The California Professional Society on the Abuse of Children

Strengthening Practice Through Knowledge

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avahealth.org

October 15, 2020

ACADEMY ON VIOLENCE & ABUSE

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A Practical Approach to Deciding the Next Right Step for Trauma Exposed Youth: The Pediatric Traumatic Stress Care Process Model

Dr Brooks Keeshin

October 15, 2020

Academy on Violence & Abuse

Advancing Health Education & Research

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CALIFORNIA ACES ACADEMY

- Is a supplemental training to enhance healthcare professionals' and others' knowledge of ACEs, trauma informed care, and of strengths, protective factors, and resilience in their patients, families and communities. If you're seeking Medi-Cal certification please visit acesaware.org
- National + local experts + small group learning collaboratives = more connected and caring communities
- Online communities of care provide a place to discuss challenges, share resources, and celebrate successes
- CAA, with funding from ACEs Aware, is a collaboration of the American Professional Society on the Abuse of Children (APSAC), the Academy on Violence and Abuse (AVA), the California Professional Society on the Abuse of Children (CAPSAC) and the Center for Innovation and Resources (CIR).

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At the end, the presenter will answer questions that have been submitted during the session.

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CME/CE CREDITS

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A PARTNER IN NCTSN The National Child Traumatic Stress Network

A Care Process Model for Pediatric Traumatic Stress

Brooks Keeshin, MD
Lindsay Shepard, PhD

PIPS

A PARTNER IN NCTSN The National Child Traumatic Stress Network

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Disclosures

- SAMHSA funding, NCTSI Category II, Grant Number 1U79SM080000-01

Objectives

- Recognize the need to identify and respond to pediatric traumatic stress
- Overview the Care Process Model (CPM) for Pediatric Traumatic Stress
- Consider pilot implementation and findings

Definitions

Trauma: Significant event or experience that causes or threatens harm to one's emotional and/or physical well-being

Traumatic stress: Intense fear and stress in response to a potentially traumatic experience, including disturbed sleep, difficulty paying attention and concentrating, anger and irritability, withdrawal, repeated and intrusive thoughts, and/or extreme distress when confronted by reminders of the trauma

Need to Identify & Respond to Traumatic Stress

- High prevalence of trauma exposure
- Trauma is connected to poor health and mental health outcomes
- Trauma symptoms often go undiagnosed or misdiagnosed
- Trauma-focused evidence-based treatments work
- AAP recommends active & routine screening

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CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Children Exposed to Maltreatment: Assessment and the Role of Psychotropic Medication

Brooks Keeshin, MD, FAAP,[a] Heather C. Forkey, MD, FAAP,[b] George Fouras, MD, DFAACAP,[c] Harriet L. MacMillan, CM, MD, MSc, FRCPC,[d] AMERICAN ACADEMY OF PEDIATRICS,COMMITTEE ON CHILD ABUSE AND NEGLECT,COUNCIL ON FOSTER CARE,ADOPTION, AND KINSHIP CARE, AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, COMMITTEE ON CHILD MALTREATMENT AND VIOLENCE, COMMITTEE ON ADOPTION AND FOSTER CARE

Pediatrics, February 2020

Emotional Dysregulation: A Trauma Informed Approach

To be published during 2021 in:

Child and Adolescent Psychiatric Clinics of North America

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How Do We Know About Trauma Symptoms?

- Observe/ask about symptoms
  - What do you look for?
  - What do you ask about?
- Standardized screens:
  - UCLA PTSD Reaction Index
  - Child PTSD Symptom Scale
  - Trauma Symptom Checklist for Children
  - Trauma Symptom Checklist for Young Children

- Diagnostic and Statistical Manual of Mental Disorders (DSM-5) Criteria for PTSD
  - Threatened death, serious injury or sexual violence
  - Intrusive
  - Avoidance
  - Negative Cognition/Mood
  - Hyperarousal
  - +/- Dissociation

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Challenges in Identifying Traumatic Stress

- Families may not volunteer trauma history unless asked directly
- PTSD is rarely the identified chief complaint
- Families don’t connect traumatic history and current symptoms
- When in a known, comfortable setting, children with PTSD may appear calm

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Differential Diagnosis

- Challenging to tease out PTSD, depression, anxiety and ADHD
- When concerned about depression, anxiety or ADHD, evaluate/rule out PTSD before proceeding with treatment
- Structured screening and assessment tools help in identifying PTSD symptoms

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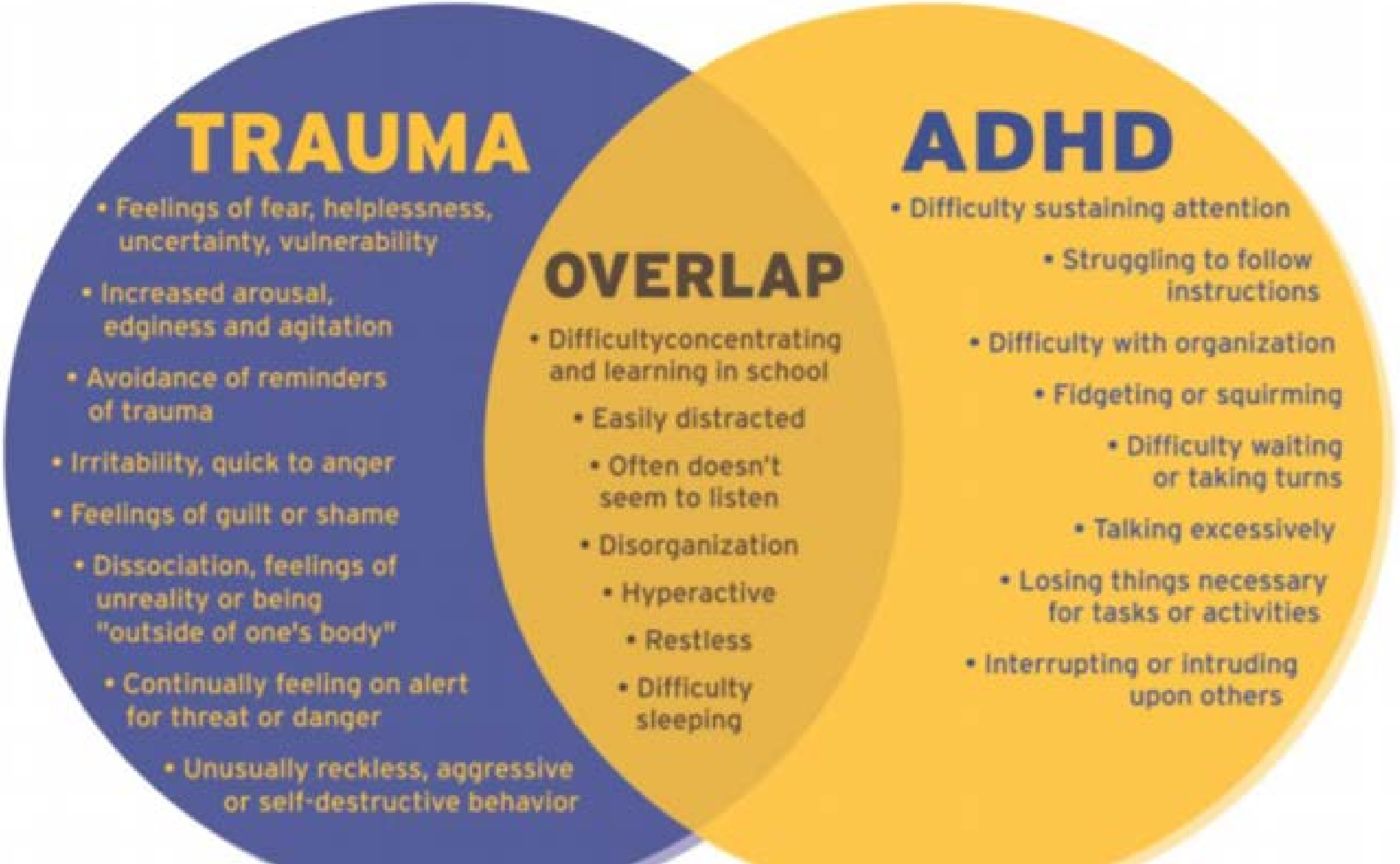
TRAUMA
• Feelings of fear, helplessness, uncertainty, vulnerability
• Increased arousal, edginess and agitation
• Avoidance of reminders of trauma
• Irritability, quick to anger
• Feelings of guilt or shame
• Dissociation, feelings of unreality or being "outside of one's body"
• Continually feeling on alert for threat or danger
• Unusually reckless, aggressive or self-destructive behavior
OVERLAP
• Difficultyconcentrating and learning in school
• Easily distracted
• Often doesn't seem to listen
• Disorganization
• Hyperactive
• Restless
• Difficulty sleeping
ADHD
• Difficulty sustaining attention
• Struggling to follow instructions
• Difficulty with organization
• Fidgeting or squirming
• Difficulty waiting or taking turns
• Talking excessively
• Losing things necessary for tasks or activities
• Interrupting or intruding upon others

