Trauma-Informed Risk Assessment in Correctional Settings

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Abstract: This paper outlines a model which infuses trauma-informed principles into the existing Risk-Needs-Responsivity model of risk assessment commonly used in correctional settings. The connection between certain types of trauma and criminality is established. Despite this, many risk assessment procedures do not include screening for trauma, or trauma-specific interventions. An overview of the lasting effects of childhood maltreatment is included. Trauma-informed practices and assessment recommendations are also provided, along with recommendations for additional resources.

Keywords: Trauma-informed, risk assessment, corrections.

INTRODUCTION

Reducing the rates of recidivism is an important challenge and major focus of criminal justice systems (Casey, Elek, Warren, Cheesman, Kleiman, & Ostrom, 2014). One method for reducing recidivism rates includes comprehensive risk assessment (Bonta & Andrews, 2007). The target outcomes of risk assessment include identification of offenders at greater risk to re-offend and matching those individuals to appropriate interventions (Desmarais & Singh, 2013; Taxman, Thanner, & Weisburd, 2006). Two types of risk factors have been established: static and dynamic (Andrews & Bonta, 1998). Static factors are unchangeable or historical and not amenable to intervention, for example, prior arrests, or age (Desmarais & Singh, 2013). Dynamic risk factors, also known as criminogenic needs, are changeable characteristics that have been linked to recidivism and are amenable to intervention. Examples include substance abuse problems, negative peer associations, and unemployment (Casey et. al, 2014; Hanson, 2010). One important static risk factor is prior exposure to childhood maltreatment. While exposure to this type of trauma is static, the lasting behavioral and health outcomes associated with childhood maltreatment are conceptualized as dynamic risk factors, and are therefore amenable to intervention. Improved assessments for these types of risks are needed in corrections settings. This paper outlines commonly used risk assessment procedures in corrections settings with the addition of assessing for the static factor of child maltreatment, as well as the dynamic factors of health and behavioral consequences of maltreatment. Improving risk assessment in corrections settings has the potential to reduce recidivism.

RISK ASSESSMENT IN CORRECTIONS

A commonly used model of risk assessment is the Risk-Needs-Responsivity (RNR) model (Andrews, Zinger, Hoge, Bonta, Gendreau, & Cullen, 1990). The RNR model aims to assess both risk and need for the purpose of identifying and implementing appropriate interventions, with the over-arching goal of reducing recidivism (Andrews *et al*., 1990). The RNR Model has evolved from earlier generations of corrections assessments, and is considered the "most influential" model used (Blanchette & Brown, 2006; Ward, Mesler & Yates, 2007). The Risk-Needs-Responsivity model provides a framework to identify the risk factors present in an individual's life, as well as the most appropriate interventions and supports to address the risks, depending on the type of risk, number, and severity. The RNR model of assessment is comprised of three principles. The *risk principle* matches the level of service or intervention to the offender's risk to re-offend (Andrews, *et al*., 2006; Bonta & Andrews, 2007; Latessa, Smith, Lemke, Makarios, & Lowenkamp, 2009). This principle states that to reduce recidivism, higher risk offenders should receive more supervision and services and individuals with lower risk should receive less. Put simply, the more risk factors an individual has, the more treatment they will likely need (Casey *et al*., 2014; Hanson, 2010). The *need principle* centers on the assessment of dynamic risk factors (Desmarais & Singh, 2013). Once an offender's dynamic risk factors have been identified through risk assessment, treatment services should target those factors specifically to reduce the likelihood of re-

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offending (Casey *et al*., 2014). The *responsivity principle* works to lower risk through addressing two types of responsivity: general and specific (Bonta & Andrews, 2007; Casey *et al*., 2014; Latessa *et al*., 2009).

