Drug Court Team Trauma Training Materials

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Produced by:
Advocates for Human Potential
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Pre-Training Knowledge Assessment

Multiple choice questions: *Please circle the corresponding letter of the choice that best completes each statement.*

1. After exposure to a violent or a tragic event

a. most people will not develop PTSD.

b. risk factors make it more likely an experience will lead to traumatic stress are common in the background of many drug court clients

c. men tend to react with hyper-vigilance, while women may become avoidant.

d. the temporary disturbances many people experience subside after a few weeks.

e. All of the above

2. Trauma histories are so common among drug court clients that

a. trauma-informed approaches are applied when it is certain someone has trauma.

b. it makes sense to use trauma-informed approaches whenever possible.

c. it is necessary to ask every drug court client about past trauma.

d. it is best to overlook certain behaviors.

e. Not sure

3. The most common traumatic exposure <u>males</u> in the court system report is

a. intimate partner violence.

b. childhood sexual abuse.

c. prison/jail rape.

d. seeing someone killed or seriously injured.

e. None of the above

4. In the general population, rates of Post-traumatic Stress Disorder (PTSD) are

a. higher than rates of PTSD among drug court clients

b. the same for males and females

c. at least twice as high among females in comparison to males

d. highest among teens, regardless of gender

e. Not sure

5. Trauma can make the court experience more difficult when it affects a person's:

a. view of authority figures

b. trust in institutions, such as courts

c. ideas about justice and retribution

d. ability to process information

e. All of the above

6. A drug court program requires trauma training for staff, offers educational materials on the subject to clients, and refers clients for specialized trauma services and supports. The program is:

a. trauma-specific

b. dual diagnosis

c. trauma-informed

d. remiss because they do not screen for trauma

e. Not sure

7. People with serious alcohol and drug problems:

a. rarely develop PTSD until they are abstinent from all substances

b. often have co-occurring trauma-related mental health problems

c. need to let go of past trauma and focus on staying clean and sober

d. will not be able to achieve recovery until they address their trauma

e. All of the above

8. When people have a diagnosis of PTSD:

a. they are more likely to be arrested than the general population

b. the majority will still have symptoms after one year; a third after 10 years

c. their rate of substance use disorders is 2-3 times the rate of the general population.

d. they are 6x more likely to have another psychiatric disorder; and 8x more likely to have three or more.

e. All of the above

Answer Sheet

1. e
2. b
3. d
4. c
5. e
6. c
7. b
8. e

PRE-TRAINING READINGS: These examples of short, non-academic articles are sent to participants in advance of the training. A short film, made by a recovering trauma survivor after completing treatment as part of a sentence for driving under the influence, is also part of the pre-training materials. It is available upon request. However, many other readings and films are equally appropriate. Jurisdictions may wish to use one or more readings or films that they feel are especially relevant to local drug court teams.

READING 1

Toward Creating a Trauma-Informed Criminal Justice System

by Chan Noether, Policy Research Associates

Recognition of the high rates of trauma and post-traumatic stress disorder among justice-involved individuals is vital.[1] It is estimated that 85 percent of women in correctional settings have an early experience of physical and or sexual abuse.[2] Other reports estimate even higher lifetime experience of traumatic events and show little difference between genders on the prevalence of trauma and abuse. In fact, in a recent study of people participating in jail diversion programs across the country both women and men, almost universally, reported a history of significant traumatic experience prior to incarceration (95.5% and 88.6% respectively).[3]

"Trauma-informed" may be a concept that you've heard of and "trauma-informed care" may be a practice you're already implementing in your organization, agency or community. n understanding of trauma and its effects, as well as the principles of being trauma-informed are key for criminal justice system professionals. Being a trauma-informed criminal justice system professional means understanding trauma and its manifestations and approaching all interactions through a trauma-informed lens. Being trauma-informed can help increase safety for you, the person with whom you are interacting and the community as a whole. Most simply, being trauma-informed is just doing your job well.

Many of us have been impacted by trauma across the lifespan and can identify at some level with the trauma experienced by others. By understanding how the effects of trauma can manifest behaviorally and may be triggered by interactions in many situations and settings that are commonplace in the criminal justice system, that information can be used to deescalate tricky situations and get people the support and assistance they may need.

So what does it mean to be "trauma-informed"? According to SAMHSA's National Center for Trauma-Informed Care, "Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives." Trauma-informed care can be implemented in all systems – the criminal justice system, health care system (including behavioral health), education system, employment and vocational system, etc. A goal of trauma-informed care is to avoid re-traumatizing an individual. Since we do not know all of the lived experiences of everyone we encounter, it is best practice to always approach a situation with a trauma-informed lens and assume that individual has experienced some sort of trauma, particularly in the criminal justice arena. By assuming that an individual may have a trauma history, we can groom ourselves to always take a trauma-informed approach when dealing with at-risk populations.

Being trauma-informed is also recognizing what trauma is. Common traumatic stressors include physical abuse, sexual abuse, surviving or witnessing a natural disaster, witnessing or experiencing violence or other traumatic events, serving in combat or being a victim of war, or experiencing historical trauma. Sometimes, trauma is repetitive, such as recurring abuse as a child. Other times, trauma is a one-time incident, such as witnessing a brutal shooting. With historical trauma, trauma is multi-generational and is experienced by a specific cultural group. We see the manifestations of historical trauma among various populations, but most notably Native Americans/First Nation People, African Americans, Immigrants, people living in poverty, and genocide survivors and refugees and their families. These manifestations

can impact peoples' perceptions of situations, intent, trust, and more. A trauma-informed criminal justice system professional is able to recognize and consider how a trauma history may impact an individual's behavior or attitude in a given situation and tailor responses accordingly.

[1] Davidson, L., & Rowe, M. (2008). Peer support within criminal justice settings: The role of forensic peer specialists. Delmar, NY: CMHS National GAINS Center.
[2] Gillece, J.B. (2009). Understanding the effects of trauma on lives of offenders. *Corrections Today.*
[3] Steadman, H.J. (2009). [Lifetime experience of trauma among participants in the cross-site evaluation of the TCE for Jail Diversion Programs initiative]. Unpublished raw data.

More: **http://www.prainc.com/toward-creating-a-trauma-informed-criminal-justice-system/**

READING 2

Bayview center pioneers approach to crime prevention by fighting stress in youths

by Mike Koozmin San Francisco Examiner

In September, District Attorney George Gascón lobbied in Washington, D.C., and received help from House Minority Leader Nancy Pelosi, D-San Francisco, to secure $1 million to evaluate victimized children in the Bayview district. In the eastern section of that neighborhood, Gascón says, 70 percent of black youths are referred to the juvenile justice system by age 17.

"If [children] are exposed to chronic adversity — gunshots, violence in the home, an unstable living environment — how are they also supposed to learn to read by the time they're 8 years old?" …. "When you're not able to read at 8, it will probably lead to behavioral problems in the classroom, suspensions and then truancy."

To begin to explain this intense type of stress, [imagine] a person's encounter with a bear in the forest. In that moment, the human body enters "fight-or-flight" mode and emergency stress hormones such as adrenaline and cortisol are released. While that reaction helps humans focus on a problem and survive, children who experience repeated intense stress often find it difficult to turn off their fight-or-flight reactions. The resulting high levels of emergency hormones can alter the structure and function of a child's growing brain and other organs, studies show.

The federal government plans to pump money locally following studies showing there are biological reasons for why a child who suffers chronic adversity might engage in high-risk behaviors as an adult.

San Francisco DA ready for a different approach to preventing crime

The District Attorney's Office is currently in the planning stages to determine how $1 million in federal funding will be used to help ease violence in the eastern Bayview district. District Attorney George Gascón wants the three-year U.S. Department of Justice grant to test the theory that helping victims and witnesses can work to reduce future crimes.

"Many people who are victims in an area where there is a high level of violence and crime become offenders at a later date," Gascón said. "It becomes a vicious cycle."

About 15 percent of San Franciscans who are on active probation live in the 94124 ZIP code, where exposure to violence is estimated to be four times higher than the citywide rate, according to Gascón. San Francisco police have seen the cycle of violence afflicting generations of Bayview children… Police Chief Greg Suhr, a former Bayview station captain, recently spoke… at a conference of police chiefs.

"Lots of funding has been provided for policing and prosecution," Gascón said. "Too little attention has been given toward working with the victims."

"It was something that didn't occur to a lot of the other chiefs," Suhr said, adding that top brass in other cities plan to apply for the same $1 million grant The City already won. Gascón wants the federal grant to lead to a "nuts and bolts strategy" on how to provide treatment and services to victims. The project will involve organizations within the community who are already doing that work, Gascón said.

More: **http://www.sfexaminer.com/sanfrancisco/bayview-center-pioneers-approach-to-crime-prevention-by-fighting-stress-in-youths/Content?oid=2643068** Crime, like health, can go in cycles. Certain factors (poverty, lack of education, etc.) start ripple effects that create and then worsen problems. But we also can *reverse* cycles in health and crime.

More importantly, the two are not separate. Another post in this forum, from Lenore Anderson of Californians for Safety and Justice, explains how counties can provide care to people in jail who need mental health or substance abuse services to stop cycles of crime.

Stopping those crimes doesn't just prevent victimization of individuals but actually has a direct correlation to health outcomes in entire communities fraught with violence, drug abuse and mental illness.

First, it's important to recognize how experiencing violence negatively affects the health of those exposed to it. Take for example, San Francisco's Bayview Hunters Point neighborhood, which has high rates of poverty and violence.

Last year, as part of my work at the California Pacific Medical Center Bayview Child Health Center, I joined Stanford psychiatrist Victor Carrion to conduct a study that analyzed the records of 701 children treated at the health clinic. Of those, two out of three had experienced some level of adversity (exposure to violence, substance abuse, etc.). Those experiencing higher levels were twice as likely to be overweight or obese, and 30 times as likely to show learning and behavior problems as those who had not.

These findings confirm previous studies on the impact of early adversity on brain development and the body. When facing a threatening or scary situation, the body releases stress hormones like adrenaline and cortisol that quicken the heart rate and increase blood pressure. Stress responses also decrease activity in parts of the brain responsible for impulse control and judgment, while stimulating inflammation by the immune system. Children repeatedly exposed to household or community stressors can experience long-term learning and health problems.

The 1998 Adverse Childhood Experiences Study of 17,000 adults found that those exposed to four or more adverse experiences in childhood had increased risk of adult diseases like heart disease, hepatitis and cancer.

Too often people living in communities exposed to violence cannot access care because they can't afford insurance. Enter the ACA.

In addition to expanding coverage, the ACA also increases reimbursements for case management, preventive services and the creation of a primary care "home." All this translates into more individualized attention for people who need to break cycles of drug abuse and mental health struggles.

