TRAUMA RECOVERY CENTER CLINICAL CASE MANAGEMENT

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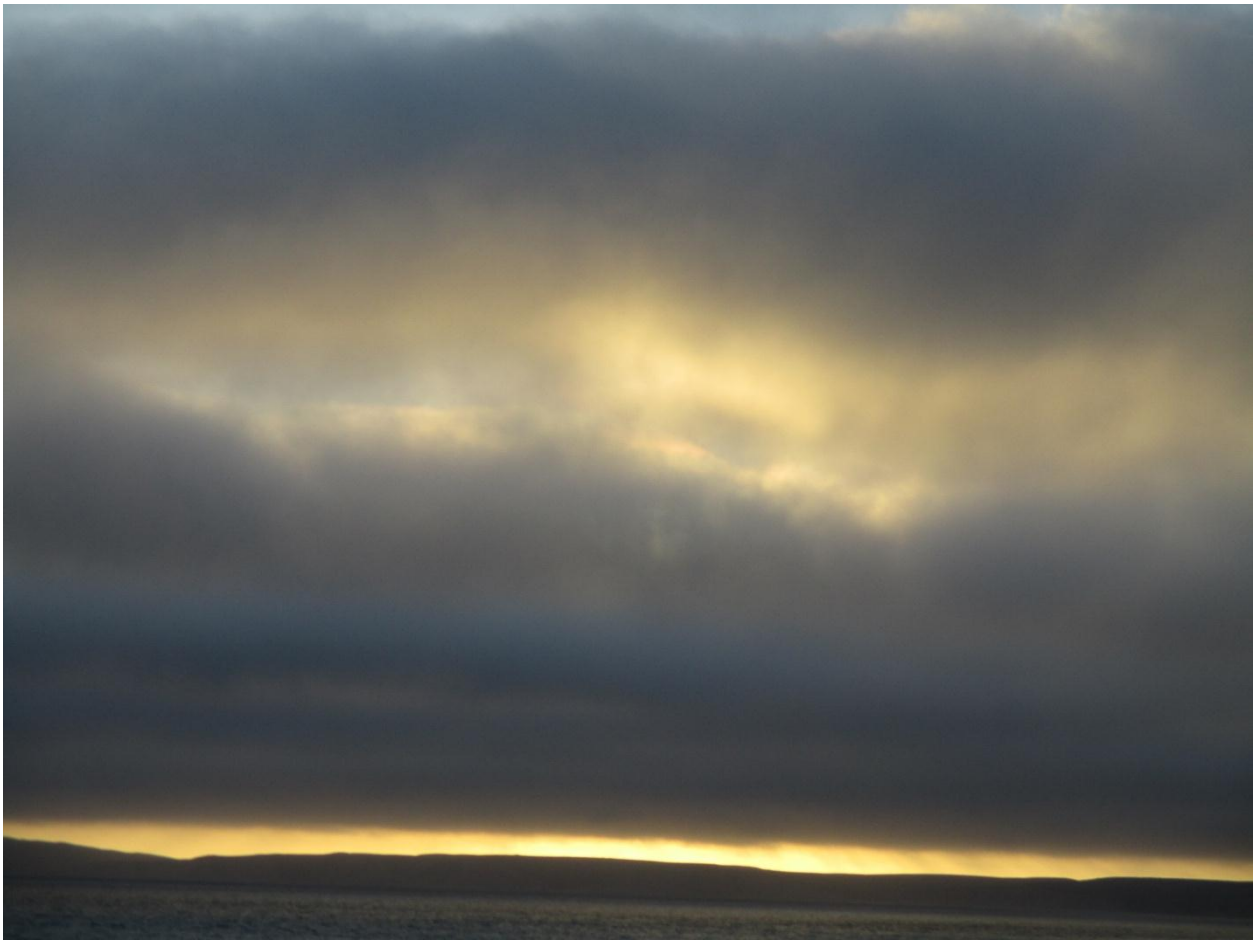

Photograph by Ezme Kozuszek

"If you lose hope, sometimes you lose the vitality that keeps life moving, you lose the courage to be, that quality that helps you in spite of it all. And so today I still have a dream."

—Martin Luther King, Jr.

