# RSAT Training Tool: Trauma-Informed Approaches in Correctional Settings

TASC
Treatment Alternatives for Safe Communities

AHP
Advocates for Human Potential, Inc.

ACJS
AdCare Criminal Justice Services, Inc.

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# Niki Miller, M.S. CPS

Advocates for Human Potential

www.ahpnet.com

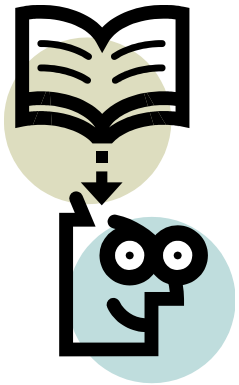
# Audience

**Residential Substance Abuse Treatment (RSAT) program staff, including:**

- Addiction Professionals
- Case Managers
- Correctional Staff
- Mental Health Counselors
- Volunteers
- Peer Recovery Support Specialists
- Chaplains

# Purpose

Cross-disciplinary training curriculum designed to increase knowledge and awareness of the relationship between trauma and substance use disorders among people involved in RSAT jail and prison programs and aftercare.



# Trauma Basics

**Introduce:**

- Trauma theory
- Research
- Practice

# Goals

Establish recognition of the impact of trauma on the lives, the behavior and the recovery and rehabilitation of offenders by:

- Instilling confidence in RSAT staff who work with clients with trauma histories;
- Introducing practical tools and resources for further learning;
- Providing an overview of best practices for treating co-occurring substance use and trauma-related disorders.

# Curriculum Principles

- Evidence-based strategies
- Integrated interventions
- Recovery-oriented approaches
- Present day accountability
- Culturally aligned content
- Strength-based orientation

# Course Relevance

**The course introduces trauma-informed (TI) approaches and related offender management skills that promote safer correctional environments by:**

- Highlighting the importance of self-care for staff working in correctional environments
- Addressing challenges and limitations of trauma informed approaches in correctional settings
- Allowing staff to play a major role in stabilizing offenders, minimizing triggers and violent or agitated responses.
- Supporting integrated trauma-specific SUD treatment practices appropriate to RSAT programs

# Module I:

# Introduction to Trauma-Informed Approaches in Correctional Settings

# Module I: Goals

- Compare prevalence & types of trauma experienced by female and male offenders with SUDs.
- List advantages of training correctional and program staff in trauma basics and addressing trauma in RSAT programs.
- Explain the impact of working among offenders with histories of trauma and identify steps to prevent secondary trauma responses among staff.

# Module I: Topics

a) Context and Background
b) Self-Care Check
c) What the Research Tells Us

# Module I: Self-Care Check

## Check-In

Use this self-care plan to identify some strategies that might help you manage your feelings when dealing with intense information. 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 my most successful clients.
- 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.

My clinical supervisor is:

# Module I: Context and Background

- **Prisons & Jails: A challenge for trauma-informed approaches**
  - Stressful work environments for staff
  - Designed to house perpetrators, not victims
- **Unavoidable triggers for those with PTSD**
  - Shackles, overcrowding, loud speakers, no privacy, pat downs, strip searches, discipline, restricted movement
  - An environment that can mimic dynamics of past abuse
  - **Absence of primary coping mechanism (substances) for offenders with histories of trauma and addiction**

# Module I: Objectives

**Upon completion participants will be able to:**

- Give examples of universal trauma-informed precautions.
- List trauma-informed principles applicable to corrections.
- Explain the R. I. C. H. model
- Identify EBPs for integrating trauma-specific treatment in RSAT programs.

# Module I: Research

**PTSD in General Population**

- 10.4% of women
- 5% of men (NIMH, 2008)

**PTSD among Justice Population**

- 48% of female inmates
- 30% of male inmates (Tull, 2005)

Data suggest a sexual assault is the type of experience most likely to result in PTSD for both men and women.

***Trauma may still gravely affect the way people react even if they do not have a diagnosis of PTSD***

# Module I: Context and Background

**Gender Differences in Trauma.**

- Males: 
  - Risk of experiencing or witnessing a sexual assault increases dramatically when they enter jail or prison
  - Threat of exposure to violence and physical assault also may increase
  - Jail/Prison = usually experienced by males as unsafe

# Module I: Context and Background

**Gender Differences in Trauma Continued.**

- Females: 
  - Studies show as many as 90% have experienced interpersonal or sexual violence in their lives
  - The rate of sexual assault in US prisons 4.3% significantly lower than rates for women on college campuses. *(Beck and Harrison, 2010; BJS, 2010)*
  - Women may be safer in Jail/Prison but feel unsafe.

# Module I: Research

**Trauma and Justice Populations:** TAPA Center for Jail Diversion (Noether and Abrue, 2005)

**TAPA Center Data on Exposure to Trauma in Jail Populations** (Noether & Abrue, 2006)

| *Women* | *Men* |
|---|---|
| 91% lifetime physical violence | 86% lifetime physical violence |
| 65% lifetime trauma witnessing | 61% lifetime trauma witnessing |
| 75% lifetime sexual trauma | 32% lifetime sexual trauma |

- Significant rates of PTSD found among death row inmates (Freedman and Hemenway, 2000)
- Violent offenders are more likely to have PTSD than not (Carlson and Shafer, 2010).

