



STUDY PROTOCOL PAPER FOR

# The Multisite Randomized Controlled Trial of Comprehensive Trauma Informed Reentry Services

FOR MODERATE TO HIGH-RISK YOUNG MALES  
RELEASING FROM STATE PRISONS

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## **Abstract**

**Introduction:** Nearly half of the individuals who release from state prisons each year are under the age of 35; 89% are men. These young men are highly likely to be re-incarcerated. Research suggests untreated trauma symptoms contribute to high rates of incarceration and re-incarceration. As trauma symptomatology can increase during reentry, implementing trauma treatment during this time is critical. The current study fills an important gap by implementing an evidence-driven trauma intervention with young, incarcerated men and extending treatment post-release in the community.

**Methods** This study evaluates the impact of the Resiliency in Stressful Experiences (RISE) program for 18-35-year-old incarcerated males releasing to participating counties. RISE is a multi-phased comprehensive trauma-based reentry program designed according to the transitional nature of reentry. The researchers will assess the influence of RISE on post-release housing and employment stability and recidivism and identify key mechanisms of change. Participants ( $n=400$ ) are randomly assigned 1:1 to RISE or a Treatment as Usual control group.

**Discussion:** This study will provide critical information about how trauma-informed reentry programming impacts traditional reentry outcomes (e.g., recidivism, housing, employment) and identify key mechanisms of action (e.g., reduced impulsivity and aggression). Coping with trauma symptomatology is a largely untapped area of scientific inquiry for criminal justice-involved populations, despite the significant role trauma plays in individuals' lives. Results advance identification of critical components of trauma-informed reentry interventions for moderate- to high-risk young men. This study provides critical data to support policymakers and corrections professionals eager for innovative approaches to improve post-release outcomes.

**Keywords:** stress disorders, trauma, employment, housing, reentry, trauma, psychological wellbeing, community stability

**Abbreviations:** RISE, Resiliency in Stressful Experiences; LTE, Lifetime Traumatic Event

## 1. Introduction

Half of all individuals (or half a million people) who release from state correctional facilities each year are under the age of 35, of which 89% are men [1]. These young men are highly likely to be re-incarcerated – particularly within the first three years of release. Seventy-five percent of incarcerated individuals who were age 24 or younger at the time of release in 2008 were rearrested within three years. Sixty-nine percent of those aged 25 to 39 at time of release were arrested within three years [1]. A growing body of research identifies untreated psychological symptoms of trauma as a driving contributor to high rates of incarceration and re-incarceration among young men. Lifetime Traumatic Experiences (LTEs) include direct personal experiences of victimization, threat or experiences of serious injury, threat of death, learning of a serious injury or death occurring to a loved one, or witnessing an event that involves death or serious injury/threat to another person in childhood, adolescence, or adulthood [2].

Up to 98% of incarcerated males report at least one LTE prior to incarceration [3-4] compared to 22-47% of men who have never experienced incarceration [5]. Experiences of LTEs increase the odds of arrest, incarceration, and return to reincarceration, which, in turn, contributes to a higher likelihood of additional trauma [6]. Previous studies have shown that experiencing trauma symptoms is associated with being arrested for both violent and nonviolent crimes [7,8] and formerly incarcerated males who have experienced LTEs are significantly more likely to have used violence prior to their incarceration and have a higher risk of engaging in violence after release compared to their non-victimized peers [9-11]. Trauma symptoms generally include intrusive memories, avoidance, negative changes in thinking and mood, and changes in physical and emotional reactions [2].

Despite incarcerated males' high rates of trauma exposure, research to date has focused disproportionately on trauma treatment for incarcerated females. On a survey of state corrections departments in 2016, only 28 states provided any correctional-based trauma treatment [12]. Of those states, only 13 offered trauma treatment to men. Therefore, 74% of states do not offer interventions to incarcerated males, despite males and females reporting nearly equivalent rates of trauma exposure. Further, the existing evidence supporting trauma-based correctional interventions is limited by a lack of randomized controlled trials (RCTs) conducted with currently or formerly incarcerated males; only one known published study to date is specific to incarcerated men [13]. Further limiting the knowledge base, nearly all trauma-based correctional interventions are delivered during custody; only one known study provided trauma treatment to men after they released to the community [13]. Therefore, the complexities inherent to an individual's community reintegration after incarceration are not integrated into existing trauma-based interventions. Because trauma symptomatology can resurface during the high-stress reentry period – typically conceptualized to begin six months prior to release from incarceration and extend through an individual's first year back in the community – it is critical that we understand more about how to implement trauma treatment for young males during this time. The current study fills an important gap in knowledge by implementing an evidence-driven trauma intervention with young, incarcerated men nearing release from incarceration and extending treatment through their release from incarceration back home to the community.

