



National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, Virginia 22314

Assessment #5

Quantitative Benefits of Trauma-Informed Care

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*Fifth in a Series of Ten Briefs Addressing: What Is the Inpatient Bed Need
if You Have a Best Practice Continuum of Care?*

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Quantitative Benefits of Trauma-Informed Care

Technical Writer:
Stephanie Hepburn

Author of:
Human Trafficking Around the World: Hidden in Plain Sight
Conversation With My Daughter About Human Trafficking
Women's Roles and Statuses the World Over

National Association of State Mental Health Program Directors

66 Canal Center Plaza, Suite 302, Alexandria, VA 22314
703-739-9333 FAX: 703-548-9517

www.nasmhpd.org

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Executive Summary

Dr. Bill Schechter, former Chief of Surgery at Zuckerberg San Francisco General and Trauma Center (SFGH) once said to his peers, “We can sew them up, but we can’t make them well.” Yes, he and his team knew lifesaving procedures, but patients were not receiving comprehensive support to address the obstacles they would likely face in recovery and those that may have contributed to their vulnerability in the first place.

This gap in treatment sparked Alicia Boccellari, PhD, to launch the Trauma Recovery Center at the University of California, San Francisco (UCSF-ZSFG TRC) in 2001. The program is world renowned and a model for trauma programs everywhere on how to effectively implement a comprehensive, integrated program steeped in what Dr. Boccellari calls a “trauma-informed compassion culture”. Not all mental health program participants are survivors of interpersonal violent crime, although adverse childhood event (ACE), rape, and domestic violence statistics indicate that many likely are. Regardless of trauma type, a trauma-informed comprehensive approach has clear benefits for consumers and caregivers alike. University of California Trauma Recovery Center (TRC) participants experienced a reduction in disparities, even if they were homeless, younger, and had less formal education. The center helped improve participants’ workforce participation and reduced the alcohol and drug use often associated with increased risk for rehospitalization.

Providers are often wary of shifting to a Trauma-Informed Care (TIC) model. They may not be certain whether they can meet a consumer’s complex needs and/or are uncertain what quantitative data exists to support the model. In reality, consumers in programs that use a TIC model often experience improved daily functioning and a decrease in substance use, psychiatric symptoms, and trauma symptoms. Trauma-Informed Care also increases consumer engagement and decreases demand for hospitalization. Increased consumer engagement is not only better for recovery, but because consumer-missed appointments result in millions of dollars in wasted staff time, it also makes TIC more cost-effective. In the case of the UC TRC, services (per hour) were 34 percent less costly than traditional services.

What is critical is that TIC care must be comprehensive and integrated across the myriad of services people need—not just limited to counseling, but also including employment, legal services, and addressing co-occurring disorders.

In this paper, we look at the UC TRC Model, Ohio State University’s Stress, Trauma and Resilience (STAR) Program’s trauma screening, violence as a public health issue, peer support, TIC training, and incorporating people with Lived Experience into treatment and recovery. We include interviews with: Charryse Wright, a social worker and military veteran with Lived Experience; Bob Oglesbee, a veteran with Lived Experience; Kenneth R. Yeager, director of OSU STAR Program; Olivia Farrow, Baltimore’s Deputy Health Commissioner; Kim Kehl, Ohio Department of Mental Health and Addiction Services

Trauma-Informed Care Project Coordinator; and Corine Brown, LCSW, Director of Wellness Services at Covenant House in New Orleans.¹

Trauma Informed Care is a high priority for the National Association of State Mental Health Program Directors (NASMHPD) and NASMHPD advocates for TIC within and across systems. Further, under the leadership of Joan Gillece, Ph.D., NASMHPD administers SAMHSA's Center for Mental Health Services National Center for Trauma Informed Care (NCTIC) and has provided on-site training and technical assistance to nearly every state in the country to develop and improve trauma-informed environments across the spectrum of public health programs. More information on NCTIC can be found at <https://www.nasmhpd.org/content/national-center-trauma-informed-care-nectic-0>. NASMHPD hopes this paper will help increase understanding of TIC and the effectiveness it has for the consumers in the health care system and the communities in which they live.

Introduction

Throughout the United States, trauma is common. It can begin as early as childhood, or even before the person was born. These experiences, called Adverse Childhood Experiences (ACEs), can put a person at higher risk for disease and even early death. They include abuse (physical, sexual, or emotional), neglect (physical or emotional), witnessing domestic violence, or growing up with alcohol or other substance abuse, mental illness, parental discord, loss of a parent, or crime in the home.

The 2011-2012 National Survey of Children's Health found that close to 35 million children in the United States, between the ages of birth and 17, have experienced one or more ACEs. That's nearly 50 percent of children—25.3 percent experienced one adverse family experience and 22.6 percent experienced two or more.² The [Centers for Disease Control and Prevention](#) report that regardless of the data source, nearly two-thirds of surveyed adults say they experienced at least one ACE; more than one-in-five adult participants reported three or more ACEs.

The negative outcomes are remarkable. People with a higher number of ACEs—four or more—are at higher risk for depression, suicide, alcoholism, drug abuse, smoking, obesity, heart disease, cancer, lung disease, and liver disease.³ Furthermore, as an individual's ACEs increase, so do the risks for lower educational attainment and unemployment. These adverse experiences impact a person throughout every aspect of

¹ Interview with Corine Brown on March 13, 2017; Interview with Olivia Farrow on April 21, 2017; Interview with Kim Kehl on April 24, 2017; Interview with Bob Oglesbee on April 27, 2017; Interview with Kenneth Yeager on May 22, 2017; and Interview with Charryse Wright on June 2, 2017.

² National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved on May 31, 2017 from <http://www.childhealthdata.org/browse/survey/results?q=2614&r=1>.

³ Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med.* 1998; 14(4):245–258.

their lives, including daily functioning. That is why Trauma-Informed Care (TIC) advocates are trying to push the mental health field away from a myopic focus on what is wrong with consumers and, instead, aim to increase trauma-informed comprehensive and integrative treatment that includes collaborating with social services and law enforcement. In essence, they want treatment to address the entirety of an individual, not just one piece.

Massachusetts Clinical Psychologist Elizabeth K. Hopper says in her article [*Shelter from the storm: Trauma-informed care in homelessness services settings*](#) that TIC can decrease demand for crisis services, such as hospitalization and crisis intervention. It is also considered cost-effective because TIC improves outcomes but is not more expensive than traditional treatment.⁴ Additionally, TIC increases consumer participation, which is clearly better for recovery but also cost-effectiveness, since missed appointments result in millions of dollars⁵ wasted in staff time.

Trauma-Informed Care also appears to have a positive effect on housing stability, one of the most significant challenges to a person attaining mental health treatment. A multi-site TIC study of homeless families discovered that, at 18 months of TIC, the vast majority of participants (88 percent) had remained in Section 8 housing or moved to permanent housing.⁶ Housing stability increased in an integrated, family-focused, TIC outreach and care coordination program for homeless mothers in Massachusetts.⁷

There are also qualitative benefits to TIC, says Kenneth R. Yeager, PhD, LISW-S, LICDC, director of Ohio State University's Stress, Trauma and Resilience (STAR) Program. It leads to improved increased staff confidence and satisfaction, better relationships between service providers and consumers, and increased self-esteem and satisfaction with services among consumers. The latter, he says, is because TIC takes into account an individual's experience in a non-judgmental way. Providers use the approach

⁴ Community Connections. Trauma and abuse in the lives of homeless men and women. Online PowerPoint presentation. Washington, DC 2002. Available from: http://www.pathprogram.samhsa.gov/ppt/Trauma_and_Homelessness.ppt; Morrissey JP, Jackson EW, Ellis AR. Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatr Serv* 2005; 56: 1213-22. Retrieved May 29, 2017 from <https://doi.org/10.1176/appi.ps.56.10.1213>; Hopper, E. K., Bassuk, E. L., and Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal*, 3, 80-100. Retrieved May 29, 2017 from <http://www.homelesshub.ca/sites/default/files/cenfdthy.pdf>.

⁵ Singh N, Barber J, Van Sant S. (2016). *Handbook of Recovery in Inpatient Psychiatry*. Series: Evidence-Based Practices in Behavioral Health. Publisher: Springer International Publishing. doi: 10.1007/978-3-319-40537-7.

⁶ Rog DJ, Holupka CS, McCombsthornon KL. Implementation of the Homeless Families Program.1. Service Models and Preliminary Outcomes. *Am J Orthopsychiatry* 1995; 65: 502-13. Retrieved May 28, 2017 from <http://dx.doi.org/10.1037/h0085057>.

⁷ Marra JV. Final evaluation report: Evaluation of the trauma center of excellence initiative. Unpublished program evaluation. Storrs, CT: University of Connecticut Department of Psychology and the CT Department of Mental Health and Addiction Services Research Division 2006.; Hopper, E. K., Bassuk, E. L., and Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal*, 3, 80-100. Retrieved May 29, 2017 from <http://www.homelesshub.ca/sites/default/files/cenfdthy.pdf>.

to understand what has happened in the person's life to lead to a certain behavior. He acknowledges that TIC is rooted in compassion, but it is also simply more effective. For instance, in a traditional treatment model, if a person does not show for his or her appointment, the clinician may call and prompt the person to reschedule. Under a TIC approach, says Dr. Yeager, the clinician thinks about *why* the person did not make his or her appointment; perhaps there was a logistical reason (transportation) or maybe they touched on a topic in therapy that is driving the client's avoidance.

“Assertive outreach and engagement techniques foster a relationship, consistency, and trust between clinician and client,” Dr. Yeager says. “This increases client investment in his or her therapy and helps minimize a hypervigilant response from trauma victims where they worry there is a problem every time their therapist calls.”

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Trauma Screening for All: Ohio State University's Stress, Trauma and Resilience Program

A TIC approach looks at a person holistically, not just as a list of issues he or she is experiencing. This is, in part, done with the realization that the majority of people in the United States have experienced trauma and that those who face illness—physical or psychological—likely experienced numerous traumas. This is why Dr. Yeager and his STAR team have begun to do trauma assessments on *all* populations treated in the Emergency Department (ED) at the Harding Hospital and Wexner Medical Center, regardless of the reason for admission. A person who enters the ED for a broken arm will be asked to participate in the screening. TIC reaches out to people where they are, says Dr. Yeager.

The assessments, which include an ACEs assessment and a Subjective Units of Distress Scale (SUDS) assessment, are essential, says Dr. Yeager, to help clinicians understand a person's overall health and whether he or she is an at-risk population. People with a higher number of ACEs are at higher risk for IV drug use, exploitation (such as human trafficking), diabetes, and cancer. “A person with four or more ACEs is 1,200 percent more likely to attempt suicide,” Dr. Yeager says. “That's an astounding number, and one the clinician needs to know.”

The assessments also include a social justice element, where the team attains a snapshot of the client's daily environment and his or her socio-economic status. The comprehensive screening helps the team determine the level of service the person needs and what other supports he or she may need to be able to engage in treatment. "This isn't guesswork," Dr. Yeager says. "We aren't sitting around assuming what the person needs. It is data-driven and we use scales to determine what the person needs." Dr. Yeager and his team perform measures throughout treatment, to ensure that the person is experiencing progress, and modify treatment when needed.

