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]

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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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DEFINITIONS

(Definitions quoted directly from source)

- **Potentially traumatic experience (trauma):** Significant event that causes or threatens harm to one's emotional and / or physical well-being.[SEG]
- **Child traumatic stress:** The intense fear and stress response occurring when children are exposed to traumatic experiences which overwhelm their ability to cope with what they have experienced. While some children "bounce back" after adversity, traumatic experiences can result in significant disruption of child development with profound long-term consequences. They may show signs of intense emotional and physiological distress — disturbed sleep, difficulty paying attention and concentrating, anger and irritability, withdrawal, repeated and intrusive thoughts, and extreme distress when confronted by reminders of the trauma.[NCTSN2]
- **Acute stress disorder (ASD):** Intense stress response with pattern of symptoms similar to PTSD (see below for definition) of duration less than 30 days. ASD may precede PTSD, but frequently the symptoms diminish with return to safety and effective support at home.[DSM]
- **Posttraumatic stress disorder (PTSD):** Prolonged (more than 30 days) occurrence of intrusive thoughts / nightmares, avoidance of reminders, hypervigilance / sleep difficulties / exaggerated startle response / irritability-anger, and negative mood / thoughts / affect following a traumatic event.[SEG]
- **Complex trauma:** Both children's exposure to multiple types of pervasive and chronic traumatic experiences that involve violence, betrayal, exploitation, and loss, such as maltreatment and living in unsafe family, community, or school settings, as well as the wide-ranging, long-term impact of this exposure. Complex trauma can disrupt the child's secure bonding with caregiver(s), as well as the development and formation of crucial competencies, positive relationships, and a clear sense of self.[NCTSN2]

BACKGROUND

The causes of traumatic stress are common and varied. Decades of research have shown that many types of events have the potential to cause traumatic stress, including these examples:

- Sexual or physical abuse
- Exposure to family or community violence
- Automobile or other accidents with injuries
- Life-threatening medical diagnoses
- Natural disasters, war, terrorism

The ACE studies, first published in 1998 and later replicated with a very large sample size by the CDC, showed that adverse childhood experiences (ACEs) are associated with many of the leading causes of death in adulthood. Results found that individuals experiencing multiple ACEs in childhood (especially four or more) were much more likely in adulthood to exhibit alcoholism, drug abuse, smoking, depression, severe obesity, sexually transmitted diseases, physical inactivity, and a history of suicide attempts. Higher ACE numbers were also strongly associated with ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease in adulthood. Additionally, research has shown that prolonged child traumatic stress symptoms (such as social withdrawal, avoidance of normative developmental experiences, and persistent anger / irritability, among others) often contribute to other comorbid problems such as low self-esteem, worsened depressive symptoms, apathy, and poor self-care.[FEL]

The risk of severe traumatic stress disorder can often be mitigated by intervention after trauma. Potentially traumatizing events often lead to traumatic stress for those involved, but not all traumatic stress leads to ASD, and not all ASD progresses to PTSD (see sidebar at left). Research has shown that effective parental support during the first few weeks after a trauma (or its discovery) may prevent the development of PTSD and / or reduce the severity of symptoms. Fairly simple in-office interventions (see page 23) can help parents / guardians support their child's use of positive coping strategies to reduce sleep disruptions, develop skills for self-calming, remain engaged in positive activities, and / or increase their sense of safety. Targeting one primary symptom (such as fear / anxiety or sleep onset difficulties) and teaching one skill (such as belly breathing or enhanced bedtime routine) can make a significant difference for many children. Use of this CPM will help providers quickly assess the children / teens who report a potentially traumatizing experience, determine who will be most likely to benefit from a treatment referral, and guide you through the process of identifying and teaching a relevant skill to the child and their parent / caregiver using a brief in-office intervention.

DEFINITIONS (continued)

- **Adverse childhood experiences (ACEs):** Include emotional, physical, or sexual abuse; emotional or physical neglect; domestic violence; parental substance use; parental mental illness; parental separation or divorce; or incarcerated household member. Such experiences are linked to long term health outcomes in a series of studies.[FEL] Recent additions include death of a parent, community violence, and poverty.[NCTSN2]
- **Toxic Stress:** A toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity — such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship — without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems and increase the risk for stress-related disease and cognitive impairment well into the adult years.[NCTSN2, DCHA]

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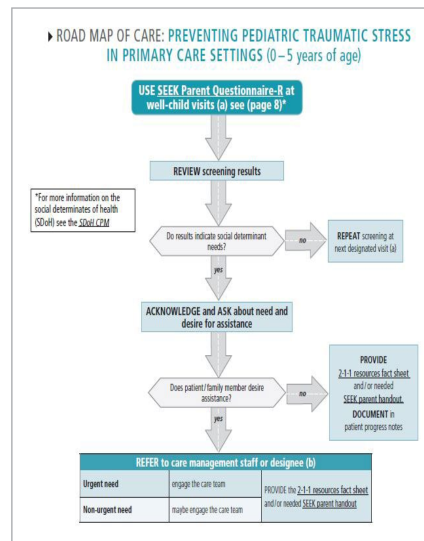
AT-A-GLANCE: Children 0–5 years of age

Prevention of trauma using the SEEK assessment

For very young children, this document focuses on the **prevention** of trauma. For children 0–5 years of age, the Safe Environment for Every Kid (SEEK) model for pediatric primary care is the recommended response (see page 8). SEEK is an effective model for the prevention of abuse/neglect in early childhood. It helps primary care providers identify areas of high potential risk for the child and provide relevant information and support to the parents/caregivers. The primary care teams use the one-page *SEEK Parent Questionnaire-R* (PQ-R) to screen for targeted problems in the family together with simple motivational interviewing skills to deliver a team-based approach to connect families with resources.

