No Lost Causes:

Bringing Cognitive Behavioral Therapy and Trauma Informed Care into Prisons

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T SOCW 533 A: Integrative Practice II

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March 16, 2025

Abstract

The United States incarceration rate has become a significant public health crisis, with marginalized communities disproportionately impacted and mental health challenges exacerbated within correctional facilities. With approximately 2.2 million individuals incarcerated annually in the U.S. and 5.4 million under correctional supervision, the financial and human costs are immense. Mental illnesses such as post-traumatic stress disorder, depression, and substance use disorders are prevalent, especially among women, and far exceed rates seen in the general population. Despite the urgent need for mental health support, many correctional facilities continue to rely on punitive measures rather than trauma-informed care (TIC), perpetuating untreated mental health issues. This proposed pilot program in Washington State aims to provide group CBT therapy for inmates and mandatory TIC training for prison staff, focusing on enhancing coping skills, reducing maladaptive behaviors, and fostering a rehabilitative, supportive environment. The program's success will be measured through improvements in inmate mental health using the PHQ-9, GAD-7, and Personality Belief Questionnaire (PBQ), as well as by evaluating prison staff attitudes using the Attitudes Regarding Trauma Informed Care (ARTIC) scale. The goal is to create a safer, more supportive environment for incarcerated individuals and prison staff, ultimately improving their mental health outcomes and facilitating successful reentry into society and a reduction in recidivism rates.

Problem Description

Introduction

Every year, 30 million individuals enter and leave prison custody worldwide (Beaudry et al., 2021). The United States has the highest incarceration rate in the world which has created a public health crisis (Al-Rousan et al., 2017). Each year in the United States, approximately 2.2 million people are incarcerated in prisons and jails (Lieber et al., 2024). As of 2022, the U.S. Department of Justice reported an estimated 5,407,300 persons under the supervision of adult correctional systems (Buehler et al., 2024). The total U.S. government expenses on public jails and prisons is $80.7 billion and on private prisons and jails it is $3.9 billion on private jails and prisons (Prison Policy Initiative, 2024). These numbers disproportionately impact young members ethnic and racial minority groups that are experiencing a lack of access to education and medical services as well as poverty (Lieber et al., 2024). Over the years, correctional facilities have become a front line for mental health care as well (Al-Rousan et al., 2017). One study determined prevalence rates for mental illnesses and related comorbidities among inmates and found that almost half of inmates were diagnosed with a mental illness (48%) of which 29% had a serious mental illness (41% of all females and 27% of all males), and 26% had a history of a substance use disorder. (Al-Rousan et al., 2017; Burgess-Proctor et al., 2024)) Females had higher odds of having both a mental illness and substance use disorder (Al-Rousan et al., 2017).

There is a substantial burden of mental illness among inmates and factors such as age, gender, and race disparities in mental health care are coupled with a general delay in diagnosis and treatment (Al-Rousan et al., 2017). Research continues to show that women in custody have disproportionately elevated rates of behavioral health conditions; however, jails and prisons have not been able to effectively address these needs (Burgess-Proctor et al., 2024).

Some studies have also shown that there are significant differences in men and women's behavioral health needs, including proportions of severe mental illness, alcohol and drug misuse, opioid preference, concerns for withdrawal, and length of jail stays (Burgess-Proctor et al., 2024).

Through research, it has become evident that incarcerated individuals have higher rates of post-traumatic stress disorder compared to the general population, with a higher prevalence for women (Bashir et al., 2023). The prevalence of PTSD is approximately five times higher among inmates than the general community (Malik et al., 2023). Compared to women in the general community, incarcerated women are nearly two times more likely to describe histories of physical and sexual abuse and incarcerated women displayed more elevated levels of Complex PTSD (C-PTSD), that is, prolonged and recurring trauma, as well as involvement with illicit substances (Bashir et al., 2023). These statistics make it alarmingly clear that inmates, notably women, are coming into environments that may only further perpetuate harm being done when rehabilitation could be occurring through healing of traumas, which would therefore impact the engagements they have in the world post-release in what one would presume to be positively.

The issue of untreated mental illness within the correctional system can be evaluated from many theoretical lenses in an attempt to understand the vast scope of the issue and underlying factors. For example, when looking through a social learning theory lens, one can see the connection between communities with high crime and therefore incarceration rates. With no real early-intervention support for those in these settings, it is no wonder that generational trauma exists and impacts the lives of those living in communities where support is needed. Another lens is the systems theory. This theory in itself acknowledges the complexities of interconnectedness of family, community, and society as a whole. This theory can provide a

framework of understanding for why people do the things they do, and why they behave the way they do. When looking at untreated mental illness within prison settings, an example would be addiction rates, homelessness, and by proxy, crime that can lead to incarceration.

Interventions

Although mental illness runs rampant within the criminal justice system, there are people making efforts to improve the quality of types of care present for inmates. One national initiative is Stepping Up. They are a partnership between The Council of State Governments Justice Center, the National Association of Counties, and the American Psychiatric Association Foundation and use a data-driven framework to assist counties across the nation by providing training to officers and correctional staff, resources, and tailoring needs so that local jurisdictions can reach measurable goals that demonstrate a reduced prevalence of severe mental illness throughout the justice system. Measures included to determine effectiveness include looking at jail bookings, average lengths of stay, connections to care, and recidivism. This framework has been utilized in Washington state for the last 10 years (Stepping Up, 2024).

The prison environment presents a challenge in providing trauma-focused therapeutic interventions as the environment and regime can be inherently damaging to mental health (Craswell et al., 2021; Crole-Rees et al., 2024; Malik et al., 2023). The need is high for trauma-based interventions though as prisoners with PTSD, depression, and anxiety are associated with behavioral problems while in custody, such as aggression and suicidality (Craswell et al., 2021; Malik et al., 2023).. Although thematic analysis and measurability can be difficult to conduct in prison settings (Craswell et al., 2021; Malik et al., 2023; Yoon et al., 2017), psychological therapies show a mid-range effect with the most evidence supporting Cognitive Behavioral Therapy (CBT) and Trauma-Focused CBT (TF-CBT) (Beaudry et al., 2021; Malik et al., 2023;

Yoon et al, 2017) and mindfulness for anxiety and depression (Yoon et al, 2017), though follow-up results may vary. Methods like CBT have been shown to reduce recidivism rates by 20-30% (Beaudry et al., 2021). There does not seem to be much of a difference with group versus individual therapy either (Yoon et al, 2017), which supports the idea that group therapy could be an approach to navigate the number of individuals who may need support in correctional settings.