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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Case management is a client-centered strategy to improve coordination and continuity of care, especially for persons who have multiple needs (Moxley, 1989). It is regarded as one of the most important innovations in mental health and community care of the past several decades (Vanderplasschen et al., 2004), as it takes into account the needs of a whole person. Various models of case management have been proven effective in the treatment of people with chronic mental illness, substance use disorders, or both (Ziguras & Stuart, 2000).

In practice, many different levels and types of service have been called case management. Some workers that provide a single type of assistance are called case managers, such as "housing case managers." Other times, the staff person at each agency where a client receives services is called a case manager, so the client may have three or more "case managers," but no one individual is necessarily coordinating and managing the services the client is receiving in multiple domains.

TRC APPROACH TO CASE MANAGEMENT. TRC clinical case management requires seeing the big picture and taking an active, ongoing role in coordinating all of the resources a client needs. This begins with a comprehensive assessment of the client's needs, then identification of available resources (such as legal services, housing, food, medical care, etc.), then helping the client access them as needed, and remaining engaged over the service period. Case management is a collaborative process that takes into account the client's priorities and readiness to access help. For example, food, housing, and financial entitlements are often needed first, while substance abuse treatment may be addressed later, as clients build motivation and incorporate new coping strategies. In many instances, just giving the client contact information for other service providers is not enough; that is a "referral," not case management. Making a phone call or filling out forms on behalf of a client is a form of brokerage case management. While it is certainly helpful, it is also of limited use to clients who have many psychosocial needs and are dealing with the aftermath of acute trauma. TRC clinical case management includes active engagement, such as going with the client to a court date, or telephoning other service providers. Case management also includes following up to see if the client was able to access the resources, and if not, engaging with both the client and the resources to solve the problem. The Clinician proactively monitors the outcomes and troubleshoots as necessary, and adjusts the plan as the client's needs change. Clinically-informed case management also includes the use of therapeutic interventions while delivering services. For example, a clinical case manager may introduce relaxation techniques to the client in order to help them tolerate sitting in a busy waiting room in order to attend an intake appointment for General Assistance.

EXAMPLE CLIENT VIGNETTE. Oscar was a twenty-year-old, Latino, monolingual Spanish-speaking man who was referred to the TRC by medical providers following hospitalization for a gunshot wound. As a result of the shooting, Oscar became paraplegic and needed to use a wheelchair. He lived with his parents and his two-year-old son. Oscar initially had difficulty getting to appointments but was open to home visits. Oscar and his TRC Clinician prioritized the following case management goals: help applying for health insurance, referral to an agency that specialized in making homes ADA accessible, and help applying for a U-Visa (as Oscar was undocumented). As trust and rapport with his TRC Clinician strengthened, Oscar began to reveal more of his grief and loss around becoming paraplegic, and the depth of his post trauma symptoms, including depression. His Clinician began providing Cognitive Behavioral Therapy (CBT) for depressive symptoms, and in addition, referred him for a psychiatric medication evaluation to help with depression and sleep. She also connected him with a weight trainer who specialized in working with paraplegic clients. As the prosecution of his assailant approached, Oscar's Clinician introduced CBT strategies for decreasing and managing anxiety in order to help him participate in the legal process. She also spoke with the District Attorney on his behalf, and provided court accompaniment during his testimony.

Clinical Case Management and Traditional Mental Health Treatment Models

Despite research demonstrating the value of case management with multiple populations, many traditional mental health service models do not incorporate it into their treatment. Private practice Clinicians who include case management interventions in their treatment are even more rare. There are multiple reasons for this omission. One is that not all professional mental health training programs include case management as a focus of study or competency; this can vary by discipline and/or by program. With the exception of social work, which developed in service of populations who often have limited access to resources, such as people living in poverty, other mental health disciplines developed with a primary focus on interventions that increase a client's emotional well-being through the relationship between the Clinician and client. The implicit assumption in ignoring resource or systems issues that can impact a person's mental health is that a client already has access to all needed external resources, such as food, medical care, and housing, or that a client should be capable of being their own advocate and securing these resources.

Clinical Case Management and the TRC Model

In the TRC model, clinical case management is a core element of our treatment approach and it is incorporated into mental health services. There are two critical reasons for this.