# Module I: Research

## Risk factors for PTSD

- History of mental illness
- Injury during traumatic event
- Seeing people hurt or killed
- Lack of social support after event
- Added stress after event- loss of a loved one, job, or home.

## Resilience factors

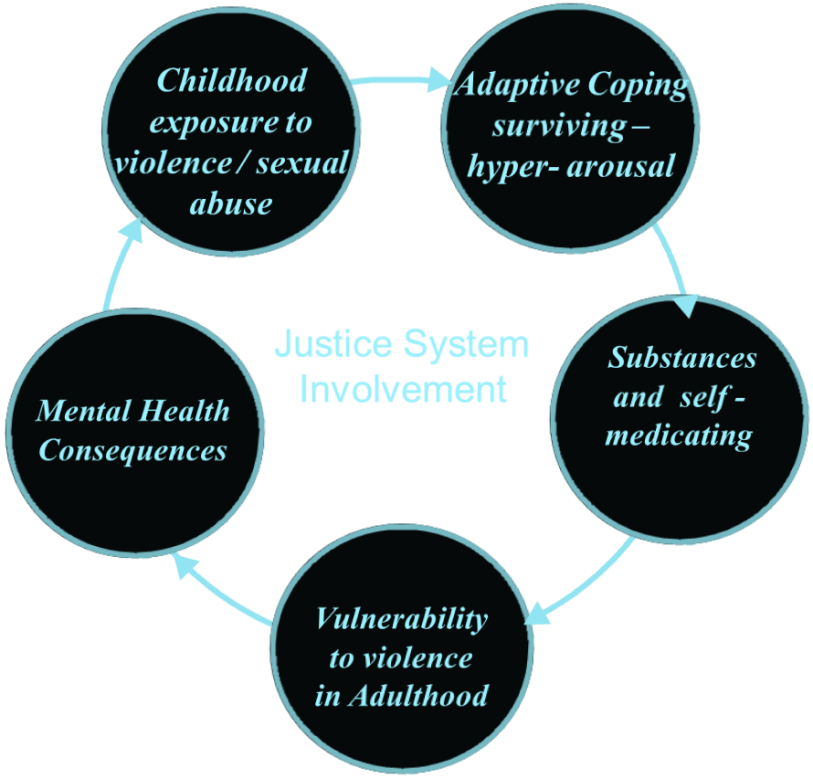
- Seeking out support from friends and family
- Finding a support group
- Feeling good about one's actions in the face of danger
- Having a coping strategy
- Learning from it

# Module I: Research

**What about substances?**

**In the general population:**

- Two thirds of men and women in substance abuse treatment report childhood physical or sexual abuse (Clark, 2001)
- Men with PTSD misuse alcohol in response to trauma at almost twice the rate of women with PTSD.(National Center for PTSD.2011)



# Module I: Research

- **Veterans and Trauma: Prevalence**
  - PTSD = most common MH disability among Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans
  - Up to 40% of veterans will return with Depression, PTSD, or Traumatic Brain Injury (VHA, 2008)
    - Often complicated by alcohol abuse, other substance problems and problems controlling anger

# Module I: Research

- **Veterans and Trauma: Types**
  - Vicariously experienced trauma-witnessing
  - Direct Injury
  - Military sexual trauma (MST)
- **Veterans and Trauma: Jail and Prison**
  - 10 % of US jail and prison inmates are veterans
  - Typically dealing with many issues (alcohol use, co- occurring psychiatric disorders, chronic homelessness, unemployment)

# Module I: Research

Prevalence: Case for Universal Precautions in RSAT

- ***Universal strategies*** *address entire groups that share the same general risk. Universal strategies are applied to groups without any prior screening, when the entire group is capable of benefiting.*

What trauma-informed principles can and cannot become part of SOPs in a correctional environment?

# Module I: Summary

- Prevalence makes the case for trauma-informed RSAT programs
- Integrated treatment that promotes recovery from SUDs and the effects of trauma is recommended
- Trauma-informed RSAT programs ensure they do no harm
- Prevent undetected and unaddressed trauma from interfering with treatment engagement
- Teach basic skills that help offenders manage responses, regulate emotions and deal with triggers
- Attend to staff's need to develop and preserve their own personal resources and resiliencies

# Module II:
# Understanding Trauma

# Module II: Topics

a) Introduction - What is Trauma
b) What Research and Practice Tell Us
c) How the Impact of Trauma Relates to Substance Use

# Module II: Learning Objectives

**Upon completion participants will be able to:**

- List at least three examples of ***physiological*** changes that take place when people perceive a threat to survival.
- Describe the characteristics of events most likely result in trauma and related behavioral health problems.
- Cite one example of each of the three major PTSD symptom groups.

