

INSPIRE & CONNECT

National Alliance of Trauma Recovery Centers Newsletter

November 2021

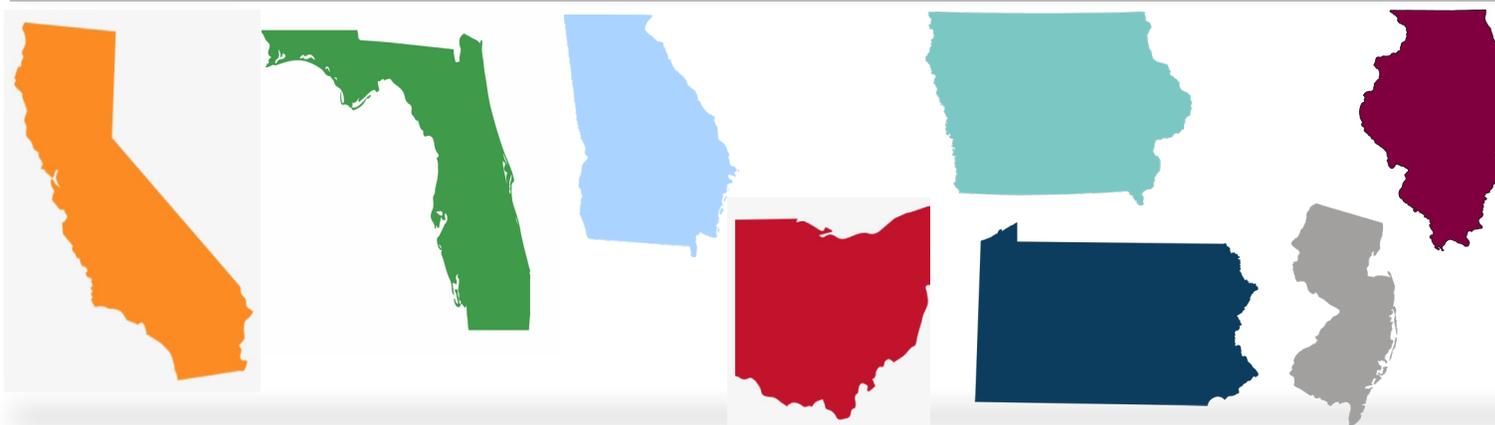
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New TRCs Joined the National Alliance of Trauma Recovery Centers since May 2021

- Amanecer Community Counseling Service, Los Angeles, California
- Olive View UCLA, Los Angeles, California
- A Quarter Blue, Orange County, California
- Palomar Health Foundation, San Diego, California
- West Contra Costa Family Justice Alliance, Contra Costa, California
- Central Pennsylvania Center for Trauma & Healing, Harrisburg, Pennsylvania
- Thriving Mind South Florida Trauma Recovery Network, Miami, Florida

39

Trauma Recovery Centers, in 8 states across the Country



“We are stronger, gentler, more resilient, and more beautiful than any of us imagine.”

—Mark Nepo

“We do not have to become heroes overnight. Just a step at a time, meeting each thing that comes up, seeing it is not as dreadful as it appeared, discovering we have the strength to stare it down.”

—Eleanor Roosevelt

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NATIONAL ALLIANCE OF
TRAUMA RECOVERY CENTERS

TRC IN THE NEWS



MetroHealth TRC announced a partnership with the Cuyahoga County Court of Common Pleas affiliated with a DOJ grant where TRC will dedicate a Recovery Coach/Counselor to provide trauma-informed interventions and supports for individuals participating in the Violence Intervention Program docket [Click here for link to article.](#)



Greater Columbus' two Level I trauma centers see surge in gunshot wound patients: The raging gun violence means that the OhioHealth Grant Medical Center and the Ohio State University Wexner Medical Center are dealing with two pandemics. [Click here for link to article.](#)



Dayton Daily News Op-Ed by Stephen Massey, Citilookout TRC & Shakyra Diaz, ASJ [Click here for link to article.](#)

TRC Acknowledgements



The SSG/HOPICS TRC at an outreach event called “National Night Out” that was hosted by our Law Enforcement partners at the 77th Division LAPD. The purpose of the event was to raise awareness to the families residing in the South Los Angeles community in regards to various resources as well as promote and build positive relationships between law enforcement and the community.