Ultimately, this new focus on individuals and a continuum of care benefits entire communities, since each life that is improved builds a healthier cycle of behavior and well-being that can reverse negative trends in our neediest neighborhoods.

PART I HANDOUTS

HANDOUT 1:

Groups with Trauma Exposure Justice Professionals Commonly Encounter

Juveniles Involved with the Criminal Justice System:
In a study of juvenile detainees, 93.2% of males and 84% of females reported a traumatic experience; 18% of females and 11% of males met criteria for PTSD (Hennessey et al, 2004. p. 3).

Childhood abuse or neglect increases the likelihood of arrest as a juvenile; for a violent crime [the likelihood of arrest] increases by 38%.

WOMEN	MEN
65% current exposure 58% current exposure	96% lifetime trauma 92% lifetime trauma

Men Involved with the Criminal Justice System:
The TAPA Center for Jail Diversion study of 2,251 offenders found high levels of exposure to traumatic events reported by both men and women in jails. Research has found [m]ales tend to externalize, have an active emergency response, (flight-and-fight) and become hyper-aroused (Perry et al, 1996).

Females Involved with the Criminal Justice System
A 1998 study found 92% of incarcerated females reported sexual, physical or severe emotional abuse in childhood. Juvenile court systems have reported that at least 75% of adolescent females adjudicated delinquent report sexual abuse.

People with Alcohol and Drug Dependency
Overall, studies estimate that 30-60% of treatment-seeking substance abusers have PTSD. (Missouri Institute of Mental Health, 2002)

The Center for Substance Abuse Treatment states that as many as two-thirds of women and men in treatment for substance abuse report experiencing childhood abuse or neglect.

Male and Female Veterans (US Veterans Administration Statistics)
In 2006, nearly 3,800 women diagnosed with PTSD were treated by the VA. They accounted for 14% of total 27,000 veterans treated for PTSD last year.

Investigators from Walter Reed Army Medical Center and Dartmouth Medical School screened 404 veterans and found (9.7%) had PTSD, depression, or both.

Motor Vehicle Accident Victims:
[I]n a study of 92 consecutive motor vehicle accident victim admissions (ages 16-65) to a major trauma hospital… 77.8% of individuals meeting full criteria for Acute Stress Disorder developed chronic Post Traumatic Stress Disorder at follow-up assessment.

Victims of Interpersonal, Domestic and Sexual Violence:
Crime victims who suffered brutal trauma showed higher frequencies of PTSD: rape (49%), torture (54%), badly beaten (32%), and sexual assault (24%). Assaultive violence of all kinds had the highest risk of PTSD (21%) compared with other traumas (9%) (National Victims Assistance Academy, 2002).

People with Serious Mental Illness:
Up to 81% of men and women in psychiatric hospitals diagnosed with major mental illnesses have experienced physical and/or sexual abuse, 67% of these individuals experienced their abuse as children (NASMHPD/NTAC Report, p. 41).

Source: *Responding To Childhood Trauma: The Promise and Practice of Trauma Informed Care*, 2006, Hodas, GR

(Miller, 2009)

HANDOUT 2

Primitive Survival Responses

Establishing a safe environment at the earliest stages of program participation helps to ensure client engagement and can make everyone's job easier. It is helpful to understand some of the dynamics that may trigger primitive reactions and to be able to recognize these aroused states:

FIGHT hyper vigilance on conscious and unconscious levels, prepared to defend; flooding of physiological changes related to aggression. ***Often in response to:*** arrest, booking, or lock-up.

FLIGHT blood flows to the limbs preparing to run, but when flight is not possible there is no relief for a revved-up nervous system. ***Often in response to:*** confinement, close quarters or closed in physical environments. Numbing, avoidance, dissociation, and other psychological "flight" behaviors may interfere with treatment engagement.

FRIGHT anxiety and fear can permeate all areas of life, or seemingly benign situations may bring on sudden terror — startle responses, shortness of breath, and inability to focus. Fear may manifest as bravado, thrill seeking, or reckless behavior. ***Often in response to:*** loud noises, an approaching anniversary or sensory reminder of a traumatic event— smells, people or situations associated with the event.

FREEZE response observed in animals, accompanied by slowed and shut down metabolism. Can also be a learned response and an attempt to remain invisible and safe. When victims are paralyzed, helplessness is reinforced in each new situation, increasing their vulnerability. ***Often in response to:*** an attack, aggression, danger, confrontation or authority.

FLAIL perceived as aggression, but reactive physical movement, such as flailing the arms, to create a safe space around the body. As when animals puff up or fan out to keep aggressors from closing in, there is no attempt to connect with a target. ***Often in response to:*** physical contact during arrest, perceived aggression, or being touched during an anxious episode.

SHIELD Protective action—like flailing, shielding by raising the hands over head and body to physically prepare for injury. Trauma survivors may shield in response to noises, chaos, and non-violent expressions of conflict. ***Often in response to***: over stimulation, criticism, a perceived rebuke or punishment.

FLIRT A protective behavior for some women when they feel overpowered. Girls who were sexualized as children may revert to placating behaviors that helped them survive in violent and abusive homes. ***Often in response to:*** new or dangerous situations; male authority figures, sexually aggressive males.

SUBMIT Renders the victim vulnerable, but more in control. Animals will submit to predator if flight is impossible. Submission and under-arousal in the face of danger may be labeled "risk taking" behavior. ***Often in response to:*** overwhelming hopelessness, difficult tasks, situations, or setbacks. (Miller, 2008)

HANDOUT 3

Common Traumatic Stress Reactions

Young Children:

Young children's reactions to disturbing events often happen in the context of relationships. The child may experience feelings of helplessness and anxiety. Typically, the child will regress and forget skills they had mastered such as speech, toileting and sleep. Children may become emotionally fragile and easily upset. They may become aggressive with others. In many cases, children engage in repetitive play, re-enacting some aspect of the traumatic event.

School Age Children May:

- Have a range of unwanted and intrusive thoughts and images
- Develop intense, specific new fears that link back to the original danger
- Struggle to make connections in school.
- Have "fears of recurrence"
- Shift between shy or withdrawn behaviour and unusually aggressive behaviour
- Have disturbances in sleep

Adolescents May:

- Feel they are "going crazy," are weak, or different from everyone else
- Be embarrassed by bouts of fear and exaggerated physical responses
- Believe that they are unique in their pain and suffering
- Have reckless behaviour that endangers themselves and others
- Have extreme avoidant behaviours that can derail their adolescent years
- Have disturbances in sleep

Source: *The Massachusetts Child Trauma Project:* **http://machildtraumaproject.org**

Adults with Substance Use Disorders May:

- Have used substances to “manage” their anxiety and stress responses for many years
- Become more reactive when they begin to abstain from substances
- Experience compounded physiological effects from the combination of trauma and withdrawal
- Have a hard time focusing on treatment and recovery and processing and retaining information

Adults in the Criminal Justice System May:

- React with emotional numbing that interferes with their ability to experience empathy and remorse
- Live in continual state of hyper-arousal and appear on edge, irritable, and explosive
- Hold deep beliefs about retribution and injustice
- Distrust institutions and seek out others that share their sense of betrayal
- Become avoidant, and distrustful, and fail to show to up when they have been referred to services
- Dissociate or “check out” at the first sign of confrontation or authoritativeness (especially females)

(Miller, 2011)

Establishing safety is foundational. Trauma responses have been identified by criminal justice researchers as a potential problem that may prevent drug court clients from engaging in and benefitting from cognitive-behavioral interventions (Brennan 2007).

HANDOUT 4

EXERCISE 1: Self-Care Check-in

Trauma-informed approaches highlight self-care for clients **and staff**—beginning with you. Working with people who have trauma histories puts caregivers at risk for secondary trauma (also known as "vicarious trauma" or "compassion fatigue"). It is normal to have strong feelings when people disclose histories of abuse or exposure to violence. When we work with people that experience traumatic events, listen to stories about past trauma, or encounter workplace situations that feel overwhelming, we need to finds ways to protecting ourselves from stress and burn out. Trauma-informed approaches seek to establish a safe environment for clients ***and*** for staff.

Instructions: Please use the self-care plan to identify some strategies to help you manage intense encounters and situations in court settings. Check off the ones you would be willing to try. Make sure to list some of the things you have discovered that work for you.

Sample Self-Care Plan: If I become exhausted, emotional, numb or angry:

- ☐ I can talk to _____ about my feelings.
- ☐ I can take a break.
- ☐ I can stretch or exercise or go for a walk.
- ☐ I can eat something nutritious.
- ☐ I can eat something not so nutritious (chocolate!)
- ☐ I can think of some of the successful clients I have helped.
- ☐ I can take a nap or lie down.
- ☐ I can watch something funny or entertaining.
- ☐ I can play with my pet or my children.
- ☐ I can shoot baskets or play another sport.

These things work well for me when I am overwhelmed at work:

1.

2.

3.

I have to watch out for: _____

_____

One thing I know that doesn't help is: _____

_____

My supervisor is: _____

_____ Miller, 2008)

PART II HANDOUTS

HANDOUT 5

Calming Solutions Form

(Adapted from the IHR *Calming Solutions* form, courtesy of Institute for Health Recovery)

It is helpful for us to be aware of the things that can help you feel better when you are having a hard time. Have any of the following ever worked for you? We may not be able to offer all of these alternatives but we can work together to figure out how best we can help you while you are here.

voluntary time alone in your room	taking a hot shower
voluntary quiet time in living room	wrapping up in a blanket
sitting near the staff office	listening to music
talking with another woman	reading a newspaper/book
talking with staff	watching TV
having your hand held	pacing
having a hug	calling a friend
punching a pillow	calling your therapist
writing in a diary or journal	pounding some clay
deep breathing exercises	exercise
going for a walk with staff	using ice on your body
going for a walk with another woman	putting hands under cold water
lying down with a cold facecloth	other? please add

2. ARE THERE PARTICULAR "TRIGGERS" THAT YOU KNOW TEND TO UPSET YOU?

being touched	being isolated
bedroom door open	people in uniform
particular time of day (when?)	time of year (when?)
Loud noise	yelling
not having control/input (explain)	others (please list)

3. WHAT ARE THE WARNING SIGNS THAT INDICATE THAT YOU ARE BECOMING UPSET?

Isolating	Loud voice
Too quiet	Sleeping too much or too little
Hyper	Laughing loud or giddy
Rocking	Bouncing legs
Wringing Hands	others (please list)
Talking Back or Swearing	
Crying	

HANDOUT 6

Trauma De-escalation Tips — Do's and Don'ts

Remember we can all relate to experiences that seem to evoke the feelings of a panicked, irrational child who feels unsafe. Those feelings can be much more intense for someone with past trauma.

