GLOBAL CORRECTIONS GROUP

# *THE EFFECTIVENESS OF CORRECTIONAL PROGRAMS IN THE FEDERAL BUREAU OF PRISONS: A SYSTEMATIC EVIDENCE-BASED REVIEW OF RESEARCH (2000-2022)*

## *CHAPTER 6 – TRAUMA PROGRAMS*


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# TRAUMA PROGRAMS

In this chapter, we review prison-based trauma programs, i.e., programs designed to address the impact of traumatic life events. The Federal Bureau of Prisons (BOP) offers eight First Step Act (FSA) approved programs in this category. This category includes five Psychology Services Branch (PSB) programs, with four programs classified by the BOP as Evidence-Based Recidivism Reduction (EBRR) Programs and one program classified as a Productive Activity (PA) Program. This category also includes three Women and Special Populations Branch (WSPB) programs, all of which are classified by the BOP as PA Programs. We begin by describing the BOP's trauma programs, to include the assessment of needs addressed by the programs. We then describe our study identification procedures, provide a review of evaluations conducted in other jurisdictions, and offer an assessment of the effectiveness of each BOP trauma program based on our review. We then conclude this chapter with recommendations for future trauma programming initiatives.

## 6.1 Overview of Trauma Needs and Programs

The BOP offers a series of programs for incarcerated persons who have experience traumatic life events. Many of these programs rely on cognitive-behavioral interventions to address treatment needs. All these trauma programs are supported by the Reentry Services Division (RSD), five by the PSB and three by the WSPB. The PSB programs are staffed primarily by doctoral level clinical and counseling psychologists. The dedicated staffing complement for each program will be noted in the program descriptions found below. WSPB programs may be facilitated by a variety of staff, contractors, and/or volunteers. Recommended program facilitators will be noted in the program descriptions found below.

As noted in Chapter 5, all psychologists are required to complete New Psychologists Training, a 24-hour training offered at the BOP's training facility in Aurora, Colorado. In addition, specialized mental health training is provided to staff working in programs for individuals with mental and/or behavioral disorders. Web-based training in cognitive-behavioral interventions is also made available to applicable staff. In addition, the BOP offers a series of continuing education opportunities throughout the year, in support of staff maintaining their expertise and professional licensure. Specialized training for individuals facilitating the Women and Special Populations Branch programs is not indicated.

Programs for incarcerated individuals who have experienced traumatic life events address a series of needs. In addition to addressing trauma needs, most of these programs directly address mental health needs. Trauma needs are also addressed in programs for incarcerated individuals with serious mental illnesses, but they are addressed more directly in the trauma programs described in this chapter. Of note, one of the programs addressed in this chapter - the Beyond Violence Program - is not characterized by the BOP as addressing a trauma need; however, the program developer characterizes the program as a trauma treatment intervention, so we have included the program in this chapter.

The procedures for identifying mental health needs are described in Chapter 5 of this report. Trauma programs may also focus on closely related needs, i.e., cognitions and anger/hostility, and some trauma programs also address ancillary needs to provide a more comprehensive treatment experience, e.g., education or work needs. Procedures for identifying trauma needs are described below. Procedures for identifying education and work needs were described in Chapters 2 and 4 respectively, and procedures for identifying cognitions and anger/hostility needs will be described in Chapter 7 of this report.

### 6.1.1 Identifying Trauma Needs

*Program Statement 5400.01 First Step Act Needs Assessment* indicates Psychology Services departments are responsible for assessing trauma needs during the initial intake screening (RSD, 2021). This policy refers staff to the BOP's internal website, Sallyport, for additional information. According to the BOP, trauma needs refer to adverse childhood experiences associated with significant increases in negative social, behavioral health, and physical outcomes (BOP, 2022). The BOP has adopted the Adverse Childhood Experiences Scale (ACES) to screen for trauma needs. Developed by Felitti et al. (1998), the 10-item ACES measures childhood exposure to trauma, including physical, verbal, and sexual abuse; physical and emotional neglect; exposure to a family member with a substance use disorder, mental illness, domestic violence, and/or incarceration; and divorce, death, and/or abandonment by a parent.

While Psychology Services is described as the department responsible for assessing trauma needs, it is important to note the ACES is a self-report instrument. Incarcerated individuals are to complete the ACES via the BOP's internal computer system. Per the BOP, "Inmates are advised of the assessments at Admission and Orientation and are reminded of the assessments at intake with Psychology Services. Additionally, the inmate computer system has a bulletin that details the availability of the assessments" (BOP, 2022). Historically, this approach to needs assessments has resulted in reduced completion rates. Per the BOP's most recent needs assessment report, 23% of incarcerated individuals refused to complete the ACES (BOP, 2022). The newly issued *Program Statement 5410.01, CN-2, First Step Act of 2018 – Time Credits: Procedures for*

*Implementation of 18 U.S.C. 3632(d)(4)* establishes an additional incentive for individuals to complete self-report needs assessments (CPB, 2023). Specifically, individuals will be unable to earn time credits until these assessments are complete. This new requirement will likely increase the number of individuals who complete these assessments. For individuals who do complete the ACES, 46% present with trauma needs (BOP, 2022). The ACES cutoff score used to make this determination is not clearly noted in publicly available documents. A more refined assessment of trauma needs is conducted within the Resolve Program, once an individual completes preliminary trauma treatment programming, which will be discussed in a subsequent section of this report.

## 6.2 Trauma Program Descriptions

The BOP offers five PSB programs focusing on the treatment of trauma-related mental disorders - the Resolve, Trauma Education, Seeking Safety/Seeking Strength, Cognitive Processing Therapy, and Dialectical Behavior Therapy Programs. In addition, the BOP offers three trauma programs specifically for women - the Advancing Career Counseling and Employment Support for Survivors (ACCESS) Program, Beyond Violence: Prevention Program for Criminal Justice Involved Women, and Pu'a Foundation Reentry Program - all of which are supported by the WSPB. All but one of these eight programs is noted to address a trauma need, as well as other relevant needs. General procedures for identifying trauma-related needs were described in the previous section of this report. Additional needs assessment procedures are incorporated into the BOP's programs for individuals with trauma-related disorders, and these procedures are described below in the context of each relevant program.

The below table outlines key features of the BOP's eight trauma programs, including the target population, needs addressed, and program dosage. In addition, the table notes the number of institutions offering the program and the number of individuals participating in the program at the close of FY 2023. Lastly, the table provides an estimate of the percentage of the target population served by the program to date. Specifically, this estimate compares the total number of program participants and graduates in custody to the total number of individuals in custody with a potential need for such a program. This estimate represents an educated guess, as we did not have access to data allowing for perfect one-to-one comparisons of needs and programs. Following the table, each trauma program is described in detail.

## Trauma Programs

| Program | Target Population | Need(s) | Dosage | Institutions at FY23 End | Participants at FY23 End | Estimated % of Target Population Served Since 1/15/20 |
|---|---|---|---|---|---|---|
| **Resolve Program (EBRR)** | Individuals with trauma-related mental disorders | Trauma, Mental Health, Cognitions | Up to 90 hours | 26 | 692 | 2.89% of individuals with a trauma need |
| **Trauma Education Program (PA)** | Individuals with a history of trauma | Mental Health, Cognitions, Antisocial Peers | 500 hours | 76 | 1,004 | 20.26% of individuals with a trauma need |
| **Seeking Safety/Seeking Strength Program (EBRR)** | Individuals with a history of trauma | Trauma, Mental Health, Substance Use, Cognitions, Antisocial Peers | 15 hours | 22 | 218 | 2.64% of individuals with a trauma need |
| **Cognitive Processing Therapy Program (EBRR)** | Individuals with trauma-related mental disorders | Trauma, Mental Health, Cognitions | 12 hours | 10 | 28 | .36% of individuals with a trauma need |
| **Dialectical Behavior Therapy Program (EBRR)** | Individuals with a trauma-related personality disorder | Trauma, Mental Health Cognitions | 50 hours | 46 | 185 | 1.74% of individuals with a trauma need |
| **Advancing Career Counseling and Employment Support for Survivors (ACCESS) Program (PA)** | Women with a history of domestic violence victimization | Cognitions, Mental Health, Trauma | 10 hours | 1 | 8 | .17% of women |
| **Beyond Violence: Prevention Program for Criminal Justice Involved (PA)** | Women with anger management issues secondary to a history of trauma | Anger/Hostility, Cognitions | 40 hours | 3 | 53 | 1.80% of women |
| **Pu'a Foundation Reentry Program (PA)** | Native Hawaiian women with a history of trauma | Family/Parenting, Trauma | 20 hours | 0 | 0 | 0% of women |

### Psychology Services Branch Trauma Programs

Five of the BOP's trauma programs are supported by the PSB, and are made available to both men and women, with gender-responsive modifications. Four of the programs are classified by the BOP as EBRR Programs - the Resolve, Seeking Safety/Seeking Strength, Cognitive Processing Therapy, and Dialectical Behavior Therapy Programs. One program is classified by the BOP as a

PA Program - the Trauma Education Program. These programs, to include gender-responsive elements, are described below.

### 6.2.1 Resolve Program

The Resolve Program was originally implemented in the agency as a comprehensive treatment protocol to address the trauma treatment needs of women. The program was subsequently expanded to serve males as well, with gender-specific revisions. In addition, the program components were adopted for use as stand-alone programs in institutions without a Resolve Program.

The Resolve Program is the BOP's foundational trauma treatment program. The Resolve Program is explicitly described in *Program Statement 5330.11 Psychology Treatment Programs* (PSB, 2016). Resolve Program institutions have a doctoral level psychologist, a Resolve Program Coordinator, dedicated to the provision of trauma treatment services. The program consists of a series of interventions, i.e., programs, for individuals with trauma-related treatment needs. Program components are delivered based on individual treatment needs, considering both an individual's diagnosis and level of functioning. Resolve Program interventions may be delivered separately as stand-alone programs at non-Resolve Program institutions.

The Resolve Program is designed to "address the trauma-related mental health needs of individuals" (BOP, 2022). The program integrates multiple component programs into a single model: (1) an initial psychoeducational workshop, the Trauma Education Program; (2) a skills-based treatment group, the Seeking Safety/Seeking Strength Program; (3) more intensive treatments in the form of the Cognitive Processing Therapy Program or the Dialectical Behavior Therapy Program; and (4) a maintenance skills group for individuals who remain interested in treatment, but whose symptoms, if present, no longer interfere with daily functioning. The program was originally implemented in the agency in 2007 as the BOP's standardized approach to trauma treatment for incarcerated women. The program was later expanded to serve incarcerated mens as well, with gender-responsive revisions to elements of the program. The stated goal of the program is to "decrease the incidence of trauma-related psychological disorders and improve level of functioning" (BOP, 2022). The target population for this program is individuals with a history of trauma. In addition to trauma needs, the program also addresses cognitions and mental health needs. Referral procedures for specific components of the program are noted below.

Up to 90 hours are required for completion of the full Resolve Program, which is delivered primarily in a group setting. Program activities include psychoeducational interventions, interactive groups and journaling, homework assignments, and skills practice. Individuals begin

the program with the psychoeducational workshop, Trauma in Life for women or Resilience Support for men. Before progressing beyond the psychoeducational intervention, individuals complete a psychosocial assessment interview, which includes a review of their completed Trauma Education journal. As a prerequisite for participation in other components of the Resolve Program, individuals must have a trauma-related mental disorder and a treatment plan must be developed to address this disorder. The Resolve Program Coordinator is responsible for conducting the assessment interview, providing a diagnosis (if applicable), and developing a treatment plan. In policy, suggested diagnostic tools include the Stressful Life Experiences Screening (SLES), a supplemental questionnaire to identify additional traumatic life experiences, and the Personality Assessment Inventory (PAI) (PSB, 2016). Sallyport offers additional guidance on appropriate diagnostic tools (see below).

Per policy, individuals with an identified trauma-related mental disorder are then admitted to the Seeking Safety/Seeking Strength program component. Individuals who complete this program component and continue to present with a trauma-related mental disorder are then referred to the Cognitive Processing Therapy program component if they are suffering from post-traumatic stress disorder, a depressive disorder, or anxiety disorder and/or to the Dialectical Behavior Therapy program component if they are suffering from a trauma-related personality disorder (PSB, 2016). The BOP's internal website suggests a slightly different organization for the program, with individuals referred to Seeking Safety/Seeking Strength and/or Dialectical Behavior Therapy following Trauma Education, then referred to Cognitive Processing Therapy if they remain symptomatic after these skills-based interventions (PSB, n.d.). While individuals are participating in these program components, they receive progress reviews every 60 days and updates to their treatment plans as appropriate. When individuals complete these phases of the program, they may be enrolled in an ongoing maintenance skills group. This group utilizes a supportive and educational orientation to maintain treatment gains. The open-ended, continuous group typically meets monthly for 60-90 minutes (PSB, 2016). Of note, this element of the Resolve Program is not offered as a stand-alone program. It is available only in the context of the Resolve Program.

When program components are delivered in the context of a Resolve Program, there are Program Review Guidelines in place to support program fidelity. As noted below, there are also fidelity checklists for each individual program component, although their use is not mandated in policy. In addition to reducing the symptoms of trauma-related mental disorders, developing coping skills, and improving institutional adjustment, the program's anticipated outcomes include a reduction in recidivism. Program outcomes for the Resolve Program are not formally measured, but intermediate outcome measures might include mental health care levels, incident reports, and further program participation.

