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1. INTRODUCTION

This Tool Kit is a step-by-step guide for the Women’s Community Service Providers. While this edited version was originally designed for NOMS and the Governors operating prisons for women in the UK, the basic process is applicable to any facility or organisation interested in developing trauma-informed and gender-responsive services. It offers an overview of the steps and process used when someone undertakes this type of culture change. The intention is to provide guidance from lessons learned from many criminal justice and community settings who have completed this process. This can be your guide for the next steps to take following the Community Day (May 27, 2016) held in London and sponsored by the One Small Thing Initiative. Consultation on Becoming Trauma Informed is also available by Dr. Covington to those seeking any assistance with this process.

a. Elements of a Trauma-Informed and Gender-Responsive Culture

Defining Trauma-Informed Care:

The definition of trauma used by the American Psychiatric Association in the DSM-5 manual is the “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).

In addition to this definition, trauma is frequently defined more broadly as “any event that overwhelms a person’s capacity for positive coping.” This latter definition highlights the somewhat subjective nature of trauma, so that an event that is traumatic for one person may not be for another.

The Five Core Values of Trauma-Informed Care have been identified and developed based on the knowledge of what is known about common responses to physical, sexual and emotional abuse (including vicarious or secondary traumatisation), as well as what survivors need for recovery.

These five values are:

1. Safety: ensuring that women seeking services feel physically and emotionally safe as they come from criminal justice settings into the community and that they remain safe;

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2. **Trustworthiness**: women know that providers and practitioners will ensure that expectations are clear and consistent and that appropriate boundaries (especially interpersonal ones) are maintained;

3. **Choice**: preferences of the women seeking services in routine practices and crisis situations will be prioritised;

4. **Collaboration**: input from women will be considered in practices and decisions so that a collaborative relationship will be encouraged between those seeking services and service providers; and

5. **Empowerment**: services are developed and delivered to maximise women’s empowerment, recognising strengths and building skills that will enable a successful transition from criminal justice settings to the community.

The centrality of violence and trauma to other major life problems such as substance abuse, homelessness, and mental health stability as a pathway to involvement with the criminal justice system has been illustrated by the research. It is now considered necessary for all service providers to become “trauma-informed” if they want to be effective. Trauma-informed services are those that are provided for problems other than trauma but require knowledge concerning violence and the impact of trauma. (This is differentiated from trauma specific services, which are services and intervention models that specifically address the consequences of trauma).

Trauma-informed services:
- Take the trauma into account;
- Avoid triggering trauma reactions and/or re-traumatising the individual;
- Adjust the behaviour of counselors, other staff, and the organisation to support the individual’s coping capacity; and
- Allow survivors to manage their trauma symptoms successfully so that they are able to access, retain, and benefit from these services.

Implementing the principles of trauma-informed care requires a culture shift within and outside of the prison environment, throughout policies and practices, and the behaviour and skill set of staff working directly and indirectly with women.

These required changes are reflected in the definition of trauma-informed services:
- **Trauma informed (versus trauma specific):**
  - All organisational staff can recognise trauma and victimisation effects in the women served whether or not they provide specific services to address the effects
  - Trauma-informed services:
    - Incorporate knowledge about trauma in all aspects of service delivery and practice;
    - Are hospitable and engaging for survivors;
    - Minimise re-victimisation;
    - Facilitate healing, recovery, empowerment;
    - Emphasise collaboration throughout the service system; and
    - Recognise effects of trauma on staff members and provide means to prevent and/or ameliorate these effects.
A trauma-informed approach involves fundamental shifts in thinking and practice at all levels. The implementation of trauma-informed care provides training and education for staff members based on the five core values that help community service providers implement a change process that will not only address these needs of the women, but also of staff themselves:

- Recognise and implement physical and emotional safety for staff members;
- Maximise trustworthiness by making tasks and procedures clear and consistent;
- Enhance staff members' choices and control of day-to-day work tasks;
- Maximise collaboration and sharing of power with staff members in the design and delivery of services and;
- Ensure the appropriate use of resources and skill-building educational opportunities to improve staff development and empowerment.

The definition and elements presented above mirror the following five questions from the Care Quality Commission and the ten Standards for Enabling Environments in the UK.

The Care Quality Commission is the independent regulator of health and social care in England. In inspecting services, they ask five questions:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people’s needs?
- Are they well led?

Also, one of the goals of the Royal College of Psychiatrists, College Centre for Quality Improvement (CCQI), is to raise the standard of care that people with mental health needs receive by helping providers to increase the quality of care they provide. They have developed the concept of ‘enabling environments’ where participants feel safe enough to develop relationships and to share experiences and ideas with others; places where everyone can get involved in helping to decide on matters that affect them.

There are ten Standards for ‘Enabling Environments’ outlining the core values of a healthy psychosocial environment with criteria demonstrating how the values can be achieved in practice. These are:

1. **Belonging**: the nature and quality of relationships are of primary importance
2. **Boundaries**: there are expectations of behaviour and processes to maintain and review them
3. **Communication**: it is recognised that people communicate in different ways

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4. Development: there are opportunities to be spontaneous and try new things
5. Involvement: everyone shares responsibility for the environment
6. Safety: support is available for everyone
7. Structure: engagement and purposeful activity is actively encouraged
8. Empowerment: power and authority are open to discussion
9. Leadership: leadership takes responsibility for the environment being enabling
10. Openness: external relationships are sought and valued

The Importance of Gender:

One of the major differences between women and men is their risk of experiencing trauma, especially interpersonal violence. As children, both women and men are at relatively equal risk of physical and/or sexual abuse from family members and people they know. In adolescence, boys have a higher risk if they are gay, young men of colour, or gang members. As males age, they are more likely to be harmed by enemies or strangers—people who dislike or hate them. In contrast, a young woman is most at risk in a relationship, from a lover or partner—the person to whom she is saying “I love you.” For an adult man, the risk of abuse comes from being in combat or being a victim of a crime—again, from the enemy or a stranger. For the adult woman, the primary risk is still in her relationship with the person to whom she says, “I love you.” Clinicians think this may account for the increase in mental health problems for women.

Because of this difference and others related to the differences between women and men in their life experiences, this Tool Kit is designed to assist in culture change by focusing on both trauma and gender. Please see the article from the *Magistrates Association* entitled "Creating Gender-responsive and Trauma-informed Services for Women in the Justice System" *(appendix i).*

Definition and Guiding Principles for Gender-Responsive Policies and Practices

Being gender-responsive means creating an environment through site selection, staff selection, programme development, content, and material that reflects an understanding of the realities of the lives of women and girls, and addresses and responds to their strengths and challenges.⁴

There are six guiding principles designed for women’s services⁵

- **Gender:** Acknowledge that gender makes a difference.
- **Environment:** Create an environment based on safety, respect, and dignity.
- **Relationships:** Develop policies, practices, and programmes that are relational and promote healthy connections to children, family, significant others, and the community.

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**Services and supervision:** Address substance abuse, trauma, and mental health issues through comprehensive, integrated, and culturally relevant services and appropriate supervision.

**Socioeconomic status:** Provide women with opportunities to improve their socioeconomic conditions.

**Community:** Establish a system of community supervision and resettlement with comprehensive, collaborative services.

### b. Key Elements for Successful Completion of this Process in the Community

The key elements to successful completion of this project include:

1. Leadership commitment to and support of the initiative
2. The formation of a BTI Guide Team at each organisation to lead and oversee the change process;
3. Identification of Trauma and Gender (TAG) champions to keep the initiative alive and “on the front burner.” The TAG champion is the point person for each community organisation and is part of the Guide Team.
4. Full representation of the organisation’s staff on the Guide Team—administrators, supervisors, support staff, and women seeking services.
5. Awareness of the scope and timeline (usually up to two or more years) for the culture shift by the entire staff.

### 2. ROLES OF KEY PARTICIPANTS:

**LEADER, TRAUMA CHAMPION(S), TRAINERS**

**The Initiative’s BTI Leader**

Each community organisation’s team will have a primary leader whose task is to lead the change efforts in their organisation. There are four primary functions:

1. To generate interest in the overall change efforts and be responsible for keeping the initiative as an important overall strategic goal.
2. To act as the “point person” for a Guide Team that will be established to ensure that the principles are implemented across the organisation.
3. To ensure that the Guide Team has representation from all stakeholders or constituency groups which receive or deliver services in the community-based programme.
4. To monitor the delivery of all trauma-informed processes in order to be able to report to senior leadership and consultants the effectiveness and work of the change initiative in an ongoing manner.

The position of Initiative Leader in each organisation does not necessarily have to be the Director of an organisation or a single individual, and a co-leadership structure may be established. The essential qualification is that the individual(s) selected must be committed to trauma-informed culture change and be granted formal authority as a leader of the culture change process by the organisation’s leadership.
Trauma and Gender Champions

These are the individuals (counselors, programme leaders, etc.) who will be tasked with the day-to-day delivery of trauma-informed services to the women seeking services. They will also serve as role models for all staff on the practical aspects of becoming trauma-informed in a manner consistent with the overall culture change goals.

Examples of the competencies required of Trauma and Gender Champions include:
1. Understanding the impact of trauma and how this shapes beliefs and behaviours in women transitioning from criminal justice settings to the community
2. Understanding the stages of trauma recovery and the different types of treatment that may be used during each stage.
3. Ability to consider trauma and gender in conceptualising the life of the woman and recovery planning in the same way age and culture might be considered.
4. Ability to communicate about the impact of trauma on behaviour during discussions of women receiving services to ensure that appropriate service referrals are made.
5. Ability to pay attention to a woman’s personal responses and be alert to signs of vicarious trauma.
6. Ability to create therapeutic relationships based on trauma-informed principles of safety, trustworthiness, choice, collaboration and empowerment.
7. Ability to promote staff self-care, professional care and organisational culture change as it relates to the provision of trauma-informed services for women.

The organisation’s leadership should keep in mind certain qualities when looking to identify Champions or Leaders who will participate in the culture change process. It will be most successful if they possess the qualities that will help to support and move forward the initiative and include the following:

1. Shows enthusiasm and commitment to the culture change process effort and can serve as an inspiration to fellow staff.
2. Models the trauma-informed principles of safety, trustworthiness, choice, collaboration and empowerment in the day-to-day work setting
3. Understands gender role messages that males and females routinely experience and uses this knowledge to enhance their work with women, as well as staff
4. Understands the complex relationship between trauma and gender
5. Understands and engages in a collaborative leadership style
6. Understands the long-term aspects of the change process and acknowledges a commitment to stay and support the goals by remaining with the organisation for an extended period of time.
7. Volunteers or applies for the positions of BTI Leader or Trauma and Gender Champion showing a commitment to the process of culture change and a desire to learn and employ trauma-informed and gender-responsive principles in practice.
8. Has a high professional standing within the organisation and is seen as an effective counselor or staff member and a leader by peers and management
BTI Trainer(s)

The process of culture change can also be supported and sustained within the organisations through the effort of BTI Trainers. They would provide basic educational and skill-building resources to support the shift to trauma-informed and gender-responsive care within the community organisation. The primary task of the trainers is to educate staff members by presenting sessions from the *Becoming Trauma Informed* training materials discussed below or another curriculum with the same focus. Trainers will monitor implementation of trauma training in collaboration with the training coordinator at the organisation (if there is one), as well as ensure that these issues are covered in new staff orientation. Trainer qualifications should include:

1. Knowledge of, or the ability and desire to acquire such, trauma-related issues.
2. Capacity to translate trauma-related concepts into understandable language for those providing services (including vicarious trauma).
3. Capacity to teach effectively or be willing to develop this capacity.
4. Capacity to work effectively as a member of a teaching team.

