INSPIRE & CONNECT

National Alliance of Trauma Recovery Centers Newsletter

www.nationalallianceoftraumarecoverycenters.org

November 2023

"By shifting the focus to others, no matter how tough life gets, you'll catch a wave of hope that will breathe fresh oxygen and tenacity into you."

-Adrienne Bankert

IN THIS ISSUE:

NATIONAL ALLIANCE OF TRAUMA RECOVERY CENTERS

TRC GOOD NEWS

TRC MAKING A DIFFERENCE

The Brenda Glass Multipurpose Trauma Center (Cleveland, OH) was awarded $500,000 by the Cleveland City Council to make needed repairs and upgrades to its shelter homes and practice center.

TRC IN THE COMMUNITY

HOPICS TRC (Los Angeles, CA) participated at the Homeless Connect Day, a Wellness Collaborative, and supported those experiencing homelessness, community members and partners, and anyone in need of resources.

TRC IN ACTION

Thriving Mind South Florida TRC (Miami-Dade, FL) hosted a Press Conference for Florida Attorney General Ashley Moody (pictured in red on the left).

TRC BRINGING AWARENESS

JCCGCI TRC (Bronx, NYC) brought awareness to Domestic Violence vitcims with the support of NY Senator Jessica Scarcella-Spanton, and standing in solidarity with survivors of domestic and intimate partner violence.

TRCs IN THE NEWS

The **University Hospital Trauma Recovery Center (Newark, NJ)** and Hospital-Based Violence Intervention Program at the University Hospital recently received the Crime Victims' Rights Award by the State of New Jersey, and honored by the Obama Foundation. The programs provide support for victims of trauma in partnership with the City of Newark.

University HOSPITAL
Newark, NJ

Click here for article: https://www.uhnj.org/university-hospital-trauma-recovery-programs-recognized-by-state-of-new-jersey-similar-work-in-partnership-with-the-city-of-newark-honored-by-obama-foundation/

The **Solano Trauma Recovery Center (Fairfield, CA)** was awarded the Regional Pilot Program Grant from the California Victim Compensation Board and will be providing additional TRC services in Napa County and Sonoma County. One of the twenty-two Trauma Recovery Centers in California, the Solano TRC opened in 2021 providing mental health services tailored to the needs of survivors of trauma.

Click here for article: https://napavalleyregister.com/news/local/trauma-recovery-center-opens-for-napa-county-crime-survivors/article_333d765a-694c-11ee-b33b-5700a060d61d.html

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The **Harvest Trauma Recovery Center (Austin, TX)**, the only TRC in Texas, opened November 1st, 2023. The TRC is created in partnership with the City of Austin and the African American Youth Harvest Foundation (AAYHF) to provide comprehensive support and healing to survivors of violence in Austin-Travis County.

Click here for article: https://www.austintexas.gov/news/first-state-harvest-trauma-recovery-center-opens-austin

HARVEST
TRAUMA RECOVERY CENTER

Inspire and Connect TRC Spotlight

Felicia Cantu, AMFT – SFGH/UCSF TRC & Wraparound Project, Bridge Clinician

In this Newsletter's Spotlight, we have an opportunity to hear from Felicia Cantu, AMFT who is currently working as the Bridge Clinician for the UCSF Trauma Recovery Center.

The National Alliance of Trauma Recovery Centers (NATRC) and the Health Alliance for Violence Intervention (HAVI) have both developed models of care for victims of violence in underserved communities with the goal of reducing racial inequities and barriers to accessing effective healing support after trauma. Both models—hospital-based violence intervention programs (HVIPs) and trauma recovery centers (TRCs)— offer intervention for victims at a crucial time of need and promote healing, which also positively impacts families and communities.

Recently, a collaboration between the HAVI and the NATRC published a brief, "Keys to Collaboration between Hospital-based Violence Intervention Programs and Trauma Recovery Centers." This brief goes into detail on the HVIP and the TRC models of care for victims and how the two models complement each other to address the needs of victims of violence. A follow-up webinar on November 15th will feature TRC panelists Felicia Cantu (UCSF TRC), Cathy Choy (University Hospital TRC), Angelica Maury (Newark Community Street Team TRC), and Geneva Sanford (OhioHealth TRC), along with their HVIP collaborating partners (see info and registration link at end of interview).

