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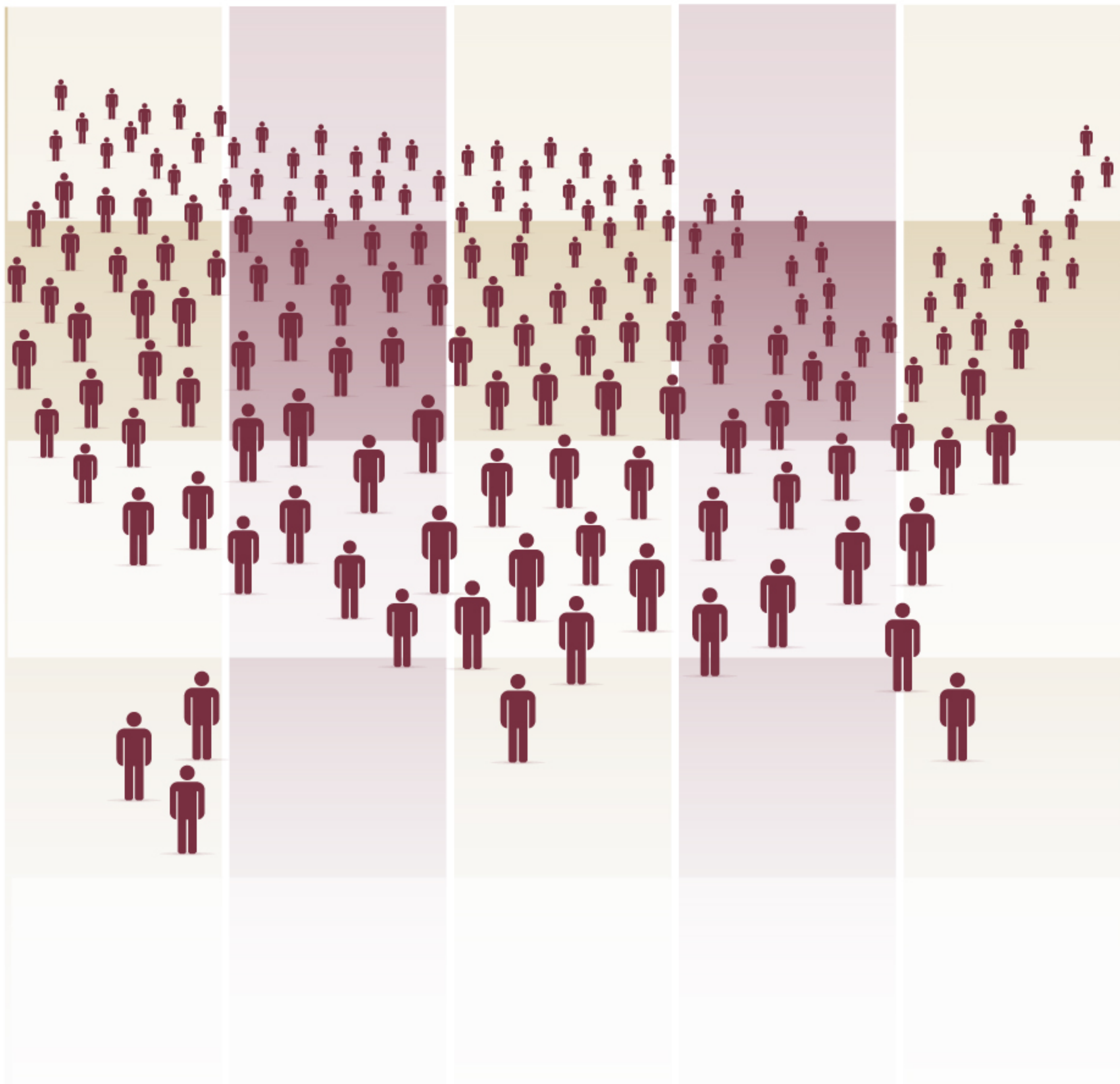

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Abstract

Research indicates that providing services to incarcerated individuals increases the chance that they will be successful upon reentry to communities. The current study assessed the provision of services (i.e. trauma and reentry) in state departments of corrections (DOCs) throughout the United States. DOCs from all fifty states and the District of Columbia were contacted to determine what services were provided to prisoners, with 44 of 51 providing responses. Results suggest that DOCs provide a range of programming, as well as assessments. Future research should explore the quality and effectiveness of programming and the capacity of existing efforts to meet the growing numbers of people releasing from prison.

