



National Treatment
Court Resource Center



Beyond the Field

Trauma

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National Treatment Court Resource Center
Wilmington, North Carolina

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Contents

Introduction 1
Kristen E. DeVall, Ph.D.
Sally MacKain, Ph.D.

Trauma-Informed Treatment Courts: Translating Knowledge into Action 3
Kristen E. DeVall, Ph.D.
Sally MacKain, Ph.D.

The What, Who and Why of Trauma-Specific Therapies 6
Sally MacKain, Ph.D.

Trauma-Informed Drug/Alcohol Testing 9
Sally MacKain, Ph.D.
Kristen E. DeVall, Ph.D.

Trauma-Informed Spaces and Courtrooms 12
Kristen E. DeVall, Ph.D.
Sally MacKain, Ph.D.

What Treatment Courts Should Know About Sleep, Trauma, & Substance Use .. 14
Sally MacKain, Ph.D.

Traumatic Brain Injury and Treatment Courts 17
Sally MacKain, Ph.D.

Introduction

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The primary mission of the National Treatment Court Resource Center (NTCRC) is to help treatment court teams design, implement, and enhance programs with an eye toward improving participant outcomes. One way that we can achieve this mission is to produce materials that bridge science and practice. To this end, we publish a blog, *Beyond the Field*, which focuses on a wide range of topics relevant to every member of the treatment court team. These short and easily digestible summaries are designed to be thought-provoking and facilitate dialogue around strategies for improving program operations and outcomes. Periodically, the NTCRC will organize these blog entries into a compilation with a specific theme.

The theme for this *Beyond the Field* compilation is **trauma**. The entries focus on how trauma affects participants, why all aspects of program structure and process should be trauma-informed, and how teams can respond to support participants and improve outcomes.

- *Trauma-informed Treatment Courts: Translating Knowledge into Action* discusses why treatment court teams need to understand and recognize the signs of trauma, and reviews SAMHSA's six key principles that guide best practices.
- Which trauma therapies have the most scientific support? *The What, Who and Why of Trauma-Specific Therapies* explores evidence-based approaches to treating trauma, why some of these therapies are a good fit for treatment court participants, and how to access them.
- As outlined in the *Adult Treatment Court Best Practice Standards* (2nd ed.) drug and alcohol testing is a key component of the treatment court model. *Trauma-informed drug/alcohol testing* reviews how treatment court programs can align their drug/alcohol testing procedures with the trauma-informed principles of safety, trust, collaboration, empowerment, and more. The hope is that these revised procedures can minimize the potentially traumatizing effects on participants.
- Drawing from the field of Environmental Psychology, *Trauma-Informed Spaces and Courtrooms* reviews tips for treatment court professionals that can help prevent or offset the negative impacts of these often-intimidating spaces. We highlight strategies that programs can implement to promote a sense of safety and respect for participants.
- Sleep problems are extremely common, yet sleep may not be on your radar when thinking about the challenges faced by treatment court participants. We know many participants have histories of trauma. However, what is discussed less often is the connection between trauma and sleep disorders. The reality is that poor sleep can derail the recovery process. *What treatment courts should know about sleep, trauma and substance use* reviews how these three phenomena are related, and how to recognize and target sleep problems that may prevent participants from fully engaging in treatment court programs.
- One potentially lasting effect of trauma is physical injury to the brain. *Traumatic Brain Injury (TBI) and Treatment Courts* notes that TBIs may be overlooked by treatment court team members and mistaken for

“personality problems” or resistance to treatment. However, research clearly shows that responding skillfully and with compassion to the needs of participants with TBIs is best practice. This article offers three online guides available on the NTCRC website.

Many of the resources mentioned in these *Beyond the Field* entries are available on our website <https://ntcrc.org/>. Additional blog entries can be found on our website—<https://ntcrc.org/category/beyond-the-field/>.

We hope you enjoy reading these entries, find the content useful to your work, and incorporate the information into your program’s structure and processes.

Trauma-Informed Treatment Courts: Translating Knowledge into Action

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Which clients in your treatment court have a history of trauma? How can you find out? Why does it matter? While the conversation about the prevalence and devastating effects of trauma has become increasingly open in justice settings, many treatment courts may be blind to it in their own programs or simply hope that good intentions will prevent further trauma. Perhaps now is the time to self-reflect as a treatment court and to take small, but meaningful actions right now.

According to SAMHSA, “Individual trauma results from an **event**, series of events, or a set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life threatening and that has lasting adverse **effects** on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being, (2014a, p. 7).” Trauma experiences can diminish the ability of treatment court participants to engage in programs and long-term recovery. So, what does it mean for organizations to be trauma-informed? First, in order for treatment court programs to fully embody a trauma-informed system of care, all program staff must:

1. Have a basic **realization** of the origins of trauma and the impact this can have on individuals, families, groups, and communities.
2. Be able to **recognize** the signs of trauma in individuals.
3. Continuously assess the ways in which policies, procedures, and practices should be revised in order to allow staff to **respond** to individuals appropriately.
4. Resist engaging in action(s) that may result in **re-traumatization**.

