Establishing Trauma Informed Care in a Correctional Setting

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Abstract

Having worked in corrections for many years, I have learned the value of trauma informed practice. Offenders are exposed to a system that is focused on security and public safety, conditions that can re-traumatize the offender. Little is known about the system's role in the traumatization of the offenders. What is known is that offenders in the correctional system experience higher trauma rates then the general population Recognizing the trauma behind the behaviour or crime of the offender might help to reduce traumatization and create a more productive healing process. Therefore, it is important to be aware of the offender's historic trauma and find new approaches focused more on the trauma and less on the behaviour or the crime. *Keywords:* trauma-informed, trauma, childhood adversity, offender, PTSD substance use. mental health, trauma trauma-informed,

Chapter 1: Introduction

Most inmates have to deal with a negative public view of their punitive actions. The public and professionals hold the opinion that "if you do the crime, you do the time" and that punitive action is required. There is little empathy toward offenders in the public view. Correctional and health care staff are trained to deal with aggressive and resistant behaviours daily, often resulting in their own trauma and impacting their behaviours towards the offenders that they are working with. Because of the stigma around offenders, it is not surprising that the community and correctional system and programs are not focused on the trauma behind the offending behaviour (Levenson & Willis, 2019). In fact, the truth is that a higher percentage of inmates have experienced trauma and childhood adversity, than the general population (Levenson & Willis, 2019). While this does not excuse the crime or behaviour of the offenders, if correctional and health professionals understand the adversity and trauma of the offender it could reduce their own exposure to trauma caused by the offender.

The term "trauma informed" refers to recognition that clients may have experienced trauma through the actions of the professionals charged with their care. When we look at trauma informed care, we often think about what the client might have experienced in their past to have awareness about how we respond to the client to not trigger a trauma response. What we often do not think about pertaining to Trauma informed care is how the process through the correctional setting can trigger trauma. Trauma could affect how they respond to a situation or event (BC Corrections, 2019). The awareness of the possible trauma that could be triggered by how professionals engage and support the client (BC Corrections, 2019). Some of the ways to reduce trauma for the client include recognition of the areas in the correctional setting that could trigger trauma, such as Pre-sentence assessments done by the Probation officers in the community to the

assessments called JSAP that an inmate engages in when they are entering the correctional settings. I believe it is important that professionals in the corrective system understand trauma and how it affects the clients to create a safety for the client through the correctional process. Professionals who learn to create safety for clients can reduce the trauma the client might be experiencing along with reducing the trauma that they are exposed to. This could be done by recognizing and changing some of the questions in the assessments by correction and health care personnel that may trigger a trauma response for an offender that has experienced trauma. It would also help by teaching awareness and understanding to the correctional and health care staff regarding trauma. The importance of teaching new ways to communicate to the inmates/clients. Incorporating knowledge about trauma into practices, policies, and procedures in the correctional system to enhance the safety and compassion of the service to the inmates (Levenson & Willis, 2019)

The connection between trauma/PTSD and substance/alcohol use is very well documented and it seems that a high percentage of inmates with substance use have some kind of trauma or PTSD (Reynolds et al., 2012). In addition, an individual that engages in a lifestyle of substance and alcohol use is more susceptible to trauma. Substance misuse is a growing problem, not only in this country but also around the world. There is still the common idea that substance misuse arises from a moral deviance therefore using incarceration as a punishment to address the addiction issue (Fischer et al., 2017). The institutions commonly address substance disorder as a criminal justice disorder instead of a health issue focusing on the criminal part of the issues and not addressing the substance's use. Fischer et al. (2017) states that “These regimes commonly fail to provide adequate support and interventions for individuals with substance problems, with many ending up in prisons due to their problems as a ‘last repository” (p.1740).

Therefore, addressing the misguided stigma around substance use in correctional centres and focusing on the health aspect along with adverse trauma will help reduce the prevalence of substance use in the correctional centre. These correctional centres are windows of opportunities to address adverse trauma and implement treatment interventions for substance use issues (Fischer et al.,2017). Yet when we come from a correctional position instead of a trauma informed approach around inmates that have substance use issues, we lose this opportunity to help make change for these clients.

The Canadian Centre on substance abuse reports that 51% of inmates have alcohol problems and 48% of inmates experience substance use problems (Canadian Centre on Substance Abuse, 2004). What is more striking, as reported from the Canadian Centre on Substance abuse, is the link between substance use and the criminal offences. “Of those offenders with severe problems, 97% reported that they used on the day of the offence; 87% reported that substance abuse was associated with their crimes over the course of their criminal history” (Canadian Centre on Substance Abuse, 2004, p.3). Clearly, this shows evidence that if the addiction issues are addressed, the crime rate should subside. Furthermore, effective treatment and therapy in a trauma to address the childhood adversities and addiction issues while in custody or after custody would not only affect the recidivism of crime but the recidivism during incarceration.

Background

Corrections in Canada has a two-tiered system as opposed to other countries' single prison system (Canadian Centre on Substance Abuse, 2004). This means that an offender sentenced in Canada would be sentenced to a provincial 0r a federal correctional system depending on the length of the sentence. If someone committed a crime and were sentenced to

two years less a day, they would go to a provincial correctional centre. If they are sentenced for a crime and received two years and over, they would go to a federal prison (Cameron et al., 2021). In many other countries such as England, Norway, Sweden, and other countries if someone is sentenced to jail, they would end up in the same jail no matter the length of time of the sentence or the type of crime (Canadian Centre on Substance Abuse, 2004). In addition, in both the federal and provincial correctional centres in Canada they classify the inmates according to their crime, institutional behavior, and their motivation to make change. The classification for both provincial and federal are minimum, medium, and maximum. This system helps to segregate the more motivated inmates and the inmates new to jail from the negative influences entrenched within the inmates classified as secure (Maximum).

Trauma is a result of a single or recurring event or circumstances that has lasting effects on a person and has lasting effects on the physical, social, emotional, and spiritual well-being (Fugate-Whitlock, 2018). Substance Abuse and Mental Health Service Administration (SAMHSA) definition of trauma is "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (Huang et al., 2014). Fugate-Whitlock (2018) states that trauma can be experienced at any time in a person's life, and it does not matter what part of the world a person may live, they can experience trauma. People experience trauma differently and it can be highly personal. The Merriam Webster dictionary defines trauma as a psychological or emotional stress that can cause mental and emotional issues (Merriam-Webster). Mental health can affect emotional, psychological, physical, and social well-being, which contributes to health problems that can affect thinking, mood, and behaviours (Williams,

2020). Trauma events can cause mental health issues through the person's inability to manage the stress caused by a traumatic event. Every person manages and copes with stress differently, which could affect the ability to recover from trauma events (Williams, 2020). DSM 5 definition from Briere and Scott (2014) indicated:

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (1) Directly experiencing the traumatic event(s); (2) witnessing, in person, the event(s) as it occurred to others; (3) learning that the traumatic event(s) occurred to a close family member or close friend – in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental; (4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse) (Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.(p. 6).

Posttraumatic stress disorder (PTSD) is a mental health disorder. PTSD mean the mental health issues that develop after a trauma event that affect day-to-day activities and mental health wellness (Williams & Omnigraphics, 2020). PTSD has many symptoms such as reliving the event, avoiding changes in beliefs and feelings, hyper-arousal, or hypo-arousal (Williams & Omnigraphics, 2020). Most treatment for PTSD is Cognitive processing therapy, prolonged exposure therapy and eye movement desensitization and reprocessing therapy (Williams & Omnigraphics, 2020). Although cognitive therapy helps to give coping skills to address the hyper-arousal state or hypo-arousal state and try to establish an optimal state window of tolerance, it does not address physiological symptoms associated with trauma (Fisher & Ogden, 2009). Psychological and pharmacological treatment have been effective for PTSD however it

can be difficult for some people with PTSD to tolerate therapies that include exposures to the traumatic event therefore avoiding or stopping the treatment is common (Bisson, et al., 2020). The absence of helping a client regulate the body's nervous state which has been altered through traumatic experiences is significant (Fisher & Ogden, 2009). Establishing better tolerant treatment therapy for PTSD that include safety and choice and less invasive approaches to exposure of the trauma (Bisson, et al., 2020).

Trauma informed practices are being implemented in the BC provincial corrections centres and BC Corrections is slowly training correctional and health care staff to understand and implement these practices. What is important is to understand what happens when an individual is triggered by a traumatic situation or memory. Understanding the concepts of trauma and PTSD.