Although the efficacy of trauma-focused therapies in prison is limited, exploration on Eye Movement Desensitisation and Reprocessing (EMDR) has begun in prison settings. EMDR has elements that may render it particularly suitable as a therapeutic intervention within prisons and the wider criminal justice system (Crole-Rees et al., 2024; Malik et al., 2023) as, unlike CBT, it does not involve direct challenging of beliefs, extended exposure, homework, or a verbalization of specific trauma (Crole-Rees et al., 2024). This would allow elements of privacy within treatment, potentially even within a group setting, though this has little evidence at this time regarding efficacy. There is acknowledgement of concerns about trauma work being done in such an environment as the prison environment cannot guarantee psychological and physical safety that is required while safely performing trauma work (Crole-Rees et al., 2024; Craswell et al., 2021; Malik et al., 2023).

Another current intervention that is being explored is the sensory modulation approach. This technique helps support inmates with self-regulation tools, distress reduction, and has shown a decreased use of seclusion and restraints when utilized (Craswell et al., 2021). This approach has additionally shown inmates benefit through empowerment, increased self-awareness, decreasing distress, anxiety, and maladaptive behaviors providing options, engaging in meaningful life roles, and helping supports understand individual needs (Craswell et al.,

2021). Although still in the beginning stages of being researched within prison settings, findings have been consistent regarding its safety, low cost, and connection with recovery-oriented, person-centered, trauma-informed practices (Craswell et al., 2021).

Finally, an approach that has been implemented across all 50 states is dog-training programs (DTPs) (Cooke et al., 2016; Department of Corrections, 2024). These programs began in 1981 at the Washington State Corrections Center for Women and have taken on various structures based on the needs and regulations of the facilities they are used at. These programs have shown that outcomes are desirable on offenders. Benefits include: a reduction in anxiety and depression; increased self control; increased self-esteem and efficacy; increased emotional intelligence and overall well being; increased empathy for both humans and dogs; improved social skills; giving a sense of purpose; increased ability to cope with grief; and increased employability (Cooke et al., 2016). These results likely not only benefit the inmates, but also the prison population as a whole.

Stakeholder Information

Although this researcher is still working to complete interviews with stakeholders, at the time of this report, two have been completed. Two additional interviews are planned within the month of December. All participants have consented to participate in this Capstone project, either verbally or written via social media message exchange of information given via consent form (Appendix A). Both completed interviews were with individuals with lived experience within the prison system. Stakeholder Emily spent around 18 months in the Washington Corrections Center for Women following 6 months in Pierce County Jail and has been out for nearing 3 years. We will call the male participant Dom due to the request to remain anonymous. He has had 3 stays in prison, accumulating around 6 years behind bars. He shared that he spent

most of his time at Stafford Creek Corrections Center but also had time at Airway Heights Corrections Center and Coyote Ridge Corrections Center. He has been free from incarceration for six years. Upcoming participants include the mother of someone who has been sentenced to life in prison within the Washington State prison system. The other stakeholder is a manager of a forensics department through Greater Lakes Mental Healthcare that has additionally experienced firsthand injustices with her own family system throughout her lifetime as a black woman.

During interviews, four questions were the focus of discussion to provide stakeholder information on the topic of untreated mental illness within the prison system. When asked to reflect on experiences regarding the quality of mental healthcare support for incarcerated individuals, Emily stated that it is “almost nonexistent” and Dom stated with a scoff, “There isn’t really any.” Emily noted that what could be considered therapy in prison settings tends to “not be from real doctors or professionals; it’s the inmates being there for each other.” Dom noted that “guys don’t really want to talk about feelings like that there. There’s more fights than any therapy happening.” He did note that, “sometimes there’s people wanting to work on themselves and they’ll do 12 step stuff together. You could tell they were trying to make the most of their time but not all of them got what they needed, myself included.”

When asked about what they feel is the primary contributing cause(s) to the high levels of untreated mental illness within correctional facilities, both had their own takes. Emily shared that she believes a lot of the barriers are due to “budgets.” She acknowledged that psychologists, social workers, therapists, and others that could provide mental healthcare services would require funding, “especially when treating hundreds to thousands of people.” She further noted that with the large numbers of people in these facilities, providing treatment would benefit all individuals if there were greater efforts to “conquer the mental illness issues aside from just prescribing

medication, which seemed to be the most used tactic." Emily also mentioned how many women she interacted with who suffered from addiction had underlying, untreated mental illness "which is the stem of most addiction. That's how most of us ended up there." Dom shared that the high levels of incarceration are likely due to not only addiction but "upbringing." He acknowledged that underprivileged communities have higher rates of involvement within the criminal justice system and that for himself, that was what he considered normal. He noted that poverty, lack of interventions when maladaptive behaviors begin, and lack of understanding of how to approach feelings such as anger perpetuate the problem.

When asked about services that inmates may benefit from that, to their knowledge, are not being offered, once again both acknowledged the need for professionals to help provide therapeutic support. Although medications are being provided to some inmates, both Emily and Dom shared that there were individuals who would benefit from more support. Emily also noted that some women would request medications that they were prescribed when in the community and were denied them. Dom stated that he felt some of the reluctance with medication and treatment is a "lack of understanding" of prisoner needs. He further noted that, "When it's all about profit, those in the system are just lost ants. It seems as if most of the C.Os don't even care, they just wanna power trip and throw guys in the hole." When asked what could help improve these attitudes he stated, "Training. A lot of us come pretty messed up. Maybe trauma informed care would help." Dom also acknowledged the need for reform regarding solitary confinement/isolation. Additionally, Emily also noted that increased mental healthcare for those showing signs of mental illness from the beginning of someone's sentence would increase chances of them "living a normal life and staying sober outside of the prison walls."

