ADAPTING THE TRAUMA RECOVERY MODEL TO RURAL COMMUNITIES

A COLLABORATION BETWEEN

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WHAT IS THE TRAUMA RECOVERY MODEL?

If someone survives a violent crime, they can face devastating consequences from trauma that can last the rest of their lives. Unaddressed trauma from violence can lead to addiction and/or revictimization, can limit someone's chances of getting and keeping a job and housing, and have costly consequences for both the individual and the community. If we can intervene early with survivors of violent crime and help them deal with the immediate consequences of trauma, we can prevent long-term negative consequences that affect all of us.

Trauma Recovery Centers (TRCs) are now delivering a transformational new model of care for survivors of violent crime that helps address the challenges someone can face after experiencing violence. The model of care combines outreach, clinical case management, and trauma-informed, evidence-based mental health and substance abuse services. It also includes cooperation with law enforcement, medical care and social services to help survivors deal with the emotional wounds and practical impact of violence

A PROVEN TRACK RECORD

TRCs have a track record of increasing crime survivors' access to victims' compensation benefits, mental health treatment, and case management services that will help them move past the trauma associated with violence. TRC clients are more likely to return to work, have improved physical and mental health, reduced substance abuse, and have a lower likelihood of being homeless, compared to other interventions and forms of care.

TRCs have also been shown to achieve these superior outcomes in a more cost-effective manner than other commonly-used interventions.

There are now more than a dozen TRCs helping urban crime survivors address the harm of violent crime in a manner that is cost-effective, trauma-informed, and helps survivors become whole again.

WHAT ARE THE SPECIFIC CHALLENGES FACING RURAL CRIME SURVIVORS?

Rural crime survivors face challenges accessing the kind of trauma recovery services that are being pioneered in urban areas, and have different needs than their urban counterparts.

Rural crime survivors have to travel long distances to access services, are less likely to be insured, and in part, because of a critical shortage of mental health providers, are less likely to have their problems recognized and addressed. Along with having less access to healthcare and worse health outcomes overall than people in urban communities, people of color in rural areas face even greater health disparities than their rural white counterparts. Rural crime survivors are more likely to live in communities with higher rates of poverty, unemployment, and lower incomes – all factors that make it harder for someone to access treatment after experiencing trauma.

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Rural survivors of crime are more likely than urban survivors to need services such as psychoeducation, housing, advocacy and legal services. Transportation and housing are top priorities for survivors of interpersonal violence, as they address barriers to getting out of abusive living situations, getting a job and achieving self-sufficiency.

All of these structural challenges make it less likely that someone will report being a crime victim, and because of that, less likely to receive basic support available through existing law enforcement or social service networks.

HOW CAN TRAUMA INFORMED CARE BE ADAPTED TO MEET THE NEEDS OF RURAL COMMUNITIES?

Accessibility is a central concern in making TRC services available to rural patients.

Telemental health is a strategy to address some of the challenges in providing trauma recovery services to people in rural communities.

Telemental health uses telecommunication technologies to support or promote long-distance health care through video teleconferencing, the internet, streaming media and wireless communications to help assess and address someone's needs.

Research has demonstrated the feasibility of telemental health and has shown high levels of client and provider satisfaction with these technologies in rural communities, and among a variety of clients that are ethnically and racially diverse.

Studies have found Telemental Health to be effective at delivering evidenced-based, trauma-focused mental health services with outcomes comparable to face-to-face interventions. Further studies found the use of video teleconferencing to be a viable way of delivering a service to survivors of interpersonal violence and sexual assault.

Along with connecting people over technology when they are at home, telemental health equipment can be used to deliver services in the offices of state, federal or community-based non-profit agencies that a rural crime survivor might access There are also approximately 2,500 mobile clinics in use that repurpose vans or other large vehicles to provide space so that clinical services can be delivered in geographically isolated areas or rural areas.

While there are fewer studies about the effectiveness of mobile clinics delivering mental health and trauma-related services in rural communities, operationally, these kinds of mobile clinics could overcome many of the systemic and structural challenges to delivering trauma recovery services to rural crime survivors.

WHAT STEPS CAN POLICYMAKERS TAKE TO ADAPT THE TRC MODEL TO RURAL COMMUNITIES?

To begin the process of delivering trauma recovery services in rural communities that are consistent with the TRC model, policymakers should develop pilot projects using a combination of telemental health and mobile clinics.

Pilot programs will partner with rural health clinics, social agencies, regional hospitals, law enforcement, domestic violence centers, and rape crisis centers in order to leverage existing resources. Partners will use video conferencing technology to create “virtual TRCs,” or have in-person TRC clinic days at existing rural clinics.