Relative Effectiveness for Behavior Problems in Young Children – Stimulant/Behavior Tx

ADHD		PTSD
Stimulant+ Behavior Therapy+		Stimulant- Behavior Therapy+ (Stopping the trauma+)

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Pediatric Traumatic Stress and Depression

PTSD symptom cluster		Overlapping trauma and depressive symptoms
Negative cognition/mood		Negative belief towards self, self-blame, negative emotional state, loss of interest, detachment
Hyperarousal & Increased reactivity		Irritable and angry, reckless and self-destructive behavior, poor concentration, sleep disturbances

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Traumatic Stress and Anxiety

Panic Attacks may not indicate panic disorder if attacks are triggered by trauma reminders, better explained as intrusive and hyperarousal symptoms of PTSD	Separation challenges may be similar to **separation anxiety**, but could be trauma specific depending on context of traumatic experience(s) and association with trauma reminders	**Generalized and social anxiety** are often independent of trauma-specific context and reminders, however, still important to consider symptoms in context of traumatic experiences

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Relative Effectiveness - Psychotherapy vs SSRI for Depression and/or Anxiety

Anxiety/Depression		PTSD
SSRI + Therapy +		SSRI –/Therapy – TFCBT + (Stopping the trauma+)

Cohen 2007; Robb 2010; Morina 2016

Choosing on the Right Bucket

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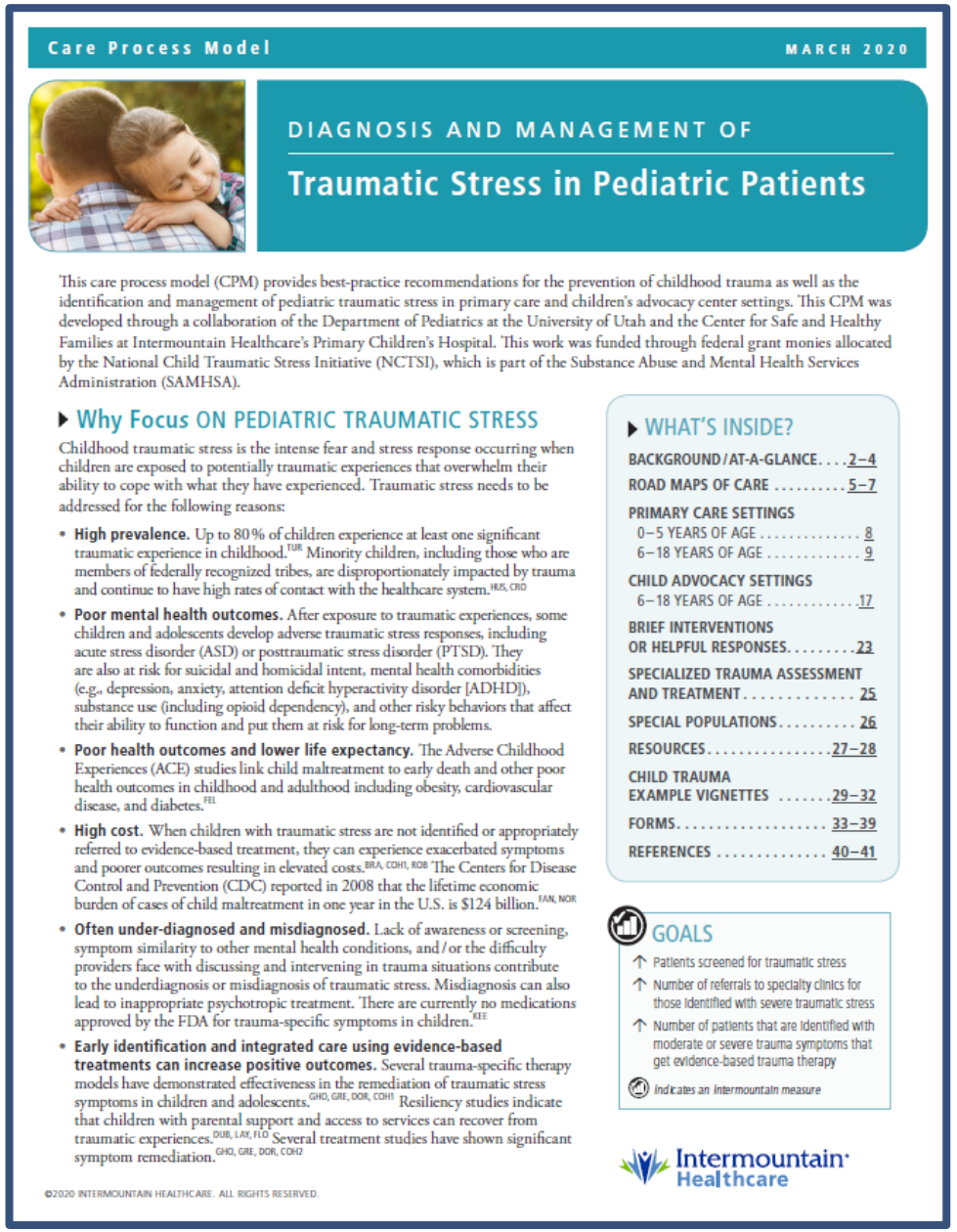
How to Identify & Respond to Traumatic Stress

