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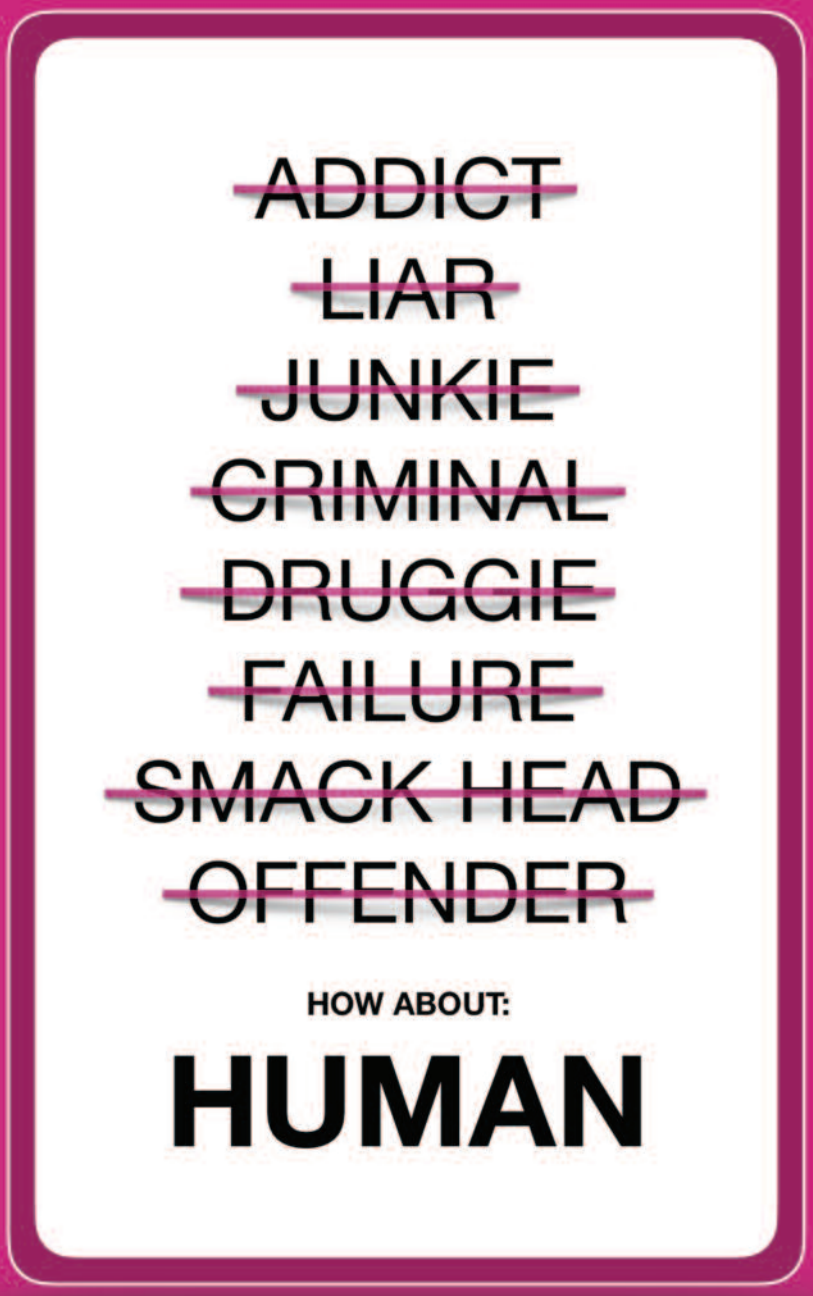

Special Edition

Recovery in Prison

The Role of Trauma-Informed Care in Building Resilience and Recovery

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Introduction

Over the last decade, services have become increasingly aware of the importance of acknowledging trauma and recognising the impact of adverse childhood experiences. Post-Traumatic Stress Disorder (PTSD) and other trauma-related conditions have consistently been shown to be over-represented in mental health and the criminal justice system[1]. Moreover, trauma is costly in both human and economic terms. Economic costs include those from lost employment, presenteeism, diminished productivity and the financial implications of the increased demands on mental health services[2]. But undoubtedly the most devastating legacy lies in terms of the intra and interpersonal consequences, exhorting not only a terrible toll on the individual's health and well-being but inflicting wide-ranging consequences across generations, socially, psychologically and even genetically.[3] This article will explore definitions, prevalence and the impact of trauma before looking at an increasingly recognised response to this—trauma informed care. The role of trauma informed care in the recovery of individuals who use substances will be considered. Finally, the opportunities and obstacles of implementing this approach within a prison setting will be discussed and recommendations made.