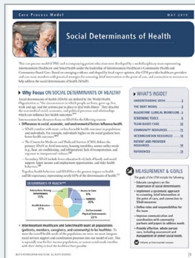
For overview, see the **Road Map of Care: Preventing Pediatric Traumatic Stress in Primary Care Settings (0-5 Years of Age)** (see page 7).



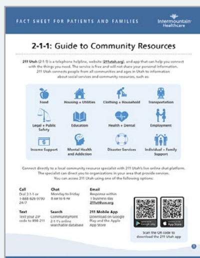
KEY RECOMMENDATIONS

Additional information about the SEEK program and community resources can be found in the links below.

- SEEK training: seekwellbeing.org/get-trained
- SEEK parent questionnaire-R: seekwellbeing.org/seek-materials
- SEEK handouts: seekwellbeing.org/the-seek-model



- *Social Determinates of Health* CPM



- *2-1-1: Guide to Community Resources* (English) / (Spanish)

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AT-A-GLANCE: Children 6 – 18 years of age

Using the three-step process

For children 6 – 18 years who report a potentially traumatic experience on the **Pediatric Traumatic Stress Screening Tool** (see pages 33 – 36), the process of responding effectively to child traumatic stress involves three steps:

1. **Report if required.** If the potentially traumatizing event does not involve alleged child abuse or family violence, reporting to law enforcement or child protection services is unnecessary. If abuse or family violence is the source of the potential trauma, determine if the event needs to be reported to appropriate investigative authorities. In Utah, reports can be made to either local law enforcement or the Child Protective Services (CPS) office of the Utah Division of Child and Family Services (DCFS) (1-855-323-3237). If the event has already been reported, there is no need to do it a second time.
2. **Respond to suicide risk.** The Pediatric Traumatic Stress Screening Tool (see pages 33– 36) includes an item assessing recent suicidal ideation. If the parent or youth endorses **any** number of days of suicidal thinking, primary care providers are directed to the *Suicide Prevention* CPM to determine the severity of the risk and appropriate response. Alternatively, providers can follow the included **Columbia Suicide Severity Rating Scale (C-SSRS)** (see page 11) to assess patient safety and determine response protocols, referring to local emergency medical services when needed.
3. **Stratify treatment approach.** Results from the **Pediatric Traumatic Stress Screening Tool** are stratified into three levels. The mild range scores (0 – 10) identify a child / teen for whom it would be appropriate to use a "protective approach" with ongoing primary care monitoring and supportive guidance building on strengths. The moderate range (11 – 20) indicates a "resilient approach" is appropriate with a brief in-office intervention and a referral to a child therapist. Scores in the severe range (21 or higher) indicate a "restorative approach" is needed, which includes a brief in-office intervention and a referral to a therapist with specialized trauma evidence-based treatments (EBT) training (in addition to safety planning, when indicated).

Brief in-office intervention

Based on screening tool results, a brief in-office intervention targeting their most prominent symptom(s) has been shown to make a big difference for many children. In addition to teaching them a useful coping skill, the child often feels an increased sense of support from parent(s) / guardian(s) who can help them practice the skill at home and remind them to use it when needed. For many children, belly breathing or mindfulness training (teens) will be able to slow down a racing heart or mind at bedtime to fall asleep easier or reduce the intensity of anxious / fearful or angry feelings. Children in the severe and moderate traumatic stress symptom range will typically benefit from an intervention based on their symptoms, but clinicians may also choose to use a brief intervention with those in the low symptom range.

Follow up at regular intervals

In primary care settings, you can evaluate the response to services using the **Pediatric Traumatic Stress Screening Tool** at follow up visits. If symptom severity remains unchanged or worsens, consider alternatives such as providing a new brief in-office intervention, reinforcing the need to follow through with treatment for those who have not, or changing the treatment stratification and therapy referral to a more intensive approach.

PEDIATRIC TRAUMATIC STRESS SCREENING TOOLS (PTSST)

AGES 6 – 10 YEARS
(LOW-RISK PATIENTS)
English: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529794096
Spanish: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529794105

AGES 6 – 10 YEARS
(HIGH-RISK PATIENTS)
English: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529795086
Spanish: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529795088

AGES 11 – 18 YEARS
(LOW-RISK PATIENTS)
English: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529795279
Spanish: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529795283

AGES 11 – 18 YEARS
(HIGH-RISK PATIENTS)
English: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529795302
Spanish: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529795307

PSST
in combination with
PATIENT HEALTH QUESTIONNAIRE (ADOLESCENTS)
AGES 11 – 18 YEARS
English: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529795311
Spanish: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529795314

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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 is 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 the treatment 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 ↗ (to Restorative); NO →	**Resilient Approach** Refer to MHI or community / private mental health (see page 14).
Mild symptoms Score ≤ 10**	YES ↗ (to Resilient); 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

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ROAD MAP OF CARE: CHILD TRAUMATIC STRESS IN CHILD ADVOCACY CENTERS (6 – 18 years of age)

Child or caregiver completes the Pediatric Traumatic Stress Screening Tool as part of a multidisciplinary evaluation for child abuse (see 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 18)	2 Respond to suicide risk (see page 19)	3 Stratify response (see page 20)
Call DCFS if child maltreatment is suspected (1-855-323-3237).	If child reports thinking about being better off dead or of harming themselves in some way, use the **Columbia Suicide Severity Rating Scale (C-SSRS)** (see page 19). To further assess and respond to risk see Intermountain's *Suicide Prevention* CPM.	• Refer to the **Pediatric Traumatic Stress Screening Tool** to assess symptom severity (see pages 33 – 36). • Engage family about their treatment preferences. • Use the treatment stratification chart below to facilitate a referral.

