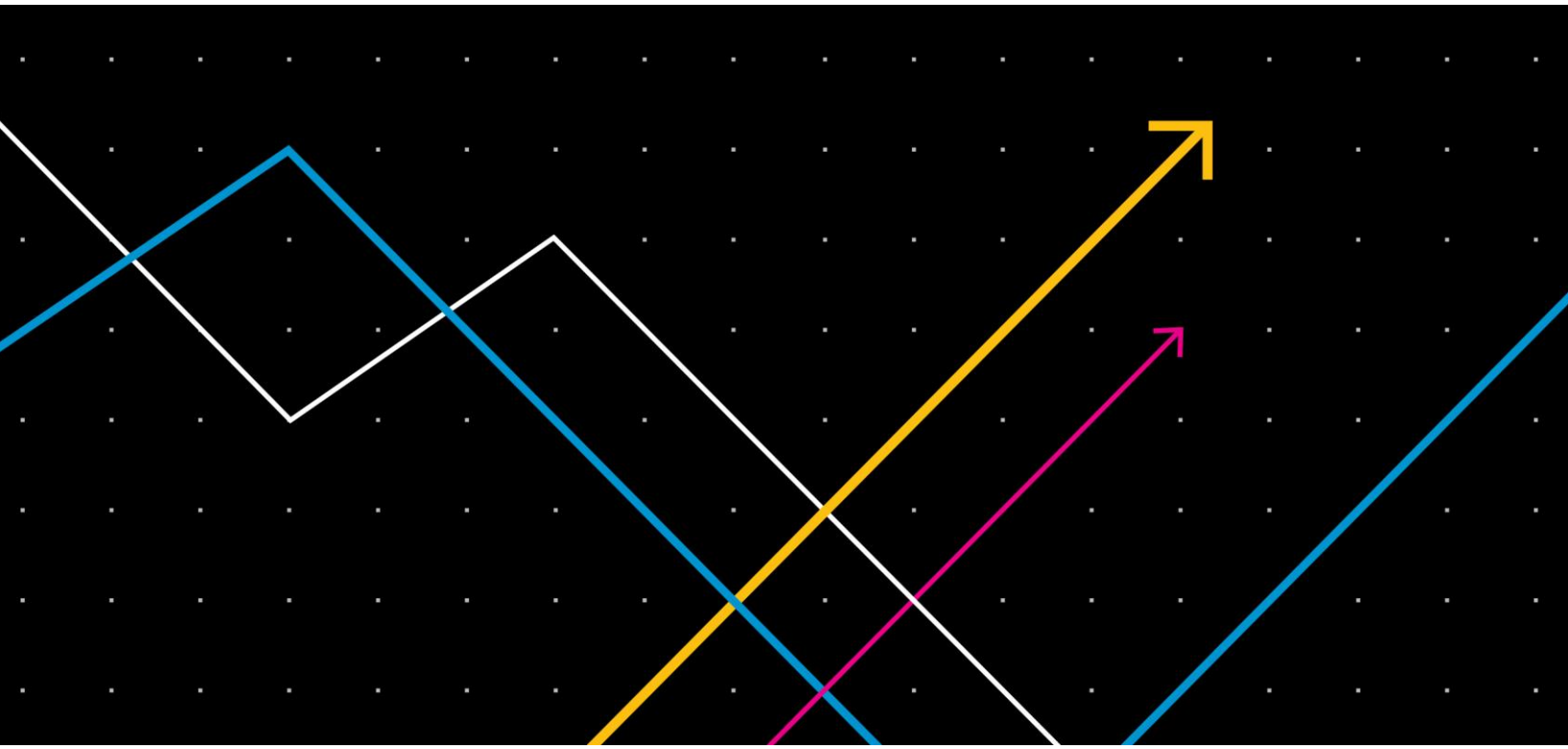

RESEARCH REPORT

Addressing Trauma and Victimization in Women's Prisons

Trauma-Informed Victim Services and Programs for Incarcerated Women

Storm Ervin
URBAN INSTITUTE

Jahnavi Jagannath
URBAN INSTITUTE

Janine Zweig
URBAN INSTITUTE

Janeen Buck Willison
URBAN INSTITUTE

Kierra B. Jones
URBAN INSTITUTE

Katy Maskolunas
NATIONAL CENTER FOR VICTIMS OF CRIME

with

Benjamin McCarty
COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Chafica Agha
NATIONAL CENTER FOR VICTIMS OF CRIME

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Executive Summary

Women are the fastest-growing incarcerated population in the United States. Between 1980 and 2017, the number of incarcerated women increased 750 percent (The Sentencing Project 2019). Despite this drastic increase, correctional institutions still often lack awareness and understanding of the victimization that many—if not most—incarcerated women experience before incarceration (Bloom 2015). Many women bring past trauma into prison settings, where they often experience similar violence, abuse, and trauma as they experienced on the outside. As the population of women incarcerated in the US grows, so does the dire need for services that address trauma and victimization. Given that incarceration can be inherently retraumatizing and many justice-involved women have experienced trauma, correctional facilities are uniquely positioned to serve as de facto victim service providers.

In 2017, the National Institute of Justice funded the Urban Institute—and its partners the Center for Effective Public Policy, the Correctional Leaders Association, and the National Center for Victims of Crime—to conduct a national scan of practice to examine the extent to which correctional facilities provide services and programming that address incarcerated women's prior and current trauma and victimization experiences. Drawing from semistructured interviews with leaders in 41 state departments of corrections (DOCs); leadership at 15 women's prisons (standout sites) that seemed to implement innovative and/or comprehensive approaches to address trauma; and staff, community partners, and incarcerated women at three case study correctional facilities, as well as from surveys of 57 state domestic violence (DV) and sexual assault (SA) coalitions, this report describes findings regarding the unique needs of incarcerated women, the ways correctional agencies identify and address trauma and victimization, the provision of victim services in prison settings, and partnerships that promote healing (the appendix includes graphics showing sites and agencies that participated in the study). This summary also examines challenges to addressing trauma and victimization and provides recommendations for practitioners working to make correctional facilities trauma-responsive (these recommendations are also listed in table 1).

Major Findings

Major findings regarding services and programming for people incarcerated in women's correctional facilities include the following:

- The DOCs that participated in this study rely primarily on standardized assessments and less-formal staff interactions with incarcerated women to detect past victimization. Of the 41 state DOCs we interviewed, 15 reported using a gender-responsive risk assessment tool at intake. When asked about victimization incidents that relate to the Prison Rape Elimination Act, facility staff reported that they learn of them through internal and external hotline calls, written reports, verbal reports, and reports from peers.
- Of the victim services available for incarcerated women, most fall into one of four types: (1) safety and security, (2) medical advocacy, (3) emotional support and therapy, and (4) legal advocacy.
- Safety and security measures largely involve separating the victim from the person who caused harm.
- State DOCs and correctional facilities reported using medical assessments and follow-up services to respond to in-custody victimization. These assessments may include a sexual assault forensic exam (SAFE), testing for sexually transmitted disease, and pregnancy testing. Either a local hospital, a local rape crisis center, or facility medical staff will administer the assessments.
- Emotional support in the form of mental health treatment is the most common service provided—both for past trauma and in-custody victimization—in the DOCs and facilities we studied. Incarcerated women, correctional staff and DOC stakeholders, and community partners expressed that mental health services in prisons are limited by a lack of internal staff expertise around sexual assault, and by infrequent opportunities for women to meet with mental health staff.
- Some DOCs and facilities provide legal services in the form of sexual assault response teams (SARTS) and assistance from victim advocates to support victims. Incarcerated women expressed a desire for more crisis intervention services and legal services, such as meetings with victim advocates.
- Interview participants infrequently mentioned religious services as a way to respond to victimization incidents.
- Programming, rather than victim services, is how most women's facilities aim to be trauma-responsive. For example, all standout sites implemented at least one evidence-based program, such as Seeking Safety, Moving On, Helping Women Recover, Beyond Trauma, and Beyond Violence. In addition, some facilities offered innovative programs, such as trauma yoga, Go Ahead, and Roadway to Freedom, to address trauma related to DV and human trafficking.

Others provided trauma-informed substance abuse treatment (Helping Women Recover) to address addiction rooted in past trauma. Many, however, could not meet the demand for such treatment programming due to limited resources. Facilities also engaged in innovative programming. For instance, some midwestern states' DOCs mentioned they partnered with organizations that serve women who are veterans (through the Family Peace Initiative) or Native American (through the organization White Bison). These constitute marginalized groups who are at increased risk of past victimization. Furthermore, some DOCs use innovative ways of celebrating women on their path to sobriety by hosting a Rally for Recovery, as a part of SAMHSA's National Recovery Month. One facility offers a unique residential unit specifically for women who have experienced sexual assault and/or domestic violence.

- Some states used technology in unique ways to deliver programs to women, especially during the advent of the COVID-19 pandemic. Some facilities begun using virtual tools such as tablets.
- Many facilities rely on peer support programs and peer mentors. These may also be called survival coaches or peer navigators. Such programs allow incarcerated women to assist other women. Some of their roles include helping incoming women orient to the facility, consulting women who have experienced victimization, speaking with facility leadership, and taking recommendations from other women to leadership. We spoke to women in the role who spoke highly of the program and appreciated being able to help their peers and witness their growth.
- Challenges with programming involved operational and budget challenges; strict eligibility criteria for program participation; and programs that are punitive and dismissive toward participants. Interview participants also cited gaps in programming that included a lack of programs for post-traumatic stress disorder, for positive sexuality, and for people who identify as LGBTQIA+.
- State DOCs partner with state DV/SA coalitions in various capacities, including training correctional staff and working toward compliance with Prison Rape Elimination Act standards. Most often, DV/SA coalitions work with facilities' victim assistance units or Prison Rape Elimination Act coordinators.
- Member agencies of state DV/SA coalitions play a crucial role in aiding survivors in women's prisons. Though we learned most information about member agencies from DV/SA coalitions, we also spoke to representatives from member agencies at our case study sites and learned that they provide advocacy after in-custody victimization and work with prison-based sexual assault response teams.

- The collaborations between state DV/SA coalitions and member agencies were most often supported by STOP Violence Against Women Formula Grant Program, Violence Against Women Act, and Victims of Crime Act funding. However, DV/SA coalitions reported that insufficient funding and difficulties accessing and maintaining contact with incarcerated women were among some of the key challenges in advancing their victim services work with DOCs and corrections facilities.
- In addition to partnerships with DV/SA coalitions, DOCs and facilities partnered with community-based providers (some of which are also member agencies) and other state agencies to provide services and train incarcerated women to serve as peer coaches. Some notable partnerships between facilities and organizations that help foster healing include the YWCA, Just Detention International, Alabama Prison Birth Project, Planned Parenthood, and Family Justice Centers.
- Two significant challenges impeding facilities' attempts to be trauma-responsive involve (1) undermining of the validity of incarcerated women's personhood and victimization experiences, and (2) staff violence against women.

Topical Recommendations

TABLE 1

Recommendations for Addressing Trauma and Victimization

Area	Recommendations
Identifying trauma and victimization in women's prisons	▪ Use gender-responsive risk assessments that ask about past trauma. ▪ Increase efforts to identify past trauma and victimization during a person's sentence. ▪ Increase efforts to proactively identify all types of victimization experiences. ▪ Identify more opportunities to teach staff about identifying flags for in-facility victimization rather than over-relying on self-reporting.
Victim services	▪ Develop more or strengthen existing in-facility sexual assault response teams, which are a major avenue for connecting victims to services (not just means of investigating incidents). ▪ Ensure that mental health staff responding to past victimization or victimization occurring in custody have training and expertise in dealing with trauma.
Programming	▪ Continue to provide evidence-based programs focused on trauma and victimization. ▪ Work with researchers to evaluate the efficacy of non-evidence-based programs. ▪ Consider virtual programs and services from outside partners. ▪ Train and provide support to people incarcerated in women's facilities to serve as peer mentors to others.