Can you please share a brief overview of your position as UCSF TRC's Bridge Clinician with the Wraparound Project?

"My position as the Bridge Clinician is a little complex. I am housed under the UCSF Trauma Recovery Center and I'm responsible for supporting the Wraparound Project, which is the hospital-based violence intervention program (HVIP), at San Francisco General Hospital (General), a Level I trauma center. I am a clinician that supports their team, and their team is comprised of VPPs, which are violence prevention professionals, trauma surgeons, a clinical research coordinator, and others that really support the robust needs of the program. Their primary focus is supporting every single person that comes into San Francisco General Hospital, specifically a violent injury, with case management support.

Part of my role is to support both the team who does that work on the ground, which are the VPPs, and supporting patients' well-being and providing emotional support. What that looks like in practice is working in collaboration with the VPPs; conducting bedsides with patients and getting an understanding of needs. Oftentimes, what I'm doing is offering emotional support and a listening ear. Again, we're talking about folks who have sustained violent injuries and so thinking about some of the hallmarks of PTSD or acute stress disorder, going over psycho-ed around depression, how this impacts us, our family, our loved ones, friends, and being able to do some advocacy while they're inpatient. That may look like medication, or support with getting folks' family members to be able to stay working with the inpatient social work team in order to get their needs met while they're in the hospital, and to really understand that they could be experiencing an acute trauma reaction. Also working to orient patients to TRC and our services to see if it's something that would be of interest to them in supporting their emotional well-being, their healing, and their recovery. My position is to really be the bridge from seeing patients at the hospital to getting them connected to TRC to decrease the barriers to mental health services."

What are some benefits of the collaboration?

“Being able to do intakes at a patient’s bedside is really helping to fill a significant gap between folks that are coming into the hospital, discharging, and then making their way to TRC for an intake. This is a population that is extremely vulnerable, especially with all their medical conditions, and it's really difficult to be in another system of care and get access to therapy. So, we can start the process to get them into mental health services and we can also start to do therapy while they're in the hospital, depending on how long they're staying. That's something that really was intentional so that we can reduce those barriers of getting into services because a lot of people are interested, but it's being able to actually get them into the TRC, waitlists, and all of those other things that create barriers to access.

Collaborating with VPPs is also another benefit to the collaboration. The VPPs are professionals who are also folks in the community that really have expertise in understanding community dynamics, community relationships, and being key players in the city. This means that a lot of folks that come into our hospital know our VPPs, and they trust them to get them connected to the care that they need. The VPPs are often violence interrupters as well. VPPs’ role also includes being able to support the patient and connect them to needed resources such as housing or mental health services. They often introduce my name early in the process or the names of other providers with whom they have an established relationship to build trust and rapport with the patient. Another benefit is the fact that we know the trauma surgeons and other members of the medical team, so we’re able to provide medical advocacy on behalf of the patient. For example, we can help advocate with the charge nurse to make sure that the patient is getting their needs met and we can also support the family as they navigate through the medical system. The VPPs are trying to help save someone's life, and so they show up and are at the hospital five days a week and they're doing a lot of that work. VPPs are one of the real benefits of and assets to this collaboration because they are seen as credible messengers who have significant lived experience and are pillars in the community here in San Francisco.

Their word carries a lot of weight and then coupled with me, who can think around what is happening to folks psychologically and how trauma may be impacting someone, can allow us to holistically support someone. The VPPs value me as the one to be able to support and ground patients and provide all that psycho-ed on their experience and I'm looking for them to also hold and support a sense of safety both physically and emotionally.

There are also the pros of having two offices and being able to have the flexibility to work from either and see clients both at the hospital and at the TRC. The Wraparound office has a therapy room and I have clients who are also wraparound clients, meaning that they work with a VPP doing case management. And so, I meet them at the hospital in the designated therapy room because often times they have other ongoing appointments within the hospital so it prevents them from having to go to multiple sites to access all of the care they need, including therapy and case management services.”