One is that violent crime is statistically more likely to happen to people with less access to resources and power, such as young men of color, people who are homeless, people who live in poverty, and people who overuse substances (Acierno et al., 1999). The second reason is the overwhelming and destabilizing nature of trauma. Being a victim of violent crime can impact the mental health and functionality of any person, including those who might generally be able to function as their own advocates or navigate complicated systems of care. The TRC model recognizes that trauma, the experience or witnessing of a terrifying event that threatens life or bodily integrity, can affect people at all levels: emotional, mental, relational, spiritual, and practical. It is impossible to ignore the potential impact of trauma on a person's ability to have their practical needs met. For example, a father who is robbed and physically assaulted at gunpoint on his way home from work may develop depressive and anxiety symptoms that prevent him from returning to work, which then impacts his health insurance coverage, and the family's ability to pay their rent on time, etc. TRC's incorporation of case management assistance into the service model recognizes the potentially devastating impact of violence on a person's functionality.

Multiple Functions of Clinical Case Management

PROMOTING SAFETY AND STABILIZATION. Trauma treatment expert Judith Herman identifies Safety and Stabilization as the first stage of trauma treatment (Herman, 1997). The inclusion of case management in the TRC model aligns with this framework. Mental health treatment interventions can help a survivor regain or achieve an increased sense of emotional well-being; however, it has long been recognized that people cannot take care of higher-level needs until basic physiological and safety needs are met (Maslow, 1943). The first stage of trauma-informed services may include helping a client access safer housing, sign up for financial entitlements, or locate a food pantry.

ENGAGEMENT. When clients are primarily interested in help meeting their basic needs, case management assistance is a natural place to start TRC services. This focus may be due to the urgency of needed resources, or to a client's higher level of comfort discussing practical assistance rather than the impact of trauma on their mental health. Regardless, case management can be an entry point into TRC services for survivors who might not initially be motivated to pursue mental health treatment.

RESTORATION OF FAITH IN HUMANITY. Many people who are survivors of violent crime report experiencing a loss of faith and trust in other people after the event. Being the survivor of another person's intentional cruelty and/or total disregard for one's suffering can alter a person's beliefs about the general nature of humanity and the intentions of others. Receiving case management assistance, especially in the immediate aftermath of a

traumatic event, can be a positive, restorative, and therapeutic experience. It serves as evidence that there are trustworthy, caring, respectful and kind people in the world, at a time when this may feel difficult to believe.

EMPOWERMENT. Being a survivor of violent crime is a disempowering experience, in which one loses a sense of control and choice over what is happening to them. The aftermath of that loss can make it extraordinarily difficult to navigate "helping" systems, such as follow up medical care, victim compensation boards, and financial entitlements. This difficulty can feel like a secondary form of victimization. TRC case management is client-centered, and conducted with the goal of assisting the client in finding their own voice, thereby increasing their ability to be an advocate for themselves.

TRC Clinicians: Mental Health Clinicians Who Are Case Managers

OVERLAPPING NEEDS. The TRC model was developed with the idea that there is often a great deal of overlap between a survivor's case management needs and mental health needs. Although there are a few clients who have only mental health treatment needs or only case management needs, the vast majority of clients accessing TRC can benefit from both kinds of services. For example, most people cannot effectively decrease their trauma-related anxiety or depression while they are worried about finding shelter, or having enough food, or participating in the legal system. Similarly, clients may not be able to maintain safe housing or stay in needed substance abuse treatment while struggling with significant PTSD or depressive symptoms. Many clients benefit from being able to address both kinds of needs simultaneously.

A SINGLE POINT OF CONTACT. Having a single Clinician function as the provider responsible for both services ensures that clients receive truly wraparound care. With a TRC Clinician who is competent at providing both case management and trauma-informed mental health treatment, clients build a trusting relationship with one provider, instead of needing to work with multiple people. The intake for services identifies both psychological symptoms resulting from the trauma and areas of practical need. The TRC Clinician and client then collaborate on a plan of care that also includes both elements of services and helps prioritize goals in both categories.

