

TRAUMA RECOVERY CENTER ASSERTIVE OUTREACH

By Stacey Wiggall, LCSW



Photograph by Ezme Kozuszek

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waiting for others to come to you.
You have to go to them © j ° ¥ © j -
A.A. Milne

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
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Assertive outreach is an essential component of the TRC model. This model was developed to work for acute survivors of violent crime, who, as medical providers observed, were falling through the cracks between crime-related medical care and follow-up support services. For multiple reasons, including feeling overwhelmed, coping with physical pain, trying to avoid reminders of trauma, the stigma associated with mental health services, and many survivors of violent crime do not connect with traditional mental health services. Assertive outreach recognizes these barriers to care and is a client-centered, trauma-informed approach to engaging people in TRC services. The TRC Clinician to work at engaging or re-engaging a recently traumatized client is not only more effective, it also sends an important and potentially healing message about the value of the client and the relationship.

RESEARCH FINDINGS REGARDING OUTREACH. While the relationship between post traumatic distress and help-seeking behavior has not been well studied in disadvantaged populations, research has shown that low-income survivors and people of color are less likely to seek general mental health treatment (Gavrilovic et al., 2005). In the past, members of communities that have been marginalized, including many trauma survivors, have felt stigmatized, judged, and poorly served by mainstream mental health services. However, the initial TRC clinical trial demonstrated that inner-city survivors of crime served by our model received mental health and case management services six times more often than comparable clients served by usual community services (Shumway et al., 2009). This rate of client engagement is partially due to early, assertive outreach that does not wait for acutely traumatized people to reach out for the help they need; it is also due to the TRC value of providing clients with a welcoming, healing, culturally relevant and compassionate approach to care.

ASSERTIVE OUTREACH ENGAGES CLIENTS WHERE THEY ARE. The goal of initial assertive outreach is to engage clients. **Clients do not need to identify mental health treatment needs in order to engage in TRC services and have an intake with a TRC Clinician.** If clients are willing to receive clinical case management services, such as help accessing healthcare and advocacy with the legal system, the assertive outreach process has worked and the clients are enrolled. Over time, most clients come to trust the Clinician and the agency, and to learn more about the potential benefits of mental health interventions. Services are never imposed on clients. But in time, most TRC clients decide they may benefit from mental health treatment and therapeutic interventions are folded in to the services they receive.

The Rationale for Assertive Outreach

In traditional mental health treatment models, if a client does not show for an appointment, the Clinician may call the client to check in and attempt to reschedule an appointment. The Clinician recognizes that recent survivors of violent crime may face significant barriers to participating in recovery services, including avoidance of trauma reminders and hypervigilance, both of which are symptoms of Post-Traumatic Stress Disorder (PTSD).

AVOIDANCE. This includes both cognitive and behavioral efforts to avoid the trauma. A person may do their best to block out any trauma-related thoughts, or any contact with people or situations that may trigger memories of the traumatic event. This PTSD symptom can make it particularly difficult for a crime survivor to come to appointments with a Clinician at a trauma recovery center.

HYPERVIGILANCE. In addition to avoidance, survivors of violent crime often experience hypervigilance, a continual sense of being in danger. People who experience this danger, and unable to relax their guard. In this state, people may be unable to tolerate navigating the world outside of their home, such as riding public transportation, walking down a street with strangers, or a myriad of situations that might not have felt dangerous prior to the trauma. At times, people may even feel unable to leave their homes. This fear of the ability to participate in trauma recovery services, the very program that can help them overcome PTSD symptoms and return to a better quality of life.

STIGMA. In addition to the PTSD symptoms that can be significant barriers to participation in TRC services, crime survivors may also be resistant to getting help from a mental health program because of the stigma they associate with it. People who have never before participated in mental health treatment may feel that such services are only for the seriously mentally ill. Even though post-trauma anxiety and depressive symptoms can cause significant suffering and changes in quality of life, people may resist reaching out if they are not seriously mentally ill they should cope with all their problems without help, and the idea of accepting help seems like a shameful failure.

For all of these reasons, the TRC model recognizes that assertive outreach to recent crime survivors is often necessary to engage clients in services. Recently victimized people face special barriers to engaging in recovery services, and assertive outreach can help to overcome those barriers.

