

Keys to Collaboration

between Hospital-based Violence
Intervention Programs *and*
Trauma Recovery Centers



THE
HEALTH ALLIANCE
for VIOLENCE
INTERVENTION



NATIONAL ALLIANCE OF
TRAUMA RECOVERY CENTERS

INTRODUCTION

The U.S. has experienced epidemic levels of interpersonal violence, largely concentrated in communities that have also suffered from decades of systemic neglect and harm. It will take continued successful collaboration among a diverse ecosystem of violence prevention strategies and treatment models—each with their own complementary strengths—to address the widespread devastation this systemic community violence has caused.

The following brief is a collaboration between The Health Alliance for Violence Intervention (The HAVI) and the National Alliance of Trauma Recovery Centers (NATRC)—two national networks that have developed models of care for victims of violence in underserved communities. These models were developed to reduce racial inequities and barriers to accessing effective healing support after trauma. They do so by offering intervention for victims at a crucial time of need and by promoting healing, which also impacts families and communities. To follow are insights, not only about The HAVI’s Hospital-based Violence Intervention Program (HVIP) model and the NATRC’s Trauma Recovery Center (TRC) model, but also the ways in which these two interventions complement one another to address the multitude of needs of victims of violence.

Experiencing violence can have a devastating effect on individuals. In addition to the physical wounds, a victim of violence is at great risk for housing and employment instability, food insecurity, social support disruption, and traumatic stress. These effects ripple and extend to loved ones, throughout families, and across communities. In the United States, the COVID-19 pandemic has brought an increase in violence—gun, domestic, and other types—creating an even greater need for services that support healing for victims

and affected communities.¹ Among people who experience violence, those who connect with effective, trauma-informed support services are much less likely to be caught in continuing cycles of violence and retaliation than those who do not. Yet, research has demonstrated that most victims of interpersonal violence do not receive help after trauma.² This is especially true for people of color and younger people, who are the least likely groups to receive timely and effective support and mental health services. This is

often due to barriers such as uncertainty about where to seek assistance and complex service eligibility requirements that call for extensive documentation related to victimization and its effects. Many lack support with the practical impacts of trauma—the inability to work, maintain housing, or connect with follow-up medical care—that need attention before individuals can attend to

their emotional or psychological well-being. Successful collaboration among compatible violence prevention treatment strategies is needed to address all the complexities of the problem. This brief speaks to the need for service providers and interventionists working with similar populations to develop good working relationships that benefit the people they serve.



DEFINITIONS

Hospital-based Violence Intervention Programs (HVIP) are multidisciplinary programs that integrate social care into medical care to intervene and serve people injured by community violence. HVIPs combine the efforts of medical staff with trusted community-based partners to provide safety planning, services, and trauma-informed care to violently injured people, many of whom are boys and men of color. Engaging patients during their recovery in the hospital provides a unique opportunity to improve the social determinants of health and reduce risk for reinjury. HVIPs connect patients with Violence Prevention Professionals (VPP)—highly trained paraprofessionals who often come from the communities they serve—who provide support and advocacy during the victim’s time in the hospital and long-term intensive case management, mentoring, and links to community-based services after discharge.

Trauma Recovery Centers (TRC) provide comprehensive mental health and support services to victims of recent violent crime, including physical assault, sexual assault, domestic violence, immigration trauma, community violence, hate crimes, human trafficking, and loss of a loved one to homicide. TRCs use a combination of assertive outreach; trauma-informed, evidence-based therapies; and case management to meet victims where they are and tailor services to each person’s needs. This integrative approach to care serves the whole person and removes barriers for those who have experienced multiple types and incidences of violence. Services are provided by a multidisciplinary team that may be hospital-affiliated or community-based.

MODEL ORIGINS

Since the introduction of the first HVIP in the mid-1990s, the model has continued to proliferate nationwide. In 2009, HVIPs from across the country came together to form the National Network of Hospital-based Violence Intervention Programs, which in 2019 became The Health Alliance for Violence Intervention. This work has proven to be effective in reducing violent reinjury and arrest for violence perpetration and has yielded other positive health outcomes.³ As of 2023, The HAVI network has grown to include over 50 member programs across the U.S. and in three other countries, with additional states and cities planning to develop an HVIP in their communities.

The UC San Francisco Trauma Recovery Center opened in 2001 with the goal of reducing health care disparities by providing comprehensive, effective mental health services to victims of violence who were

falling through the cracks of traditional victim services. The TRC model was developed to reach victims who are also people of color, people experiencing homelessness, immigrants and non-English speakers, and people from LGBTQ communities, as these individuals often face many barriers to accessing help after trauma. Research has demonstrated that the model is both clinically effective and cost-effective.^{4,5} TRC replication began in 2014, and as of 2023, the National Alliance of Trauma Recovery Centers has grown to include over 50 member programs across the U.S., with additional states and cities planning to develop a TRC in their communities.