General responsivity emphasizes use of skill-based social learning to change behavior and focuses on the style and structure of programming (Bonta & Andrews, 2007). Style speaks to cognitive-behavioral programs and interventions as the preferred method of teaching new behaviors (Bonta & Andrews, 2007; Dowden & Andrews, 2004). Programming structure refers to a warm, respectful relationship between provider and offender with particular emphasis on influencing offender behaviors via appropriate modeling, reinforcement, and problem-solving (Andrews, *et al*., 2006; Egan, 2010; Hanson, 2010). *Specific responsivity* accounts for offender-specific characteristics, such as cognitive ability or learning style, that may impact treatment outcomes (Bonta & Andrews, 2007). More specifically, Bonta and Andrews (2007) asserted that offender treatment programs must attend to the personal, cognitive, and social factors of offenders. For example, if the offender has limited verbal skills and thinks concretely, abstract treatment concepts should be reduced and more emphasis placed on behavioral interventions (Bonta & Andrews, 2007). Researchers have further suggested treatment providers may need to first address existing mental health disorders to allow full participation in programming geared towards dynamic risk factors (Andrews, *et al*., 2006; Hanson, 2010;). For example, an anxiety disorder may reduce concentration, and impair one's ability to internalize treatment messages (Andrews, *et al*., 2006; Bonta & Andrews, 2007).

To implement the RNR model successfully, accurate risk assessment is necessary (needs principle) to enhance treatment-matching (risk principle), and individual factors must be considered to increase treatment responsiveness (responsivity principle) (Desmarais & Singh, 2013). There are several validated instruments for use in this population, including the COMPAS (Brennan & Oliver, 2000) and the R-PACT (Hay, 2013). Despite the breadth of information collected in these commonly used assessments, inclusion of childhood trauma and/or trauma-related behaviors are notably absent. The R-PACT does assess for static risk factors such as family history (family antisocial/criminal history) and mental health history, but Hay (2013) noted that while such factors may be important for addressing individual needs, they themselves, as static factors, do not predict re-offending. The existing framework of the RNR model, particularly the responsivity principle, supports the additional assessment of both static and dynamic risks associated with childhood trauma, an experience known to be high among offending populations (Wolff, Chugo, Shi, Huening, & Frueh, 2015).

THE TRAUMA-CORRECTIONS CONNECTION

The relationship between exposure to child abuse and trauma and consequent aggressive or criminal acts is well-documented (Showyra & Cocozza, 2006; Smith, Ireland, & Thornberry, 2005; Wolff *et al*., 2015; Widom & Maxfield, 2001). Researchers have estimated that as many as 90% of incarcerated women have experienced some form of interpersonal or sexual violence (Miller & Najavits, 2012; Women in Prison Project, 2006). The exposure to childhood and adult trauma has been shown to be overrepresented in correctional populations when compared to the general population (Ardino, 2012; Wolff *et al*., 2015; Wolff, Huening, Shi, & Frueh, 2014; Wolff & Shi, 2012). One in six male inmates, incarcerated in state facilities, reported being physically or sexually abused before age 18; many also reported witnessing interpersonal violence (Wolff & Shi, 2012). Researchers also noted that 56% of male inmates reported experiencing childhood physical trauma (Wolff & Shi, 2012). Rates of sexual trauma are lower (estimated between 10-16%), yet still substantially higher than the general population (estimated at 1-3%; Wolff *et al*., 2015; Wolff & Shi, 2012). More broadly, researchers have documented rates of trauma exposure for incarcerated men between 62.4% and 100% compared with 43% to 92% in the general population (Wolff *et al*., 2015; Wolff *et al*., 2014, Wolff & Shi, 2009). Researchers have noted that the lifetime rate of assaultive violence for incarcerated men is approximately 97% compared to approximately 43% for non-incarcerated men (Wolff *et al*., 2014).

