Chapter 7

Trauma-Informed Corrections

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INTRODUCTION

The pervasive impact of psychological trauma on the health and well-being of individuals, families, and communities has gained copious attention in recent years. Traumatic events such as natural disasters (i.e., Hurricane Sandy) or extreme acts of violence (i.e., Boston Marathon bombing) bring to mind community, regional or national suffering that can linger long after the rescue operation has been completed. Individuals affected by these events may experience symptoms of anxiety and anger, and have reactions to the "triggers" that remind them of the initial trauma and their losses. The very public nature of these events results in a collective sensitivity and an awareness of how the trauma may impact the involved individuals. In response, various programs, organizations and institutions became "trauma sensitive" (i.e., aware of the effects of trauma) or possibly "trauma-informed."

Trauma-informed organizations or systems of care are consciously created to recognize, understand and minimize the potentially long-term effects of exposure to a traumatic event, even if the individual may not recognize their behavior as related to the traumatic event. A trauma-informed approach involves: "(1) realizing the prevalence of trauma; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) responding by putting this knowledge into practice" (SAMHSA, 2013, p. 4). At the core of these trauma-informed organizations are individuals (professionals, non-professionals, administrators) who can provide trauma-informed care or trauma-informed services. (Note: These two terms are often used synonymously.) Trauma-informed services require a deep knowledge of the ways in which individuals may have perceived, adjusted to, and responded to their traumatic experiences and a commitment to modify organizational practices that may unintentionally trigger reminders of the traumatic event or the feelings of helplessness they experienced. By doing so, everyone from front-line staff to professionals and administrators, are more likely to project a common organizational message that the person affected by past trauma possesses valuable expertise and knowledge about their own problems. "Working collaboratively to facilitate the individual's sense of control and to maximize their autonomy and choices throughout the engagement process is crucial in trauma-informed services (SAMHSA, 2014, p. 22).

While this approach is conceivable and well-accepted in situations where the trauma is a public or a community-wide event, it may be more difficult to

Trauma Informed: An understanding of trauma and an awareness of the impact it can have across settings, services, and populations.

Trauma-Informed Services: A strengths-based service delivery approach, grounded in an understanding of and responsiveness to the impact of trauma, avoiding institutional processes and individual practices that are likely to retraumatize.

Trauma-Specific Treatment: Evidence-based and promising practices that facilitate recovery from trauma.

SAMHSA, 2014

conceptualize if the traumatic event is personal or if there is any sense of shame related to the event that silences the victim. For example, survivors of sexual assault may not disclose their victimization due to fears of not being believed or being judged as "asking for it." In these instances, the trauma has occurred and the individual is feeling similar symptoms to those who experienced the more public event, but we may not know it occurred and may have difficulty understanding the reactions or behavior of the person when they seek medical, substance abuse and/or mental health treatment. Therefore, many behavioral health service providers are moving toward "universal precautions" – or applying the same principals of care to all individuals – through becoming trauma-informed organizations. Trauma-informed organizations may or may not provide trauma-specific treatment services, but they do create a trauma-informed environment that "continues to demonstrate a commitment to compassionate and effective practices and organizational reassessment, and it changes to meet the needs of consumers with a history of trauma" (SAMHSA, 2014, p. 160).

The majority of individuals who interface with the criminal justice system – including prisons, jails and detention centers – have been exposed to traumatic events across the life-course. However, institutional confinement is intended to house perpetrators and not victims (Miller & Najavits, 2012) and may not acknowledge or recognize that individuals involved in the criminal justice system are often victims before they were "offenders" (Widom & Maxfield, 2001) or that hurt people often hurt others. When individuals enter confinement settings, they arrive with their personal histories of trauma exposure and may experience additional trauma since it is likely that the incarcerate setting is the site of new traumatic exposure. Moreover, routine correctional practices (i.e., strip searches, pat-downs) may trigger previous trauma and increase trauma-related symptoms and behaviors such as impulsive acts and aggression that may be difficult to manage within the prison or jail (Covington, 2008). While correctional environments may be reluctant to adopt the principles associated with a "trauma-informed organization," as it may run counter to the organizational culture and training received by correctional/jail/detention staff, hopefully the benefits of such a transformation are compelling. Prisons that have implemented trauma-informed services have experienced substantial decreases in institutional violence. For example, after implementing a trauma-informed institutional environment in the mental health unit at the Framingham facility in Massachusetts, there was a 62 percent decrease in inmate assaults on staff and a 54 percent decrease in inmate on inmate assaults (Benedict, 2014). Moreover, there is evidence to suggest that trauma-informed services resulted in a decrease of other behavioral and mental health situations: a 60 percent decline in the number of suicide attempts, a 33 percent decline in the need for one-on-one mental health watches, and a 16 percent decline in petitions for psychiatric petitions. In their seminal work on trauma-informed services, Fallot and Harris (2006) articulate the five core values: safety (both physical and emotional), trustworthiness, choice, collaboration, and empowerment. Incorporating these values into practice, becoming trauma-informed manifests as:

Five Core Values of Trauma-Informed Serices:

Safety	Collaboration
Trustworthiness	Empowerment
Choice	

(Fallot & Harris, 2006)

- Understanding how individuals may be affected by and cope with trauma and victimization.
- Recognizing and minimizing power dynamics – trauma can take away a feeling of power from victims, and advocates or corrections staff are in positions of power. Trauma-informed strategies focus on restoring a sense of power for the person who was victimized.
- Explaining why certain events are happening, to increase their sense of safety and control.
- Providing an atmosphere of safety.
- Working in a manner designed to prevent relapse, revictimization, and retriggering of trauma.