The expansion of TRC and HVIP programs has resulted in overlapping catchment areas in multiple cities, including Columbus, OH; Newark, NJ; Los Angeles; and San Francisco; among others. In 2020, for example, New Jersey implemented both HVIPs and TRCs throughout the state to expand victim services to break cycles of violence. This effort was in recognition that the two models operating together create a more robust support network for people injured by violence. These networks are leveraging their connections and using the opportunity to develop best practices for collaboration between the models that draw on the strengths of each.

Provider networks are developing best practices for collaboration between the HVIP and TRC models that draw on the strengths of each.

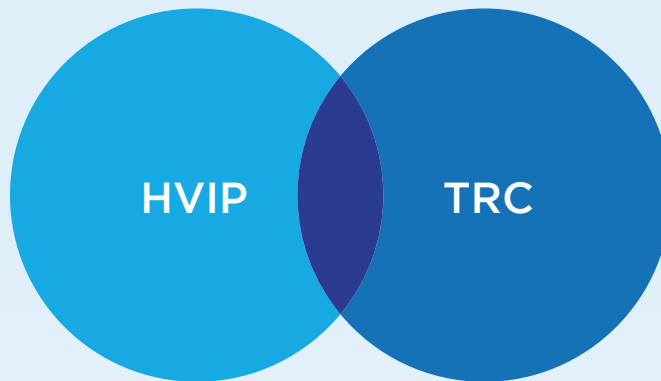
MODEL EVIDENCE

Studies have shown that clients receiving HVIP services experience reduced rates of reinjury compared to control groups, along with reduced rates of substance use, convictions for violent crime, involvement with the criminal justice system, and reduced arrests for violence perpetration.⁶ Clients have increased rates of employment, utilization of community services, and stable housing than comparison groups. Studies on the cost-effectiveness of HVIPs have also revealed savings to the health care system.⁷ For example, during the initial implementation of the Affordable Care Act, one study estimated that if HVIP service delivery had been provided to all violently injured hospitalized patients, it would have resulted in a national savings of \$69 million to the Medicaid program.⁸

The evidence for TRCs is also compelling. The California legislation that initially established the UC San Francisco TRC mandated a randomized trial to evaluate both the clinical and cost-effectiveness of the model.

With 541 participants, this trial is one of the largest longitudinal studies ever conducted with underserved crime victims. Results demonstrated that 77% of victims who received TRC services engaged in mental health treatment compared to 34% who did not receive TRC services.⁹ More recent data demonstrates clinical outcomes: clients seen for 16 sessions experience a 44% decrease in symptoms of PTSD and a 43% decrease in depressive symptoms.¹⁰ These findings have been duplicated at other TRCs since replication of the model began. In addition, clients overwhelmingly report such positive outcomes as feeling better able to handle daily activities (91%), saying treatment helped them feel better emotionally (93%), reducing or coping more effectively with substance use (89%), and effectively linking with other community services (82%). TRC services are also more cost-effective and cost approximately one-third less per unit of service than fee-for-service care covered by victim compensation.¹¹

MODEL COMPATIBILITY



Both the HVIP and TRC models focus on engaging historically underserved communities, increasing access to healing services after violent crime, and addressing acute trauma while acknowledging chronic trauma resulting from systemic inequalities. They are nationally replicated and seek to transform the field of victim services and remove the victim/perpetrator binary from healing services. The overlap in HVIP and TRC structures allows for partnership building based on program strengths. Areas of overlap related to the population served, staffing, and services make up the core of HVIPs and TRCs. Areas of alignment and model distinctions are described below.

Populations Served

HVIPs and TRCs both support individuals who have been violently injured and their loved ones. HVIPs focus on victims of community violence and engage them through referral from the medical trauma center or hospital where they are being treated. HVIPs respond as soon as possible after a violent injury, ideally when the person is still in the hospital, to take advantage of the “Golden Moment” when an injured person may be particularly receptive to receiving care. TRCs serve victims of all types of interpersonal violence, family members, and loved ones of homicide victims. This non-siloed approach increases access and removes barriers to receiving services and care. TRCs’ multiple entry points include hospital inpatient units and emergency departments, victim services offices, domestic violence shelters, rape crisis centers, primary care clinics, district attorneys’ offices, law enforcement, and other community partners. TRCs actively include clients with challenges that commonly result from trauma, such as substance

abuse, suicidality, high levels of anxiety, and low motivation to engage in services.