Treatment Stratification

Symptoms	Family preference?	Recommended response
Severe symptoms Score ≥ 21**	YES or NO	**Restorative Approach** Facilitate referral to Evidence-based Trauma Treatment (see page 21).
Moderate symptoms Score 11 – 20**	YES (→ Restorative Approach) NO	**Resilient Approach** Facilitate referral to Evidence-based Trauma Treatment (see page 21).
Mild symptoms Score ≤ 10**	YES (→ Resilient Approach) NO	**Protective Approach** Facilitate referral to primary care for continued monitoring (see page 21)

** Scores from the **Pediatric Traumatic Stress Screening Tool.** See page 17 for more information and pages 33-36 for copies of the screening tool.

TEACH a helpful response see (page 22)

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

FOLLOW UP (see page 22)

Give a phone call to the family after 2 – 4 weeks, to check on follow through with referrals and / or primary care provider. This gives another opportunity for family support or problem-solving assistance

With permission, send a letter to the child's primary care provider:
- Low symptom letter (see page 38)
- Moderate / high symptom letter (see page 39)

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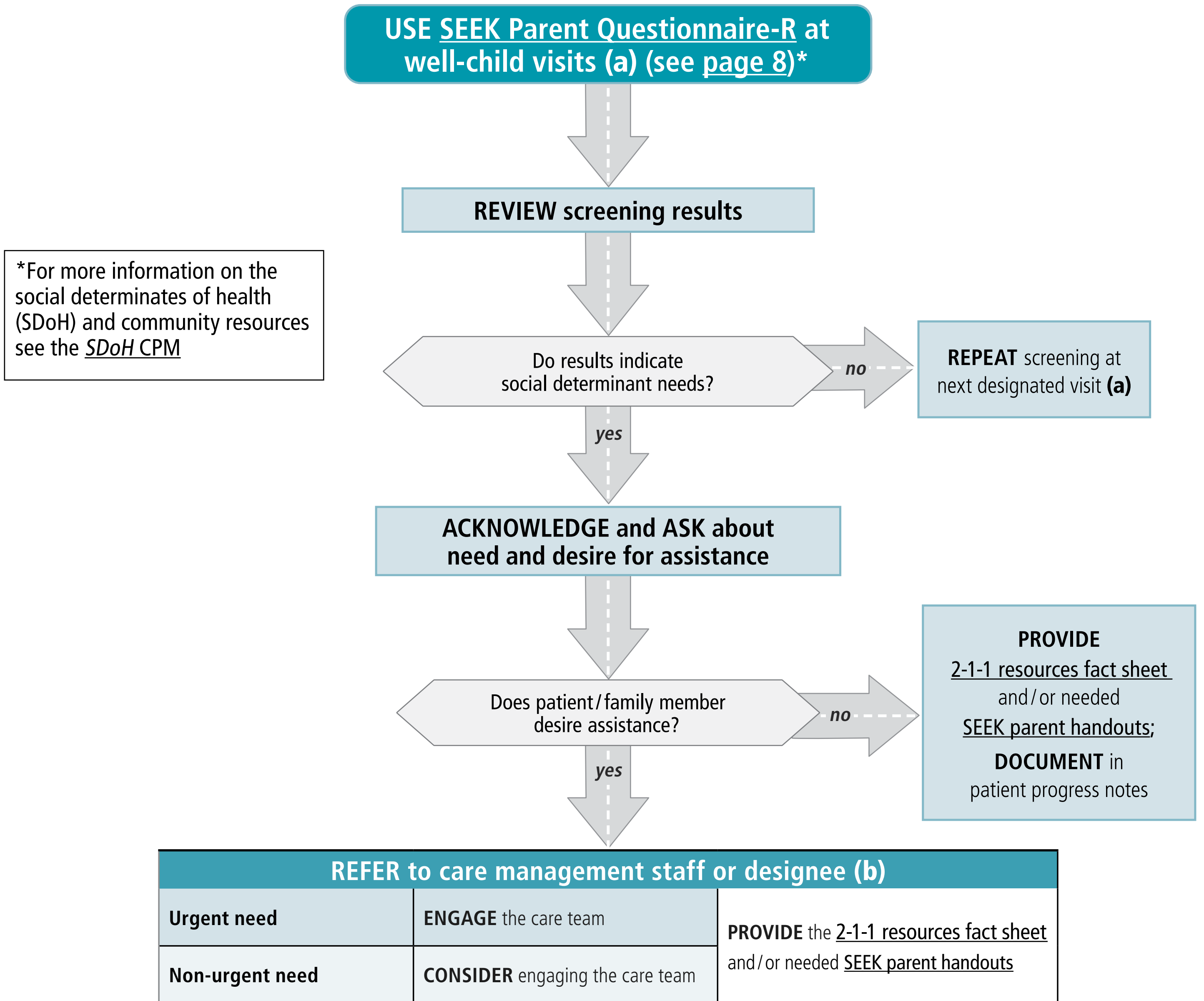
ROAD MAP OF CARE: PREVENTING PEDIATRIC TRAUMATIC STRESS IN PRIMARY CARE SETTINGS (0 – 5 years of age)



REFER to care management staff or designee (b)		
Urgent need	**ENGAGE** the care team	**PROVIDE** the 2-1-1 resources fact sheet and / or needed SEEK parent handouts
Non-urgent need	**CONSIDER** engaging the care team	

ALGORITHM NOTES

(a) SEEK screening

The *SEEK Parent Questionnaire-R* is used at the 2-month, 9-month, 15-month, 2-year, 3-year, 4-year, and 5-year well-child visits.

(b) Referring to care management at the point of care

Referrals to Care Management (CM) should be based on need and relationship. Patients / parents who have an established relationship with a care manager or have higher needs, (e.g., homelessness, intimate partner violence) should be referred to a care manager. Other patients / parents with identified unmet social needs can be referred to a care guide or medical assistant.

