NATIONAL ALLIANCE OF
TRAUMA RECOVERY CENTERS

THE TRAUMA RECOVERY CENTER MODEL CORE ELEMENTS

1. SERVING SURVIVORS OF ALL TYPES OF VIOLENT CRIMES.

Serve survivors of a wide range of violent crimes, including, but not limited to: survivors of sexual assault, community violence, domestic violence, battery, physical assault, vehicular assault, human trafficking, and family members who have lost a loved one to homicide.

2. ASSERTIVE OUTREACH AND ENGAGEMENT WITH UNDERSERVED POPULATIONS.

Conduct outreach and provide services to survivors of violent crime who typically are not well served by traditional models of care, including, but not limited to: survivors who are of diverse ethnicity or origin, survivors who are unhoused, members of immigrant and refugee groups, members of the LGBTQ community, survivors who are disabled, who have severe trauma-related symptoms or complex psychological issues, survivors with severe and persistent mental illness, or juvenile survivors, including minors who have had contact with the juvenile dependency or justice system. Outreach is conducted for the purposes of communicating with and engaging survivors who have either been referred for services or are currently open for services but not well-engaged (see Definitions: Assertive Outreach).

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.

Staffing consists of a multidisciplinary team that includes but is not limited to: psychiatrists, psychologists, social workers and/or 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. All members of the treatment team must be employed by the program, except for psychiatrists who may provide services as a consultant, or via telehealth, when necessary. In addition to the core multidisciplinary staff, program staffing may include outreach workers and/or peer support specialists who are integrated members of the treatment team.

5. COORDINATED CARE TAILORED TO INDIVIDUAL NEEDS.

Psychotherapy and case management services are coordinated through a single point of contact for the survivor, with support from an integrated multidisciplinary trauma treatment team. All treatment team members shall collaboratively develop treatment plans in order to achieve positive outcomes for clients, and all clients shall have access to the full array of TRC services needed to help them achieve their treatment goals (i.e., mental health treatment, case management for linkage to community resources, and medication services). The single point of contact shall be either:

1) A licensed mental health clinician who provides both evidence-based psychotherapy and clinical case management; OR
2) In teams where service provision is split between separate mental health clinician and case manager positions (within the same agency), the primary point of contact (a specific staff

member) is clearly defined and all additional staff working with a client are co-located in the same program, function as part of the same treatment team, meet regularly to discuss treatment progress and goals, and meet jointly with a client as needed.

6. CLINICAL CASE MANAGEMENT.

Services 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 if clients choose to do so, 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 FACING COMPLEX CHALLENGES.

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 are competent and fluent in the use of established, evidence-based practices for treating the sequelae of trauma, including but not limited to: Motivational Interviewing, Seeking Safety, Cognitive Behavioral Therapy, Narrative Exposure Therapy, Prolonged Exposure Therapy, Cognitive Processing Therapy, and Eye Movement Desensitization and Reprocessing. Evidence-based practices for children and families include but are not limited to: Child Parent Psychotherapy, Parent Child Interaction Therapy and Trauma-Focused Cognitive Behavioral Therapy. Evidence-based practices are defined as those that have been identified by nationally or internationally recognized trauma experts (such as the American Psychological Association, the U.S. Department of Defense, SAMHSA, and the International Society for Traumatic Stress Studies) as having demonstrated clear research outcomes to support their use for the treatment of trauma. Evidence-based practices that are considered emerging/promising based on research outcomes may also be used. In addition to the requirement of using evidence-based practices, programs may incorporate other interventions as an enhancement, such as specific culturally-rooted and/or innovative healing practices. TRCs support the expansion of research conducted to assess and potentially demonstrate the efficacy of culturally-rooted and alternative healing practices.

9. GOAL-DRIVEN.

Services are survivor-centered, and are focused to address the psychological and psychosocial impact of trauma. 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 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.

11. ALL ARE WELCOME.

Services are provided regardless of immigration status. Programs use a trauma-informed and healing-centered framework to inform and guide all aspects of service provision and organizational functioning. Services build on the best evidence available for client and family engagement, empowerment, and collaboration. All staff and trainees should have regular opportunities to learn and practice cultural humility skills with each other, in order to foster a culture of equity and lifelong learning / skills-building. Organizational leadership should infuse policies and protocols with trauma-informed principles and language, and work towards the goal of ending systemic inequities.

DEFINITIONS:

I. **Assertive outreach** is the efforts made by program staff to communicate with and engage survivors of violent crime who have either been referred to the program or are currently in TRC services but are lost to contact or not well-engaged in services. Outreach includes making home visits and other community visits, sending letters and/or text messages, and making phone calls for the purpose of engaging clients into treatment and helping to identify and remove barriers to care. NOTE: Tabling events and disseminating program brochures to groups of people at community events is a marketing outreach strategy that does not meet the definition of assertive outreach made to a specific survivor.

II. **Evidence-based practice** is a treatment intervention that has been demonstrated to work through research, meta-analysis, and expert analysis, and has been recommended by nationally or internationally recognized experts as effective for treating particular psychological symptoms. EBPs have clear research evidence to support their use. EBPs are to be used not only for the treatment of PTSD but also other co-existing problems related to trauma, such as depression, anxiety, and substance abuse. While TRCs should be prioritizing the use of strongly recommended EBPs in mental health service provision, it is also possible to include the use of EBPs that have emerging/promising evidence to recommend them. However, mental health services should not consist only of interventions that have been demonstrated through research to have little or no evidence of their efficacy.

III. **Single Point of Contact** means that the TRC clinician (or other designated single point of contact) helps to coordinate and integrate care across multiple domains: mental health, medical, substance abuse, social services and legal services. This is done in a way that facilitates clear communication among all service providers and across systems of care, and decreases fragmentation and duplication of services.
NOTE: Contracting out to separate off-site programs for either mental health or case management services can lead to fragmented services and an opportunity for clients to fall through the cracks. This approach is considered “usual care” and is not considered to be part of the TRC model.