# Module II: Trauma

## What is Trauma?

- Trauma is extreme stress brought on by ***shocking or unexpected events*** that ***overwhelm a person's ability to cope***, resulting in ***feelings of helplessness, and extreme fear and horror.*** The survivor perceives the event as a ***bodily violation or a threat of serious injury or death or of self or a loved one***. Events may be ***witnessed (vicariously) or experienced directly.***

# Module II: Trauma

**Some examples of events likely to be traumatic when *experienced or witnessed* include:**

- Hate crimes, genocide, torture, combat and war
- Domestic violence and family violence
- Childhood physical abuse
- Adult or childhood sexual abuse or assault
- Natural or man-made disasters
- Automobile and airplane accidents
- Confinement, imprisonment, forced institutionalization
- Persecution, oppression and community violence
- Psychological and emotional abuse
- Childhood sexual abuse/exploitation
- Sex work, sexual exploitation or harassment
- Homelessness, displacement
- Medical trauma or intense surgical interventions

# Exercise I

Please list a few events that have been reported as traumatic by people you have worked with:

1.

2.

3.

# Module II: Trauma

## What is the Nature of a Traumatic Experience?

- What one person may perceive as a frightening, traumatic event, another might experience as difficult or distressing, but not traumatic.

# Module II: Trauma Exercise

Rochelle is Joan's older half-sister. Rochelle lived with her dad for part of her childhood, but moved in with her sister, Joan, when their mom re-married. One night, the girls saw their mom's new husband break her nose. Rochelle was devastated, but Joan was traumatized. Each perceived the event differently as illustrated below:

| Joan's Perceptions | Rochelle's Perceptions |
|---|---|
| **Mommy is going to die. Her head is all bloody.** | **Got to get help. I think he broke her nose.** |
| **He is going to kill us too.** | **If he comes near me I'll call the police.** |
| **My heart is racing. I have to cry.** | **We have to keep quiet, Joan, don't cry.** |
| **This is happening to us because I am bad.** | **Why did I have to come back here to live?** |

# Exercise II

## What qualifies Joan's experience as a traumatic event?

- ❑ Perception of threat to her survival
- ❑ Overwhelms her capacity to cope
- ❑ Unusual, sudden or out of the ordinary
- ❑ Feelings of helplessness and extreme horror
- ❑ Threat of death or serious injury to self or loved one

## How about Rochelle?

- ❑ Perception of threat to her survival
- ❑ Overwhelms her capacity to cope
- ❑ Unusual, sudden or out of the ordinary
- ❑ Feelings of helplessness and extreme horror
- ❑ Threat of death or serious injury to self or loved one

# Module II: Research & Practice

**The Adverse Childhood Experiences (ACE) Study:**

- The largest study of its kind ever to examine the health, social, and economic effects of adverse childhood experiences over the lifespan (17, 421 participants)

| Types of Adverse Childhood Experiences | |
|---|---|
| **Abuse by Category** | **Household Dysfunction, by Category** |
| Emotional/Psychological (recurrent) | Substance Abuse |
| Physical (recurrent) | Mental Illness |
| Sexual Abuse (contact) | Mother Treated Violently |
| | Imprisoned Household Member |
| | Separated from biological parent |

Source: ACE & their Relationship to Adult Health & Wellbeing. Feletti & Anda, CDC & Kaiser Permanente, 2005.

# Module II: Research & Practice

## Ace Score:

- The ACE study used a simple scoring method to determine the extent of exposure to childhood trauma. Exposure to each category of adverse childhood events counts as one point; points are added for a total ACE score. An ACE score of 0 indicates no exposure to any of the categories of adverse events, while a score of 8 indicates at least one exposure in all of the categories listed.

**What's YOUR ACE Score?**
Help me calculate my ACE Score
http://acestudy.org/files/ACE_Score_Calculator.pdf

# Module II: Research & Practice

**The Impact of Childhood Trauma on Adult IV Drug Use and Alcoholism in Women:**

- Women with ≥ 4 types of childhood *trauma* had a 78% attributable risk for IV drug use.
- Women with no exposure to these events in childhood had a .05% attributable risk for IV drug use.
- Women with histories of childhood sexual abuse were 60% more likely to abuse alcohol and 70% more likely to use illegal drugs.

# Module II: Research & Practice

## The Impact on Males and on Chronic Disease

- A male who experienced at least 6 types of adverse childhood experiences was 4,600% more likely to become an IV drug user.

- Self-acknowledged alcoholism in men and women increased 500% in relation to adverse childhood experiences.

- Among the 7% of the sample that did experience 4 or more types of abuse or dysfunction, high rates of mental illness, tobacco and substance use, teen pregnancy and chronic disease were found (Felitti, 2007).