Definition and Prevalence of Trauma

Originating from the ancient Greek word for 'wound,' the profound emotional impact of witnessing traumatic events went largely unrecognised until, perhaps unsurprisingly, the terrible events of World War One, where the term 'shell shock' entered the world's lexicon. Sadly, in the years since, further international conflicts, natural disasters and ever-increasing acts of interpersonal violence have served only to reinforce the pervasive impact of trauma on an individual's health and well-being.

Broadly speaking, trauma refers to events or circumstances that are experienced as harmful or life-threatening and that have lasting impacts on mental, physical, emotional and/or social well-being.[4] Trauma can relate to a singular or a series of events compounded over time (the latter often referred to as 'complex' traumatisation). Such exposure may occur directly or indirectly by witnessing the event, learning of the event occurring to a loved one, or repeated confrontation with aversive details of such event (for example, as in the case of emergency responders).[5]

The list of potentially precipitating events is understandably diverse, ranging from accidental injury through to natural disasters or the loss of a loved one. Less recognised early developmental traumas can also include community or social trauma such as inequality, marginalisation, racism and poverty as well as historical (generational) trauma.[6] The nature of the resulting trauma is far more complex than a simple equation of trauma equals PTSD however. Clearly individual interpretation and the accumulation of personal coping resources has a significant impact in ameliorating the impact of traumatic events.[7] Furthermore, certain traumas, for example, interpersonal victimisation, are thought to inflict greater psychological harm than accidental events such as natural disasters, possibly as a consequence of the devastating impact the realisation

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4. Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* Rockville, MD.
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6. Blanch, A., Filson, B., Penney, D. and Cave, C. (2012). *Engaging Women in Trauma-informed Peer Support:* A Guidebook. National Center for Trauma-Informed Care, Rockville, MD.
7. Rice, V, Liu, B. (2016). Personal resilience and coping with implications for work. Part 1: A *review. Work,* 54: 325–333.

of deliberate harm has on an individual's beliefs and assumptions).[8 9] Unsurprisingly, sexual assault remains the strongest predictor of PTSD in both genders.[10]

Contrary to what might be popular belief, experiencing trauma is far from uncommon. A population study conducted across 24 countries with nearly 69000 adults discovered that over 70 per cent of respondents reported a traumatic event, with over 30 per cent reporting being exposed to four or more traumatic events.[11] Research has demonstrated that people in contact with the mental health system have higher rates of historical interpersonal violence than the general population, which, as discussed earlier, has a high propensity to result in post-traumatic psychological harm. A systematic review estimated that half of those in the mental health system had experienced physical abuse (ranging from 25 per cent to72 per cent) and more than one-third had experienced sexual abuse (between 24 and 49 per cent) in childhood or adulthood, significantly higher than in the general population. Unsurprisingly within the criminal justice system it is generally acknowledged that there is a much higher prevalence of serious trauma, although rates vary markedly across studies, ranging from 4 per cent to 32 per cent in male and from 16 per cent to 58 per cent in female prisoners.[12]

One theory is that experiencing complex childhood trauma creates a 'template' through which future events are processed.

Impact of trauma

There is an ever-increasing catalogue of research that implicates the role of trauma in the development of later mental health and substance abuse issues. The original Adverse Childhood Experiences (ACEs) Study formed one of the largest investigations ever conducted into associations between childhood maltreatment and later health and well-being, initiating over 50 subsequent research projects.[13] ACEs were strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse, mental ill-health and behavioural problems. This impact was dose-dependent in that the more adverse life events people experience prior to the age of eighteen, the greater the impact on health and well-being over the lifespan, including; poor mental health, severe physical health problems, sexual and reproductive health issues, engaging in health-risk activities and premature death [14, 15]

But what is the mechanism underpinning this process? One theory is that experiencing complex childhood trauma creates a 'template' through which future events are processed. Within the brain neural responses become 'sensitised', ready to be reactivated by seemingly minor stresses.[16] This means that trauma survivors are 'primed' to respond to situations and relationships that embody characteristics of past traumatic events, or in which there is a perceived threat. As well as fitting with many of the therapeutic models around PTSD where the sufferer is perceived as hyper-vigilant towards threat, further studies have identified physical changes to the neurological pathways of the brain in response to extreme or prolonged stressors in childhood.[17] These changes appear to centre around the amygdala and ventromedial prefrontal cortex of the brain (areas implicated in, amongst others, the processing of fear and the ability to regulate negative emotions).