Keywords: *Criminal justice; Service delivery; Prison-based Programming*

Introduction

Over 1.3 million people are housed in state prisons on any given day and each individual has a multitude of complex needs (Carson & Anderson, 2016). Prisoners have consistently reported poor physical health outcomes, higher rates of mental health complications, and histories of traumatic experiences (Wolff et al., 2015; Dumont et al., 2012). Furthermore, prison perpetuates economic, social, and racial disparities among those who are incarcerated (Western & Pettit, 2010). Annually, the United States expends $80 billion on the incarceration of individuals (Kearney, Harris, Jacome, Parker, & 2014), while not providing holistic services that address the unique needs of those incarcerated. Yet, a recent meta-analysis on the provision of reentry services (i.e., job readiness, education, life and coping skills, family support, etc.) shows they can help formerly incarcerated individuals overcome their challenges and effectively reenter into their communities upon exiting prison (Ndrecka, 2014).

With 95% of those incarcerated eventually release back to communities (Travis, 2005), the extent of the impact of providing comprehensive services to those incarcerated may be massive. Approximately 77% of those released from prison are rearrested for a new crime within five years of their release (Durose, Cooper, & Snyder, 2014). This high rate of recidivism suggests that the needs of those individuals reentering communities from prisons remain largely unmet. Thus, gleaning a better understanding of the current status of the state departments of corrections programming is critically important.

The status and unique needs of prisoners has had a detrimental impact of the overall well-being of the incarcerated and formerly incarcerated. For example, nearly 98% of all incarcerated men and women report lifetime traumatic experiences prior to or during their incarceration (Wolff, et al., 2015; McDaniels-Wilson & Belknap, 2008). Evidence indicates that trauma may

lead to increased mental health disorders (i.e. anxiety, depression, and post-traumatic stress disorder; Ghafoori, Fisher, Korosteleva, & Hong, 2016), as well as decreased functioning, antisocial behavior, drug abuse, and violent behavior (Ballard, et al., 2015; Bruce & Laporte, 2015; Levenson, 2014). Over the past two decades, state prison systems have further embraced the role of trying to address the poor well-being of the incarcerated by focusing on programming that meets the unique circumstances of their clients such as high rates of lifetime traumatic experiences. Despite there being a dearth of evidence for trauma interventions delivered during incarceration (Van Buren, Stocke, Wunderlich, & Thurston-Snoha, 2014), providing trauma services is increasingly seen by corrections professionals as a necessary tool to promote successful rehabilitation (Miller & Najavits, 2012).

Relatedly, an emerging body of research is discovering that traumatic brain injuries (TBI; generally related to a lifetime traumatic experiences) are disproportionately high among the incarcerated and contribute to more behavioral difficulties than previously known (Farrer & Hedges, 2011; Diamond et al., 2007). According to the Centers for Disease Control and Prevention, 25 to 87% of prison inmates report experiencing a TBI at some point in their life, compared to 8.5% in the general population (CDC, 2016). TBI assessment relies heavily on self-reporting. Current medical tests such as brain imaging and scans are unable to identify anything but the most severe or chronic cases of TBI (Dams-O'Connor et al., 2014). While the most common treatment practices for TBIs are focused on the individual, there is evidence that family interventions may be an important part of healing (Godwin, Lukow, & Lichiello, 2015).

Unfortunately, during incarceration, many individuals are cut off from the very support systems that could aid them in recovering post-incarceration (Datchi, Barretti, & Thompson, 2016). Growing attention is being paid to the fact that family disruption is extremely high for

those who have become incarcerated. Individuals are physically removed from their families and maintaining contact through phone, post mail, or in-person visits is financially and logistically prohibitive. Moreover, research also shows that when incarcerated individuals can maintain positive family connections, their chances of success during and after incarceration are much higher (Datchi et al., 2016; Granja, 2015; Christian, 2005). Family programming provided by prisons creates more opportunities for family members to have structured and beneficial visits. While not all incarcerated individuals will have families willing to participate in programming, for those who do, the benefits could have great potential in affecting outcomes and reducing the negative impact of incarceration (Datchi et al., 2016). In fact, family programming has been found to be beneficial in many diverse therapeutic settings (e.g. substance abuse and traumatic brain injury treatment) (Godwin, et al., 2015; Guo, Slesnick, & Feng, 2015).