In addition, SAMHSA (2014a) identifies six key principles that should serve as the foundation for developing your trauma-informed systems of care.

1. **Safety** (this is #1 for a reason) – above all else, participants’ physical & emotional safety should be promoted in all settings & through all interactions. Individuals (i.e., staff and participants) who do not feel safe will not fully engage.
2. **Trustworthiness & Transparency** – treatment court operations should be transparent and conducted with an eye toward developing and maintaining mutual trust between and among stakeholders and participants.
3. **Peer Support** – incorporating peer recovery support specialists into your treatment court program is an effective way for individuals with lived experience to assist participants in their recovery.
4. **Collaboration & Mutuality** – recognizing and acknowledging that all treatment court team members and participants have unique roles/responsibilities is key to developing collaborative relationships based on mutuality and respect.

5. **Empowerment, Voice, & Choice** – treatment court team members look for opportunities to empower participants to make decisions and have a voice in their recovery.
6. **Cultural, Historical, & Gender Issues** – the treatment court program provides participants with access to clinical and recovery support services that are responsive to their cultural, racial/ethnic, and gender needs.

A good place to start moving toward being a trauma-informed treatment court is to screen participants for trauma exposure to determine which individuals are in need of a more thorough assessment and trauma-specific services. Several screening and assessment tools have been validated with justice-involved populations and are listed below. This is by no means an exhaustive list, and note that separate tools have been developed for youth (Collaborative for Change, 2016) and adults (SAMHSA, 2015). Many of these tools are free, while some charge a nominal fee.

Youth Instruments	Screening Tool	Assessment Tool
Adverse Childhood Experiences Study (ACES)	x	
Childhood Trust Events Survey (CTES)	x	
Juvenile Victimization Questionnaire (JVQ)	x	
Massachusetts Youth Screening Instrument, Version 2 (MAYSI-2)	x	
Trauma Events Screening Inventory for Children (TESI-C)	x	
Trauma Symptom Checklist for Children (TSCC)	x	
UCLA Posttraumatic Stress Disorder Reaction Index (UCLA-PTSD-RI)	x	
PTSD Checklist for DSM-V	x	
Child & Adolescent Trauma Screen (CATS)	x	
Clinician-Administered PTSD Scale for Children & Adolescents (CAPS-CA)		x
Child and Adolescent Psychiatric Assessment (CAPA)		x
Anxiety Disorders Interview Schedule (ADIS)		x
Developmental Trauma Disorder (DTD) -- these 2 instruments should be administered together:		x
1. Structured Interview for Child		
2. Structured Interview for Parent/Caregiver		
Adult Instruments	Screening Tool	Assessment Tool
Impact of Events Scale-Revised (IES-R)	x	
Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) ¹	x	
Primary Care PTSD Screen (PC-PTSD)	x	
Trauma Symptom Checklist (TSC-40)	x	
The Trauma Symptom Inventory (TSI)	x	
Life Stressor Checklist (LSC-R) ²	x	
Stressful Life Events Screening Questionnaire-Revised (SLESQ-R)	x	
Trauma History Questionnaire (THQ)	x	
Trauma History Screen (THS) ²	x	
Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)		x
Posttraumatic Stress Diagnostic Scale (PDS)		x
Posttraumatic Symptom Scale- Interview Version (PSS-I)		x

To conduct a screen sensitively that will yield valid responses, it is recommended that programs “take the time to prepare and explain the screening and assessment process to the client gives him or her a greater sense of control and safety over the assessment process.” (SAMHSA, 2014b, p. 94). Be prepared to reassess individuals as they grow more willing to disclose information over time.

In the coming months, *Beyond the Field* entries will periodically highlight literature on trauma-informed practices for different components of treatment courts, including drug testing, courtroom set-up and structure, team dynamics, use of language, and providing participants opportunities to have a voice and make choices.

References

- Collaborative for Change. (2016). *Trauma Among Youth in the Juvenile Justice System*. Retrieved from <http://adq631j7v3x1shge52cot6m1-wpengine.netdna-ssl.com/wp-content/uploads/2018/02/Trauma-Among-Youth-in-the-Juvenile-Justice-System-for-WEBSITE.pdf>
- Substance Abuse and Mental Health Services Administration (2014a). *SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884.
- Substance Abuse and Mental Health Services Administration. (2014b). *Trauma-Informed Care in Behavioral Health Services*. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801.
- Substance Abuse and Mental Health Services Administration. (2015). *Screening and Assessment of Co-occurring Disorders in the Justice System*. HHS Publication No. PEP19-SCREEN-CODJS. Rockville, MD: Substance Abuse and Mental Health Services Administration.