Consistent with the TRC model, all services will be coordinated through a single point of contact for the survivor. The client will receive assistance in the completing and filing of applications for victim restitution funds, filing police reports, obtaining housing and financial entitlements, linkages to medical care, and securing employment, as needed. In keeping with the TRC model, staff will work as a liaison to other community agencies, law enforcement and other service providers as dictated by the client’s needs.

Policymakers should develop pilot projects to help expand Trauma Recovery Center services to rural communities.

To fully capitalize on using technology to deliver trauma recovery services in rural communities, money would need to be available to cover the initial cost and ongoing maintenance of equipment, as well as strategies to reimburse services. Credentialing and licensing issues would need to be overcome, and the challenge of limited internet connectivity issues in rural areas would need to be addressed. Measured against the cost of doing nothing when communities fail to address the needs of rural crime survivors, policymakers should prioritize efforts to overcome these challenges, and develop ways to deliver trauma recovery services to those in need through pilot projects.

ADAPTING THE TRAUMA RECOVERY MODEL TO RURAL COMMUNITIES

INTRODUCTION

Without treatment, approximately 50 percent of people who survive a traumatic, violent injury experience psychological or social difficulties. Untreated psychological trauma has significant economic impact, often resulting in overutilization of costly emergency medical services, loss of income, failure to return to gainful employment, and loss of medical insurance and stable housing. Increases in alcohol and substance abuse are also common consequences of untreated trauma. In addition, without timely, effective treatment, people who have a history of victimization tend to become revictimized and retraumatized, leading to them have a poor quality of life—something that has costly consequences for the individual and for taxpayers.

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Early intervention is essential to help survivors of violent crime deal with the immediate consequences of trauma and to prevent long-term disability. The provision of trauma-informed services is especially important to groups that experience high rates of victimization, notably people of color, homeless people, substance-abusing survivors, immigrant and refugee groups, and people living in poverty.

The University of California, San Francisco (UCSF) Trauma Recovery Center (TRC) pioneered a comprehensive model of care for survivors of violent crime that combines outreach, clinical case management, trauma-informed, evidence-based mental health and substance abuse services. This model also incorporates coordination with law enforcement, medical care and social services to help survivors deal with both the emotional wounds and practical impact of violence.[1] Research on this model (including a randomized clinical trial) demonstrates that this model is clinically and cost- effective.[2]

The UCSF TRC Model has core elements that are being implemented across diverse communities and[3] geographic regions around the country, and across the world, and is demonstrating that the model is flexible and adaptable, as it can be modified to fit local needs. After starting in San Francisco, the TRC model is currently being replicated in 12 cities in California, 7 in Ohio, 1 in Michigan and 2 in Illinois.

Despite the success of this model, several questions remain. How can the TRC model be implemented in places that lack infrastructure? Can this model be adapted to rural, non-urban settings?

It is well documented that there is significant unmet need for mental health services in rural communities. It is estimated that 19 percent of residents in rural communities have some sort of significant behavioral health issues, which amounts to more than 6.5 million people in the United States. In addition, 3.5 percent (or about 1.3 million) residents of non-metropolitan counties experience serious thoughts of suicide in a given year.[4] Despite significant mental health needs, many barriers prevent services from being offered to rural residents, including:

- *Accessibility* – Rural residents have to travel long distances to access services; they are less likely to be insured; and they are less likely to have their problems recognized;
- *Availability* – There is a chronic shortage of mental health professionals who live in rural areas;
- *Acceptability* – Stigma related to needing or receiving mental health care creates significant barriers to accepting care.[5]

Rural residents face specific challenges in receiving the types of health and mental health services that someone impacted by crime might need.

Rural communities face economic challenges, and issues in providing health and mental health services that make it harder to meet the needs of crime survivors.

Rural communities have a higher percentage of poverty and unemployment compared to metropolitan counties. For example, 16.7 percent of the rural population in the U.S. is poor, compared with 3 percent of the urban population. Nearly a third of the rural working poor face extreme levels of poverty, with incomes below 50 percent of the poverty line (an income of $12,000 for a family of four). Nearly 20 percent of rural families have an income less than 150 percent below the poverty line, as compared to 13.5 percent of urban families.[6]

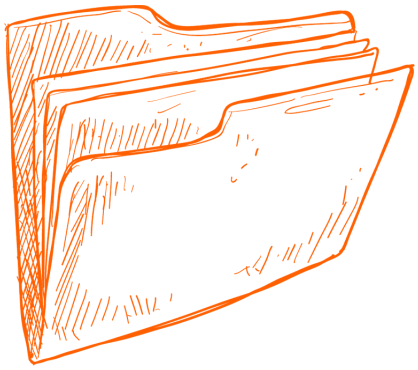
Despite significant mental health needs, the barriers of unavailability, inaccessibility, and the stigma associated with services currently prevent rural crime survivors from receiving the type of help that Trauma Recovery Centers can provide.