Area	Recommendations
	▪ Implement programming around positive sexuality outside the context of domestic violence and sexual assault. ▪ Develop more trauma-focused and/or victimization-focused housing units as a wraparound approach for addressing these issues for incarcerated women. ▪ Implement programs or incorporate a lens in existing programs to better serve the needs of women convicted of sex offenses. ▪ Expand programs for women with life and long sentences as well as women at low risk of recidivating.
Partnerships	▪ Work to forge collaborative partnerships with state DV/SA coalitions. ▪ Increase community-based providers' contact with and services for incarcerated women. ▪ Partner with other state-based organizations

Overall Recommendations

Based on the findings detailed above, we make the following recommendations for stakeholders and practitioners seeking to make their correctional facilities and environments more trauma-responsive:

- Revamp correctional facilities' cultures, operational practices, and programming to be trauma informed, trauma responsive, and trauma specific (Covington, forthcoming). In the companion report, *Adapting Custodial Practices to Reduce Trauma for Incarcerated Women* (McCoy et al. 2020), we describe approaches to correctional culture, operations, and practices that may reduce harm, address trauma, and increase women's well-being.
- **Increase efforts to identify victims' responses to trauma.** Given victimization often produces symptoms and triggers over time, victims may exhibit behaviors that appear misguided but are actually responses to trauma. If prison staff are trained to recognize these behaviors, they can tailor their responses in ways that are trauma specific. This approach may include connecting victims with mental health services, community partners, and/or programming.
- **Respond to the unique needs of people in women's prisons who are not heterosexual cisgender women.** One major challenge in correctional institutions is their polarized approach to gender and sexuality. Women's prisons often have people who do not identify as cisgender women, such as trans men, trans women, nonbinary people, people who are gender nonconforming, and others who identify as LGBTQIA+. People in these communities have unique victimization needs and are more likely to have experienced childhood sexual assault and in-custody sexual assault (Meyer et al. 2017). Given their heightened risks, correctional practices should work to prevent their continued victimization.

- **Partner with community victim service providers to provide services that facilities may not be able to.** Facilities use innovative approaches to provide services to incarcerated women, many of which involve external partnerships. These partnerships can allow facilities to provide specialized services to women of different identities and with different needs. Partnerships with external agencies also allow women to continue relationships with service providers after incarceration, thus promoting sustainability of positive outcomes.
- **Partner with research organizations to evaluate programs and services.** This national scan of practice highlights several practices related to addressing trauma and victimization. However, the extent to which women benefit from these efforts is largely unknown. By partnering with research organizations to evaluate programs and services, DOCs can learn what works best to improve their practices and address women's needs.

Addressing Trauma and Victimization in Women's Prisons

During the past few decades, women—disproportionately women of color—have been the fastest-growing incarcerated population in the United States (Huebner, DeJong, and Cobbina 2010; Kaeble et al. 2016; The Sentencing Project 2019; Swavola, Riley, and Subramanian 2016). Between 1980 and 2017, the number of women incarcerated in the US increased 750 percent, and African American women were incarcerated at twice the rate (92 per 100,000) of white women (49 per 100,000). In addition, Latinx women were imprisoned at 1.3 times the rate (66 per 100,000) of white women. Furthermore, women are more likely to be incarcerated for nonviolent crimes, such as property offenses, public order offenses, and drug offenses (The Sentencing Project 2019).

People incarcerated in women's prisons have unique needs that corrections systems must address. Legal-system stakeholders are often unaware of, or fail to understand, the victimization that many (if not most) incarcerated women experience before entering the legal system (Bloom 2015). As the number of incarcerated women increased during the past several decades, correctional institutions have become de facto victim services agencies for people incarcerated in women's prisons—including transgender and gender-nonconforming people—with histories of victimization and trauma. However, correctional facilities' programs, policies, and practices have historically oriented toward the circumstances of cisgender men, with little consideration for the unique needs of cisgender women, trans men, trans women, and nonbinary people. This orientation may cause treatment and services to be less effective for the growing population of people confined in women's prisons (Benedict 2014; Bloom 2015). If correctional institutions are to consider the specific needs, pathways to incarceration, and histories of violence that people other than cisgender men experience before and during incarceration, then certain changes will be necessary.

A burgeoning body of literature suggests that implementing gender-responsive and trauma-informed care to better reflect this profound shift in incarcerated populations will aid in successful reentry, restore women's health and well-being, and enhance prison safety and security (Benedict 2014). Innovative approaches to programming and practices are paramount to ensure adequate treatment and to reduce recidivism (Benedict 2014; Huebner, DeJong, and Cobbina 2010). Despite correctional institutions' increased efforts to make their practices more gender responsive and trauma informed, little is known about the full nature and scope of what departments of corrections (DOCs) are doing in these areas.

In 2017, the National Institute of Justice funded the Urban Institute to evaluate in-prison programming for incarcerated women (formally titled the Evaluation of In-Prison Programming for Incarcerated Women: Addressing Trauma and Prior Victimization). With our partners at the Center for Effective Public Policy, the Correctional Leaders Association, and the National Center for Victims of Crime, we conducted a 33-month mixed methods study of policies, programs, and practices used nationwide to address incarcerated women's victimization and trauma experiences. In this report, we address two of the project's goals:

- Capture a national snapshot of how state DOCs attempt to address the impacts of victimization on incarcerated women and of how traditional victim service providers are reaching into facilities to provide services.
- Identify and document promising and innovative prison-based victim service models through case studies.

We examine services and programs for incarcerated women who experienced victimization before and during incarceration. Drawing from semistructured interviews with leaders in 41 state DOCs; leadership at 15 women's prisons (standout sites) that seemed to implement innovative or comprehensive approaches to address trauma; staff, community partners, and incarcerated women at three case-study facilities;[1] and surveys of 57 state domestic violence (DV) and sexual assault (SA) coalitions, this report includes the following:

- a review of literature on women's experiences with trauma before and during incarceration
- ways facility staff become aware of women's histories of trauma and victimization and/or their experiences while incarcerated
- services and programming that correctional facilities provide to people in women's prisons who experienced victimization before or during incarceration
- the nature of DOCs' and correctional facilities' collaborations with state-level DV and SA coalitions as well as local victim service providers

We conclude the report by (1) describing challenges that DOCs and correctional facilities face when addressing trauma and victimization; (2) discussing the study's limitations; and (3) articulating a call to action through recommendations for how practitioners and policymakers can address the unique needs and improve the experiences of incarcerated women. The appendix includes graphics depicting organizations that participated in this study.

BOX 1

Data Collection Activities and Methods

The Urban Institute and its partners, the Center for Effective Public Policy, the Correctional Leaders Association, and the National Center for Victims of Crime, were funded by the National Institute of Justice to conduct a two-tiered, 33-month, exploratory mixed methods study of departments of corrections' policies, programs, and practices for addressing incarcerated women's prior trauma and victimization and for preventing in-custody victimization. We used the following activities and methods to collect data for this study:

- **Web-based survey of domestic violence and sexual assault coalitions.** We sent an electronic survey to 81 such coalitions; 57 completed it, yielding a 70 percent response rate.
- **Phone interviews with leadership from state DOCs.** We interviewed 108 correctional leaders—a mix of state DOC commissioners, directors of programming, specialized gender-focused professionals, and some facility leaders—in 41 states, with a response rate of 82 percent.
- **Phone interviews with standout states.** After analyzing 41 interviews with state DOC leaders, we identified 16 states taking innovative or comprehensive approaches to addressing trauma and victimization. With the data analysis and input from DOC leaders, we selected facilities in those states and interviewed a combination of wardens (or superintendents) and programming directors, or wardens (or superintendents) and clinical directors. We spoke with 31 staff at 15 facilities.
- **Case-study interviews with facility staff, community partners, and incarcerated women.** We conducted case-study site visits to three women's prisons, during which the team conducted 40 semistructured interviews with 81 stakeholders (including correctional leadership, security staff, program providers, peer navigators, and community partners) and 28 incarcerated women. All of the incarcerated women that we interviewed indicated that they use she/her pronouns.

What Do We Know about the Unique Needs and Experiences of Incarcerated Women?

To provide context about the need for in-prison programming and services for incarcerated women, in this section, we review literature on women's histories of victimization, in-prison victimization, and incarcerated women's unique needs.

Justice-Involved Women's Victimization Histories

Incarcerated women have histories of victimization and trauma at higher rates than incarcerated men (Swavola, Riley, and Subramanian 2016). Women entering the justice system have often dealt with

trauma exposure, interpersonal trauma, victimization, post-traumatic stress disorder (PTSD), and other violence.[2] For example, in a multisite study of urban and rural jails, Lynch and coauthors (2014) found that the lifetime prevalence of PTSD among a sample of incarcerated women was 53 percent, compared with a prevalence of 10 percent in the general population. Moreover, women are more likely than men to have experienced violence and/or sexual victimization before incarceration (Lynch, Fritch, and Heath 2012; Swavola, Riley, and Subramanian 2016). Such histories are frequently linked to the pathways that lead women to incarceration.

Moreover, a large share of incarcerated women serve sentences for drug-related offenses that can be traced to their experiences with trauma and victimization (DeHart et al. 2014). Women are often incarcerated for crimes connected to intimate partner violence, such as defense against an abusive partner or the inability to keep children from being harmed by an abusive partner (Renzetti, Miller, and Gover 2012).

Women are more likely to experience victimization not only *before* incarceration, but also *during* incarceration (Beck, Rentala, and Rexroat 2014). Though women constitute a small minority of the incarcerated population in the US, they are disproportionately represented among victims of assault and other violence in prison. Analyzing data provided by correctional authorities about substantiated incidents of sexual victimization in facilities, Beck, Rentala, and Rexroat (2014) found that women accounted for only 7 percent of the incarcerated population in the US between 2009 and 2011 but represented 22 percent of victims of assault perpetrated by other incarcerated people and 33 percent of victims of assault perpetrated by facility staff in state and federal prisons.

Correctional facilities have not evolved to address growing concerns around victimization. Although corrections institutions have become marginally aware of the traumatic pathways women take to incarceration, turning awareness and understanding of trauma histories into actionable programs and procedures is imperative to working with women in correctional spaces, which are inherently traumatizing.

In-Custody Victimization and the Prison Rape Elimination Act

Women are disproportionally represented among victims of violence in prisons, particularly sexual violence (Beck, Rentala, and Rexroat 2014). Sexual violence also disproportionately affects other marginalized groups in prisons, including people with disabilities, LGBTQIA+ people, and people who have experienced sexual violence before incarceration (Beck et al. 2013; Just Detention International 2018a, 2018b, 2018c; Meyer et al. 2017). Prisons' unique context and characteristics—including

inherent power imbalances and limited movement and freedom—require special consideration and protections for people at elevated risk of victimization.

In 2003, the federal government began to address sexual violence in prisons by passing the Prison Rape Elimination Act (PREA), which outlines provisions for preventing and eliminating sexual violence. Later, it formed the National Prison Rape Elimination Commission (Just Detention International 2018a).[3] Since PREA was implemented, rates of sexual violence in US prisons have significantly increased, likely because *reporting* of victimization experiences has increased, as opposed to actual victimization rates. From 2011 to 2015, reports of such victimization increased 180 percent, from 8,768 to 24,661, respectively (Rantala 2018). Although reporting increased, fewer reports have been substantiated (Santo 2018).[4] Findings suggest that though PREA mandates influenced reporting and research efforts, they may fall short in regulating investigative processes, which are largely left to facility and/or state discretion.

Correctional facilities are in a unique position not only to prevent instances of sexual violence, but to adequately address and provide services to victims when incidents occur. Facilities across the US have implemented several strategies for supporting victims, such as hotlines for reporting, medical and clinical response teams (e.g., sexual assault response teams [SARTs]), and ongoing continua of care for survivors (Zweig et al. 2006). Despite these innovations, steps still need to be taken to create comprehensive victim services and eliminate sexual violence in prisons altogether.

