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Creating a Trauma-Informed Justice System for Women

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In the past decade, the pervasive impact of psychological trauma on the health and well-being of individuals, families, and communities has gained a great deal of attention. Traumatic events, such as natural disasters and extreme acts of violence, can cause individual, community, regional, and national suffering that can linger long after the rescue operation has been completed. These events are what we may call public suffering or public trauma. We know that individuals affected by such events may experience symptoms of anxiety and anger and have reactions to "triggers" that remind them of their initial traumas and losses. In response, various programs, organizations, and institutions have become *trauma sensitive*, *trauma informed*, and *trauma responsive* (with *specific trauma responses to address specific experiences of trauma*). The main purpose of this chapter is to describe and discuss these possibilities, drawing on examples from correctional settings in both the United Kingdom and the United States.

There also are hidden or private traumas. A very high number of women in criminal justice settings have experienced physical, sexual, and emotional abuse throughout their lives. Many of them have had no treatment or counseling to address their trauma. Therefore, it becomes imperative for criminal justice systems to facilitate opportunity to reveal traumas, to have knowledge about trauma and its effects, as well as to create trauma-informed and trauma-responsive environments.

Definitions of Trauma Sensitive, Trauma Informed, Trauma Responsive, and Trauma Specific

It is important to be clear on what these different concepts mean. The term *trauma sensitive* is used to depict broad awareness of the likely experience and impact of personal trauma on those in conflict with the law.

Trauma-informed work (what is known): doing *trauma informed* work means having knowledge about adversity and trauma and its effects on individuals, communities, and society more generally. All staff members in correctional settings need to understand the process of trauma and its link to mental health problems, substance use disorders, behavioral challenges,

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and physical health problems in women's lives. Staff members also need to understand how childhood experiences of trauma affect brain development and how individuals may be affected by and cope with trauma and victimization.

Trauma-responsive work (what is done): being trauma-responsive involves ensuring that there are policies and practices in place to minimize damage and maximize opportunities for healthy growth and development in all populations at risk. It also involves the creation of an environment for healing and recovery.

After becoming trauma informed, a custodial or community-based criminal justice setting or program needs to become trauma responsive by reviewing policies and practices in order to incorporate this information into all operational practices. This involves all administration and staff members and in most, if not all, facilities to create a culture change.

Trauma-specific work (what is provided): here, services are designed to specifically address violence and trauma, the related symptoms, and to facilitate healing and recovery. To become trauma specific, custodial settings (and community programs) for women provide therapeutic approaches that focus on trauma (Covington & Bloom, 2018).

A criminal justice system provides appropriate service when it incorporates all three levels. Trauma-informed organizations or systems of care are consciously created to understand, recognize, and minimize the potentially long-term effects of exposure to traumatic events, even if the traumatized individuals do not recognize their behaviors as related to the traumatic events. A trauma-informed approach includes: "(1) realizing the prevalence of trauma; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) responding by putting this knowledge into practice" (Substance Abuse and Mental Health Services Administration, 2013, p. 4). At the core of trauma-informed organizations are individuals (professionals, nonprofessionals, and administrators) who can provide trauma-informed care or trauma-informed services (these two terms are often used synonymously). Provision of trauma-informed services requires a deep knowledge of the ways in which individuals may have perceived, adjusted to, and responded to their traumatic experiences and a commitment to modify organizational practices that may unintentionally trigger reminders of the traumatic events or the feelings of helplessness they engendered. Everyone from frontline personnel to professionals and administrators needs to convey a common organizational message that people affected by past trauma possess valuable expertise and knowledge about their own problems. "Working collaboratively to facilitate the individual's sense of control and to maximize their autonomy and choices throughout the engagement process is crucial in trauma-informed and trauma-responsive services" (Substance Abuse & Mental Health Services Administration, 2014, p. 22).