In addition, persons in rural communities have less access to healthcare and worse health outcomes than those in urban communities. It has also been demonstrated that rural racial/ethnic minority populations have even greater health disparities, greater health-related risk behaviors, and worse health outcomes when compared to their rural white, non-Hispanic counterparts. [7]

Despite the significant need for mental health services in rural communities, there is a notable shortage of mental health providers.

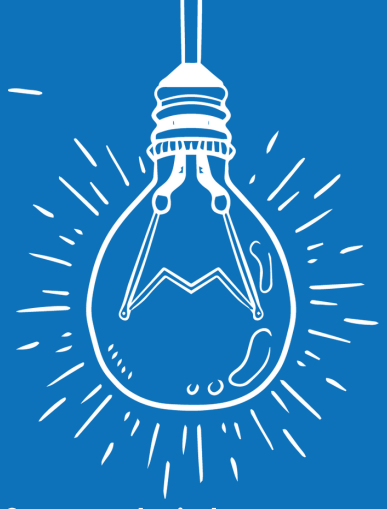
More than 85 percent of the 1,669 federally-designated "Mental Health Professional Shortage Areas" (MHPSAs) are located in rural communities. [8] Of the 3,075 rural counties in the United States, 55 percent have no practicing mental health providers. [9] Federally-Qualified Health Centers (FQHCs) are frequently the only source of primary care services in rural areas. FQHCs provide comprehensive primary and preventive health care services. About half (49 percent) of FQHCs are located in rural areas, and these centers serve about 1 in 7 of all rural residents.[10] Often it is the primary care provider who initially assesses the need for mental health services. There is a growing awareness that rural FQHCs may be a critical delivery mechanism for mental health services. [11]

Rates of violent crime may be lower in rural areas,[12] but the types of interpersonal violence that frequently occur in rural communities - child abuse, sexual assaults, domestic or intimate partner violence (IPV) and violence or abuse based on sexual orientation [12] cause the same physical, mental, and social sequelae as they do for survivors in urban settings. However, in rural America, the possibility of healing and recovery is compounded by other barriers unique to these communities: limited access to services, transportation barriers, the isolation and stigma associated with abuse, and poverty.[13]



In rural communities, there is often an "overlap among healthcare providers, law enforcement offices and abuse victims." [14] This leads to underreporting of violent crime based on fearing a loss of privacy, or that reputations may be damaged, or reports not taken seriously. There is a perception of lack of confidentiality and privacy in small communities that is associated with "closely-tied social networks." [15]

WHAT SERVICES DO RURAL VICTIMS OF VIOLENCE NEED?



Along with the unique characteristics of rural communities in general that make it more challenging to deliver the health and mental health services a crime survivor might need, rural crime victims also have other distinctive service needs.

According to a 2005 study, rural survivors of crime are more likely than urban survivors to need services such as psychoeducation, transportation, housing, advocacy and legal services.

Transportation and housing are especially top priorities for survivors of interpersonal violence.[16] It is estimated that "over 25% of women in small, rural and isolated areas live more than 40 miles from the local closest intimate partner violence program, compared to less than 1% of women living in urban areas. [17]

Lack of transportation and housing can be a "barrier not only to getting out of an abusive living situation, but also to finding employment and becoming self-sufficient enough to leave the relationship or seek social service support."[18]

Another top priority for rural violent crime survivors is access to timely and effective trauma-informed mental health services. A particular challenge is creating and delivering evidence-based practices (EBPs) to rural residents that are currently being used to address trauma in TRCs. The majority of rural areas lack the resources to develop and sustain rural-specific EBPs that are effective in addressing the trauma associated with crime.[19]

In summary, all of these structural conditions make it less likely that a rural crime survivor will receive the kinds of services that will help them heal, and avoid the long-term negative consequences associated with trauma.

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HOW DO TRAUMA RECOVERY CENTERS ADDRESS THE NEEDS OF SURVIVORS OF VIOLENT CRIME?