In addition to these unimodal service categories that are receiving increasing attention, multimodal reentry programming continues to be highly valued in the corrections field. Prisoner reentry programming typically involves a multimodal continuum of care spanning pre-release and-post release (Seiter & Kadela, 2003). Generally, reentry programs address job readiness, life skills, coping skills, cognitive behavioral therapies, care coordination, and achieving security and stability upon release from prison. However, defining exactly a quality reentry program is difficult because of a general lack of consistency in reentry program models employed across the U.S. (Jonson & Cullen, 2015; Petersilia, 2003). Unfortunately, reentry programs have also largely been deficient in resources and inconsistent in the ability to impact recidivism outcomes (Jonson & Cullen, 2015; Ndrecka 2014). Yet, because of the promise of prisoner reentry programs, many argue that these initiatives are not prevalent enough.

Since the turn of the 21st century, ample evidence has pointed toward the needed services for those who are incarcerated in the United States (Travis, 2005; Petersilia, 2003). To date, surveys of prison programming have been conducted related to substance abuse and mental illnesses have been conducted (Epperson et al., 2014; Taxman Perdoni, & Harrison, 2007). The proposed research is in response to there being less clarity on the extent to which state department of corrections are offering programming to address the highly prevalent needs of the incarcerated that contemporary research has identified – trauma, traumatic brain injury, family, and general prisoner reentry services. Continued calls for prison to be a place of rehabilitation as a part of criminal justice reform efforts, underscores the need for a survey of existing services in the DOCs of all 50 states and the District of Columbia. Comprehensive literature reviews have helped to identify the state of knowledge about best practices for supportive services for incarcerated individuals. However, to assess whether practices that researchers are identifying as effective are actually being adopted, the research team surveyed the DOCs of all 50 states and in the District of Columbia to ask about the availability of trauma, TBI, family, and reentry programming within their prison system. The research questions for the proposed work were the following: (1) What are the services being provided by state DOCs? (2) If the services were being provided, what were the specific types of programming being delivered? (3) If relevant, what type of assessment was being used by the state DOCs to place individuals into programming?

Methods

All state DOCs were contacted to assess the availability of services. Initial contact was made by phone, followed by e-mail if needed. The research took place between October 2015 and October 2016 by graduate level research assistants at Washington University in St. Louis.

Scripts were developed to guide the conversations with DOCs. Following the question of service provision, which established if the state offered the specific service area, follow-up questions about the specific service were asked. For example, if a DOC offered trauma, family, and/or reentry services, the respondent was asked to provide details on each set of services offered, if services were delivered to men and/or women, who delivered services, and how long the applicable service category had been offered by the DOC. TBI related questions focused specifically on how assessments of TBI were conducted.

Results

Table 1 provides a summary of the service categories offered by each state DOC to incarcerated individuals. Response rates by a DOC varied by the service category. This is because services were housed under different divisions in many cases, so one division contact person might reply, whereas another division contact person may not. For trauma interventions, 44 out of 51 DOCs responded to this inquiry; 37 out of 51 responded to TBI assessment inquiries, 34 responded to the family programming survey, and 41 responded to surveys about reentry programming.

Table 2 presents data on the survey responses from the DOCs, which includes: the number who responded, the number who responded affirmatively to delivering the service, and then details on the services offered by the DOCs. In terms of the provision of trauma services, nearly 73% of state DOCs provided any kind of programming and of those states that did provide programming almost 97% provided it women and approximately 66% of the states provided it to men. A wide variety of trauma programming was delivered across the states, with Seeking Safety being used the most frequently at 59% of the time.