When Emily and Dom were asked if they believe that rehabilitation and healing can happen in a prison setting, Emily acknowledged that for her, “prison saved my life.” She further noted that “it’s all about the mentality you choose to have for yourself while incarcerated.” Dom also agreed that overall, healing is possible. However, he shared that he feels a lot of harm can occur while inmates are serving their sentence, perpetuating diagnoses such as PTSD, and the judgement post-release and lack of opportunities can increase depression. He did agree that “mindset is everything” and how taking advantage of programs, such as schooling, gardening, and the job training offered, can give focus and help an individual “see their way out, beyond the walls.” Dom also acknowledged that his time incarcerated “helped me realize I couldn’t keep doing what I was” and that his time in prison brought time for reflection that has since led him to change patterns of behavior.

Resources

The most evident resource for inmates with mental illness challenges is the Department of Corrections itself. The state of Washington has 12 state prisons, 1 federal prison, ranging from short-term minimum to maximum security and houses over 17,000 incarcerated men and women (Department of Corrections, 2024). Each prison offers a variety of different programs. Currently offered programming suggests hope for progress and change within the confines of prison with programs ranging from family and relationship programs, learning and working programs, religious, spiritual and cultural programs, as well as therapeutic and support programs to support inmates (Department of Corrections, 2024).

The variety of programs differs per prison, especially as security levels change. Although many programs are peer-led, such as 12 step recovery meetings, some programs collaborate with local resources to work with offenders pre and post release. An example would be the Drug

Offender Sentencing Alternative (DOSA), where substance abuse is being addressed as a primary culprit of the overlying problem. This program is a collaborative effort between jails, prisons, judges, and community mental healthcare providers (Department of Corrections, 2024). Another program being offered is Alternatives to Aggression (A2A) which is a series delivered to both the general population and maximum custody populations, with different intended purposes. Overall, the focus is on recidivism reduction prior to release whereas in maximum populations, the goal is to see a reduction in violent behavior to reduce the likelihood of returning to a maximum custody setting. Other programs being utilized across Washington include: animal training or adoption programs that benefit communities and teach responsibility; the Freedom Project which provides nonviolent communication and mindfulness programs; the Sex Offense Treatment and Assessment (SOTAP) that is offered to offenders that have been committed of a sexually motivated crime with treatment targeting identification of thoughts, feelings, and behaviors that led to their behavior and learning skills to decrease likelihood of re-offense; and Thinking for a Change 4.0 (T4C) which is an integrated cognitive behavioral change program to help restructure thoughts and feelings to promote more productive behaviors (Department of Corrections, 2024).

Looking at a specific agency for inspiration, Summit County Sheriff's Department in Colorado is also making efforts to help inmates by using the Strategies to Avoid Relapse and Recidivism (STARR) program. This includes a jail-based mental health team that has a Licensed Mental Health Clinician that responds to inmate mental health concerns along with the availability of prescription and over the counter medication during twice a day med calls, medicated assisted treatment for SUD, access to medical appointments and dental care, case management, as well as individual and group therapy available for motivated inmates who wish

to focus on changing behaviors such as anger, communication and life skills, trauma, and substance use. EMDR is often utilized by trained professionals through this program which has been showing effectiveness (Summit County Colorado, 2024). The biggest downside to this program is that inmates are held responsible for the payment of costs of medical care and while incarcerated, benefits are shut off past a period of time which makes affordable access to care less likely for the overall population (Summit County Colorado, 2024).

One local resource for mental healthcare that has programs available to address community re-entry for inmates is Greater Lakes Mental Healthcare in Pierce County. Although therapeutic interventions are not happening pre-release, the collaboration begins prior to discharge when case managers and program team members work together to problem solve and navigate common barriers that individuals transitioning from prison experience. Two of the court and criminal justice services offered through the forensics department include the Offender Reentry Community Safety Program (ORCSP) and the Pierce County Superior Court Felony Mental Health Court (FMHC) which are parts of the Felony Mental Health Court and Forensic Assertive Community Treatment (FACT) model. In collaboration with the Pierce County Superior Court, individuals with mental health or substance-use disorder who have committed a non-violent felony can participate in a rigorous program to avoid official charges (Greater Lakes Mental Healthcare, 2024). Currently, billing does not allow for engagement with inmates beyond assessments and email coordination as most inmates are not set up with benefits due to their current housing situation in a correctional setting.

The final resource to be discussed is the United States' National Alliance on Mental Illness (NAMI). To help support those with mental illness, NAMI utilizes strong advocacy, are involved in policy and directive creation and ongoing recommendations, created a national crisis

line, offer virtual and in person support groups, education resources and opportunities for a variety of stakeholders, podcasts and webinars, and conventions to help spread their message (National Alliance on Mental Illness, 2024). On their website, NAMI notes that they believe all people with mental health conditions who are incarcerated deserve the right to access quality mental health treatment. As such, they are a part of a Consensus Workgroup on Behavioral Health Issues in the Criminal Justice System and have made recommendations to Congress regarding suggestions on next steps to further support the inmate population such as providing facilitation and support of evidence-based screenings, assessments, and treatment in jails and prisons, both pharmacological and psychosocial kinds (National Alliance on Mental Illness, 2024).

Statement of Need

As prisons are often ill equipped to provide quality mental healthcare and tend to use control and punitive approaches to self-harm and other trauma responses of incarcerated individuals (Craswell et al., 2021; Craswell et al., 2021), interventions to support trauma-informed approaches and shifting from the medical model of mental health care to a trauma-informed care model would benefit prisoners. As such, correctional facilities need mental healthcare programs to effectively support individuals with severe mental illness. Policies and practices need to be reassessed to prevent re-traumatization, such as a reduction, if not elimination, of practices such as seclusion and restraint (Craswell et al., 2021). This kind of prison environment can be detrimental to one’s mental health through the loss of autonomy, disconnection from family and social supports, decreased meaning and purpose, increased boredom, overcrowded facilities, unpredictability of sentencing and other adverse experiences, such as unexpected lockdowns (Crole-Rees et al., 2024) which indicates the high need for inmate

support with some flexibility. Regardless of the challenges for therapy in prison, there are unique opportunities available when engaging therapeutically during a time when an individual is likely to be substance free (Crole-Rees et al., 2024) and away from environments that promote further harm to their psyche. Navigating this approach will take ethical and clinical assessments to reduce potential harm and promote the success of delivery of trauma-informed practices in prison settings.