Statement of the Problem

Trauma informed practices are rarely addressed by corrections or community corrections in addressing criminal behaviours. People who commit crimes are often victims of abuse, neglected and maltreated as a child, resulting in childhood trauma. Therefore, clients from the correctional facilities experience higher adverse childhood effects (Levenson & Willis, 2018). Childhood trauma does not give offenders excuses for the crimes they committed but it may help the correctional professional understand and address the underlying issues that might help promote change and growth. "Over two thirds of the general population sample reported at least one adverse childhood event before the age of 18 and approximately 13% reported four or more" (Levenson & Grady, 2016, p25). The need for awareness around trauma is imperative to healing and growth. For example, a woman officer working in segregation would have to deal every day, as she would walk past a certain inmate; this inmate would start yelling and banging in a

hysterical state. The officer did not know why this inmate always responded to her with this intensity and aggression. She thought the inmate just did not like her even though she had not done anything to provoke him. The inmate disclosed information to the psychologist about trauma events from his childhood where he would be locked up for days at a time and when his father came to let him out, he would hear the keys and he would get beaten before he was allowed out. What the psychologist and the correctional officer realized is that the sound of keys rattling when she walked by set off his trauma experience and he would respond aggressively towards the officer. The correctional officer started to hold her keys, so they did not rattle and make noise and the inmate started to have a different response to the correction officer. The idea of looking past the behaviour and recognizing the trauma that might cause the behaviour is much more productive than to give consequence to the behaviour.

Correctional staff and health care staff that work directly with the offenders and experience traumatic events every day. The type of abuse could be physical or could be emotion, mental and spiritual, which can cause PTSD. Fusco et al. (2021) stated, “Institutional correctional workers face a complex and unique set of challenges as a result of their confined workplace spaces and their daily interactions with incarcerated individuals" (p. 2). They also face stress from negative outcomes and increase work related stress, which in turn has a higher rate of PTSD (Fusco et al., 2021). Most incidents that affect correctional staff and healthcare staff relating to exposure of traumatic events go unreported. Correctional staff that work in human service or rehabilitation orientated work report less stress (Fusco et al., 2021). Fusco et al. (2021) also states that healthcare staff in corrections are at increased risk for PTSD. Because of the correctional staff and the health care staff consistent exposure to traumatic events, it can be difficult to have the capacity to form a therapeutic and working alliance with the offenders

(Fusco et al., 2021). Therefore, it is difficult to engage in trauma informed practices with the offenders.

Another problem that arises from trauma is the fact that substance and alcohol are widely used in correctional settings as a result of dealing with the trauma from incarceration. Learning to use trauma informed practice can help alleviate the substance use issue in corrections. It is not the total answer to the substance use issues in correctional centres however using trauma informed practice can help.

Purpose

The purpose of this literature review is to explore outcomes more conducive to this population and to help alleviate the stigma of substance misuse and criminal behaviour through trauma informed practices with correctional inmates. Looking at how we gather information valuable to promote change for the offender in a way that is not retraumatizing. Exploring practices and therapy that is trauma informed and productive to the growth of change around crime, addiction and to reduce recidivism. Bring awareness to correctional and healthcare staff in a systemic approach around childhood adversities, which causes trauma for offenders. To create a program to bring education and awareness to trauma informed care in the correctional system. Explore options for change in mental attitudes of correctional and health care personnel around punitive solutions instead of corrective solutions. Learning our own biases around offenders as correctional and health providers and recognizing when external pressures affect our biases and beliefs.

Question

With the high recidivism in corrections and mistrust of the inmates towards correctional staff, how can correctional and health care professionals create safety within correctional populations through a trauma informed practice to reduce recidivism and help inmates address childhood adversity, trauma and substance misuse? How is correctional and health care staff learning to gather the same required information for offenders in a way that does not re-traumatize the offenders. How can Correctional and health care staff be more aware of the stigma and beliefs that come with offenders in a correctional setting to avoid traumatization? What are some of the tools that correctional staff and health care staff use to help alleviate re-traumatization? What can the correctional system do to support the use of trauma informed care?

Position of Self

Working in the field of addictions for Twenty-two years I have made mistakes in which gave me the opportunity to learn and grow. My position when I first enter the field of counseling and addiction was based on my perceptions of motivation of the client and the behaviour they exhibit. I have come a long way from the hard nose position that a client is not ready because of low motivation of behaviour that not conducive of making change. Although it is important to assess for motivation of making change, I have learned that sometimes the passive or aggressive behaviours of a client could be based on past adverse trauma and not about the motivation of a client. For my own experience as someone that struggles with addiction in my past is that it was very difficult to make myself vulnerable. My experience out on the streets is that if I make myself vulnerable thing when bad. Therefore, having that understanding that a client coming into treatment and are asked to be vulnerable can cause a traumatic trigger and automatic behaviours.

It only makes sense that we clinicians recognised where negative behaviour comes from and try to understand the client.

My experience of working in a treatment centre for many years is that we are quick to not understand the client and remove the client from treatment based on the external behaviour however it is only natural for a person to be afraid, anxiety and be at a hyper arousal state when entering treatment. We used to ask a screening question to the clients before coming into treatment "what are you willing to do for your recovery". Most client would respond with "I will do anything". When they get to treatment, we find that are having behaviour that are causing them problem. We wonder what happen with the response that 'I will do anything". Understanding the trauma from an individual could make a whole lot of difference and can definitely correlate to the exhibiting behaviour. My goal with clients today that come into treatment is to establish safety with the client. If I can establish safety, then I can gain the co-operation of the client and change is possible.

I have worked in corrections for 13 years and if only they can teach the correction staff and the health care staff about awareness of trauma and establishing safety, we could make a difference. For example, I was up in segregation the other week. You can see that most clients are in this hyper arousal state constantly. Most clients are also dealing with concurrent mental health and addictions issues. We had one client start banging on the window to get the attention of myself as he wanted to talk with me. The correction officer that was with us started to slam on his window of his cell and proceed to tell him to calm down. At that point the client escalating and started screaming and yelling and kicking the door. That client started to bang his head against the door which was causing injury. This could have all been avoided if the office look past the behaviour and recognized the possible trauma behind the behaviour of this individual.

In corrections I have seen many situations that could have had a different outcome if only we approach the issues without judgement, stigma, and an understanding of the past and current experiences of the individual.

Correction Officers are trained around security and housing of the correctional inmates. My experience is that I see new Correctional officer show compassion, empathy, and respect towards the inmates however learn quickly through experiences and influences that it is better to use authoritarian approach. The Jail house mentality of the inmates is that if you show kindness, empathy, and compassion towards another inmate, that is perceived as a weakness which will be exploited by the inmates. That same mentality transfers to correctional officers and therefore the approach to the inmates is not about trauma informed. The correctional officer is taught about trauma informed however emphasis is on security and safety. The correction Guards have to show a force of unity therefore if a correction guard was to show caring, compassionate and empathetic towards the inmate if could be look at as going against you fellow co-workers. The sigma that I hear may times is that they Inmates and the idea from correctional officer and health care staff is that “if they do the crime. they do the time”. These stigmas of correctional inmates make it difficult show empathy and understand the past trauma of the inmate.

I believe that as a correctional employee or health care employee it is important to understand trauma, PTSD and a good understanding of Trauma informed practices. I believe that it is our responsibility as a employee that works in the correctional system to help rehabilitate the inmates by understanding the possible trauma or childhood adversities that they may have faced in their past. Therefore, this capstone is based on research around addiction, trauma and trauma informed care to construct a workshop that could help to train correctional officers and health care staff around trauma informed care.

Significance of the Literature Review

To explore literature that supports and offers information to help establish the need for trauma informed practices in the correctional system. Reviewing studies that have made an impact on the recognition of childhood adversities and the correlations between these adversities and criminal behaviour. Also exploring the correlation between substance misuse and childhood adversities, which eventually become a correctional issue. Finally, exploring literature around modalities that uses trauma informed practices. Looking at literature that will help establish a trauma informed workshop for corrections and healthcare staff in corrections.

Definitions

Autonomic nervous system (ANS): The autonomic nervous system is a control system that acts largely unconsciously and regulates bodily functions, such as the heart rate, digestion, respiratory rate, pupillary response, urination, and sexual arousal (Wikipedia)

Childhood adversity, "Childhood adversity is identified as **any exposure to abuse** (emotional, physical, sexual), neglect (emotional, physical), and/or family dysfunction (parental separation/divorce, family member with mental illness and/or substance abuse, domestic violence, family member imprisoned" (Felitti and Anda, 2010)

Corrections," the treatment and rehabilitation of offenders through a program involving penal custody, parole, and probation Offenders" (Merriam-webster)

Recidivism: "the act of continuing to commit crimes even after having been punished" (Cambridge dictionary)

Retraumatizing: "one's reaction to a traumatic exposure that is colored, intensified, amplified, or shaped by one's reactions and adaptational style to previous traumatic experiences" (Alexander 2012)

Trauma, “is an emotional response to a terrible event like an accident, rape or natural disaster” (APA).

Trauma informed: “Trauma-Informed Care understands and considers the pervasive nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize (Buffalo Center for Social Research, 2019)

Trauma focused Behaviour therapy Safety: “is a conjoint parent-child treatment developed by Cohen, Mannarino, and Deblinger that uses cognitive-behavioral principles and exposure techniques to prevent and treat posttraumatic stress, depression, and behavioral problems” (de Arellano 2014).