Calm, patient, adult reassurance will help.

Remember most abusers shame, belittle and control their victims. During childhood, they are usually authority figures. To avoid re-creating these dynamics, it is helpful to modifying command language.

Present choices, make suggestions, and invite them to try things that will help.

WHEN SOMEONE IS HAVING DIFFICULTY, AVOID RECOUNTING PROBLEM BEHAVIORS

You are withdrawing.

You're not listening.

Do make positive statements

I know you're afraid, but you have survived much more difficult things.

Nothing is likely to be as hard as what you've been through in the past.

You are probably safer right now than you have been at other times.

AVOID GENERAL QUESTIONS THAT OPEN THE DOOR TO THE PAST SUCH AS:

What is going on for your?

What does this remind you of?

Are you flashing back to something?

Do use his or her name, your name, and mention where you are now is safe.

Do ask what has helped them feel safer and more in control in the past.

Remind them of how they have regained control effectively in the past.

Call attention to recent successes or activities where they have done well.

Do explain options to help them feel safer and more in control.

Present them with choices, and describe what will happen and when.

Try lowering your voice as things agitation builds.

Try modeling deep slow breathing and a calm tone of voice.

Try change positions and make eye contact.

(Miller, 2008)

HANDOUT 7

Organizational Assessment Exercise:

EXERCISE 2: The chart below compares trauma-informed treatment to traditional treatment. Think about where you work now or have worked in the past.

In the light blue shaded columns rate each of the statements according to how accurately they describe the program on a scale of 1 to 4.

1 = strongly agree with the statement
2 = somewhat agree the statement
3 = somewhat disagree the statement
4 = strongly disagree with the statement

RATING	TRAUMA-INFORMED PROGRAMS	TRADITIONAL PROGRAMS	RATING
	Reasonable adjustments to minimize triggering or re-traumatizing clients and increasing safety and engagement	Tradition of defining appropriate client behavior as the ability to adjust to the setting and engage in treatment	
	Power and control minimized, empowerment and choice maximized	Accent on accepting powerlessness, and surrendering self-will and control	
	Programs are structured, consistent and predictable, without being authoritative	Programs are goal oriented and more authoritative, but may not place a high value on consistency	
	Collaboration focused (client with staff)	Compliance focused	
	Staff training in research-based and trauma-informed approaches	Clients may be labeled resistant; staff training may include overcoming resistance	
	Understand the function of adaptive behaviors such as, trauma re-enactment and self-injury	Behaviors are targets for change seen as irrational and self-destructive	

Adapted from : *Fallot & Harris*, 2002; *Cook* et al., 2002; *Ford*, 2003; *Cusack* et al., *2004; Jennings,* 1998; *Prescott,* 2000

Add the numbers in each column.
The heading of the column that has the lowest score best describes your program.

Is your drug court program more traditional or more trauma-informed?
Either way, this training will give you information and resources that can improve a drug court's trauma-informed rating.

HANDOUT 8

Staff Self-Assessment Exercise:

EXERCISE 3: The chart below compares trauma-informed staff to untrained staff. Think about your level of comfort with the material in this training, future training needs and professional development.
In the light purple shaded columns rate each of the statements according to how accurately they describe your readiness to deal with trauma on a scale of 1 to 4.

1 = strongly agree with the statement
2 = somewhat agree the statement
3 = somewhat disagree the statement
4 = strongly disagree with the statement

RATING	TRAUMA-INFORMED PROGRAMS	TRADITIONAL PROGRAMS	RATING
	Confident clients can develop new coping skills and learn grounding to re-connect to the here and now.	Very concerned when clients are distressed by past traumatic events and directs focus to other issues.	
	Adaptive behaviors are assumed to serve a function. Escalation is a sign of feeling unsafe.	Considers the possibility that a behavior may be an attempt to manipulate staff.	
	Focus is on person, not the task.	Focus is on the task, not person.	
	Comfortable with dealing with trauma. Helps clients to identify strengths and supports them in recovery.	More comfortable referring trauma issues. Considers symptoms to indicate a need for higher levels of care.	
	Forms healing, equitable relationships, and empathic connections, but also models self-care and boundaries.	Focus on identifying and confronting defenses; relationships prioritize boundary setting.	

Adapted from : *Fallot & Harris*, 2002; *Cook* et al., 2002; *Ford*, 2003; *Cusack* et al., *2004; Jennings,* 1998; *Prescott,* 2000

HOW DID YOU DO?

Trauma-Informed Individualized Safety Plan (from NCTSN 's *Think Trauma*)

Facility: _____ Name of youth: _____

Date: _____ Name of staff: _____

We would like to make you as safe as possible while you are here with us. Please complete the following safety plan with your social worker, psychologist, or trusted staff member. Read the following questions and answer all that apply to you.

Have you ever been in a detention facility before? ☐ Yes ☐ No

Have you ever experienced or witnessed? (Please check all that apply)

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Emotional abuse
- ☐ Death of a friend due to violence
- ☐ Death of a friend due to accident/illness
- ☐ Abandonment
- ☐ Seclusion
- ☐ Restraint
- ☐ Injuring your self
- ☐ Other: (Please describe)

- ☐ Neglect
- ☐ Domestic violence
- ☐ Death of a loved one due to violence
  - ☐ Parent
  - ☐ Sibling
  - ☐ Family member
- ☐ Observed a fight
- ☐ Room confinement
- ☐ Homelessness

- ☐ Prostitution
- ☐ Forced labor
- ☐ Death of a loved one due to accident/illness
  - ☐ Parent
  - ☐ Sibling
  - ☐ Family member
- ☐ Been in a fight
- ☐ Strip searched
- ☐ Fear of being attacked

- ☐ Natural disaster
- ☐ Serious injury
  - ☐ Been stabbed
  - ☐ Been shot or shot at
- ☐ Serious Illness
- ☐ Serious accident
- ☐ Bullying
- ☐ Suicidal thoughts
- ☐ Suicide attempts
- ☐ Running away

_____

_____

_____

If you feel unsafe are you able to communicate about your safety level? For example, could you tell staff when you are struggling or upset? ☐ Yes ☐ No ☐ Sometimes

In what situations would this be difficult for you?

_____

_____

What are your trauma reminders or triggers? (Please check all that apply)

- ☐ Being touched
- ☐ Time of year *(When)*
- ☐ Particular time of day *(When)*
- ☐ Seeing others out of control
- ☐ Room checks
- ☐ Other:

- ☐ Not having input
- ☐ Bedroom door open
- ☐ Being isolated
- ☐ Specific person *(Who)*
- ☐ People being to close

- ☐ People in uniform
- ☐ Yelling
- ☐ Fighting
- ☐ Anniversaries *(What)*

- ☐ Loud noise
- ☐ Being forced to talk
- ☐ Being around men
- ☐ Being around women

_____

_____

Trauma-Informed Individualized Safety Plan (continued)

Please describe your warning signs, for example, what your body feels when you are losing control and what other people can see changing? (Please check all that apply)

- ☐ Sweating
- ☐ Breathing hard
- ☐ Racing heart
- ☐ Clenching teeth
- ☐ Clenching fists
- ☐ Red faced
- ☐ Wringing hands
- ☐ Loud voice
- ☐ Sleeping a lot
- ☐ Bouncing legs
- ☐ Rocking
- ☐ Pacing
- ☐ Squatting
- ☐ Can't sit still
- ☐ Swearing
- ☐ Crying
- ☐ Isolating
- ☐ Hyper
- ☐ Nauseous
- ☐ Shortness of breath
- ☐ Sleeping Less
- ☐ Eating less
- ☐ Eating more
- ☐ Being rude or agitated
- ☐ Singing inappropriate songs
- ☐ Other:

_____

_____

What helps you feel or stay safe? (Please check all that apply)

- ☐ Yelling
- ☐ Having male staff support
- ☐ Reading
- ☐ Getting exercise/sports
- ☐ Writing
- ☐ Having female staff support
- ☐ Ice
- ☐ Drawing/coloring
- ☐ Watching TV/Movie
- ☐ Having support from peers
- ☐ Playing video games
- ☐ Taking a shower
- ☐ Listening to music
- ☐ Walking
- ☐ Talking
- ☐ Weighted blankets/vests
- ☐ Other:

_____

_____

What helps you stay in control? _____

_____

What has helped you stay in control in the past? _____

_____

What kind of space is most comfortable when you need it?

☐ Quiet Area ☐ Your room ☐ Safety room ☐ In bed ☐ Other: _____

Is there a safe place here you can use? ☐ Yes ☐ No ☐ Describe: _____

What positive alternative behaviors can you use when you begin feel unsafe?

_____

What incentives work for you?

_____

Is there anything else you can tell us that you think would be helpful?

_____

Thank you for completing this form. We will update it with you in three months. Please sign below

Youth: _____ Staff: _____

Supporting Recovery from Trauma, Abuse and Exposure to Violence
RESOURCE GUIDE

This guide is a compilation of resources and information intended to help drug court teams begin to integrate trauma-informed approaches. It offers an array of follow-up activities that reinforce and expand what teams learn in initial trauma trainings. The guide offers myriad opportunities to learn more about the impact of trauma, its relationship to drug use, mental health difficulties, and criminal behavior. People find their own unique ways of coping with terrifying events and surviving harrowing experiences.
Some may make certain discoveries about the utility of substances.

A combat veteran finds that alcohol is a reliable antidote for a highly aroused nervous system. A young woman dealing with the aftermath of a sexual assault is unable to erase it from her mind until the day she takes a Percocet she is offered.

Fortunately, there are many pathways to recovery from the co-occurrence of trauma and addiction, and many ways to heal. Some of them are yet to be discovered, and others have been with us for millennia. Cultures and communities shape reactions to violence and victimization, but communities are also shaped by our responses. When drug court teams respond to high levels of trauma among clients by learning more about how people are affected, how they survive, and the ways that they recover, they can pass on critical information to men and women who stand at a crossroads, awaiting a harbinger of hope.

You can access the resources in this guide two ways:

1. Visit the **New England Association of Drug Court Professionals** website. Click on the Resources tab, and open the document titled, *"Supporting Recovery from Trauma, Abuse and Exposure to Violence."* Once the document is open, you can browse each category. When you find a resource that interests you, click the link to directly access it online. You can download information, or email links and attachments. (**http://www.neadcp.org/**)

2. The Guide is also available on the Judicial Institute web page of the Massachusetts Trial Court intranet. This version shows the complete URL's for all online resources, so they are easily copied and pasted into your browser. Most of the material is also posted on the intranet in a library of PDF files. You can view them by clicking on the folders for various categories and selecting the file(s) you want. You can view the content, download, or email files.