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TRAINING IN TRAUMA

This CPM is most effective in a system that is already trauma-informed. There are many resources at The National Child Traumatic Stress Network (nctsn.org) that can help with this.

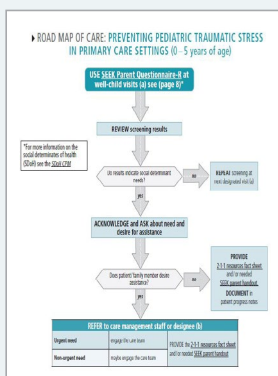
For further training in trauma awareness and trauma-informed care specific to pediatricians and pediatric care teams, see **The Pediatric Approach to Trauma, Treatment, and Resilience (PATTeR)** courses made available via collaboration between NCTSN and the American Academy of Pediatrics (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/related-initiatives/Pages/Resources.aspx)

KEY RECOMMENDATIONS

Additional information on prevention and SEEK program resources can be found in the links below:

- SEEK training: https://seekwellbeing.org/get-trained/
- SEEK parent questionnaire-R: https://seekwellbeing.org/seek-materials/
- SEEK handouts: https//seekwellbeing.org/the-seek-model/
- *Social Determinates of Health* CPM

The detailed information to the right refers to the **Road Map of Care: Preventing Pediatric Traumatic Stress in Primary Care Settings (0–5 years)** (see page 7).



PRIMARY CARE

This CPM includes two processes to address child traumatic stress across the pediatric lifespan. First, primary care providers and care teams can meaningfully respond to family needs that may prevent trauma exposure in children (0–5 years) through the use of the SEEK questionnaire and **Road Map of Care for Pediatric Trauma Prevention** (see page 7). Second, primary care providers and care teams can intervene with children (6–18 years) who have experienced a potentially traumatic experience through the use of the **Pediatric Traumatic Stress Screening Tool** and **Road Map of Care for Pediatric Traumatic Stress** (see page 5).

Please note that awareness of and responding to childhood traumatic stress may increase exposure to trauma for the entire care team. Secondary traumatic stress, or vicarious trauma, is traumatic stress in care providers exposed to and working with patients with trauma. It is important that care providers realize that they too can experience traumatic stress, recognize its signs and symptoms, and respond. Self-care, supervision or mentorship, personal support, and / or formal assistance via community mental health or an Employee Assistance Program (EAP) can help. See **The Healthcare Toolbox** for more information on and resources for secondary traumatic stress (https://www.healthcaretoolbox.org/self-care-for-providers.html).

PRIMARY CARE SETTINGS CHILDREN 0–5 YEARS OF AGE

Using the SEEK model

Screening with SEEK Parent Questionnaire-R (PQ-R)

For preschool-age children, the SEEK model for pediatric primary care is recommended to guide providers in screening for, assessing, and addressing problems related to child safety. SEEK is an effective model for prevention of abuse / neglect in early childhood. It helps primary care providers identify areas of potential high risk for the child and provide relevant information and support to the parents / caregivers. For children 0–5 years old, primary care teams use the one-page **SEEK Parent Questionnaire-R** (PQ-R) (https://seekwellbeing.org/seek-materials/) to screen for problems in the family associated with unsafe situations for young children (e.g., increased risk for child maltreatment) (see box at left for links to implementation information).

Management of pediatric trauma risk

Once identified, the clinician uses simple motivational interviewing techniques to help engage parent(s) / guardian(s) in developing a plan to reduce the risks and build on family strengths. Using the SEEK model involves a separate online training with **Motivational Interviewing** examples (https://seekwellbeing.org/get-trained/) and customization of the SEEK parent handouts with information on local resources (https://seekwellbeing.org/the-seek-model/) to connect caregivers with supportive resources or helpful information. Other local resources to help address social determinants of health needs can be found in Intermountain's *Social Determinants of Health* CPM.

Note, SEEK does not screen for symptoms of traumatic stress and some preschool age children with known potentially traumatic experiences may warrant referral for additional evaluation and possible trauma focused treatment. See additional information about trauma-focused treatment on page 25.

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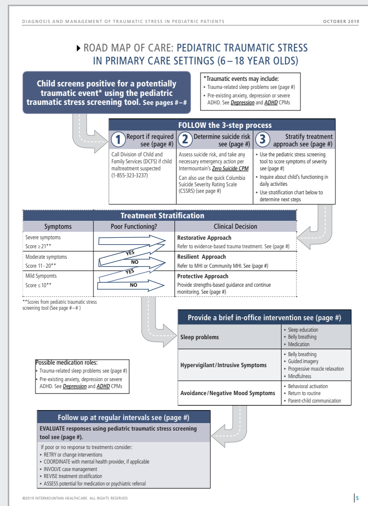
KEY RECOMMENDATIONS

- **SCREEN** using the Pediatric Traumatic Stress Screening Tool
- **MANAGE traumatic stress** if trauma exposure is indicated using the 3-step method.
  - REPORT if required
  - RESPOND to suicide risk
  - STRATIFY treatment approach
- **PROVIDE brief in-office intervention**
- **FOLLOW UP**

For overview click below



PRIMARY CARE SETTINGS: CHILDREN 6 – 18 YEARS OF AGE

The Pediatric Traumatic Stress Screening Tool

The **Pediatric Traumatic Stress Screening Tool** is a 15-item questionnaire including the *UCLA Brief Screen For Trauma and PTSD (UCLA Brief Screen)*, a validated measure based on the Brief UCLA PTSD Reaction Index for DSM-5. The UCLA Brief Screen, made available here by permission at no charge, is part of an integrated set of broadly adopted evidence-based measures for PTSD and trauma-informed care. You can learn more at www. reactionindex.com

The **Pediatric Traumatic Stress Screening Tool** can be quickly completed in the clinic waiting room on a tablet or paper as a self-report measure for ages 11 – 18 years or by the parent / caregiver for ages 6 – 10 years. The screening tool is available in English and Spanish as well as in print (see pages 33 – 36) or electronic versions (see page 4). The 15 items include two trauma exposure questions (recent vs. remote events), one suicide screening question (from the PHQ-A), and 12 traumatic stress symptom questions (from the UCLA Brief Screen).