The TRC model for survivors of violent crime is based on the concept of trauma-informed care that strives to:

- Identify and remove barriers to care
- Reject stigmatization of people seeking mental health treatment
- Provide comprehensive, well-coordinated care that includes evidence-based mental health services, physical healthcare, psychosocial services and legal advocacy and does so in a manner which increases access to these services
- Provide these services in a culturally-sensitive manner, using a cultural humility lens
- Evaluate the model to ensure that it is both treatment-effective and cost-effective

The TRC model emphasizes clinical case management to address the needs of survivors of violent crime. That is, TRC staff coordinate the medical, legal, financial, housing and social service needs a crime survivor is likely to have. TRCs provide evidence-based, trauma-informed mental health services to target emotional and psychological distress and increase interpersonal safety. When the treatment is appropriate to the needs of the client, a TRC helps the survivor receive evidence-based mental health services.

TRCs have been shown to get better outcomes, while delivering services in manner that is more cost effective than other forms of care.

TRCs have a track record of increasing crime survivors' access to the kind of victims' compensation, mental health and case management services that will help them move past the trauma associated with violence. TRCs clients have been shown to be more likely to return to jobs, have improved health and mental health following treatment, are less likely to abuse substances, and are less likely to be homeless compared to other inventions and forms of care for comparable populations. TRCs have been shown to get better outcomes, while delivering the service in manner that is more cost effective than other forms of care.[20]

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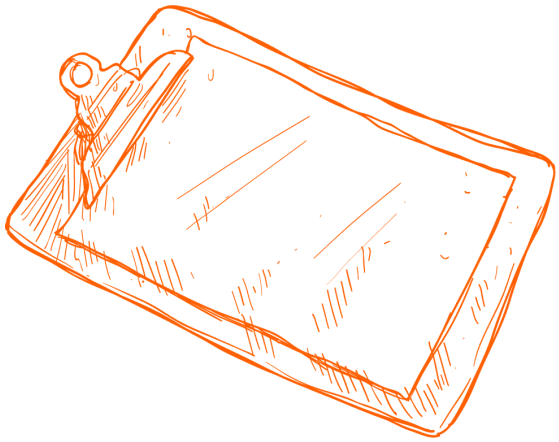
After starting in San Francisco as the result of a pilot project, the TRC model is currently being replicated throughout California and in some Midwestern states, with additional states planning implementation. The TRC model has bipartisan support, with Republican and Democratic lawmakers voting in support for their establishment and funding.



HOW COULD THE TRC MODEL BE ADAPTED TO ADDRESS THE NEEDS THAT EXIST IN RURAL COMMUNITIES?

The main challenge to delivering the kind of trauma recovery services someone can receive through an urban TRC is making these services accessible to people in rural communities. There are at least two models that could be combined to deliver the kind of services that are currently being delivered by TRCs in urban communities: Telemental Health Services and Mobile Clinics.

Telemental health (or "telehealth") is defined as: "the use of electronic information and telecommunication technologies to support or promote long-distance clinical health care, patient and professional health-related education, public health or health administration."[21] Technologies may include video teleconferencing (VTC), the internet, streaming media, and wireless communications.

Telemental health may be home-based (i.e. using technology in a client's home) or center-based (i.e. client travels to a health center to use this technology). With VTC, a client (or group of clients) are in one location and the clinician is in a different location, each looking at a computer monitor and seeing and hearing each other in real time.

Prior to telemental health, many people living in rural communities had no access to mental health care or had to travel many hours to receive services. By using technology, the model has been shown to address the accessibility issues that are a barrier to rural residents receiving mental health services.

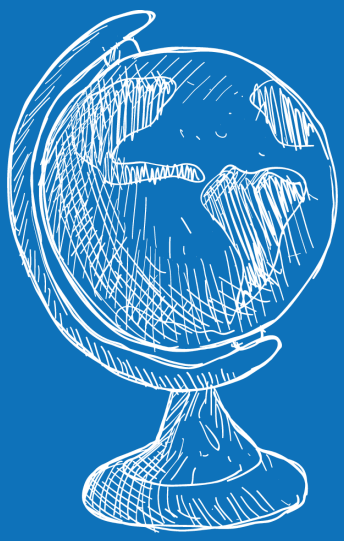
Over the last 10 years, the body of literature related to telemental health has yielded positive results.[22]

Telemental health has been applied successfully in delivering psychoeducation, clinical screening and assessment, providing both individual and group evidence-based mental health interventions, and medication monitoring.

Telemental health's use, success and positive outcomes have been well documented across many populations (adult, child, geriatric, ethnically diverse and rural communities).