In the BOP's FSA Approved Programs Guide, the Resolve Program is described as available at 31 institutions; however, at the close of FY 2023 the program was offered at 26 institutions (BOP, 2023). In calendar year 2021, 493 individuals were enrolled in the program and 52 individuals completed the program (BJS, 2022). At the close of FY 2023, there were 692 individuals participating in the program, up from 629 individuals participating in the program at the close of FY 2022 (BOP, 2023; BOP, 2022). At present, 2.89% of the BOP population with a trauma need either (1) are enrolled in the program or (2) have completed the program since implementation of the FSA (BOP, 2023). It is not clear whether there is a waiting list for this program.

Descriptions of each of the component programs of the Resolve Program are provided below. At non-Resolve Program institutions, a Psychology Services staff member, typically a doctoral level psychologist, can facilitate these components as stand-alone programs, i.e., "Priority Practices" referenced in *Program Statement 5310.16 Treatment and Care of Inmates with Mental Illness* (PSB, 2016).

### 6.2.2 Trauma Education Program

The Trauma Education Program is designed to facilitate understanding of traumatic experiences and their impact (BOP, 2022). The program is both a stand-alone program and the first component of the Resolve Program. This psychoeducational program is gender-specific, with gender-responsive interactive journals – Trauma in Life for females and Stress and Resilience for males. The stated goal of the program is to enhance individuals' understanding of traumatic life events and their impact. The program is also designed to encourage participation in additional treatment, to include the Seeking Safety/Seeking Strength, Cognitive Processing Therapy, and Dialectical Behavior Therapy Programs. The target population for this program is individuals with a trauma need, as well as a mental health need. The Trauma Education Program is noted to be designed for individuals who meet any of the following three criteria: (1) evidence the individual has a history of traumatic life events, (2) evidence that the individual suffers from a mental disorder potentially associated with a traumatic life event, and/or (3) the individual expresses an interest in learning more about trauma and its potential impact; e.g., an individual who physically abused her children wants to learn more about the potential impact of her actions (PSB, 2016). Individuals are referred to the program based on their ACES score, presentation with a trauma-related mental disorder, and/or an expressed interest in the impact of trauma.

The Trauma Education Program is a psychoeducational course consisting of 4 2-hour sessions with a combination of instruction, group discussions, and interactive journaling. The program does not include explicit discussion of personal traumas. Instead, the program focuses on understanding traumatic experiences and their impact, building resilience, and encouraging participation in further treatment as applicable. Because the program is intended to motivate

individuals to volunteer for additional treatment, the program is typically provided at the beginning of the individual's sentence, ordinarily within 12 months of their initial designation.

Resources for the program include facilitator guides and participant manuals, developed in collaboration with the Change Companies (The Change Companies, n.d.). Per the BOP's internal website, Sallyport, at the end of the Trauma Education Program, all participants are administered the following assessment instruments: Generalized Anxiety Disorder 7-Item (GAD-7) Scale, Beck Depression Inventory II (BDI-II), and the PTSD Checklist for Civilians (PCL-5) (BOP, n.d.). Based on the results of these assessments, participants' trauma need will be noted as fully addressed or they will be referred to the Seeking Safety/Seeking Strength Program. The BOP's internal website provides specific guidance as to how to proceed based on scores on these assessments. If an individual obtains a score of 30 or lower on the PCL-4, 4 or lower on GAD-7, and 13 or lower on BDI II, the individual's trauma need will be considered fully addressed. If an individual obtains a score 30 or less on PCL-5 and a score of either 14-19 on BDI-II or 5-9 on GAD-7, a brief clinical interview is conducted, and the individual is referred to the Seeking Strength/Seeking Strength Program. If the individual obtains a score of 31 or higher on PCL-5, or a score of 20 or higher on BDI-II, or a score of 10 or higher on GAD-7, a brief clinical interview is conducted, and the individual is referred to the Resolve Program in its entirety. Individuals may transfer to a Resolve Program institution to participate in the program.

*Program Statement 5330.11 Psychology Treatment Programs* requires the Trauma Education Program be offered at all female institutions, excluding Federal Transfer Centers, Federal Detention Centers, and Metropolitan Detention Centers – although they may implement the program if available resources allow (PSB, 2016). In addition, *Program Statement 5200.07 Female Offender Manual* requires gender-responsive programming for women at Federal Detention Centers and Metropolitan Detention Centers, and the Trauma Education Program meets this requirement (WSPB, 2022). The Trauma Education Program is also referenced in *Program Statement 5242.01 Management of Inmate Veterans*. Per this policy: "Psychology Services staff at institutions with more than 50 Veterans offer the Trauma in Life or Seeking Safety workshops (females) and the Traumatic Stress and Resilience or Seeking Strength workshops (males) at least annually" (WSPB, 2022). The workshops are not required to be made up of only veterans but can include all individuals with trauma-related needs.

In the context of the Resolve Program, the Trauma Education program is facilitated by a Resolve Program Coordinator. As a stand-alone program, the program may be facilitated by a variety of Psychology Services Staff, including a psychologist or treatment specialist. No specialized training for program facilitators is noted. Successful completion of the program appears to be based on attendance and participation to include completion of the journal and the post-program assessments. The program's anticipated outcome is an increased understanding of traumatic life

events and their impact, as well as participation in additional treatment for any trauma-related issues. Program outcomes are formally measured using the assessment instruments referenced above. In addition, given the program's objective to encourage participation in additional trauma-related programming, this could serve as a viable and easily accessible outcome measure.

In the BOP's FSA Approved Programs Guide, the Trauma Education Program is described as available at all institutions; however, at the close of FY 2023 the program was offered at 76 institutions (BOP, 2023). This number may include instances when the program is offered as a component of the Resolve Program. In calendar year 2021, 2,143 individuals were enrolled in the program and 3,931 individuals completed the program (BJS, 2022). At the close of FY 2023, there were 1,004 individuals were participating in the program, up from 866 individuals participating in the program at the close of FY 2022 (BOP, 2023; BOP, 2022). At present, 30.26% of the BOP population with a trauma need either (1) are enrolled in the program or (2) have completed the program since implementation of the FSA (BOP, 2023). It is not clear whether there is a waiting list for this program.

### 6.2.3 Seeking Safety/Seeking Strength Program

The Seeking Safety/Seeking Strength Program is intended to facilitate the resolution of mental health and substance use symptoms associated with traumatic life experiences. The program relies on a treatment protocol of cognitive, behavioral, and interpersonal interventions developed by psychologist Dr. Lisa Najavits of Harvard Medical School and McLean Hospital. The target population for this program is individuals with a history of trauma-related mental health issues as well as substance use issues. The primary needs addressed by this program are trauma and substance use, but the BOP also notes the program addresses antisocial peers, cognitions, and mental health needs (BOP, 2022). At female institutions the program is referred to as the Seeking Safety Program and at male institutions the program is referred to as the Seeking Strength Program. The Seeking Safety Program was originally implemented in the agency in 2007 as a component of the Resolve Program. Subsequently, the program was expanded to all institutions, with gender-responsive revisions to serve men. As noted above, individuals are referred to the program based on the results of Trauma Education Program assessments.

The Seeking Safety/Seeking Strength Program is a "present-focused, evidence-based approach to treat trauma symptoms and substance use concurrently" offering participants techniques to "manage and decrease symptoms and gain control over both disorders by addressing current life programs" (BOP, 2022). Dr. Najavits' protocol is detailed in the book: *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (Najavits, 2001). The protocol includes facilitator guidance, reproduceable handouts for participants, and program fidelity and satisfaction measures. Program interventions include facilitator-led interactive groups and homework

assignments from the manual. The 25 topics addressed in the manual include: Introduction/Case Management, Safety, PTSD: Taking Back Your Power, When Substances Control You, Honesty, Asking for Help, Setting Boundaries in Relationships, Getting Others to Support Your Recovery, Healthy Relationships, Community Resources, Compassion, Healing from Anger, Creating Meaning, Discovery, Integrating the Split Self, Recovery Thinking, Taking Good Care of Yourself, Commitment, Respecting Your Time, Coping with Triggers, Self-Nurturing, Red and Green Flags, Detaching from Emotional Pain (Grounding), Life Choices, and Termination (Najavits, 2001).

In the BOP, the Seeking Safety/Seeking Strength Program is conducted as a 12-15 session treatment protocol, delivered in a group setting over the course of 12-15 weeks, in 60-minute sessions (BOP, 2022; PSB, 2016). The BOP's internal website also notes the protocol can be delivered individually. The BOP's internal website suggests more sessions may be required for men at higher security levels, due to the challenges in establishing rapport. In the BOP version of the program, all 25 topics may not be addressed, and some topics may be delivered over multiple sessions (BOP, 2022; PSB, 2016; BOP, n.d.). This approach is not inconsistent with the protocol described by Dr. Najavits, as she notes topics can be offered in any order and as few or as many topics as time allows may be addressed (Najavits, 2001). The BOP's internal website offers facilitators considerable latitude, to include operating the group in a closed or open enrollment format (BOP, n.d.). A group size of 6-12 participants is recommended and the duration of each session may vary based on group size. The BOP's internal website notes a 12-member group requires sessions of 80-120 minutes to accommodate the group format and process the treatment topic (BOP, n.d.).

The BOP's internal website outlines a format for each session consistent with Dr. Najavits' protocol, which includes the following components: (1) A check-in by each participant answering four questions, i.e., how are you feeling, what good coping have you done, any unsafe behavior, did you complete your commitment? Check-ins are brief, no more than 5 minutes per participant. (2) A quotation is included with each session topic. A participant is asked to read the quotation and the group discusses what the quotation means to them. (3) Each group session is based on a specific topic, with a handout provided at the close of the previous session to prepare participants for the upcoming session. Each topic includes a facilitator guide to encourage and support discussion of the material, with a focus on relating the topic to the participants' lives. (4) A check out is conducted, with each participant offering what they learned from the session. Participants are also asked to make a new commitment. The commitment is a goal the participant sets for themselves to identify areas they need to work on and commit to actions to help them achieve these goals. In some circumstances the facilitator may assign a commitment (BOP, n.d.).

When implemented in the context of the Resolve Program, the Seeking Safety Program has a dedicated staff facilitator – the Resolve Program Coordinator. As a stand-alone program, the

program may be "facilitated by independent practitioners or mid-level practitioners with appropriate clinical supervision. Seeking Safety facilitators should be familiar with the three key areas of the treatment which include substance abuse, PTSD, and CBT. If a facilitator is not familiar with one of these areas, specialized training or supervision is recommended." (BOP, n.d.). Facilitators are also encouraged to read Dr. Najavits treatment manual, visit the Seeking Safety website, and view Seeking Safety Training Videos available on the website or borrowed from the PSB. The PSB also offers continuing education credit for reviewing two journal articles related to the Seeking Safety protocol. The Seeking Safety Adherence Scale is made available on the BOP's internal website, along with Practice Outcome Monitoring resources, including reference to a process measure contained in Dr. Najavits' workbook. However, use of these fidelity tools is not mandated in policy.

The Seeking Safety/Seeking Strength Program is referenced in multiple BOP policies. In the context of the Resolve Program, *Program Statement 5330.11 Psychology Treatment Programs* describes the purpose, target population, admission procedures, and treatment protocol for the Seeking Safety Program in some detail (PSB, 2016). Programming for women is also generally referenced in *Program Statement 5200.07 Female Offender Manual* (WSPB, 2022). This program statement directs female institutions to provide at least one gender-responsive program from the FSA Approved Programs Guide per quarter and the Seeking Safety Program fulfills this requirement. As noted above, the program is also referenced in *Program Statement 5242.01, Management of Inmate Veterans* and the Seeking Safety/Seeking Strength Program also meets programming requirements outlined in this policy (WSPB, 2022).

Successful completion of the program is based on achieving treatment targets, which include elimination of substance use, reduction in PTSD symptoms, and the development of safe coping strategies for use in the institution and upon reentry (BOP, n.d.). No specific requirements are outlined in policy in terms of a minimum number of sessions or degree of participation for successful completion. Anticipated outcomes for the program are a reduction in the symptoms of trauma-related mental disorders, as well as the acquisition of coping-skills and a reduction in the risk of recidivism. The BOP's internal website offers three outcome measures which may be administered, although policy does not require their use. These measures include the Trauma Symptom Inventory (TSI) (Briere, 1995), the Detailed Assessment of Posttraumatic Stress (DAPS) (Briere, 2001), and the PTSD Checklist-Civilian Version (PCL-C) (Weathers, Litz, Huska, & Keane, 1994).

In the BOP's FSA Approved Programs Guide, the Seeking Safety/Seeking Strength Program is described as available at all institutions; however, at the close of FY 2023 the program was offered at 22 institutions (BOP, 2023). This number may include instances when the program is offered as a component of the Resolve Program. In calendar year 2021, 109 individuals were

enrolled in the program and 136 individuals completed the program (BJS, 2022). At the close of FY 2023, there were 218 individuals participating in the program, up from 165 individuals participating in the program at the close of FY 2022 (BOP, 2023; BOP, 2022). At present, 2.64% of the BOP population with a trauma need either (1) are enrolled in the program or (2) have completed the program since implementation of the FSA (BOP, 2023). It is not clear whether there is a waiting list for this program.

### 6.2.4 Cognitive Processing Therapy Program

The Cognitive Processing Therapy Program is designed for the treatment of post-traumatic stress disorder, and other trauma-related mental disorders. Cognitive Processing Therapy was originally developed in the Veterans Administration by Drs. Patricia Resick, Candace Monson, and Katherine Chard as a treatment for post-traumatic stress disorder. The stated goal of the program is to provide treatment for trauma-related mental disorders, most notably post-traumatic stress disorder. Consequently, the target population for this program is individuals with a history of trauma-related mental illnesses, e.g., post-traumatic stress disorder, depressive disorders, anxiety disorders. Needs addressed by the program include trauma, cognitions, and mental health. Individuals may be referred to the program based on the results of the targeted assessments referenced above (i.e., DAPS, TSI, PCL-C).