Unique Behavioral and Clinical Health Needs for Justice-Involved Women

Recent research indicates that incarcerated women have substantial behavioral health needs as they experience higher rates of mental health and substance use disorders (including rates of co-occurring disorders) than men and nonincarcerated adults (James and Glaze 2006; Bronson et al. 2017). Over 70 percent of women in US state prisons and jails reported a mental health problem (James and Glaze 2006). Nearly 70 percent reported symptoms meeting the criteria for drug dependence or abuse detailed in the Diagnostic and Statistical Manual of Mental Disorders (fourth edition);[5] furthermore, nearly 50 percent of incarcerated women used drugs in the month before the offense and at the time of the offense (Bronson et al. 2017). As such, justice-involved women's behavioral health needs are complex and require additional resources for assessing and treating (Lynch et al. 2012).

Correctional settings do not always approach people's behavioral health needs in trauma-informed ways. However, because women who experience mental health and substance abuse issues also often

experience victimization and trauma, providing trauma-responsive and trauma-specific treatment is relevant and necessary to ensure adequate care.

As the field continues to evolve with how it approaches and understands trauma, how it grapples with women's histories of victimization, and how it addresses incarcerated women's behavioral health needs, correctional institutions must also reconsider their understanding of trauma. Stephanie Covington, a subject matter expert who developed evidence-based programming that we discuss later in this report, calls for drawing clear distinctions between trauma-sensitive, trauma-informed, trauma-responsive, and trauma-specific practices (Covington, forthcoming). According to her definitions, **trauma-sensitive** work involves a broad awareness that people who become justice involved have likely experienced trauma; **trauma-informed** work involves awareness of trauma and how it effects people, communities, and the public at large; **trauma-responsive** work involves using policies and practices to lessen damage and make the most of opportunities for healthy progress and growth; and **trauma-specific** work involves providing specific services that explicitly respond to violence, trauma, and associated symptoms to promote healing and recovery (Covington, forthcoming). Throughout this report, we use these definitions to contextualize our findings around state DOC practices to understand how correctional institutions are responding to trauma through services and programs.

This study is the first national scan of practice to examine the extent to which correctional facilities provide services and programs to address incarcerated women's histories and experiences of trauma and victimization. It establishes the state of the field around these issues in the US, identifies recommendations for what facilities can do to improve such practices, and documents strategies that future research can use to understand which of these approaches mitigate trauma for incarcerated women and improve their overall well-being.

How Departments of Corrections and Correctional Settings Identify Trauma and Victimization

Identifying trauma and victimization that women have experienced before becoming justice involved and while in custody is key to ensuring that programs and services are trauma responsive and trauma specific. We found that state DOCs and correctional settings use several methods to identify past trauma and victimization experienced while in custody. Nearly all of these methods involve having women self-report their experiences.

Identifying Past Victimization and Trauma

Most prisons use a combination of standardized assessments and informal staff interactions with incarcerated women to detect past victimization and trauma. Facility intake staff and/or mental health staff conduct assessments with people entering their facilities, mostly to understand their housing and programming needs. These assessments may start right when a woman arrives or may be delayed until after the full intake process (which may take days or weeks). Staff may reassess a woman's needs throughout their incarceration to reevaluate programming and mental health service needs.

Staff reported using various assessment tools. Per PREA standards, prison staff conduct early assessments to understand a person's history and risk of victimization, as a person's history might indicate their vulnerability to physical and/or sexual assault.[6] Nearly half of state DOCs that we connected with reported that they assess for past trauma and/or victimization in addition to conducting their PREA assessment. Of the 41 participating state DOCs, 15 reported using a risk assessment tool that is either gender responsive and/or assesses for past trauma. Examples include the Women's Risk Needs Assessment, the Service Planning Instrument for Women, and the Static Risk and Offender Needs Guide – Revised.

In addition to assessment tools, facilities use less standardized mechanisms to identify past victimization. Examples include having people voluntarily disclose their histories during support groups, participate in trauma-informed programs (such as Beyond Trauma), and relay their histories of personal trauma to mental health counselors.

Identifying In-Custody Victimization Experiences

Most women's facilities offer incarcerated people multiple ways to report victimization, some of which are required by PREA standards. Practices for detecting victimization in prisons vary from state to state; most rely on people to self-report their experiences. People incarcerated in women's prisons learn how to report a PREA incident during intake and/or orientation, often by watching a video about what would be considered a PREA incident and how to report it. In some cases, women's prison staff offer incarcerated people multiple opportunities to view these videos during their sentence. Facilities also typically display information about PREA using posters and/or flyers. In addition, some facilities allow incarcerated women to serve as peer mentors for others; one of the roles of peer mentors—sometimes called survivor coaches and peer advocates—is to help other incarcerated people learn about PREA policies. Interview participants, including women, stated that information on how to report such incidents is well known in their facilities; however, other types of in-custody victimization, such as

harassment and intimidation, were rarely discussed or considered when facility staff discussed processes for reporting victimization policies with women. Stakeholders identified various avenues through which people can report PREA incidents. These include the following:

- internal hotlines (which can be connected to PREA coordinators and/or compliance officers at the facility and DOC levels, internal affairs, state ombudsmen, and other investigative offices and bodies)
- external hotlines that connect to outside agencies (such as local- and state-level sexual assault service providers or law enforcement agencies)
- written reports (which could include request and complaint slips, kites,[7] internal emails, or PREA-specific complaint forms)
- verbal reports to staff (made directly to a corrections officer, a superintendent or warden, or other facility staff such as health staff or chaplains
- third-party reporting through peers inside a facility or through family members or friends outside a facility

We see a video and get information [about PREA] at orientation.
—Incarcerated woman

Processes for identifying in-custody victimization appear to differ from those for identifying past trauma. While facilities and DOCs have set protocols for reporting PREA incidents—and respondents reported that women and staff are well aware of how to report—past trauma *may be* identified through less formal methods. Or, in the case of 15 DOCs that we connected with, prison staff may learn of past trauma through gender-responsive assessments done during intake or at another point during custody.

We just set this up, actually, about a year ago, to where everybody, every institution has this. There's a toll-free number at every single institution where the inmates can report to their local rape crisis center, where we have a memorandum of understanding. That phone call can be made on the inmate pay phone. It is not recorded. It's truly anonymous. We've opened that up as well, to our offender population, all in hopes that, no matter what, nobody would fear reporting any type of allegation.
—DOC leader

Challenges to Women Reporting and Identifying In-Custody Victimization

Several interview respondents reflected on why women face difficulties reporting PREA incidents and violations and why it is challenging to identify in-facility victimization. Many challenges involved facility staff members' perceptions of PREA, and others involved women's concerns about what will happen after they report.

Regarding PREA perceptions, facility staff understand PREA to varying degrees and are concerned about both over- and under-reporting. For example, some staff reported that they do not fully understand what a PREA incident is and is not, despite having received training on the subject. Thus, they are unable to identify victimization flags unless people report to them directly about an incident. Similarly, some staff shared confusion about whether every sexual encounter should be considered a PREA incident or whether consensual interactions can occur between two incarcerated people. They also raised questions about whether they should respond to consensual experiences as they would to those actually involving coercion, harm, and victimization. However, others raised concerns that women make false reports to change their housing assignment, though the extent to which false reporting actually occurs is unclear. In addition, other staff and community partners worried that facilities did not create environments where survivors feel comfortable enough to report victimization, either because the officers who they would report victimization to are male or because of correctional culture more broadly.

Retaliation is one of the main reasons victims do not report … [along with] further abuse, being taken to segregation, etc. … Typical concerns that come up.
—Community partner

Furthermore, it was the perception of some interview participants that women do not report PREA incidents for fear that they may end up in administrative segregation for protection. Similarly, others noted that women fear retaliation if they report. Retaliation may come in the form of continued victimization or losing their programming or jobs as a result of their disclosure.

We do retaliation follow-ups with every person that makes an allegation. So, I believe a 30-, 60- and 90-day follow-ups just to make sure that there's nothing going on. Whether, you know, if people are giving them a hard time? Or trying to get them to say that it's a false claim.
—Facility leader

Recommendations for Identifying Victimization

In sum, we found that facilities have several mechanisms through which women can report in-custody victimization (particularly PREA incidents), which constitute trauma-responsive practices. However, facilities focus less on actively identifying trauma that people have experienced before incarceration, although some use assessments that specifically ask about such histories. Overall, facilities tend to rely on self-reporting to learn about past and in-custody victimization, which can be challenging for women who fear being retaliated against for making such reports. Given these findings, we make the following recommendations for how facilities and DOCs can identify victimization:

- **Use gender-responsive risk assessments that ask about past trauma**. The Women's Risk Needs Assessment (Van Voorhis et al. 2010) and the Correctional Offender Management Profiling for Alternative Sanctions Women Risk/Needs Assessment and Case Planning (Northpoint, n.d.) are two tools used in correctional settings that assess child abuse histories, adulthood abuse, and mental health needs. By relying on such tools, correctional staff in

women's prisons will become more aware of people's past trauma and can design responses that are trauma specific.

- **Increase efforts to identify past trauma and victimization during a person's sentence.** Though facilities use PREA standards and other intake assessments to identify victimization at the beginning of incarceration, incarcerated people may not be ready to fully disclose their histories of trauma and violence when they arrive at a facility. Offering continuous opportunities for women to disclose information about their past can enhance decisions about housing assignments, services provision, and programming eligibility.
- **Increase efforts to proactively identify all types of victimization experiences.** Interview participants rarely mentioned that their facilities identify or respond to certain verbal and psychological kinds of victimization, such as harassment and intimidation. By increasing efforts to identify and respond to such harms, facilities may better prevent them.
- **Identify more opportunities to teach staff about identifying flags for in-facility victimization rather than over-relying on self-reporting.** Facility staff should have enough training and education on victimization to proactively identify and address the dynamics of abuse (i.e., beyond reacting to people who report such experiences). Enhancing staff's ability to identify such flags and approach people to ask whether they need assistance relieves women of the burden of having to (1) label what is happening to them as abuse, (2) summon the courage to disclose what is happening to them, and (3) identify someone they feel they can trust in order to make such a report. This approach should not be used in lieu of offering women multiple ways to report PREA incidents; rather, it can enhance facilities' procedures for detecting victimization. Furthermore, given facilities focus nearly exclusively on PREA-related victimization, staff and incarcerated people should be educated about and offered ways to report all types of victimization and harassment, not just sexual misconduct and assault.

Types of Victim Services That State Prisons Provide

State DOC stakeholders reported taking multiple approaches to addressing trauma and victimization in trauma-responsive ways. Facilities most often address people's histories of past victimization through programs (discussed in the next section) rather than victim services, with some notable exceptions. Of the victim services that facilities reported providing, most fall into four types: (1) safety and security, (2) medical advocacy, (3) emotional support and therapy, and (4) legal advocacy. In this section, we describe

services within these four categories and the extent to which they respond to victimization and trauma experienced before and during incarceration.

Safety and Security

Respondents from correctional facilities and state DOCs reported taking immediate measures to keep victims safe after PREA-related incidents occur. These measures largely involve separating the victim from the person who caused harm. In cases where the victim and the person who caused harm are both incarcerated, one party is moved to a different housing unit (if applicable). When the person who caused harm is a facility staff member, they may be reassigned to another area of the facility or, in more severe cases, placed on administrative leave. Once separated, the investigative body with jurisdiction (at the facility or DOC level) begins the investigation process and the victim is referred to other services.[8]

Medical Advocacy

Many DOCs and facilities reported providing some kinds of medical assessments and follow-up services in response to in-custody victimization. If staff responding to a victimization incident believe that a Sexual Assault Forensic Exam (SAFE) is necessary (sometimes determined through screening by medical staff), they will ensure examination occurs, by connecting either with a local hospital or a local rape crisis center to administer it:

> We reach out to our rape crisis centers for SART exams, for sexual assault exams if necessary. We give them the circumstances of the allegation. They determine whether or not that forensic exam is necessary. —DOC leader

> If the incarcerated female says that she was raped, we have nurses through our contracted provider that can do the SAFE SANE [sexual assault forensic exam, sexual assault nurse examiner] kit. We have a process to enter that evidence as collected and analysis completed for the investigation. —DOC leader

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If they do go [to] our local hospital, we do have an agreement with them, also, to make sure that there's a SANE [sexual assault nurse examiner] nurse available to come in, so that if evidence collection needs to take place and so on, that it's done very respectfully. —DOC leader

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Some facilities reported that their own medical staff conduct SAFEs. If a victim needs medical care in addition to a SAFE, services may be offered on site and provided by DOC medical staff or a contracted medical provider. One facility noted that its internal medical staff provide follow-up testing for pregnancy and sexually transmitted infections (though these services may also be provided as part of a SAFE). Quality medical services—specifically, gender-responsive services—are imperative to all people's well-being and are particularly crucial in mitigating harms from previous and recent traumatic experiences.