These 15 items facilitate the identification and management of traumatic stress in pediatric patients.

Screening can be implemented universally with all pediatric patients (6 – 18 years) at well visits and / or it can be implemented with targeted groups, such as patients presenting with mental / behavioral health concerns. When serving a more at-risk community, universal screening is preferable (see **Special Populations** on page 26). The **Pediatric Traumatic Stress Screening Tool** also can be applied with branching logic, wherein patients only continue to respond to traumatic stress symptom questions if they endorse trauma exposure on items one or two. See low-risk screening tools (page 4). However, when serving a more at-risk population, completion of the full screening tool is preferable. See high-risk screening tools (page 4).

Identification of traumatic exposure

If the patient / caregiver indicates trauma exposure on items one or two of the **Pediatric Traumatic Stress Screening Tool**, see (pages 33 – 36), continue on to the management of traumatic stress by following the three-step process. If no trauma exposure is indicated or known, and no symptoms of traumatic stress are reported, no provider response is indicated.

Management of traumatic stress (3 – step method)

1. Report if required

Referencing the top two items on the **Pediatric Traumatic Stress Screening Tool** (see pages 33 – 36), determine whether a report for suspected child maltreatment is required. More information from the patient / caregiver may be needed to make such a determination. In most cases, no report will be needed; quite often for remote traumas, the report and / or investigation will have already occurred. However, for first-time disclosures of events or additional information, the provider will need to make a mandated report to CPS or law enforcement. Please note, providers do not have to be able to prove their concerns, only have "reason to believe." It is the responsibility of CPS and law enforcement to investigate allegations of child maltreatment.

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REPORTING LAWS

Every state has mandatory reporting laws, but they differ based on whom a state considers a "mandatory reporter." In Utah, all are mandatory reporters, including healthcare professionals. Utah law **62A-4a-403** states, "… when any person including persons licensed under the Medical Practice Act, or the Nurse Practice Act, has reason to believe that a child has been subjected to abuse or neglect, or who observes a child being subjected to conditions or circumstances which would reasonably result in abuse or neglect, that person shall immediately notify the nearest peace officer, law enforcement agency, or office of the division."

The definitions of reportable abuse and age of consent laws also vary from state to state. The presence of a minor in the event of domestic violence, for example, may be considered reportable child maltreatment. All providers are obligated to be aware of child abuse reporting laws and requirements in their state.

SUICIDE AND UTAH'S YOUTH

Suicide is the number one cause of death among young people (ages 10–17 years) in Utah and has been consistently higher than the national rate.[UDOH]

The rate of suicide among young Utahns is increasing. A 2015 Utah Student Health and Risk Prevention Survey found that, during the previous 12 months, 14.4 % of youth in grades 6–12 had seriously considered attempting suicide (an increase of 53 % since 2011).[UDOH]

Exposure to trauma can contribute to suicide risk along with other individual, relationship, community, and societal factors.[MID]

Detecting suicide risk early is key to preventing suicidal behavior and connecting patients with the right therapeutic services.[HOR]

How to report. The statewide number to use for reporting to DCFS is 1-855-323-3237 (in Idaho, call 1-855-552-5437). For areas outside Utah or Idaho, the national child abuse reporting number is 1-800-4-A-CHILD.

Report the following information:

- Identity of the child
- Date of birth
- Parents' / legal guardians' names
- Where the child lives
- What type of suspected child maltreatment you are reporting (i.e., child endangerment, domestic violence-related child abuse, emotional abuse, physical abuse, sexual abuse, or neglect)

Law enforcement or child protection authorities may request medical records that support the allegations, which may be released without parental consent (not a HIPAA violation). Utah law 62A-4a-406 allows physicians to document injuries by taking photos of trauma visible on a child or premises / objects relevant to a reported circumstance of abuse or neglect. The law also allows for x-rays to be taken. Both photos and x-rays relevant to trauma-related injuries are to be made available to DCFS and / or law enforcement and the courts via non-distributive means (e.g., CD, DVD, flash drive).

In instances of concern for child abuse, consider communication with the Children's Advocacy Center [CAC; or Chidren's Justice Center (CJC) as they are called in Utah] multi-disciplinary team (MDT).

> **Note:** If concerns about the safety of the child or the parent / caregiver is due to family violence, report to DCFS and / or refer the parent / caregiver to the Utah Domestic Violence Coalition for immediate assistance with safety planning and shelters: http://udvc.org/ or 1-800-897-5465.

2. Respond to suicide risk

Screening for suicide using the **Pediatric Traumatic Stress Screening Tool** is consistent with Intermountain Healthcare's *Depression* CPM and *Suicide Prevention* CPM.

Initial screening for suicide risk is determined by the final question on the **Pediatric Traumatic Stress Screening Tool** (see the bottom item). The question is adapted from the **Patient Health Questionnaire for Adolescents** (PHQ-A) which is often used in medical settings: "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?" When this question is answered negatively ("not at all"), no further assessment is needed. When this question is answered affirmatively in any way, ("several days," "more than half the days," or "nearly every day"), it indicates the need for additional assessment of suicide risk.

Additional assessment of suicide risk and response is accomplished by utilizing the Columbia Suicide Severity Rating Scale (C-SSRS). The C-SSRS screen is comprised of three initial questions (1–2, 6), with the option of three additional questions (3–5) to assess suicide risk (low, medium, and high) and response. An excerpt of the C-SSRS from the *Suicide Prevention* CPM can be found in table 1 on the next page). Refer to Intermountain's *Suicide Prevention* CPM for full details regarding screening in an outpatient clinic setting.