Researchers have also established a strong link between exposure to adverse childhood events (ACEs) and substance use problems (Dube, Felitti, Dong, Chapman, Giles, & Anda, 2003; Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, & Koss, 1998). Adverse childhood events such as emotional or physical neglect or abuse, sexual abuse, witnessing violence in the home, living with someone dealing with mental illness, drug use, criminality, and/or divorce influence later substance use problems (Dube *et al*., 2003). One study found that ACEs accounted for 50 to

75 percent of substance use disorders (Dube *et al*., 2003). Considering childhood trauma as another barrier to successful treatment programming, and assessing for it, serves to support the existing goals of the RNR model. Trauma exposures have the potential to contribute to six of the eight central predictive risk factors for recidivism: namely antisocial behavior, antisocial cognition, family/marital problems, school or work problems, leisure and recreation problems (i.e. too much free time or lack of healthy peer group), and/or substance abuse (Andrews & Bonta, 1998; Ardino, 2012; Briere & Scott, 2013; van der Kolk, 2014). The experience of childhood trauma may be a static risk factor, but trauma-related behaviors that can result are dynamic and amenable to intervention (Briere & Scott, 2013; van der Kolk, 2014) and are therefore important risk factors to target.

Defining Trauma and Understanding its Impact

Trauma can be a single event, a single point in time (i.e. a rape, car accident, robbery), or can be chronic and repeated (Substance Abuse and Mental Health Service Administration (SAMHSA), 2014). Chronic traumas (multiple traumas happening to the same individual over time), include sexual abuse, neglect, or emotional abuse, living in poverty, ongoing exposure to violence, or being chronically under threat of violence, injury, or death (SAMHSA, 2014). Repeated traumas which are sustained or chronic in nature have been shown to reduce both resilience and adaptability (SAMHSA, 2014). The term *child maltreatment*, a specific type of chronic trauma, encompasses interpersonal forms of violence, neglect, or exploitation, including sexual abuse, physical abuse, emotional abuse, emotional neglect, and physical neglect, and typically refers to events that occurred in the home between a caretaker and child (Felitti *et al*., 1998; World Health Organization and International Society for Prevention of Child Abuse and Neglect, 2006). Due to the intimate and often enduring nature of this form of trauma, it has lasting negative impacts on individuals who are exposed and survive.

According to Felitti *et al*. (1998) and SAMSHA (2014), the cognitive effects from child abuse and maltreatment contribute to deficits in problem solving, memory, concentration, conflict resolution, organizational skills, and other executive functioning required for successful learning, educational and training outcomes. Lasting effects of child maltreatment include reduced capacity to cope with stress and regulate emotions (Shenk, Griffin, & O'Donnell, 2015), and difficulty in building relationships with others (SAMHSA, 2014). Behavioral and learning disabilities have been categorized as sequelae resulting from maltreatment (Sullivan & Knutson, 1998). Exposure to sexual and physical abuse in childhood significantly contributes to mental and emotional disorders in adulthood (Fergusson, Boden, & Horwood, 2008). Severity of maltreatment was found to increase mental illnesses in adulthood even when controlling for confounding factors (Fergusson, McLeod, & Horwood, 2013). An exceptionally high connection was detected between child maltreatment and adult substance abuse (Dube, Anda, Felitti, Edwards, & Croft, 2002), even when controlling for family history of alcoholism (Dube *et al*., 2003). A meta-analysis of studies investigating child sexual abuse reported numerous connections among maltreatment and alcohol, nicotine, and other drug use in adolescence, as well as risky sexual behaviors that result in negative health outcomes (Draucker & Mazurczyk, 2013).

The physiological responses to chronic and toxic stress in the form of maltreatment are well understood (Shonkoff & Garner, 2011). When a threat is detected, stress hormones (i.e. cortisol, adrenaline) are released resulting in increased heart rate, blood pressure, and respiration; such increases are in preparation for fight or flight (van der Kolk, 2014). When stress is manageable, false threats are detected and the stress response is halted.