3. **CREATING A BTI GUIDE TEAM AND DETERMINING READINESS**

Each organisation creates a BTI Guide Team for their community organisation, as per their interest in this process. The team would consist of 8-10 people who are committed to the process of becoming trauma informed and represents a cross-section of the administration and staff. The team composition would include a senior leader, supervisory staff, support staff, and women seeking services. The Guide Team is expected to meet twice per month initially, then once per month thereafter. The team will be involved in all related events including advance planning for events, pre-training meetings, conference calls and telephone consultations. The Trauma Champion will help coordinate activities related to this initiative and clarify expectations as necessary.

**How to determine motivation, commitment and readiness**

Questions to be considered by the community organisations as they begin this process:

- What factors have influenced our decision to become more trauma-informed and gender-responsive?
- What barriers may we encounter? How will we address these to avoid losing momentum?
- In terms of resources, particularly staff time, what are we willing to commit to?
- Are there currently other organisational commitments that could hinder our ability to move this project forward?
- Do we currently have the internal capacity to do this project?
- How will enthusiasm for the project be communicated?
- How will all staff be informed of the project?
4. **ASSESSING CURRENT PRACTICE**

Throughout the entire initiative, organisations will be assessing their practices and whether or not they are aligned with trauma-informed practices and gender-responsive principles. The materials in "Six Domains of Trauma-Informed Services (includes Five Core Values): Questions to Consider" *(appendix ii)* and the "Implementation Plan and Goal Attainment Scale" *(appendix vi)* can be used as the tools to help “self-assess” current practice. Be sure to also keep in mind the definition of gender-responsive services and the guiding principles for a gender-responsive system of service *(pages 4-5)*. This self-assessment should be done within the first 30 days of the establishment of the BTI Guide Team.

a. **Doing a Walk Through**

This can be done by exchanging with another local organisation or doing this yourself. A sister organisation’s workgroup can come to your organisation and you can visit theirs. It is often more productive to have “new eyes” when doing a organisational walk-through. Reading the "Walk Through Exercise and Team Meeting" *(appendix iii)* material can help you to structure your walk through. In addition, the article "Moving towards Trauma-Informed Practice in Addiction Treatment: A Collaborative Model of Agency Assessment", *Journal of Psychoactive Drugs*, November 2013 *(appendix iv)* will provide additional information which will be helpful to consider when doing a walk through.

b. **Completing the Self-Assessment**

Some organisations may have had an opportunity to work with the "Implementation Plan and Goal Attainment Scale" *(appendix vi)* at the Women’s Community Service Providers meeting on May 27, 2016. Using this as your guide, please also reference the following items:

- "Six Domains of Trauma-Informed Services (includes Five Core Values): Questions to Consider" *(appendix ii)*
- "Opportunities for Implementing Trauma-Informed Practice in Women’s Services" *(appendix vii)*
- Review the definition of gender-responsive services and the guiding principles for a gender-responsive system of service *(pages 4-5)*.

These items coupled with your Walk Through Exercise will provide you with the information to begin to assess the issues in your organisation that need to be addressed in order to become more trauma informed.

5. **USING THE IMPLEMENTATION PLAN AND GOAL ATTAINMENT SCALE**

You will notice that the "Implementation Plan and Goal Attainment Scale" *(appendix vi)* allows you to list the issues of concern and ideas for resolution that were generated by assessing current practice. This will be your primary guide for the 2-3 year process. It also allows you to check your progress, see where you need to adjust and self-correct.
It is suggested that after doing the self-assessment progress you pick 2-4 issues where you would like to begin. Its often a good idea to pick at least one issue where you can be successful quickly. This helps the morale of both the committee and the organisation’s staff.

You may find some of the information in the booklets from the Community Day, May 27, 2016, as well as the National Institute of Corrections' (NIC) Strategies for Implementation' information (appendix v), to be useful supplements.

6. **BECOMING TRAUMA INFORMED TRAINING**

There is a one-day training curriculum which was made available at the May 27 Community Providers Day, *Becoming Trauma Informed: A Training Programme for Criminal Justice Professionals*. The training materials are on a CD-Rom and consist of a facilitator’s guide, a participant’s booklet and PowerPoint slides. In addition, a copy of the Table of Contents for this training programme can be found in appendix viii. There may be other training materials available in the UK that we are unaware of.

Some organisations find that staff self-care needs to be an immediate focus. Others realise that all staff may not be familiar the basic information about trauma. During the next year you will probably want to be sure that minimally these two topics have been covered for all staff: a basic information session on trauma and a training session on staff self-care.

7. **TRAUMA-SPECIFIC SERVICES**

The focus of the BTI Initiative is to assist prisons and community organisations in expanding their understanding of trauma in women’s lives in order to create healing environments.

In addition, some organisations may be providing trauma-specific services and treatment; while others may be interested in expanding their services. In appendix ix you will find the descriptions and the tables of contents for two new trauma-specific programmes for women.

8. **CONSULTATION, REPORT OUTS AND TRANSITION**

Consultation on this process is available by Dr. Covington to community providers seeking assistance over the course of the next two years. Please contact info@stephaniecovington.com to set up a telephone or Skype call with Dr. Covington.

There is also a plan for follow-up with the Women’s Community Service Providers. This will be a Report Out day where representatives from the organisations will come together for the sharing of issues and joint problem solving. It is often helpful to see the challenges others are facing and their solutions. This will be scheduled in the Autumn 2016.
Appendix:
Reading Materials
The Great War
Life as a magistrate 100 years ago

Annual Report
Activities and accounts

Fireworks
Cases in court

Higher fines
Are they a deterrent?
Creating gender-responsive and trauma-informed services for women in the justice system

Stephanie S. Covington gives details of research related to women offenders and their needs

Some of the most neglected and misunderstood individuals in our society are the women in the criminal justice system.

Although the number of justice-involved women has increased by 115% in the UK in the last 15 years, the criminal justice system has not adapted to meet women’s needs, which often are quite different from those of men.

Gender-responsive services

Research demonstrates that treatment services for women need to be based on a holistic and woman-centred approach that acknowledges their psychosocial needs. Gender-responsive treatment includes the creation of an environment — through site selection, staff selection, programme development, and programme content and materials — that reflects an understanding of the realities of females’ lives and that addresses and responds to their challenges and strengths. Because of the high rates of violence in many women’s lives, especially those in the criminal justice system, treatment services can be gender-responsive only if they are trauma informed.

The issue of gender

Developing effective services for women includes understanding and acknowledging the effects of living as a female in a male-based society. In most of the world, males are dominant; this influence is so pervasive that it often is unseen. One result is that programmes and policies called ‘gender neutral’ are actually male based. Administrators may take a traditional programme designed for men, change the word ‘he’ to ‘she’ and call the result a ‘programme for women.’ Such programmes do not take into account the psychosocial development of females, which differs from that of males.

Gender responsive principles

A review of the literature and research on women’s lives in the areas of substance abuse, trauma, health, mental health, education and training and employment was conducted as part of a research-based report for the (USA) National Institute of Corrections. The report cites six guiding principles for working with women:

- gender: acknowledge that gender makes a difference;
- environment: create an environment based on safety, respect, and dignity;
- relationships: develop policies, practices, and programmes that are relational and that promote healthy connections to children, family members, significant others, and the community;
- services and supervision: address substance abuse, trauma, and mental health issues through comprehensive, integrated, and culturally relevant services and supervision;
- socioeconomic status: provide women with opportunities to improve their socioeconomic conditions;
- community: establish a system of comprehensive and collaborative community services.

Understanding trauma

One of the most important developments in health care over the past decade is the recognition that trauma plays a vital and often unrecognised role in the evolution of physical and mental health problems. A high number of females in the criminal justice systems in the UK, Canada, and the USA have experienced physical, sexual, and emotional abuse. The connection between trauma and subsequent health issues is substantiated by the ongoing Adverse Childhood Experiences (ACE) Study, which was designed to examine the childhood origins of many adult physical and mental 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 increased the risk of both mental and physical health problems in adult life. This study was a model for research done on women in the criminal justice system. For women who scored seven or more, the risk of a mental health problem was increased by 980%.

Trauma is not limited to suffering violence; it includes witnessing violence as well as stigmatisation because of gender, race, poverty, incarceration, or sexual orientation. The terms violence, trauma, abuse, and post-traumatic stress disorder (PSTD) are often used interchangeably. One way to clarify these terms is to think of trauma as a response to violence or another overwhelmingly negative experience. Trauma is both an event and a particular response to an event. PTSD is one type of anxiety disorder that results from trauma.

Justice-involved women have the highest rates of abuse in the UK (and other countries):

- 49% 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 were estimated to be suffering from different types of anxiety and depression;
- 46% of women in prison have been identified as having suffered a history of domestic abuse;
- 53% of women in prison reported having experienced emotional, physical, and/or sexual abuse as a child, compared to 27% of men.

Gender differences in experiences of violence and trauma

Risk for abuse is affected by gender. When young, both female and male children are at relatively equal risk from family members and people they know.

In adolescence, boys in many white-majority countries are at risk if they are gay, young men of colour, or gang members. Their risk comes from people who dislike or hate them. As they age, males are more likely to be harmed by enemies or strangers. For an adult man, the risk for abuse comes from being in combat or being a victim of crime.

For a young or adult woman, the primary risk is in her relationship with an intimate partner. This may account for the higher rate of mental health problems among women: it is more confusing and distressing to have the person who is supposed to love and care for you do harm to you than it is to be harmed by someone who dislikes you or is a stranger.

Trauma and the criminal justice system

For both service providers and the women survivors who access services, it is important to understand what trauma is and its impact on the thoughts, feelings, beliefs, values, behaviour, and relationships of the victims. It is imperative that addiction treatment services incorporate relational-cultural theory (women’s psychosocial development), addiction theory, and trauma theory. A gender-responsive and trauma-informed programme can provide the safe, nurturing, and empowering environment that women need to find their inner strengths, to heal, and to recover.

Understanding the impact of trauma and the issue of ‘triggers’ is particularly important when working with women in the criminal justice system. Unfortunately, standard practices – such as searches, seclusion, and restraint – may traumatisé or retraumatisé many women. Experiences in the criminal justice system can trigger memories of earlier abuse. It can be retraumatising when a survivor of sexual abuse has a body search, must shower with male correctional officers nearby, or is yelled at or cursed at by a staff member. Incarceration can be traumatising in itself, and the racism and class discrimination that are characteristic of the criminal justice system can be even more traumatising.