(*Note:* For more information on trauma informed services, the following resource may be of assistance: The National Center for Trauma- Informed Care, http://www.samhsa.gov/nctic.)

In this chapter we define trauma and trauma-related disorders, the prevalence of traumatic experiences among those involved in the criminal/legal systems, and how the institutional setting may exacerbate trauma symptoms. In addition, we define and discuss how correctional settings can become trauma-informed organizations and staff within them can become trauma-informed. Finally, we provide some information on trauma-specific interventions for trauma survivors that have been utilized within correctional settings.

Defining Trauma, Trauma-related Symptoms, and Vulnerability to Exposure

The *Diagnostic and Statistical Manual of Mental Disorders*, or *DSM-5*, defines trauma as "exposure to actual or threatened death, serious injury or sexual violence in one or more of four ways: (a) directly experiencing the event; (b) witnessing, in person, the event occurring to others; (c) learning that such an event happened to a close family member or friend; and (d) experiencing repeated or extreme exposure to aversive details of such events, such as with first responders" (American Psychiatric Association, 2013, pp. 271–280). These events have been conceptualized most frequently as: involvement in war, natural disaster, experiencing physical and/or sexual abuse, witnessing death and/or physical violence, and the unexpected death/loss of a loved one. Whenever anyone experiences one of these events, there are likely to be alterations in cognitive and emotional functioning. These alterations can result in sleep disturbances, nightmares, explosive outbursts, irritability, and risky or impulsive behaviors.

Overall, epidemiological studies tell us that *most people experience a trauma event over their lives.* However, only some people (8%-20%) of those who experience a life-threatening event actually manifest symptoms that culminate in a trauma-related disorder such as posttraumatic stress disorder – PTSD (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Since the vast majority of those exposed to a trauma adapt over time, the development of PTSD is considered by some to be "pathological"; however, others have challenged the notion of pathology, noting that ongoing responses to a trauma are influenced by many situational factors (i.e., whether it was a natural disaster or violence by a loved one; whether it was a single event or ongoing; whether the person have support afterward, etc.). Vulnerability to PTSD has been linked to characteristics of the individual as well as a history of a specific type of trauma or chronic exposure (Brewin, Andrews, & Valentine, 2000). Furthermore, various traumatic events may have differential impact. For example, interpersonal victimization is thought to inflict greater psychological harm than random or accidental events such as natural disasters. It is the deliberate action by another human being that enhances the perception of harm (Green, 1990; Herman, 1992) and shatters our assumptions of the world and our place in it (Janoff-Bulman, 1985; Freyd, 1996). In fact, epidemiological studies demonstrate that sexual assault most strongly predicts PTSD in both men and women (Kessler et al., 1995; Perkonigg, Kessler, Storz, & Wittchen, 2000; Cortina & Kubiak, 2006).

At its most basic, trauma is part of a continuum of stressful events. The stress continuum includes six types of events, from those that are most continuous (chronic stressors such as poverty) to those that are most discrete such as a sudden trauma (Wheaton, 1996). In between these poles are life changing events (i.e., job loss, divorce), daily hassles (i.e. traffic, parenting), macro-system stressors (i.e., unemployment), and nonevents (i.e., failed expectations such as not being able to have a child). Although trauma is considered a severe form of stress, it is rarely situated within a stress continuum in the trauma literature. This absence results in a lack of knowledge about the effects of other types of stress in the manifestation of trauma disorders and negates the cumulative effect of stress on any one individual. In other words, chronic stress can debilitate coping mechanisms, and those who experience chronic poverty or who have experienced other stressful events are more likely to manifest symptoms of PTSD.

One important example is stress that is referred to as "toxic stress" – or prolonged and chronic stress (i.e., ongoing child abuse, witnessing chronic domestic violence, living in extreme poverty) in the absence of supportive or buffering relationship. Toxic stress, particularly when cumulative, can derail normal physiological and psychological development in children, creating problems for a lifetime. The more adverse experiences in childhood, the greater the

likelihood of developmental delays and later health problems, including heart disease, diabetes, substance abuse, and depression (Shonkoff et al., 2012). Research has found that chronic stress, as well as experiencing a trauma, changes the neural pathways in the brain. For example, when extreme and prolonged stressors are experienced by a child, they have a great potential to severely compromise the child's development, including the way the brain develops (Gatt et al., 2010; Herman, 1997). In fact, researchers have found three areas of the brain (i.e., the hippocampus, the amygdala, and the medial frontal cortex) that look very different in those with PTSD compared with those without (Nutt & Malizia, 2004).

Most of the research on trauma focuses on exposure to a particular event (e.g., natural disaster, war, rape) and efforts to measure more than one event (i.e., cumulative trauma or chronic exposure), or assess trauma within a "stress continuum" have been rarer. Complex PTSD (or complex traumatic stress reactions) is the consequence of a history of repeated (or multiple) traumatic experiences, such as childhood sexual abuse and domestic violence. Generally, there are more symptoms and a more complicated recovery process with complex PTSD (Herman, 1997; Najavits, 2002; Roth, Newman, Pelcovitz, Van der Kolk, & Mandel, 1997; Williams & Sommer Jr, 2013).

