

THE UC SAN FRANCISCO TRAUMA RECOVERY CENTER MODEL AND CORE ELEMENTS

**An Integrated, Evidence-Based Approach for Survivors of
Violent Crime**



Photograph by John P. Boccellari

**“Change will not come if we wait for some other person or
some other time. We are the ones we’ve been waiting for.
We are the change that we seek.”**

—Barack Obama

*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 &
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Background

The Trauma Recovery Center (TRC) model at Zuckerberg San Francisco General Hospital / University of California, San Francisco was developed for survivors of violent crime. It is founded on the belief that people are resilient and can recover from the potentially devastating impact of violent crime if they are given the right combination of support, advocacy and compassionate care. By providing this combination of services in an integrated approach, TRC services facilitate healing and a return to pre-trauma functioning or higher, with improved quality of life. The TRC vision is a community of survivors and providers that heals the wounds of violence, and embraces hope for a non-violent, compassionate world.

Statement of the problem

Survivors of violent crime have a significant unmet need for mental health treatment and psychosocial services. Specialized services are necessary because general mental health treatment settings are typically not equipped to address survivors' complex needs. For a multiplicity of reasons, many crime survivors are unlikely to seek out mental health treatment, and most do not receive post-trauma mental health services. Vulnerable populations, such as young people of color, the homeless, LGBTQ people, the chronically mentally ill, people with substance abuse problems, non-English speaking people, and those living in poverty often face substantial barriers to accessing treatment. In addition, trauma and violence often drive survivors into isolation and a reluctance to engage in treatment.

Goals and objectives

The overarching goal of TRC is to support the healing of the client's emotional and physical wounds along with restoration of their disrupted life circumstances. At the close of treatment, the client's health, broadly defined, will be stabilized and improving. Goals include working toward: having safe housing; having an income sufficient to meet their needs; safety from further violence; the emotional health to cope with daily life, including a sense of hope for the future; access to needed physical or behavioral health treatments; incorporating healthy self-care strategies; employment or school, as appropriate; and being meaningfully engaged with others, such as family, church, and community. Unlike many mental health programs, in TRC the mental health of the client is not the primary focus and life circumstances secondary; instead, mental health and life circumstances are seen as inseparable pieces of a whole life and are addressed at the same time.

Target population

TRC is for survivors of violent crime who are experiencing post-traumatic distress but are not receiving other mental health care. The model has been successfully used with recent survivors of sexual assault, domestic violence, gunshot injuries, human trafficking, stabbings, physical assaults, and criminal motor vehicle accidents, as well as family members of homicide victims. Many of the individuals served have risk factors that made them vulnerable to becoming survivors of crime. These include one or more of the following: poverty, homelessness, social isolation, sequelae of previous traumatic events, ongoing exposure to community or domestic violence, substance use, and pre-existing mental disorders.

TRC Treatment Approach and Process

Overview of TRC treatment approach

This overview is shown in graphic form on page 34, *TRC Service Flow*. The chart shows the sequence of TRC activities, beginning with assertive outreach to identified clients, moving through provision of services by the TRC Clinician including clinical case management, individual and group psychotherapy, and advocacy, through to ongoing care provided by partner agencies as needed. Page 9 of this chapter shows a comparison of the TRC model to customary care.

The TRC model is unique in how it integrates different state-of-the-art approaches—assertive outreach, clinical case management, trauma-informed psychotherapy, and trauma-specific, evidence-based treatments such as Seeking Safety, as well as psychiatric medication management. TRC is a stepped-care model: the TRC Clinician collaborates with clients to initially focus on their safety and stabilization. An individualized care plan guides the provision of comprehensive services, and the Clinician provides most services including clinical case management, psychotherapy, advocacy, and substance abuse treatment, and conducts assertive outreach as needed to initiate treatment and keep the client engaged. If services are split between Clinicians and Case Managers, there is a single point of responsibility for the coordination of the client's treatment, and care is taken to ensure a unified team approach and clear communication among all service providers. This ensures coordination across various systems of care. It can be understandably difficult for clients to trust service providers and others after victimization, yet building trust and rapport is key to the client engaging in treatment and recovering from trauma. The organization's structure, procedures, and culture support this integrated treatment approach.