# Exercise III

## Harriet's Story

*I grew up with an alcoholic father and a bi-polar mother. My dad was a military man and was always either angry or distant. When my mom was delusional, she would beat me and my older brother, Pete. She went into a mental hospital when I was 11, and I went to live with my aunt. For the next 2 years, my uncle came into my room at night and sexually abused me. When I went back home, I told Pete about it----he broke into my aunt's house and threatened my uncle with a gun. He got 3 years for assault with a deadly weapon. After Pete went away, I drank every night and started doing ecstasy. I got addicted to pain meds and was using heroin with my boyfriend until I got pregnant at age 17—that's when he started hitting me. After Ashley was born, I tried to get away from him, even tried going to treatment in 1991. I finally left after he broke my collar bone. I worked as a dancer for a while and had 3 arrests for possession and soliciting. I did some prison time but they gave me a chance at early release, if I completed treatment. I jumped at the chance — the state had taken Ashley and I would have done anything to get her back.*

# Exercise III

## Pete's Story

*My dad believed in discipline. When he caught me smoking cigarettes behind the shed in 6th grade, he forced me to lie on my stomach with my pants off in the sun all day while he worked in the backyard. He drank cold beer after cold beer until sundown. Then he switched my sun burnt butt and legs until welts popped out all over. It didn't stop me from smoking, but it did make me hate him. I drank, huffed and then started snorting crank.*

*Mom was so nuts. Before Harriet was born the old man used to beat her up. Mom thought she was the bride of Jesus and was usually pretty happy about it until she accused my sister and me of sending her messages from Satan. I loved her though, and when they put her away, they shipped Harriet off too. I couldn't stand the sight of the old man, so I left and lived in a tent in the woods for about a year, until Harriet came home.*

*I did break into our uncle's house after she told me what he did, and I would have shot him. But, my auntie was begging me to let him live. I was 17 when I went to prison. Things that happened there I will never talk about. I stabbed one guy and I hurt him pretty good. I got time added to my sentence, but it was worth it.*

# Exercise III

## Harriet and Pete's ACE Score

Use the ACE simple scoring method to determine the how many categories of adverse childhood events each family member was exposed to. Give one point for each category of events and add them for a total ACE score:

ACE score of 0 = no exposure to any of the of adverse events

ACE score of 8 = at least one exposure to all of the categories

1. What is Harriet's ACE score?
2. What is Pete's ACE score?
3. How many categories of adverse childhood experiences has Harriet's daughter, Ashley, had so far?

# Module II: Impact of Trauma

- Trauma ➡ Can lead to serious and persistent problems
  - Dealing with the **ongoing effects of trauma in the present day** is often more painful than the original event
  - Increases risk for future victimization, additional trauma, substance use and mental health disorders and chronic disease.

# Module II: Impact of Trauma

## What is PTSD?

- Anxiety Disorder developed after seeing or living through a terrifying event that prevents survival responses from functioning properly.
  - Not everyone who experiences danger/violence gets PTSD!

# Module II: Impact of Trauma

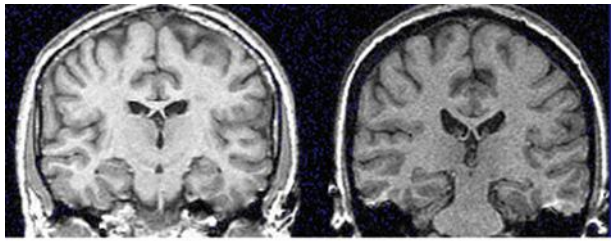
**How the Brain and Body React to Trauma:**

- Amygdala: primitive part of the brain that initiates a “fight or flight” response
- Increased heart rate and respiration
- Blood flows out of the thinking centers of the brain and into the limbs to prepare for action.
- When the threat is over, the brain should return the body to normal.

# Module II: Impact of Trauma

## Trauma and Altered Cognitive and Emotional Functioning

- Scientists think that the pathways through which sensory stimuli reach the Amygdala are worn "deeper and wider" by repeated trauma and activation of the "fight or flight" response. The system becomes more excitable; reactions are faster and more automatic (Phelps, 2004).
- Enlarged ventricles crowd the path from the Amygdala to memory circuits; as these paths narrow it slows down the brain's ability to put information in context and decide whether or not it poses a threat (Smith, 2005).
- Young brains are more malleable, the earlier the exposure to trauma, the more rapidly changes take place and the more long-lasting they appear.



# Module II: Impact of Trauma

...Leads to changes in arousal, attention, perception and emotion

**Arousal**-Extreme excitability response to stimuli ***or*** numbing-detachment from the world

Hyper-arousal ⟺ Numbing

**Attention**-Directed away from stimuli-completely absent ***or*** deeply, exclusively focused

Dissociation ⟺ Hyper-focus

**Perception-**Pupils dilated, vision and hearing sharpened ***or*** dulled with memory absent

Heightened ⟺ Dulled

**Emotion-** Devastating, painful feelings ***or*** inappropriately detached from experience

Absent ⟺ Overwhelming

# Module II: Impact of Trauma

**3 Main PTSD Symptom Groups**

1. Avoidance
   - Voluntary suppression of memory
   - Restriction of daily activities
   - Dissociation; substance use
2. Arousal
   - Startle Reflex
   - Inability and Vigilance
   - Sleep disturbances
3. Intrusion
   - Flashbacks
   - Nightmares
   - Trauma Re-enactment