The What, Who and Why of Trauma-Specific Therapies

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Perhaps you have heard these common misconceptions about trauma therapy for treatment court participants:

“Trauma therapies are too harsh—they could relapse and they won’t graduate.”

“Better to treat the substance use first, THEN address the trauma.”

“Whatever trauma-focused therapy is available, that will be good enough.”

“It is expensive (for providers) to learn trauma-focused therapies, and they are too complicated.”

The National Treatment Court Resource Center provides free resources to enable treatment courts to implement evidence-based practices and maximize the effectiveness of their programs. In this fourth article in our series on trauma-informed practices, we provide a brief overview of trauma-specific treatments that have the most scientific support, why these therapies are a good fit for many treatment court participants with trauma, and ways to facilitate greater access to these effective treatments.

Importance of integrating treatment for PTSD and substance use treatment

It is well known that trauma and substance use disorders co-occur at very high rates, and treatment courts are well positioned to provide treatment for both, concurrently. This *integrated* model offers outcomes that are far superior to the outdated, *sequential* approach that requires treating substance use disorder first, THEN the trauma (Flanagan et al., 2016). *Integrated* treatment allows clients to address PTSD symptoms that are directly linked to substance use, and vice versa. A *sequential* model that focuses on treating substance use “first” reduces the chances that trauma will ever be addressed before the treatment court participant either drops out or completes the program. Providers may fear that clients with PTSD are too fragile in that encouraging clients to face their trauma memories and intense emotions directly could lead to relapse or dropping out of treatment. Conversely, treatment court participants have greater supports and structure in place than in any other time in their lives, so treatment courts are encouraged to take advantage of this window of opportunity.

Trauma-focused therapies with the best outcomes

The following trauma-focused treatments have been rigorously studied and are recommended/strongly recommended by the American Psychological Association and the U.S. Department of Defense (Veteran’s Services). All are fairly brief (8–16 sessions), and share a direct focus on exposure to memories of the trauma. Some also emphasize changing clients’ maladaptive beliefs about the trauma and themselves. All the approaches involve temporary discomfort, as distressing memories are activated through exposure (imagined or real-life) and processed in a structured, systematic manner under the direction of the therapist (Watkins et al., 2018). Decisions about which treatment approach is the best fit will depend on nature of the trauma (e.g., combat-related, victim of sexual assault, witness to a violent event), the complexity of the trauma, client preference, and realistically, availability of clinical providers who offer the intervention.

Cognitive Processing Therapy (CPT). People who have experienced trauma try to make sense of the occurrence and can develop distorted beliefs about themselves and the trauma. These “stuck points” can keep the individual from healing, and include beliefs such as “I have myself to blame” and “As long as I trust no one, I will be safer.” Treatment extends over 12 sessions and involves activating the traumatic memory, which includes writing and reading a narrative account of the trauma. At the same time, the therapist helps the client to identify the maladaptive cognitions

associated with the traumatic event and shift them to become more accurate and helpful (Resick, Monson & Chard, 2017).

Prolonged Exposure (PE). After educating the patient about the nature of PTSD and how PE works, the therapist uses exposure to both imagined and real-life situations, as well as people and places associated with the client's unique trauma. After repeated exposures, the client ultimately learns that the feared (avoided) consequence will not occur and is able to move forward and use more adaptive coping strategies as opposed to avoidance. The therapy typically takes 8–15 sessions (e.g., Foa et al, 2007).

Trauma-focused Cognitive Behavior Therapy (TFCBT). Many have heard of this as an evidence-based therapy for children. However, adults also benefit from the integration of behavioral (e.g., imaginal exposure to the distressing memory) and cognitive components. Clients learn to identify triggers of re-experiencing, practice discriminating between “then vs. now,” identify and dispute dysfunctional thoughts, as well as reshape beliefs about themselves, the trauma, and the world.

Eye Movement Desensitization Reprocessing (EMDR). In this treatment the therapist utilizes exposure to the traumatic memory, coupled with eye movements (left and right) and sometimes tapping and sounds. EMDR differs from the other recommended approaches in that cognitions are not explored, exposure to the distressing memory is briefer, and there is no assigned homework. The therapy typically takes 6–12 sessions (Shapiro, 2017).

These therapies have been found to be very effective for people who are actively using substances, have thoughts of suicide (but low intent), are unhoused, or have minimal education. There are a few exclusions. Trauma specific treatment is not recommended for people who currently have unmedicated mania or psychosis, or who are at current high-risk for suicide, or who require immediate detoxification services.

Who should receive these therapies?

First, assessment of trauma symptoms is critical. Treatment court participants may not report or display trauma symptoms at the initial screening and assessment for admission to treatment court, as they may have normalized their experiences or may not be ready to disclose such sensitive information. However, members of the treatment court team should be on alert for signs of trauma and refer participants to trauma therapy providers for assessment. Providers should routinely assess participants for PTSD and continue to assess throughout treatment.

