TRAUMA RECOVERY CENTER ASSESSMENT AND TREATMENT PLANNING

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Photograph by Ezme Kozuszek

"Hope is the thing with feathers—that perches in the soul—
and sings the tune without the words—
and never stops at all."

—Emily Dickinson

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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Trauma-informed assessment and treatment planning are important elements of effectively caring for those who have been survivors of violent crime, particularly in a short-term treatment model. Both assessment and treatment planning ensure that services offered are relevant for each client, and that treatment is tailored to help a client achieve their particular goals. This chapter provi trauma-informed assessment, describes how this information is presented to a multidisciplinary intake team, and outlines both treatment planning and continued assessment throughout a client's services. this chapter (Appendix 1) illustrates the intake process from the time a referral for TRC services is made to the point at which a client is matched with a TRC Clinician.

Overview of Trauma-Informed Assessment

THE IMPORTANCE OF COMPREHENSIVE ASSESSMENT. Every survivor of severe trauma should have the right to be screened for mental health needs, and to receive access to timely, effective, evidence-based care. Post-trauma mental health services should be as accessible to public health clients as they are to clients with the financial resources to pay for services out-of-pocket. A trauma-informed assessment sets the stage for clients to receive services that best meet their needs. Not every client needs every service, and assessment ensures that treatment is individualized. Some clients have multiple target areas for treatment, such as previous severe victimizations and/or pre-existing psychological symptoms, and by identifying these issues at the start of services, the team is better able to meet the client's needs. the individual treatment plan that will help clients feel stronger, safer, and better able to go forward with their lives after TRC services are complete.

WHAT IS COMPREHENSIVE TRAUMA-INFORMED ASSESSMENT? The TRC intake is a standardized, comprehensive psychosocial assessment that utilizes specific tools (described below) to guide the interview. The TRC model is not a one-size-fits all approach; every client is different. The assessment helps a Clinician get to know each client as a whole person, and explore how aspects of their personal history interact with their traumatic experience and current symptoms. With a client's conse Clinicians also review other relevant medical and psychiatric records prior to meeting with the client. Records from past mental health treatment providers, current primary care providers, and others who know the client well can provide important information, and save the client from having to repeat information to multiple providers.

BUILDING RAPPORT VS. OBTAINING INFORMATION. During the intake assessment, the Clinician must balance building trust and rapport with the need to gather information that will help determine diagnosis, case disposition, and treatment planning. All clients

engaging in mental health services—particularly those who have been recently traumatized—benefit from feeling safe, seen, and heard. One way to begin establishing trust is through the informed consent process. It is critical that Clinicians give clients a clear picture of the TRC treatment model and assure them that, aside from mandated reporting exceptions related to their safety, the information they provide will be kept confidential within the TRC treatment team. Clinicians also give clients the opportunity to ask questions, and encourage them to take their time in reviewing consent documents so they can feel in control of their participation in the intake process.

Intake Clinicians also clearly explain what clients can expect during the intake assessment. For example, "The intake is different from a counseling session because I'll be asking a lot of questions, not only about what happened to you, but to learn about you as a person." Clinicians let clients know that they are in control with guidelines such as, "You ask for a break if you need one, or choose not to answer specific questions. And please feel free to ask me any questio

USE A CULTURAL HUMILITY APPROACH. One feature of cultural humility is a desire to fix power imbalances where none ought to exist (Tervalon & Murray-Garcia, 1998). When Clinicians interview clients, it should be recognized that the client is the expert on their own life experiences. The Clinician has knowledge about mental health symptoms and trauma sequelae that may be unfamiliar to the client and the client has knowledge and understanding outside the scope of the Clinician. Cultural humility requires a collaborative approach, and the understanding that the client and Clinician working together will produce the best outcome.

LIMIT GRAPHIC DETAILS. In order to help clients feel emotionally safe and grounded during the intake process, TRC Clinicians explain to clients that they do not need to share explicit details of their trauma experience. This is an important aspect of a trauma-informed approach. The goal is to get the minimum amount of information necessary to understand what happened to a client without re-traumatizing them by causing them to relive the memory of the trauma, increase their distress, or become overwhelmed. If a client begins to share more trauma details than necessary, they are gently and respectfully redirected. Clinicians may also introduce grounding techniques during the interview to assist the client in managing any overwhelming and/or dissociative symptoms that emerge.

TWO COMPONENTS. Two tools, described below, make up the standardized clinical intake interview at the UC San Francisco TRC: the intake evaluation worksheet and the Multi-Area Review and Trauma History Assessment or MARTHA (see chapter on Measuring Clinical Outcomes and Conducting Program Evaluation). These particular

measures are not necessary for implementing the TRC model, but any tools used should assess similar diagnostic categories (see Appendix 2 for a list of measures used by the UC Francisco TRC and Appendix 3 for citations).

INTAKE EVALUATION WORKSHEET. The intake evaluation worksheet is an interview guide that helps the Clinician stay on track and gather information from the client in a structured way. This tool starts with prompts for the Clinician to utilize the MARTHA to obtain identifying information and then guides the Clinician to ask for a brief description of the client's "chief concern," or reason for coming to the appointment that day: what are they hoping to get out of services? The Clinician is then guided to ask open-ended questions related to the index crime, or History of Presenting Problems. The goal here is to obtain brief information about the crime itself, any related symptoms, and how these have impacted functioning. Clinicians are then instructed to use the MARTHA to more formally assess these areas.