Telemental health interventions have been successfully used in rural communities with Native Americans, Asian Americans, Latinos, and migrant farm workers.[23] For example, the successful facilitation of Native American talking circles using telehealth has been demonstrated.[24]

Numerous research studies have reported on telemental health's specific use in the treatment of Post Traumatic Stress Disorder (PTSD)—something that is associated with being a victim of violence. Findings suggest that evidence-based PTSD treatments provided by telemental health provide comparable outcomes to services provided face-to-face.[25]



A recent large randomized clinical trial, using predominately rural veterans suffering from PTSD, found that a collaborative care model including evidence-based trauma treatment, medication, case management and psychiatric consultations delivered via telemental health, produced larger reductions in PTSD symptoms and improved access to care when compared to usual care.[26]

In addition, a smaller research pilot studied the effectiveness and feasibility of VTC to provide evidence-based treatment to rural survivors of interpersonal violence and sexual assaults. Participants evidenced large reductions in symptoms on measures of PTSD, and also reported a high level of satisfaction with services.[27]

Telemental health can be "home-based" for certain types of trauma-related challenges—with some caveats[26] —or "center-based." Home-based approaches may be particularly helpful for clients struggling with the inability to leave their homes due to agoraphobia or limited mobility. However, the benefit of home-based VTC services should be weighed against the feasibility of equipment cost, and potential safety risks. The initial and ongoing costs of having communications equipment in a client's home may not be feasible. Also, the delivery of mental health services in the homes of individuals with interpersonal violence may increase the risk of further violence. And in general, there may be a reduction in privacy and confidentiality when services are provided in a household where multiple other people reside.

A center-based approach has been achieved in rural communities by placing the telemental health equipment in a rural health center, FQHC, or community-based social service agency. Providing client-based telemental health TRC services at a rural FQHC would be one way of increasing access to timely and effective care, and may help to circumvent the stigma of going to a mental health clinic for services. Telemental health allows a small rural clinic to offer access to "specialized interventions and specialists in PTSD, which the clinic would normally not be able to provide." [27]

HOW MIGHT MOBILE CLINICS ALSO DELIVER TRC SERVICES TO RURAL CRIME SURVIVORS?

Combined with telemental health approaches, mobile clinics could offer an opportunity to deliver the kinds of services to rural crime survivors that someone might receive through a TRC.

Mobile health clinics typically provide prevention, medical and dental services and less frequently they provide mental health services.[28] Mobile clinics exist in each state. It is estimated that there are approximately a total of 2,000 mobile clinics in the United States.[29]

Each mobile clinic serves an average of 3,100 patients per year, totaling about 5-6 million visits annually across the United States.

Mobile clinics typically serve communities with the poorest access to care. Target populations include: "those of racial and ethnic minority backgrounds, the homeless, displaced populations, recent immigrants, migrant workers and people lacking insurance."[30]

Mobile clinics are well-established for providing medical services in both urban and rural communities. While mobile mental health clinics have been used to provide acute crisis services in urban areas, few exist to provide ongoing mental health services. In addition, very little is reported in the literature about using mobile clinics to deliver ongoing mental health services in rural communities, especially for the delivery of ongoing specialty mental health services associated with treatment of trauma-related disorders.

There are some challenges associated with the models that can deliver the kind of services TRCs provide to rural crime survivors, but they can be navigated.

To fully capitalize on the promise of using technology to deliver trauma recovery services in rural communities, some key issues would have to be navigated, but they are not insurmountable. The challenges include:

- *The initial cost and ongoing maintenance of equipment*. This includes the cost of ensuring that all technological equipment used is encrypted so that it is HIPAA compliant and protects the privacy of clients.

- *Limited internet connection in some rural communities.* Although it appears that many rural health clinics have internet capacity, rural clinics relying on telemental health would need to have a backup plan if video conferencing connection is lost during a session. If the connection cannot be corrected quickly, the session would continue over the phone.

- *Funding and reimbursement policies.* The funding and reimbursement of services for telemental health varies from state to state. Private insurance, MediCare and Medicaid rules that disallow or limit telemental health services would need to be addressed.[31]

- *Licensing issues and credential issues.* Several studies have yet to resolve licensing and credentialing issues. Some states require that practitioners be licensed in the same state of patients being served, thereby limiting access to trauma specialists outside that state.

- *Having onsite mental health clinicians.* A significant clinical challenge is that the mental health clinician is not on site to deal with crises associated with suicidal ideation and/or aggression, which are commonly associated with PTSD. However, this can be somewhat mitigated if services are rendered in a rural health clinic rather than home-based settings. Procedures and policies can be set in place for how the rural clinic health care providers will handle such emergencies.