# Module II: Impact of Trauma

## Primitive Survival Responses to Fear & Trauma:

- **Fight-** hyper vigilance on conscious and unconscious levels, prepared to defend; flooding of ***physiological*** changes related to aggression.
- **Flight-** blood flow to the limbs prepare us to run; when flight is thwarted - no relief or outlet for the primed nervous system. Avoidance, dissociation, hiding are psychological "flight" behaviors.
- **Fright-** responding with terror, often to seemingly benign triggers; anxiety permeates all areas of life. Shortness of breath, startle responses, sleeplessness and inability to focus or think clearly.
- **Freeze-** response in animals, accompanied by slowed, shut down metabolism. Can be a learned response to remain safe and invisible; paralyzes victims—makes them vulnerable, reinforces helplessness.

# Module II: Impact of Trauma

- **Flail**- perceived as aggression---movements, such as flailing arms, meant to create safe space –not to connect with a target. In animals puffing up or fanning out to keep aggressors from closing in.
- **Shield-**protective-like flailing- shielding, raising hands over head and body to prepare for injury. Trauma survivors may shield in response to noises or non-violent conflict.
- **Flirt**-Particular to some women survivors of sexual violence in childhood. Instinctive placating behavior for girls sexualized in violent homes. Incest perpetration is highly correlated with violence (Edleson, 1999; Paveza, 1988).
- **Submit -** Renders the victim vulnerable, but is an attempt at safety or escape. Animals submit to predator if flight is impossible. Submission or numbing in the face of danger may be labeled "risk taking" behavior

# Module III:

# Integrated Treatment in the Criminal Justice System

# Module III: Topics

a) Understanding Criminal Justice Theory and Practice
b) Cognitive Behavioral Interventions
c) Compatible Evidence-Based Principles

# Module III: Learning Objectives

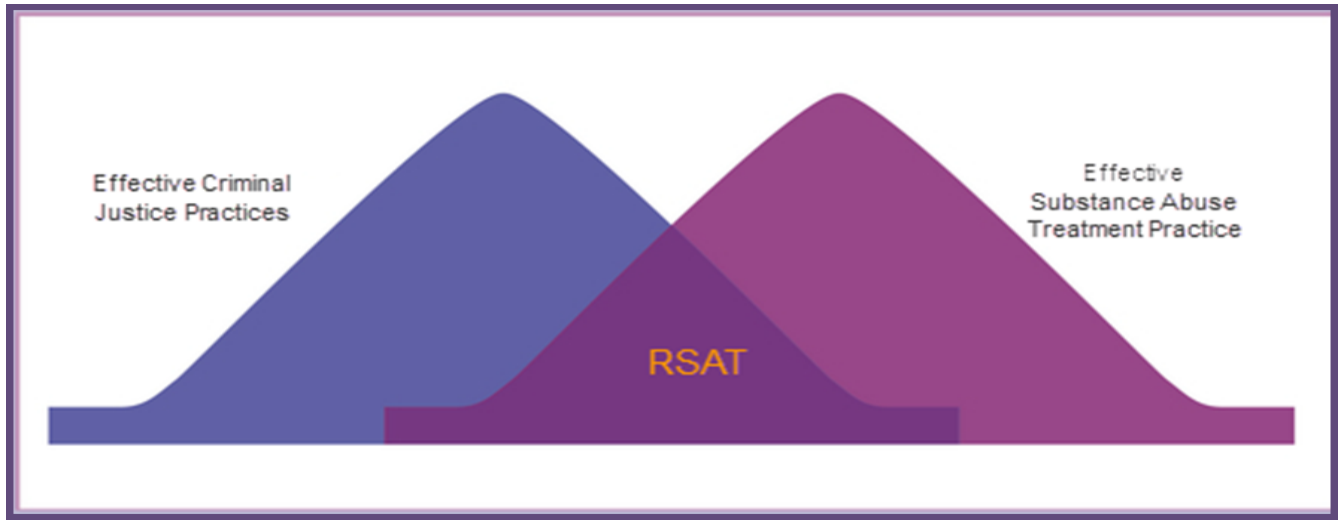
**Upon completion participants will be able to:**

- Describe offenders most likely to benefit from programming.
- Name at least two criminal risk factors associated with trauma that can contribute to recidivism.
- Identify principles of evidence-based offender rehabilitation compatible with best practices for SUD treatment.

## In-Prison Rehabilitation Programing Goals:

a) reduce disruptive behavior within the institution

b) reduce the risk of recidivism when offenders are released to the community




**RSAT's that are effective for both are of maximum benefit to clients**

**Risk classification assessment:**

- What level of security is best
- Where the offender should be housed
- What type of rehabilitation programs should be prioritized

## Risk, Needs, Responsivity Theory (RNR):

- Offenders have many needs and factors that indicate different levels of risk.
- Certain needs are associated with an increased likelihood of committing new crimes.
- Identifying high-risk offenders and assigning them to programs that target the needs that are drivers of crime can reduce recidivism

# Module III: Criminal Justice Theory and Practice

**Risk, Needs, Responsivity Theory (RNR):**

- **Who** needs intensive programming?
- **What** should the programming target?
- **What** program approach will reach the offender?