The photos attached are of the HOPICS TRC and WTP (Women's Treatment Program) staff that participated in the event. Photo number one is: Brandon Burkhardt, LCSW (TRC Mental Health Therapist), Sophia Salazar, ACSW (TRC Clinical Case Manager) and Agion Quinney (WTP Case Manager). Photo number two is: Brandon Burkhardt, LCSW (TRC Mental Health Therapist), Gabriella Lewis, ACSW (TRC Program Manager) and Agion Quinney (WTP Case Manager).



Self Care: Grady Health TRC visits the Atlanta Botanical Gardens together and it was a beautiful day. This looks like such a great time! Thank you for practicing self-care!



The Role of Trauma Outreach Workers at Advocate TRC in Chicago, Illinois:

Interview with Dr. Kim Miiller, Director, and Jordan Penman, Trauma Outreach Worker

by: Meghan Golden



**Dr. Kim Miiller, Director
Advocate TRC**



**Jordan Penman, Trauma Outreach Worker
Advocate TRC**

Can you please describe your role as a Trauma Outreach Worker?

Jordan: We wear a lot of different hats! We carry our own caseloads, meeting with our patients usually once a week at the office, virtually or in the community. When we cannot meet the direct need ourselves, we help refer them to community resources. We also engage in different forms of advocacy, both legal and medical—anything that a patient might need: employment, housing, education, food, and other needs. We also rotate, each spending one day a week in the hospital and partnering with a psychology fellow or psychologist, working with patients in the emergency rooms and hospital floors. We provide a lot of emotional support, build rapport and help to problem solve why sometimes they are not able to follow up on the advice of their medical providers. We also provide information about the Trauma Recovery Center (TRC) and get them connected to services if they are interested. We work in the community as well, making sure other community agencies and area hospitals know that we are available. An example is our involvement in a local Race Against Gun Violence where we worked to promote the race and the support we can provide at our TRC.

Kim: The Trauma Outreach Workers (TOWs) also run our client support groups and our Welcome Workshop where we provide basic psychoeducation on trauma. The workshop gives people that initial guidance and information. It's modeled after the original UCSF program. They are also involved in our weekly drop in session about different social service needs such as filling out victim compensation forms, food security, and others. This is open to both the TRC patients and people from the community.

How do Trauma Outreach Workers approach engaging potential patients?

Jordan: It really helps to make that personal connection while people are still in the hospital. They really appreciate seeing someone who is a little less clinical than a doctor, psychologist, or nurse. We can relate a bit more and I think that initial connection shows that we're here for them and want to support them. This can help with some of the mistrust many of our patients have with the medical field. While they are in the hospital we make sure to continue to visit them throughout their entire stay and work to get them connected to services once discharged.

How do Trauma Outreach Workers build strong partnerships with community agencies?

Jordan: We work to build personal relationships, looking for ways we can mutually benefit. We make a personal connection with the people who work in the agency. We want to build a foundation for the relationship rather than making it just a business transaction. We get to know the staff and the mission and vision of the organization.

What are the primary barriers to engaging people who have survived violence in services?

Jordan: COVID brought major barriers. We are taking advantage of telehealth, but some patients struggle with technology. Some would rather come in person. It is also harder to keep track of people when we only see them on a screen. In general, sometimes people aren't ready for services yet because their trauma is so fresh. They might start to engage but things might be too intense for them. They have three years to take advantage of our services, so we encourage them to return when they are ready. It also helps that we can relate to the patients. We wear business casual clothing and understand how to connect with them, since we often look like them and have a similar background.

Kim: A key barrier is how large Chicago is. We provide transportation assistance but even then it's still a challenge. We've addressed this in part by expanding our hours to include evenings, and are considering adding Saturdays. Kids really need those evening appointments, because they don't need to be missing more school than necessary for appointments. We currently have two primary locations but are trying to add satellite locations to expand services. Lastly, trust is a huge issue. We have had numerous examples of times when our patients aren't willing to follow through with their care and the TOWs help identify the specific issue. They can help uncover what is triggering a client. We have numerous stories of them helping identify what the problem is so we can address that and help them stay engaged. One current project involved the TOWs partnering with a local agency working to stop retaliation-related community violence. We are meeting with this group twice monthly to build this partnership.

