TRAUMA RECOVERY CENTER SERVICE FLOW

Photograph by Ezme Kozuszek

"What wisdom can you find
that is greater than kindness?"

—Jean Jacques Rousseau

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

As shown in the appendix to this chapter, *TRC Service Flow Graphic*, the model incorporates a number of stages and targeted services. The purpose of this narrative is to explain how the flow works in practice. Other parts of this manual describe each service component in detail; this narrative concentrates on how the components relate to each other as a client enters the program and moves from assertive outreach through clinical and case management services to ongoing care with partner agencies as needed.

Assertive Outreach

Assertive outreach is often essential for starting services, and for keeping a client engaged throughout treatment. As shown on the Service Flow diagram, assertive outreach is conducted in a number of stages in the TRC model. It is important in the referral process, because traumatized survivors may be too overwhelmed, embarrassed, or ashamed to seek help on their own. For many people, receiving another phone number to call for help can be perceived as being given yet another burdensome task with unclear benefits. The TRC Clinician reaches out to clients in the referral process, building a relationship and demonstrating how services can help with their most pressing problems. Later, assertive outreach can help keep clients engaged in their recovery and moving towards post-traumatic growth.

Referral Sources

TRC services begin with identification of potential clients by community partners, including medical services, victim services, law enforcement and other agencies. Cultivating partnerships with these referral agencies is crucial because clients are unlikely to know about a trauma recovery program and so are unlikely to self-refer. Referring agencies are motivated to identify and refer clients not only to benefit the client in abstract terms, but because they know TRC involvement will facilitate their own work with the client. For example, survivors of violent crime often fail to keep their follow-up medical appointments, but the support of a TRC program increases the likelihood that they will be able to attend. Establishing a TRC program requires informing potential referral agencies about the trauma recovery center and building effective community partnerships with them.

Medical services

Medical services—especially emergency services and inpatient medical trauma units that treat patients with crime-related physical injuries—are a key source of referrals because they are often the first contact any helping service has with a crime survivor. Once

oriented, medical staff become invaluable collaborators in identifying people needing TRC and putting them in contact with TRC Clinicians. TRC staff often contact and screen potential clients on site in emergency and trauma care units.

Victim services and law enforcement

Most states have established services for survivors of crime that are funded by that state's Victim Compensation Program, and these agencies are important sources of referrals. Law enforcement (police, district attorneys) often refer survivors to state victim services, and, when oriented, these advocates are effective in identifying and referring appropriate clients to TRC services as well.

Domestic violence shelters and rape crisis centers

Shelters and rape crisis centers work with similar clients to those seen in TRC, but may operate from a peer counseling model, or have limited capacity to provide individual psychotherapy. There are many ways that TRC and peer-support services can complement each other, and clients can benefit from the opportunity to access both simultaneously. For example, a client who receives individual psychotherapy and medication from TRC providers may experience a decrease in post-trauma symptoms that allows her to participate in a peer support group. A reciprocal referral relationship is in the best interest of both programs, and most importantly, of clients who can benefit from both types of services.

Other community agencies

Other community agencies, such as substance abuse treatment programs, homeless shelters, and housing programs, are also potential referral sources for TRC. Developing a referral network includes informing these community organizations about the availability of trauma recovery services and building ongoing relationships for cross-referral.

TRC Clinical Services

In the TRC model, all clinical services other than medication evaluation and management are provided by a single point of contact, usually the TRC Clinician. This means that the Clinician is able to target the services provided to the needs of each individual client. Having a single point of contact also makes it easier for clients to access any needed aspect of TRC services, and ensures that service delivery will be more seamless than if clients had to work with multiple providers across multiple sites. It also minimizes duplication of services.

Evaluation, Assessment, and Service Plan

Clinical services begin with an intake assessment, which is conducted by a TRC Clinician. The intake determines if the prospective client could benefit from brief, evidence-based, trauma-informed services. It encompasses a psychosocial assessment composed of validated measures (see chapter on Measuring Clinical Outcomes and Conducting Program Evaluation) and leads to an initial diagnosis that is used to guide and inform treatment at TRC, or elsewhere if a client is referred out. When a client is accepted into TRC services, treatment starts with the collaborative development of an individualized Plan of Care that details how the client's goals will be met. The Plan of Care outlines how the Clinician and the client will work together on practical issues (immediate safety, housing, medical care) and on reducing post-trauma symptoms.

16-Session Treatment Episodes

When completing the consent for treatment and the plan of care, the Clinician and client usually contract for 16 sessions of treatment. However, if clients are reluctant to commit to 16 sessions due to unfamiliarity with services, avoidance, or ambivalence, it is possible for the Clinician to contract for less than 16 sessions. When this happens, it is also possible to extend to 16 sessions if the client becomes engaged in treatment and interested in doing so.