This study protocol describes the RCT of Resiliency in Stressful Experience (RISE) conducting with men (18-35) within four to six months of release from state correctional facilities in one southeastern state. RISE is delivered to participants over six months; the program begins two months prior to an individual's release from incarceration and continues throughout their first four months in the community after release.

## 2. Study Aim and Procedure

### 2.1. Study Overview and Design

The purpose of this study is to evaluate the impact of the RISE program for moderate to high-risk incarcerated males between the ages of 18-35 releasing to one of the four participating counties. RISE is a multi-phased comprehensive trauma-based reentry program designed according to the transitional nature of reentry. The researchers are assessing the influence of RISE on post-release outcomes and key mechanisms of change (mediating variables). The primary outcomes are housing stability and employment stability and the secondary outcome is recidivism (i.e., re-arrest for technical violation to community supervision or committing a new crime; time to re-incarceration). The key mechanisms of change are trauma symptoms [posttraumatic stress disorder (PTSD), depression, anxiety, and substance use disorders], coping, impulsivity, and aggression. To determine the influence of RISE on the primary and secondary outcomes and the key mechanisms of change, 400 research participants are being randomly assigned with a 1:1 allocation to RISE or a Treatment as Usual (TAU) control group. Participants in the TAU control group are able to receive reentry services in the correctional facility and in the community that they normally would have received if they were not a research participant. The study is guided by the following three research questions:

**Research Question One:** Does the RISE program improve key mechanisms of change for moderate- to high-risk incarcerated males between the ages of 18-35? *Hypothesis 1: RISE program group members will show improvements in key mechanisms of change compared to TAU control group members.*

**Research Question Two:** Does the RISE program improve community stability for moderate- to high-risk incarcerated males between the ages of 18-35? *Hypothesis 2: RISE program group members will have increased community stability compared to TAU control group members.*

**Research Questions Three:** Does the RISE program improve recidivism outcomes for moderate- to high-risk incarcerated males between the ages of 18 and 35? *Hypothesis 3: RISE program group members will have lower rates of recidivism and those who do recidivate will spend more days in the community prior to recidivism compared to TAU control group.*

#### 2.1.1. Sample

The goal for the study is to recruit 400 18-35-year-old males releasing to one of the four participating counties. Participants must be English-speaking and planning to remain in one of the participating counties for at least one year after release from the correctional facility. Participants must have the cognitive capacity to understand what being a study participant entails and to provide informed consent.

**2.1.2. Power.** The research team conducted an a priori power analysis with the software program G\*Power to determine that the study would be able to detect differential effects on key mechanisms of change (i.e., trauma symptoms; research question one) and community stability (research question two) between participants allocated into the two study conditions. The research team powered the study based on conducting multivariate analysis using ANCOVA. The research team used a small effect size estimate - Cohen's  $d$  of .15 - based on guidance and data from the Clinician Administered PTSD Scale on a similar population [14]. Being able to detect small effects is important as we may find minimal difference between group members. Using an alpha of .05 and powered at a .80 level across two groups with up to seven covariates, a sample of 352 would allow us to detect small effects. Thus, a targeted sample size of 400 provides statistical power greater than .80, giving us strong confidence that we will be able to detect even small difference between study conditions.

Additionally, to answer research question three, the researchers will conduct survival analysis to analyze time-to-event on recidivism outcomes (i.e., time to arrest). Bureau of Justice Statistics (BJS) 2008-2018 data show that 71.5% of incarcerated individuals age 39 or younger released in 2008 were arrested within three years. The research team's goal is to reduce recidivism by 39% over three years. Using these data and the method described by Collett (2015), the research team calculated the hazard ratio of recidivism for this study at 1.39, meaning that members of the control group will experience recidivism 39% faster than participants receiving the targeted treatment [15]. Using the same BJS data, the research team calculated the median survival time (pre-recidivism) for members of the control group at 19.87 months. The median survival time suggests that 50% of the control group will experience recidivism by 19.87 months after release from incarceration. These data provided the basis for the power calculation. The power analysis was conducted using PS software [16]. Results show that for a study with 200 experimental participants and 200 control participants, a hazard ratio of recidivism of 1.39, and a median survival time for the control group of 19.87 months, the researchers will be able to reject the null hypothesis that the treated and control survival curves are equal with a probability (power) of .782. The Type I error probability associated with this test of this null hypothesis is 0.05. Therefore, the study will have adequate statistical power.