Trauma Among Men and Women Entering Prisons, Jails. Victimization histories are important when thinking about trauma-informed services as a history of previous victimization has been linked with subsequent victimization (Arata, 2002; Kessler et al., 1995; Perkonigg et al., 2000; Siegel & Williams, 2003). A Bureau of Justice Statistics report based upon personal interviews with 7,000 jail inmates found that women reported higher rates of past year physical (45%) and sexual abuse (36%) than men (11% physical and 4% sexual abuse) (James, 2004). Moreover, one in 10 women experienced both types of abuse compared to 1 percent of men. Interestingly, for men, the primary abusers were parents/guardians, while for women it was their romantic partners. For females involved in the criminal justice continuum, the higher rates of victimization as children and adults, compared to their male counterparts can be found across studies (Belknap & Holsinger, 2006; Desai, Arias, Thompson, & Basile, 2002; McClellan, Farabee, & Crouch, 1997; Messina & Grella, 2006; Payne, Gainey, & Carey, 2005). Women who have experienced sexual victimization prior to prison are three to five times more likely to experience sexual victimization in prison than women without such histories (Wolff, Blitz, & Shi, 2007).

For men entering prison, the most common traumatic event experienced is witnessing death or serious physical injury (Sarchiapone, Carli, Cuomo, Marchetti, & Roy, 2009). Some researchers suggest that males may experience higher rates of sexual victimization than what has been previously thought, owing to how sexual victimization is defined in national studies (Stemple & Meyer, 2014). A recent Center for Disease Control survey found that 23 percent of men have experienced some form of sexual victimization (compared to 44% of women), equating to 26 million men nationally. However, as a society we rarely discuss or understand the ramification of sexual victimization on adolescent and adult males. For example, recent media and political attention to sexual assaults within the military and on college campuses have ignored or minimized the likelihood of males as victims. This inattention to male victimization – and the emotional and physical trauma – may result in aggression and risk-taking that increases the risk of detention and incarceration.

However, preincarceration experiences only tell one part of the story. Victimization within the facility is also a concern. Violence within correctional institutions can take many forms, such as coercion, physical and sexual victimization. Compared to women, males experience greater physical violence at the hands of prison staff than from other inmates, but the rate of physical violence varies greatly by institution (Wolff, Blitz, Shi, Siegel, & Bachman; 2007). In an estimate derived by the Bureau of Justice Statistics (based on the National Inmate Survey), 80,600 incarcerated individuals experienced sexual victimization in the previous 12 months (Beck, Berzofsky, Caspar, & Krebs, 2013). A survey conducted in 2008 to determine sexual victimization by those recently discharged from prison found that 9.6 percent said they were victimized during incarceration, 5.4 percent by another inmate and 5.3 percent by staff (Beck & Johnson, 2012). Wolff and colleagues (2007) found that victimization is more likely if the prisoner has a mental health problem.

Correctional Facilities as Trauma-Informed Organizations. At best, correctional facilities in the United States are rehabilitative, and at worst, punitive warehousing. Minimally, movement is monitored and there is little privacy. Confined individuals are subject to pat downs, strip searches, frequent discipline from authority figures, and constant threats of physical and/or sexual aggression. Staff members, charged with maintaining order and security, assume that each inmate is potentially violent and behave accordingly (Miller & Najavits, 2012). As a "closed system," prisons, jails, and detention centers typically create an environment of "total control" for those within the system where violations and violence are often contained and intensified within these closed settings (Hearn & Parkin, 2001). Therefore, most prisons, rather than reducing the effects of traumatic exposure, often produce new traumatic events and exacerbate symptoms of previous trauma.

Creating a trauma-informed correctional organization within a prison, jail, or detention facility is a unique challenge that differs from creating a trauma-informed behavioral or physical health system. While all organizations require a "trauma champion" who understands the impact of violence and victimization to facilitate the transformation into a trauma-informed institution (Harris & Fallot, 2001); the correctional facility requires a visionary leader! This visionary leader – one with administrative power – will need to translate the benefits of trauma-informed organization for staff! As Carol Dwyer a warden in the Rhode Island Department of Corrections states, "Officers need to know that some inmate behavior is an adaptation that stems from trauma and that there are things they can do to help a person 'chill' when something sets off the alarms" (SAMHSA, 2013, p. 5).

Using the Five Core Values of Trauma-Informed Services within a Correctional Environment

Safety: Eye contact, explanations, procedures to report abuse.

Trustworthiness: Following through; model trust; appropriate boundaries.

Choice: Emphasize individual choice; informed consent.

Collaboration: Solicit input; acknowledge insights about self.

Empowerment: Teaching skills; provide tasks where they can succeed.

In general, a trauma-informed organizational approach supports and facilitates an understanding of the prevalence of trauma, recognizing how trauma affects all individuals involved within the organization, and responding by integrating this knowledge into practice (SAMSHA, 2014). *A trauma-informed correctional organization is one in which administration have committed to creating a trauma-informed setting and will facilitate an infrastructure to initiate, support, and guide changes.* This requires a long-term administrative commitment (often 3–5 years) and leadership, particularly in the review and revisioning of current policies and practices. The long-term nature of this organization change requires a "champion" who can guide the process and a steering committee or advisory group.

