



# **The UC San Francisco Trauma Recovery Center Manual:**

**A Model for Removing Barriers to Care and  
Transforming Services for  
Survivors of Violent Crime**

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Produced in collaboration with Allen/Loeb Associates

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The University of California, San Francisco Trauma Recovery Center is a partnership of the University of California, San Francisco with the City and County of San Francisco Department of Public Health.

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## Preface

The UC San Francisco TRC first opened its doors in 2001. This model of care was developed to provide comprehensive, high quality, effective mental health services to survivors of violent crime from underserved populations, many of whom faced insurmountable barriers to connecting with support services after victimization. Since that time, research has shown this model to be both clinically and cost-effective. We have witnessed the expansion of the TRC model throughout the state of California, as funds have been made available for the development of additional TRC programs. The model is now expanding to transform services for survivors of violent crime in other states as well; at the time of this writing, there are Trauma Recovery Centers in Ohio, and funds are earmarked for TRCs in Illinois and several other states.

The UC San Francisco TRC began as a partnership between Zuckerberg San Francisco General Hospital, the University of California, San Francisco, the San Francisco Department of Public Health, and the California Victim Compensation Board. It was developed from the ground up as a new program that uses assertive outreach and clinical case management to reach survivors who had been falling through the cracks of existing services. In recent years, some newer TRCs have been designed and built from the ground up, while others have developed out of existing programs that were already working with populations with high rates of criminal victimization, such as homeless women, young men of color, and youth survivors of human trafficking.

This manual is designed to be of use for new TRCs whether they are entirely new programs or are adding services to an existing program structure. Freestanding chapters can be downloaded individually, so that programs can access the information that is most relevant for their work or phase of development. For this reason, there is some information that is duplicative across chapters. However, some information is only mentioned in one chapter and expanded in depth in another. The manual can also be downloaded as a whole.

We are incredibly excited about the expansion of this model and hope that sharing our experience will provide useful information and tools, and prevent new TRCs from having to reinvent the wheel. We recognize that programs will also tailor services to meet the needs of their region or client population(s), and hope that the information presented here will serve to promote the goal of increasing survivors' access to trauma-informed, evidence-based, culturally responsive and effective services.

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# TRAUMA RECOVERY CENTER MISSION AND VISION

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*Photograph by Ezme Kozuszek*

“Compañeros, take heart—though your roots be torn,  
they will grow in new ground, and brighter days  
will rise from the fertile dark.”

—From *Sanctuary: The Spirit of Harriet Tubman*

*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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It is estimated that the U.S. population over age 12 experiences over 5.4 million incidents of violent crime every year (U.S. Department of Justice).

The consequences of interpersonal violence on physical and emotional health can be devastating, but few survivors of violent crimes receive mental health treatment or other forms of support. The most disadvantaged crime survivors, including individuals who are poor, people of color, people with disabilities, the homeless or unstably housed, and those living in inner city areas, are among those least likely to receive needed services (Newmark, 2004; Californians for Safety and Justice, 2013).

**IMPACT OF VIOLENT CRIME.** Approximately 50% of people who survive a traumatic violent injury experience psychological or social difficulties unless they are given some form of effective treatment (Breslau et al., 1991). A person who survives trauma related to interpersonal violence usually has to cope with both physical and psychological problems. These psychological problems may include symptoms of Post-Traumatic Stress Disorder (PTSD) such as flashbacks of the traumatic event, nightmares, insomnia, intrusive memories of the trauma, and feelings of depression, anger and fearfulness. People may become socially isolated, develop an assortment of phobias (particularly being afraid to leave their home), have difficulty concentrating, be distractible and have trouble making decisions. Increases in alcohol and drug abuse are also common consequences of untreated trauma. In essence, lives frequently get turned upside down and begin to unravel. Early intervention is essential to help crime survivors deal with the immediate consequences of violent crime and to prevent long-term disability.

**BARRIERS TO CARE.** Despite the serious and often debilitating consequences of criminal victimization, most crime survivors do not receive needed services. Less than one-third of crime survivors experiencing PTSD symptoms receive specialty mental health services in the year following the crime (Hembree and Foa, 2003).

Although specialized programs for crime survivors do exist, many survivors are unaware of these services or not able to take advantage of them. For example, the Victim Services Office in every state helps to identify crime survivors and assists the survivor in applying for Victim Restitution funds. However, aggressive outreach to crime survivors is generally not done, and unless a survivor files a police report, they are not identified by Victim Services (Californians for Safety and Justice, 2013).

Local Victim Services Offices may assist survivors by referring them to mental health treatment. Traditionally, treatment is provided by fee-for-service, private practice therapists in the community. These traditional mental health services tend to be exclusively office-based. For some crime survivors, this type of mental health service is

sufficient to help them in their recovery. However, the majority of survivors who come from vulnerable populations (such as people with disabilities, the homeless, the chronically mentally ill, people who abuse substances, immigrant and refugee groups, non-English speaking survivors, people of color and people living in poverty) typically have so many complex psychosocial problems that the traditional private practice therapy model is not sufficient to address them all. Many traditional mental health clinicians do not provide much if any case management assistance; some are without any specialized training in evidence-based, trauma-specific treatment modalities.

Linguistic and cultural factors can pose additional barriers to care. Embarrassment, shame, and stigma about receiving mental health treatment are also barriers. In addition, trauma and violence, by their very nature, often drive the survivor into isolation, withdrawal and a reluctance to become involved with treatment, particularly treatment that can only be accessed in the provider's office. Ironically, avoiding reminders of the traumatic event is a symptom of PTSD, and yet healing and recovery cannot take place until the impact of the trauma is addressed.

For many survivors of crime, particularly those from vulnerable populations or those with debilitating trauma-related symptoms—including the 50% who have mental health issues related to trauma—it is difficult to become engaged in services. To reach them, an active, flexible approach is necessary. The service providers must be able to leave their offices when necessary and go *to* the survivors in the hospitals or their homes, and, when needed, go *with* the survivors to their court appearances or medical appointments.

## **Development of the University of California, San Francisco Trauma Recovery Center (UCSF TRC) Model**

**BACKGROUND.** Zuckerberg San Francisco General (ZSFG) is a Level 1 Trauma Center; for this reason, anyone in the San Francisco area who has suffered severe physical traumatic injuries is brought to ZSFG for medical treatment. The seeds for the creation of the Trauma Recovery Center model were planted when Dr. Bill Schechter, the Chief of Surgery at ZSFG, commented that, “We can sew them up, but we can’t make them well.” Dr. Schechter was lamenting the fact that, despite the expert surgical interventions that succeeded in saving lives and improving medical outcomes in patients with severe traumatic injuries, these same patients were not healing from the psychological aftermath of a life-altering traumatic event. And, the majority of these patients received no follow-up mental health or trauma-specific support services after being discharged from the hospital.

This comment led to the development of a small pilot study (Boccellari et al., 1997). This was a descriptive study looking at clients' levels of functioning over time, rather than an intervention study. Forty seriously-injured patients were identified while still hospitalized. They were all gainfully employed at the time of their injuries. They were interviewed and evaluated within 48 hours of hospital discharge, using a variety of standardized measures, including a measure of Acute Stress Disorder. At the time of discharge, these patients were given a referral to community-based mental health services. They were then re-evaluated at 6-month follow-up.

At baseline, while in the hospital, 39 out of 40 patients (97%) reported experiencing a variety of psychological symptoms. Particularly prominent were symptoms associated with Acute Stress Disorder such as intrusive memories, nightmares and attempts to avoid thinking about the trauma.

At the point of six-month follow-up, only 32% of these patients had returned to work, despite the fact that most had recovered from their physical injuries (Petersen, et al, 1999). All of the patients reported continuing to experience high levels of distress, and demonstrated no improvement in traumatic stress symptoms. And, none of these 40 patients had accessed mental health services.

With this data in hand, a small needs assessment and intervention pilot was launched that focused on assertive outreach to acute crime victims. Staff approached survivors of violent crime at bedside while they were recovering from their injuries at ZSFG. What quickly became apparent was that many of these survivors had practical needs that needed to be addressed (i.e. need for safe housing, access to financial entitlements and legal advocacy) before they could avail themselves of mental health interventions. In addition, stigma related to mental health services, and avoidance symptoms associated with acute and post-traumatic distress, made many of these survivors reluctant to engage in treatment. Based on these preliminary findings, the TRC model was created in 2001 by the University of California, San Francisco, in partnership with the City and County of San Francisco's Department of Public Health. This was made possible through funding by the California Victim Compensation Board (VCB), as enacted by California Assembly Bill AB1740 (Ducheny, Chapter 52, Statutes of 2000) and Assembly Bill AB2491 (Jackson, Chapter 1016, Statutes of 2000).

A goal of the new TRC model was to provide safety net services for survivors of violent crime who were not likely to engage in existing mainstream mental health or social services. An additional goal was to develop a new model of clinically effective and cost effective care for underserved survivors of violence, combining assertive outreach,



clinical case management, assistance with law enforcement, and trauma-informed therapy to deal with the emotional wounds of interpersonal violence.

**RANDOMIZED CLINICAL TRIAL.** The 2000 California Legislation that established the UCSF TRC mandated a randomized trial to evaluate both the clinical effectiveness and cost-effectiveness of the model (Ducheny, Chapter 52, Statutes of 2000; Jackson, Chapter 1016, Statutes of 2000). This trial is one of the largest longitudinal studies ever conducted to characterize underserved, public-sector crime survivors (Boccellari et al., 2007). Five hundred and forty-one injured violent crime survivors were randomized to receive either TRC services ( $n = 337$ ) or care as usual in the community ( $n = 204$ ) and were assessed 4 times over 12 months.

**TRIAL OUTCOMES.** The TRC trial revealed that while crime survivors had high levels of pre-existing mental health needs, only **10%** had received outpatient mental health care in the 6 months prior to victimization, while far more needed such care (details below). The data show that the crimes that brought survivors to the TRC trial were rarely a first exposure to criminal violence. **Ninety-one percent** of trial participants were polyvictims, having experienced an average of three broadly-defined types of criminal victimization over their lifetimes (such as adult sexual assault, assault with a weapon, physical assault, kidnapping, domestic violence, witnessing violent death, childhood physical abuse or childhood sexual abuse) in addition to at least one other non-crime-related trauma (natural disaster, accident, combat, or life-threatening illness). **Forty-six percent** had experienced childhood abuse, which is associated with both risk of subsequent victimization and poor psychosocial and functional outcomes. More than **72%** of the sample presented with clinically significant mental health symptoms (intrusive thoughts, nightmares, hyperarousal). Participants also had high levels of psychosocial and financial needs. More than **74%** needed assistance obtaining food, safe housing, financial entitlements, medical services, employment, and/or assistance working with police and other agencies. More than **70%** expressed interest in talking about their trauma and receiving mental health services.

The TRC trial demonstrated that the TRC model is both clinically effective and cost effective. Results document that the TRC model was successful in engaging survivors in mental health services. **Seventy-seven percent** of survivors receiving TRC services engaged in mental health treatment, compared to **34%** receiving usual care. TRC services were particularly effective in helping survivors access Victim Compensation benefits: **56%** of TRC clients submitted applications for Victim Compensation benefits compared to **23%** of usual care clients. TRC also reduced access disparities for clients who were younger, or homeless, or had lower levels of education. (Alvidrez et al., 2008). In addition, TRC services were more cost effective than fee-for-service care traditionally

supported by the Victim Compensation Board: each hour of TRC services cost **34%** less than traditional services. Importantly, the TRC's use of assertive outreach (engaging victims soon after victimization and helping them meet their immediate needs) was essential to achieving these outcomes. (Kelly et al., 2010). The TRC model utilizes a comprehensive, flexible approach that emphasizes assertive community outreach, evidence-based, trauma-specific mental health treatment, and clinical case management that coordinates and integrates psychosocial, medical, legal, and other human services. Coordination and active collaboration across these complex systems is essential in order to cost effectively reduce the consequences of violence and trauma.

## **Legislative Advocacy to Remove Barriers to Care and Transform Survivor Services Throughout California**

This randomized treatment trial demonstrated that the UC San Francisco TRC model reduced barriers to care for underserved survivors of violent crime. Based on these results, and through the persistent advocacy of California State Senator Mark Leno and the Californians for Safety and Justice, California Senate Bill (SB) 71 was enacted into law in 2013. SB 71 revised Section 13963.1 of the Government Code, directing the California Victim Compensation Board to award and administer grants to develop additional TRCs in California (California Government Code, 2013). This implementation is currently underway.

In January 2015, a voter initiative, the SAFE Neighborhoods and Schools Act was enacted into law. This law changes sentencing for low-level, non-violent crimes (such as simple drug possession) from felonies to misdemeanors. It directs savings from reduced prison and jail sentences to fund mental health and drug treatment diversion programs, community violence and support programs in schools, and additional TRCs throughout California. This implementation is also currently underway.

## **Values and Philosophy of the UCSF TRC Model**

What does it take for someone to heal from the devastating effects of deliberate cruelty and violence? Violence robs people of their sense of safety in the world. Violence disrupts people's lives and their relationships. It damages the spirit. It destroys hope. It disrupts our sense of good and evil and causes people to believe that the world **is** a bad and dangerous place.

The TRC model recognizes that people are resilient and can overcome challenges if they are given the right combination of services and compassionate support. It includes the idea that it takes a team of people to undo the effects of cruelty and violence and restore

hope and a sense of safety to shattered lives. Healing does not take place in isolation. Survivors of violence need others to walk with them on their journey to recovery. The TRC model exemplifies the power of a team of people coming together to bear witness, to honor and support survivors of violence. This compassionate approach serves to remind providers and the clients we serve that, despite cruelty and violence, that there is still a great deal of kindness and “goodness” in this world. As the poet Louise Bogan wrote: we are here today “to restore a portion of the world’s lost heart” (Bogan, 1977).

The TRC model uses a Positive Psychology framework (Seligman, 2002). The focus of Positive Psychology is on personal growth rather than pathology and “mental illness.” The TRC model embraces the concept that survivors of violence can move beyond experiencing post traumatic stress to finding post traumatic growth. By focusing on their strengths and tapping into their resilience, many survivors can use their traumatic event as a turning point to make important positive changes in their lives, and in the communities in which they live.

A critical factor in the TRC model is the development of a trauma-informed culture of compassion that is made up of the following elements: collective hope, collective vision, and collective leadership. Additional elements include attention to issues of social injustice and health disparities, and the adoption of a stance of cultural humility.

**A CULTURE OF COMPASSION.** There is power and efficacy in developing an organizational culture of compassion (Dutton et al., 2002). Research shows that a person’s caring gestures in a work setting increase the well being of both the recipient and the provider, as well as the wellbeing of others who witness or hear about the compassionate acts. Developing a culture of compassion is essential when working with traumatized survivors of violent crime. It provides a calming, safe, and non-judgmental frame for client services. Moreover, it creates a protective buffer for staff against the development of vicarious trauma (see chapter on Vicarious Trauma and Staff Support).

**ORGANIZATIONAL COMMITMENT.** The TRC model institutionalizes rituals that celebrate compassion and kindness, and encourage the expression of gratitude. One example is the use of informal story-telling that book-ends each TRC staff meeting. At the beginning of the meeting, staff have the opportunity to share a client’s success. This allows for all staff to witness and celebrate the small (or large) successes that clients have made, even when they are faced with huge obstacles. At the end of the meeting’s agenda are staff acknowledgements. All staff have the opportunity to acknowledge each other by sharing stories of compassionate and kind acts that have been observed at the TRC, such as a staff member going “above and beyond” to assist a co-worker or to creatively respond to a client’s need. This deliberate, public recognition of small acts of kindness and the

expression of gratitude has a huge impact and an institutional ripple effect. Research demonstrates that the opposite approach—non-compassionate responses, staff detachment, lack of interest, and publically pointing out failures or mistakes—also spreads throughout an organization, and leads to poor morale, low productivity, discouragement and hopelessness (Dutton, Frost, et al., 2002). Encouraging staff to recognize small acts of kindness serves several purposes. It balances out the impact of vicarious trauma with vicarious joy. It reminds us that, despite the enormous obstacles our clients face and the fact that staff bear witness, on a daily basis, to lives hijacked by trauma, sadness, hopelessness and darkness, that the world is also a place of hope, kindness, resiliency and light—factors that allow us all to flourish. Compassion has a ripple effect that awakens the best in us. When nurtured and encouraged to flourish, it ricochets off each of us and returns to us in a magnified form. It helps to generate our own resilience, reinforces shared values and helps us cultivate an attitude that leads to greater effectiveness in our work.

A culture of compassion in the Trauma Recovery Center model also plays an important role in maintaining spirit and inspiration, and keeping hope alive. Many survivors of crime live in poverty and in communities riddled with violence; many of them present with feelings of despair and hopelessness. The TRC Clinician is often confronted with how to keep hope alive for survivors who may have given up long ago, and who cannot imagine their lives being any different. The TRC Clinician becomes the “holder of hope” for these survivors.

“Hope” is often described as an emotion or a feeling, but in fact there is a body of research (Snyder, 2000) that demonstrates that hope is not just an emotion, it is a “dynamic, powerful and pervasive cognitive process” that can be measured, observed and also taught (Helland and Winston, 2005). Hope can be contagious.

**TRC LEADERSHIP.** In the TRC model, leadership plays an important role in creating a viable infrastructure by establishing team goals and vision, and motivating staff to believe that they can make a difference in the lives of the clients they work with (Helland and Winston, 2005). Giving staff the resources they need, demonstrating goal-directed thinking, and cultivating a culture of compassion all help to instill hope, and the belief that healing and recovery can take place. Hopeful thinking—backed by clinical skill and expertise—transforms a TRC into a healing community. There is power when a group of people come together with a shared vision and mission, and construct a culture to fulfill the organization’s purpose. Hope, vision, compassion and collective leadership are activating forces that enable survivors of violent crime to envision a promising future, even when faced with overwhelming obstacles (Seligman, 2002; Helland and Winston, 2005).

Just as hope is difficult to sustain if you are the only one hoping, leadership is not just about one person. Everyone on the TRC team plays an important role, including psychiatrists, social workers, psychologists, trainees, paraprofessionals, and administrative and clerical staff. Effective leadership permeates all levels of a Trauma Recovery Center. A leader may help create change, but a collective sense of leadership is about creating a positive environment in which staff thrive and are empowered to act: every voice gets heard (Ancona and Schaefer, 2005). Staff not only feel supported, but are capable of actively participating and fully contributing to the team's collective mission and vision: recovery for survivors of violent crime. This vision is built on shared values and beliefs. The heart of collective leadership is about developing a culture filled with compassion, and an environment in which compassion is not only expressed but it spreads.

## **Social Justice, Healthcare Disparities and Cultural Humility**

As with many other healthcare disparities, violence in the U.S. disproportionately affects people of color and people living in poverty. Because of this, the TRC model incorporates mindfulness of social justice principles and cultural humility.

Social justice embodies “the vision of a society that is equitable and in which all members are physically and psychologically safe” (Levy & Sidel, 2006). It requires that all people have a right to basic human dignity, including having their basic economic needs met. Since health and wellness are impacted by a variety of social factors, it is not possible to effectively address trauma and violence while ignoring poverty, racism, sexism, classism, homophobia, and all other forms of stigma. We must openly and honestly struggle with these deep-seated inequalities as we seek to solve the problems of violence and trauma (What is Social Justice?, 2016).

Removing barriers to care for survivors of violent crime is a basic tenet of the TRC model. However, it is not enough to merely remove barriers to care; true healthcare equity requires that all survivors of violent crime have the right to receive high-quality, effective, evidenced-based treatment.

**USE OF EVIDENCE-BASED PRACTICES.** What are evidenced-based practices (EBPs)? EBPs are practices that are developed through research and implementation and are interventions that have been shown to work. EBPs are consistent with scientific evidence showing that the intervention can improve client outcomes (Sackett et al., 1996). The TRC model utilizes EBPs. Some TRC interventions (the TRC outreach and case management approach) have been developed by the UC San Francisco TRC and some are mental health interventions that have been developed by other clinical researchers (see

TRC Evidence-Based, Trauma-Informed Psychotherapy chapter). The use of EBPs by a TRC is one way to promote social justice and to ensure that healthcare disparities are reduced.

**DATA-INFORMED, GOAL-ORIENTED APPROACHES AND ADVOCACY.** In a similar vein, the TRC model is data-informed. Creating an infrastructure for evaluating program and clinical effectiveness is critical to ensure that the TRC is accountable to the survivors we serve and to our funding agencies.

A robust program evaluation plan includes collection, analysis, and reporting of client demographics, needs assessments, clinical outcome measures, information on client flow, attrition rates, as well as measures of staff productivity.

This approach allows a TRC to evaluate current treatment interventions, and it encourages innovative approaches that can be applied and evaluated for treatment effectiveness. In addition, a credible program evaluation can be a useful tool for maintaining and acquiring new sources of funding. And, very importantly, it can be used to advocate for system-wide policy changes in victim services to remove barriers to care for underserved survivors of violent crime. Data is a tool hopeful people can use to achieve their goals.

**CULTURAL HUMILITY.** The TRC model adopts a stance of cultural humility. Given that survivors of violent crime and those who serve them are a diverse group, cultural humility becomes an important principle that guides the engagement and treatment of survivors and enhances our community-based partnerships.

Cultural humility requires a “life-long commitment to self-evaluation and self-critique” (Tervalon and Murray-Garcia, 1998), and it involves a willingness to assess one’s self and one’s limitations as we work with people different from ourselves. In the TRC model, this approach encourages staff to understand their own world view by realizing their own power and prejudices, in addition to any oppression or discrimination they may have experienced. It also involves seeing all people, including clients, as the experts on their own lives and experiences, and requires a truly collaborative approach to service provision.

## Summary

It is the mission of the Trauma Recovery Center to reach out to members of our community who have suffered from trauma, violence, and loss. We are dedicated to promoting healing by providing respectful, compassionate, and effective mental health

and medical services. Our vision is a community that heals the wounds of violence and embraces hope for a non-violent, compassionate world.

Violence disrupts lives and damages the spirit. The TRC model is based on the belief, supported by evidence, that people are resilient and can overcome even the greatest challenges when given the right combination of services, support, and non-judgmental care.

## References

Alvidrez, J., Shumway, M., Boccellari, A., Green, J. D., Kelly, V., & Merrill, G. (2008). Reduction of state victim compensation disparities in disadvantaged crime victims through active outreach and assistance: A randomized trial. *American Journal of Public Health*, 98, 882-888.

Ancona, D., Schaefer, M. (2005). *Leadership in an Age of Uncertainty*. MIT Leadership Center. <http://sloanleadership.mit.edu>.

Boccellari, A., Alvidrez, J., Shumway, M., Kelly, V., Merrill, G., Gelb, M., et al. (2007). Characteristics and psychosocial needs of victims of violent crime identified at a public-sector hospital: Data from a large clinical trial. *General Hospital Psychiatry*, 29, 236-243.

Bogan, L. (1977). *The blue estuaries poems: 1923-1968*. New York: Ecco Press.

Breslau, N., Davis, G. C., Andreski, P., & Peterson, E. (1991). Traumatic events and posttraumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry*, 48, 216-222.

Californians for Safety and Justice. (2013). *California Crime Victims' Voices*. Findings from the first-ever survey of California crime victims and survivors. 2013. [www.safeandjust.org/resources/2013-06](http://www.safeandjust.org/resources/2013-06), 1-42.

Couzen, J.R. & Bigelow, T.A. (2016). Proposition 47, The Safe Neighborhoods and Schools Act. [www.courts.ca.gov/documents/Prop47-Information](http://www.courts.ca.gov/documents/Prop47-Information).

Ducheny (AB 1740). California Government Code, California Legislature, Chapter 52, Statutes of 2000. Chaptered: 6/30/00.

Dutton, J. E., Frost, P. J., Worline, M. C., Lilius, J. M., & Kanov, J. M. (2002). Leading in times of trauma. *Harvard Business Review*, 55-61.

Fichter, D. (1986). *Sanctuary: The Spirit of Harriet Tubman*. Exterior mural at the Paul Robeson Theater. Atlanta, GA.

Helland, M. R., & Winston, B. E. (2005). Towards a deeper understanding of hope and leadership. *Journal of Leadership & Organizational Studies*, 12(2), 42-54.

Hembree, E. A., & Foa, E. B. (2003). Interventions for trauma-related emotional disturbances in adult victims of crime. *Journal of Traumatic Stress*, 16, 187-199.

Jackson (AB 2491). California Government Code, California Legislature, Chapter 6, Section 13974.5, Statutes of 2000. Chaptered: 9/30/00.

Kelly, V. G., Merrill, G. S., Shumway, M., Alvidrez, J., & Boccellari, A. (2010). Outreach, engagement, and practical assistance: Essential aspects of PTSD care for urban victims of violent crime. *Trauma, Violence, & Abuse*, 11 (3), 144-156.

Levy, B. S., & Sidel, V. W. (2013). *Social injustice and public health*. Oxford University Press.

Newmark, L. C. (2004). Crime victims' needs and VOCA-funded services: Findings and recommendations from two national studies. Report to the National Institute of Justice.

Petersen, J., Papadakis, L., Morabito, D., Boccellari, A., MacKersie, R.C., (1999) Return to Economic Productivity Following Traumatic Injury: The Influence of Physical, Financial and Psychosocial Factors. Abstract. American Association for the Surgery of Trauma, Boston, Massachusetts.

Sackett, D. L., Rosenberg, W. M., Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't. *British Medical Journal*, 312, 7-12.

SB71. California Government Code, California Legislature, Chapter 28, Section 13963.1, Statutes of 2013. Chaptered: 6/27/13.

Seligman, M. E. (2002). Positive psychology, positive prevention, and positive therapy. Snyder, C.R. & Lopez, S.L (Eds.), *Handbook of Positive Psychology*. Oxford University Press, 3-9.

Snyder, C. R. (2000). The past and possible futures of hope. *Journal of Social and Clinical Psychology*, 19, 11-28.



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 Underserved*, 9, 117-125.

U.S. Department of Justice. (2015). Bureau of Justice Criminal Victimization, 2014. NCJ 248973. [www.ojp.usdoj.gov](http://www.ojp.usdoj.gov).

What is social justice?. (2016, October 20). Retrieved from <http://www.nonviolenceandsocialjustice.org/FAQs/What-is-Social-Justice/43/>

# THE UC SAN FRANCISCO TRAUMA RECOVERY CENTER MODEL AND CORE ELEMENTS

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**An Integrated, Evidence-Based Approach for Survivors of  
Violent Crime**



*Photograph by John P. Boccellari*

**“Change will not come if we wait for some other person or  
some other time. We are the ones we’ve been waiting for.  
We are the change that we seek.”**

**—Barack Obama**

*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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## **Background**

The Trauma Recovery Center (TRC) model at Zuckerberg San Francisco General Hospital / University of California, San Francisco was developed for survivors of violent crime. It is founded on the belief that people are resilient and can recover from the potentially devastating impact of violent crime if they are given the right combination of support, advocacy and compassionate care. By providing this combination of services in an integrated approach, TRC services facilitate healing and a return to pre-trauma functioning or higher, with improved quality of life. The TRC vision is a community of survivors and providers that heals the wounds of violence, and embraces hope for a non-violent, compassionate world.

## **Statement of the problem**

Survivors of violent crime have a significant unmet need for mental health treatment and psychosocial services. Specialized services are necessary because general mental health treatment settings are typically not equipped to address survivors' complex needs. For a multiplicity of reasons, many crime survivors are unlikely to seek out mental health treatment, and most do not receive post-trauma mental health services. Vulnerable populations, such as young people of color, the homeless, LGBTQ people, the chronically mentally ill, people with substance abuse problems, non-English speaking people, and those living in poverty often face substantial barriers to accessing treatment. In addition, trauma and violence often drive survivors into isolation and a reluctance to engage in treatment.

## **Goals and objectives**

The overarching goal of TRC is to support the healing of the client's emotional and physical wounds along with restoration of their disrupted life circumstances. At the close of treatment, the client's health, broadly defined, will be stabilized and improving. Goals include working toward: having safe housing; having an income sufficient to meet their needs; safety from further violence; the emotional health to cope with daily life, including a sense of hope for the future; access to needed physical or behavioral health treatments; incorporating healthy self-care strategies; employment or school, as appropriate; and being meaningfully engaged with others, such as family, church, and community. Unlike many mental health programs, in TRC the mental health of the client is not the primary focus and life circumstances secondary; instead, mental health and life circumstances are seen as inseparable pieces of a whole life and are addressed at the same time.

## Target population

TRC is for survivors of violent crime who are experiencing post-traumatic distress but are not receiving other mental health care. The model has been successfully used with recent survivors of sexual assault, domestic violence, gunshot injuries, human trafficking, stabbings, physical assaults, and criminal motor vehicle accidents, as well as family members of homicide victims. Many of the individuals served have risk factors that made them vulnerable to becoming survivors of crime. These include one or more of the following: poverty, homelessness, social isolation, sequelae of previous traumatic events, ongoing exposure to community or domestic violence, substance use, and pre-existing mental disorders.

## TRC Treatment Approach and Process

### Overview of TRC treatment approach

This overview is shown in graphic form on page 34, *TRC Service Flow*. The chart shows the sequence of TRC activities, beginning with assertive outreach to identified clients, moving through provision of services by the TRC Clinician including clinical case management, individual and group psychotherapy, and advocacy, through to ongoing care provided by partner agencies as needed. Page 9 of this chapter shows a comparison of the TRC model to customary care.

The TRC model is unique in how it integrates different state-of-the art approaches—assertive outreach, clinical case management, trauma-informed psychotherapy, and trauma-specific, evidence-based treatments such as Seeking Safety, as well as psychiatric medication management. TRC is a stepped-care model: the TRC Clinician collaborates with clients to initially focus on their safety and stabilization. An individualized care plan guides the provision of comprehensive services, and the Clinician provides most services including clinical case management, psychotherapy, advocacy, and substance abuse treatment, and conducts assertive outreach as needed to initiate treatment and keep the client engaged. If services are split between Clinicians and Case Managers, there is a single point of responsibility for the coordination of the client’s treatment, and care is taken to ensure a unified team approach and clear communication among all service providers. This ensures coordination across various systems of care. It can be understandably difficult for clients to trust service providers and others after victimization, yet building trust and rapport is key to the client engaging in treatment and recovering from trauma. The organization’s structure, procedures, and culture support this integrated treatment approach.

## **Entry to the program**

Despite the serious consequences of criminal victimization, research shows that survivors are unlikely to seek out mental health treatment due to the social withdrawal and anxiety inherent in PTSD and decreased ability to function and initiate actions. TRC proactively addresses this by (1) mobilizing medical care providers, domestic violence shelters, rape crisis centers, substance abuse treatment providers, victim services, and others to identify and refer clients, and (2) by assertive outreach—TRC Clinicians visit can work with clients in the community as needed to facilitate entry. In addition, Clinicians often begin the treatment relationship by providing clinical case management services because immediate practical help is often required to support clients' stabilization and safety.

## **Assessment and treatment planning**

TRC services begin with a comprehensive clinical evaluation conducted by an Intake Clinician in a two-hour intake interview. The interview covers current and past symptoms; medical, mental health, trauma, family/social, legal, and occupational history; risk assessment; and a formulation of the situation that emphasizes a client's strengths and takes their cultural background into account. As treatment begins, the TRC Clinician conducts a needs assessment that includes both case management needs and psychological, social, and emotional needs. The Clinician and client then collaborate to create an individualized treatment plan.

## **Clinical case management**

Clinical case management is a central component of the TRC model. Including case management in the repertoire of services offered by TRC Clinicians allows clients to receive assistance with practical needs that may be a higher priority than engaging in mental health services. In addition, providing clinical case management first fosters the trust and alliance necessary for clients who may initially be put off by the stigma of mental health treatment or previous negative experiences with "helping" resources, including mental health. Initially, TRC Clinicians may provide legal advocacy and address immediate needs for financial entitlements and shelter. They coordinate medical appointments and help clients complete compensation claims. Clinicians seek out clients in the community if they miss appointments and make home visits if they are unable to come to the agency. As clients' immediate needs are met, Clinicians help with long-term needs such as vocational rehabilitation and safer housing. Throughout treatment, Clinicians can work with the Police Department, District Attorney's office, and Victim Services office to support clients in their experience with the criminal justice system as needed.



## **Evidence-based, individual psychotherapy**

Clients are offered up to 16 sessions of trauma-informed individual clinical services; an extension of treatment is offered to clients with continued symptoms and primary focus on recent trauma. Treatment may involve a variety of evidence-based approaches, including anxiety management skills (e.g., Trauma-Informed Cognitive Behavioral Therapy), emotion regulation skills (e.g., Dialectical Behavior Therapy or Skills Training in Affect and Interpersonal Regulation [STAIR]), as well as several options for reprocessing of the trauma as indicated (e.g., Cognitive Processing Therapy, Narrative Story Telling, or Prolonged Exposure Therapy). Substance abuse treatment comes from a harm reduction stance and emphasizes Motivational Interviewing. Substance abuse treatment is integrated with psychotherapy and case management—all are provided by the TRC Clinician. Psychotherapy for acute trauma begins with a supportive interpersonal approach and initially prioritizes safety, self-care for re-establishing physical homeostasis, and sleep. The intermediate goals of therapy are to reduce post-trauma anxiety and depression, build healthy coping skills, and increase awareness of risk factors for re-victimization. For clients who achieve psychological and psychosocial stability, the focus turns to reprocessing the trauma, finding meaning in their lives despite the victimization, and integrating the trauma into their overall life experience.

## **Group psychotherapy**

Most acute trauma survivors report an initial preference for individual therapy, but once clients have benefitted from individual treatment they may be encouraged to also attend group therapy. The primary group model is Seeking Safety, a program for people with co-occurring post-traumatic stress and substance abuse. Additional groups focus on domestic violence, drug-facilitated sexual assault, anxiety management, emotional regulation, and the special needs of African American family members of homicide victims. Group participation can help clients come out of isolation, learn they are not alone in their experiences, reconnect with others and find new roles for themselves.

## **Medication management and support**

TRC services include the provision of psychiatric medication support as needed. Medication management can reduce sleep problems and anxiety and increase clients' ability to participate in treatment. TRC Clinicians work closely with psychiatrists to support medication adherence. If clients wish to continue medication upon completion of TRC, medication management responsibilities are transferred to the client's primary care physician or a community mental health psychiatrist.

