TRAUMA RECOVERY CENTER MISSION AND VISION

By Alicia Boccellari, Ph.D.

Director, UC San Francisco Trauma Recovery Center

Photograph by Ezme Kozuszek

"Compañeros, take heart—though your roots be torn,
they will grow in new ground, and brighter days
will rise from the fertile dark."

—From Sanctuary: *The Spirit of Harriet Tubman*

The UC San Francisco Trauma Recovery Center Model: Removing Barriers to Care and Transforming Services for Survivors of Violent Crime. Edited by Stacey Wiggall, LCSW & Alicia Boccellari, Ph.D. Produced in collaboration with Allen/Loeb Associates.
Version 1: March 15, 2017

It is estimated that the U.S. population over age 12 experiences over 5.4 million incidents of violent crime every year (U.S. Department of Justice).

The consequences of interpersonal violence on physical and emotional health can be devastating, but few survivors of violent crimes receive mental health treatment or other forms of support. The most disadvantaged crime survivors, including individuals who are poor, people of color, people with disabilities, the homeless or unstably housed, and those living in inner city areas, are among those least likely to receive needed services (Newmark, 2004; Californians for Safety and Justice, 2013).

IMPACT OF VIOLENT CRIME. Approximately 50% of people who survive a traumatic violent injury experience psychological or social difficulties unless they are given some form of effective treatment (Breslau et al., 1991). A person who survives trauma related to interpersonal violence usually has to cope with both physical and psychological problems. These psychological problems may include symptoms of Post-Traumatic Stress Disorder (PTSD) such as flashbacks of the traumatic event, nightmares, insomnia, intrusive memories of the trauma, and feelings of depression, anger and fearfulness. People may become socially isolated, develop an assortment of phobias (particularly being afraid to leave their home), have difficulty concentrating, be distractible and have trouble making decisions. Increases in alcohol and drug abuse are also common consequences of untreated trauma. In essence, lives frequently get turned upside down and begin to unravel. Early intervention is essential to help crime survivors deal with the immediate consequences of violent crime and to prevent long-term disability.

BARRIERS TO CARE. Despite the serious and often debilitating consequences of criminal victimization, most crime survivors do not receive needed services. Less than one-third of crime survivors experiencing PTSD symptoms receive specialty mental health services in the year following the crime (Hembree and Foa, 2003).

Although specialized programs for crime survivors do exist, many survivors are unaware of these services or not able to take advantage of them. For example, the Victim Services Office in every state helps to identify crime survivors and assists the survivor in applying for Victim Restitution funds. However, aggressive outreach to crime survivors is generally not done, and unless a survivor files a police report, they are not identified by Victim Services (Californians for Safety and Justice, 2013).

Local Victim Services Offices may assist survivors by referring them to mental health treatment. Traditionally, treatment is provided by fee-for-service, private practice therapists in the community. These traditional mental health services tend to be exclusively office-based. For some crime survivors, this type of mental health service is

sufficient to help them in their recovery. However, the majority of survivors who come from vulnerable populations (such as people with disabilities, the homeless, the chronically mentally ill, people who abuse substances, immigrant and refugee groups, non-English speaking survivors, people of color and people living in poverty) typically have so many complex psychosocial problems that the traditional private practice therapy model is not sufficient to address them all. Many traditional mental health clinicians do not provide much if any case management assistance; some are without any specialized training in evidence-based, trauma-specific treatment modalities.

Linguistic and cultural factors can pose additional barriers to care. Embarrassment, shame, and stigma about receiving mental health treatment are also barriers. In addition, trauma and violence, by their very nature, often drive the survivor into isolation, withdrawal and a reluctance to become involved with treatment, particularly treatment that can only be accessed in the provider's office. Ironically, avoiding reminders of the traumatic event is a symptom of PTSD, and yet healing and recovery cannot take place until the impact of the trauma is addressed.

For many survivors of crime, particularly those from vulnerable populations or those with debilitating trauma-related symptoms—including the 50% who have mental health issues related to trauma—it is difficult to become engaged in services. To reach them, an active, flexible approach is necessary. The service providers must be able to leave their offices when necessary and go *to* the survivors in the hospitals or their homes, and, when needed, go *with* the survivors to their court appearances or medical appointments.