HVIP	TRC
<ul style="list-style-type: none"> ■ Provide timely bedside response to a person with a penetrating trauma or sustained injuries due to community violence victimization ■ Majority of patients served are youth and young adults (age 18-35) ■ Support provided during the initial treatment, hospitalization, and post-discharge 	<ul style="list-style-type: none"> ■ Serve victims of all types of violence (physical assault, sexual assault, domestic violence, community violence, hate crime, loved one of homicide victim) ■ May specialize in work with adults, youth, or both ■ May specialize in work with particular communities (i.e., people who are homeless; asylum seekers/refugees; victims of community violence)

OVERLAP

- Violently injured people and their loved ones/family members
 - Family members of homicide victims
 - Engage with individuals who have historically been marginalized and experience higher rates of violence

Staff

Program staff may be employed by a hospital, community-based organization, or academic medical center for both HVIPs and TRCs. In each model, diverse teams work collaboratively to provide comprehensive services. HVIP staff are largely paraprofessional and have diverse experience and skills sets. The core of HVIP work is done by Violence Prevention Professionals (VPP). These highly trained individuals, who often come from the communities in which they are working, quickly engage violently injured patients and their families in the emergency department, at the hospital bedside, or soon after discharge. TRC staff are a multidisciplinary team of licensed mental health providers, social workers, psychologists, and a psychiatrist, and often include peer support specialists or outreach workers. TRC staff also have training and supervision in trauma-informed,

evidence-based therapies to decrease symptoms of distress and increase well-being. The diverse staff of these distinct models work collaboratively to provide comprehensive services.

HVIP	TRC
<ul style="list-style-type: none"> ■ Staff with lived experience of violence who have earned the community's trust ■ VPPs trained in violence prevention ■ Clinically trained staff ■ Health care providers trained in community violence and referrals 	<ul style="list-style-type: none"> ■ Multidisciplinary licensed mental health team ■ Clinical fluency in evidence-based and evidence-informed therapies ■ Many include outreach workers/peer support navigators

OVERLAP

- Use a trauma-informed, client-centered approach
- May be employed by a hospital, community-based organization, or academic medical center

Services

HVIPs and TRCs take a strengths-based team approach to care and provide case management tailored to the needs of participants, connections to resources, as well as community outreach, accompaniment, and systems advocacy. Both models also use data to identify service needs and to demonstrate program service outcomes. HVIPs explicitly work to reduce risk of reinjury to interrupt ongoing cycles of violence. They use a trauma-informed, client-centered approach to patient engagement and provide services that actively address social determinants of health and structural racism. HVIP staff work with patients to understand/assess levels of risk, create safety plans, develop personal goals that guide the specific services provided, and provide intensive long-term case management after hospital discharge. Intensive long-term case management involves trust-based relationships that offer increased access to clients. TRCs use a client-centered, assertive outreach approach to engagement after violent victimization. TRCs work to reduce the stigma attached to mental health services, and frame interventions in the context

of systemic racism and inequities that underlie higher rates of trauma and violence in communities of color and other marginalized groups. TRCs' outreach approach is flexible, and helps to address practical needs, while building trust.

HVIP	TRC
<ul style="list-style-type: none"> ■ Post-discharge services in the community that are geared toward addressing the social determinants of health and structural racism ■ Ongoing services in locations where program participants live, feel safe, and are comfortable ■ Accessible and available to people with physical, cognitive, and intellectual disabilities 	<ul style="list-style-type: none"> ■ Evidence-based therapies to heal from the impact of trauma and increase safety/well-being ■ Crisis intervention, individual, group, and family services ■ Cultural humility approach to serving diverse populations in a community ■ Assertive outreach and community or home visits

OVERLAP

- Case management tailored to the needs of participants/ connection to resources
- Community outreach and accompaniment
- Systems advocacy
- Team approach to care
- Strengths-based approach
- Cultural humility
- Client-centered advocacy and support



CLIENT VIGNETTE¹

Carlos, a 19-year-old Latino man, was referred to a TRC by medical staff at the hospital where he was being treated for injuries from a physical assault. After leaving his restaurant job late one night, he had been waiting at a nearby bus stop when he was approached and beaten by multiple unknown assailants who also threatened him with a gun.

After the assault, Carlos experienced symptoms of post-traumatic stress disorder, including hypervigilance—intense fear for his safety that made it difficult to leave his house or return to work—and intrusive memories of the attack that left him feeling distressed, anxious, and unable to sleep. Additionally, he worried that he had been targeted because of a limp he'd had since childhood and that he would never be safe in the world because of it.

Hospital staff referred Carlos to a TRC for trauma-focused therapy and case management services. There, he worked with Alberto, a licensed clinician, who explained the physiological effects of PTSD to normalize hypervigilance as a response to trauma. Alberto introduced cognitive behavioral therapy (CBT) and acceptance and commitment therapy (ACT) interventions to reduce Carlos' PTSD symptoms, including the feelings of hypervigilance that spiked in the evening when he would leave work.

Alberto assisted Carlos with his case management needs, including linking

him to immigration legal services to file a U-Visa application and helping him file an application for victim compensation. Alberto also helped Carlos apply for a discounted bus pass for adults with disabilities and enroll in the county's public health insurance to cover the costs of follow-up medical care. After 16 sessions with Alberto, Carlos felt more grounded and hopeful about his future and was able to return to his job.

A year later, Carlos was hospitalized again after being shot in the leg in his neighborhood. He was referred to the hospital's HVIP. Ruben, a Violence Prevention Professional, met with him at his hospital bedside to introduce services, provide support, and assess his needs. As Ruben noted, "When you're at the hospital, they want to fix you and send you home as quickly as possible. Mentally, psychologically, you're not ready. You want to have somebody to talk to—to tell you that you're human and that this is horrible, and to hold your hand through all these services."