# Exercise V

Below is a chart of offender risk and needs assessment scores in a prison facility and the rates of recidivism for each scoring range. The staff applies the risk and needs theory to assign a cut off score for participation in a new pre-release program. All offenders below the cut off will complete a parole plan as usual. Offenders who score above the cut off point will join an intensive pre-release case management group. What should the cut off score be?

| Risk Assessment Score | Recidivism Rate |
|---|---|
| Low (0-37) | 18% |
| Low/Moderate (38-54) | 30% |
| Moderate (55-75) | 43% |
| High (76-115) | 58% |

**a)** 100 and above **b)** 25 and above **c)** 76 and above **d)** 65 and above

**Criminogenic Needs:** Factors that have been shown to drive criminal behaviors

| Factors Associated With Crime | |
|---|---|
| Changeable | Static |
| Criminal Thinking | Criminal History |
| Criminal Associates | |
| Substance Use | |
| Anti-Social Values | |
| Anti-Social Personality Traits | |
| | |

**Trauma affects criminogenic risk factors:**

- Substance use and dependency
- Anti-social personality traits
- Criminal values
- Criminal associations

# Exercise VI

Read the quotes from clients with PTSD and substance use disorders in RSAT programs. Write the letter that indicates which risk factor best matches the trauma response described in the quote in the space provided.

a) Criminal Thinking/Values
b) Anti-social Personality Traits
c) Criminal Associates

# Exercise VI

*"When I got home from Iraq, I isolated from my family, stayed in the basement and drank. On 4th of July weekend, I could hear fireworks going off. My wife wanted to go downtown that night with the kids to see them. Instead I got arrested after I made my kids get down in the bathtub and hide for 11 hours. When my wife tried to let them out of the bathroom, I fired six shots into the ceiling."* _____

# Exercise VI

*"I was sent to church camp every summer. One of the 'brothers' came into our bunks at night and did stuff. I didn't know he was doing it to the other boys. I thought there was something about me that made him do it, so I kept it a secret. The summer I turned 14, I broke into the camp office, took all the cash I could find and ran away. I decided to make my way stealing and dealing. There was no reason to play by the rules. Nobody else did."*

_____

# Exercise VI

*"I was terrified of my ex-husband. Even after I divorced and left town, he always tracked me down. I met Jared when I was trying to get away. One night my ex saw me get in a car with Jared. He chased us through the streets. Jared forced him off the road, got out and wailed on him. My ex-husband lost an eye and had to have his jaw reconstructed, but he never messed with me again. That night Jared went and got my stuff and moved me in."*

_____

## What Treatments Work?

- Cognitive Behavioral Treatments (CBT):
  - Cognitive: targets attitudes and thought processes--
    Behavioral: practices skills, role modeling, reinforcement.

  Tasks of treatment: Restructuring criminal thought patterns (cognitive restructuring), developing pro-social coping skills

  - CBT has the advantage of benefiting people with mental health problems, substance use problems and difficulties resulting from trauma.

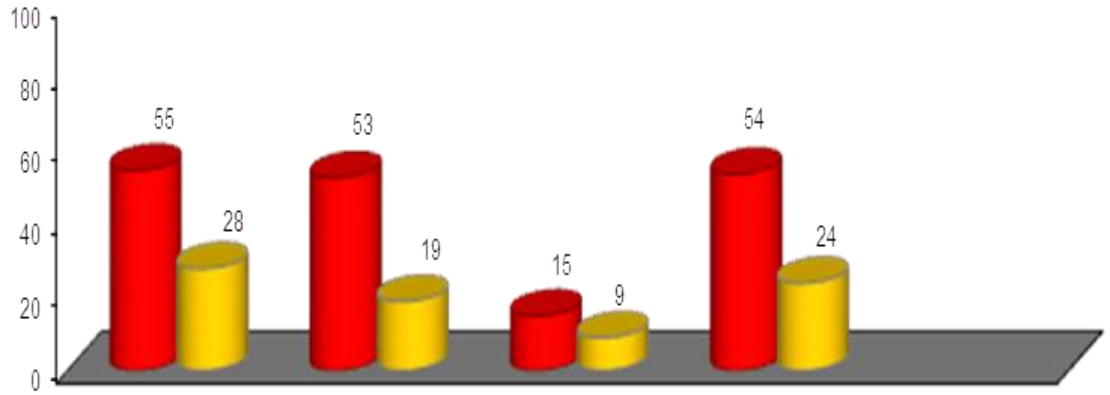
# Module III: Cognitive Behavioral Interventions

**Characteristics of effective cognitive-behavioral Groups:**

- Rehearse and role play skills and behaviors
- Positive reinforcement
- Peer encouragement
- Small groups
- Meet at least 2x weekly
- Individual sessions that support group work
- Staff training, supervision and fidelity monitoring

# Module III: Compatible Evidence-based Principles

**Dosage Principle-**Long term treatment programs that are at least 90 days begin to show better outcomes. High-risk offenders require significantly more structure and services than low-risk offenders. Match programs to each offender's risks & needs.