The Cognitive Processing Therapy Program is a 12-session intervention combining "cognitive techniques with written exposure therapy to address negative affect, intrusive images, dysfunctional thoughts, and avoidance behavior" (BOP, 2022). In the BOP, the program consists of 60-90 minute sessions on a weekly basis over the course of 12 weeks. Curriculum for the program is found in the book, *Cognitive Processing Therapy for PTSD: A Comprehensive Manual* by Resick, P., Monson, C., & Chard, K. (2016). The manual includes facilitator guidance and reproducible client handouts. Topics for each of the 12 sessions are as follows: introduction and education, the meaning of the event, identification of thoughts and feelings, identification of stuck points, challenging questions, patterns of problematic thinking, challenging beliefs, safety issues, trust issues, power/control issues, esteem issues, and intimacy issues and meaning of the event (Resick et al., 2016). The protocol begins with psychoeducational information related to trauma, thoughts, and emotions, focusing on the relationship between automatic thoughts and the symptoms. The next phase of the program involves processing the trauma(s) by writing a detailed account to be read in session, with the facilitator helping to challenge unhelpful thoughts about the traumatic event. Of note, this component of the program is not required and may be omitted. In the final phase of the program, participants continue to practice evaluating and modifying their beliefs related to traumatic events addressing key topic areas, e.g., safety, trust, power/control, esteem, and intimacy. The program can be delivered in a group setting, or individually, and out-of-session practice assignments are also a component of the program.

A Cognitive Processing Therapy Adherence Scale is provided on the BOP's internal website as a program fidelity measure, along with copies of the basic therapist manual, group manual, and therapist and patient handouts (BOP, n.d).

In their clinical practice guidelines for the treatment of post-traumatic stress disorder, the American Psychological Association strongly recommends Cognitive Processing Therapy as an intervention (APA, 2017). The protocol is also endorsed by the U.S. Departments of Veterans Affairs and Defense, the International Society of Traumatic Stress Studies, and the U.K. National Institute for Health and Care Excellence (NICE) as a best practice for the treatment of post-traumatic stress disorder. A meta-analysis by Amundson et al. (2019) concluded Cognitive Processing Therapy outperformed inactive control conditions (e.g., wait list, placebo) and active treatments at the close of treatment on outcome measures related to PTSD and other mental health concerns; however, they did not find a significant difference between Cognitive Processing Therapy and other active treatments at the time of follow-up, i.e., 1-12 months post-treatment. The studies reviewed in this meta-analysis did not include a correctional population.

When the program is offered in the context of the Resolve Program, the program has a dedicated staff facilitator – the Resolve Program Coordinator. When offered as a stand-alone program, a psychologist also facilitates the program. The BOP's internal website provides links where staff can obtain training in Cognitive Processing Therapy, through the Veterans Administration and/or from the authors of the protocol. Facilitators are encouraged to read Patricia Resick's book, *Cognitive Processing Therapy for Rape Victims.* Successful completion of the program is based on attendance and participation, to include completing out of session practice assignments. In addition to reducing the symptoms of trauma-related mental disorders, the program is expected to produce a reduction in recidivism. Program outcomes are not formally measured, but mental health care level could serve as a viable outcome measure, as could re-administration of the assessments referenced above.

In the BOP's FSA Approved Programs Guide, the Cognitive Processing Therapy Program is described as available at all institutions; however, at the close of FY 2023 the program was offered at 10 institutions (BOP, 2023). This number may include instances when the program is offered as a component of the Resolve Program. In calendar year 2021, 12 individuals were enrolled in the program and 11 individuals completed the program (BJS, 2022). At the close of FY 2023, there were 28 individuals participating in the program, consistent with the 27 individuals participating in the program at the close of FY 2022 (BOP, 2023; BOP, 2022). At present, .36% of the BOP population with a trauma need either (1) are enrolled in the program or (2) have completed the program since implementation of the FSA (BOP, 2023). It is not clear whether there is a waiting list for this program.

### 6.2.5 Dialectical Behavior Therapy Program

The Dialectical Behavior Therapy Program is designed as "a cognitive-behavioral treatment for self-management of emotions and distress" (BOP, 2022). As noted above, the program is offered as a stand-alone program and as a component of the Resolve Program. Dialectical Behavior Therapy skills training is also used within the STAGES Program, the BOP's residential treatment program for individuals with borderline personality disorder (see Chapter 5). Dialectical Behavior Therapy was originally developed by psychologist Dr. Marsha Linehan of the University of Washington as a treatment for borderline personality disorder. The stated goal of the program is to reduce life-threatening behaviors and therapy-interfering behaviors, while facilitating positive quality of life behaviors and skills acquisition. The target population for this program is individuals with a history of trauma-related mental illnesses, with a focus on individuals with personality disorders. Needs addressed in the program include trauma, mental health, and cognitions. Individuals are referred to the program based on the results of the above referenced assessments and/or a borderline personality disorder diagnosis.

Dialectical Behavior Therapy Skills Training focuses on four skill areas: "mindfulness skills, distress tolerance skills, emotional regulation skills, and interpersonal effectiveness skills" (BOP, 2022). The reference to "dialectical" relates to establishing "a "dialectic" between helping individuals to accept the reality of their lives and their own behaviors on the one hand and helping them learn to change tier lives, including dysfunctional behaviors, on the other" (APA, n.d.). As traditionally delivered, the protocol includes four components: individual psychotherapy, skills training, in-the-moment phone coaching, and consultation teams for therapists (behavioraltech.com, n.d.). The protocol is found in the book, *Dialectical Behavior Therapy Skills Training Manual* by Marsha Linehan, with client resources found in the accompanying *Dialectical Behavior Therapy Skills Training Handouts and Worksheets,* also by Dr. Linehan (2014). In addition, the website www.behavioraltech.org contains other Dialectical Behavior Therapy resource materials, to include program fidelity checklists and copies of evidence for the protocol's effectiveness. This evidence includes randomized controlled trials associated with use of the protocol to treat a variety of conditions, i.e., borderline personality disorder, eating disorders, and depression. In most instances, these studies compared Dialectical Behavior Therapy Skills Training to a wait list condition. The limited number of studies available on the website comparing Dialectical Behavior Therapy Skills Training to treatment as usual do not report significant differences across treatment modalities.

In the BOP, the Dialectical Behavior Therapy Program focuses on the skills training component of Dr. Linehan's protocol, teaching these four core skills: (1) mindfulness, the practice of being fully aware and present in this one moment, (2) distress tolerance, how to tolerate pain in difficult situations, not change it, (3) interpersonal effectiveness, how to ask for what you want and say

no while maintaining self-respect and relationships with others, and (4) emotion regulation, how to change emotions that you want to change. Assigned homework is also an important part of the skills training protocol. The program is implemented as a 25-session, 2-hours/session protocol. When the program is offered in the context of the Resolve Program, the program has a dedicated staff facilitator – the Resolve Program Coordinator. When offered as a stand-alone program, a psychologist also facilitates the program. Facilitators are encouraged to read Dr. Linehan's book, as well as the book *Depressed and Anxious: The Dialectical Behavior Therapy Workbook for Overcoming Depression and Anxiety* by Thomas Marra. The BOP's internal website notes this resource offers a simplified version of dialectical behavior therapy appropriate for individuals suffering from mild to moderate anxiety and depression (BOP, n.d.). The author's book, *Dialectical Behavior Therapy in Private* Practice is also offered as a resource, especially the accompanying CD with client worksheets and skills training slideshows. Successful completion of the program appears to be based on attendance and participation in the program. In addition to reducing the symptoms of trauma-related mental disorders, the program is expected to produce a reduction in self-harming behaviors, suicidal ideation, and suicide attempts as well as a reduction in recidivism. Program outcomes are not formally measured; however, a reduction in suicide risk assessments and suicide watches are viable outcome measures.

In the BOP's FSA Approved Programs Guide, the Dialectical Behavior Therapy Program is described as available at all institutions; however, at the close of FY 2023 the program was offered at 46 institutions (BOP, 2023). This number may include instances when the program is offered as a component of the Resolve Program or STAGES Program. In calendar year 2021, 71 individuals were enrolled in the program and 70 individuals completed the program (BJS, 2022). At the close of FY 2023, there were 185 individuals participating in the program, up from 166 individuals participating at the program at the close of FY 2022 (BOP, 2023; BOP, 2022). At present, 1.74% of the BOP population with a trauma need either (1) are enrolled in the program or (2) have completed the program since implementation of the FSA (BOP, 2023). It is not clear whether there is a waiting list for this program.

### Women and Special Populations Branch Trauma Programs

The BOP offers three trauma programs supported by the WSPB and exclusively for women, and each of these programs addresses a specific trauma-related issue or population. The Advancing Career Counseling and Employment Support for Survivors (ACCESS) Program offers women who have experienced the trauma of domestic violence support in establishing independence from abusive relationships; the Beyond Violence: Prevention Program for Criminal Justice Involved Women focuses on women with trauma-related anger management issues; and the Pu'a Foundation Reentry Program addresses trauma issues from a culturally sensitive Native Hawaiian perspective.

### 6.2.6 Advancing Career Counseling and Employment Support for Survivors (ACCESS) of Domestic Violence Program

The Advancing Career Counseling and Employment Support for Survivors of Domestic Violence (ACCESS) Program is "designed for incarcerated women who are survivors of domestic violence" (BOP, 2022). The program focuses on helping women identify career options to increase their economic independence. The program was developed by Krista M. Chronister, a licensed psychologist known for her research on partner violence and survivors' vocational and economic development. The stated goal of the ACCESS Program is to aid in increasing financial independence through employment; however, given its focus on domestic violence, this program was not categorized as a vocational training program for the purposes of this report. The target population for this program is women with a cognitions, mental health, or trauma need.

The ACCESS Program is a 5-week, 10-hour program consisting of a combination of lectures, class discussions, and computer-based resources. These resources include an interactive component to explore career options as well as a self-assessment to identify the best career fields for participants. The program aims to enhance domestic violence survivor's career development by "(a) increasing women's awareness of supportive and abusive power dynamics in their lives, (b) increasing women's awareness and development of occupational and life skills, (c) facilitating women's ability to use their skills to make life decisions, and ultimately, (d) increasing women's ability to use their skills to contribute to their families and communities" (Chronister, 2013). Program sessions are as follows: (1) introductions, a discussion of accomplishments, and introduction of the skills assessment activity; (2) review of skills assessment activity results and discussion of career resources; (3) discussion of power and control in relationships and a progressive relaxation exercise; (4) discussion of equality and support in relationships; (5) career goal planning exercise with a focus on a 2-year career vision. Program resources available on Sallyport include Powerpoint presentations on power, control, equality, and support; an introductory questionnaire; a skills assessment instrument with supporting documentation; session satisfaction surveys for participants and facilitators; a progressive relaxation exercise outline; and personal safety plan outline. According to the developer's website, resources also include a facilitator's curriculum manual and participant workbooks, as well as a career information system and program CD available on the ACCESS website. However, the website does not appear to be active, and these materials are not accessible at this time.

The program does not have a dedicated staff facilitator. According to the BOP (2022), the program is facilitated by a special programs coordinator. No formal training is required to facilitate the course, nor does the agency provide any formal training to facilitators, apart from the facilitator guide. Successful completion of the program is based on attendance and

participation. The program's anticipated outcome is increased assertiveness and a career path plan. Program outcomes are not formally measured.

In the BOP's FSA Approved Programs Guide, the ACCESS Program is described as available at all female institutions; however, at the close of FY 2023 the program was offered at 1 institution (BOP, 2023). In calendar year 2021, 22 individuals were enrolled in the program and 28 individuals completed the program (BJS, 2022). At the close of FY 2023, there were 8 individuals participating in the program, whereas at the close of FY 2022, there were no individuals participating in the program (BOP, 2023; BOP, 2022). At present, .17% of incarcerated women in the BOP either (1) are enrolled in the program or (2) have completed the program since implementation of the FSA (BOP, 2023). It is not clear whether there is a waiting list for the program, or why there are so few participants in the program.

### 6.2.7 Beyond Violence: Prevention Program for Criminal Justice Involved Women

The Beyond Violence: Prevention Program for Criminal Justice Involved Women is focused on anger management issues. The program is "designed to assist women in understanding trauma, the aspects of anger, and emotional regulation" (BOP, 2022). The program was developed by Stephanie Covington, a psychologist and social worker. The stated goal of the program is to reduce the risk of violence. The target population for this program is women with anger/hostility and cognitions needs.

The Beyond Violence Program is a 40-hour, 20-session program consisting of a combination of education, role plays, and cognitive-behavioral techniques, e.g., mindfulness activities, grounding skills. The program is "an evidence-based manualized curriculum for women in criminal justice settings…with histories of aggression and/or violence" (Covington, 2013). Program modules address the interplay between individual, relationship, community, and societal factors putting people at risk for experiencing and/or perpetrating violence. Each module includes quiet time, a lecture, group discussion, and a series of activities. Following an initial orientation session, the module topics are thinking our thoughts, feeling our feelings, violence and trauma in our lives, the effects of trauma, women and anger, understanding ourselves, our families, communication, power and control, conflict resolution, creating our relationships, our communities, the importance of safety, creating communities, the power of community, society and violence, creating change, transforming our lives, honoring ourselves and our community (Covington, 2013). Resources for the program include a facilitator guide, participant workbook, and DVD, available on the Covington Books website.