The challenges and steps to address them, and the costs associated with developing new service delivery models need to be counted against the billions of dollars lost to the economy, and millions of lives affected by unaddressed trauma in rural communities.[32]

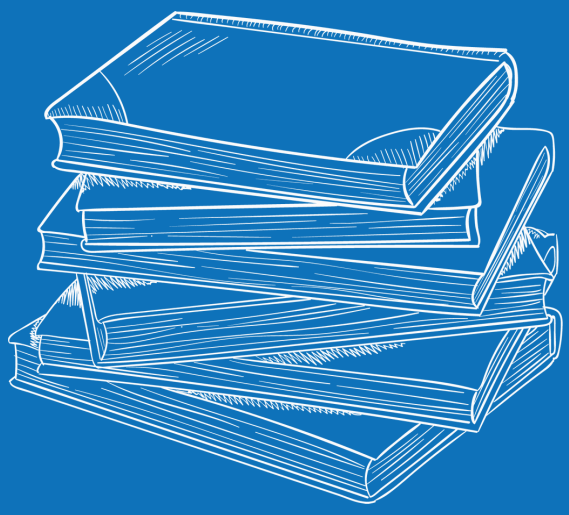
Measured against the cost of doing nothing when communities fail to help rural crime survivors become whole, policymakers should prioritize efforts to overcome the challenges to delivering trauma recovery services in rural settings.

WHAT STEPS CAN POLICYMAKERS TAKE TO ADAPT THE TRC MODEL TO RURAL COMMUNITIES?

The TRC model has core elements that can be implemented across diverse communities. Particularly when services are combined, coordinated and delivered in a compassionate and culturally-sensitive manner, this model is readily accepted by survivors of violent crime. The TRC model has been proven to be clinically and cost-effective. The evidence suggests that through the flexible and innovative use of telemental health technology and other service delivery vehicles, the TRC model could be adapted to address the needs of rural crime survivors on a larger scale.

Measured against the cost of doing nothing when communities fail to make rural crime survivors whole, policymakers should prioritize efforts to overcome the challenges to delivering trauma recovery services in rural settings.

Based on the best available evidence, and the huge need to address the trauma of people who are victims of crime in rural parts of the United States, the following recommendations are made for policymakers and practitioners:



- *Establish pilot projects for rural TRCs.* The TRCs being developed in urban areas across the country were spawned as part of a pilot project in San Francisco, but now exist in more than a dozen cities in California, and have been established in Ohio and Michigan. As part of a series of pilot projects to determine the feasibility of the various models described, the rural counties most in need of trauma mental health services within a given state would need to be identified. Consideration should be given to rural counties with the highest rates of violent crime.

- *Develop rural "virtual TRCs."* The creation of a "virtual TRC" could be the type of model that could be successfully deployed to serve rural communities. This virtual TRC would be made up of a multidisciplinary team of mental health providers. Virtual TRC teams could be created by using existing staff from the developed urban TRCs. The delivery of telemental health TRC services could be delivered using a "center-based approach" at rural health care clinics. In addition, it will be helpful to identify existing mental health providers in rural areas that can be trained to provide trauma specialty mental health services, so they could become part of the "virtual TRC team."

Pilot projects using service delivery models that could address the needs of rural crime survivors should focus on communities with the highest violent crime rates, and are the most in need of trauma mental health services.

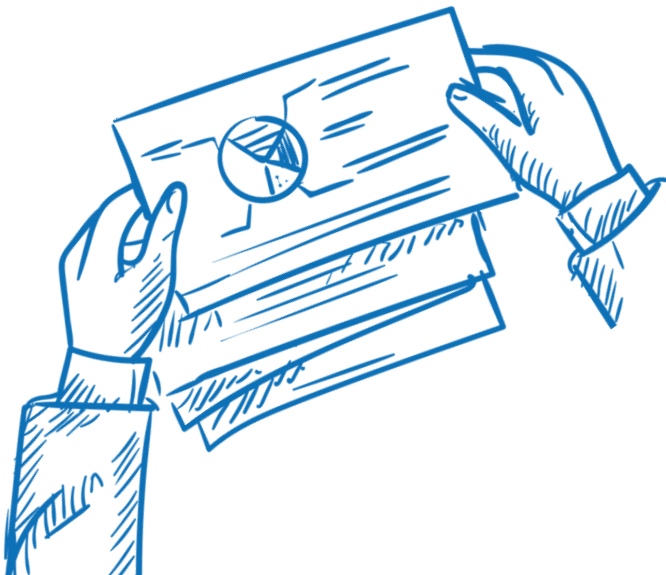
- *Develop partnerships with rural health clinics, social service agencies, law enforcement and other entities working with crime survivors.* Partnerships with rural health clinics (FQHCs), will be critical in providing the infrastructure and support for providing TRC services. Primary care providers can be trained to screen for PTSD and other related trauma related problems. Universal screening for trauma in rural health centers can ensure that more survivors of violent crime are identified. In addition, some rural health clinics may already have behavioral health specialists on site. Leveraging these existing resources and providing trauma specific training to current staff will be an essential component of delivering trauma-informed mental health services.