When the system is overwhelmed, however, it can malfunction. The system reverts back to survival mode; when a threat is perceived, the brain goes straight into preparation for fight or flight (van der Kolk, 2014). Behaviorally, this can result in hypervigilance, exaggerated startle responses, intense anger or agitation in response to small annoyances, and/or freezing in physical encounters (Briere & Scott, 2013; van der Kolk, 2014). The body's survival response may engage before a person knows what is going on; this means that a person may react out of instinct before rational thought has occurred. If a threat persists, this triggered defensive system remains activated, resulting in continued arousal and agitation (van der Kolk, 2014).

Essentially, the body is always on guard and working to protect from threats that may not actually exist; decreased concentration, increased isolation, irritability and agitation, decreased ability to feel positive emotions, and/or emotional numbing can result (Briere & Scott, 2013; van der Kolk, 2014). The diminished ability to control responses such as the

startle reflex or aggressive outbursts can complicate one's ability to conform to the expectations of the correctional environment, as well as those in healthy relationships (Saakvitne, 2000).

The variability of trauma responses is noteworthy and there is no typical trauma response (Briere & Scott, 2013). One person may respond with short-lived symptoms and mild distress, while another may develop a long-lasting, diagnosable stress disorder. Trauma responses may encompass depressive symptoms, grief responses, anxiety, and/or panic (Briere & Scott, 2013). van der Kolk (2014) describes traumatization as "continuing to organize your life as if the trauma were still going on…as every new encounter or event is contaminated by the past" (pg. 53).

TRAUMA-INFORMED CORRECTIONAL CARE

Despite the significant problems associated with the lasting impact of maltreatment, research supports that recovery from this type of trauma is possible (Foa, *et al*, 2011; SAMSHA, 2014). Established, evidence-based practices for resolution of trauma symptoms exist (Cortois & Ford, 2009; SAMSHA, 2014). Treatment is not possible, however, if trauma is not identified as part of the RNR assessment procedures. Further, environments which are hostile, or dismissing of the connection between trauma and crime, acts to further invalidate the experience, which contributes to worsening of symptoms and problem behaviors (Briere & Scott, 2013). Trauma-informed corrections professionals are needed to better identity risks and needs, so that the responsivity principle can be fully satisfied. Trauma-informed services are predicated on understanding the biological, psychological, social, and neurological impacts of child maltreatment, in the lives of survivors. To paraphrase Maxine Harris and Roger Fallot (2001) from over a decade ago, there are plenty of systems that serve people who have survived trauma without providing any meaningful treatment for the trauma, and these providers may in fact be contributing to worsening of trauma-related symptoms. Uninformed providers can inadvertently contribute to treatment failures, worsening of symptoms, and increasing stigma (Harris & Fallot, 2001; SAMSHA, 2014).

A provider who does not know the rates of child maltreatment among those incarcerated, and how these experiences are connected to current behavioral patterns, cannot fully understand or appreciate how and why clients demonstrate such behaviors. Considering the same behavioral patterns through the lens of trauma adds context, both social and physiological, and provides direction towards remediation and appropriate care. While not yet firmly established in all human service agencies, trauma-informed care has grown in the last decade, and is becoming more available and prominent in schools and health delivery systems including pediatric care offices, mental health agencies, domestic violence shelters, and substance abuse treatment facilities (Capezza & Najavits, 2012). The relatively recent emergence of Trauma-Informed Correctional Care (TICC; Miller & Najavits, 2012) underscores the growing understanding of trauma's impact in the correctional realm. Proponents of TICC note the centrality of trauma in the lives of offenders (Harris & Fallot, 2006; Miller & Najavits, 2012).