Becoming trauma informed

As the understanding of trauma increases, mental health theories and practices are changing. It is important for criminal justice professionals to understand trauma theory as a conceptual framework for their policies and practices. Trauma-informed services do the following:

- take the trauma into account;
- avoid triggering trauma reactions or retraumatising the woman;
- adjust the behaviour of counsellors and custodial staff members to support the woman’s coping capacity;
- allow survivors to manage their trauma symptoms successfully, so that they are able to access, retain, and benefit from the services.

In order to be trauma informed, service providers need to understand and espouse five core values:

1. safety: ensuring physical and emotional safety;
2. trustworthiness: maximising trustworthiness, making tasks clear, and maintaining appropriate boundaries;
3. choice: prioritising client choice and control;
4. collaboration: maximising collaboration and sharing power with clients;
5. empowerment: prioritising client empowerment and skill building.

Gender-responsive and trauma-informed materials

In developing gender-responsive services, the material used is a crucial ingredient. It has been developed to help service providers bring this theoretically and evidence-based approach to the delivery of trauma-informed (the treatment environment) and trauma-specific (the treatment provided) services.

There are websites (see full article) which provide specific information on materials to use with women and girls that incorporate the principles discussed in this article. There are seven areas, each of which includes a facilitator’s guide and a participant’s workbook. There are cognitive-behavioural, relational, mindful, and expressive-arts techniques used throughout. These materials also can be used to educate staff members. There are additional articles and book chapters on these websites that discuss gender and trauma: www.stephaniecovington.com and www.centerforgenderandjustice.org

Conclusion

Addressing the health and mental health needs of justice-involved women involves the development of comprehensive, coordinated services that address the women’s histories of poverty and trauma, recognise their mental and physical health issues, and incorporate the emotional and psychological components that females need to heal and recover. With new understanding based on research and practice, it is time for correctional facilities and community care providers to work together and create meaningful systems of care.

Dr. Stephanie Covington is a clinician, author, organisational consultant, and lecturer. Recognised for her pioneering work in the area of women’s issues, Dr. Covington specialises in the development and implementation of gender-responsive and trauma-informed services in both the public and private sectors. Her full article with references can be found on the MA website under publications/MAgisterate
Appendix ii

Six Domains of Trauma-Informed Services
(includes Five Core Values)

Questions to Consider

DOMAIN 1: FIVE CORE VALUES

Domain 1A. Safety—Ensuring Physical and Emotional Safety

Sample Specific Questions:

• How safe is the area around the program’s building? Are sidewalks and parking areas well-lit? How far do women need to walk to get to the building or program entrance? Is this walk a safe one?
• Are directions to the program’s location readily available? Are they clear?
• Once a woman arrives, are directions to the receptionist or other offices clear?
• Where are services delivered? In the office, institution, home, or community? What safety considerations are important in the location of various services?
• When are they delivered? Are there services available in addition to usual office hours? If so, what safety considerations are important in the timing of various services?
• Who is present (other clients, etc.)? Are security personnel present? What impact do these others have?
• What signs and other visual materials are there? Are they welcoming? Clear? Legible?
• Are doors locked or open? Are there easily accessible exits?
• How would you describe the reception and waiting areas, interview rooms, etc.? Are they comfortable and inviting?
• Are toilets easily accessible? Are there signs indicating their location?
• Are the first contacts with women welcoming, respectful, and engaging?
• Do clients receive clear explanations and information about each task and procedure? Are the rationales made explicit? Is the program mission explained? Are specific goals and objectives made clear? Does each contact conclude with information about what comes next?
• Are staff attentive to signs of client discomfort or unease? Do they understand these signs in a trauma-informed way?
• What events have occurred that indicate a lack of safety—physically or emotionally (e.g., arguments, conflicts, assaults)? What triggered these incidents? What alternatives could be put in place to minimize the likelihood of their recurrence?
• Is there adequate personal space for individual clients?
• In making contact with women, is there sensitivity to potentially unsafe situations (e.g., domestic violence)?
Domain 1B. Trustworthiness—Maximizing Trustworthiness through Task Clarity, Consistency, and Interpersonal Boundaries

Sample Specific Questions:

- Does the program provide clear information about what will be done, by whom, when, why, under what circumstances, at what cost, with what goals?
- When, if at all, do boundaries veer from those of the respectful professional? Are there pulls toward more friendly (personal information sharing, touching, exchanging home phone numbers, contacts outside professional appointments, loaning money, etc.) and less professional contacts in this setting?
- How does the program handle dilemmas between role clarity and accomplishing multiple tasks (e.g., especially in residential work and counseling or case management, there are significant possibilities for more personal and less professional relationships)?
- How does the program communicate reasonable expectations regarding the completion of particular tasks or the receipt of services? Is the information realistic about the program’s lack of control in certain circumstances (e.g., in housing renovation or time to receive entitlements)? Is unnecessary client disappointment avoided?
- What is involved in the informed consent process? Is both the information provided and the consent obtained taken seriously? That is, are the goals, risks, and benefits clearly outlined and does the client have a genuine choice to withhold consent or give partial consent?

Domain 1C. Choice—Maximizing Client Choice and Control.

Sample Specific Questions:

- How much choice does each woman have over what services she receives? Over when, where, and by whom the service is provided (e.g., time of day or week, office vs. home vs. other locale, gender of provider)?
- Does the client choose how contact is made (e.g., by phone, mail, to home or other address)?
- Does the program build in small choices that make a difference to client-survivors (e.g., When would you like me to call? Is this the best number for you? Is there some other way you would like me to reach you or would you prefer to get in touch with me?)
- How much control does the client have over starting and stopping services (both overall service involvement and specific service times and dates)?
- Is each client informed about the choices and options available?
- To what extent are the individual client’s priorities given weight in terms of services received and goals established?
- How many services are contingent on participating in other services? Do women get the message that they have to “prove” themselves in order to “earn” other services?
- Do women get a clear and appropriate message about their rights and responsibilities? Does the program communicate that its services are a privilege over which the woman has little control?
- Are there negative consequences for exercising particular choices? Are these necessary or arbitrary consequences?
- Does the woman have choices about who attends various meetings? Are support persons permitted to join planning and other appropriate meetings?

Domain 1D. Collaboration—Maximizing Collaboration and Sharing Power

Sample Specific Questions:

- Do women have a significant role in planning and evaluating the agency’s services? How is this “built in” to the agency’s activities? Is there a Client Advisory Board? Are there members who identify themselves as trauma survivors? Do these individuals understand part of their role to serve as client advocates? As trauma educators?
- Do providers communicate respect for the woman’s life experiences and history, allowing the client to place them in context (recognizing women’s strengths and skills)?
• In service planning, goal setting, and the development of priorities, are client preferences given substantial weight?
• Are women involved as frequently as feasible in service planning meetings? Are their priorities elicited and then validated in formulating the plan?
• Does the program cultivate a model of doing “with” rather than “to” or “for” clients?
• Does the program and its providers communicate a conviction that the woman is the ultimate expert on her own experience?
• Do providers identify tasks on which both they and clients can work simultaneously (e.g., information-gathering)?

Domain 1E. Empowerment—Prioritizing Empowerment and Skill-Building

Sample Specific Questions:
• Do client-survivor advocates have significant advisory voice in the planning and evaluation of services?
• In routine service provision, how are each woman’s strengths and skills recognized?
• Does the program communicate a sense of realistic optimism about the capacity of women to reach their goals?
• Does the program emphasize client growth more than maintenance or stability?
• Does the program foster the involvement of women in key roles wherever possible (e.g., in planning, implementation, or evaluation of services)?
• For each contact, how can the woman feel validated and affirmed?
• How can each contact or service be focused on skill-development or enhancement?
• Does each contact aim at two endpoints whenever possible: (1) accomplishing the given task and (2) skill-building on the part of the woman?

Domain 1F. Safety for Staff—Ensuring Physical and Emotional Safety

Sample Specific Questions:
• Do staff members feel physically safe? Do staff members provide services in areas other than the office? If so, what safety considerations are important?
• Do staff members feel emotionally safe? In relationships with administrators and supervisors, do staff members feel supported?
• Is the physical environment safe—with accessible exits, readily contacted assistance if it is needed, enough space for people to be comfortable, and adequate privacy?
• Do staff members feel comfortable bringing their clinical concerns, vulnerabilities, and emotional responses to client care to team meetings, supervision sessions or a supervisor?
• Does the program attend to the emotional safety needs of support staff as well as those of clinicians?

Domain 1G. Trustworthiness for Staff—Maximizing Trustworthiness through Task Clarity, Consistency, and Interpersonal Boundaries

Sample Specific Questions:
• Do program directors and clinical supervisors have an understanding of the work of direct care staff? Is there an understanding of the emotional impact (burnout, vicarious trauma, compassion fatigue) of direct care? How is this understanding communicated?
• Is self-care encouraged and supported with policy and practice?
• Do all staff members receive clinical supervision that attends to both client and clinician concerns in the context of the clinical relationship? Is this supervision clearly separated from administrative supervision that focuses on such issues as paperwork and billing?
• Do program directors and supervisors make their expectations of staff clear? Are these consistent and fair for all staff positions, including support staff?
• Do program directors and supervisors make the program’s mission, goals, and objectives clear?
• Do program directors and supervisors make specific plans for program implementation and changes clear? Is there consistent follow through on announced plans? Or, in the event of changed plans, are these announced and reasons for changes explained?

• Can supervisors and administrators be trusted to listen respectfully to supervisees’ concerns—even if they don’t agree with some of the possible implications?

**Domain 1H. Choice for Staff—Maximizing Staff Choice and Control.**

*Sample Specific Questions:*

- Is there a balance of autonomy and clear guidelines in performing job duties? Is there attention paid to ways in which staff members can make choices in how they meet job requirements?

- When possible, are staff members given the opportunity to have meaningful input into factors affecting their work: size and diversity of caseload, hours and flex-time, when to take vacation or other leave, kinds of training that are offered, approaches to clinical care, location and décor of office space?

**Domain 1I. Collaboration for Staff—Maximizing Collaboration and Sharing Power**

*Sample Specific Questions:*

- Does the agency have a thoughtful and planned response to implementing change that encourages collaboration among staff at all levels, including support staff?

- Are staff members encouraged to provide suggestions, feedback, and ideas to their team and the larger agency? Is there a formal and structured way that program administrators solicit staff members’ input?

- Do program directors and supervisors communicate that staff members’ opinions are valued even if they are not always implemented?

**Domain 1J. Empowerment for Staff—Prioritizing Empowerment and Skill Building**

*Sample Specific Questions:*

- Are each staff member’s strengths and skills utilized to provide the best quality care to clients and a high degree of job satisfaction to that staff member?

- Are staff members offered development, training, or other support opportunities to assist with work-related challenges and difficulties? To build on staff skills and abilities? To further their career goals?

- Do all staff members receive annual training in areas related to trauma, including the impact of workplace stressors?

