Impact of Trauma on Health Outcomes and High Risk Behaviors and the UCSF Trauma Recovery Center Model

Alicia Boccellari, Ph.D.

December 9, 2016

Acknowledgements

Slides adapted from:

- San Francisco Department of Public Health Trauma Informed System of Care

- Robert Anda, MD and Vincent Felleti, MD
  Kaiser Permanente and the Centers for Disease Control

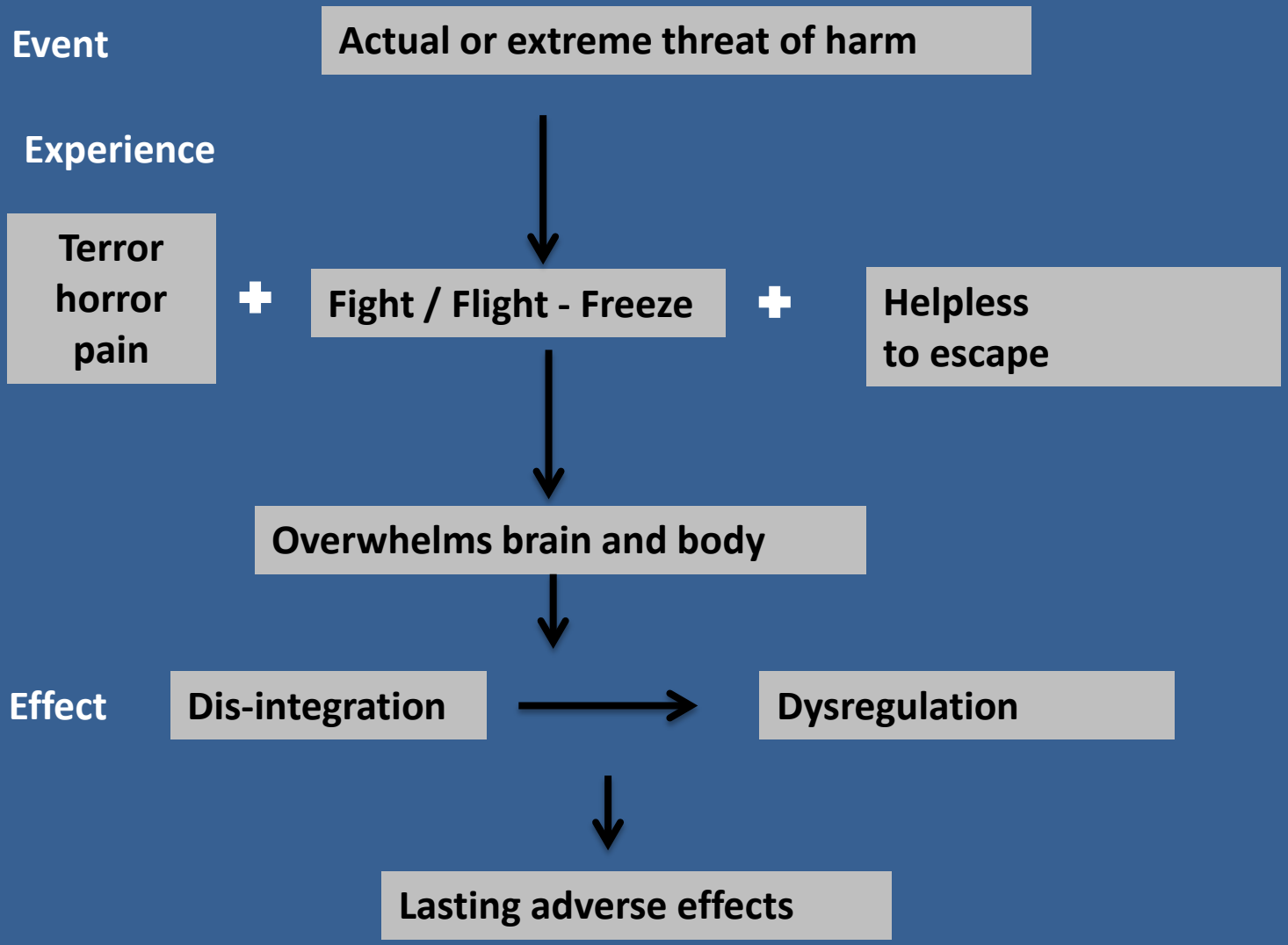
WHAT IS TRAUMA?

What is Trauma?

- “Trauma is not an event in itself but, rather, a response to an experience that is so stressful that it overwhelms an individual’s capacity to cope”.

Susan Craig (2008) Reaching and Teaching Children Who Hurt

Trauma = Event, Experience, & Effect



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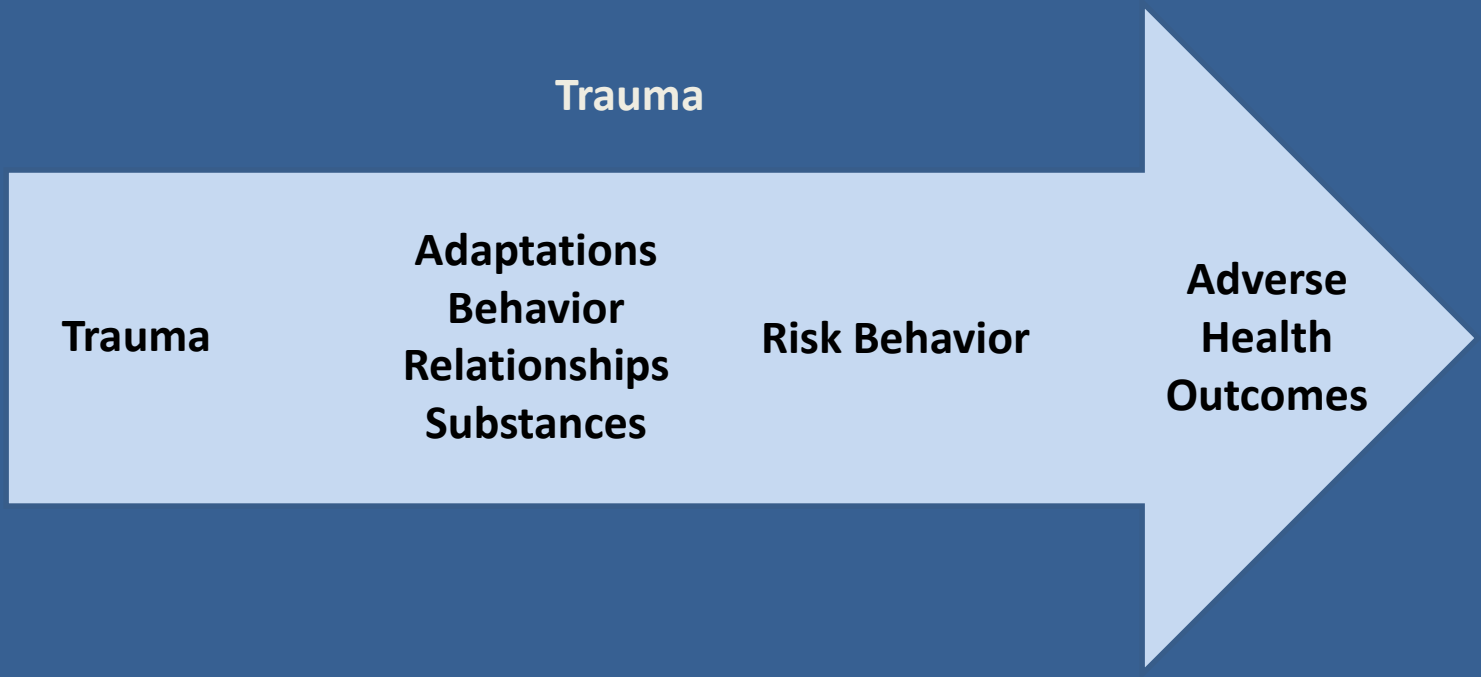
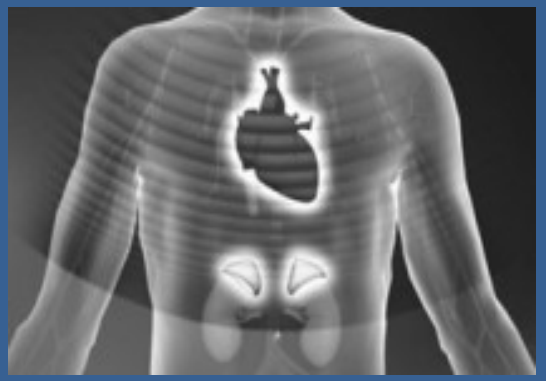
(Herman, 1997; Van der Kolk, 2005; DSM-IV-TR; SAMHSA; Siegel, 2012; Bloom, 2013)


Trauma
Trauma
Adaptations
Behavior
Relationships
Substances
Risk Behavior
Adverse
Health
Outcomes

Chronic Stress Causes "Wear and Tear" on the Body



- Medical illnesses
  - Immune system suppression
  - Inflammatory diseases
  - Obesity
- Adverse effects on brain and cognitive functioning
- From stressors that are chronic, **uncontrollable**, experienced **without support** from caring others
- Can result from stressors like bigotry, poverty, chronic hunger

(Bloom, 2013; McEwen, 2000)

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Stress and Trauma Are Public Health Issues

- Stress linked to 6 leading causes of death
- Heart disease, cancer, lung ailments, accidents, cirrhosis of the liver, and suicide
- Trauma impacts more than just the individual
- Ripple effect to others
- Some communities disproportionately affected:
- Bigotry + Urban Poverty + Trauma = Toxic
- Intergenerational transmission of trauma
- Systemic, preventative approach needed

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Lets talk about Adverse Childhood Experiences ACES

Felitti, Anda, et al. 1998

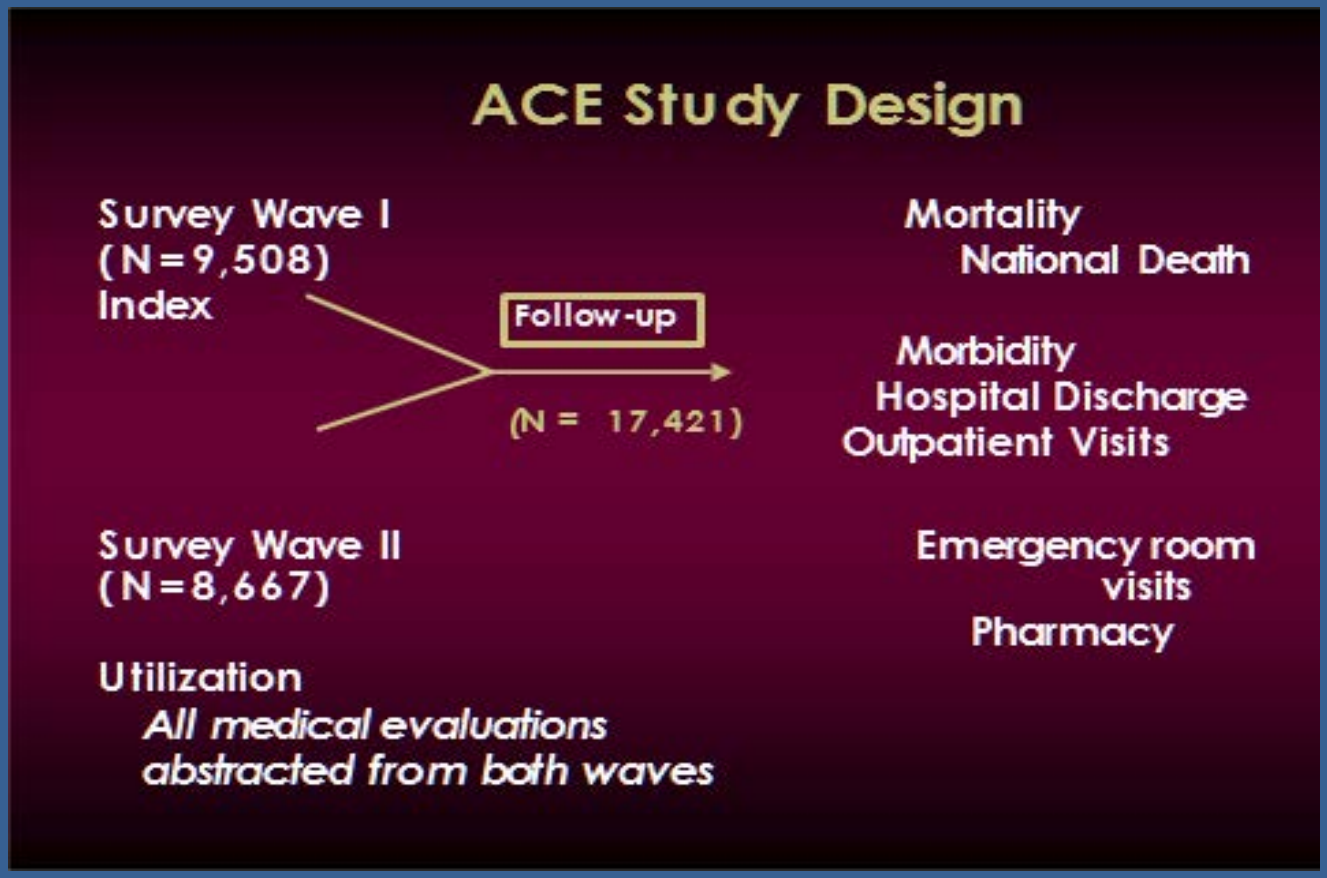
The Adverse Childhood Experiences (ACE) Study

Examines the health and social effects of ACEs throughout the lifespan among 17,421 members of the Kaiser Health Plan in San Diego County

What do we mean by Adverse Childhood Experiences?