## **Duration of treatment**

Treatment typically lasts for 16 sessions. For those with ongoing problems and a primary focus on trauma, treatment can be extended after special consideration with a clinical supervisor. Extension beyond 32 sessions requires approval by a clinical steering and utilization group that considers the client's progress in treatment and remaining need. The 16-session model is based both on the efficacy of many evidence-based treatments, and the program's need to remain accessible by having treatment slots available as needed.

## **Staffing and Organization**

### **Organizational characteristics and culture**

The organization itself is an important part of the TRC model. This trauma-informed organizational culture emphasizes compassion and safety in all aspects of the program. Everyone who works in the program, including non-clinical staff such as receptionists, custodians, and managers, understands the mission of the organization. In any interaction they may have with clients, even nonverbal, they take into account the trauma the clients have experienced and strive to create a compassionate, welcoming and safe environment. In addition, all staff receive ongoing support in using a cultural humility approach to services, recognizing that clients are the experts on their own lives and that we are all lifelong learners when it comes to understanding cultural differences. This organizational culture, reinforced with ongoing training and supervision, keeps staff supported and centered to ensure that clients receive the highest quality of care.

### **Self care**

Serving survivors of crime who have experienced severe trauma can be traumatizing to the service providers. TRC explicitly incorporates self care to address the stress and trauma of working with traumatized clients. Staff meetings begin with an opportunity to share examples of clients' successes and resiliency and end with an opportunity for staff to acknowledge each other's contributions and kind acts. Another norm is to be mindful when discussing clients' trauma experiences and not bring up graphic details that needlessly upset other staff members and increase the likelihood of vicarious trauma. Individual supervision, discussed below, provides a safe place for staff members to process disturbing things they have seen and heard. A weekly self care group is offered to all staff, trainees, and volunteers, with no distinctions made between clinical and support staff.

## Staffing and training

Clinical staff are masters-level clinical social workers, marriage and family therapists, psychologists, and psychiatrists who are licensed or pursuing licensing. TRC Clinicians have expertise in the assessment and treatment of acute and chronic trauma, and co-occurring mental health and substance abuse disorders, such as anxiety disorders, mood disorders, and personality disorders. They are trained to provide evidence-based treatments such as Motivational Interviewing and Seeking Safety.

## Supervision and training

Because the work of the TRC Clinicians is complex and demanding, regular clinical supervision is necessary to develop knowledge and skills as well as to support the Clinicians in their difficult and stressful work. TRC provides ongoing weekly supervision for all clinical staff regardless of licensure status. Trainees and new staff attend a year-long weekly Trauma Seminar on the assessment and treatment of trauma. In addition, all staff attend a weekly Professional Development seminar, in order to keep abreast of best practices, learn particular interventions, and ensure ongoing commitment to high quality care.

## Data-informed approach

In order to provide ongoing evaluation of TRC services to ensure they are clinically and cost effective, the UC San Francisco TRC has developed a relational database and uses standardized tools to measure client outcomes, track client flow and measure staff productivity.

## TRC model core elements

### **1.ASSERTIVE OUTREACH AND ENGAGEMENT WITH UNDERSERVED POPULATIONS.**

Conduct outreach and provide services to survivors of violent crime who typically are unable to access traditional services, including, but not limited to, survivors who are homeless, chronically mentally ill, members of immigrant and refugee groups, disabled, who have severe trauma-related symptoms or complex psychological issues, are of diverse ethnicity or origin, or juvenile survivors, including minors who have had contact with the juvenile dependency or justice system.

**2.SERVING SURVIVORS OF ALL TYPES OF VIOLENT CRIMES.** Serve survivors of a wide range of crimes, including, but not limited to, survivors of sexual assault, domestic violence, battery, crimes of violence, vehicular assault, human trafficking, and family members who have lost a loved one to homicide.



**3. COMPREHENSIVE MENTAL HEALTH AND SUPPORT SERVICES.** Mental health and support services are structured and evidence-based, including but not limited to crisis intervention, individual and group treatment, medication management, substance abuse treatment, case management and assertive outreach. Care must be provided in a manner that increases access to services and removes barriers to care for survivors of violent crime. This includes providing services in the client's home, in the community, or other locations that may be outside the agency.

**4. MULTIDISCIPLINARY TEAM.** Staff shall consist of a multidisciplinary team that includes psychiatrists, psychologists, social workers, and marriage and family therapists. The TRC Clinician is a licensed clinician, or in some cases a closely supervised clinician engaged in the applicable licensure process. Clinical supervision and other support are provided to staff on a weekly basis to ensure the highest quality of care and to help staff constructively manage the vicarious trauma they experience as service providers to survivors of violent crime.

**5. COORDINATED CARE TAILORED TO INDIVIDUAL NEEDS.** Psychotherapy and case management are coordinated through a single point of contact for the survivor, with support from an integrated multidisciplinary trauma treatment team. All treatment teams shall collaboratively develop treatment plans in order to achieve positive outcomes for clients.

**6. CLINICAL CASE MANAGEMENT.** Services shall encompass assertive case management, including but not limited to: accompanying a client to court proceedings, medical appointments, or other community appointments as needed; case management services such as assistance in the completing and filing of applications to the Victim Compensation Board, the filing of police reports, assistance with obtaining safe housing and financial entitlements, linkages to medical care, providing assistance securing employment, working as a liaison to other community agencies, law enforcement or other supportive service providers as needed.

**7. INCLUSIVE TREATMENT OF CLIENTS WITH COMPLEX PROBLEMS.** Clients are not excluded from services solely on the basis of emotional or behavioral issues that result from trauma, including but not limited to: substance abuse problems, low initial motivation or high levels of anxiety.

**8. USE OF TRAUMA-INFORMED, EVIDENCE-BASED PRACTICES.** TRC staff shall adhere to established, evidence-based practices, including but not limited to: Motivational Interviewing, Seeking Safety, Cognitive Behavioral Therapy, Dialectical Behavior and Cognitive Processing Therapy.

**9. GOAL-DRIVEN.** Primary goals are to decrease psychosocial distress, minimize long-term disability, improve overall quality of life, reduce the risk of future victimization, and promote post-traumatic growth.

**10. ACCOUNTABLE SERVICES.** Provide holistic and accountable services that ensure treatment shall be provided up to 16 sessions. For those with ongoing problems and a primary focus on trauma, treatment may be extended after special consideration with the clinical supervisor. Extension beyond 32 sessions requires approval by a clinical steering and utilization group that considers the client's progress in treatment and remaining need.

## TRC Services Compared to Customary Care

This summary of TRC services describes key features of the model that need to be reflected in services if a program is to incorporate the TRC model. The characterization of customary care reflects widespread practices in the field, although programs vary.

<b>Services</b>	<b>Traditional Office-Based Services</b>	<b>TRC Services</b>
1. Provide on-site crisis intervention in a hospital-based Emergency Department.	Not Available	Available
2. Provide bedside assessments and interventions on Inpatient Medical Trauma Units.	Not Available	Available
3. Proactive, multi-disciplinary trauma team meetings to develop integrated Plan of Care for each client's services.	Not Available	Available
4. Flexible location of services: client's home, school, provider's office, District Attorney's office, etc.	Not Available	Available
5. Assist clients with finding emergency housing. Help client relocate to safe housing.	Not Available	Available
6. Fill out Victim Witness application and gather all supporting documents.	Not Available	Available
7. Actively arrange for and escort clients to medical appointments and to legal proceedings if client is unable to get to an appointment on their own.	Not Available	Available
8. Assist clients in completing disability forms, applications for General Assistance, leave of	Not Available	Available

<b>Services</b>	<b>Traditional Office-Based Services</b>	<b>TRC Services</b>
absence from work forms; assist with procuring medical record documentation.		
9. Assertive, proactive outreach and follow-up to clients; tracking, locating and finding clients who miss appointments.	Not Available	Available
10. Meet with employer or school district around developing a “Return to Work” or “Return to School” plan.	Not Available	Available
11. Coordinate with local Victim Services office, District Attorney’s office, and police department.	Not Available	Available
12. Individual and family psychotherapy.	Available	Available
13. Medication support services.	Available	Available
14. Psychotherapy groups.	Available	Available
15. Multi-disciplinary Trauma Team provides services #12, 13, and 14 in a coordinated fashion with ongoing review of the client’s Plan of Care and goals for treatment.	Not Available	Available
16. Multi-lingual, ethnically diverse staff to provide services.	Limited panel of multilingual Victim Witness private practitioners available	Available

<b>Services</b>	<b>Traditional Office-Based Services</b>	<b>TRC Services</b>
17. Ongoing evaluation of services to ensure quality of care, i.e., adherence to quality improvement protocols and utilization review.	Utilization Review available by the State to the FFS Provider, limited Quality Assurance controls in place.	Available
18. Ongoing treatment and cost effectiveness studies utilizing objective measures of outcome and patient satisfaction studies.	Not Available	Available
19. Provide education and in-services to community-based agencies.	Not Available	Available
20. Provide education to the public on staying safe in the community.	Not Available	Available
21. Provide specialty trauma training to psychology and social work interns and to medical students.	Not Available	Available

## References

<http://www.nytimes.com/2008/02/05/us/politics/05text-obama.html>, accessed November 22, 2016.



# TRAUMA RECOVERY CENTER SERVICE FLOW

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*Photograph by Ezme Kozuszek*

“What wisdom can you find  
that is greater than kindness?”

—Jean Jacques Rousseau

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

## **Assertive Outreach**

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

## **Referral Sources**

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

## **Medical services**

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

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

### **Victim services and law enforcement**

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

### **Domestic violence shelters and rape crisis centers**

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

### **Other community agencies**

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

### **TRC Clinical Services**

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



## Evaluation, Assessment, and Service Plan

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

## 16-Session Treatment Episodes

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

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

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

- A brief summary of the client and the index crime

- What the treatment goals have been and what interventions the Clinician has used to help the client achieve their goals
- What the client's participation in treatment has been like (i.e., attendance, completion of agreed-upon tasks or homework, etc.)
- Why the Clinician is requesting an extension of treatment at TRC instead of linking the client with other longer-term services
- A clear plan for what the treatment goals will be for the extension and what interventions the Clinician plans to use

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

### **Individualized psychotherapy, substance abuse treatment, and case management**

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

### **Legal advocacy**

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

## **Group psychotherapy and support groups**

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

## **Medication Management**

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

## **Services provided by partners**

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

## **Completion of TRC Services**

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

## **Referral to partner agencies**

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

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

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

### **Participation in Speakers Bureau**

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

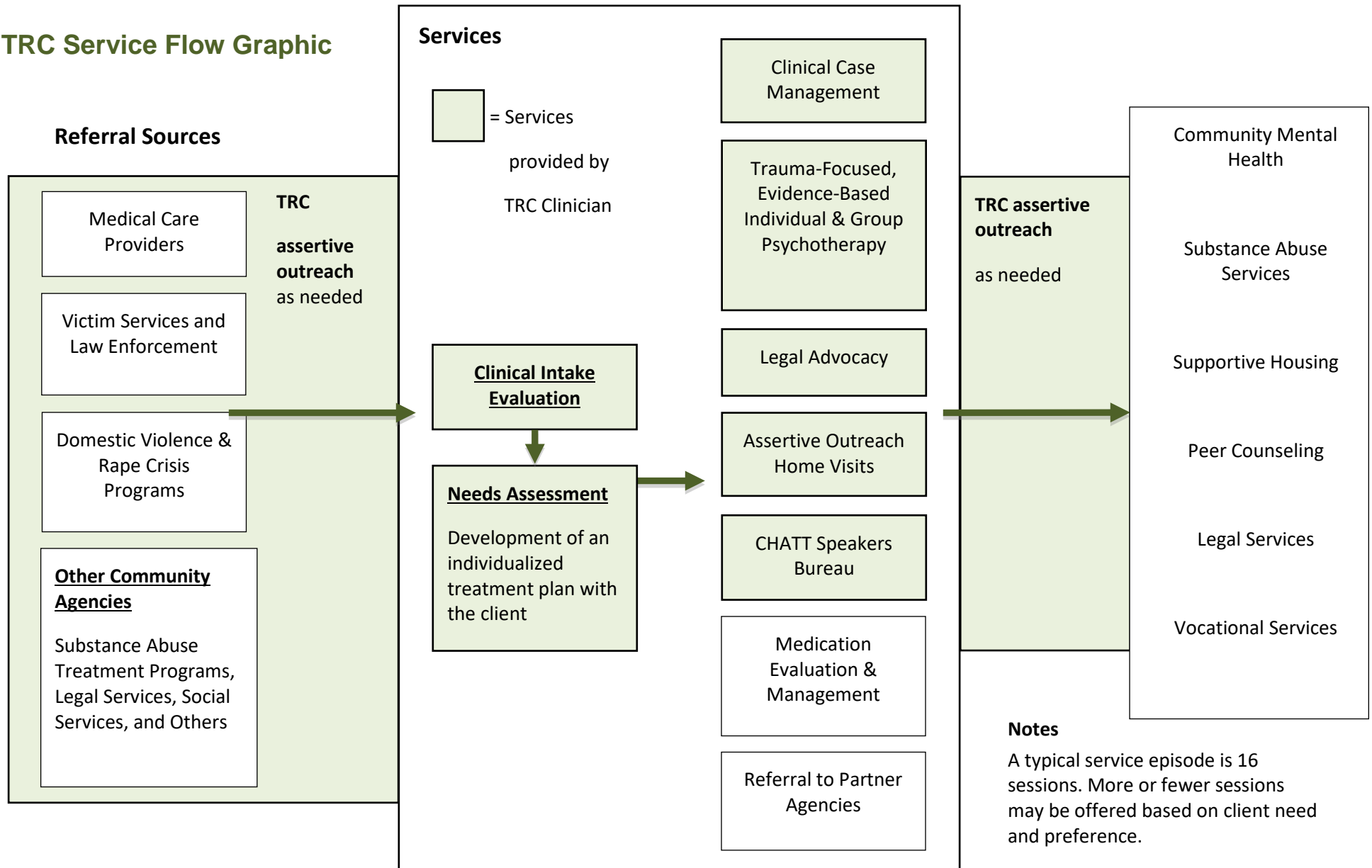
### **References**

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

## **Appendix to TRC Service Flow: Service Flow Graphic**

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

## TRC Service Flow Graphic





# WHO ARE TRAUMA RECOVERY CENTER CLIENTS?

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By Stacey Wiggall, LCSW



*Photograph by Ezme Kozuszek*

“Blessed are the hearts that can bend;  
they shall never be broken.”

—Saint Francis de Sales

*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



The clients of Trauma Recovery Center Services are survivors of interpersonal violence, including sexual assault, domestic violence, physical assault, gunshots, stabbings, vehicular assault, gang violence, human trafficking, and hate crimes. In addition, TRC serves family members of homicide victims. Unlike programs that were developed to provide services for a specific type of violence, the TRC model seeks to provide compassionate, effective treatment to any survivors who have recently experienced interpersonal violence. This is based on recognition that: 1) Most evidence-based treatments for trauma-related mental health sequelae are symptom-based, not based on a type of crime; and 2) Many survivors of crime have experienced a lifetime of polyvictimization that defies categorization. For example, even though a client may have been referred for a recent physical assault, he or she may have experienced other types of violent incidents such as domestic violence, childhood abuse, and losing loved ones to homicide, and the long-term effects of this polyvictimization need to be taken into account as treatment is planned and delivered.

**ENTRY CRITERIA.** Each agency's specific program entry criteria will implement the TRC Core Elements according to their circumstances, such as service capacity, geographic region, etc. Services are typically limited to those individuals experiencing post-traumatic distress who are not receiving other mental health care in order to avoid duplication of services.

**PSYCHOSOCIAL FACTORS.** The same circumstances that put people at higher risk of experiencing violent crime can also be obstacles to recovery. These include being homeless or marginally housed, living in poverty, and living in communities with high rates of violent crime. People of color are also over-represented in the TRC client population, due to current and historical inequities that prevent access to resources such as safer neighborhoods, quality education, better-paying jobs, and a strong political voice. While being a survivor of a violent crime is extremely disruptive to anyone, regardless of their demographics or income level, it can be easier to cope if one has a broad, high-functioning social support system, access to high-quality medical care, and financial reserves. Most, though not all, people who require TRC services have very few such resources to help them cope with the physical and psychological consequences of trauma.

**CO-OCCURRING PROBLEMS.** Many TRC clients have co-occurring psychiatric disorders, substance use issues and medical problems, which are discussed below. These are understood as both a potential correlation and a consequence of trauma, sometimes lifelong or even intergenerational. **Co-occurring substance use, or psychiatric disorders that do not prevent participation in treatment, should not be exclusionary criteria for TRC services.**

**PSYCHOLOGICAL PROBLEMS.** A person who experiences severe interpersonal violence usually has to cope with correlated psychological problems. Many clients experience symptoms of posttraumatic stress disorder (PTSD), such as flashbacks of the traumatic event, nightmares, insomnia, intrusive memories of the trauma, feelings of depression, anger and fearfulness. Survivors may isolate themselves. They can develop avoidance-related fears, such as being afraid to leave their homes to venture out into public. They may have difficulty concentrating, have trouble making decisions, and become suicidal. Increased abuse of both legal and illegal substances often follows trauma as clients seek to medicate themselves for anxiety and sleep disturbance. In addition, some TRC clients have a long history of psychological problems such as major depression, bipolar disorder, or schizophrenia, as these conditions put people at greater risk of being victimized. After trauma, people's psychological problems often intensify. TRC helps reverse this downward spiral by treating both the trauma and the pre-existing psychological problems at the same time.

**SUBSTANCE USE PROBLEMS.** The circular link between trauma and substance abuse has been well documented. Many clients have pre-existing and co-occurring substance use problems that put them at risk for being victimized, and also function to self-medicate trauma-related symptoms. Some clients who did not have substance problems before may turn to alcohol and other drugs to medicate themselves for trauma-related symptoms. For example, it is common for people who drink alcohol to increase their drinking post-trauma in order to numb their anxiety. Pain medications prescribed as a result of clients' physical injuries offer another pathway to substance abuse. TRC accepts that many traumatized people will need help related to their substance use in order to benefit from psychotherapy and other services, which is why substance abuse interventions such as Motivational Interviewing (Miller & Rollnick, 2012) and a harm reduction philosophy (Marlatt, Larimer, & Witkiewitz, 2011), are integrated within the model.

**MEDICAL PROBLEMS.** While specific physical issues vary according to the type of injuries a client sustained, some clients have serious medical problems and need ongoing medical care. Many TRC clients face barriers to accessing ongoing medical care after being discharged from the hospital, both because of practical problems and psychological symptoms. Clients may need case management to help them arrange transportation and child care so they can attend follow-up appointments. If clients are afraid to leave their homes—a fear which may be a reaction to trauma, and/or may be well-justified—they need help addressing this problem in order to access medical care.

## Case Examples

Below are three examples of TRC clients. They provide an overview of the services clients received, and describe how the TRC Clinician provided an integrated approach, using case management and psychotherapy to help clients move towards post-traumatic growth. Treatment is trauma-informed and culturally relevant, with use of evidence-based, trauma-specific interventions as indicated.

### Example 1. Homicide of a family member

Vanessa is a 51-year-old Samoan American woman. Her 26-year-old daughter, her 20-year-old son and her 2-year-old grandson were all shot during a drive-by shooting. Her daughter died and her son and grandson were left with serious injuries. Vanessa was left raising her daughter's four children as well as her own three children. Vanessa was forced to quit her jobs as a sales clerk and a part-time taxi driver in order to take care of this expanded family.

At entry to TRC, Vanessa was completely overwhelmed by the sudden and violent loss of her daughter, and having to quit her jobs to manage and care for seven children. She was suffering from acute stress disorder, bereavement, and depression, and was having daily debilitating panic attacks which affected her ability to drive. She began having sleep difficulties, and was fearful of allowing the children outside due to her concern that they were in danger as well. She was preoccupied by painful images of her daughter's death.

### How TRC helped

Priorities for Vanessa's treatment included reducing her debilitating symptoms, helping her learn coping skills to manage the panic and depressive symptoms, and medication management. The Clinician incorporated Cognitive Behavioral Therapy (CBT) strategies to address both panic and depression; after Vanessa's sleep problems were improved by medication, she had an easier time carrying out her regular life activities and participating in TRC treatment. The TRC Clinician helped her apply for State of California Victim Compensation Board (VCB) benefits. The TRC Clinician also assisted her in applying for Section 8 Housing so she could move into a house that would accommodate the newly expanded family. Most importantly, from the initial point of engagement throughout the provision of services, the TRC Clinician used a strengths-based approach to highlight examples of Vanessa's capacity for resilience, which included being a dedicated and loving mother and grandmother.

Vanessa's daughter had been driving her mother's car the day of the homicide and her vehicle was impounded by the police as evidence. Rather than relying exclusively on government entitlements, the TRC Clinician leveraged community support and received a donation of a SUV for this family. This donation allowed her to take all of the children to their various schools, therapy and medical appointments and the multitude of agencies she had to deal with. Additional private fund-raising efforts by the TRC Clinician led to the donation of new clothing for the children and a carload of toys for Christmas.

Another priority was assisting Vanessa to gain legal custody of all the children, and supporting her as she worked closely with the Police Department around her daughter's homicide.

Vanessa was heartbroken by her daughter's murder, but needed to "stay strong" for the children, so therapy was one of the only places she could fully grieve and talk about her sadness, anger, and despair. The TRC Clinician helped her to reconnect to her church, and to some childcare support and assistance with meals. The Clinician also eventually helped her move to a new, safer community where the family is now residing. There, the children can safely walk to school, and they have a yard and friends in the neighborhood. After one year of treatment, Vanessa returned to work as a sales clerk.

Under the usual system of care, Vanessa would have needed to wait to receive services until her Victim's Compensation Board (VCB) application was approved. VCB benefits would not have included case management services or coordination of care across multiple agencies, practical services so vital in helping this family heal. The TRC model's combination of assertive outreach, trauma-focused psychotherapy, and case management to bring about close coordination amongst medical, law enforcement and social service agencies was essential for Vanessa's recovery.

## **Example 2. Domestic violence**

Sylvia, a 48-year-old, Mexican, monolingual Spanish-speaking woman, was referred by the inpatient medical staff at the hospital following a domestic violence-related incident. TRC staff began the engagement process with Sylvia bedside at the hospital, where she remained for several days due to the severity of her injuries. Her husband, from whom she was separated, had broken into her home in the middle of the night and chased her with an axe, threatening to murder her in front of their children, an adolescent and young adult. In order to escape from him, Sylvia jumped from a second-story window. The hospital treated her for a severe concussion, broken ribs, internal injuries, and a broken arm sustained in the referring trauma. Sylvia suffered from post-trauma anxiety symptoms that included intrusive memories, insomnia, and intense fear for her personal

safety and the safety of her children. She also experienced major depressive symptoms because her spouse, for whom she still cared, had attempted to end her life. In addition, Sylvia felt overwhelmed by the emotional responses of her children, including their own post-trauma symptoms, and their anger at her for allowing their father, a chronically violent man, to remain in their lives for as long as he had.

### How TRC helped

Sylvia was matched with a Spanish-speaking TRC Clinician who oriented her to TRC services, provided normalization of her symptoms in the context of the extreme violence she had experienced, and helped her overcome language barriers by providing assistance accessing other resources as needed. The Clinician incorporated Cognitive Behavioral interventions to help Sylvia reduce her anxiety and depression, and connected her with a TRC Psychiatrist for medications to help with debilitating insomnia and other symptoms. The Clinician also supported Sylvia in her physical recovery by accompanying her to follow-up medical appointments until she no longer felt that she needed the Clinician present in order to participate. Although Sylvia's husband was incarcerated pending the trial, the Clinician assisted her in obtaining a domestic violence restraining order in case of his release. Because Sylvia was attending sessions regularly, benefitting from services, and had the significant, ongoing trauma-specific stressor of a lengthy legal process, her treatment was extended to 32 sessions. The TRC Clinician was then able to support her throughout the criminal prosecution, accompanying her to meetings with the District Attorney and to court, and sitting with her on the stand during her difficult testimony. Because Sylvia was undocumented, her Clinician also linked her with legal support for the U-Visa process and provided supporting documentation. In addition, the Clinician supported Sylvia in processing her complex feelings about her abusive partner, and what it meant to her to separate from him.

When Sylvia felt ready to participate in group treatment, the Clinician referred to her to a Spanish-language domestic violence peer support group facilitated by a TRC community partner, a local domestic violence agency. The group helped to break down the isolation that Sylvia had been experiencing and reduce her feelings of shame about her complex feelings regarding her abusive partner. The TRC Clinician also linked Sylvia's young adult child with his own TRC Clinician, and linked the adolescent with other age-appropriate services.

By the 40<sup>th</sup> session, the majority of her debilitating symptoms were significantly decreased or eliminated altogether, so that Sylvia was able to return to work, to all of her parenting duties, and to feeling a sense of hope about her ability to have a happy future, and she attributes these successes to the services she received at TRC.

### **Example 3. Sexual and physical assault, substance abuse**

Linda was referred to the TRC after receiving treatment in the Emergency Department following a sexual assault. She was a 47-year-old African American woman with four adult children, as well as two infant grandchildren whom she often cared for. She was receiving General Assistance and food stamps. Linda reported an extensive trauma history—including being physically and sexually abused as a child, witnessing domestic violence between her parents, and experiencing two prior sexual assaults. She also reported a history of dependence on crack cocaine and had last used this drug for a 7-day period following the recent assault. Linda said that she began to use multiple substances in high school—including alcohol, marijuana, and cocaine—in an attempt to cope with feelings related to the abuse she experienced as a child. At the time of her intake, Linda was suffering from significant post trauma anxiety and depressive symptoms—including passive thoughts of suicide—and met criteria for Post-Traumatic Stress Disorder, Major Depressive Disorder, and Cocaine Use Disorder. Linda initially expressed some ambivalence about entering treatment. She told the TRC Clinician that she had been referred for services elsewhere after one of her previous sexual assaults, but had not followed through at that time because she felt unworthy of help, and that in any case no one would believe that she had been raped.

Despite not engaging in services in the past, Linda seemed to really want to engage in treatment and said, “I’m here to see what services you have because I want to heal,” and “I want to know why this keeps happening to me.” Linda seemed to be at a stage of readiness where she was considering how her trauma and substance abuse history were connected and had some motivation to learn new ways to cope. Among the strengths she had at that time were a strong family support system and a desire to get better so that she could continue to be a part of the lives of her grandchildren.

### **How TRC helped**

At her first individual therapy appointment, Linda described a recent physical assault by a former partner, which led her to relapse on crack cocaine again in an attempt “to numb me when I can’t cope.” She also expressed continued suicidal ideation, without a specific plan or intent. Linda only attended four appointments in the first three months of services, so engagement and tracking played a huge role in her initial treatment. Over the course of that time period, her Clinician conducted outreach with Linda including phone calls, letters, and home visits. At one point, Linda called in crisis with a plan for self-harm. During this encounter she abruptly hung up the phone, and San Francisco’s mobile crisis team was sent to check in with her.

Linda continued to have difficulty engaging in services over the next two months. When she did have contact with the TRC Clinician, much of what they focused on was related to safety planning and coping. The Clinician began to talk to Linda about the possibility of taking medication to help alleviate some of her symptoms, but at that time she felt that doing so would mean that she was “crazy.”

After four months of outreach, Linda began to benefit from the Clinician’s Motivational Interviewing interventions and nonjudgmental, harm reduction approach. Consistent with Stage One: Safety and Stabilization (see Psychotherapy chapter), she and her Clinician then jointly identified treatment goals of: (1) Decreasing PTSD and depressive symptoms, (2) finding new ways to deal with emotional pain rather than using substances, and (3) increasing her involvement with safe people and activities, such as her church community. After they identified her goals, her attendance increased and during month four of treatment, the TRC Clinician saw her every week.

Linda’s case is also an example of the rationale for extending a case beyond 16 sessions. Because of Linda’s extensive trauma history and substance use, it took time and assertive outreach for her to build trust with the Clinician and fully engage in TRC services. Although it was clear that Linda could eventually benefit from referral to longer-term mental health services, the rapport she had built with the TRC Clinician was critical to her ability to participate in treatment, and a transfer of care would have disrupted that. Also, Linda needed trauma-specific services to get immediate help with reducing and managing the symptoms that interfered with so much of her life and relationships.

By month six of treatment, Linda agreed to meet with the psychiatrist and began taking an antidepressant to target her PTSD and depressive symptoms. These symptoms then began to diminish and she was no longer experiencing suicidal ideation. The TRC Clinician also used Motivational Interviewing techniques to help Linda look at how her drug use contributed to suicidal ideation and other problems. By this time, she had cut back her crack cocaine use significantly and then used for the last time.

By month seven of treatment, Linda met with a primary care doctor, and was diagnosed with ovarian cancer. After receiving this diagnosis, a significant shift in her suicidal ideation occurred and she stated, “God, please heal me and my addiction. I’m not ready to die.” She also began attending the TRC Seeking Safety group.

Treatment over the next several months revolved around safety, stabilization, coping with her cancer diagnosis, preparing for her upcoming sexual assault court hearing, and tolerating negative emotions. Linda continued to express occasional suicidal ideation over this time period but was committed to utilizing her safety plan when necessary. By



month nine of treatment, Linda's sense of self-worth was growing and she stated, "I'm beginning to see a change in myself. I'm beginning to like myself and am becoming more accepting of my family and me. Before I was keeping clean for my grandchildren... Now it's for me. I want to see how much I can grow."

After Linda's cancer surgery and court date, the TRC Clinician worked with her to focus on stabilizing her life in other ways, including finding ways to pay overdue bills, dealing with issues related to her landlord, and obtaining Supplemental Security Income. They also continued to work on strengthening her motivation to remain sober and reinforcing the other gains she'd made thus far. At the end of treatment, Linda stated that she felt "seventy-five percent better than when I started coming here. I think clearer, I love myself, and I have things I want to do in the future."

## In Summary

The clients of TRC are a diverse group, but all share the experience of being victimized by crime, often repeatedly. TRC services integrate trauma-informed, evidence-based psychotherapy and clinical case management in order to simultaneously address the many levels at which people are impacted by trauma and violence.

## References

Camus, J.P. (2012). *The beauties of St. Francis de Sales, selected and tr. from the writings of john peter camus*. France: Ulan Press.

Marlatt, G. A., Larimer, M. E., & Witkiewitz, K. (Eds.). (2011). *Harm reduction: Pragmatic strategies for managing high-risk behaviors*. Guilford Press.

Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change*. Guilford Press.

# THE TRAUMA RECOVERY CENTER CLINICIAN

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By Stacey Wiggall, LCSW



*Photograph by Ezme Kozuszek*

“She is a friend of my mind... The pieces I am,  
she gather them and give them back to me  
in all the right order.”

—Toni Morrison

*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

## Overview of TRC Clinician Roles

This chapter provides an overview of the roles of the TRC Clinician. More detailed information about each role, including assertive outreach, assessment and treatment planning, clinical case management, and trauma-informed psychotherapy can be found in subsequent chapters of this manual.

## Who is the TRC Clinician?

The TRC Clinician is a licensed mental health professional who conducts outreach, assessment, case management and psychotherapy services with clients, and brings a trauma-informed, cultural humility lens to each aspect of these services. This integration of roles is what sets the TRC model apart from many other trauma approaches and has been critical to the successful engagement and treatment of public sector survivors of violent crime.

TRC Clinicians have training and expertise in the assessment and treatment of acute trauma and polyvictimization, along with co-occurring mental health and substance use disorders, including anxiety disorders, mood disorders, and personality disorders. They are trained to provide evidence-based treatments including, but not limited to, Motivational Interviewing (Miller & Rollnick, 2012), Cognitive Behavioral Therapy (Craske & Barlow, 2006), and Skills Training in Affective and Interpersonal Regulation (STAIR) (Cloitre, Cohen & Koenen, 2011).

TRC Clinicians also have the flexibility to work with a wide variety of clients. While victims of crime are overrepresented in marginalized populations—such as people who are homeless, substance-dependent, chronically mentally ill, or living in poverty—survivors come from all walks of life. A Clinician’s clients might include a young African American man who is a survivor of gun violence, a Caucasian woman who is homeless, diagnosed with Bipolar Disorder and in a violent relationship, and an Asian American university student who is the survivor of a drug-facilitated sexual assault on campus. As clients’ needs dictate, Clinicians tailor their approaches to be more office-based or community-based, and to include more or less case management. The variability of clients’ needs requires the Clinician to see the clients within the context of their environment, and recognize both the challenges and supports in that environment. Whatever their professional discipline (social work, psychology, marriage and family therapy, etc.), the TRC Clinician must recognize the value and necessity of providing trauma-informed case management within the treatment framework.

## Engagement through Assertive Outreach

There are many reasons why survivors of violent crime avoid treatment, including the stigma associated with mental health services, embarrassment or shame, distrust of systems or providers based on previous negative experiences, emotional numbness, and making efforts to avoid any reminders of the recent trauma. For all of these reasons and more, the TRC model was founded to incorporate an assertive outreach approach to engaging clients in services. UC San Francisco TRC defines assertive outreach as making at least three attempts to contact a client within 30 days of the referral or missed appointment, including at least one of each: phone calls, letters, and home visits. The Clinician conducts assertive outreach to clients for the purposes of 1) initial engagement in services and 2) maintaining retention in services. Comprehensive contact information is collected at the time a referral is taken. Clients are asked for their permission to be contacted by phone, mail, and in person at their home address. This allows the Clinician to follow up if clients do not show up for appointments at the clinic, or to schedule appointments out in the community if clients are too psychologically or physically impaired to come to the clinic. This flexibility helps with both client engagement and retention.

## Initial Assessment

As the first step to entering TRC services, the client completes an intake assessment with a Clinician. The assessment is conducted at the TRC, at bedside in the hospital as the client is recovering from their crime-related injuries, or at a client's home. The Clinician conducts a comprehensive psychosocial assessment using validated measures to assess psychiatric symptoms and pre-and post-trauma functioning (for more information on measures, see chapter on Measuring Clinical Outcomes and Conducting Program Evaluation). The goal of the intake is to assess all the needs of the client as a whole person, including immediate concrete needs. The survivor's hierarchy of pressing needs can result in psychological support ranking at the bottom, under food, shelter, income, and safety. The Clinician helps clients prioritize needs and gain access to needed resources. For many clients, this help is the "carrot" that draws them into a therapeutic relationship and facilitates engagement in mental health services. As with any mental health interview, the Clinician needs to balance rapport-building with information gathering. However, because of the nature of acute trauma, the Clinician is especially attentive to the need to establish safety and trust, and to provide a nonjudgmental approach to care. At the same time, the Clinician begins instilling a sense of hope that recovery from the acute aftermath of trauma is possible.