Factors such as sentence length must be considered when providing treatment as shorter sentence lengths and high levels of mobility across prison locations impact the ability to deliver trauma-focused therapies (Crole-Rees et al., 2024; Malik et al., 2023). The development of new treatment approaches should focus on risk factors that perpetuate recidivism rates, especially as there is often no additional support being offered upon release if someone is not directly connected to a re-entry team through a referral and acceptance into such a program. Approaches that integrate support factors for inmates, such as employment, housing, and help navigate financial stressors while providing skills to practice distress tolerance and self-regulation would only support successful reentry.

One intervention that may be implemented within Washington State could be a program following a similar framework to the Summit County Detention Facility in Summit County Colorado STARR program, but on a larger scale. STARR utilizes approaches like EMDR (Summit County Colorado, 2024) and as research continues to show, this is a promising approach to treating mental health and trauma in a prison setting (Crole-Rees et al., 2024; Malik et al., 2023). EMDR has begun making its way into Washington State as it was a presentation topic at the 2024 Behavioral Healthcare state conference. Accessibility wise, starting with basic Cognitive Behavioral Therapy may be more ideal as it is easier to find clinicians with skills

within this framework as EMDR takes specific training. Though, it will be acknowledged that a meta-analysis of randomized clinical trials has suggested that EMDR is more effective than CBT in decreasing post-traumatic symptoms and anxiety among individuals with PTSD (Basher et al., 2023).

When thinking about a problem as large as the numbers of mental illness within the criminal justice system, it can feel overwhelming. However, it is time that new approaches be taken to see what can be changed for the better. It is this researcher's belief that through therapy offered within a prison setting paired with an improved environment through prison staff being trained in trauma-informed care approaches, lives could only be improved for the better. Theoretical frameworks to support this include the theory of cognitive behavioral therapy, which looks at how thoughts, feelings, and behaviors are connected. By identifying inaccurate or negative thinking, one can challenge situations and respond to them in a more effective way (American Psychological Association, 2017). The community engagement model can also be applied when thinking of trauma-informed care in the prison environment as it provides structured approaches for effectively involving community members in decision-making processes, collaborative efforts, and problem-solving (Centers for Disease Control and Prevention, 1997).

Program Description

This pilot program will focus on 2 women's prisons and 2 men's prisons in Washington state with reported high rates of behavioral health concerns over the course of at least 2 years, with the intent of establishing roots in all state prisons. The purpose of this program is to bring cognitive behavioral therapy within a group cohort context into prisons, alongside in person

trauma-informed care training for prison staff at the pilot location. Four therapists with at least a bachelor's degree in psychology, Social Work, or a related field will utilize The Comprehensive Clinician's Guide to Cognitive Behavioral Therapy along with Cognitive Behavioral Therapy Made Simple (Appendix A) for groups held within the walls of the prison. They will tailor handouts used based on the needs identified with each cohort. These groups will utilize pre-existing group rooms. The group size will be between 8 and 15 individuals and they will meet weekly for 12 weeks. Recruitment will occur through current case managers at the selected pilot prisons through the distribution of flyers and posting them in areas of the prison they deem appropriate. All CBT cohorts are voluntary, though case managers and staff may encourage individuals that they believe may benefit from the program.

When looking at curriculum to approach TIC training for all prison staff, Washington State Department of Social and Health Services outlines 5 modules that can be referenced that are free to access, including one for correctional settings. Due to the importance of this training, it will be mandatory for pilot prison staff, held in person, paid, and include a lunch. This will help start building a rapport with the new therapists that will begin working in these pilot program prisons as well. There will be at least two opportunities to attend the TIC training so that all prison personnel may attend.

Potential barriers regarding successful implementation of this program and the TIC strategy include internalized stigma regarding both therapy and incarceration. It has been found through surveys that many people believe that inmates do not deserve basic rights. It can be speculated then that there are times when prison staff may have a reluctance to provide empathetic care towards an individual who committed a heinous crime. Also to consider, prison staff have worked in an environment without significant support in many areas. The burnout

rates are high. To implement new strategies may prove difficult if settings have a system that they find fit or if the workers have lost a sense of engagement with their job. It is also important to note that many of those who are incarcerated may have been raised to have a distrust of professionals, including social workers and therapists. These systemic issues may cause some push back during recruitment and initial implementation. Incarcerated individuals may also fear backlash for their engagement in this sort of program. They could fear being viewed as weak, an easy target, and avoid engagement in a program they may benefit from. However, through engagement in the prison community, it is believed that observations will promote future engagements for the better. The incorporation of a variety of types of learning styles will also be necessary to work with the barrier regarding homework/self-work for CBT group therapy, as some incarcerated individuals may not have a comprehensive level to read handouts to implement skills independently.

Project Goals and Outcomes

The goal of this pilot program is to provide mental health support to incarcerated individuals to improve coping skills that will decrease maladaptive behaviors that may have led to incarceration, along with reducing recidivism rates by focusing on rehabilitation rather than punishment through a supportive environment long term. To determine if these goals are met, 2 outcomes will be met. The first will be that incarcerated individuals will report improvement in mood and world beliefs following completion of CBT group therapy. This will be indicated through reports of improved levels of anxiety and depression after incarcerated individuals have completed their CBT group cohorts. The PHQ9 and GAD7 scales will be utilized to measure this (Appendix B). A second indicator unique to this pilot program is the utilization of the Personality

Belief Questionnaire (PBQ). This indicator will show reported improved levels regarding negative world beliefs following completion of their cohort.

The second outcome will be that prison staff will learn about trauma informed care approaches that promote an environment that supports rehabilitation and not punishment. This will be indicated by at least 50% of prison staff reporting an improved attitude related to trauma-informed care following their training. The Attitudes Related to Trauma-Informed Care, or ARTIC, scale will be utilized (Appendix B). Due to the complexity of the environment that this TIC training will be offered in, it the full form with 45 items will be utilized to assess attitudes. This assessment will be given pre and post training and is generally completed within 15 to 20 minutes (Baker et al., 2016). Another indicator to show the effectiveness of this intervention will be that prison staff will be able to identify at least 3 of 7 trauma-informed care approaches they will use in case of a mental health crisis.