GETTING PAST THE STIGMA OF MENTAL HEALTH TREATMENT. As discussed in other chapters, many survivors of violent crime may feel that there is a stigma attached to mental health services, or that mental health treatment is only for "crazy people." The opportunity to build a trusting relationship with a TRC Clinician through case management can erase that barrier. As a client gets to know and feel comfortable with the

Clinician, they often become more open to discussion of the psychological impact of the trauma, and to receiving help with related symptoms.

REMOVING BARRIERS TO CARE. In other models that split case management and mental health services among different providers, clients often begin with case management services. This can create barriers to accessing mental health treatment. One barrier is that, without an assessment by a mental health clinician, both post-trauma and pre-existing mental health problems may go unrecognized. Clients cannot receive treatment for issues that are never identified or acknowledged. Another barrier is that if clients begin with only case management services, the responsibility for referral to mental health treatment is put on either the client to request it, or the case manager to recognize the need for it. For the client, stigma, shame, and lack of knowledge about available treatments can be significant obstacles to requesting mental health services. For the case manager, lack of clinical expertise, and lack of understanding of the specific ways that trauma-informed mental health treatment can be beneficial, can also be substantial barriers to making a referral. This case-splitting system places an unfair and unreasonable burden on clients and case managers. It can rob clients of the opportunity to receive services that are often a significant part of recovery from trauma. It can also result in a majority of clients who need mental health services and case management services receiving only case management services, which is contrary to the core values of the TRC model.

In programs that split case management and psychotherapy between different providers, it can be helpful to structure services so that clients automatically have access to both. It is also critical for providers to be in regular communication with each other and to present a unified, team approach in their work with clients.

Principles of TRC Case Management

Case management provided by a mental health clinician is clinical case management, in which the Clinician is using their clinical judgment and expertise to guide them in the provision of client-centered services. Case management is integrated into a comprehensive psychosocial treatment plan. Three central principles of clinical case management (Kanter, 1989) are outlined below:

TITRATING SUPPORT AND STRUCTURE. Clinicians may offer higher levels of support and structure at the beginning of the treatment relationship, when clients' functioning can be greatly impacted by the immediate aftermath of violence. As clients stabilize, practical support may be reduced in acknowledgment of clients' ability to function more autonomously.

USE OF THE CASE MANAGEMENT RELATIONSHIP. The case management relationship encompasses all of the interpersonal dynamics found in psychotherapy. Although clinicians attempt to interact with their clients on a conscious and concrete level, transference and countertransference reactions can occur (Kanter, 1989). This can be especially true for clients with histories of polyvictimization dating back to childhood, for whom problems with boundaries and trust may shape all of their interpersonal relationships. Clinicians can recognize and work with these reactions even while focused on case management goals.

FLEXIBILITY. Clinicians should be able to tailor their intervention strategies to meet diverse client needs. The frequency, type, and location of interventions should reflect each client's individual needs and goals.

TRC Case Management Goals

Linkage with Community Resources

- **HOUSING OR SHELTER.** This includes homeless shelters, domestic violence shelters, public housing, supportive housing programs, and any specialized community programs (such as a homeless outreach team) that exist.
- **FOOD.** TRC Clinicians should be knowledgeable about food pantries and free meal programs in their community.
- **HEALTH INSURANCE.** If clients do not already have medical insurance, help linking with either state-run or private insurance.
- **MEDICAL CARE.** This includes both ongoing primary care and any specialty follow-up care that is needed (i.e., wound care, dentistry). Depending on the client's needs and capacity, this could include help finding resources, scheduling appointments, and/or client accompaniment.

Linkage with Financial Entitlements

- **GENERAL ASSISTANCE.** If clients are not already linked with financial entitlements for which they are eligible, TRC Clinicians should help them navigate these systems and apply for benefits.
- **STATE DISABILITY INSURANCE.** If clients are disabled by a trauma, either physically or psychologically, TRC Clinicians can help them apply for appropriate benefits. This could be state disability insurance (SDI); or, if a

disability is judged to last longer than one year, Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)

- **VICTIM COMPENSATION.** If TRC clients have not already completed an application for victim compensation in order to help recover eligible crime-related expenses, TRC Clinicians can aid and advocate for clients in this process.