## Motivating RSAT Clients

- Motivational Interviewing (MI)
  - Directive
  - Increases self-efficacy
  - Reinforcement of change
  - Goal setting
  - Rewards and privileges
  - Immediate Sanctions

# Module IV:

# Implementing Trauma-Informed Approaches

# Module IV: Topics

a) Foundations of Trauma-Informed Approaches
b) Identifying Triggers and Alternative Coping
c) Integrating Trauma-Specific Approaches

# Module IV: Learning Objectives

**Upon completion participants will be able to:**

- Name three elements of trauma-informed programs
- Identify two distinguishing characteristics of trauma specific programs
- Define and utilize the PEACE approach to unavoidable triggers and the RICH model of healing relationships.
- Identify integrated treatments for SUDs and co-occurring trauma-related mental health problems.

## Value of Trauma-Informed Addiction Treatment

The measures outlined in this module can decrease the likelihood of:

- Low program engagement
- Increased trauma-related distress due to institutional triggers
- Inaccurate mental health diagnoses and ineffective medications
- Relapses into substance use
- Decreased self-efficacy; learned hopelessness in clients
- Depression and increased risk of suicide
- The use of seclusion and restraint
- Staff burnout and secondary trauma responses

# Exercise VII

Read the story below, then choose the approach that is the best use trauma-informed principles for Harriet. (choices on next slide)

*"In 1991 I finally got away from my boyfriend who was beating the crap out of me, and got into a treatment program. After about 5 days without drugs and alcohol, I began having flashbacks about my uncle. I felt dirty all the time and started taking 6 or 7 showers a day. The treatment center said they weren't equipped to deal with my symptoms and dropped me off at a psych hospital. I guess I wasn't equipped either because I kept using. I went back to my boyfriend and didn't get away 'til after he broke my collar bone."*

# Exercise VII

a) We can start you on a medication for obsessive compulsive disorder to help you get through this.

b) Many women in early recovery have things like that surface and have been able to learn ways to cope.

c) We are transferring you to a dual diagnosis program.

d) I know this is difficult, but it is important to keep the focus on your alcohol and drug problem right now.

# Module IV: Trauma-Informed Approaches

**Trauma informed substance abuse programs:**

- ***All staff*** understands trauma & its impact on the addiction/recovery process
- Services are designed to enhance safety, minimize triggers, and prevent re-traumatization
- Staff and client relationships are based on equity and healing; survivors are empowered with information, referrals and hope.

**Trauma specific services**

- Clinical and program staff have specialized training in integrating trauma treatment and recovery practices.
- Specific interventions are aimed at coping with the aftermath of trauma, decreasing symptoms of trauma-related disorders and increasing knowledge about trauma.
- People are empowered to manage the effects of victimization and trauma without the use of substances in ongoing recovery.

# Module IV: Trauma-Informed Approaches

- Recovery from trauma encompasses multiple aspects of people lives, changing deep-seated beliefs and gaining knowledge and skills.
- The assumption of a trauma history guides encounters, whether or not clients disclose or remember trauma.
- Responses are reframed as survival strategies that served a safety function and seen as evidence of strength and resiliency.
- Creating safety is a primary task; the safer and more predictable the treatment environment, the better the engagement.
- Education and information about trauma, it relationship to substance use disorders and recovery is part of treatment.
- Empowering survivors to change is the basis of helping relationships founded on respect, information, connection and hope.

# Exercise VIII

The chart on the next slide compares trauma-informed approaches to traditional SUD treatment.

Think about where you work now or have worked in the past.

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

# Exercise VII

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

| Rating | Trauma-informed Programs | Traditional Substance Abuse Programs | Rating |
|---|---|---|---|
| | Minimize practices that may re-traumatize; sensitive to individual adaptations | Tradition of toughness, client adjustment to environment and community norms | |
| | Power and control minimized; empowerment and client choice maximized | Accent on powerlessness, breaking down self-will and surrendering control | |
| | Programs are structured and goal oriented, without being authoritative | Programs are authoritative, but some-times lack structure | |
| | Collaboration focused (client with staff) | Compliance focused ( client surrenders) | |
| | Staff training and professional development in research-based approaches | Clients labeled resistant as a fallback when scope of training is exhausted | |
| | Understand the function of adaptive behaviors such as, trauma re-enactment and self-injury | Behaviors are seen as intentionally provocative, volitional, and self-destructive irrational and self-destructive | |

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

## Trauma Screening Guidelines

- Explain the screening in advance and how the information will be used to benefit the client.
- Let the client know that *yes* or *no* answers are fine unless he or she wishes to say more.
- Use valid screening tools that focus on present-day symptoms (ex: Trauma Symptom Checklist).
- If screening for specifics of past trauma exposure, use a checklist the client can read and mark off rather than an interview format.
- Give the client as much control as possible, including time and location, passing on questions and taking breaks.
- Be aware of your own nonverbal responses during the interview.
- If the clients become upset or agitated, redirect by asking about strengths, the people and things that helped them get through, how these events affect them today and what has worked to help them feel better.