Entry to the program

Despite the serious consequences of criminal victimization, research shows that survivors are unlikely to seek out mental health treatment due to the social withdrawal and anxiety inherent in PTSD and decreased ability to function and initiate actions. TRC proactively addresses this by (1) mobilizing medical care providers, domestic violence shelters, rape crisis centers, substance abuse treatment providers, victim services, and others to identify and refer clients, and (2) by assertive outreach—TRC Clinicians visit can work with clients in the community as needed to facilitate entry. In addition, Clinicians often begin the treatment relationship by providing clinical case management services because immediate practical help is often required to support clients' stabilization and safety.

Assessment and treatment planning

TRC services begin with a comprehensive clinical evaluation conducted by an Intake Clinician in a two-hour intake interview. The interview covers current and past symptoms; medical, mental health, trauma, family/social, legal, and occupational history; risk assessment; and a formulation of the situation that emphasizes a client's strengths and takes their cultural background into account. As treatment begins, the TRC Clinician conducts a needs assessment that includes both case management needs and psychological, social, and emotional needs. The Clinician and client then collaborate to create an individualized treatment plan.

Clinical case management

Clinical case management is a central component of the TRC model. Including case management in the repertoire of services offered by TRC Clinicians allows clients to receive assistance with practical needs that may be a higher priority than engaging in mental health services. In addition, providing clinical case management first fosters the trust and alliance necessary for clients who may initially be put off by the stigma of mental health treatment or previous negative experiences with "helping" resources, including mental health. Initially, TRC Clinicians may provide legal advocacy and address immediate needs for financial entitlements and shelter. They coordinate medical appointments and help clients complete compensation claims. Clinicians seek out clients in the community if they miss appointments and make home visits if they are unable to come to the agency. As clients' immediate needs are met, Clinicians help with long-term needs such as vocational rehabilitation and safer housing. Throughout treatment, Clinicians can work with the Police Department, District Attorney's office, and Victim Services office to support clients in their experience with the criminal justice system as needed.

Evidence-based, individual psychotherapy

Clients are offered up to 16 sessions of trauma-informed individual clinical services; an extension of treatment is offered to clients with continued symptoms and primary focus on recent trauma. Treatment may involve a variety of evidence-based approaches, including anxiety management skills (e.g., Trauma-Informed Cognitive Behavioral Therapy), emotion regulation skills (e.g., Dialectical Behavior Therapy or Skills Training in Affect and Interpersonal Regulation [STAIR], as well as several options for reprocessing of the trauma as indicated (e.g., Cognitive Processing Therapy, Narrative Story Telling, or Prolonged Exposure Therapy). Substance abuse treatment comes from a harm reduction stance and emphasizes Motivational Interviewing. Substance abuse treatment is integrated with psychotherapy and case management—all are provided by the TRC Clinician. Psychotherapy for acute trauma begins with a supportive interpersonal approach and initially prioritizes safety, self-care for re-establishing physical homeostasis, and sleep. The intermediate goals of therapy are to reduce post-trauma anxiety and depression, build healthy coping skills, and increase awareness of risk factors for re-victimization. For clients who achieve psychological and psychosocial stability, the focus turns to reprocessing the trauma, finding meaning in their lives despite the victimization, and integrating the trauma into their overall life experience.

Group psychotherapy

Most acute trauma survivors report an initial preference for individual therapy, but once clients have benefitted from individual treatment they may be encouraged to also attend group therapy. The primary group model is Seeking Safety, a program for people with co-occurring post-traumatic stress and substance abuse. Additional groups focus on domestic violence, drug-facilitated sexual assault, anxiety management, emotional regulation, and the special needs of African American family members of homicide victims. Group participation can help clients come out of isolation, learn they are not alone in their experiences, reconnect with others and find new roles for themselves.

Medication management and support

TRC services include the provision of psychiatric medication support as needed. Medication management can reduce sleep problems and anxiety and increase clients' ability to participate in treatment. TRC Clinicians work closely with psychiatrists to support medication adherence. If clients wish to continue medication upon completion of TRC, medication management responsibilities are transferred to the client's primary care physician or a community mental health psychiatrist.

Duration of treatment

Treatment typically lasts for 16 sessions. For those with ongoing problems and a primary focus on trauma, treatment can be extended after special consideration with a clinical supervisor. Extension beyond 32 sessions requires approval by a clinical steering and utilization group that considers the client's progress in treatment and remaining need. The 16-session model is based both on the efficacy of many evidence-based treatments, and the program's need to remain accessible by having treatment slots available as needed.