-childhood abuse and neglect
-growing up with domestic violence, substance abuse or mental illness in the home, parental discord, crime

Felitti, Anda, et al. 1998


ACE Study Design
Survey Wave I
(N=9,508)
Index
Follow-up
(N = 17,421)
Mortality
National Death
Morbidity
Hospital Discharge
Outpatient Visits
Survey Wave II
(N=8,667)
Emergency room visits
Pharmacy
Utilization
All medical evaluations abstracted from both waves

Adverse Childhood Experiences Are Common

Household dysfunction:

Substance abuse	27%
Parental sep/divorce	23%
Mental illness	17%
Battered mother	13%
Imprisoned household member	6%

Abuse:

Psychological	11%
Physical	28%
Sexual	21%

Neglect:

Emotional	15%
Physical	10%

Adverse Childhood Experiences Score

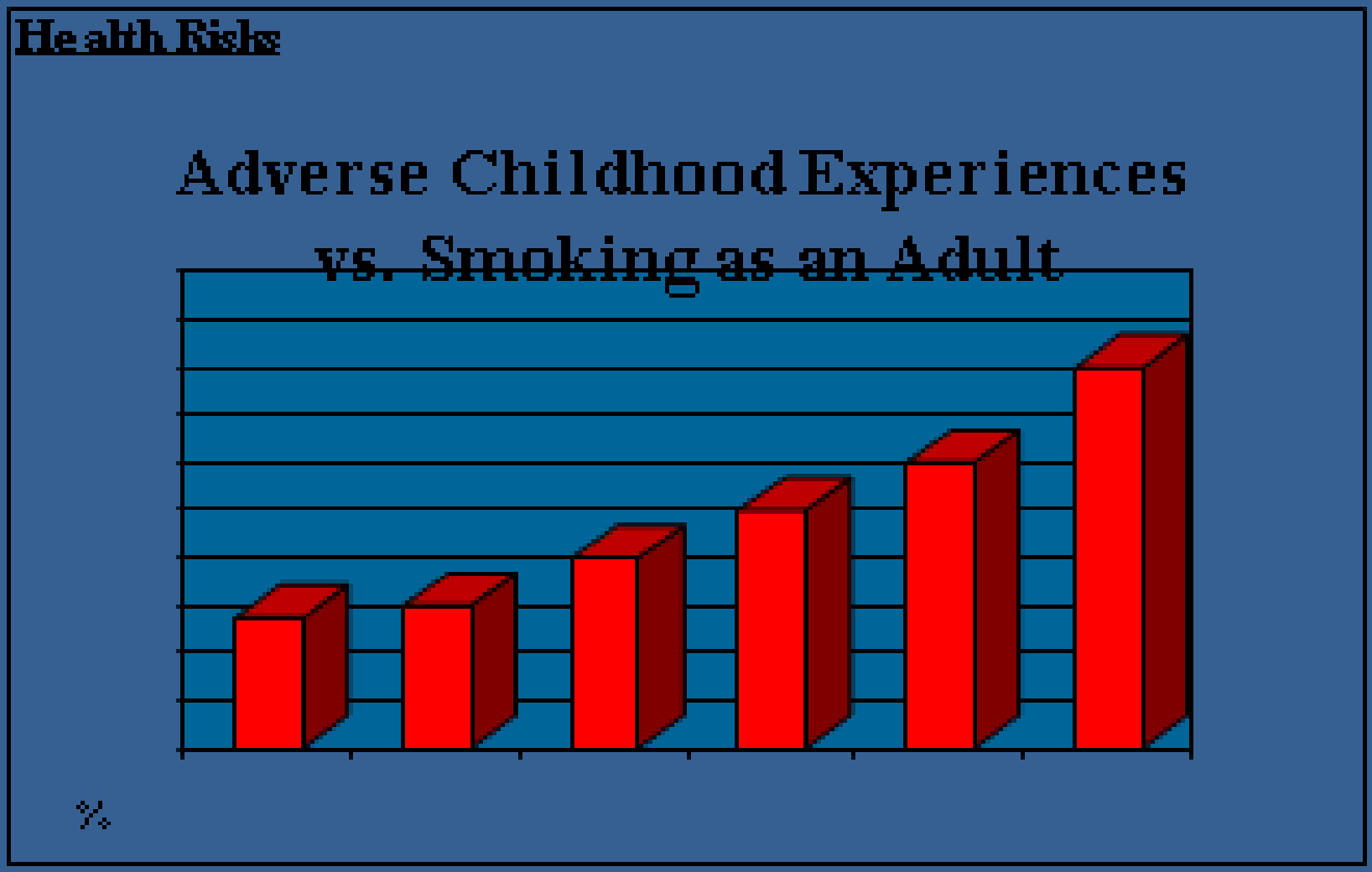
Number of <u>categories</u> (not events) is summed…

ACE Score	*Prevalence*
0	33%
1	25%
2	15%
3	10%
4	6%
5 or more	11%*

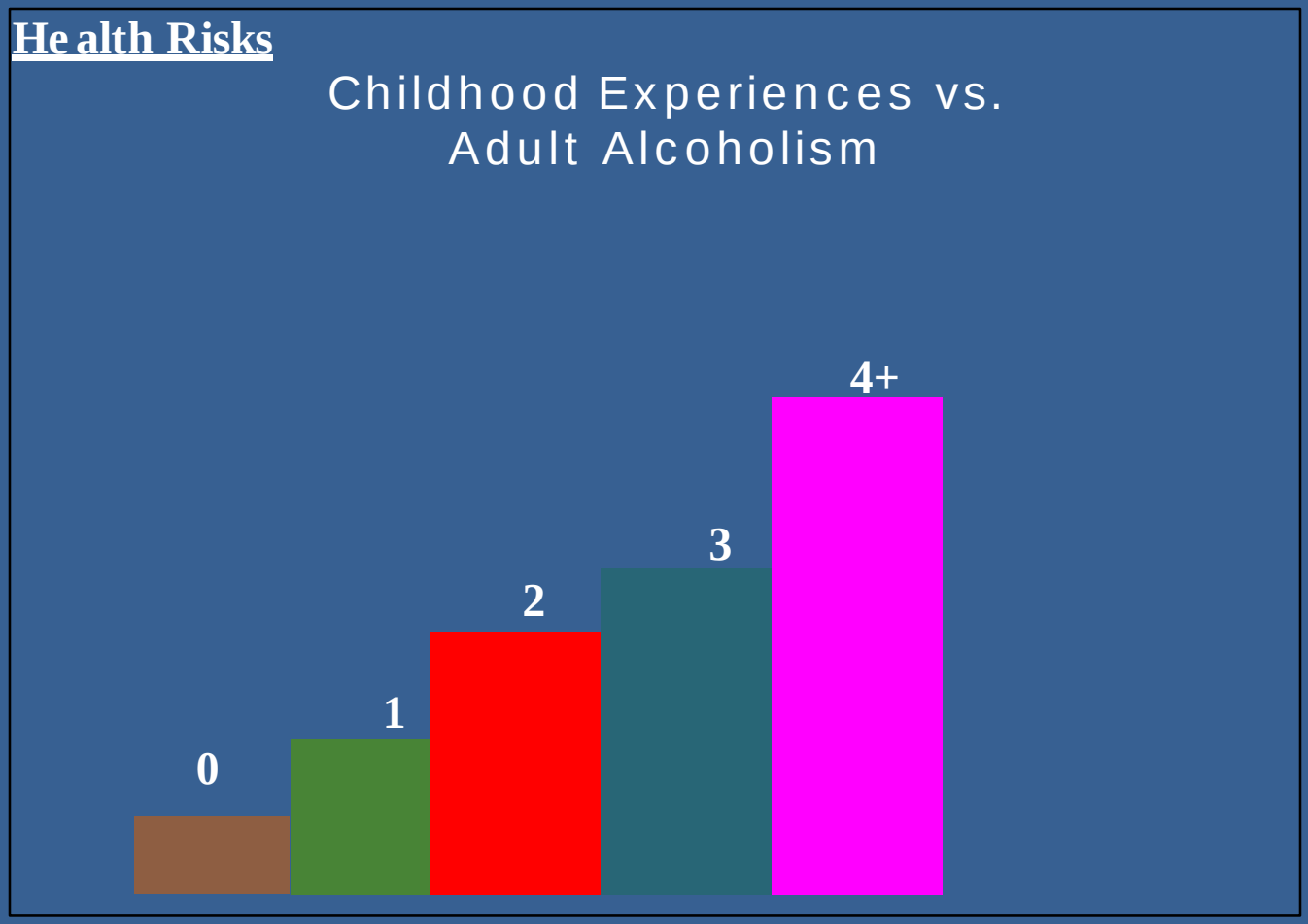
- **Two out of three experienced at least one *category* of ACE.**
- **If any one ACE is present, there is an 87% chance *at least* one other category of ACE is present, and 50% chance of 3 or >.**

* **Women are 50% more likely than men to have a Score >5.**

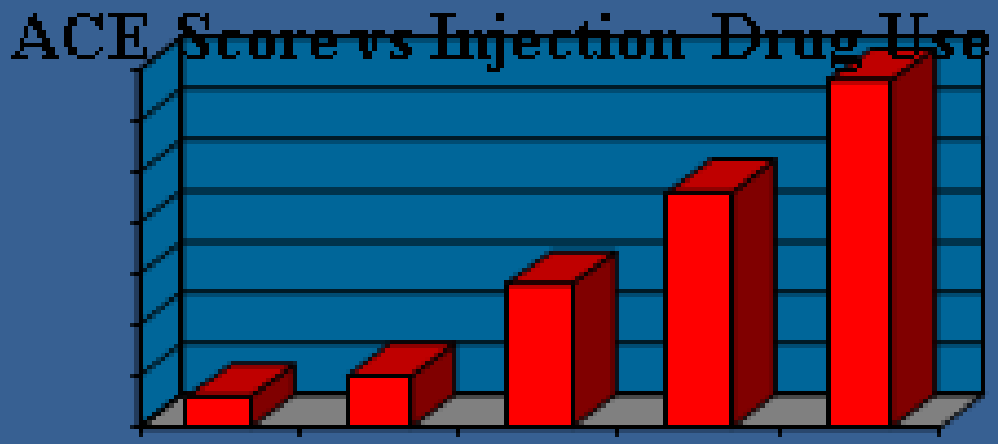
Health Risks



He alth Risks

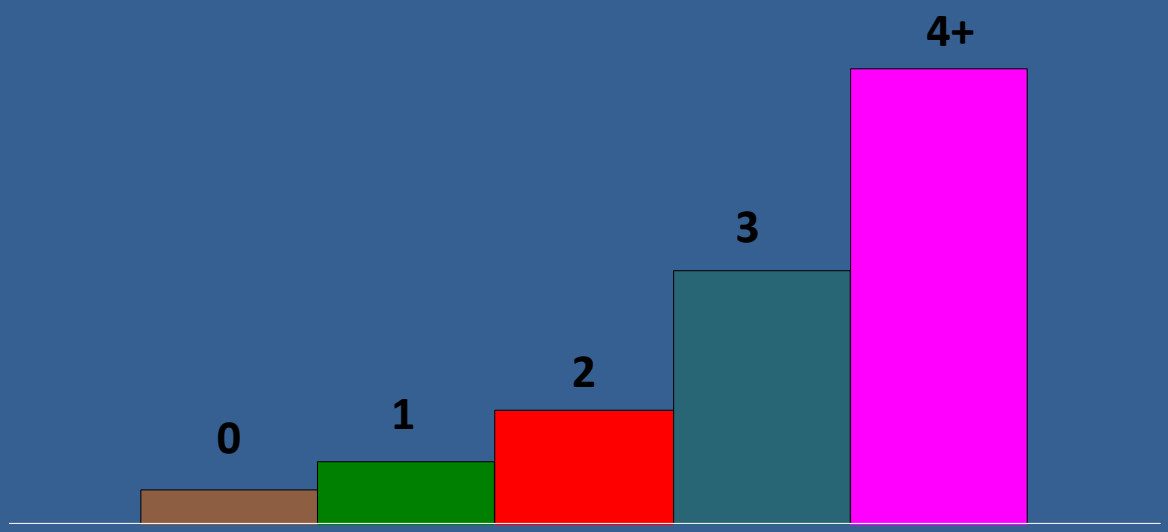


Health risks



Emotional costs

Childhood Experiences Underlie Suicide Attempts



With an ACE Score of 0, the majority of adults have few, if any, risk factors for these diseases.

However, with an ACE Score of 4 or more, the majority of adults have multiple risk factors for these diseases or the diseases themselves.

Adverse Childhood Experiences Rarely Occur in Isolation…

They come in groups.

Synergy

A principle finding of recent work is the extent to which two or more adverse experiences interact so that the risk of a psychological disturbance following is multiplied, often many times over.

(John. Bowlby, The origins of attachment theory, 1988)

Synergistic ACES Increase Complex Adult Psychopathology

- People who experience one ACE are statistically more likely to experience two or more ACES.
- Synergy is the interaction of two or more ACES so that their combined effect is greater than the sum of their individual effects

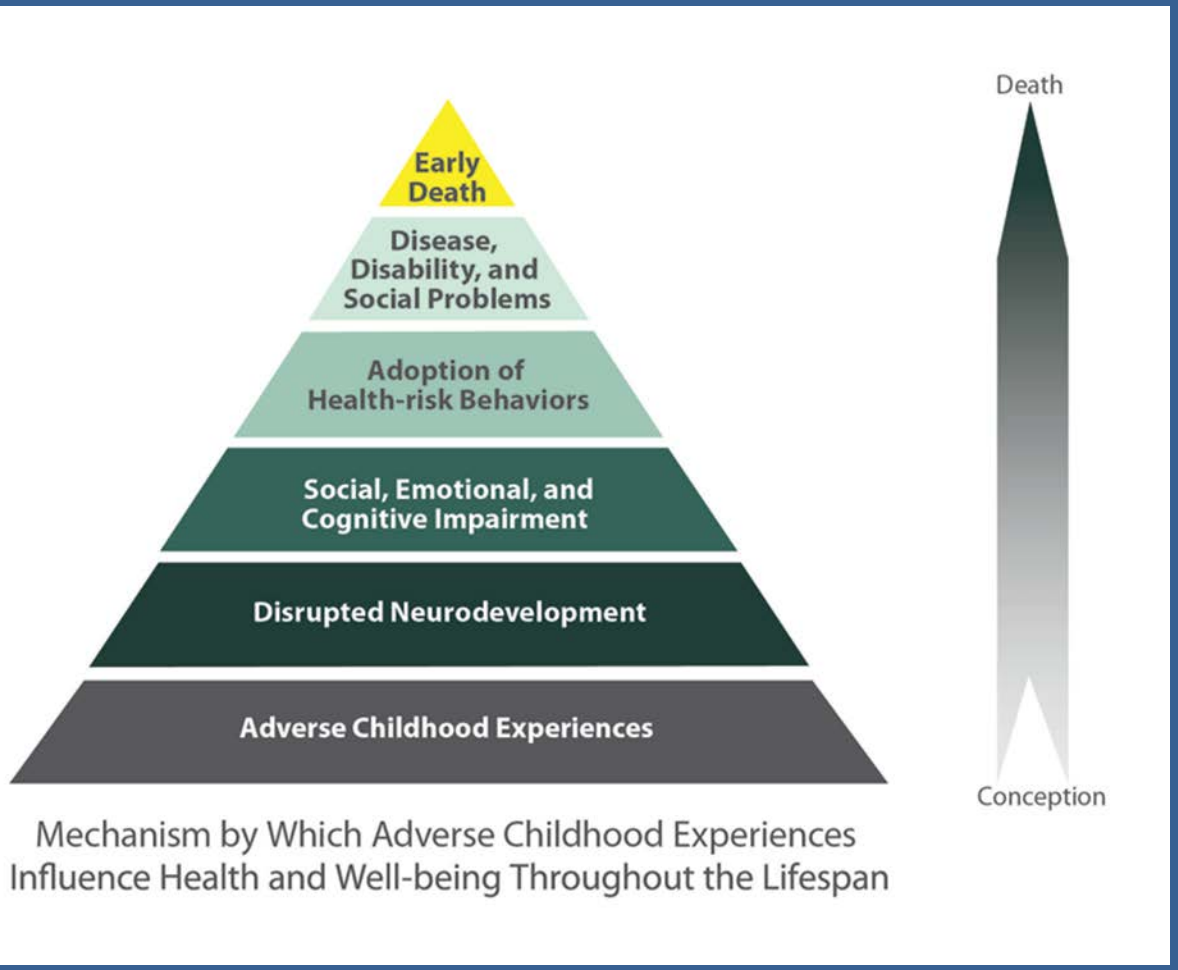
Many chronic diseases in adults are determined decades earlier, in childhood.