[M]edical services [are] always offered with any allegation, whether it be true or not. —Facility leader

Emotional Support and Therapy

Emotional support, often in the form of mental health services, was the type of victim service that DOCs and facilities most commonly reported offering. Correctional facilities rely on mental health services to address both past trauma and in-custody victimization. Leaders at the DOC and facility levels reported that women who experience victimization typically meet with mental health staff. Some DOCs reported using faith-based services (albeit infrequently) to respond to victimization. These options represent the range of services discussed by correctional stakeholders:

> If somebody comes in and is having—is expressing issues with victimization or whatever from things that have happened in the past … we would refer them to mental health and they would be seen one on one and added to one of the caseloads for one of the behavioral health specialists. —DOC leader

> If, for an example, we have substantiated or even, potentially, an unsubstantiated situation of harassment, abuse, or assault, then behavioral health services has to provide mental-health services to those individuals. —Facility leader

> [It is] part of our PREA protocols, that they are referred to mental health. Mental health will follow up with them and will give them ongoing support as needed. —Facility leader

> [After an alleged PREA allegation], they're assessed by medical, mental health. They're seen by religious services. —DOC leader

BOX 2

Innovation in Mental Health Services

One innovation in emotional support and mental health services (though not necessarily in victim services) was the reportedly mandated partnership between two distinct state-based agencies: the New York State Department of Corrections and Community Supervision and the New York State Office of Mental Health. In the state of New York, the former contracts with the latter to provide mental health services for incarcerated people. The Office of Mental Health does not work for the Department of Corrections and Community Supervision; rather, it is a distinct government agency created to provide mental health services to incarcerated and nonincarcerated people statewide. Its responsibilities in prisons include administering gender-responsive risk assessments, operating mental health units and residential treatment programs, facilitating evidence-based programs (EBPs) such as Seeking Safety and Beyond Violence (evidence-based programs are discussed more later in this report), and providing mental health services. This partnership demonstrates the state's willingness to provide similar services to people who are and are not in prison. It also ensures that the staff providing mental health services have specialized expertise to work in mental health, not solely in corrections.

Women at our case study sites had varying experience with mental health services. One woman reported that she could easily and quickly get an appointment with a mental health provider or a caseworker. A woman at another site reported that although counseling was available, her treatment largely involved medication management, which she did not find beneficial. Women at a different facility spoke highly of the supportive services available through a community-based service provider, stating that its staff are supportive, listen, and are understanding of the women and situations they deal with.

Legal Advocacy

Legal services, whether offered in response to victimization or in general, are extremely limited. For example, one site mentioned that there were very few services outside of having an electronic law library. In most cases, legal advocacy involves the help of victim advocates. They are called in after PREA-related incidents to assist victims throughout investigations. Advocates, who are sometimes part of facility-based SARTs, will accompany victims through PREA investigative interviews and to hospitals for SAFE exams, if necessary. Stakeholders discussed some ways that facilities and DOCs offer such services to incarcerated victims:

> We have the electronic law library is all. —Correctional staff

> We do sometimes get requests for information to funnel to victims, who are incarcerated, regarding cases, and we work with either our paralegals, or sometimes we facilitate that through different methods, depending on the facility. That doesn't really address helping them get legal services, but we do act as providers of that service when it's needed for those who have current cases where there's a victim. We do that for PREA, too, if there's any progression on a criminal case in the PREA realm. —DOC leader

> They can get in touch with a SART member and that SART member and say that they'd like to see an advocate and then we would make that happen. —DOC leader

> They will come in and be present for interviews. They will go with them if there's a scenario where we're going out to the hospital for a SANE exam, they will go with 'em for that. They also come in and do follow-up as the offender would like. —Facility leader

One case study site demonstrated a comprehensive approach to legal advocacy through its DOC-coordinated and facility-based SART. A SART is a multidisciplinary team of coordinated community responders that provides agency-specific interventions to sexual assault. SART teams also work with responders from other local agencies to facilitate a streamlined response to victims and alleged aggressors of sexual assault (OVW 2013). Furthermore, SARTs are also responsible for determining whether a case is unfounded, unsubstantiated, or substantiated. At this particular site, the prison-based SART consists of security staff, medical staff, behavioral health services staff, training staff, and a community-based partner. They focus mostly on investigating incidents and on providing advocacy to victims throughout that process. For example, it is responsible for interviewing victims, the person(s) who cause harm, bystanders, and witnesses. In addition, after an incident, staff at this facility contact a PREA advocate from the local service provider, whereupon the advocate will connect with women either within the facility or by phone and support them through investigative interviews and SAFEs. Outside of investigations, SART members—including the PREA advocate from the community provider—try to meet monthly for quality assurance and to further improve the team's trauma-informed practices.

Having a site-based team that focuses on helping victims of sexual assault is one way correctional facilities can incorporate widely adopted and comprehensive victim services approaches. From the perspective of some women and staff we spoke with, internal victim services are available and could be improved with correct training and focus; however, external services with victim-centered missions and approaches may better address incarcerated people's mental health and legal services needs.

Challenges with Victim Services

As interview participants discussed services available for incarcerated women who have experienced victimization, they also discussed challenges with providing such services. Challenges with providing

mental health services include a lack of victim services, a lack of expertise among internal mental health staff, and infrequent opportunities for incarcerated people to connect with staff. In addition, respondents mentioned challenges around the dearth of available legal services.

Overall, mental health services were the most common service available for people who experienced victimization. One challenge with providing mental health services is the lack of sexual-assault and rape-crisis counseling expertise among facility-specific mental health staff. Internal mental health staff at one prison are not trained clinicians, but rather correctional officers who worked their way into clinical roles. Community partners specializing in victim services and women we spoke with had similar assessments of mental health staff and reported on their lack of expertise:

> We don't provide rape counseling or crisis counseling services per se, but more along the lines of things that will help inmates cope with their distress and trauma related to their incident. —Facility staff

> We have clinical services here, and we have the job title called a counselor, but these counselor positions are actually officers that have worked with upward mobility through the union and have been able to get this counselor title without any sort of degrees or anything. —Facility staff

> I don't think that they have the expertise to deal with women who have been sexually assaulted. —Community partner

Women we interviewed also reported not being able to access mental health staff as often as they would like. One woman reported that she only met with an internal mental health service staff twice and described it as largely ineffective. A woman at another site expressed that she can meet with mental health staff, but that the treatment largely involved "medication management," which she viewed as negative. One reason mental health services may not be frequently available (in addition to staff shortages and lack of expertise) is that mental health staff may be responsible for both managing their caseloads and responding to victimization. Given these dual responsibilities, such staff often cannot adequately address one or both.

Yeah. I would say increasing mental health services, that's a struggle for us. We don't—we never seem to have enough mental health staff to—as we know, the high rates with women population.
—DOC leader

Women we spoke with expressed that legal advocacy and crisis intervention services at the facility level could be greatly improved. In one site, women reported that no legal services are available. Interviewees at the same site shared that although their case workers advocate for them individually, they go through extended periods without access to them. At another site, people shared that there is no information about safety or crisis intervention for victims of violent crime (e.g., rape, assault) in prison. However, women expressed hopefulness toward legal services available from a local victim services agency. One expressed that she looked forward to contacting the local DV agency for help filing a restraining order after the COVID-19 pandemic ends given that she was worried about the threat of DV upon release.

We have 80 percent of our women are diagnosed with a mental illness, so we—we see everybody. Nobody gets lost in the shuffle. [I wish] that we had more so that we could do a lot more short-term individual therapy versus putting out fires or triaging for the psychiatrists. —DOC leader

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A unique challenge in one state was that the only victim advocates available to incarcerated women are those employed by prosecutors. As that DOC leader reported, "Most of the victim advocates are associated with prosecutors' offices, and that doesn't meet PREA criteria." Because of this, the women's facility has difficulty finding victim advocates from nongovernmental organizations to work with. Addressing the problem of where a victim advocate works and who they work for requires statewide systems change to support people incarcerated in women's prisons as victims and people convicted of a crime.

Recommendations for Victim Services

Although services for addressing victimization are available at the DOCs and facilities we studied, those services are not without limitations. One of the most troubling concerns is the lack of rape-crisis and sexual-assault counseling expertise among internal mental health and correctional staff who provide mental health services, and some women we spoke with reported limited access to mental health services. To adequately address women's trauma and histories of victimization, future research should evaluate the efficacy of existing services, and victim service providers and facility staff should

collaboratively examine practices at local prisons to ensure people incarcerated in women's prisons have sufficient access to qualified service providers. We make the following recommendations regarding victim services:

- **Develop more or strengthen existing in-facility SARTs, which are a major avenue for connecting victims to services (not just means of conducting investigations).** Community-based SARTs have multiple goals that are not just related to the investigation and prosecution of people who cause harm. These multidisciplinary teams are often victim centered and ensure that people have access to advocacy, ongoing supportive care, and medical services. Rather than using SARTs to simply investigate incidents, facilities can use them to center victims' need for services and support. Facilities without SARTs should consider developing and implementing them, and those with existing SARTs should examine their implementation and fidelity to victim-centered care and recalibrate their approaches if necessary.
- **Ensure that mental health staff responding to past victimization or victimization occurring in custody have training and expertise in dealing with trauma**. Mental health services are a critical victim service response, both immediately after victimization occurs and throughout therapeutic care. These services are commonly available across US facilities. However, not all mental health service providers have expertise in providing trauma-responsive and trauma-specific care after victimization, such as domestic violence and sexual assault. In-facility providers should have such expertise and the skills necessary to help women move past such harmful experiences, given most women who become incarcerated have had such experiences. In addition to developing in-facility expertise, facilities should partner with outside agencies with such expertise—and ensure women have access to such partners—to supplement their offerings.

Types of Trauma-Informed and Victim-Focused Programming Provided in State Prisons

Through programming, some correctional facilities aim to be trauma responsive, trauma specific, and conducive to the growth of people incarcerated there. Providing programs aimed at specific physical, mental, and emotional forms of well-being is one way facilities carry out this goal. Through interviews with DOC leaders, facility staff, community partners, and women, we learned that facilities implement a host of programs, including evidence-based, behavioral health, and substance abuse programs (among other innovative kinds of programs). We also learned of challenges and limitations that correctional facilities encounter in providing trauma-responsive programming. In this section, we elaborate on those programs and challenges.

Evidenced-Based Programs

In attempts to be trauma responsive and trauma specific, some correctional institutions have implemented evidence-based programs. These are curricula-based programs that have been evaluated and associated with positive outcomes (Duwe 2017).[9] For example, at least 18 of the 41 state DOCs and 15 out of 15 standout sites[10] discussed using at least one EBP to address trauma. These programs rely on predetermined activities that have been tested and standardized to promote specific desired outcomes. They specifically address aspects of victimization and trauma and help participants work through traumatic experiences. Examples of common EBPs used with incarcerated women are listed in table 2.

TABLE 2

Examples of Evidenced-Based Programs

Program	Description
Seeking Safety	Twenty-five-session program that focuses on cognitive, behavioral, interpersonal, and case management content areas and addresses PTSD and substance abuse (Najavits 2002).[a]
Moving On	Twenty-six-session program built around nine modules: Setting the Context for Change, Women in Society, Taking Care of Yourself, Family Messages, Relationships, Coping with Emotions and Harmful Self-Talk, Problem-Solving, Becoming Assertive, and Moving On (Van Dieten 2010).[b]
Helping Women Recover	Seventeen-session program that provides gender-responsive treatment to women recovering from alcohol and substance abuse (Covington 1999).
Beyond Trauma	Eleven-session program with three modules: (1) violence, (2) abuse, and (3) trauma, the impact of trauma, and healing from trauma (Covington 2003).[c]
Beyond Violence	Twenty-session program with four modules that focuses on the transactions and exchanges between the self, relationships, community, and society (Covington 2015). Uniquely, it focuses on the violence women have experienced as well as the violence they may have caused.
Healing Trauma	Six-session trauma intervention for women that is being expanded to be more gender inclusive for the transgender population (Covington and Russo 2017).