Valid and reliable trauma screening and assessment measures are available to licensed professionals free of charge (see the National Center for PTSD for more information—https://www.ptsd.va.gov/professional/assessment/list_measures.asp#list1).

When working with justice-involved individuals with SUD or COD, SAMHSA (2015) recommends the use of the following trauma screening instruments:

PTSD Checklist for DSM-5 (PCL-5)

and

Select 1 of the following publicly available resources:

- The Trauma History Screen (THS)
- Life Stressor-Checklist (LSC-R)
- Life Events Checklist for DSM-V (LEC-5)

Similarly, SAMHSA (2015) recommends the use of one of the following trauma assessment instruments, which should be administered by a licensed clinician:

- Posttraumatic Symptom Scale (PSS-I) (request from author)
- Posttraumatic Diagnostic Scale (PDS) (request from author, can serve as both a screen and diagnostic assessment)
- Clinician Assisted PTSD Scale for DSM-5 (CAPS-5) (online request form, child version available)

How available are trauma specific therapies to treatment court participants?

There are few studies on the use of trauma therapies in treatment court populations, and more work needs to be done to assess barriers to access as well as mental health and substance use outcomes. Veterans Treatment Courts (VTCs) are likely to be more familiar with and offer trauma specific therapies. The U.S. Veterans Administration has been a leader in funding the development, research, training and dissemination of these interventions. The therapies are applicable to non-veteran populations, and clinicians are encouraged to receive training to provide these interventions. All approaches are related to aspects of cognitive and behavior therapies, and most providers should already be familiar with the theories and be able to utilize the therapy manuals, handouts, and free phone apps for patients (e.g. “PE Coach” and “CPT Coach”).

Treatment Courts are encouraged to pursue training for providers in these strongly recommended trauma-specific approaches and to utilize the free and low-cost resources below to learn more.

References

- Flanagan, J. C., Korte, K. J., Killeen, T. K., & Back, S. E. (2016). Concurrent treatment of substance use and PTSD. *Current Psychiatry Reports*, 18(8), 70. <https://doi.org/10.1007/s11920-016-0709-y>
- Foa, E. B., Hembree, E. A., & Rothbaum, B.O. (2007). Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences. Therapist Guide. Oxford University Press.
- Meyer, B. L. (2016). Practical Application: Research to Practice Cognitive Processing Therapy. National Drug Court Institute. https://ndcrc.org/wp-content/uploads/2022/01/Research_to_Practice_Overview_of_the_Evidence-Based_Intervention.pdf
- Resick, P.A., Monson, C.M. & Chard, K.M. (2017). Cognitive Processing Therapy for PTSD: A Comprehensive Manual. Guilford Press.
- Shapiro, F. (2017). Eye Movement Desensitization and Reprocessing (EMDR) Therapy, Third Edition. Basic Principles, Protocols, and Procedures. Guilford Press.
- Substance Abuse and Mental Health Services Administration. Screening and Assessment of Co-occurring Disorders in the Justice System. HHS Publication No. PEP19-SCREEN-CODJS. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.
- Watkins, L. E., Sprang, K. R., & Rothbaum, B. O. (2018). Treating PTSD: A review of evidence-based psychotherapy interventions. *Frontiers in Behavioral Neuroscience*, 12, 258. <https://doi.org/10.3389/fnbeh.2018.00258>

Additional Resources

National Center for PTSD—<https://www.ptsd.va.gov/>. Free assessment, intervention, and training resources for providers, including apps for patients.

Cognitive Processing Therapy—<https://cptforptsd.com/cpt-resources/>

Trauma-Informed Drug/Alcohol Testing

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This is the third in a series of articles regarding trauma-informed treatment courts. In December 2021, we offered an overview of SAMHSA's (2015) six principles of trauma-informed care and evidence-based strategies for the screening and assessment of trauma in participants. In January 2022, we explored literature on trauma-informed spaces and courtrooms and reviewed findings from environmental psychology. In this edition of *Beyond the Field*, we review work related to trauma-informed drug testing as it relates to the trauma-informed principles of safety, trust and transparency, collaboration and mutuality, empowerment/voice & choice, peer support, and cultural, racial/ethnic and gender needs.

According to Best Practice Standard #7, "Drug and alcohol testing provides an accurate, timely, and comprehensive assessment of unauthorized substance use throughout participants' enrollment in the Drug Court" (NADCP, 2018, 26). Treatment court teams use drug/alcohol results to monitor participants use of substances to make decisions regarding appropriate treatment services, supervision levels, and the administration of both incentives and sanctions. To this end, "the success of any Drug Court will depend, in part, on the reliable monitoring of substance use" (NADCP, 2018, 27). Given the vital role of drug/alcohol testing plays within the treatment court environment and the frequency with which participants engage in this program activity (minimum of twice per week during first few months of enrollment is best practice), it is vital that testing protocols are trauma-informed and do not undermine other aspects of the program.