- A Care Process Model (CPM) for Pediatric Traumatic Stress



Care Process Model MARCH 2020

DIAGNOSIS AND MANAGEMENT OF

Traumatic Stress in Pediatric Patients

This care process model (CPM) provides best-practice recommendations for the prevention of childhood trauma as well as the identification and management of pediatric traumatic stress in primary care and children's advocacy center settings. This CPM was developed through a collaboration of the Department of Pediatrics at the University of Utah and the Center for Safe and Healthy Families at Intermountain Healthcare's Primary Children's Hospital. This work was funded through federal grant monies allocated by the National Child Traumatic Stress Initiative (NCTSI), which is part of the Substance Abuse and Mental Health Services Administration (SAMHSA).

Why Focus ON PEDIATRIC TRAUMATIC STRESS

Childhood traumatic stress is the intense fear and stress response occurring when children are exposed to potentially traumatic experiences that overwhelm their ability to cope with what they have experienced. Traumatic stress needs to be addressed for the following reasons:

- **High prevalence.** Up to 80% of children experience at least one significant traumatic experience in childhood.[TUR] Minority children, including those who are members of federally recognized tribes, are disproportionately impacted by trauma and continue to have high rates of contact with the healthcare system.[HUS, CRO]
- **Poor mental health outcomes.** After exposure to traumatic experiences, some children and adolescents develop adverse traumatic stress responses, including acute stress disorder (ASD) or posttraumatic stress disorder (PTSD). They are also at risk for suicidal and homicidal intent, mental health comorbidities (e.g., depression, anxiety, attention deficit hyperactivity disorder [ADHD]), substance use (including opioid dependency), and other risky behaviors that affect their ability to function and put them at risk for long-term problems.
- **Poor health outcomes and lower life expectancy.** The Adverse Childhood Experiences (ACE) studies link child maltreatment to early death and other poor health outcomes in childhood and adulthood including obesity, cardiovascular disease, and diabetes.[FEL]
- **High cost.** When children with traumatic stress are not identified or appropriately referred to evidence-based treatment, they can experience exacerbated symptoms and poorer outcomes resulting in elevated costs.[BRA, COH1, ROB] The Centers for Disease Control and Prevention (CDC) reported in 2008 that the lifetime economic burden of cases of child maltreatment in one year in the U.S. is $124 billion.[FAN, NOR]
- **Often under-diagnosed and misdiagnosed.** Lack of awareness or screening, symptom similarity to other mental health conditions, and/or the difficulty providers face with discussing and intervening in trauma situations contribute to the underdiagnosis or misdiagnosis of traumatic stress. Misdiagnosis can also lead to inappropriate psychotropic treatment. There are currently no medications approved by the FDA for trauma-specific symptoms in children.[KEE]
- **Early identification and integrated care using evidence-based treatments can increase positive outcomes.** Several trauma-specific therapy models have demonstrated effectiveness in the remediation of traumatic stress symptoms in children and adolescents.[GHO, GRE, DOR, COH1] Resiliency studies indicate that children with parental support and access to services can recover from traumatic experiences.[DUB, LAY, FLO] Several treatment studies have shown significant symptom remediation.[GHO, GRE, DOR, COH2]

WHAT'S INSIDE?

GOALS

- ↑ Patients screened for traumatic stress
- ↑ Number of referrals to specialty clinics for those identified with severe traumatic stress
- ↑ Number of patients that are identified with moderate or severe trauma symptoms that get evidence-based trauma therapy

Indicates an Intermountain measure

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Overview

The Care Process Model (CPM) for Pediatric Traumatic Stress

Who

Children ages 6-18

- Well-child visits
- Mental health related visits

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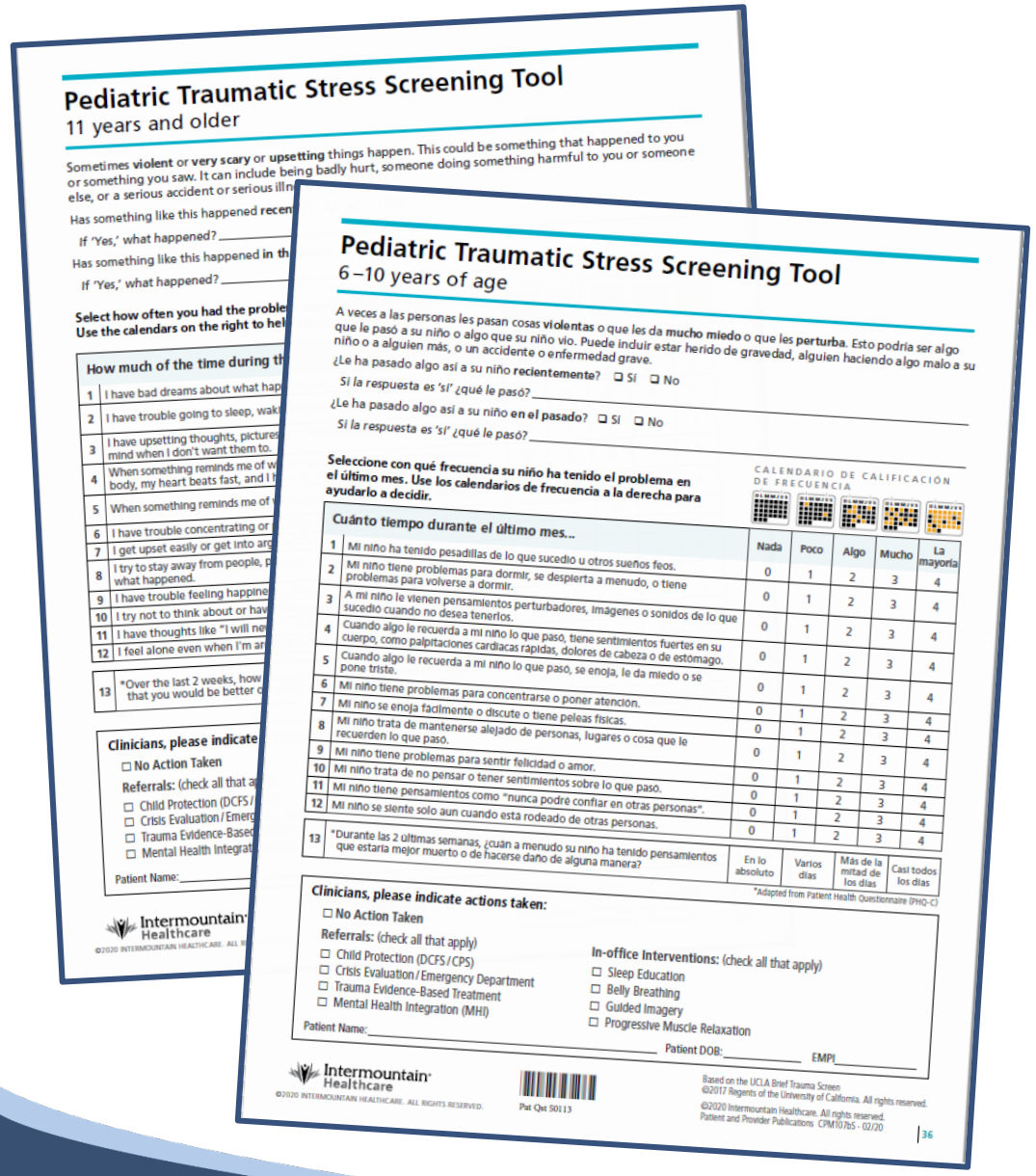