From there, the intake evaluation worksheet outlines areas to cover during the assessment, including:

- Mental health treatment history
- Past psychiatric symptoms
- Medical history
- Primary care provider information
- Medication history
- Family and social history
- Trauma history
- Work and school history
- Legal history
- Substance use, both current and past

The intake evaluation worksheet also guides the Clinician in conducting a full mental status exam and a complete risk assessment of current danger to self and others.

The final page of the worksheet guides Clinicians in discussing initial target problems and goals with the client. This discussion should also help to instill hope for recovery.

The TRC intake should be guided by each client's responses to the interview questions and be flexible enough for Intake Clinicians to tailor the flow of questions to the needs of the client. For example, if a client presents in crisis, the goal of the intake becomes

ensuring immediate safety through risk assessment and safety planning. A second appointment can then be scheduled for completion of the remaining intake questions.

STRENGTHS AND RESILIENCY. Throughout the interview, the Clinician is tracking examples of a client's sinicia may choose to point these resil out to a client who seems unaware or undervaluing of these examples; this is done without minimizing the trauma or its impac strengths in the written report of the intake assessment under the "Case F summary at the end.

THE MARTHA. The second interview tool used at the UC San Francisco TRC is the Multi-Area Review and Trauma History Assessment or MARTHA (see chapter on Measuring Clinical Outcomes and Conducting Program Evaluation). The MARTHA brings together a variety of standardized measures, some developed by the UC San Francisco TRC and many that were developed by other researchers and widely used in the mental health field. It is composed of 4 main sections: (1) identifying information, (2) symptom-specific scales and measures, (3) observational items for PTSD and Complex PTSD, and (4) Clinician-rated assessments of a client's level well as the services recommended for each client.

The first part of the MARTHA assists Clinicians in collecting demographic information. The second part guides Clinicians in gathering information about mental health symptoms, in order to identify trauma-related disorders and other mental health disorders. This is not done to pathologize clients; the TRC model recognizes that accurate diagnosis is the foundation of an individualized, effective treatment plan. The MARTHA uses measures that have been shown to have a high degree of reliability and validity across various populations and cultures, including measures for PTSD, depression, and Complex PTSD. Additional measures help assess a cl The third section includes observational items for PTSD and Complex PTSD that are completed by the Clinician after the intake. The final portion of the MARTHA assists Clinicians in identifying the client's lev services to mental health services to food and shelter. It also prompts Clinicians to consider what resources might be helpful to a client, both at TRC and elsewhere in the community.

POST-INTAKE PROCESS. After completing the interview, the Intake Clinician writes a report summarizing the information (see Appendix 4, Sample Intake Report). The Clinician then presents their report to the intake team, a multidisciplinary group that offers feedback and supervision to all Intake Clinicians. This approach ensures that the

evaluation and treatment plan for each client are completed with accountability, and promotes the highest quality of care for TRC clients.

From the time an intake appointment is scheduled, the Intake Clinician is the point person for the client until they are matched with a TRC Clinician. After the intake, Intake Clinicians will continue to provide outreach and tracking, ongoing risk assessment/management, regular assessment of any changes in symptoms and coping strategies, and brief check-ins with each client to offer support. Intake Clinicians inform clients that if they have questions or need information or support, they can contact their Intake Clinician directly. Clients are also informed that if they are in crisis, they can speak to the TRC Building Officer of the Day during regular business hours, and can use 24-hour crisis resources for immediate support on evenings and weekends.

Presentation to the Intake Team

Intake presentations address two levels of priorities. Level one priorities must be addressed when presenting an intake. Level two priorities are valuable but may skipped if time is limited due to the number of intake reports to be presented that week.

LEVEL ONE PRIORITIES

- To discuss whether any information emerged during the intake that would indicate that the TRC treatment model is not in the client's best interest (i.e client needs a higher level of care than what TRC can provide)
- To provide information to help inform the client and Clinician match
- To communicate risk assessment factors that will impact case assignment prioritization

LEVEL TWO PRIORITIES

- To facilitate a discussion of differential diagnosis, both to assist the Intake Clinician as needed, and to help teach the group as a whole. Clinicians learn that accurate diagnosis is the foundation of effective, individualized treatment planning. With knowledge of a client's trauma symptoms, a Clinician is able to choose evidence-based treatments that are the most appropriate and effective for helping that client achieve their particular goals.
- To facilitate a discussion of comprehensive c presentation, particularly cultural considerations. This formulation also includes a summary of a client's strengths and curren
- To facilitate a discussion of potential treatment considerations, including case management resources, with relevant information passed along to the treating Clinician.

¶ To provide an opportunity for the team to debrief with the Intake Clinician, as this is an important element in supporting staff in the challenging work they do.

Clinicians are encouraged to begin their presentation with a question that they would like help with from the team. Questions may include issues related to differential diagnosis, risk assessment, or appropriateness of fit for the TRC model.

ELIGIBILITY. One purpose of the intake team is to confirm eligibility for services at a TRC. At the UC San Francisco TRC, basic criteria includes: having been a survivor of violent crime within the last 3 years, San Francisco residency, being 18 or older, and not currently participating in other mental health services. Eligibility questions are also asked over the phone at the time a referral is taken; however, sometimes circumstances change or a client discloses different information to an Intake Clinician. If clients are not eligible for TRC services or the team decides that a client could benefit more from a different agency or level of care, the Intake Clinician will help the client link to other services.