Once a commitment is made to become a trauma-informed organization that uses trauma-informed services, there are several steps. First, there is a need for an assessment of policies, procedures, and current practices within the organization (Brown, Harris, & Fallot, 2013). Do those policies and procedures support or interfere with a trauma-informed environment? This will likely include a "walk-through" by an objective outsider with knowledgeable about trauma responses and triggers. Once the assessment is conducted and issues are identified, the second step is creating an action plan. Covington and Fallot (2015) have created the Implementation Plan and Goal Attainment Scale expressly for this purpose. The scale assists the organization in "naming" the problem, identifying who is responsible for making changes, and what the timeline is for completion. Simultaneous to these changes, ongoing training for staff – all staff – needs to ensue. Priority areas for training include basic information about trauma and the self-care needs of staff. All institutional staff needs to receive ongoing training and support, as being trauma-informed will shift the organizational culture of the institution. Once the changes have been implemented and staff is trained, ongoing assessment needs to occur and problem areas identified.

Why would correctional staff want a trauma-informed environment?

- Jobs become easier
- Facilities become safer
- Programming becomes more productive/effective

Routine Strategies for Decreasing Retraumatization within Correctional Settings

While individual staff members or treatment professionals may engage in trauma-informed services, unless there is a trauma-informed culture across the correctional organization, the likelihood of revictimization remains high. Trauma-informed care is distinct from trauma-specific treatment, as it is not specifically designed to address the consequences of trauma or provide relief from trauma related symptoms or behaviors. Rather, a trauma-informed approach prevents or decreases revictimization and the triggering of previous traumatic events.

As discussed previously, trauma-informed services are grounded in five key principles: (1) safety, (2) trustworthiness, (3) choice, (4) collaboration, and (5) empowerment (Fallot & Harris, 2006; SAMHSA, 2014). Staff members at all levels of responsibility within the organization can be trained to become trauma-informed. These principles can be applied to trauma-informed services, trauma-specific treatment and trauma-informed organizations or systems. Implementing trauma-informed services within a correctional setting involves incorporating knowledge about trauma in all aspects of service delivery. For individuals in the criminal justice system, incremental steps are needed to build an integrated, trauma-informed culture based upon trauma-informed treatment modalities and organizational approaches.

A trauma history can influence responses to the incarceration setting:

- People, particularly women, may be afraid to be touched, especially in pat-downs and strip searches. They may be perceived as resistant and noncompliant with such procedures when, in fact, they are terrified due to a previous victimization – or "reliving" that victimization.
- Due to the restrictive environment of the jail or prison, individuals may react in ways that they perceive as self-protective, but that staff will perceive as either hostile or "closed off."
- Medical exams may be retraumatizing. Women may refuse medical care or fail to reveal health concerns and issues in response. This may be particularly true of gynecological exams, and medical staff should be particularly sensitive to how invasive and triggering this routine procedure can be.

Often, staff members working within institutional settings believe that their behaviors and mannerisms need to be forceful as a mechanism to convey authority. Often these mannerisms include yelling or name-calling. However, those under correction's supervision understand clearly who has authority, and they recognize the power imbalance between staff and themselves. At the same time, they want to be treated with dignity. Therefore, speaking in a calm and respectful manner is considered responsive to

Table 7.1
COMPARING TRAUMA-INFORMED AND NON-TRAUMA-INFORMED BEHAVIORS.

Trauma-Informed Behaviors/Actions	*NOT Trauma-Informed Behaviors/Actions*
Saying "Hello" and "Goodbye" at the beginning and end of your shift.	Coming and going without any acknowledgement to the persons within the unit.
Quietly moving and respectfully informing individuals of where they need to be.	Yelling "Lunch" or "medications."
Language such as "Let's talk" or "Let's find someone to help you"' or "May I help you?"	'Superior' and 'Punishing' language such as, "Step away from the desk."
Referring to someone by name (i.e., Ms. Smith).	Using their identification number or last name only to refer to an individual.

the needs of trauma survivors. Staff members who demonstrate respect and fairness can play an important role in minimizing the traumatic memory that routine practices within the prison may evoke. To do that, it is critical that staff first recognize that *practices that may seem routine and "uncharged" to them may not seem that way at all to a traumatized individual.*

Institutional Practices that Prevent Retraumatizing and Enhance Safety

- Ensure policies of only same-sex exams, pat-downs, and strip searches.
- Do not engage in a practice that involves physical touching (e.g., pat-down) without first telling the person what you will be doing.
- If there is a policy of strip searching inmates after contact visits, offer the opportunity for a "noncontact" visit as an alternative. Although this often puts particularly women in the position of choosing between hugging or kissing their children and other family during a visit, and the humiliating and degrading practice of a strip search after they leave – being offered the choice will enhance a sense of autonomy and safety.
- Use a demeanor that carries respect – for example, instead of calling a person by their prison identification number, use their name.

Becoming Trauma-informed: Training Correctional Staff

Doctor Stephanie Covington, perhaps best known for her trauma-focused interventions for women in the criminal justice system, has written curricula to assist criminal justice professionals in becoming trauma-informed. To date, most of the training has taken place in Canada and the UK, but is beginning to be applied more in U.S prisons and jails. When using her training materials entitled, *Becoming Trauma Informed: A Training Program for Correctional Professionals*, she has three primary objectives:

- To provide information in order to help corrections staff better understand the effects of violence, abuse, and trauma on men and women in the criminal justice system;
- To provide opportunities for skill enhancement; and
- To provide an opportunity for staff members to reflect and learn more about themselves.

When beginning the training sessions, Doctor Covington has staff complete an Adverse Childhood Experiences survey. The instrument queries experiences of deprivation, abandonment, and abuse during childhood. This instrument gained visibility with studies by Felitti and colleagues (1998), which demonstrated a link between traumatic experiences during childhood and negative physical and mental health outcomes in adulthood. Once staff have completed the instrument about themselves, she asks them to complete one for an average individual confined within the criminal justice institution in which they work.