- Do program directors and supervisors adopt a positive, affirming attitude in encouraging staff, both clinicians and support staff, to fulfill work tasks?

- Is there appropriate attention to staff accountability and shared responsibility or is there a “blame the person with the least power” approach? Is supervisory feedback constructive, even when critical?

**DOMAIN 2. FORMAL SERVICES POLICIES**

*Some Possible Indicators:*

- Policies regarding confidentiality and access to information are clear; provide adequate protection for the privacy of both clients and staff members; and are communicated to the client and staff in an appropriate way.

- The program avoids involuntary or potentially coercive aspects of treatment—involuntary hospitalization or medication, representative payeeship, outpatient commitment—whenever possible.

- The program has developed a de-escalation or “code blue” policy that minimizes the possibility of retraumatization.

- The program has developed ways to respect client preferences in responding to crises—via “advance directives” or formal statements of client choice.
• The program has a clearly written, easily accessible statement of clients’ and staff members’ rights and responsibilities as well as a grievance policy.
• The program’s policies address issues related to staff safety. For example:
  • Policies address if and when a staff member may be alone in the building or on duty.
  • Policies govern specific ways for staff to offer home - or community-based services.
  • Incident reviews follow verbal or physical confrontations and lead to effective plans to reduce staff vulnerability.

**DOMAIN 3A. THEORETICAL FOUNDATION AND PROGRAMME DESIGN FOR WOMEN**

*Some Possible Indicators:*

- The program design has a theoretical foundation based on research on women.
- The implementation of the program considers the women being served.

**DOMAIN 3B. TRAUMA SCREENING, ASSESSMENT, SERVICE PLANNING AND TRAUMA-SPECIFIC SERVICES**

*Some Possible Indicators:*

- Staff members have reviewed existing instruments to see the range of possible screening tools.
- At least minimal questions addressing physical and sexual abuse are included in trauma screening.
- Screening avoids overcomplication and unnecessary detail so as to minimize stress for women.
- The program recognizes that the process of trauma screening is usually much more important than the content of the questions. The following have been considered:
  - What will it mean to ask these questions?
  - How can they be addressed most appropriately—for the likely clients, for the service context, time available, prior relationship, possible future relationship, at various points in the intake/assessment process?
- The need for standardization of screening across sites is balanced with the unique needs of each program or setting.
- The screening process avoids unnecessary repetition. While there is no need to ask the same questions at multiple points in the intake or assessment process, there is often a good rationale for returning to the questions after some appropriate time interval.
- Screening is followed as appropriate (given the nature and goals of the program, the length of time clients are involved, and the specific relationships established with staff members) by a more extensive assessment of trauma history (type, duration, and timing of trauma) and of trauma-related sequelae (addressing resilience-related strengths and coping skills as well as vulnerabilities and problems).
- In service planning, clinicians and clients discuss ways in which trauma may be taken into account in clinicians’ work with the client to achieve the client’s goals (e.g., the place of trauma and trauma-related strengths and problems in giving shape to the recovery plan, its priorities, and the services and other supports that may be useful).
- The program either offers or makes referrals to accessible, affordable, and effective trauma-specific services. Group and individual approaches to trauma recovery and healing are both available.

**DOMAIN 3C. GENDER-RESPONSIVE TRAUMA SERVICES**

*Some Possible Indicators:*

- Trauma-specific services are provided.
- All trauma-specific services are designed for women.
DOMAIN 4. ADMINISTRATIVE SUPPORT FOR PROGRAMME-WIDE TRAUMA-INFORMED SERVICES

Some Possible Indicators:

- The existence of a policy statement or the adoption of general policy statement from other organizations that refers to the importance of trauma and the need to account for client experiences of trauma in service delivery.
- The existence of a “trauma initiative” (e.g., workgroup, trauma specialist).
  - Designation of a competent person with administrative skills and organizational credibility for this task.
  - Chief administrator meets periodically with trauma workgroup or specialist.
  - Administrator supports the recommendations of the trauma workgroup or specialist and follows through on these plans.
- Administrators work closely with a Client Advisory group that includes significant trauma survivor membership. Client-survivor members of this group identify themselves as trauma survivors and understand a part of their role as client advocacy. They play an active role in all aspects of service planning, implementation, and evaluation.
- Administrators make collaboration and shared decision-making a key part of their leadership style. When working with staff members and client advisors, they listen respectfully and solicit ideas for project development. Whenever possible and practical, they involve both staff and clients in planning, implementing, and evaluating program changes.
- Administrators make basic resources available in support of trauma-informed service modifications (e.g., time, space, training money).
- Administrators support the availability and accessibility of trauma-specific services where appropriate; they are willing to be creative about finding alternative reimbursement strategies for trauma services.
- Administrators find necessary sources of funding for trauma training and education (this sometimes requires going outside the usual funding mechanisms in a creative way).
- Administrators are willing to release both direct service and support staff from their usual duties so that they may attend trainings, plan trauma-informed changes, and deliver trauma-specific services. Funding is sought in support of these activities.
- Administrators are willing to attend trauma training themselves (vs. sending designees in their places); they allocate some of their own time to trauma-focused work (e.g., meeting with trauma initiative representatives, keeping abreast of trauma initiatives in similar program areas).
- Administrators participate actively in identifying objectives for systems change.
- Administrators monitor the program’s progress by identifying and tracking core objectives of the trauma-informed change process.
- Administrators may arrange pilot projects for trauma-informed parts of the system.

DOMAIN 5. STAFF TRAUMA TRAINING AND EDUCATION

Some Possible Indicators:

- General education (including basic information about trauma and its impact) has been offered for all employees in the program with a primary goal of sensitization to trauma-related dynamics and the avoidance of retraumatization.
- Staff members have received education in a trauma-informed understanding of unusual or difficult behaviors. (One of the emphases in such training is on respect for people’s coping attempts and avoiding a rush to negative judgments.)
- Staff members have received basic education in the maintenance of personal and professional boundaries (e.g., confidentiality, dual relationships, sexual harassment).
- Clinical staff members have received trauma education involving specific modifications of services in their content area: clinical, residential, case management, substance use, for example.
• Staff members have received training in basic coping skills for trauma survivors, including psychoeducational framing of trauma-related experiences and coping responses, grounding and emotional modulation techniques, and safety planning,
• Trauma clinicians have received training in additional skills-based and other trauma-specific approaches.
• Staff members offering trauma-specific services are provided adequate support via supervision and/or consultation (including the topics of vicarious traumatization and clinician self-care).

**DOMAIN 6. HUMAN RESOURCES PRACTICES: "TO WHAT EXTENT ARE TRAUMA-RELATED CONCERNS PART OF THE HIRING AND PERFORMANCE REVIEW PROCESS?"

Some Possible Indicators:

• The program seeks to hire (or identify among current staff) trauma “champions,” individuals who are knowledgeable about trauma and its effects; who prioritize trauma sensitivity in service provision; who communicate the importance of trauma to others in their work groups; and who support trauma-informed changes in service delivery.
• Prospective staff interviews include trauma content (What do applicants know about trauma? about domestic violence? about the impact of childhood sexual abuse? Do they understand the long-term consequences of abuse? What are applicants’ initial responses to questions about abuse and violence?)
• Incentives, bonuses, and promotions for line staff and supervisors take into account the staff member’s role in trauma-related activities (specialized training, program development, etc.).

Adapted from Roger Fallot, Ph.D. & Maxine Harris, Ph.D.
Appendix iii

Walk-Through Exercise and Team Meeting

Walk-Through Exercise
For maximum effectiveness, a manager and/or client advocate/mentor should be part of the walk-through of the agency. Begin with calling the intake point as a potential client and document the process of admission. Examples: Do you get a welcoming, respectful, and engaging person on the phone? Do you have to call back? Do you feel motivated to enter the program?

Then, set up an intake appointment/screening and assessment. Proceed through the entire process of entering the program and experiencing the first few days/sessions of treatment, case management, etc.

Document the process, as well as your feelings at each step of the process, and identify problems/barriers/bottlenecks.

Questions to guide the assessment of the program.

A. Safety
1. Where are services delivered? Does the agency location feel safe?
2. Are security personnel present?
3. How would you describe the reception and waiting areas? Are they comfortable and inviting?
   a. Interview rooms?
   b. Children’s space? Play area?
   c. Bedrooms (for residential)?
4. Are the first contacts with consumers welcoming, respectful, and engaging?
5. Do the clients receive clear explanations and information about each program procedure?
6. Are staff attentive to signs of consumer discomfort or unease? What do staff do about the discomfort?
7. Are there any events that indicate a lack of safety, e.g., arguments, conflicts, etc.?
8. In intake, is there sensitivity to unsafe situations, such as domestic violence? Is the client asked about the safety of his/her current living situation?
9. Do staff understand the need for clear boundaries? Do staff maintain boundaries?

B. Choices
1. How much choice does the client have over what services s/he receives? Are clients given choices regarding services for their children?
2. Do the clients have a choice how contact is made (e.g., by phone, mail, visit to home)?
3. Do the clients get a clear and appropriate message about their rights and responsibilities?
4. Do the clients have a significant role in planning and evaluating the agency’s services?
5. Do providers communicate respect for the clients’ life experiences and histories?

C. Service Policies
1. Are policies regarding confidentiality clear and do they provide adequate protection for the privacy of consumers?
2. Does the program avoid involuntary or potentially coercive aspects of treatment, whenever possible?
3. Has the program developed a de-escalation policy that minimizes the possibility of re-traumatization?
4. Are staff sensitive to the potential of re-traumatization of the clients during certain procedures (e.g., urine testing, searching belongings, administration of medications)?
D. Trauma Screening, Assessment, and Service Planning

1. Are two questions about trauma, at a minimum, included in program screening:
   a. Have you experienced sexual abuse at any time in your life?
   b. Have you experienced physical abuse at any time in your life? If yes, currently?

2. Does the screening/assessment integrate substance use, mental health, and trauma?
3. Does the program recognize that the process of screening and assessment is as important as the content?
4. Does the screening and assessment process avoid unnecessary repetition?
5. Do staff have an understanding of the clients’ cultural/ethnic/racial identities and how trauma may have different meanings for different cultural groups (e.g., historical trauma)?
6. Are initial community support contacts facilitated for the clients? Are transitions from one phase of treatment/service to another facilitated?

E. Services

1. Are trauma-specific services available?
2. If possible, observe a trauma-specific group (e.g., Seeking Safety). How do the clients respond to the content and the facilitators? Are clients taught skills (e.g., grounding and self-soothing) for dealing with trauma symptoms?
3. Do staff use shaming or demeaning language?

Team Meeting

When you have completed the walk-through, meet with the team. For each trigger or barrier you have identified, brainstorm with your team members what possible changes could be made. At this point, if staff need to get back to their work, schedule another session. When time is available, the team then can begin to rate priority (greatest risks) and feasibility (how “doable”) for each possible change listed. The team then discusses how these possible solutions fit into an Action Plan, including who might be responsible for taking the lead on each action item and the dates when each item is to be completed. Then discuss the proposed Action Plan with managers and staff, and revise if necessary. The Plan-Do-Study-Act (PDSA) option allows staff to try out all possible solutions/changes they have come up with and to see which lead to the best outcomes.