Somatic: “relating to the body as opposed to the mind”. (Cambridge University Press, n.d.)

Substance misuse: “It includes the use of illegal drugs and the inappropriate use of legal substances, such as alcohol and tobacco. Whether through overindulgence in alcohol, misuse of prescription medication, or use of illegal drugs, such misuse is harmful to our health” (American Public Health association (2021).

Window of tolerance: “the optical zone of arousal for a person to function in everyday. ((National Institute for the Clinical Application of Behavioral Medicine, 2017)

Chapter 2: Literature Review

Substance Uses in Correctional Settings

Substance abuse is prevalent in most correctional facilities. Fazel et al. (2017) state that recidivism and mortality rates are directly correlated to substances use throughout the correctional facilities all over the world. Many studies have reported ineffective treatment for substances use in prisons, which contribute to recidivism and mortality rates (Fazel et al., 2017). The method of this study is to search databases from 2004 to 2015 which consisted of: PsycINFO, MEDLINE, Global Health, PubMed, CINAHL, National Criminal Justice Reference Service and EMBASE (Fazel et al., 2017). They used search terms such as substance use disorders, substance, alcohol, drug, misuse, dependent, abuse and prisoners, inmate, sentenced, remand, detainee, felon, prison, incarcerated (Fazel et al., 2017). They used 24 studies in main analysis in which 13 were from previous reviews and 11 were new studies (Fazel et al., 2017). These studies consisted of 10 different countries (Fazel et al., 2017). There were 18,388 offenders that were both sentenced and remanded as participants. Alcohol use disorder was present in 24% of the overall participants. The study found that one in six men met the criteria for alcohol disorder and 1 in 10 women met the criteria for alcohol disorder (Fazel et al., 2017). Fazel et al. (2017) state "The second major finding was that drug use disorder was as high as the alcohol estimates, and possibly higher in female prisoners, with a pooled estimate of 51% (95% CI = 43–58). Importantly, the lowest prevalence study in women found that 30% had a drug use disorder" (p. 1734). Fazel et al. (2017) found through their findings that drugs use disorder is increasing in the correctional centres in the past 30 years. Their conclusions state that correctional centres need to have assessments in place for new intakes to identify substances and alcohol use disorders (Fazel et al., 2017). They should also have a management plan for

withdrawal of substances and alcohol along with a psychosocial and pharmacological treatment should be readily available (Fazel et al., 2017). They should also have community integration programs to help prevent relapse or recidivism (Fazel et al., 2017). Finally, Fazel et al. (2017) states that because of the high presence of alcohol and drug use disorders in correctional centres it will take interventions from all components and stages of the correctional centre and criminal justice system as a whole.

Substances and Trauma

There is a high rate of substance abuse among criminal offenders in the corrections system that can have a high correlation to the childhood trauma that they have experienced. When children are constantly exposed to aggression, threats, and intimidation in the home their minds and bodies prepare to manage the danger. Therefore, it becomes normal to remain in a hyper aroused state thus causing constant unhealthy emotional regulation and unhealthy behaviours (Levenson & Grady, 2016). Professionals working with offenders should keep in mind the possible trauma that might cause the behaviour (Levenson & Grady, 2016). Levenson and Grady (2016) did a qualitative study to determine the correlation of childhood adverse effects on offenders with substance use problems. They stated that they believe offenders in the correctional centre with substance use problems have higher correlation to childhood trauma (Levenson & Grady, 2016). The study consisted of a survey that was conducted from two-outpatient programs in Florida and a prison in New Jersey, which had 180 participants (Levenson & Grady, 2016). The participants were 146 males and 34 females which were all adult offenders in which most were of minority race and under 40 years old (Levenson & Grady, 2016). The study used a survey called the adverse childhood experience scale that consisted of yes /no questions pertaining to childhood adverse effects such as physical, sexual, emotional,

mental abuse and neglect along with household dysfunction (Levenson & Grady, 2016). The other part of the survey collected information regarding incarceration, substance use and violent behaviors (Levenson & Grady, 2016). The results of this study clearly showed a correlation between childhood adversity and substance use and violence criminal offenders; similar studies arrived at the same conclusion. Levenson & Grady (2016) makes it clear that there are other factors not included in this study that influence the outcome. This study has its limitations in regard to the self-reporting required by the offenders (Levenson & Grady, 2016). The question from the adverse childhood experience scale only covers a limited number of traumatic experiences and does not measure the level of experience of the traumatic events (Levenson & Grady, 2016). Also, it does not take all offenders as a whole and the participants are all from treatment programs and did not ask information about substance use at the time of the crime committed (Levenson & Grady, 2016). Levenson & Grady (2016) concluded childhood adversity is linked to substance abuse and violence and that the use of trauma informed practice is a cornerstone to addressing substance abuse and criminal behaviours such as anger, violence, and abuse.

As Levenson and Grady (2016) stated there is a correlation between childhood adversities and substance misuse. Marotta (2017) looked further into the correlations between childhood trauma and substance misuse as well as the implications of treatment and practices in a correctional setting. Recognizing the treatment and practices in correctional settings, we must first understand the relationship between childhood trauma and substance use amongst these offenders (Marotta, 2017). Prisons are made to house offenders and correctional personnel are trained to keep inmates incarcerated and maintain the safety of the facility and staff (Miller & Najavits, 2012). Marotta (2017) states that the number of offenders with substance use issues has

grown over the years and that childhood trauma is high amongst the prison population. Marotta also states that the treatment for substance use, and mental health could be influenced by childhood trauma. Marotta used the survey of inmates in state and federal facilities in the United States (SISFF) to initiate his study to examine the correlation between childhood adversity and substance misuse. The study collected data from offenders with prior criminal history, gun perceptions, delinquent activities, crime characteristics, substance misuse and mental health (Marotta, 2017). The result suggested a difference between childhood trauma and substance misuse amongst men and women who are incarcerated (Marotta, 2017). Women reported more sexual abuse while men reported more physical abuse (Marotta, 2017). Marotta (2017) also stated that implementing trauma informed practices into the exciting practices and modalities are suggested. The study also suggested changes to current assessment to further explore childhood adversities to help implement trauma informed practices (Marotta, 2017). The last suggestion was the integration into the community using trauma informed practices to help alleviate recidivism (Marotta, 2017). Marotta also concluded that childhood adversities influence the development of substance use in offenders. Effective treatment for substance misuse in corrections based around trauma-informed practices are needed through assessment, treatment programs, and correctional health policies and after care treatment (Marotta, 2017).

Types of Trauma Therapy

Somatic Therapy

At work, we have six goats. What is odd is that we have one goat, that when startled it freezes up stiff and falls over. It is amazing to see this, as I have never witnessed a goat doing that before. Once the goat feels safe and the threat is gone the goat resumes as normal. PTSD can work in the same way in which PTSD can inhibit the appropriate defence responses (Grabbe

& Miller, 2018). Somatic psychotherapy believes that trauma affects the body as much as the mind and that the Autonomic Nervous System (ANS) overactivation permits trauma to continue through the body (Fisher & Ogden, 2009). For years, there has always been knowledge and research to substantiate the relationship between autonomic dysregulation and PTSD (Fisher, 2019). When a person is affected by trauma, the prefrontal cortex of the brain puts the body in a state of flight or fight (Fisher & Ogden, 2009). This happens when a person is presented with a traumatic or stressful situation; the brain activates a stress response system called the Autonomic nervous system (ANS) which is responsible for the physiological changes through what is called the sympathetic and parasympathetic nervous systems (Perez-Gavino, 2021). Somatic therapy believes that addressing the trauma by focusing on the changes in the body from the activation of the ANS which is called a bottom-up process (Marzillier, 2014). Somatic therapy believes that the body's neurological system is important to understanding and releasing the trauma (Marzillier, 2014). When there is trauma, people can experience a hyperarousal state or a hypo-arousal state. Somatic psychotherapies seek to re-establish what is called the window of tolerance. Window of tolerance as a zone between the hyper arousal zone and the hypo arousal zone which is the zone of optimal state (Ogden et al., 2006). Somatic therapy is based on the theory of window of tolerance, the polyvagal theory, and the bottom-up approach.

Bottom-Up vs Top-Down Therapy

Top-down therapy means addressing the emotions and the cognitive process to modify behaviour and the bottom-up therapy addresses the body sensations and patterns to modify change and awareness (Mulloy, 2019). The bottom-up processing means that it is a fast pathway that uses the thalamus to send messages through the limbic system to the brain and nervous system which does not activate the frontal lobe of the cortex (Field, 2019). The bottom-up

process happens when there is threat and the body and brain need to act quick (Field, 2019). The Top-down approach is a slower process that is for decision making using the frontal lobe (Field, 2019). Field states therefore sometimes people have difficulty thinking before reacting (Field, 2019).