- *Developing partnerships with other social services, rural law enforcement, regional hospitals, rape crisis centers, and domestic violence programs will also help to leverage existing resources and insure the creation of a safety net for survivors of violent crime.*

- *The rural pilot projects would adhere to key features of the TRC model.* Consistent with the TRC model, all psychotherapy and case management services would be coordinated through a single point of contact for the survivor, with support from the integrated multidisciplinary trauma team. Clinical case management will include assistance in the completing and filing of applications for victim restitution funds, the filing of police reports, obtaining housing and financial support, linkages to medical care, providing assistance securing employment, and working as a liaison to other community agencies, law enforcement or other service providers as needed. All treatment teams would collaboratively develop treatment plans in order to achieve positive outcomes for clients. The TRC model often includes inviting family members to meet with TRC staff and this too can be accomplished via video teleconferencing.

In a similar vein, it will also be possible for the TRC client to meet with the multidisciplinary team if needed, also via teleconferencing. These rural TRC adaptations could also coordinate services with primary care providers of the rural health clinic. Survivors of violent crime would have access to the full array of TRC services through the use of HIPAA-compliant video conferencing, online interventions and other mobile health technologies. These services would include evidence-based trauma mental health services (therapy, medication management, substance abuse treatment and case management services). The TRC model typically includes accompanying clients to court proceedings or other community appointments—something that will not be possible through the virtual team model. However, most of the case management activities can be conducted by phone or via the internet.

By forging partnerships with rural health clinics, social service agencies, law enforcement and other entities working with crime survivors, new models could address the unmet needs of people impacted by violence and trauma.



- *Consider establishing roving, mobile TRC treatment teams for rural communities.* In addition to offering telemental health services, it might be possible to set up an in-person TRC clinic, one day a month at the rural health center. This would allow face-to-face contact between the client and TRC "roving" staff to help reinforce the therapeutic alliance and consolidate treatment gains.

It is recognized that the needs of rural crime survivors differ from those of urban survivors: a special "rural skill set" that rural mental health providers have will need to be integrated into adaptations of the TRC to be able to effectively provide services to their community. Rural providers are in a better position to understand the unique needs of their communities, and tapping into their knowledge will be critical in adapting EBPs to these communities.

Sensitivity and openness to the differences will be important, and it will be critical to draw on the expertise of rural mental health providers, community workers who have lived in rural communities, and crime survivors themselves from rural communities, if we hope to adapt the TRC model in a culturally-sensitive and accountable manner.

Sensitivity and openness to specific community needs are critical to successful adaptations of the TRC model. Rural TRCs will need to draw on the expertise of rural mental health providers, rural community workers and rural crime survivors to be successful.

CONCLUSION

The needs of survivors of violent crime in urban areas have been well-documented. Much less is known about the needs of those living in rural communities. A review of the literature about the use of telemental health services in rural communities has consistently demonstrated that telemental health services are feasible and effective. In a similar vein, the UCSF TRC model has been demonstrated to be clinically and cost-effective.

The TRC model has core elements that can be implemented across diverse communities. It would appear that the UCSF TRC model can be modified to accommodate the needs of rural communities through the use of telemental health and the creation of "virtual TRC teams." These adaptations would help remove barriers to care for survivors of violent crime, increase accessibility and help address the shortages of trauma mental health specialists in rural communities.

OTHER RESOURCES:

Trauma Recovery Centers: A website dedicated to explaining and expanding the use of the model.

The UC San Francisco Trauma Recovery Center Manual: A Model for Removing Barriers to Care and Transforming Services for Survivors of Violent Crime.

The Rural Health Information Network.