The program does not have a dedicated staff facilitator. According to the BOP (2022), the program is facilitated by a special programs coordinator. No formal training is required to

facilitate the course, nor does the agency provide any formal training to facilitators, apart from the facilitator guide which does provide specific guidance to facilitators. Successful completion of the program is based on attendance and participation. The program's anticipated outcome is a reduction in the symptoms of anger and hostility. Program outcomes are not formally measured.

In the BOP's FSA Approved Programs Guide, the Beyond Violence Prevention Program for Criminal Justice Involved Women is described as available at all female institutions; however, at the close of FY 2023 the program was offered at 3 institutions (BOP, 2023). In calendar year 2021, 57 individuals were enrolled in the program and 58 individuals completed the program (BJS, 2022). At the close of FY 2023, there were 53 individuals participating in the program, up from 33 individuals participating in the program at the close of FY 2022 (BOP, 2023; BOP, 2022). At present, 1.80% of incarcerated women in the BOP either (1) are enrolled in the program or (2) have completed the program since implementation of the FSA (BOP, 2023). It is not clear whether there is a waiting list for this program.

### 6.2.8 Pu'a Foundation Reentry Program

The Pu'a Foundation Reentry Program is a program grounded in Hawaiian culture. The program focuses on "families affected by trauma and incarceration with a special emphasis on women, girls, and Native Hawaiian participants" (BOP, 2022). The program was developed by the Pu'a Foundation, a non-profit organization with a mission to "actively engage, facilitate and serve communities and their efforts to build a resilient society and improve quality of life through healing and reconciliation efforts" (Pu'a Foundation, n.d.). The stated goal of the program is to support healing. The target population for this program is Native Hawaiian women with family/parenting and trauma needs.

The Pu'a Foundation Reentry Program consists of a 12-week course with 20 hours of programming, the Cultural Healing and Well Being Course. The Cultural Healing and Well Being Course focuses on "sharing Native Hawaiian culture and history" with the aid of community educational resources, i.e., Ua Mea Ke Ea textbook and DVD. Resource materials are available on the foundation's website. A Pre-Transition Course focused on "life success planning for women about to exit prison and connecting resources to actual needs" is also available (Pu'a Foundation, n.d.). As noted above, resources for the Pu'A Foundation Reentry Program include a textbook and DVD, made available to the institution via the foundation's website.

The program does not have a dedicated staff facilitator. According to the BOP (2022), the program may be facilitated by a variety of staff, including Education and Unit Team staff, contractors, and volunteers. No formal training is required to facilitate the course, nor does the

agency provide any formal training to facilitators, apart from the referenced textbook and DVD. Successful completion of the program is based on attendance and participation. A fidelity checklist for the program is available on the BOP's internal website (WSPB, n.d.). The program's anticipated outcome is not clearly stated. Program outcomes are not formally measured.

In the BOP's FSA Approved Programs Guide, the Pu'a Foundation Reentry Program is described as available at FDC Honolulu; however, at the close of FY 2023 the program was not offered at the institution (BOP, 2022). In calendar year 2021, no individuals were enrolled in the program and no individuals completed the program (BJS, 2022). At the close of FY 2023, there were no individuals participating in the program, nor were there any individuals participating in the program at the close of FY 2022. No women currently in BOP custody are noted to have completed the program in the past. It is not clear why there are no participants in the program in recent years.

## 6.3 Study Identification Procedures

To create our study database, we first examined all published meta-analyses and systematic reviews of prison-based trauma programs published during our review period (2000-2022). Three meta-analyses and systematic reviews were identified (See Appendix Table 6A). All studies identified in each of these meta-analyses and systematic reviews and published from 2000 to present were included in our preliminary study review database. As noted in Chapter 1, a strong argument can be made evaluations of prison trauma programs operating in the 1990's and earlier are not relevant today, because of changes in program design components and incarcerated populations.

The next step in our study identification process was to determine whether these meta-analyses and systematic reviews perhaps missed relevant evaluations due to the search procedures employed; or excluded them from their review due to their study inclusion criteria. Based on the topics covered in this chapter, we decided to use an expanded electronic database search by including all databases available from UMass Lowell's entire Discovery Service:

- APA PsycInfo
- Complementary Index
- Academic Search Premier
- MEDLINE
- Criminal Justice Abstracts
- CINAHL Plus with Full Text
- Gale Academic OneFile

- National Criminal Justice Reference Service Abstracts
- Gale OneFile: Health and Medicine
- Gale General OneFile
- Supplemental Index
- Education Research Complete
- Gale Academic OneFile Select
- Springer Nature Journals
- Books at JSTOR
- Research Starters
- APA PsycArticles
- Gale Health and Wellness
- Business Source Complete
- ScienceDirect
- Gale in Context: Science
- Gale OneFile: High School Edition
- IEEE Xplore Digital Library
- Regional Business News
- ERIC
- Gale OneFile: News
- Historical Abstracts
- Political Science Complete

We used the following specific terms for our systematic search of electronic databases:

***(trauma informed care OR trauma informed practice OR trauma OR trauma informed approach) AND (prison OR jail OR incarceration OR imprisonment OR correction facilities) NOT (youths OR young people OR adolescents OR teenagers) AND (recidivism OR reoffending OR repeat offenders)***

This search yielded 265 hits, with an initial list of 108 studies once duplicate articles across the databases were removed. Visual inspection of the titles and abstracts by the research team further reduced the number of potential studies to 20 titles identified by the research team as requiring in-depth review. Specifically, we focused on studies that included one of the outcomes

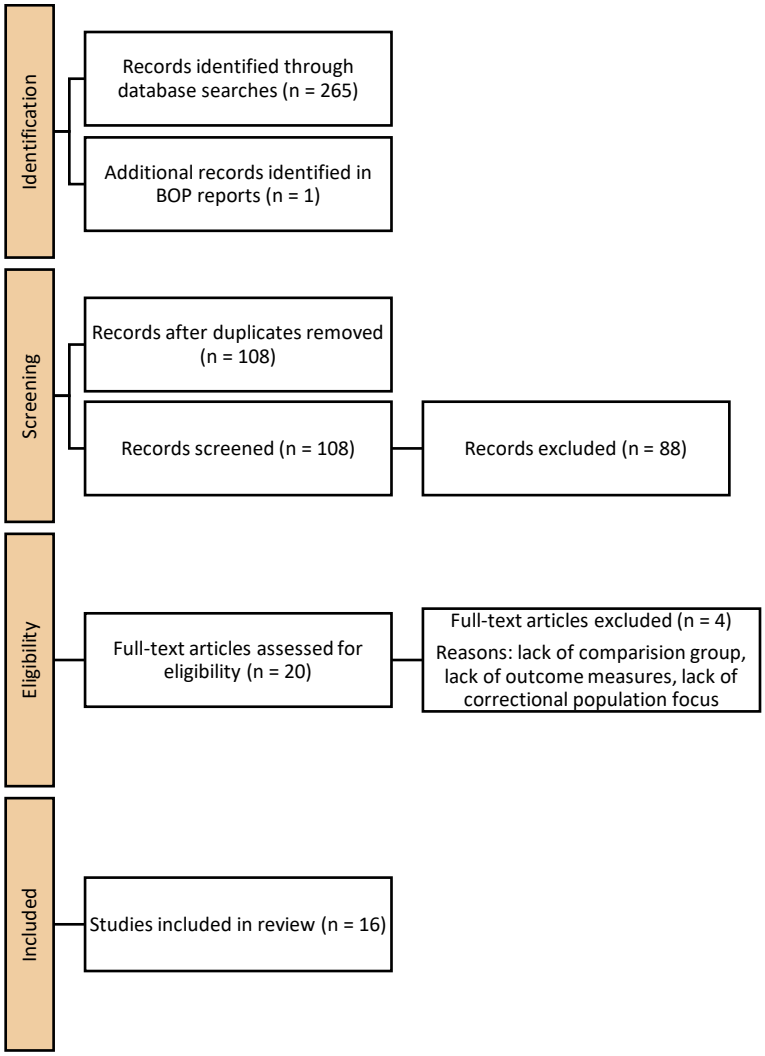
measures described in Chapter 1 (i.e., recidivism reduction, misconduct reduction, improved institutional adjustment, skills acquisition) and identified a control group for comparison.[1]

In addition, the BOP provided us with an unpublished preliminary internal evaluation report for the Resolve Program which was included in our database. The individual studies are presented in Appendix Table 6B.

Not all the 20 studies we examined in-depth met our review criteria. Based on our review of the studies included in the eight meta-analyses and systematic reviews highlighted in Appendix Table 6A, along with the results of our search of electronic databases and the report provided to us by the BOP, we identified 20 evaluations of prison-based trauma programs for the period 2000 to 2022 that meet our review criteria (see Appendix Table 6B for an overview of each study).

[1] Some programs initially ranked by the research team as meeting minimum quality standards were later found to include a non-equivalent comparison group. We discuss this issue in our findings section.

**Flowchart of Study Identification Procedures**




## 6.4 Evaluations of Trauma Programs Inside the BOP

Six of BOP's eight trauma programs— Trauma Education, Seeking Safety/Seeking Strength, Cognitive Processing Therapy, Dialectical Behavior Therapy, ACCESS, Beyond Violence: Prevention Program for Criminal Justice Involved Women, and Pu'a Foundation Reentry Programs —have not been the subject of either an internal or external BOP evaluation during our

2000-2023 review period. However, the BOP is conducting an internal evaluation of the Resolve Program, which appears to include two of these stand-alone programs – Trauma Education and Seeking Safety/Seeking Strength (DOJ, 2023). The BOP recently completed a preliminary report related to this evaluation, which they shared with our review team near the close of our project (ORE, 2023). The program is described as follows:

*"The Resolve Treatment Program (RTP) was designed to treat those inmates suffering from trauma-related disorders. Broadly, the RTP is a group-based treatment protocol that includes one psychoeducational and three treatment groups. The three treatment groups are Seeking Safety, Dialectical Behavior Therapy (DBT), and Cognitive Processing Therapy (CPT). All phases are designed to treat symptoms of PTSD, substance abuse and other trauma-related disorder" (2023,1).*

Researchers were not able to use a research design that included a treatment and control group, so they opted to simply examine pre-program vs. post-program changes in incident reports, major psychological services events (MPSEs), and days in restrictive housing units ( i.e. SHU) for a group of program participants, which varied significantly by the outcome measure used (n=409 misconduct; n=296 for time in SHU, and n=88 for MPSEs). While no differences in misconduct were found, pre-post differences in both time in SHUs and MPSEs were identified. Limitations of this preliminary, level 1 study were identified by the research team, who correctly observed that,

"While this analysis points to a positive impact on the behavioral outcomes measured here, it is not enough to show the causal impact of this trauma- informed intervention. Nor does it show us the effect of this programing compared to a group of similarly situated individuals who did not participate in the RTP "(2023, 3).

Currently, BOP does not have plans to conduct an external evaluation of any of its trauma programs. Without high quality evaluation findings, we will not be able to determine the effectiveness—in-prison and post-release—of these programs.

## 6.5 Evaluations of Trauma Programs Outside BOP

We begin our assessment of programs targeting incarcerated individuals with trauma-related needs by looking first at the results of available meta-analyses and systematic reviews. The findings from three recent meta-analyses and systematic reviews examining trauma-focused interventions (Malik et al., 2021; Tripodi et al., 2011; and Givens et al., 2021) are presented in

Appendix Table 6A.[2] Only the Malik et al. (2021) meta-analysis/systematic review focused exclusively on prison-based trauma programs, but there were a small number of trauma programs included in the other two systematic reviews, which is why the findings from these reviews are also included here. Overall, these three meta-analyses/systematic reviews underscore the need for more research evaluating the intermediate program effects of trauma-focused interventions in prison, based on a standard set of outcome measures. The authors of three separate meta-analyses/systematic reviews reported positive overall findings regarding the reduction of PTSD and other trauma-related symptoms for several different trauma-focused interventions. However, the authors of these three meta-analyses/systematic reviews caution readers that the research base supporting the efficacy of these interventions is limited. The following summary of findings offered in the meta-analysis/systematic review conducted by Malik and colleagues (2021: 8) bears careful consideration as BOP assesses the status of their trauma-focused programming:

*Overall, our results highlight that published literature on the efficacy of trauma-focused therapies in prison settings is sparse and its interpretation is challenging. The lack of studies trialing robustly controlled NICE recommended trauma-specific therapeutic approaches likely reflects the difficulties with which the delivery of such therapy in prison presents. This is consistent with previous prison studies which have found PTSD to be significantly under-treated compared to other disorders (Jakobowitz et al., 2017; Tyler et al., 2019). The most widely implemented trauma-focused interventions across studies in our review were group-based, phase 1 treatments, addressing current trauma-related distress and functioning through skills-based work aimed at increasing safety and stability. We identified five studies which involved trauma-processing components, with only one evaluating an evidence-based, NICE-recommended therapy for the treatment of PTSD. The most commonly evaluated trauma processing approach were trauma-focused writing interventions, which were not delivered by qualified psychologists or other mental health professionals.*

As we noted in our review of prison programs targeting serious mental illnesses (see Chapter 5), these trauma programs should be evaluated on whether they achieve their intended outcome, which is reduction in trauma symptoms. Of particular interest is whether proposed new trauma programs perform better than existing programs, i.e., treatment as usual (TAU). If they do not,

[2] We summarized the key findings of the Givens et al. (2021) systematic review in Chapter 5. The review covered both SMI and Trauma Program evaluations; we focus on the results of trauma studies here.

then BOP program administrators are free to consider other factors (e.g., cost, training, qualifications of staff) when establishing policies and practices in this program area.