Window of Tolerance

The exposure to trauma can stimulate autonomic nervous system (ANS) which can result in a hyper or hypo arousal state (Corrigan et al., 2011). Dan Seigel came up with a model called window of tolerance in he states that it is a state in which optimal arousal in which the body and the mind is at optimal state to tolerate emotions and learn from experiences (Corrigan et al., 2011). This is a state where the ANS is regulated and allows for functional responses. Someone who experiences trauma could become dysregulated and might not have the ability to handle the emotions that are experienced. The person can be then having a dysregulated state. This can place a person in a hyper-arousal state in which the brain can shut down and has the inability to learn skills that will support recovery of the trauma cognitively (Ogden et al., 2006). Behaviour such as heightened sensitivity, impulsivity and self-protecting behaviours are common behaviours of the hyperarousal state (Ogden et al., 2006). Clients with trauma might also experience a hypo-arousal state in which a person might show signs of withdrawal, timid, passive or lack of sensation (Ogden et al., 2006). The window of tolerance is a state that allows the mind and the body to adjust, regulate emotions and execute cognitive functioning (Ogden et al.,2006).

Polyvagal Theory

Somatic experiencing therapy uses the polyvagal theory as a basis of its therapy. Polyvagal theory is focused on the origin of the brain that regulates the social and survival

defence mechanism and the physiology of the nervous system that provide sub trades of emotional and affective processes of social behaviours (Porges, 2001). Polyvagal theory has three phylogenetic systems, the vagal brake, evolution and dissolution, and the social engagement system (Porges, 2001). The autonomic nervous system, which regulates and monitors the organ in the body (Perez-Gavino, 2021). This autonomic nervous system has three states which are the safe state (Ventral Vagal) in which the body is calm, connected, and relaxed (Perez-Gavino, 2021). Secondly, the mobilized state (sympathetic system) in which the autonomic nervous system perceives threat and engages flight or fight response (Perez-Gavino, 2021). Third is the immobilized state (Dorsal vagal) which is considered the freeze state. Polyvagal theory calls these states within the autonomic nervous system the Ventral Vagal state, the sympathetic state, and the Dorsal vagal state (Perez-Gavino, 2021). The ventral vagal state is when the body feels connected, safe and relaxed (Perez-Gavino, 2021). Everything is good and comfortable. No perceived threats and the body's nervous system is managing and handling well (Baxter & Sukie, 2020). The sympathetic system is the state where there is a perceived threat or stress, and the body goes in a flight or fight mode (Baxter, Sukie, 2020). The importance of this stage is to mobilize when there is stress or threat. The body is compounding stress and is trying to manage the threat (Baxter, 2020). In this state the body can experience health problems, anxiety, or panic for a prolonged period. For example, if my brother crossed a boundary of mine, I would go into the Sympathetic stage and set the boundary with my brother. After I set that boundary, I will move back into ventral vagal if the threat disappears or the boundary is respected. However, if my brother did not respect the boundary, then I would remain in the sympathetic stage or possibly move to the dorsal vagal stage. The dorsal vagal state is the immobilization state where the body shuts down for protection (Baxter, 2020). For example,

when a person is facing a threat such as a cougar or a lion, the ANS can deploy a freeze response that can inhibit a defence response that might better suit the situation for establishing safety. It is a primal protection that can show up in a state of collapse or in a freeze response (Baxter, 2020). It will conserve energy for the basic functions. It is in a state of sleep, slow down and repaired. This is related to inability to self-motivate and the feeling of hopelessness and shame (Baxter, 2020). the body will move back and forth through life challenges from the ventral vagal, sympathetic system and the dorsal vagal (Baxter, 2020). Therefore, when the body is in the sympathetic activation system (flight or fight) for a long period of time the body cannot sustain that state (Baxter, 2020). After time, the dorsal vagal state will take over to protect the body (Baxter, 2020). This is accomplished through what is called the Vagal brake. The vagal brake is part of the autonomic nervous system which helps to regulate between the different states (Maguire, 2020). The idea is if I was offended by my brother, instead of moving quickly to the sympathetic state of fight or flight to the point of physical fight immediately. The vagal brake would activate to slowly move to the sympathetic state enough to allow me to communicate my concern and not go directly to flight or fight. A healthy nervous system would help the vagal brake engage just enough to address the problem or stress and slow us back down, however, if we experience trauma, our nervous system can completely release the Vagal brake and place us into a fight or flight response. At this point, we can go into the dorsal Vagal state in which the body shuts down or protects itself. The key is to learn how to apply the vagal brake to go at the appropriate speed to the conditions we are facing (Maguire, 2020).

Sensorimotor Psychotherapy

Pat Ogden believes that trauma affects the body (Ogden & Minton, 2000). Traditional psychotherapies address the cognitive and emotional pieces of trauma however neglects the

physiological elements of trauma (Ogden & Minton, 2000). Sensorimotor psychotherapy focuses on physiological effects of trauma as well as the psychological effects of trauma (Fisher, 2019). Sensorimotor psychotherapy is using the therapist relationship to regulate sensorimotor state and by self-regulation through mindful, tracking and articulating sensorimotor processes (Ogden & Minton, 2000). The sensorimotor processes of the body are the target by the awareness of the cognitive process and the sensorimotor process to interrupt the somatic narratives with the long-term memory of the autonomic nervous system (Masero, 2017). The idea is to have the client build an awareness of interbody awareness of physical feelings such as clamminess, tightness, numbness, tingling and vibrating sensations (Ogden & Minton, 2000). So instead of focusing on verbal talk therapy the client is asked to focus on mindfulness around the sensations in the body (Fisher & Ogden, 2009). Ogden and Minton (2000) state that when asking a client to describe how they are feeling, they describe emotional states such as terror or fear instead of the sensations that are happening in the body and mind. Sensorimotor psychotherapy tries to focus on the sensations that are happening in the body like tingling, tightness, and numbness to understand whether the hyper or hypo arousal state are apparent and to help the client achieve a window of tolerance. The therapist wants the client to pay close attention to the automatic reactions and notice the automatic responses, which help the client recognize patterns of movement, physical response, reactivity, and posturing that are associated with thoughts, beliefs, and emotions (Fisher, & Ogden, 2009). With continued focus and drawing attention to these automatic reactions of the body and the relationship between thoughts, beliefs and the body responses the client can start understanding how these responses can reinforce beliefs of helplessness and hopelessness (Fisher, & Ogden, 2009).

Somatic Experiencing

Peter Levine somatic experience (SE) takes a unique therapeutic approach to PTSD in which it integrates a body awareness through psychotherapeutic process (Brom et al., 2017). Peter Levine draws heavily on the Polyvagal theory in which the body lives in a fear-based immobilization state called the Dorsal Vagal from a traumatic event (Levine, 2010). SE believes that PTSD is a result of stress and an incomplete defence reaction to a traumatic event (Brom et al., 2017). SE also believes that the body needs biological completion after a traumatic event to achieve a state of ventral Vagal (Levine, 2010). SE is also a bottom-up approach to addressing PTSD. This means that the SE therapy is a body-oriented therapy that focuses on the symptoms of PTSD (Kuhfuß et al., 2021). Its focus is to start by calming the body and building safety before focusing on the mind. SE believes that PTSD is an overreaction of the innate stress system from a traumatic event in which a person is unable to initiate the body or the mind's defence system (Kuhfuß et al., 2021). Peter Levine states "by understanding the biological nature of fear we are able to grasp the very taproot of trauma" (Levine 2010) The client is focused on the internal sensations of the body then the cognitive or emotional experience (Kuhfuß et al., 2021). SE therapy helps to reduce the arousal state that comes from a traumatic event by increasing the tolerance, acceptance, and awareness level of the sensations from the body (Kuhfuß et al., 2021). SE also approaches trauma memories indirectly and gradually which avoids the re-traumatisation to the client (Kuhfuß et al., 2021). A study by Kuhfuß et al. (2021) showed SE was effective in reducing symptoms from PTSD and improved quality of life.

Trauma Informed Practices

Pringer and Wagner (2020) stated that research has been starting to explore trauma that affects incarcerated offenders whether they are in jail or before they are incarcerated. Pringer and Wagner (2020) also stated that the DSM definition of trauma is,

> trauma is a stressor in an individual's life, such as exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence. Individuals may experience these stressors through direct exposure (e.g., witnessing or learning about exposure of a close friend or relative) or indirect exposure (e.g., listening to another person talk about past traumas or engaging in discussions about traumatic experiences (p.52).