At the mid-way point in treatment, around the 8th session, the Clinician and client use the Plan of Care to review progress toward the client's goals, and make adjustments to the treatment plan accordingly (see Assessment and Treatment Planning chapter for more detail). At that point the Clinician also begins to consider whether the client will likely meet their goals by the end of 16 sessions, or might need additional sessions in order to do so. The TRC Clinician can decide, in conjunction with their clinical supervisor, to offer a client an extension of services for an additional 16 sessions.

As the Clinician and client approach 32 sessions of treatment, if the Clinician (with the agreement of their supervisor) wants to extend treatment further, there should be a review by the clinical care team to help ascertain whether the client should receive additional TRC services, or may benefit from a referral out to longer-term mental health services. At the UC San Francisco TRC, a Clinician who wants to extend a client's services beyond 32 sessions presents the case to clinic supervisors at their weekly meeting. The Clinician comes to the meeting prepared to talk about:

A brief summary of the client and the index crime

What the treatment goals have been and what interventions the Clinician has used to help the client achieve their goals

What the client's participation in treatment has been like (i.e., attendance, completion of agreed-upon tasks or homework, etc.)

Why the Clinician is requesting an extension of treatment at TRC instead of linking the client with other longer-term services

A clear plan for what the treatment goals will be for the extension and what interventions the Clinician plans to use

This review process helps ensure that treatment is conceptualized in brief, 16-session episodes; that Clinicians are accountable for the services they are providing; that TRC retains the capacity to work with as many eligible clients as possible; and that clients who demonstrate the need for longer-term, trauma-specific interventions that cannot be easily accessed through other resources are able to receive them by continuing at TRC. This case review also provides clinical consultation from the supervisors group that helps inform the treatment plan for extended sessions.

Individualized psychotherapy, substance abuse treatment, and case management

Individual psychotherapy and substance abuse treatment are provided simultaneously by the TRC Clinician. This integrated treatment is an important evidence-based practice within TRC. The TRC Clinician (not another separate case worker) also provides the trauma-informed case management. At the beginning stages, the client often needs more case management to address pressing life problems such as safety, housing, and medical care. During the case management process, psychotherapy and substance abuse counseling are incorporated as rapport is built, and opportunities arise in the interaction between TRC Clinician and client.

Legal advocacy

Legal advocacy includes helping clients understand and navigate the legal system, and assisting them in working with law enforcement as appropriate. This might include helping a client file a police report, or obtain a restraining order. If a client is participating in a criminal case against their perpetrator, TRC Clinicians also provide court accompaniment. For clients who are undocumented, advocacy includes support with the U-Visa process, to help clients begin a path to lawful permanent resident status.

Group psychotherapy and support groups

Although many acutely traumatized clients prefer to start with individual services, once clients are stable enough to participate in group services, these are also offered as part of the TRC model. Time-limited, evidence-based groups such as Seeking Safety, Skills Training in Affective and Interpersonal Regulation (STAIR), and Cognitive Behavioral Anxiety Reduction groups are helpful for reducing isolation and stigma, and increasing social support.

Medication Management

When needed, the TRC Clinician connects clients with a TRC psychiatrist who is part of the program staff. The psychiatrist provides medication evaluation and management, which can help address symptoms such as sleep disruption, anxiety, and depression. Receiving help with these problems also reduces the inclination of clients to self-medicate with alcohol and other drugs, which tend to be less effective than psychiatric medications and which often create additional problems.

Services provided by partners

Concurrent services provided by other agencies in coordination with TRC may include legal assistance, medical care, peer counseling, housing support, and/or residential treatment for substance abuse. During the typical 16-session TRC service period, these concurrent services complement but do not replace services provided by TRC. As clients are referred to partners, the TRC Clinician is actively involved in the process; for example, the TRC Clinician may accompany the client to the partner agency for a warm hand-off at the first meeting.

Completion of TRC Services

Many clients who have achieved increased safety and stabilization and have returned to their prior level of functioning or higher terminate from TRC with no need for a referral to additional, longer-term mental health services. In other instances, clients need longer term care.

Referral to partner agencies

During the 16-session service period, some clients have begun receiving services from partner agencies, such as specialized substance abuse treatment or housing, and this facilitates the transition to post-TRC care.

As the end of TRC services approaches, the TRC Clinician also helps clients link with longer-term, community mental health services when needed, or with other mental health resources (i.e., at a clinic with sliding scale fees, or through a client's insurance) if there are non-trauma related issues the client would like to address (i.e., couples counseling, long-term therapy for eating disorders, etc.).

If a client experiences a re-activating event down the road after terminating from TRC services, the client may return for additional treatment, or "booster shots"—a few sessions focused on reinforcing previous gains and helping the client regain stability.