TICC is similar to trauma-informed policies and practices in health services, but considers the unique corrections environment (Miller & Najavits, 2012). When TICC is implemented, researchers suggest that reductions in the cost of inmate healthcare can be realized as a result of improved assessment of needs and responsivity (Miller & Najavits, 2012). The unique experience of being incarcerated presents challenges to providing trauma-informed care. For instance, the negative psychological effects of living in a correctional environment can trigger the effects of childhood maltreatment, making recovery from trauma particularly difficult (Briere & Scott, 2013; Miller & Najavits, 2012). TICC aims to accurately identify trauma and associated symptoms, promote staff training around such issues and symptoms, and minimize inadvertent re-traumatization of inmates (Hodes, 2006; Miller & Najavits, 2012). Symptoms and behaviors resulting from trauma exposure, paired with a correctional environment that can feel unsafe, may inadvertently repeat aspects of past abuse (i.e. restraint, seclusion), and may increase perception of threat and activate or prolong the corresponding protective responses (Ardino, 2012; Covington, 2008; Miller & Najavits, 2012).

When trauma is present, protective mechanisms may be internalized and manifest as psychological or physical avoidance and they may also appear as aggression or arousal, which contribute to increases in aggressive and violent act. (Briere & Scott, 2013; Freedman & Hemenway, 2005; van der Kolk, 2014). A traumatized individual may respond to a perceived threat *with* a threat or preemptive strike as a means of

protection. When correctional staff discount the trauma, this adaptive means of survival can be misperceived as indiscriminate, random violence, or indicative of antisocial tendencies—thereby increasing risk (Andrews & Bonta, 1998; Miller & Najavits, 2012). Correctional settings and institutional dynamics present an array of trauma triggers. Some examples include the authority and power differentials between staff and inmates, discipline from authority figures, restricted movement, a decrease in or a lack of choices and opportunities, and shackles or periodic use of other restraints (Miller & Najavits, 2012). Further triggers include pat downs and strip searches, crowded conditions and/or lack of privacy, unexpected loud noises or abrupt changes in routine (i.e. sirens or spontaneous counts), the inability to remove oneself from a situation, lack of environmental control (i.e. some lights left on 24 hours a day, temperature settings), and restricted contact with family and friends (Ardino, 2012; Miller & Najavits, 2012; Owens, Wells, Pollock, Muscat & Torres, 2008). The risk of sexual assault significantly increases following incarceration compared to the general population (Miller & Najavits, 2012; National Prison Rape Elimination Act Commission, 2009).

For inmates with trauma histories, or for those who are traumatized while incarcerated, such triggers can complicate rehabilitation efforts and present significant barriers to change. For example, the dynamic risk factor of *antisocial personality* has indicators that include impulsivity, aggressiveness, irritability, and adventure-seeking (Hanson, 2010). Considering such traits in isolation, an anger management intervention seems appropriate to increase affect regulation and decrease impulsiveness. If an individual with antisocial personality has a history of childhood trauma, anger management would likely be more effective after first addressing trauma history in a therapeutic process. Without trauma-specific treatment, anger management alone is less likely to lead to behavioral change, and growth may be limited (Miller & Najavits, 2012; Saakvitne, 2000). More specifically, someone who is quick to anger may be more criminogenic or they may be exhibiting lingering trauma symptoms. Aggression, impulsiveness, and general dysregulation may stem from hormonal changes in the body linked to the past trauma and survival responses, not an antisocial personality or an unwillingness or inability to change (Briere & Scott, 2013; van der Kolk, 2014). As such, interventions targeting criminogenic behaviors are more likely to lead to change when done from a trauma-informed perspective. New insight and healing of the underlying trauma can reduce the need for the protective responses (i.e. aggression or impulsiveness; Briere & Scott, 2013; van der Kolk, 2014); thus modifying behaviors while satisfying both general and specific responsivity principles.

In order to distinguish trauma symptoms from criminogenic needs unrelated to traumatic events, however, assessments need to specifically screen for trauma and associated symptoms. Current risk assessment instruments fail to specifically consider trauma-related symptoms. Comprehensive trauma assessment will not only inform determinations of risk, but also identify treatments or services that may help reduce risk long-term.

