CALIFORNIA ACES ACADEMY

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Live Webinar

avahealth.org

October 15, 2020
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
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).
AUDIO

Your audio is set to come through your computer
Please check to make sure your volume is turned up

PLUGGED IN & TURNED ON!
Questions

Use the Q&A feature to ask the presenter any questions you may have.

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

Tech Support Questions will be answered in Chat.
CME/CE CREDITS

Those who require CME units, please visit www.cmeuniversity.com to complete the PIM evaluation necessary to receive credits. Search "ACES ACADEMY" in the search-bar at the top and select today’s session.
A Care Process Model for Pediatric Traumatic Stress

Brooks Keeshin, MD
Lindsay Shepard, PhD
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
Children Exposed to Maltreatment: Assessment and the Role of Psychotropic Medication

Brooks Keeshin, MD, FAAP; Heather C. Forkey, MD, FAAP; George Fournas, MD, DFAPA

Emotional Dysregulation: A Trauma Informed Approach
To be published during 2021 in:
Child and Adolescent Psychiatric Clinics of North America
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
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
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
Overlap of trauma with anxiety, depression, and ADHD.

**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

**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

**OVERLAP**
- Difficulty concentrating and learning in school
- Easily distracted
- Often doesn't seem to listen
- Disorganization
- Hyperactive
- Restless
- Difficulty sleeping
<table>
<thead>
<tr>
<th>ADHD</th>
<th>PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stimulant+</td>
<td>Stimulant-</td>
</tr>
<tr>
<td>Behavior Therapy+</td>
<td>Behavior Therapy+</td>
</tr>
<tr>
<td></td>
<td>(Stopping the trauma+)</td>
</tr>
</tbody>
</table>
### Pediatric Traumatic Stress and Depression

<table>
<thead>
<tr>
<th>PTSD symptom cluster</th>
<th>Overlapping trauma and depressive symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative cognition/mood</td>
<td>Negative belief towards self, self-blame, negative emotional state, loss of interest, detachment</td>
</tr>
<tr>
<td>Hyperarousal &amp; Increased reactivity</td>
<td>Irritable and angry, reckless and self-destructive behavior, poor concentration, sleep disturbances</td>
</tr>
</tbody>
</table>
### 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 |
Relative Effectiveness - Psychotherapy vs SSRI for Depression and/or Anxiety

<table>
<thead>
<tr>
<th>Anxiety/Depression</th>
<th>PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRI + Therapy +</td>
<td>SSRI −/Therapy − TFCBT + (Stopping the trauma+)</td>
</tr>
</tbody>
</table>
Choosing on the Right Bucket

Anxiety & Depression

Traumatic Stress

Problematic Behaviors
  Acting Out/ADHD
  Suicide
  Substance Use
How to Identify & Respond to Traumatic Stress

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

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 centers. 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 19% of children experience at least one significant traumatic event by childhood.1,23 Minority children, including those who are members of racially/ethnically marginalized subgroups, are disproportionately impacted by trauma and continue to have high rates of contact with the healthcare system.110

- **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 mood and behavioral trauma, mental health comorbidities (e.g., depression, anxiety, attention deficit hyperactivity disorder (ADHD), substance use (including opioid dependence), and other risky behaviors that affect their ability to function and put them at risk for longer-term problems.

- **Poor health outcomes and lower life expectancy.** The American Childhood Experiences (ACE) study links child maltreatment to early death and other poor health outcomes in childhood and adulthood including obesity, cardiovascular disease, and diabetes.24

- **High cost.** When children with traumatic stress are not identified or appropriately referred or evidence-based treatments, they can experience exacerbation of symptoms and poorer outcomes requiring more dollars. The Centers for Disease Control and Prevention (CDC) reported in 2009 that the lifetime economic burden of child maltreatment in one year in the U.S. is $104 billion.117

- **Often under-diagnosed and misdiagnosed.** Lack of awareness or screening, symptoms similarity to other mental health conditions, and/or the difficulty providers face with diagnosing and intervening in trauma situations contribute to the underdiagnosis or misdiagnosis of traumatic stress. Misdiagnosis can lead to inappropriate psychotropic treatment. Up to 40% of adolescents meet criteria for a trauma-specific diagnosis.118