King (2015) did a study on trauma informed interventions with women that are incarcerated. King's definition of trauma is an event that an individual experiences that reduces the ability to cope with the event or brings feelings of fear, hopelessness, and despair. The definition of trauma-informed interventions are practices that promote the awareness and influences, acknowledgment, and recovery from the trauma. King also stated that trauma informed interventions have been established however, it is undetermined and needs more exploration of the most effective intervention. King's objective in this study is to review the experimental, quasi-experimental and pre-test/post-test studies around trauma informed practices. The review did a search in electronic databases such as PsycINFO, Social Sciences Full-Text, Academic Search Complete, ISI Web of Science, and PubMed. The researcher did a complete review of all women that are incarcerated with trauma or abuse and located all outcomes of trauma informed practices with them. The criteria that needed to be met was that the research that was used needed to have random controlled studies, studies with pre/post-test and quasi-experimental studies. All participants had to be over age. The primary focus of the intervention was manualized, and trauma focused which also included mental health and substances use measures (King, 2015). Lastly the articles were peer reviewed and written in English around women that are incarcerated in the U.S. There were 414 articles that were retrieved which were broken down

to 225 (King, 2015). Of the 225 articles, only nine articles met the inclusion and exclusion criteria (King, 2015). Four interventions that were manualized – seeking safety, helping women recover/beyond trauma, esuba, and beyond violence were reviewed. The limitations to this review were that random assignments to find participants for treatment were only used in three studies. Five of the studies used a comparison group but no studies used a control group (King, 2015). The articles that were reviewed were only English written articles and only in the U.S. The review did not include a meta-analysis. Results of the study stated that trauma-informed practices had a positive impact on trauma symptoms and the interventions used had a positive change to the participants in the studies.

A randomized control study by Van Damin et al. (2013) discussed if combined intervention for post-traumatic stress disorder (PTSD) and substance use disorder (SUD) are effective using a combination of trauma focused treatment and Cognitive Behavioural treatment. They found that Structured Writing Therapy (Trauma Focused) in combination with cognitive Behaviour therapy was effective with PTSD and SUD (Van Damin et al., 2013). Calleja did a study in 2020 pertaining to treating and assessing trauma in adolescent offenders and the efficacy of Trauma focused Behaviour therapy (T-F CBT). They used a sample population of 117 adolescent offenders that were residing in two structured treatment centres (Calleja, 2020). All participants were male while 65.8% were African American, 29.9 % were Caucasian, 3.4% were mixed race and 0.09% were Asian (Calleja, 2020). They had an age range of 13 years old to 18 years old (Calleja, 2020). They used *The Trauma Symptom Checklist for Children* (TSCC) to assess the presence of trauma symptoms. All participants were involved and detained by the juvenile justice system (Calleja, 2020). They used nineteen master level clinicians to implement the therapy. Each therapist had a caseload of 10 participants and strictly worked one on one with

each participant to avoid distractions and disruptions (Calleja, 2020). Every therapist participated in the same on-line training on T-F CBT (Calleja, 2020). The finding of this study was that T-f-CBT was effective in treating adolescent inmates by the reduction of trauma symptoms from pre-treatment to post treatment (Calleja, 2020). There is a need for standardized assessment of trauma symptoms and treatment programs as a result of long-term adverse effects from untreated trauma symptoms (Calleja, 2020). Lastly, Calleja (2020) found that limited participation by the caregiver in the treatment process has little effect on the reduction of trauma symptoms in the participants.

Although trauma informed practices have been well documented there is very little documentation around trauma informed forensic mental health assessment (Goldenson et al., 2022). Goldenson et al. (2022) state that the mental health evaluators have a difficult time distinguishing between the clinical and forensic roles. This means when a probation officer who does a pre-sentence report on an individual that is in a criminal justice system, they have to retrieve sensitive and traumatic history information from the individual and many times can trigger a traumatic reaction from the individual. Goldenson, et al. also state in the article that Therapeutic jurisprudence (TJ) is a school of thought that questions psychological-legal professionals should change their practice to avoid re-traumatizing correctional individuals without affecting the legal and clinical process. TJ recognizes the need for trauma informed mental health assessment for correctional individuals (Goldenson, et al., 2022).

Trauma Informed Training

Trauma informed training is essential to implementing trauma informed practices. Most people seeking mental health services have a history of experiencing trauma therefore sometimes trauma is not evident within the client's issue and can often be overlooked (Nation et al., 2022).

Issues like substance use, social difficulties, paranoia, and criminal activity can be secondary manifestations of trauma therefore the idea of trauma Informed care is to develop principles of safety, trustworthy, choice empowerment and collaboration (Nation et al., 2022). Trauma informed training is not effective standing on its own. It requires a systematic approach in which the whole organization encompasses routine clinical practices around Trauma informed Practices (Nation et al., 2022). The difficulties of implementing Trauma informed care in any organization is establishing trauma informed culture within the organization, the dominance of clinical or medical models, and misconceptions (Nation et al., 2022). Nation et al did a mixed-methods study whose aim was to evaluate the improvement around trauma-informed care across eight rehabilitation teams in Australian mental health services (Nation et al., 2022). The results were that trauma informed training was necessary however not enough to establish routine care systematically within the organization and that a commitment systemically is imperative for implementation of trauma informed care (Nation et al., 2022). Palfrey et al. (2019) states from past research that mental health clinicians are aware of the client's trauma; they are reluctant to screen or enquire around the client's trauma symptoms. They state that the lack of education at the undergraduate level has contributed to the clinician's confidence in addressing trauma (Courtois & Gold, 2009 as cited in Palfrey et al. 2019). Palfrey et al. (2019) study is to assess whether a single day workshop around trauma informed care single day workshop increases awareness, attitude, and self-confidence towards working with clients with trauma history. The study also wants to see if it reduces the reluctances and berries towards clients with trauma history (Palfrey et al., 2019). They also want to explore the clinical characteristics of the training, the changes in practices and additional training needs (Palfrey et al., 2019). As a result of the study, there was an increase in self-confidence, awareness and attitude around assessment and

treatment of clients with adversity and trauma history (Palfrey et al., 2019). The participants of the workshop also showed more of a willingness to incorporate a trauma history into the assessment and more confident to address the trauma in the treatment plan (Palfrey et al., 2019).

Substance Abuse and Mental Health Services Administration (SAMHSA) states that a multifaceted, systematic, multilevel approach around awareness and understanding of trauma is crucial to implementation of a trauma informed perspective when dealing with clients with trauma (SAMHSA, 2014). SAMHSA also states that the organization and institution programs and assessments that are meant to help are at the same time trauma inducing such as the intimidating practices of the criminal justice system (SAMHSA, 2014). SAMHSA has developed a trauma informed care approach that can work for an array of services (SAMHSA, 2014). They approach this by using research, practical knowledge from the providers and information from trauma survivors (SAMHSA, 2014). The concepts that SAMHSA suggest are the Event, experience, and the effect which are called the three E's (SAMHSA, 2014). The event is what has happened that caused the trauma which could be a single or recurring event (SAMHSA, 2014). The experiences are what the client has experienced from the event. This experience can be different from each individual (SAMHSA, 2014). The effects refer to the adverse effect from the Traumatic event. These effects could be immediate or delayed, they could also be short or long lasting (SAMHSA, 2014). SAMHSA also introduced the Four R's concepts which are Realization, Recognize, Respond, Resist (SAMHSA, 2014). Realization means to have knowledge and understanding as a clinician and an organization about trauma (SAMHSA, 2014). Recognize means to be aware and have the understanding as a clinician and organization of the signs of trauma (SAMHSA, 2014). Response refers to clinician and organization response to clients with trauma (SAMHSA, 2014). The ability to respond by the language, behaviours, and

policies to reflect trauma informed care. Resist means for clinicians and the organization to resist the attitude or language that could re-traumatize a client (SAMHSA, 2014). SAMHSA also introduced 6 key principles that a clinician should follow to establish a trauma informed care practice. These principles are (a) safety; (b) (Maguire, 2020). trustworthiness and transparency; (c) peer support; (d) collaboration and mutuality; (e) empowerment, voice, and choice; and (f) cultural, historical and gender issues (SAMHSA, 2014). SAMHSA suggests that change needs to happen in a multifaceted approach in all levels of the organization using these 6 principles (SAMHSA, 2014). SAMHSA guidance to a multi- level approach is introduced in the ten domains of the organization (SAMHSA, 2014). These domains are,
a Governance and leadership b. Policy c. Physical Environment d. Engagement and involvement e. Cross sector collaboration f. Screening, assessment and treatment services g. Training and workforce development h. Progress monitoring and quality assurance i. Financing j. Evaluation (SAMHSA, 2014). In conclusion SAMHSA has provided a framework to promote and establish trauma informed care into a multi-level organization to help benefit not only the clients but the organization as a whole (SAMHSA, 2014).

Conclusion

Changing the way, we address offenders and help reduce recidivism starts with changing our perspective and stigma of offenders in the correctional centres. First, the importance of changing the stigma around substance use to a health care perspective can help reinforce trauma informed care. Second, training for both correctional staff and health care staff around trauma informed care is needed. Thirdly, practices need to be implemented that are focused on trauma

informed care including therapy that is used to help address mental health and substances use by both the correctional staff and the health care staff. Four the systematic approach of trauma informed care is imperative to the continuation use of trauma informed care among staff for the offenders. Finally, there is a need to have continuous community transition of the practices and therapy that they receive in the correctional centers.