Once a week, all TRC Clinicians meet as a team to review intake assessments. Each Clinician who has conducted an intake presents it to their colleagues, and supervisors

confirm program eligibility, diagnosis, and treatment recommendations. Once a client enters TRC services, the Clinician helps the client through a staged model of evidence-based, trauma-informed treatment. This allows the Clinician to choose evidence-based interventions that are appropriate for a client's stage of recovery, from an initial focus on safety and stabilization, to reprocessing of the trauma when that is indicated, to assisting the client in creating or maintaining healthy relationships, and participating in meaningful activities. The Clinician is an expert in meeting a client where he or she is while supporting the client's growth and recovery.

## **Treatment Planning**

When a client who has completed an intake begins treatment, the Clinician and the client use a Plan of Care (see appendix) to guide and focus short-term treatment. The Clinician asks the client to rate their level of need for help or services in areas such as medical care, food/clothing, legal assistance, and emotional/psychological care. The client and Clinician then prioritize three measurable goals for treatment. Typical goals include: linking with needed resources, establishing safety, and reduction of post-trauma symptoms. They also jointly identify client strengths that will help that person to meet their goals, and the plan for interventions and resources. The Plan of Care is referenced throughout treatment. If treatment is extended, or when treatment is ending, the client is asked to rate their progress made toward the identified goals. This serves to validate their achievements and/or to identify a need for transition to longer-term services.

## **Trauma-Informed Clinical Case Management**

Most of the clients who enter TRC services can benefit from assistance with practical needs, including shelter, food, entitlements, medical care, and/or health insurance. At the UC San Francisco TRC, the Clinician provides this through case management. This contrasts with some other approaches, which divide psychotherapy and case work between two or more staff members. Integrating case management and psychotherapy within the role of Clinician has many advantages. It makes it faster and easier for clients to get help, as they don't have to navigate relationships with multiple providers or access different systems of care. The Clinician's provision of case management also helps build trust between the client and Clinician, which is especially important when clients do not initially identify mental health treatment as a need due to more pressing practical concerns or to perceived stigma. It also has therapeutic value, as people who have been recently victimized often find it curative to be helped by others. In addition, the Clinician's expertise enables her or him to fold therapeutic interventions into the provision of case management as appropriate. For example, a Clinician might introduce



anxiety management interventions in order to help a hypervigilant client tolerate sitting in a waiting room full of strangers while waiting to see a medical provider.

## **Trauma-Informed Psychotherapy**

The TRC Clinician uses a staged model of care and evidence-based treatments to address post-trauma symptoms and help increase functioning and recovery. As mentioned above, this process begins with collaboratively identifying treatment goals. As goals are identified, the Clinician chooses appropriate therapeutic interventions. Psychotherapy is not restricted to special 50-minute office sessions—it can be provided during home visits, and integrated into other interactions with clients during case management, or interactions that may happen while transporting the client, sitting in agency waiting rooms, and any time the client is open and the Clinician can be of service.

## **Constructively Addressing Substance Abuse**

The TRC model acknowledges the relationship between trauma, substance use, and other unhealthy coping behaviors, and does not require abstinence from substances as a precondition to enter services. Instead, the Clinician integrates substance abuse interventions with psychotherapy, case management, and the rest of the TRC care. A Harm Reduction approach (Marlatt, Larimer, & Witkiewitz, 2011) is used, accepting clients where they are while recognizing the need to help clients identify or learn healthier ways of coping that increase their ability to participate in and benefit from treatment. Clinicians directly address clients' substance use problems through the use of Motivational Interviewing, and also help clients link to higher levels of treatment, such as medical detox or residential programs, when needed. Clients can benefit from participating in both TRC services and externally-provided substance abuse treatment simultaneously.

## **Legal Advocacy**

Clinicians provide assistance reporting to law enforcement, court accompaniment, and support with the U-Visa process (for undocumented survivors of violent crime). Clinicians also facilitate communication with the District Attorney's office, and teach clients anxiety/stress management strategies that help them to participate in the criminal justice process as needed. In a similar vein, the Clinician, with the client's permission, may consult with the police or the District Attorney's office in order to help bridge any communication issues and thus increase cooperation with law enforcement. Clinicians also link clients with assistance filing restraining orders as needed and provide relevant documentation.

## Community Partnerships

The TRC Clinician builds and maintains good relationships with community partnership referral agencies. Many community agencies regularly work with clients who present with complex needs secondary to acute and chronic trauma, substance abuse, and/or severe mental illness. Yet, these clients have traditionally fallen through the cracks and have not received the trauma-related services they need. And the agencies may lack much-needed access to licensed mental health clinicians. By conducting community presentations and trainings, and working collaboratively with other agencies to address the needs of local crime survivors, Clinicians help increase partner agencies' participation in identification and referral of survivors of interpersonal violence. Over time, these partnerships help increase access to TRC and other services for all local survivors of violent crime.

## Resources in this Manual

This manual has chapters on the different functions of the TRC Clinician. In addition, the case examples given in *Who Are TRC Clients?* illustrate how the Clinician individualizes comprehensive treatment to provide effective services to diverse clients with a range of needs.

## References

- Cloitre, M., Cohen, L.R., & Koenen, K.C. (2011). Treating survivors of childhood abuse: Psychotherapy for the interrupted life. Guilford Press.
- Craske, M. G., & Barlow, D. H. (2006). *Mastery of your anxiety and panic: Therapist guide*. Oxford University Press.
- Marlatt, G. A., Larimer, M. E., & Witkiewitz, K. (Eds.). (2011). Harm reduction: Pragmatic strategies for managing high-risk behaviors. Guilford Press.
- Miller, W. R., & Rollnick, S. (2012). Motivational interviewing: Helping people change. Guilford Press.
- Morrison, T. (1987). *Sula*. New York: New American Library.



## **SAMPLE TRC Clinical Coordinator Job Description**

### **JOB SUMMARY**

The UCSF-ZSFGH Trauma Recovery Center (TRC) is an award-winning program that is the first of its kind in California. It is designed to help victims of violent crime overcome barriers to accessing mental health treatment, health care, and legal resources in the acute aftermath of trauma. The TRC serves recent victims of violent crime, including survivors of physical assault, sexual assault, gun shot wounds, stabbings, domestic violence and human trafficking.

Under the supervision of the TRC Director, the incumbent will recruit, orient and train new TRC clinical staff to provide assertive outreach, clinical case management, and trauma-informed, evidence-based psychotherapy services to acute survivors of violent crime. The incumbent will also develop policies and procedures to direct clinical practice, monitor client flow, and develop/maintain community partnerships. The incumbent will also carry a caseload of individual clients and may facilitate group treatment as well.

### **KEY RESPONSIBILITIES**

#### **Mental Health Staff Management and Client Flow:**

- Recruit, select, and orient candidates for temporary and career positions when vacancies exist. Provide 1 hour of individual weekly supervision to six TRC staff clinicians.
- Determine caseload and work load for all clinical social workers based upon number of on-call shifts, intakes, clients, and administrative duties. This will be done in consultation with other clinical supervisors when applicable.
- Determine total number of clinical slots available and trouble-shoot when census is overly full or down.
- Develop, implement, and monitor compliance on policies related to standards of clinical care (i.e., outreach, case management, timely termination, etc.), documentation, productivity, and utilization of petty cash/gift cards, emergency hotel vouchers, muni token/taxi voucher etc.
- Communicate and clarify policies and procedures at all-staff meeting as needed.
- Develop monthly schedule for on-call shifts and intakes
- Coordinate needs assessment and implementation of cultural humility training
- Field requests for presenters from other community agencies and schools and assign staff to provide educational presentations
- Approve and coordinate all vacation and leave requests
- Perform probationary and annual performance evaluations for supervisees.

#### **Clinic Oversight**

- Train and oversee all Building Officer of the Day clinicians to ensure uniform practices with respect to triaging new referrals and assigning them appropriately (quarterly meeting)
- Serve as on-site supervisor and handle all on-site emergencies including de-escalation and containment of the emergency, reporting to the Director and risk management, debriefing with all

involved staff, clarifying roles and expectations between different teams and team members, and ensuring that clinical follow-up is appropriate to all involved clients

- Train and oversee all on-call mental health staff to ensure standard of care is provided to victims of crime being seen in the emergency department, inpatient medical visits, and on-site for medical follow-ups

### **Liaison Work Within TRC**

- Attend bi-weekly data meeting with database / administrative staff around productivity and billing
- Meet as needed with front desk staff to address inter-team issues and conflicts that are happening as well as to increase coordination. Provide training on healthy boundaries to new front office hires as needed.
- Meet as needed with Rape Treatment Center team manager to discuss coordination/issues between medical provider team and mental health team
- Meet weekly with the Director to report on all activities and make decisions on issues that have arisen
- Attend weekly all-staff meeting

### **Teaching and Trainings**

- Conduct annual safety and de-escalation training for all TRC staff and trainees
- Provide presentations and workshops to community partners

### **Community and Hospital Liaison Work**

- Attend monthly Sexual Assault Response Team meeting as TRC mental health team representative
- Develop and maintain relationship with Zuckerberg San Francisco General Hospital Medical Social Work and Trauma NP staff to facilitate referrals and client flow
- Develop and maintain relationship with local Victim Services Office of the District Attorney's Office to promote cooperation and collaboration
- Attend ad hoc task forces, meetings, and forums as requested

### **Clinical Care**

- Provide coverage for 1 Building Officer of the Day on-call shift weekly (up to 2 shifts when extra coverage is needed)
- Serve as primary clinician for 4-5 clients.
- Co-facilitate support group as needed.

## KNOWLEDGE, SKILLS AND ABILITIES

	Required	Preferred
The Clinical Coordinator must be able to move between and integrate assertive outreach, clinical case management, and trauma-informed, evidence-based mental health interventions with survivors of violent crime.	X	
The Clinical Coordinator must demonstrate cultural humility and a strengths-based, recovery philosophy.	X	
The Clinical Coordinator will need to have knowledge of both Trauma Recovery Center and ZSFGH policies and practices regarding client and staff safety, including mental health mandated reporting requirements.	X	
Excellent organizational and strong interpersonal skills	X	
Demonstrated excellent attendance and reliability	X	
People of color and ethnic minorities are encouraged to apply		X
Bilingual Spanish preferred		X

## EDUCATION, TRAINING AND EXPERIENCE

	Required	Preferred
Masters degree in social work, psychology, or counseling from an accredited university and licensure as an LCSW or MFT as determined by the California Board of Behavioral Sciences.	X	
Must be registered with the Board of Behavioral Sciences and be in good standing with the Board.	X	
Experience working with trauma survivors from underserved populations, including young people of color, people who are homeless and/or chronically mentally ill, people from immigrant and refugee groups, and LGBTQ people.	X	
Excellent documentation and clinical skills, ability to set priorities, work independently, excellent follow-up, work well under pressure and deadlines.	X	
Experience doing case management, outreach, and home visits.	X	

## **SAMPLE TRC Clinical Social Worker Job Description**

### **JOB SUMMARY**

The UCSF-ZSFGH Trauma Recovery Center (TRC) is an award-winning program that is the first of its kind in California. It is designed to help victims of violent crime overcome barriers to accessing mental health treatment, health care, and legal resources in the acute aftermath of trauma. The TRC serves recent victims of violent crime, including survivors of physical assault, sexual assault, gun shot wounds, stabbings, domestic violence and human trafficking.

Under the supervision of a senior staff clinician, the incumbent will provide clinical intakes, individual and group psychotherapy, assertive outreach, and clinical case management services, using evidence-based practices that are effective for the service population. Incumbent will also provide crisis intervention and emotional support to patients in the Zuckerberg San Francisco General Hospital Emergency Department and medical inpatient units.

### **KEY RESPONSIBILITIES**

#### **Clinical Intervention, Consultation, Psychotherapy, Liaison, Outreach and Case Management :**

- Conducts clinical intakes of new clients using a trauma-informed approach and identifies service needs when appropriate. Assessment includes identifying presenting problems, psychosocial history, mental status exam, and DSM-5 diagnosis.
- Clinical interventions include: crisis intervention in the ZSFGH Emergency Department as well as on-site at the TRC.
- Clinical services also include short-term, trauma-informed individual and group psychotherapy as well as comprehensive clinical case management, liaison with other health care providers, and referral and accompaniment to community services when appropriate.
- May visit patient at home and/or in the community for the purpose of outreach and follow-up if the patient is unable to keep regularly scheduled appointments.
- Caseload consists of complex clients, all of whom have histories of trauma, including acute and chronic physical and sexual abuse, and are victims of interpersonal violence such as sexual assault, physical assault, domestic violence, gunshot wounds, political torture, and immigration trauma. Many clients also have concurrent medical problems, psychosocial problems, and may have substance abuse problems as well.
- Utilizes knowledge of the mental health, medical, and community resources in San Francisco and maintains familiarity with new programs.
- Develops a comprehensive treatment and service plan for each client, integrating knowledge from

a wide range of human service resources.

- Facilitates coordination of services among various agencies; advocates for and links client to needed services. Helps to eligibilize clients for social security disability, Victim of Crime, and other financial entitlements. Provides assistance with U-Visas and psychological asylum evaluations as needed. Serves as a client advocate and liaison with the District Attorney's Office and Police Department for victims of crime wishing to file police reports, restraining orders, etc.

**Clinical Supervision, Teaching, Training, and Program Development:**

- May provide supervision to clinical interns.
- Participates in in-service trainings and case conferences.
- Conducts community presentations.
- May assist with program development, including identification and implementation of types of appropriate measurement-guided mental health treatment.

**Record Keeping and Administration and Other Duties:**

- Maintain client records according to California, City, and County requirements.
- Records data in client's chart according to JCAHO standards.
- Meets program productivity standards; Completes productivity forms, clinical documentation and other documentation of services in a timely fashion.
- Assists in processing Quality Improvement requests.
- Assists in data collection for program evaluation and research purposes; Works collaboratively with the TRC Research Team.
- Attends staff meetings and other assigned meetings, participates in training sessions (e.g. in-services, grand rounds).
- Performs other related duties as assigned.

## KNOWLEDGE, SKILLS AND ABILITIES

	Required	Preferred
The Clinical Social Worker I/II must be able to move between different treatment approaches (clinical case management and evidence-based, trauma-focused psychotherapy) depending on the needs of the client.	X	
The Clinical Social Worker I/II must demonstrate cultural humility and a strengths-based, recovery philosophy.	X	
The Clinical Social Worker I/II will need to have knowledge of both Trauma Recovery Center and ZSFGH policies and practices regarding client and staff safety, including mental health mandated reporting requirements.	X	
Excellent organizational and strong interpersonal skills	X	
Demonstrated excellent attendance and reliability	X	
People of color and ethnic minorities are encouraged to apply		X
Bilingual Spanish preferred		X

## EDUCATION, TRAINING AND EXPERIENCE

	Required	Preferred
Clinical Social Worker I: Masters degree in social work, psychology, or counseling from an accredited university. Must be registered with the California Board of Behavioral Sciences as a Social Work Associate or Marriage and Family Therapy Intern, and in good standing with the Board.	X	
Clinical Social Worker II: Masters degree in social work, psychology, or counseling from an accredited university and licensed as an LCSW or MFT with the California Board of Behavioral Sciences. Must be in good standing with the Board	X	
Experience working with trauma survivors from underserved populations, including young people of color, people who are homeless and/or chronically mentally ill, people from immigrant and refugee groups, and LGBTQ people.	X	
Excellent documentation and clinical skills, ability to set priorities, work independently, excellent follow-up, work well under pressure and deadlines.	X	
Experience doing case management, outreach, and home visits.	X	

## **SAMPLE TRC Psychologist Job Description**

### **JOB SUMMARY**

The UCSF-ZSFGH Trauma Recovery Center (TRC) is an award-winning program that is the first of its kind in California. It is designed to help victims of violent crime overcome barriers to accessing mental health treatment, health care, and legal resources in the acute aftermath of trauma. The TRC serves recent victims of violent crime, including survivors of physical assault, sexual assault, gun shot wounds, stabbings, domestic violence and human trafficking.

The TRC has an opening for a full time licensed psychologist. The incumbent will serve in a leadership role as a senior clinician and provide trauma-informed assessment, psychotherapy and assertive case management services to survivors of violent crime. The incumbent will also provide clinical supervision, consultation and training to staff and trainees on trauma-informed evidence-based interventions. The incumbent will also be involved in program development and provide inservice trainings to other programs.

### **KEY RESPONSIBILITIES**

#### **Clinical Intervention, Consultation, Psychotherapy, Liaison, Outreach and Case Management :**

- Conducts clinical intakes of new clients using a trauma-informed approach and identifies service needs when appropriate. Assessment includes identifying presenting problems, psychosocial history, mental status exam, and DSM-5 diagnosis.
- Clinical interventions include: crisis intervention in the ZSFGH Emergency Department as well as on-site at the TRC.
- Clinical services also include short-term, trauma-informed individual and group psychotherapy as well as comprehensive clinical case management, liaison with other health care providers, and referral and accompaniment to community services when appropriate.
- May visit patient at home and/or in the community for the purpose of outreach and follow-up if the patient is unable to keep regularly scheduled appointments.
- Caseload consists of complex clients, all of whom have histories of trauma, including acute and chronic physical and sexual abuse, and are victims of interpersonal violence such as sexual assault, physical assault, domestic violence, gunshot wounds, political torture, and immigration trauma. Many clients also have concurrent medical problems, psychosocial problems, and may have substance abuse problems as well.
- Provides consultation to a multidisciplinary treatment team on the psychosocial ramifications of trauma, substance abuse, psychiatric problems and chronic medical problems.



- Utilizes knowledge of the mental health, medical, and community resources in San Francisco and maintains familiarity with new programs.
- Develops a comprehensive treatment and service plan for each client, integrating knowledge from a wide range of human service resources.
- Facilitates coordination of services among various agencies; advocates for and links client to needed services. Helps to elibilize clients for social security disability, Victim of Crime, and other financial entitlements. Provides assistance with U-Visas and psychological asylum evaluations as needed. Serves as a client advocate and liaison with the District Attorney's Office and Police Department for victims of crime wishing to file police reports, restraining orders, etc.

**Clinical Supervision, Teaching, Training, and Program Development:**

- Provides clinical and administrative supervision to clinical staff and interns.
- Takes the lead in preparing, planning and conducting inservice trainings and case conferences.
- Assists in organizing and co-teaching a didactic Trauma Seminar on the assessment and treatment of acute and chronic trauma in underserved populations, using evidence-based practices.
- Conducts community presentations on the assessment and treatment of trauma.
- Takes the lead in working with the TRC Director on program development and initiating innovative models of care.

**Record Keeping and Administration and Other Duties:**

- Maintain client records according to California, City, and County requirements.
- Records data in client's chart according to JCAHO standards.
- Meets program productivity standards; Completes productivity forms, clinical documentation and other documentation of services in a timely fashion.
- Assists in processing Quality Improvement requests.
- Assists in data collection for program evaluation and research purposes; Works collaboratively with the TRC Research Team.
- Attends staff meetings and other assigned meetings, participates in training sessions (e.g. in-services, grand rounds).
- Performs other related duties as assigned.

## KNOWLEDGE, SKILLS AND ABILITIES

	Required	Preferred
Demonstrated experience supervising clinical staff and interns.	X	
Must demonstrate cultural humility and a strengths-based, recovery philosophy.	X	
Excellent organizational and strong interpersonal skills	X	
Demonstrated excellent attendance and reliability	X	
People of color and ethnic minorities are encouraged to apply		X
Bilingual Spanish preferred		X

## EDUCATION, TRAINING AND EXPERIENCE

	Required	Preferred
Possession of a valid license in Psychology issued by the California Board of Psychology.	X	
Able to obtain Medical Staff Privileges at UCSF/SFGH.	X	
At least 3 years post licensing.	X	
Experience working with trauma survivors from underserved populations, including young people of color, people who are homeless and/or chronically mentally ill, people from immigrant and refugee groups, and LGBTQ people.	X	
Experience providing evidence-based, trauma-focused treatment.	X	
Experience doing case management, outreach, and home visits.	X	

## **SAMPLE TRC Psychiatrist Job Description**

### **JOB SUMMARY**

The UCSF-ZSFGH Trauma Recovery Center (TRC) is an award-winning program that is the first of its kind in California. It is designed to help victims of violent crime overcome barriers to accessing mental health treatment, health care, and legal resources in the acute aftermath of trauma. The TRC serves recent victims of violent crime, including survivors of physical assault, sexual assault, gun shot wounds, stabbings, domestic violence and human trafficking.

This position is for a part-time board certified or board eligible psychiatrist at the UCSF TRC. Under the supervision of the TRC Director and TRC Medical Director, the incumbent will provide mental health consultation and direct psychiatric assessment and brief treatment to adult patients with acute and chronic trauma, medical illnesses and complex psychiatric and psychosocial problems at the TRC for 10 hours/week.

### **KEY RESPONSIBILITIES**

#### **Clinical Intervention, Consultation, Psychotherapy, Liaison, Outreach and Case Management :**

- Conducts clinical assessments for new clients, using a trauma-informed approach to care.
- Provides medication management to ongoing clients.
- Liaisons with TRC mental health clinicians to discuss possible referrals and provide a team approach to client care.
- May visit client at home and/or in the community for the purpose of outreach and follow-up if the client is unable to keep regularly scheduled appointments.
- Caseload consists of complex clients, all of whom have histories of trauma, including acute and chronic physical and sexual abuse, and are victims of interpersonal violence such as sexual assault, physical assault, domestic violence, gunshot wounds, political torture, and immigration trauma. Many clients also have concurrent medical problems, psychosocial problems, and may have substance abuse problems as well.
- Works with primary care providers to continue medications as needed for clients terminating from TRC clinical care who are still in need of medication.
- Works in partnership with clients' primary TRC clinicians to help eligibilize clients for financial entitlements as needed.
- Attends and co-facilitates weekly multidisciplinary intake team meetings; consults on medical

aspects of client presentation and helps identify when referral to psychiatric assessment may be appropriate.

- Consults with clinical team on high-risk clients

**Clinical Supervision, Teaching, Training, and Program Development:**

- May provide supervision to medical students and/or clinical interns.
- Participates in in-service trainings and case conferences.
- May assist with program development, including identification and implementation of types of appropriate measurement-guided mental health treatment.

**KNOWLEDGE, SKILLS AND ABILITIES**

	<b>Required</b>	<b>Preferred</b>
Demonstrated interest in and commitment to working with underserved populations and special sensitivity to the cultural diversity of the population served by TRC	<b>X</b>	
Demonstrated skills in the areas of diagnosis and treatment planning (including pharmacotherapy).	<b>X</b>	
Skilled in navigating legal issues in patient care, interdisciplinary collaboration and coordination of resources within the service and across service units in a community setting.	<b>X</b>	
Excellent skills in communication and clinical supervision.	<b>X</b>	
People of color and ethnic minorities are encouraged to apply		<b>X</b>
Bilingual Spanish preferred		<b>X</b>

**EDUCATION, TRAINING AND EXPERIENCE**

	<b>Required</b>	<b>Preferred</b>
State of California Medical Board Licensure	<b>X</b>	
DEA Certification	<b>X</b>	
Must be able to obtain medical staff privileges at SFGH		
Experience working with trauma survivors from underserved populations, including young people of color, people who are homeless and/or chronically mentally ill, people from immigrant and refugee groups, and LGBTQ people.	<b>X</b>	

# TRAUMA RECOVERY CENTER ASSERTIVE OUTREACH

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By Stacey Wiggall, LCSW



*Photograph by Ezme Kozuszek*

“You can’t stay in your corner of the Forest  
waiting for others to come to you.  
You have to go to them sometimes.”

—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

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 previous negative experiences with “helping” providers/systems, 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’s willingness 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, but that is usually the extent of any “outreach.” In contrast, the TRC model 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 symptom are in a constant “fight or flight” mode, over-attuned to potential threats or 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 can be a major barrier to people’s ability to carry out their usual daily activities, including 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 for help for fear they will be considered “crazy.” Many people believe that 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 facilitate referrals. Such a partnership increases survivors' access to early TRC 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 can receive case management, e.g., “we can help with practical things you might need, like housing, or getting to medical appointments, or insurance, or whatever you are needing help with when you leave here.” They inform the client that TRC also offers 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 scheduled intake, the Intake Clinician then uses the “three attempts in 30 days” protocol 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 client frequents and where they sleep, and if there’s 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 “stalking.” 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. As one client stated, “It made me feel like you cared if I lived or died.”

**HOW MUCH FOLLOW-UP OUTREACH?** The guideline for follow-up assertive outreach is “three attempts in thirty days” during the initial engagement phase. If a client misses a 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, 2012) to address a client’s reluctance to participate in services. The Clinician may also decide to share Cognitive Behavioral techniques or other evidence-based therapeutic interventions, such as relaxation training (Bernstein & Borkorec, 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 situation who has been participating 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 understanding of possible reasons for non-engagement in 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 decide to make a home visit in order to check on the client's well-being and 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 client at home, with the goal of improving the client's overall functioning and, by 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 assess candidates' comfort level and experience with meeting clients out in the 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 is 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 substance use. A client's use of substances is understood as a coping strategy, albeit a 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.

## **References**

Bernstein, D & Borkorec, T. (1973). *Progressive relaxation training: A manual for the helping professions*. Champaign, IL: Research Press.

Camus, A. (1955). Return to tipasa, *The myth of sisyphus and other essays* (J. O'Brien, Trans.) New York: Alfred A. Knopf, Inc.

Gavrilovic, J.J., Schutzwahl, M., Fazel, M. & Priebe, Stefan. (2005). Who seeks treatment after a traumatic event and who does not? A review of findings on mental health services utilization. *Journal of Traumatic Stress*, 18(6), 595-605.

Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change*. Guilford Press.

Milne, A.A. (1926). *Winnie-the-pooh*. Shepard, E. H. (Illustrator). London: Methuen & Company, Ltd.

Shumway, M., Alvidrez, J., Boccellari, A., Fields, L., Richer, L., Merrill, G., Smart, S. (2009, July). *Increasing access to mental health care for victims of violent crime*. Poster presented at the NIMH Conference on Mental Health Services Research, Washington, DC.



## **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

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

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

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

<b>Index Crime/Trauma</b> (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		
<b>Date of Crime/Trauma</b>	____/____/____	<b>Police Report?</b>	0 = No 1 = Yes
		<b>Case #</b>	_____

<b>Does this person have a TBI from the referring incident?</b>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	<b>Victim of Crime &amp; TBI?</b>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>
---	--	-----------------------------------	--

<b>Gender</b>	0 = female 1 = male 2 = transgender (M-F) 3 = transgender (F-M)
<b>Sexual Orientation</b>	1 = gay/lesbian 2 = heterosexual 3 = bisexual 4 = unsure/questioning 5 = declines to state/unknown
<b>Race/Ethnicity</b>	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

<b>Not Evaluated Because</b>	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
<b>RTC Consent to contact?</b>	1 = signed 0 = not signed -1 = not applicable

   <b>Eligibility and Risk Criteria</b>  	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 #

YELLOW COPY IS THE ORIGINAL CHART COPY—DO NOT MAKE CHANGES ON COPIES THAT ARE NOT YELLOW

<b>Primary Address</b> (include address where pt will be for next two weeks in one of these spaces)	number	street	city	state	zip	
	Type:	1=own home   2=relative's/friend'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?	0 = No   1 = Yes
<b>Other Address</b>	number	street	city	state	zip	
	Type:	1=own home   2=relative's/friend'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?	0 = No   1 = Yes

<b>Primary Phone</b>	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			
<b>Other Phone</b>	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			

<b>Contact person "most likely to know how to get in touch with you"</b>			OK to: Call?	Leave msgs?	Identify as TRC?
last name	first name	phone number			

<b>PCP</b>	last name	first name	clinic
------------	-----------	------------	--------

<b>Currently on Psychotropic Medications</b>	0 = No   1 = Yes	Which?	
--	------------------	--------	--

<b>Location of RTC Services</b>	1 = ED Zone 4   2 = 6 <sup>th</sup> Floor   3 = Other _____
---------------------------------	---

<b>TRC Medical Follow-up</b>	<b>1</b>	Date	Time	Place	With	0 = no show	1 = attend	2 = cancelled
	<b>2</b>	Date	Time	Place	With	0 = no show	1 = attend	2 = cancelled
<b>Clinical Intake</b>	<b>1</b>	Date	Time	Place	With	0 = no show	1 = attend	2 = cancelled
	<b>2</b>	Date	Time	Place	With	0 = no show	1 = attend	2 = cancelled
	<b>3</b>	Date	Time	Place	With	0 = no show	1 = attend	2 = cancelled
	<b>4</b>	Date	Time	Place	With	0 = no show	1 = attend	2 = cancelled

<b>Contact Log</b>	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?**

Location \_\_\_\_\_

Where will you be going after you leave here?

**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**  
123 Street Address  
San Francisco, CA 94110  
Tel: 415-444-0000  
Fax: 415-444-0001

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, 9:00-11:00 AM**  
**At 123 Street Address (at Cross Street)**

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 24<sup>th</sup> 2016, at 9:00 AM.**

Thanks,

Carol Jones LCSW, 415-435-9008



**San Francisco TRC/RTC**  
123 Street Address  
San Francisco, CA 94110  
Tel: 415-444-0000  
Fax: 415-444-0001

X  
X  
X

February 3, 2017

Dear Ms. 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 415-444-0008 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, 415-444-0008

# TRAUMA RECOVERY CENTER ASSESSMENT AND TREATMENT PLANNING

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By Melissa Murphy, LCSW, MPH and Stacey Wiggall, LCSW



*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

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 provides an overview of the UC San Francisco TRC's 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. The Intake Flow Chart graphic at the end of 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 assessment provides a firm foundation for 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 consent, TRC Intake 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 and others’ 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 can ask for a break if you need one, or choose not to answer specific questions. And please feel free to ask me any questions you have, at any time.”

**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 a client's functioning. Clinicians then 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 strengths and resiliency. The Clinician may choose to point these out to a client who seems unaware or undervaluing of these examples; this is done without minimizing the trauma or its impact. The Clinician also highlights each client's strengths in the written report of the intake assessment under the "Case Formulation" 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 of need in various life categories, as 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 client's sleep quality and physical pain level. 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 level of need in life categories ranging from medical 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 be 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., if it becomes clear that a 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 specific post-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 case formulation of each client's presentation, particularly cultural considerations. This formulation also includes a summary of a client's strengths and current coping strategies.
- 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 eligibility is a client who presents with 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, “The client experienced a drug-facilitated sexual assault on 3/9/16 by a co-worker” is preferable to detailed information such as, “The client went out for drinks after work and ended up staying late at the bar with one of her co-workers, then went back to his apartment....” Although more trauma details are provided in the written intake format in order to create a comprehensive understanding of the client’s clinical 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 the client's current symptoms and work together 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 listening, 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 of the Plan of Care allows the Clinician to independently rate their sense of a client's level of need. 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 where they don't need help or services. 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 the client's level of need in this realm as higher than the client's own rating. This separate rating allows the Clinician to flag problematic issues for nonjudgmental discussion with the client. It can also provide the basis for the use of motivational interviewing strategies that increase a client's level of readiness to acknowledge and address these behaviors during the course of treatment. If there is a difference between a client's rating and a Clinician's, it is always discussed respectfully, 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, and use them to brainstorm the client's 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." Clinicians are trained to be specific, rather than choosing goals such as "increase self-esteem," which are difficult to quantify and to 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 internal strengths, 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 bolster a client's healing and recovery.

## **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 those needs met. It also captures changes in a client's 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 individual clients' progress, 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 used to track both individual clients' responses to 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 information on considerations related to treatment extension, see chapter on TRC Service Flow Description.

**TREATMENT CLOSING REPORT.** Clinicians complete this report at the time a client's TRC services are ending. It includes a brief summary of services provided, a snapshot of the client's current functioning, and whether closure of TRC services includes linkage to 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's progress toward their goals 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.

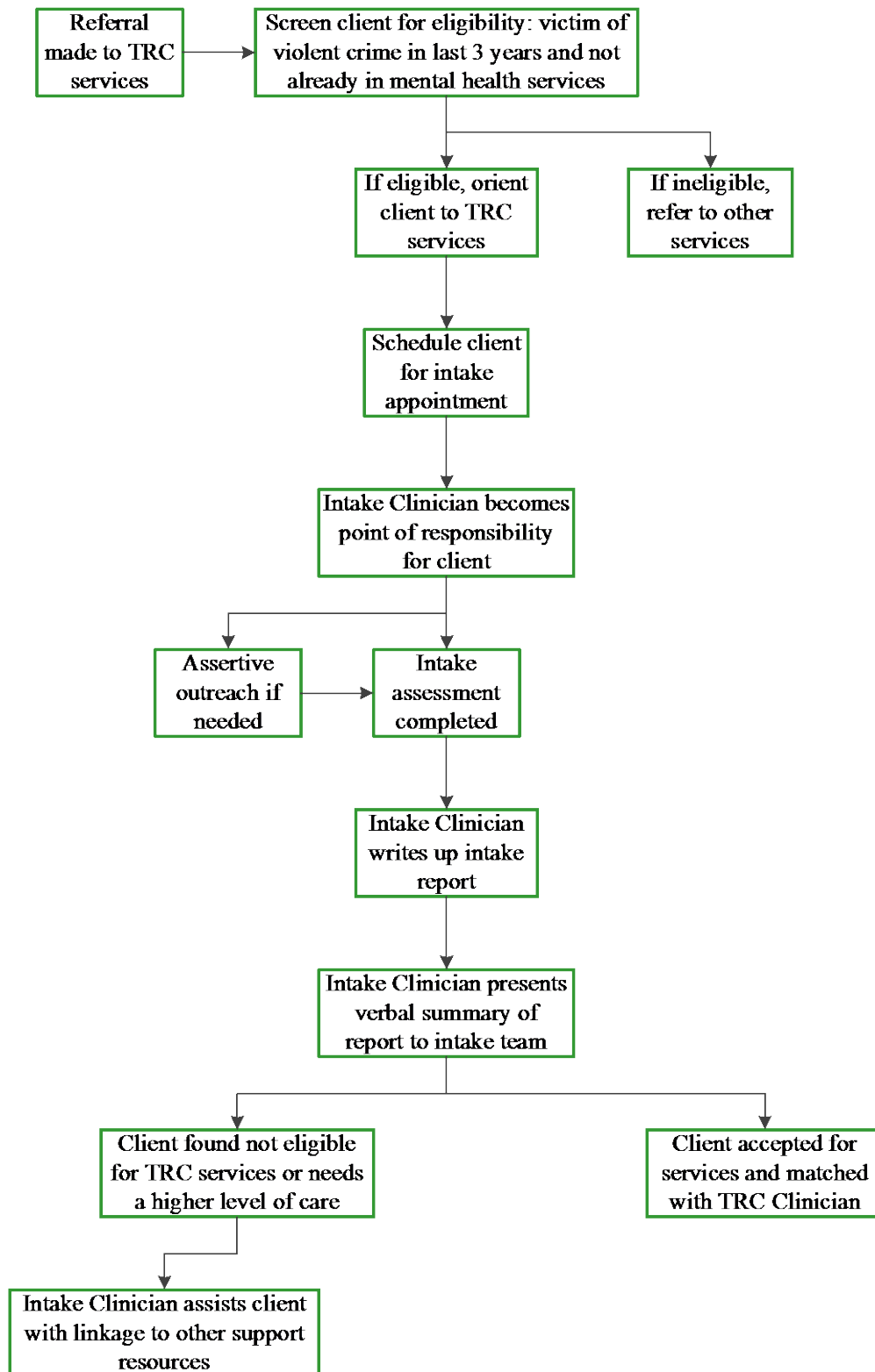
Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, 9, 117-125.