RISK ASSESSMENT THROUGH THE TICC OPTICS

Researchers have asserted that accounting for trauma in the daily interactions with offenders has shown promise in increasing responsivity to interventions aimed at reducing risk of re-offending (Miller & Najavits, 2012). Additionally, trauma-informed workplaces are safer for all, including staff, and trauma-informed settings can reduce staff burnout and turn-over associated with working with offenders (SAMSHA, 2014). Trauma-informed care can include trauma-specific treatment, but the term *trauma-informed care* as it refers to most settings, including correctional settings, describes an environment that is conducive to the services available. Harris and Fallot (2001) use the analogy of disability-accessible environments providing convenient parking, ramps, braille, non-verbal signs, and other features that promote inclusion of all people, but is not specifically treating a disability. A system-wide trauma-informed approach is recommended (Harris and Fallot, 2001), since this approach maximizes the likelihood of a conducive environment for specific RNR interventions. TICC ensures that the people most likely to interact with trauma survivors are knowledgeable and sensitive in ways that prevents re-traumatization, and enhances service outcomes. The Substance Abuse and Mental Health Services Administration (2014) outlines principles for trauma-informed approaches, which include the following: 1) awareness of types of trauma and the impact on life outcomes; 2) recognition of symptoms and behaviors known to result from trauma exposure; 3) response to trauma with appropriate interventions and services; and finally, 4) sensitivity to the possibility of re-traumatization so that efforts are made to prevent this. These principles guide policies and practices that can be tailored to specific

environments, and are aligned with the risk-needs-responsivity model used in correction settings outlined previously.

Several important steps are recommended to enhance trauma-informed correctional care. The first step is for administrators and supervisors to receive training so that a culture of trauma-informed correctional care is possible. As explained earlier, a system-wide approach is recommended, with tailored and more expansive training for therapeutic staff, and those involved in the RNR process. Specific trauma-informed practices as they relate to gender and corrections settings are recommended to enhance effectiveness. For this level of trauma-informed training, there are a plethora of free resources available online, most of them targeting children and non-offending populations. Specific curriculum and training materials pertinent to offending populations are available from several sources, including the Institute for Health and Recovery (2012; 2011); Miller and Najavits (2012); the National Institutes of Health (2017), and SAMHSA (2017a).

In order to promote a trauma-informed culture within corrections, a minimum level of training can be provided to all staff by accessing free, publicly available resources, such as the Trauma-Informed Care in Behavioral Health Services manual which can be accessed from the Substance Abuse and Mental Health Services Administration (SAMSHA, 2014) website. This resource includes facts about trauma, and outlines the principles stated earlier. Contained within this resource is an assessment tool that can be used to determine the level of trauma awareness among the remaining correctional staff. This instrument, *The Trauma-Informed Counseling Competencies Checklist* (SAMSHA, 2014) is geared for counselors, but can be modified for use with other human service professionals. Results from this scale can help administrators identify and prioritize staff training needs so that targeted training related to trauma-informed care and practices can be determined for specific settings, or specific staff members and job roles.

For staff who use the RNR model to assess for risks and design responsivity interventions, tailored training on evidenced-based practices is needed. There are evidenced-based programs and curriculum available for use within health care settings, substance abuse treatment facilities, and school settings. The current authors recommend SAMSHA's National Registry of Evidence Based Programs and Practices (2017b), which grades available programs, describes the intended audience, and outlines the outcomes, including promising outcomes. This resource can guide administrators and other personnel as they identify suitable programs that best fit their roles and correction-specific context. These programs can be purchased and used for those who require more targeted training to enhance the responsivity principle. For instance, some trauma interventions target adults with substance abuse histories and behavioral disorders; others target mental health symptoms such as depression. Some programs are geared for adolescents, while others are specific to adults.

