NATIONAL ALLIANCE OF TRAUMA RECOVERY CENTERS™

THE TRAUMA RECOVERY CENTER MODEL CORE ELEMENTS

1. **SERVING SURVIVORS OF ALL TYPES OF VIOLENT CRIMES.**
   TRCs serve survivors of a wide range of violent crimes, including, but not limited to: survivors of gun violence, sexual assault, community violence, domestic violence, battery, physical assault, vehicular assault, human trafficking, and family members who have lost a loved one to homicide. TRCs serve adults and may also serve youth/children; eligibility is not limited to one gender.

2. **ASSERTIVE OUTREACH AND ENGAGEMENT WITH UNDERSERVED POPULATIONS.**
   TRCs 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 if served by the TRC, 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, and to identify and remove barriers to care. Assertive outreach includes: sending text / email messages and making phone calls, making home visits if safe for survivors and staff or making other community visits, and reaching out to additional contact people who may know how to reach the client, per the client's consent. NOTE: Tabling events and disseminating program brochures to people at community events is a community-level outreach strategy that does not meet the definition of assertive outreach made to a specific survivor.

3. **COMPREHENSIVE MENTAL HEALTH AND SUPPORT SERVICES.**
   TRC mental health and support services are structured and evidence-based, including but not limited to: crisis intervention, both individual and group treatment, medication management, substance use disorder treatment, case management/care coordination 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. NOTE: Contracting out to separate off-site programs for different components of TRC services (either mental health, case management, or outreach) can lead to fragmented services and is not the TRC model. All core TRC services must be provided by the TRC team. The only potential exception is for contracted psychiatric evaluation/medication services if needed; in this case, a contracted psychiatrist still participates in some TRC multidisciplinary team meetings and has availability for consultation from other team members.

4. **MULTIDISCIPLINARY TEAM.**
   TRC core staffing consists of a multidisciplinary team that includes but is not limited to: Master's-level mental health clinicians (social workers, marriage and family therapists, licensed professional counselors), at least one psychologist, and access to psychiatric medication services. All mental health clinicians are licensed or registered with the appropriate regulatory board and working toward licensure. Clinical supervision and other support are provided to all 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 TRC team must be employed by the program, except for psychiatrists/psychiatric nurse practitioners 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 TRC 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 collaborate with clients and each other to develop treatment plans in order to achieve positive outcomes for clients, and all clients have access to the full array of TRC services needed to help them achieve their treatment goals. **The TRC Single Point of Contact** helps to coordinate and integrate care across multiple domains: mental health, medical, substance use disorder treatment, 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.). The single point of contact shall be either:
    A. A licensed mental health clinician who provides both evidence-based psychotherapy and clinical case management; OR
    B. 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 victim compensation applications, the filing of police reports if clients choose to do so, assistance obtaining safe housing, health insurance and financial entitlements, linkages to medical care, linkage to vocational training and/or assistance, and 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 use disorders, low initial motivation or high levels of anxiety.

USE OF TRAUMA-INFORMED, EVIDENCE-BASED PRACTICES.
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 use disorders. Evidence-based practices that are considered emerging/promising based on research outcomes may also be used. However, mental health services should not consist only of interventions that have been demonstrated through research to have little or no evidence of their effectiveness.

A. TRC staff are competent and fluent in the use of multiple established, evidence-based practices/therapies for treating PTSD and other impacts of trauma, including but not limited to: motivational interviewing, cognitive behavioral therapy, narrative exposure therapy, prolonged exposure therapy, cognitive processing therapy, eye movement desensitization and reprocessing, and seeking safety. 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.
B. 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 engagement strategies or healing practices. TRCs support the expansion of research conducted to assess and potentially demonstrate the efficacy of culturally-rooted and alternative healing practices.

8. **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.

9. **ACCOUNTABLE SERVICES.**
TRCs provide holistic and accountable services with a base treatment model of 16 sessions. Extensions up to 32 sessions to continue services with a primary focus on trauma can be approved by a clinical supervisor. Extensions beyond 32 sessions require approval by a TRC's clinical steering and utilization group that considers the client's progress in treatment' and remaining need.

10. **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. Leadership, staff and trainees should participate in ongoing training in trauma-informed engagement, culturally responsive care, working with diverse identities and communities, and related practices, in order to foster a culture of equity and lifelong learning / skills-building. Organizational leadership should implement policies, protocols, and practices with trauma-informed principles and language, and work towards the goal of ending systemic inequities.