The meta-analysis of 16 prison-based trauma programs by Malik and colleagues (2021) did not include a single study with recidivism outcomes. Similarly, Givens et al. (2021) did not include studies with recidivism outcomes for the trauma programs in their systematic review. Only the Tripoldi et al. (2011) systematic review of a variety of women's programs included risk reduction outcomes, but these outcomes were reported only for substance abuse programs, not trauma programs. While there will always be interest in assessing post-release behavior of prison treatment program participants, it is the evidence of in-prison program effects—reduced PTSD, and other trauma symptoms--that can be directly linked to prison trauma programs; there is little evidence that in-prison trauma programs have an impact on post-release behavior in the community. Since men and women in prison are typically involved in multiple types of prison programs, disentangling individual program effects post-release is difficult, if not impossible, especially when participation in post-release treatment—and supervision—is not also assessed.

Appendix Table 6B provides an overview of the key findings from our review of 18 individual trauma-focused interventions. Since these studies use a range of outcome measures, a summary of study findings is challenging. Eleven of the studies we reviewed used 3 or more outcome measures, three studies used 2 outcome measures, and four used only 1 outcome measure. The most often-used measure was PTSD (11 studies), followed by depression (8 studies), trauma (4 studies), personality disorders (2 studies), substance use (1 study), misconduct (1 study), restrictive housing placement (1 study), crisis contacts (1 study), and recidivism (1 study).[3]

Several of the programs included in our evaluation review appear to be similar—at least in name--- to a current BOP trauma program, the Seeking Safety/Seeking Strength Program. Of the 18 trauma program evaluations included in Appendix Table 6B, six are evaluations of Seeking Safety Programs. Two other program evaluations also relate to programs offered in the BOP - the Beyond Violence Prevention Program for Criminal Justice Involved Women and the Dialectical Behavior Therapy Program. In addition, two studies focus on a treatment intervention closely linked to dialectical behavior therapy, the STEPPS Program. Five program evaluations address additional psychoeducational interventions and/or exposure-based therapies, including Survive

[3] In addition, there were 8 studies with over 3 measures, which included a variety of additional outcome measures, including behavioral stability (Mahoney et al., 2020), and psychopathy (Zlotnick et al., 2009).

and Thrive, TARGET, Helping Women Recover/Beyond Trauma, SHARE, and Traumatic Incident Recovery. There is also a single program evaluation for a Transcendental Meditation Program.

Our examination of these 18 trauma-related program evaluations points to a generally favorable review, in terms of the short-term reduction in trauma symptoms by participants, but several evaluators report that similar reductions in symptoms were also identified in the various control groups employed. We also note that only one study provided data on recidivism (the Kubiak et al., 2016 evaluation of the Beyond Violence Program), which limits our assessment of this post-release outcome. In the Kubiak et al. study, no statistically significant differences between treatment and control groups were found for both re-arrest and reincarceration at 12-months post-incarceration; similar no effect findings were reported for relapse, using positive drug screen as the outcome.

One component of BOP's Resolve Program is their Seeking Safety/Seeking Strength Program. As we mention above, there were six separate state-specific evaluations of the Seeking Safety Program available for review: Barrett et al. (2015), Tripodi et al. (2019), Zlotnick et al. (2009), Lynch et al. (2012), Heath (2009), and Wolff et al. (2015). Four of these evaluations were randomized control trials, while two were quasi-experiments. Regardless of design type or how the trauma outcome measures were operationalized by researchers, the results of these six evaluations revealed a similar pattern: significant pre-post improvements in one trauma-related outcome (PTSD symptom severity) were identified in *both* the treatment and control groups, which suggests that the Seeking Safety Program does not offer an improvement over current practices (i.e., treatment as usual) in these prison systems. However, in one study, participants in the Seeking Safety Program did have better outcomes than a control group that received no treatment, using three different trauma-related outcome measures: mental health symptoms, self-esteem, and proactive coping (Wolff et al., 2015). In this same study, there was some preliminary evidence that the Male Trauma Recovery Empowerment Model (MTREM) may work better at reducing PTSD severity than the Seeking Safety Program. We view these overall results as evidence that (1) when it comes to addressing trauma-related problems, some treatment is better than no treatment; but (2) there is research evidence that suggests that the Seeking Safety Program may not offer any improvement over current practice. For this reason, we rate it as ***ineffective,*** but it is important to note that both the treatment and TAU groups showed improvements in trauma-related outcomes.

In addition to the six Seeking Safety Program evaluations, our review includes evaluations of six trauma-treatment programs with potential similarities to BOP programs: Mahoney et al., 2020; Swopes et al., 2017; Cole, 2007; Ford et al., 2013; Valentine & Smith, 2001; and Karlsson, 2022. The programs described in these six evaluations include both psychoeducational and exposure-based therapies. The results of the higher quality research studies conducted by Mahoney et al.

(2020) and Swopes et al. (2017) revealed no differences in trauma outcomes between treatment and control groups for psychoeducational-based interventions. The results from the three lower-level studies addressing exposure therapies were mixed. We rate both these types of trauma programs as ***ineffective***.

The one high quality evaluation of Dialectical Behavior Therapy we reviewed (a level 3 study by Bradley & Follingstad, 2003) identified in-prison improvements in trauma symptoms, including depression. We rate the in-prison intermediate effects of this program as ***promising***. No post-release measures were included in this study; the post-release effects of this program are **unknown.**

## 6.6 Trauma Program Comparability Assessment

As noted above, the BOP's trauma treatment protocol, the Resolve Program, includes a suite of programs. While we did not identify a program comparable to the Resolve Program, we do note two of the Resolve Program components are directly comparable to programs found in our review of the literature – the Seeking Safety/Seeking Strength and the Dialectical Behavior Therapy Programs. These programs are referenced in the following studies, not all of which met our review criteria: Barrett et al. (2015), Tripodi et al. (2019), Zlotnick et al. (2009), Lynch et al. (2012), Heath (2009), Wolf et al. (2015), Bradley & Follingstad (2003), Black et al. (2008), Black et al. (2013). Based upon our review of program descriptions in these evaluations, these programs appear very comparable to the BOP's programs. These programs were developed outside of the BOP, adopted by the BOP in a manner consistent with their developer's model, and implemented in the referenced studies in this manner as well. Consequently, these two programs can be classified as very comparable to the research we reviewed.

In addition, the Survive and Thrive Program described in the Maloney et al. (2018) study appears to share many similarities with the BOP's Trauma Education Program. Both programs can be described as brief, purely psychoeducational, group interventions. While the BOP's Trauma Education Program is eight hours, the Survive and Thrive Program is slightly lengthier at ten hours. Based on content, dosage, and delivery method, we would characterize the Trauma Education Program and Survive and Thrive Program as somewhat comparable. The other program with a significant psychoeducational component, TARGET, is lengthier at 15 hours, and includes skills training which is not found in the Trauma Education Program. However, we did not identify sufficient research to assess the effectiveness of psychoeducational interventions, so a full comparability assessment is not relevant.

Although the BOP's Cognitive Processing Therapy Program is not represented in the current literature on correctional programs, an element of the program is shared with the programs

discussed in our review – exposure therapy. However, it is important to note the exposure portion of Cognitive Processing Therapy is optional, so a meaningful comparison cannot be made to this program and the exposure-based programs found in our review.

With respect to the three trauma programs supported by the WSPB, only one program has been subject to an evaluation - the Beyond Violence: Prevention Program for Criminal Justice Involved Women. The program evaluated in the 2016 Kubiak et al. study appears to be the same program offered by the BOP, as both programs use program materials developed by Dr. Stephanie Covington and adhere to the program structure contained in these materials. Consequently, these two programs appear to be very comparable.

No comparable programs were identified for the ACCESS and Pu'a Foundation Reentry Programs.

## 6.7 Trauma Program Recommendations

In the BOP's most recent needs assessment report, compliance with the ACES assessment is noted to be relatively low. Ideally, new procedures related to earned time credits have increased compliance with self-report assessment measures. If not, the BOP may want to identify a proxy measure for individuals who refuse to complete the ACES, such as a review of the individual's PSR to identify traumatic events.

The BOP's current approach to assessing trauma-related needs focuses on the presence of trauma, as opposed to the presence of a trauma-related impairment. To streamline the assessment and make more efficient use of resources, it might be of value to reframe trauma as a potential underlying cause of another need, e.g., mental health, cognitions, substance abuse. Assuming any individual with a history of trauma has a trauma-related need does not give sufficient weight to the concept of personal resilience. Assessment measures used in the Resolve Program appear to offer more appropriate methods to assess trauma-related needs. A more efficient approach might be to use the ACES in conjunction with other needs assessment measures to refine treatment recommendations. For example, program referrals for individuals with substance use disorders might vary based on whether the individual also has an elevated ACES score.

In concluding comments, the Malik et al. (2021) meta-analysis/systematic review addresses implications for policy and practice by discussing provisional conclusions drawn about the most effective approaches to addressing trauma-related mental disorders. In their comments, they suggest individual interventions may be more effective than group interventions, an important consideration since BOP programs in this area are delivered primarily in a group setting. The authors also suggest stabilization interventions (e.g., Seeking Safety Program) may be less

effective than trauma-processing interventions (e.g., Cognitive Processing Therapy Program). In line with these suggestions, the BOP may want to consider increasing the availability of the Cognitive Processing Therapy Program as an individual intervention by providing additional staff training and/or directing more individuals to this intervention. Rather than referring individuals who score highly on the PCL-C to the Seeking Safety/Seeking Strength Program, these individuals might be referred to the Cognitive Processing Therapy Program. Of course, as noted in our review of the literature, definitive conclusions cannot be drawn at this time, and a formal evaluation of the Cognitive Processing Therapy Program is necessary as our review did not support its status as an EBRR Program.

As noted in Chapter 5, with the residential treatment programs for individuals with serious mental illnesses, clarity in program participation numbers is lacking. From a tracking standpoint, the use of trauma-treatment interventions both within the broader Resolve Program and independent of the program is problematic. For example, do the 28 individuals reported to be participating in the Cognitive Process Therapy Program at the close of FY 2023 reflect all the individuals participating in this program, or are there additional participants within the Resolve Program participation numbers?

The Resolve Program is described in *Program Statement 5330.11 Psychology Treatment Programs* which supports the use of fidelity measures within this program and its component programs. This policy should be updated to include recent program enhancements, i.e., expansion of the program to serve men, refinement of screening methods, the use of trauma-treatment interventions outside the context of the Resolve Program. For example, the trauma programs offered by the BOP now include several targeted assessments both for program placement (i.e., GAD-7, BD-II, PCL-5) and as potential outcome measures (i.e., TSI, DAPS, PCL-5). The programs could be strengthened by incorporating requirements to administer these assessments into policy as well as by requiring staff to re-administer relevant assessments at the conclusion of the programs to serve as consistent outcome measures. Given the significant number of changes in the program since issuance of the policy, it might be more effective and efficient to create a stand-alone policy for trauma programs.

With respect to the three trauma programs supported by the WSPB, we question whether these programs add significant value to the BOP's trauma programming efforts. There is a lack of research support for these Productive Activity Programs. The one study we identified related to the Beyond Violence: Prevention Program for Criminal Justice Involved Women did not support its effectiveness, and we did not identify any studies related to the two other WSPB supported programs. In addition, participation in these programs is quite low, with fewer than 100 women combined participating in the three programs at the close of FY 2023. On the other hand, in the Resolve Program and its components, the BOP has a gender-responsive approach to trauma

programming staffed by doctoral level psychologists with experience in treating trauma-related mental illnesses. The BOP might benefit from reallocating its WSPB resources to interventions outside the trauma domain, such as gender-responsive programming related to communication skills and relationships.

As noted above, the BOP's ORE is currently evaluating the effectiveness of the Resolve Program. This evaluation is particularly important as BOP has classified most of its trauma-treatment programs as EBRR Programs. Our review has not supported this classification with a correctional population. The evaluation by ORE should address all components of the Resolve Program, including Cognitive Processing Therapy and Dialectical Behavior Therapy since these components have been classified by the BOP as stand-alone EBRR Programs. Completing this evaluation will allow the BOP to capitalize on its unique strengths, i.e., doctoral level treatment providers and programs with high retention rates, which may enhance program effectiveness. With this additional data the BOP can make more informed decisions about treatment resources in this area. As with the BOP's programming choices related to individuals with serious mental illnesses, there is merit in the selection of programs with empirical support outside of corrections, but there is a need to ensure these programs are effective with a correctional population, especially if the BOP chooses to classify the programs as EBRR Programs.

## 6.8 Summary of Results

Four of eight BOP programs examined in this chapter are currently classified by BOP as EBRR Programs - the Resolve, Seeking Safety/Seeking Strength, Cognitive Processing Therapy, and Dialectical Behavior Therapy Programs. Based on our review of the evaluation research conducted on these programs published between 2000 and 2022, we did not find support for continuing to classify three of these programs as EBRR Programs. With respect to the Seeking Safety/Seeking Strength Program, while this program was found to favorably impact trauma-related symptoms, the program was not found to perform significantly better than treatment as usual, an issue we address in Chapter 1 of this report. As a major component of the Resolve Program, this finding related to the Seeking Safety/Seeking Strength Program also impacts our view of the Resolve Program. With respect to the remaining two programs - the Cognitive Processing Therapy and Dialectical Behavior Therapy Programs - we did not find sufficient evidence to support classification of the Cognitive Processing Therapy Program as an EBRR Program, but we did find support to *provisionally* classify the Dialectical Behavior Therapy Program as an EBRR Program. Until additional evaluations of these programs are conducted, and a body of quality evaluation research is available for review, there is no justification for classifying the majority of these programs as EBRR Programs.