The Adverse Childhood Experiences Study

One of the most important developments in health care over the past decade is the recognition that trauma plays a vital and often unrecognized role in the evolution of physical and mental/behavioral health problems. The connection between trauma and subsequent health issues is substantiated by the Adverse Childhood Experiences (ACE) Study (Felitti & Anda, 2010; Felitti et al., 1998), which was designed to examine the childhood origins of many adult physical and behavioral health problems. Ten types of childhood traumatic events were assessed: emotional abuse and neglect, physical neglect, physical abuse, sexual abuse, family violence, family alcoholism, parental separation/divorce, incarcerated family member, and out-of-home placement. A score of four or more events increased the risk of both mental and physical health problems in adult life. The women in the ACE study were 50% more likely than

the men to have scores of five or more. Having a score of four or more increases a woman's risk of having a variety of chronic health problems, including heart disease, autoimmune diseases, lung cancer, pulmonary disease, skeletal fractures, and sexually transmitted infections.

A review of over 2,000 studies around the world that used the ACE questions found that individuals who have experienced four or more ACEs have higher risks for multiple concerns than those with fewer than four ACEs (Hughes et al., 2017). The higher risks include the following points:

- 3.70 times more likely to have anxiety;
- 4.40 times more likely to have depression;
- 5.62 times more likely to engage in illicit drug use;
- 5.84 times more likely to have problematic alcohol use;
- 7.51 times more likely to experience violent victimization in adulthood;
- 10.22 times more likely to have problematic drug use; and
- 30.15 times more likely to attempt suicide as an adult.

Many women who have experienced psychological, physical, and sexual abuse wind up in correctional settings. The original ACE study was a model for research done on women in the US criminal justice system, and similar results were found. The women with the higher scores had more physical and behavioral health problems. For women who scored 7 or more, the risk of a mental health problem was increased by 980% (Messina & Grella, 2006).

Trauma and the Criminal Justice System

The majority of individuals who interface with the criminal justice system – including prisons, jails, and detention centers – have been exposed to traumatic events across their life courses. However, institutional confinement is intended to house perpetrators, not victims, and may not recognize or acknowledge that individuals involved in the criminal justice system often are victims before they are "offenders" or that hurt people often hurt others (Miller & Najavits, 2012; Widom & Maxfield, 2001). When individuals enter custodial settings, they arrive with their personal histories of trauma. Unfortunately, custodial settings often are the sites of new trauma. Moreover, routine correctional practices – such as strip searches and pat downs – may trigger previous trauma and increase trauma-related symptoms and behaviors – such as impulsive acts and aggression – that may be difficult to manage within the prison or jail (Covington, 2008).

Although correctional institutions may be reluctant to adopt the principles associated with trauma-informed organizations, as it may run counter to the organizational culture and training received by staff members, the benefits of such a transformation are compelling. Prisons that have implemented trauma-informed services have experienced substantial decreases in institutional violence. After staff members became trauma informed and created a trauma-responsive institutional environment in the mental health unit at the Framingham facility in Massachusetts, there was a 62% decrease in inmate assaults on staff members and a 54% decrease in inmate-on-inmate assaults (Bissonnette, 2013; National Resource Center on Justice Involved Women, 2014). There also was a decrease in other behavioral and mental health situations: a 60% decline in the number of suicide attempts, a 33% decline in the need for one-on-one mental health watches, and a 16% decline in petitions for psychiatric services.

In their seminal work on trauma-informed services, Fallot and Harris (2006) identify five core values: safety (both physical and emotional), trustworthiness, choice, collaboration, and empowerment. These values can be applied to trauma-informed services, trauma-responsive

environments, and trauma-specific treatment. Incorporating these values into practice is demonstrated by:

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

Women in the Justice System

Extensive research on female jail and prison populations in the United States indicates an overwhelming prevalence (between 77% and 90% of incarcerated women) of childhood histories of exposure to traumatic events (*Battle* et al., *2003*; *Kubiak* et al., *2018*; *Wolff & Shi, 2012*). Between 59% and 90% of incarcerated women also report continued patterns of physical and sexual abuse by intimate partners in their adolescent and adult relationships (*Berzofsky* et al., *2013*; *Owen* et al., *2017*). A study compared the occurrence of adverse childhood events reported by 427 incarcerated men and 315 incarcerated women (*Messina* et al., *2007*). The women had significantly greater exposure to childhood traumatic events than did the men. Recent statistics from Canada indicate that females are over-represented in cases of complex trauma (70.0% compared to 58.8% of males) (*Brown* et al., *2021*).