Correctional staff members become invested in the training when they understand that mastering trauma-informed practices will make their jobs easier and help them in their own lives. To assist them in understanding what it means to be trauma-informed, Doctor Covington takes the staff members through a series of exercises that use everyday activities and compares a "trauma informed" versus "not trauma-informed" method of engaging in these activities (see Table 7.1).

Perhaps most importantly to the incarcerated individuals, as well as staff members, the training assists correctional staff in understanding possible triggers. A trigger or "threat cue" can set off a trauma reaction, such as fear, panic, agitation, or lashing out.

Table 7.2
TABLE OF CONTENTS FOR BECOMING TRAUMA-INFORMED.

Becoming Trauma Informed: A Training Program for Correctional Professionals (Covington, 2012)
Section 1: Goals of Training: Violence in our World
Section 2: Understanding Trauma (Process and Effects)
Section 3: Trauma-Informed Services
Section 4: Triggers, Nonverbal Communication and Grounding Strategies
Section 5: Vicarious Trauma
Section 6: The Work Environment: Escalation and Deescalation

Typical triggers are for those with histories of physical and/or sexual abuse, include yelling, loud noises, restraint, being touched or threatened. Staff members learn the usefulness of learning what makes someone feel scared or upset or angry and could cause him or her to go into crisis mode. Each individual has a unique history and specific triggers. There is no single profile.

In addition to learning about trauma responses, triggers, and self-harming behaviors, correctional staff members also learn useful strategies to prevent or minimize negative responses. These strategies include self-calming techniques, as well as psychological and physical grounding exercises. These grounding techniques are useful in assisting a person who is dissociating "come back" into current reality and feelings; helping the person realize that they are in the present and that the experiences of the past are not happening currently.

Trauma-Specific Treatment. Different from creating trauma-informed environments, there are trauma-specific treatments that are therapeutic approaches for individuals with trauma related disorders such as PTSD. Literature surrounding the efficacy of trauma-informed treatment models for adults involved in the criminal justice system has generally focused on women involved in the criminal/legal system. *Seeking Safety* (SS), an evidence-based, cognitive-behavioral treatment for individuals with substance use disorder (SUD) and PTSD, utilizes a trauma-informed approach to address the unique needs of women. The intervention focuses on safety and coping skills in the framework of integrated treatment for substance use and PTSD (Najavits, 2002). Zlotnick, Najavits, Rohsenow, and Johnson (2003) evaluated SS in a sample of incarcerated women with co-occurring PTSD and SUD; 53 percent of the women no longer met the criteria for PTSD after completing treatment, and 46 percent still no longer met the criteria three months after. Another study from Gatz et al. (2007) found that women receiving SS improved significantly more on symptoms of PTSD and use of coping skills when compared to women in the comparison group. Other trauma-informed, gender-specific treatment interventions developed for women involved in the criminal/legal system have shown similar outcomes. For example, studies evaluating the effectiveness of *Helping Women Recover* and *Beyond Trauma*, both gender-responsive and trauma-informed programs, show that participants had reductions in PTSD and depression symptoms (Messina, Calhoun, & Warda, 2013; Covington, Burke, Keaton, & Norcott, 2008). More recently, a trauma-specific treatment curriculum focused on women who engage in violent behavior, *Beyond Violence* (Covington, 2013), has been found to be efficacious in decreasing women's anxiety and anger, as well as improved long-term outcomes, compared to women in the "treatment as usual" condition (Kubiak, Kim, Fedock, & Bybee, under review; Kubiak, Kim, Fedock, & Bybee, 2015).

Evidence for effective trauma-specific treatment interventions for males involved in the criminal/legal system that are trauma-informed is emerging. A pilot study conducted to evaluate the effectiveness of SS with male prisoners with histories of substance use and trauma found high treatment satisfaction and retention from participants (Barrett et al., 2015). The T*rauma Adaptive Recovery Group Education and Therapy* (TARGET) model, a trauma-focused, present-centered approach to integrated treatment for individuals with PTSD and SUD, has been piloted with both men and women (Ford & Russo, 2006). In addition, Covington and Rodriguez (2016) have developed a trauma-focused brief intervention for men entitled, *Exploring Trauma.* This is being piloted in both the general population and secure housing units within male prisons.

Prison Rape Elimination Act (PREA)

From a policy perspective, one of the most recent advances in attempting to prevent new trauma from occurring within the prison is the Prison Rape Elimination act of 2003. Signed into law by President Bush, the legislative act was for the expressed purpose of preventing sexual victimization within prisons, jails, and detention facilities, increasing the reporting and treatment of such victimization, and creating research efforts to assess and monitor the prevalence of sexual victimization by other inmates, as well as by staff.

1. Behaviors prohibited by the Prison Rape Elimination Act of 2003 include:
   - Staff sexual misconduct: Due to the power imbalances between staff and prisoners, consent is not possible. *Staff members are*

prohibited from engaging in any sexual behavior with inmates.

- Staff sexual harassment: This includes repeated verbal statements or comments of a sexual nature to an inmate by an employee, volunteer, official visitor, or agency representative, including:
  a. Demeaning references to gender or derogatory comments about body or clothing, or
  b. Profane or obscene language or gestures.