### **2.1.3. Recruitment**

The research team is recruiting participants from 18 participating correctional facilities over the course of nine months and ends in November 2021. The state department of correction provides the research team with a list of participants meeting the basic eligibility criteria. Lists are received on a monthly basis. Meetings with participants occur in a private space, where potential participants complete the screening checklist assessing for presence of at least one LTE. Participants are then consented using an IRB approved consent form. If the individual meets screening criteria and consents into the study, the research team member and the participant then complete the baseline interview.

### **2.1.4. Randomization**

The research team uses a random number generator to allocate participants to the RISE program group or to the TAU control group after screening and baseline data collection. Using a random number generator to create groups eliminates human error and bias which might otherwise result in individuals assigned to the RISE program group being different from

individuals assigned to receive standard reentry services. Randomization occurs on a monthly basis and letters are mailed to participants to notify them of the group to which they are assigned.

### 2.1.5. Intervention Description

RISE is a manualized, cognitive-behavioral, present-centered trauma-based program designed for young men with a history of LTEs who are experiencing trauma symptoms. RISE helps participants understand and manage trauma memories by providing psychoeducation and skills-based learning on how to process and manage trauma-related reactions to stressful life situations, including PTSD symptoms, traumatic grief, and shame. The goal of RISE is to increase emotional regulation and coping, helping participants gain control of intense emotions and posttraumatic stress reactions while simultaneously solving daily stressors. RISE provides a systematic approach to processing trauma that does not require memory processing and related risk to re-traumatization. Consistent with the most promising reentry approaches, RISE uses trauma-trained reentry specialists to deliver the intervention and provide reentry supports to help improve community stabilization.

RISE is designed to include a focus on reentry planning, community stabilization, and trauma treatment in each of the 19 sessions. Every session contains four structured components to be carried out with participants, including a check-in, goal development, the interactive lesson, and a check-out. The layout of RISE has up to four sessions taking place in the correctional facilities prior to release and up to 15 sessions taking place in the community upon release. Sessions that are delivered inside the correctional facility provide psychoeducational information on trauma and reentry and facilitate reentry planning with a focus on community stabilization. Sessions that occur in the community after release from incarceration focus primarily on emotion awareness and regulations, recognizing and positively responding to triggers, evaluating thoughts, and identifying emotions. The conceptual frameworks underlying the RISE intervention are the Trauma Based Reentry Framework and the Well-Being Development Model described in detail in previous publications [17, 18]. Additionally, the RISE curriculum was informed by Trauma Affect Regulation: Guide for Education and Therapy (TARGET), which is an evidence-based intervention that has been found to be effective with adolescents in juvenile justice settings [19]. Table 1 details the constructs addressed during each RISE session.

*Table 1. Session overview of the RISE curriculum*

<b>Module/Session</b>	<b>Construct</b>
Module 1*, Session 1	Psychoeducation on Trauma/Reentry Planning and Realistic Expectations
Module 1, Session 2	Psychoeducation on Trauma/Positive Interpersonal Relationships
Module 1, Sessions 3 & 4	Distress Reduction and Self-Compassion/Meaningful Work Trajectories
Module 2, Session 1	Therapeutic Alliance/Individualized Assessment of Triggers/Effective Coping
Module 2, Session 2	Recognizing and Positively Responding to Triggers/Meaningful Work Trajectories
Module 2, Session 3	Emotional Regulation/Effective Coping Strategies

Module 2, Session 4	Recognizing and Positively Responding to Triggers/ Meaningful Work Trajectories
Module 2, Session 5	Emotional Regulation/Effective Coping Strategies
Module 3, Session 1	Emotional Regulations/Effective Coping Strategies
Module 3, Session 2	Health Thinking Patterns, Positive Interpersonal Relationships
Module 3, Session 3	Trauma-Processing/Meaningful Work Trajectories
Module 3, Session 4	Health Thinking Patterns/Housing Stability
Module 3, Session 5	Trauma Processing/Housing Stability
Module 4, Session 1	Individualized Assessment of Triggers/Maintaining a Positive Trajectory
Module 4, Sessions 2 & 3	Trauma Processing, Improving Interpersonal Skills/ Maintaining a Positive Trajectory
Module 4, Session 4	Improving Interpersonal Skills/Maintaining a Positive Trajectory
Module 4, Session 5	Maintaining a Positive Trajectory