Legal Advocacy

- **LIAISON AND ACCOMPANIMENT.** Some clients are reluctant to participate in the legal system, due to avoidance of trauma reminders, fear of the perpetrator, or their own past negative experiences with the criminal justice system. If there is a police investigation or criminal prosecution in which clients are asked or subpoenaed to participate, TRC Clinicians can provide support, including communicating with attorneys (with a release of information and the client's consent), or providing court accompaniment.
- **U-VISAS.** Undocumented clients who have been a survivor of certain types of crime can apply for a U-Visa, which provides eligible survivors with a "nonimmigrant status" that allows them to legally remain in the United States while assisting law enforcement with the investigation or prosecution of a crime (Victims of Trafficking and Violence Prevention Act, 2000). This process can be the beginning of a path to permanent residency; if certain conditions are met, an individual with a U-Visa may later adjust to lawful permanent resident status. TRC Clinicians can provide referrals to legal services that assist with this process and can also provide needed documentation of the crime and its impact on the client.
- **RESTRAINING ORDERS.** Clients who have experienced domestic violence or stalking can benefit from linkage to legal assistance for help obtaining a restraining order. TRC Clinicians can also provide court accompaniment during this process.

Considerations for Peer Support Case Management

Peer support has been incorporated into programs for substance use disorders, persistent and severe mental illness, veterans, and violence prevention. Advocates for the inclusion of peer staff in these services note the potentially transformative power of peer support (Davidson, 2015) resulting from the sharing of life experiences, strengths, and accrued wisdom. Some advocates believe that peer staff are better equipped to outreach to and

engage members of disenfranchised communities, who may be more open to connecting with providers from shared cultural backgrounds and/or and similar life experiences. At the UC San Francisco TRC, staff have witnessed the life-changing impact that hearing another survivor's recovery story can have for many clients. While the UC San Francisco model utilizes the mental health clinician as both Clinician and clinical case manager, staff work closely with peer support providers from partner agencies. Former TRC clients also work in peer support roles through the TRC CHATT Speakers Bureau and through support group co-facilitation. It is recognized that some agencies may wish to split some services between mental health clinicians and peer support staff, and the following are some considerations for application of the TRC model.

NATIONAL PEER SUPPORT GUIDELINES. There are multiple considerations for the inclusion of peer staff in a TRC model. One is that, as with other staff, roles and practice standards need to be clear. As the field of peer support is still in the early stages of its evolution (Davidson, 2015) and practice standards are not defined by a licensure process, leadership should take special care to ensure that this clarification occurs. Peer staff can be oriented to the same issues clinicians face when working with clients, including confidentiality, boundaries, and the role of self-disclosure. The National Practice Guidelines for Peer Supporters (Supporters, 2013) is an example of a tool that helps clarify some of these issues.

POTENTIAL BARRIERS TO CARE. If mental health services are split between peer supporters who provide engagement and case management services and Clinicians who provide trauma-informed assessment and treatment, the team must ensure that clients do not fall through the cracks between providers, but have equal access to both types of services. This equal access is at the core of the TRC model. Clients with severe symptoms such as suicidality need clinical care; a core value of the TRC model is that all survivors of interpersonal violence deserve access to trauma-informed, evidence-based clinical care. This is one way that the TRC model helps to reduce healthcare disparities.

CLIENT NEEDS MUST COME FIRST. If a team has separate case managers and Clinicians, special care must be taken to ensure that there is consistent, clear communication among every provider working with a particular client. This regular communication is needed to ensure that both case management and therapy needs are identified and addressed in order to avoid duplication, and that providers are never working at cross purposes. It is also essential that both case managers and Clinicians are educated about and value each other's work and roles, so that the client experiences a unified and well-coordinated team approach. Joint meetings among the client, case manager and Clinician also help ensure that the client perceives both providers as a team and that everyone is clear on treatment goals and plans.

MORE RESEARCH NEEDED. More research is needed to demonstrate the effectiveness of peer support on client outcomes. If a program decides to split service provision between Clinicians and case managers, it would be beneficial to evaluate each service component separately in order to demonstrate the advantages of doing so.

Conclusion

People recovering from trauma are at risk for mental health problems, but they also have many other pressing issues. By providing individualized, ongoing clinical case management and simultaneous mental health services, the TRC model addresses the trauma survivor's service needs across several domains in an integrated way.

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