An example of a potentially "gray area" regarding eli psychotic symptoms or delusions, which can make it difficult for an Intake Clinician to know whether or not the client has, in fact, been recently victimized. Depending on the outcome of the intake assessment, the team may recommend that the client is matched with a TRC Clinician for brief treatment that includes further assessment, work on safety and stabilization, and a potential referral to longer-term community mental health services; or, the team may recommend re-engaging with community mental health for a client who has a long history of treatment there. It is helpful for the Intake Clinician to have a team of colleagues at intake team for consultation in these and other complex situations.

VICARIOUS TRAUMA CONSIDERATIONS. Given that intake team members are exposed to details of many traumatic experiences during the course of intake presentations, it is critical that all Clinicians are mindful of vicarious traumatization considerations. In order to help mitigate the effects of trauma exposure on team members, verbal presentations should be a summary of pertinent information, and not devolve into story-telling. For example, stating, "Facilitated sexual assault on 3/9/16 by a co-worker" is preferable to detailed informa "Facilitated sexual assault on 3/9/16 by a victimized in the with after work and ended up staying late at the bar with one of her co-workers, then went back to his apartment…." Avoid more tra intake format in order to create a compreh presentation, Clinicians should only document trauma details that are deemed clinically relevant.

DIAGNOSES. In mental health services, DSM-5 diagnoses allow the Clinician to envision the most effective treatment approaches. The intake team meeting provides an opportunity for team members to discuss th to develop accurate, helpful diagnoses. Because the TRC model uses best practices in selecting evidence-based treatments, the Clinician uses the intake diagnoses as the foundation for deciding how best to start helping a client reduce symptoms and increase functionality.

DISPOSITIONS AND CASE ASSIGNMENTS. After intake team meetings, team leaders meet to discuss service dispositions and case assignments. Given that clients are prescreened for eligibility prior to intake, most clients are accepted into TRC services. Whenever possible, clients are matched with their Intake Clinician as their TRC Clinician. This helps clients feel more connected and safe, rather than starting with a new person. However, client requests related to gender, language, specialty, schedule, and/or other characteristics of the client-Clinician match are also taken into account and accommodated whenever possible.

Plan of Care

The Plan of Care (for example, see Appendix 5) is completed in collaboration with the client during the first few sessions of treatment with their TRC Clinician. It identifies and prioritizes treatment goals, describes how those goals will be achieved, and helps ensure that treatment stays focused and effective.

CLIENT-CENTERED AND COLLABORATIVE. The Plan of Care is client-centered, collaborative, and strengths-based. It combines mental health and case management needs in an effort to identify and help achieve goals that are important to the client, and addresses safety, symptom reduction, and coping.

The first page of the Plan lists areas in which trauma survivors often experience problems—including concrete case management items like medical, legal, housing, and financial needs, emotional/psychological functioning, substance use, interpersonal problems and spirituality. Clients rate how much help or services they need in each area on a scale of 1 (not at all) to 5 (extremely). Through this process, the client and Clinician create a current snapshot of needs. It also serves as an opportunity for the client and Clinician to build trust and rapport through the TRC Clinician's active list validation, and normalization of trauma-related symptoms. The Clinician also offers psychoeducation about trauma and coping that can build a foundation for healing and growth.

OPPORTUNITY FOR THE CLINICIAN TO RATE LEVEL OF NEED SEPARATELY. Given that there may be times when a client rates their level of need in a specific area lower than the Clinician's perception of it, one section independently rate the ed. This can be particularly helpful when it comes to areas where people tend to minimize their need for help, such as substance use. For example, though a client may report using alcohol or crack cocaine regularly, depending on their level of insight into this behavior and their readiness to change it, they may rate this area as one However, given that substance use can potentially put a client at risk for revictimization, result in serious health problems, exacerbate mental health symptoms, and/or prohibit healing, the Clinician may choose to rate than the client's own rating. This separat issues for nonjudgmental discussion with the client. It can also provide the basis for the use of motivational interviewing strategie acknowledge and address these behaviors during the course of treatment. If there is a difference between a client's rating and a Clinician and the client has ultimate control over their choices.

COMBINES MENTAL HEALTH AND CASE MANAGEMENT GOALS. The second part of the Plan of Care combines mental health and case management priorities and outlines a plan to achieve them. In this section, the TRC Clinician and client collaborate in choosing 2-3 target problems from the list on page one, goals/objectives that are possible to reach over the course of treatment and where progress can be measured. For example, a measureable and achievable goal might be "being able to take the bus to work." Clin choosing goals - such as when are difficult to quantify and to self know when they have been achieved. The Clinician typically also spends time outside of session identifying potential interventions to use that can best assist a client in reaching their goals, and shares these suggestions with clients at the next meeting in order to get buy-in and enhance motivation around specific treatment strategies.

STRENGTHS-BASED TREATMENT PLANNING. A strengths-based approach is utilized from the moment a client enters the clinic and throughout their intake. Everyone who comes to services at the TRC is a survivor, and is doing the best job they can to cope and recover. It is also essential to the treatment planning process. During Part II of the Plan of Care, the client and Clinician spend time identifying the client's in external resources and motivations. These qualities and reasons for healing serve as assets for clients on their journey towards recovery, and promote a sense of hope.

