The State of Corrections

American Correctional Association Annual Conferences

Integrating Gender-Responsive and Trauma-Informed Services into Your Program Model

Susan M. Moitozo, MEd
Earl Warren, MBA
Jaime O'Neil, BS
Spectrum Health Systems Inc,
Worcester, Massachusetts

The concept of services for women that are gender responsive and trauma informed has been the subject of definition, review, research, writings, discussion, and critique for the past two-to-three decades**.** Some would debate, prominently and others would say insufficiently. There has been a corresponding evolution of programs designed and heralded as gender responsive and trauma informed. There has also been a growing understanding that the dissemination of these foundation concepts, theories, and approaches has not been as widespread as one would think, nor are there enough resources, tools, and "how to" guides to help behavioral-health providers assess their own progress in implementing these new approaches and measuring their achievements and future need areas as they evolve.

This essay has three purposes. First, it provides a brief review of the meaning and relevance of gender-responsive and trauma-informed treatment within behavioral-health programs. Second, practical examples of translating concept and theory into program content and structure are discussed; and third, the reader is provided with suggested strategies to foster staff's assimilation of

these concepts, knowledge, and skills and a framework for assessing progress and measuring achievements and the impact of these changes within their programs is provided.

What is the buzz word today? Doesn't that phrase convey a collective feeling of struggle to keep pace with and figure out if it is an innovation, a re-conceptualization or a profound discovery of great significance in the field of practice? What are gender- responsive services? What are trauma-informed services? Who needs them and why? What happens if our clients do not receive them? Does my program provide these? How well does my program provide these services? Does our staff know how to provide these services? These are the questions we hear when presenting an in-service program or workshop at a local or national conference on this topic. The questions come from program administrators, managers, supervisors, and direct care staff. The staff work in programs in community settings and in correctional settings and have backgrounds in mental health, substance abuse, social work, law enforcement, criminal justice, education, and many other fields.

First, here is our preferred definition for each of the terms. "Being gender responsive refers to the creation of an environment–through site selection, staff selection, program development, and program content and materials–that reflects an understanding of the realities of women's and girls lives and that addresses and responds to their challenges and strengths" (Covington, 2007, p.1). "To be trauma informed means to understand the role that violence and victimization play in the lives of most consumers of mental health and substance-abuse services and to use that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allow services to be delivered in a way that will facilitate consumer participation in treatment" (Harris and Fallot, 2001, p.4). These are well-accepted definitions in the literature, but what do they actually mean to the service provider? Why is it necessary to consider a different approach to working with women? Whether the program is addressing substance abuse, co-occurring substance abuse and mental health, medical issues, education, or vocational training, and whether the program is community based or corrections based, the women seeking services share some very meaningful commonalities that impact their ability to access and benefit from services.

Increased rates of domestic violence, sexual abuse histories, other trauma histories, lower education and socioeconomic status are well-documented demographics of the female behavioral-health client in community and correctional settings (as compared to male-client demographics). According to Goodman (1997), 97 percent of mentally ill women have endured serious physical and/or sexual trauma, 87 percent lived through this abuse starting as children and continuing into adulthood. Teenagers with addictive disorders are six-to-twelve times more likely to have a trauma history and up to twenty-one times more likely to have experienced sexual abuse than those without addictive disorders (Clark, 1997). Nearly eight out of every ten mentally ill female offenders report a history of physical and/or sexual abuse (Smith, 1998).

Bloom, Owen, and Covington present a national profile of women offenders, which details the following: they are disproportionately women of color, in their early to mid-thirties. Most likely they have been convicted of a drug-related offense; their family histories are fragmented. They have a family history of involvement with the criminal justice system, are survivors of physical and sexual trauma as children and adults, have considerable addictive disorders, several physical and mental health problems. They are single mothers of minor children, with a high school degree or GED, but with inadequate vocational training and erratic work histories (Boom, Owen, and Covington, 2005).

