degree of injury and traumatization 	Contact Dr. Vrana	5 minutes	Scott Vrana, Ph.D. srvrana@saturn.vcu.edu
Traumatic Life Events Questionnaire ²⁹	<ul style="list-style-type: none"> • 23-item self-report • Assesses 2 types of traumatic events • Yes/no format; frequency of event 	Contact Dr. Kubanay	15 minutes	Edward Kubanay, Ph.D., ABPP kubany@hawaii.rr.com
Stressful Life Events Screening Questionnaire ³⁰	<ul style="list-style-type: none"> • 13-item self-report • Assesses trauma in 11 specific and 2 general categories 	Contact Dr. Goodman	10–15 minutes	Lisa Goodman, Ph.D. goodmanlc@bc.edu
Life Events Checklist ³¹	<ul style="list-style-type: none"> • 17-item self-report • 5 options for each event (happened to me, witnessed it, learned about it, not sure, and doesn't apply)^a 	Contact Dr. Weathers	10–15 minutes	Frank W. Weathers, Ph.D. weathfw@auburn.edu
Brief Trauma Questionnaire ³²	<ul style="list-style-type: none"> • 10-item self-report • Derived from the Brief Trauma Interview • May be used to assess for Criterion A events 	Contact Dr. Schnurr	5–10 minutes	Paula P. Schnurr, Ph.D. paula.schnurr@dartmouth.edu

Source: SAMHSA⁶; other sources as indicated.

^a The Life Events Checklist has three formats: standard self-report (to establish whether an event occurred), extended self-report (to establish worst event if more than one event occurred), and interview (to establish a PTSD Criterion A traumatic event).

- **Evidence-based or evidence-informed treatment.** Fathers with PTSD or other disorders related to trauma exposure may require clinical treatment. Some evidence-based treatments are available for trauma and PTSD, such as [prolonged exposure therapy](#), [Cognitive Processing Therapy](#), [Eye Movement Desensitization and Reprocessing](#), the [Trauma Recovery and Empowerment Model](#), and [Trauma Affect Regulation: Guidelines for Education and Therapy](#), 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.
- **Group-based treatment designed for men.** Two group-based treatments, Men's Trauma Recovery and Empowerment Model ([M-TREM](#)) and [Helping Men Recover](#), have been designed or adapted specifically for men and could prove useful for clients in fatherhood programs, if available in these fathers' communities. M-TREM was developed by adapting the well-established Trauma Recovery and Empowerment Model (TREM) to be specific for men.
- **Group-based services for delivery by nonclinical staff.** Several group-based programs that do not require delivery by clinical staff are promising options for implementation by ReFORM and fatherhood programs. They include [Seeking Safety](#), [Addictions and Trauma Recovery Integration Model](#), [Helping Men Recover](#), and [Safety, Emotions, Loss, and Future](#) (SELF).

Table 4. Trauma-specific services

Name	Description	Provider qualifications and setting
Nonclinical trauma-specific services		
Seeking Safety ³³	<ul style="list-style-type: none"> • Counseling model for men and women with histories of trauma or substance use • 25 modules that address cognitive, behavioral, and case management domains • Providers can choose which modules to address and can deliver them in any order • Can be used with groups or individuals • Has been implemented with criminal justice populations, veterans, and individuals with behavioral health problems 	<ul style="list-style-type: none"> • Delivered by any provider, including peer specialists, and in any setting
Addictions and Trauma Recovery Integration Model ³⁴	<ul style="list-style-type: none"> • Designed for survivors and perpetrators of physical or sexual abuse or violence, including those with addictive behaviors and those with serious health conditions • 12 sessions cover three phases of treatment • Addresses the physical, mental, and spiritual impact of trauma through psychoeducation, interpersonal skills training, and activities such as meditation and self-expression • Not specifically designed for men, but has been delivered to groups of men 	<ul style="list-style-type: none"> • Delivered by professionals or peers • Can be implemented in several settings, including behavioral health agencies, prisons, and peer-support groups
Safety, Emotions, Loss, and Future (SELF) ³⁵	<ul style="list-style-type: none"> • Group-based psychoeducational program designed as part of an organizational change model for implementing trauma-informed approaches • Includes 37 lessons that focus on safety, emotions, loss, and the future • Flexible program that allows group facilitators to select and present sessions in any order and adjust the length of time spent on a topic • Curriculum not specific to men or fathers, but the developers describe it as addressing issues that span all ages, genders, races, and religions 	<ul style="list-style-type: none"> • 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 ³⁶	<ul style="list-style-type: none"> • Group-based, trauma-informed program to treat addictions in men • 18 modules that address self, relationships, sexuality, and spirituality • Modules incorporate information on the social messages men receive and the ways in which “male socialization” affects recovery, relationships, and trauma and abuse 	<ul style="list-style-type: none"> • Delivered by an experienced, licensed addictions specialist or an individual with a bachelor’s degree in the human services field • Designed to be delivered in prisons and other settings, including outpatient, residential, and community-based settings
Trauma-specific services requiring delivery by a mental health specialist		
Cognitive Processing Therapy ^{39,40}	<ul style="list-style-type: none"> • Treatment for PTSD • Generally delivered over 12 sessions • Client writes about the traumatic event, discusses negative thoughts about the event, and learns more adaptive ways of thinking about it • Includes out-of-session practice assignments 	<ul style="list-style-type: none"> • Provided by licensed mental health professionals • Can be delivered both individually and in structured group sessions
Eye Movement Desensitization and Reprocessing ⁶	<ul style="list-style-type: none"> • Treatment for PTSD • Grounded in the theory that PTSD is a result of traumatic memories that have been inadequately processed • The client first learns techniques to manage emotional distress, then thinks about the traumatic event or an aspect of the traumatic event while focusing on 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 distress decreases, and then processes the experience with the therapist 	<ul style="list-style-type: none"> • Provided by licensed mental health professionals or students working under the supervision of licensed mental health professionals • Traditionally delivered in individual therapy sessions; some studies are investigating the therapy’s effectiveness in group settings
Trauma Affect Regulation: Guidelines for Education and Therapy ⁶	<ul style="list-style-type: none"> • Psychotherapy designed to prevent and treat PTSD • 12 sessions • Teaches skills for managing problems that result from high stress, explains the difference between normal and extreme stress, and teaches 7 steps to manage extreme stress reactions • Recently adapted for men and women who are incarcerated 	<ul style="list-style-type: none"> • Delivered by clinicians, case managers, rehabilitation specialists, and teachers • Group or individual settings

Source: Dion et al.⁵ and SAMHSA.⁶

SUMMARY

Many men recently released from incarceration have a history of trauma, which may negatively impact their ability to emotionally and financially support their families. Fatherhood programs are in a unique position to support fathers in coping with their trauma histories as well as in becoming better parents by incorporating the principles and elements of a trauma-informed system of care into their programs. This requires an organizational commitment to incorporating trauma approaches into policies, programs, and procedures; ongoing staff training; and fostering a culture that supports healing. It also requires developing a network of trauma-related services and supports for men who may need clinical care to address their trauma histories. Several resources are available to fatherhood programs interested in learning more about trauma-informed systems of care and the steps they can take to incorporate trauma-informed practices into their programs.

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