\*Module 1 occurs inside correctional facilities before participants are released

### 2.1.6. Fidelity Monitoring

Fidelity monitoring practices assist researchers in measuring the accuracy to how well the intervention is delivered in relation to how it was intended to be delivered. Additionally, assessing fidelity allows the research team to account for the potential impact of lower or higher performing practitioners (those who maintain treatment integrity better) on participant outcomes. Fidelity monitoring occurs with participants assigned to RISE. The research team developed the fidelity tool by adapting an existing well-being based reentry program fidelity tool to match the RISE session components [20]. The research team named this adapted fidelity tool the Reentry Program Fidelity Tool and it is used to assure RISE is being implemented as intended. Researchers measure fidelity using the Reentry Program Fidelity Tool for 25% of RISE sessions that occur in prisons and 25% of RISE sessions that occur in the community. Sessions are randomly selected for fidelity monitoring; fidelity observations are conducted by study team members. Practitioners who score lower on the fidelity ratings participate in further training until they are able to obtain and maintain fidelity to the RISE intervention.

### 2.2.6. Measures

Measures include administrative records as well as direct data collection from the participants. Demographics from state Department of Corrections administrative data include date of birth, race, ethnicity, marital status, level of education, age at first offense, number of prior incarcerations, and most serious offense. The researchers screen for trauma using the *Trauma Assessment for Adults* (TAA) as study eligibility requires having experienced at least one lifetime traumatic event [21]. The TAA was created to assess exposure to potentially traumatic events, has satisfactory convergence validity with a clinical sample ( $r=.65$ ) and adequate temporal stability ( $r=.80$ ) [21].

Trauma exposure is also measured throughout the study. The 24-item *Trauma History Questionnaire* (THQ) assesses participants' experiences of LTEs, and trauma that has occurred since their last interview [22]. Each THQ item examines a specific traumatic experience categorized as interpersonal violence, accidents and disasters, serious illness, traumatic loss, and

criminal victimization. Participants indicate whether they have experienced the event, and if so, provide age at time of exposure and a brief description. The THQ is a reliable measure (3-month test-retest coefficients=.51-.91) and has strong convergent validity ( $k=.61-1.00$ ).

The primary outcome measures for the study are housing stability and employment stability. Housing stability is defined as living in one's own room, apartment, or house, or with family, with an expected duration of residence of four months or more, or tenancy rights. The research team developed a 7-item housing measure to assess housing stability at all post-release timepoints. These items assess housing stability after release from prison. The housing measure asks participants where and with whom they currently live, whether they consider themselves to be homeless, and if they have been unsure where they would sleep at night.

Employment stability is defined as the number of jobs held in the last four months and the number of days worked at each job. Individual respondents must work a minimum of 15 hours a week for their responses to be captured. The research team developed a 10-item measure to assess the participants' employment stability. During the baseline interview, participants are asked about their employment four months prior to incarceration. In all post-release interviews, participants are asked about employment during the previous four months. The employment measure asks about current and previous employment and income.

The secondary outcome measures include recidivism due to technical violation and recidivism due to reincarceration. Specifically, recidivism is measured as number of days to reincarceration for technical violation and number of days to reincarceration for a new crime one, two, and three years after release from prison. Other pre-specified outcome measures include symptoms of PTSD, depressive symptoms, anxiety symptoms, incidences of substance use disorders, coping self-efficacy, impulsivity, aggression and physiological wellbeing.

The 20-item *PTSD Checklist for DSM-5* (PCL-5) is used to assess PTSD symptoms and screen for PTSD at all interview timepoints. All items are scored on a 5-point Likert scale with 0= "not at all" and 4= "extremely". Scores above 33 indicate meeting the diagnostic criteria for PTSD. The PCL-5 has strong reliability ( $\alpha=.94$ ), test-retest correlations ( $r=.82$ ), and has strong convergent validity and discriminant validity [23].

Depression is measured through both the *MINI International Neuropsychiatric Interview* (MINI) and the *Brief Symptom Inventory* (BSI) [24, 25]. The 11-item major depressive disorder subscale of the MINI is used to assess lifetime incidence of major depressive episodes at baseline. Items are rated on a dichotomous Yes/No scale and follow DSM-5 psychiatric guidelines. The MINI has strong interrater reliability and the kappa value for the major depressive disorder construct was adequate ( $k=.72$ ) [24].