Substance Abuse Treatment: Addressing the Specific Needs of Women: A Treatment Improvement Protocol Tip 51 is a current and useful resource to consult for developing a rich understanding of the complexity of the needs of women and the research and program development that has occurred to meet those needs. For example, chapter one contains (among other information) a detailed explanation of gender-responsive treatment principles. Reflecting on the importance of these principles, we have discovered numerous ways in which the principles may be applied in a treatment setting. Ensuring that treatment includes the provision of education on employment readiness, training in job-related skills and experience in working and taking responsibility, increases the likelihood of women finding and maintaining jobs that will allow them to improve their socioeconomic conditions.

Recognizing, acknowledging, and understanding how cultural differences may affect a women's response to treatment efforts is essential. This means that providing cultural-competence training for your staff is fundamental not optional. Representing the populations you serve by hiring staff with similar cultural backgrounds will also foster treatment engagement and increase participation and retention. By knowing the cultural issues relevant to women and the subculture they exist in, treatment barriers may be reduced and opportunities to engage and motivate may be increased. Relationally informed treatment provides women opportunities to relate in healthy ways with other women. By allowing women to become mentors and role models for other women, positive interactions and healthy connections are reinforced throughout treatment. The aim is for women to experience the benefits of the positive relationships they have created, and encourage them to seek out more functional relationships that will support their recovery. The relational emphasis proves important when introducing necessary information related to women's health; particularly in discussing topics that women have come to believe are taboo.

Treatment can challenge the taboos by offering a nonjudgmental approach in the education and discussion of sexually transmitted disease (STD) symptoms, gynecological care, maintenance of chronic illnesses, and other relevant women's health topics that are geared to diverse developmental stages. It is important to acknowledge that a young, single mother is in a vastly different life stage than a post-menopausal grandmother. This gender-responsive treatment approach allows women to gain an increased level of confidence in discussing intimate topics, ultimately leaving them better informed and able to make better choices about their health.

In addition to a woman's developmental stage being medically relevant, it also influences how she views herself, how she views the other women in the program, as well as how she views her treatment providers. Providing opportunities to acknowledge and empower women in each developmental stage can set a foundation for healthier relationships, improve self-esteem, and increase recognition of an individual's developmental needs as they relate to continuing care.

Women are either caregivers or they experience expectations that they should be caregivers, either from themselves or from others. This creates a level of duplicity in how this role is addressed throughout treatment. It is important to support the role of the parent through increasing access to parenting education and family reunification programs, but it is also necessary to challenge a woman's desire to care for others at the expense of self. Treatment planning and continuing care planning that recognizes the long-term impact that neglecting self will have on a woman's ability to sustain care for others, will encourage the identification of resources that cohesively link all need areas.

It is important to recognize that a dominant stigma exists for women who use substances, and it is important to address this at each developmental stage. The stigma is pervasive and has the potential to undermine motivation and self-worth and create self-doubt regarding the likelihood of success in treatment; therefore, it is important for treatment providers to remain objective and use a nonjudgmental approach "to interact in a manner that assists and causes no harm" (Tip 51, p. 189.)

It is beneficial for treatment to encourage women to effectively communicate the progress they have made from where they were to where they are now. By consistently reinforcing this, they may gain an acceptance of where they came from, who they are, and what they are capable of achieving. This increased awareness leads to improved self-esteem and a higher likelihood of success with opportunities that arise. A strengths-based model supports achievements by providing opportunities to make choices and promote self-efficacy. Providing an awareness of behaviors lets women know that it is within their power to continue them or change them.

Women are also offered recognition for positive behaviors and achievements and they are encouraged to recognize and vocalize their strengths. A gender-responsive environment provides safety and security to avoid re-traumatization, which could place a woman at a high risk for relapse, isolation, and withdrawal from treatment. A majority of women in treatment have co-occurring disorders. The integration of substance abuse, mental health, medical health, wellness, and correctional services allows for the treatment of the whole person. The bridging of various treatment modalities opens the lines of communication for providers to make informed decisions on how behaviors are best treated and, across the board, there will be similarities in the problems addressed in treatment plans. Trauma-informed services are important and relevant in all areas of treatment because most of the women who enter treatment programs and prisons have histories that include traumatic events, whether isolated, repeated, or ongoing. Many of these women have experienced trauma starting as early as childhood and the impact has led to destructive behaviors and detrimental consequences.