Table 1. *Programming Summary by State DOC*

State	Trauma	Family	Reentry	TBI assessment	TBI treatment
Alabama	*	*	Yes	*	*
Alaska	Yes	*	*	Yes	No
Arizona	No	*	*	Yes	*
Arkansas	No	*	*	*	*
California	Yes	Yes	Yes	Yes	No
Colorado	Yes		Yes	*	*
Connecticut	Yes	No	Yes	No	*
Delaware	*	*	*	Yes	Yes
District of Columbia	*	*	Yes	*	*
Florida	No	Yes	Yes	Yes	No
Georgia	Yes	Yes	Yes	Yes	No
Hawaii	No	*	*	No	*
Idaho	Yes	No	Yes	Yes	Yes
Illinois	Yes	Yes	Yes	*	*
Indiana	*	*	Yes	Yes	No
Iowa	Yes	No	Yes	Yes	No
Kansas	Yes	Yes	Yes	Yes	Yes
Kentucky	Yes	Yes	Yes	Yes	No
Louisiana	Yes	*	Yes	Yes	*
Maine	Yes	Yes	Yes	No	*
Maryland	Yes	Yes	Yes	Yes	Yes
Massachusetts	No	*	Yes	Yes	Yes
Michigan	Yes	*	*	*	*
Minnesota	No	No	Yes	Yes	Yes
Mississippi	No	No	Yes	No	*
Missouri	Yes	Yes	Yes	Yes	Yes
Montana	Yes	*	*	*	*
Nebraska	Yes	No	Yes	Yes	No
Nevada	Yes	No	Yes	No	*
New Hampshire	Yes	Yes	Yes	Yes	Yes
New Jersey	*	*	*	*	*
New Mexico	Yes	Yes	Yes	*	*
New York	*	*	*	*	*
North Carolina	No	No	Yes	*	*
North Dakota	Yes	No	Yes	Yes	Yes
Ohio	Yes	*	Yes	Yes	Yes
Oklahoma	*	No	*	Yes	No
Oregon	No	No	Yes	Yes	No
Pennsylvania	Yes	No	Yes	Yes	Yes
Rhode Island	Yes	No	Yes	No	*
South Carolina	No	Yes	Yes	Yes	No
South Dakota	Yes	No	Yes	Yes	No
Tennessee	Yes	*	Yes	*	*
Texas	No	Yes	Yes	Yes	No
Utah	Yes	Yes	Yes	*	*
Vermont	Yes	No	Yes	No	*
Virginia	No	Yes	Yes	Yes	No
Washington	Yes	No	Yes	Yes	No
West Virginia	Yes	No	Yes	*	*
Wisconsin	Yes	Yes	Yes	Yes	No
Wyoming	Yes	No	Yes	Yes	Yes

* Denotes that the information to complete this section of the interview was not able to be collected.

For a majority of the states, the delivery of trauma programming was rather new, with 69% of states having begun trauma programming within the last ten years at the time of the survey. In terms of the head injury portion of the survey, most state DOCs (75.7%) conducted some form of assessment while an individual was incarcerated. About half (46.4%) assessed for TBI at the time of intake into the prison facility, while 39.3% only assessed at the time of new injury or symptoms. There was a small percentage (14.3%) that assessed for TBI at both intake and when a new injury or symptoms occurred. Multiple different assessment tools were used across states, with self-report (28.5%) and neuropsychological testing (25%) being the most common. For those who assessed and were confirmed to have experienced a TBI, under half (42.9%) received programming in response to the head trauma. With programming related to family planning, under half (47.1%) provided any services in this area and the most common type of programming was specialized visitation (43.8%). Additionally, there were a range of other programs offered across states, such as housing for mothers and children (25%) and reunification services (18.8%). Lastly, of the states we were able to speak with about reentry services, all of them provided some level of reentry programming for individuals. There was a variety of programs that state DOCs constituted as reentry services. Some of the most frequent services in this area were mental health (68.3%), substance abuse treatment (53.7%), housing (51.2%), and community resources (41.5%). Of the programming that was offered around reentry, 46.3% was based on a theoretical model (i.e. Risk-Needs-Responsivity).