The STAR team also evaluates the individual's quality of life, and by examining a person comprehensively, including his or her ACEs, it becomes clear what challenges stand in their way. The issue, says Dr. Yeager, is that people do not experience a marked improvement unless they experience comprehensive treatment that addresses challenges such as poverty, education, and job preparedness. This triggered Dr. Yeager and his team to launch the STAR Recovery Center in 2017, which takes a much more comprehensive approach to helping trauma victims, specifically crime victims and their family members. "A person's quality of life doesn't markedly improve if we can't address the numerous hurdles in his or her way," Dr. Yeager says.

Dr. Yeager says trauma recovery centers are mental health game-changers because they look at the totality of the person, linking at-risk people to services at state-of-the-art facilities. The comprehensive approach includes intervention for safety and stabilization, and processing trauma and loss. The STAR Recovery Center program includes safety-related interventions, such as helping people to get clothing, medication, and housing. Dr. Yeager says it is a time-intensive, hands-on program where improvements are not immediate, but they are rapid. "Our objective is to meet the clients where they are, not to retraumatize them, and to build their skills to address the trauma they experienced."

According to Dr. Yeager, the University of California's Trauma Recovery Center (TRC) Model in San Francisco is the best quantitative support to illustrate how the right combination of identification, TIC support, and TIC services can reduce avoidable psychiatric hospitalization and hospitalization. The model incorporates what its founder, Dr. Alicia Boccellari, calls a trauma-informed compassion culture.⁸ This culture includes collective hope, vision, and leadership, paying careful attention to social justice and health disparities.

Trauma Recovery Center Model

It all began with an utterance from a colleague, says Dr. Boccellari in [*The UC San Francisco Trauma Recovery Center Model: Removing Barriers to Care and Transforming Services for Survivors of Violent Crime*](#). Dr. Bill Schechter, former Chief

⁸ The UC San Francisco Trauma Recovery Center Model: Removing Barriers to Care and Transforming Services for Survivors of Violent Crime. Edited by Stacey Wiggall, LCSW & Alicia Boccellari, Ph.D. Produced in collaboration with Allen/Loeb Associates. Version 1: March 15, 2017. Retrieved May 17, 2017 from <http://traumarecoverycenter.org/wp-content/uploads/2017/05/TRC-Manual-v1-5-10-17.pdf>.

of Surgery at Zuckerberg San Francisco General and Trauma Center (SFGH), lamented to his peers, “We can sew them up, but we can’t make them well.” His point was that, despite his team’s vast knowledge in life-saving procedures, the treatment survivors received did not address psychological obstacles the person would likely face after a traumatic, life-altering experience. This disconnect is what triggered his colleague and Chief of Psychology at SFGH, Alicia Boccellari, PhD, to develop the Trauma Recovery Center (TRC) at the University of California, San Francisco (UCSF) in 2001.⁹ The program gives comprehensive mental health and social services for survivors of interpersonal violent crime, including people who are rape, domestic violence, and assault victims. It also supports family members whose loved ones are violent crime victims.¹⁰ Many participants come from vulnerable, marginalized population who suffer from [trauma, violence, and poverty](#).

Dr. Boccellari first did a pilot study not based on intervention, but instead on participants’ functioning after injury. The study included 40 seriously-injured participants who were identified while hospitalized; each participant was gainfully employed when they were injured and were given a referral to community-based mental health services on discharge.¹¹ Researchers interviewed and evaluated participants within 48 hours after discharge and again at a six-month follow-up.

Nearly all patients (97 percent) reported psychological symptoms while in the hospital; they experienced Acute Stress Disorder symptoms such as nightmares, intrusive memories, and cognitive avoidance of the trauma they experienced. At the six-month follow-up, most participants had physically recovered from their injuries, but only 32 percent returned to work. *None* had obtained mental health services and all continued to experience high distress levels.¹² This confirmed what Dr. Schechter had suggested and led Dr. Boccellari to conclude that violent crime trauma survivors need complex care.

The results triggered Dr. Boccellari to launch a needs assessment and intervention pilot that focused on assertive outreach for survivors of traumatizing violent crimes. Once again, participants were identified while hospitalized and it was quickly evident to researchers that many survivors had immediate practical needs that needed to be addressed before mental health interventions, such as safe housing, legal advocacy, and financial entitlements.¹³

⁹ The UC San Francisco Trauma Recovery Center Model: Removing Barriers to Care and Transforming Services for Survivors of Violent Crime. Edited by Stacey Wiggall, LCSW & Alicia Boccellari, Ph.D. Produced in collaboration with Allen/Loeb Associates. Version 1: March 15, 2017. Retrieved May 17, 2017 from <http://traumarecoverycenter.org/wp-content/uploads/2017/05/TRC-Manual-v1-5-10-17.pdf>.

¹⁰ Gordon, R. (2010). “Budget fear for S.F. trauma survivors' lifeline, Program is a lifeline for trauma survivors - but struggles itself with tight budgets.” *SFGate*, July 20. Retrieved May 17, 2017, from <http://www.sfgate.com/health/article/Budget-fear-for-S-F-trauma-survivors-lifeline-3181162.php>.

¹¹ The UC San Francisco Trauma Recovery Center Model: Removing Barriers to Care and Transforming Services for Survivors of Violent Crime. Edited by Stacey Wiggall, LCSW & Alicia Boccellari, Ph.D. Produced in collaboration with Allen/Loeb Associates. Version 1: March 15, 2017. Retrieved May 17, 2017 from <http://traumarecoverycenter.org/wp-content/uploads/2017/05/TRC-Manual-v1-5-10-17.pdf>.

¹² Ibid.

¹³ Ibid.

Corine Brown, Director of Wellness Services at the New Orleans homeless shelter Covenant House, says these challenges are not unique. In fact, she says, regardless of trauma, the most significant challenges to a person's mental health treatment are immediate needs, such as safe housing, money, and transportation. Additionally, she says mental health providers often have to counter stigma. "We have to be creative and take a holistic approach, helping residents develop behavioral, internal resources before they are willing to commit to formal treatment." Dr. Boccellari's research team faced each of these challenges and, in addition to immediate practical needs, the barriers presented by stigma and avoidance symptoms deterring survivors from engaging in treatment. All of this made the need for a TRC even more clear.