## **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

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

<i>Items / Measure</i>	<i>Domain</i>	<i>Schedule</i>	<i>Completed By</i>
<b>Follow-Up Measures-</b> includes:		8 <sup>th</sup> session and 15 <sup>th</sup> or 16 <sup>th</sup> session; Also at next-to-final session if treatment >16 sessions	Therapist
<b>Updated Demographics</b>	Update from baseline demographics		
<b>PCL-5*</b>	PTSD		
<b>Complex PTSD Measure*</b>	PTSD and Complex PTSD		
<b>PHQ9*</b>	Depression		
<b>PROMIS</b>	Sleep		
<b>PEG</b>	Physical Pain		
<b>Needs/barriers assessment, TRC services and referrals provided</b>	Areas of need and barriers to care; case management assistance provided and services received		
<b>WHOQOL-BREF plus Service Satisfaction*</b>	Quality of life; patient evaluation of services received		Client
<b>Plan of Care*</b>	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

<i>Items / Measures</i>	<i>Citations</i>
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 <a href="http://www.ptsd.va.gov/">http://www.ptsd.va.gov/</a> , 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.



		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">NAME</td> <td>Sample, Client</td> </tr> <tr> <td>DOB</td> <td>November 17, 1980</td> </tr> <tr> <td>MRN</td> <td>63264475</td> </tr> <tr> <td>PCP</td> <td>Davidson, Aaron (Silver A)</td> </tr> </table>			NAME	Sample, Client	DOB	November 17, 1980	MRN	63264475	PCP	Davidson, Aaron (Silver A)
NAME	Sample, Client											
DOB	November 17, 1980											
MRN	63264475											
PCP	Davidson, Aaron (Silver A)											
REFERRED BY: <b>Sandy Heron</b>	REFERRING AGENCY/DEPARTMENT: <b>Victim Witness</b>	PHONE: <b>(415)546-3729</b>	PAGER: <b>(415)246-8993</b>	REFERRAL DATE: <b>12/28/2016</b>								
REASON FOR REFERRAL: <b>Physical Assault</b>												
<b>Intake Evaluation</b>		<b>Date of Intake:</b> 01/31/2017										
<b>ID:</b> SAMPLE INTAKE REPORT BASED ON COMPOSITE, UNIDENTIFIABLE CLIENT INFORMATION: 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.												
<b>CC:</b> "I'm going through a lot and it's too much sometimes. I'd like to get some support."												
<b>HPI:</b> 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 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.												
<b>Medical History</b>												
		<b>Medication</b>	<b>Dosage</b>	<b>Date Start</b>	<b>Prescribing MD</b>							
<b>Current Meds?</b>	No											
<b>Past Meds?</b>	Yes	Zoloft	75 mg	2012	Alice Vos at South of Market							
<b>Allergies?</b>	No											
<b>Med Hx Comments:</b>		Client is sexually active, uses condoms for birth control and is HIV-negative. She is currently linked with primary care.										
<b>Past Mental Health Treatment History</b>												
				<b>Past MH Sxcs? Yes</b>	<b># of Episodes</b>							
<b>Past Sx:</b>	Auditory hallucinations	No	Self mutilation	No	2 Psychotherapy							
	Visual hallucinations	No	Suicide gestures/parasuicidal	No	2 Medications							
	Suicidal ideation	Yes	Paranoid ideation	No	1 Psychiatric Emergency							
					0 Inpatient							
<b>Psy Hx Comments:</b>		Clit 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.										

NAME **Sample, Client**  
 DOB **November 17, 1980**  
 MRN **63264475**  
 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 grandmother 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				
Witness DV	No							

**Victim of Crime 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.

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

<b>Suicidality &amp; Risk of Self Harm:</b>	Ideation	No	<b>Danger to Others and Risk of Danger to Others:</b>	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 of harm 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 (DSMS)**

**Diagnosis (code and description)**

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 commitment 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.

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

### 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**

CLINICIAN'S NAME (PRINT)	CLINICIAN'S SIGNATURE	LICENSE NO.	PHONE	DATE
SUPERVISOR'S NAME (PRINT)	SUPERVISOR'S SIGNATURE	LICENSE NO.	PHONE	DATE

Print Date: 6/1/2017

MEDICAL RECORDS

Page 4 of 4

## **Appendix 5 to Assessment and Planning: Sample Plan of Care**

See next page for a sample Plan of Care.

MRN: 01234567

## Plan of Care, Part 1

LCSF SICH Trauma Recovery Center Plan 7/2015

Client Name (Last, First):

Sample, Client

Therapist Name (Last, First):

Sample, ChristianDate: 4/10/17Please 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	A Little	Moderately	Quite a Bit	Extremely	Description	Client rated level of need (1-5)
Medical	1	2	3	4	5		
Safety	1	2	3	4	5	Recovering from stab wound would like to return home after home invasion	4
Food/Clothing	1	2	3	4	5	"I can't cook."	3
Housing	1	2	3	4	5	Wants to return to apartment	1
Financial	1	2	3	4	5	Fixed income	3
Legal	1	2	3	4	5	Ongoing criminal investigation	4
Vocational/Educational	1	2	3	4	5	Retired	1
Physical Rehabilitation	1	2	3	4	5	Physical Therapy 2x/week	3
Language/Literacy	1	2	3	4	5		1
Emotional/Psychological	1	2	3	4	5	Fearful, sad, losses	5
Interpersonal/Social	1	2	3	4	5	loss of independence	3
Spiritual/Religious	1	2	3	4	5		1
Sexual	1	2	3	4	5		1
Substance Abuse	1	2	3	4	5	Not worried about alcohol use; captive to monitor	3



MRN: 01234567

## Plan of Care, Part 2

UCCSF-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 #

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?
"Can't cook or drive."	Return to independence.	- Case management (home care/ meals) - Para transit	- Family + friend support - Motivated	16	<input type="checkbox"/> Not at All <input type="checkbox"/> A Little Bit <input type="checkbox"/> Moderately <input checked="" type="checkbox"/> Quite a Bit <input type="checkbox"/> Extremely
Target Problem 2	Client Goal or Objective	Plan/Intervention	Strengths that will help Client achieve goal	# of Sessions	Goals Met?
"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	<input type="checkbox"/> Not at All <input type="checkbox"/> A Little Bit <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a Bit <input checked="" type="checkbox"/> Extremely
Target Problem 3	Client Goal or Objective	Plan/Intervention	Strengths that will help Client achieve goal	# of Sessions	Goals Met?
"I'm sad."	Reduce sadness, feelings of loss and self-blame.	- Use CBT to help with challenge negative thoughts	- Insightful - Experienced - Intelligent	16	<input type="checkbox"/> Not at All <input type="checkbox"/> A Little Bit <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a Bit <input checked="" type="checkbox"/> Extremely

Client's Signature (1) Client Sample  
 Date: 1/10/17  
 Therapist's Signature (1) Theresa Sample  
 Date: 1/10/17  
 Supervisor's Signature (1) Supervisor, LCSW  
 Date: 1/10/17

Client's Signature (2) Client Sample  
 Date: 6/20/17  
 Therapist's Signature (2) Theresa Sample  
 Date: 6/20/17  
 Supervisor's 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.

		NAME Sample, Client DOB 11/17/1980 MRN 63264475 PCP Aaron Davidson, - Silver Ave		
REFERRED BY: <b>Sandy Heron</b>	REFERRING AGENCY/DEPARTMENT: <b>Victim Witness</b>	PHONE NUMBER: <b>(415) 546-3729</b>	PAGER: <b>(415) 246-8993</b>	REFERRAL DATE: <b>12/28/16</b>
REASON FOR REFERRAL: <b>Physical Assault</b>				DATE OF INTAKE: <b>1/31/2017 12:28:</b>
SUMMARY TYPE: <b>Treatment Closing</b>				DATE COMPLETED: <b>6/22/17</b>
TREATMENT DISPOSITION: <b>Individual Trauma-English</b>		THERAPIST: Stacey Wiggall		
Date of first session: 2/13/17		Number of sessions contracted: 16		
Date of last session: 6/19/17		Number of sessions attended: 16		
<b>Current Psychiatric Medications</b>				
<u>Medication</u>	<u>Dose</u>	<u>Date Start</u>	<u>Prescribing MD/Refill Plan</u>	
Lexapro	10 mg	3/15/17	Primary care provider	
<b>Treatment Update Diagnoses (DSMS)</b>				
<b>Diagnosis (code and description)</b> - NO DIAGNOSIS <b>Medical Diagnosis</b>				
<b>Discharge Plan:</b>				
No additional treatment planned				
<b>Clinical Summary:</b>				
<b>Clinical Change:</b> much better <b>Clinical Summary:</b> SAMPLE CLOSING SUMMARY REPORT BASED ON COMPOSITE, UNIDENTIFIABLE CLIENT INFORMATION: 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.				
CLINICIAN'S NAME (PRINT)	CLINICIAN'S SIGNATURE	LICENSE NO.	PHONE	DATE
SUPERVISOR'S NAME (PRINT)	SUPERVISOR'S SIGNATURE	LICENSE NO.	PHONE	DATE

Print Date: 6/1/2017

MEDICAL RECORDS

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# TRAUMA RECOVERY CENTER CLINICAL CASE MANAGEMENT

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By Stacey Wiggall, LCSW



*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

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.

## References

- Acierno, R., Kilpatrick, D. G., & Resnick, H. S. (1999). Posttraumatic stress disorder in adults relative to criminal victimization: Prevalence, risk factors, and comorbidity. In *Posttraumatic stress disorder: A comprehensive text*, (pp. 44-68). Needham Heights, MA, US: Allyn & Bacon.
- Davidson, L. (2015). Peer support: coming of age of and/or miles to go before we sleep? an introduction. *The journal of behavioral health services & research*, 42(1), 96.
- Herman, J. L. (1997). *Trauma and recovery* (Vol. 551). Basic books.
- Kanter, J. (1989). Clinical case management: Definition, principles, components. *Psychiatric Services*, 40(4), 361-368.
- Maslow, A. H. (1943). A theory of human motivation. *Psychological review*, 50(4), 370.
- Moxley, D. P. (1989). *Practice of Case Management* (Vol. 58). Sage.
- Supporters, I. A. (2013). *International Association of Peer Supporters*. Retrieved March 2016, from <http://inaops.org/national-standards/>
- Vanderplasschen, W., Rapp, R. C., Wolf, J. R., & Broekaert, E. (2004). The development and implementation of case management for substance use disorders in North America and Europe. *Psychiatric Services*, 55(8), 913-922.
- Victims of Trafficking and Violence Prevention Act. (2000). *Pub.L. No. 106-386, Stat. 1464-1548*. United States.

Ziguras, S. J., & Stuart, G. W. (2000). A meta-analysis of the effectiveness of mental health case management over 20 years. *Psychiatric services*, 51(11), 1410-1421.

<https://kinginstitute.stanford.edu/king-papers/documents/i-have-dream-address-delivered-march-washington-jobs-and-freedom>.



# TRAUMA RECOVERY CENTER TRAUMA-INFORMED, EVIDENCE-BASED PSYCHOTHERAPY

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By Laurie Fields, Ph.D.



*Photograph by Ezme Kozuszek*

“Courage doesn’t always roar. Sometimes courage is the  
quiet voice at the end of the day saying,  
I will try again tomorrow.”

—Mary Anne Radmacher

*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 &  
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TRC psychotherapy interventions fall within an established three-stage model of trauma treatment that addresses survivors' differing needs and environments (Herman, 1997) (see *Clinical Model Overview* in this chapter's Appendix 1). The TRC Clinician selects from evidence-based, trauma-informed and trauma-specific therapy models appropriate for this population—a diverse group of survivors, many of whom have experienced multiple incidents and types of violent crime. The treatment stages are:

**STAGE ONE:** Stabilization and establishment of safety

**STAGE TWO:** Addressing and processing the trauma memories or related beliefs, and/or grieving the losses inherent in trauma

**STAGE THREE:** Restoring or creating connection between survivors and their communities by increasing engagement in meaningful, positive activities and relationships

This overarching stage model serves as a useful tool to guide decisions about treatment selection. Within each stage of treatment, evidence-based practices (EBPs) are used. EBPs require clinicians to use techniques and approaches that are based on the best available research evidence (Sackett et al., 2000). This includes those that are empirically supported as well as those recommended in expert consensus treatment guidelines.

Although every client is different, many people benefit from 12-16 sessions of Stage One treatment. Clinicians generally start services by offering 16 sessions of treatment, or less if clients are reluctant to engage. There is a process by which services can be extended beyond 16 sessions if treatment will continue beyond Stage One and certain other criteria are met, or if extenuating circumstances require a slower pacing of Stage One interventions (see Supervision chapter for more detail).

However, in their Expert Consensus Treatment Guidelines For Complex PTSD in Adults, the International Society for Traumatic Stress Study (ISTSS) states that the “length of treatment for patients with Complex PTSD symptom profiles in the research literature has varied from 4 to 5 months and these timelines have been associated with substantial benefits.” ISTSS experts in this survey recommended the need for longer courses of treatment than have been applied in clinical trials.” They consider “6 months to be a reasonable amount of time for Stage One, and another 3 to 6 months for Stages Two and Three, producing a combined treatment duration of 9 to 12 months” (Cloitre et al., 2012). For clients with a history of early and repeated trauma, Clinicians and their supervisors can consider extending treatment in increments of 16 sessions.

## Stage One Interventions for Safety and Stabilization

The goals of this initial stage include identifying and addressing any safety concerns, stabilizing biological rhythms, and reducing post-trauma distress.

### Establish a Sense of Safety and Trust in the Clinician

The TRC Clinician begins therapy by helping the client establish feelings of safety and trust in the Clinician. After being victimized, a person's ability to trust others is typically significantly compromised. This contributes to under-engagement in usual services, or causes premature drop-out. Building a positive therapeutic alliance is key to any successful therapy and can be a particular challenge when working with acute survivors of violent crime (Norcross, 2011), and those with complex PTSD. Strategies to build the alliance include:

- Offering an overtly warm, welcoming stance in order to demonstrate caring about the client and their needs.
- Following through with planned session start/stop times and any treatment plans discussed. This increases trust in the Clinician's word.
- Providing clinical case management along with therapy to serve as a concrete demonstration of caring, respect, attunement with needs, and trustworthiness.
- Limiting talk of the most distressing details of the client's trauma. At the start of treatment, the client has not yet developed a healthy trust in the Clinician and the Clinician does not yet know if the client is stable enough to tolerate revisiting these details (see *Safety in the Therapy*, below).
- Using a collaborative approach to set treatment goals.
- Asking the client for their perspective about how early sessions are going. This can increase the client's trust that the Clinician is attuned to their unique needs and feelings about the process.
- Offering the client choices when possible (e.g., appointment times, therapy interventions) to increase feelings of control and balance power.
- Providing psychoeducation to normalize trauma responses (Appendix 2) and the need for mental health care.
- Communicating recognition of the client's culture, identity, history, and community, as well as differences between the client and Clinician.
- It can also be helpful to educate about the "culture of therapy" including weekly attendance. This is a culturally sensitive intervention in recognition of the fact that

many people experience stigma in regards to mental healthcare or may not understand the way therapy works.

### **Use a Culturally-Sensitive Trauma-Informed Approach**

The TRC Clinician is attuned to the client's identity and history as well as beliefs about psychotherapy that may impact treatment engagement. For some clients, there may be an unspoken assumption that one goes to appointments only when feeling very bad or sick. In this case, the Clinician should briefly provide education about the expectation of weekly appointments in order to have an effective "dose" of treatment, as well as highlighting the importance of making therapy a priority for their recovery. Stigma about having a mental health issue, about being a victim, about receiving mental health services, or about taking psychotropic medication are culturally-mediated beliefs that should be recognized and addressed early in treatment. Psychoeducation that normalizes traumatic stress reactions can be helpful, as can reframing a client's ability to acknowledge vulnerabilities and accept help as a strength.

The TRC Clinician must be sensitive to a wide variety of human diversity issues in order to work meaningfully with clients in their trauma recovery. For example, gender, sexual orientation, and gender presentation can be intimately linked to trauma history and recovery. A disproportionate percentage of transgender individuals experience violence and discrimination. Among American Indians, the cumulative effects of historical injustices coexist with individual victimization. Likewise, among black Americans, intergenerational trauma stemming from slavery and ongoing/institutionalized racism can be intertwined with the effects of current community violence and crime victimization. The trauma histories of these and other clients may be very complex, and it is critical for providers to acknowledge that complexity in order to create a trusting therapeutic alliance.

### **Use Safety Interventions for the Therapy Itself**

Survivors of violence often presume they will have to talk about the details of their trauma—a very anxiety-arousing prospect for most. They are usually struggling with the desire to avoid any trauma reminders, and can feel triggered (the experience of psychological and/or physiological distress) when coming to the "trauma center." The Clinician addresses this early in the treatment by communicating that there is no *expectation* that clients must talk about the details of their trauma(s), and that there are many other ways therapy can help them recover (e.g., anxiety management skills, increasing safety, decreasing depression, improving sleep). Many clients wind up wanting to discuss their trauma, but this relieves them of the pressure to do so.

In order to help a client feel safe while talking about trauma-related topics, the TRC Clinician teaches the client how to communicate their level of emotional distress by use of a *subjective units of distress* (SUDS— see Appendix 3) rating or distress scale (Wolpe & Lazarus, 1973). The Clinician also monitors the client for any signs of emotional numbing or dissociation. If a client’s distress level rises to the point that they are flooded with painful memories, intense emotion or anxiety, or if they are dissociating (e.g., numbing or spacing out or “going away”), the SUDS rating gives them a way to communicate this to the Clinician. The Clinician will then help by teaching the client strategies for *grounding* (Najavits, 2002). Grounding is a key intervention that refocuses a client’s attention away from upsetting trauma-related thoughts to neutral and calming thoughts, often described as “changing the channel.” The Clinician and client assess SUDS levels before and after grounding to measure the effectiveness in reducing emotional distress or dissociation. The client can choose which of the three types of grounding they prefer to use and can increase the effectiveness by practicing outside the session as well.

The Clinician may choose to use 10-15 minutes at the end of each session to check distress levels, do grounding, and plan for self-care and skills use that evening and the rest of the week to aid clients with anticipating and managing difficult feelings in a healthy way.

### **Address Threats to Safety in the Client’s Environment and Behavior**

Acute trauma and crime victimization carry increased risk for a variety of safety concerns, including risk for revictimization by perpetrators or others around them, as well as risk due to severe psychiatric symptoms. The term *continuous traumatic stress* has been used for clients in ongoing traumatic and aversive environments such as domestic violence, community violence, homelessness, stalking, gang involvement, and human trafficking (Eagle & Kaminer, 2013). These clients have ongoing acute stress symptoms as well as chronic PTSD, because they are in *current danger*. In these cases the TRC Clinician focuses on helping the client reduce current threats to their safety and well-being by providing case management assistance (e.g., moving to a safe location, obtaining a restraining order, making a police report) and safety planning (Appendix 5, LEAP).

There may also be a risk of homicidal ideation (HI) towards a perpetrator after an assault or after the murder of family members. A client may have recurring thoughts of retribution, including harming or murdering the perpetrator. The client may say something like, "Since they’re not going to prosecute the shooter, I think about killing him. I can't seem to stop thinking about it. I've never been a violent person. I know these

are awful thoughts, but they keep coming back to me. Especially at night, I get all wound up and I can't sleep.” The TRC Clinician conducts a full HI risk assessment when indicated (Appendix 6) and considers whether higher intensity services or mandated reporting (Tarasoff) are warranted. If able to be managed on an outpatient basis, the Clinician assists the client by normalizing the thoughts (“It's natural to have these kinds of thoughts after a traumatic loss like the one you had”) and discussing strategies for dealing with them. These include helping clients to distinguish thoughts and urges from actions, and realizing that they do not have to act on the urges; considering negative consequences of acting on urges such as further harming family members or going to prison; helping the client express the positive intention or goal underlying the thoughts such as protection and the desire to be safe; and exploring alternative actions to attain such goals.

Suicidal ideation (SI) is quite common after trauma as well, with clients who have experienced repeated or severe traumas and substance use at significantly higher risk. Early and ongoing assessment and monitoring of SI and correlated safety planning are indicated as priorities in the treatment for such clients. The TRC Clinician may use the *Brief Risk Assessment Protocol* (BRAP, Appendix 7) to fully assess SI and the *Collaborative Assessment and Management of Suicidality* tools to help join with the suicidal client in uncovering their most distressing concerns, and give them hope in collaboratively developing a plan to address them (Jobes, 2012).

**IMMEDIATE SAFETY CHECKLIST.** If at any point in the therapy the Clinician becomes aware of any of the immediate safety issues specified in this checklist (Appendix 8), then risk management and safety become the focus of treatment. All of these are considered threats to environmental and bodily integrity and require the Clinician to address these safety issues immediately. Regularly review the client’s situation and determine if any of the following risks are present:

- In danger of harming self or others (SI, HI, self-injury, recklessness)
- In danger of being harmed by perpetrator(s)
- Acute community violence, domestic violence, unsafe living environment
- Untreated serious medical condition(s)
- Severe substance abuse/dependence
- Eating disorder with regular purging or severe restriction with Body Mass Index below 17
- Severe dissociation during which client loses awareness/memory for events
- Psychosis with command hallucinations; paranoid delusions

The Clinician and the team assess the degree of structure needed to ensure safety (e.g., day treatment for cutting or other self-harming behaviors, medical detoxification facility for alcohol withdrawal, psychiatric hospitalization for containment of suicidality), and also help to arrange safe housing/shelter. They also obtain restraining orders, arrange urgent medical care, or more intensive mental health care as needed. Safety planning for any ongoing or future danger to client or others is a part of the therapeutic process.

### **Address Risk Due to Problems with Regulation of Emotions and Impulses**

Clients who have longer-term histories of childhood and repeated interpersonal trauma will likely also manifest emotional dysregulation symptoms of Complex PTSD (CPTSD) or Borderline Personality Disorder (BPD). Emotional dysregulation is the inability to flexibly respond to and manage emotional reactions in a safe or healthy way, and it can result in increased risk of re-victimization and self-harm. The Clinician provides case management interventions to address dangerous environments and people as described above, and focuses therapeutic interventions on client emotions, reactions, and behaviors which place them at risk.

**Capacity to Handle Emotions.** The TRC Clinician does an early assessment of the client's most troubling feelings and their capacities for coping with them (Saakvitne, Gamble, Pearlman, & Lev, 2000). When faced with strong feelings, does the client:

- Rarely or never express them?
- Become unsafe with self or others/lose control?
- Dissociate (space out, lose connection with self)?
- Lose touch with external reality—become delusional, hallucinate?
- Isolate, become depressed, lethargic?
- Use alcohol or other substances?
- Engage in other excessive or addictive behaviors?

A critical element in the treatment of acute crime survivors and chronically traumatized clients is to help them find words for emotional states. Naming feelings gives a sense of control and mastery over what has had to be avoided or seemed unknowable. Increasing a client's insight by connecting events to feelings also increases their sense of control. The client can learn to see the TRC Clinician as a support— providing strength, understanding, and companionship in times of pain. The Clinician's tools for this work may include face/feeling charts and emotion words handouts.

The TRC Clinician selects from several evidence-based approaches to address risk behaviors related to impulsivity and emotion dysregulation depending on the specific types of behavior and the client's stage of readiness for addressing the behaviors.

**DIALECTICAL BEHAVIOR THERAPY (DBT).** For clients whose trauma adaptations have interfered with emotion regulation and interpersonal relating, methods drawn from DBT can be very helpful (Linehan, 1993). DBT provides specific instruction in skills for emotional modulation, self-soothing, and assertiveness, including psychoeducation and tools for managing overwhelming emotions. For example, clients can be told “Intense emotions may come and go in waves, and like the seemingly overpowering ocean wave, will recede and pass.” The Clinician can ask the client to recall times they felt overwhelming emotional distress in the past, and how it passed with time. Clients with longstanding trauma histories in addition to acute crime victimization often benefit from focusing on these skills for the duration of their 16 treatment sessions.

**SKILLS TRAINING IN AFFECTIVE AND INTERPERSONAL REGULATION (STAIR).** This is a manualized brief skills approach that the Clinician can use to provide emotion regulation skills to clients and to address problematic relationship patterns (Cloitre, Cohen, & Koenen, 2011). It was originally created as a two-phase, 16 session, individual therapy protocol: Phase 1: Emotional and interpersonal regulation skill building; and Phase 2: Narrative Therapy. It was developed for adults who are dysregulated because of complex childhood trauma histories and is now being implemented with single-trauma populations as well. STAIR was also recently adapted as a 12-session group treatment. Utilizing STAIR in this fashion can help restore clients' sense of safety and stabilization before shifting into more trauma-focused treatment. STAIR is an alternative to DBT that is less time intensive and can be a good fit for briefer treatment.

### **Integrate Substance Abuse Treatment with Trauma-Focused Therapy**

Trauma survivors often have substance use problems, and one of the Clinician's important roles is to help clients address them. Referrals to substance abuse agencies, such as detox and residential treatment, can augment the Clinician's interventions but not replace them. Integrated treatment is needed because PTSD symptoms can trigger substance use and the use of substances increases the risk that clients will be exposed to further traumatic experiences, creating a vicious cycle. However, abstinence from substances can increase PTSD symptoms. This puts the client in a double bind. When trauma survivors have substance use problems, the Clinician is faced with the challenge of finding a non-shaming way to address this in therapy.

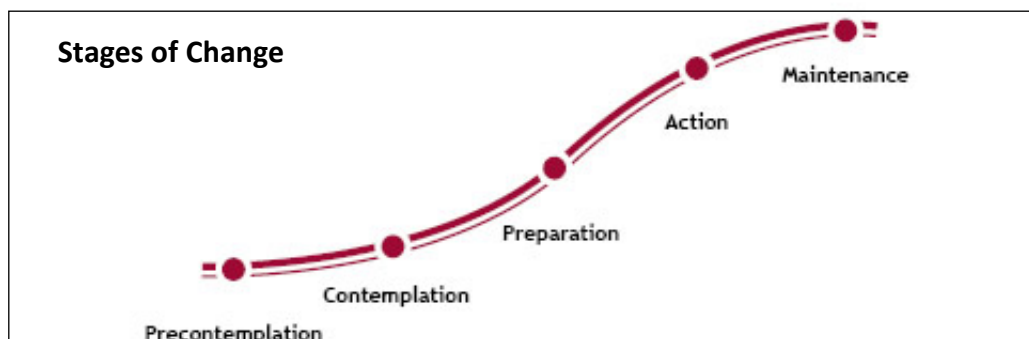


TRC incorporates a harm reduction approach to substance use, as it is unrealistic to require total abstinence from clients who are caught in this bind (Marlatt, Larimer, & Witkiewitz, 2011). It is helpful to begin the conversation about substance use at the start of therapy when educating clients about common reactions to trauma, which includes substance use. Normalizing the desire to use alcohol and/or drugs after a terrible experience helps reduce shame, gently cautions about the use of substances to self-medicate symptoms, and brings up the idea of the need to re-think use of substances in order to avoid additional problems.

There are a number of ways to address substance abuse during the trauma recovery process. Effective management requires individualized, sequential assessment and planning. Treatment is dynamically adapted over time based on an individual's changing course and treatment readiness.

**SEEKING SAFETY.** This is a Cognitive Behavioral Therapy (CBT)-based manualized treatment for co-occurring substance abuse and PTSD, specifically developed for those in the early stages of readiness to acknowledge or address the problem. It has been widely used and its efficacy established in several randomized clinical trials (Najavits, 2002). The psychoeducation piece alone has great value in decreasing shame, and an emphasis on increasing safe coping skills empowers clients to make safer choices without requiring abstinence to participate. Seeking Safety has a positive psychology slant that addresses the demoralization inherent in both disorders and evokes humanistic themes with the goal of restoring a client's belief in the potential for a better future. For example, the title of each session is framed as a value or ideal such as honesty or authenticity. Seeking Safety can be used in individual therapy as well as in group settings.

**MOTIVATIONAL INTERVIEWING (MI).** This is a key intervention in TRC treatment to facilitate client movement toward commitment to change risk behaviors, especially when they are not motivated or hardly motivated to change (Miller & Rollnick, 2012). MI is generally applied in combination with the transtheoretical model of change (Prochaska & DiClemente, 1982). From this perspective, an unmotivated client is seen as being in the precontemplative stage of change as represented in the figure:



In working with substance abuse as well as other risk behaviors (e.g., ongoing involvement with a violent partner, sex work), the TRC Clinician responds with strategies that meet the client at their stage of readiness for change. The spirit of MI is based on three elements, including: collaboration between client and Clinician, drawing out the client's ideas about change, and emphasizing the autonomy of the client.

For substance-abusing clients who are already in the stages of preparation or action, the Clinician provides chemical dependency counseling (e.g. the American Society of Addiction Medicine's chemical dependency treatment model, Perkinson, 2011) and/or provides case management for residential rehabilitation or detoxification facility arrangements, depending on client needs.

### **Stabilize Emotional and Symptomatic Distress by Regulating Biological Rhythms**

In early treatment, the Clinician provides information about the importance of self care in coping with trauma. Trauma can destabilize people emotionally, physically, interpersonally, and cognitively (i.e., thinking). It can throw people off balance in many ways. Clients can also become numb or disconnected from themselves after trauma. They do not notice how their lack of self care impacts their physical and emotional well-being. After trauma, people need not just good self care, but radical self care because it helps rebuild their foundation for emotion regulation. The Clinician collaborates with the client to consider the different areas of self care and assess which ones they are already on top of, and which could use some work).

**Address Insomnia.** Sleep is a priority because insomnia is prominent after trauma and exacerbates PTSD symptoms if left untreated. Insomnia can lead to problems with attention and concentration, increase irritability, and interfere with activities that require sustained effort. The TRC Clinician introduces Sleep Hygiene, offers an evaluation with the psychiatrist for sleep medications early on if indicated, and provides CBT for insomnia (DeViva & Capehart, 2015).

The Clinician assesses and helps create a self care plan if needed for other domains including:

- Getting care for any illness
- Taking medications as prescribed
- Eating three balanced meals and two snacks daily
- Staying hydrated

- Limiting caffeine and substances
- Structuring daily routines
- Delegating tasks
- Getting some physical activity
- Self-soothing

## **Prioritize Anxiety and Other Severe Symptoms**

Heightened anxiety and physiological distress at reminders of trauma are hallmark PTSD symptoms. Survivors become sensitized to react to even milder problems and can feel overwhelmed by daily living tasks, such as shopping at the grocery store or caring for children. Symptoms often rise to the level of anxiety attacks or panic attacks, and the TRC Clinician prioritizes these symptoms in treatment. The Clinician provides psychoeducation to normalize the anxiety attacks as the “fight or flight” response after trauma and explains that these symptoms are normal survival responses and are not actually dangerous, although they are unpleasant to experience. For example, the Clinician can explain, “After trauma certain things may trigger strong, upsetting, ‘false alarm’ reactions in the body, as though the trauma or danger is occurring in the present. But the danger is over now and is in the past.” If panic attacks continue to occur, the Clinician considers a psychiatric medication referral early on in treatment, and provides CBT for panic attacks (Craske & Barlow, 2006). The Clinician incorporates other acute distress management interventions including grounding, calming breath, progressive muscle relaxation, and mild physical activity such as walking and yoga. The Clinician also monitors depressive symptoms and introduces additional CBT interventions for depression as needed.

## **Caution about Debriefing**

Prior to 2002, psychological debriefing, also termed critical incident stress debriefing (CISD) was the customary and most widely used early intervention after trauma (Litz, Gray, Bryant, & Adler, 2002). Group or individual, single-session intervention components included education about trauma, recounting of the recent traumatic event, and encouragement of emotional expression about trauma-related experiences. The idea was that if those who had been exposed to a traumatic event were debriefed, it would reduce the likelihood of PTSD. However, debriefing is no longer recommended, as evidence indicates that it is not effective and may possibly cause harm (Forneris et al., 2013).

## **Stage Two Interventions for Processing Trauma and Loss: Remembrance and Mourning**

A large percentage of survivors will complete their TRC therapy without moving beyond Stage One interventions. This is still a successful treatment because safety and stabilization are increased. However, when a client has attained basic safety and stabilization and can approach the trauma and loss, or their beliefs about them, there are additional benefits to including Stage Two interventions.