Dismissing them as “bad habits” or “self-destructive behavior” comfortably misses their functionality.

The risk factors underlying these adult diseases are helpful short-term coping devices.

Evidence from ACE Study Indicates:

Adverse childhood experiences are the most *basic* cause of health risk behaviors, disease, disability, mortality, and healthcare costs.



Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Challenges faced

- Inability to process information
- Unable to meaningfully distinguish between threatening and non-threatening situations
- Form trusting relationships with adults
- Modulate emotions

Impact on Memory

- Trauma can interfere with ability to encode, process and store information

- Trauma causes problems in both implicit (unconscious) and explicit (conscious) storage systems which thereby interferes with recall and recognition.

Why does trauma impact health?

- Stress, inflammation, epigenetic changes and neuroendocrine
- Psychological and social factors
- Adaptive behaviors to trauma that become maladaptive

- Machtinger et al. Womens' Health Issues 25- 3 (2015) 193-197

How does trauma impact behavior

- Inappropriate behaviors
- Failure to understand directions
- "Overreacting" to comments or facial expressions.
- Hypervigilence
- Aggression
- Failures to connect cause and effect
- Perfectionism
- Depression
- Anxiety
- Self-destructive behaviors.
- Fear and Vulnerability

Thinking Brain and Survival Brain

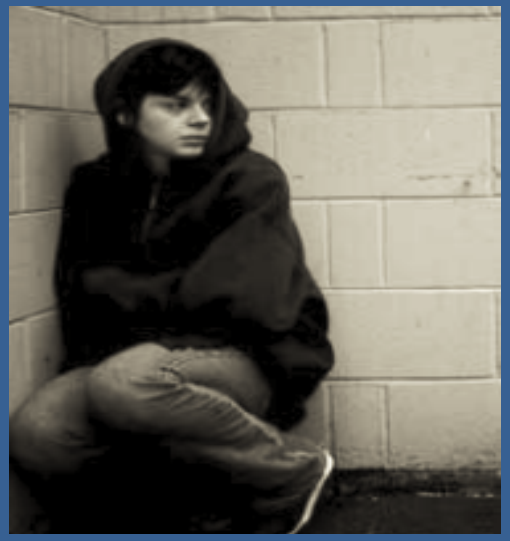
- **Thinking Brain = Rider**
  Makes informed, rational decisions
- **Survival Brain = Horse**
  Protective instincts based on feelings
- **When triggered, the rider falls off the horse**

(Van der Kolk)(Ford, 2009)

Reframing Risk Behaviors

Tension reduction behaviors

- Drugs and alcohol
- Risk-taking behavior
- Self-injurious behavior
- Aggression
- Problematic sexual behaviors (where any connection feels better than abandonment and isolation)



(from training on Integrated Treatment for Complex Trauma by John Briere, 2009)
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Dysregulation

- Dysregulation is difficulty controlling the influence of stress arousal on how we think, feel, behave and interact with others.

- This can happen when we are “triggered” into Survival Brain.

Prevalence of the dual diagnosis of PTSD and Substance Abuse

- Co-occurring diagnosis of PTSD and Substance Abuse in addiction treatment facilities - 12% - 34%
- Women in substance treatment – 30% - 59%
- Men in substance treatment – 11% - 38%

Typically PTSD symptoms preceded the onset of substance abuse.

Najavits, L. M., (2002) *Seeking Safety A Treatment Manual for PTSD and Substance Abuse.* New York: Guilford

Links Between PTSD and Substance Abuse

- Two main themes of both disorders are secrecy and control
- Each of the disorders makes the other more likely
- PTSD symptoms widely reported to become worse with initial abstinence
- Both situations produce a profound need to be in an altered state

Najavits, L. M., (2002) *Seeking Safety A Treatment Manual for PTSD and Substance Abuse.* New York: Guilford

Some trauma findings

- Being abused or neglected as a child increases the likelihood of arrest as a juvenile by 59%.

  (Widom, 1995)

- Arrest rates of trauma-exposed youth are up to 8 times higher than community samples of same-age peers.

  (Saigh et al, 1999; Saltzman et al, 2001)

- Childhood trauma is believed to have long term impact in the frontal, temporal and parietal regions of the brain and how information is processed.

  (Cook et al., 2009)

In a study of 77 women with current PTSD and substance dependence most of the treatment focused on substance abuse.

- 80% would choose to treat PTSD (either combined with substance abuse or alone)

- Fewer than 20% would choose substance abuse treatment alone

Najavits, L. M., (2002) *Seeking Safety A Treatment Manual for PTSD and Substance Abuse.* New York: Guilford

“As far back as I can remember someone was abusing me: my brother, my father, my distant mother. By the time I was 12, I was falling into abusive relationships with men, many who took advantage of a young desperate girl. I had begun to treat myself as I had been treated, as unimportant outside of giving people what they wanted from me. To cope with the memories and repeated traumas, I was using drugs supplied by people who professed to love me.”

“The more I use, the more I won’t feel anything. The pain is so bad you just want to die. There is no other way out. If you talk about it, it will hurt too much. So instead, keep it a secret. No one will know.”

Najavits, L. M., (2002) *Seeking Safety A Treatment Manual for PTSD and Substance Abuse.* New York: Guilford

Disruptive behavior

- Is a way of communicating
- Has meaning
- What need is this communicating?
- How can we meet this need?
- What is the healthy/caring intention behind this behavior?
- Ask yourself- what is happening here?

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Definition of Trauma Informed Care

- Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.

-National Center for Trauma Informed Care (NCTIC, www.samsha.gov/nctic, 2013)

Trauma-Informed Approach

1. Realizes the widespread impact of trauma and understands potential paths for recovery;

2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;

3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and

4. Seeks to actively resist *re-traumatization*.

SAMSHA

Context

- Trauma provides the context for behaviors

- Move from:

  - What is wrong with you?
  - What has happened to you?

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SAMHSA's Six Key Principles of a Trauma-Informed Approach

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, Historical, and Gender Issues

Common mistakes

- In intervening with people who are responding due to their trauma we tend to:
    - Not pay attention to the context of trauma
    - Intervene too late
    - Intervene with a mismatched strategy
    - Not pay attention to how we are reacting (we have triggers too)

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Relationship Building Tool:

Connect, then Re-Direct (Siegel)

- **P**artnership “Let’s work together”
- **E**mpathy “That sounds frustrating”
- **A**pology “I’m sorry that happened”
- **R**espect “You have gone through a lot”
- **L**egitimation “It makes sense that you feel this way”
- **S**upport “Let’s see what we can do”

(American Academy on Communication in Health)

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Removing Barriers to Care and Transforming Services for Survivors of Violent Crime

Alicia Boccellari, Ph.D.

December 9, 2016

Vanessa – What Happened?

- 50 year old African American woman
- Mother of 4, grandmother of 6
- Works full time as a security guard, PT hair stylist
- Drive by shooting:
  - Vanessa's 31 year old daughter was killed
  - 18 year old son and 3 year old grandson seriously injured

Vanessa – What Happened?

Additionally

- Vanessa's son-in-law had died 6 months earlier
- Vanessa needs to quit her jobs to care for her expanded family of 3 children and 6 grandchildren

National Institute of Justice Study: Data From California and 5 Other States

- Only 20% of crime victims were aware of victim's restitution funds.
- Only 4% of victims' needs were addressed by the current victim services system.
- Ethnic and racial minorities had the highest amount of unmet needs.

Californians for Safety and Justice Study - 2013

- 1 in 5 Californians have been a victim of crime in the last five years. Half of these were a victim of a **violent crime.**
- 2 in 3 of these crime victims have been victims of multiple crime in the past five years. **African Americans and Latinos are more likely to have been victims of three or more crimes in the past five years.**
- Victims of violent crime are more likely to be low-income, young (especially under 30), and Latino or African American.
- 2 in 3 crime victims report anxiety, stress and difficulty with sleeping, relationships or work. Half of these reported that it took more than six months to recover from these experiences.
- 4 of 5 services available to crime victims (including assistance with accessing victims' compensation) – were unknown to the majority of victims. **Of those who had used the services, almost 50% have trouble accessing services.**

Verification of VCP Claims Eligibility

ORGANIZATION	INFORMATION NEEDED
Law enforcement	Crime reports
Hospitals	Verification that services provided to victims were crime-related and known reimbursement sources
Physicians	Verification that services provided to victims were crime-related
Mental health providers	Verification that services provided to victims were necessary and crime-related
Employers	Employment dates and salary for lost wage requests
Employment Development Department	Unemployment or disability insurance payments
Department of Motor Vehicles	Insurance coverage in auto-involved crimes
Franchise Tax Board	Tax returns, if victim requests compensation for lost wages
Department of Health Services	Medi-Cal assistance
Department of Social Services	Verification of public assistance received
A contract bill review service	Review and reduction of medical bills to allowable rates

Governor Schwarzenegger – California Performance Review - 2005

Time to Process VCP Applications

TRC Data N: 541 crime victims

- Average time between receipt of application and hearing date:

  109 days or about 3 months

- For denied claims:

  203 days or about 6 months

California Bureau of Audit

- 30% of applications take more than 3 months to process
- 51% of bills submitted take longer than 3 months to be paid
- 20% take more than 6 months to be paid

Vanessa – The Aftermath of Violence

- Flashbacks, nightmares, insomnia
- Panic attacks, fainting spells
- Fear of driving her car
- Loss of 35 lbs.
- Increase in High Blood Pressure, worsening of Diabetes
- Afraid to have her children/grandchildren leave the house
- Dealing with her “overwhelming” grief as well as needing to be “strong” for her family as her children/grandchildren grieved
- Suicidal ideation but a commitment to live for her children/grandchildren

Economic Consequences of Violence

- Untreated trauma results in greater likelihood of engaging in high risk health behaviors: smoking, alcohol, substance use, poor eating & exercise habits
- Victims of violence access health care 2 to 2.5 times more frequently than those without a history of violence
- Cost to the Health Care System in the U.S. $333 Billion to $750 Billion annually
- 17% - 37% of the total health care dollar is spent on the chronic medical consequences of untreated trauma

Academy on Violence and Abuse, 2009

Economic Consequences of Violence

Annual costs to victims due to medical expenses, lost wages, lost property

$17 Billion

Annual Costs to employers, insurers, government programs due to lost productivity, lost revenues, reliance on government entitlements

$330 Billion

NIJ Study, 2007

Traditional Psychotherapy for Trauma Victims

- Office-based, no home visits
- No practical assistance or coordination with other service systems
- 50-minute hour
- Feeling, insight, and disclosure-oriented

Vision:

Our vision is a community that heals the wounds of violence and embraces hope for a non-violent, compassionate world.

Vision: A New Model of Care
Integrated Trauma Recovery Services

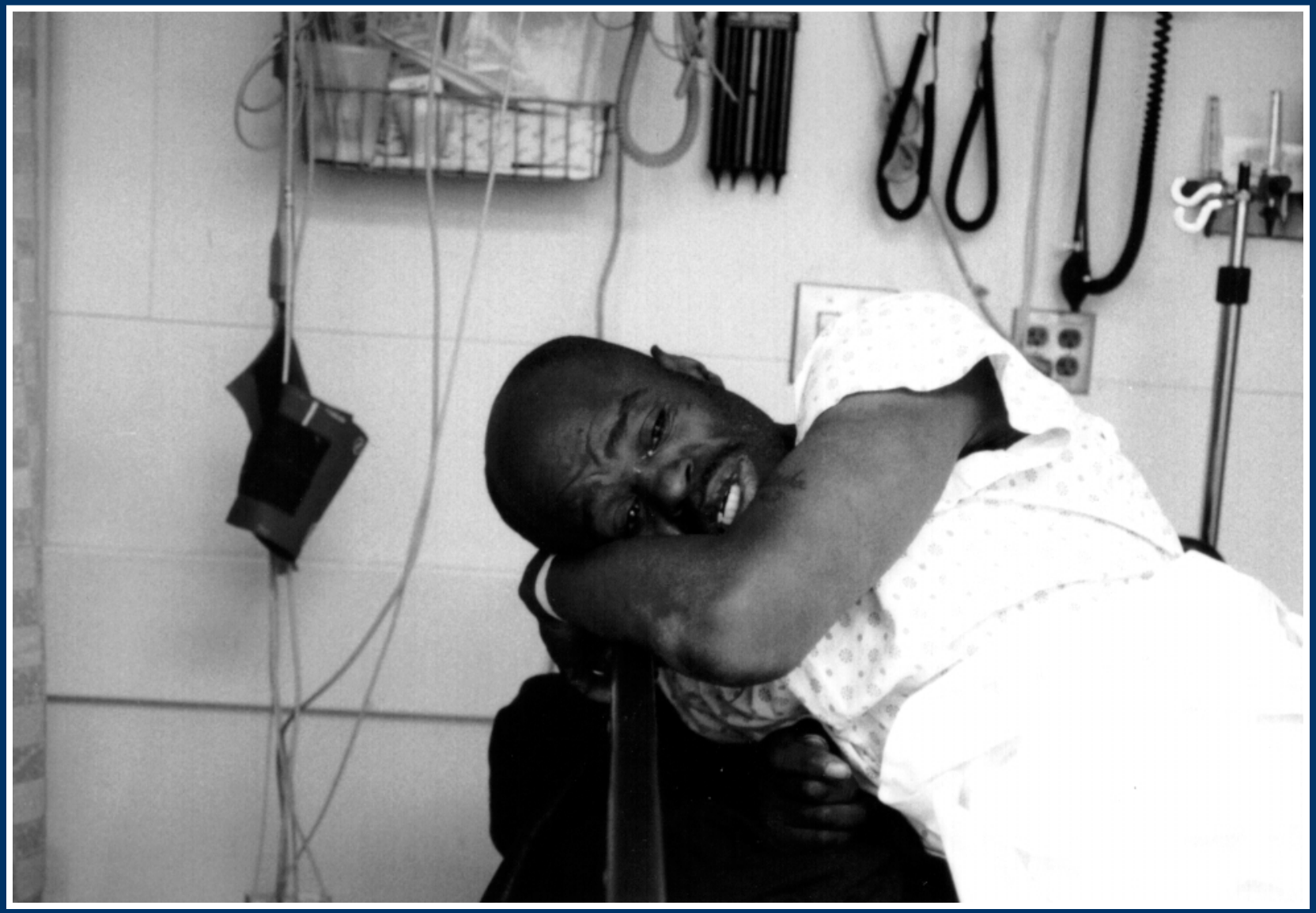
- Emphasis upon assertive tracking, outreach, and engagement into services; AND
- Clinical case management to address all basic needs (medical, legal, financial, housing, services etc.); AND
- Evidence-based psychotherapy to target psychiatric distress and increase interpersonal safety

Engagement, Tracking & Outreach

- Many victims feel ashamed about entering therapy and/or avoid trauma reminders.
- We work with them on what is most important to them first until rapport is built.
- We will see them at the hospital, at their home, or in their community (including homeless encampments, shelters, etc.).