Chapter 3: Discussion and Application

Introduction to Workshop

As suggested in these literature reviews, people who engage in criminal behaviour have a high rate of childhood adversity. It also shows the importance of a trauma informed approach for the offenders that have experienced high childhood adversity. Offenders who have experienced childhood adversities show higher rates of substance use and the number of offenders who have substance use issues in corrections is rising. This literature review clearly shows the need to have better assessments and approaches geared toward trauma informed practices along with community integrations for offenders to have a higher percentage of success and low rate of recidivism. The importance of establishing training around trauma for the correction of personal and healthcare staff around trauma informed care and practices. The acknowledgement that more efficient training around trauma will help the correctional and health care staff reduce altercations and promote unity, empathy and connection with the client or inmate. The literature also shows that a systematic approach to trauma informed care can be impactive and enhance sustainability of the individual practices. The importance of implementing and providing continual training around trauma informed practices for correctional and healthcare personnel would change the idealism and stigma around clients that are incarcerated and alleviate the negative behaviour and responses from these clients.

Currently there is trauma informed care training for correctional staff in both federal and provincial corrections systems. However, what I found is that the trauma informed care training is limited, and more emphasis is spent on security and constraint of the inmates. As I stated earlier in the paper correctional officer are focused on security and safety of the prisons therefore the mentality that is adapted by correctional officers is an us against them attitude. The inmates

often say “me against the officers, red against blue”. This mentality is also adapted by the correctional personal and healthcare staff. It is almost impossible to work a trauma informed care practice with this kind of mentality. Therefore, from the information and the literature I proposed to create a workshop that will help correctional officers and healthcare staff understand trauma informed care and possibly bring some awareness to the negative mentality and sigma that causes a negative and untherapeutic atmosphere. The workshop is to help correctional officers and health care staff establish some skills and awareness around trauma informed care as to use when working with difficult clients that could possibly be experiencing trauma responses.

This workshop will consist of a facilitators guide, a participation book, and a power point. The workshop was designed for a full day session. The workshop uses psychoeducational, processing, and roleplays to help create a further understanding of trauma informed care. Using the information from the research from the paper, the workshop will discuss what trauma is along with the different types of traumas. The workshop will also talk about the stress responses, signs of trauma responses, and the impacts of trauma. It will cover PTSD and addictions related to trauma. The second half of the workshop will focus on trauma informed care and how to implement trauma informed care in our worksite. The last part of the workshop will focus on a trauma informed care action plan. The idea of the workshop is to have the participants engaging in new ideas and concepts through interactive discussions and process. The workshop is designed to address different types of learning style from the booklet, PowerPoint, discussions and role plays to videos that support the information.

Participation Book

The importance of this workshop is to establish safety first and fore-most. The workshops establish safety at the beginning to create a positive and safe learning environment. In the workshop the participants come up with the group norms as a group through discussion. The discussion about triggers to self from the material of workshop and coming up with positive management skills is important. The participation book was designed for the participants and if the facilitator can help to bring participate ownership to workshop brings a more positive learning environment. It is a workbook that covers the material around trauma informed practice in the course. It is encouraged that the participants use the book during the workshop to follow along with the presentation and to reinforce the learning process in the workshop. The participating book can be used for a wide range of level of education and is easy to read and understand. The material is also reinforced by group discussions, roleplays, PowerPoints, and videos. The idea is to accommodate all types of learning styles. After establish group norms and discussion around safety we introduce the agenda and how the day is laid out with the idea that the participates can offer small suggestions of change keeping in mind that we need to keep to a basic format to cover all the information. This will take us to the first break of the day. After the break we will start to discuss some of the definition of trauma and what trauma is. We will also discuss type of trauma, trauma responses signs of trauma and types of traumas. We also discuss PTSD and the relationship between trauma and substances and alcohol use. By this time, the participates should be ready for lunch. After lunch we will start to talk about trauma informed care, what is the meaning and what it is. We will discuss how to implement trauma informed care. This will take most of the afternoon with some breaks in there. The last part of this workshop is based on coming up with a trauma informed action plan. This is done by breaking

participates off in groups of three and using a scenario to come up with a plan. One group will be a correctional officer plan another group will be a health care employee plan and the other group will be a community probation officer plan. This will help to put all the information of the day together and help to solidify the information. This will be presented in class along with discussion.

Facilitators Guide

The facilitators guides will give explicit instructions to the facilitator on how to deliver this program. This facilitators guide was constructed on the idea that any facilitator that has been trained and understands the material will deliver this program with fidelity and fluency. Within the facilitators guide are time increments to help keep the workshop on track. It also has instruction on group activities and how to execute and process the activities with the group. The facilitators guide also offers more information on presenting topics along with references and you tube video links. This guide should consist of enough information that a facilitator would have the pertinent information to walk in and facilitate the group.

Power Point

The other part of this program consisted of a PowerPoint presentation that accompanied the participation book. It helps to accommodate the different learning styles of the participants in the workshop. The PowerPoint follows the participant's book to help the participant and the facilitator to follow along with the workshop.

Through the literature review and my personal experiences of working in corrections as a therapist, this workshop should help to expand the knowledge of trauma informed care and bring awareness around another’s past trauma experiences, child adversities and PTSD. The hope is to bring a new mindset and understanding to correctional offices and healthcare staff that deal with

correctional inmates around past trauma and experiences. In helping to educate correctional staff and health care staff the hope is to reduce aggression and possibly promote healing and wellness within correctional inmates.

Limitations

This workshop is based on the information and research from this paper however the workshop has never been conducted or facilitated. It is encouraged to have some trial workshop sessions with participates to evaluate the effectiveness of the workshop. It is recommended that a questionnaire be constructed for the participants at the beginning of the workshop and at the end of the workshop to evaluate the legitimacy and effectiveness of the course. This workshop has been constructed for the pure purpose of this paper and adjustments to the content or structure of the workshop could be a possibility for its effectiveness.

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Appendix A

Trauma Informed Care for Corrections Participant Book

By George Lemyre

Welcome to the trauma informed workshop

Facilitator instructions

House Keeping

_____

_____

_____

Introduction Activity

Do introduction exercise with group

Have group break up in pairs and interview each other

Name

Place of employment

Where they are from

Any prior training around trauma informed practice

Three things about the person

What you hope to learn from the course

Introduce your person you interviewed

Agenda

- Establishing group norms
- Safety
- break
- What is Trauma
- Types for trauma
- Stress response
- Signs of trauma response
- Impact of Trauma
- What is PTSD
- Trauma and addictions in corrections
- Exposures to trauma
- lunch
- What is trauma informed care
- How to implement trauma informed care
    - a three E's
    - b Four R's
    - Six principles
- Break
- Trauma informed action plan
- Wrap up

Activity on Group Norms

Awareness of the nature of the material and taking care of yourself

Respecting others

Keeping confidentiality

Awareness of the personal information shared and how it could affect others

Safety

Trauma could be a sensitive topic and that their own experiences could be triggered.

A person that has experienced past trauma may be triggered and feels the need to share their personal experience.

Others may withdraw and go quiet. Setting ground rules around how to keep yourself and other safe is important

Class discussion around how to keep myself and everybody safe through this course

Introduction exercise

Discussed how their employment or practice would benefit from greater awareness of others/ client's trauma history.

Would greater awareness of trauma or adversities help benefit you in your daily practice.

Break

What Is Trauma

The Merriam Webster dictionary defines trauma as a psychological or emotional stress that can cause mental and emotional issues (Merriam-Webster).

Substance Abuse and Mental Health Service Administration (SAMHSA) definition of trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (Huang et al,.2014).

2 in 3 children will experience a traumatic event by age of sixteen

People that are of color, women, poverty, and martialized gender communities are more likely to be impacted by trauma events or adverse experiences

Adverse childhood experience impact how we see and experience the world

Trauma comes from experiences that are overwhelming and inhibit our ability to cope

Trauma experience can come from one-time event to events that are consent exposure to trauma events

Understand that childhood adversity is common in a high percentage of inmates. Exposure to more than one type of trauma events is high

Types for Trauma

Acute trauma: one time trauma event Eg: single accident, natural disaster

Chronic Trauma: ongoing exposure to a trauma event that is repeated and prolonged, example: family violence, bullying,

Complex trauma: Exposure to multiple trauma events for a long period of time, example: ongoing physical, emotional, and sexual abuse, Neglect.

Historic trauma: collective and cumulative trauma experiences, example: Residential Schools. Racism,

Systematic oppressions.

Stress response system

We have an alarm system in our body that protects and keeps us safe

Our brain activates our autonomic nervous system in our body when there is a perceived threat

Sensorimotor therapy

The autonomic nervous system has three states

Hyperarousal states: body and mind in heighten sensitivity, impulsivity, and self-protecting behaviours

Window of tolerance state; The mind and body have ability to regulate emotions and execute cognitive functioning.

Hypo-arousal state; withdrawal, isolation, passive and timid

Video

https://www.youtube.com/watch?v=7cben51_kEg

Break

Polyvagal Theory.

The autonomic nervous system consisted of the

Ventral Vagal: The body is relaxed, calm and connected

Sympathetic system: This stage the body perceived threat, engages fight, flight, importance of this stage is to mobilize when perceived threat.