Can you share a time when a Trauma Outreach Worker was able to work with a patient, including both positive outcomes and areas of struggle?

Jordan: One patient I worked with was a survivor of domestic violence, as well as physical and sexual assault. She and her child had to move from their home due to safety issues. We were able to build rapport pretty quickly. When she moved into her new apartment she was worried about her doors not having deadlocks, and that someone might break into her home. That sense of safety is so important with everything she went through. We were able to provide her with a door alarm that fits under the door, so if someone forces the door open, it's a really loud alarm. She told me it was really helpful. Another client was recently shot. We were able to provide him with a TENS unit to help with continued pain related to his injury after his insurance kept denying it. That was a big win.

Kim: We had a client who was shot and struggling with serious medical problems. Our TOW was able to go in and build a relationship and understand what was really needed. The TOW followed him closely and helped support him in gaining weight and improving his health. He had been kicked out of every home health agency and everyone had thrown in the towel on him. After three months working with a TOW he was able to get a surgery no one thought he would be able to get.

How did you incorporate Trauma Outreach Workers into your existing team? How do they communicate and collaborate about patients?

Kim: With our patient population there are so many social needs. We were afraid that if the same provider provided both case management and therapy, the social needs would be so great that we would never get to the therapy. As we grew, we began to identify what was missing. We realized we didn't have a strong enough presence in the hospital or in the community. We also knew that we needed to increase diversity of our staff, and Trauma Outreach Workers have helped us meet these goals.

I've been working with outreach groups in the community since the beginning. We worked closely with street outreach organizations, but we found that by outsourcing the case management, things started falling through the cracks. We wanted to be able to do this work internally, have them use the same electronic health record, and meet with the team. We now have 6 Trauma Outreach Workers in our south region site and 2 in our north region site, so 8 currently.

Regarding communication, we meet every morning for our "daily huddle" to check in and review any client needs and safety concerns. Following the client's initial intake, there is a treatment planning session in which any needed team members are present. If there is a desire to work with a TOW they would be present for that session. Sometimes social service needs are the only ones initially identified, so in that case the TOW would attend the treatment planning session and take it from there. There is also frequent communication between team members throughout the day.

Jordan: I think our team is really cohesive in that we're all striving for the same thing. If I can't make something happen I can ask the clinician. We are a big teams-focused organization!

How are Trauma Outreach Workers involved with your education and training program?

Kim: Each day a TOW is paired with a psychology fellow or psychologist in the hospital, as Jordan previously described. This allows the fellows to have a lot of contact with the TOW. There are also many opportunities for our trainees to go out into the community with the TOWs. The TOWs provide a great deal of ongoing education related to what patients are really experiencing. Trainees are able to get a more diversified understanding when they are in the community than they get in the office setting about the daily lives of patients we serve which helps improve overall treatment and understanding.

Reflective Supervision / Reflective Practice

Interview with Dr. LaDonna Butler, Founder and Executive Director

The Well for Life in St. Petersburg, Florida

By: Stacey Wiggall

A cornerstone of the TRC model is providing quality supervision that supports provider/staff wellbeing and integrates best practices. NATRC invited Dr. LaDonna Butler to share her expertise in the use of Reflective Supervision in work with survivors of trauma.



Hello Dr. Butler, can you please tell us about the work you do at The Well for Life?

The Well for Life is a healing space. I created the Well because I needed a well. I needed a space where I could do my real work in a place where I felt supported, challenged, and held. At The Well, we focus primarily on folks who have historically been marginalized. We do that by leveraging our strengths, and our history of resilience, resistance, and all of the other beautiful things that make us, us. I know that it is by our focus on those who have been most harmed, that we are able to apply that to the general population. I'm a part of that community that has been impacted by legacies of harm, and so we use strategies we have developed over time to help us with our struggles. For the Well, we have three basic things that we do, and that I needed for myself: The first thing is that we're a place to heal – meaning we provide direct clinical care for individuals, families and communities. The second is that we're a place to learn. In the State of Florida we provide CEUs and do work on equity and mental health. We do trainings from implicit bias to reflective supervision – how to connect with other people and how to sit back and listen. And the third, and one of the most powerful things, is that we provide a space for connection. And in our connection, we're able to leverage all of our strengths to change practices and policies that don't serve our community well. So the Well is a place to heal, learn, and connect.