Development of the University of California, San Francisco Trauma Recovery Center (UCSF TRC) Model

BACKGROUND. Zuckerberg San Francisco General (ZSFG) is a Level 1 Trauma Center; for this reason, anyone in the San Francisco area who has suffered severe physical traumatic injuries is brought to ZSFG for medical treatment. The seeds for the creation of the Trauma Recovery Center model were planted when Dr. Bill Schechter, the Chief of Surgery at ZSFG, commented that, "We can sew them up, but we can't make them well." Dr. Schechter was lamenting the fact that, despite the expert surgical interventions that succeeded in saving lives and improving medical outcomes in patients with severe traumatic injuries, these same patients were not healing from the psychological aftermath of a life-altering traumatic event. And, the majority of these patients received no follow-up mental health or trauma-specific support services after being discharged from the hospital.

This comment led to the development of a small pilot study (Boccellari et al., 1997). This was a descriptive study looking at clients' levels of functioning over time, rather than an intervention study. Forty seriously-injured patients were identified while still hospitalized. They were all gainfully employed at the time of their injuries. They were interviewed and evaluated within 48 hours of hospital discharge, using a variety of standardized measures, including a measure of Acute Stress Disorder. At the time of discharge, these patients were given a referral to community-based mental health services. They were then re-evaluated at 6-month follow-up.

At baseline, while in the hospital, 39 out of 40 patients (97%) reported experiencing a variety of psychological symptoms. Particularly prominent were symptoms associated with Acute Stress Disorder such as intrusive memories, nightmares and attempts to avoid thinking about the trauma.

At the point of six-month follow-up, only 32% of these patients had returned to work, despite the fact that most had recovered from their physical injuries (Petersen, et al, 1999). All of the patients reported continuing to experience high levels of distress, and demonstrated no improvement in traumatic stress symptoms. And, none of these 40 patients had accessed mental health services.

With this data in hand, a small needs assessment and intervention pilot was launched that focused on assertive outreach to acute crime victims. Staff approached survivors of violent crime at bedside while they were recovering from their injuries at ZSFG. What quickly became apparent was that many of these survivors had practical needs that needed to be addressed (i.e. need for safe housing, access to financial entitlements and legal advocacy) before they could avail themselves of mental health interventions. In addition, stigma related to mental health services, and avoidance symptoms associated with acute and post-traumatic distress, made many of these survivors reluctant to engage in treatment. Based on these preliminary findings, the TRC model was created in 2001 by the University of California, San Francisco, in partnership with the City and County of San Francisco's Department of Public Health. This was made possible through funding by the California Victim Compensation Board (VCB), as enacted by California Assembly Bill AB1740 (Ducheny, Chapter 52, Statutes of 2000) and Assembly Bill AB2491 (Jackson, Chapter 1016, Statutes of 2000).

A goal of the new TRC model was to provide safety net services for survivors of violent crime who were not likely to engage in existing mainstream mental health or social services. An additional goal was to develop a new model of clinically effective and cost effective care for underserved survivors of violence, combining assertive outreach,

clinical case management, assistance with law enforcement, and trauma-informed therapy to deal with the emotional wounds of interpersonal violence.

RANDOMIZED CLINICAL TRIAL. The 2000 California Legislation that established the UCSF TRC mandated a randomized trial to evaluate both the clinical effectiveness and cost-effectiveness of the model (Ducheny, Chapter 52, Statutes of 2000; Jackson, Chapter 1016, Statutes of 2000). This trial is one of the largest longitudinal studies ever conducted to characterize underserved, public-sector crime survivors (Boccellari et al., 2007). Five hundred and forty-one injured violent crime survivors were randomized to receive either TRC services (n = 337) or care as usual in the community (n = 204) and were assessed 4 times over 12 months.