Review of trauma and its associated symptoms. SAMHSA defines trauma as resulting "from an event, series of events, or a set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, psychological, social, emotional or spiritual well-being" (2014). Because trauma is common among treatment court participants, teams will want to take action to minimize its negative impact on engagement in services, communication, problem-solving, decision making, and outcomes.

Symptoms of Posttraumatic Stress Disorder (PTSD) and related Acute Stress Disorder (ASD) include the following four "clusters" (American Psychiatric Association, 2013):

- a. Re-experiencing the traumatic event, or having intrusive, recurring memories or dreams related to the event. Places, sounds, lighting, thoughts, objects, and even words can trigger re-experiencing.
- b. Avoidance of situations, thoughts and feelings related to the event. Avoidance symptoms can cause people to resist instructions or escape to "safety."
- c. Disturbance in arousal and reactivity. People may be easily startled, on edge, irritable, or become angry or aggressive. They may have trouble focusing, sleeping, and paradoxically, may engage in risky or destructive behavior.
- d. Numbing and/or other changes in cognition and mood. Numbing, emotional withdrawal or "shutdown" when triggered, negative thoughts, self-blame, feelings of isolation and apathy are common.

You can probably picture participants who exhibit these behaviors, but might not have considered them to be trauma-related reactions. Trauma-informed courts recognize that the people, places and things embedded in everyday treatment court operations can trigger and exacerbate PTSD and ASD, or even re-traumatize participants. They respond by altering policies and practices to minimize these risks, often at low or no costs.

The where, who and how of trauma-informed drug testing.

The National Center on Substance Abuse and Child Welfare (NCSACW) conducted a trauma-informed care assessment project, or “Walkthrough” process, with five sites across the country (NCSACW, 2015). The site visits of child welfare, substance use treatment centers, and family treatment courts identified several common trauma triggers, including drug testing spaces and procedures. Restrooms tended to be noisy, uncomfortable, and located in high-traffic areas with little or no privacy.

A tip sheet, “Trauma Informed Urine Drug Screens” was developed by Trauma Informed Oregon (2019) that provides detailed guidance for programs aiming to reduce the impact of trauma on justice-involved individuals with substance use disorders (found at this link <https://traumainformedoregon.org/wp-content/uploads/2019/05/Urine-Drug-Screen-tip-sheet.pdf>)

The information and examples are wisely organized by the principles of trauma-informed care.

Some highlight include:

Safety

- Give participants written AND verbal information about what to expect during a UDS each time a screen is required
- Have signage available in the restroom such as where to place the sample, when it is OK to flush and wash hands. Do not rush.
- Close off restroom when in use and be sure it is clean and free of hazards
- Ensure alternative means of testing, e.g. mouth swabs

Trust and Transparency

- Inform participants and provide documentation explaining why the UDS is being conducted, and when/how participants can access results
- Allow participants to observe the sample being closed and labelled
- Ensure participants know who to contact if they have questions, complaints or want to follow-up

Collaboration and Mutuality

- Provide a checklist of options about decisions they can make (if available) regarding use of a hat, whether or not they want to have conversation or quiet, soft music, or have water running.
- The tip sheet provides a sample information sheet that along with the above options, lists the purpose, substances tested for, and includes the statements “We understand this can be an uncomfortable process and want you to feel as safe as possible...”
- Provide a way for participants to offer feedback.

Empowerment, Voice & Choice

- Give participants a choice of which trained staff is giving the UDS.
- Ensure participants are aware of their rights as a service user, and provide in writing
- Avoid stigmatizing language “e.g. “dirty UA”).

Peer Support & Mutual Self-help

- If peer support is requested during the UA, ensure this option is available.

Culture, Gender & History

- Require staff to participate in trauma-informed care, cultural humility, and equity training as part of onboarding process.
- Ensure UDS staff represent the population being served.
- Ensure easy access to menstrual products.

The UDS tips provided by Trauma Informed Oregon are not particularly expensive or difficult to implement, but they do require leadership and consistency. Drug/alcohol testing is a key component of the drug treatment court model and can/should be conducted with an eye toward minimizing the potentially traumatizing effects on participants. Treatment court teams should examine current policies and procedures and make necessary modifications where appropriate. Ensuring that all aspects of treatment court programs are trauma-informed will improve participant retention rates and increase the likelihood of participant success.

References

Substance Abuse and Mental Health Services Administration (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD.

Trauma Informed Oregon (2019). Trauma Informed Urine Drug Screens. Oregon Health Authority.

Trauma-Informed Spaces and Courtrooms

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When you go into a court you don't know what's going on because you're terrified. There are guns, they've got you chained up, and you're under the influence. All these things are happening at once. — Trauma Survivor (SAMHSA et al., 2013).