For psychologists and counseling staff, specific training for treatment of Posttraumatic Stress Disorder is recommended (Foa *et al*., 2009). Additionally, for probation officers and correctional staff whose role includes safety management and enhancement, specific crisis intervention strategies can be tailored with trauma-informed practices so that re-traumatization is minimized, and can be addressed if symptoms of trauma are triggered or exasperated (Miller & Najavitis, 2012).

System-Wide Screening

Inclusion of trauma-assessments as part of the RNR process, enhances the needs-matching and responsivity outcomes. Given the over-representation of trauma exposure in the corrections population, and the wide-ranging symptoms and impacts on individuals, system-wide screening is recommended for all as part of a comprehensive RNR assessment. Several instruments are recommended for use. The Stressful Life Events Screening Scale (SLESS), (Goodman, Corcoran, Turner, Yuan, & Green, 1998), contains 11 items, and is recommended for broad use, covers a range of traumatic events, including many forms of adult and childhood traumas, including two forms of child maltreatment: sexual and physical abuse. While this instrument is inclusive of many types of trauma, three types of child maltreatment, physical neglect, emotional neglect, and emotional abuse, are not included. For these domains, we recommend use of the Childhood Trauma Questionnaire CTQ (Bernstein & Fink, 1998). The CTQ is recommended for use in adults, and contains 26 items covering five categories of childhood maltreatment: physical abuse, sexual abuse, physical neglect, emotional abuse, and emotional neglect.

Targeted Screening

Targeted assessment is recommended for inmates who screen positively for trauma exposure using the above listed instruments. The PTSD Checklist for DSM-5 (PCL-5) is recommended in these instances. The PCL-5 (Weathers, Litz, Keane, Palmieri, Marx, & Schnurr, 2013) is a 20-item self-report measure that assesses for the presence of DSM-5 PTSD symptoms. The instrument is designed to screen individuals for PTSD (using a lower cutoff), provide a provisional diagnosis of PTSD (using a higher cutoff), and/or to monitor treatment response (i.e. symptom change during and after treatment). The initial screen would identify individuals with trauma symptoms; a follow-up meeting with a trained clinician to determine if the individual meets provisional or full diagnostic criteria could follow. This procedural recommendation is in line with current risk assessments that rely on structured professional judgment (Andrews, *et al*., 2006).

The Ohio Risk Assessment System (ORAS; Latessa *et al*., 2009), a 4th generation risk instrument, specifically lists mental health issues as an optional