Staffing and Organization

Organizational characteristics and culture

The organization itself is an important part of the TRC model. This trauma-informed organizational culture emphasizes compassion and safety in all aspects of the program. Everyone who works in the program, including non-clinical staff such as receptionists, custodians, and managers, understands the mission of the organization. In any interaction they may have with clients, even nonverbal, they take into account the trauma the clients have experienced and strive to create a compassionate, welcoming and safe environment. In addition, all staff receive ongoing support in using a cultural humility approach to services, recognizing that clients are the experts on their own lives and that we are all lifelong learners when it comes to understanding cultural differences. This organizational culture, reinforced with ongoing training and supervision, keeps staff supported and centered to ensure that clients receive the highest quality of care.

Self care

Serving survivors of crime who have experienced severe trauma can be traumatizing to the service providers. TRC explicitly incorporates self care to address the stress and trauma of working with traumatized clients. Staff meetings begin with an opportunity to share examples of clients' successes and resiliency and end with an opportunity for staff to acknowledge each other's contributions and kind acts. Another norm is to be mindful when discussing clients' trauma experiences and not bring up graphic details that needlessly upset other staff members and increase the likelihood of vicarious trauma. Individual supervision, discussed below, provides a safe place for staff members to process disturbing things they have seen and heard. A weekly self care group is offered to all staff, trainees, and volunteers, with no distinctions made between clinical and support staff.

Staffing and training

Clinical staff are masters-level clinical social workers, marriage and family therapists, psychologists, and psychiatrists who are licensed or pursuing licensing. TRC Clinicians have expertise in the assessment and treatment of acute and chronic trauma, and co-occurring mental health and substance abuse disorders, such as anxiety disorders, mood disorders, and personality disorders. They are trained to provide evidence-based treatments such as Motivational Interviewing and Seeking Safety.

Supervision and training

Because the work of the TRC Clinicians is complex and demanding, regular clinical supervision is necessary to develop knowledge and skills as well as to support the Clinicians in their difficult and stressful work. TRC provides ongoing weekly supervision for all clinical staff regardless of licensure status. Trainees and new staff attend a year-long weekly Trauma Seminar on the assessment and treatment of trauma. In addition, all staff attend a weekly Professional Development seminar, in order to keep abreast of best practices, learn particular interventions, and ensure ongoing commitment to high quality care.

Data-informed approach

In order to provide ongoing evaluation of TRC services to ensure they are clinically and cost effective, the UC San Francisco TRC has developed a relational database and uses standardized tools to measure client outcomes, track client flow and measure staff productivity.

TRC model core elements

1. ASSERTIVE OUTREACH AND ENGAGEMENT WITH UNDERSERVED POPULATIONS.

Conduct outreach and provide services to survivors of violent crime who typically are unable to access traditional services, including, but not limited to, survivors who are homeless, chronically mentally ill, members of immigrant and refugee groups, disabled, who have severe trauma-related symptoms or complex psychological issues, are of diverse ethnicity or origin, or juvenile survivors, including minors who have had contact with the juvenile dependency or justice system.

2. SERVING SURVIVORS OF ALL TYPES OF VIOLENT CRIMES. Serve survivors of a wide range of crimes, including, but not limited to, survivors of sexual assault, domestic violence, battery, crimes of violence, vehicular assault, human trafficking, and family members who have lost a love one to homicide.

3. COMPREHENSIVE MENTAL HEALTH AND SUPPORT SERVICES. Mental health and support services are structured and evidence-based, including but not limited to crisis intervention, individual and group treatment, medication management, substance abuse treatment, case management and assertive outreach. Care must be provided in a manner that increases access to services and removes barriers to care for survivors of violent crime. This includes providing services in the client's home, in the community, or other locations that may be outside the agency.

4. MULTIDISCIPLINARY TEAM. Staff shall consist of a multidisciplinary team that includes psychiatrists, psychologists, social workers, and marriage and family therapists. The TRC Clinician is a licensed clinician, or in some cases a closely supervised clinician engaged in the applicable licensure process. Clinical supervision and other support are provided to staff on a weekly basis to ensure the highest quality of care and to help staff constructively manage the vicarious trauma they experience as service providers to survivors of violent crime.

5. COORDINATED CARE TAILORED TO INDIVIDUAL NEEDS. Psychotherapy and case management are coordinated through a single point of contact for the survivor, with support from an integrated multidisciplinary trauma treatment team. All treatment teams shall collaboratively develop treatment plans in order to achieve positive outcomes for clients.