When concluding that this pilot program has been successful, self-reported assessments would show that prison staff observations of inmate behavior have shown a reduction of violence and aggression between incarcerated individuals following the introduction of this program. Data reviewers during these interviews will also assess for prison staff attitudes regarding unit behaviors following TIC training and the implementation of group therapy. The unit write up's will also be reviewed to assess numbers 6 months prior to group therapy and TIC and 6 months after starting. A suspected outcome is that 6 months following the completion of the first cohort, unit write up's will show a reduction of disruptive behaviors by at least 10%.

Based on evidence in support of TIC, it is this researcher's belief that implementing this strategy with prison staff will be a unique approach when working towards incarcerated individuals rehabilitation while still in active custody. By having case managers and therapists

working at the prisons and engaging with both the prison staff and incarcerated individuals, there will be opportunities to build relationships that do not have to result in violence or clear power differentials. By humanizing everyone, growth can happen.

This pilot program will be established with an initial duration of 2 years. Based on findings and feedback from both incarcerated individuals that have completed their group cohort alongside prison staff, these programs will find cause to expand to every prison within the state. The PHQ9, GAD7, and PBQ-SF (Appendix B) will be administered to cohort members prior to beginning the group and then again at 6 months, 12 months, and 24 months. A 5 year review will be completed to assess recidivism rates in all incarcerated individuals who participated in the CBT group cohorts, including those who may not have finished the cohort duration. If effective, rates will have reduced by 20% in individuals who completed their cohort's 3 month group therapy through the utilization and continued building of skills learned during this time.

Budget

Agencies to be contacted regarding grants could include the: Department of Corrections, National Alliance on Mental Illness, Substance Abuse and Mental Health Services Administration, Mental Health America, Prison Policy Initiative, National Institute of Health, Department of Health, National Commission on Correctional Healthcare, and the American Psychological Association.

Salaries	4 therapists, 1 admin	$55,000/year x2	$550,000
Benefits	4 therapists, 1 admin		$17,500
One time bonus	Current prison case managers	$750/person	$7,500
Travel	4 therapists, 1 admin	Up to $500/year reimbursed	$60,000

Technology	5 work phones + monthly costs per line		$6,000
Technology	5 work computers		$2,000
Technology	2 Printers + Supplies (ink and paper)		$1,000
Curriculum	4 CBT Clinician Guides; 4 CBT Made Easy guides		$200
Materials	2 rolling whiteboards and erasable markers: $350 Clipboards and pens/pencils : $200 Spiral journals: every inmate - $150 Projector - $600		$1500
Food	Lunch for prison staff during TIC Training + Final day of cohorts	$500 each prison	$1,400
Flex spending			$2,900
		TOTAL BUDGET REQUEST:	**$650,000**

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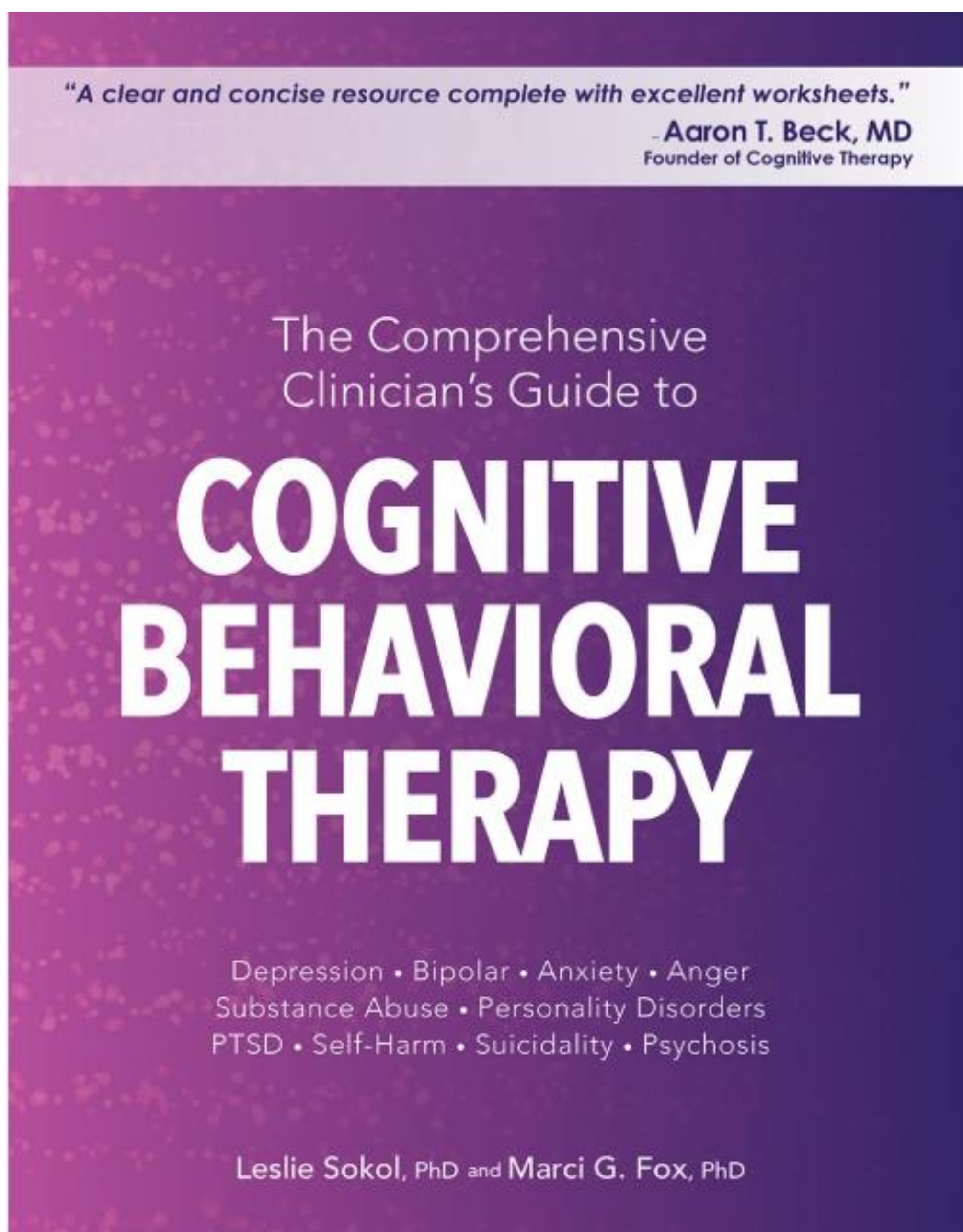
APPENDIX A: CBT Curriculum