Some clients may be so demoralized that they have a difficult time identifying their own strengths and motivations. When this is the case, the Clinician can help identify client strengths as they see them, to help bolste

Interval Forms and Measure-Guided Treatment

Ongoing assessment assists clients in meeting their treatment goals. The *Clinical Interval Assessment Form* is a tool that guides Clinicians in measuring symptoms related to PTSD, complex trauma, depression, and physical pain. The UC San Francisco TRC gives baseline measures to clients at the start of treatment, and then repeats interval assessments jointly with clients every 8 sessions (see Appendices 3 and 4: for specific measures used and citations for each).

These assessments serve as important tools for guiding treatment. This review is an opportunity to note both the progress made toward achieving goals and linking with services, and any barriers to getting thos clinical presentation. When assessments reveal a decrease in symptoms, this progress is shared with clients to validate their healing efforts: their hard work is paying off! This review can also highlight and enhance motivation for targeting specific symptoms that persist, and might benefit from trying a different approach. The review is a collaborative process, with Clinicians and clients partnering to review what has been working and what additional work might be needed.

In addition to its usefulness in assessing quantitative analysis of interval assessments helps clinic supervisors to monitor the effectiveness of services on a program-wide basis, and meet quality assurance goals.

TRC Database Reports

The UC San Francisco TRC has developed a relational database that is designed to track information and produce reports that aid Clinicians with treatment planning, and aid administrative staff with program evaluation and staff supervision. The database produces the following clinical reports for each client:

INTAKE ASSESSMENT REPORT. This report captures data from the intake assessment and is the basis for the verbal summary that an Intake Clinician presents to the multidisciplinary intake team.

INTERVAL REPORT. This report holds data from the interval assessments that are completed every 8 sessions, and can be use
treatment, and to look at overall treatment effectiveness for the program as a whole.

TREATMENT UPDATE REPORT. Clinicians complete a treatment update report every time a client's services are extended. For more
treatment extension, see chapter on TRC Service Flow Description.

TREATMENT CLOSING REPORT. Clinicians complete this repo
TRC services are ending. It includes a brief summary of services provided, a snapshot of the client's current functioning, and whet
other programs for follow-up care (for an example, see Appendix 7).

In addition, the database captures information that supervisors and administrators can use to track units of service, types of services provided, and staff productivity (see chapter *Measuring Clinical Outcomes and Conducting Program Evaluation*).

Summary of TRC Assessment

The TRC treatment model is founded on the premise that all clients deserve access to a comprehensive assessment, which is strengths-based, nonjudgmental, and trauma-informed, and in which they are acknowledged as a whole person. Collaborative treatment planning and continued assessment of a client'
help to ensure that all clients receive individualized and effective care.

References:

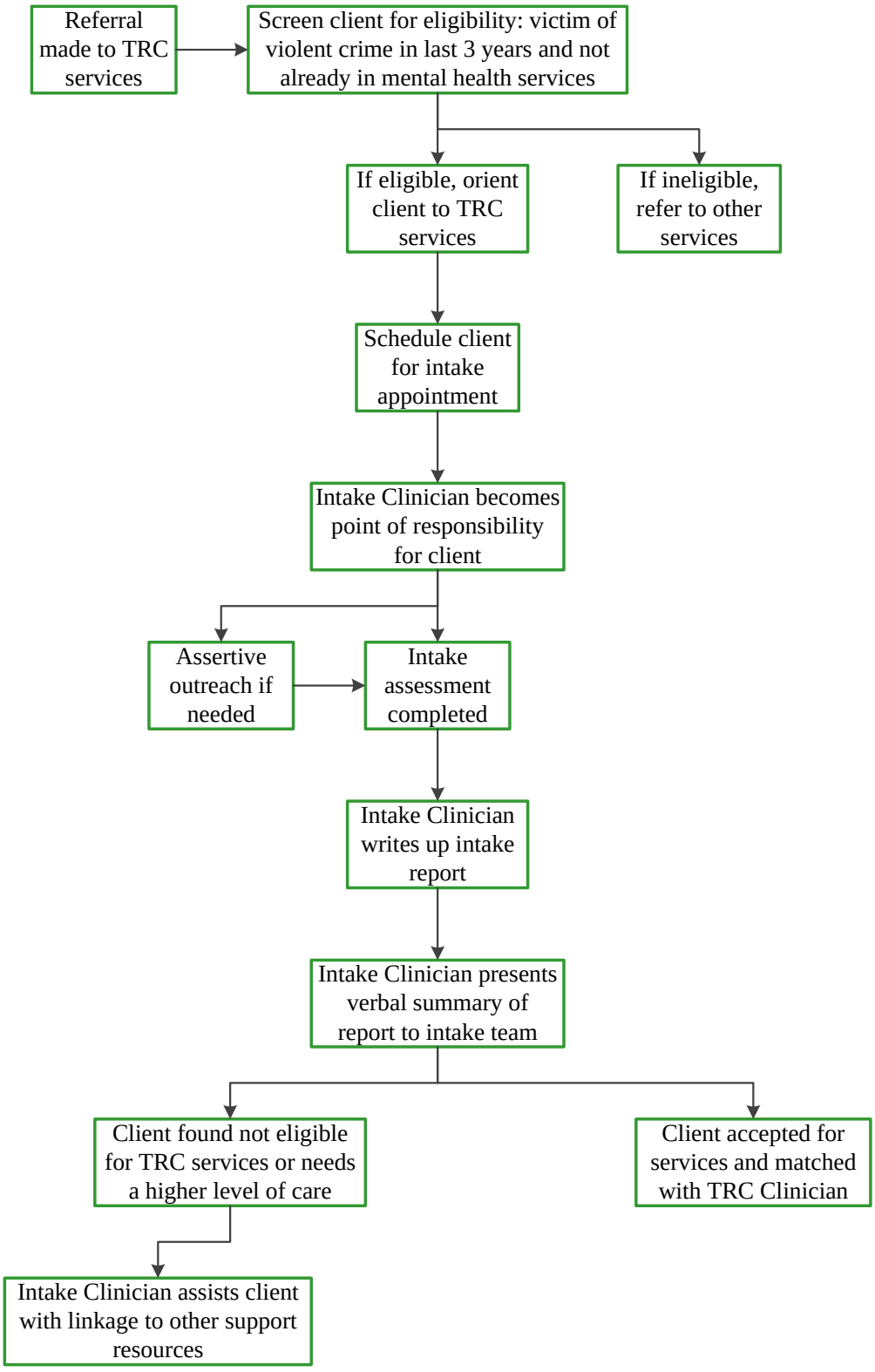
Dickinson, Emily (1960). *The complete poems of Emily Dickinson.* New York, NY: Little, Brown and Company.