After completing a safety assessment, Ruben concluded that Carlos was not at high risk of reinjury. Carlos didn't know who shot him and had no desire to retaliate, and Ruben was aware that people in his community were being assaulted after leaving their jobs because it was known that they left work with money in hand. Ruben had no reason to believe that Carlos had been targeted and determined that he had

likely experienced a second instance of “wrong place/wrong time.”

After determining that Carlos was at “medium-low” risk of reinjury, Ruben referred him back to the TRC to work with Alberto again since he was experiencing a resurgence of PTSD and depressive symptoms. Alberto supported him through stresses and role changes that were “unspeakables” at first—temporarily losing his ability to work, then losing housing and having to move in with distant family members in another county, and guilt over not being able to send money back to his family in Mexico. Alberto also supported Carlos in individual therapy and referred him to “El Taller” (workshop), a skills-based TRC support group for Spanish-speaking clients.

Carlos benefited from the group discussions about trauma symptoms, which helped him normalize his reactions. Meeting with the group provided peer support and increased his sense of community and belonging.

After several therapy sessions, Carlos was doing much better. He had become a leader in the support group and frequently referred to elements of his own post-traumatic growth during their discussions. He encouraged new members to keep attending to gain the benefits of group support. His physical recovery allowed him to move back to his former neighborhood. By continuing to use the CBT and ACT skills he had practiced to reduce his PTSD symptoms, Carlos was once again able to take public transportation, return to work, and regain his independence.

1. This vignette is based on an actual client; names and some information have been changed to maintain anonymity.





CLIENT VIGNETTE²

James is a 24-year-old male who arrived in the emergency department with a friend after being shot in the leg. He was extremely agitated and yelled at the nurses as they began to cut off his pants to treat the wound. They called hospital security and told him he had to calm down or they would have to restrain him. This angered him further, and he shouted at them to leave him alone. When he stood up to leave, the nurses said he needed treatment and was leaving against medical advice. James left anyway. Once outside, he was so upset he punched a wall and broke his hand. His friend convinced him to go back in and “let them get the bullet out and stop the bleeding.”

James reentered the ED and waited while his friend talked to the nurse who had checked him in before. Martin, a Violence Prevention Professional with the hospital’s HVIP, approached James and introduced himself. He arranged for a private room where they could talk. He listened while James explained that his brother had died from a gunshot wound in this hospital. James knew he was unlikely to die from a bullet in his leg but shared that “this place gives me the creeps.” Martin said he understood and that he used to hate the hospital too, because many of his family and friends had been treated poorly there. Martin shared that he knew of James’ late brother and offered his condolences for James’ loss.

With Martin accompanying him and explaining what to expect, James received care for his hand and prepared for surgery on his leg. Before surgery, Martin asked where James would go when he was discharged later that day. James shared that his girlfriend had kicked him out, and he didn’t know where he would stay. Martin asked if James had been the intended target of the shooting. James said he had been in an argument with a friend, but the gun had discharged by accident. When James came out of surgery, his friend who brought him to the ED said he could stay with him for a couple weeks while he recovered. Martin remained with James until he received his discharge instructions and medications. Before leaving, Martin told James that he would stop by the next day to check on him.

Martin visited James every few days for the next two weeks and then weekly for several months. He worked with James to identify his primary goals—stable housing, a new job, and support in negotiating with his girlfriend to see their two-year-old son. He helped him apply for Crime Victims Compensation to cover his medical bills. After James left his friend’s house where he’d been staying, Martin arranged a hotel stay for a month while they waited for his application for public housing to proceed. James started training for a commercial driver’s license to drive a delivery truck and obtained a job with a local company.

He identified an uncle of his girlfriend whom they both trusted, and Martin got the uncle to agree to help them have a civil conversation focused on what was best for their son.

Martin also helped James understand how his brother's murder was still affecting him. His insomnia and explosive anger had started shortly after his brother's death. He was unable to return to the block where his brother had been shot, enter the hospital where he died, or visit his sister-in-law in the home where she had lived with his brother. Martin explained that while he could continue to support James, working through trauma was best done with someone with more expertise. James was wary of people thinking he was crazy if he saw a therapist. Martin explained that he knew the counselors

at the Trauma Recovery Center and assured him that they were cool. He let James know that since the TRC is connected to the hospital, James could enter through the hospital, and no one would know where he was headed. Martin accompanied James to meet Tony, the counselor at the TRC, and James was amazed that Tony was so down to earth. He started seeing Tony weekly to manage his insomnia, work through his anger and grief, and learn coping strategies that would help him stay safe.

Three months later, James had a bad day and blew up at his boss. He was fired and had to restart his job search. Martin and Tony continued to support him through the ups and downs of his healing process.

2. This vignette is based on a composite of several patient experiences.



BENEFITS OF COLLABORATION

The HVIP and TRC models operating in collaboration offer several benefits including removing barriers to care, addressing racism in systems of health and healing, supporting staff wellness, and network building for advocacy and sustainability.