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TRAUMA-INFORMED SUICIDE PREVENTION

Suicidal youth with trauma exposure might additionally benefit from a trauma-informed response. Safety planning, for example, might include conversations about and strategies to respond to the patient's trauma reminders and traumatic stress symptoms (see brief in-office interventions on page 23).

For further training in trauma-informed suicide prevention strategies specific to pediatricians and pediatric care teams, see The Adolescent Suicide/Self Harm and Substance Abuse Project (ASAP) and Family Intervention for Suicide Prevention (FISP) (asapnctsn.org).

TABLE 1: 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-Behavioral Health[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 had any thoughts of killing yourself?	Nonspecific thoughts		
3. Have you been thinking about how you might kill yourself?	Thoughts with method (without a specific plan or intent to act)	**Moderate**	• Assess risk factors and either facilitate evaluation for inpatient admission or complete the *Pediatric 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

See Vignette 3: Trevor (Anxiety / Avoidance) for an example of addressing suicidal thoughts (page 31)

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3. Stratify Treatment Approach

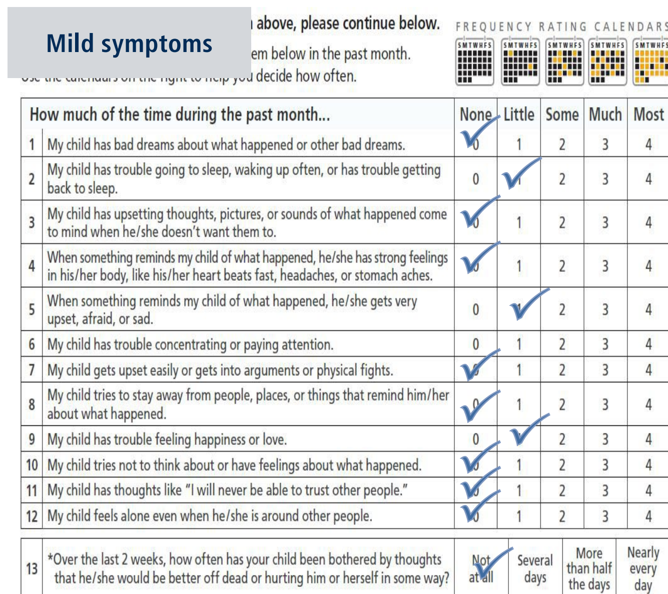
Stratify the treatment approach to one of three options (restorative, resilient, or protective approach) based on the child's trauma symptom severity and the presence of functional impairment in the child's life

Trauma symptom severity

The overall severity of traumatic stress symptoms is determined by summing the numeric scores for items 1 – 12 on the **Pediatric Trauma Screening Tool**. Total scores in the 0 – 10 range indicate mild or no risk for PTSD and ongoing problems associated with the potentially traumatic experience(s). Scores in the 11 – 20 range identify a moderate risk, and scores 21 or greater identify a severe risk.

If clinical time does not permit scoring items 1 – 12 on the **Pediatric Traumatic Stress Screening Tool** paper form, quick visual cues might distinguish patient symptom severity. A patient who primarily identifies their symptoms occurring "much" or "most" of the time (right-hand side of the scale) likely has a symptom score in the severe range (≥ 21). A patient who primarily identifies their symptoms occurring "some" of the time (middle of the scale) or mixed high and low ratings likely has a symptom score in the moderate range (11 – 20). A patient who primarily identifies their symptoms occurring "little" or "none" of the time (left-hand side of the scale) likely has a mild symptom score (≤ 10). Examples of typical visual patterns seen in patient assessments with mild, moderate and severe symptoms are shown below.

Visual patterns of responses help indicate symptom severity level



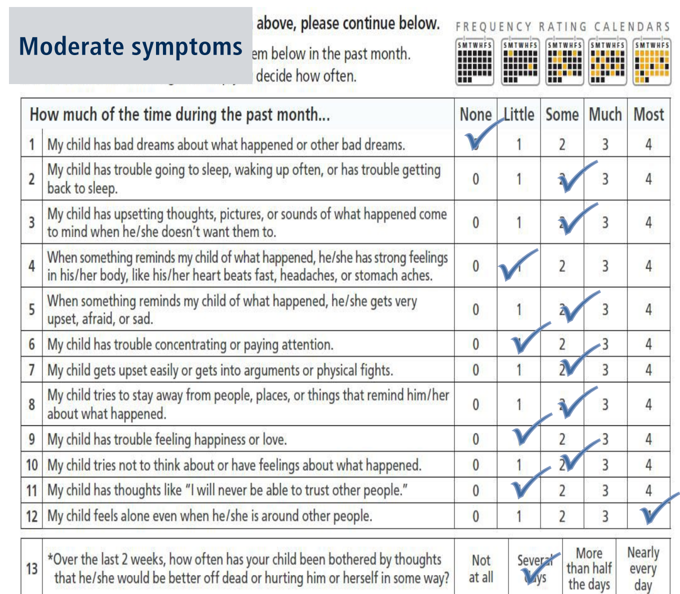
Mild symptoms

above, please continue below.
em below in the past month.
decide how often.

FREQUENCY RATING CALENDARS

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

		Not at all	Several days	More than half the days	Nearly every day
13	*Over the last 2 weeks, how often has your child been bothered by thoughts that he/she would be better off dead or hurting him or herself in some way?				