MATRIX AND LISTINGS BY SUBJECT OR SOURCE

The table that accompanies this resource guide is a matrix of trauma-informed implementation guidance, trauma specific treatment/recovery models, and information and tools relevant to trauma and justice populations that were reviewed during the development of these materials. These sources were particularly relevant to this introductory training curriculum for drug court teams that have clients with histories of exposure to violence or abuse. The matrix is organized according to source and according to subject. The following resource listing is designed to offer a range of options that support drug court teams in continued post-training learning about trauma and recovery..

Resources for Judges

What Every Judge Needs To Know About Trauma: **Essential Components of Trauma-Informed Judicial Practice.** From the National Center on Trauma-informed Care: http://www.nasmhpd.org/docs/NCTIC/JudgesEssential_5%201%202013finaldraft.pdf

The ***Juvenile and Family Court Journal*** has published two special editions (Winter 2006 and Fall 2008) on child trauma as it relates to dependency and delinquency issues that come before the court. They are available at: http://www.ncjfcj.org/content/blogcategory/364/433/

Helping Traumatized Children: Tips for Judges, The National Child Traumatic Stress Network: www.nctsn.org

NCTSN Bench Card for the Trauma-informed Judge, The National Child Traumatic Stress Network: http://www.nctsn.org/sites/default/files/assets/pdfs/judge_bench_cards_final.pdf

Judges and Child Trauma: Findings from the National Child Traumatic Stress Network/National Council of Juvenile and Family Court Judges Focus Groups, The National Child Traumatic Stress Network: http://www.nctsnet.org/sites/default/files/assets/pdfs/judicialbrief.pdf

Ten Things Every Juvenile Court Judge Should Know About Trauma and Delinquency
Kristine Buffington, MSW, Carly B. Dierkhising, MA, Shawn C. Marsh, Ph.D.
http://www.nctsn.org/sites/default/files/assets/pdfs/trauma_20bulletin.pdf

National Child Traumatic Stress Network (NCTSN)

http://www.nctsn.org
The mission of this site is to improve the quality, effectiveness, provision, and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events. NCTSN has done a great deal to operationalized trauma-informed approaches within the juvenile justice system. Much of this this work

- Think Trauma- Juvenile Justice Staff Training (see Matrix)

In Trauma-Informed Juvenile Justice Roundtable: Current Issues and New Directions in Creating Trauma-Informed Juvenile Justice Systems (2013) Carly B. Dierkhising, Susan Ko, and Jane Halladay Goldman, staff at the National Center for Child Traumatic Stress, discuss the Juvenile Justice Roundtable event, describe the current issues and essential elements of a trauma-informed JJ system, and outline possible new directions for the future.

- The Role of Family Engagement in Creating Trauma-Informed Juvenile Justice Systems (2013) Liane Rozzell, founder of Families and Allies of Virginia Youth, discusses the importance of partnering with families, explores strategies for doing so, and emphasizes ways that justice settings expand their outreach to supportive caregivers by broadening their definition of family.

Center for Nonviolence and Social Justice:

http://www.nonviolenceandsocialjustice.org/About-Us/22/

Drexel University's School of Public Health

Mission:
To promote health, nonviolence and social justice through trauma-informed practice, research, professional development, and advocacy for policy change.

Online Training:
What is Stress?

How Might Stress Affect My Clients?

What is Trauma Informed Care?

Center for Nonviolence and Social Justice Staff members include: Sandra Bloom, MD, creator of the *Sanctuary Model*, and Josiah Rich, MD, author of *Wrong Place, Wrong Time: Trauma and Violence in the Lives of Young Black Men*

Adverse Childhood Experience (ACE) Study

Centers for Disease Control and Prevention – ACE Study Page
www.cdc.gov/violenceprevention/acestudy
Adverse Childhood Experiences (ACE) Study is one of the largest investigations of associations between childhood maltreatment and later-life health and well-being. The Centers for Disease Control and Prevention and Kaiser Permanente' collected more than 17,000 surveys about childhood experiences of abuse, and neglect. Findings suggest ACE's are major risk factors for the leading causes of illness and death as well as poor quality of life. Realizing these connections is likely to improve efforts towards prevention and recovery.

Adverse Childhood Experiences Screening Questionnaires are available for use and in the Public Domain–both the Male and Female versions are available from the CDC:
http://www.cdc.gov/ace/findings.htm

Center for Disease Control and Prevention - Violence Prevention Home Page
http://www.cdc.gov/ViolencePrevention/index.html
Site provides information on preventing child maltreatment, elder maltreatment, global violence, intimate partner violence, school violence, sexual violence, suicide, and youth violence.

The Adverse Childhood Experience Study: www.acestudy.org
Presentations, Graphics, ACE Newsletter, Publications and Speakers ACE Score Calculator in 7 languages

ACE Response: www.aceresponse.org
Prevention Programming and Policy based on ACE findings; affiliated with **Post Trauma Wellness** and **ACE's too High**

National Center for Posttraumatic Stress Disorder:

Department of Veterans Affairs
www.ncptsd.va.gov

PTSD Coach is a new mobile app that is a self-help option for people with trauma. It can be downloaded at no charge. (See matrix)

Screening and assessment tools are categorized and obtainable at:

- Self-assessment screens are available
- Information for clients about the assessment process
- Four question screen
- PTSD Checklist
- Trauma Exposure Measures
- PTSD Screens
- Adult Self-Report
- Adult Interviews
- Deployment Measures
- Child Measures
- Assessment Request Form

ELearning ***(PTSD 101)***

About Face
Learn about posttraumatic stress disorder (PTSD) from Veterans who live with it every day. Hear their stories. Find out how treatment turned their lives around.

Self-care and Vicarious Trauma

Headington Institute
International Humanitarian Service Workers
"Care for the Caregivers"
http://www.headington-institute.org/Default.aspx?tabid=2646

The Vicarious Trauma Institute
http://www.vicarioustrauma.com/blog.html

The Homeless Resource Center
Archived webcast
Responding to Vicarious Trauma Self-Care for Homeless Service Providers

Vicarious Traumatization: A Guide to Recognizing, Responding to, and Preventing a Serious Consequence of Providing Mental Health Care in Jails, Prisons, and Community Corrections Maria Masotta PsyD, Senior Clinical Operations Specialist, MHM: For clinical staff, correctional officers, administrators, and medical personnel working in correctional mental health settings are at heightened risk for vicarious, or secondary, traumatization.

Intimate Partner Violence

CSAP Pathways on-line course: Safety planning for women returning to dangerous living situations: ***Silence Hurts: Alcohol Abuse Violence Against Women***- **http://pathwayscourses.samhsa.gov/vawp/vawp_intro_pg1.htm**

National Center on Domestic Violence, Trauma & Mental Health
http://www.nationalcenterdvtraumamh.org/
The National Center on Domestic Violence, Trauma & Mental Health provides training, support, and consultation to advocates, mental health and substance abuse providers, legal professionals, and policymakers as they work to improve agency and systems-level responses to survivors and their children. **Announcing the Trauma-Informed Domestic Violence Services Special Collection – Now Available on VAWnet.org!**

Jane Doe, Inc.
www.janedoe.org
Jane Doe Inc., The Massachusetts Coalition Against Sexual Assault and Domestic Violence bring together organizations and people committed to ending domestic violence and sexual assault. Their mission is to create social change by addressing the root causes of this violence, and to promote justice, safety and healing for survivors

National Coalition Against Domestic Violence
www.ncadv.org
NCADV is dedicated to the empowerment of battered women and their children and therefore is committed to the elimination of personal and societal violence in the lives of battered women and children.

National Institute on Domestic Violence in the African American Community
www.dvinstitute.org
The mission of this site is to provide an interdisciplinary vehicle and forum by which scholars, practitioners and observers of family violence in the African American community will have the opportunity to articulate their perspectives on family violence through research findings, the examination of service delivery and the intervention mechanisms and the identification of appropriate and effective responses to present/reduce family violence.

National Network to End Domestic Violence
www.nnedv.org
The National Network to End Domestic Violence is a membership and advocacy organization of state domestics violence coalitions, allied organizations and supportive individuals.

Other Important Centers, Organizations, and Resources

National Association of State Mental Health Program Directors (NASMHPD) **National Center for Trauma for Care** (NCTIC)
ENGAGING WOMEN IN TRAUMA-INFORMED PEER SUPPORT:
A Guidebook by Andrea Blanch, Beth Filson, and Darby Penney with contributions from Cathy Cave

SAMHSA. Treatment Improvement Protocol # 57. *Trauma-Informed Care in Behavioral Health Services:* **http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816**

SAMHSA Co-Occurring Disorders
http://www.samhsa.gov/co-occurring/
The Building Blocks Webinar Series, located on SAMHSA's Co-Occurring Disorders Web site, is designed to address SAMHSA's Strategic Initiatives through providing expert guidance on co-occurring disorders systems, services integration, and implementing evidence-based practices. The Series includes current and archived webinars. **http://www.samhsa.gov/co-occurring/events/building-block.aspx**

Creating trauma-informed correctional care: A balance of goals and environment. Miller, N., and L. Najavits. *(2012)**. European Journal of Psychotraumatology,* **3, DOI: 10.3402/ejpt.v3i0.17246**
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3402099/

The Trauma Center
The Center is a program of Justice Resource Institute .The Executive Director of the Trauma Center is Joseph Spinazzola, Ph.D., and the Medical Director and Founder of the Trauma Center is Bessel van der Kolk, MD, who is an internationally recognized leader in the field of psychological trauma.**http://www.traumacenter.org/**

Trauma Center and NCTSN
National Action Partnership on Polyvictimization: Complex Trauma Webinar Series
http://www.traumacenter.org/initiatives/Polyvictimization_Webinars_2014_rev.pdf

David Baldwin's Trauma Information Pages
www.trauma-pages.com
The purpose of the site is to provide information for clinicians and researchers in the traumatic stress field.

The Institute on Violence, Abuse and Trauma (IVAT) at Alliant International University
www.ivatcenters.org/
This site disseminates state-of-the art information on an international level to those working in the family violence and sexual assault fields.

International Society for Traumatic Stress Studies
http://www.istss.org
The International Society for Traumatic Stress Studies (ISTSS) is dedicated to trauma treatment, education, research and prevention. Through this organization, professionals share information about the effects of trauma, seeking to reduce traumatic stressors and their immediate and long-term consequences.