Pediatric Traumatic Stress Screening Tool
11 years and older

Sometimes **violent** or **very scary** or **upsetting** things happen. This could be something that happened to you or something you saw. It can include being badly hurt, someone doing something harmful to you or someone else, or a serious accident or serious illn

Has something like this happened recen

If 'Yes,' what happened? _____

Has something like this happened in th

If 'Yes,' what happened? _____

Select how often you had the proble
Use the calendars on the right to hel

How much of the time during th	
1	I have bad dreams about what hap
2	I have trouble going to sleep, wak
3	I have upsetting thoughts, pictures mind when I don't want them to.
4	When something reminds me of w body, my heart beats fast, and I
5	When something reminds me of
6	I have trouble concentrating or
7	I get upset easily or get into arg
8	I try to stay away from people, p what happened.
9	I have trouble feeling happine
10	I try not to think about or hav
11	I have thoughts like "I will ne
12	I feel alone even when I'm ar
13	*Over the last 2 weeks, how that you would be better

Clinicians, please indicate

☐ No Action Taken

Referrals: (check all that a

☐ Child Protection (DCFS /
☐ Crisis Evaluation / Emerg
☐ Trauma Evidence-Based
☐ Mental Health Integrat

Patient Name: _____

Intermountain Healthcare

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Pediatric Traumatic Stress Screening Tool
6–10 years of age

A veces a las personas les pasan cosas **violentas** o que les da **mucho miedo** o que les **perturba**. Esto podría ser algo que le pasó a su niño o algo que su niño vio. Puede incluir estar herido de gravedad, alguien haciendo algo malo a su niño o a alguien más, o un accidente o enfermedad grave.

¿Le ha pasado algo así a su niño **recientemente**? ❑ Sí ❑ No

Si la respuesta es 'sí' ¿qué le pasó? _____

¿Le ha pasado algo así a su niño **en el pasado**? ❑ Sí ❑ No

Si la respuesta es 'sí' ¿qué le pasó? _____

Seleccione con qué frecuencia su niño ha tenido el problema en el último mes. Use los calendarios de frecuencia a la derecha para ayudarlo a decidir.

CALENDARIO DE CALIFICACIÓN DE FRECUENCIA

Cuánto tiempo durante el último mes...	Nada	Poco	Algo	Mucho	La mayoría
1 Mi niño ha tenido pesadillas de lo que sucedió u otros sueños feos.	0	1	2	3	4
2 Mi niño tiene problemas para dormir, se despierta a menudo, o tiene problemas para volverse a dormir.	0	1	2	3	4
3 A mi niño le vienen pensamientos perturbadores, imágenes o sonidos de lo que sucedió cuando no desea tenerlos.	0	1	2	3	4
4 Cuando algo le recuerda a mi niño lo que pasó, tiene sentimientos fuertes en su cuerpo, como palpitaciones cardiacas rápidas, dolores de cabeza o de estómago.	0	1	2	3	4
5 Cuando algo le recuerda a mi niño lo que pasó, se enoja, le da miedo o se pone triste.	0	1	2	3	4
6 Mi niño tiene problemas para concentrarse o poner atención.	0	1	2	3	4
7 Mi niño se enoja fácilmente o discute o tiene peleas físicas.	0	1	2	3	4
8 Mi niño trata de mantenerse alejado de personas, lugares o cosa que le recuerden lo que pasó.	0	1	2	3	4
9 Mi niño tiene problemas para sentir felicidad o amor.	0	1	2	3	4
10 Mi niño trata de no pensar o tener sentimientos sobre lo que pasó.	0	1	2	3	4
11 Mi niño tiene pensamientos como "nunca podré confiar en otras personas".	0	1	2	3	4
12 Mi niño se siente solo aun cuando está rodeado de otras personas.	0	1	2	3	4

13 *Durante las 2 últimas semanas, ¿cuán a menudo su niño ha tenido pensamientos que estaría mejor muerto o de hacerse daño de alguna manera?	En lo absoluto	Varios días	Más de la mitad de los días	Casi todos los días

*Adapted from Patient Health Questionnaire (PHQ-C)

Clinicians, please indicate actions taken:

☐ **No Action Taken**

Referrals: (check all that apply)

☐ Child Protection (DCFS / CPS)
☐ Crisis Evaluation / Emergency Department
☐ Trauma Evidence-Based Treatment
☐ Mental Health Integration (MHI)

In-office Interventions: (check all that apply)

☐ Sleep Education
☐ Belly Breathing
☐ Guided Imagery
☐ Progressive Muscle Relaxation

Patient Name: _____ Patient DOB: _____ EMPI _____

Intermountain Healthcare

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Pat Qst 50113

Based on the UCLA Brief Trauma Screen
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Patient and Provider Publications CPM1076S - 02/20