The TRC, [in partnership with the California Victim Compensation Board](#), launched in 2001 with the explicit goals of providing safety net services for violent crime survivors and their family members (particularly those from marginalized populations), developing clinically and cost-effective care for underserved violence survivors, and achieving comprehensive outreach for survivors. In essence, its founders wanted the TRC to provide comprehensive, integrated care that included trauma-informed therapy, clinical case management, and assistance with law enforcement.

To evaluate the TRC Model's clinical and cost-effectiveness, California legislation mandated a randomized trial that resulted in a longitudinal study that included 541 participants, each a violent crime survivor. They were randomized to receive either TRC services (337 participants) or community care (204 participants). Researchers assessed participants four times over 12 months. What the study revealed was groundbreaking—the TRC Model was far more successful in engaging participants in mental health services. In fact, the vast majority (77 percent) of survivors who received TRC services engaged in mental health treatment, compared to 34 percent of those who received community care. The TRC was also far more effective in helping victims apply and access victim compensation benefits in California—56 percent of TRC participants submitted applications compared to 23 percent of usual care participants.¹⁴ Further, TRC services cost, per hour, 34 percent less than traditional services,¹⁵ making them more effective *and* less costly.

State-level victim compensation funds are available in California to aid crime victims' recovery—not only physically, but also financially and psychologically. Even so, application rates for the funds are low, particularly among physical assault survivors who are male, young, and an ethnic minority. The TRC study included 407 males, 294 of

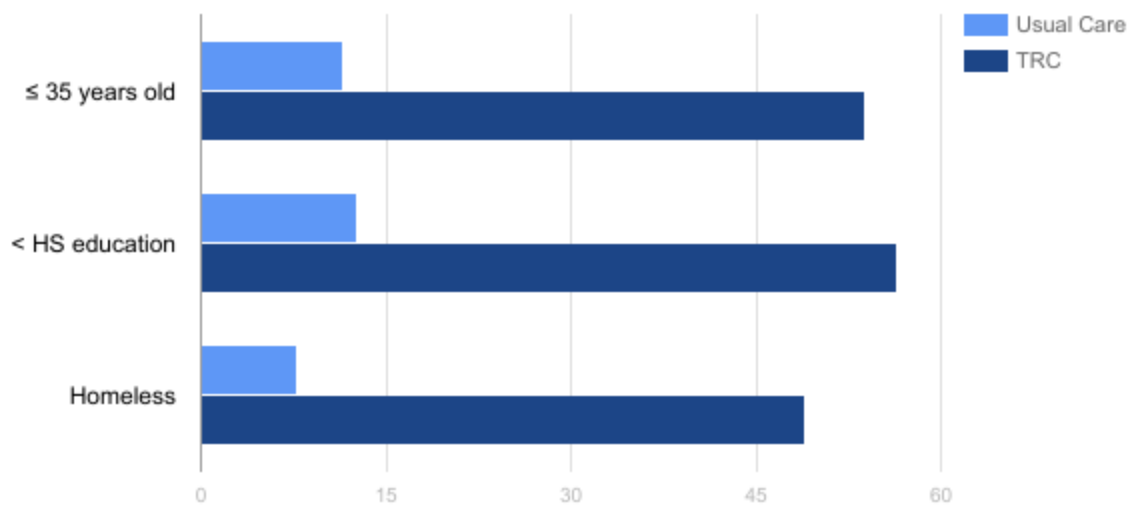
¹⁴ Alvidrez, J., Shumway, M., Boccellari, A., Green, J. D., Kelly, V., & Merrill, G. (2008). Reduction of state victim compensation disparities in disadvantaged crime victims through active outreach and assistance: A randomized trial. *American Journal of Public Health*, 98, 882-888. Retrieved May 20, 2017 from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2374813/>.

¹⁵ The UC San Francisco Trauma Recovery Center Model: Removing Barriers to Care and Transforming Services for Survivors of Violent Crime. Edited by Stacey Wiggall, LCSW & Alicia Boccellari, Ph.D. Produced in collaboration with Allen/Loeb Associates. Version 1: March 15, 2017. Retrieved May 17, 2017 from <http://traumarecoverycenter.org/wp-content/uploads/2017/05/TRC-Manual-v1-5-10-17.pdf>.

whom were ethnic minorities (Black, Latino, or Mixed/Other); the average age was 37 years and the average education level was 12 years.¹⁶ They were mostly unemployed and uninsured, and more than 40 percent were homeless.

The TRC’s comprehensive services reduced disparities for participants who were younger, homeless, and had less formal education.¹⁷ Significantly more members of these vulnerable groups filed a victim compensation claim when receiving TRC services than those in usual care, illustrating the impact of comprehensive outreach to trauma survivors. (See Figure 1.)

Figure 1. Percentage of Participants Filing Victim Compensation Claim



Populations	Usual Care	TRC
≤ 35 years old	11.5	53.8
< HS education	12.7	56.5
Homeless	7.8	49

Source: Journal of Public Health

¹⁶ Alvidrez, J., Shumway, M., Boccellari, A., Green, J. D., Kelly, V., & Merrill, G. (2008). Reduction of state victim compensation disparities in disadvantaged crime victims through active outreach and assistance: A randomized trial. *American Journal of Public Health*, 98, 882-888. Retrieved May 20, 2017 from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2374813/>.

¹⁷ Ibid.