People who have experienced trauma can be easily and suddenly overwhelmed, hypersensitive to sounds, confined spaces and objects. They may reflexively respond to these as life-threatening and can't attend to or remember essential court proceeding or treatment-related information.

The field of Environmental Psychology studies how the the physical environment, such as building design, floor-plans, signage, and other features of buildings impact our behavior. Designs that provide privacy and a sense of safety are ideally suited for people who have experienced trauma (Garcia, 2020).

Of course, few courts, probation departments, treatment providers, etc. have the luxury of designing their own buildings. However, SAMHSA and other collaborators (2013) compiled tips for treatment court professionals that can help prevent or offset negative impacts of these often-intimidating spaces and promote a sense of safety and respect in participants. They highlight aspects of the physical environment that treatment courts can consider without great expense or delay.

Does your courtroom have seating that provides easy access to aisles and exits? If not, can seats be reserved near aisles? Where does the judge sit? DO they loom above the court, making eye contact and respectful connection difficult? Are people placed in handcuffs and shackled where all in attendance can see? Are the bathrooms where drug tests take place well lit? Is there a space where people can get some privacy if they need a space to calm down? Is the signage posted respectful? OR does it just instruct people what NOT to do?

The article provides a table that describes potential triggers in the environment, the possible reactions of a trauma survivor, and a more trauma-informed approach that treatment courts may take. Here is an excerpt:

Table 1. Courtroom Environment (from SAMHSA et al, 2013)

PHYSICAL ENVIRONMENT	REACTION OF TRAUMA SURVIVOR	TRAUMA-INFORMED APPROACH
The judge sits behind a desk (or “bench”), and participants sit at a table some distance from the bench.	Feeling separate; isolated; unworthy; afraid.	In some treatment courts, the judge comes out from behind the bench and sits at a table in front.
Participants are required to address the court from their place at the defendant’s table.	Fear of authority; inability to communicate clearly, especially if an abuser is in the courtroom.	When practical, ask the participant to come close; speak to them beside or right in front of the bench.
Multiple signs instruct participants about what they are not allowed to do.	Feeling intimidated; lack of respect; untrustworthy; treated like a child.	Eliminate all but the most necessary of signs; word those that remain to indicate respect for everyone who reads them.
A court officer jingles handcuffs while standing behind a participant.	Anxiety; inability to pay attention to what the judge is saying; fear.	Eliminate this type of nonverbal intimidation, especially if you have no intention of remanding the individual. Tell the court officers not to stand too close. Respect an individual’s personal space.
A judge asks a participant to explain her[his] behavior or the impact of abuse without acknowledging the impact of others in the courtroom.	Intimidation or fear of abusers who may be in the courtroom; reluctance to share information in front of family members or others who do not believe them.	Save questions about sensitive issues for when the courtroom is empty or allow the participant to approach the bench. If ongoing abuse or intimidation is suspected, engage those people in activities outside the courtroom while the participant shares her[his] story.

According to Garcia (2020), “The goal of trauma-informed design is to create environments that promote a sense of calm, safety, dignity, empowerment, and well-being for all occupants. These outcomes can be achieved by adapting spatial layout, thoughtful furniture choices, visual interest, light and color, art, and biophilic design.” It would behoove treatment court teams to assess the physical spaces where participants engage in program-related activities with a critical eye toward minimizing trauma.

References

- Garcia, A.M. (September 4, 2020). *Empathy in Architecture: Using Trauma-Informed Design to Promote Healing*. Environments 4 Health Architecture. <https://e4harchitecture.com/empathy-in-architecture-using-trauma-informed-design-to-promote-healing/>
- Substance Abuse and Mental Health Services Administration, SAMHSA’s National Center on Trauma-Informed Care and SAMHSA’s National GAINS Center for Behavioral Health and Justice, (2013). *Essential Components of Trauma Informed Judicial Practice*. Rockville, MD: Substance Abuse and Mental Health Services Administration. https://www.nasmhpd.org/sites/default/files/DRAFT_Essential_Components_of_Trauma_Informed_Judicial_Practice.pdf

What Treatment Courts Should Know About Sleep, Trauma, & Substance Use

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This is the fifth in our Beyond the Field series of articles that explore trauma and its impact on treatment court work. Treatment court participants can face challenges including complex health problems, poverty, discrimination, substance use, trauma, just to name a few. As a result, poor sleep may not rise to the top of the list of issues to address with individuals. Yet sleep disturbances underlie many of the physical, cognitive, and emotional struggles that can derail recovery. Over 80% of people who have been diagnosed with post-traumatic stress disorder (PTSD) also have a sleep disorder, and adding substance use to the mix compounds sleep problems exponentially (Vandrey et al. 2014). Recognizing and targeting sleep problems as one dimension of treatment could not only improve health and well-being but may be key to helping people more fully engage in treatment court activities.