36

How

Waiting room screening tool

- Parent vs adolescent report
- English or Spanish
- Paper or electronic

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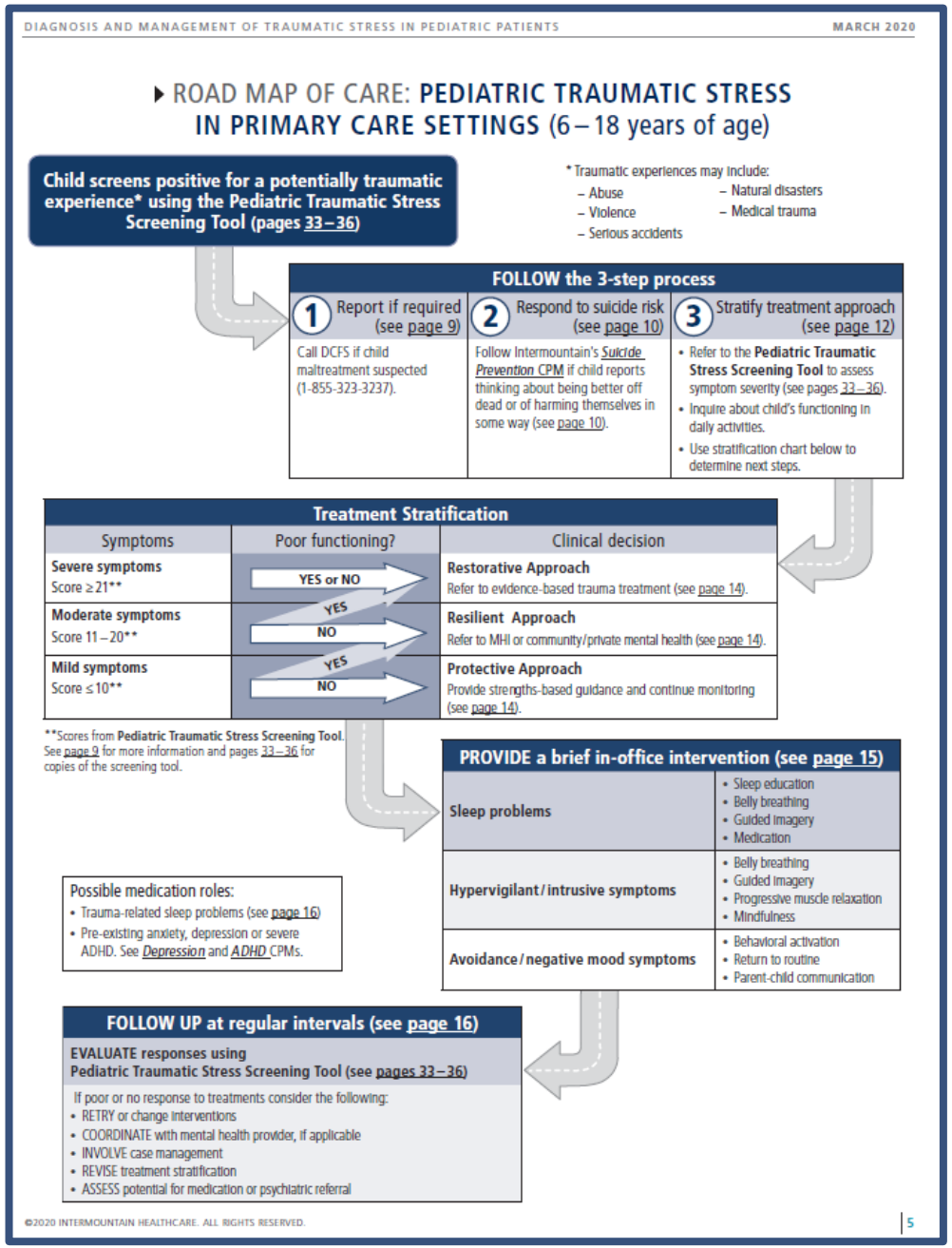

DIAGNOSIS AND MANAGEMENT OF TRAUMATIC STRESS IN PEDIATRIC PATIENTS — MARCH 2020

ROAD MAP OF CARE: PEDIATRIC TRAUMATIC STRESS IN PRIMARY CARE SETTINGS (6 – 18 years of age)

Child screens positive for a potentially traumatic experience* using the Pediatric Traumatic Stress Screening Tool (pages 33–36)

*Traumatic experiences may include:
- Abuse
- Violence
- Serious accidents
- Natural disasters
- Medical trauma

FOLLOW the 3-step process

1 Report if required (see page 9)	2 Respond to suicide risk (see page 10)	3 Stratify treatment approach (see page 12)
Call DCFS if child maltreatment suspected (1-855-323-3237).	Follow Intermountain's *Suicide Prevention CPM* if child reports thinking about being better off dead or of harming themselves in some way (see page 10).	• Refer to the **Pediatric Traumatic Stress Screening Tool** to assess symptom severity (see pages 33–36). • Inquire about child's functioning in daily activities. • Use stratification chart below to determine next steps.

Treatment Stratification

Symptoms	Poor functioning?	Clinical decision
Severe symptoms Score ≥ 21**	YES or NO	**Restorative Approach** Refer to evidence-based trauma treatment (see page 14).
Moderate symptoms Score 11 – 20**	YES / NO	**Resilient Approach** Refer to MHI or community/private mental health (see page 14).
Mild symptoms Score ≤ 10**	YES / NO	**Protective Approach** Provide strengths-based guidance and continue monitoring (see page 14).

Scores from **Pediatric Traumatic Stress Screening Tool. See page 9 for more information and pages 33–36 for copies of the screening tool.

PROVIDE a brief in-office intervention (see page 15)

Sleep problems	• Sleep education • Belly breathing • Guided imagery • Medication
Hypervigilant / intrusive symptoms	• Belly breathing • Guided imagery • Progressive muscle relaxation • Mindfulness
Avoidance / negative mood symptoms	• Behavioral activation • Return to routine • Parent-child communication

Possible medication roles:
- Trauma-related sleep problems (see page 16)
- Pre-existing anxiety, depression or severe ADHD. See *Depression* and *ADHD* CPMs.

FOLLOW UP at regular intervals (see page 16)

EVALUATE responses using Pediatric Traumatic Stress Screening Tool (see pages 33–36)

If poor or no response to treatments consider the following:
- RETRY or change interventions
- COORDINATE with mental health provider, if applicable
- INVOLVE case management
- REVISE treatment stratification
- ASSESS potential for medication or psychiatric referral

CPM Roadmap of Care

Provider meets with youth and caregiver:

1. **Report if required**
2. **Respond to suicide risk**
3. **Stratify treatment response**

Follow-up

Pediatric Traumatic Stress Screening Tool

11 years and older

Sometimes violent or very scary or upsetting things happen. This could be something that happened to you or something you saw. It can include being badly hurt, someone doing something harmful to you or someone else, or a serious accident or serious illness.

Has something like this happened **recently**? ❑ Yes ❑ No

If 'Yes,' what happened? _____

Has something like this happened **in the past**? ❑ Yes ❑ No

If 'Yes,' what happened? _____

FREQUENCY RATING CALENDARS

Select how often you had the problem below in the past month.
Use the calendars on the right to help you decide how often.