Being trauma-informed means paying attention to safety, boundaries, environment, and creating a non-punitive atmosphere in which conflict is addressed by negotiation-- when possible. Treatment providers are encouraged to use "universal precautions" in treating women, which means operating under the assumption that any woman in treatment may have experienced trauma and should not be expected to disclose it in order to receive trauma-informed treatment.

"Universal precautions" is also a term cited by Harris and Fallot: "Regardless of their primary mission, all human service agencies can begin by screening individuals seeking services to determine whether they have a trauma history" (Harris and Fallot, 2001, p.6). What is important to distinguish about trauma-informed services is that everyone who might interact with the individual should have a basic understanding of trauma-informed care.

Trauma-specific services are services that treat the impact of the trauma and may be provided by those with specialized training in trauma-treatment modalities. The goal of ensuring your agency staff are trauma informed is to provide an open, engaging reception to clients and avoid unnecessary triggers or re-traumatization. Victims of trauma are vulnerable in ways we may not consider. For example, banging doors or flickering lights may trigger a trauma response. Even common terms and phases may trigger a trauma response. It is impossible to know every trauma trigger because these are highly individualized; however, we can take steps to ensure that triggers are minimized in the services we provide.

In their Advice to Clinicians the consensus panel for TIP 51 offers the following guidance on re-traumatization: "Some staff and agency issues that can result in retraumatization of the client include the following: Violating the client's boundaries, breaking trust with the client, unclear expectations, inconsistent enforcement of rules, chaotic treatment environment, rigid agency policies that do not allow a woman to have what she needs to feel safe, disruption in routines, disrespectfully challenging the client's reports of abuse, labeling intense rage and other feelings about the trauma as pathological, minimizing, discrediting, or ignoring the client's feelings or responses, disturbing relationships' because of shift changes and reassignments, obtaining urine specimens in a nonprivate manner" (TIP 51, page 169).

We want all staff to understand what happens to an individual who has been exposed to trauma (common and predictable responses) as well as to be able to recognize when someone might have been triggered by observing their behaviors. It is beyond the scope of this essay to provide that level of review, but that is the goal of educating program and agency staff.

Here again the TIP 51 is a comprehensive resource of education, clinical strategies, tools, and guidance. However, you must actually read the TIP, consider the content, select what is meaningful for your program and client population, and create a strategy for implementing and assessing your successes and your ongoing needs to ensure both gender-responsive treatment and trauma-informed care are understood and appropriately integrated throughout your programs. A set of guidelines we have found useful in educating staff and assessing our own approach organizationally are the ten principles of trauma-informed care:

1. Trauma-informed services recognizes the impact of violence and victimization on development and coping strategies
2. Trauma–informed services identify recovery from trauma as a primary goal
3. Trauma-informed services employ an empowerment model
4. Trauma-informed services strive to maximize a woman's choices and control over her recovery
5. Trauma-informed services are based in a relational collaboration
6. Trauma-informed services create an atmosphere that is respectful of survivor's need for safety, respect, and acceptance
7. Trauma-informed services emphasize women's strengths, highlighting adaptation over symptoms, and resilience over pathology
8. The goal of trauma-informed services is to minimize the possibilities of re-traumatization
9. Trauma-informed services strive to be culturally competent and to understand each woman in the context of her life experiences and cultural background
10. Trauma-informed agencies solicit consumer input and involve consumers in designing and evaluating services (Elliot, Bjelajac, Fallot, Markoff, Glover Reed, 2006, pp 464-469).

If you are an administrator, executive, or occupy another significant leadership position and are committed to advancing both gender-responsive and trauma-informed care across your organization, you may find the following description of our evolving process at Spectrum Health Systems offers some helpful suggestions. I have streamlined our approach into a series of steps that are supported by the various other literatures that offer such guidance as well.