### **Consider Whether Stage Two Interventions are Indicated**

Although there is no one clear indicator of readiness, considerations about whether or not to move to Stage Two interventions include:

- That the client is no longer in unsafe situations such as domestic violence, sex work, or severe substance use
- Has some ability to self-care and self-soothe
- Does not have active suicidal ideation, disabling anxiety or high-risk self-harm
- Does not currently meet full criteria for anorexia, bulimia or a primary psychotic disorder
- Does not have continuing exposure to traumatic stress such as chronic community violence or stalking
- Does not have severe ongoing major psychosocial stressors such as serious medical illness (e.g. cancer), or persistent severe pain

An assumption underlying most trauma processing therapies is that the trauma is in the past and is no longer occurring. After assessing these considerations, the Clinician can consider Stage Two processing to target intrusive re-experiencing symptoms, or when subsequent avoidance keeps a client functionally impaired.

### **Potential Risks and Benefits of Trauma Processing**

Trauma processing does not necessarily require revisiting the actual details of the trauma itself. It may include exploration and integration of actual traumatic memories, and/or it may focus on discussion of changes in beliefs due to the trauma, and/or it may include a grieving process in which losses incurred as a result of the trauma are identified and experienced.

The TRC Clinician can discuss these alternatives with the client, as well as reasons to undertake trauma processing. These types of interventions can help:

- “Cognitively metabolize” the trauma memories through repeated verbal mediation (talking). This changes the way memories are experienced, from being highly emotionally charged to more calmly recalled memories. This stops alarm reactions to memories and triggers because they lose their power to reactivate the fight-or-flight response.
- Decrease nightmares, intrusive memories, flashbacks, distress at reminders—with less need to avoid reminders. Clients are able to move out of the cycle of avoidance and intrusive memories that is emblematic of PTSD.
- Uncover and shift assumptions and beliefs that generate emotional distress, for example, “The world is a dangerous place,” “It’s my fault that someone did this to me,” or other common thinking distortions that develop after trauma.
- Increase empowerment/mastery of experience. Clients can feel more in control of their experience by deciding to address it in therapy. This changes their self-view from incompetent and weak to competent and strong.
- Decrease anxiety and increase self-confidence. This can help clients who are participating in a criminal trial and can also be an important step toward achieving a sense of post-traumatic growth.

### **How does the TRC Clinician make the decision about Stage Two processing for a given client?**

Consider Briere’s concept of the “therapeutic window” which refers to a psychological midpoint between inadequate and overwhelming activation of trauma-related emotion during therapy (Briere & Scott, 2014). When a Clinician undershoots this window, they consistently avoid discussion of trauma memories, and instead focus primarily on supporting and validating a client who could actually tolerate greater processing. Many Clinicians make the mistake of colluding with the client’s avoidance of the trauma material.

On the other end, a Clinician may inadvertently allow too much trauma memory exposure relative to the client’s existing affect regulation and ability to cope with emotional distress. Additionally, some clients insist on plunging headlong into details of trauma, with the idea of “ripping off the band aid” and a fantasy of a violent cathartic cure which will get rid of the trauma. In either case a client may dissociate, be flooded with trauma memories, or feel anxious or panicky. When the client becomes too upset to deal

constructively with the material, the Clinician needs to back off, slow down, do grounding, and establish a more appropriate pace. Judith Herman's metaphor (1997) that compares recovery to a marathon where clients need to prepare, pace themselves, and train in order to build stamina is useful here. When a Clinician helps the client titrate exposure to the trauma material, emotional activation does not exceed the client's coping capacities, which allows the client to process trauma memories without needing to shut down or becoming re-traumatized.

## Overview of Trauma Processing Approaches

What are the empirically supported approaches for processing trauma? In reviewing this research it is important to keep in mind that the majority of data is for those approaches that are more easily studied experimentally. Additionally, the population characteristics in most of these studies are often very different from those of diverse, urban communities with high rates of polyvictimization. Given these caveats, meta analyses and reviews of randomized clinical trials (RCTs) indicate that prolonged exposure therapy (PE), cognitive therapy, including Cognitive Processing Therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR) are very helpful in reducing PTSD symptoms. Repeated therapeutic exposure to the trauma memory and/or to situations avoided since the trauma, as well as cognitive restructuring and EMDR, were found to lead to markedly greater reductions in PTSD than no treatment, waitlist, and supportive counseling which is often the "treatment as usual." There were no substantial differences among types of CBT, whether exposure, cognitive, a blend of the two, or EMDR (Pole, Fields, & D'Andrea, 2016). When the exposure and cognitive processing components of CPT were dismantled and tested separately and together, the combination was not superior to the individual components.

For Complex PTSD (CPTSD), moderate to large effect sizes were noted for PTSD and emotional and interpersonal regulation outcomes for skills-based DBT and STAIR treatments. CPTSD treatments that included both skills and trauma memory processing were superior to skills-only treatments.

The TRC Clinician simultaneously considers the evidence from the clinical trials and aspects of their clients' lives to make decisions about which *type* of trauma processing will be best for a given client. Considerations include:

- Whether there is history of long-term, childhood, or repeated victimization
- Comorbidity of other psychological disorders

- Cultural considerations (e.g., overt discussion of sexual trauma by unmarried Islamic women; touching on vulnerable feelings of victimization for Latino males)
- Whether the client has memory of the trauma itself
- Coping and affect regulation capacities
- Client preference and choice

Given all of the above considerations, TRC clinicians often find the greatest overall benefit with the least risk in selecting Stage Two approaches that are oriented toward cognitive changes and skill building, and/or that emphasize a supportive, titrated processing of trauma memories. These include Cognitive Processing Therapy (CPT) (Resick & Schnicke, 1993), Stress Inoculation Training (SIT) (Meichenbaum, 1985), Narrative Storytelling (NST) which is the second stage of the STAIR skills approach for Complex PTSD (Cloitre et al., 2011), and Briere's Self-Trauma model (2014).

**COGNITIVE PROCESSING THERAPY.** This is a comprehensive approach that uses a written impact statement to identify and challenge mistaken beliefs that are causing distressing emotions for clients after victimization (Resick & Schnicke, 1993). Trauma survivors with PTSD tend to exhibit specific cognitive distortions and CPT addresses these. They neglect or forget key facts, for example, that during the trauma they were in a fight-or-flight state and did not have the same capacities available to them that they do now in looking back at it. They are unaware of these errors but have intense emotional pain as a result of them. They avoid thinking about or talking about trauma because their distress is compounded by these errors. Avoidance prevents access to corrective information. The TRC Clinician decides whether to include the additional component of writing about the trauma details. This is followed by a sequential presentation of five domains of beliefs affected by trauma: safety, trust, power, esteem, and intimacy, for further focused processing of beliefs in those domains.

**NARRATIVE STORY TELLING** is framed as “revisiting” the traumatic memories to put the trauma in perspective as an experience that is part of an evolving life story (Cloitre et al., 2011). It includes calm breathing, the use of SUDS ratings to monitor distress, and emotion regulation skills applied to the processing itself. In collaboration with the client, the Clinician constructs a memory hierarchy of a small number of traumatic memories without much detail and assigns a SUDS rating to each, with a focus on those that are most disturbing and disruptive in the client's current life. The Clinician reminds the client that they have many more coping resources now than they did in the past, and helps the client to revisit memories of the past while incorporating the strengths and resources of the present. The Clinician also reminds the client that they will not be going through it



alone. Together the client and Clinician discuss beliefs about self and others that are identified while revisiting the memories explicitly seeking to uncover, process, and transform narratives of fear, shame, and loss into more positive and self-affirming beliefs.

**BRIERE'S SELF-TRAUMA MODEL** provides a helpful clinical framework for reprocessing work. It offers guidance to help Clinicians manipulate the intensity of trauma processing so that it remains within a therapeutic window that does not retraumatize (Briere and Scott, 2014). This model gives the Clinician tools to regulate the intensity during sessions in several ways. Intensity can be increased by asking for specific trauma details, emotional reactions, or sensory details (e.g. auditory, visual, etc. memories of the event) or what happened to their body. To decrease the intensity when distress or dissociation increase too much, Briere suggests asking content questions not specifically related to trauma (e.g., “How old were you at that time?”); using a soothing voice tone to calm; suggesting the client stop talking about the trauma and ground them in the present; rephrasing what the client has just said; getting the client to open their eyes and describe the current setting; using relaxation and breathing techniques in session; and asking the client to talk about neutral events in the present not related to the trauma.

**CULTURALLY ADAPTED TRAUMA-SPECIFIC THERAPY.** Culturally adapted treatment refers to the modification of psychotherapy to better match the preferences of culturally diverse clientele (Pole, Fields & D’Andrea, 2016). Understanding a client’s culture is enhanced by adopting a stance of cultural humility (Tervalon & Murray-Garcia, 1998). The TRC Clinician makes every effort to culturally adapt the therapy by incorporating cultural values and traditional healing practices; respectfully considering race, ethnicity, and language preference; and increasing accessibility by providing services nearer to clients’ communities. Culture-specific treatment and treatment provided in clients’ native language have been shown to be much more effective. An important predictor of positive outcome is respecting, accepting, and incorporating the client’s illness explanation into the treatment plan, which highlights the importance of attending to culture-bound syndromes and conceptualization of post-trauma experiences. Culturally Adapted CBT has been developed for PTSD (CA-CBT) (Hinton, Rivera, Hofmann, Barlow, & Otto, 2012). This approach addresses challenges in applying evidence-based trauma treatments to some immigrant populations by including culturally relevant references such as Christian symbols when working with Catholic Latinos and Buddhist imagery when working with Southeast Asians. It addresses limitations in English language skills, education, and familiarity with mental health concepts; and makes adaptations for culture-specific idioms of distress and difficulty tolerating exposure therapy techniques.

**GRIEVING THE LOSSES INHERENT IN TRAUMA.** General processing of grief for losses incurred due to the trauma, including recognition of the traumatized self, is considered a

more routine aspect of this stage for a majority of clients. Trauma usually involves loss of some sort. The losses are different for each person but may include:

- Loss of a sense of safety and security in the world
- Loss of a healthy sense of invulnerability and entitlement
- Loss of easy connectedness with others
- Actual loss of other people through death or sudden ending
- Loss of physical integrity from injury or related health issues
- Loss of easy comfort in one's own skin
- Loss of self-esteem, identity
- Loss of future plans, meaning or purpose in life

The TRC Clinician is attuned to the client's expressions of loss and grief and helps name them, and also provides psychoeducation about the grieving process: "Grief or mourning is a natural emotional reaction to a significant loss. The words sorrow and heartache are often used to describe feelings of grief. Grieving is the process of emotional and life adjustment after a loss" (see Appendix 8 for client handout).

**BENEFITS OF GRIEVING.** Although there is no doubt that grieving is painful, it has its benefits:

- Giving voice to underlying feelings about loss can be very relieving, and can free up life energy as well as positive feelings that have been numbed
- Acknowledging the loss or what one has endured can be a way to move into compassion for the traumatized self and away from self-blame, shame, or anger
- Acknowledging loss provides direction in finding ways to fill now unmet needs such as purpose or relationships
- Grief is a way to show how much you care for yourself

#### **GUIDELINES FOR GRIEVING.**

It is OK to cry; to be sad; to mourn. We are built for it. Tears serve a purpose.  
Why should we not honor our grief as we do our joy and happiness?

Over time the trauma and loss can be mastered by putting the feelings and experiences into words shared with a caring other.

There is no "normal and expected" period of time for grieving.

A wide range of feelings and symptoms are common during grieving. While one may feel shock, numbness, sadness, anger, guilt, anxiety, or fear, there may also be moments of relief, peace, or happiness.

Although grieving is not simply sadness, "the blues," or depression, some may become depressed or anxious during the grieving process.

Sometimes when we grieve, the anger fades.

Find a safe place or someone safe to be able to express the sadness.

Each person is unique in the way they grieve—it is not one size fits all.

Balance the grief with taking a break, finding humor, or being active.

Have faith that there is an end to it.

### **Traumatic Loss: Homicide**

When the trauma is the violent death of a family member or loved one, grief can take on additional layers of complexity and severity. Stage One interventions focus on provision of support during criminal judicial proceedings, burial and memorial services, and handling financial matters, as well as the prioritization of self care, as survivors may be destabilized, numb, or in shock for quite some time. In addition, the TRC Clinician also considers incorporating Stage Two interventions that have been specifically developed for traumatic loss and complicated grief such as “restorative retelling” which involves commemorating the living memory of the deceased as well as discussing the most distressing thoughts and memories associated with the death (Rynearson, Favell, & Saindon, 2002). The Clinician includes positive as well as negative memories of the deceased, cognitive restructuring to address thinking errors, goal setting, and pleasant event planning as well. Such treatments have been found to be efficacious in reducing psychological symptoms (Simon, 2013). Ongoing support is especially important for this client group because of the loss of relationship and length of recovery time, and a special support group for this client subgroup is discussed below in Stage Three treatment.

### **Stage Three Interventions: Restoring Connection and Ending Treatment**

The third stage of therapy focuses on building or restoring connection between survivors, their recovering selves, and their communities through increasing engagement in

meaningful activities and relationships. The goal is to create new and positive directions for the future. At this point the client is fairly stable and has established environmental and behavioral safety. Treatment has addressed distressing beliefs that developed as a result of the trauma, and/or traumatic memories have been integrated and resolved, and/or related losses incurred have been recognized and grieved. At this stage, the survivor benefits by connecting with self and others in a way that moves beyond the conceptualization of a “victim” to become an active participant in life, and to gain or regain meaning and purpose. After coming to terms with the trauma in these ways, the survivor can reconnect to stronger aspects of the self, and becomes ready to engage more actively in the world. Many survivors naturally begin to move in this direction.

Interventions to assist this process include encouraging the client to connect with safe and positive others, and to explore what is meaningful to the self. Clients may need assertiveness skills, CBT for agoraphobia (if phobic about going out, consider desensitization through imaginal or in-vivo exposure) or activities scheduling interventions to help get them started with social reconnection.

### **Address Avoidance and Fears in Activating and Reconnecting**

Recovery is not always a perfectly linear process, and avoidance and fears may still be present or may re-emerge and interfere with the process of restoring connection. The Clinician monitors avoidance, helps clients face underlying fears, and when triggers reappear, helps the client work through them so they can continue on the path toward a better life. The Clinician implements Stress Inoculation Training (SIT) interventions or other CBT imaginal coping and in-vivo exposure practices, as well as activities scheduling, in order to increase the client’s ability to engage in activities that may be anxiety-provoking but will improve their lives (Meichenbaum, 1985).

**STRESS INOCULATION TRAINING (SIT.)** Is another treatment that has been shown to be efficacious (Pole et al., 2016) in treating PTSD. It differentiates aspects of trauma and trauma reactions that are changeable and those that cannot change, so that coping efforts can be adjusted accordingly (Meichenbaum, 1985). Acceptance-based coping is appropriate for aspects of situations that cannot be altered, while more active interventions are appropriate for more changeable stressors. It includes a menu of emotion regulation, relaxation, cognitive appraisal, problem-solving, communication and socialization skills. There is an emphasis on practice of coping skills using simulation methods to increase the realism of coping practice (e.g., visualization exercises, imaginal practice (i.e., practicing in imagination first); modeling and vicarious learning; role playing of feared or stressful situations). Simple repetitious behavioral practice of coping routines is encouraged until they become over-learned and easy to carry out. Clinicians

especially use this approach when the client has been avoiding places or activities that they would like to be comfortable visiting or doing due to the trauma.

Simple repetitious behavioral practice of coping routines is encouraged until they become over-learned and easy to carry out. Clinicians especially use this approach when the client has been avoiding places or activities that they would like to be comfortable visiting or doing due to the trauma.

## **Facilitating Posttraumatic Growth**

In discovering what is meaningful, clients may take on a “survivor mission” and may find benefit in taking social action. The TRC Clinician facilitates this process by detecting and attending to the subtle beginnings of these experiences in earlier recovery, and highlights or even celebrates when the client feels celebratory about them. The TRC speakers bureau CHATT (Communities Healing and Transforming Trauma) was created to support this process (see chapter on TRC Speakers Bureau). Other clients may take on roles such as youth mentor or peer counselor. As survivors venture forth, establish an agenda for their lives, return to work or obtain vocational training, and discover aspirations, they accumulate restitutive, gratifying emotional experiences that contribute to reparation of past injuries to the self. This posttraumatic growth enables clients to (re)connect with their empowered selves, (re)establish social connections, and (re)gain a sense of interpersonal efficacy.

## **TRC Group Therapy**

TRC utilizes group therapy as a tool to facilitate reconnection as well as to impart skills. Many survivors benefit greatly by coming out of isolation and by finding meaningful new roles for themselves there. Outside support groups or religious communities may also be of benefit. TRC Clinicians provide specific shorter-term, structured therapy groups which include psychoeducation and skills. Seeking Safety groups and Surviving to Thriving: Allies in Recovery from DFSA (STAR-D) (Fields, Stein, Smith, Richer, & Shumway, 2011) groups for sexual assault have been found to be beneficial and popular among clients. Ongoing meetings of Family Members of Homicide Victims support groups have also been well received due to the tremendous impact of this type of loss, the length of recovery, and the importance of building new connections with others.

## **Ending the Therapy: Progress Review, Relapse Prevention, and Loss Revisited**

At the end of the therapy, a collaborative review of progress toward goals, accomplishments in the work, and areas for the client to continue to work on can be very important. Relapse prevention that addresses past risk behaviors and trauma-related symptoms is a key Stage Three intervention. Together with the client, the Clinician identifies when and where the symptoms or behaviors may be triggered in the future (e.g., anniversary dates of traumas, settings where substances were used). Then, they make a plan to permit difficult feelings to happen at that future time, while simultaneously planning for safe coping that addresses the reactions in a healthy way. In this manner, the work of the therapy continues on after the treatment ends. The ending of the therapy relationship may engender current feelings of loss, and may re-trigger past losses as well. The Clinician addresses the impact of this ending, and also facilitates an opportunity for a healthy ending that allows direct expression of sadness, anger, gratitude, love, relief, or other responses, in addition to a mutual celebration of accomplishments and recovery.

## References

- Briere, J. N., & Scott, C. (2014). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Sage Publications.
- Cloitre, M., Cohen, L. R., & Koenen, K. C. (2011). Treating survivors of childhood abuse: Psychotherapy for the interrupted life. Guilford Press.
- Cloitre, M., Courtois, C.A., Ford, J.D., Green, B.L., Alexander, P., Briere, J., Herman, J.L., Lanius, R., Stolbach, B.C., Spinazzola, J., Van der Kolk, B.A., Van der Hart, O. (2012). The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults. Retrieved from [http:// www.istss.org/](http://www.istss.org/)
- Craske, M. G., & Barlow, D. H. (2006). *Mastery of your anxiety and panic: Therapist guide*. Oxford University Press.
- DeViva, J. C., & Capehart, B. (2015). PTSD and insomnia. *A practical guide to PTSD treatment: Pharmacological and psychotherapeutic approaches*. (pp. 119-133) American Psychological Association, Washington, DC.
- Eagle, G., & Kaminer, D. (2013). Continuous traumatic stress: Expanding the lexicon of traumatic stress. *Peace and Conflict: Journal of Peace Psychology*, 19(2), 85.
- Fields L., Stein R., Smith G., Richer L., Shumway M. (2011). Developing a brief manualized therapy for victims of drug-facilitated sexual assault. Proceedings of the Annual Conference of the International Society for Traumatic Stress Studies: Baltimore MD.
- Forneris, C. A., Gartlehner, G., Brownley, K. A., Gaynes, B. N., Sonis, J., Coker-Schwimmer, E., ... & Lohr, K. N. (2013). Interventions to prevent post-traumatic stress disorder: A systematic review. *American Journal of Preventive Medicine*, 44(6), 635-650.
- Herman, J.L. (1997). *Trauma and Recovery*. New York: Basic Books
- Hinton, D. E., Rivera, E. I., Hofmann, S. G., Barlow, D. H., & Otto, M. W. (2012). Adapting CBT for traumatized refugees and ethnic minority patients: Examples from culturally adapted CBT (CA-CBT). *Transcultural psychiatry*, 49(2), 340-365.



Jobes, D. A. (2012). The Collaborative Assessment and Management of Suicidality (CAMS): An evolving evidence- based clinical approach to suicidal risk. *Suicide and Life-Threatening Behavior*, 42(6), 640-653.

Linehan, M. M. (1993). Skills training manual for treating borderline personality disorder. Guilford Press.

Litz, B.T., Gray, M.J., Bryant, R.A., & Adler, A.B. (2002). Early intervention for trauma: Current status and future directions. *Clinical Psychology: Science and Practice*, 9, 112–134.

Marlatt, G. A., Larimer, M. E., & Witkiewitz, K. (Eds.). (2011). Harm reduction: Pragmatic strategies for managing high-risk behaviors. Guilford Press.

Meichenbaum, D. (1985). Stress inoculation training. Elmsford, New York: Pergamon Press.

Miller, W. R., & Rollnick, S. (2012). Motivational interviewing: Helping people change. Guilford Press.

Najavits, L. M. (2002). Seeking safety: A treatment manual for PTSD and substance abuse. Guilford Press.

Norcross, J. C. (Ed.). (2011). *Psychotherapy relationships that work: Evidence-based responsiveness*. Oxford University Press.

Perkinson, R. R. (2011). Chemical dependency counseling: A practical guide. Sage.

Pole, N., Fields, L., & D'Andrea, W. (2016). Stress and trauma disorders. In J.C. Norcross & D. Freedheim (Eds.), *APA handbook of clinical psychology, Vol IV: Psychopathology and health*. Washington, DC: American Psychological Association.

Prochaska, J. and DiClemente, C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research, and Practice* 19:276-288.

Radmacher, M. (2009). *Courage doesn't always roar*. San Francisco: Conari Press.

Resick, P. A., & Schnicke, M. K. (1993). Cognitive processing therapy for sexual assault victims: A treatment manual. Newbury Park CA: Sage Publications.

Rynearson, E. K., Favell, J., & Saindon, C. (2002). Group intervention for bereavement after violent death. *Psychiatric Services*, 53(10), 1340-1340.

Saakvitne, K. W., Gamble, S., Pearlman, L. A., & Lev, B. T. (2000). *Risking connection: A training curriculum for working with survivors of childhood abuse*. The Sidran Press.

Sackett, D. L., Richardson, W. S., Rosenberg, W., & Haynes, R. B. (2000). Evidence-based medicine: how to practice and teach. *EBM. Second Edition*. Churchill Livingstone: Edinburgh.

Simon, N. M. (2013). Treating Complicated Grief. *JAMA*, 310(4), 416-423.

Tervalon, M. & Murray-García, J. "Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education." *Journal of Health Care for the Poor and Underserved* 9.2 (1998): 117-125.

Wolpe, J., & Lazarus, A. A. (1973). *Behavior therapy techniques: A guide to the treatment of neuroses*. Pergamon.

#### Additional Resources

<http://www.leapsf.org/html/index.shtml>

[http://www.mirecc.va.gov/VISN16/docs/Sleep\\_Therapy\\_Group\\_Patient\\_Manual.pdf](http://www.mirecc.va.gov/VISN16/docs/Sleep_Therapy_Group_Patient_Manual.pdf)

[http://www.mirecc.va.gov/visn16/docs/Sleep\\_Therapy\\_Group\\_Therapist\\_Manual.pdf](http://www.mirecc.va.gov/visn16/docs/Sleep_Therapy_Group_Therapist_Manual.pdf)

<https://cpt.musc.edu/introduction>

[http://www.ptsd.va.gov/PTSD/ptsd\\_search.asp?SECT=2&QT=STAIR&RPP=20](http://www.ptsd.va.gov/PTSD/ptsd_search.asp?SECT=2&QT=STAIR&RPP=20)

## **Appendix 1 to Trauma-Informed Psychotherapy: TRC Clinical Model Overview**

Please see following page.

### TRC Clinical Model Overview

The following table shows how the TRC clinical model follows a 3-stage model of trauma treatment (Herman, 1992), with goals and guiding principles for each stage and typical treatment modalities/interventions used. The table is meant to be an overview of the clinical model rather the outline of a specific process, keeping in mind that recovery from trauma generally follows these stages, but is not always a linear progression. Also, because the TRC model is short-term, it is possible for some clients to remain in the Safety and Stabilization phase while having met their goals for the treatment episode. The Common Interventions column is not exhaustive, as some TRC Clinicians have expertise in additional treatment modalities (i.e. Narrative Therapy, Image Rehearsal Therapy, etc.). However, the interventions listed are commonly used by TRC Clinicians.

Treatment Stage	Goals	Guiding Principles	Common Interventions
Safety and Stabilization	<p>Symptom reduction and management</p> <p>Self-regulation of emotions and impulses</p>	<p>Harm Reduction re:</p> <ul style="list-style-type: none"> <li>• Substance abuse</li> <li>• Self-harming behaviors</li> <li>• Abusive or violent relationships</li> <li>• Anything that puts the client at risk of further victimization</li> </ul> <p>Strengths Perspective</p> <ul style="list-style-type: none"> <li>• Identification and growth of existing internal and external resources</li> <li>• Expanding options for positive coping</li> </ul> <p>Provision of a Restorative, Healing Experience</p> <ul style="list-style-type: none"> <li>• Build and strengthen the therapeutic and institutional alliances</li> <li>• Use these alliances to foster an experience of safety, caring, acceptance, trust, and healing</li> </ul>	<p>Outreach and assertive engagement</p> <p>Clinical case management and linkage to resources</p> <p>Psychoeducation</p> <p>Motivational Interviewing</p> <p>Cognitive Behavioral Therapy</p> <p>Skills Training in Affect and Interpersonal Regulation (STAIR)</p> <p>Crisis Intervention &amp; safety planning</p> <p>Relaxation training</p> <p>Grounding skills</p> <p>Mindfulness training</p> <p>Seeking Safety</p> <p>Dialectical Behavior Therapy</p>

<b>Treatment Stage</b>	<b>Goals</b>	<b>Guiding Principles</b>	<b>Common Interventions</b>
Remembrance and Mourning	<p>Reduction/resolution of any continuing intrusive symptoms</p> <p>Find meaning in the trauma experience</p>	<p>Integration of Traumatic Memories</p> <ul style="list-style-type: none"> <li>• Sufficient safety and stabilization will allow a client to tolerate and benefit from revisiting the trauma and its impact</li> <li>• Support client in grieving any losses (of a loved one, an aspect of their physical/mental functioning, an identity or role, a belief about the world, etc.)</li> <li>• Support client in reviewing the trauma experience</li> </ul>	<p>Continuation of Stage One Interventions as needed</p> <p>Cognitive Processing Therapy</p> <p>Prolonged Exposure Therapy</p>
Reconnection	<p>Reduce focus on trauma and relegate it to being only one aspect of a full life experience</p>	<p>Reconnection to or Development of a Healthy Self Identity</p> <p>Reconnection to or Development of Relationships with Safe Others, in areas of:</p> <ul style="list-style-type: none"> <li>• Romantic relationships</li> <li>• Family</li> <li>• Work</li> <li>• Education</li> <li>• Etc.</li> </ul> <p>Reconnection to or Development of Connection to Meaningful Activities</p>	<p>Continuation of Stage One Interventions as needed</p> <p>Supportive Psychotherapy</p>

## **Appendix 2 to Trauma-Informed Psychotherapy: Psychoeducation**

For a psychoeducation handout on normal responses to trauma, please see following page.

## **Normal Reactions to Trauma**

**EVERYONE** is affected when they experience traumatic stress:

- Traumatic events are so frightening or overwhelming that they would upset anyone - your mind and body are in shock
- After a trauma, almost everyone has some symptoms of post-traumatic stress.
- Different people may be affected in different ways.

**Traumatic stress reactions are NORMAL & not signs of danger or weakness:**

- People sometimes think it means they are going crazy, are mentally ill, are having a heart problem, or are weak.
- These are normal reactions to such an abnormal situation and although it may FEEL like that, it does **not** mean you are going crazy, are mentally ill, are having a heart problem, or weak.

**Traumatic stress reactions may affect the way you work and relate to others temporarily:**

- It may be harder to concentrate, remember, or get motivated
- You may be less patient or withdraw from family, friends, or coworkers
- You may have decreased sexual or loving feelings
- **DO NOT** add to the problem by beating yourself up - it is hard enough that you were traumatized - be gentle with yourself and know that these will pass with time.

**Traumatic stress reactions DO get better:**

- People may worry these feelings will never go away or will keep getting worse. Symptoms can pass with time and are also highly treatable.



### **Learning about the different reactions people can have:**

- One group of symptoms are the hyper-arousal symptoms in which a person's mind and body are keyed-up, tense & nervous.
- Another group includes the re-experiencing of the traumatic event such as trauma memories popping into your head, or nightmares. There may be a lot you don't remember, but you can feel distressed when things remind you of the trauma.
- A third group includes avoiding trauma reminders and/or feeling numb. In fact, this strong tendency after trauma to avoid anything that reminds them of the trauma, is a major reason people avoid coming to treatment.
- It is also normal for trauma to contribute to depression symptoms temporarily that often relate to feelings of shame, tendencies for self-blame, and beliefs about being responsible for what happened.
- Sometimes with early trauma and interpersonal violence, people can have symptoms of complex trauma that may include a rollercoaster of painful emotions, very low self-esteem, and difficulty trusting others.
- A common problem for people after trauma (and sometimes before) is to use alcohol or drugs to self-medicate bad feelings or anxiety. This is also one way people avoid trauma reminders. We do not judge anyone for this but rather have compassion for the pain involved.
- While it is common to use alcohol or drugs after trauma, treatment will help develop other more adaptive skills to feel better. Substance use can create additional problems or make symptoms worse in the long run.

**The main things to remember about all of these reactions is that they are normal reactions, are not dangerous, do not signify mental illness, are not shameful, & will improve with treatment.**

## **Appendix 3 to Trauma-Informed Psychotherapy: Subjective Units of Distress (SUDS)**

For a subjective units of distress handout, please see following page.

## **Subjective Units of Distress Scale (SUDS)**

100 = Highest level of anxiety, distress, or agitation. Overwhelmed or out of control.

90 = Extremely anxious or distressed; feeling that you are losing control.

80 = Very anxious or distressed. Bodily signs (increased heart rate, shaking, sweating, gastrointestinal distress) are present.

70 = Quite strong anxiety or distress. Bodily signs may be present.

60 = Somewhat strong anxiety or distress.

50 = Moderate anxiety or distress. Unpleasant feelings are still manageable with some effort.

40 = Mild-to-moderate anxiety or distress. Tolerable but unpleasant.

30 = Mild anxiety or distress that does not interfere with functioning.

20 = Minimal anxiety or distress.

10 = Feeling basically good; able to think and concentrate well.

0 = No anxiety or distress. Total relaxation.

## **Appendix 4 to Trauma-Informed Psychotherapy: Time Out for Calming Breath**

For a Calming Breath relaxation handout, please see following page.

# Time Out for Calming Breath

- One tool you can use that will bring distress down is calming breath.
- When we breathe out, it activates the relaxation part of our nervous system.
- There are many different types of relaxation breathing – the one we’re using here is just to focus on the out-breath rather than trying to breathe deeper or slower or from the belly.

## Guidelines:

- Follow the natural flow of the breath.
- The next time you breathe out, start to notice in your arms, legs, and lower body, there is a slight shift into a heavier feeling of relaxation there.
- Each time you breathe out, notice this feeling.
- You may want to experiment with slightly extending the outbreath to increase this effect.
- Be careful – you might end up having a relaxation attack...our brains and bodies are wired to feel relaxing pleasurable feelings naturally and without using substances.

## **Appendix 5 to Trauma-Informed Psychotherapy: LEAP Safety Planning Guide**

For LEAP Safety Planning Guide, please see following page.

# My Safety Plan

You deserve to be safe and happy.

Do not take this with you unless it is safe to do so.

## My Relationship and My Safety

Being in a relationship that is hurtful can cause a lot of different feelings. It is normal to have some or all of these feelings. Check all that you feel:

- |                                   |                                   |
|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Ashamed  | <input type="checkbox"/> Confused |
| <input type="checkbox"/> Hopeful  | <input type="checkbox"/> Sad      |
| <input type="checkbox"/> Afraid   | <input type="checkbox"/> Love     |
| <input type="checkbox"/> Angry    | <input type="checkbox"/> Numb     |
| <input type="checkbox"/> Hopeless | <input type="checkbox"/> Happy    |
| <input type="checkbox"/> Trapped  | <input type="checkbox"/> Alone    |

What do I think about my relationship?

- ☐ I'm not sure how I feel about this relationship.
- ☐ I think this relationship will get better.
- ☐ I want to end this relationship.

Many people love their partners and also feel that their relationships put them in danger. Does my relationship have any of these signs of danger?

- ☐ My partner has injured me badly enough that I needed medical treatment.
- ☐ My partner follows me everywhere I go.
- ☐ My partner has threatened to hurt my children.
- ☐ My partner uses alcohol or drugs.
- ☐ My partner has forced me to have sex when I didn't want to.
- ☐ My partner has threatened to kill me.
- ☐ My partner has threatened to kill himself/herself.
- ☐ My partner has a gun or can get a gun easily.

Other things my partner does that concern me:

---

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## Safety during a fight:

Move away from

- Weapons (guns and knives)
- Small and dangerous places  
(car, kitchen, bathroom)

Move toward a safer place such as

- Room with exit
- Room with phone
- Public place

If I need to call the police

- I will give them my address and tell them if there is a weapon.

The closest place I can go if I need help or need to leave:

Police/fire station: \_\_\_\_\_

Hospital/clinic: \_\_\_\_\_

Friend's/neighbor's/family member's house:

\_\_\_\_\_  
(name/address/phone number)

Other: \_\_\_\_\_

## Steps to staying safe:

Keep a little money with me.

Keep my cell phone charged and with me.

Teach my children to go to a safe place:














\_\_\_\_\_  
(friend's, neighbor's, relative's home)

Teach my children to call the police when there is danger and to give their full name, address, and phone number.

Keep an emergency bag ready in a safe place.