Dorsal vagal: is the immobilization stage where the body shuts down

Stress can become traumatic

Trauma triggers can activate the autonomic nervous system

Responses to these triggers could be mis-understood

Video

https://www.youtube.com/watch?v=zYvZUorQbrg&t=94s

Break

Signs of trauma response

• Sweating

• Change in breathing (breathing quickly or holding breath)

• Muscle stiffness, difficulty relaxing

• Flood of strong emotions (e.g., anger, sadness, etc.)

• Rapid heart rate • Startle response, flinching • Shaking

• Staring into the distance

• Becoming disconnected from present conversation, losing focus

• Inability to concentrate or respond to instructions • Inability to speak

(Huang et al., 2014)

Impact of Trauma

Environment Factors that impact a client's response

Individual factors that affect a client's response

Correction and health care personal play a key role on preventing and reducing stress in their clients.

Impacts on staff that has continuous exposure to clients with trauma

1. Secondary trauma: the emotions stress that comes from hearing another person's experience of traumatic event or events
2. Vicarious trauma: the trauma from clients that accumulates on the caregiver

3. Compassion fatigue: desensitized to the cumulative exposure to trauma
4. Burnout: exhaustion because of prolonged stress Physically, emotionally, mentally, and spiritually

What is PTSD

Posttraumatic stress disorder (PTSD) is a mental health disorder. PTSD means the mental health issues that develop after a trauma event that affect day-to-day activities and mental health wellness (Williams, 2020).

Symptoms of PTSD

Avoiding,

Change in beliefs

Change in feelings

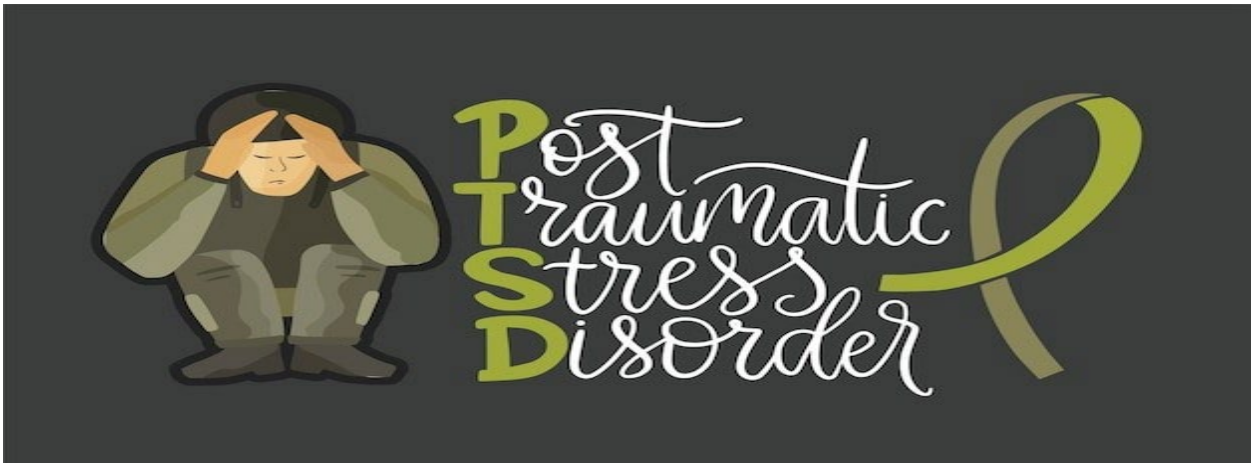
Flashbacks

Re-experiencing

Numbness

Hyper aroused

Hypo aroused



Trauma and Substance/Alcohol use in Corrections

- The connection between trauma/PTSD and substance/alcohol use is very well documented and a high percentage of inmates with substance use has trauma.
- Individuals that engage in a lifestyle of substance and alcohol use is more susceptible to trauma
- addressing the misguided stigma around substance use in correctional centres and focusing on the health aspect along with adverse trauma will help reduce the prevalence of substance use in the correctional centre
- correctional centres are windows of opportunities to address adverse trauma and implement treatment interventions for substance use issues
- The Canadian Centre on substance abuse reports that 51% of inmates have alcohol problems and 48% of inmates experience substance use problems (Canadian Centre on Substance Abuse 2004).
- Of those offenders with severe problems, 97% reported that they used on the day of the offence; 87% reported that substance abuse was associated with their crimes over the course of their criminal history (Canadian Centre on Substance Abuse 2004).

- effective treatment and therapy in a trauma to address the childhood adversities and addiction issues while in custody or after custody would not only affect the recidivism of crime but the recidivism during incarceration

LUNCH

What is Trauma Informed Care

The definition of trauma informed interventions are practices that promote the awareness and influences, acknowledgment, and recovery from the trauma (King 2017).

Trauma informed care is an understanding that every person we encounter could be experiencing some level of trauma

Trauma informed is about creating an environment that helps move a client from a Sympathetic or dorsal state to a ventral state.

Interact with the client with compassion and care

Reduce the risk of traumatization

Video

https://www.youtube.com/watch?v=-876Zw-NA94

How to implement trauma informed care

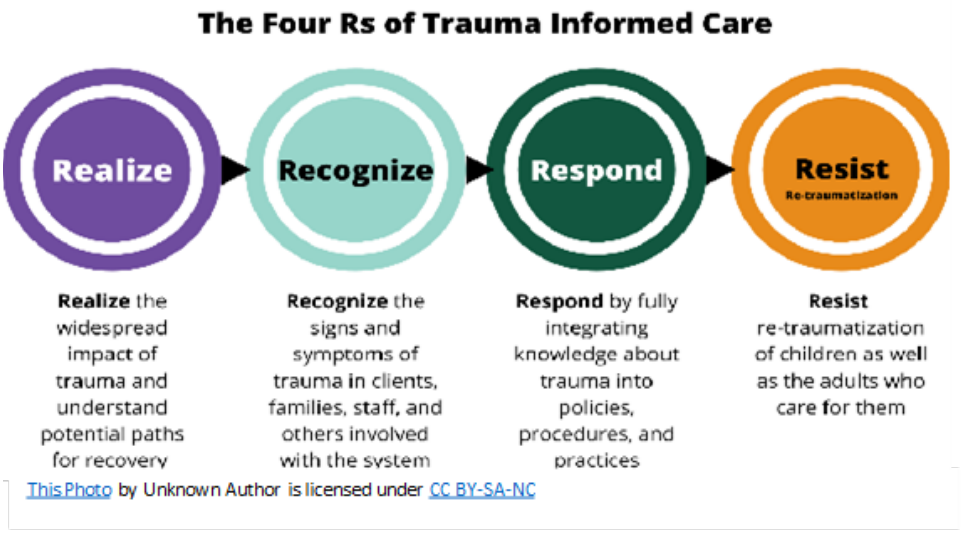
Three E ‘s of trauma informed care

Event: The event is what has happened that caused the trauma which could be a single or recurring event

Experience: The experience is what the client has experienced from the event. This experience can be different from each individual

Effects: The effects refer to the adverse effect from the Traumatic event. These effects could be immediate or delayed, they could also be short or long lasting

Break



Realization

Realizing that trauma is prevalent and the effects it has on family, groups, and communities.

Realization that there are multiple paths to healing from trauma.

Recognizing

The symptoms of trauma in the individual. How the impact of trauma effects the individual. Trauma impact the body and the nervous system. They could experience Physical medical conditions that could be related to trauma.

Symptoms of PTSD

- Changes in arousal and reactivity
- Nervous system continues to overly arouse and reactive
- Sense of hyperarousal
- Lake of safety

Intrusive images and re-enactments

- Nightmares
- Thoughts
- Flashbacks
- Re-experiencing
- Negative Changes in mood and beliefs systems

Trauma impact beliefs about ourselves

- Shame
- Avoidance
- Avoiding feeling about trauma
- Avoiding talking about trauma

Responding

Putting practices in place to reduce the trauma using Six principles of trauma informed care

Safety- ensuring physical and emotional safety, calmness to avoid hyperarousal, establishing relationship

Trustworthiness- predictability, accountability, clarity

Empowerment – allowing the client to be the expert, giving client control over change, offering choice, build upon client's strength

Collaboration- clients are part of the decision making and the team, allowing clients perspective, and inviting questions

Peer support- connecting clients to supports, community, family. Connecting client to information through resources.

History, gender, and culture- recognizing and moving past stigmas, stereotypes, and biases, recognizing historic trauma,

Resist

Resist re-traumatisation of the clients and the staff.

Trauma can be inflected intentionally by systems, policies, and language.

Practices and structures that are focused on not harming client any further.