Advocacy Organizations and Victim's Services

Online Training: Free Webinar Series - NCVC also offers:

- National Training Institute:
- Stalking Resource Center Training
- DNA Resource Center Training
- National Crime Victim Bar Association

Witness Justice E-Learning

http://www.witnessjustice.org/index.cfm

Witness Justice's advocacy program focuses on the gaps in services felt by survivors of violence and trauma. On-going initiatives include fostering trauma education and awareness; address trauma-specific concerns (i.e. veterans, domestic violence, survivors of disaster), and meeting the needs of survivors with mental illness or disabilities. Funded by Office of Violence Against Women, offers timely courses on topics, trends and issues relevant to service providers serving domestic violence victims.
http://www.trainingforums.org/lms/index.php

Three online trainings are available:

- ***Trauma Informed Care***
- ***Cultural Competency***
- ***Working with Undocumented Survivors***

Violence Against Women National Online Resource Center
http://www.vawnet.org/domestic-violence/summary.php?doc_id=2562&find_type=web_desc_SC
This collection provides a sampling of available Online Learning Tools with subject matter related to violence against women prevention and intervention. Materials included in this collection have four key components: they are 1) free, 2) available online, 3) interactive, and 4) self-guided.

Online Learning Tools on Violence Against Women include: http://www.vawnet.org/training-tools/

Online Toolkits (9)
Online Learning (67)
Curricula (52) Webinars & Web Conferences (32)
Audio (15)
Videos (28)

National Organization of Victim Assistance
www.try-nova.org
The National Organization of Victim Assistance is a private, non-profit organization of victim and witness assistance programs and practitioners, criminal justice agencies and professionals, mental health professionals, researchers, former victims and survivors and others.

Children and Families

Massachusetts Children's Trauma Project
The Massachusetts Department of Children and Families (DCF), in partnership with LUK inc., Justice Resource Institute, Boston Medical Center's Child Witness to Violence Project, and the University of Massachusetts Medical School, collaborate together to integrate trauma-informed and trauma-focused practice into child protection service delivery.
poster: http://www.umassmed.edu/uploadedFiles/cmhsr/About_Our_Center/MCTP_Poster.pdf

Child Welfare Information Gateway
www.childwelfare.gov
This Clearinghouse is a national resource for professionals and others seeking information on child abuse and neglect and child welfare.

New York Center for Child Development
http://www.nyccd.org
The New York Center for Child Development is a nonprofit organization dedicated to promoting the optimal development of young children. The Center published a brochure presenting succinct and clear information about the importance of recognizing and responding to young childhood trauma:
Trauma in Young Children: A Huge Problem Hiding in Plain Sight And How You Can Help.

United Nations Office of Drug Control Policy
Compilation of Evidence-Based Family Skills Training Programmes
http://www.unodc.org/docs/youthnet/Compilation/10-50018_Ebook.pdf

National Center on Substance Abuse and Child Welfare
http://www.ncsacw.samhsa.gov/default.aspx
The National Center on Substance Abuse and Child Welfare (NCSACW) is an initiative of the Department of Health and Human Services and jointly funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) and the Administration on Children, Youth and Families (ACYF), Children's Bureau's Office on Child Abuse and Neglect (OCAN). In addition to webinars, distance training series, (which are archived available at the website) technical assistance and a variety of excellent handbooks and publications, NCSACW offers the following e-**Learning courses at no charge:**

- *Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals*
- *Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Child Welfare Professionals*
- *Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Legal Professionals*
- **http://www.ncsacw.samhsa.gov/training/default.aspx**
- *Helping Child Welfare Workers Support Families with Substance Use, Mental, and Co-Occurring Disorders*
- **http://www.ncsacw.samhsa.gov/training/toolkit/**

Media Resources – Podcasts, Videos & Radio Shows

RADIO SHOWS

About NY State's use of the Sanctuary Model in the Juvenile Justice System- Recording of Radio Interview: **http://vimeo.com/18128949**

Wrong Place Wrong Time - Radio Interview with Josiah Rich MD about effects trauma and exposure to violence among young African American men: **http://vimeo.com/18130193**

VIDEOS

Overcoming the Tyranny of the Past: The Psychobiology of Violence and Recovery - Whole Video (Download large file) This presentation interviews Sandra L. Bloom, M.D., author of Creating Sanctuary: Toward the Evolution of Sane Societies and past-President of the International Society for Traumatic Stress Studies. Dr. Bloom provides a clear discussion of the psychobiological sequelae of traumatic experiences and draws implications for the intergenerational and societal transmission of trauma in layman's terms.

Wally – A MA. **Jail Diversion Trauma Recovery Program** graduate talks about his multiple deployments and the help he received through the program:
https://www.youtube.com/watch?v=Rp454cEfvHA&feature=youtu.be

Excerpts from the film "**Boys and Men Healing**" presents the perspectives and stories of men as they discuss their experiences of child sexual abuse. 10 min excerpts from Boys and Men Healing, an independent documentary about the impact of sexual abuse of boys and the importance of healing.

Healing Neen - Feature length film
After surviving a childhood of abuse and neglect, Tonier "Neen" Cain lived on the streets for two nightmarish decades, where she endured unrelenting violence, hunger and despair while racking up 66 criminal convictions related to her addiction. Incarcerated and pregnant in 2004, treatment for her lifetime of trauma offered her a way out... and up. Her story illustrates the consequences that untreated trauma has on individuals and society at-large, including mental health problems, addiction, homelessness and incarceration. Today, she is a nationally renowned speaker and educator on the devastation of trauma and the hope of recovery.

Thurston County Drug Court Program's implementation of two empirically supported trauma treatments: Eye Movement Desensitization and Reprocessing (EMDR) and Seeking Safety

1. Brown, S. H., Gilman, S. G., Goodman, E. G., Adler-Tapia, R., & Freng, S. (2010). Integrated trauma treatment in drug court: Combining EMDR and seeking safety.

Abstract:
Trauma histories with co-occurring Substance Use Disorder (SUD) are disproportionately prevalent for individuals in the criminal justice system. A study was implemented in the Thurston County Drug Court Program to determine the prevalence of trauma exposure and evaluate the feasibility of implementing an Integrated Trauma Treatment Program (ITTP) combining two empirically supported treatments: Eye Movement Desensitization and Reprocessing (EMDR) and Seeking Safety (SS). It was hypothesized that individual trauma treatment would lead to improved program outcomes, including increased graduation rates and lower recidivism. Two hundred nineteen males and females, ages 18-65 were screened. One hundred sixty one participants (73.5%) were eligible for the ITTP based on a self-report of at least one "criterion A" event in their lifetime. Fifty-eight participants (26.5%) did not report criterion A trauma and were assigned to program as usual (PAU). Participants who completed only the SS groups (N=50) graduated at a rate of 62% compared to 91.3% of those who completed both SS and EMDR (N=69). After implementation of the ITTP, recidivism for graduates was 7.4% and 18% for terminators, compared to 25% and 30.6% respectively prior to the ITTP.

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2. Brown, S., & Gilman, S. (2007). An integrated trauma treatment program (ITTP) in the Thurston County Drug Court Program: Program summary - An integrated trauma treatment program (EMDR and seeking safety) as an enhancement in the Thurson County drug court program.

Abstract:
The prevalence of co-occurring Posttraumatic Stress Disorder (PTSD) and Substance Use Disorder (SUD) in the criminal justice system is a serious issue for both men and women. The inattention to trauma before, during, and after involvement in the criminal justice system is problematic. Some research suggests that trauma-related disorders among those with SUD negatively affect post-incarceration outcomes (Kubiak, 2004). Therefore, from a practice and policy perspective, interventions addressing these co-occurring disorders should be made available to men and women within the criminal justice system. Current research recommends a phased and integrated treatment approach for co-occurring PTSD and SUD. SAMHSA (2005) reports that the integration of substance abuse treatment and mental health services for persons with co-occurring disorders (COD) has become a major treatment initiative. The specific Integrated Trauma Treatment Program (ITTP) described in this report is one possible treatment approach for this challenging population. This report will outline the rationale for the ITTP implemented in the Thurston County Drug Court Program (TCDCP) in Olympia, WA. In addition, it is hoped that results from this project will be considered when making policy recommendations for Drug Courts and other programs in the criminal justice system, as well as other public and private substance abuse treatment settings.

EMDR Associations

- **EMDR International Association (EMDRIA)**
- **EMDRIA Foundation**
- **EMDR Humanitarian Assistance Programs (EMDR-HAP)**

Incentives and Sanctions

Law Hum Behav. 2013 Feb;37(1):1-9. doi: 10.1037/h0093989. Epub 2012 May 7. **A multi-site study of the use of sanctions and incentives in mental health courts. Callahan L**[1], **Steadman HJ**, **Tillman S**, **Vesselinov R**.**Author information**

Mental health courts (MHCs) have become widespread in the United States as a form of diversion for justice-involved individuals with mental illness. Sanctions and incentives are considered crucial to the functioning of MHCs and drug courts, yet with little empirical guidance to support or refute their use, and there are no definitions of what they are. The use of sanctions and to a lesser degree incentives is the focus of this article, with particular emphasis on jail sanctions. Subjects are participants (n = 447) in four MHCs across the United States. Results show that jail sanctions are used in three of four MHCs, and other sanctions are similarly used across the four MHCs. Participants charged with "person crimes" are the least likely to receive any sanctions, including jail, whereas those charged with drug offenses are most often sanctioned. The factors associated with receiving a jail sanction are recent drug use, substance use diagnosis, and drug arrests; being viewed as less compliant with court conditions, receiving more bench warrants, and having more in-custody hearings; and MHC program termination. No personal characteristics are related to receiving sanctions. Knowing which MHC participants are more likely to follow court orders and avoid sanctions, and identifying those who have difficulty adhering to court conditions, can help guide court officials on adjusting supervision, perhaps avoiding reoffending and program failure.

NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS

NATIONAL DRUG COURT INSTITUTE - Lists of Incentives and Sanctions - This list includes annotations to offer helpful tips and cautions, garnered from professional experience and research findings.

National Residential Substance Abuse Treatment (RSAT) Training and Technical Assistance Center

Trauma Informed Approaches in Correctional Settings – Manual and PowerPoint

Resource Guide for Women and Girls in Substance Recovery Programs in Correctional Settings.
Developed for programs that work with women offenders

Trauma-Informed Correctional Care: Promising for Prisoners and Facilities
NIC Corrections & Mental Health Review of (Miller and Najavits, 2012) by Lori Whitten, Staff Writer, RTI International, Rockville, MD

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

Date: February 15, 2012, 2:00 PM EST
Presenter: Niki Miller
Title of Presentation: **Trauma-Informed Correctional Care**

Date: December 18, 2013, 2:00 PM EDT
Presenter: Joan Gillece
Title of Presentation: **What is Trauma and Why Must We Address it**

GAINS Center

The STAR Center and SAMHSA's GAINS Center for Behavioral Health and Justice Transformation have collaboratively developed a three-part series on supporting the recovery of justice-involved consumers. The series is most effective when used collectively, but can also be used individually.