*Developed by LEAP. May be used unaltered without permission as long as you credit LEAP (Look to End Abuse Permanently),  
c/o Maxine Hall Health Center, 1301 Pierce St., San Francisco, CA 94115 [www.leapsof.org](http://www.leapsof.org).*

### Things to put in my emergency bag:

- |  |  |
|--|--|
| <input type="checkbox"/> Medications/<br>prescriptions  | <input type="checkbox"/> Money    |
| <input type="checkbox"/> Phone card/<br>change          | <input type="checkbox"/> Cell phone<br>and charger                      |
| <input type="checkbox"/> Extra keys                     | <input type="checkbox"/> Photo ID/<br>driver's<br>license               |
| <input type="checkbox"/> Bank card/<br>credit card      | <input type="checkbox"/> Restraining<br>order  |
| <input type="checkbox"/> Custody order   | <input type="checkbox"/> Passports/green<br>cards/immigration<br>papers  |
| <input type="checkbox"/> Work permits  | <input type="checkbox"/> Electronic Benefit<br>Transfer<br>(EBT) card  |
| <input type="checkbox"/> Photos of<br>abuser          | <input type="checkbox"/> Clothes                                      |
| <input type="checkbox"/> Address<br>book              | <input type="checkbox"/> Toiletries<br>and<br>diapers                 |
| <input type="checkbox"/> Special toys                 | <input type="checkbox"/> Other: _____<br>_____   |

If you have any proof of abuse, bring it with you.

### Building my independence:

I can start **saving money** and store it in a safe place (like my own bank account).

I can **get help** from a counselor, an advocate, a health care provider, or legal services.

I can try to **keep in touch** with a friend or family member who I trust.

### Important phone numbers:

Police 9-1-1

#### Local Domestic Violence Hotlines:

La Casa de Las Madres 1-877-503-1850

WOMAN, Inc. 415-864-4722

Local Sexual Assault Hotline 415-647-7273

For restraining order help call 415-255-0185

SF Suicide Prevention Hotline 415-781-0500

LGBT support (CUAV) 415-333-HELP

Bay Area Legal Aid 1-800-551-5554

National DV Hotline 1-800-799-SAFE

National Sexual Assault Hotline 1-800-656-HOPE

National Teen Abuse Hotline 1-866-331-9474

National Suicide Prevention Hotline 1-800-SUICIDE

### Help after sexual assault:

If my partner or anyone else has forced me to have sex when I did not want to, I can:

Go to **SFGH Emergency Department/Rape Treatment Center, 1001 Potrero Avenue**

Call the **Trauma Recovery Center** between 8:00- 5:00 Monday through Friday: **(415) 437-3000**

Call **SF Women Against Rape's 24 hour hotline: (415) 647-7273**

*Developed by LEAP. May be used unaltered without permission as long as you credit LEAP (Look to End Abuse Permanently), c/o Maxine Hall Health Center, 1301 Pierce St., San Francisco, CA 94115 [www.leapsof.org](http://www.leapsof.org). LEAP thanks San Francisco Kaiser Permanente and La Casa de las Madres for their contributions to this safety plan.*



## **Appendix 6 to Trauma-Informed Psychotherapy: Brief Risk Assessment Protocol Part Two: Homicidal Ideation**

For the *Brief Risk Assessment Protocol (BRAP) Part Two*, please see following page.

**Brief Risk Assessment Protocol (B-RAP)  
Part Two: Homicidal Ideation**

**Section A- Recent Homicidal Ideation**

**Any Recent Homicidal Ideation**

A1. Sometimes people feel very angry when they've had such difficult experiences. Have you found yourself thinking about hurting or wanting to kill someone in the last 6 months?

NO YES

If YES, continue. If NO, go to section B on page 2.

**Recency and Frequency of HI**

A2. When did you last have these thoughts? \_\_\_\_\_

A3. How often do you think about it? \_\_\_\_\_

**Active Homicidal Ideation**

A4. Have you been thinking of acting on these thoughts by doing something to hurt someone?

NO (passive) YES (active )

If YES, continue. If NO, go to section B on page 2.

**Homicide Plan/Identified Target**

A5. Can you tell me what you have thought about doing and to whom? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(if NO ANSWER, gently inquire:)

Have you thought about physically attacking them or using a gun?.....pause.... Or something else? \_\_\_\_\_

NO YES

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If YES, continue. If NO, go to A8 on page 2.

**Means Available/Access to Target**

- |     |  |    |     |
|-----|--|----|-----|
| A6. | Clinician assess whether client has access to means mentioned in A5 above (e.g. Do you have a knife at home?)              | NO | YES |
| A7. | Clinician assess whether client has access to target person(s) in A5 above (e.g. Do you know how to find (person's name)?) | NO | YES |
| A8. | Do you have access to a firearm?   | NO | YES |

**Intent**

- |     |   |    |     |
|-----|---|----|-----|
| A9. | Do you think you will follow through with the plan to harm/kill (someone)? If so, when? _____ | NO | YES |
|     | _____   |    |     |
|     | _____   |    |     |

**Section B- Past History of Homicidality:**

- |     |  |    |     |
|-----|--|----|-----|
| B1. | In the past have you thought about hurting or killing someone?                           | NO | YES |
| B2. | In the past have you ever hurt or killed someone, or threatened to hurt or kill someone? | NO | YES |

If YES to B2, continue. If NO, go to question C



- a. When was that?
- b. What exactly happened?

Dates: \_\_\_\_\_

Lethality: \_\_\_\_\_

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**Section C – Future Orientation and Alliance Building**

- C1. What is it that made you decide to share these thoughts with me (us)? \_\_\_\_\_
- \_\_\_\_\_
- C2. What has kept you from taking action on these thoughts so far? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## **Appendix 7 to Trauma-Informed Psychotherapy: Brief Risk Assessment Protocol Part One: Suicide Assessment**

For the *Brief Risk Assessment Protocol (BRAP) Part One*, please see following page.

**Brief Risk Assessment Protocol (B-RAP)  
Part One: Suicide Assessment**

**Section A- Recent Suicidality**

**Any Recent Suicidal Ideation**

A1. When faced with a lot of difficulties, people sometimes have thoughts of wanting to die or wishing they weren't alive. Have you felt this way in the last 6 months? NO YES

If YES, continue. If NO, go to section B on page 2.

**Recency and Frequency of SI**

A2. When did you last have these thoughts? \_\_\_\_\_

A3. How often do you think about it? \_\_\_\_\_

**Active Suicidal Ideation**

A4. Have you been thinking of acting on these thoughts by doing something to end your life? NO (passive) YES (active)

If YES, continue. If NO, go to section B on page 2.

**Suicide Plan**

A5. Can you tell me what you have thought about doing to end your life? \_\_\_\_\_  
\_\_\_\_\_

(if NO ANSWER, gently inquire:)

Have you thought about taking an overdose of pills or using a gun?.....pause.... Or something else? NO YES

Continue to next page.

**Means Available/Preparations**

- A6. Clinician ask if client has access to means mentioned in A5 above (e.g. Are you around trains? Do you have pills at home?)
- A7. Clinician estimate lethality of available means:  
Low      Moderate      High
- A8. Do you have access to a firearm? NO YES
- A9. What kinds of preparations have you made for ending your life? (circle item for any yes responses) (e.g. arrangements to give away treasured items, suicide note, will, precautions to avoid interruption) Note: other \_\_\_\_\_

**Intent**

- A10. Do you think you will follow through with the plan to end your life, If yes, when? NO YES  
\_\_\_\_\_  
\_\_\_\_\_

**Section B - Past History and Family History of Suicidality**

- B1. In the past have you thought about suicide or ending your life? NO YES
- B2. Have you ever attempted to end your life in the past? NO YES

If YES to B2, continue. If NO, go to question B3 below



- a. What did the attempt(s) involve?

Dates: \_\_\_\_\_  
Lethality: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- b. Did you want to die? NO YES ?

- B3. Has anyone in your family or anyone close to you ever attempted or committed suicide? NO YES ?  
\_\_\_\_\_  
\_\_\_\_\_

**Section C – Future Orientation and Alliance Building**

- C1. What is it that made you decide to share these thoughts with me (us)? \_\_\_\_\_
- C2. What has kept you from taking action on these thoughts so far? \_\_\_\_\_

## **Appendix 8 to Trauma-Informed Psychotherapy: Grieving the Losses**

For a handout on the benefits for grieving, please see following page.

## Grieving the Losses Inherent in Trauma

Trauma usually involves loss of some sort. The losses are different for each person but may include:

- **loss of a sense of safety and security in the world**
- loss of a healthy sense of invulnerability and entitlement
- loss of easy connectedness with others
- actual loss of other people through death or sudden ending
- loss of physical integrity from injury or related health issues
- loss of easy comfort in your own skin
- loss of your self-esteem, your identity
- loss of your future plans, meaning or purpose in life
- 

**Grief** is a natural emotional reaction to a significant loss. The words sorrow and heartache are often used to describe feelings of grief.

**Grieving is the process** of emotional and life adjustment you go through after a loss. There is no "normal and expected" period of time for grieving. A wide range of feelings and symptoms are common during grieving. While you may be feeling shock, numbness, sadness, anger, guilt, anxiety, or fear, you may also find moments of relief, peace, or happiness. And although grieving is not simply sadness, "the blues," or depression, you may become depressed or anxious during the grieving process. There is an end to it.

**Benefits of Grieving** Although there is no doubt that grieving is painful, it has its benefits:

- giving voice to underlying feelings about loss can be very relieving, and can free up life energy as well as positive feelings that have been numbed
- acknowledging the loss or what one has endured, can be a way to move into compassion for the traumatized self, and away from self-blame, shame, or anger
- acknowledging loss provides direction in finding ways to fill now unmet needs such as purpose or relationships
- grief is a way to show how much you care for yourself

### Guidelines for Grieving

1. It is OK to cry; to be sad; to mourn. We are built for it. Tears serve a purpose. Why should we not honor our grief as we do our joy, happiness, etc.
2. Over time the trauma and loss can be mastered by putting the feelings and experiences into words shared with a caring other.
3. Sometimes when we grieve, the anger fades.
4. Find a safe place or someone safe to be able to express the sadness.
5. Each person is unique in the way they grieve – it is not one size fits all.
6. Balance the grief with taking a break, finding humor, being active.



# TRAUMA RECOVERY CENTER PSYCHIATRY AND PSYCHOPHARMACOLOGY: THE ROLE OF THE PSYCHIATRIST

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By Laurie Richer, D.O. and Sharon Smart, M.D., Ph.D.



*Photograph by Ezme Kozuszek*

“My friend is one who takes me for what I am.”

—Henry David Thoreau

*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

The TRC psychiatrist is an essential member of the TRC treatment team, working closely with the TRC Clinician and other staff to provide comprehensive care to trauma survivors. TRC psychiatrists have special expertise in the area of treating Acute and Posttraumatic Stress Disorders and providing a more intensive level of services in a briefer period than usual care.

## **How are TRC Psychiatric Services Different?**

In the TRC model, the Psychiatrist is involved in a more hands-on, time-intensive way than is usual in community mental health. They have the capacity to devote considerable time to meeting with clients and other members of the treatment team, and this has a greater impact than usual care. By providing an intensive level of services in a short period of time (normally 16 weeks), the Psychiatrist and other members of the TRC team bring about a major and lasting reduction in PTSD symptoms, helping prevent trauma survivors from developing chronic mental health problems. The Psychiatrist's intensive involvement may serve to reduce clients' potential reluctance to receive psychiatric services, to enhance adherence, and to optimize effective pharmacological treatment as quickly as possible. Many trauma survivors have never received mental health services before, and because of societal stigma around psychiatric medication, may feel considerable anxiety and shame about meeting with a Psychiatrist to consider medication. As will be discussed below, the TRC psychiatrist's accessibility and relationship to the team help to gently overcome a client's potential anxiety and facilitate engagement in psychiatric services.

## **TRC psychiatrist is on-site**

The TRC psychiatrist is on-site, ideally in the same area as the TRC Clinician, not located on a different floor or in a different building. This co-location makes it possible for the Psychiatrist to participate as an active member of the multidisciplinary team. The Psychiatrist is available for consultation with the Clinician, and works collaboratively with him or her, sharing information about the client. The Psychiatrist and Clinician also meet jointly with the client when indicated.

## **Caseload**

Because TRC is a brief, intensive program, Psychiatrists have a smaller caseload with clients being seen more frequently and with significantly higher client turnover than in a typical outpatient clinic. This smaller caseload size is essential for providing a higher level of care, especially at the beginning of a client's treatment.

## Relationship to the TRC team

The TRC team is collaborative, not hierarchical. The TRC Psychiatrist participates as a member, with special expertise in pharmacological approaches and other medical aspects of trauma treatment. Because of the Psychiatrist's active involvement, the client soon becomes familiar with the Psychiatrist and comes to understand that he or she is a part of the team. This makes it much easier for the Psychiatrist to establish a therapeutic alliance with the client.

**INTERFACE WITH THE TRC CLINICIAN.** The Psychiatrist interfaces closely with the Clinician. At TRC, the Clinician is the client's central point of contact for psychotherapy, case management, and outreach, and is the source of the on-site referral of the client to the Psychiatrist. Clinicians should consider referring clients to the TRC Psychiatrist in the following circumstances:

- When a client is already taking a psychotropic medication prescribed by an outside provider
- When a client requests a psychiatric assessment
- When a client has been diagnosed with any of the following: Major Depressive Disorder (particularly when it is moderate to severe), Panic Disorder, Bipolar Disorder, Obsessive Compulsive Disorder, Schizophrenia or Schizoaffective Disorder
- When a client's PTSD symptoms are impairing their daily functioning and are not clearly improving with psychotherapy

During the beginning phase of treatment with psychotropic medications, the Psychiatrist and Clinician discuss the information that the Psychiatrist has shared with the client after the psychiatric assessment, including diagnoses, goals for treatment with the prescribed medications, target symptoms, potential side effects, assessment of efficacy, and medication compliance. The Psychiatrist monitors the client's medication adherence and response during medication management follow-up visits, and keeps the Clinician informed. The Clinician also regularly updates the Psychiatrist about any important additional observations that may help shape psychiatric treatment decisions. This close communication helps to ensure that the client receives individualized, effective treatment and that TRC providers function as a team providing care.

**INTERFACE WITH OTHER TEAM MEMBERS.** Although the Psychiatrist works most closely with the Clinician, she or he also interacts with the receptionists, paraprofessionals, supervisors, and other team members as an integral part of the TRC community of providers.

**INTAKE TEAM MEETINGS.** The TRC Psychiatrist participates in intake teams where new cases are presented. This allows the Psychiatrist to gain some familiarity with clients who may be referred for a psychiatric assessment prior to their first meeting. Additionally, the Psychiatrist can provide some initial orientation to other intake team staff about how psychiatry may be able to help each new client. In addition, the Psychiatrist gives the team the benefit of their expertise in considering medical conditions that may have a psychiatric interface, as well as in diagnosis and treatment planning.

**STAFF MEETINGS.** The TRC Psychiatrist participates in regular staff meetings. This participation keeps the Psychiatrist updated and on the same page with the rest of the team, and gives the team the benefit of the Psychiatrist's regular and timely input.

## **Meetings with the Client**

It is important to be aware that the TRC model is a short-term, intensive treatment approach (therapy is generally planned for 16 sessions, with extensions as deemed appropriate by the team). In this model, the Psychiatrist does not see clients for a brief review on a regular (e.g., monthly) basis for an extended period of time. Rather, the Psychiatrist's initial session with the client will be a 90-minute evaluation, followed by weekly meetings for 2 to 4 weeks, with each session lasting about 30 minutes. After that, the sessions are bi-weekly or monthly, depending on treatment complexity and response, until the completion of the course of TRC treatment.

### **Initial informal meeting**

Because the Psychiatrist is on-site, the Clinician may invite the client to meet the Psychiatrist briefly for an introduction and initial conversation. This introduction, with some unstructured discussion, can lessen a client's anxiety about working with a Psychiatrist, and make the idea of receiving psychiatric services more acceptable.

### **Initial 90-minute meeting**

Once the client is officially referred to the Psychiatrist, they meet together for approximately 90 minutes. Prior to this meeting, the Psychiatrist carefully reviews the Clinician's chart notes and any additional available medical records. The Psychiatrist is sensitive to the fact that requiring the client to tell his or her trauma history over again in an initial meeting may be quite stressful for the client, and so refrains from doing so if adequate information is available from the medical record. During this meeting, the Psychiatrist performs a comprehensive diagnostic assessment to identify potential target

symptoms that may be amenable to psychopharmacologic intervention. The interview covers:

- The client's treatment priorities
- The client's questions and concerns about receiving treatment from the Psychiatrist
- Medical history, current health status, and current medications
- Client's psychiatric history and past psychiatric medications, if any

Following this assessment, if medication management is indicated, and the client is in agreement with this recommendation, the Psychiatrist will prescribe medication as appropriate and will communicate findings and recommendations to the client's Clinician.

### **Ongoing follow-up meetings**

After the initial 90-minute evaluation session, the Psychiatrist schedules medication follow-up appointments to monitor treatment adherence, tolerability and response. To ease the burden on the client, these appointments are scheduled to coordinate with weekly therapy appointments whenever possible.

**LOCATION OF MEETINGS.** The TRC model requires flexibility in where clients are seen. The TRC Psychiatrist and Clinician may make home visits to clients who are homebound. Seeing the home environment can be very useful in assessing the client's functioning and needs, and in determining appropriate treatment goals. The Psychiatrist and Clinician may also make hospital visits to clients who are confined to a hospital bed.

If the client is monolingual non-English speaking, the inclusion of an interpreter may make the sessions longer, and this is factored into the client's scheduling.

### **Substance abuse issues**

Severely traumatized clients are at increased risk for substance use disorders, either pre-dating the index trauma or developing subsequent to the trauma. The Psychiatrist addresses this issue by: 1) completing a thorough assessment regarding substance use and misuse; 2) providing psychoeducation about the substances identified including medical risks, and the relationship between substance use and PTSD and co-morbid conditions; 3) offering addiction-focused pharmacotherapy or referral for medical detoxification as indicated; 4) supporting the client in use of psychosocial treatments both within TRC and



through external treatment programs; and 5) coordinating management of substance use disorders with the client's primary care provider and their Clinician. A key aspect of the approach to substance use disorder treatment in TRC is the concurrent treatment of Substance Use Disorder, PTSD, and other co-morbid conditions.

**NONJUDGMENTAL STANCE.** The Psychiatrist takes a nonjudgmental, harm reduction approach to substance use, but this is far from enabling. Very often, the Psychiatrist lets the client know that they understand how drugs of abuse (e.g., alcohol, stimulants) may provide the client with temporary symptom relief. The Psychiatrist also makes sure to educate clients that self-medication with these drugs may lead to worsening of PTSD symptoms or those of co-morbid conditions such as major depressive disorder, or may lead to development of a substance use disorder.

**INSOMNIA.** Insomnia is probably the most frequent complaint presented by traumatized clients, as it interferes with their ability to function. For example, the Psychiatrist may see a woman who, until she experienced a recent physical assault, had no history of substance abuse. She had some history of exposure to interpersonal violence, and met criteria for diagnoses of PTSD and major depression. When she came to the Psychiatrist she had started drinking alcohol to fall asleep. The Psychiatrist provided education about how alcohol can temporarily reduce symptoms, but on the rebound, ends up making things worse. This is because alcohol can help in falling asleep, but at the same time results in frequent awakenings and decreased sleep quality. The client understood and cooperated with other, more effective approaches to her sleep problems.

**SUBSTANCE USE: UNDERSTANDING WHY.** It is essential that the Psychiatrist probe to understand exactly why the client is using a substance and what they hope it will do for them. Once this is understood, the Psychiatrist can help the client identify safe and more productive coping options. For example, sleep difficulties often relate to the client's experience of nightmares that directly disrupt sleep and may secondarily lead to sleep avoidance. Instead of the client using alcohol in this context, the Psychiatrist can directly reduce the nightmares with a medication known to be efficacious for this purpose.

**AN EXAMPLE.** Clients with PTSD and anxiety disorders may use stimulants such as methamphetamines and cocaine, which then worsen the symptoms of their anxiety. A recent instance of this occurred with a client who had a history of long-time poly substance abuse but had achieved abstinence. Then she was informed by the District Attorney's office that they did not feel they had a case against her perpetrator and were releasing him. Soon, she encountered the perpetrator in public. That event re-triggered her symptoms of PTSD and, in response, she used crack cocaine twice. The Psychiatrist provided education about how using a stimulant makes things worse overall by increasing

anxiety reactions, and helped the client make an informed choice about her use. With support from the Psychiatrist and the rest of the team, the client was able to return to abstinence from stimulants.

**EDUCATING RESPECTFULLY.** Education about the risks posed by substance use should be presented candidly but respectfully, with an appreciation of the fact that the client truly does have severe symptoms to deal with. The Psychiatrist recognizes that the client's desire to self-medicate with drugs of abuse is understandable, though acting on it is unhelpful. This education helps the client adjust to alternative ways of coping with symptoms such as insomnia, depression, or anxiety, including the use of psychotropic medications when warranted.

### **Consultation with primary care providers**

Survivors of violent crime may have complicating physical issues. The Psychiatrist may need to consult with the client's primary care provider (PCP) to get more information about how the client is dealing with physical problems and to discuss the use of pain medications that may have potential for abuse under the circumstances. They also may discuss other medications the client is taking that may have complications or potential interactions with psychiatric medications.

After TRC treatment there is a need to establish continuity of care, since the Psychiatrist will not be seeing the client over the long term. Often the client will need continued management of psychiatric medications. In this case, the Psychiatrist coordinates the transfer of care to the client's PCP or a community psychiatrist, depending on the complexity of the client's treatment.

### **Co-morbid disorders**

As mentioned previously, many TRC clients have co-morbid disorders. Of those with PTSD, 50% or more have major depression. By providing appropriate medications, Psychiatrists help clients manage major depression, as well as other disorders such as bipolar disorder and borderline personality disorder. These co-occurring issues can prevent the client from participating actively in the cognitive-behavioral therapy and psychoeducational programs they need to overcome their trauma. By helping clients manage or recover from these other issues, the Psychiatrist helps make trauma recovery possible.

## How to discuss medications with clients

The TRC Psychiatrist understands that psychiatric medications can be frightening and stigmatizing for clients. The Psychiatrist educates the client about why the medications are being prescribed and the expected treatment duration. Clients are assured that they can choose to decline the recommended medication without impact on their eligibility to continue treatment with the Clinician. Providing options and allowing the client some choice and control in the medication decision-making process when possible is an important aspect of treating trauma survivors, who by definition had control taken away during the trauma. This can be empowering for clients and facilitates a positive therapeutic alliance with the TRC Psychiatrist.

## Payment issues

When clients cannot self-pay for medications and do not have insurance, the TRC needs to mobilize case management services to help the client become eligible for Medicaid or access another program that will arrange payment for medications.

## Psychopharmacology: Overview and Resources

TRC Psychiatrists prescribing medications for survivors of trauma and people suffering from PTSD are well-informed about medication guidelines for trauma, PTSD and co-occurring disorders. Evidence supports the use of selective serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors (SNRIs) in PTSD treatment. The current evidence base is strongest for SSRIs, and currently only sertraline (Zoloft) and paroxetine (Paxil) are approved by the Food and Drug Administration for PTSD. All other medication uses are off label, though there are differing levels of evidence supporting their use. For example, there is strong evidence for the SSRI fluoxetine (Prozac) and for the serotonin norepinephrine reuptake inhibitor (SNRI) venlafaxine (Effexor) which are first-line treatments in the Veterans Administration/Department of Defense (VA/DoD) Clinical Practice Guidelines for PTSD (VA/DoD Clinical Practice Guidelines for PTSD.)

There are excellent technical resources that provide complete and detailed information on the recommendations and contraindications of medications for the TRC target population. A useful review chapter, Pharmacologic Treatment of PTSD (Raskind, 2009), is included in *Post-Traumatic Stress Disorder: Basic Science and Clinical Practice* .

**ON-LINE RESOURCES.** Many resources can be found at the Veterans Affairs PTSD web site <http://www.ptsd.va.gov/>



- For a more complete overview of PTSD psychopharmacology, see the *Clinician's Guide to Medications for PTSD* at <http://www.ptsd.va.gov/professional/treatment/overview/clinicians-guide-to-medications-for-ptsd.asp>
- *Psychopharmacology of PTSD* is a longer series of videos (90 minutes, in 6 parts) at <http://www.ptsd.va.gov/professional/materials/videos/emv-psychopharm-mhcp.asp>

## Trauma Psychiatrists and Self Care

One of the concerns for anyone working directly with trauma survivors is *vicarious trauma*, which is discussed in another chapter of this manual (Vicarious Trauma and Staff Support). The TRC Psychiatrists at the UC San Francisco Trauma Recovery Center have found that working as part of a team is an essential element in preventing vicarious trauma and compassion fatigue. The program structure is very helpful, in that no one feels alone in dealing with traumatized clients or in crisis situations. For example, if a client is expressing suicidal ideation, there is a whole team and a structure for bringing in the support of the other team members.

**SELF CARE GROUP.** Self care is as important for TRC Psychiatrists as it is for other team members. At the UC San Francisco Trauma Recovery Center, where there are separate self care groups for line staff and supervisors, the Psychiatrists participate in the supervisors' self care group. Because the Psychiatrists see a larger caseload than the Clinicians, they are exposed to increased trauma information and self-care becomes very important in addressing vicarious traumatization and increasing resiliency.

## TRC Psychiatrists as Fully Integrated Treatment Team Members

In summary, TRC Psychiatrists are fully integrated into the TRC treatment team, as co-providers, staff members, and supervisors. Close collaboration between Psychiatrists and Clinicians helps erase barriers to psychiatric care for TRC clients. The specialized training and knowledge that TRC Psychiatrists bring to their role of working exclusively with trauma survivors ensures that clients receive effective, individualized treatment that is complementary to the services provided by their TRC Clinician.

## References

Raskind, M. A. (2009). Pharmacologic treatment of PTSD. In *Post-Traumatic Stress Disorder* (pp. 337-361). Humana Press.

Thoreau, H.D. (n.d.) QuoteAddicts.com. Retrieved November 7, 2016 from QuoteAddicts website: <http://quoteaddicts.com/908224>

# VICARIOUS TRAUMA AND STAFF SUPPORT

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By Alicia Boccellari, Ph.D. and Stacey Wiggall, LCSW



*Photograph by Ezme Kozuszek*

“Hope and fear cannot occupy the same space  
at the same time. Invite one to stay.”

—Maya Angelou

*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

In a typical mental health agency, staff work with clients who face multiple problems including poverty, trauma, mental disorders, and social isolation. People recovering from serious interpersonal violence may experience all of these, and in addition, frequently experience a kind of absolute powerlessness and vulnerability that results from being intentionally victimized by another person or people. While the stresses of working with clients who face significant obstacles to recovery and have limited access to resources have been well documented (Lloyd, King, & Chenowith, 2002), the TRC model incorporates special attention to the risk of *vicarious trauma*—a combination of emotions and attitudes that can render staff incapable of effectively helping survivors of trauma. This chapter describes vicarious trauma and discusses how team culture, staffing, training, and institutionalizing support for staff can prevent the effects of vicarious trauma from undermining a program’s effectiveness.

### **What is vicarious trauma?**

From a theoretical point of view, vicarious traumatization, based in constructivist self-development theory (Pearlman & McCann, 1990), is a negative transformation in the self of a trauma helper who engages empathically with traumatized clients. Its symptoms in part parallel those of PTSD, and include anxiety, despair, intrusive imagery, sleep disruption, cynicism, hostility, and difficulty in maintaining helping relationships. Beliefs that go along with vicarious trauma may include, “this situation is hopeless,” “the clients bring it on themselves,” and “there’s nothing anyone can really do to help.” Vicarious traumatization was first identified in mental health professionals working with trauma survivors, but it can also affect medical providers, law enforcement, and others who work with severely traumatized people.

### **Stress and burnout vs. vicarious trauma**

Providing services at any social service agency can be stressful for staff who may struggle to help people coping with multiple problems in an underfunded system. Helpers experience tremendous pressure as they try to deliver services while at the same time complete needed documentation and billing, attend meetings, and cope with the feeling that they are constantly asked to do more with less. But, unlike vicarious traumatization, this stress does not bring about a specific transformation of agency workers. More serious long-term stress can result in “burnout,” a feeling of being exhausted and unmotivated. While vicarious traumatization can overlap with stress and burnout, it has specific symptoms that parallel PTSD (such as intrusive images of another person’s trauma). It can result in pervasive changes in how workers view themselves and the world, and how they relate to the trauma survivors they are ostensibly trying to help. Both stress and burnout can usually be mitigated or resolved by providing time off, support and

encouragement, professional training, or motivational workshops. While vicarious trauma is also mitigated by these strategies, it requires other intensive efforts that target it specifically.

Working with severely traumatized individuals presents different and unique challenges that go beyond stress and burnout. The effects of vicarious trauma on staff can seriously undermine the effectiveness of an agency.

### **The process of vicarious traumatization**

Consider a TRC Clinician who, in the morning, visits someone in the hospital who has been raped and then thrown out of a moving car. In the early afternoon, the Clinician meets with a client who is recovering at home after being beaten by multiple assailants, his jaw fractured and wired shut. The final hour of the day is spent talking with a woman whose child was killed by a drive-by shooting's stray bullet. These stories are not intended to traumatize the reader; they are provided only to convey the severity of what a Trauma Recovery Center worker encounters on a daily basis. TRC Clinicians and other Trauma Recovery Center staff work closely with real people who have had such horrific experiences, day after day, week after week.

**OTHER EXPOSURE.** In addition to working with their own clients, TRC Clinicians may be exposed to the details of other clients' trauma when cases are discussed at team meetings, in supervision, or informally as staff debrief with each other. Without mindfulness about what is communicated and guidelines about the sharing of trauma content, this secondary exposure can cause and/or intensify the experience of vicarious trauma.

**INSTITUTIONALIZED TRAUMA.** If enough individual staff members suffer from unmitigated vicarious trauma, there is also a risk that it becomes institutionalized. For example, when senior staff or program managers communicate a sense of hopelessness or despair, or an attitude of blaming the survivor, this can create a culture that reinforces vicarious trauma. Possible outcomes then include the erosion of healthy communication and boundaries among staff, and the risk of truly dysfunctional interpersonal dynamics in which staff may view each other or leadership as perpetrators of harm and themselves as victims. All staff who work with severely traumatized people are vulnerable to the experience of vicarious trauma. This is recognized in the DSM-5 under the criteria for Post-Traumatic Stress Disorder, which includes "Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse)" (American Psychiatric Association, 2013). Many TRC Clinicians go through intermittent periods of

feeling more intensely impacted by the stories and experiences of their clients. Research has shown that helpers have increased vulnerability to vicarious trauma early in their careers, while they are still developing their own effective coping strategies (Pearlman & McCann, 1995). Vulnerability also increases during periods of personal stress, i.e., undergoing a divorce, or the serious illness or death of a family member. The degree to which a clinician identifies with the experience of a client, either because of similar sociocultural demographics or a similar past trauma experience, also increases vulnerability to vicarious trauma.

## **Manifestations of vicarious traumatization**

**OVERIDENTIFICATION WITH CLIENTS.** Staff can become overwhelmed and come to identify themselves as helpless victims. They deeply sympathize with clients, but have trouble establishing appropriate boundaries, and their own emotional reactions to witnessing trauma in their clients prevent them from being able to provide effective help. They may experience the normal friction that happens in any agency as persecution, and experience changes in their world view that results in feelings of despair and hopelessness.

**CYNICISM AND HOSTILITY.** The other typical manifestation of long-term, unmitigated vicarious traumatization is the development of a stance of cynicism, or “compassion fatigue” (Figley, 2002). The cognitive dissonance caused by repeatedly seeing bad things happen to good people can cause providers to take on the view that clients are responsible for their own victimization. This survivor-blaming reduces staff performance and efficacy, both because staff’s negativity precludes them from establishing rapport with clients, and because their view of clients as “bad people” gives them little motivation to try to be helpful. They may unknowingly justify their unhelpful stance by thinking, “The client was asking for it” or “The client deserved it.”

If vicarious trauma goes unrecognized and unmitigated, staff develop an entrenched sense of personal victimization, globalized helplessness, and/or a cynical, blame-the-survivor point of view. When these cognitive and emotional symptoms of vicarious trauma persist for a significant length of time, they can be difficult to reverse.

## **Workforce and agency problems**

In addition to observing the behaviors described above, management may observe the following problems that originate in vicarious trauma:

- Staff absenteeism



- High staff turnover
- Pervasive negativity in staff meetings and other collegial communication
- Low staff morale
- Client complaints about staff on satisfaction surveys, to other agencies, etc.
- Grievances filed by staff
- Grievances filed by clients
- Low client retention rates

## **Strategies to Institutionalize Staff “Self Care” and Promote Organizational Well-being**

The challenge of vicarious trauma can be met by implementing a system of supports into the program from the beginning. When implemented together, the following strategies help mitigate the impacts of vicarious trauma on staff and promote an organizational culture of wellness and efficacy.

### **Culture of compassion**

Leadership needs to develop a culture of compassion and support throughout all levels of the program in order to keep staff healthy and effective. This culture must include all staff and volunteers, including professionals, paraprofessionals, trainees, front office reception, clerical staff, evaluation and research staff, and senior management.

This culture should be developed and maintained through specific policies, procedures, and regular activities, such as those outlined below. Because staff must be supported in order for them to be able to help clients, a culture of support does not conflict with making client-centered services an agency’s top priority.

### **Hiring**

From the very beginning, emphasize the core values of TRC: compassion, respect for each other and clients, and a shared commitment to working with underserved populations. Initial job postings and position descriptions should refer to the core values.

During the interviewing process, explicitly mention TRC core values and assess applicants’ fit. This is necessary for all levels of staffing.

The interview process should assess the capacities of the applicant to know when they are experiencing stress and to use healthy coping strategies. In addition, applicants with previous experience working with traumatized people should be queried about attitudes that can result from vicarious trauma, such as excessive cynicism. These can be red flags in the interviewing process.

### **Promoting “self care” through self care groups**

“Self care” refers to the staff taking care of themselves in a regular, organized way. However, rather than relying solely on individual staff’s coping strategies that are implemented in their personal time, such as exercising and getting enough sleep, TRC emphasizes making an organizational commitment to staff well-being by providing one or more self care groups at dedicated times during the work schedule.

**SCHEDULE.** A weekly group is necessary in order to have sufficient impact. Often the self care group is scheduled for one hour per week. While this is “protected” time, attendance needs to be voluntary, as mandatory self care can feel like more of a burden than an opportunity. New employees and trainees should be oriented to the importance of setting this time aside, and not working through it.