Goals of the Trauma Recovery Center

- Help to streamline the eligibility process for victims
- To identify additional barriers to accessing services
- To develop a comprehensive well-coordinated model of care that includes mental health, physical health, psychosocial services and legal advocacy and to do so in a manner which increases access to services.
- To provide these services in a culturally competent and sensitive manner.
- To evaluate this model to insure it is both treatment effective and cost effective.



from “Faces of Trauma” project, photographs by Oliver Saria

from “Faces of Trauma” project, photographs by Oliver Saria

Comprehensive Intensive Clinical Case Management

- Victim Compensation benefits
- Other financial entitlements (SDI, SSI, GA, Medi-Cal)
- Arrangement for stable, safe housing
- Linkages with medical care (primary and specialty care)
- Accompany patients to appointments
- Liaison with community-based agencies
- Liaison with District Attorney's office and San Francisco
- Police Department and legal advocacy
- Linkages with religious community
- Assistance in return to work

Outcomes

- An increase in victims of crime being able to access treatment, as measured by the number of approved victim witness applications and the number of treatment sessions attended
- A decrease in psychological and medical symptoms
- An increase in functional abilities (i.e. work, parenting, daily living activities)
- Minimization of long-term disability
- An overall improvement in quality of life
- Increased cooperation with law enforcement
- Increased linkages to other entitlements
- Patient satisfaction with services provided

Vanessa - Interventions

- Home visits by TRC
- Mental health services for Vanessa (trauma-focused therapy, support group, medication, grounding techniques)
- Mental health services for her children & grandchildren
- Help in returning her children/grandchildren to school
- Connection to child care assistance
- Assistance with meals
- Filed VCP application
- Filed State Disability
- Obtained Medi-Cal for the family
- Connection to primary care
- Section 8 housing
- Legal advocacy with SF Police & DA
- Car impounded as evidence - Donation of SUV
- Fund raising for family-donation of clothes, gifts for children/grandchildren
- Legal help to get custody of all the grandchildren
- Reconnection to Vanessa's church

Vanessa – 1 year later

- Decrease in flashbacks, nightmares, improved sleep. No panic attacks.
- Able to leave house, drive her car
- Better managing High Blood Pressure & Diabetes
- TRC helped move family to new housing outside of SF
- Safe community, big back yard, children can walk to school
- Vanessa has returned to work as a hair stylist
- “I can function again. I went to TRC crying out for help, and their doors were open. They helped me find the strength to go on.”

from “Faces of Trauma” project, photographs by Oliver Saria

Who provides these services?

- A multidisciplinary, culturally diverse staff of:
  - social workers
  - psychologists
  - psychiatrists
  - nurse practitioners / physician assistants
  - a research team
  - psychology and social work interns
  - medical students
- Language capacity in English, Spanish, Portuguese, Vietnamese, Japanese, Hindi, Urdu, Russian
- International Institute Partner: Amharic, Arabic, Mongolian, Tigre, Tigringa

Multi-lingual Clinical Capacity

Cantonese **Burmese** **Arabic**

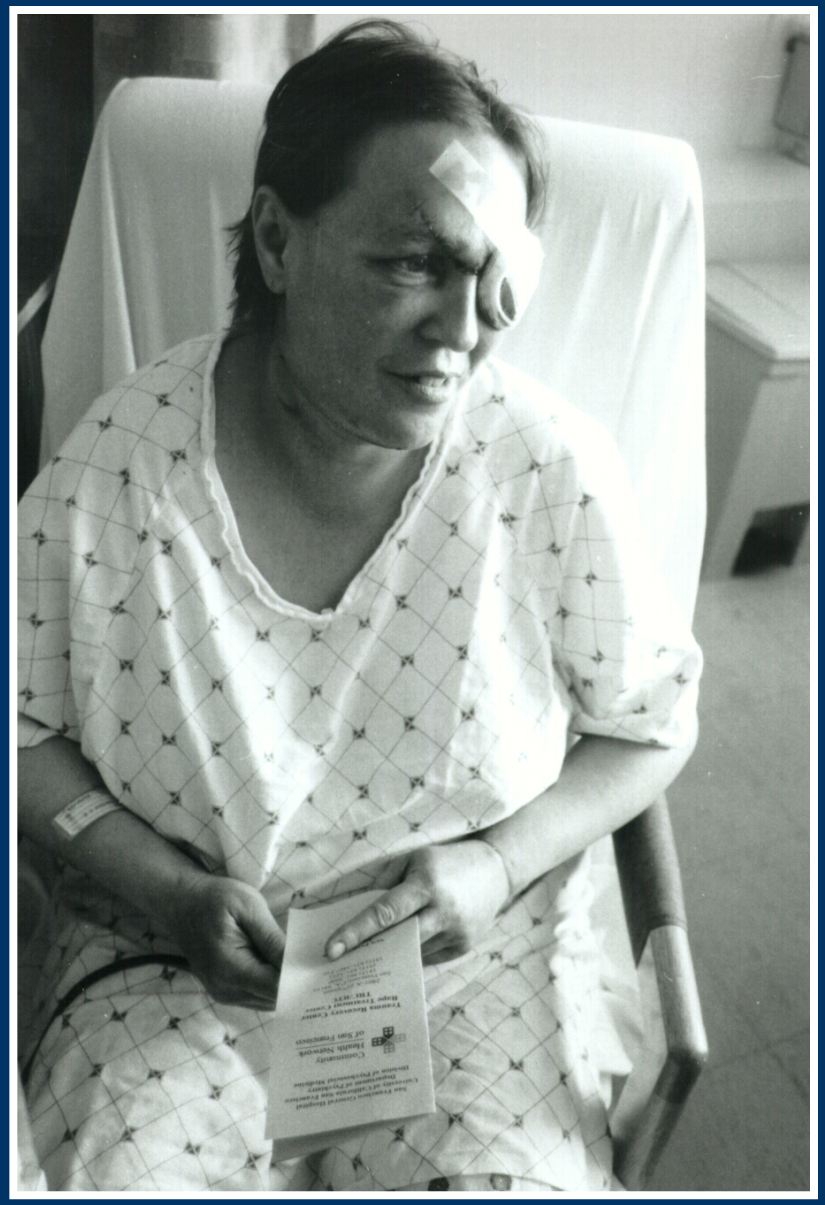
Russian **Amharic**

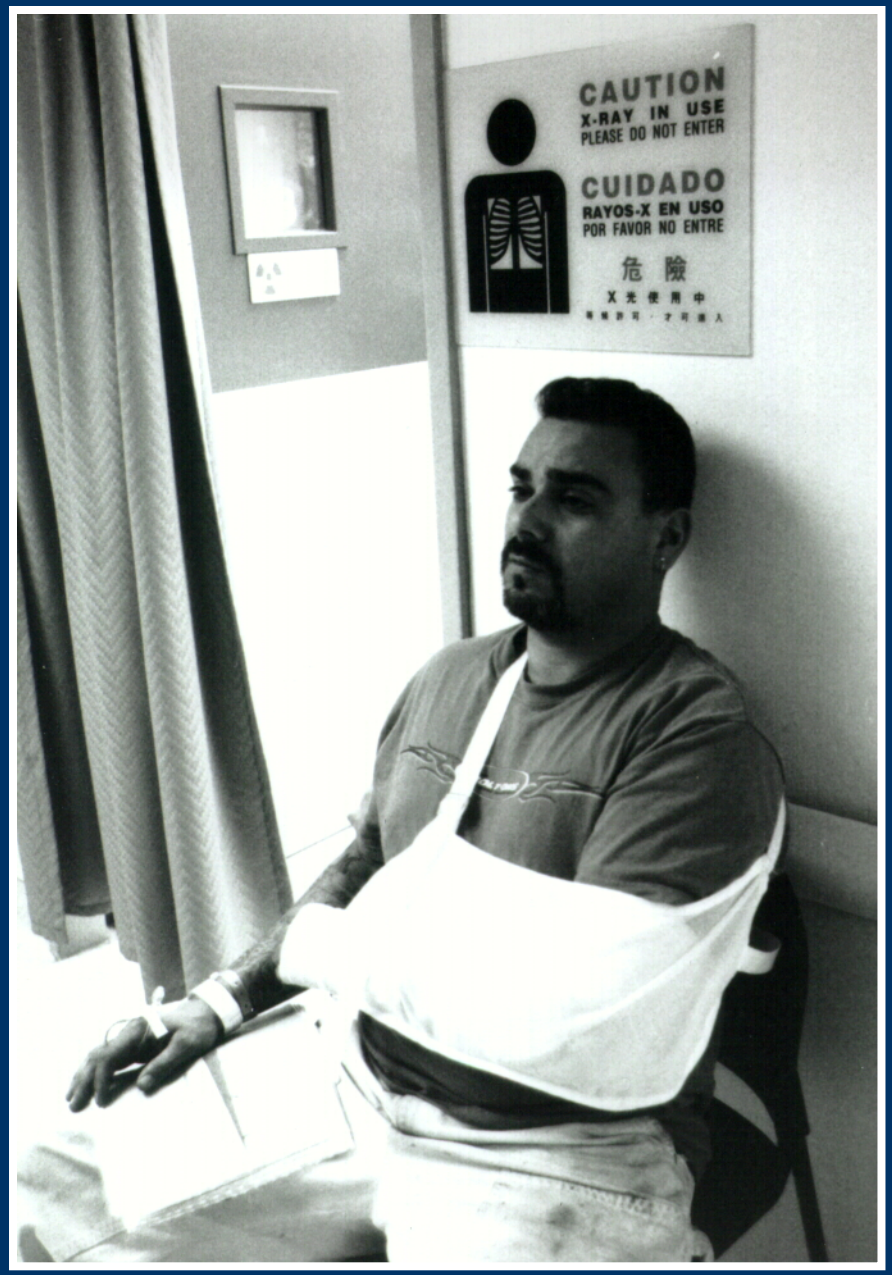
Spanish Mandarin

Vietnamese

Portuguese Mongolian

Tigrinya





from “Faces of Trauma” project, photographs by Oliver Saria

Mental Health Services

- Crisis debriefing, crisis intervention
- Individual trauma focused psychotherapy (16 sessions, with extensions possible)
- Psycho-education and support
- Medication management
- Family work
- Groups (Women's Self Care, Domestic Violence, Seeking Safety, Mothers of Homicide Victims)
- Evidenced-based treatment: CBT, DBT, CPT, Harm Reduction, Motivational Interviewing
- Skill training (relaxation, containment, "seeking safety" skills)
- "Making positive meaning" of the trauma
- Community Debriefings

from “Faces of Trauma” project, photographs by Oliver Saria

Trauma History (N = 541)

Childhood physical abuse	40%
Childhood sexual abuse	24%
Average total types of trauma	4.6

Psychosocial characteristics (N = 541)

Alcohol abuse	71%
Any weekly drug use	58%
Polysubstances	24%
Ever been arrested	81%
Currently on probation or parole	25%

Trauma Symptoms

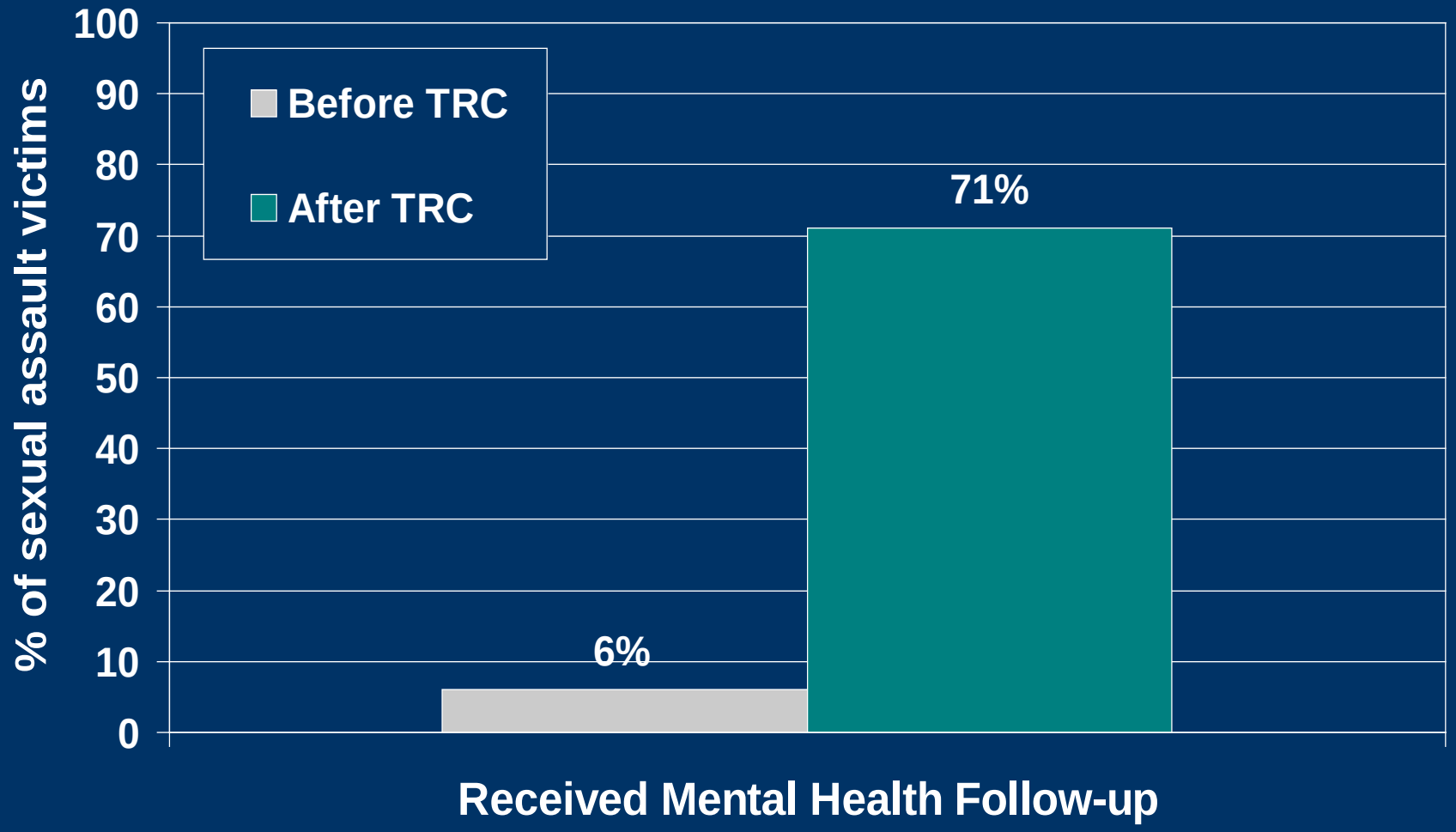
(reported by 402 randomized trial participants at baseline)

Intrusive memories	83%
"On guard" (hypervigilant)	82%
Difficulty concentrating	77%
Easily startled	70%
Insomnia	70%
Avoiding things that remind them of the trauma	60%
Flashbacks	52%
Nightmares	48%