Trauma informed action plan

Preparing for trauma informed Practice:

- self-awareness, trauma awareness, understanding. Language, building relationship rapport, shift in thinking and language

Engagement:

- apply the six principles into action

Asking about trauma:

- engage and build relationship when assessment and screening
- consider the need for the information collected and if it benefits the client's care
- keep conversation safe
- offer choices and emphasize client's autonomy
- establish sense of safety
- give rationale for asking question around history and trauma
- Normalize the reactions from discussing trauma
- Recognize signs and symptoms
- Balance the assessment process with engagement
- Limit the number of questions ask in a row
- Use judgement of when to ask and not ask questions
- Use nonjudgmental terms
- Awareness of cultural considerations

Making links

- Adjusting information shared with clients to a more trauma informed way
- Consisted of age, race, culture, stage of development, experiences, type of trauma, and the capacity to understand
- Destigmatize and normalize the trauma

- Emphasizing

  resiliency and hope.

  It is not their fault.

  You are not alone

Skill building and empowerment

- Notice self-internal reactions
- Awareness and sensitivity of the client's body Responses and the words they use
- Use grounding techniques and supports
- Be present with the client
- Remain calm in voice and tone
- Help them recognize what is happening to their body in the moment
- Ask for help

Break

Marks is a 35-year-old male. He has been sentenced and incarcerated for thief under, possession of stolen vehicle. Fleeing the police and possession for the purpose/ trafficking charges. He has an extensive criminal record and spend many times incarcerated both juvenile and adult. Mark is first nations. He has never lived on his reserve. His mother has addiction issues. He had never known his father. His mother had many men in her life. Mark states that he was physically abused by most men in his mother's life. Mark also states that he was physically and sexually abused while in the care of the ministry. Mark struggled in school and only completed grade 8 education. His mother passed away from a drug overdose when he was 16 years old while he was in the

custody of the ministry. Mark was involved in Gangs and sold drugs. Mark ran away from his group home many times. When Mark aged out of the ministry, he had no place to live. He sold drugs and stole cars to get by. Mark was also involved in the Gang lifestyle as an adult.

Group activity

Break

Wrap up

What is one thing you can take away from this course

What was your experience from today course

Notes

_____

_____

_____

_____

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Appendix B

Trauma Informed Care for Corrections Facilitator Guide

Facilitator Guide

By George Lemyre

Trauma Informed Care

for Corrections

Start 8:00 am

Welcome

2 min

-welcome everyone for participating in this group

- affirm and thank participants for taking time out of their busy schedule to participate in this workshop

Introduction

2 min

- Instructors' introduction

Name

Employment

My role

My experience as a trainer and credentials

Housekeeping

1 min-

-Locations of the exits

-Locations of the washrooms

Introduction exercise

20 min

-Have group break up in pairs and interview each other

Name

Place of employment

Where they are from

Any prior training around trauma informed practice

What you hope to learn from the course

-Introduce the person you interviewed

Introduce the agenda

2 min

Establishing group norms

5min

Safety

15min

15 min Break 9:00-9:15

What is Trauma

20min

-Talk about the proposed definitions and group discussion around definitions

Types of Trauma

20 min

-Talk about Acute, Chronic, Complex and Historic trauma

Stress response

20 min

-Discussion around the body's alarm system

-discussion around atomic nervous system

15 min Break 10:15-10:30

sensorimotor therapy

20 min

-Hyper-arousal meaning

-Window of tolerances meaning

-Hypo-arousal meaning

Video

https://www.youtube.com/watch?v=7cben51_kEg

Poly vagal theory

20 min

-Ventral Vagal meaning

-sympathetic system Meaning

-Dorsal Vagal Meaning

Video

https://www.youtube.com/watch?v=7cben51_kEg

signs of trauma response

10 min

-discussion around signs of responses from trauma

Impact of Trauma

20 min

-Environmental Factors

-Individual Factors-Impacts of the system or individual that is continuously exposed to a trauma setting

Secondary trauma

Vicarious Trauma

Compassion trauma

Burnout trauma

What is PTSD

10min

-Discussion around PTSD and what it is

- Talk about symptoms of PTSD

Trauma and substance/alcohol use

10 min

-Discussion regarding the connections between Trauma and substances/alcohol use

-Stigma of addiction and trauma

- windows of opportunity

-effective therapy

45 min Lunch 12:00-12 45

What is trauma informed care

20 min

-The definition of trauma-informed interventions are practices that promote the awareness and influences, acknowledgment, and recovery from the trauma (King 2017).

-Trauma informed care is an understanding that every person we come in contact with could be experiencing some level of trauma

-Trauma informed is about creating an environment that helps move a client from a Sympathetic or dorsal state to a ventral state.

-Interact with the client with compassion and care

-Reduce the risk of traumatization

6 min-Video

https://www.youtube.com/watch?v=-876Zw-NA94

How to implement trauma informed care

20 min

-Three E-'s of trauma informed care

Event The event is what has happened that caused the trauma which could be a single or recurring event

Experience The experiences are what the client has experienced from the event. This experience can be different from each individual

Effects The effects refer to the adverse effect from the Traumatic event. These effects could be immediate or delayed, they could also be short or long lasting

The 4 R's of trauma informed care

20 min

Realization: realizing that trauma is prevalent and the effects it has on family, groups, and communities. Realization that there are multiple paths to healing from trauma.

Recognizing: The symptoms of trauma in the individual. How the impact of trauma effects the individual. Trauma impact the body and the nervous system. They could experience Physical medical conditions that could be related to trauma.

Symptoms of PTSD

Changes in arousal and reactivity

Nervous system continues to overly arouse and reactive

Sense of hyperarousal

Lake of safety

Intrusive images and re-enactments

Nightmares

Thoughts

Flashbacks

Re-experiencing

Negative Changes in mood and beliefs systems

Trauma impact beliefs about ourselves

Shame

Avoidance

Avoiding feeling about trauma

Avoiding talking about trauma

Responding: putting practices in place to reduce the trauma

Six principles of trauma informed care

Safety- ensuring physical and emotional safety, calmness to avoid hyperarousal, establishing relationship

Trustworthiness- predictability, accountability, clarity

Empowerment – allowing the client to be the expert, giving client control over change, offering choice, build upon client's strength

Collaboration- clients are part of the decision making and the team, allowing clients perspective, allowing, and inviting questions

Peer support- connecting clients to supports, community, family. Connecting client to information through resources.

History, gender, and culture- recognizing and moving past stigmas, stereotypes, and biases, recognizing historic trauma,

Resist: resist re-traumatisation of the clients and the staff. Trauma can be inflected intentionally by systems, policies, and language. Practices and structures that are focused on not harming clients any further.

Expectation that every person we encounter has experience trauma

Trauma responses are normal reactions to abnormal events

The focus is to build trauma awareness on what already works in your programs and have knowledge around trauma informed approaches

15 Break 1:45-2:00

Trauma informed action plan

Preparing for trauma informed Practice: self-awareness, trauma awareness, understanding.

Language, building relationship rapport, shift in thinking and language

Engagement: apply the 6 principles into action

Asking about trauma:

engage and build relationship when assessment and screening

consider the need for the information collected and if it benefits the client's care

keep conversation safe

offer choices and emphasize client's autonomy.

establish sense of safety

give rationale for asking question around history and trauma

Normalize the reactions from discussing trauma

Recognize signs and symptoms

Balance the assessment process with engagement

Limit the number of questions ask in a row

Use judgement of when to ask and not ask questions

Use nonjudgmental terms

Awareness of cultural considerations

Making links

Adjusting information shared with clients to a more trauma informed way

Consisted of age, race, culture, stage of development, experiences, type of trauma, and the capacity to understand

Destigmatize and normalize the trauma

Emphasizing

resiliency and hope.

It is not their fault.

You are not alone

Skill building and empowerment

Notice self-internal reactions

Awareness and sensitivity of the client's body Responses and the words they use

Use grounding techniques and supports

Be present with the client

Remain calm in voice and tone

Help them recognize what is happening to their body in the moment

Ask for help

15 min Break 2:45-3:00

Activity 45 min

Marks story

Marks is a 35-year-old male. He has been sentenced and incarcerated for thief under, possession of stolen vehicle. Fling the police and possession for the purpose/ trafficking charges. He has an extensive criminal record and spend many times incarcerated both juvenile and adult. Mark is first nations. He has never lived on his reserve. His mother has addiction issues. He had never known his father. His mother had many men in her life. Mark states that he was physically abused my most men in his mother life. Mark also states that he was physically and sexually abused while in the care of the ministry. Mark struggle in school and only completed grade 8 education. His mother passed away from a drug over doze when he was 16 years old while he was in the custody of the ministry. Mark was involved in Gangs and sold drugs. Mark ran away from his group home many times. When Mark aged out of the ministry, he had no place to live. He sold drugs and stole cars to get by. Mark was also involved in the Gang lifestyle as an adult.

Group activity

Break group up in four group

First group will be representing Probation officers

Second group will represent correction officers

Third group represents healthcare personal

Fourth group represent therapist and doctors

Have each group read marks story and come up with some ways to approach this client using the trauma informed tools

Have each group present to the class.

Break 3:45 to 4:00

Wrap up

30 min

Have each member in the group talk about their experience with the course

Have them mention something that they can pull away from the group

Finish