**FACILITATORS.** An outside facilitator can be helpful in establishing a new self care group, so that the burden does not fall on one of the staff. However, some groups may prefer to facilitate for themselves, especially after they have become established and have a good sense of what works for them. In that case, it can be helpful to have the facilitator role rotate to a new staff member every six months in order to share the work.

**ACTIVITIES.** Activities can vary from week to week. In a process-oriented self care group session, staff can check in with each other about the ways they are noticing that they are impacted by the work, and can offer each other normalization and coping strategies. In addition, staff may also benefit from group sessions that provide activity and camaraderie such as walking, yoga, meditation, cooking, etc. In order to accommodate different ways of coping, it can be helpful to alternate process-oriented sessions with activity-oriented sessions.

**SUPERVISORS GROUP.** Supervisors may not want to attend the weekly self care group comprised of the people they supervise so that staff might feel more comfortable discussing how they are impacted by the work, and can then benefit from peer support. Instead, supervisors can hold their own self care group.



**REVIEW AND CHANGE.** It is important to recognize that self care needs of the staff are likely to change over time and leadership needs to be sensitive to these changes. Periodic use of a survey, augmented by group discussion, can be helpful for reviewing how the self care activities are going and identifying what is working and what is not working. Changing the self care group helps meet changing needs, as well as keeping the self care activities fresh and engaging.

### **Staff meetings that promote optimism and support**

In addition to transacting agency businesses, staff meetings are an important part of maintaining a culture of compassion, optimism and mutual support. They can incorporate institutional rituals that explicitly remind staff that—in spite of the horrific experiences of traumatized people—the world is not a bad place. To the outsider, sometimes these staff meeting practices may seem sentimental or like cheerleading. But in the context of the grim realities of helping traumatized individuals, this emphasis on the positive is healing, and necessary.

Some useful practices include:

- Staff meeting **BOOK ENDS** (informal “story telling” at the start and end of each meeting). At the beginning of the meeting, offer the opportunity for staff to share a brief summary of a client’s success. Even a “small success” is meaningful, and a cause for celebration, considering the huge obstacles TRC clients face. At the end of the meeting, offer the opportunity for staff to acknowledge each other, so that the whole group is witness to some way that a co-worker helped another out that week, or was observed doing something exceptional in their work. This reminds staff that small acts of kindness have a real impact and creates an institutional ripple effect. Practicing gratitude has been demonstrated to increase optimism, joy and other positive emotions. It increases staff resiliency, strengthens relationships and helps to increase altruism and compassion (Emmons & Mishra, 2012).
- **CELEBRATING AND RECOGNIZING THOSE WHO CONTRIBUTE TO THE “HEALING COMMUNITY.”** The concept of a “healing community” is not restricted to the four walls of the TRC. In order to support clients, staff rely on their community partners, such as other health care providers, other service agencies, law enforcement, or local businesses who donate goods to the TRC. These partners are part of the healing community, and they not only concretely support clients, but provide further evidence to clients that they are not alone, and others are “walking with them” on their healing journey. Once a month, during staff meeting, the UC San Francisco TRC chooses a community partner who has made a significant contribution to the work we do. All staff pass around and sign a thank-you card that is sent to the identified person or program. The ripple effects of gratitude

increase positive emotions among the TRC staff, reminding us that we, too, are “not alone” in working with our vulnerable clients. This practice helps to reinforce the good works of our partners while it strengthens and expands the TRC as a healing community.

- **HEALTHY VENTING.** Communication about clients explicitly excludes sharing graphic details that can engender vicarious traumatization. Staff can share how they feel, including frustration and unhappiness, but if they have a need to talk about a particularly terrible or painful occurrence they have either witnessed or been told about, this is done in individual supervision.
- Invite staff to **SHARE INSPIRATIONS**, such as quotations or events. Ask “What inspired you today?” or “What touched you today?”
- Regular **CULTURAL HUMILITY** practices create space for dialogue and help institutionalize cultural humility as a core value. The group could alternate dedicated time for discussion of issues that have arisen with clients during the week with group exercises designed to increase both self-awareness and awareness of others. An example of an exercise is asking a few people each week to volunteer to take a couple of minutes to talk about their name(s), and to share reflections on both the background of their name and their experience of having it. Note that these exercises are most beneficial when all staff feel safe to participate, and when there is general buy-in among all staff to the core value of adopting a cultural humility approach to all relationships.
- **CLIENT MEMORIALS.** At the UC San Francisco Trauma Recovery Center, staff hold client memorials twice a year to acknowledge clients and others who have died. In this way, those losses are held by the entire team, rather than solely with the TRC Clinician who worked with that client. The memorial often consists of a brief reading or acknowledgment, followed by a reading of clients’ names.
- **CELEBRATIONS**, such as receptions, staff lunches, or parties should be organized around occasions such as work anniversaries, funding awards, birthdays, and other events that have positive meaning for staff.

## Individual supervision

Individual supervision, described in detail in the Supervision chapter, is essential to preclude vicarious trauma. To address vicarious trauma, supervision should at least periodically include discussion of how the supervisee is feeling in relation to the work, and explore whether the Clinician is experiencing symptoms of vicarious trauma. The supervisor should check to see if any specifics that are not appropriate for group discussion need to be discussed individually, and encourage and facilitate the supervisee’s self care.

## **Training**

Orienting new staff and trainees at the beginning is very important. They need to be informed about vicarious trauma, and about how a culture of compassion, optimism and support, along with regular structured activities, will help prevent it. Before they start seeing clients, they need to know why, how, and when to get support for themselves. Supervisors should inquire about staff members' mindfulness of the ways they are impacted by trauma work, as well as the specific coping strategies that are most effective for them, or that they would like to experiment with.

In addition, all staff should receive ongoing professional development training on a regular basis, such as in a weekly staff development meeting. In addition to enhancing the professional competence and efficacy of staff, these trainings also serve as a buffer to stress-related responses. Clinicians are able to engage with relevant topics and each other on a different level than during their clinical work; feelings of collegiality and increased competency are an excellent counterbalance to feelings of isolation and hopelessness. Training topics can range from new evidence-based treatment interventions to implementing a social justice lens. Sample topics include: learning new developments in the assessment and treatment of trauma, information about the history and cultures of different client populations, and how we work with the "isms" our clients experience, including racism, sexism, homophobia and transphobia.

## **Additional considerations for leadership**

Supervisors need to maintain a balance between supporting staff in their self care activities versus meeting the demands of the organization for high productivity and adhering to high expectations for success. At the same time that practice of self care for staff is institutionalized and encouraged, the organizational culture must also stay client-centered. The provision of high-quality mental health support services for traditionally underserved clients is always the program's top priority. Self care addresses this priority by ensuring that staff remain effective in their work and promoting their longevity in the field.

When addressing vicarious trauma, supervisors also need to support staff by empowering them and believing in their resiliency, but not disempowering them by giving the message that the work is, in fact, too overwhelming. While vicarious trauma is a real work hazard, it can also be effectively managed. For example, when a supervisee discusses the impact of vicarious trauma in individual supervision, the supervisor's response should be validating and normalizing, and include the exploration of coping strategies both inside and outside of client sessions. But if a supervisee has significant

problems with attendance or time management that are negatively impacting their clients, these cannot be written off as the employee's response to vicarious trauma.

Other considerations for TRC leadership include:

- “Every voice gets heard.” Supervisors need to communicate and demonstrate that every staff member is important and has something valuable to offer.
- Leadership should promote the idea that it takes a compassionate community of people working together to heal from trauma.
- Balance out the “bad” with the “good;” balance violence and trauma with compassion and kindness; vicarious trauma with vicarious gratification/vicarious joy.
- Finding meaning in trauma/altruistic activity or client advocacy is utilized as an antidote to feeling hopeless and helpless.

## Policies

A Trauma Recovery Center should adopt specific policies to help address vicarious trauma. These include:

- Explicitly encouraging staff to take regular lunch breaks, to use vacation leave, and take sick leave as needed.
- Explicit discussion of self care in staff meetings and individual supervision.
- When there is a clinical emergency, self-care is to be put on hold until the crisis is dealt with.

## Closing Comments

While vicarious trauma is a formidable problem, agencies can prevent it by establishing a culture of self-care, along with concrete steps including addressing the issue in employee selection, training, supervision and staff meetings, and by establishing weekly self-care groups.

## References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5<sup>th</sup> ed)*. Arlington, VA: American Psychiatric Publishing.

Angelou, M. (1994). *The Complete Collected Poems of Maya Angelou*. New York: Random House Inc.

Emmons, R.A. and Mishra, A. (2012). Why gratitude enhances well-being: What we know, what we need to know. In Sheldon, K., Kashdan, T. & Steger, M.F. (Eds.). *Designing the future of positive psychology: Taking stock and moving forward*. New York: Oxford University Press.

Figley, C. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. In *Session: Psychotherapy in Practice*, Vol. 58(11), 1433–1441.

Lloyd, C., King, R. and Chenoweth, L. (2002). Social work, stress and burnout: A review. *Journal of Mental Health* 11, (3) 5-25.

McCann, I., and Pearlman, L. (1990). Vicarious traumatization: A framework for the psychological effects of working with victims. *Journal of Traumatic Stress*, 3(1), 131-149.

Pearlman, L. and Mac Ian, P. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, 26(6), 558-565

# TRAUMA RECOVERY CENTER SUPERVISION AND TRAINING

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By Alicia Boccellari, Ph.D. and Stacey Wiggall, LCSW



*Photograph by Ezme Kozuszek*

“When we strive to become better than we are,  
everything around us becomes better too.”

—Paulo Coelho

*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

The TRC supervision model provides essential structure and support for staff. Weekly individual supervision encompasses both administrative and clinical aspects and is given to all staff who provide client services, including mental health clinicians (regardless of licensure status), paraprofessional case managers and peer counselors. TRC Clinicians who are not yet licensed, who conduct clinical intakes with new clients, also receive weekly intake supervision in order to develop their assessment skills and accrue needed hours toward licensure. In addition, all Clinicians and other staff can receive brief on-the-spot supervision, or check-ins, from the Building Officer of the Day (BOD).

In some mental health service contexts, weekly individual supervision for staff is viewed as impossible due to limited resources. However, the TRC model views weekly individual supervision as a necessity to ensure high-quality care, and because of the high risk of vicarious trauma and burnout when providing services exclusively to recent survivors of violent crime. When staff receive regular support and guidance, they provide a higher quality of care to clients and are more productive. In addition, because well-supervised staff are able to maintain career longevity, both clients and colleagues benefit from lower rates of staff turnover.

## Primary Supervisors

Primary supervisors provide weekly individual supervision. Supervisors need to be senior, licensed staff with experience in trauma-informed, evidence-based therapeutic approaches. They provide clinical supervision of individual cases, including help with treatment planning and guidance with therapeutic models. Primary supervisors also provide administrative supervision, ensuring that each Clinician meets productivity standards but is not overwhelmed with cases. They check on documentation responsibilities and co-sign as needed for unlicensed supervisees. The primary supervisor is also responsible for approving requests to extend treatment beyond 16 sessions, to as many as 32 sessions (See *TRC Service Flow* chapter for more detail on this process.)

## Intake Supervisors

Trainees and unlicensed staff who conduct clinical intakes with new clients are given an hour a week of intake supervision in addition to their primary supervision. Intake supervision may happen individually or in a group. Intake supervisors help TRC Clinicians to refine their interviewing, assessment and diagnostic skills; supervisors also address barriers to effective rapport-building and client engagement if any are present. In addition, supervisors review written intake reports and co-sign documentation.



## Characteristics of Individual Supervision

Supervision of staff, like client services, should be trauma-informed. The following are characteristics of TRC supervision:

**STRENGTHS-BASED.** Supervision should be collaborative and empowering. It emphasizes acknowledgement of what the TRC Clinician is doing well, in addition to feedback on areas of growth or new ideas/practices to consider. This does not mean saying, “You’re doing a good job in general, but . . .” and then addressing weaknesses. The supervisor gives specific, genuine, positive feedback highlighting strengths, and offering constructive feedback as well in order to facilitate Clinicians’ growth.

**TRANSPARENCY AND STABILITY.** Supervisors’ expectations and work-related protocols should always be clear; supervision should be scheduled on a weekly basis.

**CULTURAL HUMILITY AND RESPONSIVENESS.** Supervision should encompass dialogue about cultural factors that impact both clients and staff.

**RESILIENCE AND RECOVERY.** Supervision should aim to highlight and build upon instances of client and staff resilience, and promote client recovery.

## Building Officer of the Day

The Building Officer of the Day, (BOD) is the lead supervisor on-call. The BOD provides on-the-spot supervision and consultation. The agency’s most experienced clinicians take turns serving as BOD. The BOD triages referrals, screening for eligibility and scheduling intake appointments. BODs also meet with any walk-in clients, assess their risk, and can schedule an intake for TRC services or help clients link with other resources (i.e., a domestic violence shelter). BODs are also responsible for helping to manage client crises that arise on-site, for example, the acutely suicidal client. TRC Clinicians who are meeting with clients out in the community can also consult with the BOD by phone. Front desk (reception) staff also receive training on when to call the BOD.

In the TRC model, a BOD should be on-site at all times. The length of shift can vary according to the needs and resources of each TRC. At the UC San Francisco TRC, BODs are assigned for 4.5 hour shifts, with a shift change in the middle of the day.

If a TRC Clinician has strong, immediate concerns about a client they are meeting with, the Clinician can excuse himself/herself from the session to consult with the BOD or ask the BOD to come in and jointly meet with the client.



**EXAMPLES OF SITUATIONS** where the BOD should be consulted by clinicians or reception staff include:

- The client appears to be at high risk of harming self or others.
- The clinician believes it may be necessary to make a mandated report (i.e, to child protective services or adult protective services).
- There is a potential Tarasoff “duty to warn” situation.
- The client is extremely agitated or potentially assaultive toward staff.

When calling in a BOD, the clinician can introduce the idea to the client by saying something like, “We work as a team here, and I’m concerned about what you’re sharing with me right now. I’m going to call in my colleague and ask her to join us so we can all discuss how to best help you through this.” Some clinicians who are newer to the TRC model may be reluctant to ask a BOD to join a client’s session, for fear the client will experience their presence as intrusive. Over the many years that UC San Francisco TRC has been operating, the great majority of clients do not object to this extra consultation, and often report feeling relieved and helped by the assistance of others on the TRC team. This is especially true when a clinician’s consultation with the BOD is 1) transparent to the client; 2) clearly motivated by genuine empathy for the client and 3) maintains focus on helping the client achieve safety and stability.

The BOD helps create a safe place both for the client and the clinician. Along with maintaining safety, the BOD system helps to reduce vicarious trauma and prevent staff burnout.

### **Time in weekly meetings and supervision**

At the UC San Francisco TRC, clinicians generally participate in:

- 1 hour of individual supervision
- 1 hour of group or individual intake supervision (for unlicensed staff and trainees)
- 1.5 hours of intake team (proposed new cases presented and discussed)
- 1 hour of general staff meeting
- 1 hour of staff professional development meeting, which usually involves either a case conference or a speaker
- 1 hour of self-care group (voluntary)

Participation in these meetings and supervision serves to promote a high quality of care for clients and to reduce vicarious trauma and burnout. Following is more detailed information about the structure and goals of meetings that are in addition to supervision. This chapter closes with sample agendas for TRC supervision and meetings.

**GENERAL STAFF MEETING.** The purpose of the general staff meeting is two-fold: an opportunity for team-building with everyone coming together, and communication. A typical weekly meeting covers recent client successes, a 10-minute discussion or exercise to increase staff cultural humility, sharing of information such as new resources or updated policies, anticipating any problem the clinic is facing, and reviewing strategic planning. The meeting closes with staff acknowledgements of each others' successes, or instances of going "above and beyond."

**WEEKLY INTAKE TEAM.** At the intake team meeting clinicians present a summary of their intake reports for new clients. After Q & A and discussion, the diagnosis and initial treatment plan is finalized (see Assessment and Treatment Planning chapter for more detail).

**WEEKLY PROFESSIONAL DEVELOPMENT.** In order to provide high-quality care based on current best practices for trauma treatment, a TRC program should have a one-hour professional development meeting each week. This can involve an outside speaker, such as an expert clinician covering a treatment approach, or a staff member from a collaborating agency discussing issues or resources of shared interest. A case conference, that focuses on cultural factors, less familiar therapeutic interventions, or complicated treatment planning also makes for a useful session. Staff can also read and discuss journal articles or have more in-depth discussions on value-driven topics such as cultural humility. In addition to ensuring high-quality services, a professional development meeting also helps buffer staff against vicarious trauma and burnout, and helps with staff retention.

**STEERING COMMITTEE MEETING.** The TRC Director and senior, supervising clinicians also meet weekly as a group. This provides an opportunity for supervisors to communicate about issues such as program planning and development, recent crises or complications, managing client flow, and other aspects of clinic management that may not be relevant for all staff and trainee participants of the larger staff meeting. The supervisors meeting also helps ensure clinicians' fidelity to the shorter-term TRC model of care. If a clinician wants to extend a client beyond 32 sessions, they present the case at the steering committee meeting for review.

## Additional Training

**DE-ESCALATION SKILLS.** On an annual basis, all TRC staff (both clinical and administrative) and trainees receive training on compassionately and effectively de-escalating agitated clients. The training is facilitated by senior TRC staff, such as the Clinical Coordinator, sometimes in conjunction with other experienced members of the team. Participants learn (or review) de-escalation skills in the context of compassionate care, in order to help ensure safe outcomes for all clients and staff.

**RISK MANAGEMENT.** Staff and trainees also receive training on the assessment and management of suicidality and homicidality. Training includes clinical assessment and safety planning, team protocols, mandated reporting requirements, and a review of local resources such as mobile crisis, urgent care shelters, and psychiatric emergency services.

**NEW EMPLOYEE TRAINING.** New Clinicians have an initial period of intensive orientation and training while building their caseloads with individual clients. New staff are oriented to all aspects of the TRC model and their role as a TRC Clinician.

**CASE MANAGEMENT DAY.** On an annual basis, a couple of UC San Francisco TRC Clinicians organize a Case Management Day in the community, during which **all trainees and new staff** spend a day visiting several community partner agencies in order to learn about their services and build collaborative relationships. Clinicians and trainees have the opportunity to view agencies and ask questions of program staff, which helps them provide linkage and effective clinical case management to TRC clients as needed.

## Guidelines for all TRC meetings

**AVOID UNNECCESSARY DISCUSSIONS OF DISTURBING MATERIAL.** As discussed in the vicarious trauma chapter, it is important that graphic or otherwise disturbing details about clients' experience not be shared in staff meetings, because this will needlessly expose other staff to potential traumatization. When a staff member needs to discuss such matters, this should occur in individual supervision. Even at intake teams, where new cases are presented to the team post-intake, clinicians need to be mindful of summarizing traumatic details and not devolving into "story-telling." More detail may be shared in the written report than is necessary to share when verbally presenting the case to colleagues.

**FOCUS ON RESILIENCE.** The positive and supportive culture of TRC is maintained by focusing on resilience. This is achieved at staff meeting by sharing client successes and discussing how they were achieved. Helpers often have a tendency to pass over discussing clients who are progressing well and instead concentrating on those who have the most problems. When successes are emphasized instead, the outlook of the whole

team is affected positively. Naturally, the team can discuss clients who have problems as well, but this should be kept in proportion, and done in a way that does not vicariously traumatize the whole team. When a Clinician or other team member is upset or overwhelmed, or when he or she needs to discuss potentially traumatizing details, in most instances this should be handled in individual supervision rather than a team meeting. Periodically, staff meeting leaders should also use meeting time to check in on group morale. During periods of lower team morale, it can be helpful for this to be communicated directly to leadership, with a discussion of both contributing factors, and possible solutions.

**PROMOTE STAFF CAMARADERIE.** At the UC San Francisco TRC, weekly staff meetings open with an opportunity to share clients' successes, as described above. Staff meetings close with Acknowledgements, an opportunity to publicly acknowledge another staff member who you observed going above and beyond in some way, or who helped you out during the week, or perhaps achieved a significant goal (such as becoming licensed). Staff appreciate the opportunity to demonstrate their appreciation and gratitude for the positive contributions of others, and sharing in these acknowledgements helps set the tone for a culture of support and positivity.

**IN SUMMARY.** TRC supervision and meeting structure gives essential support to staff. The practices outlined above help create culture of compassion and camaraderie that promotes staff longevity and high-quality client services.

## References

Coelho, Paulo. (1994). *The alchemist*. San Francisco: HarperCollins.



# TRAUMA RECOVERY CENTER SPEAKERS BUREAU

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By Carla Richmond, LCSW and Melissa Murphy, LCSW, MPH



*Photograph by Ezme Kozuszek*

“Sometimes it’s the scars that remind you that you survived.  
Sometimes the scars tell you that you have healed.”

—Ashley D. Wallis

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Crime survivors who have recovered enough from their trauma to talk about their experiences have powerful messages to deliver. A speakers bureau is one way that survivors can feel that they have a voice, that what happened to them matters, and that they can be powerful advocates for other survivors. A speakers bureau is a partnership between survivors and providers that provides education and advocacy to audiences while empowering survivors to speak truth to power.

TRC Clinicians have seen many clients in later stages of recovery benefit from engaging in a “survivors mission” as advocates for violence prevention and the value of trauma-focused treatment. These survivors find that such advocacy helps them make meaning of their suffering. The overwhelming experience of trauma is transformed through the creation of a cohesive narrative of the impact the trauma has had on their lives.

**POST TRAUMATIC GROWTH.** Post traumatic growth (PTG) describes a psychological process experienced by some trauma survivors in which a survivor’s relationship to him or herself and the world is positively transformed following a traumatic event (Meichenbaum, Calhoun & Tedeschi, 2006). Survivors who describe PTG as part of the recovery process are changed by the event and can experience the pains and losses of the trauma, but they also report positive shifts in their sense of themselves and others (e.g., a renewed valuing of life or their own capacity or a mission to make change in the world).

A TRC speakers bureau can promote post traumatic growth and provide trauma survivors with support to advocate for trauma-sensitive services and violence prevention. Survivors have important and powerful experiences to share with policy makers, mental health and medical providers, law enforcement, and others in the community. Many trauma survivors have found it is meaningful to use their experiences to advocate for change and social justice and describe this advocacy as a vehicle for continued healing that extends the work done in therapy.

**CHATT.** Individual TRCs will find their own ways to create and use speakers bureaus. As a resource and potential inspiration, the following is a description of the UC San Francisco TRC’s Speakers Bureau, which is called CHATT (Communities Healing and Transforming Trauma). We also include some general observations and suggestions for making a speakers bureau effective.

In CHATT, members (participating clients) have the opportunity to put together and practice telling the story of how violence affected their lives. Being able to tell their story has helped these survivors feel more confident and capable.

CHATT members educate audiences about:

- The impact of violence on the speakers' own lives
- Facts about violence in the community
- The process of recovery
- The need for trauma-sensitive services

## How CHATT Started

With some uncertainty, the UC San Francisco TRC asked several clients to speak at city council meetings about their experience of TRC services, because clinic funding was in jeopardy. The clients gave incredibly moving and persuasive testimony, and funding was restored. This happened several times over a period of years.

After speaking, the participating clients reported that they found speaking in these settings to be empowering. It was an opportunity to give back to the TRC and to help their communities. It helped to make meaning of their traumatic experiences. The speaking engagements also appeared to promote post-traumatic growth. Inspired by these experiences, TRC staff began the process of creating a speakers bureau for survivors of violent crime, and benefited from the support of the San Francisco Mental Health Association who had their own speakers bureau for mental health consumers. TRC also had the benefit of a proposed guide for creating a speakers bureau for trauma survivors (Blecker, 2010). TRC clinicians adapted these models, with feedback over time from CHATT members, into the trauma-informed model that it is today. TRC's who are considering creating a speakers bureau may find it useful to learn from CHATT's experience as they develop their own approach.

## Benefits for Clients

### Re-storying the trauma

The speakers bureau allows survivors to author their own story of the traumatic experience, including their story of recovery and healing, not just victimization (Fields et al., 2015). Speaking out can help trauma survivors construct a more healing narrative through seeing the self-transformed or transforming the world in some way. It gives voice to a previously-silenced experience. This process of re-storying has great potential to inspire audiences and it allows survivors to place the trauma story in the larger, ongoing story of their lives. CHATT speakers have reported that—

*“It helps continue the healing process and take away self-stigma to be empowered again. I didn’t have to feel so bad about what happened.”*

## **Community building**

The experience of surviving trauma is often isolating. Learning to reengage with others is an important part of the recovery process after trauma. Establishing a speakers bureau helps to break isolation by creating a healing community of survivors. At the UC San Francisco TRC, having a “social space” for trauma-telling has been vitally important for CHATT speakers.

*“Knowing there are others who have survived trauma ... gives hope/a sense of community.”*

—A CHATT Speaker

## **Restoring agency and a sense of competency**

As trauma removes power and control from survivors, the CHATT speakers bureau model emphasizes the restoring of survivors’ agency. Maximizing speaker’s choice is therefore another key feature. This includes allowing speakers to determine whether and where they wish to speak. CHATT speakers are supported to regularly assess their level of anxiety about speaking and readiness to speak and to let this guide the process for them. This allows speakers to keep their healing process at the center of their participation in the speakers bureau. Eliciting speakers’ “dream audiences” (i.e., groups they most want to speak out to) is another way to gain input from the group.

The speakers bureau provides an opportunity for survivors to practice telling their story. This helps to increase public speaking skills and gives voice to a silenced experience, providing a sense of competency.

*“Every time I speak out I feel stronger for having done so.”*

—A CHATT Speaker

## **Containment strategies**

Speaking about trauma has great potential for triggering both speakers and audiences. With this in mind, the CHATT speakers bureau integrates strategies to help survivor-speakers speak safely about their experiences. This includes storybuilding guidelines that



limit trauma detail, a strong focus on self-care, and time in each meeting to practice and strengthen affect regulation skills.

## **Starting a Speakers Bureau**

### **Who Is Involved in a Speakers Bureau?**

CHATT consists of 10 to 15 speakers and at least two TRC Clinicians who act as guides and facilitators for speakers bureau events and meetings. TRC Clinicians hold annual trainings for newly recruited members; they also host monthly Speaking Support Meetings.

Speakers undergo two 3-hour training sessions, where they receive support and guidance from both TRC Clinicians and current speakers bureau members. During training, speakers begin preparing their personal stories, detailing the impact of the trauma on their lives.

### **Protocol for selecting speakers**

In order to protect vulnerable clients, clinicians should evaluate the appropriateness of a potential participant and ensure that they are ready to be in CHATT before inviting them to join the speakers bureau. Although a speakers bureau benefits the community by providing education, and may benefit the agency by building support, the primary priority is that participation benefits the clients.

Potential speakers are dealing with profound losses. They will not always exhibit all of the positive indicators listed below. These items are meant to suggest a way of considering where clients might be in their healing, not as a checklist of criteria for where they should be. For many individuals, speaking out becomes a pathway for getting to a place of greater healing.

### **Have they integrated their trauma into their personal narrative?**

Of course, this narrative is never entirely completed. New stressors and different life stages will bring the trauma experience back into the forefront for all survivors.

- Have they developed, at least to some extent, a cohesive narrative in which the trauma experience is assimilated into their life story?

- How dominant are sensory images of the trauma, and how likely are they to experience significant re-experiencing symptoms when talking about the trauma?
- Do they have room for complexity in their narrative—vulnerability and strength, bad and good?

### **Have they begun to make meaning of their experience?**

Although survivors are still likely to ask “Why did this happen?”, they have integrated their experience into something larger.

- Have they learned that they are stronger than they thought?
- Have they changed their priorities about what is important?
- Have they come to a greater appreciation for life or their relationships?
- Are they looking for something good to come of their loss?

### **How is their social support?**

Support is associated with positive changes after trauma. Also, engaging in advocacy may increase survivors’ need for support.

- Does the client ask for support when they need it?
- What kind of responses do they get from their support network?
- Will they be able to get more support if necessary?

### **How is their self care?**

Self care is important for recovery and for dealing with the secondary trauma and exposure that may come up for speakers.

- How does this client take care of him/her self?

### **How is their spiritual life?**

Spiritual engagement, both positive and negative, is correlated with post traumatic growth.

- How does this survivor address spiritual or existential issues?

### **Additional questions to consider:**

- Is the client in a stage of physical and psychological *safety*?
- How are their coping skills?
- Has the client moved through the *remembrance and mourning* phase and are they able to reconstruct their trauma story?
- Can they think or talk about their trauma in an individual or group setting without flooding? (“Flooding” means to become dysregulated or overwhelmed.)
- Do they have hope and energy for engaging with life and community?

### **Deciding whether or not to invite clients to participate**

The team should discuss the points raised above and carefully consider whether a client seems ready to be invited to participate in the speakers bureau. Many clients will not be ready during their time of receiving TRC services, and many will. Clients should not be hurried into this role, and the team should reach consensus that an individual is ready before he or she is invited. It may also be appropriate to invite clients to participate in the speakers bureau near the time they are terminating their own TRC support services.

### **Suggested language for introducing the speakers bureau to clients:**

“We have a group of current and former TRC clients who speak about their trauma experiences and the services they received to different groups of people, such as service providers, students, or government officials. Speakers attend an initial training and also receive ongoing support. We think you have an important story to tell. If you’re interested, telling it could be powerful for you and for the community.”

You can explain that survivors will be speaking about the impact of the crime on their life and things that were helpful to their recovery, rather than the details of their trauma.

If the client is not interested, staff should not press the point. If they are interested, staff can explore their expectations and motivations by asking questions like:

“What would you want to get out of speaking?”

“How might it be helpful to you?”

Clients who are ready for the experience are apt to answer: “I want to give back,” “I want to prevent future violence,” or “I want to protect others.”

Speakers can address questions such as:

- How did your traumatic experience change you?
- How have you gotten to where you are now?
- What did receiving therapy do for you?

**INTRODUCING THE SPEAKERS BUREAU TO CLIENTS.** You can use language such as: “We provide speakers with training and support. After you’ve had a chance to participate in the training, the speakers bureau holds a monthly Speaking Support Group to give members a chance to develop and practice sharing their story with the group first. After practicing with the group, members use meetings to sign up for speaking events and to prep their talks for specific audiences.”

## **Speakers Bureau Training and Support**

### **CHATT speakers bureau training**

The six-hour training is the next step in preparing clients to become part of the speakers bureau (Fields et al., 2015). The CHATT Training takes place over two days and includes the following components:

- Group Guidelines
- Why Speak? Benefits of Speaking (Appendix 1)
- Writing Your Story with Storybuilding Structure (Appendices 2 and 3)
- Small Group Practice Telling Your Story and Giving Structured Feedback
- Challenges of Speaking and using SUDS (Appendix 4) for Distress Monitoring (Wolpe & Lazarus, 1973)
- For Survivors, from Survivors: Ideas for Coping and Telling Our Stories (Appendix 5)
- Evaluation/Feedback

## **CHATT speakers bureau resources**

Each participant in the CHATT training receives a binder of the training curriculum materials and other resources that will help them learn the CHATT speaking format and speak at public events.

## **CHATT monthly support groups**

The CHATT speakers bureau has a monthly meeting, facilitated by two TRC Clinicians (Valdez et al., 2015). Speakers attend the group to practice speaking, to learn about and sign up for new speaking events, to prepare for events, and to practice self-care and affect regulation skills. Part of the activity in the monthly meeting is for the speakers to do self-monitoring of their level of distress and anxiety and readiness to speak, as well as for clinicians to monitor clients' readiness to speak. The focus of the group is on building and supporting speakers' presentation skills; it is not a therapy group.

## **Guidelines for training and monthly meetings**

Guidelines are established and reviewed at the start of each training and at each monthly meeting to establish a sense of safety.

**CONFIDENTIALITY.** To maintain a trusting environment, staff and speakers are asked to maintain confidentiality about personal information shared at trainings, meetings and speaking events. This allows participants to share more freely and to access as much support and feedback as possible. Speakers are, of course, free to share their own stories outside of CHATT activities.

**GROUP SUPPORT.** Members are encouraged to attend monthly Speaking Support Group meetings to remain up to date on speaking opportunities, to build speaking and self-care skills and to access support about speaking experiences. Members are also encouraged to contact CHATT Staff Facilitators regarding emergencies, scheduling conflicts, or for speaking support.

**RESPECT.** Members are encouraged to be open and honest with each other and with Staff Facilitators and also to maintain a positive, safe and supportive environment for each other. This includes being respectful of the varying perspectives, approaches and healing journeys of other members. Members are encouraged to access support from Staff

Facilitators as needed to discuss strong reactions to stories or actions of other group members.

**ATTENDANCE.** Attendance at monthly meetings and signing up for speaking events is voluntary. Speakers are encouraged to attend the group for support and self-care, but there is no attendance requirement. Speakers are asked to arrive at training sessions, group meetings and speaking events on time, and to notify Staff Facilitators if running late.

**SUPPORT AND SELF CARE.** Speaking about trauma and hearing others' experiences can bring up strong feelings or reactions. Speakers are encouraged to practice self-care before, during and after events. If members feel triggered at trainings, meetings or speaking events they are also encouraged to access one to one support from CHATT Staff Facilitators.

**SHARE HEADLINES, NOT DETAILS.** Speakers are encouraged to talk about the kind of trauma they experienced and the impact it has had on their lives but to avoid sharing the overly graphic details in trainings, monthly meetings or at speaking events. This increases safety and decreases anxiety for speakers and audiences. Speakers are encouraged to only share information they feel comfortable sharing. We acknowledge that that may vary from talk to talk and day to day with variations in a speaker's distress level.

**ANYTHING ELSE...?** Members and Staff Facilitators are encouraged to add to the guidelines and tailor them to the needs of the group. It is considered a "living list."

## Story-Building Process

The primary focus of the CHATT Training and monthly meetings is supporting speakers in telling their story of the trauma. CHATT guides speakers to use a Four-Step Story-Building Process for drafting their written story and in preparing their presentation.

**1. HEADLINE.** What was the trauma that you survived? 1-2 lines. No graphic trauma details.

**2. IMPACT OF THE TRAUMA.** How did the trauma affect you (mind, emotions, body, relationships, work, school)? How did it affect the way you view yourself, others, the world?

**3. YOUR RECOVERY PROCESS.** What helped your healing, and what didn't? Was there a turning point? What was the role of therapy?