Notes: [a] Searcy and Lipps (2012) evaluated Seeking Safety; [b] Gehring, Van Voorhis, and Bell (2010) evaluated Moving On; [c] Covington and coauthors (2008) evaluated Helping Women Recover and Beyond Trauma.

During one of our site visits, we observed the eleventh session of Beyond Violence and the first session of Beyond Trauma. The two programs were held in a classroom setting, with tiled floors and inspirational posters on the walls. Posters also listed ground rules encouraging women to speak up and reminding them that program discussions were confidential. In Beyond Violence, one facilitator was a man and one was a woman, and the group discussed what constitutes healthy relationships and falling in and out of love. In Beyond Trauma, there were two women facilitators, who introduced the program and stated that over the next few weeks, participants would work toward improving their relationship with themselves. Facilitators built rapport with participants by starting conversations, being reflective, and

inserting dry humor. Participants discussed topics as a group. The one downside is that one of the sessions lasted two hours and participants did not get a break.

Every standout site implemented trauma-specific evidence-based programming.

Programs in Addition to Evidence-Based Programs

We also found that facilities offer programs besides EBPs that address specific traumatic experiences and provide activity-based programming, such as yoga and meditation. Program providers discussed the merits of innovative approaches besides EBPs. For example, one facility used a program that previously operated as a therapeutic community that held participants accountable by requiring them to report on each other's infractions and shortcomings. This caused participants to act punitively toward one another. Noticing these negative side effects, providers piloted a "relational empowerment" model whereby women were not responsible for reporting on other women's shortcomings, but instead were responsible for proactive collective growth. Program providers are collecting data on this model's efficacy and outcomes, which could provide an approach to addressing trauma in women's prisons nationwide. Examples of non-evidence-based programming also include peer-based mentorship and domestic violence and sexual health education.

Many facilities rely on peer support programs and peer mentors (which may also be called survival coaches or peer navigators). Such programs allow incarcerated women to assist other women. Some of their roles include helping incoming women orient to the facility, consulting women who have experienced victimization, speaking with facility leadership, and taking recommendations from other women to leadership. We spoke to women in the role who spoke highly of the program and appreciated being able to help their peers and witness their growth.

> It's called Support…. It's not really a core curriculum … but it's where we train other women, inmates who are longer term sentenced … We train them with mental health to just do low-level interventions for people. —Facility leader

> You'll see the compassionate companion's program. They are the peer support program, basically. When there's an emergency or some trauma or inmates that are dealing with a tragedy or illness […] they come around and they've been trained to give them support. —Facility leader

> We have a group here called survival coaches that are long-term adults in our custody that have gone through 40 hours of trauma-informed care [training]. Other adults in custody can ask to

speak to one of the survival coaches for any reason and that survival coach can go to their unit and respond. —Facility leader

The good news, women being proud of themselves … Watching women become good and being proud of themselves, there's no payment like it.
—Survival coach

We also found that some women's prisons provide nontraditional programs to people with special circumstances who are not comfortable in the general population. Women with such circumstances were assigned a correctional counselor and social worker who created an individualized plan for them. Nontraditional programs included incentives and events for people on a journey to sobriety, such as recovery rallies. Another program, Roadway to Freedom, works with people with histories of sex work or human trafficking and uses a lens focused on trauma and healing. Roadway to Freedom participants lead discussions with other incarcerated people. Furthermore, Go Ahead, a program for women who have experienced DV, provides classroom-based programming and peer-led discussion groups, and partners with other programs that work with DV survivors.

We have domestic violence education, which is voluntary. They can sign up to attend that, that's provided by Safe House, which is a domestic violence shelter in the area.
—DOC leader

Addressing the Substance Abuse Treatment Needs of Incarcerated Women

Because of the criminalization of substance use and the lack of accessible community treatment for people with substance use disorders, many women enter prison with substance use challenges. Incarcerated women experience particularly high rates of substance abuse—more than 80 percent of women entering corrections facilities suffer such issues (Staton, Leukefeld, and Webster 2003). Women who suffer from substance abuse also have related treatment needs. Research shows a connection between substance use and histories of trauma, as people who experience trauma may turn to

substance use and abuse to cope with painful experiences. For example, a 2011 Urban Institute study found that participants on community supervision were more likely to relapse to substance use if they experienced physical or sexual victimization (Zweig, Yahner, and Rossman 2011). Another study found that people who had experienced in-facility victimization were more likely to relapse to substance use upon reentry (Zweig et al. 2015). Still other research suggests that victimization and substance use co-occur at high rates among women generally (Logan et al. 2002). For these reasons, many correctional facilities have procedures for addressing substance use disorders and symptoms.

To help people with substance use treatment needs, DOCs and facilities in this study offer one or more of the following: medication-assisted treatment, counseling, the Seeking Safety program, and the Helping Women Recover program. In addition, some DOCs offer residential substance abuse units that have a victim services component. Some facilities partner with external organizations to provide victim services or provide them through internal staff. Service providers in some residential treatment units worked with women with specific needs and facilitated DV classes.

Although DOCs provide programming to address substance use issues, facilities were limited by physical location and lack of staff expertise. Some DOCs were not equipped to respond to substance use issues or issues around trauma generally. Stakeholders at one facility discussed the difficulty of being in a rural area and having more new women on medication-assisted treatment. Facilities in more rural areas may have less access to methadone (used to treat certain forms of substance abuse) and other medications for medication-assisted treatment, as well as less access to specialized medical care for those who experience substance use disorders.

Innovation in Programming

Some facilities implemented innovative approaches to programming. Examples include programs specifically intended for women from marginalized backgrounds, with greater accessibility and availability during the COVID-19 pandemic, that allowed women more agency to craft the programs themselves and that involved unique ways to celebrate sobriety. One site had a unique housing unit specifically for women who had experienced domestic violence and sexual assault.

In some states, including Kansas, Minnesota, North Dakota, and Colorado, correctional facilities offer programs for women from marginalized backgrounds. The Family Peace Initiative in Kansas works specifically with veterans in correctional facilities to provide supportive services. In Minnesota, North Dakota, and Colorado, facilities work with White Bison to provide programming focused on generational trauma experienced by Native American women. White Bison provides support on

sobriety, recovery, addiction prevention, and well-being through learning circles, trainings, and 12-step programs.

Furthermore, we found that facilities and DOCs in some states used technology to deliver programs to women, especially during the COVID-19 pandemic. Prior to the pandemic, facilities had begun using virtual tools, such as video chat and tablets:

> We have a tablet program, so we have partnered with Edovo [a secure tablet technology provider] to provide the women with tablets, so they can do hours, and hours, and hours of programming on their own, typically provided in a group setting … parenting specific, or healthy relationships, decisionmaking, anything. —Facility leader

One woman described the facility's response to COVID-19 as "amazing."

In addition, some facilities allow women to provide feedback on programs and services and use feedback to inform future practices; for example, one DOC stakeholder reported, "We adapted our curriculum based on women's feedback to Seeking Safety."

Some interview participants mentioned innovative approaches to promoting wellness. For example, the Rhode Island DOC organizes a "Rally for Recovery," which celebrates women on the path to sobriety. The rally prioritizes peer support and collaborative healing and serves as an encouraging reminder to incarcerated women that their progress is worthy of celebration. The rally often happens in multiple states as a part of National Recovery Month, an initiative created to reinforce the message that recovery is possible. The rally features speakers, events, music, and activities for children and adults. It includes a ceremony commemorating lives lost and celebrating lives that have been changed.

Moreover, stakeholders in Pennsylvania shared an innovative approach to housing at one of the state's women's facilities. The "House of Hope" is a residential unit and an "inpatient abuse program" that addresses women's histories of sexual assault and domestic violence. It is a six-month program for incarcerated women who self-select into it. Though women who have committed particular offenses, such as offenses against children and sex offenses, are not eligible to participate, other outpatient services are available to them.

These innovative approaches and other nontraditional methods of program delivery open the door for wider and more comprehensive in-prison programming.

Eligibility and Women's Perceptions of Programs

In our research, we found that program eligibility is often based on risk assessment scores, housing classification, conviction type, and counselors' recommendations. Facility staff try to make decisions based on program availability to ensure that everyone who needs programming has access, but this practice is not always followed. Facilities have staff determine eligibility to ensure that incarcerated people who are reentering society soon can get treatment and leave with positive outcomes. However, this approach leaves some people who have longer sentences and/or lower risk scores without trauma-responsive programming.

Women we interviewed considered programs incredibly valuable spaces to address trauma, reflect on their backgrounds and life circumstances, and move forward. For instance, various women described Beyond Trauma, Beyond Violence, Healthy Relationships, and Helping Women Recover as "pulling scabs" off, and "helping them to realize their triggers." One woman said such programs were "doing wonders" in her life. Another mentioned that Beyond Trauma helped her think through issues that had been deeply rooted in her thought processes for 20 to 30 years. Women also shared that Beyond Trauma helped them address and come to terms with their trauma while learning to move through it rather than avoid it. In addition, women said programs (including Seeking Safety) that contextualized their trauma and helped them address past abuse were valuable. Lastly, they mentioned that parenting classes, trauma-informed yoga, and classes on healthy relationships added value during incarceration.

Incarcerated women described Beyond Trauma, Beyond Violence, Healthy Relationships, and Helping Women Recover as "pulling scabs" off and helping them realize their triggers. One woman said such programs were "doing wonders" in her life. Another mentioned that Beyond Trauma helped her think through issues that had been deeply rooted in her thought processes for 20 to 30 years.

Multiple women provided insights about who they considered to be effective and vulnerable facilitators. They appreciated facilitators who were aware of and honest about their own trauma and who reminded participants that they were not alone. For instance, one woman reported that if you have an instructor who is "really willing to work with you, it can do a lot of good," an approach that may remove the shame from women's personal experiences with trauma and treat it as universal. However,

not everyone had positive experiences with facilitators. Some recalled that facilitators asked them not to share traumatic experiences in the group because it could traumatize others, which made them feel shut down. Others recalled that facilitators did not encourage any real discussion. Although women saw value in facilitators, additional training around trauma and vulnerability may strengthen facilitators' engagement with women and participants' experience with programs.

Challenges

All research participants—DOC leaders, facility staff, community partners, and women—shared challenges with programming. State DOC leaders and facility staff expressed operational and budget challenges. Program staff, community partners, and women revealed that the limited criteria for eligibility often delayed or prevented some from accessing programs. Staff also mentioned that program structure can be punitive and may not facilitate the healing that participants seek. Women also highlighted a lack of available programs, especially as they relate to trauma, PTSD, LGBTQIA+ identities, and positive sexuality.

Many DOCs and facilities cited resource and time shortages, which limit their ability to provide programming to everyone who needs it. Facilities also had difficulty finding staff to facilitate programs. Volunteers and other partners instructed programs in some facilities, but outsourcing for providers made access and continuity difficult when volunteers were not available:

> There's a lack of space, funding, personnel … Over 400 volunteers can come in, but where will they host these events[?] —DOC leader

> Our biggest challenge right now is I just don't have the staff to facilitate the volume of classes that we've identified for women over the last two years. —DOC leader

Staff and women in multiple facilities and DOCs reported issues with eligibility. Sentence length, risk level, and assessment results are often the benchmarks facility staff use to determine program eligibility; this automated actuarial manner can leave women with longer sentences out of programs. Women described this practice as prioritizing programming for people who are "on their way out," which leaves people with longer sentences without trauma treatment. Another woman experienced delays accessing services because of her assessment results: she was unable to access needed treatment immediately after being diagnosed with PTSD and reportedly was only able to get treatment for it after being reassessed a year and half later. Though stakeholders mentioned that their facilities tried to make program experiences positive, women at one site discussed the difficulty of having to advocate for themselves in order to receive programming, mental health counseling, and other services.