The profiles of justice-involved women in other countries are similar to those of women in the United States. In the United Kingdom, women in the justice systems have higher rates of mental health issues and abuse than the general population (Prison Reform Trust, 2017).

- Forty-nine percent of women prisoners in a Ministry of Justice study were assessed as suffering from anxiety and depression. Only 19% of the general, female UK population was estimated to be suffering from different types of anxiety and depression.
- Forty-six percent of women in prison have been identified as having suffered a history of domestic abuse.
- Fifty-three percent of women in prison reported having experienced emotional, physical, and/or sexual abuse as a child, compared to 27% of men.

Data from Switzerland on aversive or traumatic experiences in the lives of women in its justice system indicate: "Around half of the women reported being a victim of violence committed by a close person (48.8%) or neglect (52.4%). There was sexual abuse of a kind in 24% of the study population. In 18.1%, threats, assaults, injuries, or torturing were reported" (Krammer et al., 2017, p. 7).

A recent meta-analysis from Canada underscores the high prevalence of victimization in the lives of justice-involved females and provides a gender comparison (Wanamaker et al., 2021). It found that a higher proportion of girls and women versus boys and men experienced physical victimization (41.6% vs. 30.7%), sexual victimization (41.9% vs. 29.9%), neglect (36.4% vs. 30.7%), and overall victimization (51.1% vs. 42.9%).

However, pre-incarceration experiences tell only one part of the story. Victimization within a correctional facility is also a concern. Violence within correctional institutions can take many forms, including coercion and physical and sexual victimization (*Kubiak* et al., *2018*). In a survey conducted in 2008 to determine sexual victimization by those recently discharged from prison, approximately 10% said they were victimized during incarceration by other inmates and by staff members (*Beck & Johnson, 2012*). Women who have experienced sexual victimization prior to prison are three to five times more likely to experience sexual victimization in prison than are women without such histories (*Wolff* et al., *2007*).

The Trauma-Informed Correctional Setting

Creating a trauma-informed organization within a prison, jail, or detention facility is a unique challenge that differs from creating a trauma-informed behavioral or physical health system. Although all these organizations require a "trauma champion" who understands the effects of violence and victimization, a correctional facility requires a visionary leader to facilitate the transformation (Harris & Fallot, 2001). This visionary leader – one with administrative power – must convey the benefits of a trauma-informed organization to the staff. As Carol Dwyer, a warden in the Rhode Island Department of Corrections, has stated: "Officers need to know that some inmate behavior is an adaptation that stems from trauma and that there are things they can do to help a person 'chill' when something sets off the alarms" (Substance Abuse and Mental Health Services Administration, 2013, p. 5).

In general, a trauma-informed organization facilitates an understanding of the prevalence of trauma and how trauma affects all individuals involved within the organization and integrates this knowledge into practice (Substance Abuse & Mental Health Services Administration, 2014). In a trauma-informed correctional organization, the administration creates an infrastructure that guides and supports a trauma-responsive environment. This requires a long-term administrative commitment (often three to five years) and leadership, particularly in the review and revisioning of policies and practices. The champion must guide the long-term process along with a steering committee or advisory group.

First, current organizational policies, procedures, and practices must be assessed to determine if they support or interfere with a trauma-responsive environment (Brown et al., 2013). This often includes a walk through by an objective outsider who is knowledgeable about trauma responses and triggers. Second, once the assessment is conducted and issues are identified, an action plan is created. Discussion of the Covington and Fallot *Implementation Plan and Goal Attainment Scale*, designed expressly for the purpose of assessment and action, can be found in Covington & Bloom, 2018. The scale assists the organization in naming the problems and determining who is responsible for making changes and what the timeline is for completion.

Simultaneously, ongoing training for all staff members at all levels of the organization must occur. There must be knowledge about trauma in all aspects of service delivery. Priority areas for training include basic information about trauma and the self-care needs of staff members.

Becoming Trauma Informed: Training the Correctional Staff

There is a written curriculum (created in 2012 and revised in 2018) to assist criminal justice professionals in becoming trauma informed (Covington, 2018; see Table 12.1 for the Table of Contents).