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What is 'Trauma Informed Care'?

Trauma informed care (TIC) originated over in the USA and constitutes a relatively recent development in mental health treatment within the UK. TIC is, essentially, a process of organisational change, creating a revised structure, ethos and treatment framework that emphasises physical, psychological and emotional safety for both service users and providers. At its core is the recognition of the need to accurately identify trauma at the earliest opportunity, in order to prevent inadvertently triggering re-traumatisation. In essence it urges mental health services to adopt a 'do no harm' approach. Clearly key in implementing such an approach is the need for staff to be well trained regarding the impact of trauma, how a traumatised individual might perceive, adapt and respond to their traumatic experiences and develop a commitment to working with that individuals' own strengths to maximise their chances of recovery.

The fundamental shift in providing support using a trauma - informed approach is to move from thinking 'What is wrong with you?' to considering 'What happened to you?'.[18]

Trauma informed care (TIC) originated over in the USA and constitutes a relatively recent development in mental health treatment within the UK.

TIC is, by its very nature, strengths-based: reframing challenging behaviour in more compassionate terms by seeking to understand its survival function and considering it as a response to situational or relational triggers. Exploration of trauma is conducted respectfully, to avoid potential re-traumatisation (but without negating the importance of the narrative). Relational security plays a vital role in trauma informed services, unsurprisingly given the key role social connection plays in recovery, particularly with regards to addiction.[19] Building trusting, collaborative relationships therefore, both within individual and group-based situations, alongside a sense of shared purpose and community, is key in the successful implementation of TIC. Again, in order to achieve this, high quality trauma-focussed staff training and support are essential.

Six key principles of trauma-informed care have been identified within the literature and provide the scaffolding by which a service can implement their trauma-informed vision.[20] They build upon the earlier 'Resiliency and Recovery-Oriented Systems of Care (ROSC) guidance which extols the value of community-based, person-centred planning to build the resilience and strengths of the individuals and their social network. The six principles proposed by SAMHSA are:

1. Safety: Throughout the service, staff and the individuals they serve feel physically and psychologically safe.

2. Trustworthiness and Transparency: Organisational operations and decisions are conducted with transparency and the goal of building and maintaining trust between staff, service users and their families.

3. Peer Support: Peer support and mutual self- help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, serving as models of recovery and healing and maximising a sense of empowerment.

4. Collaboration and Mutuality: TIC believes that healing happens in relationships, and in the meaningful sharing of power and decision-making. Key within this is the deliberate levelling of the power imbalance between staff and clients and among organisational staff (from direct care to administrators). Everyone has a role to play and a person does not have to be a therapist to be therapeutic.

5. Empowerment, Voice and Choice: The individuals' strengths and experiences are recognised and built upon; they are given the chance to experience having a voice and their choices heard. Resilience is supported and encouraged and self-advocacy and empowerment are actively encouraged.

6. Cultural, Historical, and Gender Issues: The TIC organisation actively moves past cultural stereotypes and biases, offers gender-responsive services, supports

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the healing value of traditional cultural connections and recognises and addresses historical trauma.

These trauma-informed principles are by no means revolutionary and there is a significant overlap with many other well-established good practice guidelines. The principles of service-user involvement, empowerment, informed choice and control have much in common with shared decision-making[21] and collaborative care planning.[22] Similarly cultural and gender sensitivity are well-established good practice principles.[23] Peer support is emerging as an important element of UK mental healthcare,[24] with the principles of trauma-informed approaches in line with grassroots movement for peer support within recovery.[25 26] Collectively however these six standards provide a scaffold to support services in acknowledging an individual's history of trauma, understanding their responses and identifying and supporting the paths survivors take in seeking out safety and recovery.