Table 2. *Programming Survey Responses of State DOCs*

Trauma services (Total DOC Responses=44)		**Head injury assessment (Total DOC Responses=37)**		**Reentry services (Total DOC Responses=41)**	
DOC provides service	72.7%	DOC conducts assessment	75.7%	DOC provides service	100.0%
Intervention (not mutually exclusive)		*Time of assessment*		*Type of services (not mutually exclusive)*	
Seeking Safety	59.4%	Intake	46.4%	Mental health	68.3%
Beyond Trauma	25.0%	New injury/new symptoms	39.3%	Government services	53.7%
Dialectical Behavior Therapy	25.0%	Intake & new injury/ symptoms	14.3%	Substance abuse treatment	53.7%
Helping Women Recover	12.5%	*Assessment tools*		Employment	53.7%
Cognitive Processing Therapy	12.5%	Self-report	28.5%	Health/medical services	43.9%
Trauma Recovery Empowerment Model	12.5%	Neuropsychological testing	25.0%	Religious support	14.6%
Male-Trauma Recovery Empowerment Model	9.4%	Medical records	3.6%	Housing	51.2%
Cognitive Behavior Therapy	9.4%	HELPS	3.6%	Community resources	41.5%
Prolonged Exposure Therapy	9.4%	Glasgow Coma Scale	3.6%	Financial education and life skills	36.6%
Healing Trauma	9.4%	PERRLA	3.6%	Family programming	36.6%
Eye Movement Desensitization and Reprocessing	6.3%	Computerized tomography (CT) Scan	3.6%	Special populations (i.e. veterans)	34.1%
Beyond Violence	6.3%	Emergency Room Evaluation	3.6%	Education	34.1%
Military Specific	6.3%	ICD-10	3.6%	Case management	26.8%
Other	34.4%	Ohio State University	3.6%	Transportation	22.0%
Treatment offered for men		Montreal Cognitive Assessment	3.6%	Supervision	9.8%
Yes	65.6%	Multiple assessments	14.1%	Mentoring	9.8%
Treatment offered for women		*Follow-up services/programs offered*		Work release	9.8%
Yes	96.9%	Yes	42.9%	Restorative justice	7.3%
Length of time since program implementation		**Family programming (Total DOC Responses=34)**		Domestic abuse services	7.3%
< 5 years	31.3%	DOC provides service	47.1%	Other	19.5%
6-10 years	37.5%	*Types of programming (not mutually exclusive)*		*Programming based on model*	
>10 years	12.5%	Housing for mothers & children	25.0%	Yes	46.3%
Unknown	18.7%	Reunification/reentry	18.8%	*Type of model*	
Interventions delivered by		Specialized visitation	43.8%	Risk, Needs, Responsivity	21.0%
Clinical Staff	53.1%	Father specific	18.8%	Transition prison to community	21.0%
Non-clinical staff	15.6%	Reading	12.5%	Cognitive Community	5.3%
Clinical/non-clinical staff	12.5%	Substance abuse	6.3%	Texas Substance Abuse Initiative	5.3%
DOC Staff/Contractors	18.8%	Counseling	6.3%	Level of Service/Case Management Inventory	5.3%
		Offer multiple types		Intensive Aftercare Program	5.3%
		Yes	50.0%	Life Skills 25	5.3%
				TIGER	5.3%
				Hazelden Curriculum	5.3%
				Cincinnati Reentry	5.3%
				Thinking for Change	5.3%
				Multiple models	10.3%

Discussion

This survey elucidated the current state of programming for incarcerated individuals in the areas of trauma treatment, TBI assessment and treatment, family programming, and general reentry services. These findings suggest that a two-prong approach could be used to assist departments of corrections in providing more efficacious services to prisoners and encourage lawmakers to allocate the appropriate resources to do so.

The research supports the recommendation the first approach should seek to fill gaps in critically needed service areas identified by this study. For example, these data identified a gap in trauma services provided to incarcerated men, with 11 states only delivering services to women. Study results show that while many states assessed for the experience of TBI, less than half (n=12) offered rehabilitation services for TBI. Furthermore, despite evidence supporting the need for family programming, only 16 states provide opportunities for family-specific programming.

Secondly, future research that aims to determine efficacy of current services in order to establish programming standards for each of the four service areas should be conducted. There is a well-established need for more rigorous research that would aid in establishing evidence-based assessments and interventions (Friedmann, Taxman, & Henderson, 2007; Scheyett, Vaughn, & Taylor, 2009). At this time, data on successful programming is limited to minimal research focused on overall recidivism data, which fails to capture the complexity of issues surrounding incarceration. For example, it is unclear why, even with 100% of incarcerated individuals receiving some form of pre-release reentry services, the recidivism rate remains incredibly high in the United States. Findings across the service areas suggest that consistent, evidence-based interventions are either not meeting the extent of needs of prisoners or are not being provided at all. The goal of determining best practices for services during incarceration is lofty, but given the

immediacy of the issue and the extent to which it affects our communities, it is worthy of our time and persistence.

The current research has multiple limitations that are important to note. First, the survey was not conducted with seven DOCs, which means there remains gaps in knowledge related to those states. Secondly, although the survey provides information at the state DOC-level it, the research fell short on identifying the delivery of the programming at the facility level and what percentage individuals incarcerated within the state are offered and/or receive the programming.

Conclusion

This survey improves the knowledge on programming being delivered by state prisons across the United States. While it is clear that states are providing some forms of programming, there are still gaps to be filled. Researchers and practitioners have an opportunity to band together to create efficacious interventions that could assist in responding to the critical needs of those who are incarcerated.

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