Although originally enumerated as components of the walk-through process, the following issues also would be addressed in the Team meeting after the walk through has ended.

F. Administrative Support for Trauma-Informed Services

1. Is there a “trauma initiative” in place in the program (e.g., workgroup, trauma specialist)?
2. Is there a consumer advisory group that includes significant trauma survivor membership?
3. Have administrators attended trauma trainings?
4. Do administrators make basic resources available in support of trauma-informed service modifications (e.g., time, space, training funds)?

G. Staff Trauma Training

1. Has general education (including basic information about trauma and its impact) been offered to all employees in the program?
2. Have clinical staff members received trauma training involving specific modifications for trauma survivors in their program areas: clinical, residential, case management, outpatient, substance use?
3. Have staff members received training in trauma-specific interventions?
4. Are staff aware of current knowledge, theory, and treatment models from a variety of diverse knowledge bases?
5. Are the staff who are offering trauma-specific services provided adequate support via supervision and/or consultation?
6. Have staff been educated about vicarious traumatization and staff self-care?

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Moving toward Trauma-Informed Practice in Addiction Treatment: A Collaborative Model of Agency Assessment
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Moving toward Trauma-Informed Practice in Addiction Treatment: A Collaborative Model of Agency Assessment

Vivian Barnett Brown, Ph.D.; Maxine Harris, Ph.D. & Roger Fallot, Ph.D.

Abstract — Clients in substance abuse treatment need, in addition to evidence-based and sensitive treatment services in general, a system of care that takes into account the impact of trauma and violence in so many of their lives. In addition, services need to be delivered in a way that avoids triggering trauma memories or causing unintentional re-traumatization. To that end, this article describes an agency self-assessment process that combines a trauma-informed assessment, a NIATx process of “walking-through” and use of the Institute of Healthcare Improvement’s Plan-Do-Study-Act (PDSA) cycles, and a user-friendly format. The trauma-informed assessment is designed to address issues of safety of clients and staff members, reduction of re-traumatization, consistency in practice, and client empowerment. It brings a non-judgmental, collaborative approach to process and practice improvement. The article describes how the assessment process can be—and has been—used to develop an Action Plan, including trainings and the identification of “trauma champions”; i.e., staff who will continue to spread trauma-informed changes and new evidence-based practices throughout the agency. As we enter a period of healthcare reform, addressing trauma as an integral part of addiction treatment also allows us to better deal with the totality of our clients’ health problems.

Keywords — addiction treatment, agency assessment, trauma-informed, walk-through

INTRODUCTION

The majority of men and women in substance abuse treatment programs have histories of trauma and abuse (Najavits, Weiss & Shaw 1997; Ouimette et al. 2000; Cohen et al. 2004; Khoury et al. 2010). In addition, approximately 35-50% of individuals in addiction treatment have a lifetime diagnosis of post-traumatic stress disorder (PTSD) (Back et al. 2000; Jacobsen, Southwick & Kosten 2001; Brady, Back & Coffey 2004). Studies have shown that co-occurring PTSD and substance use disorders add to greater problem severity and have negative addiction implications. Persons with these co-occurring disorders respond less favorably to treatment, drop out of treatment earlier, and are less likely to remain in continuing care (Ross, Cutler & Sklar 1997; Brown, Melchior & Huba 1999; Claus & Kindleberger 2002).

Historically, addiction treatment programs did not address trauma and/or PTSD for fear of exacerbating trauma symptoms (e.g., nightmares, flashbacks) and jeopardizing early and unstable periods of abstinence.
in their clients. However, the studies above show that not addressing clients’ trauma may lead to inadequate recovery and negative outcomes such as treatment drop-out.

In general, systems serving individuals with co-occurring disorders (such as mental health issues, substance use disorders, health conditions, and trauma) have been characterized by compartmentalization, fragmentation, and a tendency to operate independently from one another. As we enter a period of healthcare reform, it is important to note that research continues to document the importance of trauma as a focus of client-centered practice. Rosenberg (2011) has stated that we cannot begin to address the totality of a client’s healthcare, “unless we address the trauma that precipitates many chronic diseases.” Nor can we reduce healthcare costs without taking trauma into account. The Adverse Childhood Experiences (ACE) Study revealed the economic costs of untreated trauma-related substance abuse disorders alone were estimated at $161 billion in 2000 (Felitti & Anda 2010).

It has been proposed that our clients need, in addition to good, evidence-based clinical services in general, a system of care that is trauma-informed; i.e., one that takes into account the role and impact of trauma and violence in their lives, that accommodates the vulnerabilities of trauma survivors, and that allows services to be delivered in a way that avoids triggering trauma memories or causing unintentional re-traumatization (Herman 1992; Harris & Fallot 2001; Gatz et al. 2007). Some of the most dramatic examples of re-traumatization occurred in our psychiatric institutions when seclusion and restraint procedures were used with trauma survivors, many of whom suffered serious consequences (Jennings 1998). In addition, consumers surveyed about their experiences in behavioral healthcare settings reported violence and fear of violence (including seclusion and restraint), as well as negative interactions with staff and feelings of being disrespected. These experiences have been called “sanctuary harm” (Robins et al. 2005).

Clients who have been traumatized enter our agencies upset and fearful of being hurt and betrayed by providers. Trust has been broken by the trauma experience. They may enter an agency afraid that they will be labeled as “crazy,” as “bad mothers” (and thus risk losing their children), and/or as “bad addicts.” It should not be surprising, therefore, that many will act vigilant, suspicious, and sometimes belligerent. It is important that substance abuse providers lead the way in understanding and responding to the challenges posed by our clients’ widespread experience of trauma. Staff are in key positions to change our services to ensure that “we do no harm.” They can help transform our system and other collaborating systems (mental health, health, criminal justice, child welfare, and education) to become trauma-informed. To that end, this paper is designed to assist addiction treatment providers to work with their own agencies and their partners to make this transformation effectively.

Trauma violates our beliefs that the world is a safe place and that people can be trusted. Herman (1992, p. 159) wrote “the first task of recovery is to establish the survivor’s safety. This task takes precedence over all others, for no other therapeutic work can possibly succeed if safety has not been adequately secured.” Establishing safety is a multi-layered process. It begins by focusing on the body (e.g., taking care of injuries, medical exams, medications) and then on controlling the environment. The process of establishing safety may be hampered if the survivor encounters an unprotected environment. Therefore, a safe physical environment—one that has building security, good lighting, and quiet rooms or other spaces—is one of the primary components of a trauma-informed agency.

The task of establishing safety is particularly complex when the client is still involved in a relationship that has been abusive in the past. Trauma-informed agencies incorporate safety plans to keep clients safe from violent partners. They help clients identify both potential triggers and self-care techniques to use when they feel they are losing control (Massachusetts Department of Mental Health 1995). Creating trauma-informed organizations requires continual review of policies and procedures to identify possible re-traumatization.

The final aspect of safety concerns the ways in which clinicians and other staff interact with clients. As Herman (1992) states, since trauma occurs (most often) in relationships, healing from trauma needs to take place within the context of relationships with safe and trustworthy helpers. In addition, many staff members in addiction treatment programs are themselves trauma survivors and many have not addressed the consequences of their own traumas. While this lived experience may make them more empathic with their clients, it also places them in a position to be overwhelmed and/or triggered by client’s stories of trauma.

In addition to promoting both physical and emotional safety in care settings, other principles of “trauma-informed care” include: an understanding of trauma and its impact; supporting consumer control and choice; enhancing collaboration between provider and consumer; empowerment; and ensuring cultural competence (Fallot & Harris 2009; Harris & Fallot 2001). But what does “trauma-informed” look like in practice? How do we know whether our agency is trauma-informed and, if it is not, how do we change it?

The trauma assessment and walk-through protocol described below was developed and refined in the SAMHSA-funded National Women with Co-Occurring Disorders and Violence Study (WCDVS) and a nationwide learning collaborative called the Network for the Improvement of Addiction Treatment (NIATx). The system improvement algorithm applies the Plan-Do-Study-Act (PDSA) framework. The three authors of this paper
all participated in the WCDVS, and the first author was also a participant in the first wave of NIATx grantees. In these experiences, the authors transformed their agencies to become trauma-informed and have a number of years of experience utilizing the Trauma Assessment and implementing walk-throughs and PDSA cycles. (There are a number of agency assessments looking at trauma-informed practices that have been developed, including The Child Traumatic Stress Network (CTSN), the WELL Assessment by Institute for Health and Recovery (IHR), The SHE Framework by the B.C.Women’s Hospital and Health Centre in Vancouver, and the National Center for Homelessness.)

**DEVELOPING AN ASSESSMENT PROTOCOL**

The WCDVS found that attending to trauma in addiction and mental health treatment improves the effectiveness of treatment for women (Gatz et al. 2007; Morrissey et al. 2005). The study also showed that women diagnosed with serious mental illness and addiction disorders found trauma-informed, integrated treatment to be more responsive to their needs and those of their children than was treatment as usual. Lessons learned from the study included specific steps that were effective in transforming systems from a traditional approach to a trauma-informed one.

In 2004, Fallot and Harris developed an Agency Self-Assessment protocol for agency staff members to determine whether their agency was trauma-informed and to decide what steps were needed to resolve any gaps (Harris & Fallot 2004). The Fallot and Harris Assessment defined five core elements of a trauma-informed system: safety; trustworthiness; collaboration; choice; and empowerment. The broad assessment questions look at whether the agency: ensures the physical and emotional safety of clients and of staff members and minimizes re-traumatization (safety); provides clear information about what the client may expect in the program, ensures consistency in practice, and maintains boundaries (trustworthiness); prioritizes consumer choice and control, maximizes collaboration and the sharing of power with consumers, emphasizes consumer empowerment, recognizes consumer strengths, and builds skills (empowerment). Each of these elements are utilized as a pre-post measure in the assessment; i.e., what does the agency look like at baseline and what does it look like after training and consultation has taken place.

In the early 2000s, the Robert Wood Johnson Foundation (RWJF) and the Center for Substance Abuse Treatment (CSAT) undertook a nationwide effort to identify and address barriers to access to and retention in addiction treatment. RWJF’s Path to Recovery initiative (begun in 2001) and CSAT’s Strengthening Treatment Access and Retention (STAR) program (begun in 2003) formed NIATx. As part of the application process for NIATx, substance abuse treatment providers conducted walk-throughs to identify problematic practices that needed to be changed in order to improve service delivery (Gustafson, 2004).

The agency trauma assessment was then adapted (2008) by the first author of this paper as a “walk-through” (available at http://www.niatx.net) that allows staff and clients/consumers to move through the providers’ processes step by step in order to identify “triggers” or potential re-traumatizing procedures and to develop an Action Plan that includes a number of possible ways to eliminate/mitigate each potential trigger (see Table 1). Walk-throughs enable organizations to better understand the experience of care from their clients’ points of view; assist staff members to understand how they may be inadvertently re-enact trauma dynamics; can uncover assumptions, inconsistencies, and limitations of systems; and generate ideas for improving organizational processes.