**4. WHERE YOU ARE NOW.** How are things now compared to before? What have you learned, discovered? What are your goals for the future?

## **Giving Feedback**

In the training and in monthly meetings, members practice telling their stories in front of each other and give each other feedback. In giving feedback members are encouraged to: 1) Focus on what worked in the story they heard; 2) Take care to avoid judgments of the content of someone else's story; 3) Remember that all CHATT members have good intentions.

### **Three-step structured feedback model**

**Please share feedback with speakers, including:**

- One thing you liked about the way the speaker told their story
- One suggestion for improving their story
- One thing that moved or touched you about their story

## **Speaking Out**

Most speakers participate in about four presentations per year, but there is a range and the TRC does not require any kind of minimum speaking events for participation. We have found that the freedom to choose seems helpful to speakers.

In this model, members decide when they are ready to speak publicly. Some clients are ready to speak sooner, some later, and some participate in monthly meetings but never elect to speak. Clients are never pressured or required to speak when they do not feel ready.

## **Audiences**

Many audiences for speakers bureau speakers are service providers such as mental health clinicians, but CHATT speakers have also addressed audiences of law students, social work and psychology students, other survivors of crime, and state legislators. CHATT speaking engagements increase audience members' awareness of violence, decrease stigma, and positively impact beliefs about trauma treatment (Valdez et al., 2015).

In preparation for arranging speakers and audiences, a TRC Clinician screens the venue and matches speakers with the audience. Speakers have a choice in whether they wish to address the audience and have permission not to speak if they do not feel comfortable or ready to speak to a particular audience.

## **Varying the speaking event structure**

The agenda—topics and their order, speakers, facilitators—can be changed to fit different situations. Here are the four main structures we have used at the UC San Francisco TRC.

### **INDIVIDUAL TALK**

- 1 to 3 speakers share their trauma stories using the storybuilding structure (Headlines, Impact, Recovery, Now)
- Q & A moderated by TRC staff facilitators.

### **PANEL PRESENTATION**

- 2 to 5 speakers respond in turn to prepared questions which follow CHATT storybuilding structure.
- Q & A moderated by TRC staff facilitators

### **CLINIC COMMUNITY PRESENTATION**

- 1 speaker accompanies a TRC staff presenter
- Speaker story is integrated into a broader presentation on a related topic (e.g. on Traumatic Loss or Domestic Violence)

### **LEGISLATIVE HEARING TESTIMONY**

- 1 or more speakers share their trauma story, w/o facilitator introduction.
- May use CHATT story-building structure or modified version based on venue protocol

## **Providing support for speaking out**

The UC San Francisco TRC CHATT speakers bureau uses a three-part structure for providing speaking event support to speakers.



**BEFORE EVENTS.** Before speaking events, staff facilitators coordinate and set up speaking venues. At the Monthly Speaking Support Meeting, members are invited to sign up for specific events. Events are sometimes tailored (e.g., to survivors of particular kinds of trauma or crime). Staff facilitators provide an overview of the event and audience, the structure of the talk (e.g., panel, legislative testimony, or individual talk), provide related handouts/panel questions and explore key messages with potential speakers. Speakers are invited to use meeting time to practice their talks for upcoming events and get structured feedback from the group. Members are invited to contact staff facilitators with additional questions or scheduling changes/emergencies.

**DURING THE EVENT.** Staff facilitators often introduce CHATT and/or the speaking topic as appropriate. They facilitate panel questions and Q & A periods after the talk. Speakers have the right to pass on questions and are supported in this by staff facilitators.

**AFTER THE EVENT.** Staff facilitators debrief with speakers to explore their reactions to the event, provide direct support, lead grounding or breathing as needed, and check in with speakers about their post-talk self care plans.

## In Summary

TRC Clinicians can further clients' healing, posttraumatic growth, and sense of empowerment by supporting them to participate in a speakers bureau. With initial training and ongoing support, survivors of violent crime can choose to share their stories for the benefit of others, while also benefitting from the process themselves.

## References

Blecker CK. CHATT, agency and post-traumatic growth: A speakers' bureau for survivors of interpersonal violence. San Francisco: San Francisco State University; 2010.

Fields, L., Valdez, C., Boccellari, A., Richmond, C., Murphy, M., & Shumway, M. (2015, November). Impact of participation in a speaker's bureau for survivors of violence on posttraumatic growth, self-efficacy & stigma. Poster presented at the 31<sup>st</sup> Annual Meeting of the International Society for Traumatic Stress Studies, New Orleans, LA.

Fields, L., Valdez, C., Shumway, M., Murphy, M., Richmond, C., & Boccellari, A. (2015, November). Teaching trauma survivors to speak out safely: A speaker's bureau training curriculum for survivors of violence. Poster presented at the 31<sup>st</sup> Annual Meeting of the International Society for Traumatic Stress Studies, New Orleans, LA.

Meichenbaum, D.; Calhoun, L. G.; Tedeschi, R. G. (2006). Handbook of post- traumatic growth: Research and practice. Mahwah, NJ: Lawrence Erlbaum. pp. 355–368.

Valdez, B., Fields, L., Boccellari, A., Murphy, M., Richmond, C., & Shumway, M. (2015, November). Impact of a speaker's bureau for survivors of violence on audience beliefs about violence, treatment, and stigma. Poster presented at the 31<sup>st</sup> Annual Meeting of the International Society for Traumatic Stress Studies, New Orleans, LA.

Valdez, C., Fields, L., Boccellari, A., Richmond, C., Murphy, M., & Shumway, M. (2015, November). Implementation of a speaker's bureau support/work group for survivors of violence: identifying needed structures, processes, challenges and benefits. Poster presented at the 31<sup>st</sup> Annual Meeting of the International Society for Traumatic Stress Studies, New Orleans, LA.

Wallis, A. (2012). *Sometimes*. Lulu.com.

Wolpe, J., & Lazarus, A. (1973). Behavior therapy techniques: A guide to the treatment of neuroses. Pergamon.

## **Additional Resources**

Gause M. SOLVE: Sharing our lives voices and experiences. Overview and Annual Report. Mental Health Assoc. of San Francisco 2010.

Najavits, L. (2002). Seeking safety: A treatment manual for PTSD and substance abuse. Guilford Press. NY, NY.

Neimeyer, R.A. (2006). Re-storying loss: Fostering growth in the posttraumatic narrative. In L. Calhoun and R. Tedeschi (Eds.), *Handbook of posttraumatic growth: Research and practice* (pp. 68-80). Mahwah, NJ: Lawrence Erlbaum.

Sheikh A. Posttraumatic growth in trauma survivors: implications for practice. *Counseling Psychology Quarterly*. 2008;21(1):85-97.

## **Appendix 1 to TRC Speakers Bureau: Benefits of Speaking Out Worksheet**

For a worksheet on the benefits of speaking out about trauma, see the following page.

## BENEFITS OF SPEAKING OUT

### 1. Some ways I might benefit from sharing my story:

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### 2. Some ways the community (including individual people, groups, agencies) could benefit from hearing my story:

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**3. My unique motivations or special purpose for speaking out:**

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**4. My dream audience would be:**

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## **Appendix 2 to TRC Speakers Bureau: Storybuilding Questions, First Draft**

For a first draft worksheet on storybuilding questions, see the following page.

**Storybuilding Questions – First Draft**

The questions below are to help guide you as you do a first draft of your speech. Take a moment to look over the questions. Think about what you want San Francisco communities to know about your story of surviving and recovering from trauma. What key message do you want to share? The questions are intended to help you to develop your story. You do not have to answer the questions in too much detail at this point, unless you want to.

**HEADLINE (What was the trauma that you survived? Eg “I was the victim of domestic violence” or “Two years ago I was shot.”)**

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**PART ONE: What was the IMPACT of the trauma on your life?**

1) What was it like for you right after?

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2) How did your exposure to violence change you?

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3) How did it affect your emotions, thoughts, behaviors, and day to day life?

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4) How were your beliefs changed?

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**PART TWO: Next write about the process of your RECOVERY**

1) How have you gotten to where you are now?

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2) What was helpful in the recovery process?

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3) What didn't work well or was missing altogether?

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4) What did therapy or the TRC do for you?

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**PART THREE: Write about where you are NOW.**

1) Where are you now?

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2) What goals were you able to achieve?

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3) How have you grown since the trauma experience?

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4) What have you learned about yourself from your recovery experience?

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5) What are your hopes and goals for the future?

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### **Appendix 3 to TRC Speakers Bureau: Storybuilding Questions, Second Draft**

For a second draft worksheet on storybuilding questions, see the following page.

## Storybuilding Questions – Second Draft

Write about the **impact** of the trauma on your life

- How did your exposure to violence change you?
  - What was it like for you right after?
  - How did it effect your emotions, thoughts, behaviors, and day to day life?
  - How were your beliefs changed?
  - In what ways are you different now?

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Write about the process of your **recovery**

- How have you gotten to where you are now?
  - What was helpful in the recovery process?
  - What didn't work well or was missing altogether?
  - What did therapy or the TRC do for you?

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Write about where you are **now**

- Where are you now?
  - What goals were you able to achieve?
  - How have you grown since the trauma experience?
  - What have you learned about yourself?
  - What are your hopes and goals for the future?

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## **Appendix 4 to TRC Speakers Bureau: Subjective Units of Distress (SUDS)**

For a SUDS handout, see the following page.

## **Subjective Units of Distress Scale (SUDS)**

100 = Highest level of anxiety, distress, or agitation. Overwhelmed or out of control.

90 = Extremely anxious or distressed; feeling that you are losing control.

80 = Very anxious or distressed. Bodily signs (increased heart rate, shaking, sweating, gastrointestinal distress) are present.

70 = Quite strong anxiety or distress. Bodily signs may be present.

60 = Somewhat strong anxiety or distress.

50 = Moderate anxiety or distress. Unpleasant feelings are still manageable with some effort.

40 = Mild-to-moderate anxiety or distress. Tolerable but unpleasant.

30 = Mild anxiety or distress that does not interfere with functioning.

20 = Minimal anxiety or distress.

10 = Feeling basically good; able to think and concentrate well.

0 = No anxiety or distress. Total relaxation.

## **Appendix 5 to TRC Speakers Bureau: For Survivors, From Survivors: Ideas and Tips on Telling Our Stories**

For a survivors' tips handout, see the following page.



# For Survivors, from Survivors:

## *Ideas for Coping & Telling our Stories*

Sharing our stories is a vital part of healing and community, but it is important to notice how these powerful stories affect us and others. Being a victim or survivor of crime may cause psychological pain or *trauma*. The story may be *re-traumatizing* for a survivor to tell or cause *secondary trauma* for people in our audiences. Below are a few tips from other survivors on coping with these possible reactions.

### **“SELF-CARE”**: taking care of yourself today and after today

Stories are important - but so are *you*! Your most important responsibility in our survivor community is to take care of yourself, especially if you feel distressed. Here are a few ideas.

- Always make sure you feel safe first before sharing your story
- Be kind in the way you think or talk about yourself - don't be hard on yourself
- Give yourself permission to cry or "let it out" if you need to
- Give yourself permission to take a break, take a nap, or do nothing at all
- "Treat yo'self!" / give yourself a treat
- Eat healthy foods, drink plenty of water and get enough rest or sleep
- Get some physical activity (e.g. stretch, walk, dance, or go to the gym)
- Hang out with or reach out to a friend - call, text, email or write them a letter
- Find a way to laugh or smile (e.g. a funny movie or internet meme, a favorite song)
- Share your experiences with someone who supports you
- Share your favorite self-care tips with others!

### **“GROUNDING”**: getting back to the present moment if you feel distressed

The idea of "grounding" is to keep yourself from feeling overwhelmed by painful thoughts or memories by doing simple physical or mental activities. Don't worry if you feel shy - most of these tips are activities no one will notice.

- Push your feet into the floor, grab the sides of your chair, or touch a nearby object
- Carry or hold a meaningful or soothing object (e.g. a "worry stone")
- Wear a meaningful piece of clothing or jewelry
- Practice breathing exercises (e.g. take a deep breath and let it out slowly)
- Look at photos that make you feel happy or enjoy a beautiful view
- Take a break with sound (e.g. listen to music or try noise-canceling headphones)
- Try eating something with a very strong taste (e.g. tart berries, minty gum)
- Enjoy a strong scent (e.g. mint, sage, palo santo, coconut)
- Do something diverting (e.g. sketch on an art pad – or just doodle on this page!)
- Take time out for grounding to "resurface" after hearing stories or telling your story

***There is no “right way” to heal.***

### **“HEALTHY COPING”**: ideas for dealing with trauma in the longer term

Everyone dealing with trauma will find their own ways of coping, but it is important to remember that there are "healthy" (e.g. grounding) and "unhealthy" (e.g. alcohol abuse) ways of coping.

- Identify the safe places and safe people in your life
- Let the people who support you know what you need from them
- Take care of your physical well-being as well as your mental health
- Develop a “support network” of people you can turn to if you need help or feel distressed
- Develop a “team” of professionals to help you deal with all aspects of how this crime may have impacted your life – physically, financially, legally, medically, etc
- Find a doctor or primary care provider
- Explore therapy or other psychological healing options if you feel like it and do not be discouraged by other people's opinions about this - it can be a private decision
- Find a therapist or other healing care provider that works for *you*. The first solution you try may not be the best - keep trying until you find what works!
- Explore meditation (e.g. guided imagery meditation, progressive relaxation meditation or a more physical meditation such as yoga)
- Explore a spiritual connection as you define it
- Seek out communities of people who have been through similar experiences to yours and remember: you are not alone
- Take time to be social and take care of your relationships
- Take time to reflect on your healing progress and remember your accomplishments
- Take time to reflect on things that make you feel grateful
- There is no “schedule” for healing - you will find it in your own time

*These tips came from survivors on the [Communities Healing and Transforming Trauma \(CHATT\) Speakers Bureau](#) at the [Trauma Recovery Center](#) in San Francisco.*

*There are many paths to healing. These are just a few ideas we learned from many different resources and from our own experiences. We wish you all the best on your healing journey. Whatever your path, always remember...*

***There is no “right way” to heal.***

# MEASURING CLINICAL OUTCOMES AND CONDUCTING PROGRAM EVALUATION

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By Martha Shumway, Ph.D. and Alicia Boccellari, Ph.D.



“Birds sing after a storm; why shouldn’t people feel as free to  
delight in whatever sunlight remains to them?”

–Rose Kennedy

*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

The UC San Francisco TRC has developed and incorporated an integrated system of standardized forms, data collection procedures, relational databases, and performance improvement processes. It also uses standardized mental health measures to assess a client's symptoms and their response to treatment interventions. The UC San Francisco TRC database enables staff to examine the effectiveness of TRC services at both a programmatic level and an individual client level.

As discussed in the chapter *TRC Assessment and Treatment Planning*, the UC San Francisco TRC uses several standardized measures to assess mental health symptoms and other clinically relevant domains, such as pain, sleep disturbance, and quality of life. Standardized measures are integrated into the initial comprehensive assessment as part of the Multi-Area Review and Trauma History Assessment (MARTHA) and are repeated every eight treatment sessions to evaluate clients' progress and response to treatment. Standardized measurement facilitates comparison of the TRC's client population to other populations and helps clinicians to monitor individual client progress, identify areas to target in treatment, and to select intervention strategies. Clinicians also discuss the standardized measurements with clients and use results to engage clients in shared decision making about their treatment. As noted previously, the ultimate goal is to use the standardized assessment data to develop algorithms to guide selection of evidence-based interventions. This chapter outlines the rationale the UC San Francisco TRC uses to select standardized measures and then describes the domains that are assessed, the measures in use at the UC San Francisco TRC, and other potentially useful measures.

## Strategy for Selecting Standardized Measures

The UC San Francisco TRC uses a set of common principles to select standardized measures for routine use. First, there should be published data showing that the measures have strong “psychometric properties.” This means that the measures should be **reliable**, in that they work similarly across people, groups, and time, **valid** in that they measure what they are intended to measure, and **responsive**, in that they are sensitive to change.

Second, measures should have low “cognitive complexity.” Survey researchers have identified several factors that make standardized questions difficult to answer (Krosnick, 1999; Sudman, Bradburn, & Schwarz, 1996; Tourangeau, Rips, & Rasinski, 2000). Questions that are long, use highly sophisticated vocabulary, or are grammatically ambiguous tend to yield poor quality answers. Similarly, measures with many similar items can lead to fatigue that limits the quality and accuracy of answers. Therefore, measures are selected that have short, straightforward questions. Measures are chosen to be as brief as possible while allowing measurement of change over time. Very brief screening measures, with only a few items, typically aren't sensitive to changes over time.

Third, measures with evidence of cross-cultural applicability are preferred because they are likely to be relevant to the TRC's diverse client population. Measures that have already been translated into other languages, particularly Spanish, are ideal.

Fourth, the UC San Francisco TRC uses measures that are available free-of-charge. Many high quality measures have been developed with government support or otherwise developed for public use. As a result, it is not necessary to use limited funding to purchase measures.

## PTSD Symptoms

PTSD symptoms are a central focus of mental health treatment for crime victims. To measure PTSD symptoms, the UC San Francisco TRC uses the PTSD Checklist (PCL). The original 17-item PCL, developed to assess PTSD as defined in DSM-IV (Weathers, Litz, Herman, Huska, & Keane, 1993), has been repeatedly shown to be valid, reliable, and highly concordant with clinician-administered diagnostic tools in a wide range of populations (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996; Grubaugh, Elhai, Cusack, Wells, & Freuh, 2007). The 20-item PCL-5 was recently developed to assess PTSD as defined in DSM-5 (Weathers, et al., 2013). Preliminary evidence suggests that it is as reliable and valid as the original PCL [(Blevins, Weathers, Davis, Witte, & Domino, 2015; Bovin, et al., 2015; Wortmann, et al., 2016). The PCL-5 items are all answered on a 5-point response scale that ranges from 0="not at all" to 4="extremely." The PCL-5 is particularly useful because it can be scored to yield a continuous measure of symptom severity and to make a provisional diagnosis of PTSD according to DSM criteria. Separate scores for the four clusters of PTSD symptoms can also be calculated. PCL scores are calculated as simple sums of the responses which makes it possible for clinicians to immediately calculate scores when that is clinically useful. Based on available data, a score of 33 or higher on the PCL-5 is associated with a diagnosis of PTSD. Additional information on the PCL is available from the National Center for PTSD at <http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>

There are many reliable and valid standardized measures of PTSD symptoms. However, not all established measures have been updated to measure PTSD as defined by DSM-5. Many measures have more questions than the PCL, which increases both administration time and clients' cognitive burden. Some measures, for example the Davidson Trauma Scale (DTS), separate the measurement of symptom frequency from the measurement of distress associated with symptoms. This additional information could be clinically useful; however the DTS is not available free of charge and the parallel sets of questions increase administration time.

## Complex PTSD

People who experience childhood abuse and/or repeated traumas in adulthood can experience what is often termed "Complex PTSD" (CPTSD), or "Disorders of Extreme Stress," which involves chronic affect dysregulation and interpersonal difficulties in addition to the symptoms of PTSD (Herman, 1997; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). The concept of CPTSD has been controversial and no practical standardized measures have been validated. The one standardized measure available, the 45-item Structured Interview for Disorders of Extreme Stress (Pelcovitz, et al., 1997), has not been well-validated and is time-consuming and potentially distressing to recently traumatized persons. To meet the need for a practical standardized measure of CPTSD, researchers working with the UC San Francisco TRC have developed an initial 23-item measure that is currently being tested. The goal is to reduce the number of items to produce a more manageable and useful measure. As part of the formulation of a CPTSD diagnostic category for ICD-11, a similar, 24-item questionnaire has been developed, but is not yet publicly available.

## Lifetime Trauma History

In planning treatment for a recently traumatized crime survivor, it is important to understand the individual's trauma history. Individuals who have experienced many prior traumas will respond differently, and have different treatment needs, than individuals who have not experienced prior traumas (Herman, 1997; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Childhood trauma is of particular interest because it has been repeatedly shown to be associated with revictimization (Coid, et al., 2001; Dong, et al., 2004) and adverse health and mental health consequences over the life course (Felitti, et al., 1998). There are many published trauma history checklists. The UC San Francisco TRC has used different checklists in the past and now uses the Trauma History Screen (THS) (Carlson, et al., 2011) because the THS describes 14 key types of trauma very succinctly. To get a basic understanding of each client's trauma history without causing the client to become distressed or overwhelmed, only the initial checklist portion of the THS is used. The detailed follow-up questions about each type of trauma are not used. The clinician can follow-up on details as clinically indicated over the course of treatment.

## Traumatic Brain Injury

Traumatic brain injuries (TBI) can have lingering effects that can impact individuals' response to traumatic events and treatment for traumatic stress. The UC San Francisco TRC screens for prior TBI using 3 yes-no questions adapted from the Ohio State University TBI Identification Method Short Form (Corrigan & Bogner, 2007). The questions are:



1. In your lifetime, have you ever injured your head?
2. (if yes to 1.) Were you "knocked out" or did you lose consciousness after (this injury / any of these injuries)?
3. (if yes to 1.) Were you dazed or did you have any gaps in your memory after (this injury / any of these injuries)?

Yes answers to 1 and 2 indicate the strong likelihood of a TBI; yes answers to 1 and 3 indicate a possible TBI.

## Depression

Depression is common following traumatic events and co-occurs with PTSD. The UC San Francisco TRC uses the PHQ9 (Kroenke, Spitzer, & Williams, 2009) to measure depression. The nine PHQ items are directly linked to DSM diagnostic criteria. All questions use the same response scale that ranges from 0=not at all to 3=nearly every day. Responses can be easily summed by the clinician as needed. The PHQ9 has been shown to be valid and reliable across a range of diverse populations and settings (Becker, Al Zaid, & Al Faris, 2002; Wulsin, Somoza, & Heck, 2002), as well as sensitive to change over time (Lowe, Kroenke, Herzog, & Grafe, 2004). Validated cut-points distinguishing five levels of depression severity have been established. The PHQ9 and its administration and publication manual are readily available for download in multiple languages at: <http://www.phqscreeners.com>.

## Sleep Disturbance

A growing body of evidence documents a strong association between sleep disturbance and persistence of PTSD symptoms (Brownlow, Harb, & Ross, 2015; Gilbert, Kark, Gehrman, & Bogdanova, 2015). The UC San Francisco TRC uses the 4-item Sleep Disturbance scale developed as part of the NIH's PROMIS (Patient-Reported Outcomes Measurement Information System) initiative. This is the shortest of the multiple PROMIS Sleep Disturbance measures that have been rigorously developed using item-response theory methods (Yu, et al., 2012). In UC San Francisco TRC data, the 4-item version was correlated with longer versions at  $r < .9$ ; therefore the 4-item version is used to reduce respondent burden and save time. The PROMIS Sleep Disturbance measure is much shorter and easier to follow than other well-established sleep measures, such as the widely-used Pittsburgh Sleep Quality Index (PSQI) (Buysse, Reynolds, Monk, Berman, & Kupfer, 1989). However, it is still somewhat problematic for clients with limited literacy, limited English proficiency, or cognitive difficulties because it includes "reversed" items in which the response scale has a different meaning for different questions. PROMIS measures are available at: <http://www.healthmeasures.net>.

## Pain

Emerging evidence suggests a bidirectional connection between chronic pain and PTSD symptoms. The UC San Francisco TRC uses the recently developed 3-item PEG pain measure (Krebs, et al., 2009) to assess pain. The PEG is based on the longer, well validated and widely used pain scale Brief Pain Inventory (BPI) (Tan, Jensen, Thornby, & Shanti, 2004). The three questions use similar 0 to 10 point scales to measure pain severity, the extent to which pain interferes with enjoyment of life and the extent to which pain interferes with general activity.

## Quality of Life

To obtain a more general more general measure of clients' well-being that goes beyond symptoms, the UC San Francisco TRC uses the 26-item WHOQOL-BREF as measure of quality of life (WHOQOL Group, 1998) The WHOQOL-BREF was multinationally developed to assess QOL related to physical health, psychological well-being, social relationships and environment. It is sensitive to changes associated with mental health treatment (Carta, et al., 2008; Chand, Mattoo, & Sharon, 2004).

## Other Diagnoses

In addition to the structured measures discussed above, the UC San Francisco TRC uses symptom checklists linked to DSM criteria that have been tailored over time to meet the needs of the clinic, such as Panic Disorder, Bipolar Disorder, and Psychotic Disorders. The M.I.N.I. (Sheehan et al., 1997) is a well-validated diagnostic tool that takes a similar approach. Information on current ways to use the M.I.N.I. can be found at: <http://www.medical-outcomes.com/index/mini>.

## Service Delivery and Program Evaluation

Along with utilizing standardized measures to track each client's response to treatment, UC San Francisco TRC collects additional data that is used to evaluate program and clinical effectiveness.

The use of standardized referral and productivity forms allows the TRC to track staff allocations, staff productivity, and client flow, including the number of clients served, units of service, and the types of service provided. It also allows for the collection of individual client data including demographics, crime type, and other variables from referral information.



**REFERRAL FORM.** This form contains information about which agency is making the referral, basic client demographics, and the type of violent crime that is necessitating the referral. It also contains information as to whether the client showed for the initial intake evaluation. Data from this form can be used to generate a “Recruitment Report” which allows the TRC to keep track of the number of referrals received, broken down by the variables of age, gender, ethnicity, and type of crime. It also allows staff to look at client attrition occurring between the point of referral and the scheduled intake, and helps to guide initial outreach attempts.

**PRODUCTIVITY FORM.** This form is filled out by the Clinicians for each service they provide in order to capture all client encounters. It includes the type of service provided (i.e., individual therapy, group therapy, case management), the type of evidence-based treatment provided, the location of the service (at TRC, at the client’s home, or in the community) and the length of time it took to provide the service. Clinicians also enter the amount of Direct time (face-to-face) or Indirect time (on the phone with a client or engaged in case management on a client’s behalf), in addition to noting the time it took to complete any service-related documentation (progress notes, intake assessment reports, etc.) This data can then be used to generate a “Productivity Report,” which captures the total number of clients seen throughout the TRC, and the number and types of services that were provided. It also allows for tracking which clients completed treatment and which dropped out. Service data can be broken down by demographic information, type of crime, or Clinician. This tool is helpful for reviewing Clinician productivity and caseload size.

**NEEDS ASSESSMENT, BARRIERS TO CARE AND LINKAGE TO SERVICES.** In an effort to help guide case management interventions and to evaluate our effectiveness in providing case management services, Clinicians complete a Needs Assessment and Barriers to Care form when a client begins services, at the 8<sup>th</sup> session, and at the close of treatment. Based on the clinical interview and using a 4-point scale that ranges from 0 (None) to 3 (Extensive Need), the Clinician rates a client’s level of need in 13 domains. These include: financial needs, legal assistance, transportation, housing, and other domains where clients may have service needs. The Clinician also indicates any existing barriers to care, such as language barriers, or difficulty leaving the house to access services. At every 8<sup>th</sup> session, the Clinician indicates whether case management services were offered to the client to meet their needs, and whether TRC provided the service or helped the client link to a resource outside of TRC.

**SERVICE SATISFACTION SURVEY.** In order to evaluate and monitor the program’s responsiveness to clients, a Service Satisfaction Survey is given at every 8<sup>th</sup> session and at the closing of treatment. The survey is composed of 13 items that use a 5-point scale,

and includes items such as, “How satisfied were you with the progress made towards your goals for treatment?”, and “How much were your cultural values and/or language preferences respected during your visits?”

## Summary

A guiding principle of the TRC model is accountability to the clients we serve and to our funding agencies. This is accomplished through the collection of data on both clinical outcomes and services provided, so that the program is evaluated for clinical effectiveness and fiscal responsibility. An effective program evaluation can be used to help maintain current funding and to acquire new funding sources. Data can also be used to advocate for system-wide policy change that removes barriers to care for underserved survivors of violent crime.

## References

- Becker, S., Al Zaid, K., & Al Faris, E (2002). Screening for somatization and depression in Saudi Arabia: a validation study of the PHQ in primary care. *International Journal of Psychiatry in Medicine*, 32, 271-283.
- Blanchard, E. B., Jones-Alexander, J., Buckley, T. C., & Forneris, C.A. (1996). Psychometric properties of the PTSD Checklist (PCL). *Behaviour Research and Therapy*, 8, 669-673.
- Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress*, 28, 489-498.
- Bovin, M. J., Marx, B. P., Weathers, F. W., Gallagher, M. W., Rodriguez, P., Schnurr, P. P., & Keane, T. M. (2015). Psychometric properties of the PTSD Checklist for Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (PCL-5) in veterans. *Psychological Assessment*. Advance online publication.
- Brownlow, J. A., Harb, G. C., & Ross, R. J. (2015). Treatment of sleep disturbances in post-traumatic stress disorder: A review of the literature. *Current Psychiatry Reports*, 17, 41.
- Buyse, D. J., Reynolds, C. F., Monk, T. H., Berman, S. R., & Kupfer, D. J. (1989). The Pittsburgh Sleep Quality Index: A new instrument for psychiatric practice and research. *Psychiatry Research*, 28, 193–213.

Carlson, E. B., Smith, S. R., Palmieri, P. A., Dalenberg, C., Ruzek, J. I., Kimerling, R., ... Spain, D. A. (2011). Development and validation of a brief self-report measure of trauma exposure: The Trauma History Screen. *Psychological Assessment, 23*, 463-477.

Carta, M. G., Hardoy, M. C., Pilu, A., Sorba, M., Floris, A. L., Mannu, F. A., ... Salvi, M. (2008). Improving physical quality of life with group physical activity in the adjunctive treatment of major depressive disorder. *Clinical Practice and Epidemiology in Mental Health, 4*, 1.

Chand, P. K., Mattoo, S. K., & Sharan, P. (2004). Quality of life and its correlates in patients with bipolar disorder stabilized on lithium prophylaxis. *Psychiatry and Clinical Neurosciences, 58*, 311-318.

Coid, J., Petruckevitch, A., Feder, G., Chung, W., Richardson, J., & Moorey, S. (2001). Relation between childhood sexual and physical abuse and risk of revictimization in women: A cross-sectional survey. *Lancet, 358*, 450-454.

Corrigan, J. D., & Bogner, J. A. (2007). Initial reliability and validity of the OSU TBI Identification Method. *Journal of Head Trauma Rehabilitation, 22*, 318-329.

Dong, M., Anda, R. F., Felitti, V. J., Dube, S. R., Williamson, D. F., Thompson, T. J., ... Giles, W. H. (2004). The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction. *Childhood Abuse & Neglect, 28*, 771-784.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ... Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*, 245-258.

Gilbert, K.S., Kark, S. M., Gehrman, P., Bogdanova, Y. (2015). Sleep disturbances, TBI and PTSD: Implications for treatment and recovery. *Clinical Psychology Review, 40*, 195-212.

Grubaugh, A. L., Elhai, J. D., Cusack, K. J., Wells, C., & Frueh, B. C. (2007) Screening for PTSD in public-sector mental health settings: The diagnostic utility of the PTSD Checklist. *Depression and Anxiety, 24*, 124-129.

Herman, J. (1997). *Trauma and Recovery: The aftermath of violence--from domestic abuse to political terror*. New York: Basic Books.

Kennedy, R. (n.d.) Goodreads.com. Retrieved November 8, 2016 from Goodreads website: <http://www.goodreads.com/quotes/251632-birds-sing-after-a-storm-why-shouldn-t-people-feel-as>

Krebs, E. E., Lorenz, K. A., Bair, M. J., Damush, T. M., Wu, J., Sutherland, J. M., ... Kroenke, K. (2009). Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. *Journal of General Internal Medicine*, 24, 733-738.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16, 606-613.

Krosnick, J. (1999). Survey research. *Annual Review of Psychology* 50, 537-567.

Lowe, B., Kroenke, K., Herzog, W., & Grafe, K. (2004). Measuring depression outcome with a brief self-report instrument: sensitivity to change of the Patient Health Questionnaire (PHQ-9). *Journal of Affective Disorders*, 81, 61-66.

Pelcovitz, D., van der Kolk, B., Roth, S., Mandel, F., Kaplan, S., & Resick, P. (1997). Development of a criteria set and a Structured Interview for Disorders of Extreme Stress (SIDES). *Journal of Traumatic Stress*, 10, 3-16.

Sheehan D., Lecrubier Y., Harnett-Sheehan K., Janavs J., Weiller E., Bonara L., Keskiner A, Schinka J, Knapp E., Sheehan M., Dunbar G. (1997). Reliability and validity of the M.I.N.I. International Neuropsychiatric Interview (M.I.N.I.): According to the SCID-P. *European Psychiatry*, 12, 232-241.

Sudman, S., Bradburn, N., & Schwarz, N. (1996). *Thinking about answers: The application of cognitive processes to survey methodology*. San Francisco: Jossey-Bass.

Tan, G., Jensen, M. P., Thornby, J. I., & Shanti, B. F. (2004) Validation of the Brief Pain Inventory for chronic nonmalignant pain. *The Journal of Pain*, 5, 133–137.

Tourangeau, R., Rips, L. J., & Raskinski, K. (2000). *The psychology of survey response*. New York: Cambridge University Press.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005) Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, 18, 389-399.

Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (1993) The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility. Presented at the International Society for Traumatic Stress, San Antonio, TX, 1993.

Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). The PTSD Checklist for DSM-5 (PCL-5). National Center for PTSD at [www.ptsd.va.gov](http://www.ptsd.va.gov).

WHOQOL Group. (1998). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychological Medicine*, 28, 551-558.

Wortmann, J. H., Jordan, A. H., Weathers, F. W., Resick, P. A., Dondanville, K. A., Hall-Clark, B., ... Litz, B. T. (2016). Psychometric analysis of the PTSD Checklist-5 (PCL-5) among treatment-seeking military service members. *Psychological Assessment*. Advance online publication.

Wulsin, L, Somoza, E, & Heck, J. (2002). The feasibility of using the Spanish PHQ-9 to screen for depression in primary care in Honduras. *Primary Care Companion to the Journal of Clinical Psychiatry*, 4, 191-195.

Yu, L., Buysse, D. J., Germain, A., Moul, D. E., Stover, A., Dodds, N. E., Pilkonis, P. A. (2012). Development of short forms from the PROMIS™ Sleep Disturbance and Sleep-Related Impairment item banks. *Behavioral Sleep Medicine*, 10, 6-24.