Assertive Outreach in Medical Settings

Survivors of violence, such as those who have experienced gunshot wounds, stabbings, sexual assault, and severe domestic violence, frequently have numerous mental health and social service needs. Because survivors are typically unaware of the services that may be available, the acute medical setting is an ideal place to make first contact.

Developing a partnership with a Level 1 Trauma Center, or a local public hospital, helps

interventions. Outreach to injured crime survivors begins with outreach to the medical care providers who treat them in emergency rooms and inpatient settings. These providers are essential partners in identifying crime survivors and referring them for services. In many instances, medical providers are often relieved to be able to provide linkage to post-discharge support services for their injured, at-risk patients. Collaboration between TRC staff and medical providers helps create a safety net for these patients that prevents them from falling through the cracks that exist between emergency medical treatment and follow-up psychosocial support services.

PERIODICALLY CONTACTING PROVIDERS. In addition to relying on medical providers to make referrals to TRC, it can be helpful, especially during the early phase of building a collaborative partnership, for the TRC staff to have an agreement that they can periodically contact providers to inquire about potentially eligible patients. This takes the burden of making the referral off of busy medical providers and is another way of helping to ensure that patients do not fall through the cracks. With a basic amount of information about a patient and their treatment needs, a TRC Clinician or outreach worker can then visit the patient at bedside while they are still in the hospital to introduce services, help identify more urgent needs and begin building rapport.

EARLY ASSERTIVE OUTREACH CAN HELP CLIENTS ENGAGE IN THE FUTURE. In some instances, patients who are still hospitalized due to crime-related injuries may be in too much pain, experiencing high levels of avoidance, feeling overly sedated by pain medication and/or poor sleep, or feeling too overwhelmed by psychosocial stressors to consent to further outreach or services from TRC when they are first approached. However, it is critical that these patients have met a TRC staff person and received both verbal and written information detailing the kinds of services that TRC provides, in their primary language. It is not uncommon that these patients will call TRC days, weeks, or even months after discharge to ask for help, remembering the person who made the effort to visit them in the hospital and introduce the idea that help is available, and recovery from trauma is possible.

Assertive Outreach Staffing

In the UC San Francisco TRC model, when a client referral is made by an inpatient medical unit at Zuckerberg San Francisco General Hospital, a TRC outreach worker visits the patient to complete the referral. TRC outreach workers are project assistants who have received training and orientation to their role and to the hospital setting. These outreach workers have the flexibility to respond quickly to the referral and to meet with the hospital patient on the same day a medical provider calls the TRC.

Initial Visit

The first step in assertive outreach is the initial visit. The objectives of the initial visit are:

- ◁ To conduct an initial screening and ensure the client meets eligibility for services (is a recent survivor of violent crime, meets program residency requirements if any, etc.)
- ◁ To begin building rapport
- ◁ To provide information about TRC services

While providing information about TRC services, outreach workers clarify that clients like housing, or getting to medical appointments, or insurance, or whatever you are counseling/mental health services. It is important to articulate this distinction, since clients may initially be more open to or interested in case management support only, and that is okay. As stated earlier, TRC clients do not need to identify mental health treatment needs in order to engage in services and have an intake with a TRC Clinician.

IF THE CLIENT IS INTERESTED IN SERVICES. The outreach worker schedules an intake appointment with a TRC Clinician, to take place either at the TRC clinic, or bedside in the hospital if the client will be remaining there for an extended stay (i.e., more than a week).

IF THE CLIENT IS NOT CURRENTLY INTERESTED IN SERVICES. The outreach worker leaves information about TRC and lets the client know they can call in the future if that changes.

NON-MEDICAL REFERRALS. Referrals coming from sources other than hospital inpatient units are screened on the phone by a TRC Clinician (see Building Officer of the Day in

the Supervision chapter) and scheduled for an intake appointment with a TRC Clinician. The Intake Clinician is then responsible for conducting outreach to that client, initially in the form of an intake reminder call and/or letter. If the client does not show to the

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to conduct outreach and, hopefully, engage the client in services.