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Undeserved, 9,* 117-125.

Appendix 1 to Assessment and Planning: Intake Flow

See next page for TRC Intake Flow Chart.

TRC Intake Flow Chart



Appendix 2 to Assessment and Planning: Measures Used in UC San Francisco TRC Intake Assessment

See next page for a list of measures used.

Standardized Measures Used by UCSF TRC

Items / Measure	*Domain*	*Schedule*	*Completed By*
TRC Referral Form (Yellow)*	Basic demographics and program eligibility	When referral is taken	Clinician taking referral
TRC Intake ï includes:		Baseline – At intake	Intake Clinician
Identifying Info*	Demographics		
PCL-5*	PTSD		
Carlson Trauma History Screen*	Trauma History & past PTSD		
PTSD Observational ?s	PTSD and Complex PTSD		
Complex PTSD Measure*	Complex PTSD		
PHQ9*	Depression		
PROMIS	Sleep		
PEG	Physical Pain		
Note: the MINI is used to assess criteria for additional DSM Mental Disorders, including Substance Use Disorders	Internationally validated, standardized diagnostic assessment for DSM disorders; must be used with permission		
Needs/barriers assessment, planned TRC services and referrals	Areas of need and barriers to care; case management assistance and services planned		
WHOQOL-BREF*	Quality of Life	Baseline – At first session	Client
Plan of Care*	Client-rated and Clinician-rated level of need for services/help in various life domains; used to collaboratively identify target goals for treatment	Within first 3 sessions	Therapist and Client

Items / Measure	*Domain*	*Schedule*	*Completed By*
Follow-Up Measures- includes:		8th session and 15th or 16th session; Also at next-to-final session if treatment >16 sessions	Therapist
Updated Demographics	Update from baseline demographics		
PCL-5*	PTSD		
Complex PTSD Measure*	PTSD and Complex PTSD		
PHQ9*	Depression		
PROMIS	Sleep		
PEG	Physical Pain		
Needs/barriers assessment, TRC services and referrals provided	Areas of need and barriers to care; case management assistance provided and services received		
WHOQOL-BREF plus Service Satisfaction*	Quality of life; patient evaluation of services received		Client
Plan of Care*	Client-rated and Clinician-rated level of need for services/help in various life domains; client rates progress made toward identified treatment goals	Every 16 sessions if treatment is extended	Therapist and Client

Appendix 3 to Assessment and Planning: Citations for Measures Used in UC San Francisco TRC Intake Assessment

See next page for citation information on measures.

Citations for Measures Used by UC San Francisco TRC

Items / Measures	*Citations*
1. TRC Referral Form (Yellow)	TRC Developed.
2. Client Identifying Info	TRC Developed.
3. PCL-5	Weathers FW, Litz BT, Keane TM, Palmieri PA, Marx BP, Schnurr, PP. The PTSD Checklist for DSM-5 (PCL-5) – Standard. Available from http://www.ptsd.va.gov/, 2013.
4. Carlson Trauma History Screen	Carlson EB, Smith SR, Palmieri PA, Dalenberg C, Ruzek JI, Kimerling R, Burling TA, Spain DA. Development and validation of a brief self-report measure of trauma exposure: the Trauma History Screen. Psychological Assessment 23:463-477, 2011.
5. Complex PTSD Measure	TRC Developed.
6. PHQ9	Kroenke K, Spitzer RL, Williams JB, Löwe B: The Patient Health Questionnaire Somatic, Anxiety, and Depressive Symptom Scales: a systematic review. General Hospital Psychiatry 32:345-359, 2010.
7. PROMIS (Sleep scale)	Yu L, Buysse DJ, Germain A, Moul DE, Stover A, Dodds NE, Johnston KL, Pilkonis PA: Development of short forms from the PROMIS™ sleep disturbance and sleep-related impairment item banks. Behavioral Sleep Medicine 10:6-24, 2011.
8. PEG (Pain scale)	Krebs EE, Lorenz KA, Bair MJ, Damush TM, Wu J, Sutherland JM, Asch SM, Kroenke K: Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. Journal of General Internal Medicine 24:733-738, 2009.
9. PTSD Observational Q's	TRC Developed.
10. WHOQOL-BREF	The WHOQOL Group. Development of the World Health Organization WHOQOL-BREF quality of life assessment. Psychol Med, 28(3) 551-558; 1998.
11. Plan of Care	TRC Developed
12. WHOQOL-BREF plus Service Satisfaction	The WHOQOL Group. Development of the World Health Organization WHOQOL-BREF quality of life assessment. Psychol Med, 28(3) 551-558; 1998. TRC Developed
13. Updated demographics	TRC Developed
14. Needs/barriers assessment, TRC services and referrals provided	TRC Developed
15. Show cards for assessments	TRC Developed

Appendix 4 to Assessment and Planning: Sample Intake Report

See next page for a sample intake report.