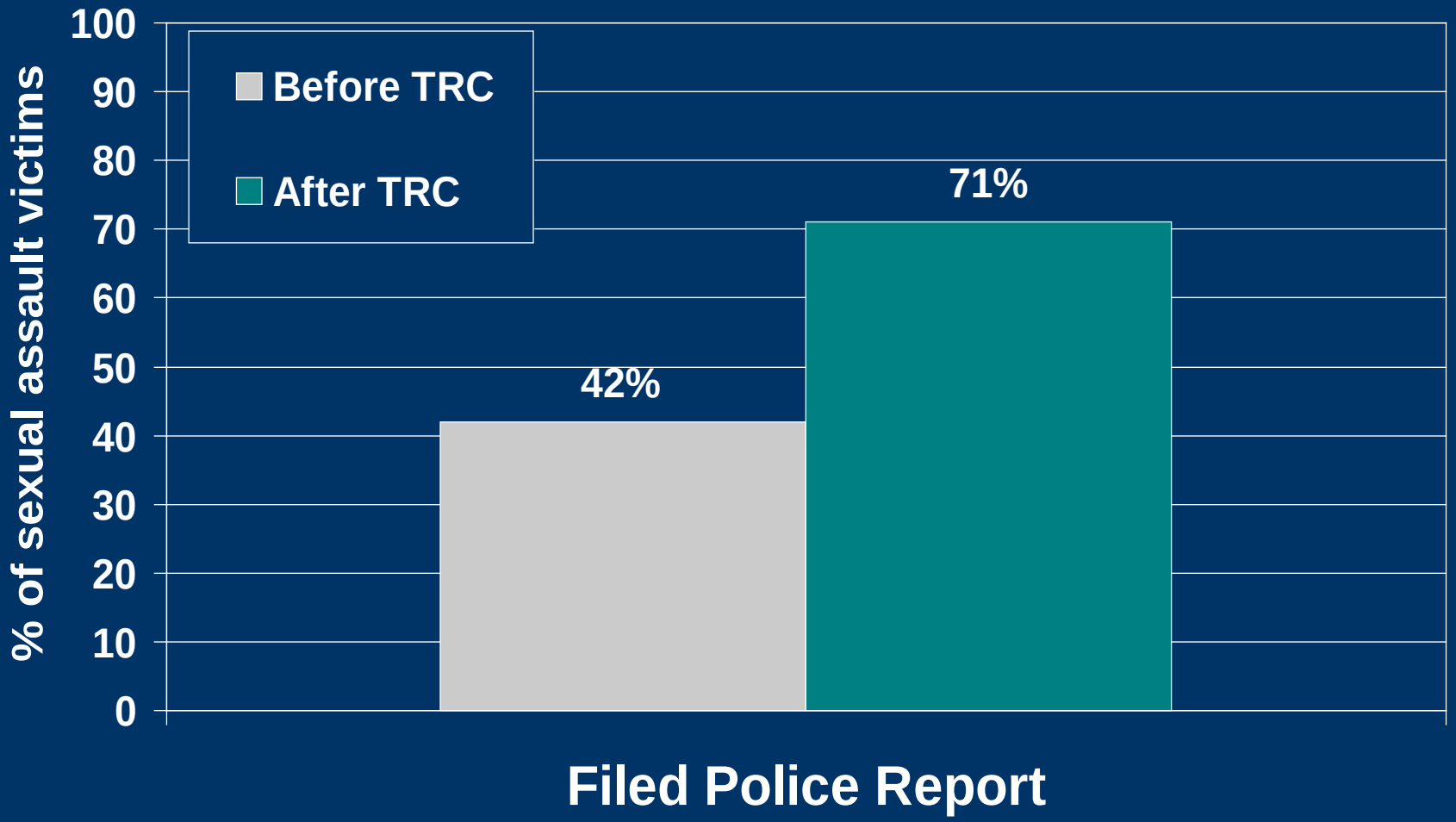
Psychosocial Needs
(reported at baseline)

- **65%** do not have health insurance
- **53%** do not have money for medication
- **52%** do not have enough money to cover rent
- **83%** want help finding safer housing
- **74%** want help finding a job or returning to work
- **70%** are interested in mental health services
- **45%** are interested in receiving substance abuse services

Improvement in Mental Health Services to Sexual Assault Victims



Increased Cooperation with Law Enforcement for Victims of Sexual Assault: Filing Police Reports



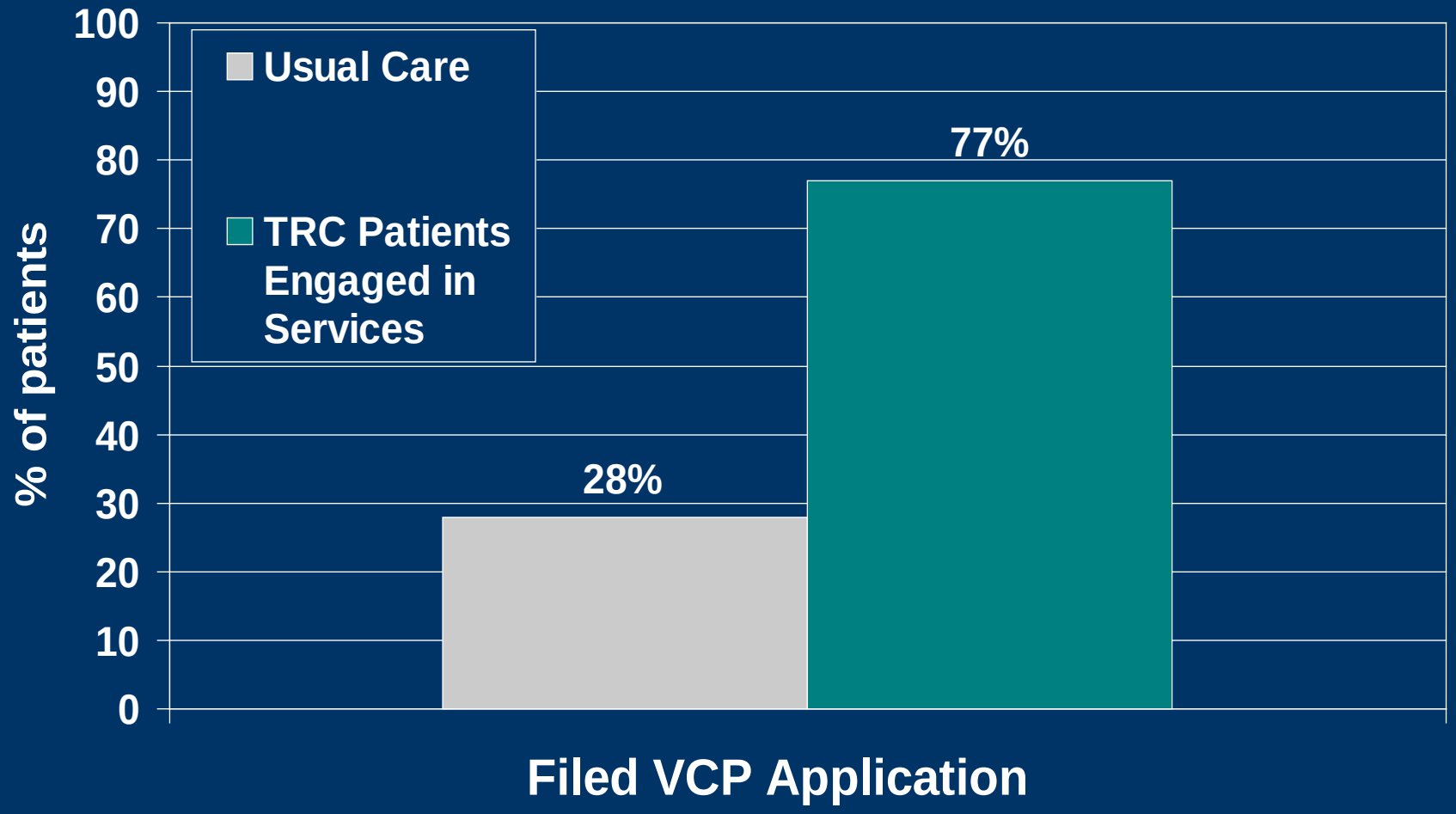
from “Faces of Trauma” project, photographs by Oliver Saria

System Barriers to Accessing Victim Compensation Funds

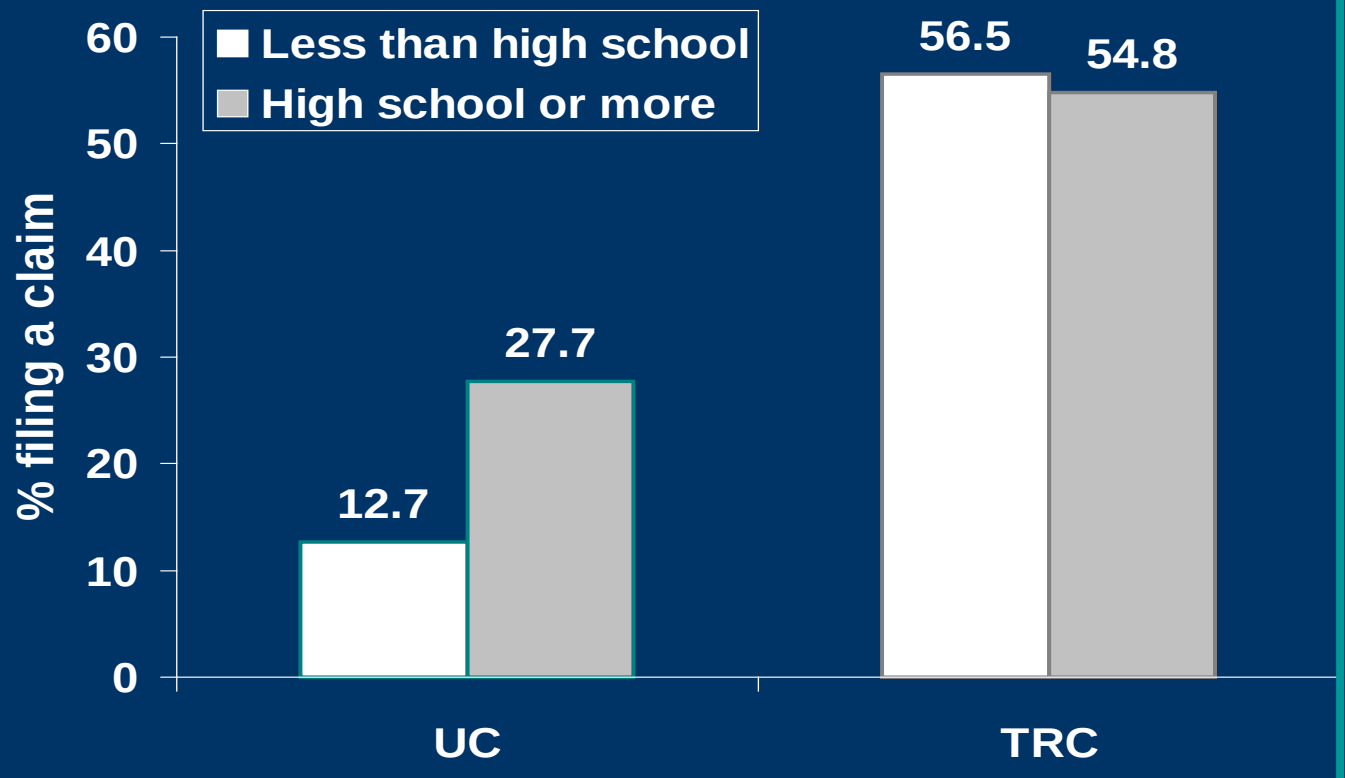
Without extensive outreach:

- Only a small number of victims file a victim compensation application.
- Disadvantaged and young victims are less likely to file applications.
- Only a small number of victims receive mental health services.