The Comprehensive Clinician's Guide to Cognitive Behavioral Therapy https://a.co/d/8vIUrhd



Cognitive Behavioral Therapy Made Simple: 10 Strategies for Managing Anxiety, Depression, Anger, Panic, and Worry (Retrain Your Brain with CBT) https://a.co/d/0Kctmu6

Cognitive Behavioral Therapy

Made Simple

10 STRATEGIES for Managing Anxiety, Depression, Anger, Panic, and Worry

SETH J. GILLIHAN, PhD

APPENDIX B: Scales

PHQ9 for Depression: https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ + ______ + ______ + ______

=Total Score: ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

GAD7 for Anxiety: https://adaa.org/sites/default/files/GAD-7_Anxiety-updated_0.pdf

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals ____ + ____ + ____ + ____ =

Total score ______

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Personality Belief Questionnaire – Short Form scale:

https://beckinstitute.org/wp-content/uploads/2021/06/PBQ-SF-Full-Documents.pdf

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PBQ-SF©

ACB 3/12/99

Name: ______________________ Date: __________

Office use only:

ID: [| | | | |]

Intake

Please read the statements below and rate HOW MUCH YOU BELIEVE EACH ONE. Try to judge how you feel about each statement MOST OF THE TIME. Do not leave any statements blank.

4	3	2	1	0
I Believe it Totally	I Believe it Very Much	I Believe it Moderately	I Believe it Slightly	I Don't Believe it at all

Example	HOW MUCH DO YOU BELIEVE IT?				
1. The world is a dangerous place. (Please circle)	4 Totally	3 Very Much	(2) Moderately	1 Slightly	0 Not at All
1. Being exposed as inferior or inadequate will be intolerable.	4	3	2	1	0
2. I should avoid unpleasant situations at all cost.	4	3	2	1	0
3. If people act friendly, they may be trying to use or exploit me.	4	3	2	1	0
4. I have to resist the domination of authorities but at the same time maintain their approval and acceptance.	4	3	2	1	0
5. I cannot tolerate unpleasant feelings.	4	3	2	1	0
6. Flaws, defects, or mistakes are intolerable.	4	3	2	1	0
7. Other people are often too demanding.	4	3	2	1	0
8. I should be the center of attention.	4	3	2	1	0
9. If I don't have systems, everything will fall apart.	4	3	2	1	0
10. It's intolerable if I'm not accorded my due respect or don't get what I'm entitled to	4	3	2	1	0
11. It is important to do a perfect job on everything.	4	3	2	1	0

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	HOW MUCH DO YOU BELIEVE IT?				
	4 Totally	3 Very Much	2 Moderately	1 Slightly	0 Not at All
12. I enjoy doing things more by myself than with other people.	4	3	2	1	0
13. Others will try to use me or manipuate me if I don't watch out.	4	3	2	1	0
14. Other people have hidden motives.	4	3	2	1	0
15. The worst possible thing would be to be abandoned.	4	3	2	1	0
16. Other people should recognize how special I am.	4	3	2	1	0
17. Other people will deliberately try to demean	4	3	2	1	0
18. I need others to help me make decisions or tell me what to do.	4	3	2	1	0
19. Details are extremely important.	4	3	2	1	0
20. If I regard people as too bossy, I have a right to disregard their demands.	4	3	2	1	0
21. Authority figures tend to be intrusive, demanding, interfering, and controlling.	4	3	2	1	0
22. The way to get what I want is to dazzle or amuse people.	4	3	2	1	0
23. I should do whatever I can get away with.	4	3	2	1	0
24. If other people find out things about me, they will use them against me	4	3	2	1	0
25. Relationships are messy and interfere with freedom.	4	3	2	1	0
26. Only people as brilliant as I am understand me.	4	3	2	1	0
27. Since I am so superior, I am entitled to special treatment and privileges.	4	3	2	1	0
28. It is important for me to be free and independent of others	4	3	2	1	0

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	HOW MUCH DO YOU BELIEVE IT?				
	4 Totally	3 Very Much	2 Moderately	1 Slightly	0 Not at All
29. In many situations, I am better off to be left alone.	4	3	2	1	0
30. It is necessary to stick to the highest standards at all times, or things will fall apart.	4	3	2	1	0
31. Unpleasant feelings will escalate and get out of control.	4	3	2	1	0
32. We live in a jungle and the strong person is the one who survives.	4	3	2	1	0
33. I should avoid situations in which I attract attention, or be as inconspicuous as possible.	4	3	2	1	0
34. If I don't keep others engaged with me, they won't like me.	4	3	2	1	0
35. If I want something, I should do whatever is necessary to get it.	4	3	2	1	0
36. It's better to be alone than to feel "stuck" with other people.	4	3	2	1	0
37. Unless I entertain or impress people, I am nothing.	4	3	2	1	0
38. People will get at me if I don't get them first.	4	3	2	1	0
39. Any signs of tension in a relationship indicate the relationship has gone bad; therefore, I should cut it off.	4	3	2	1	0
40. If I don't perform at the highest level, I will fail.	4	3	2	1	0
41. Making dealines, complying with demands, and conforming are direct blows to my pride and self-sufficiency.	4	3	2	1	0
42. I have been unfairly treated and am entitled to get my fair share by what ever means I can.	4	3	2	1	0
43. If people get close to me, they will discover the "real" me and reject me.	4	3	2	1	0
44. I am needy and weak.	4	3	2	1	0
45. I am helpless when I'm left on my own.	4	3	2	1	0