Table 12.1 Table of Contents for Becoming Trauma Informed.

Becoming Trauma Informed: A Training Program for Correctional Professionals (Covington, 2018)
Section 1: Goals of Training; Violence in Our World
Section 2: Understanding Trauma (Process and Effects)
Section 3: Trauma-Informed Services
Section 4: Triggers, Nonverbal Communication, and Grounding Strategies
Section 5: Vicarious Trauma
Section 6: The Work Environment: Escalation and De-escalation

To date, most of the training has taken place in Canada and the United Kingdom, but it is beginning to be applied more in US prisons and jails. The training msaterials (facilitator guide, participant booklet, and PowerPoint slides) are entitled *Becoming Trauma Informed: A Training Program for Correctional Professionals* and have three primary objectives:

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

When beginning the training, each staff member completes an ACEs survey in regard to herself or himself and then completes one in regard to an average woman confined within the institution in which he or she works. As described earlier, the instrument targets experiences of deprivation, abandonment, and abuse during childhood.

Correctional staff members become invested in the training when they understand that mastering trauma-informed practices will make their jobs easier and help them in their own lives. In order to assist them in understanding what it means to be trauma informed, the staff members participate in a series of exercises that use everyday activities to compare trauma-informed and not-trauma-informed methods of engaging in these activities (see Table 12.2).

Perhaps most importantly to the incarcerated individuals as well as the staff members, the training assists the staff in understanding possible triggers. A trigger or *threat cue* can set off a trauma reaction, such as fear, panic, agitation, and lashing out. Typical triggers for those with histories of physical and/or sexual abuse are yelling, loud noises, restraint, being touched, and being threatened.

Table 12.2 Comparing trauma-informed and not-trauma-informed behaviors.

Trauma-Informed Behaviors	*Not-Trauma-Informed Behaviors*
Saying "Hello" and "Goodbye" at the beginning and end of your shift	Coming and going without any acknowledgment of the persons within the unit
Quietly moving and respectfully informing individuals of where they need to be	Yelling "Lunch" or "Medications"
Language such as "Let's talk," "Let's find someone to help you," and "May I help you?"	Superior and punishing language, such as "Step away from the desk"

Staff members learn the usefulness of understanding what makes someone feel scared or upset or angry and could cause her to go into crisis mode. They learn that there is no single profile. Each individual has a unique history and specific triggers.

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

When staff members understand the connections between past trauma and current behavior, it helps custodial settings become safer, staff jobs become easier and less challenging, and programming becomes more effective. The staff needs to receive ongoing training and support, as being trauma-informed changes the organizational culture. Once the changes have been implemented and the staff has been trained, there needs to be ongoing assessment and identification of problem areas.

Routine Strategies for Decreasing Re-traumatization within Correctional Settings

Although individual staff members and/or treatment professionals may engage in trauma-informed services, unless there is a trauma-responsive culture across the correctional organization, the likelihood of revictimization remains high. Trauma-informed services are distinct from trauma-specific treatment, as they are not specifically designed to address the consequences of trauma or provide relief from trauma-related symptoms or behaviors. However, a trauma-informed and trauma-responsive approach prevents or decreases revictimization and the "triggering" of previous trauma.

A history of trauma can influence a person's responses to the incarceration setting:

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

Often, staff members within institutional settings believe that their behaviors and mannerisms need to be forceful in order to convey authority. These behaviors may include yelling and name calling. However, those under correctional supervision understand clearly who has authority and they recognize the power imbalance between staff members and themselves. At the same time, they want to be treated with dignity. Speaking in a calm and respectful manner is considered responsive to the needs of trauma survivors. Staff members who demonstrate respect and fairness can play an important role in minimizing the traumatic memory that routine practices within a prison may evoke. It is critical that staff members recognize that practices that may seem routine and "uncharged" to them may not seem that way at all to a traumatized individual.