TRIAL OUTCOMES. The TRC trial revealed that while crime survivors had high levels of pre-existing mental health needs, only **10%** had received outpatient mental health care in the 6 months prior to victimization, while far more needed such care (details below). The data show that the crimes that brought survivors to the TRC trial were rarely a first exposure to criminal violence. **Ninety-one percent** of trial participants were polyvictims, having experienced an average of three broadly-defined types of criminal victimization over their lifetimes (such as adult sexual assault, assault with a weapon, physical assault, kidnapping, domestic violence, witnessing violent death, childhood physical abuse or childhood sexual abuse) in addition to at least one other non-crime-related trauma (natural disaster, accident, combat, or life-threatening illness). **Forty-six percent** had experienced childhood abuse, which is associated with both risk of subsequent victimization and poor psychosocial and functional outcomes. More than **72%** of the sample presented with clinically significant mental health symptoms (intrusive thoughts, nightmares, hyperarousal). Participants also had high levels of psychosocial and financial needs. More than **74%** needed assistance obtaining food, safe housing, financial entitlements, medical services, employment, and/or assistance working with police and other agencies. More than **70%** expressed interest in talking about their trauma and receiving mental health services.

The TRC trial demonstrated that the TRC model is both clinically effective and cost effective. Results document that the TRC model was successful in engaging survivors in mental health services. **Seventy-seven** percent of survivors receiving TRC services engaged in mental health treatment, compared to **34%** receiving usual care. TRC services were particularly effective in helping survivors access Victim Compensation benefits: **56%** of TRC clients submitted applications for Victim Compensation benefits compared to **23%** of usual care clients. TRC also reduced access disparities for clients who were younger, or homeless, or had lower levels of education. (Alvidrez et al., 2008). In addition, TRC services were more cost effective than fee-for-service care traditionally

supported by the Victim Compensation Board: each hour of TRC services cost **34%** less than traditional services. Importantly, the TRC's use of assertive outreach (engaging victims soon after victimization and helping them meet their immediate needs) was essential to achieving these outcomes. (Kelly et al., 2010). The TRC model utilizes a comprehensive, flexible approach that emphasizes assertive community outreach, evidence-based, trauma-specific mental health treatment, and clinical case management that coordinates and integrates psychosocial, medical, legal, and other human services. Coordination and active collaboration across these complex systems is essential in order to cost effectively reduce the consequences of violence and trauma.

Legislative Advocacy to Remove Barriers to Care and Transform Survivor Services Throughout California

This randomized treatment trial demonstrated that the UC San Francisco TRC model reduced barriers to care for underserved survivors of violent crime. Based on these results, and through the persistent advocacy of California State Senator Mark Leno and the Californians for Safety and Justice, California Senate Bill (SB) 71 was enacted into law in 2013. SB 71 revised Section 13963.1 of the Government Code, directing the California Victim Compensation Board to award and administer grants to develop additional TRCs in California (California Government Code, 2013). This implementation is currently underway.

In January 2015, a voter initiative, the SAFE Neighborhoods and Schools Act was enacted into law. This law changes sentencing for low-level, non-violent crimes (such as simple drug possession) from felonies to misdemeanors. It directs savings from reduced prison and jail sentences to fund mental health and drug treatment diversion programs, community violence and support programs in schools, and additional TRCs throughout California. This implementation is also currently underway.

Values and Philosophy of the UCSF TRC Model

What does it take for someone to heal from the devastating effects of deliberate cruelty and violence? Violence robs people of their sense of safety in the world. Violence disrupts people’s lives and their relationships. It damages the spirit. It destroys hope. It disrupts our sense of good and evil and causes people to believe that the world **is** a bad and dangerous place.

The TRC model recognizes that people are resilient and can overcome challenges if they are given the right combination of services and compassionate support. It includes the idea that it takes a team of people to undo the effects of cruelty and violence and restore

hope and a sense of safety to shattered lives. Healing does not take place in isolation. Survivors of violence need others to walk with them on their journey to recovery. The TRC model exemplifies the power of a team of people coming together to bear witness, to honor and support survivors of violence. This compassionate approach serves to remind providers and the clients we serve that, despite cruelty and violence, that there is still a great deal of kindness and "goodness" in this world. As the poet Louise Bogan wrote: we are here today "to restore a portion of the world's lost heart" (Bogan, 1977).

The TRC model uses a Positive Psychology framework (Seligman, 2002). The focus of Positive Psychology is on personal growth rather than pathology and "mental illness." The TRC model embraces the concept that survivors of violence can move beyond experiencing post traumatic stress to finding post traumatic growth. By focusing on their strengths and tapping into their resilience, many survivors can use their traumatic event as a turning point to make important positive changes in their lives, and in the communities in which they live.