Furthermore, there are also limited programs for women convicted of sex offenses, though one state mentioned it has a residential treatment program at a men's facility for men convicted of sex offenses. One DOC leader reported that this programming gap is due to a lack of evidence around such programs: "I only do the evidence-based programs. If there is none with the evidence-base that is out there, such as some of the sexual offense programming and sexual predator programming, we can't find any evidence-based." Another reported, "They offer [every program] at every one of those facilities minus sex-offender programming."

Furthermore, staff at some facilities discussed how programming practices are sometimes not conducive to healing. For instance, program staff and the criteria for participating in programs can perpetuate punitive practices. For example, women at one prison can be removed from a program for being unstable or having serious physical health issues. Moreover, women who miss program sessions—such as for issues around restrictive housing or disabilities—can be removed from the program entirely. We found that some facilities do not allow programs in restrictive housing for people on disciplinary detention or administrative segregation. One woman reported that because she was assessed as a low risk to reoffend, she had been excluded from programs. However, she was able to participate in religious and other programs to an extent. In other instances, staff failed to create spaces conducive to healing by discouraging participants from sharing traumatic experiences. Staff also mentioned that program facilitators had been triggered when participants shared their experiences, making participants less comfortable opening up.

I have providers, clinicians, others who expect pretty high levels of performance and behavior from those people and are ready to kick them to the curb way too quick, when they, more than anybody, are the ones that need [it] … They want to kick them out of treatment. I think there's a disconnect.
—Facility staff

Recommendations for Programs

Though women across case study sites shared some positive experiences they had had with programs during one-on-one interviews, they also cited a need for more trauma-specific and specialized programs. Women expressed the need for programming around PTSD, healthy relationships in an

LGBTQIA+ context, and the intersection between trauma and substance abuse. Similarly, many women and program providers discussed gaps in program topics and conveyed the need for more wide-reaching programs and programs that integrate a trauma-responsive lens and the needs of LGBTQIA+ people. They expressed a lack of available programs and, where programs were provided, a lack of available seats. Staff at one Oregon facility expressed an interest in engaging women in more programs around positive sexuality, citing a lack of programming on sexual health delivered through a lens of healthy and forward-looking sexuality (rather than a lens of sexual assault). We recommend that DOCs and facilities do the following:

- **Continue to provide evidence-based programs focused on trauma and victimization**. Programs proven to be effective should be continued, and facilities should work to make programs available to all who might benefit from them.
- **Work with researchers to evaluate the efficacy of non-evidence-based programs.** Facilities implement numerous programs besides EBPs to address trauma. Non-evidenced-based programs can be evaluated to learn how they work, what aspects promote healing, and what aspects can be adjusted to ensure participants are getting the treatment they need. Lessons from such programs and evaluations may encourage other facilities to adopt them.
- **Consider virtual programs and services from outside partners.** Particularly during the COVID-19 pandemic, some services and programs have stopped as facilities have been closed to outsiders. Rather than stopping such programming, prison staff can consider offering virtual programs so women have continuity in services. Even when COVID-19 is no longer a concern and prisons are opened to visitors, virtual programming may help facilities provide greater variety in (and a larger number of) service and program offerings.
- **Train and provide support to people incarcerated in women's facilities to serve as peer mentors to others**. These mentorships and relationships can play a significant role in women's interconnectedness and support during incarceration. Peer coaches, navigators, and mentors help orient incoming people and serve as a resource to women throughout their sentence.
- **Implement programming around positive sexuality outside the context of domestic violence and sexual assault.** Because facilities often focus programming on sexual assault and/or negative outcomes, a gap exists in programming around positive sexuality. Such programming can help women learn about and understand positive behaviors and better prepare for situations and relationships that will arise after reentry.

- **Develop more trauma-focused and/or victimization-focused housing units as a wraparound approach for addressing these issues for incarcerated women**. Few DOCs and facilities offer housing units that are trauma responsive to address residents' histories of domestic and sexual violence. Units that address the unique needs of women who experienced victimization could enhance women's well-being in prison, though more research on the impacts of such units is needed so the field can understand how to maximize outcomes.
- **Implement programs or incorporate a lens in existing programs to better serve the needs of women convicted of sex offenses.** In some cases, women with sex crimes are excluded from programs; though, they may be in need of them. Classes that address the reasons women may have used violence or may otherwise be linked to a sexual offense should be trauma specific and aim to support growth and change.
- **Expand programs for women with life and long sentences as well as women at low risk of recidivating.** During our interviews with incarcerated women and DOC stakeholders, respondents mentioned how women with longer sentences are often not a priority for prison programs. Correctional institutions invest significant time in people who will soon reenter society, an approach that excludes people who will not. If women's prisons are to address trauma for everyone incarcerated there, they have to focus on people who will be in custody for a long time.

State DOC Partnerships with Domestic Violence Coalitions, Sexual Assault Coalitions, and Local Victim Service Providers

Many state correctional systems included in this study reported providing a range of services and programs to meet the needs of incarcerated women who have victimization and trauma histories, and many did so through external partnerships. In this section, we explore the extent to which state DOCs reported partnering with state-level DV/SA coalitions and the issues involved in those partnerships, as well as how women's facilities within those DOC systems collaborate with local victim services organizations to address people's histories of trauma and victimization.

Survey of State DV/SA Coalitions

There are approximately 81 statewide domestic violence and sexual assault coalitions nationwide; some states have dual agencies that focus on DV and SA, and others have multiple coalitions that focus on these issues separately. Coalitions provide centralized information about victim services efforts and provide a range of training, technical assistance, and educational support to member agencies (local victim service agencies focused on DV and SA) and external agencies. To better understand the work these state coalitions do—including the extent to which they or their member agencies partner with state DOCs and local correctional facilities—Urban identified 81 state DV/SA coalitions and surveyed 57 over a six-month period, from late 2018 to early 2019. Surveys asked respondents about the structure and size of their coalition (background information); services (including programming and training) provided by the coalition; collaboration with state DOCs and local facilities, including factors promoting and/or inhibiting such collaboration; and any programs or member agencies noteworthy for addressing the needs of incarcerated women.

Most respondent coalitions (88 percent) were relatively small, employing fewer than 20 staff members, and 60 percent had fewer than 40 member agencies. In contrast, just 4 percent of respondent coalitions employed more than 40 staff, and roughly 10 percent had 80 or more member agencies. Despite this variation, the 57 coalitions we surveyed conducted similar activities: nearly all provide training (96 percent) and technical assistance (98 percent) to member agencies, advocate for public policy (96 percent), disseminate information (96 percent), and engage in public awareness campaigns (89 percent).

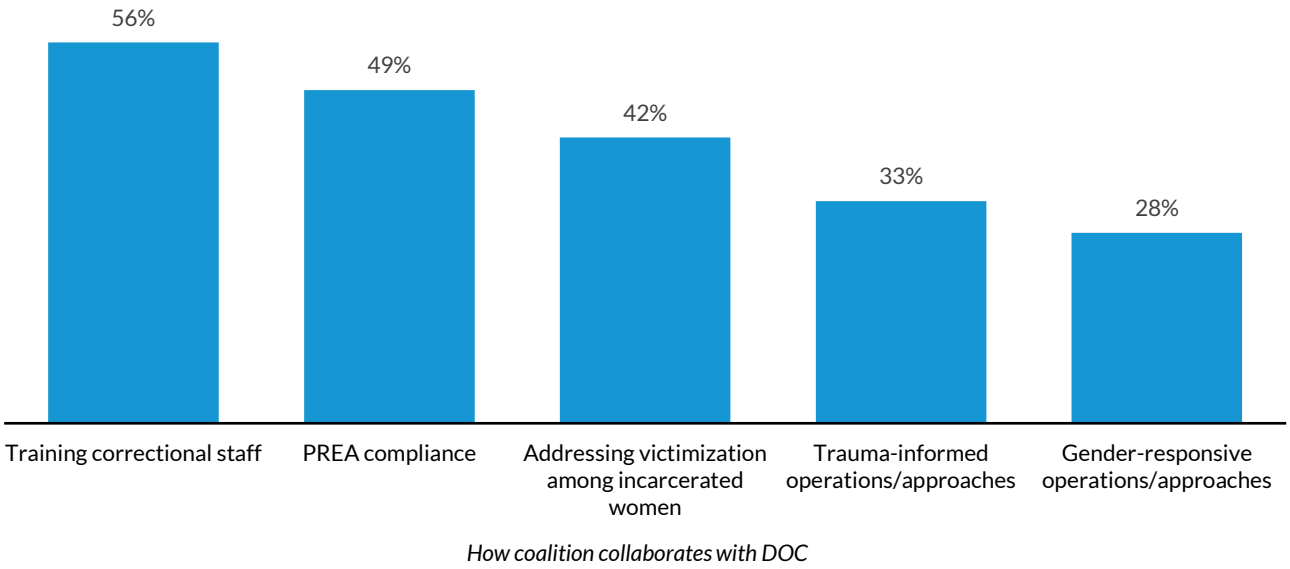
Coalition Collaboration with State DOCs

The majority of state DV/SA coalitions (78 percent) reported collaborating with their state's DOC, and nearly half (49 percent) cited the passage of the Prison Rape Elimination Act as the impetus for that partnership. Interestingly, however, roughly 53 percent of these partnerships were relatively new, having been established within the past five years. Just over half (54 percent) had received funding to collaborate with their state DOC, most notably federal funding: over half (57 percent) reported they had received Violence Against Women Act funding, and one-third (33 percent) had received Victims of Crime Act funding. As might be expected, DV/SA coalitions most frequently worked with a facility's PREA coordinator, the prison facility administrator, and the facility's victim assistance unit to prevent or address in-custody victimization. Relatively few coalitions (22 percent) reported collaborating directly with their state DOC's director or commissioner, suggesting that such partnerships are more

likely to occur at the facility levels than the department level. Furthermore, the majority of state DV/SA coalitions characterized their collaboration with their state DOC as important to preventing in-custody victimization (76 percent) and effective at improving access to relevant programs and services (54 percent) for incarcerated women who had experienced trauma or victimization. Coalitions that collaborate with DOCs at the department level reported that their work typically centers on correctional staff training (56 percent) or PREA compliance (49 percent), followed by helping DOCs address victimization (specifically among incarcerated women [42 percent]) or advance trauma-informed (33 percent) or gender-specific (28 percent) operational approaches. Moreover, coalitions most frequently work with the victim assistance unit, PREA coordinator, and/or prison facility administrator at their state DOC.

FIGURE 1

Ways that Coalitions Collaborate with DOCs (n=43)



Notes: PREA = Prison Rape Elimination Act. Coalitions most frequently collaborate with their state DOC on training for correctional staff (56 percent), PREA compliance (49 percent), and addressing victimization (42 percent).

Coalition Member Agency Collaboration with DOC Facilities

Nearly three-quarters (73 percent) of state DV/SA coalitions reported that their member agencies collaborate with correctional facilities throughout their state; on average, each coalition had at least seven member agencies that regularly collaborate with state-level correctional facilities, with most (67 percent) having partnered with these facilities for one to five years. Like the state DV/SA coalitions,

member agencies' collaborations with state DOCs had received federal funding, such as Victims of Crime Act (45 percent), Stop Violence Against Women Formula Grant Program (36 percent), and Violence Against Women Act (27 percent) funding. The structure and nature of member agencies' DOC collaborations at the facility level largely mirrored those of the state DV/SA coalitions: member agencies were most likely to collaborate with facility PREA staff (50 percent), facility victim services directors (30 percent), and facility administrators (23 percent), and to focus on issues of PREA compliance, past victimization, in-custody victimization policy, and staff training.