Participation in Speakers Bureau

Some clients, as part of their post-traumatic growth, participate in a TRC speakers bureau which provides survivors with training and support to advocate for trauma-sensitive services and violence prevention. Being able to tell their story has helped some survivors feel more confident and capable, while at the same time educating the community and policy makers about the impact of violent crime and the need for these specialized services.

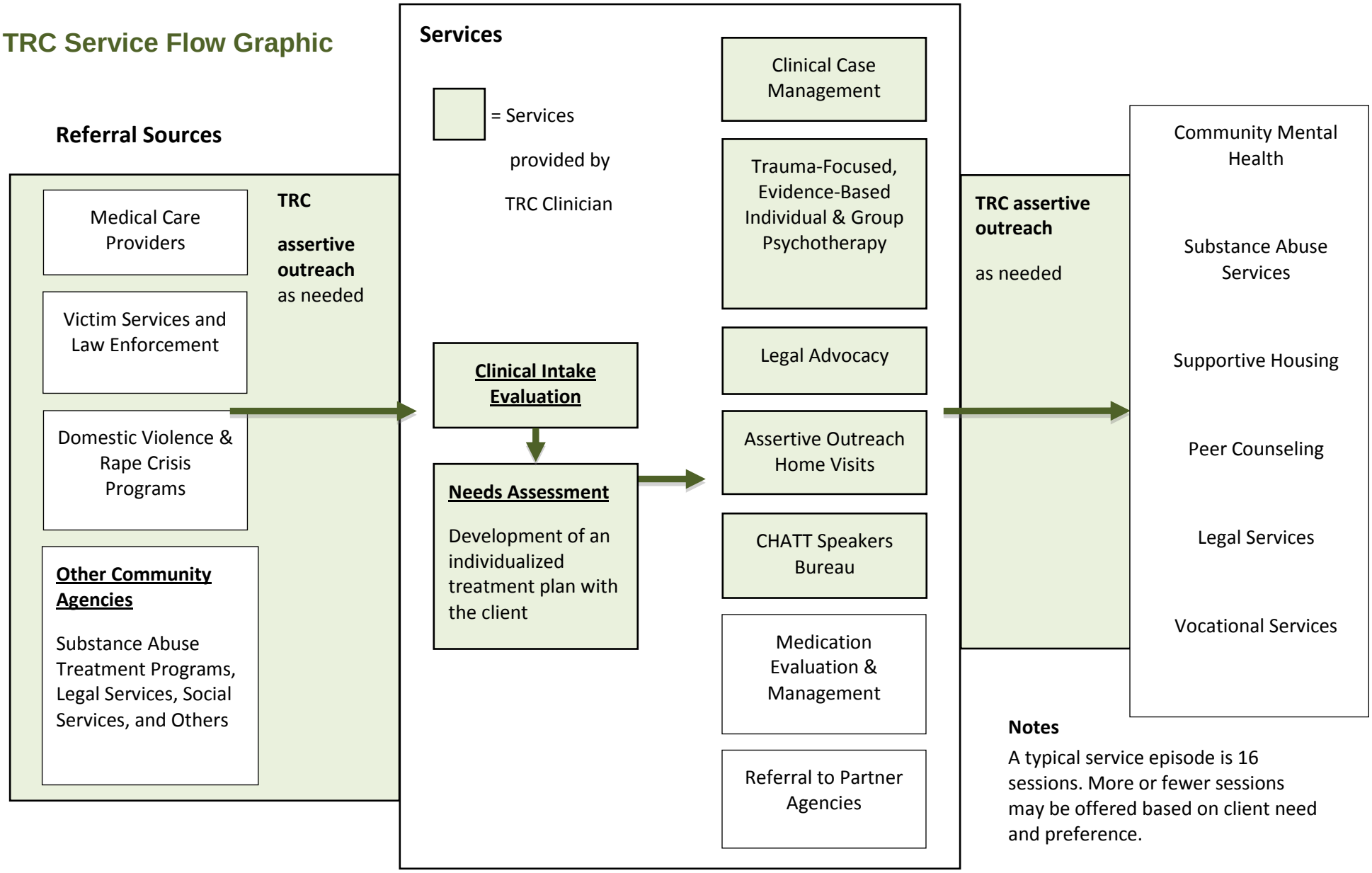
References

Rousseau, J. (n.d.). BrainyQuote.com. Retrieved November 7, 2016, from BrainyQuote.com Web site: https://www.brainyquote.com/quotes/quotes/j/jeanjacqu406107.html

Appendix to TRC Service Flow: Service Flow Graphic

See next page for a graphical description of TRC service flow.

TRC Service Flow Graphic



Notes

A typical service episode is 16 sessions. More or fewer sessions may be offered based on client need and preference.