A critical factor in the TRC model is the development of a trauma-informed culture of compassion that is made up of the following elements: collective hope, collective vision, and collective leadership. Additional elements include attention to issues of social injustice and health disparities, and the adoption of a stance of cultural humility.

A CULTURE OF COMPASSION. There is power and efficacy in developing an organizational culture of compassion (Dutton et al., 2002). Research shows that a person's caring gestures in a work setting increase the well being of both the recipient and the provider, as well as the wellbeing of others who witness or hear about the compassionate acts. Developing a culture of compassion is essential when working with traumatized survivors of violent crime. It provides a calming, safe, and non-judgmental frame for client services. Moreover, it creates a protective buffer for staff against the development of vicarious trauma (see chapter on Vicarious Trauma and Staff Support).

ORGANIZATIONAL COMMITMENT. The TRC model institutionalizes rituals that celebrate compassion and kindness, and encourage the expression of gratitude. One example is the use of informal story-telling that book-ends each TRC staff meeting. At the beginning of the meeting, staff have the opportunity to share a client's success. This allows for all staff to witness and celebrate the small (or large) successes that clients have made, even when they are faced with huge obstacles. At the end of the meeting's agenda are staff acknowledgements. All staff have the opportunity to acknowledge each other by sharing stories of compassionate and kind acts that have been observed at the TRC, such as a staff member going "above and beyond" to assist a co-worker or to creatively respond to a client's need. This deliberate, public recognition of small acts of kindness and the

expression of gratitude has a huge impact and an institutional ripple effect. Research demonstrates that the opposite approach—non-compassionate responses, staff detachment, lack of interest, and publically pointing out failures or mistakes—also spreads throughout an organization, and leads to poor morale, low productivity, discouragement and hopelessness (Dutton, Frost, et al., 2002). Encouraging staff to recognize small acts of kindness serves several purposes. It balances out the impact of vicarious trauma with vicarious joy. It reminds us that, despite the enormous obstacles our clients face and the fact that staff bear witness, on a daily basis, to lives hijacked by trauma, sadness, hopelessness and darkness, that the world is also a place of hope, kindness, resiliency and light—factors that allow us all to flourish. Compassion has a ripple effect that awakens the best in us. When nurtured and encouraged to flourish, it ricochets off each of us and returns to us in a magnified form. It helps to generate our own resilience, reinforces shared values and helps us cultivate an attitude that leads to greater effectiveness in our work.

A culture of compassion in the Trauma Recovery Center model also plays an important role in maintaining spirit and inspiration, and keeping hope alive. Many survivors of crime live in poverty and in communities riddled with violence; many of them present with feelings of despair and hopelessness. The TRC Clinician is often confronted with how to keep hope alive for survivors who may have given up long ago, and who cannot imagine their lives being any different. The TRC Clinician becomes the "holder of hope" for these survivors.

"Hope" is often described as an emotion or a feeling, but in fact there is a body of research (Snyder, 2000) that demonstrates that hope is not just an emotion, it is a "dynamic, powerful and pervasive cognitive process" that can be measured, observed and also taught (Helland and Winston, 2005). Hope can be contagious.

TRC LEADERSHIP. In the TRC model, leadership plays an important role in creating a viable infrastructure by establishing team goals and vision, and motivating staff to believe that they can make a difference in the lives of the clients they work with (Helland and Winston, 2005). Giving staff the resources they need, demonstrating goal-directed thinking, and cultivating a culture of compassion all help to instill hope, and the belief that healing and recovery can take place. Hopeful thinking—backed by clinical skill and expertise—transforms a TRC into a healing community. There is power when a group of people come together with a shared vision and mission, and construct a culture to fulfill the organization's purpose. Hope, vision, compassion and collective leadership are activating forces that enable survivors of violent crime to envision a promising future, even when faced with overwhelming obstacles (Seligman, 2002; Helland and Winston, 2005).