- Identify current leaders at the local and state level invested in the goal of advancing trauma-informed and gender responsive services and practices
- Attend and network at key events promoting this agenda
- Explore opportunities for establishing and developing partnerships with stakeholders and experts in the field
- Inform and promote to key policymakers and senior management, the value and importance of advancing these practices within your agency
- Form an internal work group of invested parties to formulate a strategic plan for assessing current performance and advancing growth and development
- Establish and clearly communicate to all levels of the organization the purpose, the process, the vision, and the mission of this plan
- Invite participation from staff at all levels of the organization and include consumers in the process
- Review, evaluate, and communicate progress at regular intervals and update the plan accordingly

Key areas to address when formulating a strategic plan for this initiative are the following: Does your state have

- A trauma policy or position statements or a task force?
- Organizational approach to staff selection, orientation, training, and job competencies?
- Rules, regulations, and standards to support access to evidence-based and emerging best practices in trauma treatment?
- Linkages with higher education to promote education of professionals in trauma?
- Clinical practice guidelines for working with people with trauma histories?
- Trauma screening and assessment?

In program content and service delivery, is the design and practice trauma-specific?

- What are the emerging best practice models and how does your current model and practices compare?
- Have you evaluated the usefulness of self-assessment and planning protocols to inform and guide further development in trauma-informed and trauma-specific service delivery?
- In your environment of care, is it trauma informed?
- What resources are available for training, program development, and closing gaps in services?

Implementation Strategies that Cultivate Staff Assimilation of Gender-Responsive and Trauma-Informed Principles and Practices

- Validate that trauma is real and prevalent in society
- Validate that gender matters when designing and delivering services–demonstrate improved outcomes that are clearly connected to trauma-informed and gender-responsive practices.
- Increase knowledge about women's realities, differences, and needs and trauma's impact on their lives; this will help staff develop constructive attitudes and interpersonal skills to work more effectively with women. This might include testimonials, consumer participation in committees, and gender-specific surveys

- Be systematic in the execution, updates, evaluation, and communication of the strategic plan
- Ensure a wide variety of people participate in the process (inter- and intra-agency and consumer voices)
- Conduct routine procedural reviews to ensure that procedures are adapted, deleted, or written for new policies (Bloom, et al., 2005)
- Conduct ongoing assessment and review of the culture/environment to monitor the attitudes, skills, knowledge, and behavior of administrative, management, and line staff (Bloom et. al, 2005)
- Provide opportunities for networking, sharing of resources and sharing of perspectives, which enhances staff engagement, commitment and knowledge base
- Recognize the many areas of strength in current performance–highlight them as steppingstones for further advancement
- Understand that gender specific includes all genders and that emerging best practices in this arena can benefit service delivery to all; be inclusive, not exclusive

Evaluating the impact of the use of trauma-informed and gender-responsive approaches within your program can be approached in a multitude of ways. One of the most useful tools our agency applies is client-satisfaction surveys. These surveys solicit consumer feedback on their experiences while accessing services within your agency. Anonymous feedback that is compiled in an aggregate fashion to protect individual's identities can prove very useful. Additionally, staff surveys that seek to identify their understanding of concepts, skills, and strategies you believe you have successfully integrated into your services can be helpful in revealing the level of success you have attained in this endeavor, as well as identify need areas for continued and future focus.

At Spectrum Health Systems, Inc., we have laid a foundation for gender-responsive and trauma-informed treatment. This essay includes practical examples of how our organization has put the concepts and theories into practice and provides suggestions as to how they may be applied in other organizations, but the potential translations of the principles for practical application is limitless. Organizations can be creative in applying the principles, based on the various factors that make their treatment programs unique. Once an organization finds what works for them, it is important to build a framework that allows for ongoing assessment and measurement, to ensure that best practice is being achieved.

Here is a list of resources that we have found useful in promoting the application and evaluation of gender-responsive and trauma-informed principles and practices.