Part 1 – **Learning about Us, Learning to Help Us: Supporting People with Psychiatric Disabilities in the Criminal Justice System (PDF 642kb)**

Part 2 – **The Self-Advocacy and Empowerment Toolkit (PDF 609kb)**

Part 3 – **The Promising Practices Guide (PDF 361kb)**

Trauma Resources

- **Fact Sheet: Childhood Trauma (PDF 349kb)**
- **Fact Sheet: Youth (PDF 226kb)**
- **Fact Sheet: LGBTQ Youth (PDF 257kb)**
- **Fact Sheet: Historical Trauma (PDF 344kb)**
- **Fact Sheet: Veterans (PDF 284kb)**
- **Trauma Specific Interventions for Justice-Involved Individuals (PDF 304kb)**
- **Creating a Trauma-Informed Criminal Justice System for Women: WHY AND HOW (PDF 1.28MB)**

Trauma - Specific Service Models for Adults

These descriptions were adapted from: Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services (Revised, 2007). Prepared by: Ann Jennings, Ph.D. for: National Technical Assistance Center for State Mental Health Planning (NTAC), National Association of State Mental Health Program Directors (NASMHPD).Full report available at: **http://www.theannainstitute.org/MDT.pdf**

Addictions and Trauma Recovery Integration Model (ATRIUM)
Developed by Dusty Miller, Ed.D., and Laurie Guidry, Psy.D., ATRIUM is a manualized, sequentially organized, 12-week curriculum designed for people who are survivors of sexual and physical abuse, those with substance abuse and other addictive behaviors, those who are actively engaged in harmful relationships, who self-injure, have serious psychiatric diagnoses, and for those who enact violence and abuse against others. ATRIUM is designed to work as a peer-led (as well as professionally led) group model.. To obtain the manual, and for information on training and technical assistance (in English and Spanish), visit www.dustymiller.org, e-mail dustymi@valinet.com, or call Dusty Miller at 413-584-8404.

Beyond Trauma: A Healing Journey for Women
Developed by Stephanie S. Covington, Ph.D., L.C.S.W., co-director of the Institute for Relational Development and the Center for Gender and Justice, Beyond Trauma: A Healing Journey for Women (Covington, 2003) Based on theory, research, and clinical practice, the materials are trauma-specific and the connection between trauma and substance abuse is integrated throughout. The program is designed for use in outpatient, residential, and criminal justice settings. The curriculum includes a facilitator manual, participant workbook, and three instructional videos (two for facilitators, one for clients). Also….
Helping Women Recover (HWR): A Program for Treating Addiction A Program for Treating Substance Abuse is an integrated, manualized curriculum for treating women with histories of addiction and trauma. It is designed for use in a variety of settings including outpatient and residential substance abuse treatment programs, domestic violence shelters, and mental health clinics, as well as jails, prisons, and community correction and has a participant's workbook. The therapeutic strategies include psycho-educational, cognitive-behavioral, expressive arts, and relational approaches. The facilitator's manual for the 17-session program is a step-by-step guide is organized into four modules: self, relationships, sexuality, and spirituality

Seeking Safety Model
Developed by Lisa Najavits, Ph.D., at Harvard Medical/McLean Hospital, Seeking Safety is a manualized 25-topic, flexible, integrated treatment designed to address safety and recovery for persons with the dual diagnosis of PTSD and substance abuse (as well as persons with a trauma history who do not meet clinical criteria for PTSD). Seeking Safety is designed to be used in a wide variety of settings including substance abuse treatment correctional facilities, health and mental health centers, etc., as well as for both group and individual format, females and males. Flexible and adaptable, topics can be conducted in any order, the number of topics covered can be changed depending on a client's length of stay, and groups can be facilitated by a wide variety of counselors. Seeking Safety recognizes establishing safety as the most urgent clinical need for persons with PTSD and substance abuse problems, and teaches a range of more than 80 "safe-coping" skills to work toward discontinuing substance use, letting go of dangerous relationships, and gaining control over dissociation and self-harm. The treatment manual includes client handouts and clinician guidelines. www.seekingsafety.org or e-mail info@seekingsafety.org or call Lisa Najavits, Ph.D. at 617-855-2305, McLean Hospital, 115 Mill Street, Belmont, MA 02478.

TRIAD Women's Group Model
Manualized, 16-session (2-hours a week for 16 weeks) cognitive behavioral group model is based on the perspective that complex disorders arise from trauma and that particular fundamental issues must be addressed for long-term recovery to occur (Herman, 1992). It is designed for and takes an integrated approach to women who experience challenges around the three issues of trauma, mental health, and substance abuse. TRIAD is structured into four phases: Mindfulness, Interpersonal Effectiveness Skills, Emotional Regulation, and Distress Tolerance, with four weekly sessions in each phase. A leaders manual, TRIAD's primary treatment goals are to reduce psychiatric and trauma-related symptoms associated with histories of violence/abuse and substance use. This cognitive behavioral model is based, in part, on Linehan's Cognitive-Behavioral Treatment model, Evans and Sullivan's work on substance abuse and trauma and Harris' work on trauma and serious mental illness. To obtain the manual and for information on training and consultation, contact Colleen Clark, Ph.D., at 813-974-90

Trauma, Addictions, Mental Health and Recovery (TAMAR) Trauma Treatment Group Model
A structured, manualized 14-week, 13-module trauma-specific group intervention combining psychoeducational approaches with expressive therapies. It is designed for women and men with histories of trauma in correctional systems. Groups are run inside detention centers, in state psychiatric hospitals, and in the community. Group sessions meet twice weekly for 90 minutes, an interval that fits smoothly into the daily schedules of county detention centers and provides basic education on trauma, its developmental effects on symptoms and current functioning, symptom appraisal and management, the impact of early chaotic relationships on health care needs, the development of coping skills, preventive education concerning pregnancy and sexually transmitted diseases, sexuality, and help in dealing with role loss and parenting issues. To obtain the manual and for information on training and technical assistance, contact Joan Gillece, Ph.D., at 410-724-3238 or gillecej@dhmh.state.md.us, or contact Jenny Howes, L.G.S.W. at 410-724-3180 or howesj@dhmh.state.md.us

Trauma Recovery and Empowerment Model (TREM)
Developed by Maxine Harris, Ph.D., and the Community Connections Trauma Work Group
TREM is a manualized, sequentially organized, 24–33 session group approach to healing from the effects of trauma. It is designed for women with major mental health, PTSD, and/or substance abuse problems. TREM combines elements of recovery skills training, psychoeducation, and other cognitive-behavioral techniques, and emphasizes peer support, which has proven to be a highly effective approach with survivors. TREM is co-facilitated by female clinicians. Also…Trauma Recovery and Empowerment Profile (TREP) and Menu of Strategies for Improving a Woman's Trauma Recovery and Empowerment Profile Developed by Maxine Harris, Ph.D., and Roger D. Fallot, Ph.D., this skills rating scale and menu of skill building strategies may be used in conjunction with the TREM group program or individually as clinical tools for clinicians and survivors to evaluate skill levels and work toward development of skills. TREP is a rating instrument with eleven dimensions. Completed by a clinician who knows the consumer/survivor well, or by the survivor him/herself, the TREP is designed to provide an assessment of the consumer/survivor's recovery skills at a particular point in time. The manual contains interventions designed to develop skills in the eleven domains of trauma recovery. Exercises may also be useful for individuals who are not trauma survivors but who desire skill development to deal with addictions or mental health problems. To obtain copies of TREP and the Menu of Strategies, visit www.ccdc1.org or contact Aisha Meertins, M.S.W., at 202-608-4734 or ameertins@ccdc1.org for information, or contact Rebecca Wolfson Berley, M.S.W., director of Trauma Training, at 202-608-4735 or rwolfson@ccdc1.org

Healing the Trauma of Abuse: A Women's Workbook
Mary Ellen Copeland, M.A., M.S. and Maxine Harris, Ph.D. Used by women participants in conjunction with their work in the TREM group, this workbook can also be used by a woman on her own, or with a therapist or supportive friend. The manual assists women recovering from the effects of physical, sexual, and emotional abuse. It is divided into four parts: Empowerment, Trauma Recovery, Creating Life Changes, and Closing Rituals. Each part has a number of topics to work on, helps women develop individual goals for the recovery work, and addresses self-care while doing recovery work. To obtain the workbook and for more information, visit www.mentalhealthrecovery.com

Spirituality and Recovery Curriculum
This is a 7-session group manual and curriculum that helps women in recovery from addiction and trauma explore their spiritual roots, assess the impact of religion and spirituality in their lives and make choices about how to grow and develop their chosen spiritual traditions to support recovery and healing from trauma. The curriculum was developed by the Boston Consortium of Services for Families in Recovery, Boston Public Health Commission, the Institute on Urban Health Research, Northeastern University. For more information or copies of these materials, please contact Dr. Hortensia Amaro at h.amaro@neu.edu or Rita Nieves, R.N., M.P.H., at Rita_Neives@bphc.org

Spirituality in Trauma Recovery Group
This manualized group intervention of 11 sessions addresses spiritual and religious resources for empowerment and recovery from physical and sexual abuse. Group topics include: What It Means To Be Spiritual; Spiritual Gifts; Spiritual Coping Strategies;
Anger; Fear and Powerlessness; Shame and Guilt; Loneliness; Despair; Forgiveness and Letting Go; Hope and Vision; and Continuing the Journey of Healing. To obtain a manual and for training and consultation information, visit www.ccdc1.org or contact Aisha Meertins, M.S.W., at 202-608-4734 or via e-mail at ameertins@ccdc1.org

Cognitive-Behavioral Treatment for PTSD among People with Severe Mental Illness
Developed by B. Christopher Frueh, Ph.D., and colleagues, this is a manualized, multicomponent Cognitive-behavioral treatment model appropriate for chronic and severe PTSD among people with serious mental illness who are treated in public-sector mental health clinics. All components are designed for administration in a group format with the exception of Exposure Therapy which takes place in 6-12 individual therapy sessions. Group work takes place in 10–14 (1-hour) sessions. The exact sequencing, implementation, and dose of components may vary across settings and among clients, but clinicians and investigators may use this model as a starting point. For information about the model and obtaining a draft manual and materials, contact B. Christopher Frueh, Ph.D. at 843-789-7967 or via e-mail at fruehbc@musc.edu

Eye Movement Desensitization and Reprocessing (EMDR)
EMDR is an integrative structured treatment for Posttraumatic Stress Disorder (PTSD) during which the client is asked to hold in mind a disturbing image, an associated negative cognition, and bodily sensations associated with a traumatic memory while tracking the clinician's moving finger in front of his or her visual field. Variations of the procedure are repeated until distressing aspects of the traumatic memory are reduced and more adaptive cognitions emerge regarding the trauma. Similar procedures are used to install alternate positive cognitions, coping strategies, and adaptive behaviors. EMDR processes historical events, current incidents that elicit distress, and future scenarios that will require different responses. The overall goal is to produce the most comprehensive and profound treatment effects in the shortest period of time, while simultaneously maintaining a stable client. To obtain information and materials on EMDR and training and consultation in this model, contact: EMDR Institute, Inc. at 831-761-1040 or online at www.emdr.com or via e-mail at inst@emdr.com