Removal of Barriers to Care: When programs with different strengths collaborate to serve, clients gain access to a wider range of care options. If HVIPs seek to increase their capacity for mental health services, for example, they can refer clients to a TRC for additional trauma-informed services. Similarly, if TRCs are working with victims of community violence who could benefit from community-based support and expertise, they can refer these clients to an HVIP. Clients will benefit from access to the full list of services that each program has to offer.

Addressing Racism in Healing Ecosystems: An equity approach to recovery services can be beneficial for communities that have experienced systemic racism. This includes communities that experience inadequate access to insurance and health care, neighborhoods that lack well-resourced schools and easy access to fresh produce, and communities where over-policing residents is common practice. The availability of programs that have different areas of expertise and serve different populations increases a community's healing capacity and provides parity with better resourced communities.

Provider Wellness: The stresses of working with victims of violence can affect providers from both HVIPs and TRCs. An important buffer against burnout and vicarious trauma is for providers to feel like they are part of a community that is making a difference. Collaboration and intentional partnership among programs can increase providers' sense of community beyond their own program and provide opportunities for professional growth. Programs can also benefit from the ability to share strategies for supporting staff wellness that might be new to their own team or work culture. Examples of such strategies include protected time for self-care, professional development opportunities that increase a sense of competency and decrease feelings of helplessness, and team activities that build supportive relationships among co-workers.

Advocacy and Sustainability: The specialized services provided by HVIPs and TRCs complement one another. Collaboration between the models can result in broader organizational and coalition advocacy that can foster expansion and highlight the need for sustainable funding.

CONSIDERATIONS FOR COLLABORATION

There are multiple examples of HVIPs and TRCs working together to address the specific needs of victims. Lessons learned reveal considerations that are important for groups interested in model collaboration.

Setting Overlap: In hospitals where there is both an HVIP and a TRC, how are referrals decided? If it's a shared referral, what are the roles of each program?

In many hospitals, HVIP VPPs are the first point of engagement with victims of gunshot wounds and other injuries resulting from targeted community violence. Their assessment of the potential risks of re-injury and/or retaliatory violence following discharge can serve as the first step in immediate safety planning. TRC clinicians may also meet with patients at the hospital bedside to introduce services, provide psychoeducation on trauma and coping, and orient victims to the ways that support for mental health and wellness can aid in their recovery from violence. When two programs are serving the same population, a client might benefit from services offered by both programs but may only have the time and bandwidth to engage with one or the other. Regular communication among HVIP and TRC providers—such as daily rounds to identify patients and jointly triage treatment planning priorities—can help clarify the role of each provider in inpatient settings.

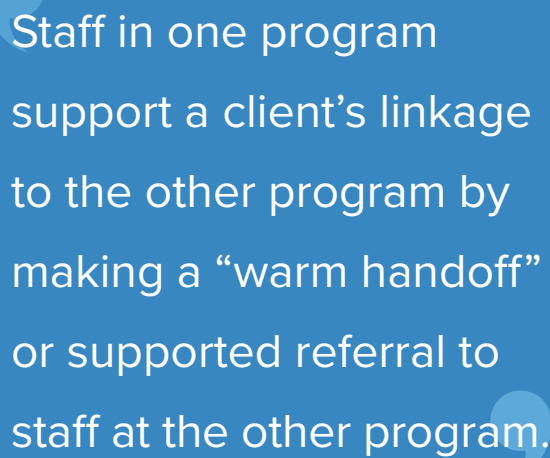
Building Trust/Rapport: For some, traditional mental health treatment may be viewed or experienced as problem-focused, too “clinical,” and not culturally responsive.

Also, stigma associated with mental health can impact whether individuals engage in mental health services and treatment or their decision to not seek care, especially if they have had negative experiences with other “helping” systems in the past. Stigma around mental health services may also be a barrier to client referral for HVIP VPPs. Those who have had no experience with mental health services or a negative experience in the past may understandably be reluctant to refer clients.

Both TRC and HVIP staff work to build trust and rapport with their clients in order to overcome any barriers to care and create a healing relationship. They also take care to orient clients to what they have to offer and explain their approach to services. The same thought and care should be put into team building for TRC and HVIP staff, and program leadership should create opportunities for cross-program education and dialogue and explore any barriers to buy-in for what the other program has to offer.

Lived Experience vs. Professional

Experience: Both lived experience with violence and specialized training in healing services can be pathways to working with victims of community violence. Expertise gained through each of these pathways can contribute to a client's healing and well-being. The pathways are not necessarily mutually exclusive, however, as mental health clinicians can also have lived experiences with violence and VPPs possess varying levels of trauma-informed training.



Staff in one program support a client's linkage to the other program by making a “warm handoff” or supported referral to staff at the other program.

To collaborate effectively, all providers must feel that their work is respected and valued. Particularly in health care settings—which often have rigidly defined hierarchies based on academic credentials—it is important to ensure that providers whose expertise comes from lived experience are validated, given equal access to patients, encouraged to pursue leadership opportunities, and compensated equitably.