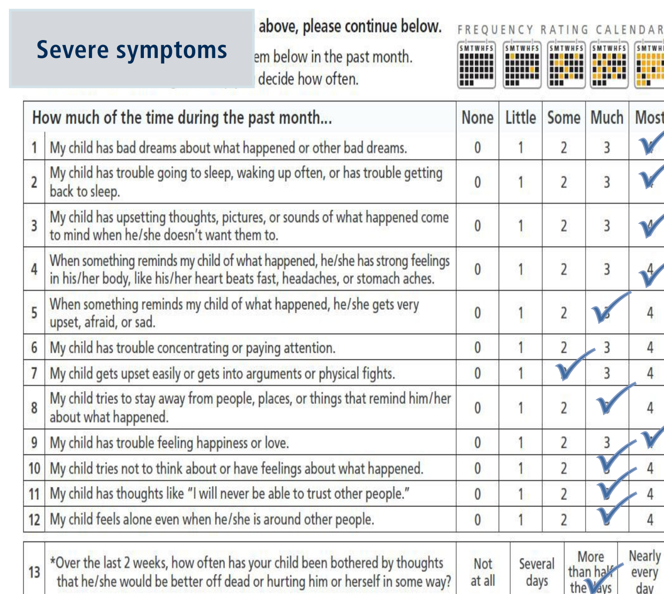
Moderate symptoms

above, please continue below.
em below in the past month.
decide how often.

FREQUENCY RATING CALENDARS

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

		Not at all	Several days	More than half the days	Nearly every day
13	*Over the last 2 weeks, how often has your child been bothered by thoughts that he/she would be better off dead or hurting him or herself in some way?				



Severe symptoms

above, please continue below.
em below in the past month.
decide how often.

FREQUENCY RATING CALENDARS

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

		Not at all	Several days	More than half the days	Nearly every day
13	*Over the last 2 weeks, how often has your child been bothered by thoughts that he/she would be better off dead or hurting him or herself in some way?				

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Functional impairment

When determining treatment stratification, consider not only the child's traumatic stress symptom score, but also the child's functional impairment in home, family, social, and school environments. A simple question to the child and caregivers, "How is (patient) doing at home, school, and with friends?" or "Are things going ok for (patient) at home, school, and with friends?" can be used to elicit information about the child's functioning. **When considered with the child's traumatic stress symptom score, the child's functional impairment, or lack thereof, may additionally inform your clinical decision for treatment stratification** (see the stratification of treatment chart on page 14). Children / teens with scores in the mild or moderate range may be appropriate for higher-level clinical response if significant functional difficulties are identified. Selecting the most effective clinical response will be enhanced if the following issues are considered:

See Vignette 2: Braden (Acting Out) (page 30)

- Some traumatic experiences (e.g., sexual assaults involving violence, witnessing traumatic deaths) warrant a restorative approach and referral to specialized evidence-based trauma treatment, regardless of their score on the **Pediatric Traumatic Stress Screening Tool**.
- Degree and quality of parental / family support can greatly affect recovery.
- Cultural, gender identity, or language issues may increase stress and complicate the healing / recovery process.
- Low social support, lack of involvement in school or community activities, or disengagement from support systems may signal a need for higher-level response.

Appearance or worsening of functional difficulties after the occurrence or discovery of the potentially traumatic experience can be an important indicator of negative impact regardless of the child's score on the **Pediatric Traumatic Stress Screening Tool**.

Asking the child and caregivers about how things are going in general also encourages shared decision-making and may help increase motivation to follow through with recommendations. It is perfectly reasonable for a child or caregiver to help choose the treatment approach, especially if opting for a more intensive treatment approach. Please note, however, that avoidance is a characteristic symptom of traumatic stress and so a symptomatic child or caregiver might be treatment-avoidant.

DIAGNOSTIC CONSIDERATIONS

Diagnosis is not a specific objective of this CPM, but pilot data has shown that the use of the screening tool will increase the detection of children / teens who are experiencing symptoms of traumatic stress and are at risk for PTSD.

Some presentations of traumatic stress symptoms can mimic other common behavioral and emotional problems. Without the awareness that a child has had a potentially traumatic experience, symptom patterns that sound similar to ADHD, depression, or various anxiety disorders may be misdiagnosed. The inability to sit still and / or stay focused, negative emotionality and / or withdrawn behavior, and "panic attacks," are common examples of symptoms that may be posttraumatic in nature. Even in situations where both diagnoses are applicable, effective treatment of the traumatic stress symptoms will be an important priority in the treatment response.

- F43.12: Post-traumatic stress disorder, chronic
- F43.11: Post-traumatic stress disorder, acute
- F43.10: Post-traumatic stress disorder, unspecified
- F43.0: Acute stress disorder
- F43.9: Reaction to severe stress, unspecified
- Z91.49: Other personal history of psychological trauma, not elsewhere classified
- F43.8: Other specified trauma and stress-related disorder
- F43.25: Adjustment disorder with mixed disturbance of conduct / emotions
- F43.23: Adjustment disorder with mixed anxiety / depression
- T74.92X: Child maltreatment, confirmed, unspecified
- T76.92X: Child maltreatment, suspected, unspecified

Event codes for the type of injury or abuse can also be important to document. For additional support with diagnosing, documenting, and/or billing for child traumatic stress, see AAP's *Trauma Coding Fact Sheet* (https://www.aap.org/en-us/professional-resources/practice-transformation/getting-paid/Coding-at-the-AAP/Pages/Private/Trauma-Coding-Fact-Sheet.aspx).

Please note, primary care providers seeking to complete a more thorough assessment of posttraumatic stress symptoms may wish to use the full *UCLA PTSD Reaction Index for DSM-5* which can be obtained from Behavioral Health Innovations, LLC at https://www.reactionindex.com.

As patients might be seen in other clinics and settings, updating the problem list and diagnosis in the electronic medical record (EMR) can promote the provision of coordinated and trauma-informed care. In the event of disclosure of family violence, however, follow institutional guidance for documentation.