VCP Applications Filed: TRC Patients Versus Usual Care Patients

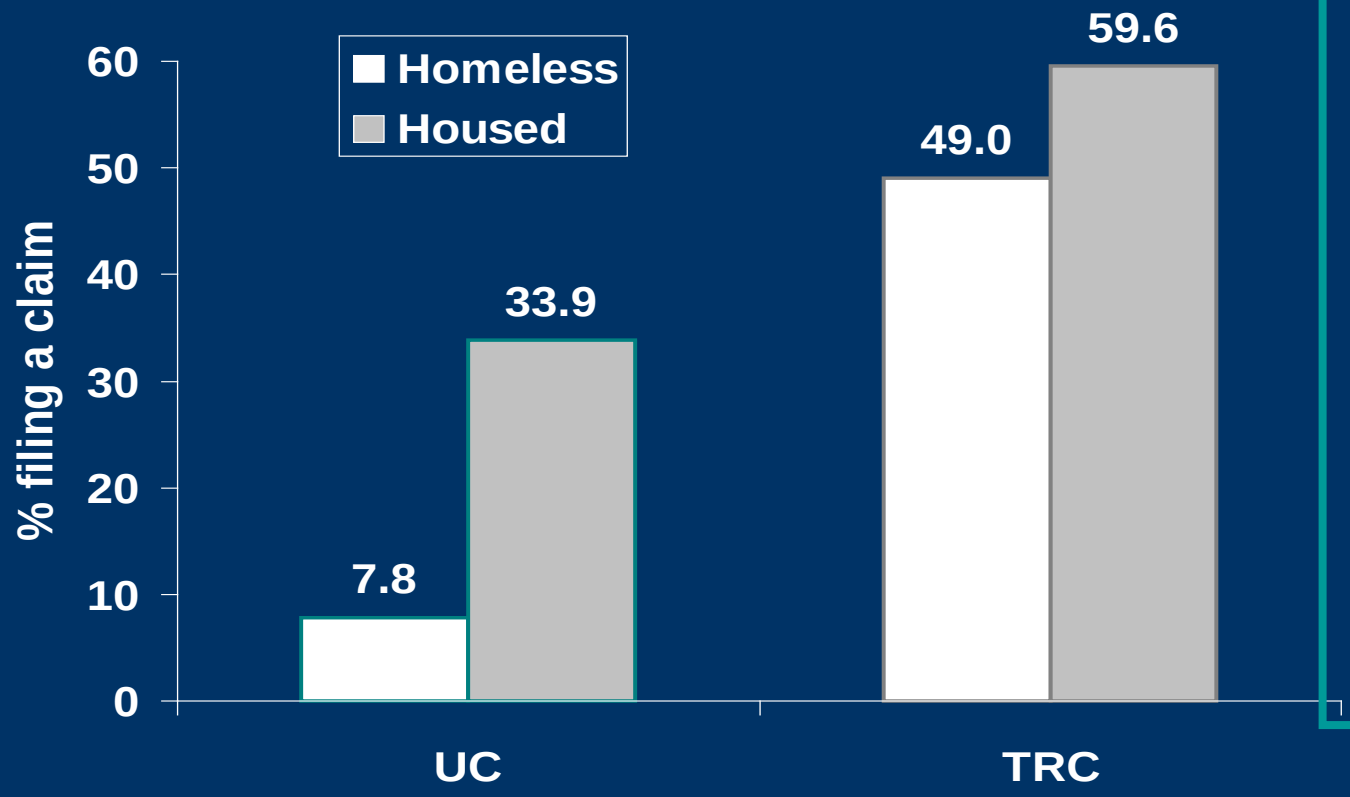


Reductions in VCP Application Disparities: Education



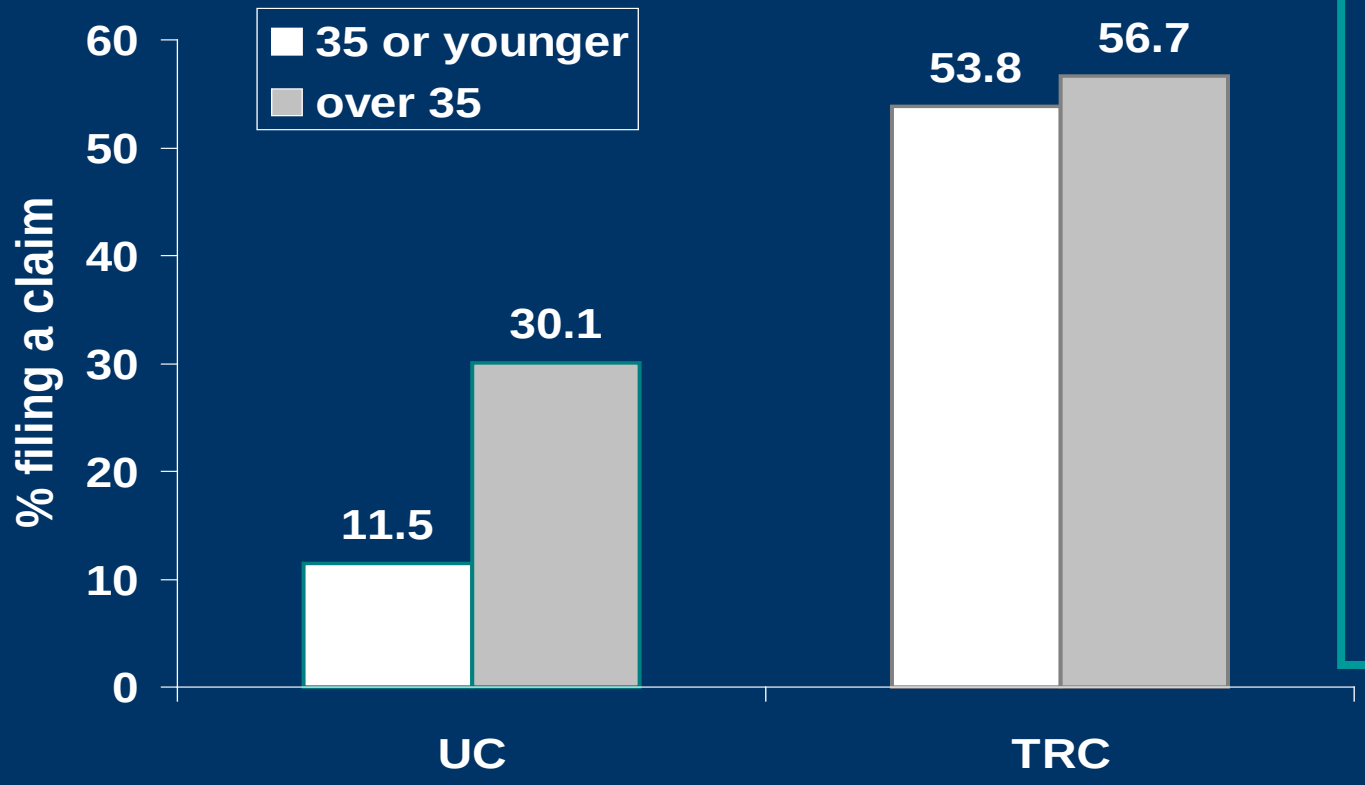
Victims with less education were less likely to file with usual care. TRC services eliminated this education disparity.

Reductions in VCP Application Disparities: Homelessness



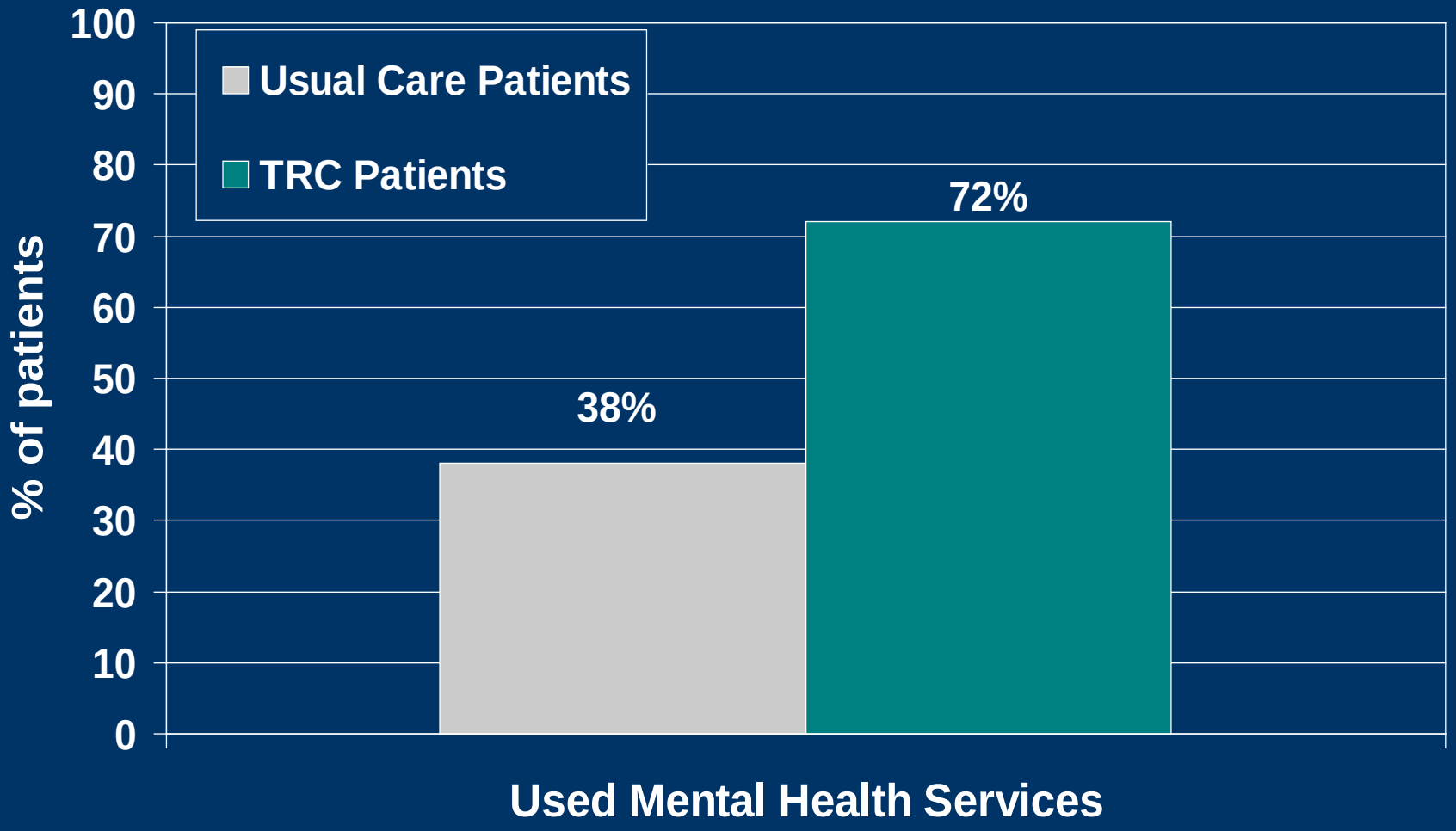
Homeless victims were less likely to file with usual care. TRC services eliminated this disparity.

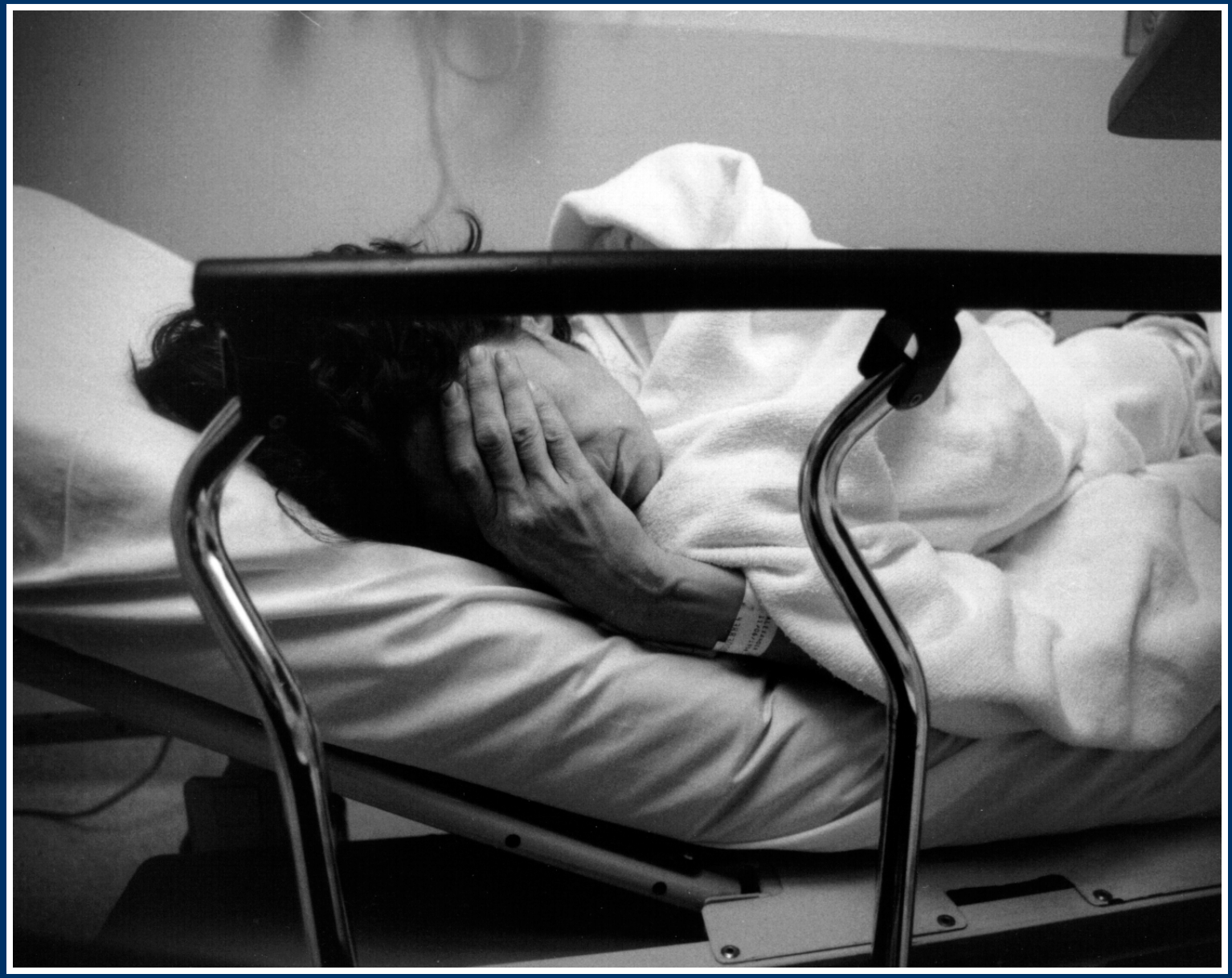
Reductions in VCP Application Disparities: Age



Younger victims were less likely to file with usual care. TRC services eliminated this age disparity.

Use of Mental Health Services: TRC vs. Usual Care Patients





from “Faces of Trauma” project, photographs by Oliver Saria

Patient Self-Ratings of Functioning at the End of Treatment

- **93%** said treatment helped them feel better emotionally
- **83%** said treatment helped them cope better with medical problems
- **88%** had improvements in day-to-day functioning
- **90%** had improvements in relationships with family and friends
- **87**% had improvements in dealing with alcohol and drug problems

Patient Satisfaction
(n=199)

99% reported that they were “moderately to extremely satisfied” with services provided.

97% reported that they would recommend the Center to their family and friends.

TRC provides a wider range of services than Fee-for-Service providers

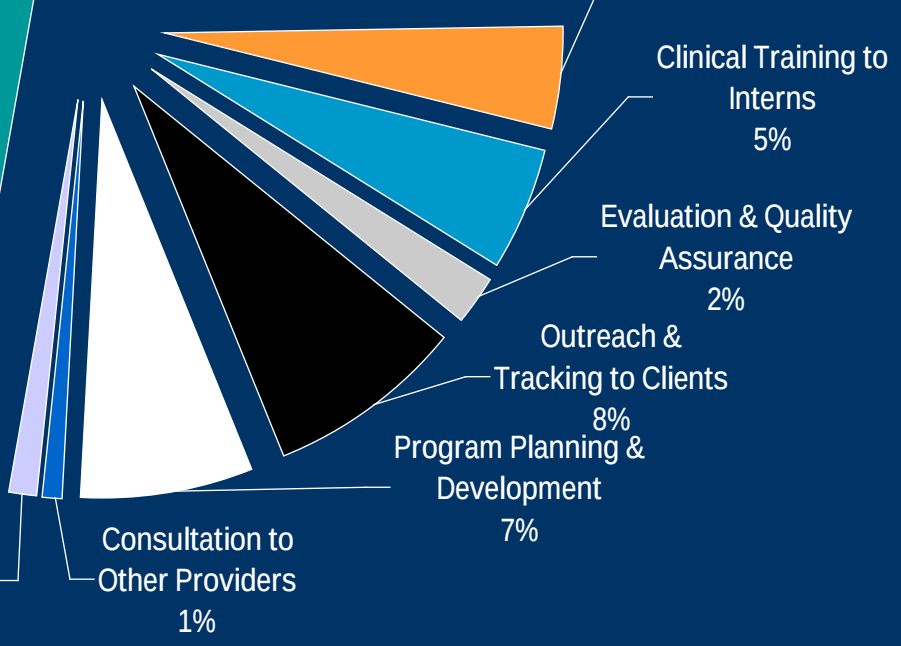
Usual Care
VCP Fee-for-Service

100% Office-based Psychotherapy

TRC

Mental Health Care 72%

(inludes clinical case management; individual, group and family psychotherapy; medication management; crisis intervention)