The Role of Trauma Informed Care in Recovery from Addiction

As discussed earlier, studies have shown that there is high comorbidity between PTSD with substance abuse disorders.[27 28 29] Certainly, there is a growing awareness of the inter-dependent relationship of trauma and addiction. It is recognised that many of those who use substances do so to escape emotional pain, often associated with past trauma.[30] The sad truth of many trauma survivors is that they often seek to manage their symptoms by themselves, perhaps as a consequence of the shame attached to their experiences. PTSD symptoms like agitation, depression, hypersensitivity to loud noises or sudden movements, social isolation and insomnia may appear to be ameliorated in the short term through the use of sedating or stimulating drugs (depending on the symptom). In the longer term however, these attempts to self-medicate can easily slide into a vicious cycle of avoidance and addiction. Conversely, a substance abuser's lifestyle often places them more at risk of experiencing trauma than that of a non-addicted person. Anti-social acquaintances, increased risk taking, high levels of violence, impaired driving, and other aspects commonly associated with drug and alcohol abuse may indeed predispose substance abusers to being traumatised by crime, accidents, violence and abuse.

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Given the symbiotic relationship of trauma and addiction it is not surprising that adopting a trauma-informed approach is highly effective in the promotion of recovery in individuals with addictive behaviours.[31] Certainly, there are inescapable parallels between the six TIC principles identified by SAMHSA and the focus on individualised care within modern addiction programmes, from the emphasis placed on safety and stabilisation during detoxification, through to the centrality of collaboration

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and transparency. The presence of trauma may not always be immediately evident however, particularly following years of substance use with the aim of dulling and diluting traumatic memories. Without treating the root cause however, treatment of the addictive behaviours is unlikely to be successful and the individual is left vulnerable to further self-destructive behaviours emerging.

Trauma Informed Care in Prison—Opportunities and Obstacles

The very concept of a prison environment makes establishing and embedding a trauma informed approach towards care difficult. Prisons were originally designed to house perpetrators, not victims (although, as we now know, it is frequently the case that the two are one and the same, with many of those incarcerated in prisons having themselves been victims in the past). The operational priority within prisons however is to maintain order and discipline, not ameliorate and treat trauma, and staff are trained to assume that a prisoner is potentially violent and behave accordingly.[32] At first glance the inevitably intrusive and restrictive nature of these security measures can threaten to undermine attempts to be trauma-informed. Many of the routine security procedures in correctional environments (such as pat-downs and body searches) are themselves triggering, serving only to increase the trauma-related impulsivity and aggression. Such escalations can be difficult for prison staff to manage,[33] potentially initiating a vicious cycle of more restriction and control.

Yet, there is much evidence to suggest that by introducing trauma-informed principles prisons experience a significant reduction in institutional violence. It has long been recognised that self-destructive and suicidal behaviours and anger and aggression towards others are linked to interpersonal trauma.[34] In America, the Massachusetts Correctional Institution at Framingham developed new training initiatives and began implementing trauma-informed models in July 2006. By July 2007, use of force incidents had decreased by 65 percent, assaults on staff had decreased by 32 percent, inmate grievances had decreased by 31 percent and employee misconduct complaints were reduced by 33 percent. The impact continued, so that between 2011 and 2012, there was a subsequent decrease in inmate-on-staff and inmate-on-inmate assaults, the use of segregation, suicide attempts, and the need for mental health watches.

So, whilst the potential benefits are manifold, the systemic barriers to implementing TIC in a prison setting are undeniable. These can potentially include:

- ❒ Underfunding and a lack of resources (particularly staffing)
- ❒ Low morale and high staff turnover potentially restricting impact and reducing sustainability
- ❒ Difficulty balancing the perceived correctional nature of prison with the perception of prisoners as having their own emotional pain and treatment needs
- ❒ Implementation of a 'risk-averse' culture
- ❒ Limited opportunities for reflection on practice and feedback from staff and service users
- ❒ Frequent top-down, unpredictable change in policies and processes. When coupled with a regular plethora of new initiatives to implement, these can lead to confusion and exhaustion[35]
- ❒ A reluctance to explore the extent of trauma due to its exposure of the cruelty of human nature (thereby challenging an individual's worldview and potentially triggering a defensive response)

> ...given the potential obstacles, what can be done to create opportunities for TIC to flourish within our prison establishments?