The TRC data reaffirm that integrative TIC models serve at-risk populations well by reducing disparities and increasing consumer engagement in mental health services, compensation claims, and cooperation with law enforcement. In fact, TRC sexual assault survivor participants increased their participation in evidence collection by [54 percent](#) and filed police reports [29 percent more often](#). The TRC also improved workforce participation and reduced trauma survivor homelessness, alcohol use, and drug use.¹⁸ This is particularly noteworthy for recovery but also because substance use disorders have been associated with increased risk for rehospitalization, future injury, and trauma.¹⁹ In essence, the TRC model appears to, at least during participation, decrease participants' marginalization while increasing resilience.

The STAR Program's director, Dr. Kenneth Yeager, says the key is continuity of TIC care, regardless of whether clients are meeting with law-enforcement or a therapist. He says that, in traditional health centers, there is a pass-the-baton approach—where the baton is passed to law enforcement, case managers, or social service providers—and, at some point, the baton gets dropped. “This is when traditional centers often lose clients,” Dr. Yeager says. “They don't feel stable and they don't trust in their care.” In contrast, trauma recovery centers are collaborative, victim-centered, and trauma-informed. The STAR Recovery Center manages its clients' transportation, outreach, and engagement. “TRCs are the nerve center and provide a continuity of care that simply isn't out there anymore. They provide stability, which is commonly absent from trauma victims' lives.”

Violence is a Public Health Issue: The Importance of Partnering with the Community

Dr. Yeager says getting crime survivors to participate in trauma recovery programs can be a challenge. In part, he says, this is because victims are frequently stigmatized. They often face an onslaught of questions and criticism that prosecute the victim in the media and the community. “Rape victims are often asked what they were wearing or why they went to the location where they were raped,” Dr. Yeager says. “They are not the perpetrators, they are the victims, but in our society victims are often treated as though they somehow brought trauma upon themselves.” Furthermore, the news and media often exacerbate a victim's trauma by replaying it over and over again. This makes establishing trust all the more challenging and critical, and why the STAR Recovery Center will soon include community support teams (CSTs) at schools, faith-based centers, and various community organizations.

¹⁸ San Francisco Trauma Recovery Center Report to the Legislature, May 2004. Prepared by California Victim Compensation and Government Claims Board. Retrieved May 25, 2017 from www.vcpcb.ca.gov/docs/reports/UCSFTRCreport.pdf.

¹⁹ Rivara FP, Koepsell TD, Jurkovich GJ, Gurney JG, Soderberg R. The effects of alcohol abuse on readmission for trauma. *Journal of the American Medical Association*. 1993;270:1962–1964. Retrieved May 25, 2017 from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3947745/>.

An early sign of waning physical health is deteriorating mental health, which is why Dr. Yeager's team will train CSTs on evidence-based emotional support crisis intervention. "This will include psychological first aid, such as cognitive reframing and motivational interviewing," he says. The center will check in with volunteers monthly to make sure they are doing it properly (i.e., maintaining model fidelity) and confirm that identified trauma victims are aware of available resources. He says CSTs help to cast a wider outreach net so that trauma survivors can not only link to the recovery center through formal entry points like the ED but also through the community.

The notion that violence is a public health issue that needs to be addressed through integrative TIC partnerships between hospitals and the community is gaining nationwide interest. Olivia Farrow, Baltimore's Deputy Health Commissioner, says violence among young people often results from a series of retaliations. "The retaliatory pattern spreads like a contagion," Farrow says.

Farrow is working to find a way to interrupt violence through the city's new comprehensive, hospital-based community violence intervention program. The program, called the Baltimore City Thriving Communities Project, will expand Baltimore's trauma-informed Safe Streets program into Johns Hopkins Hospital's ED. Safe Streets has already made significant strides in mitigating violence. In fact, in 2016, it mediated [888 conflicts](#), 73 percent of which were deemed to be very likely/likely to result in violence. The new Communities project will collaborate with Hospital Responders to reduce violence-related ED readmissions. "Baltimore hospitals don't want to see people returning to their EDs and Safe Streets wants to stop the violence and address the underlying issues that keep sending them there," Farrow says.

Dr. Leana Wen, Baltimore's Health Commissioner, said in a September 2016 [press release](#) that expanding the Safe Streets model into local hospitals can reduce trauma, save lives, and prevent rehospitalization by disrupting retaliation:

As an emergency physician who has treated patients dying from gunshot wounds, I will never forget the cries of mothers whose children could not be resuscitated in our EDs. I have seen the cycle of violence and trauma, and why we need every interaction to be the point of intervention to stop this vicious cycle. Safe Streets has shown us that violence interruption works: We can prevent shootings and cure violence with credible messengers.

In Baltimore, collaborations between EDs and Safe Streets were established long ago, and have been functioning informally until now. Just last year, says Farrow, a Hospital Responder at Sinai Hospital reached out to the program after speaking in the emergency room to a violent crime victim—a young man who had been shot. The Hospital Responder talked to the victim about what had led him to this point and what challenges were happening in his life. The victim wanted to make sure his friends did not retaliate. The responder, says Farrow, reached out to Safe Streets and worked with the victim to put a stop to an all-out street war. Through the program, the two warring factions came

together and agreed to stop retaliating. Safe Streets then worked with the victim to get his GED. “Today, he has his GED and is working,” Farrow says.

Trauma-Informed Care Trainings Include People with Lived Experience

Kim Kehl, Trauma-Informed Care Project Coordinator at the Ohio Department of Mental Health and Addiction Services, says it’s been integral to include people with Lived Experience in TIC training. Kehl partners with the Department of Developmental Disabilities on Ohio’s interactive Trauma-Informed Care Initiative, which has trained more than 25,000 police officers and will likely train 11,000 more by the end of the year. Attendees also include other first responders, caregivers, and service providers. Day 1 of the training addresses the trauma that clients bring with them when they access services. Day 2 focuses on vicarious trauma and workforce resilience. “A local EMT may be psychologically prepared to help someone experiencing a heart attack, but are they prepared to witness a five-year-old give his mom Naloxone because she overdosed on heroin?” Kehl asks.