Community Health Network
San Francisco General Hospital
Department of Psychiatry
Trauma Recovery Center/RTC
(415) 437-3000

NAME	**Sample, Client**
DOB	**November 17, 1980**
MRN	**63264475**
PCP	Davidson, Aaron (Silver A)

REFERRED BY:	REFERRING AGENCY/DEPARTMENT:	PHONE:	PAGER:	REFERRAL DATE:
Sandy Heron	**Victim Witness**	**(415)546-3729**	**(415)246-8993**	**12/28/2016**

REASON FOR REFERRAL:
Physical Assault

Intake Evaluation

Date of Intake: 01/31/2017

ID: Client is a 36 y.o., partnered, African American woman. Income: PT employment in retail. Medicaid insurance. Section 8 housing. Lives with two of her daughters, ages 3 & 4. 14 y.o. daughter lives primarily with father, shared custody.

CC: "I'm going through a lot and it's too much sometimes. I'd like to get some support."

HPI: Client was referred to TRC by SF Victim Services. On 12/17/16, client sustained a traumatic brain injury with loss of consciousness in an assault to the back of the head with a blunt object. Clt reports that she was coming out of a store when she was followed by 3 unknown assailants who tried to rob her; a witness saw the assault and called 911, and clt was brought to SF General Hospital by ambulance. Client was treated in the ED for a mild concussion and various contusions and d/c'd home. Client endorses the following post trauma anxiety symptoms: intrusive thoughts, nightmares, flashbacks, distress & physiologic reactivity at reminders, cognitive and behavioral avoidance, inability to experience positive emotions, strong negative beliefs, self blame, anhedonia, initial and middle insomnia, difficulty concentrating, hypervigilance, feeling in a a daze, and sense of foreshortened future. Client endorses additional depressive symptoms that have persisted since 2007 secondary to domestic violence and multiple losses of family members: depressed mood, poor appetite, psychomotor slowing, and shame several days of the week, with anhedonia more than half the days. She reports that these symptoms "come and go," and denies a 2-month period of remission. Denies manic symptoms. No current SI/HI. Denies problematic current substance use or changes in use since the assault. Client reports a history of crack cocaine use that contributed to prior homelessness, with last use in 2008.

Medical History

		Medication	Dosage	Date Start	Prescribing MD
Current Meds?	*No*				
Past Meds?	*Yes*	Zoloft	75 mg	2012	Alice Vos at South of Marke
Allergies?	*No*				

Med Hx Comments: Client is sexually active, uses condoms for birth control and is HIV-negative. She is currently linked with primary care.

Past Mental Health Treatment History

						Past MH	# of Episodes	
Past Sx:	Auditory hallucinations	*No*	Self mutilation	*No*	**Svcs?** *Yes*	2	Psychotherapy
	Visual hallucinations	*No*	Suicide gestures/parasuicidal	*No*		2	Medications
	Suicidal ideation	*Yes*	Paranoid ideation	*No*		1	Psychiatric Emergency
						0	Inpatient

Psy Hx Comments: Clt reports ongoing depressive symptoms since 2007, related to DV and multiple family losses. Reports that symptoms vary in intensity/frequency; denies daily symptoms and denies 2 months without symptoms. Clt reports a history of passive SI, with thoughts of "being better off not being here" when under stress. Clt reports one previous episode of psychiatric treatment that included Zoloft which clt did not find helpful, and therapy which client attended for 3 months.

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PCP	Davidson, Aaron (Silver A)

Family and Social History

Client reports she was primarily raised by her grandmother and describes her extended family as "loving and there for me." She has 2 siblings, and reports ongoing contact and support from her family, although most no longer live in SF. Client reports that her mother was physically abusive and her father left when client was very young, and that she "was very close" with the grandmorther who raised her. Clt reports past domestic violence with a partner in 2007, and past domestic violence from current partner, with last physical incident in 2011.

Education and Work History

Client graduated from a local high school and reports she is currently working 32 hours/week in retail. Reports history of cashiering and office work.

Legal History

Children/Guardian issues	*No*
Incarceration/Criminal history	*No*
Parole/Probation	*Yes*
Other legal issues	*No*

Notes

Shared custody with father of 14 y.o. daughter. 1 arrest related to substance use while homeless in 2006; cleared probation.

Trauma History

Childhood	Verbal	*Yes*	**Adult**	Verbal	*No*	**Domestic Violence**	Current	*No*
	Physical	*Yes*		Physical	*No*		Past	*Yes*
	Sexual	*No*		Sexual	*No*			
	Neglect	*No*		Witness Violence	*No*	**Victim of Crime**		
	Witness DV	*No*				**in past 2 yrs?:**		

Trauma Comment: Client reports that 2007 DV included verbal and physical abuse and stalking; reports no physical violence with current partner since 2011. Also reports being "homeless for a few months" in 2006 which contributed to feeling dependent on her abusive partner in 2007.