We were also asked to assess trauma programs currently classified by the BOP as PA Programs – the Trauma Education, ACCESS, Beyond Violence Prevention Program for Criminal Justice Involved Women, and Pu'a Foundation Reentry Programs; however, our review did not find sufficient research to make any determination about their PA Program designations. Once again, the necessary research has not been conducted. At this point, findings related to the Beyond Violence Prevention Program for Criminal Justice Involved Women are not encouraging, rated as not promising based on a single review finding no differences between the treatment and control groups.

The table below provides a summary of the results of our research review.

**The Effectiveness of Prison-Based Trauma Programs**
**Summary of Program Rankings**

| BOP Program | Status of BOP Evaluations | Evidence Rating: BOP Evaluations | Evidence Rating: Outside Evaluations - Intermediate Outcomes | Evidence Rating: Outside Evaluations - Post-Release Outcomes | Comparability Assessment |
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| **Resolve Program (EBRR)** | Preliminary Evaluation Completed<br>Anticipated Completion FY 2024 | Unknown | **Ineffective: improvements noted for both treatment and control groups** | Unknown | Somewhat Comparable |
| **Trauma Education Program (PA)** | Preliminary Evaluation Completed<br>Anticipated Completion FY 2024 | Unknown | Unknown | Unknown | N/A |
| **Seeking Safety/Seeking Strength Program (EBRR)** | Preliminary Evaluation Completed<br>Anticipated Completion FY 2024 | Unknown | **Ineffective** | Unknown | Very Comparable |

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| **Cognitive Processing Therapy Program (EBRR)** | Evaluation Planned for FY 2026* | Unknown | Unknown | Unknown | N/A |
| **Dialectical Behavior Therapy Program (EBRR)** | Evaluation Planned for FY 2026* | Unknown | **Promising** | Unknown | Very Comparable |
| **ACCESS Program (PA)** | No Evaluation Planned | Unknown | Unknown | Unknown | N/A |
| **Beyond Violence Program (PA)** | No Evaluation Planned | Unknown | Unknown | **Not Promising: 1 study no effects on recidivism or post-release substance use relapse** | Very Comparable |
| **Pu'a Foundation Reentry Program (PA)** | No Evaluation Planned | Unknown | Unknown | Unknown | N/A |

*Per conversations with the BOP's ORE staff, we understand these two Resolve Program components are not included in the current research effort.

# APPENDICES

| Table 6A: Summary of Meta-Analyses and Systematic Reviews of the Effectiveness of Prison-Based Trauma Programs | | | | | |
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| **Study (Year)** | **Program Type** | **Review Period** | **Review Criteria** | **Number of Studies** | **Key Findings** |
| **1) Malik et al. (2021)**<br><br>Systematic Review and Meta-Analysis | Trauma-focused interventions in prison settings | 2000-2020<br><br>All of the studies fell within our review period. | Level 2 or higher, included both adult and juvenile populations; 3 studies rated strong, 6 studies moderate, and 7 studies weak | 16 studies:<br><br>11 studies were phase 1 interventions, & 5 included phase 2 trauma processing components.<br>14 studies examined group therapies.<br>14 studies used adult and 2 studies used juvenile samples | Small but significant overall effect size for trauma-focused interventions in reducing PTSD and other trauma-related symptoms, relative to control group comparisons.<br><br>Individual trauma therapies were found to be significantly more effective at reducing trauma-related symptoms compared to group interventions.<br><br>Phase 1 stabilization interventions were effective in reducing trauma symptoms, but stronger effects noted in phase 2 trauma processing interventions, based on cognitive processing therapy, NICE-recommended trauma-focused CBT, trauma incident reduction, or expressive trauma-based writing exercises, were more effective. |
| **2) Tripodi et al. (2011)**<br><br>Systematic Review | Interventions for incarcerated women, including risk reduction studies (using TC for substance abuse) that look at recidivism outcomes, and enhancement studies (using group-based CBT) that focus on psychological and physical well-being. | 1988-2008<br><br>Only 5 studies conducted post-2000 reported trauma-related outcomes. | Level 1 or above studies. Studies including both women and men in sample were included only if separate results for women were reported. | 24 studies:<br>8 RCTs, 7 quasi-experiments, 9 used one-group pretest-post-test designs.<br>6 risk reduction model studies<br>18 enhancement model studies<br>2 had outcomes for both risk reduction and enhancement. | 9 studies included in this meta-analysis examined psychological well-being outcomes for females (6 RCTs and 3 quasi-experiments). Moderate effect sizes noted.<br><br>Authors reported that “overall, our systematic review showed that women who participate in correctional-based interventions tend to improve their psychological well-being as compared to women who did not participate in such programs.” (25)<br><br>In terms of recidivism reduction, they found that “the three studies with the largest demonstrated reduction in recidivism were evaluations of prison-wide therapeutic community programs designed to reduce substance abuse.” (27) |
| **3) Givens et al. (2021)**<br><br>Systematic Review | Prison-based interventions for early adults (age 15-35) with mental health needs. Multiple interventions | 1970-2019<br><br>Only 1 study prior to 2000. | National Institute of Health Study Quality Assessment tool | 18 studies:<br>6 RCTs<br>7 quasi-experiments, and 5 studies conducted 1 group | Overall positive results reported in most studies (12/18) included in this review. 12 studies found significant improvements for the treatment group compared to the control group in depression or depressive symptoms, PTSD, bipolar symptoms, health-related markers, and self-esteem. 7 of these studies examined trauma- |

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| | including 2 studies of Seeking Safety, 2 studies of biblio-therapy, and 2 studies of the Texas Implementation of Medication Algorithm, and several other interventions with 1 evaluation (621).<br>Most interventions were group-based (621), but 5 were administered individually. | Note: 10 studies drew samples from adult prisons, 3 studies drew samples from adult jails, and 6 studies drew samples from youth correctional facilities. | ranked 3 studies as good, 12 as fair, and 3 as poor. | pre-post assessments of the interventions | focused interventions; none of these studies examined post-program impact on recidivism post-release.<br><br>The 2 Seeking Safety program evaluations reported overall improvements in trauma-related outcomes; but one study (Zlotnick et al., 2009) found no significant differences between treatment and control groups.<br><br>Limitations: There were significant differences in intervention program models, intervention types (group, individual, blended, milieu), and outcome measures. In addition, sample size was very small for most studies, with only 3 studies with sample sizes over 60.<br><br>Due to these limitations, no conclusions can be reached about the impact of these multiple programs on the various trauma-related outcomes measured. |

| Table 6B: An Overview of Prison-Based Trauma Programs Evaluation Research (2000-2022) | | | | |
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| **Author(s)** | **Program Under Review (Jurisdiction)** | **Research Design & Sample Size** | **Quality Ranking: Low (1) – High (5)** | **Key Findings** |
| **1) Ford et al. (2013)** | TARGET program<br><br>"A group psychotherapy designed to enhance affect regulation without trauma memory processing—Trauma Affect Regulation: Guide for Education and Therapy (TARGET)—was compared to a supportive group therapy (SGT) in a randomized clinical trial with 72 incarcerated women with full or partial PTSD." (262)<br><br>(York Correctional Institution in Connecticut) | Randomized Control Trial (RCT):<br><br>"Randomized Control Trial with two groups (72 participants total). To achieve a randomized design, participants were placed in cohorts of N= 10–12 as they enrolled in the study, and cohorts were randomly assigned to first receive one of the two group therapies. After completing the assigned group therapy, participants in each cohort were re-tested for the posttreatment assessment, and then provided the other group therapy. Posttreatment data collected following the first type of group therapy that each participant received are reported in order to avoid a confounding of the effects of the two therapies. Participants were informed during the consent process that they would receive two group therapies believed to be helpful for women coping with stress, with a 50-50 chance of receiving either type of group therapy first." (264) | **5** - "Of 197 women screened, 80 were eligible and randomized (by a study assessor with numbers concealed in sealed envelopes prepared by another study staff who used an Excel random number generator)." (265) 38 participants received the TARGET therapy first, 32 participants went through SGT therapy first. Results were compared after the first therapy was completed. | "Dropout rates were very low (5%) compared to those reported in prior studies of group therapy with incarcerated women (approximately 33%). However, full remission from PTSD occurred for only 12% to 23% of participants. The reduction, on average, in CAPS PTSD severity was comparable to that reported by Zlotnick and colleagues (2009), i.e., approximately 12 to 13 points, but only half the amount of improvement reported in studies of TARGET as a one-to-one therapy for women and girls." (271)<br><br>"TARGET did not achieve greater improvement in affect regulation than SGT. The small increase in Negative Mood Regulation (NMR) scores achieved on average by TARGET recipients suggest that the gains in affect regulation from brief group therapy may not be sufficient to reverse the trend of worsening affect dysregulation that has been documented among incarcerated women over time." (271)<br><br>"TARGET participants' increase in sense of forgiveness (while SGT participants reported a decrease). This finding suggests that a therapeutic focus on affect regulation may provide a basis for incarcerated women with PTSD to achieve a greater sense of emotional resolution in relation to past victimization or betrayal." (271) |

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| **2) Nidich et al. (2016)** | Transcendental Meditation ™ program<br><br>This study investigates "the effects of the transcendental meditation (TM) program on total trauma symptoms, anxiety, depression, dissociation, sleep disturbance, and perceived stress in a population of incarcerated individuals with a moderate- to high-risk criminal profile." (1)<br><br>It "is the first known published study to evaluate the effects of the TM program on trauma symptoms in prison inmates." (1)<br><br>(Two facilities for males in Oregon, one medium security and one maximum security) | Randomized control trial (RCT):<br><br>"The treatment group was taught the TM technique in a standard 7-step course (during 5 sessions lasting approximately 1 hour per session). They were then encouraged to practice this stress reduction technique for 20 minutes twice a day, once in the morning and once in the late afternoon. Two certified TM teachers who had more than 10 years of teaching experience were the instructors for this study. Subjects in the control group continued with their daily schedule and did not participate in the TM program. All subjects in both groups continued to receive their usual care." (2) | **5** - Well-designed RCT. Of 181 participants initially randomly assigned, 144 were ultimately included in the analyses with essentially equivalent *n*'s. | "Significant reductions in total trauma ($F[1, 141] = 19.73$, $p < 0.001$), as well as the dissociation ($F[1, 141] = 18.21$, $p < 0.001$), depression ($F[1, 141] = 13.32$, $p < 0.001$), anxiety ($F[1, 141] = 14.23$, $p < 0.001$), and sleep disturbance subscales ($F[1, 141] = 21.61$, $p < 0.001$) on the TSC, and perceived stress ($F(1, 140) = 27.09$, $p < 0.001$) were observed in the TM group compared with controls. Effect sizes were mostly in the moderate to large range, with depression and anxiety subscales = 0.50 and the Perceived Stress Scale= 0.75, relative to a usual-care control group." (4-5)<br><br>"Results for the high-trauma symptoms subgroup indicated that the TM program might be particularly efficacious for those with higher levels of trauma symptoms." (5) |
| **3) Wolf et al. (2015)** | Seeking Safety program<br><br>"A controlled trial of Seeking Safety (SS) and Male-Trauma Recovery Empowerment Model (MTREM) examined implementation and effectiveness of integrated group therapy for | Randomized Control Trial:<br><br>Participants "were assigned randomly to either random assignment (n = 142) or preference assignment (n = 88) to receive SS or MTREM, with a waitlist group of (n = 93). Manualized interventions were group-administered for 14- | **5 -** Overall a well-designed RCT. "There were no significant differences in the age, years incarcerated, and veteran status characteristics between the eligible and declined participation groups, although the eligible group, compared to the decliner group, was more likely to | As one of the first studies to implement and test a group cognitive–behavioral integrated treatment for PTSD and addiction problems in a male prison population, the feasibility evidence is strong. "Study results modestly support the effectiveness of SS and M-TREM for incarcerated males. In terms of absolute effectiveness (waitlist comparison), participants receiving integrated treatment (SS or M-TREM) showed statistically and clinically significant improvement in PTSD symptom severity over time, although the difference in |

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| | comorbid post-traumatic stress disorder (PTSD) and substance use disorder (SUD) on PTSD and mental health symptoms plus self-esteem and efficacy" (66)<br><br>(A high security prison for males in Pennsylvania) | weeks. The waitlist design controls for threats to internal validity; the waitlist group includes subjects who were eligible for treatment assignment but participated only in study assessments for the 3 months, while the treatment group is assigned to a 3-month intervention (SS or M-TREM). The comparison group trial uses random and preference assignment to SS and M-TREM to test for measurable differences in primary and secondary outcomes post-intervention and at 3-and 6-month follow-up. Intent-to-treat and completer analyses are conducted, as well as analyses that controlled for the nesting of data within individuals and interventions." (72) | include African Americans (52% vs. 36%, $p < 0.05$) and violent offenders (56% vs. 43%, $p < 0.05$), and less likely to include drug offenders (14% vs. 25%, $p < 0.05$) and without a high school or GED (18% vs. 28%, $p < 0.05$). Those who declined mentioned several reasons for not participating including not being ready to address trauma issues, not needing treatment, expecting to be released or transferred, or scheduling conflicts with other required programs." (72) | improvements was not statistically significant compared to the waitlist group (controlling for baseline differences) and the effect size was small. When treatment was disaggregated by intervention type, the effect of M-TREM on PTSD severity was double that found for SS (regression coefficient −8.36 vs. −3.87) and significantly different from the waitlist group. SS was found to outperform no treatment on three outcomes: mental health symptoms, self-esteem, and proactive coping." (78) |
| **4) Barrett et al. (2015)** | Seeking Safety program<br><br>This study examines the efficacy of implementing partial-dose (eight-session) Seeking Safety (SS) among males.<br><br>(Australia Prison) | Randomized Control Trial (RCT):<br><br>A randomized controlled trial was conducted in which male prisoners were allocated to receive either SS plus treatment-as-usual (TAU) or TAU alone. Randomization was stratified by correctional center and was performed face-to-face via an envelope selection task and occurred prior to the baseline assessment (1:1). "Fifteen participants were | **4 -** RCT design, with one experimental group that received SS plus TAU, and one group receiving TAU alone. Relatively small sample size (15 participants in each group). | "The SS group increased confidence ratings in their ability to resist substance use in future situations, with an increase from 70% at baseline to 91% at six-month follow-up. The confidence rating for the TAU group, on the other hand, remained relatively stable over time (76% at baseline and 79% at six-month follow-up.)" (50)<br><br>"Both study groups appear to show reductions in PTSD diagnosis and PTSD symptom severity at eight-week and six-month follow-ups. Similarly, evidence indicates that both groups evidenced reductions in PTSD-related cognitions over the study period." (50) |