What are sleep disorders?

Sleep is essential to our ability to regulate our mood, make wise decisions, avoid accidents, encode and retrieve memories, and learn new things. Treatment court clients are expected to do all these tasks, and not doing so impedes their progress to graduation and blocks long-term recovery. Not all difficulties with sleep meet criteria for a sleep disorder, but sleep disorders affect people with PTSD at much higher rates than the general population. The most common sleep disorder is insomnia, which includes problems with falling asleep, staying asleep, and returning to sleep after waking. Other sleep disorders that commonly occur with trauma are nightmares and obstructive sleep apnea (Coloven et al., 2018).

How are sleep, trauma, and substance use related?

The relationship between substance use and sleep problems is fairly well studied, and treatment court practitioners and providers should be aware of the importance of addressing sleep problems within the process of recovery. Use of stimulants, alcohol, opiates (e.g., too much sleep and insomnia rebound), and marijuana withdrawal all can cause or exacerbate sleep disturbance. The self-medication hypothesis is well supported as well, as people who struggle with sleep may turn to substances to help. Much more research is needed to determine best treatment practices, and the Substance Abuse and Mental Health Services Administration has published a useful resource to learn more (SAMHSA, 2014; <https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4859.pdf>)

The impact of trauma on sleep is powerful. Re-experiencing traumatic events often occurs in the form of nightmares, and people become hypervigilant, or intensely on guard against future dangers. Depending on the nature of the trauma, people may have come to associate nighttime, darkness, and sleepiness with extreme vulnerability. We are never more defenseless than when asleep, and people who have experienced trauma form negative expectations and cognitions related to the inevitability of future harms.

There is growing evidence that PTSD, substance use disorders, and sleep disorders are bi-directionally linked (Vandrey et al. 2014).

For example, disordered sleep can make people more susceptible to trauma (e.g. accidents) and more likely to use substances to help them sleep; people with PTSD have symptoms that directly interfere with sleep (e.g. nightmares), and may misuse substances to get relief from both; and people who use or are withdrawing from substances find their sleep is disturbed and can experience heightened PTSD symptoms. Substance use offers quick relief from their distress, but then withdrawal from the same substances leads to sleep disturbance. These are just a sample of the

dynamic relationships among these factors, but more research is needed to understand the interplay among them and find effective treatments to address all three factors in concert.

Assessing sleep problems

Whether an individual reports “trouble sleeping” or has a diagnosable sleep disorder, it is important for providers to assess sleep disturbances. While parasomnias (e.g., sleepwalking) and obstructive sleep disordered breathing may require specialists and technologies (e.g., polysomnography) to diagnose, there are validated self-report measures of insomnia that can identify triggers in order to promote use of coping skills direct sleep interventions (see Colvonen, et al. 2018). Sleep diaries are another tool that asks the individual to track their own sleep, recording bedtimes, wake times, sleep latency, night awakenings and total amount of sleep. The data collected can inform not only diagnoses but provide a road map for developing treatment plans. As sleep disturbances do not occur in a vacuum, it is essential also assess trauma symptoms and substance use at the same time.

Treatment of sleep disorders as they co-occur with trauma and substance use

Research shows that treatment of trauma does not necessarily lead to improved sleep, and the same is true for treatment of substance use. Identifying and addressing sleep problems early in treatment may provide several benefits for people with trauma. Since disordered sleep is widely accepted as a common problem, providers may focus on sleep as a “foot in the door” to express empathy for their distress and begin the winding therapeutic pathway forward toward.

Pharmacological interventions can be effective in treating sleep disorders, however there is a risk of misuse that should be considered. Obstructive sleep apnea, narcolepsy, parasomnias, and restless leg syndrome need to be addressed by specialists and generally are not relieved by talk therapies alone. Non-pharmacological therapeutic interventions, at least for insomnia, have been found to be more effective than medications in people with PTSD and substance use disorders (SAMHSA 2014; Colvonen et al., 2018; Vandrey et al., 2014).

Cognitive behavioral therapy for insomnia (CBT-I), is a brief (6–8 sessions) approach comprised of well-supported behavioral interventions like restricting sleep, stimulus control, such as structuring the environment to be more conducive to quality sleep. It also integrates cognitive therapies that target negative thoughts about sleep and other dysfunctional beliefs that interfere with sleep. The approach is heavily researched and is endorsed by the Department of Veteran’s Affairs (VA) and the American College of Physicians as a first line of treatment for insomnia—even as it co-occurs with PTSD. The manualized intervention can be administered with individuals or groups, and there are mobile technologies such as apps that supplement in-person treatment (e.g., the VA’s CBT-i Coach). Imagery Rehearsal Therapy, or IRT has shown promise in the treatment of nightmares in PTSD. A cognitive therapy, IRT involves “re-writing” of recurrent nightmares to make them less distressing and repeatedly imagining and rehearsing the new scenarios to make them less potent (Colvonen et al., 2018).