Addiction treatment providers understand that confronting staff and agency administrators with their deficits is not a very effective way to help change a system. The walk-through is a mutual data-gathering strategy that does not feel judgmental because the process is placed in the context that we now know more than we did when some of the treatment procedures and practices were put in place and that only when we look through a “trauma lens” do we understand that we may have been unintentionally re-traumatizing clients. The walk-through also assists in the building of “trauma champions” i.e., staff who will continue to spread trauma-informed changes and new evidence-based practices throughout the organization. The walk-through assessment thus becomes an important intervention in and of itself. Trainings and technical assistance then grow out of the assessment and Action Plan. It is a working document, a collaborative effort to improve the way the agency provides services, based on the facts that: (1) trauma is the “expectation, not the exception” in our clients’ lives; and (2) we now have data that show how we can improve care for individuals who have been traumatized.

The assessment allows the team (managers, staff, and senior clients or program graduates) to walk through the agency procedures from the first call to the agency, to the intake process, to the first counseling session, and all the way through termination or transfer to another level of care. The constant question is: “Could this procedure/step/practice/design element upset or trigger the client?” In some treatment programs that are residential, there are a number of common practices that can potentially trigger/upset clients. For example, in one agency, staff reported that a client “had a panic attack” when the counselor came into the dormitory room to do a night-check. It was a relatively easy fix to explain to the staff that, for a client who has been a survivor of childhood sexual abuse, someone unexpectedly showing up in her room at...
TABLE 1
Guidelines for Trauma-Informed Assessment

Walk-Through Exercise
For maximum effectiveness, a manager and/or client advocate/mentor should be part of the walk-through of the agency. Begin with calling the intake point as a potential client and document the process of admission. Examples: Do you get a welcoming, respectful, and engaging person on the phone? Do you have to call back? Do you feel motivated to enter the program? Then, set up an intake appointment/screening and assessment. Proceed through the entire process of entering the program and experiencing the first few days/sessions of treatment, case management, etc. Document the process, as well as your feelings at each step of the process, and identify problems/barriers/bottlenecks.

Questions to guide the assessment of the program.

A. Safety
1. Where are services delivered? Does the agency location feel safe?
2. Are security personnel present?
3. How would you describe the reception and waiting areas? Are they comfortable and inviting?
   a. Interview rooms?
   b. Children’s space? Play area?
   c. Bedrooms (for residential)?
4. Are the first contacts with consumers welcoming, respectful, and engaging?
5. Do the clients receive clear explanations and information about each program procedure?
6. Are staff attentive to signs of consumer discomfort or unease? What do staff do about the discomfort?
7. Are there any events that indicate a lack of safety, e.g., arguments, conflicts, etc.?
8. In intake, is there sensitivity to unsafe situations, such as domestic violence? Is the client asked about the safety of his/her current living situation?
9. Do staff understand the need for clear boundaries? Do staff maintain boundaries?

B. Choices
1. How much choice does the client have over what services s/he receives? Are clients given choices regarding services for their children?
2. Do the clients have a choice how contact is made (e.g., by phone, mail, visit to home)?
3. Do the clients get a clear and appropriate message about their rights and responsibilities?
4. Do the clients have a significant role in planning and evaluating the agency’s services?
5. Do providers communicate respect for the clients’ life experiences and histories?

C. Service Policies
1. Are policies regarding confidentiality clear and do they provide adequate protection for the privacy of consumers?
2. Does the program avoid involuntary or potentially coercive aspects of treatment, whenever possible?
3. Has the program developed a de-escalation policy that minimizes the possibility of re-traumatization?
4. Are staff sensitive to the potential of re-traumatization of the clients during certain procedures (e.g., urine testing, searching belongings, administration of medications)?

D. Trauma Screening, Assessment, and Service Planning
1. Are two questions about trauma, at a minimum, included in program screening:
   a. Have you experienced sexual abuse at any time in your life?
   b. Have you experienced physical abuse at any time in your life? If yes, currently?
2. Does the screening/assessment integrate substance use, mental health, and trauma?
3. Does the program recognize that the process of screening and assessment is as important as the content?
4. Does the screening and assessment process avoid unnecessary repetition?
5. Do staff have an understanding of the clients’ cultural/ethnic/racial identities and how trauma may have different meanings for different cultural groups (e.g., historical trauma)?
6. Are initial community support contacts facilitated for the clients? Are transitions from one phase of treatment/service to another facilitated?

E. Services
1. Are trauma-specific services available?
2. If possible, observe a trauma-specific group (e.g., Seeking Safety). How do the clients respond to the content and the facilitators?
   Are clients taught skills (e.g., grounding and self-soothing) for dealing with trauma symptoms?
3. Do staff use shaming or demeaning language?

(Continued)
TABLE 1
(Continued)

Team Meeting
When you have completed the walk-through, meet with the team. For each trigger or barrier you have identified, brainstorm with your team members what possible changes could be made. At this point, if staff need to get back to their work, schedule another session. When time is available, the team then can begin to rate priority (greatest risks) and feasibility (how “doable”) for each possible change listed. The team then discusses how these possible solutions fit into an Action Plan, including who might be responsible for taking the lead on each action item and the dates when each item is to be completed. Then discuss the proposed Action Plan with managers and staff, and revise if necessary. The Plan-Do-Study-Act (PDSA) option allows staff to try out all possible solutions/changes they have come up with and to see which lead to the best outcomes. Although originally enumerated as components of the walk-through process, the following issues also would be addressed in the Team meeting after the walk through has ended.

F. Administrative Support for Trauma-Informed Services
1. Is there a “trauma initiative” in place in the program (e.g., workgroup, trauma specialist)?
2. Is there a consumer advisory group that includes significant trauma survivor membership?
3. Have administrators attended trauma trainings?
4. Do administrators make basic resources available in support of trauma-informed service modifications (e.g., time, space, training funds)?

G. Staff Trauma Training
1. Has general education (including basic information about trauma and its impact) been offered to all employees in the program?
2. Have clinical staff members received trauma training involving specific modifications for trauma survivors in their program areas: clinical, residential, case management, outpatient, substance use?
3. Have staff members received training in trauma-specific interventions?
4. Are staff aware of current knowledge, theory, and treatment models from a variety of diverse knowledge bases?
5. Are the staff who are offering trauma-specific services provided adequate support via supervision and/or consultation?
6. Have staff been educated about vicarious traumatization and staff self-care?

THE ASSESSMENT PROCESS

The walk-through involves specific steps, the first being the selection of the team—ideally one or two managers, one or two staff members, and one or two senior clients/graduates. The staff member leading the assessment should present a briefing on trauma and trauma-informed practice. Part of that briefing is the discussion of re-traumatization and the need to look at practices in order to avoid any “triggers” for the client. Next, the team reviews the Trauma Assessment. When they are ready to do the assessment, they need to let all staff know in advance that they are implementing the walk-through. The team then goes through the experience just as a client would go through the program. At each step, they write down any possible trigger or barrier on the worksheet.

Once the team has identified all potential triggers, they brainstorm what possible changes could be made to eliminate/mitigate each trigger or barrier. The team can then rate which changes are most urgently needed and which solutions are the most feasible to implement.

Alternatively, staff may decide to do PDSA experiments (Institute for Healthcare Improvement, Network for Improvement of Addiction Treatment) on each possible solution they identify. The PDSA cycle, which tests multiple possible changes on a small scale, is an important way of reducing staff fears of making changes, deciding which combination of changes will have the greatest impact, and minimizing resistance upon implementation of changes in practice. In addition, staff can test their ideas in the field, rather than spend a great deal of time trying to conceptualize a “better way” of practice. In a PDSA cycle, the goal is to test a particular change on a small scale, learn what you can, and get better in the next application.

The steps in the PDSA cycle are: (1) PLAN – state the objective of the test, make predictions about what will happen, and develop a plan to test the change and identify what data needs to be collected; (2) DO – try out the test on a small scale (e.g., test on the next five clients), document problems and unexpected observations, analyze data; (3) STUDY – set aside time to study the results, compare
the data to the team’s predictions, and reflect upon what was learned; (4) ACT – refine the change based upon what was learned and prepare the plan for the next change. If the test shows that a change is not leading to improvement, the test should be stopped.

Examples of possible changes include the following. Under the category of “choice/control,” the staff could give each the client a list and description of all groups available and ask which ones she would care to attend. To improve “safety,” the Massachusetts De-Escalation Scale (Massachusetts Department of Mental Health 1995) could be utilized. This instrument asks clients what situations might cause them to be upset and what might help calm them when they are getting upset. As part of the Action Plan, trainings for groups of staff and all staff are often suggested by the team. It is later that a comprehensive look at all policies, staffing, and HR practices can take place; by this point, potential defensiveness on the part of staff should have been diminished.

This assessment has been utilized in a county in California as part of a Family Drug Court Collaborative. All key collaborating agency staff members took part in the assessment of the steps by which families go through the court processes. This led to the development of a comprehensive Action Plan to make the court more trauma-informed. Table 2 illustrates, for one category, how the assessment works.

In a recent qualitative study (Drabble, Jones & Brown 2013), staff members and administrators from a variety of agencies involved in a California county’s Family Drug Court Collaborative reported that the Trauma-Informed Assessment: (1) heightened their awareness of what parents have to go through and how that impacts their children; (2) increased their understanding of trauma; (3) increased their sensitivity and respect for parents, which, in turn, helped them find better ways to affirm parents in their parenting roles; (4) challenged them to examine how they inadvertently contribute to re-traumatizing their clients; and (5) helped them understand what it means to be trauma-informed.

The model of trauma assessment we are proposing is a first step in moving us toward a collaborative, trauma-informed health and behavioral health system of care.

DISCUSSION

Becoming trauma-informed involves a shift in culture, practice, and theoretical framework (Harris & Fallot 2001). This shift can seem daunting for agencies and staff who are struggling with multiple demands, funding cutbacks, and major changes in healthcare that will directly impact addiction treatment. However, many facility and process improvements involve little or no cost while offering large payoffs in client outcomes. The proposed trauma-informed protocol combines a trauma-informed assessment, a NIATx process of “walking-through,” with which many substance abuse treatment providers are already familiar, and a user-friendly format. While resources are limited in these economic times, this process can be conducted with relatively little expense.

By including senior residents or recent graduates of addiction treatment, as well as staff with lived experience of trauma, this process can focus on aspects of services that
may be quite different from those that clinicians and managers believe need changing. Clients are often best placed to identify the things that are not working and to offer clear and direct ideas on how to improve things. Making improvements requires focusing on solutions, rather than fixating on problems and, perhaps, finding fault. Measuring change as it happens enables quick decisions to be made and plans to evolve. There is an emphasis on quality improvement and the development of a network of trauma champions.