2. In compliance with the federal guidelines outlined as a result of the Prison Rape Elimination Act of 2003, the Act:
   - Protects prisoners from abuse – jails and prisons should be secure environments;
   - Creates a culture within facilities that promotes safety, instead of one that tolerates abuse;
   - Contains information for all inmates about their right to be safe within the facility;
   - Utilizes strict limits on cross-gender searches and viewing of prisoners of the opposite sex who are nude or performing bodily functions;
   - Creates reporting procedures that instill confidence and protects individuals from retaliation without relying on isolation;
   - Sets standards guaranteeing that all prisoners can easily report abuse. Staff are required to report abuse, and reports are taken seriously in every facility. A serious response to every report of abuse is also the best way to handle any false allegations;
   - Requires sanctions to be fair, consistent, and sufficiently tough to deter abuse. Everyone who engages in abuse in a correctional setting must be held accountable for their actions; and
   - Ensures immediate and ongoing access to medical and mental health care and supportive services for those who experience abuse (Kubiak, Sullivan, Fries, Nnawulezi, & Fedock, 2011).

CONCLUSION

Developing a trauma-informed organization requires a commitment to incorporating trauma-informed services in all aspects of practice. While trauma-specific treatment focuses on the individual level of care, trauma-informed organizations implement the principles of trauma-informed service at multiple system levels. In other words, departments such as healthcare, education, programs or housing within a prison each have to examine their policies and practices to develop trauma informed services. Establishing a trauma-informed organizational approach requires that administrators and staff members understand the impact and prevalence of trauma. The organization should incorporate trauma-informed principles in staff hiring and training, written policies and procedures, and program guidelines, and create a physical environment that promotes a sense of safety. All screening and assessment processes, and services provided by the organization that involve contact with individuals should be trauma-informed (SAMSHA, 2014).

One specific guide that was designed to help create a trauma-informed organization is The Sanctuary Model. The Sanctuary Model has been effective at helping traumatized clients across various human service organizations, including residential treatment centers, schools, drug and alcohol treatment centers, and domestic violence shelters. The model aims to create a culture of nonviolence, emotional intelligence, social learning, shared governance, open communication, social responsibility, and growth and change (Bloom, 2008).

Organizations and institutions that serve men and women in the criminal/legal system could benefit from incorporating a trauma-informed approach. One survey sponsored by the National Institute of Justice sought to identify the needs of incarcerated women as perceived by correctional staff, administrators, and women involved in the criminal/legal system. The needs identified included more gender-specific programming, screening and assessment tools, and management styles (Morash, Bynum, & Koons, 1998). One of the core concepts of a trauma-informed approach is acknowledging the different needs of men and women, which would be beneficial in a correctional setting. Miller and Najavits (2012) argue that the use of trauma-informed correctional care could help create a safe and rehabilitative environment for both staff and inmates.

The centrality of trauma in the lives of adult men and women involved in the criminal/legal system necessitates the need for the development of additional

Table 7.3

How Being Trauma-Informed Improves Criminal Justice Responses
(SAMHSA National Gains Center, 2010)

Although prevalence estimates vary, there is consensus that a high percentage of justice-involved women and men have experienced serious trauma throughout their lifetime. The reverberating effects of trauma experiences can challenge a person's capacity for recovery and pose significant barriers to accessing services, often resulting in an increased risk of coming into contact with the criminal justice system.

How Being Trauma Informed Improves Criminal Justice Responses is a training program for criminal justice professionals to create an awareness of the impact of trauma on behavior and to develop trauma informed responses. This 1-day cross-systems workshop helps local criminal justice services become trauma-informed. The first ½ day provides information about trauma and justice-involved women and men with mental illness. The second ½ day gathers key stakeholders to develop an action plan for trauma-informed policies and services.

Goals

The primary goals of this workshop are to help criminal justice professionals to:

- Understand the impact of trauma on women and men with serious mental illness, and
- Interact with people in ways that help to engage them in services, keep them out of the criminal justice system, ease processing through the system, and avoid re-traumatizing.

Benefits of a Trauma-Informed Staff

When staff members are trauma-informed, it can help to:

- Reduce recidivism,
- Reduce disciplinary infractions in jail or prison,
- Reduce use of seclusion and restraint (and associated injuries to officers, arrestees and inmates), and
- Reduce relapse treatment failure.

Trauma-informed criminal justice responses can help avoid re-traumatizing individuals, and thereby, increase safety for all, decrease recidivism, and promote and support recovery of justice-involved women and men with serious mental illness. This highly interactive training is specifically tailored to community-based criminal justice professionals including:

- Police,
- Community corrections (probation, parole, pre-trial services officers),
- Court personnel, and
- Other human service providers.

How Being Trauma-Informed Improves Criminal Justice System Responses is a half-day training for criminal justice professionals to:

- Increase understanding and awareness of the impact of trauma,
- Develop trauma-informed responses, and
- Provide strategies for developing and implementing trauma-informed policies.

http://gainscenter.samhsa.gov/trauma/trauma_training.asp

trauma-informed treatment models and trauma-informed organizational approaches specific to this population. The principles of trauma-informed services are especially important for those working with people who have experienced trauma. While gender-specific programming, screening, and assessment, and organizational practices have gained attention in recent years, they have disproportionality focused on the needs of women. More recent approaches have argued for gender-specific and trauma-informed programming that recognizes that (1) both men and women have experiences of trauma, (2) circumstances surrounding their traumatic event(s) often differ, and (3) that the variation in cultural/social gender norms requires differing approaches to trauma-informed services and trauma-specific treatment. The integration

of trauma-informed services and a trauma-informed organizational approach has the potential to improve rehabilitation outcomes and reduce adverse events (Miller & Najavits, 2012). Trauma impacts the health and well-being of all individuals, communities, and organizations, and trauma-informed services can help minimize the risk of re-traumatization and promote a culture of safety and collaboration for all people involved.