## Trauma Stabilization

- Grounding →
- Self-soothing
- Self-care
- Strength-based

*"When the CO told me to pick up the mop, I could feel myself starting to get crazy. I could feel something pounding up through my chest and into my throat; my fists were clenched. I started grounding. I counted the trees outside that lined the fence perimeter. Then I counted how many colors were on each tree. I forgot why I was so pissed off and picked up the mop."*

# Module IV: Triggers and Alternative Coping

**Advanced Directives:** Working with clients to answer:

- What kinds of reminders are difficult to deal with?
- What helps you calm down when you are triggered?
- What are the things staff can do to help when you are reacting to a trigger?
- Is there anything staff should avoid doing when you are having difficulties?

# Module IV: Triggers and Alternative Coping

**PEACE:** An acronym for the approach to coping with unavoidable triggers

- **P**redict and prepare—*"When we go to court, your husband will be in the room. What would make you feel safest in court?...What could you do to take care of yourself afterward?"*
- **E**nlist—*"What has helped you in the past not to drink when you had to deal with your mother yelling at your kids?"*
- **A**cknowledge—*"Many people have a difficult time sleeping with the lights on all night. I can understand why it makes you anxious."*
- **C**hoice and control—*"Since we have to search everyone's cell for contraband for safety reasons, do you want to be in the room when I check it or would you rather I do it while you are in group?"*
- **E**xplain—*"We ask each person to go through the metal detector to check for anything unsafe that might come into the building. If you turn your back toward me I won't have to reach around you. I will need to run this wand along side you. Would you mind putting your arms out?"* (*Miller, 2010)*

# Module IV: Triggers and Alternative Coping

**RICH Model:** Every encounter with offenders should communicate the following:

- **R**espect
- **I**nformation
- **C**onnection
- **H**ope

## Treating PTSD


- Pharmacological
- Physiological approaches
- Past-based
- Present-based

There are effective treatments available for trauma related disorders. As many as 60-90% of clients who complete a course of evidence-based trauma specific treatment report improvement.

## Stages and Tasks of Trauma Recovery (Herman, 1992)

*Stage One:* Establishing Safety- (**RSAT programs)**
*Stage Two:* Remembrance and Mourning
*Stage Three:* Reconnection

These stages involve specific tasks. Each person's path is unique, some tasks are easier than others. Treatment in correctional environments usually focuses on Stage One and some of the stabilizing tasks listed below.

**Tasks**

- Gain authority over the memory
- Safety
- Self-soothing
- Grounding
- Self-regulation/affect regulation
- Identification and elimination of triggers
- Grieving
- Empowerment

**Trauma-Specific Manualized Treatments for Integrating Trauma Recovery into RSAT programs:**

- Seeking Safety
- Essence of Being Real
- Trauma, Addiction, Mental Health, and Recovery (TAMAR)
- Trauma Recovery & Empowerment Model (TREM)
- Addiction & Trauma Recovery Integration Model (ATRIUM)
- Trauma Affect Regulation: Guide for Education & Therapy (TARGET)

# Module IV: Secondary Trauma, Burnout, Counter Transference

**Transference** - the client's displacement of feelings toward others (usually the parents) onto the therapist

**Counter Transference-** the therapist's emotionally reactive involvement or displacement of feelings onto the client

Since traumatic experiences are not unusual among correctional staff and their loved ones, transference is a common reaction. Strong reactions of empathy, impatience, hopelessness or anger can indicate a need for supervision, support and additional training in trauma-informed approaches.

# Module IV: Secondary Trauma, Burnout, Counter Transference

**Secondary or Vicarious Trauma:** changes in the inner experience of service providers that come about as a result of empathic engagement with people who have experienced trauma.

- Intrusive flashbacks or obsessive thoughts
- Difficulties regulating emotions
- Physical symptoms and frequent illness
- A change in outlook and beliefs about the world
- Hopelessness, hyper-vigilance and exhaustion
- Anger and frustration
- Overworking

# Module IV: Secondary Trauma, Burnout, Counter Transference

ABC's of Building Personal Resilience

a) **A**wareness- monitor emotions, needs, limits and resources.

b) **B**alance- set aside time for reflection, play, relaxation, and family.

c) **C**onnections- utilize social support, resist tendencies to isolate.

*For more information on RSAT training and technical assistance visit:*

*http://www.rsat-tta.com/Home*

*or email Jon Grand, RSAT TA Coordinator at*

*jgrand@ahpnet.com*