- **Early identification and integrated care using evidence-based treatments can increase positive outcomes.** Several trauma-specific therapy models have demonstrated effectiveness in the amelioration of traumatic stress symptoms in children and adolescents.92,119,120,121,122,123,124 RCTs and CRCTs indicate that children with parental support and access to services can recover from traumatic experiences.119,120 Several treatment studies have shown significant symptoms improvement.119,120,122

**WHAT’S INSIDE?**

- BACKGROUND AT-A-GLANCE...
- ROAD MAPS OF CARE...
- PRIMARY CARE SETTINGS...
- BRIEF INTERVENTIONS...
- SPECIALIZED TRAUMA ASSESSMENT...
- AND TREATMENT...
- SPECIAL POPULATIONS...
- RESOURCES...
- CHILD TRAUMA EXAMPLE VIGNETTES...
- REFERENCES...

**GOALS**

- PATIENTS SCREENED FOR TRAUMATIC STRESS
- NUMBER OF REFERRALS TO TREATMENT SERVICES FOR PATIENTS IDENTIFIED WITH MAJOR TRAUMATIC STRESS
- NUMBER OF PATIENTS THAT ARE IDENTIFIED WITH MAJOR TRAUMATIC STRESS BUT THAT DO NOT GET SCREENED FOR TRAUMATIC STRESS

Intermountain Healthcare
Overview

The Care Process Model (CPM) for Pediatric Traumatic Stress
Who

Children ages 6-18

• Well-child visits
• Mental health related visits
How

Waiting room screening tool

- Parent vs adolescent report
- English or Spanish
- Paper or electronic
Provider meets with youth and caregiver:
1. Report if required
2. Respond to suicide risk
3. Stratify treatment response

Follow-up
1. Report if Required

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.

How much of the time during the past month...

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Little</th>
<th>Some</th>
<th>Much</th>
<th>Most</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I have bad dreams about what happened or other bad dreams.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>I have trouble going to sleep, waking up often, or getting back to sleep.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I don’t want them to.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>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.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>When something reminds me of what happened I get very upset, afraid, or sad.</td>
<td>0</td>
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<td>3</td>
</tr>
<tr>
<td>6</td>
<td>I have trouble concentrating or paying attention.</td>
<td>0</td>
<td>1</td>
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<tr>
<td>7</td>
<td>I get upset easily or get into arguments or physical fights.</td>
<td>0</td>
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<td>2</td>
<td>3</td>
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<td>8</td>
<td>I try to stay away from people, places, or things that remind me about what happened.</td>
<td>0</td>
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</tr>
<tr>
<td>9</td>
<td>I have trouble feeling happiness or love.</td>
<td>0</td>
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<td>3</td>
</tr>
<tr>
<td>10</td>
<td>I try not to think about or have feelings about what happened.</td>
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<td>3</td>
</tr>
<tr>
<td>11</td>
<td>I have thoughts like “I will never be able to trust other people.”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12</td>
<td>I feel alone even when I’m around other people.</td>
<td>0</td>
<td>1</td>
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<td>3</td>
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*Adapted from Patient Health Questionnaire (PHQ-4).
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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<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

*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 More than half Nearly every days | the days | | days |

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

Higher risk for suicide
Based on suicide risk, providers may:

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

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

**Scores from Pediatric Traumatic Stress Screening Tool (see page 9 for more information)**
KEY COMPONENTS OF EVIDENCE-BASED TRAUMA TREATMENT

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

- Developmentally and culturally sensitive
- Evidence-based
- Focused on overwhelming assistance of trauma sequences
- Traumatized group based
- Skills and safety focused

For additional information about trauma-specific evidence-based treatment, see "https://psych2000asp.asapharps.com/ trauma/marsh/traumaguide/ta/ readabouttreatments.asp"

To learn more about trauma-informed treatment for children please visit the National Child Traumatic Stress Network (NCTSN) site at: https://www.nctsn.org/