Referral Threshold: HVIP VPPs and TRC clinicians may come to differing conclusions about when a client should be referred for mental health services. Open communication and dialogue can be helpful in these situations. For example, weekly case conferences can be used to discuss whether a referral is needed for any emerging mental health issues a VPP may have observed in a client. To further support the referral process, TRC clinicians can also provide training and education to HVIP VPPs about PTSD, depression, and other mental health disorders. Such training benefits VPPs by increasing their awareness of the symptoms of mental distress and better equips them to ask their clients more effective questions.

Communication: If providers working with the same client are not in regular communication, the client won't experience a team approach to care. Regular communication helps to ensure that goals are client-centered and that services between programs aren't duplicated.

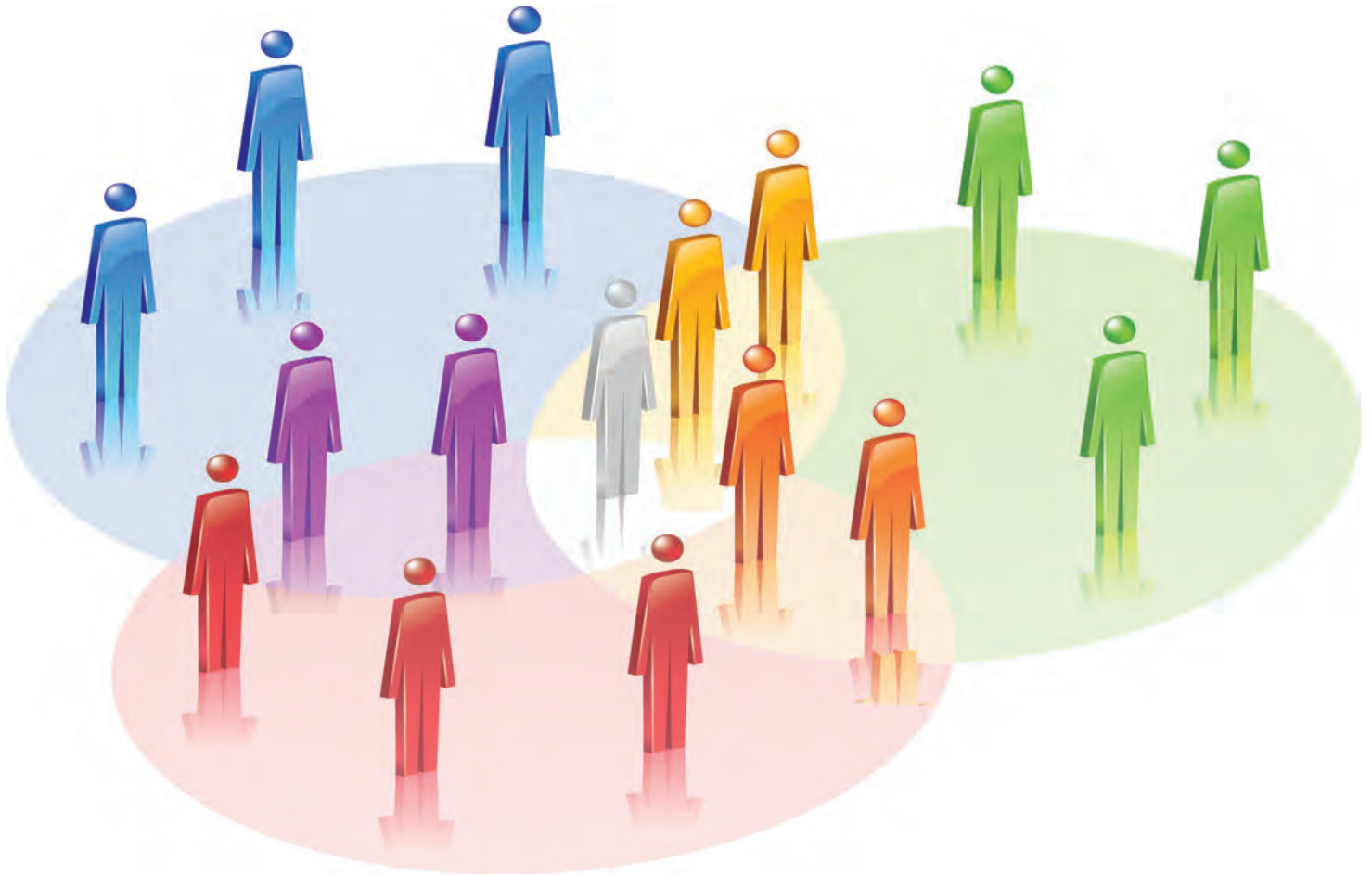
Cross Referral: If HVIPs seek to increase their capacity for mental health services and support, they can refer clients who need them to a TRC for additional trauma-informed services. If TRCs are working with victims of community violence who could benefit from community-based support and expertise, they can refer these clients to an HVIP. At this level of collaboration, clients participate in either HVIP or TRC services, and staff in one program support a client's linkage to the other program by making a “warm handoff” or supported referral. This can happen from either direction, such as when an HVIP VPP has been providing support and case management to a survivor whose mental health is not improving or is worsening, or when a TRC clinician has provided mental health treatment and then refers a client to an HVIP for ongoing community-based support and violence intervention. The process of a warm handoff includes providing information to a client about how the other program can be helpful and sharing positive experiences the provider has had with the other program to help the client build trust with a new provider.