Growing Beyond Survival: A Self Help Toolkit for Managing Traumatic Stress
Created by Elizabeth G. Vermilyea, M.A., this manualized approach teaches skills that empower survivors to take control of and de-escalate their most distressing trauma related symptoms. The workbook is intended for use in therapist-run symptom management therapy groups. It can also be used effectively by survivors for managing trauma symptoms for individual survivor self-help. Developed in part and extensively field tested at Trauma Disorders Programs at Sheppard Pratt Hospital in Baltimore, it offers tools enabling survivors who suffer from trauma-related symptoms to find relief. It also examines the relation between trauma and self-harming behaviors, difficulties with sexuality, and substance abuse. For additional information, contact the Sidran Institute at 410- 825-8888 or online at www.sidran.org/catalog/vegb.html or via e-mail at orders@sidran.org

Trauma Adaptive Recovery Group Education and Therapy (TARGET)
Developed by Julian Ford, Ph.D., TARGET is a manualized gender-specific group or individual treatment that begins with 3 to 12 sessions of self-regulation skills based on the neurobiology of complex trauma, and may continue for up to 26 sessions. The model is more commonly implemented in versions of different lengths: 3 to 5 sessions, 12 sessions for groups in addiction treatment programs, and 26 sessions for groups in community mental health or inpatient/residential psychiatric programs, and 16 sessions for one-to-one outpatient psychotherapy. TARGET teaches a practical 7-step sequence of skills for processing and managing the trauma-related components of current stressful experiences (e.g., PTSD symptoms, rage, traumatic grief, survivor guilt, shame, interpersonal rejection, and existential/spiritual alienation). To obtain a manual and for information on training and consultation, contact Eileen Russo, M.A., L.A.D.C., at Russo@psychiatry.uchc.edu or online at www.ptsdfreedom.org

The Trauma and Recovery Group: Cognitive Behavioral Therapy Approach for PTSD in People with Serious Mental Illness
Developed by Stanley Rosenberg, Ph.D., and Kim Mueser, Ph.D. of the New Hampshire Dartmouth Psychiatric Research Institute, the Trauma and Recovery Group model is a manualized, 16-session one-to-one psychoeducation intervention for women or men with chronic and persistent mental illness and PTSD. It is intended for use in community mental health or inpatient psychiatric settings. Offered individually and in groups, the model contains relaxation exercises, video facilitated psychoeducation about trauma and its effects, and cognitive restructuring to address unhelpful thoughts, beliefs and Behaviors. Stress Inoculation Training (SIT) instills skills for actively managing stress reactions. Focuses on here-and-now coping skills to n manage intrusive memories. To obtain the manual, The Trauma and Recovery Group, the educational videotape, Recovery From Trauma, and for training and consultation, contact Kim.T.Mueser@Dartmouth.edu or Stan.Rosenberg@Dartmouth.edu

Trauma Safety Drop-In Group: A Clinical Model of Group Treatment for Survivors of Trauma
Designed by Pat Gilchrist of Ulster County Mental Health and Peri Rainbow of Women's Studies at New Paltz State University of New York, this model provides trauma survivors with basic safety skills. A low-intensity group requires no commitment from participants, is open to all survivors regardless of diagnosis, level of functioning, and place in the healing process. Goals of the group include increasing safety, to learn about the healing process and the after-affects of trauma, and to assess readiness for further treatment. The drop-in nature of the group is helpful to Survivors who are beginning trauma-specific treatment and often not prepared to attend as much as required by traditional group therapy. Manuals are available from the New York State Office of Mental Health Trauma Unit at nominal - NYS OMH Printing and Design Services. Their fax number is 518-473-2684.

Parenting Interventions

Also adapted from: Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services (Revised, 2007). Prepared by: Ann Jennings

Impact of Early Trauma on Parenting Roles
A 14-session group intervention for women whose traumatic experiences of early sexual and/or physical abuse have created symptoms and responses that make parenting tasks difficult, designed to address the connections between trauma sequelae and parenting. To obtain the manual Non-Traditional Parenting Interventions, which contains this group intervention, contact www.ccdc1.org or Aisha Meertins, M.S.W., at 202-608-4734 or ameertins@ccdc1.org For information on training or consultation, call Rebecca Wolfson Berley, M.S.W., director of Trauma Training, at 202-608-4735 or rwolfson@ccdc1.org

Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma
This is a parenting curriculum offered in groups for women and children in recovery from substance abuse, mental illness, and trauma that provides a first step in repairing fractured parent-child relationship. Developed and piloted by the Institute for Health and Recovery, the curriculum builds upon IHR's Nurturing Program for Families in Substance Abuse Treatment and Recovery, which was recognized by the Center for Substance Abuse Prevention as a model program for best practices in strengthening families. Also…..**Parenting at a Distance** -A 10-session group intervention to address issues of parenting for women who are involved in some form of partial parenting, but who do not have full-time residentialcustody of their children. To obtain the manual on Non-Traditional Parenting Interventions, which contains both of these group interventions, visit www.ccdc1.org or contact Aisha Meertins, M.S.W., at 202-608-4734 or ameertins@ccdc1.org for training or consultation, call Rebecca Wolfson Berley, M.S.W., director of Trauma Training, at 202-608-4735-- **rwolfson@ccdc1.org**
Pathways to Family Reunification and Recovery

(Caminos Para la Reunificacion y la Recuperacion): An educational group curriculum for women in recovery The manual focuses on scenarios that women in recovery may encounter in the process of reuniting with their children. Curriculum explores the different stages of reunification, reactions and emotions children and mothers might experience and tools for parents to develop nurturing relationships with children. Available in Spanish and English, this multi-session group intervention was developed by the Boston Consortium of Services for Families in Recovery, Boston Public Health Commission and the Institute on Urban Health Research, Northeastern University. To obtain the manual and for further information, contact Dr. Hortensia Amaro at h.amaro@neu.edu or Rita Nieves, R.N., M.P.H., at **Rita_Nieves@bphc.org**

Recovering Families Parenting Curriculum
This curriculum is a standard service offered in many substance abuse treatment programs throughout San Joaquin County, California. Developed as a part of the SAMHSA Women Co-Occurring Disorders and Violence Study (WCDVS) Allies project, Recovering Families builds on a prior existing parenting curriculum based on the work of Bavolek and Dellinger-Bavolek and the Nurturing Program for Families in Substance Abuse Treatment and Recovery curriculum developed by the Institute for Health and Recovery. The it is a 13-week intervention that blends discussions and activities for parents with co-occurring disorders and trauma histories, with each session focusing on specific parenting skills. To obtain the curriculum and for information Frances Hutchins, division director of San Joaquin County Office of Substance Abuse, at **fhutchins@sjgov.org**

Strengthening Multi-Ethnic Families and Communities: A Violence Prevention Parent Training Program

A CSAP model for ethnic and culturally diverse parents of children ages 3 to 18 years, this program addresses violence against the self (drugs/alcohol), violence in the family (child abuse, domestic violence), and violence against the community (juvenile delinquency, crime, gangs). Information is presented within a "cultural framework" in 12 weekly 3-hour sessions or Parent Workshops (organized by component areas). The importance of ethnic/cultural/family/spiritual roots and five major components: Cultural/Spiritual Focus; Rites of Passage; Positive discipline; Enhancing Relationships; and community Involvement. The program is used with high-risk and hard-to-reach groups, including teens, foster parents, court-ordered parents, grandparents, parents of teens, migrant families, gay parents, single parents, fathers, etc., from a variety of ethnic/cultural backgrounds. Facilitator Training Workshops and materials in six languages can be obtained (US English, Spanish, Vietnamese, Korean, Cambodian, Russian, UK English) from Dr. Marilyn Steel, Ph.D., at 323-936-0343 or dr_mls@earthlink.net

Trauma and Triumph: Parenting Abused and Neglected Children-This is a 6-hour training from the Foster and Adoptive Parent Toolbox: Child Welfare Training Institute, Institute for Public Sector Innovation, Muskie School of Public Service. It is part of a series of six core topics designed for foster and adoptive parents new to parenting abused and maltreated children and youth for whom a continuous series of traumatic moments have become a regular part of the child's existence. Parents are taught the short and long-term impacts of trauma on the child's development, interventions for working with these children, how to create a home environment that promotes emotional and physical safety for the children, and how to access community resources. For more information, contact Leslie Rozeff, C.W.T.I., co-director, at 207-626-5218 or **Leslie.Rozeff@maine**.

Trauma & justice materials and trauma-informed & trauma-specific models that influenced this curriculum					
Name & Designer	**Category**	**Length**	**Target Population**	**Delivery**	**Description**
Trauma-informed organizational tools					
Risking Connection *Sidran Press*	Provider, organizational and/or community TIC training	20 hours of potential curriculum delivered based on need & audience.	Direct care staff, management, & clinicians. Validated for: (1) State Psychiatric Hospitals; (2) Community Mental Health Centers; (3) Community Hospitals; (4) Partial hospitalization programs; (5) Substance abuse treatment; (6) Domestic and sexual violence agencies; (8) Crisis services; (9) For adults abused as children.	Onsite training for individual providers and agencies, or trainings of trainers. Includes the RICH relational model, which is used in justice settings. For more: Click here	Model for understanding & responding effectively to people wounded in interpersonal relationships Focuses on: (1) quality, value, & skills for building relationships; (2) promoting healing; & (3) self-awareness & self-care.
The Sanctuary Model: A Trauma-Informed Operating System for Organizations *Sandra Bloom, MD*	Evidence-supported, TIC approach for creating or changing organizational culture.	54 slide overview, abstract, and FAQ's	Training on Sanctuary principles targets agency personnel and clients, and enlists them in ways to use the Sanctuary Toolkit in day-to-day operations and how to evaluate how these initiatives are taking hold in the organization. (see Resource Guide for additional materials)	Can be implemented at different levels; Sanctuary certification begins with the five-day intensive Sanctuary Institute training for 5-8 agency staff. For info: Click here	The model includes a Toolkit and the SELF psycho-educational training curriculum for both staff and clients; Seven Sanctuary Commitments are the model's guiding principles
Creating Accessible , Culturally Relevant, Domestic Violence & Trauma Informed Agencies *National Center on DV, Trauma & Mental Health*	Trauma-informed assessment and change Model for DV Services	Self-evaluation divided into 7 domains.	Agency self-assessment & planning for trauma-informed domestic violence services that integrate mental health recovery support for women and families. Includes attention to cultural concerns among women of color, immigrant families and other groups. For advocates, crisis center staff, mental health, & other agencies.	Agency self-reflection facilitated by an outside consultant, agency staff or allied professional from a collaborating agency. Guide is online: Click here	Trauma-informed domestic violence services in domains: (1) organizational commitment; (2) physical & sensory environment; (3) intake & assessment; (4) program services; (5) staff support; (6) external relationships (7) evaluation.