What are some challenges of the collaboration?

“One of the challenges with this collaboration is seeing people in very acute states, like physically, it’s a lot to see their injuries because they are pretty significant and profound. And self-care, boundaries and managing the impacts of vicarious and secondary trauma is something I had to think through once I started doing bedsides consistently. Boundaries are really important because this is significant trauma work, right? So, I also look at what are ways that I can contain myself and I really try to contain the work between Monday through Friday, 8 to 5 no matter which setting I am working at, and I also don’t take my pager home.

Being that the General is a Level I trauma center, there's always going to be something that happens unfortunately because this is the hospital that folks come to when they need the most critical care. Before I see patients, I try to get as much information as possible, to prepare myself for the situation I am walking into so I can make sure that I'm properly resourced. I want to reduce the amount of times that a patient has to repeat the details or information about their situation. We can't gather all the details from the medical record, but at least enough to know what someone's physical state is, what their injuries are, because it's very important. If you don't know that information and you're walking in and you're talking about hope, and you find out someone is paraplegic and they have a spinal cord injury, this is really important information to have because it informs my approach and facilitation of conversations about discussing hope and recovery. So those are pieces that I'm constantly looking for so that I can prepare myself to know what I'm walking into and to understand resources, and to ground myself.

In a place like the General, things move really quickly and feel chaotic at times, which can also be a barrier because I'm trying to figure out how can we slow down. It can feel like constantly moving on to the next patient and the next. And I'm like, hold on, let's just slow things down a little bit. Let's actually take a minute and really honor this person because there's just so much happening. I really want to give people the time that they deserve so I've sat with people for a couple of hours and offered to just watch tv with them, or maybe it looks like honoring someone's space if they don't want a visitor or to talk with me just yet. You really have to be able to just go with the flow. I also have to be resourced with things like basic needs, especially when we're talking about trauma. Just even simply walking in and introducing yourself and helping the patient to understand expectations about how long they might be in the hospital or what we are going to be talking about is helpful. Because oftentimes people are so scared and fearful about if someone's going to come back and reinjure them. There was an incident where I walked in with some of our VPPs and the patient was like, 'you look like the person that shot me.' That's significant because we're in an acute trauma state and so there are a lot of things that I think we have to be really prepared for.

Working in multiple places, with multiple providers, and within multiple systems, it can be really hard to navigate in and with. I sit in those different spaces and try to figure out how we can all best work and collaborate together at very different paces and approaches because each of these systems have their own goals and their own priorities, and so it can sometimes be really hard to navigate, pivot, code switch and shift back and forth between everyone's goals and figure out, how can I be really creative to use this in the client's best interest or benefit.

Another barrier for me is being housed in two places. It involves a lot of back and forth, literally walking back and forth between the clinic and the hospital, doing intakes at the clinic and at the hospital, so there's a lot of actual moving around. And again, there are different needs and different priorities in each program, and I interact with a lot of people on a day-to-day basis. Because I'm in both spaces, I then have two separate staff meetings, two separate everything which is a lot in terms of coordinating time to be physically present and available in both spaces."

University of California, San Francisco
Trauma Recovery Center

https://divisionoftraumarecovery services.org/trauma-recovery-center/

The Wraparound Project

https://wraparound.ucsf.edu/

Can you please share a brief, de-identified vignette of a client that demonstrates the collaboration?

"There was an incident that happened in the community and we conducted many bedsides. However, this one individual in particular was able to meet with a VPP first, both on the scene and then a few days afterwards. He's in his late twenties, and an African American cis-gender male and this was the first time he'd ever been physically injured in this way. He had a history of traumatic loss in the context of community violence to two loved ones and experienced PTSD, depression, and so, to now be a victim of community violence and trying to recover from his injuries totally disrupted his world, and also reminded him of all the past things in his life.