FIGURE 2

Who Member Agencies Collaborate With (n=30)

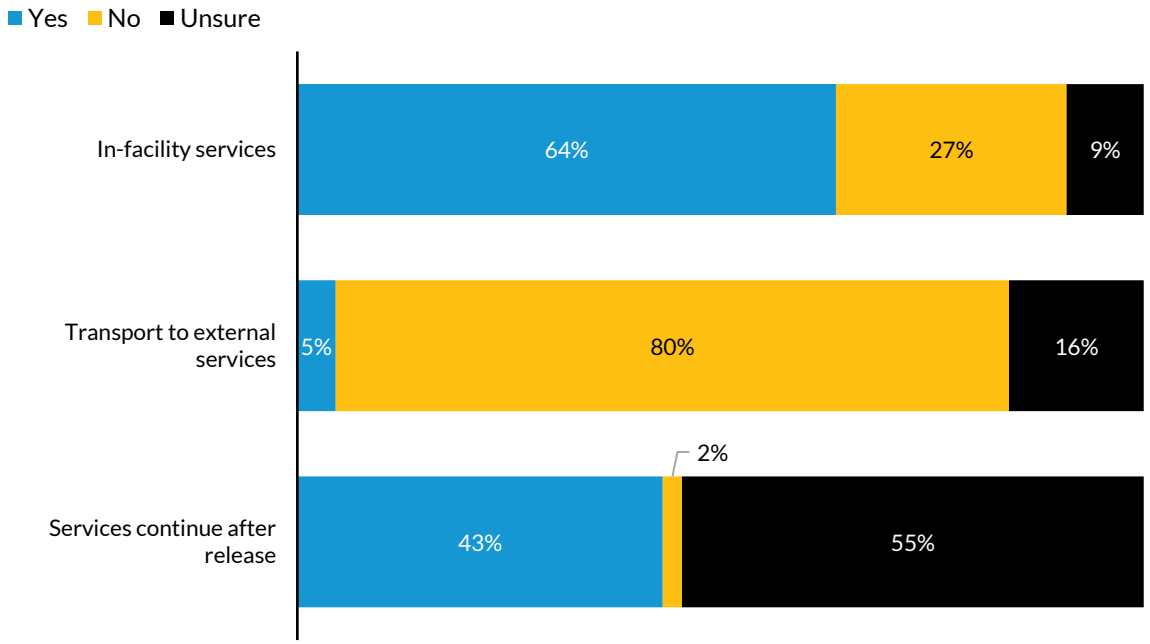
Notes: PREA = Prison Rape Elimination Act. Member agencies most frequently work with PREA staff, victim services directors, and facility administrators at state correctional facilities.

Respondent coalitions reported that 64 percent of member agencies provided services and programming to incarcerated women (in facilities) before release and 43 percent continued offering services in the community after release. Just 5 percent of member agencies transport women to external services. During case study site visits, we interviewed representatives from member agencies that work with the local facility. For example, in Iowa, victim advocates from Polk County Crisis and Advocacy Services, a member agency of the Iowa Coalition Against Sexual Assault, are called in to assist victims after incidents of in-custody victimization. Similarly, the Center for Hope and Safety, part of the

Oregon Coalition Against Domestic Violence and Sexual Assault, works with its local facility's sexual assault response team. When asked, women spoke highly of their experiences with member agencies.

They listen, and [I] feel they understand [me] and know what [I'm] dealing with.
—Incarcerated woman

FIGURE 3
Service Provision by Member Agencies (n=44)



Challenges and Opportunities in DV/SA Coalition Work with Incarcerated Women

Coalitions and member agencies face challenges working with incarcerated women because of limited funding and staff shortages. However, both reported drawing on the unique needs of women and positive relationships with state DOCs and facilities to advance their work in women's prisons. Most state DV/SA coalitions (61 percent) cited insufficient funding as a key challenge to working with incarcerated women, followed by staffing shortages (68 percent), difficulties accessing and maintaining contact with incarcerated women (27 percent), and the lack of a working relationship with local

correctional facilities (23 percent). Coalition respondents perceived these challenges to be slightly more pronounced for member agencies: 74 percent cited insufficient funding and limited staff as critical barriers to working with incarcerated women, followed by a lack of trained staff (44 percent). Over a third (38 percent) also identified the unique context of corrections as a challenge. In contrast, state DV/SA coalitions identified organizational capacity (44 percent), staff capacity (41 percent), and positive working with relationships with the state DOC (38 percent) as key factors that facilitate their work with incarcerated women; for member agencies, staff capacity figured most prominently (49 percent) followed by organizational capacity (11 percent) and positive relationships with local facilities (8 percent). These factors suggest that additional funding and increased staffing could help coalitions and member agencies enhance their organizational reach and their delivery of programs and services to incarcerated women with histories of trauma and victimization.

How State DOCs Partner with DV/SA Coalitions and Local Victim Services

Analysis of interviews with DOC stakeholders suggests that few state DOCs partner with their states' DV/SA coalitions, and that far more rely on local community-based providers—which may or may not be member agencies—to address a range of issues related to incarcerated women's experiences of victimization and trauma. A handful of state DOCs also described partnering with other state-level agencies to fulfill these needs. Just 10 percent of state DOC representatives reported having no connections with a state DV/SA coalition or a local victim services provider.

Although our survey found that a large share (78 percent) of state DV/SA coalitions collaborate with their state's DOC, just 10 percent of DOC leaders interviewed for this study specifically named their state's DV/SA coalition as a partner. What accounts for this apparent disconnect? We propose two possible answers: (1) respondent coalitions may have been distinguishing between collaboration at the facility level and the DOC level; (2) because the DOC leaders we interviewed likely were not the actual collaborative touchpoints with the DV/SA coalitions for their administrations, they may not have been as familiar with their departments' collaborations in this area. In either case, just four state DOC leaders reported partnering specifically with their state DV/SA coalition. As with the coalition survey, however, DOC leaders identified a similar set of issues for which they engaged with the state DV/SA coalition, including PREA-related services (including operation of the DOC's PREA hotline and counseling support to victims), PREA compliance, staff training on issues of victimization, and policy guidance and resources. Roughly half of the states whose DOC leadership identified partnering with their state DV/SA coalition had formalized these partnerships by executing memoranda of understanding.

In contrast, nearly two-thirds (25 of 41 states, or roughly 61 percent) of the DOC representatives we interviewed reported partnering with community-based service providers to address the needs of incarcerated women who had been assaulted or had experienced other kinds of trauma (such providers include victim services agencies, rape crisis centers, DV centers, and faith-based organizations). Only a handful of states reported using formal memoranda of understanding with these providers; most DOCs solidified these partnerships and secured services by contracting directly with providers.

Lastly, local community-based organizations provide a range of services to incarcerated women, services that include educational programing (e.g., classes for DV survivors), counseling, therapeutic programming, trauma-informed and cognitive-based programming (e.g., Seeking Safety, Beyond Trauma, Beyond Violence), and legal services. For example, the YWCA provides victim advocates for one of our standout sites, Just Detention International provides services and training to women in other sites, and Planned Parenthood provides sexual health education to women in one site. Another notable community-based provider partnership is the Alabama Prison Birth Project, which facilitates a trauma-responsive doula program for pregnant people. Some facilities also reported partnering with family justice centers.

We also have a contract—or, not a contract, an MOU [memorandum of understanding] with an agency local through the YWCA that's a separate agency within them. Center for Safety and Empowerment.
—-Facility leader

During PREA investigations, many community-based partners reportedly provide direct support to incarcerated women, either by accompanying women who have been assaulted to the hospital or being present at the hospital during physical examinations. These same partners can also provide support to facility-based SARTs and to women during and after PREA investigations. Several state DOCs reported partnering with local hospitals to ensure a Sexual Assault Nurse Examiner is available when DOC staff bring an incarcerated woman who has been assaulted to the hospital for examination and treatment.

Lastly, a few state DOCs reported forming atypical partnerships to assist incarcerated women with histories of trauma and victimization. For example, the DOCs in Illinois and Oregon collaborate with their respective state departments of public health to deliver gender-specific, trauma-informed

programming and to train selected incarcerated women to serve as peer advocates or peer coaches to lead support groups in designated women's correctional facilities. Another state DOC reported partnering with a local university to design and implement a trauma-informed care initiative specifically for incarcerated women.

Recommendations for DOC partnerships

Based on our findings from the DV/SA coalition survey and interviews with state DOCs, we recommend that DOCs do the following to create and improve partnerships with state coalitions:

- **Work to forge collaborative partnerships with state DV/SA coalitions.** Although few DOC leaders explicitly reported collaborating with their state's DV/SA coalition, those that did rely on these partnerships for policy guidance, training expertise, and critical PREA support. These coalitions can be valuable sources of expertise and experience and can help DOCs properly train staff and ensure policies and procedures comport with policy changes. They can also help DOCs employ best practices essential to providing effective care for women in custody.
- **Increase community-based providers' contact with and services for incarcerated women.** Although some DV/SA member agencies and community partners provide counseling support to victims, much of the interaction between external victim service agencies involve PREA compliance and staff training. More than half of DV/SA coalitions noted difficulties accessing and maintaining contact with incarcerated women. To better connect incarcerated women to the victim services field and vice versa, facilities should create more opportunities for engagement. Such encounters could entail training incarcerated women to recognize and understand sexual assault and victimization and to assist peers who have experienced victimization.
- **Partner with other state-based organizations.** The state DOCs in Illinois, New York, and Oregon partner with other state-based agencies to provide services to women. In New York, the New York State Office of Mental Health provides mental health services to all incarcerated people and facilitates EBPs among incarcerated women in particular. The DOCs in Illinois and Oregon partner with their states' departments of public health to deliver programs that train women to become peer coaches. Partnerships of this nature can decrease silos between agencies and increase expertise among incarcerated populations.

Challenges to Addressing Past Trauma and Victimization in Correctional Settings

The punitive nature and predominately male orientation of US correctional facilities present many challenges for women's correctional institutions attempting to be trauma responsive and to adequately address the high rates of trauma among incarcerated women. Because correctional facilities have not traditionally provided this type of care, some challenges still exist to ensuring that victim services and trauma-responsive programs meet incarcerated women's needs. Two significant challenges impeding facilities' attempts to be trauma responsive involve (1) the undermining of the validity of incarcerated women's personhood and victimization experiences, and (2) staff violence against women.

Underlying assumptions about the personhood and victimization experiences of incarcerated people can be barriers for victim services and trauma-related programming. For example, one state reportedly does not recognize certain rights and protections for people who are incarcerated. Its state's victims' rights statutes *do not recognize people who are incarcerated when crimes are committed against them as victims.* Provisions in other states reportedly restrict incarcerated women from guardianship. For instance, personhood may manifest in the way that states approach parenting during incarceration. Moreover, one DOC stakeholder reported, "Our visitation policy is pretty strict around children visiting. Our attorney general has said that an inmate cannot pose as a guardian, so when it comes to allowing the children to come in, they need to have a guardian sign off on it." With limits around who can and cannot be a legal guardian, states may fail to recognize incarcerated parents as holistic people by denying them the opportunity to demonstrate capable legal guardianship. Both policies undermine the personhood of incarcerated people, and the former even challenges whether incarcerated people can be both victims and people who engage in crime.

Our visitation policy is pretty strict around children visiting. Our attorney general has said that an inmate cannot pose as a guardian, so when it comes to allowing the children to come in, they need to have a guardian sign off on it. A lot of times, the residents have not gone through the legal steps to make somebody a guardian.
—DOC leader

We also found that the challenge of approaching incarcerated women as victims or survivors extended to correctional practices. Correctional staff frequently mentioned that they get false PREA reports, though how many—and how they are deemed false—is unclear. Although false reporting may occur, not all allegations are false, and research shows that women are among the most common incarcerated victims of in-custody victimization (Beck, Rentala, and Rexroat 2014). Some interview participants spoke to this reality, citing instances in which staff had sexually assaulted incarcerated women.

Such abuses speak to the power imbalances and inherent challenges in correctional facilities' design and operations. People who are incarcerated are at heightened risk of victimization from other incarcerated people and from staff, and programming challenges may be exacerbated by program staff who abuse their power. At least two facilities discussed instances of sexual assault by program staff. One DOC leader recounted, "We, unfortunately, had a chaplain at the [redacted] unit that left our employment ... After he left , we had some inmates that came forward and reported that he had been sexually assaulting them." Another facility staff person said that "several teachers" at their facility had "had sex with students." While our study did not verify these accounts, these instances illustrate the critical challenges in providing supportive services in such settings.