The BSI is used to measure depressive symptoms that may be occurring at all study timepoints. The BSI is a 53-item measure with a 6-item question subscale of depressive symptoms in which the participant characterizes the intensity of distress (0 = "not at all" to 4 = "extremely") [25]. Anxiety symptoms include apprehension or fear of impending actual or imagined danger, vulnerability, or uncertainty. Anxiety symptoms are measured using a 6-item subscale of the BSI in which respondent's characterize the intensity of anxiety (0 = "not at all" to 4 = "extremely") [25]. Both the depression ( $\alpha=.87$ ) and anxiety ( $\alpha=.84$ ) subscales of the BSI demonstrate good internal consistency.

Incidences of substance use are defined as a pathological pattern of impairment related to the overuse of, or dependence on, psychoactive drugs, prescription medications, or other substances [26]. The 9-item substance use disorder subscale of the MINI assesses the criteria for substance use disorders at all interview timepoints. Items are rated on a dichotomous Yes/No scale and follow psychiatric guidelines of the DSM-5. The MINI has strong interrater reliability and the kappa value for the substance use disorder construct was adequate ( $k=.74$ ) [27].

Self-efficacy is defined as a cognitive mechanism based on expectations or beliefs about one's ability to perform actions necessary to produce a given effect [27]. The 26-item Coping Self-Efficacy Scale (CSES) is used to assess self-efficacy and confidence in coping with stress at all interview timepoints [28]. The scale response options range from 0-10 with 0 being "Cannot Do at All" and 10 being "Certain Can Do". The higher the score, the higher the level of coping self-efficacy. The CSES has been found to be reliable and valid ( $\alpha=.80-.91$ ) [28].

Impulsivity is defined as a predisposition toward rapid, unplanned reactions to internal or external stimuli without regard to the negative consequences of these reactions to the impulsive individual or to others. Impulsivity is measured using the *Barratt Impulsivity Scale* (BIS)[29]. The BIS is composed of 30 items describing common impulsive or non-impulsive behaviors and preferences. Participants select from the following: (1) if you rarely or never act or think that way, (2) if you occasionally think that way, (3) if you often think that way, or (4) if you almost or always think that way. The BIS is used to assess general impulsiveness at all interview timepoints. The BIS has been validated among community, clinical, and correctional samples ( $\alpha=.79-.83$ ) [29].

Aggression is defined as behavior that intends to harm other people who want to avoid the harm [30, 31]. The 12-item Brief Aggression Questionnaire (BAQ) evaluates physical aggression, verbal aggression, anger, and hostility at all interview timepoints [32]. Participants respond on a scale from one to five, with one being "extremely uncharacteristic of me" and five being "extremely characteristic of me". The BAQ has stable test-retest reliability and convergent validity with behavioral aggression measures.

Psychological well-being is a complex combination of various psychological and personality characteristics. The 42-item Ryff Scale of Psychological Wellbeing [33] is used to assess well-being in the following six areas: autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance. Respondents rate statements on a scale of 1 to 6, with 1 indicating strong disagreement and 6 indicating strong agreement. The six subscales show good internal consistency with coefficient alphas ranging .83-.91 [33]. The six subscales perform with reasonable factorial validity [34].

### **2.1.7. Data collection**

Data collection with all recruited participants occurs four times. The baseline interview occurs 4-6 months prior to an individual's release immediately following recruitment and obtaining informed consent. The first data collection session (T1) occurs in the community two weeks following release. The second data collection session (T2) occurs four months after release. The final data collection session occurs eight months after release (T3). Data collection

occurs by telephone, Zoom, at the participants' home, or a community location. Administrative data is collected at baseline and then every six months for three years post-release.

## **2.2. Analysis strategy**

STATA version 17 will be used for data cleaning, coding, and analysis. Prior to analysis, data will be examined for missing and outlier values to resolve any issues. Descriptive statistics will be computed for each variable. Correlation matrices and squared multiple correlations will be examined for multicollinearity and singularity. We will assess the reliability of scales composed of multiple items. Precautions will be taken to minimize the amount of missing data (i.e., robust methods of participant tracking and incentives to participate). If missing data occurs, analyses will be undertaken to test for the assumption of missing at random (MAR) or missing completely at random (MCAR). Based on the determined pattern and proportion of the missing data, the recommended procedures for multiple imputation may be performed. Multivariate statistical methods must meet multiple assumptions before analyses can occur. We will test for the following assumptions: normality, multicollinearity, homoscedasticity, independence of error terms, and linearity and will make appropriate corrections and transformations should assumptions not be met.