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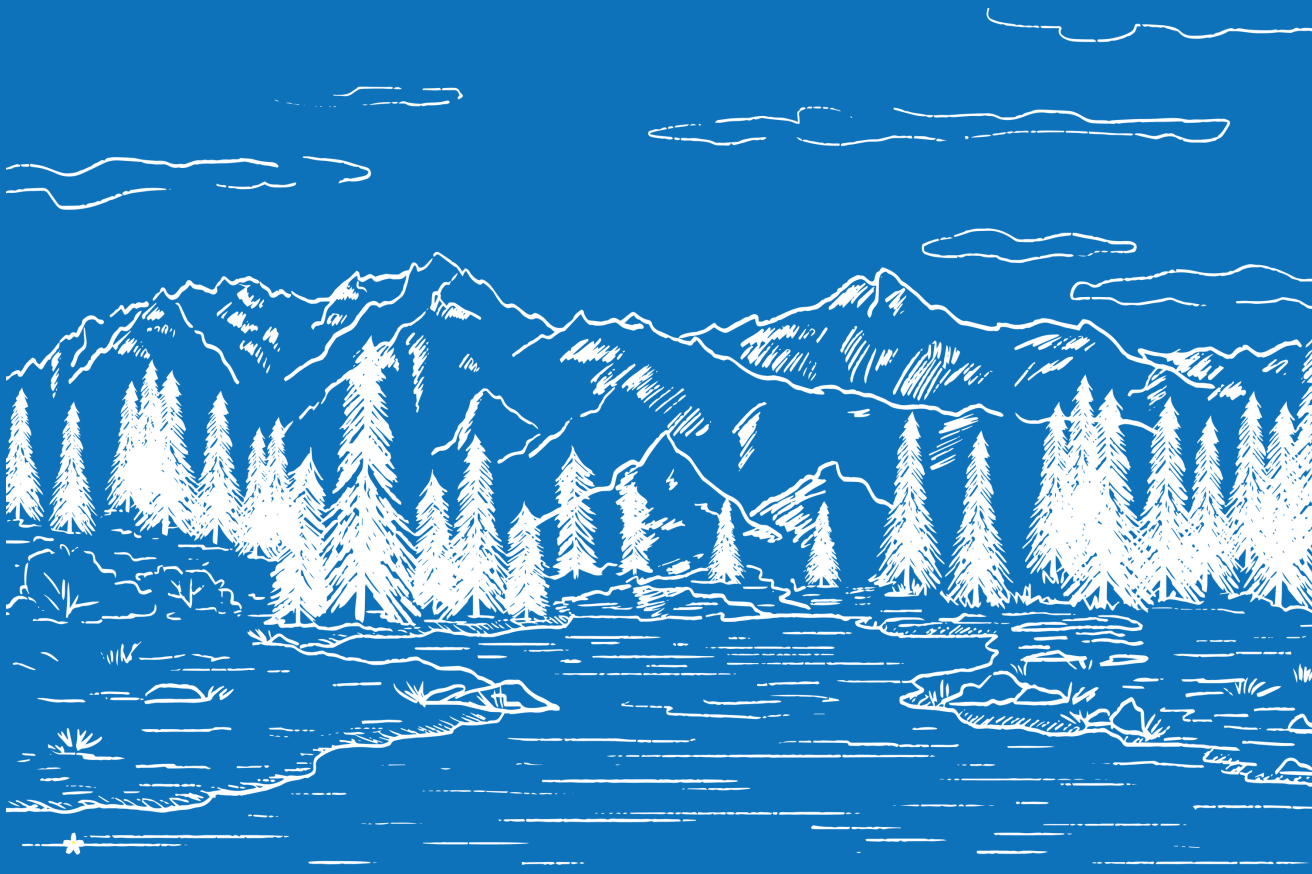
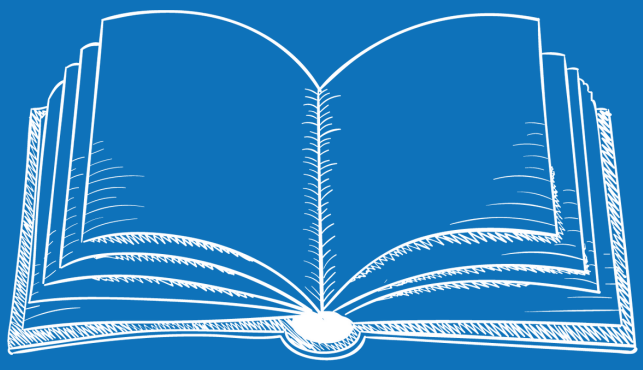


ENDNOTES



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3. Additional evidence that this model is flexible, adaptable and effective, is that it is also being used, in San Francisco, to treat survivors of political torture from around the world. This includes survivors from more than 45 countries, 21 different ethnicities and 7 different religions. Positive clinical outcomes for these survivors of political torture have been demonstrated, suggesting its use with diverse survivors of violent crime. See, Shumway, M., Tran, A., Wiggall, S., Lipp, C., Haque, A., McIntyre, J., Boccellari, A. Measuring Outcomes Among Torture Survivors: Applying Lessons Learned About Cognitive Aspects of Measurements. Annual Meeting of the National Partnership for Community Training. Baltimore, Maryland, February 2015.

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