Institutional Practices that Prevent Re-traumatization and Enhance Safety

Leaving aside the big question as to whether strip searches are absolutely necessary on grounds of safety and security (with sub-questions as to whether there is evidence to support the continuation of such practices) if there have to be searches, they should reflect the following principles:

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

Trauma-Specific Treatment

There are trauma-specific treatments that are therapeutic approaches for individuals with trauma-related disorders such as post traumatic stress disorder (PTSD). *Seeking Safety* is an evidence-based, cognitive-behavioral treatment for individuals with substance use disorders and PTSD (Najavits, 2002). The intervention focuses on safety and coping skills. A study from Gatz colleagues (2007) found that women who received the treatment improved significantly more on symptoms of PTSD and use of coping skills than did women in the comparison group. Other trauma-informed, gender-specific treatment interventions for women in the criminal/legal system have shown similar outcomes. For example, studies evaluating the effectiveness of *Helping Women Recover* (Covington, 2019) and *Beyond Trauma* (Covington, 2016) show that participants had reductions in symptoms of PTSD and depression (Messina et al., 2013). In addition, a trauma-specific treatment curriculum for women who engage in violent behavior, *Beyond Violence* (Covington, 2013), has been found to be efficacious in decreasing women's anxiety and anger, as well as improving long-term outcomes, compared to women in the *treatment as usual* group (Kubiak et al., 2015, 2016; Messina et al., 2016). There also is a six-session intervention for women, *Healing Trauma* (Covington & Russo, 2016), that has been evaluated for women in the general prison population in the United States and United Kingdom, as well as in a secured housing unit (Messina & Calhoun, 2019; Petrillo et al., 2019).

Two Case Studies

England In Spring, 2014, after multiple presentations were made to different sectors in various parts of England, a decision was made to begin a process of assisting Her Majesty's Prison and Probation Services (formerly National Offender Management Services) in the process of becoming trauma informed. The *Becoming Trauma Informed* initiative was sponsored by

Lady Edwina Grosvenor (prison philanthropist) and the National Offender Management Service (NOMS).[1]

The initial Leader's Day in September, 2015, was attended by Governors and a small team of staff from each of the twelve women's prisons in England to introduce the initiative, with a focus on the impact of trauma on the lives of justice-involved women. The all-day event incorporated information on the process of trauma and its effects on mental health and behavior, including the impact on staff members. The prison leaders were introduced to the values of becoming trauma informed and the results (i.e., prisons become safer, staff jobs become easier, and programming becomes more effective). The concept of culture change and the three- to five-year process involved in this endeavor were explained, and all prisons agreed to participate.

Some of the completed tasks are:

1. Each prison sent trainers to train-the-trainer sessions to become able to train all the women's prison staffs in the basics of becoming trauma informed, using *Becoming Trauma Informed (BTI): A Training for Criminal Justice Professionals* (UK edition) (Covington, 2017). BTI includes a facilitator guide, participant booklet, and PowerPoint slides, which allows the training to remain consistent across the Women's Estate. It is designed as a one-day training for criminal justice staff members who work with women; however, some prisons delivered it in segments because of scheduling issues. Each year, there has been refresher training for the in-prison trainers. (This is the trauma-informed part of the work.)
2. Each prison set up a Guide Team to manage the BTI Initiative. This team of five to eight people represented a cross section of the prison workforce, not just upper management or clinical staff members. Part of its role was to do an initial walk through as a self-assessment and to select the areas in which to start the change process. Some prisons selected reception/induction and "first night" areas (where women spend their first night after induction into the prison), while others focused on programming. Some teams visited one another's prisons and did walk throughs to provide new perspectives. They were guided by a tool kit that includes the *Implementation Plan and Goal Attainment Scale* (see the Covington & Fallot discussion in Covington & Bloom, 2018). (This represents the trauma-responsive part of the process.)
3. Group meetings with the Guide Teams were held at least twice each year to allow them to report on their focus and progress. The teams learned from one another and often were motived by one another's accomplishments. The *Implementation Plan and Goal Attainment Scale* provided the focus for these meetings.
4. Each prison also received the training and the materials needed to incorporate a brief, trauma-specific intervention for women entitled *Healing Trauma* (Covington & Russo, 2016). The intervention can be peer- or staff-led. Some prisons began to train peers and provide the program immediately. Implementation was slower in others. At this time, ten of the twelve prisons are using the program. There is a small outcome study using pre- and post-tests showing the positive results of the intervention. Focus groups also were conducted, with the women expressing their gratitude for the program (Petrillo et al., 2019).
5. Because of the success of the *Becoming Trauma Informed* Initiative in the women's prisons, the process has been implemented in the Long-Term High Security estate for men in England.