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| | | randomized to receive Seeking Safety, and 15 randomized to receive TAU." (47) | | |
| **5) Kubiak et al. (2016)** | Beyond Violence (BV) program<br><br>Assessment of Beyond Violence (BV) — a 20-session curriculum-based intervention for women. The program "has a core goal of preventing recidivism and further violent behavior by women who have already engaged in violence; it also aims to improve women's mental health and anger expression and reduce substance use." (663)<br><br>(Female-prison in a midwestern state) | Randomized Control Trial:<br><br>"At the point of prison treatment, a randomized control trial was designed, assigning women to receive one of two treatments in 1:1 ratio. Randomization selection criteria for the intervention study included conviction of a violent offense, substance abuse dependency or positive drug screen during incarceration, no serious mental health issue that specifically involved housing on the mental health unit, and eligibility for release on parole within 18 to 24 months." (664-5)<br><br>"Data were extracted from parole officer case notes and a state-level department of corrections database." (666) | **4 -** RCT design, relatively small sample size. "35 women were included in the analysis, with the independent variable being treatment condition (TAU *n* =16; BV *n* = 19). Of the women involved in this study, there were no differences in measures of mental health (i.e., depression, anxiety, PTSD) at pretest. All of the women in the BV condition completed the treatment intervention (defined as 75% or more of the sessions), but 5 of the women in the TAU condition did not complete treatment. However, women in the TAU condition attended a significantly greater number of sessions, irrespective of their completion status (TAU 33.75 vs. BV 18.47; *t* = 4.57, *p* < .001)." (665-6) | The study "found no differences between the treatment groups on demographic characteristics of age at offense (M= 30.26, SD = 9.17), age at time of treatment (M = 33.66, SD = 8.91) or race (46% White, 54% African American). Although all women had a current or previous offense categorized as an assaultive felony, there was a greater period of time between prison treatment admission and release onto parole status for women in the BV condition as compared to the TAU (562 days vs. 378 days; *t* = 2.88, *p* =.007)." (667)<br><br>"In terms of recidivism, no woman from either condition returned to prison during the 12-month study period, which suggests that none of the women in the sample committed any serious offense or parole violation. When using arrest as an outcome, 11% (*n* = 2) of BV women and 38% (*n* = 6) of TAU women had evidence of a new arrest (*x2* = 3.58; *p* = .06)." (667)<br><br>"There were no significant differences between groups on any of the variables associated with relapse. Of the 34 women, 13 had at least one positive drug screen during the 12-month post incarceration period; 5 (26%) were from the BV condition, and 8 (50%) were from the TAU group (*x2* = 2.09; *p* =.15)." (669) |
| **6) Mahoney et al. (2020)** | Survive and Thrive (S&T) Psychoeducation program<br><br>This study "investigated the efficacy of a pure psychoeducational intervention for complex trauma. A brief 10-session | Randomized Control Trial (RCT).<br><br>"The study design utilized a control WL/TAU comparator group. Existing psychotherapeutic and pharmacological treatments (i.e., 'usual care') did not | **4 -** RCT design with some limitations due to exclusion of 38% (53/139) of initially eligible cases, leading to significantly smaller *n*'s of program completers in both groups and participants who | "There were few statistically significant differences across the majority of measures in the analyses. Small, non-statistically significant symptom increases for the S&T group were evident for behavioral stability. The behavioral stability total score indicated that the symptom increase was predominantly observed between T1 (M = 69.94, SD = 23.72) and T2 (M = 73.18, SD = 19.84). There were however no statistically |

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| | intervention was delivered to n = 44 female prisoners in a compressed format to accommodate short sentence lengths and was compared with usual care (n = 42).” (597)<br><br>“Survive & Thrive (S&T) is a brief psychoeducational group-based intervention for the stabilization of symptoms associated with complex interpersonal trauma such as childhood sexual abuse (CSA)” (598).<br><br>(Two high-security female prisons in Scotland) | constitute a standardized intervention for interpersonal trauma. S&T is a manualized psychoeducational intervention of 8–10 sessions. Each session focused on a separate symptom or rehabilitative concern often attributed to the distress caused by interpersonal trauma.” (599)<br><br>The S&T experimental group had 44 participants; TAU had 42 participants. | provided data at multiple collection phases. | significant differences between the groups, and results indicated a wide variance in participant's outcomes, β = 2.99, 95% CI [−10.97, 16.96], p = .668.” (603)<br><br>“As an intervention designed to ameliorate PTSD symptoms, S&T did not produce statistically or clinically significant levels of change compared with a WL/TAU control group. As a psychoeducational intervention, S&T's limited impact on trauma symptomatology was expected. However, as an intervention designed to stabilize symptoms, there are concerns about how effective this intervention might be in a prison setting.” (606) |
| **7) Tripodi et al. (2019)** | Seeking Safety program<br><br>This study examined the effectiveness of Seeking Safety (SS) with incarcerated women who completed the intervention in medium/maximum security prison.<br><br>(North Carolina) | Randomized Control Trial:<br><br>“This study employed an RCT design with an intended treatment-to-control allocation of 1:1 in order to meet the specific aims and test the hypotheses. A certified Seeking Safety facilitator delivered the intervention to the treatment group (two groups of Seeking Safety), and the control group did not receive Seeking Safety but continued treatment as usual (TAU). TAU programming included residential substance abuse, psychological services, mindful meditation, group | **4 -** RCT design, with 2 separate experimental groups and one control group. Relatively small sample size: four-month follow-up analyses included 29 total subjects (13 experimental group participants and 16 control group participants). Observed differences between groups despite random assignment possibly a function of the low *n*. | Depression: “There was a statistically significant difference in pretest depression scores between the treatment group (M = 27.67, SD = 10.75) and the control group (M = 35.78, SD = 11.32) conditions, *t* = 2.10, *p* = .044. Both groups’ depression scores improved from pretest to posttest and from pretest to follow-up. The treatment group’s depression scores improved by 10.14 points from pretest to posttest and by 11.82 points from pretest to follow-up, whereas the control group’s scores improved by 6.72 points from pretest to posttest and by 8.46 points from pretest to follow-up.” (285)<br><br>PTSD: “There was not a statistically significant difference in pretest PTSD scores between the treatment group (M = 53.87, SD = 14.95) and the control group (M = 59.83, SD = 15.04) conditions, *t* = 1.14, *p* = .264. Both groups reduced their PTSD scores from pretest to posttest and from pretest to follow-up. The treatment group improved their PTSD scores by 19.54 points from pretest |

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| | | intervention, and/or anger management." (282) | | to posttest and by 23.41 points from pretest to follow-up, whereas the control group improved their scores by 13.66 points from pretest to posttest and by 18.02 points from pretest to follow-up." (286) |
| **8) Valentine & Smith (2001)** | Traumatic Incident Recovery (TIR) program<br><br>Study examines "the effectiveness of traumatic incident reduction (TIR). It is a brief, memory-based, therapeutic intervention and was used to treat symptoms of post-traumatic stress disorder (PTSD), depression, anxiety, and low expectancy of success (i.e., low self-efficacy)" (40).<br><br>(BOP institution in Florida that housed low- to medium security females) | Randomized Control Trial (RCT). "The study used a true experimental design with a pretest-posttest control condition and a 3-month follow-up. One hundred and twenty-three people met the criteria for inclusion in the study and were randomly assigned either to a treatment or a control condition. In the experimental condition, 56 individuals were pretested, received TIR, and were post-tested a week after treatment. In the control condition, the remaining 67 individuals were pretested and post-tested but did not receive TIR treatment during the study period." (44) | **4 -** Small sample RCT with relatively low mortality. Study had "exclusion criteria represented acute situations that would be counterproductive to the process of TIR" (44), indicating the treatment may have efficacy for a specific type of individual only. Study used "four measures comprised a multidimensional measurement battery of PTSD." (45) | "The efficacy of TIR in alleviating PTSD, depression, anxiety, and low expectancy of success received support from this study: Statistically significant results were observed on all measures at both posttest and follow-up measurement periods except for the Intrusion subscale of the PTSD Symptom Scale at the posttest interval. However, differences were found at the follow-up testing interval. It appears that the control group's scores remained stable across all three testing periods, whereas the treatment condition's scores decreased steadily." (49)<br><br>"The treatment condition inmates scored higher on the pretest than did the control condition inmates. The treatment condition inmates' decrease continued over time, and the control condition's mild decrease stabilized." (50) |
| **9) Zlotnick et al. (2009)** | Seeking Safety (SS) Therapeutic Community treatment program for women with substance use disorder and PTSD<br><br>(Rhode Island prison) | Randomized Control Trial (RCT):<br><br>27 women in the TC were compared to 22 women in the treatment as usual (TAU) comparison group. Analyses included 23 of 27 experimental group and all 21 of 22 controls.<br><br>Seeking Safety (SS) program description: "SS was conducted in group modality for 90 min, typically three times a week for | **4 -** RCT with limitations, such as small sample size and lack of post-program data. Researchers noted the following: "Study limitations include lack of assessment of SS outcomes at end of group treatment; lack of blind assessment; omission of the SS case management component; and possible contamination between the two conditions." ( 325) | No difference between groups. Researchers noted: "The consistent pattern was that women in both SS and TAU improved significantly from intake to each subsequent time point (12 weeks, 3- and 6-month follow-ups) on each category of measurement (e.g., PTSD, substance use, psychopathology)." ( 331)<br><br>"Six months after release from prison, 53% of the women in both conditions reported a remission in PTSD." (325) |

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| | | 6 to 8 weeks while the women were in prison, with three to five women per group. After release from prison, each woman in SS was offered weekly individual 60-min "booster" sessions for 12 weeks to reinforce material from the group sessions." (328) | | |
| **10) Bradley & Follingstad (2003)** | Dialectical Behavior Therapy (DBT) program<br><br>"This study evaluated effectiveness of group therapy for incarcerated women with histories of childhood sexual and/or physical abuse. The intervention was based on a two-stage model of trauma treatment and included Dialectical Behavior Therapy skills and writing assignments." (337)<br><br>"Participants were selected from a larger sample of 165 incarcerated women in a medium security prison in a southeastern state." (338) | Randomized Control Trial (RCT):<br><br>Participants were randomly assigned to treatment or no-contact comparison groups. "Group sessions were 2.5 hr. Nine treatment sessions focused on education about interpersonal victimization and affect regulation (e.g., identifying and naming emotions and precipitating factors; using breathing exercises to decrease distress). The skills were based on Linehan's Dialectical Behavior Therapy (DBT) model (Linehan, 1993) and one of the leaders for each group had completed a 40-hr DBT training. Nine sessions focused on structured writing assignments. The writing assignments asked women to describe specific times in their lives (e.g., write about your childhood) and included specific prompts (e.g., write about relationships in your family; write about some | **3 -** RCT design, hampered by small sample size. "Of 24 women initially assigned to the treatment condition; four were paroled or sent to another facility prior to completing the group, two dropped out after the first session, and the rest dropped out after completing the first (n = 3) or second (n = 2) of the sessions focused on writing assignments. Of the 13 women who completed the group, 12 attended at least 15 of the 18 sessions. One participant attended 10 of the 18 We assigned 25 women to the comparison condition. Five were paroled or sent to another facility and two dropped out." (338) | Dependent variables in the study were (BDI, Beck Depression Inventory; IIP, Inventory of Interpersonal Problems; TSI, Trauma Symptom Inventory).<br><br>"A repeated measures MANOVA yielded a significant overall Group x Time interaction, Wilk's A = 0.41, $F(9,21) = 3.40$, $p < .01$. Follow-up repeated measures ANOVAs indicated significant interactions on all dependent variables except the TSI Defensive Avoidance scale. The average pre-post effect sizes for the treatment group were in the moderate-to-large range whereas those for the comparison group were in the average-to-small range." (339)<br><br>Results "provide some support for the effectiveness of a treatment combining psychosocial skills and writing. There were clinically significant decreases in depression (from severely to mildly depressed as measured by the BDI)." (339) |