Just as hope is difficult to sustain if you are the only one hoping, leadership is not just about one person. Everyone on the TRC team plays an important role, including psychiatrists, social workers, psychologists, trainees, paraprofessionals, and administrative and clerical staff. Effective leadership permeates all levels of a Trauma Recovery Center. A leader may help create change, but a collective sense of leadership is about creating a positive environment in which staff thrive and are empowered to act: every voice gets heard (Ancona and Schaefer, 2005). Staff not only feel supported, but are capable of actively participating and fully contributing to the team's collective mission and vision: recovery for survivors of violent crime. This vision is built on shared values and beliefs. The heart of collective leadership is about developing a culture filled with compassion, and an environment in which compassion is not only expressed but it spreads.

Social Justice, Healthcare Disparities and Cultural Humility

As with many other healthcare disparities, violence in the U.S. disproportionally affects people of color and people living in poverty. Because of this, the TRC model incorporates mindfulness of social justice principles and cultural humility.

Social justice embodies "the vision of a society that is equitable and in which all members are physically and psychologically safe" (Levy & Sidel, 2006). It requires that all people have a right to basic human dignity, including having their basic economic needs met. Since health and wellness are impacted by a variety of social factors, it is not possible to effectively address trauma and violence while ignoring poverty, racism, sexism, classism, homophobia, and all other forms of stigma. We must openly and honestly struggle with these deep-seated inequalities as we seek to solve the problems of violence and trauma (What is Social Justice?, 2016).

Removing barriers to care for survivors of violent crime is a basic tenet of the TRC model. However, it is not enough to merely remove barriers to care; true healthcare equity requires that all survivors of violent crime have the right to receive high-quality, effective, evidenced-based treatment.

USE OF EVIDENCE-BASED PRACTICES. What are evidenced-based practices (EBPs)? EBPs are practices that are developed through research and implementation and are interventions that have been shown to work. EBPs are consistent with scientific evidence showing that the intervention can improve client outcomes (Sackett et al., 1996). The TRC model utilizes EBPs. Some TRC interventions (the TRC outreach and case management approach) have been developed by the UC San Francisco TRC and some are mental health interventions that have been developed by other clinical researchers (see

TRC Evidence-Based, Trauma-Informed Psychotherapy chapter). The use of EBPs by a TRC is one way to promote social justice and to ensure that healthcare disparities are reduced.

DATA-INFORMED, GOAL-ORIENTED APPROACHES AND ADVOCACY. In a similar vein, the TRC model is data-informed. Creating an infrastructure for evaluating program and clinical effectiveness is critical to ensure that the TRC is accountable to the survivors we serve and to our funding agencies.

A robust program evaluation plan includes collection, analysis, and reporting of client demographics, needs assessments, clinical outcome measures, information on client flow, attrition rates, as well as measures of staff productivity.

This approach allows a TRC to evaluate current treatment interventions, and it encourages innovative approaches that can be applied and evaluated for treatment effectiveness. In addition, a credible program evaluation can be a useful tool for maintaining and acquiring new sources of funding. And, very importantly, it can be used to advocate for system-wide policy changes in victim services to remove barriers to care for underserved survivors of violent crime. Data is a tool hopeful people can use to achieve their goals.

CULTURAL HUMILITY. The TRC model adopts a stance of cultural humility. Given that survivors of violent crime and those who serve them are a diverse group, cultural humility becomes an important principle that guides the engagement and treatment of survivors and enhances our community-based partnerships.

Cultural humility requires a "life-long commitment to self-evaluation and self-critique" (Tervalon and Murray-Garcia, 1998), and it involves a willingness to assess one's self and one's limitations as we work with people different from ourselves. In the TRC model, this approach encourages staff to understand their own world view by realizing their own power and prejudices, in addition to any oppression or discrimination they may have experienced. It also involves seeing all people, including clients, as the experts on their own lives and experiences, and requires a truly collaborative approach to service provision.

Summary

It is the mission of the Trauma Recovery Center to reach out to members of our community who have suffered from trauma, violence, and loss. We are dedicated to promoting healing by providing respectful, compassionate, and effective mental health

and medical services. Our vision is a community that heals the wounds of violence and embraces hope for a non-violent, compassionate world.

Violence disrupts lives and damages the spirit. The TRC model is based on the belief, supported by evidence, that people are resilient and can overcome even the greatest challenges when given the right combination of services, support, and non-judgmental care.