It is not always clear why a person with trauma behaves a certain way, even to the person exhibiting the behavior. Kehl says this is because, “when the fire alarm happens”—fight, flight, and freeze—he or she isn’t able to verbalize what’s wrong. This is frustrating for both providers and clients. “It’s the epitome of being scared speechless,” Kehl says.

Kehl shares the story of a client whose parents, when he was a child, took him to the doctor 2 or 3 times a day. The doctor, to appease the parents, would give the child a placebo shot. Fast forward to adulthood when the client was hospitalized and experienced forced medication: “He would lose it and the experience would retraumatize him, again and again,” Kehl says. He says it takes a TIC approach to delve into the cause of a client’s behavior, focusing on what happened to the person, when, and with whom. This helps foster understanding and breaks the cycle of retraumatization. It is people with Lived Experience who are best able to share with providers and caregivers that a TIC approach promotes a greater sense of safety, security, and equality. “They often share that it would have helped them to avoid seclusion, restraint, and multiple hospitalizations,” Kehl says.

Kehl is working with Ohio Veterans Homes to help its facilities become trauma-informed and trauma-responsive. Bob Oglesbee, a veteran with Lived Experience and a resident, helped roll out the program and explained why this approach is so critical. When Oglesbee first arrived at Veterans Homes, he refused to shower in the communal bathroom. The staff could not understand his reluctance, so they contacted Kehl. Oglesbee shared his story with Kehl—he was sexually abused by a family member when he was a young boy and raped by his superior when in the military. Kehl worked with the residence to put a deadlock on the bathroom door and Oglesbee resumed showering. “It was so simple, but it meant taking the time to figure out Bob’s story,” Kehl says.

Oglesbee says what has been most critical in his recovery is sharing his story and seeing how helpful it is for caregivers and peers alike. “I spent so much time hating myself,” Oglesbee says. “I’ve learned to like myself and realize that I have a gift, which is the ability to talk to anyone about getting help.” He says he can talk to a corporate president, biker, social worker, or nurse about what he or she is going through and share his own story of recovery. Just talking to people and showing kindness, says Oglesbee, may deter them from committing suicide. He says sharing his story with others is mutually beneficial. “I feel useful and it has taught me to approach every situation with compassion. When someone gives another person time, time to get something off their chest, it helps.”

Meet People Where They Are

Charryse Wright, a social worker with Lived Experience, says it’s essential that law enforcement, first responders, caregivers, and providers from all human services and behavioral health disciplines hear specifically from those with Lived Experience. She says it gives training attendees real-life examples on how technical TIC approaches work and provides hope for service providers. “Service providers get burned out and often feel as though they are continuously doing work, but their clients aren’t improving,” Wright says. “Speaking with those with Lived Experience reminds them that they are doing amazing work that’s changing lives for the better.”

One of the most important reasons to include people with Lived Experience in TIC trainings, she says, is that it helps those working with trauma survivors understand why people may be resistant or act in a way that seems counter-intuitive. For example, perhaps the person does not trust men because she was abused by her father. Understanding and compassion, Wright says, helps first responders, providers, and caretakers meet survivors where they are.

Wright says her own experiences made her wary of women and law enforcement. Her mother, addicted to crack cocaine, began selling her for sex in exchange for money when she was eight-years-old. There were two points in her life, she says, where people assigned to protect her could have drastically altered the outcome of her life had they simply done their job. They had not.

The first instance was when truancy officers came to Wright’s home because her school had reported her numerous absences. She thought she was going to be protected when she realized law enforcement officials were coming to the home. “I was excited because kids are taught that police officers are your friends—they are here to protect and serve, and they are who you call in an emergency,” said Wright. “I thought they were going to stop the sexual abuse.” Instead, the officers exchanged sexual favors with Wright’s mother and left.

The second occurrence was when a Florida Department of Children and Families (DCF) case manager/social worker was assigned to Wright and her siblings. She says the caseworker planned to put them in foster care but changed her mind after speaking with

the children's teachers, who had no idea they were living at home without a parent. At 13-years-old, Wright had long been a caretaker to her brother and two sisters—ensuring they were clothed, fed, went to school, and did their homework. The case manager determined that it was best to keep the family together under the young teen's care. Wright said she was given cash assistance and food stamps, but did not receive therapy or any other psychological support. "The Florida DCF at that time was making a lot of mistakes and children were dying," Wright says. "I thank God we were not one of the many statistics. We could have easily been, because of how dysfunctional the system was."

Wright hopes that sharing her story will help those working with trauma survivors understand why trust is so incredibly hard for them to establish. She recommends that responders be patient with people they encounter because simply seeing a police uniform or even a service provider's gender can be triggering. In Wright's case, she had difficulty establishing trust and rapport with women, including her therapists. "I had some positive male models, like my grandfather and uncle," Wright says. "It was my mother who abused me."

Wright was surrounded by women throughout her life, from primary school onward. She joined the Army to be able to provide for her siblings, but that too became a challenge when, in basic training, she was once again in an environment with mostly women. "I continually struggled to develop intimate relationships with women. If I couldn't trust my mother, who I was genetically predisposed to connect with, then how could I trust any other woman?"

In the Army, Wright developed physical pain from her childhood sexual abuse injuries and was told, by her doctor, that she would likely be unable to have children. Her doctor mandated she go to a therapist to address the psychological trauma she had experienced. As in school and the Army, Wright had challenges building trust with her therapists, who were all women. It was not until attending the Miami Veterans Administration (VA) Hospital that she was able to open up. The difference, she realized, was that her therapist was a man.

The catalyst that finally pushed Wright to address her trust issues with women was attending school for social work training. She was surrounded by women peers, but more distressing was that many of her clients faced similar challenges to her mother. "They were on drugs, homeless, and had a mental illness," said Wright. "They looked like my mother and it really triggered me."