6. CLINICAL CASE MANAGEMENT. Services shall encompass assertive case management, including but not limited to: accompanying a client to court proceedings, medical appointments, or other community appointments as needed; case management services such as assistance in the completing and filing of applications to the Victim Compensation Board, the filing of police reports, assistance with obtaining safe housing and financial entitlements, linkages to medical care, providing assistance securing employment, working as a liaison to other community agencies, law enforcement or other supportive service providers as needed.

7. INCLUSIVE TREATMENT OF CLIENTS WITH COMPLEX PROBLEMS. Clients are not excluded from services solely on the basis of emotional or behavioral issues that result from trauma, including but not limited to: substance abuse problems, low initial motivation or high levels of anxiety.

8. USE OF TRAUMA-INFORMED, EVIDENCE-BASED PRACTICES. TRC staff shall adhere to established, evidence-based practices, including but not limited to: Motivational Interviewing, Seeking Safety, Cognitive Behavioral Therapy, Dialectical Behavior and Cognitive Processing Therapy.

9. GOAL-DRIVEN. Primary goals are to decrease psychosocial distress, minimize long-term disability, improve overall quality of life, reduce the risk of future victimization, and promote post-traumatic growth.

10. ACCOUNTABLE SERVICES. Provide holistic and accountable services that ensure treatment shall be provided up to 16 sessions. For those with ongoing problems and a primary focus on trauma, treatment may be extended after special consideration with the clinical supervisor. Extension beyond 32 sessions requires approval by a clinical steering and utilization group that considers the client's progress in treatment and remaining need.

TRC Services Compared to Customary Care

This summary of TRC services describes key features of the model that need to be reflected in services if a program is to incorporate the TRC model. The characterization of customary care reflects widespread practices in the field, although programs vary.

Services	Traditional Office-Based Services	TRC Services
1. Provide on-site crisis intervention in a hospital-based Emergency Department.	Not Available	Available
2. Provide bedside assessments and interventions on Inpatient Medical Trauma Units.	Not Available	Available
3. Proactive, multi-disciplinary trauma team meetings to develop integrated Plan of Care for each client's services.	Not Available	Available
4. Flexible location of services: client's home, school, provider's office, District Attorney's office, etc.	Not Available	Available
5. Assist clients with finding emergency housing. Help client relocate to safe housing.	Not Available	Available
6. Fill out Victim Witness application and gather all supporting documents.	Not Available	Available
7. Actively arrange for and escort clients to medical appointments and to legal proceedings if client is unable to get to an appointment on their own.	Not Available	Available
8. Assist clients in completing disability forms, applications for General Assistance, leave of	Not Available	Available

Services	Traditional Office-Based Services	TRC Services
absence from work forms; assist with procuring medical record documentation.		
9. Assertive, proactive outreach and follow-up to clients; tracking, locating and finding clients who miss appointments.	Not Available	Available
10. Meet with employer or school district around developing a “Return to Work” or “Return to School” plan.	Not Available	Available
11. Coordinate with local Victim Services office, District Attorney’s office, and police department.	Not Available	Available
12. Individual and family psychotherapy.	Available	Available
13. Medication support services.	Available	Available
14. Psychotherapy groups.	Available	Available
15. Multi-disciplinary Trauma Team provides services #12, 13, and 14 in a coordinated fashion with ongoing review of the client’s Plan of Care and goals for treatment.	Not Available	Available
16. Multi-lingual, ethnically diverse staff to provide services.	Limited panel of multilingual Victim Witness private practitioners available	Available

Services	Traditional Office-Based Services	TRC Services
17. Ongoing evaluation of services to ensure quality of care, i.e., adherence to quality improvement protocols and utilization review.	Utilization Review available by the State to the FFS Provider, limited Quality Assurance controls in place.	Available
18. Ongoing treatment and cost effectiveness studies utilizing objective measures of outcome and patient satisfaction studies.	Not Available	Available
19. Provide education and in-services to community-based agencies.	Not Available	Available
20. Provide education to the public on staying safe in the community.	Not Available	Available
21. Provide specialty trauma training to psychology and social work interns and to medical students.	Not Available	Available

References

<http://www.nytimes.com/2008/02/05/us/politics/05text-obama.html>, accessed November 22, 2016.