### **2.2.1. Research Questions One and Two.**

We will use the multivariate statistical test of Analysis of Covariance (ANCOVA) to test our study aims around key mechanisms of change (i.e., trauma symptoms, coping, impulsivity, and aggression) and community stability (i.e., housing and employment). One two-level independent variable indicates the study condition: the comprehensive trauma-based reentry program condition and the TAU control condition. ANCOVA allows for an assessment of between-group differences on key mechanisms of change and community stability after controlling for the effects of one or more covariates (e.g., race, other program participation, or criminal history). The purpose of this analysis is to partial-out the effects of study condition on key mechanisms of change and community stability, determining whether any effects are due to the covariates and/or are a result of study condition assignment.

### **2.2.2. Research Question Three.**

Survival analysis will be conducted to analyze time-to-event on recidivism outcomes (i.e., time to arrest and time to incarceration). Participants without the occurrence of the events will be censored at their last known event-free time point. Survival curves will be constructed using Kaplan-Meier estimates. Using the Kaplan-Meier curve allows us to derive the median, or that time at which 50% of cases of the event of interest has occurred, and the mean (i.e., the average time it took for the event to occur). Although there are several methods available to analyze time-to-event curves, the proposed study uses a Cox proportional hazard model which is a regression method for survival data and has been used in previous criminal justice-related studies. The Cox model allows for the identification of differences in survival rate due to study condition and prognostic factors, such as covariates. Further, the Cox model provides an estimate of the hazard ratio and its confidence interval. There are two underlying assumptions of the Cox proportional hazard model: (1) the hazard ratios of two people are independent of time and (2) are valid only for time independent covariates. For the current study, results will be displayed for comparison of survival distributions for three years post-release.

### 3. Study Timeline

Individuals are recruited approximately four to six months prior to release; researchers will remain in contact during and after the intervention to complete follow-up interviews. Participants can be engaged with the study for a maximum of 18 months. Table 2 provides the timeline for participant involvement in the project. Recidivism data will continue to be collected via department of correction's administrative data for three years beyond participant involvement.

*Table 2. Study Timeline*

<b>Study Timeline of Research Activities by Months</b>	2	4	6	8	10	12	14	16	18	20	22	24
Recruitment of Study Participant	x	x	x	x	x							
Programming Inside Facilities	x	x	x	x	x	x	x	x				
Community Programming	x	x	x	x	x	x	x	x	x			
T1 (Interviews 2 weeks after release)	x	x	x	x	x	x	x	x				
T2 (Interviews 4 months after release)			x	x	x	x	x	x	x			
T3 (interviews 8 months after release)					x	x	x	x	x	x	x	x

### 4. Discussion

Because trauma is highly prevalent among young males releasing from prison and the symptoms of untreated trauma are correlated with poor public safety and public health outcomes, it is critical to understand how to effectively treat trauma while simultaneously promoting other community stability facilities for individuals releasing from prison. It cannot be assumed that evidence based trauma treatment approaches for the general population are appropriate or effective approaches to responding to lifetime traumatic experiences among males leaving correctional facilities. This study is a critical first step in building an evidence base of comprehensive trauma informed approaches to reentry.

This study will provide us critical information about the types of impact trauma informed reentry programming may have on traditional reentry outcomes (e.g., recidivism, housing, employment) as well as potential key mechanisms of action (e.g., reduced impulsivity) within the reentry intervention itself. Coping with, and recovering from, trauma symptomatology is a largely untapped area of scientific inquiry for criminal justice involved populations, despite the significant role it plays in these individuals' lives. Results from this study will advance identification of critical components of trauma informed reentry interventions, which post-release outcomes are enhanced, as well as the shelf life of intervention effects. This study comes at an important moment in time as policymakers and corrections professionals are hungry for novel approaches to rehabilitation programming that are likely to better support individuals as they return home to their families and communities.

**Disclosures**

The authors declare no conflicting interests.

**Ethics Approval and Trial Registration**

This protocol is an interventional study that is recruiting a vulnerable population of individuals releasing from state prisons. The entire study was approved by a large Southeastern University's Institutional Review Board (STUDY00001064). Additionally, Researching Resiliency in Stressful Experiences (RISE) program for Men Leaving Incarceration was registered on ClinicalTrials.gov (reference #NCT04785677) on March 8<sup>th</sup> 2021.

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