In addition, research has identified a number of barriers to enquiring about childhood abuse, including holding a predominantly biomedical (as opposed to psychosocial) model of mental distress[36] and having the belief that people want to be asked about their experiences by someone of the same gender or cultural background. Positively, identifying these barriers can signpost some of the changes needed to support staff to work fully in trauma-informed ways.

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So, given the potential obstacles, what can be done to create opportunities for TIC to flourish within our prison establishments?

The Route to becoming Trauma Informed

Change at the organisational level

In order for a service to become truly trauma-informed there must first be a focus on implementing organisation-wide change, specifically though a change in culture and policy. Trying to implement trauma specific clinical practice without first making these systemic adaptations has otherwise been likened to 'throwing seeds onto dry earth'.[37] Successful organisational change requires the steady and visible support of senior leaders who can empower the workforce to be part of the evolution, ensuring buy-in at multiple levels and championing the rationale behind the transformation. It is important for the service to consider trauma when developing any new policies, procedures and practices within the prisons and attempt to limit re-traumatisation. In addition, changing culture and clinical practice will require significant resources, from rolling programmes of training to the physical modifications to the environment.

All staff should be offered training on trauma and the trauma informed service model and how it is relevant to their work.

Collaborative Service Development

At the point when a service has made the commitment to move towards TIC, the inclusion of 'experts by experience' from the inception as consultants within the process is recommended. Aside from living the values of TIC with respect to choice, empowerment, collaboration and peer support; service users can provide invaluable first-hand experience and are often in a unique position to comment on suggested developments. Co-production in the form of discussion/focus groups including both staff and prisoners can be invaluable in creating shared ownership over the TIC principles and how they can be implemented in the establishment.

Staff Training

Provision of high quality, accessible training is vital, both for clinical and non-clinical staff. As well as being given a thorough grounding on the nature and impact of trauma staff should feel confident in their abilities to create a safe, non-threatening environment where relationships are themselves a therapeutic vehicle. All staff should be offered training on trauma and the trauma informed service model and how it is relevant to their work. Ideally this should be face-to-face to allow for reflection and collaborative planning, however given staffing pressures, an e-learning package may be easier to facilitate. Trauma Informed Service training materials should be incorporated into the Personal Officer Training Package and made freely available across the prison

Key within the development of frontline staff should be the promotion of the following:

- **Early identification and intervention:** Screening prisoners for trauma at induction can help them access support early on. In particular, early information made easily available around identifying triggers and effective grounding / calming techniques can help prevent rapid escalations
- **Sensitive trauma enquiry:** Judging how and when to enquire about trauma is in itself a challenge for front line staff, however trauma informed research has consistently emphasised the need to routinely enquire, particularly within mental health services, in order to uncover the presence of trauma within the population. Despite this, research has shown that between 0 and 22 per cent of service users within an adult mental heath setting report being asked about abuse experiences[38]
- **Compassionate view of coping:** It is all too easy to view some of the behaviours displayed by trauma survivors as manipulative, perplexing, dangerous or bizarre if they are not viewed through a 'trauma lens'.[39] An alternative perception can be to view their responses as their best attempt at coping, connecting and communicating.
  - **Coping:** Risk taking and self-destructive behaviour may play a role in helping the individual manage their own shame, low

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self-esteem and wider issues in regulating intense emotion that may result from their traumatic experiences

- **Connecting:** Instead of viewing behaviours as 'manipulative' or 'attention seeking' in nature, the service can reframe them as attempts to get needs met and communicate difficulties—encouraging connection rather than rejection of the individual as a result and moving towards restorative relationships and recovery.
- Communicating: As discussed childhood trauma has a major effect on neurodevelopment, making threat responses extreme and easily triggered and reducing the ability to self-soothe.[40] Distress of this kind is hard to articulate. In addition, language has failed many survivors in stopping abuse, particularly where 'No' is ignored or violation continue.

Consequently, extreme behaviours can be the only means a trauma survivor has to express or communicate the extreme distress they are in.