It was recommended that I follow-up with him to offer services as well as explore his mental health and other issues that he was presenting with. After introducing myself and talking with him more about TRC services, he stated that he was not interested in therapy and expressed that therapy is for white people, which as a Black clinician, I hear quite often. His family was supportive of therapy, and so I decided it was best to leave my contact information at that time. So, I let him know that I was going to check in with him and affirmed that he had a lot going on in the moment and that he could take some time to think about whether he wanted to move forward with services or not. I then consulted with a VPP and they also planned to follow-up with and encourage him to participate in mental health services with the TRC. The VPP continued to be in touch with him, getting him his services that he needs, and I made contacts with his family who were his identified support systems. He ended up being referred for TRC services by one of the inpatient social workers who he talked to afterwards and expressed interest in mental health services, and I believe this was because we had so many touch points with him and continued to reach out and follow-up with him. Once he was referred to the TRC, the assigned BOD (Building Officer of the Day) was making efforts to reach out to him but he wasn't responding. I worked with that BOD who eventually asked me if I could reach out to him since I already had a relationship with him. He answered for me, I was able to schedule him for an intake and he showed up! It also ended up that he was assigned to my caseload and therefore, I was the treating clinician.

He's still physically recovering and cannot walk on his own and so there's been a lot of focus on his physical recovery and helping him to get set up. We're also starting to work on other things such as loss of income and all of these things that impact his recovery such as disability benefits and housing. All of this is happening through collaboration with the VPPs which includes joint sessions as well as referring him to to other community agencies.

So, we're just constantly trying to wrap around and provide the support that he needs, and working together to continue building trust, and getting him connected to the programs in the city that could help. He's a really good example of how that collaboration happens and this trust building happens. He also sat with some of the VPPs who are older males who have been able to hold space for him to heal and cry. He and I also do that in our own sessions and are also starting to do some trauma processing and how it has impacted every facet of his life from all the loss he has experienced, including the loss of his ability to walk. He is completely engaged and we meet every week which also includes ongoing interactions with VPPs and him feeling comfortable enough to express his needs, which can be hard to do. We've talked about the difficulties of being a young Black man in the city and asking for help and support and being really vulnerable.

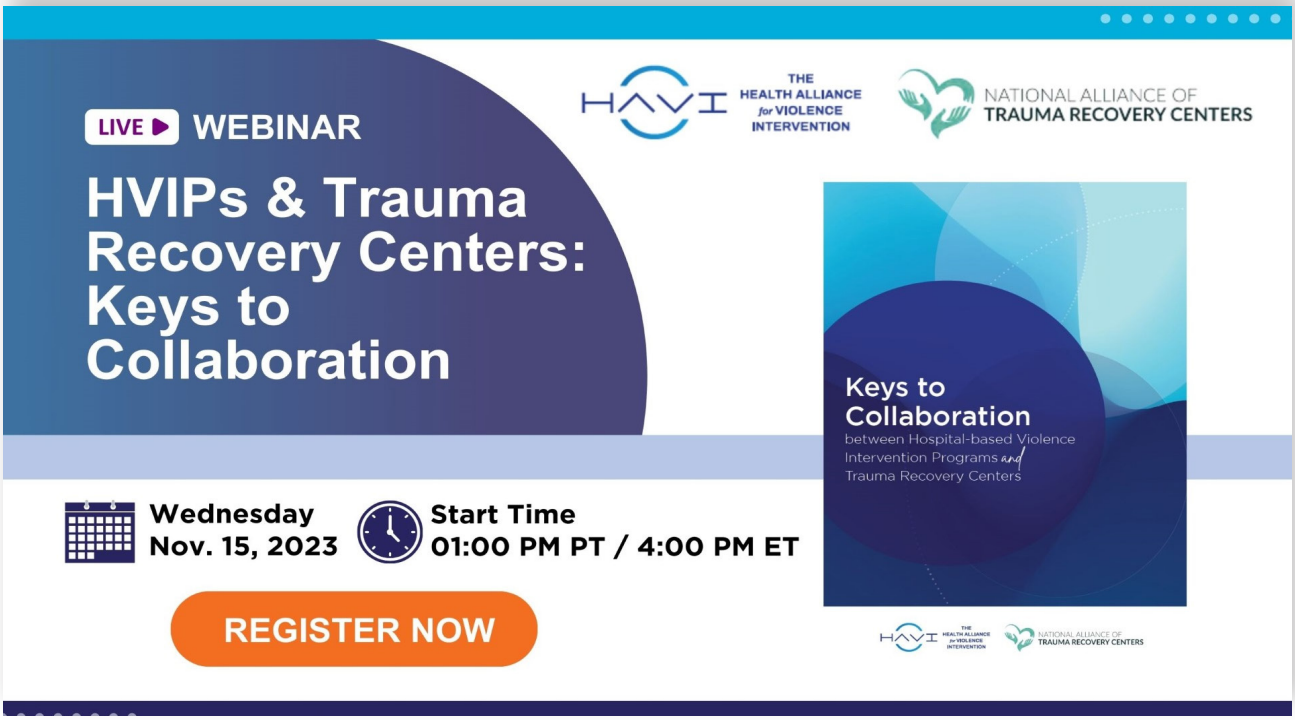
I think we've been able to create that as team here. The VPPs being older men that these young men can confide in and be their true, genuine, vulnerable and authentic selves around; they create a really special space. And that's how they show up in the work every day, going beyond the resource part and just really checking in on the person and how they are doing. One of the VPPs I work closely with is Al, and he does that beautifully and we often find ourselves crying together because he knows how to just go so deep because he wants to know how you're doing internally and even how's your soul doing. It's profound to see a male of color doing this work and having this impact."