Trauma & justice materials and trauma-informed & trauma-specific models that influenced this curriculum

Name & Designer	Category	Length	Target Population	Delivery	Description
Models for Developing Trauma-Informed Behavioral Health Systems & Trauma Specific Services *Dr. Ann Jennings*	Review of trauma-informed care models and trauma-specific interventions	Descriptions of 84 trauma-specific interventions and trauma-informed approaches divided into 9 categories.	Agencies, individuals & organizations creating or providing trauma-oriented supports.	Report available online: Click here for link	Trauma-informed & trauma-specific service models - listed: (1)name (2)description of model content & materials (3)target population (4) research (5) contact for the model.
Trauma Informed Organizational Toolkit for Homeless Services *National Center on Family Homelessness*	Model of trauma-informed organization change strategies	12- 15 modules over 2-6 months	Developed for Housing & homelessness services providers, but the organizational change model is appropriate for other human services agencies.	Inter or intra agency virtual or in person trainings delivered by SAMHSA TA staff & other trained facilitators. Toolkit available online: Click here	Self-assessment-domains includes: (1) supporting staff; (2) creating a safe environment; (3) assessing & planning services; (4) involving consumers; & (5) adapting policies. Exercises & steps guide planning & implementation.
Adverse Childhood Experiences: Relationship of Adult Health Status to Childhood Abuse & Household Dysfunction. *Felitti & Anda, 1998*	Scholarly articles, websites, other ACE study materials	Pencil and paper survey instrument	Large scale study of adult subjects (n= 17,000) seeking routine medical care through an HMO. Subjects filled out a questionnaire on different categories of adverse childhood experiences, including multiple types of abuse and household dysfunction. 70% response rate on survey; data revealed highly elevated health risks correlated with higher numbers of ACE's.	The ACE survey has been used for trauma screening and for researching the correlation between trauma & offending among inmates. See CDC ACE page for more: Click here	52% exposure rate to at least one category of adverse childhood experience. Men with exposure to 6 or more ACE's are 46x more likely to use IV drugs. Women with exposure to 4 or more have a 78% attributable risk for IV drug use compared to a .05% risk for women with none.

Trauma & justice materials and trauma-informed & trauma-specific models that influenced this curriculum					
Name & Designer	**Category**	**Length**	**Target Population**	**Delivery**	**Description**
Understanding & Addressing Vicarious Trauma *Headington Institute (Pearlman & McKay, 2008)*	eLearning – on vicarious trauma	8 modules to be completed at own pace	Developed to support international humanitarian aid workers, but applicable to other professionals with high levels of exposure to traumatized individuals and communities.	Online access to self-study course and handouts: Click here for link:	Includes causes, risk factors, and coping techniques. Supports reasonable work boundaries, renewal through- rest, escape and play, and organizational awareness and support.
Developing Trauma-Informed Organizations *Norma Finkelstein, Ph.D. Laurie Markoff, Ph.D. Institute for Heath Recovery*	Archived webinar on steps for trauma-informed organizations	90 minutes	Presented to family court staff and allied professions, but has wide application, especially for agencies that serve women and families and treat SUD's.	Can be accessed online by visiting the Child and Family Futures website: Click here for link	Assists organizations to implement trauma-informed policies and operations. Introduces a tool kit by the Institute for Health and Recovery. Topics include principles of integrated, trauma-informed services delivering trauma-informed services.
Trauma and justice: specialty courts, corrections and related service systems					
Women's Forensic Assessment Training *University of Cincinnati Center for Criminal Justice Research*	Gender Specific Risk and Needs Assessment Training	3 full days	Program staff, secure facility intake staff, and community corrections staff and others who work with women offenders.	National Institute of Corrections TA providers & UC trained facilitators. For more, link to UC Center for Criminal Justice Research: Click here	Comprehensive training on gender, trauma and criminogenic risks & needs; administering 4 - question trauma screen; screens for DV, victimization, PTSD, mental health and substance use disorders.
Trauma Among Girls in Juvenile Justice *Dr. Bonita Veysey, Rutgers University*	Training presentation	Half-day	Advocates, agencies, & programs working with justice-involved adolescent women. Juvenile justice workforce. Presented by webinar and in – person.	Gender and trauma research; best practices for trauma-informed supervision of female juveniles. For related papers: Click here	Most justice-involved girls have mental health disorders. Yet, they rarely are screened, assessed or treated w/ services that meet their unique needs: comprehensive assessment & trauma-specific treatment

Trauma & justice materials and trauma-informed & trauma-specific models that influenced this curriculum

Name & Designer	Category	Length	Target Population	Delivery	Description
Trauma-Informed Approaches in Correctional Settings *BJA-funded RSAT National Training and TA Center, Led by AHP (Miller, 2011)*	Manual, presentation slides & archived webinar	Manual is 93 pages; 88 slides are available; webinar is 1 hour	Developed for Department of Justice funded RSAT programs that provide long-term substance use disorder treatment to offenders in custody. Applicable to other addiction treatment settings that serve justice-involved populations, and to other criminal justice settings.	Manual and slides available online: Click here Webinar 2/15/12: Click here RSAT programs can request TA and training.	Introduces trauma theory, research, and useful practices for supporting recovery from trauma and addiction in the justice system. Discusses challenges of implementing trauma-informed approaches in criminal justice settings, and reviews effective trauma-specific interventions.
Think Trauma *The National Children's Traumatic Stress Network*	Training and toolkit for trauma-informed approaches in juvenile justice settings	4 two hour modules	The juvenile court system, detention centers, residential placement facilities, community supervision, and allied professionals working with juveniles, including judges and attorneys. Most of the information is applicable, to some degree, to adult and youthful offenders.	4 modules, each about 2 hours, can be accessed online. Can be delivered in one day or as 4 consecutive sessions. Click here for link (see Resource Guide for more on NCTSN)	Think Trauma is a 4-module, PowerPoint-based training curriculum, including activities and exercises. It contains six case studies of representative youth who have been involved with the juvenile justice system.
Essential Components of Trauma-informed Judicial Practice *National Center for Trauma Informed Care* DRAFT for review and comment	SAMHSA-funded Issue Brief on trauma-informed judicial practice	12 pages	Provides information, specific strategies, and resources that many treatment court judges have found beneficial. For Judges, drug court teams and allied professionals working in problem-solving courts and diversion programs.	Posted on the National Center for Trauma-informed Care webpage in draft form for review and comment at: National Association of State Mental Health Program Directors	Presents a summary of key research studies and tips for judges on trauma-informed communication styles, court processes and procedures, and the courtroom environment. Touches on vicarious trauma, and offers resources for further information.

Trauma & justice materials and trauma-informed & trauma-specific models that influenced this curriculum					
Name & Designer	**Category**	**Length**	**Target Population**	**Delivery**	**Description**
Child Welfare Trauma Training Toolkit Tool Kit *National Children's Traumatic Stress Network*	Comprehensive SAMHSA-funded toolkit to implement TIC in the Child Welfare System	44 pages	Aimed at those who work in the child welfare system, family courts, child advocacy centers, the foster system, and resource parents.	Available from the National Children's Traumatic Stress Network: Click here for link	Provides tools and strategies for addressing trauma as part of standard child welfare Practice. Offers resources, supports, and practical assistance. Intervention strategies can be employed immediately with children and families.
Trauma-specific interventions					
Trauma Recovery & Empowerment Model (TREM) *Dr. Roger Fallot & Dr. Maxine Harris*	Trauma Specific Intervention	24 - 33 sessions	Women ages 18-55 & men ages 25-55 enrolled in mental health & SUD treatment, enrolled in residential & non-residential, corrections, homeless & domestic violence programs. Adapted for & validated on a variety of ethnic groups.	Group sessions delivered by a clinician. For more go to National Registry of Evidence-based Programs Practices (NREPP): Click here	Facilitates trauma recovery among women exposed to sexual & physical abuse. Uses cognitive restructuring, psycho-education, & skills-training techniques to address short & long term effects of violence.
TAMAR (Trauma, Addictions, Mental health, & Recovery)	Trauma Specific Intervention	15 modules delivered in weekly 90 minute sessions.	Originally developed as part of a pilot program that treated women inside detention centers, it has now been adapted for incarcerated men, used with veterans, and delivered in community settings.	Group sessions delivered by detention center employees or community workers. The manual and the modules can be accessed on-line: Click here	Education on: (1) symptoms & current functioning; (2) symptom management; (3) early chaotic relationships & health care needs; (4) coping skills; (5) prevention of pregnancy, STIs; (6) sexuality; (7) parenting & role loss Uses expressive and cognitive behavioral therapy.

Trauma & justice materials and trauma-informed & trauma-specific models that influenced this curriculum					
Name & Designer	**Category**	**Length**	**Target Population**	**Delivery**	**Description**
Seeking Safety Training *Lisa Najavits, Treatment Innovations LLC*	Trauma Specific Intervention	25 modules delivered in any order.	Integrated treatment for PTSD and SUD's and those that are affected by trauma, but may not have PTSD. Outpatient, inpatient or residential addiction treatment clients; people in jails and prisons, homeless shelters, mental health clients, homeless populations; veterans. Translations in 5 languages.	Individual or group sessions delivered, by counselors, peers, or clinicians. May be delivered in any order; clients can benefit even when they complete as few as 4 sessions. For more link to NREPP: Click here	Cognitive behavioral, present-focused therapy to establish safety as an urgent clinical need by teaching "safe-coping" skills to work towards discontinuing substance use, unsafe relationships, & skills building in grounding, self-nurturing, boundaries & asking for help.
PTSD Coach *National Center for PTSD Veteran's Administration*	Trauma Specific Recovery Self -Management Tool	Choose from 17 issue areas and work on one or more at your own pace	The PTSD Coach was developed as a mobile app, and now an online tool, to allow veteran's with PTSD to access confidential recovery support, stress reduction and other coping tools. It is useful for many others, as well.	Available online at the National Center for PTSD Website with links to mobile app: Click here	PTSD Coach has tools for coping with sadness, anxiety, and other things people who have been through traumas deal with. Some tools are brief and others tackle bigger problems, change thinking patterns, and help with long term goals. PTSD Coach is for anyone who can benefit.