Therapy not only allowed Wright to develop relationships with women but also led her to participate in TIC trainings and peer support. It taught her to step back, be patient and calm, and meet people where they are. "Trauma-Informed Care is not about forcing people to be where you want them to be," Wright says. Sharing her story, she says, continually helps others and also aids her own recovery. It has helped her to let go of the shame and guilt that so often plagues trauma survivors. "People who experience trauma often carry guilt and embarrassment that's not theirs to carry. Saying it out loud, in a safe

space, can make you realize how ridiculous some of these thoughts are. It helps take away their power to torture you.”

Wright says continually sharing her story over the past six years has been therapeutic and helped her draw correlations that were not always instantly obvious. For example, one evening, a friend was visiting Wright at home when, in the middle of the conversation, Wright ran to her bedroom. Wright had seen a mouse and, without saying anything to her friend, went to her bedroom, closed the door, and sat in the middle of her bed. Her friend came in and asked what happened. “I saw a mouse,” said Wright. “So?” asked her friend. It was not until Wright later shared her story at a training that she figured it out. She says that, as a child, she lived in a crack house without electricity and running water, and where mice ran freely. “I didn’t realize mice were a trigger, but it took exposure to them in adulthood and sharing my story to put it together.”

Peer Support

The Substance Abuse and Mental Health Services Administration (SAMHSA) lists peer support as one of the six key principles of a trauma-informed approach.²⁰ Trauma survivors, like Charryse Wright and Bob Oglesbee, who engage in mutual self-help or peer support are essential vehicles, says SAMHSA, for establishing safety and hope, and promoting recovery. Peers are role models who demonstrate to recipients that recovery is possible, fueling in recipients a tangible hope that they too will recover from mental illness. Hope is such an essential component to recovery that SAMHSA, in [Guiding Principles of Recovery](#), calls it the recovery process catalyst.

“Peer support gives trauma survivors access to a person who has walked the walk and who can share, in context, how to apply concrete academic techniques to their lives,” Wright says. “It makes hope much more tangible. Otherwise, it [trauma] can quickly turn into hopelessness.”

Wright says that sharing her story with a retired veteran allowed him to let go of his guilt over his daughter’s rape. Years ago, while he was stationed overseas, his wife and daughter lived with his best friend in the United States. During that time, his best friend raped his daughter. His daughter went to therapy and so did her father, but he could not let go of the feeling that it was his fault. “He couldn’t have stopped it... he was on the other side of the world,” Wright says. “His daughter didn’t blame him, but he couldn’t forgive himself.” Wright suggested that he write a letter to his daughter’s rapist and either mail it or burn it. The idea, she says, was to give him space to say what he needed to. He wrote the letter and decided to burn it. “It allowed him to release his guilt and he felt so much better.”

²⁰ Substance Abuse and Mental Health Services Administration. SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. Retrieved May 30, 2017, from <https://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf>.

Getting consumers to engage and buy into treatment is critical for recovery and cost-effectiveness. Consumer failure to attend scheduled treatment appointments results in millions of dollars in wasted staff time and decreases the likelihood that patients will stay in treatment and achieve their recovery goals.²¹ Studies illustrate that peer support can increase treatment participation among consumers. This includes populations traditionally difficult to engage in mental health, such as people with comorbid mental health and substance use disorders²² and veterans with substance use disorders.²³ A study of peer support among veterans with substance use disorders found that increased engagement not only occurred under integrative treatment conditions but also under traditional treatment,²⁴ illustrating the strength of this treatment tool.

Peer support is considered a best practice because of its positive benefits for recipients,²⁵ but also because of the positive impact on the supporting peers themselves, psychologically and financially. A study examining the benefits of working as a Certified Peer Specialist (CPS) revealed that CPSs experience significant reductions in inpatient hospitalization and crisis services. The study included 151 CPS participants in Pennsylvania, 28 percent of whom were not working before CPS employment.²⁶ Participants were able to reduce or eliminate their dependence on Social Security Benefits. This illustrates that peer support programs can bring previously unemployed people into the formal labor market, giving them economic stability.

Furthermore, CPS training helped the study participants learn critical skills for their recovery. The vast majority of participants agreed or strongly agreed that CPS training helped them develop skills applicable to their life and recovery, and made them more hopeful about their future and more confident that they could further their recovery and seek employment. They also agreed/strongly agreed that the job gave them an ability to give back to others, impact the agency where they worked, increased their confidence, and gave them an opportunity for personal development and to learn from peers.

Participants experienced changes in hospitalizations and ED visit frequency after training, with most of them experiencing a decrease. Forty-nine people experienced a

²¹ Singh N, Barber J, Van Sant S. (2016). Handbook of Recovery in Inpatient Psychiatry. Series: Evidence-Based Practices in Behavioral Health. Publisher: Springer International Publishing. doi: 10.1007/978-3-319-40537-7.

²² Ibid.

²³ Tracy, K., Burton, M., Nich, C., Rounsaville, B. Utilizing peer mentorship to engage high recidivism substance-abusing patients in treatment. *The American Journal of Drug and Alcohol Abuse*. 2011;37:525–531.

²⁴ Dixon LB, Holoshitz Y, Nossel I. Treatment engagement of individuals experiencing mental illness: review and update. *World Psychiatry*. 2016;15:13–20. doi: 10.1002/wps.20306. Retrieved May 30, 2017, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4780300/#wps20306-bib-0052>.

²⁵ Salzer, M., & Mental Health Association of Southeastern Pennsylvania. (2002). Consumer-delivered services as a best practice in mental health care and the development of practice guidelines. *Psychiatric Rehabilitation Skills*, 6, 355–382. Retrieved May 30, 2017, from doi:10.1080/10973430208408443.