Ongoing Assertive Outreach in the Community

CONSENT FOR FOLLOW-UP. At the time a client agrees to treatment, a TRC Clinician or outreach worker obtains a HIPAA-compliant consent for follow-up from the client. They also ask for contact information from the client, including their phone number, their mailing address, and their home address (see Appendix 1, TRC Referral form). Staff explicitly ask the client whether it is okay for them to outreach to the client by phone, by mail, and if need be, in person. Staff also ask for the name and phone number of a contact person who usually knows where the client is and/or how to get in touch with them. In addition, if a client is homeless or marginally housed, staff ask for additional contact information, including areas a cli g p v " h t g s w g p v u " c p f " y j g t g " v j g { "

anyone in the community who would be willing to take a message for the client, such as a clerk at a corner store where the client is a regular customer (see Appendix 2, Additional Contact Information). With this information, staff is able to assertively outreach to clients who do not show up for scheduled appointments.

OUTREACH IS GENERALLY WELCOMED BY CLIENTS. Early on, TRC Clinicians were concerned that assertive outreach could be re-traumatizing for clients who had recently been survivors of violent crime, and that it might even be perceived as ð u v c n m k p i 0 ö

However, that concern has not borne out. In part, this is because clients can decline to provide any contact information they are not comfortable disclosing. Clients can also give different levels of permission for outreach. For example, a woman who is a survivor of ongoing domestic violence may feel that it is okay for staff to call her, but not to leave her a message if she does not answer her phone, and not to outreach by mail or home visit. Another client may be comfortable receiving phone calls and letters but declines the option of staff making a home visit because he does not want family members to know that he is accessing support services. During the randomized clinical trial of the TRC model, many of the most disenfranchised clients, especially those who were homeless, reported feeling deep appreciation that a Clinician would take the time to look for them in the community if they did not show up for their appointments because no one else in their lives was reaching out to them or keeping track of them. C u " q p g " e n k m g d e v " u v c v g o g " h g g n " n k m g " { q w " e c t g f " k h " K " n k x g f " q t " f k g f 0

HOW MUCH FOLLOW-UP OUTREACH? The guideline for follow-up assertive outreach is scheduled appointment during this phase, the expectation is that the TRC Clinician will make at least three attempts to contact the client and use all available contact information before deciding to close the referral. Clinicians generally start with the easiest and least intrusive ways of getting in touch first, usually trying to reach a client on the phone. If that is unsuccessful or the client does not respond to messages within a week, the Clinician sends a letter (see Appendix 3: sample outreach letters). Then if there is no response to outreach by phone and letter, the TRC Clinician will attempt to visit the client where they live. Whether the client lives in a permanent residence, a single-room occupancy hotel, or a shelter, the Clinician tries to check in with the client in person in order to further engagement and build a trusting relationship.

OUTREACH CAN BECOME A THERAPEUTIC VISIT. Community visits provide an opportunity for therapeutic intervention with clients who have not been able to show up for appointments at the clinic. In addition to problem-solving concrete barriers, such as childcare or transportation, the TRC Clinician may use Motivational Interviewing (Miller & Rollnick, 1991). The Clinician may also decide to share Cognitive Behavioral techniques or other evidence-based therapeutic interventions, such as relaxation training (Bernstein & Borkovec, 1973), that can target specific anxiety or depressive symptoms that are preventing the client from coming to the clinic. The Clinician may also decide to schedule regular home visits for a period of time so that a client who is too impaired to come to the clinic can still participate in treatment.

Assertive Outreach Later in Treatment

When a client is perceived as engaged in treatment but begins inexplicably missing appointments, a TRC Clinician may conduct assertive outreach in order to re-engage the client. However, since the Clinician will likely know more about the circumstances of a client's non-participation in services, the Clinician can also use their clinical judgment in deciding whether or not the client might benefit from a home visit at that point.

Factors that influence the extent of outreach at this point in treatment include:

- ◀ How well the client has been functioning
- ◀ The Clinician's engagement in providing services

For example, if a client who is stably housed and functioning well in work and school stops coming to therapy, and the Clinician believes that the client is receiving voicemails but might be avoiding saying goodbye to the Clinician and terminating services, the Clinician might decide not to make a home visit, which could feel intrusive to the client, but to make calls and send a letter instead. However, if a client who has been suffering from depression and anxiety that prevent him from working stops showing up for appointments with no explanation, and does not respond to phone calls or a letter, a Clinician can f g e k f g " v q " o c m g " c " j q o g " x k u k -being and" q t f g t ' assess whether increased post-trauma symptoms are preventing him from making it in to the clinic. In this case, the Clinician may also decide to schedule some sessions with the e n k g p v " c v " j q o g . " y k v j " v j g " i q c n " q h " k o r t q x k p i extension, his ability to return to keeping appointments at the clinic.