REFERENCES

American Psychiatric Association. (2013). *The diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Arata, C. M. (2002). Child sexual abuse and sexual revictimization. *Clinical Psychology: Science and Practice, 9*(2), 135–164.

Barrett, E. L., Indig, D., Sunjic, S., Sannibale, C., Sindicich, N., Rosenfield, J., Najavits, L. M., & Mills, K. (2015). Treating comorbid substance use and traumatic stress among male prisoners: A pilot study of the acceptability, feasibility, and preliminary efficacy of Seeking Safety. *International Journal of Forensic Mental Health, 14*(1), 45–55. doi: 10.1080/14999013.2015.1014527

Beck, A., Berzofsky, M., Caspar, R., & Krebs, C. (2013). *Sexual victimization in prisons and jails reported by inmates, 2011–2012.* National Criminal Justice Reference Service.

Beck, A. J., & Johnson, C. (2012). *Sexual victimization reported by former state prisoners, 2008.* National Criminal Justice Reference Service.

Belknap, J., & Holsinger, K. (2006). The gendered nature of risk factors for delinquency. *Feminist Criminology, 1*(1), 48–71.

Benedict, A. B. (2014). *Using trauma-informed practices to enhance safety and security in women's correctional facilities.* Retrieved from: https://www.bja.gov/Publications/NRCJIW-UsingTraumaInformedPractices.pdf

Bloom, S. L. (2008). The sanctuary model of trauma-informed organizational change. *The National Abandoned Infants Assistance Resource Center, 16*(1), 12–17.

Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology, 68*(5), 748–766.

Brown, V. B., Harris, M., & Fallot, R. (2013). Moving toward trauma-informed practice in addiction treatment: A collaborative model of agency assessment. *Journal of Psychoactive Drugs, 45*(5), 386.

Cortina, L. M., & Kubiak, S. P. (2006). Gender and posttraumatic stress: Sexual violence as an explanation for women's increased risk. *Journal of Abnormal Psychology, 115*(4), 753–759.

Covington, S. S. (2008). Women and addiction: A trauma-informed approach. *Journal of Psychoactive Drugs, 40,* 377–385.

Covington, S. (2013). *Beyond violence: A prevention program for women.* Hoboken, N.J: Wiley & Sons Publishing;

Covington, S. S., Burke, C., Keaton, S., & Norcott, C. (2008). Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment. *Journal of Psychoactive Drugs, 40,* 387–399.

Covington, S. S., & Rodriquez, R. (2016). *Exploring trauma: A brief intervention for men.* Center City, MN: Hazelden.

Covington, S. S., & Fallot, R. (2010, rev. 2014, rev. 2015). Implementation plan and goal attainment scale. In the *Trauma and gender criminal justice toolkit.* Hamden, CT: Connecticut Women's Consortium.

Cuomo, C., Sarchiapone, M., Giannatonio, M. D., Mancini, M., & Roy, A. (2008). Aggression, impulsivity, personality traits, and childhood trauma of prisoners with substance abuse and addiction. *The American Journal of Drug and Alcohol Abuse, 34*(3), 339–345.

Desai, S., Arias, I., Thompson, M. P., & Basile, K. C. (2002). Childhood victimization and subsequent adult revictimization assessed in a nationally representative sample of women and men. *Violence and Victims, 17*(6), 639–653.

Fallot, R., & Harris, M. (2006). *Trauma-informed services: A self-assessment and planning protocol.* Washington, DC: Community Connections.

Felitti, V. J., Anda, R. F., Nordenberg, D. F., Williamson, D. F., & Spitz, A. F. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245–258.

Ford, J. D. & Russo, E. (2006). Trauma-focused, present-centered, emotional self-regulation approach to integrated treatment for posttraumatic stress and addiction: Trauma adaptive recovery group education and therapy (TARGET). *American Journal of Psychotherapy, 60*(4), 335–355.

Freyd, J. J. (1996). *Betrayal trauma: The logic of forgetting childhood abuse.* Cambridge MA: Harvard University Press.

Gatt, J. M., Williams, L. M., Schofield, P. R., Dobson-Stone, C., Paul, R. H., Grieve, S. M., Nemeroff, C. B. (2010). Impact of the HTR3A gene with early life trauma on emotional brain networks and depressed mood. *Depression and Anxiety, 27*(8), 752–759. doi: 10.1002/da.20726

Gatz, M., Brown, V., Hennigan, K., Rechberger, E., O'Keefe, M., Rose, T., & Bjelajac, P. (2007). Effectiveness of an

integrated trauma-informed approach to treatment women with co-occurring disorders and histories of trauma: The Los Angeles site. *Journal of Community Psychology, 35*(7), 863–878. doi:10.1002/jcop.20186

Green, B. L. (1990). Defining trauma: Terminology and generic stressor dimensions. *Journal of Applied Social Psychology, 20*(2), 1632–1642. doi: 10.1111/j.1559-1816.1990.tb01498.x

Harris, M., & Fallot, R. D. (2001). Envisioning a trauma-informed service system: A vital paradigm shift. *New Directions for Mental Health Services, 89*, 3–22.