²⁶ Salzer, M. S., Darr, N., Calhoun, G., Boyer, W., Loss, R. E., Goessel, J., Schwenk, J., & Brusilovskiy, E. (2013). Benefits of working as a certified peer specialist: Results from a statewide survey. *Psychiatric Rehabilitation Journal*, 36 (3), 219-221. Retrieved May 30, 2017, from doi:10.1037/prj0000016.

change in frequency after training; 41 (83.7 percent) experienced a decrease while 8 people experienced an increase (16.3 percent). Fifty-five participants experienced a decrease in hospitalization (83.3 percent) compared to 11 who reported an increase (16.7 percent).

Wright says that peers sharing how far they have come is mutually beneficial because it illustrates to recipients a living recovery example and reminds peers how far they have come. Recovery, she says, is a continuous journey with obstacles. “When I go back and hear my story, I realize how much I have overcome. I may be struggling with a particular challenge, but sharing my story reminds me that I can overcome this too.”

Recovery is not a straight line—there are often steps back and sideways. Peers, says Wright, share this struggle and do not gloss over challenges. They share with recipients of services that there were days they wanted to quit and did not think they were going to make it. “People need to know that it’s okay if they fall down,” Wright says. “You can’t just get up and run a marathon; you have to practice.” She says recovery is retraining your mind and body, which takes time. There are days you have to just acknowledge that you made it to breakfast or to that very moment. “Recovery is done piece by piece,” she says.

Technology, Felt Safety, Hope, and Resilience

Trauma patients often have difficulty feeling safe in a variety of settings. This is where technology, as an accessory to treatment, is crucial, says the STAR program’s Dr. Yeager. It allows people, at any point, to access tools for grounding, relaxation, and cognitive reframing exercises. The nonprofit [Trauma Resource Institute](#) has developed [iChill](#), an application that teaches users self-help skills that follow the [Community Resiliency Model](#), such as tracking, resourcing, grounding, and “shift and stay”. It also includes immediate strategies for the user to get into a resilient zone when he or she is feeling stressed that include counting backward from 10 as the user walks around the room, pushing against a wall, or naming six colors the user sees in the room or outside. The application is not interactive and can feel a bit like a PowerPoint or classroom lecture, but the skills are useful.

As previously mentioned, the feeling of hope is so critical that SAMHSA calls it the recovery process catalyst. The National Center for Telehealth & Technology (T2) developed the [Virtual Hope Box](#) (VHB), with military service members and veterans with Post-Traumatic Stress Disorder in mind. The developers collaborated with the Portland VA Medical Center and the Military Suicide Research Consortium, and, in 2014, was awarded the Department of Defense Innovation Award.

The app is designed to foster help and hope through positive thinking, coping, relaxation, and distraction. Users can personalize their VHB with personal virtual content—such as family photos, videos, recorded messages from loved ones, music, positive life experiences, and reminders of previous successes—from their phones. Users can work with their providers to develop personalized coping cards that address a problem area and

identify associated feelings (e.g., sad, angry, lonely) and physical symptom (e.g., nausea, headache), as well as adaptive thoughts and behaviors. The app also allows users to enter their support contacts and provides emergency hotlines such as the Veterans Crisis Line and the Defense Centers of Excellence Outreach Center.

The same developers have created an app to boost provider resilience, aptly named [Provider Resilience](#). Users fill out a self-assessment, rating their risk for secondary traumatic stress, burnout, and compassion fatigue. The scores can be viewed as graphs that providers can monitor over time. The app also includes inspirational cards, stretches, Dilbert comics, and a clock that illustrates the last time the user had a day off. It also includes motivational videos highlighting the positive impact health care providers have had on service members' lives, reminding users of the positive and life-changing impact they have on their clients. Hope is not just important for clients, but for providers, too.

Conclusion

Every person we interviewed talked about how the hope that TIC fosters is critical to recovery, a concept that seems, on its face, impossible to measure. In fact, most experts said that TIC is low-tech and hard to access. Yet, it turns out to be less complicated than it seems. The TRC Model illustrates how comprehensive, integrated, trauma-informed treatment can dramatically improve outcomes for less cost. It also, remarkably, evens out the playing field for disparities such as homelessness, education level, and age. Participants experience decreased homelessness, improved workforce participation, and reduced alcohol and drug use. In essence, TRC helps reduce vulnerability and boosts resilience.

The objective of TRC is to aid interpersonal violent crime survivors with psychological trauma and logistical hurdles, creating a model on how to do so in an integrated and comprehensive way. Common hurdles among victims, regardless of trauma type, include housing, employment, legal advocacy, financial entitlements, stigma, and avoidance. By addressing the entire person, holistically, the TRC Model has been shown to be far more successful in engaging participants in mental health services than usual services (77 percent compared to 34 percent of those who received community care). Getting people to buy into treatment improves recovery outcomes *and* is more cost-effective.

Other programs have demonstrated TIC benefits such as reduced demand for crisis services, including hospitalization and crisis intervention, improved consumer participation, and increased housing stability. States and cities are beginning to involve the community, particularly when it comes to violence, resulting in TIC partnerships between communities and EDs to decrease crime and address underlying issues. These TIC teams have been able to mitigate killings by disrupting retaliation and addressing underlying challenges victims face.

Involving people with Lived Experience in TIC training and peer support is mutually beneficial for those sharing their stories and recipients. In fact, peers in a Pennsylvania study experienced significant reductions in inpatient hospitalization and crisis services,

and were able to reduce or eliminate their dependence on Social Security Benefits. Including people with Lived Experience fosters hope across the board, for those in the mental health field who may be burned out and need to see success stories, for those in the early steps of recovery who need hope to be tangible and attainable lest they become hopeless, and for those sharing their stories who need a reminder of all they have managed to accomplish. The hope that Trauma-Informed Care fosters is, and must be, tangible and accessible.

NASMHPD prioritizes TIC and continues to see the difference that TIC makes in environments across the spectrum of public health programs.