Safety Considerations

MANAGING RISK. Some settings where assertive outreach is conducted pose risks to staff. Staff safety is always a top priority. When hiring TRC Clinicians, interviewers should c u u g u u " e c p f k f c v g u ø " e q o h q t c h e i t s n o g t i n t h e " c p f " g z r g t community, as this is not a component of traditional mental health models. All staff should receive training on outreach safety considerations. Staff should also use both their own judgment and consultation with supervisors to assess any relevant safety concerns in a particular situation. For example, if a client lives in public housing in a high-crime neighborhood, the TRC Clinician may decide to bring a co-worker along on the outreach visit, and/or to visit first thing in the morning, when the neighborhood is generally quieter.

SUBSTANCE USE. It well-documented that some trauma survivors use substances to self-medicate trauma-related distress. Because the connection between trauma and substance use is a common one, the TRC model adopts a harm reduction philosophy toward u w d u v c p e g " w u g 0 " C " e n k g p v ø u " w u g " q h " u w d u v c p e g suboptimal one that may have significant negative consequences. Using substances does not make a client ineligible for TRC services. However, when a Clinician knows that a client has been struggling with alcohol or drug use, and believes that relapse may be the reason for missed appointments, the Clinician can use their judgment about whether or not a home visit is indicated and is safe. For example, if a client has been using alcohol, a Clinician may decide to make a home visit in the morning, when the client is more likely to be sober, in order to check in with them and discuss strategies for increasing participation in treatment and other important life activities. However, if a Clinician knows that a client has been using methamphetamines and exhibiting impulsive, erratic

behaviors, the Clinician may not feel that a home visit is indicated. In that case, a better option might be arranging to meet the client at a café or another public place.

OPTIONS FOR HOME VISITS. If a client has given permission for a home visit but staff decide it may not be safe, whether because of substance abuse, or other issues such as ongoing domestic violence, staff may in that case decide to outreach by phone and letter only. Another option is to enlist the help of other community services better-equipped to deal with potential risk, such as some mobile crisis teams. However, the fact that a client lives in a community or neighborhood with a higher concentration of crime and poverty is not a reason to avoid a home visit, as that describes many clients referred for TRC services. And, it is important that staff understand the rationale for and embrace the value of assertive outreach; in spite of the occasional risks that need to be managed, it is a critical component of engaging disenfranchised, multiply-traumatized survivors of crime.

Assertive Outreach: A Fundamental Part of TRC

Assertive outreach is an essential component of the TRC model. While assertive outreach does require clinical skills, time, and careful consideration of staff safety, it addresses the needs of clients who face multiple barriers to accessing trauma recovery services.

Assertive outreach goes beyond initial engagement, helping retain clients in services and ensuring they can complete their recovery.

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Appendix 1 to Assertive Outreach: TRC Referral Form

See next page for a sample TRC Referral Form.

TRC/RTC REFERRAL FORM

Mental Health Clinician assigned: _____

11/2016

Date	____ / ____ / ____	Time	____ : ____ am/pm	Completed By (staff initials):	_____	ZAP? Y <input type="checkbox"/> N <input type="checkbox"/>
						HIPAA? Y <input type="checkbox"/> N <input type="checkbox"/>

Patient Name	last name	first name	mi
Patient Alias	last name	first name	mi
Social Sec #	_____ - ____ - ____	MRN	_____
Mother's maiden name	_____	Date of Birth	____ / ____ / ____

Entry Point	1 = TRC 2 = SFGH ED 3 = SFGH In-pt Unit _____ 4 = Other:				
Referral Source	1 = Self	2 = Law Enforcement	7 = SF VOC Office	6 = Non-SFGH Service	5 = SFGH Service: BHT In-Pt SW NHP NSGY Other
Referred By	last name	first name	phone	pager	service/clinic/agency