In addition, having trainings on trauma and on trauma-informed care grow out of the assessment can lead to more meaningful staff support of and active engagement in the trainings. Examples include: a requested training on trauma and men, specifically Latino and Vietnamese men, that evolved from the assessment in a substance abuse treatment program; a requested training on trauma-informed children’s activities; and a requested training on trauma and staff self-care. Before engaging in the assessment, all staff members can benefit from a general training on trauma in order to help them understand that trauma is the expectation, not the exception. This training should include receptionists, security personnel, and kitchen staff. The purpose of the training is to help everyone become more aware of and sensitive to issues of trauma and less likely to frighten or upset clients seeking services. In the case of non-counseling staff, training also helps them to feel empowered and reduces their discomfort around responding to trauma survivors.

Assessment tools, such as the trauma-informed systems walk-through, are important for organizational and service delivery improvement. They can help bring about meaningful systems change at minimal cost, or even in cost-neutral ways. This is especially critical given the current fiscal climate. An important part of the systems change is the awareness that trauma-informed practice includes the implementation of trauma-specific interventions; i.e., those groups and individual sessions that focus directly on helping clients learn to cope with their trauma histories. Some examples of trauma-specific interventions are Seeking Safety (Najavits 2002) and Trauma Recovery and Empowerment (TREM) (Harris 1998). A monograph (Finkelstein et al. 2004) was written to assist substance abuse agencies in selecting an appropriate trauma-specific intervention for their clients.

There is also an understanding that trauma is not confined to the behavioral health system, but is integral to other collaborating systems including healthcare, criminal justice, education, child welfare, and military systems. As we plan for implementation of services under the Affordable Care Act, improvements in the entire system of services that impact clients with addictive disorders is an important next step. Looking through the “trauma-lens” at all services and practices will not only improve those services and practices, but can improve both the healthcare and behavioral healthcare systems as a whole.

REFERENCES


In order to implement trauma-informed services, the following overarching strategies are applicable to all of the core values and domains:

**Adopt**
Each value and domain should be adopted as policy on a system-wide and programmatic level.

**Support**
Adoption and implementation should receive full support of the administration.

**Resources**
An evaluation of financial and human resources should occur to ensure adequate implementation and allocation adjustments made to accommodate any new policies and practices.

**Training**
Ongoing training is essential to the implementation of trauma-informed practices.

**Oversight**
Oversight of the new policies and practices should be included in management plan development.

**Congruence**
Procedural review is essential in order that procedures are adapted/deleted/written for new policies.

**Environment**
Ongoing assessment and review of the culture/environment should occur to monitor attitudes, knowledge, and behavior of administration, management, and line staff.

**Evaluation**
An evaluation process should be developed to consistently assess management, supervision, and services.

Creating Trauma-Informed and Gender-Responsive Systems of Care
Implementation Plan and Goal Attainment Scale for United Kingdom

DOMAIN 1A: Safety – Ensuring Physical and Emotional Safety
The organisation considers gender-responsive issues (i.e. what are the different issues to consider for women and men) to ensure the physical and emotional safety of women. For each identified issue with ensuring physical and emotional safety for women, specify the required action to resolve the issue, the timeframe, and the person responsible for that resolution.

<table>
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<th>Safety Issue</th>
<th>Who is responsible?</th>
<th>Who else is on the team?</th>
<th>Timeline?</th>
<th>Goal Attained* 1-3</th>
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* Scoring Code: (1) goal has not been met and has been dropped from future plans; (2) goal still needs work and will be included in future plans; or (3) goal has been fully met
Creating Trauma-Informed and Gender-Responsive Systems of Care
Implementation Plan and Goal Attainment Scale for United Kingdom

**DOMAIN 1B: Trustworthiness – Maximising Trustworthiness through Task Clarity, Consistency and Interpersonal Boundaries**

The organisation maximises trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate to the setting taking into consideration gender-responsive issues. For each identified issue with maximising trustworthiness for women, specify the required action to resolve the issue, the timeframe, and the person responsible for that resolution.

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DOMAIN 1C: Choice – Maximising Client Choice and Control
The organisation’s activities and settings maximises client experience of choice and control taking into consideration any female-specific issues.

For each identified issue with maximising choice and control for women, specify the required action to resolve the issue, the timeframe, and the person responsible for that resolution.

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DOMAIN 1D: Collaboration – Maximising Collaboration and Sharing Power

The organisation's activities and settings maximise collaboration and sharing of power between staff and clients taking into consideration specific female issues. For each identified issue with maximising collaboration and sharing of power for women, specify the required action to resolve the issue, the timeframe, and the person responsible for that resolution.

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DOM AIN 1E: Empowerment – Prioritising Empowerment and Skill-Building
The organisation's activities and settings prioritise client empowerment and skill-building while taking into consideration specific issues for women. For each identified issue with prioritising client empowerment and skill-building for women, specify the required action to resolve the issue, the timeframe, and the person responsible for that resolution.

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DOMAIN 1F: Safety For Staff – Ensuring Physical and Emotional Safety

The organisation's activities and settings ensure the physical and emotional safety of staff while taking into consideration specific issues of female and male staff members. For each identified issue with ensuring physical and emotional safety for female and male staff, specify the required action to resolve the issue, the timeframe, and the person responsible for that resolution.

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Implementation Plan and Goal Attainment Scale for United Kingdom

**DOMAIN 1G: Trustworthiness For Staff – Maximising Trustworthiness through Task Clarity, Consistency and Interpersonal Boundaries**

The organisation's activities and settings maximise trustworthiness for female and male staff by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate to the programme while taking into consideration gender-responsive issues of staff members. For each identified issue with maximising trustworthiness for female and male staff, specify the required action to resolve the issue, the timeframe, and the person responsible for that resolution.

<table>
<thead>
<tr>
<th>Trustworthiness For Staff</th>
<th>Who is responsible?</th>
<th>Who else is on the team?</th>
<th>Timeline?</th>
<th>Goal Attained* 1-3</th>
<th>What did you learn?</th>
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DOMAIN 1H: Choice For Staff – Maximising Staff Choice and Control

The organisation's activities and settings maximise female and male staff’s experiences of choice and control while taking into consideration any gender-responsive issues of staff members.

For each identified issue with *maximising choice and control for female and male staff*, specify the required action to resolve the issue, the timeframe, and the person responsible for that resolution.

<table>
<thead>
<tr>
<th>Choice For Staff</th>
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<th>Who else is on the team?</th>
<th>Timeline?</th>
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<th>What did you learn?</th>
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**DOMAIN 11: Collaboration For Staff – Maximising Collaboration and Sharing Power**

The organisation's activities and settings maximise collaboration and sharing of power between staff, their supervisors, administrators and clients while taking into consideration any specific issues of female and male staff members. For each identified issue with maximising collaboration and sharing of power for female and male staff, specify the required action to resolve the issue, the timeframe, and the person responsible for that resolution.

<table>
<thead>
<tr>
<th>Collaboration For Staff</th>
<th>Who is responsible?</th>
<th>Who else is on the team?</th>
<th>Timeline?</th>
<th>Goal Attained* 1-3</th>
<th>What did you learn?</th>
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**DOMAIN 1J: Empowerment For Staff – Prioritising Empowerment and Skill-Building**

The organisation's activities and settings prioritise female and male staff empowerment and skill-building while taking into consideration any gender-responsive issues of female and male staff members. For each identified issue with prioritising staff empowerment and skill-building for female and male staff, specify the required action to resolve the issue, the timeframe, and the person responsible for that resolution.

<table>
<thead>
<tr>
<th>Empowerment For Staff</th>
<th>Who is responsible?</th>
<th>Who else is on the team?</th>
<th>Timeline?</th>
<th>Goal Attained*</th>
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**DOMAIN 2: Formal Service Policies**

The formal policies of organisation reflect an understanding of female trauma survivors’ needs, strengths and challenges and reflect an understanding of gender-differences. To what extent do the formal policies of the organisation reflect an understanding of the role of gender in the trauma survivors’ needs, strengths and challenges? Of staff needs? Are these policies monitored and implemented consistently?

<table>
<thead>
<tr>
<th>Formal Service Policies</th>
<th>Who is responsible?</th>
<th>Who else is on the team?</th>
<th>Timeline?</th>
<th>Goal Attained* 1-3</th>
<th>What did you learn?</th>
<th>What must be changed?</th>
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Service Policies Issue A:

Action to Resolve A:

Service Policies Issue B:

Action to Resolve B:

Women

Men

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**Creating Trauma-Informed and Gender-Responsive Systems of Care**  
Implementation Plan and Goal Attainment Scale for United Kingdom  
**DOMAIN 3A: Theoretical Foundation and Programme Design for Women**

The organisation has a theoretical foundation and a programme design that reflects an understanding of gender-responsive issues for women. To what extent is the organisation's programme design and development based on a theoretical foundation (research and practice) that reflects the women being served and their needs?

<table>
<thead>
<tr>
<th>Theoretical Foundation and Programme Design</th>
<th>Who is responsible?</th>
<th>Who else is on the team?</th>
<th>Timeline?</th>
<th>Goal Attained* 1-3</th>
<th>What did you learn?</th>
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**DOMAIN 3B: Gender-specific Trauma Screening, Assessment and Service Planning**

The organisation has a consistent gender-specific way to identify women who have been exposed to trauma and to include trauma-related information in planning services with the client. To what extent does the organisation have a consistent gender-responsive way to identify women who have been exposed to trauma, to conduct appropriate follow-up assessments, to include trauma-related information in planning services with the client, and to provide access to effective and affordable trauma- and gender-specific services?

<table>
<thead>
<tr>
<th>Gender-specific Trauma Screening, Assessment and Service Planning</th>
<th>Who is responsible?</th>
<th>Who else is on the team?</th>
<th>Timeline?</th>
<th>Goal Attained* 1-3</th>
<th>What did you learn?</th>
<th>What must be changed?</th>
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Creating Trauma-Informed and Gender-Responsive Systems of Care
Implementation Plan and Goal Attainment Scale for United Kingdom

DOMAIN 3C: Gender-responsive Trauma Services
The organisation provides gender-responsive trauma-specific services to women.

To what extent are the programme’s content and materials gender-responsive? Do they utilise trauma materials that are specifically designed for women??

<table>
<thead>
<tr>
<th>Gender-responsive Trauma Services</th>
<th>Who is responsible?</th>
<th>Who else is on the team?</th>
<th>Timeline?</th>
<th>Goal Attained* 1-3</th>
<th>What did you learn?</th>
<th>What must be changed?</th>
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</table>
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| Action to Resolve A: _________________________
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| Services Issue B: _________________________
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| Action to Resolve B: _________________________
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DOMAIN 4: Administrative Support for Programme-Wide Trauma-informed Services
Organisation administrators support the integration of knowledge about violence and abuse specific to women into all programme practices.
To what extent do organisation administrators support the integration of knowledge about gender and trauma into all programme practices?