What Treatment Courts Can Do

- Assure that the whole team is educated about the complex relationship among mental health, substance use disorders and sleep.
- Ask participants about sleep troubles and have empathy for some of their cognitive and emotional struggles in this context.
- Locate and contract with providers who are trained to assess sleep disorders and who can offer non-pharmacological, cognitive, and behavioral treatments. Although online programs and self-help books have been shown to help, the complexity of co-occurring disorders and treatment court clients are at high risk, high need symptoms.
- Don’t expect sleep to get better just because mental health symptoms and/or substance use improves. Consider

offering treatment for sleep, especially insomnia, separately but as an integrated part of treatment for other mental health and/or substance use disorders. If all treatments are not integrated, there is a real risk of playing a winless game of “Whack-a-Mole.”

- At minimum, offer participants sleep hygiene information as part of their health and self-care and recovery services. While this information may not fully address many of the complexities of the trauma-substance use-sleep disorder cycle, sleep hygiene skills overlap and reinforce other skills participants are already learning in treatment, including mindfulness, relaxation training, exercise, and changing self-talk to be more accurate and self-compassionate.

Improving sleep in treatment court participants can potentially impact the cognitive, emotional and physical impairments that interfere with recovery. Participants could engage more fully in treatments for PTSD and other mental health struggles, as well as substance use interventions, improving the chances of successful recovery.

References

- Colvonen, P. J., Straus, L. D., Stepnowsky, C., McCarthy, M. J., Goldstein, L. A., & Norman, S. B. (2018). *Recent advancements in treating sleep disorders in co-occurring PTSD*. *Current Psychiatry Reports*, 20(7), 48. <https://doi.org/10.1007/s11920-018-0916-9>
- Substance Abuse and Mental Health Services Administration. (2014). *Treating Sleep Problems of People in Recovery From Substance Use Disorders*. In Brief, 8(2), 1-8. <https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4859.pdf>
- Vandrey, R., Babson, K.A., Hermann, E.S., & Bonn-Miller, M.O. (2014). *Interactions between disordered sleep, post-traumatic stress disorder, and substance use disorders*. *International Review of Psychiatry*, 26(2), 237-247. <https://doi.org/10.3109/09540261.2014.901300>

Traumatic Brain Injury and Treatment Courts

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A client continually misses appointments, drug tests and curfews. Another has no insight into their problems and repeatedly puts themselves in dangerous situations. Another can't focus in group treatment and interrupts with off-topic, embarrassing comments. Another is irritable and gets angry quickly. Are these signs of long-term substance use? Mental illness? Traumatic brain injury (TBI)? It could be *any* and *all* of these, as they frequently co-occur.

Treatment courts target people with mental health and substance use challenges, but TBI and its long term impacts are often “off the radars” of court professionals and providers. Lasting effects of TBIs can be easily mistaken for “personality problems” or intense resistance to treatment. The prevalence of TBIs among treatment court clients is unknown, but they are common in the justice system, resulting from accidents, falls, fights, domestic violence, and military service (CDC, 2010).

So can people with a TBI benefit from treatment court programs? The structure, predictability and case management support that treatment courts provide can make it a good fit, especially if the team is knowledgeable and adapts their practices to meet client needs. Veteran's Courts are especially aware of these issues, and trainings are periodically offered (check the calendar—<https://ndcrc.org/events/>).

But you don't need to wait: three online guides for substance use treatment, criminal justice, and mental health professionals are listed below and offer strategies for assessing the impact of TBIs and for adapting daily practices and services. Adaptations include using visual aids, patiently repeating information, slowing down interactions, demonstrating self regulation skills, and tailoring clients' environments for reminders. Trauma-informed care in this case requires that teams be aware of the cognitive, emotional and behavioral challenges that can persist well beyond the initial injury, and a willingness to respond with compassion—even though it can be very challenging.

References

- Centers for Disease Control, (2010). Traumatic Brain Injury: A Guide for Criminal Justice Professionals. <https://www.brainline.org/article/traumatic-brain-injury-guide-criminal-justice-professionals>
- Center for Substance Abuse Treatment. (2010). Treating Clients With Traumatic Brain Injury. Substance Abuse Treatment Advisory, Volume 9, Issue 2. <https://store.samhsa.gov/product/Treating-Clients-With-Traumatic-Brain-Injury/SMA10-4591>
- Struchen, M.A, Davis, L.C., McCauley, S.R, Clark, A.N., (2009). Guidebook for Psychologists: Working with Clients with Traumatic Brain Injury. Baylor College of Medicine. <https://www.brainline.org/article/guidebook-psychologists-working-clients-traumatic-brain-injury>



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