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	HOW MUCH DO YOU BELIEVE IT?				
	4 Totally	3 Very Much	2 Moderately	1 Slightly	0 Not at All
46. Other people should satisfy my needs.	4	3	2	1	0
47. If I follow the rules the way people expect, it will inhibit my freedom of action.	4	3	2	1	0
48. People will take advantage of me if I give them the chance.	4	3	2	1	0
49. I have to be on guard at all times.	4	3	2	1	0
50. My privacy is much more important to me than closeness to people.	4	3	2	1	0
51. Rules are arbitrary and stifle me.	4	3	2	1	0
52. It is awful if people ignore me.	4	3	2	1	0
53. What other people think doesn't matter to me.	4	3	2	1	0
54. In order to be happy, I need other people to pay attention to me.	4	3	2	1	0
55. If I entertain people, they will not notice my weaknesses.	4	3	2	1	0
56. I need somebody around available at all times to help me to carry out what I need to do or in case something bad happens	4	3	2	1	0
57. Any flaw or defect or performance may lead to a catastrophe.	4	3	2	1	0
58. Since I am so talented, people should go out of their way to promote my career.	4	3	2	1	0
59. If I don't push other people, I will get pushed around.	4	3	2	1	0
60. I don't have to be bound by the rules that apply to other people.	4	3	2	1	0
61. Force or cunning is the best way to get things done.	4	3	2	1	0
62. I must maintain access to my supporter or helper at all times.	4	3	2	1	0
63. I am basically alone -- unless I can attach myself to a stronger person.	4	3	2	1	0
64. I cannot trust other people.	4	3	2	1	0
65. I can't cope as other people can.	4	3	2	1	0

Personality Belief Questionnaire – Short Form (PBQ-SF)
Scoring Key

Patient Name: ______________________________ Date on PBQ: __________

Scored By: ______________________________ Date of Scoring: __________

PBQ Scale	Sum items to calculate raw score	Raw Score	Use formula to calculate Z-score	Z-score
Avoidant	Sum items 1, 2, 5, 31, 33, 39, & 43	____	(Raw score – 10.86)/6.46	_____
Dependent	Sum items 15, 18, 44, 45, 56, 62, & 63	____	(Raw score – 9.26)/6.12	_____
Passive-Aggressive	Sum items 4, 7, 20, 21, 41, 47, & 51	____	(Raw score – 8.09)/5.97	_____
Obsessive-Compulsive	Sum items 6, 9, 11, 19, 30, 40, & 57	____	(Raw score – 10.56)/7.20	_____
Antisocial	Sum items 23, 32, 35, 38, 42, 59, & 61	____	(Raw score – 4.25)/4.30	_____
Narcissistic	Sum items 10, 16, 26, 27, 46, 58, & 60	____	(Raw score –3.42)/4.23	_____
Histrionic	Sum items 8, 22, 34, 37, 52, 54, & 55	____	(Raw score – 6.47)/6.09	_____
Schizoid	Sum items 12, 25, 28, 29, 36, 50, & 53	____	(Raw score – 8.99)/5.60	_____
Paranoid	Sum items 3, 13, 14, 17, 24, 48, & 49	____	(Raw score – 6.99)/6.22	_____
Borderline	Sum items 31, 44, 45, 49, 56, 64, 65	____	(Raw score – 8.07)/6.05	_____

Note: Z-scores are based on a sample of 683 psychiatric outpatients with mixed diagnoses.

Attitudes Related to Trauma Informed Care (ARCTIC) Scale

ARTIC *Attitudes Related to Trauma-Informed Care Scale*
VERSION: ARTIC-45 HUMAN SERVICES

TRAUMATIC STRESS INSTITUTE

People who work in human services, health care, education, and related fields have a wide variety of beliefs about their clients, their jobs, and themselves. The term "client" is interchangeable with "student," "person," "resident," "patient," or other terms to describe the person being served in a particular setting.

Trauma-informed care is an approach to engaging people with trauma histories in human services, education, and related fields that recognizes and acknowledges the impact of trauma on their lives.

INSTRUCTIONS

For each item, select the circle along the dimension between the two options that best represents your personal belief during the past two months at your job.

Sample

	1	2	3	4	5	6	7	
Ice cream is delicious	○	●	○	○	○	○	○	Ice cream is disgusting.

Note: *In this SAMPLE ITEM, the respondent is reporting that he/she believes that ice cream is much more delicious than disgusting.*

I believe that...

		1	2	3	4	5	6	7	
1	Clients' learning and behavior problems are rooted in their behavioral or mental health condition.	○	○	○	○	○	○	○	Clients' learning and behavior problems are rooted in their history of difficult life events.
2	Focusing on developing healthy, healing relationships is the best approach when working with people with trauma histories.	○	○	○	○	○	○	○	Rules and consequences are the best approach when working with people with trauma histories.
3	Being very upset is normal for many of the clients I serve.	○	○	○	○	○	○	○	It reflects badly on me if my clients are very upset.
4	I don't have what it takes to help my clients.	○	○	○	○	○	○	○	I have what it takes to help my clients.
5	It's best not to tell others if I have strong feelings about the work because they will think I am not cut out for this job.	○	○	○	○	○	○	○	It's best if I talk with others about my strong feelings about the work so I don't have to hold it alone.
6	The clients were raised this way, so there's not much I can do about it now.	○	○	○	○	○	○	○	The clients were raised this way, so they don't yet know how to do what I'm asking them to do.
7	Clients need to experience real life consequences in order to function in the real world.	○	○	○	○	○	○	○	Clients need to experience healing relationships in order to function in the real world.
8	If clients say or do disrespectful things to me, it makes me look like a fool in front of others.	○	○	○	○	○	○	○	If clients say or do disrespectful things to me, it doesn't reflect badly on me.
9	I have the skills to help my clients.	○	○	○	○	○	○	○	I do not have the skills to help my clients.
10	The best way to deal with feeling burnt out at work is to seek support.	○	○	○	○	○	○	○	The best way to deal with feeling burnt out at work is not to dwell on it and it will pass.
11	Many clients just don't want to change or learn.	○	○	○	○	○	○	○	All clients want to change or learn.