<table>
<thead>
<tr>
<th>Administrative Support for Programme-Wide Trauma-informed Services</th>
<th>Who is responsible?</th>
<th>Who else is on the team?</th>
<th>Timeline?</th>
<th>Goal Attained*</th>
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Implementation Plan and Goal Attainment Scale for United Kingdom  

DOMAIN 5: Staff Trauma Training and Education  
All staff members have received appropriate gender-responsive training in trauma for women and its implications for their work. 
To what extent have all staff members received appropriate training in trauma, gender differences, and the implications for their work?

<table>
<thead>
<tr>
<th>Staff Trauma Training and Education</th>
<th>Who is responsible?</th>
<th>Who else is on the team?</th>
<th>Timeline?</th>
<th>Goal Attained* 1-3</th>
<th>What did you learn?</th>
<th>What must be changed?</th>
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<th>Who else is on the team?</th>
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<th>What did you learn?</th>
<th>What must be changed?</th>
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<td>HR Issue A: __________________________</td>
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<td>Action to Resolve A: __________________________</td>
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<td>HR Issue B: __________________________</td>
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<td>Action to Resolve B: __________________________</td>
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</tbody>
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(Becoming Trauma Informed Tool Kit for United Kingdom)

* **Scoring Code:** (1) goal has not been met and has been dropped from future plans; (2) goal still needs work and will be included in future plans; or (3) goal has been fully met

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(Append Extra Sheets as Needed)
## Appendix vii

### Opportunities for Implementing Trauma-Informed Practice in Women's Services

<table>
<thead>
<tr>
<th>Contact Point</th>
<th>Trauma-Informed Practices</th>
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<tbody>
<tr>
<td></td>
<td>(Apply principles of safety, trust, choice, collaboration and empowerment)</td>
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<tr>
<td>Intake/Admissions and Screening</td>
<td>✓ Let women choose where to sit in a defined, safe and secure intake/admission space</td>
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<td></td>
<td>✓ Let women know what you will be asking, why and who will have access to the information</td>
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<td></td>
<td>✓ Review the programme’s rules and expectations, emphasising physical, emotional, and</td>
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<td></td>
<td>sexual safety, and the policies that support all three</td>
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<td></td>
<td>✓ Train intake staff to recognise and respond to trauma symptoms</td>
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<td>Assessment</td>
<td>✓ Train assessment staff to use a trauma-informed approach when conducting assessments</td>
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<tr>
<td></td>
<td>and recognise trauma symptoms</td>
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<td></td>
<td>✓ Let women know what you will be asking, why, and who will have access to the information</td>
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<td></td>
<td>✓ Assess for past and recent trauma as well as current trauma symptoms/responses</td>
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<td></td>
<td>✓ Utilise information about women's past trauma in programming decisions</td>
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<tr>
<td>Case Planning and Case</td>
<td>✓ Define case management goals with women; offer options and respect the choices</td>
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<td>Management</td>
<td>women make about goals and case management targets</td>
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<td></td>
<td>✓ Work in a spirit of collaboration with the woman</td>
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<td></td>
<td>✓ Ensure that case-management sessions have clear agendas</td>
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<td></td>
<td>✓ Actively define and discuss confidentiality with women, including its limitations</td>
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<td></td>
<td>✓ Provide women with copies of their case plans and help each develop a plan for keeping</td>
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<tr>
<td></td>
<td>her safe from other clients or staff members</td>
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<td></td>
<td>✓ Reference the women's strengths</td>
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<td></td>
<td>✓ Utilise Motivational Interviewing skills</td>
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<tr>
<td>Staff-Women Interactions</td>
<td>✓ Facilitate productive and safe interactions between women as part of unit meetings,</td>
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<td></td>
<td>recreation, and other activities</td>
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<td></td>
<td>✓ Celebrate women's strengths and accomplishments as part of routine interactions</td>
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<td></td>
<td>✓ Use a tone of voice and pace of speaking that encourages stability and physiological</td>
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<td>regulation (i.e., relaxation)</td>
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<td></td>
<td>✓ Use postures and body proximity that convey safety and support (versus control)</td>
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<td></td>
<td>✓ Utilise Motivational Interviewing skills</td>
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<tr>
<td>Disciplinary Issues</td>
<td>✓ Use trauma-informed de-escalation techniques (e.g., maintain an even and respectful</td>
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<td>tone, use women's names, use short encouraging phrases)</td>
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<td></td>
<td>✓ Introduce sensory boxes (boxes that contain comfort items that can be used for de-</td>
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<td>escalation and relaxation such as squishy balls, mini-bean bags, and soft plastic balls</td>
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<td></td>
<td>✓ Talk about what happened with women after an infraction has occurred</td>
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</tbody>
</table>
| Programming and Treatment | ✓ Develop group agreements with women for all group work, including expectations about emotional safety and confidentiality  
 ✓ Define treatment options with women; do not force treatment of trauma or disclosure of trauma  
 ✓ Assure that substance abuse programs recognise the impact of trauma on substance dependence  
 ✓ Do not begin any type of trauma treatment if there is not sufficient time to work with issues that arise  
 ✓ Maintain provider consistency so women can cultivate trust  
 ✓ Ensure treatment plans define coping strategies women can develop to deal with the challenges of life in the community  
 ✓ Implement programs that offer opportunities for women to connect with and bond with their children |
| Medical Services | ✓ Ensure that women are aware of what medications they are on, why, any potential side effects, etc.  
 ✓ Encourage women to keep journals in which they can track their bodies’ responses to the medications they are on and share observations, concerns, and ideas with providers  
 ✓ Utilise same-sex practitioners where possible and offer chaperons during OB/GYN visits when same-sex practitioners cannot be provided  
 ✓ Uphold privacy as part of all medical practises  
 ✓ Ensure that all medical visits adopt a basic trauma-informed protocol (e.g., the goals of the visit are explained first, women are invited to ask questions or raise concerns before beginning and during any medical procedures, and women have a voice in what procedures take place and how they take place)  
 ✓ Implement protocols that maximise early bonding opportunities between mothers and infants  
 ✓ Empower women with knowledge by offering classes and workshops on basic anatomy and physiology, the mind-body connection, etc. |
| Mental Health Services | ✓ Complement utilisation of psychotropic medications with interventions that give women the opportunity to develop brain-body regulation skills, such as mindfulness-based stress reduction (MBSR), yoga, biofeedback, and various somatically-based therapies/interventions  
 ✓ Empower women with knowledge by offering classes and workshops on mental health and wellness and that describe the links between trauma, substance abuse, and mental health  
 ✓ Adopt strength-based language (e.g., providers should talk with women about survival behaviours and patterns versus impaired function and maladaptive coping)  
 ✓ Establish protocols that are designed to support women during times of grief and loss, including immediately following visits with loved ones, transitions, etc. |
| Transition and Resettlement | ✓ Address how women can deal with trauma symptoms as part of their resettlement plan  
 ✓ Facilitate women's contact with individuals and organisations with whom they will be working during resettlement  
 ✓ Ensure that women have a written, specific, individualised Community Safety Plan (including the names and numbers of organizations they can call when needed); ideally, this plan is informed by the Personal Safety Plan that is initially developed at intake  
 ✓ Conduct departure rituals that honour and encourage women as they move on to a new phase in their lives |

Appendix viii

Becoming Trauma Informed:  
A Training Programme for Criminal Justice Professionals

Table of Contents

Section One
1. Welcome and Introductions
2. Violence in Our World
3. Women in the Criminal Justice System

Section Two
1. Understanding Trauma
2. The Process of Trauma
3. The Effects of Trauma

Section Three
1. Trauma-informed Services
2. Breaking Down the Bars Video

Section Four
1. Welcome Back and Questions
2. Nonverbal Communication
3. Triggers
4. Calming and Grounding Strategies

Section Five
1. Vicarious Trauma and Work-related Stress
2. A Trauma-informed Environment for Staff Members
3. Self-care

Section Six
1. The Work Environment
2. Escalation and De-escalation
3. Closing Activity:  The ORID Process
4. (Optional) Evaluation

Appendices
1. Opportunities for Implementing Trauma-informed Practice in Women's Facilities
2. Achieving the Trauma-informed Values Through a Unit Meeting
Beyond Trauma:
A Healing Journey for Women

The newly revised and expanded Beyond Trauma program is a 12 session manualized curriculum that incorporates the insights of neuroscience with the latest understanding of trauma and PTSD. Each session has also been adapted for girls. The evidence-based materials are designed for trauma treatment, although the connection between trauma and addiction in women’s lives is a primary theme throughout. The Beyond Trauma materials include a facilitator’s guide, a participant’s workbook entitled A Healing Journey, and three DVDs (2 for facilitator training and 1 for participants). The program is based on the principles of relational therapy; it uses cognitive-behavioral techniques (CBT), mindfulness, expressive arts and body-oriented exercises (including yoga).

Table of Contents for Beyond Trauma:

Chapter 1: Background Information
Chapter 2: Introduction to the Program

Part 2: Session Outlines
Module A: Violence, Abuse, and Trauma
  Session 1: Introduction to the Program
  Session 2: The Connections between Violence, Abuse, and Trauma
  Session 3: Power and Abuse
  Session 4: The Process of Trauma and Reactions to Trauma

Module B: The Impact of Trauma on Women’s Lives
  Session 5: How Trauma Affects Our Lives
  Session 6: Abuse and the Family

Module C: Healing from Trauma
  Session 7: The Connection between Trauma and Addiction: Spirals of Recovery and Healing
  Session 8: Grounding and Self-Soothing
  Session 9: The Mind and Body Connection
  Session 10: Our Feelings
  Session 11: Healthy Relationships
  Session 12: Endings and Beginnings

Appendix 1: The Five Senses
Appendix 2: Yoga Poses
Appendix 3: Local Resources
Appendix 4: Handouts for the Girls’ Adaptation
Appendix 5: Facilitator Feedback Form
Appendix 6: Participant Feedback Form
Resources
Healing Trauma: A Brief Intervention for Women

Healing Trauma (HT) has been updated and expanded into a 6 session adaptation of the best selling evidence-based Beyond Trauma. It is particularly designed for settings requiring a shorter intervention: jails, domestic violence agencies, and sexual assault services. The CD format allows users to print as many copies of the Facilitator's Guide and Participant's Workbook as needed. The Facilitator's Guide includes detailed instructions (lesson plans) for the session topics: the process of trauma, power and abuse, grounding and self-soothing, and healthy relationships. The workbook can be printed in both English and Spanish.

Table of Contents for Healing Trauma:

Part 1
Introduction
  The World Women Live In
  Trauma
  The Therapeutic Environment
  The Program
  Design of This Facilitator's Guide
  Facilitation

Part 2
Session Outlines
  Session 1: Welcome, Group Agreements, and an Introduction to the Subject of Trauma
  Session 2: Power and Abuse
  Session 3: Women, Anger and Re-visiting the Power and Control Wheel
  Session 4: The Process of Trauma and Self-Care
  Session 5: Healthy Relationships
  Session 6: Love, Endings, and Certificates

Appendix: Yoga Poses
Appendix: Pre-Surveys
  Pre-Survey in English
  Pre-Survey in Spanish
Appendix: Post-Surveys
  Post-Survey in English
  Post-Survey in Spanish