Index Crime/Trauma (circle one)	1 = Sexual Assault 2 = Domestic Violence 3 = Physical Assault 4 = Stabbing 5 = Shooting 6 = Vehicular Assault 8 = Family of Victim 7 = Other Crime 9 = Non-Crime Related Trauma 11 = Refugee/Outside US trauma (torture/war trauma/gender based violence) 12 = Human Trafficking				
Date of Crime/Trauma	____ / ____ / ____	Police Report?	0 = No 1 = Yes	Case #	_____

Does this person have a TBI from the referring incident?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Victim of Crime & TBI?	YES <input type="checkbox"/> NO <input type="checkbox"/>
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Gender	0 = female 1 = male 2 = transgender (M-F) 3 = transgender (F-M)
Sexual Orientation	1 = gay/lesbian 2 = heterosexual 3 = bisexual 4 = unsure/questioning 5 = declines to state/unknown
Race/Ethnicity	1 = White 2 = African-American 3 = Latino 4 = Asian/Pacific Islander 5 = Native American 6 = Mixed Race/Ethnicity 7 = Other _____ 8 = declines to state/unknown

Not Evaluated Because	1 = Refused Interview/Contact 2 = Discharged/Left Before Evaluation 3 = Too Ill, Confused, or Unconscious 4 = Refused Services 5 = Clinical Caseloads Full 6 = SA/DV Consult Only 0 = Evaluated		
RTC Consent to contact?	1 = signed	0 = not signed	-1 = not applicable

 Eligibility and Risk Criteria 	1. Acutely Suicidal, Dangerous, Psychotic and/or unable to give consent?	1 = Yes	0 = No
	2. Current or Previous TRC Client?	1 = Yes	0 = No
	3. Currently Receiving Mental Health Services?	1 = Yes	0 = No
	4. Younger than Age 18?	1 = Yes	0 = No
	5. NON-SF Resident?	1 = Yes	0 = No
	6. NOT able to receive services in English? If not, Preferred Language _____	1 = Yes	0 = No

ADMINISTRATIVE	Referral DB entry date	_____	Referral #	_____
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YELLOW COPY IS THE ORIGINAL CHART COPY—DO NOT MAKE CHANGES ON COPIES THAT ARE NOT YELLOW

Primary Address <small>(include address where pt will be for next two weeks in one of these spaces)</small>	number	street	city	state	zip
	Type:	1=own home 2=relative's/home 3=shelter 4=mail pickup only 5=other _____			
	Here for next 2 wks?	0=No 1=Yes	Mail contact OK?	0=No 1=Yes	Visit OK?
Other Address	number	street	city	state	zip
	Type:	1=own home 2=relative's/home 3=shelter 4=mail pickup only 5=other _____			
	Here for next 2 wks?	0=No 1=Yes	Mail contact OK?	0=No 1=Yes	Visit OK?

Primary Phone	Number:	(____) _____ - _____			
	Type:	1 = home	2 = work	3 = cell	7 = other
	OK to call?	0=No 1=Yes	OK to leave messages?	0=No 1=Yes	
	OK to identify as TRC?	0=No 1=Yes	Other identifier, if No		
Other Phone	Number:	(____) _____ - _____			
	Type:	1 = home	2 = work	3 = cell	7 = other
	OK to call?	0=No 1=Yes	OK to leave messages?	0=No 1=Yes	
	OK to identify as TRC?	0=No 1=Yes	Other identifier, if No		

Contact person I most likely to know how to get in touch with you				OK to Call?	Leave msgs?	Identify as TRC?
lastname	firstname	phone number				

PCP	lastname	firstname	clinic
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Currently on Psychotropic Medications	0=No 1=Yes	Which?	
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Location of RTC Services	1 = ED Zone 4	2 = 6 th Floor	3 = Other _____
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TRC Medical Follow-up	1	Date	Time	Place	With	0 = no show	1 = attend	2 = cancelled
	2	Date	Time	Place	With	0 = no show	1 = attend	2 = cancelled
Clinical Intake	1	Date	Time	Place	With	0 = no show	1 = attend	2 = cancelled
	2	Date	Time	Place	With	0 = no show	1 = attend	2 = cancelled
	3	Date	Time	Place	With	0 = no show	1 = attend	2 = cancelled
	4	Date	Time	Place	With	0 = no show	1 = attend	2 = cancelled