CONTINUED →

ARTIC *Attitudes Related to Trauma-Informed Care Scale*
VERSION: ARTIC-45 HUMAN SERVICES

TRAUMATIC STRESS INSTITUTE

I believe that…

#		1	2	3	4	5	6	7	
12	Clients often are not yet able or ready to take responsibility for their actions. They need to be treated flexibly and as individuals.	○	○	○	○	○	○	○	Clients need to be held accountable for their actions.
13	I realize that clients may not be able to apologize to me after they act out.	○	○	○	○	○	○	○	If clients don't apologize to me after they act out, I look like a fool in front of others.
14	Each day is uniquely stressful in this job.	○	○	○	○	○	○	○	Each day is new and interesting in this job.
15	The fact that I'm impacted by my work means that I care.	○	○	○	○	○	○	○	Sometimes I think I'm too sensitive to do this kind of work.
16	Clients have had to learn how to trick or mislead others to get their needs met.	○	○	○	○	○	○	○	Clients are manipulative so you need to always question what they say.
17	Helping a client feel safe and cared about is the best way to eliminate undesirable behaviors.	○	○	○	○	○	○	○	Administering punitive consequences is the best way to eliminate undesirable behaviors.
18	When I make mistakes with clients, it is best to move on and pretend it didn't happen.	○	○	○	○	○	○	○	When I make mistakes with clients, it is best to own up to my mistakes.
19	The ups and downs are part of the work so I don't take it personally.	○	○	○	○	○	○	○	The unpredictability and intensity of work makes me think I'm not fit for this job.
20	The most effective helpers find ways to toughen up – to screen out the pain – and not care so much about the work.	○	○	○	○	○	○	○	The most effective helpers allow themselves to be affected by the work – to feel and manage the pain – and to keep caring about the work.
21	Clients could act better if they really wanted to.	○	○	○	○	○	○	○	Clients are doing the best they can with the skills they have.
22	It's best to treat clients with respect and kindness from the start so they know I care.	○	○	○	○	○	○	○	It's best to be very strict at first so clients learn they can't take advantage of me.
23	Healthy relationships with clients are the way to good client outcomes.	○	○	○	○	○	○	○	People will think I have poor boundaries if I build relationships with my clients.
24	I feel able to do my best each day to help my clients.	○	○	○	○	○	○	○	I'm just not up to helping my clients anymore.
25	It is because I am good at my job that the work is affecting me so much.	○	○	○	○	○	○	○	If I were better at my job, the work wouldn't affect me so much.
26	Clients do the right thing one day but not the next. This shows that they are doing the best they can at any particular time.	○	○	○	○	○	○	○	Clients do the right thing one day but not the next. This shows that they could control their behavior if they really wanted to.
27	When managing a crisis, enforcement of rules is the most important thing.	○	○	○	○	○	○	○	When managing a crisis, flexibility is the most important thing.
28	If I don't control clients' behavior, bad things will happen to property.	○	○	○	○	○	○	○	As long as everyone is safe, it is ok for clients to become really upset, even if they cause some property damage.
29	I dread going to my job because it's just too hard and intense.	○	○	○	○	○	○	○	Even when my job is hard and intense, I know it's part of the work and it's ok.

CONTINUED →

I believe that…

#		1	2	3	4	5	6	7	
30	How I am doing personally is unrelated to whether I can help my clients.	○	○	○	○	○	○	○	I have to take care of myself personally in order to take care of my clients.
31	If things aren't going well, it is because the clients are not doing what they need to do.	○	○	○	○	○	○	○	If things aren't going well, it is because I need to shift what I'm doing.
32	I am most effective as a helper when I focus on a client's strengths.	○	○	○	○	○	○	○	I am most effective as a helper when I focus on a client's problem behaviors.
33	Being upset doesn't mean that clients will hurt others.	○	○	○	○	○	○	○	If I don't control clients' behavior, other clients will get hurt.
34	If I told my colleagues how hard my job is, they would support me.	○	○	○	○	○	○	○	If I told my colleagues how hard my job is, they would think I wasn't cut out for the job.
35	When I feel myself "taking my work home," it's best to bring it up with my colleagues and/or supervisor(s).	○	○	○	○	○	○	○	When I feel myself "taking my work home," it's best to keep it to myself.

Note: *Some of the following items pertain to people working at organizations that have ALREADY implemented trauma-informed care to some degree. If you do NOT work at such an organization, use the "N/A" option for any items that are not applicable to you.*

I believe that…

#		1	2	3	4	5	6	7	N/A	
36	Clients react positively to the trauma-informed care approach.	○	○	○	○	○	○	○	○	Clients react negatively to the trauma-informed care approach.
37	I do not have enough support to implement trauma-informed care.	○	○	○	○	○	○	○	○	I have enough support to implement trauma-informed care.
38	The trauma-informed care approach takes too much time.	○	○	○	○	○	○	○	○	The trauma-informed care approach saves time in the long run.
39	When I feel like I can't handle this alone, I can go to my colleagues and/or supervisor(s) for help.	○	○	○	○	○	○	○	○	There is not much support from my colleagues and/or supervisor(s) for my work.
40	The trauma-informed care approach is effective.	○	○	○	○	○	○	○	○	The trauma-informed care approach is not effective.
41	I have the support I need to work in a trauma-informed way.	○	○	○	○	○	○	○	○	The program talks about trauma-informed care, but it is really business as usual.
42	I am able to carry out all my responsibilities with respect to the trauma-informed care approach.	○	○	○	○	○	○	○	○	I am not able to carry out all my responsibilities with respect to the trauma-informed care approach.
43	There is not much support from the administration for my work.	○	○	○	○	○	○	○	○	There is clear indication that the administration supports my work.
44	I cannot manage all that the trauma-informed care approach requires.	○	○	○	○	○	○	○	○	I can manage all that the trauma-informed care approach requires.
45	Everyone is committed to working in a trauma-informed way long term.	○	○	○	○	○	○	○	○	This emphasis on working in a trauma-informed way is just a passing phase.

Thank you for your participation.