- ✓ **Using Trauma Theory to Design Service Systems,** edited by Maxine Harris, Ph.D., and Roger Fallot, Ph.D. (2001). A self-assessment and planning protocol accompanies implementation of this model. Community Connections' website at www.ccdc1.org
- ✓ **Developing Trauma-Informed Organizations: A Tool Kit,** Developed by members of the Massachusetts State Leadership Council of the WCDVS Women Embracing Life and Living (WELL) Project of the Institute for Health and Recovery; www.healthrecovery.org
- ✓ **Beyond Trauma: A Healing Journey for Women,** developed by Stephanie S. Covington, Ph.D., L.C.S.W., co-director of the Institute for Relational Development and the Center for Gender and Justice; www.stephaniecovington.com
- ✓ **Helping Women Recover (HWR): A Program for Treating Addiction** (with a special edition for criminal justice settings entitled *Helping Women Recover: A*

Program for Treating Substance Abuse) www.stephaniecovington.com

- ✓ **Seeking Safety Model:** Developed by Lisa Najavits, Ph.D., at Harvard Medical/McLean Hospital; www.seekingsafety.org
- ✓ **Trauma Recovery and Empowerment Model (TREM)** Developed by Maxine Harris, Ph.D., and the Community Connections Trauma
- ✓ Work Group; www.ccdc1.org

References

Bloom, B., B. Owen, and S. Covington. 2005. G*ender Responsive Strategies for Women Offenders: A Summary of Research, Practice, and Guiding Principles for Women Offenders,* U.S. Department of Justice, National Institute of Corrections. May. pp. 3, 10.

Center for Substance Abuse Treatment. 2009. *Substance Abuse Treatment: Addressing the Specific Needs of Women.* Treatment Improvement Protocol (TIP) Series 51. HHS Publication No. (SMA) 09-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Clark, H., T. McClanahan, and K. Sees. 1997. Cultural aspects of adolescent addiction and treatment. *Valparaiso University Law Review 31*(2).

Covington, S. S. 2007. *Women and Addiction: A Gender Responsive Approach*. Clinical Innovators Series. Center City, MN: Hazelden.

Desai, R. A, I. Harpaz-Rotem, L. M. Najavits, and R. A. Rosenheck.2008. *Impact of the Seeking Safety Program on Clinical Outcomes Among Homeless Female Veterans with Psychiatric Disorders.* Psychiatric Services, ps.psychiatryonline.org, Sept. Vol. 59, No. 9

Elliott, Denise E., Paula Bjelajac, Roger D. Fallot, Laurie S. Markoff, Beth Glover Reed. 2006. *Trauma-Informed or Trauma-Denied: Principles and Implementation of Trauma Informed Services for Women. Journal of Community Psychology 33,* 4: 464-469.

Goodman, L., S. Rosenberg, K. Mueser, and R., Drake. 1997. Physical and Sexual Assault History in Women with Serious Mental Illness: Prevalence, Correlates, Treatment, and Future Research Directions. *Schizophrenia Bulletin 23*: 685-696.

Harris, M. and R. D. Fallot. 2001. Envisioning a trauma-informed service system: A vital paradigm shift. In M. Harris and R. D. Fallott, eds. *Using Trauma Theory to Design Service Systems*. New Directions for Mental Health Services, No 89. San Francisco: Josey-Bass, p.4.

Jennings, Ann; *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services*. 2004. Prepared for National Technical Assistance Center, National Association of State Mental Health Program Directors, under contract with the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

LeBel, J., N. Stromberg, K. Duckworth, J. Kerzner, R. Goldstein, M. Weeks, et al. 2004. Child and adolescent inpatient restraint reduction: A state initiative to promote strength-based care. *Journal of the American Academy of Child and Adolescent Psychiatry 43*: 37-45.

Maine Department of Behavioral and Developmental Services. 1998. *Augusta Mental Health Institute consent decree class member assessment.*

Originally published in:
***The State of Corrections 2011 Proceedings**, American Correctional Association Annual Conferences, Winter Conference San Antonio, Texas, Summer Congress of Correction Kissimmee, Florida.*