Limitations of the Study

This exploratory study has limitations that merit consideration. For example, although we achieved respectable response rates across our data collection efforts—we interviewed 82 percent of all state DOCs (41 out of 50) and surveyed 70 percent of the DV/SA coalitions we targeted (57 out of 81)—the findings we present reflect just a sample (not the totality) of current correctional practices. In addition, we only spoke to state-level DV/SA coalitions, which reflected on what they know about their member agencies' activities. Had we directly surveyed member agencies, we would have richer information about local-level partnerships between individual correctional facilities and local victim service providers. Furthermore, we only interviewed incarcerated women in three prisons. These interviews, while critically informative, are not representative of all women or people in women's facilities, nor are they generalizable to all people incarcerated in women's prisons. However, they offer important insights about the availability and importance of services and programs that address trauma and victimization. Lastly, qualitative and quantitative data collection and analyses were based on people's self-reports and may be subject to respondents' biases and subjective views. We hope the findings in this report can be a baseline for future evaluations.

A Call to Action: What Facilities Can Do to Address Trauma and Victimization

Women constitute the fastest-growing incarcerated population in the United States: between 1980 and 2017, the number of incarcerated women increased 750 percent (The Sentencing Project 2019). There is often an absence of awareness and understanding of the victimization that many, if not most, incarcerated women have experienced (Bloom 2015) and bring to incarceration, where they can experience the same kinds of violence, abuse, and trauma they experienced on the outside. As the number of incarcerated women increased over the past several decades, correctional institutions became de facto victim services agencies for women with histories of victimization and trauma. However, correctional facilities' programs, policies, and practices have not been oriented to women's unique needs, the pathways they take to incarceration, and their histories of victimization and violence, and facilities and staff face many challenges to helping women restore their well-being.

Through this national scan of practice, we aimed to identify (1) the ways facility staff become aware of women's histories of trauma and victimization and/or their experiences during incarceration; (2) the services and programming that correctional facilities provide to women who have experienced victimization before or during incarceration; (3) the nature of DOCs' and correctional facilities' collaborations with state-level DV/SA coalitions and local victim service providers in pursuit of these goals; and (4) the factors that facilitate and impede access to and the success of victim services and trauma-specific programming for incarcerated women. In previous sections, we describe the state of practice and the challenges associated with delivering trauma-informed, trauma-responsive, and trauma-specific care, as well as challenges associated with providing victim services during incarceration.

Below, we identify some ways corrections agencies can do better for people incarcerated in women's prisons. The following recommendations are based on what we learned through this study and on our thinking about what DOCs can do to enhance or even fully revise their approaches to treating incarcerated people:

- **Revamp correctional facilities' cultures, operational practices, and programming to be trauma informed, trauma responsive, and trauma specific (Covington, forthcoming).** In a companion report, *Adapting Custodial Practices to Reduce Trauma for Incarcerated Women* (McCoy et al. 2020), we describe approaches related to correctional culture, operations, and practices with the goal of reducing harm, addressing trauma, and increasing women's well-being.

- **Increase efforts to identify victims' responses to trauma.** Given victimization often produces symptoms and triggers over time, victims may exhibit behaviors that appear misguided but are actually responses to trauma. If prison staff are trained to recognize these behaviors, they can tailor their responses in ways that are trauma specific. This approach may include connecting victims with mental health services, community partners, and/or programming.
- **Respond to the unique needs of people in women's prisons who are not heterosexual cisgender women.** One major challenge in correctional institutions is their polarized approach to gender and sexuality. Women's prisons often have people who do not identify as cisgender women, including trans men, trans women, nonbinary people, people who are gender nonconforming, and others who identify as LGBTQIA+. People in these communities have unique needs related to victimization and are more likely to have experienced childhood sexual assault and in-custody sexual assault (Meyer et al. 2017). Given their heightened risks, correctional practices should work to prevent their continued victimization.
- Recognize that people confined in women's prisons may be both survivors of crime and people convicted of crime. The punitive nature of prisons and, sometimes, programs, reduce incarcerated women to the crimes that led to their conviction. It often ignores that many women who enter corrections systems are also crime survivors.[11] This awareness of past victimization can inform how prisons operate, and correctional staff may want to adopt a more rehabilitative and victim-services-oriented approach.
- **Partner with community victim service providers to provide services that facilities may not be able to provide.** Facilities use innovative approaches to provide services to incarcerated women, many of which involve external partnerships. These partnerships can allow facilities to provide specialized services to women of different identities and with different needs. Partnerships with external agencies also allow women to continue relationships with service providers after incarceration, thus promoting sustainability of positive outcomes.

Partner with research organizations to evaluate programs and services. This national scan of practice highlights several practices related to addressing trauma and victimization. However, the extent to which women benefit from these efforts is largely unknown. By partnering with research organizations to evaluate programs and services, DOCs can learn what works best to improve their practices and address women's needs.

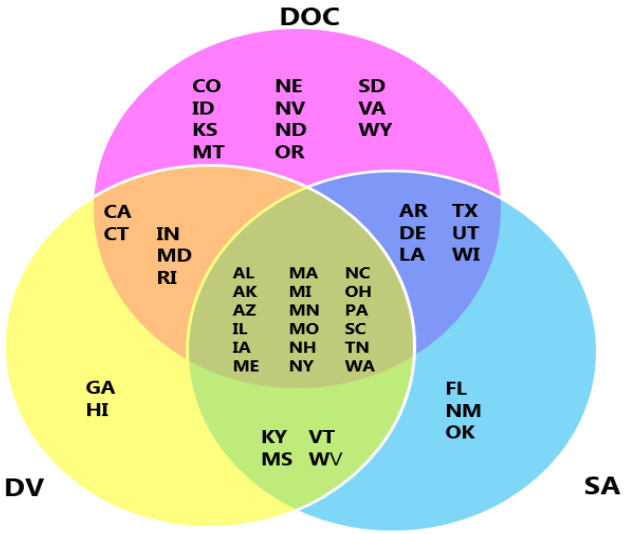
Appendix. Participating Sites and Agencies

FIGURE A.1

State DOCs That Participated in This Study

FIGURE A.2

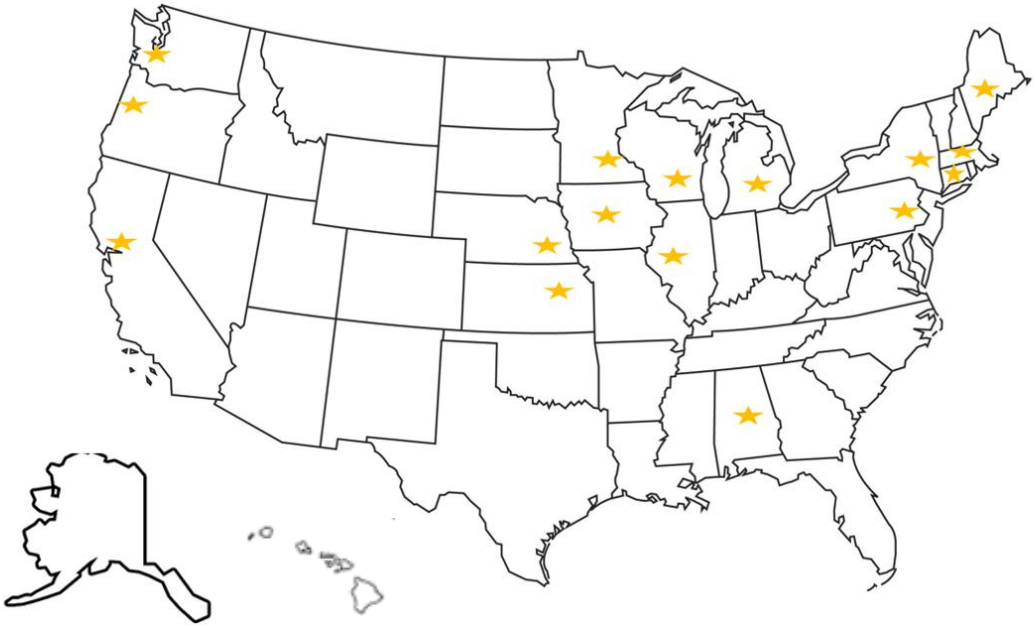
States Whose State DOCs and/or DV/SA Coalitions Participated in Surveys and Interviews



Notes: DOC = department of corrections; DV = domestic violence coalition; SA = sexual assault coalition.

FIGURE A.3

Location of Standout Sites (Correctional Facilities) That Participated in This Study



Notes

[1] For brevity, we commonly refer to women who are incarcerated simply as women when we report our findings.

[2] See Carlson and Shafer (2010), Green and coauthors (2016), Harner and coauthors (2015), Lynch , Fritch, and Heath (2012), and Lynch and coauthors (2014).

[3] "Prison Rape Elimination Act," National PREA Resource Center, accessed August 27, 2020, https://www.prearesourcecenter.org/about/prison-rape-elimination-act-prea.

[4] Alysia Santo, "Prison Rape Allegations Are on the Rise," The Marshall Project, July 25, 2018, https://www.themarshallproject.org/2018/07/25/prison-rape-allegations-are-on-the-rise.

[5] The Diagnostic and Statistical Manual of Mental Disorders is a peer-reviewed and widely used tool for diagnosing mental disorders in the United States, and is published by the American Psychological Association.

[6] "4. Screening for Risk of Sexual Victimization and Abusiveness," National PREA Resource Center, accessed September 28, 2020, https://www.prearesourcecenter.org/node/1695.

[7] Jeffrey E. Keller, "'Kite?' Where Did That Come From?" Corrections.com, January 16, 2017, http://www.corrections.com/news/article/45186-kite-where-did-that-come-from-#:~:text=Everybody%20percent20who%20percent20works%20percent20in%20percent20jails,need%20percent20to%20percent20see%20percent20the%20percent20doctor.

[8] Details on the specific ways that facilities conduct investigations is outside of the scope of this report. This is because investigations are primarily focused on holding people who cause harm accountable, and this report focuses on services that address the harms caused to victims. As such, we do not classify investigation as a victim service.

[9] Evidence-based programs are based on research literature, have rigorous quality assurance, and can be replicated with fidelity (Duwe 2017).

[10] These are facilities that we selected from the state DOCs that stood out.

[11] See Carlson and Shafer (2010), Harner and coauthors (2015), Green and coauthors (2016), Lynch, Fritch, and Heath (2012), and Lynch and coauthors (2014).

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About the Authors

Storm Ervin is a researcher in the Urban Institute's Justice Policy Center, where she conducts research and evaluations on legal system processes, services, and programs for people who experience harm, cause harm, and those who both experience and cause harm.

Jahnavi Jagannath is a policy assistant in the Justice Policy Center, where she conducts research and partnership building regarding care for justice-involved women, strengthening community and family for incarcerated individuals, and community-oriented alternatives to traditional policing.

Janine Zweig is associate vice president of justice policy and a senior research fellow in the Justice Policy Center, where she conducts research, evaluation, and technical assistance work on understanding interpersonal violence (e.g., sexual violence, intimate partner and dating violence) and program and policy responses to those experiences.

Janeen Buck Willison is a senior research fellow in the Justice Policy Center, where she conducts research, evaluation, and technical assistance on prison and jail reentry, specialized courts, corrections and community supervision, and juvenile justice, and leads numerous multisite mixed methods studies for local, state, and federal governments and private foundations.

Kierra B. Jones is a research analyst in the Justice Policy Center, where she works on projects related to victimization, the opioid crisis, and the impact of the criminal justice system on families.

Katy Maskolunas is the director of events and special projects at the National Center for Victims of Crime, where she oversees execution of the annual National Training Institute as well as multiple projects related to victim advocacy and criminal justice reform.

Benjamin McCarty is the former program director for the Project Safe Neighborhoods program at the National Center for Victims of Crime. While there, he also worked on programs related to criminal justice reform.

Chafica Agha is an attorney and program associate with the National Center for Victims of Crime. She works closely with a range of criminal justice actors to promote victim-centered justice system responses.

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