Substance Use

Substance	Frequency (past 12 months)	Last Use Date	Number of symptoms
Tobacco	Daily/Almost Daily	2011	
Alcohol	**Weekly**	**1/28/17**	**1**
Cannabis	Once or Twice	2011	
Cocaine	**Daily/Almost Daily**	**2008**	**11-Severe**

NOTE--FOR ALL SUBSTANCES: Mild: 2-3 symptoms; Moderate: 4-5 symptoms; Severe: 6 or more symptoms

Ever Received Substance Use Services? *Yes*

Service Type	# Episodes	Description
Outpatient Detox	1	Iris Center in 2006
Inpatient Detox	0	
Methadone Maintenance	0	
Self Help/12 Step	1	NA 2008-2009
Residential Program	1	Walden House in 2008

Substance Use - Additional Notes: Client reports having a glass of wine once a week. Denies increased use since the assault. Client reports past use of cigarettes and crack cocaine, with last cocaine use in 2008. Client found residential treatment helpful and attended one year of 12-step meetings as well.

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NAME	**Sample, Client**
DOB	**November 17, 1980**
MRN	**63264475**
PCP	Davidson, Aaron (Silver A)

Mental Status Exam

Domain	Summary
Appearance	Appropriately groomed, casually dressed
Behavior and Motor Activity	Slightly slowed psychomotor
Orientation	Oriented x 4
Attitude	Cooperative, pleasant
Speech	Normal rate, volume and tone
Mood	"Emotional"
Affect	tearful/anxious; dysphoric
Thought Process	Largely linear; avoidant re: index crime
Thought Content	Fear for safety
Perception	Within normal limits; no distortions noted
Cognition	Insight and judgement appear good; no formal testing conducted

Suicidality & Risk of Self Harm:	Ideation	*No*	**Danger to Others and Risk of Danger to Others:**	Ideation	*No*
	Plan	*No*		Plan	*No*
	Means	*No*		Means	*No*
	Intent	*No*		Intent	*No*

Risk Comment:

Although client reports a history of passive SI she denies any current SI, passive or active. Client accepted crisis numbers list and agreed to use it if she becomes overwhelmed; cites her children as strong protective factors and appears at low risk ofharm to self or others. Denies current or past HI.

Provisional Target Problems:

1. "I don't feel safe"
2. "I want to be happy"
3. "I don't have anyone outside my family"

Provisional Goals:

1. Reduce, manage & resolve PTSD symptoms
2. Reduce, manage & resolve depressive symptoms
3. Increase social support

Provisional Diagnoses (DSM5)

Diagnosis (code and descriprtion)

F43.10 Posttraumatic stress disorder
F34.1 Persistent depressive disorder (dysthymia)
F14.20 Cocaine use disorder, Severe
- In sustained remission

Medical Diagnosis

Case Formulation:

Client is a 36 y.o., partnered, African American woman referred to TRC s/p an assault and attempted robbery that occurred on 12/17/16. Since the index trauma, client reports experiencing post-trauma anxiety and distress; also unremitting depressive symptoms occurring since 2007. Client is motivated to engage in services at this time in order to reduce and manage post-trauma anxiety, and could additionally benefit from addressing persistent symptoms of depression. Her strengths include her committment to her children, familial and partner support, prior level of functioning at work, and ability to sustain full remission from a past severe substance use disorder.

Recommendation & Plan:

Trauma-focused therapy and case management; possible medication evaluation for sleep, anxiety, and mood symptoms.

Community Health Network
San Francisco General Hospital
Department of Psychiatry
Trauma Recovery Center/RTC
(415) 437-3000

NAME	**Sample, Client**
DOB	**November 17, 1980**
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Treatment Disposition

Individual Trauma-English

It may take several weeks before your patient enters treatment at TRC/RTC. Please let us know if there are any significant changes in the patient's mental status or condition

Stacey Wiggall, LCSW		21477		
CLINICIAN'S NAME (PRINT)	CLINICIAN'S SIGNATURE	LICENSE NO.	PHONE	DATE
SUPERVISOR'S NAME (PRINT)	SUPERVISOR'S SIGNATURE	LICENSE NO.	PHONE	DATE

Appendix 5 to Assessment and Planning: Sample Plan of Care

See next page for a sample Plan of Care.

MRN: 0123567

Plan of Care, Part 1

UCSF-SFGH Trauma Recovery Center Plan 7/2015

Date: 1/10/17

Client Name (Last, First): Sample, Client

Therapist Name (Last, First): Sample, Clinician

Please indicate: ☒ Beginning Treatment ☐ Treatment Extension, Session # ____

In collaboration with your client, please develop a plan of care within the first two weeks of each treatment episode.

I'm going to read a list of areas in which people may experience problems. Please tell me how much you think you need help or services in each of these areas.