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| | | of the best and worst things that happened to you growing up).” (338) | | |
| **11) Lynch et al. (2012)** | Seeking Safety program<br><br>“Seeking Safety (SS) is an empirically supported cognitive behavioral manualized treatment for individuals with PTSD and substance use disorders.” (88)<br><br>This study examined the effectiveness of SS with incarcerated women who completed the intervention in an<br><br>(Unidentified prison) | Quasi-experimental research design:<br><br>Program participants (n= 114) were divided into two groups: those who participated in the program (n=59) and a group that was waitlisted (n=55). SS groups met twice weekly, 2 hrs. per session, for approximately 12 weeks. | **3 -** “After an initial interview, participants were assigned to the treatment or waitlist condition on the basis of anticipated release or transfer dates. This method of assignment was chosen because the prison administration could not support keeping all participants (treatment and waitlist) for the 24 weeks necessary to offer waitlist and treatment via random assignment; thus, prison staff ultimately determined which individuals would receive treatment immediately or after a waitlist period based on estimated release/transfer dates.” (93) | Participants in both conditions demonstrated improvements in PTSD symptoms. “However, offenders who participated in SS appear to have benefited significantly more than the waitlisted individuals given their decreased symptoms of depression, improved interpersonal functioning, and decreased maladaptive coping.” (98)<br><br>“Although the treatment gains from the time-limited SS intervention are modest, given the extent of trauma exposure and distress reported by these study participants, these results are promising and suggest the need for further assessment.” (98) |
| **12) Swopes et al. (2017)** | HWR/BT program<br><br>“The present study evaluated an integrated treatment program, Helping Women Recover/Beyond Trauma (HWR/BT), supplemented with additional modules on domestic violence, relapse prevention, and a 12-step program.” (1143) | Quasi-Experimental Research Design:<br><br>“The HWR/BT combined treatment program was compared with a matched comparison sample that did not receive the target treatment. Self-report measures were collected from 95 incarcerated women, with 56 women in the completer sample. Women in the treatment condition | **3 -** Non-equivalent groups design, with inclusion criteria pre-determined by the prison clinical staff for selection into the treatment group and adopted in the study for compiling the matched comparison sample. | “The hypotheses were largely unsupported, in that of the seven dependent variables, only posttraumatic cognitions showed significant between-group decreases. PTSD symptoms and substance-related self-efficacy demonstrated pre–post, but not between group differences. The present findings are consistent with many previous studies of integrated trauma-focused treatments for PTSD-SUD that have failed to find a unique advantage over comparison groups.” (1157)<br><br>Further, “no pre–post or between-group differences were found for depression, anxious arousal, dissociation, or tension reduction.” (1159) |

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| | (Minimum Security Correctional Facility in the Midwest) | attended a 4-month group treatment." (1143)<br><br>"At completion of the study, fidelity checklists indicated that 100% of the required activities were completed across all cohorts and treatment groups for the HWR/BT components." (1149) | | |
| **13) Cole et al. (2007)** | Trauma Treatment program<br><br>This research "evaluates the efficacy of a time-limited, trauma-focused group intervention with a group of recently incarcerated women volunteers who had experienced childhood sexual assault (CSA)." (97-8)<br><br>Program met bi-weekly for 2.5 hours for a total of 8 weeks.<br><br>(Secure Washington state facility) | Randomized Control Trial (RCT):<br><br>Researchers "developed and implemented a 16-session trauma focused group intervention with recently incarcerated women who volunteered to participate. It was hypothesized that this brief group intervention would reduce trauma-related symptomatology when compared to a wait-list control group. Two trauma-specific and one general measure were administered pre and post treatment. A randomly selected wait-list control group was given the same measures, and then also offered the treatments after the initial treatment group went through post-tests." (105) | **2 -** Weak research design – even though randomization was present, due to constraints of time and available participants, resulting *n*'s for both the experimental and control groups were only 5 and 4, respectively.<br><br>Note: Study authors acknowledge that the sample size is not large enough to draw strongly generalizable conclusions, and results should be considered preliminary. | **"**Decreases were found in the mean Trauma Content Inventory scores from the pre- to the post-treatment measure for the experimental group only (Exp. Group = .29 to .07; Control group = .27 to .28). There were no apparent changes from pre- to post-treatment on the Trauma Symptom Inventory. In addition, comparisons between the treatment and the control group also suggest no differences." (113)<br><br>"Although there were few apparent changes due to treatment found in this study, results did indicate that the 16-session treatment modality utilized may have prevented the exacerbation of symptomatology among participants in the treatment group." (113-4) |
| **14) Heath (2009)** | Seeking Safety program | Quasi-experimental Design: 46 women were placed in the treatment group were | **2** - weak research design employed with matching on a small number of variables | No overall difference between the treatment and control group. For both groups, **"**Women in this sample |

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| | Women with PTSD and substance use problems were placed in twice weekly groups, 2 hours per session, for approximately 10-12 weeks. (42)<br><br>"Seeking Safety is a cognitive-behavioral, manualized treatment which is conceptually based on the goals of safety in stage one of Herman's (1992b) model. Thus, it attempts to establish safety via several means (e.g., managing substance use triggers, controlling self-harm behaviors, and managing strong affect." (15)<br><br>(Idaho Correctional Institution) | compared to 44 who were placed on the waitlist.<br>No details were provided on the comparability of these two groups.<br><br>Note: "All participants in this study endorsed a trauma history prior to incarceration and the vast majority, 95.6%, specifically reported histories of interpersonal violence." (45) | (PTSD symptom level, emotion regulation, and self-efficacy) to assess whether comparison group was like the treatment group in terms of mental health. The authors noted that "the treatment and waitlisted conditions may have varied on some variables which were not assessed by this study." (57)<br><br>Additionally, it was unclear exactly what criteria were used to select participants and separate out these two groups. | reported significant decreases in PTSD symptoms from pre- to post-treatment." (56)<br><br>"Results suggest significant decreases in PTSD from pre- to post-treatment and significant increases in self-efficacy and emotion regulation skills. However, these changes do not appear to be superior to waitlist." (xi) |
| **15) Karlsson et al. (2022)** | SHARE program<br><br>"Survivors Healing from Abuse: Recovery through Exposure (SHARE) is a brief, exposure-based group treatment for incarcerated female survivors of sexual violence" (534). | Women from 27 different SHARE groups (average 4.96 women per group) were recruited. A total of 57 women had at least two data points (pre-test, post-test, and/or follow-up) and were included in the study's analytic sample. No comparison group was used. | **1 -** one-group pre-post comparisons on selected outcomes; No control or comparison group. No information if program completers/those who provided information during multiple data collection waves differed from those who did not. | PTSD: "Results from a one-way repeated-measures ANOVA indicated a significant effect of time on PTSD symptom severity ($p < .001$) with a large effect size (partial $\eta 2 = 0.78$). Bonferroni pairwise comparisons showed significant reductions in PTSD symptom severity from pre- to posttreatment ($p < .001$), pretreatment to follow-up ($p < .001$), and posttreatment to follow-up ($p = .001$)." (537-8)<br><br>Depression: "Results from a one-way repeated-measures ANOVA also indicated a significant impact of time on depressive symptom severity ($p < .001$) with a large |

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| | (minimum security Mid-Southern State prison) | | | effect size (partial η2 = 0.75). Bonferroni pairwise comparisons showed significant reductions in depressive symptom severity from pre- to posttreatment (p < .001), pretreatment to follow-up (p < .001), and posttreatment to follow-up (p = .012)." (538) |
| **16) Black et al. (2013)** | Evaluation of a manual-based group treatment for persons with borderline personality disorder (BPD) -- Systems Training for Emotional Predictability and Problem Solving (STEPPS). (124)<br><br>(Men and Women in the Iowa DOC) | Open trial design, pre- post-comparison with no control/comparison group. Seventy-seven subjects were gauged using self-report assessments included the Borderline Evaluation of Severity Over Time (BEST) to assess thoughts, feelings, and behaviors associated with BPD; the Beck Depression Inventory (BDI) and the Positive and Negative Affect Schedule (PANAS) to assess positive and negative dispositions.<br><br>Note: While the research team developed guided the methodology, the program was administrated, and data were collected by, prison staff. | **1 -** "STEPPS is a group treatment program for persons with BPD that combines cognitive behavioral elements with skills training but does not involve individual therapy. The program consists of 20 two-hour weekly sessions with therapists who follow detailed lesson plans. (We generally recommend having two co-therapists.) Key elements include psychoeducation about BPD, emotion management skills training, and behavior management skills training. A systems component is unique to the program. For the prison setting, this involved one-time 2-hour evening sessions for system members. In addition to family members and friends, corrections officers and other staff members are in attendance. These individuals are educated about BPD and how best to respond to their relative or friend or an | "STEPPS produces clinically significant improvement in male and female offenders with BPD. The participants experienced improvements in BPD-related symptoms, mood, and negative affectivity. Importantly, the data show a significant reduction in the number of suicide/self-harm behaviors and disciplinary infractions occurring in prison. Thus, the benefit of STEPPS seems to extend beyond subjective experience, and the program may help correct an individual's behavior. The magnitude of change is consistent with what has been reported for STEPPS programs conducted in the community in the United States, United Kingdom, and Holland." (127)<br><br>"The data show that STEPPS can be successfully transported to the correctional setting ''as is'' and without modification." (128) |

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| | | | offender with the disorder." (125-6) | |
| **17) Black et al. (2008)** | An uncontrolled pilot study of a manual-based group treatment for women with borderline personality disorder (BPD) -- Systems Training for Emotional Predictability and Problem Solving (STEPPS).<br><br>(Mt. Pleasant Correctional Facility in Mt. Pleasant, Iowa, a medium-security facility). | Open trial pilot study, pre- post-comparison with no control/comparison group. Twelve subjects were gauged using self-report assessments included the Borderline Evaluation of Severity Over Time (BEST) to assess thoughts, feelings, and behaviors associated with BPD; the Beck Depression Inventory (BDI) and the Positive and Negative Affect Schedule (PANAS) to assess positive and negative dispositions. | **1 -** "STEPPS is a manual-based group-treatment program for persons with BPD that combines cognitive-behavioral elements with skills training but does not include individual therapy. The program consists of 20 2-hour weekly sessions with facilitators who follow detailed lesson plans. The program involves psychoeducation about BPD, emotion-management skills training, and behavior-management skills training. The first component teaches subjects to replace misconceptions about BPD with an awareness of the thoughts, feelings, and behaviors that define it, and to identify their own schemas (i.e., cognitive filters) that drive their behaviors. The second component teaches skills to better manage the cognitive and emotional effects of BPD: distancing, communicating, challenging, distracting, and problem management. The third component teaches behavioral skills that subjects are encouraged to master: | **"**The women who participated in the STEPPS program experienced significant and clinically meaningful improvement across a spectrum of illness-specific measures, in their negative affectivity, and in their mood. These results are encouraging because they suggest that a relatively brief adjunctive program for BPD can deliver "real world" benefit to offenders and improve quality of life. The effect sizes reported herein are simi lar in magnitude to those reported in our RCT.[28] This project also shows that STEPPS can be successfully implemented in a prison setting without modifying the existing manual, and that incarceration is not a barrier to improvement." (885)<br><br>"The STEPPS program helped subjects to better understand their BPD and taught them new skills to better manage their disorder. Of course, the program may have provided social support, hope and therapeutic alliance, factors common to most forms of therapy. The results also suggest that the women were less likely to feel hopeless and helpless or to have negative self-impressions. These changes reflect the emphasis of the program on instructing subjects to self-regulate their intense emotions and maladaptive behaviors. The women also had high levels of satisfaction with the program." (885) |

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| | | | goal setting, healthy eating behaviors, sleep hygiene, regular exercise, leisure activities, health monitoring (e.g., medication adherence), avoiding self-harm, and interpersonal effectiveness." (883) | |
| **Office of Research and Evaluation (2023)** | Resolve Treatment Program (RTP) - only Trauma Education and Seeking Safety/Seeking Strength components.<br><br>(Federal Bureau of Prisons) | 897 women who completed the program during the reference period of 2014-2019.<br><br>A retrospective evaluation of the effects of program participation on behavioral outcomes. Modeling approaches in the study resulted in a large number of subjects being excluded from aspects of the study (ranging from excluding 488-830 subjects).<br><br>Subjects had to meet observation criteria for 365 days pre- and post-program participation.<br><br>Outcome measures: misconduct, Major Psychology Services Events (MPSEs) (e.g., crisis intervention, disruptive behavior, suicide risk assessments), restrictive housing placements. | **1 -** "The first set of models utilized conditional logistic regression to determine if there was a change in the probability of any of the outcome measures during the post treatment risk period. The second round of modeling used conditional Poisson models to determine the extent to which change in the number of events in the outcome measures from pre to post program." (2)<br><br>Limitations: methodological approach, large number of excluded subjects, lack of access to clinical outcome measures. | "Overall, the results from the fixed effects analysis showed support for the impact of the RTP on post program behaviors of those who completed treatment." (2)<br><br>For misconduct: "…we found a 10.4% decrease on average from pre to post program misconduct events. However, this was not statistically significant, and we cannot conclude there was a difference between risk periods. The same held true for the probability model: Although the direction of the estimated coefficient was in the expected direction (decrease), it was not statistically significant." (2)<br><br>For restricted housing placements: "The estimated coefficient from the count model was in the expected direction and statistically significant, indicating suggesting that the number of restrictive housing days decreased over the observation periods. The estimated coefficient [in] the conditional logistic model was also significant, indicating that the odds of being placed in SHU decreased 28.7% from the pre risk period to the post risk period." (2-3)<br><br>For MPSEs: "The estimated coefficient for the number of MPSE was in the expected direction (decrease) but was not statistically significant. As with the conditional logistic model for SHU, the same analysis for MPSE showed a statistically significant decrease in the odds of |

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| | | | | an MPSE event from the pre risk to the post risk period. Specifically there was a 54.3% reduction in the odds of an MPSE event in the post risk period compared to the pre risk period.” (3) |