Staff wellbeing and support

It is well recognised within the literature that prison officers are often at a heightened risk of physical health problems, psychological distress and post-traumatic stress disorder [41] [42] [43]A multitude of factors contribute to this; including the poor working environment, lack of training, heavy workload, lack of perceived autonomy, low staffing and the emotional demands of working with a difficult population. These risks are often amplified when working in a trauma informed manner due to the potentially emotive nature of the interactions. Without safeguards in place to help both clinical and frontline staff process their emotions, anyone working with individuals who have experienced trauma may be subject to chronic emotional stress such as secondary traumatic stress, vicarious traumatisation, and burnout. This stress can then negatively affect their own physical and psychological health. Providing targeted training that creates an awareness of this emotional stress and the importance of self-care is often highly beneficial. Organisationally it is also important that there a culture of acceptance (and even encouragement) of seeking support, maintaining boundaries and undertaking considered workloads and that sufficient investment is made in staff wellbeing strategies. In addition to this regular supervision and the opportunity to access reflective supervision session can also prevent, mitigate, and even heal vicarious trauma.[44] [45] [46] [47] Research, although sparse in this area, has supported the notion that the greater the frequency and duration of nonevaluative supervision received by a worker the lower the levels of secondary traumatic stress.[48]

The former referring to the systemic awareness and sensitivity to the presence of trauma while the latter refers to the direct targeting of traumatic symptoms with treatment.

Access to Trauma Specific Interventions

A common confusion when discussing Trauma Informed Care is the distinction between this and Trauma specific interventions. The former referring to the systemic awareness and sensitivity to the presence of trauma while the latter refers to the direct targeting of traumatic symptoms with treatment. In developing a trauma responsive service

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48. Dalton, L. E. (2001). *Secondary traumatic stress and Texas social workers.* Unpublished doctoral dissertation, The University of Texas at Arlington.

it is vital that pathways exist in order for individuals to access more intensive governed psychological interventions.

Trauma-focused cognitive behavioural therapy (CBT), such as Prolonged Exposure (PE), and Eye Movement Desensitisation and Reprocessing (EMDR) therapy, have been found to be among the most effective treatments for PTSD.[49] PE is an evidenced-based, manualised protocol based in Emotional Processing Theory, which views PTSD symptoms as a result of cognitive and behavioural avoidance of trauma-related thoughts, reminders, activities and situations. PE helps the client interrupt and reverse this process by blocking this avoidance, introducing corrective information and promoting the re-processing of the trauma memory and associated thoughts and beliefs. This is achieved through a combination of in vivo and imaginal exposure. Alternatively, EMDR focuses more specifically on the identification of unprocessed traumatic material. The client is asked to recall the worst aspect of the memory together with the associated thoughts and bodily sensations whilst simultaneously moving their eyes from side to side (or employing some other form of bilateral stimulation). The goal of this is not only to desensitise the client to the distressing memory but, more importantly, to reprocess the memory so that the associated thoughts become more functional. More recently integrated-treatment programs employing cognitive-behavioural therapy to target both trauma and substance misuse symptoms have emerged, although research into their efficacy is limited.[50]

Conclusions and recommendations

As services become increasingly aware of the far-reaching impact of past trauma on an individual's health and well-being and their vulnerability towards engaging in self-damaging behaviours, there is an urgent need for care to become more trauma-informed. Trauma Informed Care (TIC), as outlined within this article, involves a recognition of the need to accurately identify trauma at the earliest opportunity, adopting a strengths-based, compassionate and individualised approach where behaviours are understood in relation to their past experiences and there is a commitment to minimising potential re-traumatisation. Within the field of addiction ensuring traumatic experiences are addressed is crucial as part of successful recovery. Embedding TIC within a prison environment brings with it a unique set of challenges, although the potential benefits in terms of a reduction in institutional violence and self-harm and improvements in staff well-being and retention are evident.

Within this article a number of suggestions were made with regards to how to approach becoming more trauma-informed. Central to this transformation is, as with all change, ensuring senior level buy-in, engaging those with lived experience and providing ample training and support to those at the front line delivering the day-to-day relational interventions. The magnitude of the task within the prison system should not be underestimated, and a number of obstacles often lie in the way of such aspirations. This does not mean that it shouldn't be undertaken however, as the benefits for services users, staff and the prison system are significant.

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