Can you please give us a brief overview of Reflective Practice and Reflective Supervision?

Absolutely. Any time we talk about Reflective Practice or Supervision we have to first say, what is reflection? Back in 2001, Parkland said the definition of reflection is simply stepping back from the immediate, intensive experience of hands-on work and taking time to wonder what the experience really means. In our daily lives, especially when we are working directly with people who have been most harmed, people who've experienced crime and violence, we can soak up those things in our very body and it impacts the way that we show up. Reflection says, let's take a step back and think about what the work is doing to us, and how our own experiences might be impacting the way in which we are doing work. It's most effective when we have a dedicated time to do it, there's a schedule, there's a process, we set aside time when we're able to slow down and most of all, when we're able to suspend certainty about all things. If I were to add anything to his definition, I would say not only suspending certainty, but actively being curious around how the experiences are shaping us. That's what reflection is. Reflective practice is the practitioner - because this is where we show up, right? - taking the time for ourselves to consider what's been done, said, felt, and thought during the interactions with the family, with our peers and colleagues, supervisors, and all of the other systems surrounding the families or individuals that we're serving, in order to give our lives meaning. So the practice is, yes, reflection, but being very very specific about these other core components. And it's not about learning from experience, it's about learning from what we think about the experience.

What are the benefits of using a Reflective Practice approach in trauma work?

As we do our trauma work with others, reflective practice allows us to consider our own trauma history and how it's showing up in the narratives in work with other people. It helps us to be more empathetic, it helps us to attune with them, and actually helps us to be more supportive. Because as we quiet the voices that tell us that we are in danger ourselves, or are reminding us of times that we may have experienced this, or are heightening our responses as we try to establish safety between us and the client, being reflective allows for greater empathy, attunement and support. What we know is, when done over time and with support, practitioners feel better prepared to slow down with their client. It also allows us to slow down and think about all of the resources that are available to support them in their challenges. And it allows us to think about the effectiveness of our approaches, and alternative meanings. Why do I say that? We can have all the interventions in the world, the best evidence-based materials, and we do encourage people to do that; however, if we don't have attunement, if we don't have the ability to slow down to fully understand what the struggle is, as well as leverage some of the strengths in the relationship, it doesn't matter how good your intervention is – it won't work. Because people must feel understood and affirmed first, before any shift can actually happen. Reflective practice, especially when working with individuals experiencing trauma, allows us to slow down and do our own work, before we provide space for others to do the same.

Dr. Butler I just want to clarify - Reflective Practice is also relevant for work with individuals, and with adults?

Absolutely. I say "families" because I don't believe that there is a "single individual." My first work was in substance abuse – prevention services, then working with severe and persistent mental illness, then training and work with individuals impacted by trauma. Then I found myself in infant and early childhood mental health. There is a philosophy in infant and early childhood mental health that I want to borrow for work with other individuals. The saying is "there is no such thing as a baby. There is always a baby, and someone else." The same is true working with individuals. There is always someone else who is connected to that person, and a community surrounding them, whatever the type of attachment they have with that person. And there are also systems that are connected to the individual, so I want to hold in mind the family systems approach. There rarely is a single person that is not connected to anything at all. If we think that we're only treating the person seated in front of us, then we've missed the mark. Especially when we're working with individuals from marginalized communities.

Why is this important, especially working with individuals experiencing trauma?