[1] The National Offender Management Service was renamed as Her Majesty's Prisons and Probation Service (HMPPS) on 1st April, 2017 in order to give greater transparency.

California The process in the California Department of Corrections and Rehabilitation (CDCR) followed a different trajectory. With the changing profile of women in the California system (i.e., nonviolent women being released), in 2014, CDCR became interested in *Beyond Violence: A Prevention Program for Criminal Justice-Involved Women* (Covington, 2013). This program initially was developed at the request of the Michigan Department of Corrections (MDOC) because of the lack of evidence-based programming for women who had committed aggressive/violent crimes. The intervention works on two levels: the violence and trauma women have experienced and the violence they have perpetrated. Research conducted by the MDOC on the program facilitated by staff members indicated effectiveness on multiple measures (see https://www.stephaniecovington.com/research-papers.php).

The following describes the chronology of the California process:

1. *Beyond Violence* was initially implemented in the California Institution for Women (CIW Chino) and the Central California Women's Facility (CCWF Chowchilla) in January, 2014. Women with long-term or life sentences were given an opportunity to volunteer to be peer facilitators, and interviews were completed by staff members. The selected women and the program coordinator were trained in the treatment protocol, then the women participated in the intervention facilitated by the program coordinator. Volunteers from the general prison population then signed up for the intervention. Research was conducted on the effectiveness of the intervention, and it was found to decrease PTSD, depression, anxiety, anger, and so forth (Messina, 2014; Messina et al., 2016). *Beyond Violence* is currently implemented at both prisons, and each program always has a waiting list.
2. Because of the effectiveness in the general population, *Beyond Violence* was implemented in the Secure Housing Unit at CIW in August, 2015. The research results reflected those in Michigan, as well as in the general population.
3. Subsequently, *Healing Trauma* was implemented in the Reception Center at CCWF and with a specific population at CIW in July, 2017. As sentences in the Secure Housing Unit were becoming shorter, it was decided to implement *Healing Trauma* there. Again, research was conducted on the program, with results indicating statistically significant change in depression, anxiety, PTSD, anger, aggression, and social connectedness (Messina & Calhoun, 2018, 2019).
4. As these programs were being implemented in the prisons, the CDCR administration decided that staff training would be of benefit in the women's facilities. A train-the-trainer model was used in June, 2018, for *Becoming Trauma Informed: A Training Program for Correctional Professionals* (US edition) (Covington, 2018). This initial training was conducted with the intention that all staff members in women's prisons in California will receive basic knowledge about trauma.
5. Because of the success of the *Healing Trauma* program in the women's prisons, *Exploring Trauma* (the version for men) (Covington & Rodriquez, 2016) has been implemented in five men's prisons (including two Secure Housing Units).

Conclusion

The centrality of trauma in the lives of women involved in the criminal/legal system necessitates trauma-informed training and trauma-responsive organizational approaches specific to this population. The integration of trauma-informed services, a trauma-responsive organizational

approach, and trauma-specific interventions has the potential to improve rehabilitation outcomes and reduce adverse events. Trauma-informed services can help to minimize the risk of re-traumatization and promote a culture of safety for all involved.

Developing a trauma-informed organization requires a commitment to incorporating trauma-informed services in all aspects of practice. While trauma-specific treatment focuses on individual care, trauma-responsive organizations implement the principles of trauma-informed service at multiple system levels. In other words, departments such as health care, education, programs, and housing all have to examine their policies and practices to develop trauma-informed and trauma-responsive services.

Establishing a trauma-informed organizational approach requires that administrators and staff members understand the impact and prevalence of trauma. The organization should incorporate trauma-informed principles in staff hiring and training, written policies and procedures, and program guidelines, and create a physical environment that promotes a sense of safety. All screening and assessment processes, and services provided by the organization that involve contact with individuals, should be trauma informed (Substance Abuse & Mental Health Services Administration, 2014).

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