	Not at All (1)	A Little Bit (2)	Moderately (3)	Quite a Bit (4)	Extremely (5)	Description	Clinician-rated level of need (1-5)
Medical				X		Recovering from stab wound	4
Safety				X		would like to return home after home invasion	4
Food/Clothing			X			"I can't cook."	3
Housing	X					Wants to return to apartment	1
Financial			X			Fixed income	3
Legal				X		Ongoing criminal investigation	4
Vocational/ Educational	X					Retired	1
Physical Rehabilitation			X			Physical Therapy 2x/week	3
Language/Literacy	X						1
Emotional/Psychological					X	Fearful, sad, losses	5
Interpersonal/Social			X			Loss of independence	3
Spiritual/Religious	X						1
Sexual	X						1
Substance Abuse	X					Not worried about alcohol use; continue to monitor	3

Plan of Care, Part 2

UCSF-SFGH Trauma Recovery Center Plan 7/2015

MRN: 0123567 Date: 1/10/17

Client Name (Last, First): Sample, Client Therapist Name (Last, First): Sample, Clinician

Please indicate: ☒ **Beginning Treatment** ☐ **Treatment Extension, Session #**_____

The Therapist and client collaborate in choosing 2-3 **Target Problems** from Part 1 to address during treatment. Define reasonable/measurable **Goals or Objectives**; then develop a **Plan** to reach those goals. Indicate the **Number of Sessions** contracted to work toward the goals.

NOTE: IF TREATMENT EXTENSION: 1) Client rates progress toward goals; 2) Client and Clinician fill out a NEW Plan of Care

Target Problem 1	Client Goal or Objective	Plan/ Intervention	Strengths that will help Client achieve goal	# of Sessions	Goals Met? Extension	Goals Met? Closing
"Can't cook or drive."	Return to Independence.	- Case management (home care / meals) - Para transit	- Family + friend support - Motivated	16	☐ Not at All ☐ A Little Bit ☐ Moderately ☐ Quite a Bit ☐ Extremely	☐ ☐ ☐ ☒ ☐

Target Problem 2	Client Goal or Objective	Plan/ Intervention	Strengths that will help Client achieve goal	# of Sessions	Goals Met? Extension	Goals Met? Closing
"Jumpiness. I get scared."	Reduce fearfulness and hyperstartle response.	- Education about trauma - Learn/practice coping (breathing, distraction)	- Healthy coping strategies - Linked to medical care	16	☐ Not at All ☐ A Little Bit ☐ Moderately ☐ Quite a Bit ☐ Extremely	☐ ☐ ☐ ☐ ☒

Target Problem 3	Client Goal or Objective	Plan/ Intervention	Strengths that will help Client achieve goal	# of Sessions	Goals Met? Extension	Goals Met? Closing
"I'm sad."	Reduce sadness, feelings of loss and self-blame.	- Use CBT to help clt challenge negative thoughts	- Insight f-l - Experienced - Intelligent	16	☐ Not at All ☐ A Little Bit ☐ Moderately ☐ Quite a Bit ☐ Extremely	☐ ☐ ☐ ☒ ☐

Clients' Signature (1) Client Sample
Date: 1/10/17
Therapists' Signature (1) Therapist Sample
Date: 1/10/17
Supervisors' Signature (1) Supervisor, LCSW
Date: 1/12/17

Clients' Signature (2) Client Sample
Date: 6/20/17
Therapists' Signature (2) Therapist Sample
Date: 6/20/17
Supervisors' Signature (2) Supervisor, LCSW
Date: 6/22/17

Appendix 6 to Assessment and Planning: Sample Treatment Closing Report

See next page for a sample treatment closing report.

Community Health Network
San Francisco General Hospital
Department of Psychiatry
Trauma Recovery Center/RTC
(415) 437-3000

NAME	Sample, Client
DOB	11/17/1980
MRN	63264475
PCP	Aaron Davidson, - Silver Ave

REFERRED BY:	REFERRING AGENCY/DEPARTMENT:	PHONE NUMBER:	PAGER:	REFERRAL DATE:
Sandy Heron	**Victim Witness**	**(415)546-3729**	**(415)246-8993**	**12/28/16**

REASON FOR REFERRAL:	DATE OF INTAKE:
Physical Assault	**1/31/2017 12:28:**

SUMMARY TYPE:	DATE COMPLETED:
Treatment Closing	**6/22/17**

TREATMENT DISPOSITION:	THERAPIST:
Individual Trauma-English	Stacey Wiggall LCSW

Date of first session: 2/13/17
Date of last session: 6/19/17
Number of sessions contracted: 16
Number of sessions attended: 16

Current Psychiatric Medications

Medication	Dose	Date Start	Prescribing MD/Refill Plan
Lexapro	10 mg	3/15/17	Primary care provider

Treatment Update Diagnoses (DSM5)

Diagnosis (code and description)
- NO DIAGNOSIS

Medical Diagnosis

Discharge Plan:

No additional treatment planned

Clinical Summary:

Clinical Change: much better

Clinical Summary:

Client was referred to TRC by SF Victim Services after sustaining a traumatic brain injury following an assault and robbery attempt. Client initially presented with symptoms of PTSD from the referring crime and Persistent Depressive Disorder stemming from an abusive relationship. Client was motivated to engage in treatment, attended sessions regularly, and benefitted from CBT interventions targeting her anxiety and depressive symptoms. Although client was initially hesitant to schedule a medication evaluation, she did so and has also benefitted from starting an antidepressant, which will now be prescribed by her PCP. Client reports significantly improved sleep and a higher level of functioning at work. No further treatment is planned at this time.

Stacey Wiggall, LCSW		21477		
CLINICIAN'S NAME (PRINT)	CLINICIAN'S SIGNATURE	LICENSE NO.	PHONE	DATE
SUPERVISOR'S NAME (PRINT)	SUPERVISOR'S SIGNATURE	LICENSE NO.	PHONE	DATE