	How much of the time during the past month...	None	Little	Some	Much	Most
1	I have bad dreams about what happened or other bad dreams.	0	1	2	3	4
2	I have trouble going to sleep, waking up often, or getting back to sleep.	0	1	2	3	4
3	I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I don't want them to.	0	1	2	3	4
4	When something reminds me of what happened I have strong feelings in my body, my heart beats fast, and I have headaches or stomach aches.	0	1	2	3	4
5	When something reminds me of what happened I get very upset, afraid, or sad.	0	1	2	3	4
6	I have trouble concentrating or paying attention.	0	1	2	3	4
7	I get upset easily or get into arguments or physical fights.	0	1	2	3	4
8	I try to stay away from people, places, or things that remind me about what happened.	0	1	2	3	4
9	I have trouble feeling happiness or love.	0	1	2	3	4
10	I try not to think about or have feelings about what happened.	0	1	2	3	4
11	I have thoughts like "I will never be able to trust other people."	0	1	2	3	4
12	I feel alone even when I'm around other people.	0	1	2	3	4

13	*Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead or hurting yourself in some way?	Not at all	Several days	More than half the days	Nearly every day

*Adapted from Patient Health Questionnaire (PHQ-A)

1. Report if Required

1. Report if Required

- If abuse or family violence was disclosed, determine if the event(s) need to be reported to child protection or law enforcement authorities and report if required
- If other safety issues are disclosed, provide support and follow up as needed

Pediatric Traumatic Stress Screening Tool

11 years and older

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If 'Yes,' what happened? _____

Has something like this happened **in the past**? ❑ Yes ❑ No

If 'Yes,' what happened? _____

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4	When something reminds me of what happened I have strong feelings in my body, my heart beats fast, and I have headaches or stomach aches.	0	1	2	3	4
5	When something reminds me of what happened I get very upset, afraid, or sad.	0	1	2	3	4
6	I have trouble concentrating or paying attention.	0	1	2	3	4
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8	I try to stay away from people, places, or things that remind me about what happened.	0	1	2	3	4
9	I have trouble feeling happiness or love.	0	1	2	3	4
10	I try not to think about or have feelings about what happened.	0	1	2	3	4
11	I have thoughts like "I will never be able to trust other people."	0	1	2	3	4
12	I feel alone even when I'm around other people.	0	1	2	3	4

13	*Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead or hurting yourself in some way?	Not at all	Several days	More than half the days	Nearly every day

*Adapted from Patient Health Questionnaire (PHQ-A)

2. Respond to Suicide Risk

2. Respond to Suicide Risk

- If the parent or youth endorses **any** number of days of suicidal thinking, use the **Columbia Suicide Severity Rating Scale (C-SSRS)** to assess patient safety and determine response protocols, referring to local emergency medical services when needed

The C-SSRS

Ask items 1-2, 6

- If yes to 1 or 2, ask items 3-5

TABLE1: Patient safety measures and response protocols based on C-SSRS Quick Screen responses. Taken from the Suicide Prevention CPM

C-SSRS Quick Screen questions *(in the last month)*			Action if patient response *"Yes"*
Question	*"Yes"* indicates	Level of risk	Outpatient clinic (non BH)
1. Have you wished you were dead or wished you could go to sleep and not wake up?	Wish to be dead	LOW	• Consider referral to MHI or BH provider • Consider patient education
2. Have you actually had any thoughts of killing yourself?	Nonspecific thoughts		
3. Have you been thinking about how you might kill yourself?	Thoughts with method (without specific plan or intent to act)	MODERATE	• Assess risk factors and either facilitate evaluation for inpatient admission or complete *Safety Plan* with follow-up with 24–48 hours • Educate patient
4. Have you had these thoughts and had some intention of acting on them?	Intent (without plan)	HIGH	• Facilitate immediate evaluation • Educate the patient
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	Intent with plan		
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?	Behavior	>1 year ago: LOW	• Consider referral to MHI or BH provider • Consider patient education
		1–12 months ago: MODERATE	• Assess risk factors and refer to MHI or BH provider • Educate patient
		Past 4 weeks, during current inpatient stay, since last assessment: HIGH	• Facilitate immediate evaluation for inpatient care • Educate patient

Higher risk for suicide

PIPS

Based on suicide risk, providers may:

- Encourage ongoing family communication
- Develop a safety plan
- Refer to MH treatment
- Refer to the ER/crisis team

Pediatric Traumatic Stress Screening Tool

11 years and older

Sometimes violent or very scary or upsetting things happen. This could be something that happened to you or something you saw. It can include being badly hurt, someone doing something harmful to you or someone else, or a serious accident or serious illness.

Has something like this happened recently? ❑ Yes ❑ No

If 'Yes,' what happened? _____

Has something like this happened in the past? ❑ Yes ❑ No

If 'Yes,' what happened? _____

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FREQUENCY RATING CALENDARS

	How much of the time during the past month...	None	Little	Some	Much	Most
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3	I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I don't want them to.	0	1	2	3	4
4	When something reminds me of what happened I have strong feelings in my body, my heart beats fast, and I have headaches or stomach aches.	0	1	2	3	4
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6	I have trouble concentrating or paying attention.	0	1	2	3	4
7	I get upset easily or get into arguments or physical fights.	0	1	2	3	4
8	I try to stay away from people, places, or things that remind me about what happened.	0	1	2	3	4
9	I have trouble feeling happiness or love.	0	1	2	3	4
10	I try not to think about or have feelings about what happened.	0	1	2	3	4
11	I have thoughts like "I will never be able to trust other people."	0	1	2	3	4
12	I feel alone even when I'm around other people.	0	1	2	3	4

MILD

MODERATE

SEVERE

		Not at all	Several days	More than half the days	Nearly every day
13	*Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead or hurting yourself in some way?				

*Adapted from Patient Health Questionnaire (PHQ-A)

3. Stratify Treatment Response with referral based on:

- **Screening tool responses,**
- **Child functional impairment, &**
- **Shared decision-making**

3. Stratify Treatment Response

- Identify:
  - Trauma symptom severity
  - Child functional impairment
- Provide appropriate treatment approach:
  - Anticipatory guidance
  - Brief, targeted intervention
  - Referral

Provide Appropriate Treatment Approach

TABLE 2. Treatment Stratification

Symptoms	Poor functioning?	Clinical decision
Severe symptoms: Score ≥ 21**	YES or NO	**Restorative Approach** Refer to EBT Treatment
Moderate symptoms: Score 11 – 20**	YES / NO	**Resilient Approach** Refer to MHI or Community MHI.
Mild symptoms: Score ≤ 10**	YES / NO	**Protective Approach** Provide strengths-based guidance and continue monitoring.