Cost-Effectiveness: TRC provides a wider range of services at a lower unit cost

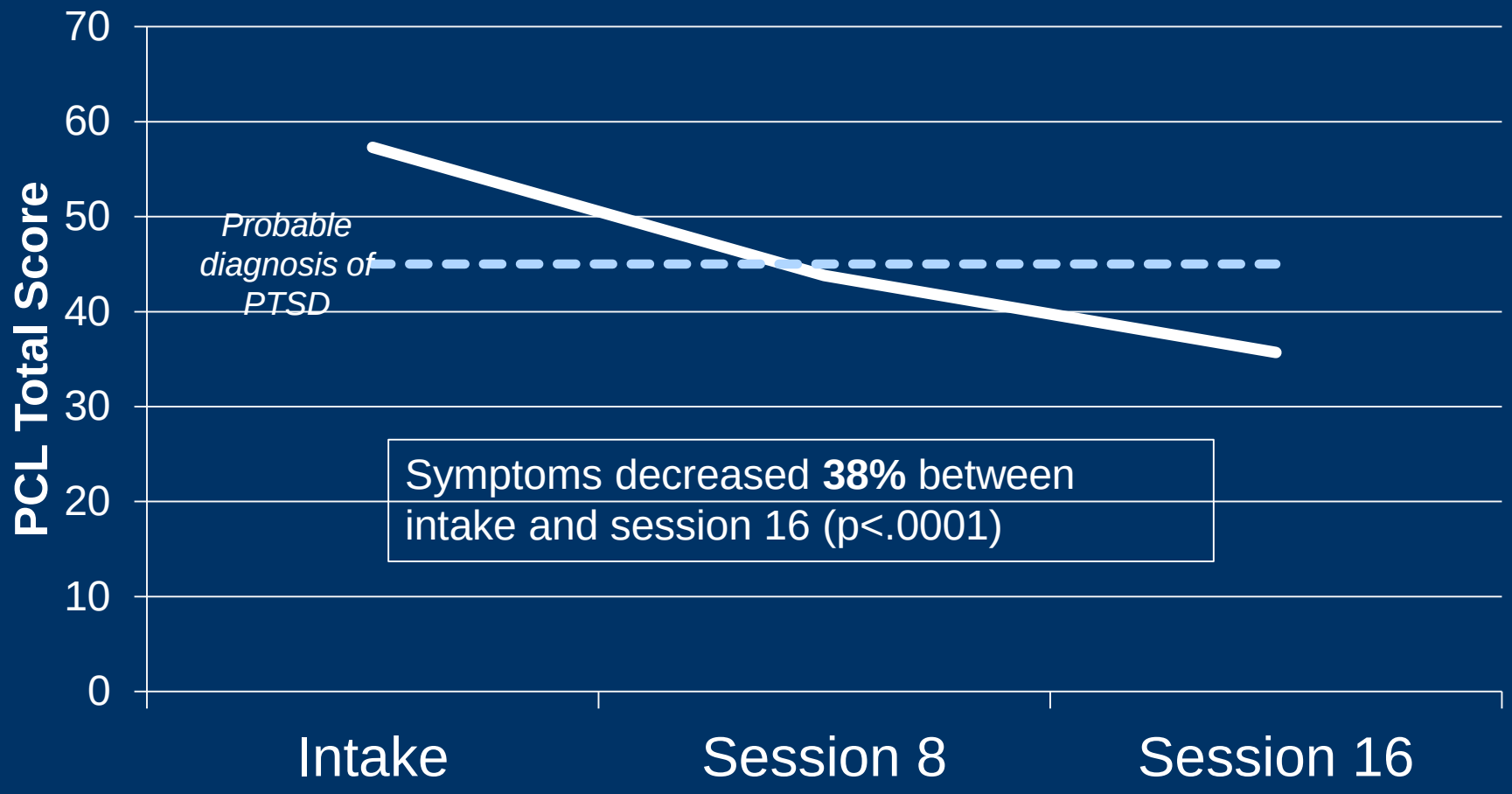
when overhead / program support costs are included, TRC unit costs are 34% lower than VCP FFS

	TRC	VCP FFS	
	(with overhead / program support costs)	(without overhead / program support costs)	(with overhead / program support costs)
Unit Cost	**$66.81**	$72.23	**$101.84**
Per Patient Cost	$1,801	$1,045	1,473
Per Patient Units of Service	20	15	

[FY03/04 costs, most recent year with complete data]

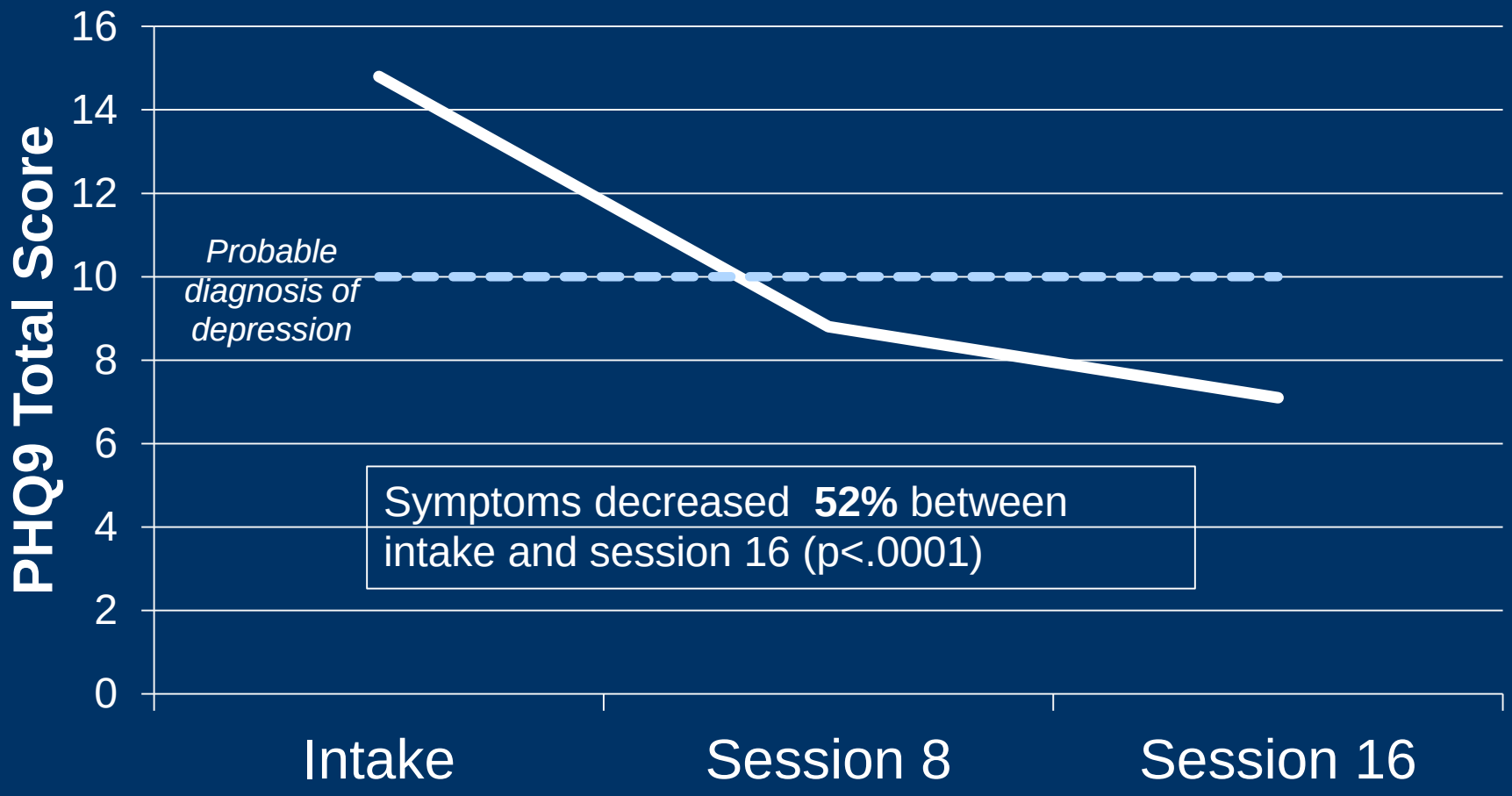
PTSD Symptoms (PCL)

N=261



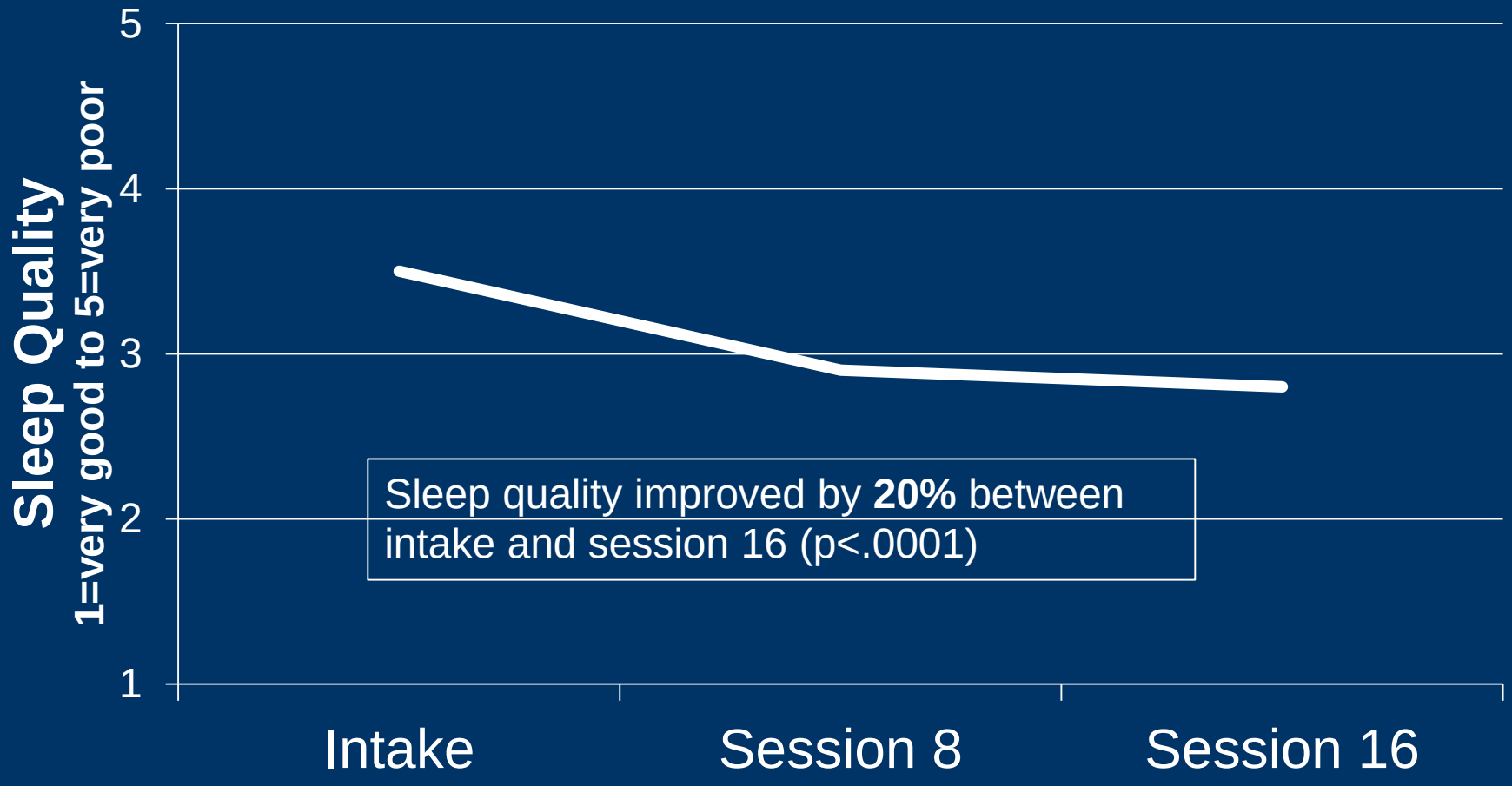
Depression Symptoms (PHQ9)

N=261



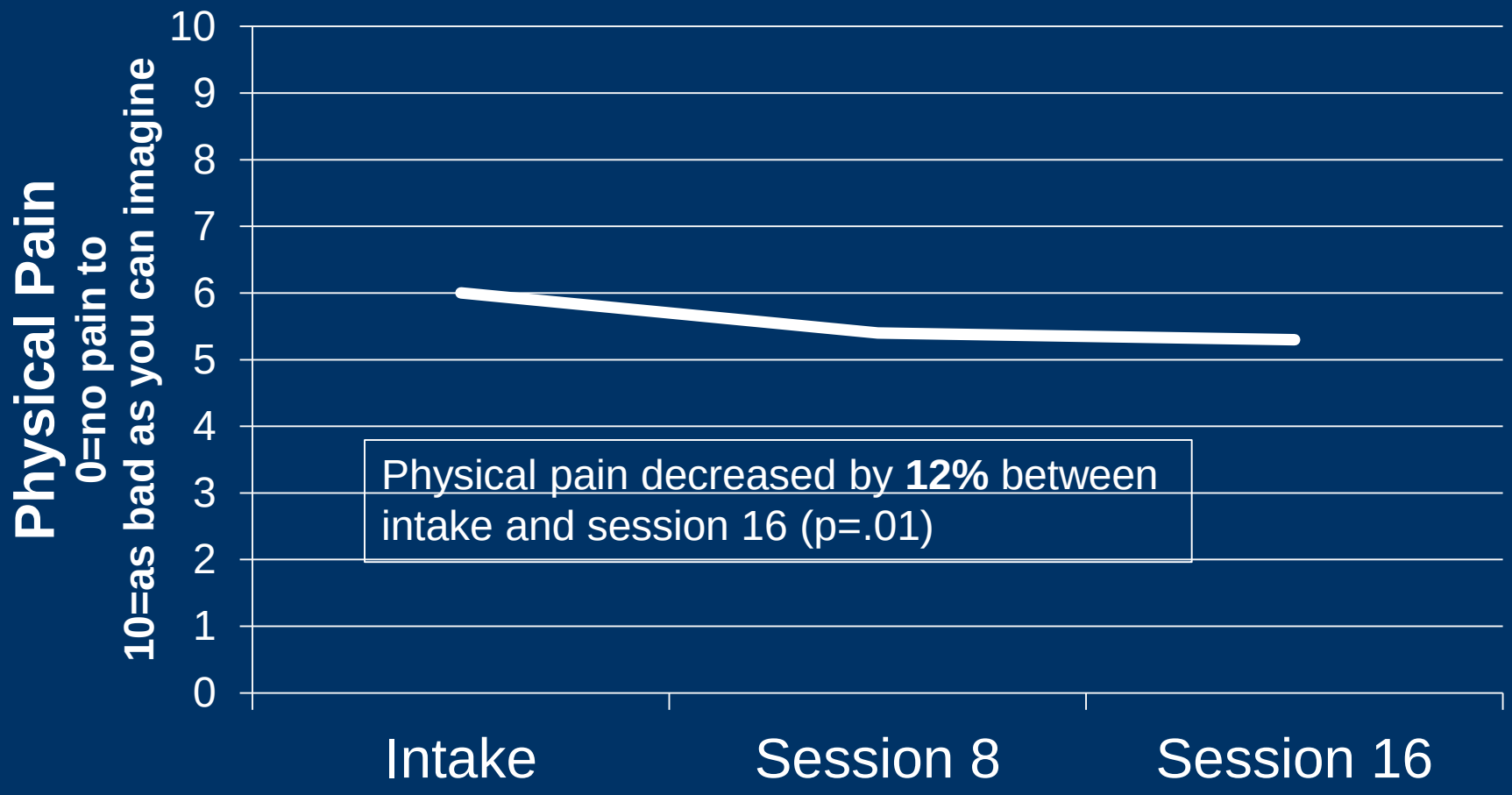
Sleep Quality (PROMIS)