References

Alvidrez, J., Shumway, M., Boccellari, A., Green, J. D., Kelly, V., & Merrill, G. (2008). Reduction of state victim compensation disparities in disadvantaged crime victims through active outreach and assistance: A randomized trial. American Journal of Public Health, 98, 882-888.

Ancona, D., Schaefer, M. (2005). Leadership in an Age of Uncertainty. MIT Leadership Center. http://sloanleadership.mit.edu.

Boccellari, A., Alvidrez, J., Shumway, M., Kelly, V., Merrill, G., Gelb, M., et al. (2007). Characteristics and psychosocial needs of victims of violent crime identified at a public-sector hospital: Data from a large clinical trial. General Hospital Psychiatry, 29, 236-243.

Bogan, L. (1977). *The blue estuaries poems: 1923-1968*. New York: Ecco Press.

Breslau, N., Davis, G. C., Andreski, P., & Peterson, E. (1991). Traumatic events and posttraumatic stress disorder in an urban population of young adults. Archives of General Psychiatry, 48, 216-222.

Californians for Safety and Justice. (2013). California Crime Victims' Voices. Findings from the first-ever survey of California crime victims and survivors. 2013. www.safeandjust.org/resources/2013-06, 1-42.

Couzen, J.R. & Bigelow, T.A. (2016). Proposition 47, The Safe Neighborhoods and Schools Act. www.courts.ca.gov/documents/Prop47-Information.

Ducheny (AB 1740). California Government Code, California Legislature, Chapter 52, Statues of 2000. Chaptered: 6/30/00.

Dutton, J. E., Frost, P. J., Worline, M. C., Lilius, J. M., & Kanov, J. M. (2002). Leading in times of trauma. Harvard Business Review, 55-61.

Fichter, D. (1986). *Sanctuary: The Spirit of Harriet Tubman*. Exterior mural at the Paul Robeson Theater. Atlanta, GA.

Helland, M. R., & Winston, B. E. (2005). Towards a deeper understanding of hope and leadership. Journal of Leadership & Organizational Studies, 12(2), 42-54.

Hembree, E. A., & Foa, E. B. (2003). Interventions for trauma-related emotional disturbances in adult victims of crime. Journal of Traumatic Stress, 16, 187-199.

Jackson (AB 2491). California Government Code, California Legislature, Chpater 6, Section 13974.5, Statutes of 2000. Chaptered: 9/30/00.

Kelly, V. G., Merrill, G. S., Shumway, M., Alvidrez, J., & Boccellari, A. (2010). Outreach, engagement, and practical assistance: Essential aspects of PTSD care for urban victims of violent crime. Trauma, Violence, & Abuse, 11 (3), 144-156.

Levy, B. S., & Sidel, V. W. (2013). *Social injustice and public health*. Oxford University Press.

Newmark, L. C. (2004). Crime victims' needs and VOCA-funded services: Findings and recommendations from two national studies. Report to the National Institute of Justice.

Petersen, J., Papadakis, L., Morabito, D., Boccellari, A., MacKersie, R.C., (1999) Return to Economic Productivity Following Traumatic Injury: The Influence of Physical, Financial and Psychosocial Factors. Abstract. American Association for the Surgery of Trauma, Boston, Massachusetts.

Sackett, D. L., Rosenberg, W. M., Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't. British Medical Journal, 312, 7-12.

SB71. California Government Code, California Legislature, Chapter 28, Section 13963.1, Statutes of 2013. Chaptered: 6/27/13.

Seligman, M. E. (2002). Positive psychology, positive prevention, and positive therapy. Snyder, C.R. & Lopez, S.L (Eds.), Handbook of Positive Psychology. Oxford University Press, 3-9.

Snyder, C. R. (2000). The past and possible futures of hope. Journal of Social and Clinical Psychology, 19, 11-28.

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor and Underserved, 9, 117-125.

U.S. Department of Justice. (2015). Bureau of Justice Criminal Victimization, 2014. NCJ 248973. www.ojp.usdoj.gov.

What is social justice?. (2016, October 20). Retrieved from http://www.nonviolenceandsocialjustice.org/FAQs/What-is-Social-Justice/43/