Collaborations should consider options for either a warm handoff from one program to another or for a client to receive services simultaneously from the HVIP and the TRC. This type of partnership expands the menu

of support options available to clients, and thoughtful collaboration can clarify roles if both programs are working in the same hospital or location.

Funding: It can be difficult to identify and secure funding for these models,

and in an environment where financial resources are scarce, programs may feel the need to compete against each other for sustainability. Consider a demonstration of collaboration to highlight the success and need for sustained funding for both models of care.



ADDITIONAL BEST PRACTICES

Each community is unique and should build on the strengths and opportunities that exist locally. While the process for establishing a strong collaboration between HVIPs and TRCs can look different for different groups, there are best-practices for collaboration that are foundational to effective partnership.

“Communication, communication, communication”: Communication at the leadership level should clarify partnership roles, structures, and responsibilities. Regular communication at the provider level ensures that clients benefit from a unified team approach to care, and promotes mutual learning.

Memorandum of Understanding (MOUs):

The partnership might begin with an agreement between leadership at both programs and VPPs so that staff know whom they can contact for questions, more information, or to check in about any challenges encountered in the referral process. Programs should create MOUs so that guidelines for working together are clear, institutionalized, and will outlast staffing changes at either program. An MOU may be needed to define confidentiality and consent for programs that will be working jointly with clients and are not under the same administrative umbrella. The MOU can also specify important details such as:

- Where does the first point of contact happen, and is one program the “home base” for clients? Can clients enter services through the HVIP, the TRC, or both?

- Does one program’s staff meet a potential client at hospital bedside to introduce services and start building a relationship, or do staff from both programs meet jointly with a survivor to introduce services at an initial visit?
- If a client is receiving both HVIP and TRC services simultaneously, how is this coordinated to avoid fragmentation and duplication of services? What are the expectations for the frequency and content of communication between the HVIP and TRC providers? Is there a weekly case conference or team meeting attended by providers from both programs? How are areas of potential overlap in services, such as with case management, assigned to providers based on their areas of expertise and client need?

Model Fidelity: Both HVIP and TRC models have defining core elements. While there is flexibility for individual programs to balance model components with local community needs and existing resources, fidelity is what makes a program a HVIP or TRC. Programs with high model fidelity are able to build partnerships based on each other’s strengths. Both models have training and technical assistance available to support program implementation and ongoing services, which has been key to ensuring high-quality care for survivors of violence.

Continuous Quality Improvement: As one HVIP program manager stated, “Be honest about what is working and what is not. Be open to trying new things. Do trials of new ideas.” Leadership and staff should be willing

to engage in and receive constructive feedback and adjust course as needed.

Embedded Staff: An additional point of collaboration is to embed one or more staff of either an HVIP or TRC into the other program and provide services at that location. For example, a TRC clinician can work part-time at an HVIP or vice versa. This arrangement increases accessibility for clients because the services of both programs are provided in one location. It also creates more regular and organic opportunities for TRC and HVIP staff to communicate, both one-on-one and in case

conferences or team meetings. An example of this model of collaboration is at the Wrap-around Project at Zuckerberg San Francisco General Hospital. Here, HVIP staff report that a benefit of having a TRC clinician at case conferences is the opportunity it provides to learn more about mental health disorder symptoms and specific questions to ask clients about what they might be experiencing, such as “Are you sleeping well?” or “Are you having nightmares or sweats?” Additionally, this type of partnership allows HVIP and TRC staff to co-facilitate support groups and have joint meetings with clients they share.

CONCLUSION

HVIPs and TRCs are complementary models that can build on the strengths of each program. Rather than duplicating services, an intentional partnership between programs benefits victims of violence by adding more support to their structures of care. They implement trauma-informed and equity-centered strategies to address the fundamental needs of clients and are a

large part of the re-envisioned public safety conversation. These distinct models are essential components for reducing trauma and violence in communities. Collaboration should build on the strengths of each program and incorporate best practices for developing a solid foundation of partnership. HVIP and TRC collaboration is happening organically in many communities where there is overlap between the two models. A mindful approach will help ensure that partnerships succeed and survivors of violence benefit from all these two models have to offer. This work needs even more recognition, support, and funding to make a difference in areas where rates of violence are high.

An intentional partnership between HVIPs and TRCs benefit victims of violence by adding more support to their structures of care.