Hearn, J., & Parkin, W. (2001). *Gender, sexuality and violence in organizations: The unspoken forces of organization violations.* London, UK: Sage Publications.

Herman, J. L. (1997). *Trauma and recovery.* New York, NY: Basic Books.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5*(3), 377–310. doi:10.1002/jts.2490050305

James, D. J. (2004). *Profile of jail inmates, 2002.* Bureau of Justice Statistics Special Report, July, NCJ 201932.

Janoff-Bulman, R. (1985). Criminal vs non-criminal victimization – victims' reactions. *Victimology, 10*(1–4), 498–511.

Kessler, R. C., Sonnega, A., Bromet, E. J., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry, 52*(12), 1048–1060.

Kubiak, S. P., Kim, W. J., Fedock, G., & Bybee, D. (2015). Testing a violence-prevention intervention for incarcerated women using a randomized control trial. *Research on Social Work Practice, 25*(3), 334–348.

Kubiak, S.P., Sullivan, C.M., Fries, L., Nnawulezi, N., & Fedock, G. (2011). *Best practices toolkit for working with domestic violence survivors with criminal histories.* Michigan Coalition Against Domestic and Sexual Violence. Retrieved from: http://www.mcadsv.org/projects/Toolkit/Files/Best_Practice_Toolkit_Entire_Document.pdf

McClellan, D. S., Farabee, D., & Crouch, B. M. (1997). Early victimization, drug use, and criminality: A comparison of male and female prisoners. *Criminal Justice and Behavior, 24*(4), 455–476.

Messina, N., & Grella, C. (2006). Childhood trauma and women's health outcomes in a California prison population. *American Journal of Public Health, 96*(10), 1842–1848.

Messina, N., Calhoun, S., & Warda, U. (2013). Gender-responsive court treatment: A randomized controlled trial. *Criminal Justice and Behavior, 39*(12), 1538–1558. doi: 10.1177/0093854812453913

Miller, N. A., & Najavits, L. M. (2012). Creating trauma-informed correctional care: A balance of goals and environment. *European Journal of Psychotraumatology, 3.* doi: 10.3402/ejpt.v3i0.17246

Morash, M., Bynum, T. S., & Koons, B. A. (1998). *Women offenders: Programming needs and promising approaches.* Washington, DC: USDOJ, National Institute of Justice.

Najavits, L. M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse.* New York, NY: Guilford Press.

Nutt, D. J., & Malizia, A. L. (2004). Structural and functional brain changes in posttraumatic stress disorder. *Journal of Clinical Psychiatry, 65*, 11–17.

Payne, B. K., Gainey, R. R., & Carey, C. S. (2005). All in the family: Gender, family crimes, and later criminality. *Women & Criminal Justice, 16*(4), 73–89.

Perkonigg, A., Kessler, R. C., Storz, S., & Wittchen, H. (2000). Traumatic events and post-traumatic stress disorder in the community: Prevalence, risk factors and comorbidity. *Acta Psychiatrica Scandinavica, 101*(1), 46–59.

Roth, S. H., Newman, E., Pelcovitz, D., Van der Kolk, B. A., & Mandel, F. S. (1997). Complex PTSD in victims exposed to sexual and physical abuse: Results from the DSM-IV field trial for posttraumatic stress disorder. *Journal of Traumatic Stress, 10*(4), 539–555.

Sarchiapone, M., Carli, V., Cuomo, C., Marchetti, M., & Roy, A. (2009). Association between childhood trauma and aggression in male prisoners. *Psychiatry research, 165*(1), 187–192.

Shonkoff, J. P., Garner, A. S., Siegel, B. S., Dobbins, M. I., Earls, M. F., McGuinn, L., & Wood, D. L. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics, 129*(1), 232–246.

Siegel, J. A., & Williams, L. M. (2003). Risk factors for sexual victimization of women: Results from a prospective study. *Violence Against Women, 9*(8), 902–930.

Stemple, L., & Meyer, I. H. (2014). The sexual victimization of men in America: New data challenge old assumptions. *American Journal of Public Health, 104*(6), e19-e26.

Substance Abuse and Mental Health Services Administration. (2013). Creating a Trauma-Informed Criminal Justice System for Women: Why and How [Draft]. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2014). Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Wheaton, B. (1996). The domains and boundaries of stress concepts. In H. B. Kaplan (Ed.), *Psychosocial stress: Perspectives on structure, theory, life-course, and methods* (pp. 29–70). San Diego, CA: Academic Press.

Widom, C. S., & Maxfield, M. G. (2001). An update on the "cycle of violence." *Research in Brief*, 1–8.

Williams, M. B., & Sommer Jr, J. F. (2013). *Simple and complex post-traumatic stress disorder: Strategies for comprehensive treatment in clinical practice.* Routledge.

Wolff, N., Blitz, C. L., & Shi, J. (2007). Rates of sexual victimization in prison for inmates with and without mental disorders. *Psychiatric Services, 58*(8), 1087–1094.

Wolff, N., Blitz, C. L., Shi, J., Siegel, J., & Bachman, R. (2007). Physical violence inside prisons: Rates of victimization. *Criminal Justice and Behavior. 34*(5), 588-599.

Zlotnick, C., Najavits, L. M., Rohsenow, D. J., & Johnson, D. M. (2003). A cognitive-behavioral treatment for incarcerated women with substance abuse disorders and posttraumatic stress disorder: Findings from a pilot study. *Journal of Substance Abuse Treatment, 25*, 99–105. doi:10.1016/S0740-5472(03)00106-5