**Scores from *Pediatric Traumatic Stress Screening Tool* (see page 9 for more information)

PIPS

KEY COMPONENTS OF EVIDENCE-BASED TRAUMA TREATMENT

Common features of evidence-based trauma treatment for children include being:

- Developmentally and culturally sensitive
- Resilience based
- Focused on overcoming avoidance of the trauma experience
- Parent/caregiver inclusive
- Skills and safety focused

For additional information about trauma-specific evidence-based treatment, see https://gucchdtacenter.georgetown.edu/TraumaInformedCare/IssueBrief4_EvidenceBasedTreatments.pdf.

To learn more about trauma-informed treatments for children, please visit the National Child Traumatic Stress Network factsheets linked in the sidebar or http://www.nctsn.org.

RESOURCES FOR SPECIALIZED TRAUMA ASSESSMENT AND TREATMENT

- **UCLA PTSD Reaction Index (RI):** https://www.reactionindex.com/
- **TF-CBT**—NCTSN fact sheet available at: http://www.nctsn.org/sites/default/files/assets/pdfs/tfcbt_general.pdf
- **PCIT**—NCTSN fact sheet available at: http://www.nctsn.org/sites/default/files/assets/pdfs/pcit_general.pdf
- **CFTSI**—NCTSN fact sheet available at: http://www.nctsn.org/sites/default/files/assets/pdfs/CFTSI_General_Information_Fact_Sheet.pdf
- **CPP**—NCTSN factsheet available at: http://www.nctsn.org/sites/default/files/assets/pdfs/cpp_general.pdf
- **AF-CBT**—NCTSN fact sheet available at: https://www.nctsn.org/interventions/alternatives-families-cognitive-behavioral-therapy

SPECIALIZED TRAUMA ASSESSMENT AND TREATMENT

Children who are at risk for traumatic stress warrant comprehensive, trauma-informed assessment to determine the right type of treatment. The use of standardized, validated measures is critical for the accurate detection of both trauma exposures and symptoms as well as common, comorbid conditions. A comprehensive assessment tool recommended for the detection of additional trauma exposures and risk for PTSD is:

- **The UCLA PTSD Reaction Index for DSM-5.** Used with children 8 years and older, the UCLA PTSD Reaction Index (RI) is an example of a well-validated measure that captures a variety of potentially traumatic experiences, has tools to help identify developmental timing of trauma exposure, and contains a 31-item symptom report that can be used to support the diagnosis of PTSD with and/or without dissociative symptoms.[ELH, STE] A derived, shortened version of the full UCLA PTSD RI is used as part of this CPM, meaning that there is cross-informing compatibility between the two measures.

Trauma-specific and trauma-informed treatments include:

- **Trauma-focused cognitive behavioral therapy (TF-CBT).** Used to treat trauma symptoms for children and adolescents in outpatient settings (ages 3–18 years). The model includes non-offending caregivers in treatment and addresses psychoeducation, parenting skills, relaxation, affect expression and modulation, cognitive coping and processing, and developing and sharing a trauma narrative. While the length of treatment varies by youth needs, TF-CBT in community settings averages about 25 weekly sessions.[CDH1]
- **Parent-child interaction therapy (PCIT).** Used in outpatient settings to coach non-offending caregivers or caregivers at high risk of physical abuse in positive parenting skills. This coaching is designed to decrease problem behaviors in children (ages 2–7 years) by encouraging their positive behaviors, strengthening their parent-child relationship, and discouraging negative behaviors. While the length of treatment depends on parent/caregiver mastery of skills, PCIT in community settings averages about 20 weekly sessions.[HEM]
- **Child and family traumatic stress intervention (CFTSI).** Used in outpatient settings with youth (ages 7–18 years) who have experienced one or multiple traumatic experiences to prevent the development of PTSD. Both an early intervention and a secondary prevention strategy, CFTSI usually begins within 30 days of the traumatic experience (or disclosure) and typically involves three to eight weekly sessions. It engages youth and their non-offending caregivers in psychoeducation, symptom monitoring, symptom-specific coping mechanisms, and parent-child communication.[BER]
- **Child-parent psychotherapy (CPP).** Used to help develop the parent-child relationship for very young children and their non-offending caregivers (ages 0–6 years). Typically applied in-home, the therapist interprets and directs parent-child interactions in more adaptive, positive ways. CPP is typically delivered in 40–50 weekly sessions.[GHD]
- **Alternatives for families cognitive behavioral therapy (AF-CBT).** Used to treat trauma symptoms from physical abuse and/or physical discipline in children and adolescents (5–18 years). The model engages offending caregivers in treatment and addresses child, parent, and conjoint components of engagement, psychoeducation, discussion of incidents of physical force, cognitive processing, skill training, and clarification of responsibility for past events. AF-CBT in community settings is about 20 weekly sessions.[KOL]

Pediatric Traumatic Stress Screening Tool

11 years and older

Sometimes violent or very scary or upsetting things happen. This could be something that happened to you or something you saw. It can include being badly hurt, someone doing something harmful to you or someone else, or a serious accident or serious illness.

Has something like this happened recently? ❑ Yes ❑ No

If 'Yes,' what happened? _____

Has something like this happened in the past? ❑ Yes ❑ No

If 'Yes,' what happened? _____

Select how often you had the problem below in the past month. Use the calendars on the right to help you decide how often.

FREQUENCY RATING CALENDARS

	How much of the time during the past month...	None	Little	Some	Much	Most
1	I have bad dreams about what happened or other bad dreams.	0	1	2	3	4
2	I have trouble going to sleep, waking up often, or getting back to sleep.	0	1	2	3	4
3	I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I don't want them to.	0	1	2	3	4
4	When something reminds me of what happened I have strong feelings in my body, my heart beats fast, and I have headaches or stomach aches.	0	1	2	3	4
5	When something reminds me of what happened I get very upset, afraid, or sad.	0	1	2	3	4
6	I have trouble concentrating or paying attention.	0	1	2	3	4
7	I get upset easily or get into arguments or physical fights.	0	1	2	3	4
8	I try to stay away from people, places, or things that remind me about what happened.	0	1	2	3	4
9	I have trouble feeling happiness or love.	0	1	2	3	4
10	I try not to think about or have feelings about what happened.	0	1	2	3	4
11	I have thoughts like "I will never be able to trust other people."	0	1	2	3	4
12	I feel alone even when I'm around other people.	0	1	2	3	4

13	*Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead or hurting yourself in some way?	Not at all	Several days	More than half the days	Nearly every day

*Adapted from Patient Health Questionnaire (PHQ-A)