RESOURCES FOR SPECIALIZED TRAUMA ASSESSMENT AND TREATMENT

- UCLA PTSD Reaction Index (RI) https://www.uclahealth.edu/ptsd
- AF-CBT — Action Fact Sheet available at: https://www.uclahealth.org/ptsd/ afcbt/afcbt_factsheet.pdf

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 comorbid conditions. A comprehensive assessment tool recommended for the detection of additional trauma exposures and risk for PTSD is the UCLA PTSD Reaction Index (RI) in 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 the relevant symptom report that can be used to support the diagnosis of PTSD with and/or without dissociative symptoms. A derived, shortened version of the full UCLA PTSD RI is used as part of this CPM, meaning that there is cross-informant 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 5–18 years). The model includes non-offending caregivers in treatment and addresses psychosocial, parenting skills, education, 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.

- Parent-child interaction therapy (PCT). Used in outpatient settings to coach non-offending caregivers or caregivers at high risk of physical abuse or in positive parenting skills. This coaching is designed to decrease problem behaviors in children (ages 2–7 years) by encouraging their positive behavior, strengthening their parent-child relationship, and discouraging negative behavior. While the length of treatment depends on parent characteristics and of skills, PCT in community settings averages about 20 weekly sessions.

- Child and family trauma 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 psychosocial symptom monitoring, symptoms-specific coping mechanisms, and parent-child communication.

- 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 intervenes and educates parent-child interactions across multiple, positive ways. CPP is typically delivered in 40–50 weekly sessions.

- 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 co-parent components of engagement, psychosocial, and symptom-dominant interventions and education of incidents of physical force, cognitive processing, skill training, and clarification of responsible for past events. AF-CBT in community settings is about 20 weekly sessions.
Provide a brief, targeted intervention
## In-Office Intervention

<table>
<thead>
<tr>
<th>TABLE 3. Brief in-office interventions (for details see page 23)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sleep problems</strong></td>
</tr>
<tr>
<td>• Sleep education</td>
</tr>
<tr>
<td>• Belly breathing</td>
</tr>
<tr>
<td>• Guided imagery</td>
</tr>
<tr>
<td>• Medication</td>
</tr>
<tr>
<td><strong>Hypervigilant/intrusive symptoms</strong></td>
</tr>
<tr>
<td>• Belly breathing</td>
</tr>
<tr>
<td>• Guided imagery</td>
</tr>
<tr>
<td>• Progressive muscle relaxation</td>
</tr>
<tr>
<td>• Mindfulness</td>
</tr>
<tr>
<td><strong>Avoidance/negative mood symptoms</strong></td>
</tr>
<tr>
<td>• Behavioral activation</td>
</tr>
<tr>
<td>• Return to routine</td>
</tr>
<tr>
<td>• Parent-child communication</td>
</tr>
</tbody>
</table>
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
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%)
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
Trauma Exposure (n=1472 completed screeners)

478 (33%) of responses endorsed a trauma exposure

- Risk characteristics:
  - Chronic medical condition
  - Mental health diagnosis
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
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
Potentially Traumatic Events (PTEs) and Symptoms of Traumatic Stress, Depression, & Suicide/Self-Harm Detected at Well Child Checks

Legend:
- ● Endorses thoughts of suicide and/or self-harm
- PTE (Potentially traumatic event); TSS (Traumatic stress symptoms); DS (Depressive symptoms)

302 adolescents were screened concurrently for depressive symptoms with the Patient Health Questionnaire (PHQ-A) and for traumatic stress symptoms with the Pediatric Traumatic Stress Screening Tool (PTSS) during routine well child care. Of 185 (61%) reporting no history of potentially traumatic event (PTE), just 10% had depressive and/or traumatic stress symptoms of concern, while 50% of 117 reporting a history of PTE and depressive and/or traumatic stress symptoms. 18/30 (63%) of adolescents endorsing thoughts of suicide or self-harm, represented with black circles, had symptoms of traumatic stress in the context of a potentially traumatic event, highlighting the clinical importance of identifying trauma history in assessment of and response to patients with concerns for suicidality.
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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