Are there any other highlights or information about HVIP models of care or your work in the Wraparound Project that you want people to know?

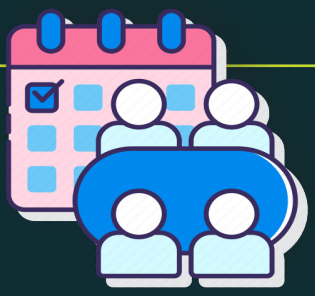
"While the work is specific, I think there is a lot of this type of worki happening. There are people that I've learned about who have similar roles that I do at other Level I or Level II trauma hospitals. It can be a lot to see someone in the ICU who has severe injuries; their entire way of life has changed, not just physically, but emotionally and we're seeing people at some of their worst days in their lives. So, we're really trying to figure out how to beautifully blend and collaborate in a way so that we can be a bridge for the gaps and barriers that exist with people being able to access the services that they need and deserve to have. And we're seeing that it works because we are seeing and catching people, and that it works to have someone bedside to try to get people in services. And that's just one story of how it works, and we see that that's happening a lot more now. And I think that's why I have a lot of Black men, specifically, that I work with, which is countering the belief that Black men don't get therapy. It's providing an opportunity for Black men who are apprehensive about being vulnerable and opening up to be able to have and share in this space. So, it's possible because of how we have created that environment for them to do so."

In collaboration with the HAVI and the NATRC, we are happy to share and invite our readers to an upcoming webinar opportunity to learn and hear more from Felicia and other TRC/ HVIP collaborating partners.

Please see the flyer below for further information, including registration information.



2023 UPCOMING MEETINGS



November 30, 2023
California TRC Monthly Meeting
Regional TRC Monthly Meeting

December 7, 2023
NATRC Collective Care

TRAUMA RECOVERY CENTERS

CALIFORNIA
22 TRCs

FLORIDA
1 TRC

GEORGIA
1 TRC

ILLINOIS
5 TRCs

IOWA
1 TRC

LOUISANA
1 TRC

NEW JERSEY
5 TRCs

NEW MEXICO
1 TRC

NEW YORK
4 TRCs

OHIO
8 TRCs

PENNSYLVANIA
1 TRC

TEXAS
1 TRC

51 TRCs Nationally in 12 States (as of 7.1.2023)

TRCs: Send us your TRC news at kathy.liu@ucsf.edu.

To subscribe to the NATRC Newsletter email kathy.liu@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

NATRC

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