N=261



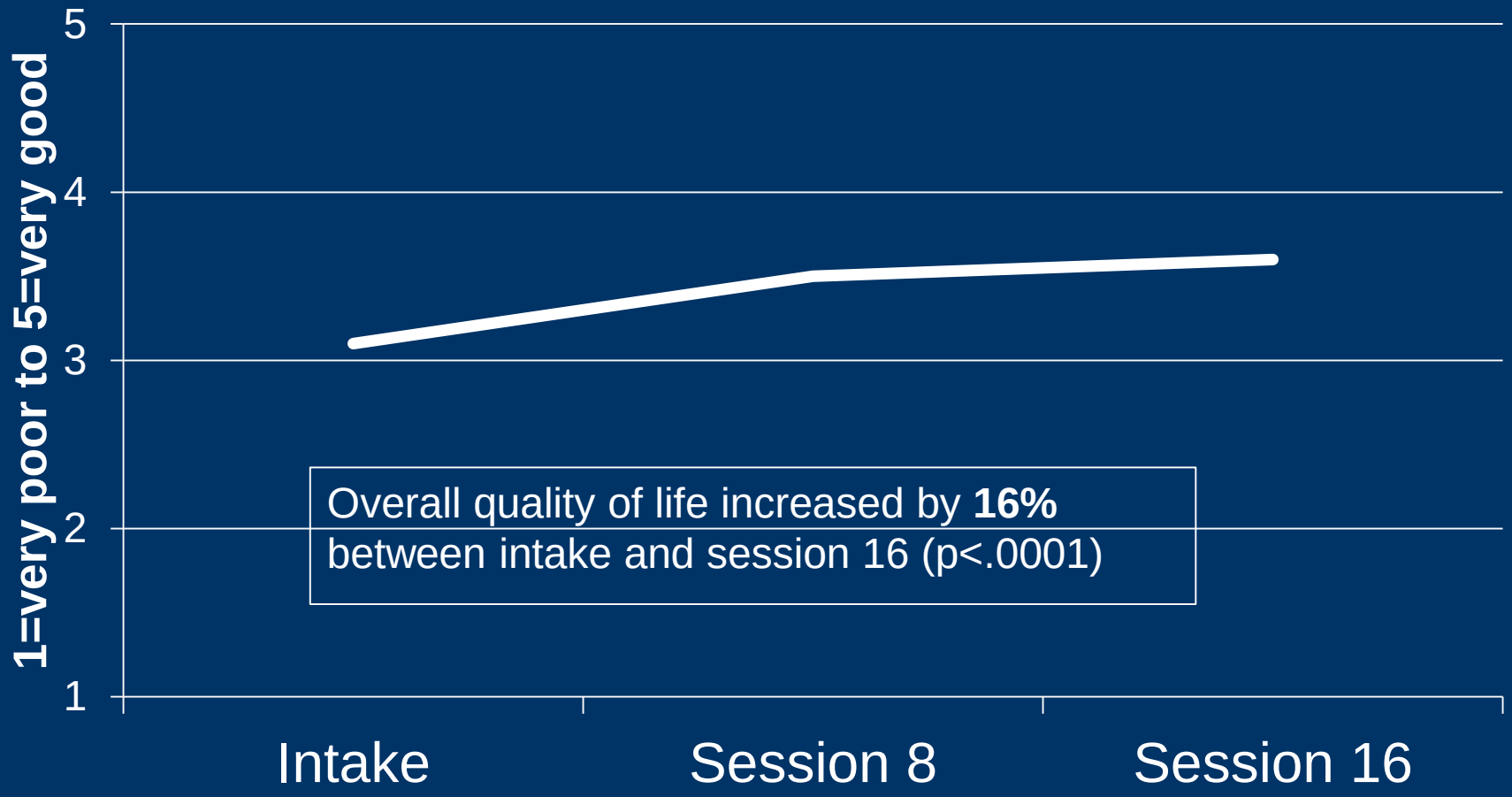
Physical Pain (PEG)

N=261



Overall Quality of Life (WHOQOL)

N=261



Teaching and Training
TRC Training Center

- TRC Trauma Training Program
  - Residents
  - Medical students
  - Masters-level Social Work interns
  - Doctoral-level and Post-Doctoral-level Psychology interns

Teaching and Training: TRC Training Center

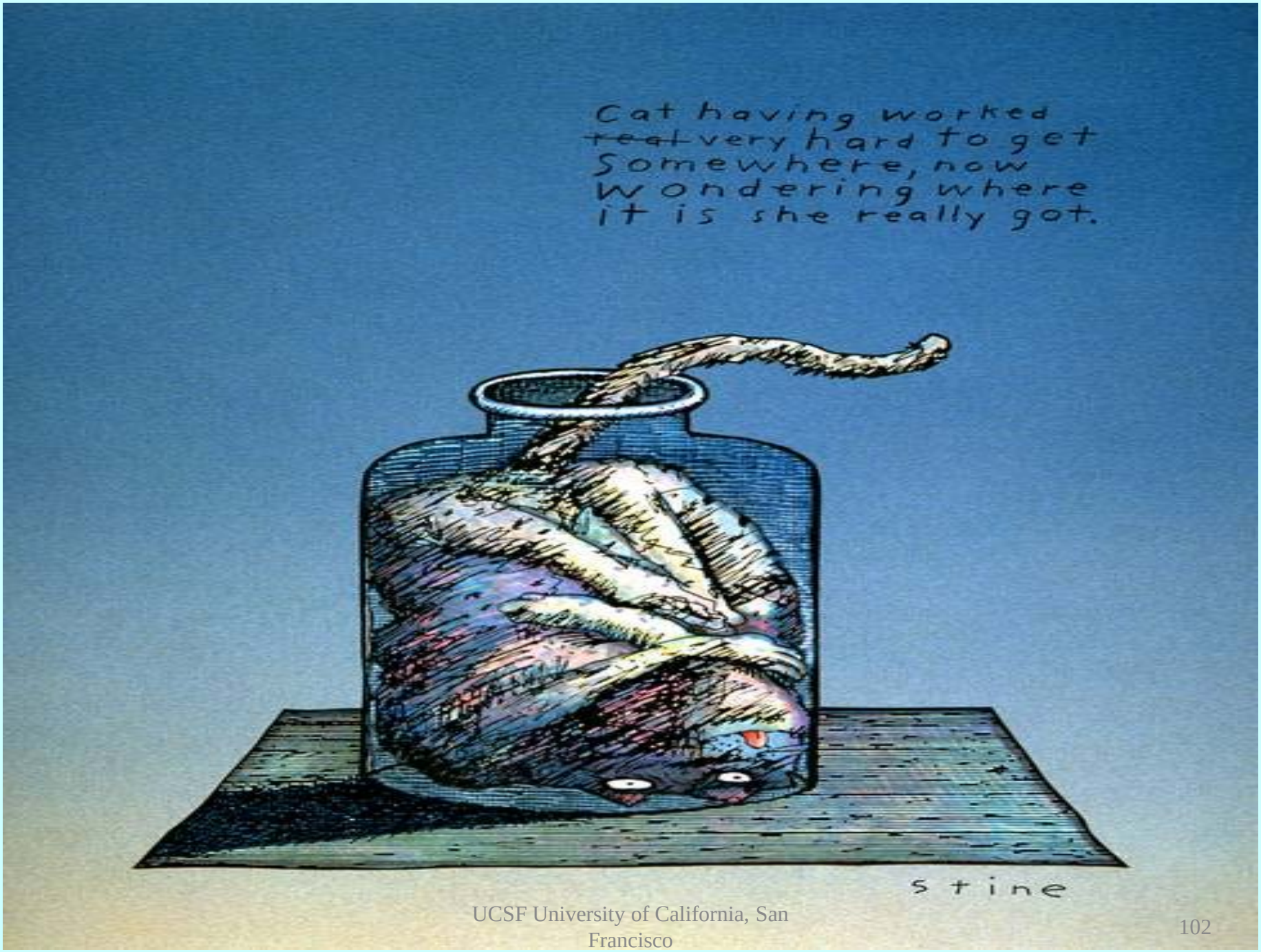
- Community-based trainings
  - health care providers
  - community workers
  - law enforcement staff, DA's office
- Clinical training & consultation
  - trauma-informed and trauma-focused treatment services
- Workshops on vicarious traumatization
  - Local and State Agencies

TRC Replication

Senate Bill 71 (Leno)

- Revised Section 13963.1 of the Government Code – directing the California Victim Compensation program to administer and award grants to develop Trauma Recovery Centers in California

- Replication began in 2014 - in Long Beach, 3 in L.A., UCSF TRC, Stockton and Solano County, Sacramento and Oakland.


Cat having worked
~~real~~very hard to get
Somewhere, now
wondering where
it is she really got.
stine

Brick walls let us know our dedication. They are there to separate us from those that really don't want to achieve their dreams.

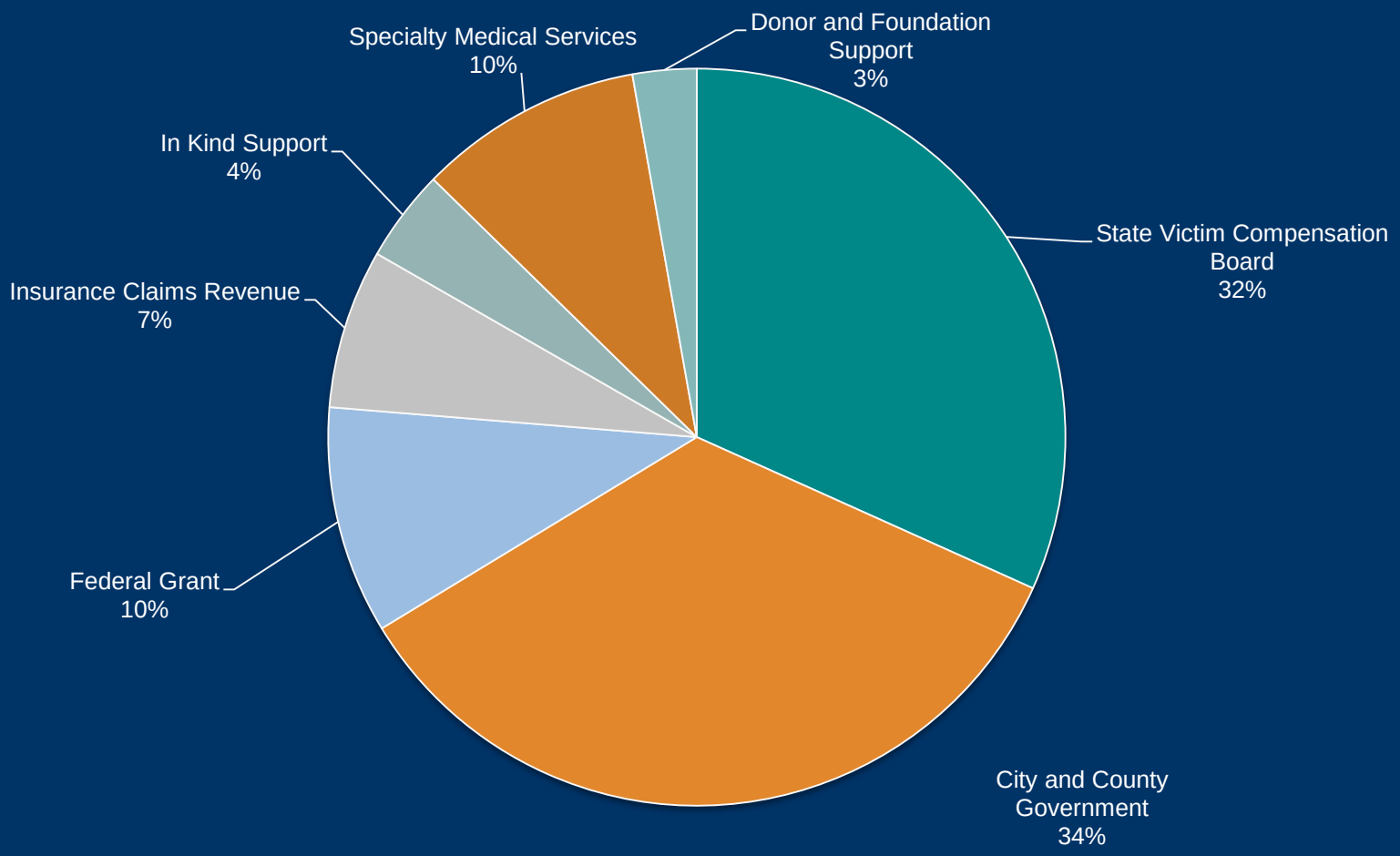
- Randy Pausch, 2007

Brick walls force us to be creative in finding our way around the walls.

Prop 47 – Safe Neighborhoods and Schools Act

- Voter initiative enacted into law January, 2015.
- Changes sentencing for low-level non violent crimes (such as simple drug possession) from felonies to misdemeanors.
- Directs savings from reduced prison and jail sentences –
  - 65% - mental health and drug treatment diversion programs
  - 25% - community violence prevention and support programs in K-12 schools
  - 10% - to fund Trauma Recovery Centers throughout California

TRC Sustainability



11/04/16

Fostering Evidence-Based Practices
Funding, Support, Accountability

Why EBPs?

Why EBPs?

- Evidence-based practices are developed through research and implementation
- EBP's are interventions that have been shown to work
- EBPs are consistent with scientific evidence showing that the intervention can improve client outcomes

Integrated Trauma Recovery Services

Core Elements

Questions:

1. How to adopt this model for rural areas?

2. How do we approach building similar models in places that lack infrastructure? For example, in places where there are not a lot of mental health service providers?

How do we build capacity?

Implementing Evidence-Based Practice at a State Level

- Effective organization
  - Solid administrative support, agency stability and shared vision
- The model needs to have core elements that can be implemented across sites but also flexible and adaptable.
- Creating the infrastructure to insure the model is successful across diverse communities and geographical regions.

Implementing Evidence-Based Practice at a State Level

- Standardized training, technical assistance and support across sites – initially and on an ongoing basis.
- Standardized Program Evaluation and Performance Measurement across sites to measure:
  - Staff productivity
  - Client outcomes
  - Quality improvement
- This involves additional costs – however the economic consequence to not creating this infrastructure are far greater than the cost of creating an accountable system.

Maintaining Spirit, Inspiration and Hope

"Do not be daunted by the enormity of the world's grief. Do justly, now. Love mercy, now. Walk humbly, now. You are not obligated to complete the work, but neither are you free to abandon it. –the Talmud






trc

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CHATT

Communities Healing and Transforming Trauma

TRC Speaker's Bureau Binder

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