Our work is fast-paced, and emotionally intense. Our work requires us to hear the stories, to share the same space, to be in connection and relationship with individuals who have been harmed. Either in single events, stressful circumstances, ongoing complex circumstances. Because of that, we want to be in a relationship that is reflective, where we can think together around, what does it mean to work in this environment? We need to be in a relationship where we can be collaborative in our thinking, and our process, and our application of really good interventions, and it needs to be regular enough so that we know that help is coming. If you think about it, that's the type of work we also want to happen with our clients. We want them to be reflective about their experiences, and how their responses are showing up, and ways to calm those responses and navigate their lives, so that they can live well. That's what we want to happen. We also want them to be able to collaborate – with us, with other providers, with informal systems and supports, in leveraging their strengths and partnering with their vulnerabilities. We want them to have regularity in their lives – to know how to set schedules, come back to routine, in a way that allows them to live a meaningful existence after traumatic events. And so it's important that we are applying this strategy with our supervisees as well as with our peers, and with the clients that we're serving, in order to reflect on our work, share our ideas, and think about our next steps, so we can do really good work.

Could you please describe a de-identified example of a therapist-client interaction, or a staff-supervisor interaction, that illustrates the use of Reflective Practice or Reflective Supervision?

I can – I'll use me (laughs). I want to come back and anchor us in this – Reflective Supervision, when done well, it builds the relationship, it promotes self-regulation and problem-solving capacity. It promotes learning, self-awareness, and personal growth, it builds our skills, and it actually provides care. It reduces burnout, and provider turnover, as well as vicarious trauma. This is the why. And this is my case: I was working with a family of four, and my identified client had experienced a sexual assault, and the very next day she was terminated from her employment, which was another traumatic event. And then a week later, her family experienced COVID. So these are three pretty significant things that all occurred at the same time. And, her story was so close to my story, that being in the same room with her, I immediately wanted to problem solve with her, versus staying in the space and allowing her to feel heard and understood. I was able to slow down. I thought about some of the key things that were being mentioned in her story during intake and how they were reminders of my story. From the very smells that she was sharing with me, from the feeling of being disconnected and discarded, from not feeling heard and respected, that interaction reminded me of my own experience. It was difficult for me, even knowing all of the things that I know about trauma, about the best interventions, about treatment - being in that space and living in that with her, reminded me of me. I have the benefit of having another reflective supervisor. This is the deal – reflective supervisors should have reflective supervisors, right? We need that. So being in relationship with my reflective supervisor, she was able to sit with me and say, "you know where some of these thoughts are coming from." She had me walk through the scenario without interruption, had me simply go over the facts of the case.

Reflective Supervision / Reflective Practice

And then, begin to ask me, in what ways were these experiences similar for me? She had me examine some of the things that were said, some of the things I was feeling during this time, my reactions – which were to problem solve versus to be with the client in that moment. And she had me actually think about some of the things I did when I was with her in that moment. What I love about my supervisor is that we focused more of our time on my strengths – we sent over the interventions that I used, the way I was able to sit and be in those interventions with the client and suspend my own desire to say, “let’s get you a job,” and start doing case management versus clinical work, which a lot of us get caught up in. Then we began to talk about where I was most vulnerable, and had we not talked about my vulnerability and my behavior of rescuing, versus resourcing, then it would have been difficult for me to show up differently the next time. We looked at my strengths as well as some of my vulnerabilities, and then we started talking about the next steps in the plan. The next steps were very different than when I first walked in the door. And again, I’m a skilled clinician. None of the things that I was planning on doing with the client aligned with why she was showing up in the first place. Reflective supervision allowed me to not discard my thoughts about good case management and good care management, because those things are necessary. And for many of the people we work with, concrete support usually precedes any of the clinical work we’re going to do. Because people must feel safe in order to go there. But it also allowed me to slow down and think about, what did I need in order to slow down, regulate my emotions, and get to a place of safety? And then consider, be really curious about, what safety would look like for her. And how do I go about creating a space of safety in our relationship, as we explore the re-creation or co-creation of safety, given what has happened in her life? What I love about reflective supervision is that it’s not about being wrong. I’m not wrong, and, there are other things that need to be attended to. I was able to build my skills and way of being to use other effective interventions. It’s not that I didn’t know them, but I was so caught up in my own stuff that I simply forgot.

Thank you for acknowledging that even most experienced and skilled supervisors need experienced and skilled supervisors, to stay connected and stay effective in this work.