Contact Log	Date	Initials	Purpose/Content
	Date	Initials	Purpose/Content
	Date	Initials	Purpose/Content
	Date	Initials	Purpose/Content
	Date	Initials	Purpose/Content

Appendix 2 to Assertive Outreach: Additional Contact Information Form

See next page for Additional Contact Information form for hard-to-reach clients

TRC/RTC Contact Information

MRN# _____

Circle one : TRC / UC

Circle one: RSA / DV / IP

Therapist: _____

1. Name

First _____
Middle _____
Last _____

2. What do your Friends call you? _____

3. Date of Birth

_____/_____/_____

4. SSN#

_____/_____/_____

Primary Address/Phone

5. What is your **current address**?

Location _____

5a. What is your **phone number**?

Phone _____

5b. Is it **OK to call/leave message/send letter** here?

Details: _____

5c. How would you like staff to **identify themselves**?

Details: _____

Other Address/phone

6. Is there **another address** that you use?
Where will you be going **after you leave** here?

Location _____

6a. What is the **phone number** there?

Phone _____

6b. Is it **OK to call/Leave Message/Send letter** here?

Details: _____

6. Where do you **hang out**?

7. Which **Shelters** do you use?

8. If Homeless, Where do you sleep?

9. Where can I send you a letter?

Address _____

10. Where can I leave a phone message?

Phone _____

11. Do you use any free meal programs?

12. Are you on GA or SSI?

Where is your check sent?

Address _____

13. Contacts-

Contacts are friends, relatives, or anyone you see on a regular basis that could get a message to you.

1

Name:

Phone:

Where do they live?

Ok to call/send letter?

Circle Yes = 1 / No = 2

2

Name:

Phone:

Where do they live?

Ok to call/send letter?

Circle Yes = 1 / No = 2

3

Name:

Phone:

Where do they live?

Ok to call/send letter?

Circle Yes = 1 / No = 2

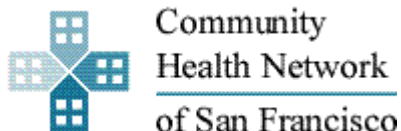
16. Are you on Probation or Parole?

Who is your Probation/Parole Officer?

17. Is there any Doctor, Counselor, or Payee that you see regularly?

Appendix 3 to Assertive Outreach: Sample Outreach Letters

See next two pages for sample outreach letters.



San Francisco TRC/RTC

2727 Mariposa Street, Suite 100

San Francisco, CA 94110

Tel: 415-437-3000

Fax: 415-437-3050

X
X
X

October 11, 2016

Dear Mr. X,

I hope you are well. I am writing to remind you of our upcoming Intake appointment at Trauma Recovery Center:

Monday October 24th, 2016, 9:00 AM

At 2727 Mariposa Street, Suite 100 (at Bryant St)

We provide assistance at no charge to survivors of violent crimes. The purpose of this meeting is to get a picture of what you may need and how we can support you as you recover.

Please feel free to arrive early to have a cup of coffee or tea beforehand. If you drive, allow extra time to find parking.

If you need to reschedule or if you have any questions or concerns about this appointment, please call during our regular hours and speak me or to the clinician on duty.

I am looking forward to talking with you on Monday, October 24th 2016, at 9:00 AM

Thanks,

Carol Jones LCSW, 415-435-9008



Community
Health Network
of San Francisco



San Francisco TRC/RTC

2727 Mariposa Street, Suite 100

San Francisco, CA 94110

Tel: 415-437-3000

Fax: 415-437-3050

X
X
X

February 3, 2017

Dear x,

I hope you are well. I am writing because we were scheduled to meet for an intake appointment last week at the Trauma Recovery Center and I have not been able to reach you by phone.

I know it can be difficult to come in when you are dealing with a lot. Sometimes it's just not the right time. And other times, when people don't feel like coming in, it's a sign that they could use more support.

Please contact me at 415-437-3008 and we can talk about what is best for you right now.

I need to let you know that we are only able to reschedule this intake appointment one more time. However, if you decide that this is not the right time to come to therapy, you will continue to be eligible for our services in the future.

I am looking forward to checking in and talking about how we can support you at this time,

Carol Jones LCSW, 415-435-9008