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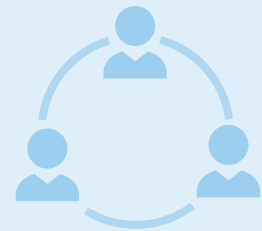
RECOMMENDED TRC STAFFING

Model Roles



TRC Director

Oversees all clinical and administrative services, including analysis and implementation of strategies to positively impact client care. Reviews program outcomes and ensures administrative and clinical services are provided using a trauma-informed/cultural humility lens, with ongoing training and support for staff. The TRC Director provides high level strategic planning, develops and maintains mutually beneficial community partnerships, represents the TRC to local and state government officials, and advocates to help remove barriers to care for clients on a system-wide level.



<h4>Administrative Coordinator</h4>	<h4>Data Coordinator</h4>	<h4>Clinical Coordinator</h4>	<h4>Psychiatrist</h4>
<p>This leadership role collaborates with Director on budgets, financial oversight, grant applications, and reporting; creates policies and procedures. Develops and maintains systems for billing and staff productivity. Supervises front office staff and ensures smooth flow of all TRC operations.</p>	<p>Collaborates with program leadership to design and implement data collection and management procedures. Helps evaluate clinical outcomes and staff productivity to support the delivery of high quality, data-driven, innovative, trauma-informed mental health services.</p>	<p>A licensed mental health clinician who provides clinical and administrative supervision to TRC clinicians, using a strengths-based approach. Manages client flow and develops related policy for intake appointments, clinicians' caseloads and duties, and clinic schedules.</p>	<p>A licensed psychiatrist who conducts clinical assessments for clients who could benefit from psychotropic medication, manages medication, consults with team members on risk issues, and helps lead multidisciplinary team meetings. Serves as a link to other medical providers to ensure coordination of all medical/psychiatric issues.</p>
<h4>TRC Clinician</h4>	<h4>Outreach Workers/Peer Support Specialists</h4>	<h4>Operations Staff</h4>	<h4>Clinical Interns and Trainees</h4>
<p>A multidisciplinary team of licensed clinical social workers, marriage and family therapists, and psychologists with fluency in trauma-informed/client-centered, evidence-based, individual and group treatments. Conduct assertive outreach and case management.</p>	<p>May provide assertive outreach, orientation to TRC services, case management/linkage, advocacy, and client accompaniment to appointments in the community.</p>	<p>Triage calls, appointments, and walk-ins, helping ensure that all people coming to the TRC will feel seen, heard, safe, and welcomed. Support clinic administrative operations.</p>	<p>Masters or doctorate-level students participating in accredited mental health training programs, who provide trauma-informed clinical services: outreach, intakes, individual and group therapy.</p>



NATIONAL ALLIANCE OF
TRAUMA RECOVERY CENTERS

RECOMMENDED HVIP STAFFING

Model Roles



Program Director/Manager

Provides programmatic oversight. Manages all aspects of program administration, planning, personnel management, fundraising/grants development, and program promotion. Fosters relationships with relevant social service providers to increase access to resources for program participants.

Violence Prevention Professional	Program Supervisor	Clinical Staff	Clinical Supervisor
<p>Serves as an advocate and resource navigator for program participants. Ideally someone with lived experience similar to the patient population and/or demonstrated ability to build trust and understand client needs. Provides immediate and long-term case management in the hospital and post-discharge.</p>	<p>Provides daily supervision and case consultation for Violence Prevention Professionals. Supports the overall coordination of treatment plans and crisis interventions.</p>	<p>Provides culturally responsive clinical/therapeutic services to program participants and ensures HVIP team members are providing trauma-informed, client-centered care.</p>	<p>Provides regular clinical supervision to all clinical staff and Violence Prevention Professionals. Provides regular opportunities for capacity building and training for intervention teams. Ensures standardization of documentation, oversight of clinical interventions, and coordination of case review.</p>
Administrator	Data Manager	Hospital Champion	<p>Roles and responsibilities are subject to change based upon the specific needs and stage of implementation of HVIPs.</p>
<p>Provides a range of administrative supports based on programmatic needs. These roles can include but are not limited to fiscal management, data collection and evaluation, grant reporting, office management and operations, and communications.</p>	<p>Oversees program data collection and data entry. Creates processes for data collection and systems for data management, conducts analysis, monitors trends, and reviews program data with staff. Supports program evaluation.</p>	<p>Promotes and advocates for HVIP services within the hospital setting. Works to remove structural barriers within hospital leadership to ensure the provision of quality care. Works to ensure coordination of hospital administration, protocols, and policies for the streamlined operation of HVIP.</p>	



ENDNOTES

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5. Metz, S., Boccellari, A., Shumway, M., & Classen, C. (2020, April) Trauma Recovery Center: Addressing the needs of victims of violence and persecution. Symposium Presentation, Annual International Society for the Study of Trauma and Dissociation Conference, San Francisco, CA.
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10. Metz, S., Boccellari, A., Shumway, M., & Classen, C. (2020, April) Trauma Recovery Center: Addressing the needs of victims of violence and persecution. Symposium Presentation, Annual International Society for the Study of Trauma and Dissociation Conference, San Francisco, CA.
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