Absolutely. Things that I know now, are that I’m allowing myself to embody this model and way of being so that I can slow down. Because there are so many pressures in the environments that we have, and many of the things we do are productivity-driven. If you don’t produce in mass quantities, you’re not able to bring enough revenue to sustain your organization. For some of us, this model may seem counter-productive to that work. I know it did for me. However, when we think about the amount of time that we spend cleaning up mistakes, or apologizing, or repairing relationships instead of being slow and intentional in our building of relationships, or the quality of care that will actually allow clients to consistently show up so we’re not having client turnover or staff turnover, this model works beautifully and actually increases productivity over time. It is slow to start, but the quality of the interventions lasts, and that protects our investment in the people that we’re serving, and the staff.

What resources would you recommend to people who are interested in this approach?

This process of reflective supervision and practice really was born out of early childhood and infant mental health. That’s where we’re seeing lots of literature coming out because when you’re working with babies and families, it’s important that you go slow. However, its application is useful across all of the work of Trauma Recovery Centers. The Michigan Association for Infant Mental Health (<https://mi-aimh.org/>) – their website provides guidance. Another place I would encourage you to look is the University of South Florida’s Family Studies Center (<https://www.stpetersburg.usf.edu/resources/family-study-center/index.aspx/>) where they’ve compiled a beautiful list of resources, including trainings. There are also wonderful articles on cultural attunement, because it’s important that we’re looking at elements of diversity that may – that will - shape the way in which we are engaging with the individuals that we serve. Despite our best efforts and good intentions, we still grapple with the difficult issues, like how do we make our places culturally inclusive? How do we create an environment of inclusion, of staff as well as clients? Looking at both barriers and accelerators to engagement is critical in the work we do.

Using this model really will enhance our ability to be effective with the people that we’re serving. It will also decrease the weathering effect of working with people who are in pain. And in best case scenarios, it will help us to better understand our own narratives, so that our healing work is transformative, not only for the clients but for ourselves.

TRCS ACROSS THE COUNTRY

Trauma Recovery Centers

Northern California

- Alameda County TRC - Family Justice Center
- West Contra Costa Family Justice Alliance
- Partnerships for Trauma Recovery, Berkeley
- Ruby's Place TRC, Castro Valley
- Solano TRC, Fairfield
- UC San Francisco TRC

Southern California

- Long Beach TRC
- Downtown Women's Center/Peace Over Violence, Los Angeles
- CSUN - Strength United, Northridge
- SafeHarbor-UCLA TRC, Torrance
- HOPICS/SSG TRC, Los Angeles
- Chadwick Center for Children & Families, San Diego
- Miracles Counseling Center TRC, Gardena
- Citrus Counseling Service, Redlands
- Amanecer Community Counseling Service (LA)
- Palomar Health Foundation, San Diego
- Olive View UCLA, Los Angeles
- A Quarter Blue, Orange County



Illinois

- Advocate TRC, Chicago
- Advocate Condell TRC, Lake County
- OSF STRIVE TRC, Peoria
- OSF St. Anthony TRC, Rockford
- SIU Survivor Recovery Center (SIU) TRC, Springfield

Iowa

- Central Iowa TRC, Des Moines

Ohio

- Seven Hills TRC, Cincinnati
- May Dugan TRC, Cleveland
- MetroHealth TRC, Cleveland
- Brenda Glass TRC, Cleveland
- OhioHealth TRC, Columbus
- OSU-STAR, Columbus
- Citilookout TRC, Springfield
- Mercy Health TRC, Toledo

Pennsylvania

- Central PA Center for Trauma & Healing - TRC, Harrisburg

New Jersey

- Jersey City Medical Center TRC, Jersey City
- Newark Community Street Team TRC, Newark
- University Hospital TRC, Newark
- CarePlus TRC, Bergen County

Georgia

- Grady Hospital TRC, Atlanta

Florida

- Thriving Mind South Florida Trauma Recovery Network

39 TRCs Nationally (as of 7.1.2021)

TRCs: Send us your good news at kathy.vang@ucsf.edu.

To subscribe to the NATRC Newsletter email kathy.vang@ucsf.edu.

Please click [here to](#) Link to the UCSF TRC Manual: A Model for Removing Barriers to Care and Transforming Services for Survivors of Violent Crime



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