SLEEP

AROUSAL/ INTRUSION

AVOIDANCE/ NEGATIVE MOOD

Provide a brief, targeted intervention

In-Office Intervention

TABLE 3. Brief in-office interventions (for details see page 23)	
Sleep problems	• Sleep education • Belly breathing • Guided imagery • Medication
Hypervigilant / intrusive symptoms	• Belly breathing • Guided imagery • Progressive muscle relaxation • Mindfulness
Avoidance / negative mood symptoms	• Behavioral activation • Return to routine • Parent-child communication

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Follow Up

- Shorter-term (2-4 weeks) & longer-term (4-6 months)
  - Re-administer screening tool
  - Monitor symptom change
  - Assess/adjust decision-making
  - Provide on-going support

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Pilot Data

The Care Process Model (CPM) for Pediatric Traumatic Stress

Description of Pilot

Date Range: May 2018 – June 2019

2 Intermountain West clinics

- Urban & suburban
- 18 pediatric providers

Child participants 6-17 years (n=2359)

- Female (52%)
- White (90%)
- Non-Hispanic (86%)
- Low social risk (82%)
- Chronic medical conditions (36%)
- Mental health diagnosis (24%)

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Description of Implementation

Date Range: May 2018 – June 2019

Pediatric Providers (n=18)

- 14 (78%) pediatric providers started the CPM
- Rate of screener introduction ranged across providers (2-82%)
- Rates of screener introduction rose from 40% first quarter to 57% the final quarter
- Screener completion varied across providers (29-94%)

Child participants 6-17 years (n=2359)

- 1472 (62%) completed screeners
- Completion rates improved from 51% first quarter to 66% the final quarter

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Trauma Exposure (n=1472 completed screeners)

478 (33%) of responses endorsed a trauma exposure

- Risk characteristics:
  - Chronic medical condition
  - Mental health diagnosis

PIPS

Traumatic Stress Symptoms (n=1472 completed screeners)

234 (16%) screened patients reported symptoms of traumatic stress

186 (39%) children with a reported trauma exposure had moderate or high symptoms of traumatic stress

- Risk characteristics:
  - Adolescence
  - Female
  - Trauma exposure
  - Chronic medical condition
  - Mental health diagnosis

PIPS

Suicidality (n=418)

48 (12%) with trauma exposure endorsed suicidal or self-harm thoughts

- Risk characteristics:
  - Traumatic stress severity

Depression (PHQ-A) vs Traumatic Stress (n=302)

41 (14%) reported clinical symptoms of depression

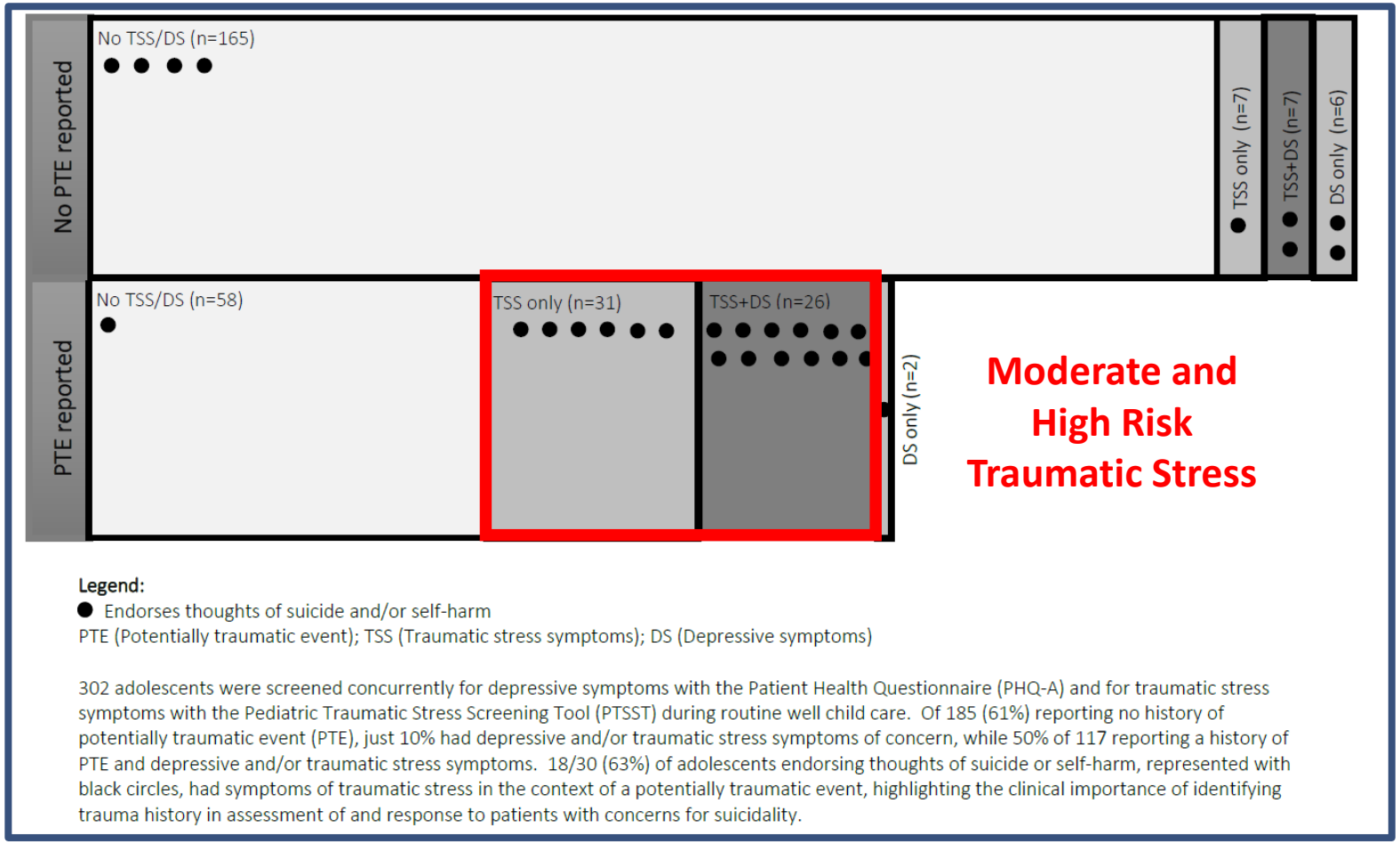
- 28 (68%) of these reported a trauma exposure

71 (24%) reported moderate or severe symptoms of traumatic stress

- 38 (54%) of these had no evidence of depressive symptoms on the PHQ-A

PIPS

Potentially Traumatic Events (PTEs) and Symptoms of Traumatic Stress, Depression, & Suicide/Self-Harm Detected at Well Child Checks



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Summary

- Many children who present to primary care report symptoms of traumatic stress
- Many children with traumatic stress have some suicidal ideation
- Providers and staff are able to provide families with:
  - Referrals to emergency services
  - Referrals to evidence-based therapy
  - In-office interventions to help families cope with traumatic stress

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