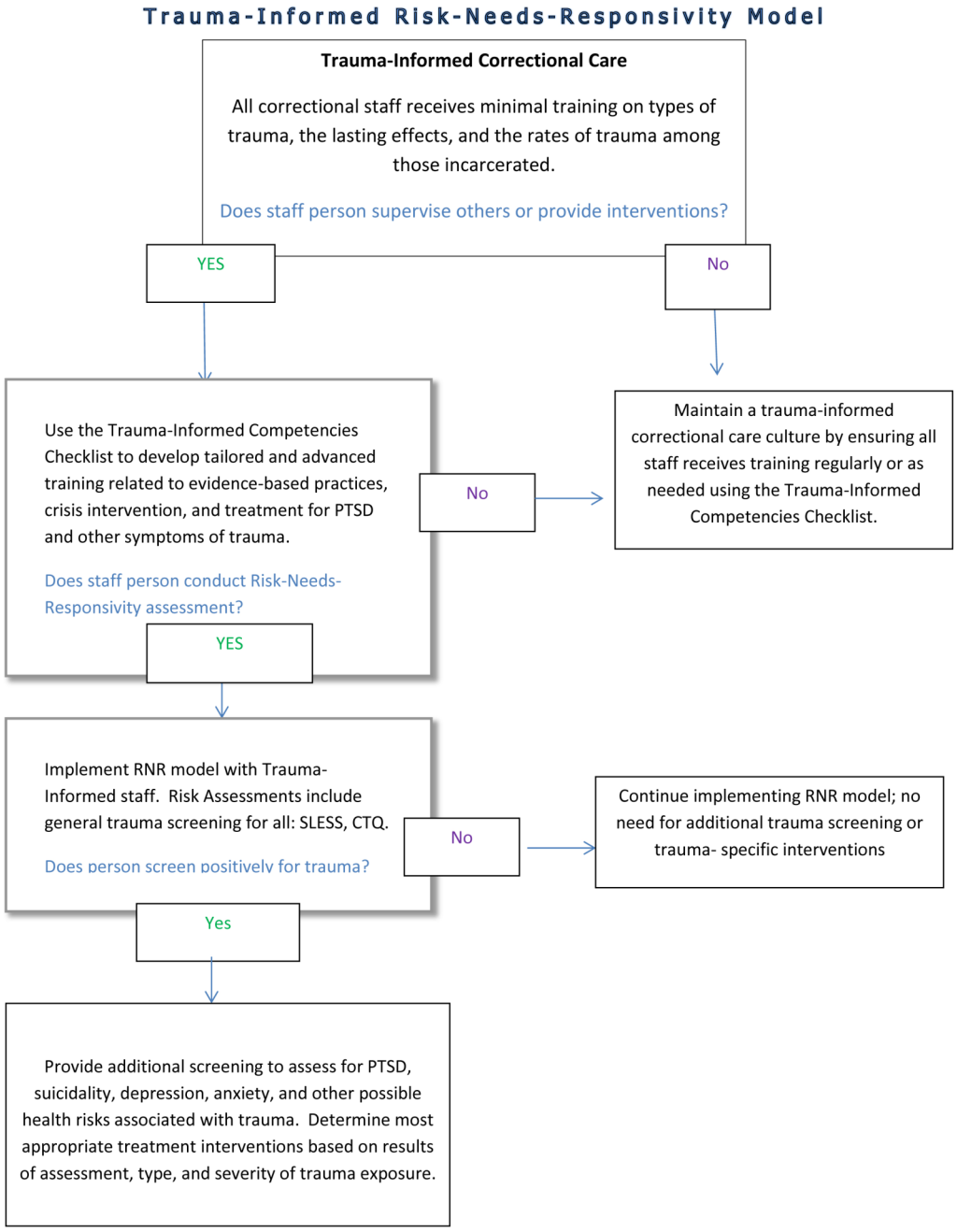

Figure 1: Trauma-Informed Risk-Needs-Responsivity Model.

override based on the professional judgment of the assessor. In short, if the assessor believes that mental health requires further evaluation in order to properly assess risk, it is noted, and further assessment is recommended (Latessa *et al*., 2009). The current recommendation of pairing the PCL-5 with existing measures of risk adds specificity; having trauma-specific information and detail at the time of targeted assessment is prudent as structured professional judgment does not *require*, but rather recommends, additional assessment (Latessa *et al*., 2009).

Additional screening for high risk behaviors such as suicidality, and substance abuse is strongly recommended as part of risk assessment protocol for all who screen positive for trauma. Professionals trained to assess for suicide and substance abuse should conduct these additional risk assessments. The current authors provide a model that incorporates the trauma-informed screening and training practices recommended as part of the existing RNR process commonly used in corrections settings.

FUTURE RESEARCH

The fairly recent emergence of trauma-informed correctional care invites opportunities to investigate the effectiveness of these procedures on a range of outcomes, including recidivism rates, behavioral change, correctional staff-offender relationship, employment and community integration outcomes, symptom reduction, substance abuse rates, and other criminogenic needs. Validation of trauma assessments in offending populations and research to determine the effectiveness of programs in corrections settings are also needed. Testing the model outlined here to guide trauma-informed assessment and practices is needed to determine if this model is viable and enhances the RNR process. Feasibility studies investigating adherence to trauma-informed policies and practices are further needed. Finally, creation of a trauma-informed correctional care culture is ambitious; a better understanding of the specific methods for reaching this goal is needed.

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