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Treatment stratification

The mild, moderate, and severe symptom risk categories correspond with protective, resilient, and restorative approaches for the clinical response (see table 2 below). The higher the symptom score and / or the more significant the functional impairment, the greater the risk of developing PTSD without effective treatment. See also special populations on page 26 for additional considerations by child population and type of trauma.

Protective approach

Children with minimal symptoms and little or no functional impairment may never need formal intervention following a potentially traumatic experience. They may benefit from a simple skill to help them feel calmer when experiencing distress (brief in-office intervention). In these situations, provide continued support and ongoing monitoring to identify future worsening of symptoms as this may occur in some situations. Provide anticipatory guidance to the child / caregivers about child traumatic stress (see page 27 for key resources for child and families)."

Resilient approach

Many children with moderate or mild symptoms and some increased functional impairment will be best served with a referral for mental health therapy, but brief non-specialized treatment with a general child mental health therapist will often be an effective response. These children will also typically benefit from anticipatory guidance about child traumatic stress (see page 27 for key resources for child and families) as well as from a targeted brief in-office intervention.

Restorative approach

This approach is appropriate for children with significant and often prolonged post-traumatic stress symptoms who are most likely to benefit from trauma evidence-based treatments. Scores in the severe range on the screening tool (or in the moderate range with increased functional impairment) identify a child who needs a specialized trauma-focused treatment approach as standard child mental health treatment may be ineffective. These children will also typically benefit from anticipatory guidance about child traumatic stress (see page 27 for key resources for child and families) as well as from a targeted brief in-office intervention.

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**	NO (YES → Restorative Approach)	**Resilient Approach** Refer to MHI or Community MHI.
Mild symptoms: Score ≤ 10**	NO (YES → Resilient Approach)	**Protective Approach** Provide strengths-based guidance and continue monitoring.

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

See Vignette 1: Ellie can't sleep for an example of using a protective approach (page 29)

See Vignette 3: Trevor (Anxiety / Avoidance) for an example of using a resilient approach (page 31)

See Vignette 2: Braden (Acting Out) for an example of using a restorative approach (page 30)

THE ROLE OF THE CARE MANAGER

Some insurance programs, such as SelectHealth, provide care management for traumatic stress.

To participate in the SelectHealth Care Management Program for PTSD, families can call 1-800-442-5305 and ask for Behavioral Health Care Management for PTSD or providers can email Medicaidumintake@imail.org with "BH Referral for PTSD" in the subject line and the member's name (child), date of birth, contact parent's name, and phone number in the body.

Care management helps members to maximize insurance benefits by:

- Assuring access to healthcare services
- Providing referral assistance to an appropriate behavioral health provider
- Ensuring alignment of treatment planning among providers
- Exploring transportation options for clinic visits
- Helping to remove cultural barriers to care resulting from language or literacy issues

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SLEEP DISTURBANCE

Sleep disturbances are common among traumatized children and are one of the main challenges of traumatic stress that pediatricians can immediately address. Disruption of sleep may also cause cognitive problems and can be a "driver" for a host of difficult symptoms.

Why is sleep important?

Children who don't sleep well can experience irritability, anxiety, exhaustion, poor concentration, hyperactivity and a variety of other problems. These concerns can lead to difficulty getting along with others, poor performance at school and eventually, deterioration in overall health. Lack of sleep can lead to obesity, diabetes and cardiovascular disease in later life.

What is considered a sleep problem?

It is common for children to have sleep problems after a traumatic experience. Most improve over time, depending on the severity of the event and the child's resiliency. Some children have a difficult time or are afraid to fall asleep, and might experience arousal or anxiety near bedtime. Others may wake up during the night and have a hard time getting back to sleep. Some have nightmares or night terrors. To solve the child's sleep difficulties, it is important to determine if trauma reminders are at the root of it .

See Vignette 1: Ellie can't sleep (page 29)

What are typical sleep interventions?

When sleep problems persist, and begin to interfere with functioning, there are interventions that can help. Educate parent(s) / guardian(s) about possible causes of sleep problems, and:

- Ensure that the child's safety concerns are addressed.
- Reinforce positive parenting skills that emphasize returning to normal healthy routines.
- Practice sleep hygiene that includes limiting screen time at night, reducing fluids, and decreasing caffeine.
- Teach skills to reduce stress, such as relaxation techniques or guided imagery.
- Consider limited medication use only after other measures have proven ineffective.

Brief In-Office Intervention

Primary care providers are often in contact with children exposed to trauma and can provide basic information and support initial skill development to alleviate traumatic stress. For educational materials about child traumatic stress for children and families, see page 27. To support decisions regarding a brief in-office intervention, the items identifying sleep problems (items 1 – 2), hypervigilant / intrusive symptoms (items 2 – 7), and avoidance / negative mood symptoms (items 8 – 12) are grouped together on the **Pediatric Traumatic Stress Screening Tool**, as shown below.

If you checked 'yes' on either question above, please continue below.

Select how often your child 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	My child has bad dreams about what happened or other bad dreams.	Sleep problems
2	My child has trouble going to sleep, waking up often, or has trouble getting back to sleep.	Both
3	My child has upsetting thoughts, pictures, or sounds of what happened come to mind when he/she doesn't want them to.	Hypervigilance and intrusive symptoms
4	When something reminds my child of what happened, he/she has strong feelings in his/her body, like his/her heart beats fast, headaches, or stomach aches.	Hypervigilance and intrusive symptoms
5	When something reminds my child of what happened, he/she gets very upset, afraid, or sad.	Hypervigilance and intrusive symptoms
6	My child has trouble concentrating or paying attention.	Hypervigilance and intrusive symptoms
7	My child gets upset easily or gets into arguments or physical fights.	Hypervigilance and intrusive symptoms
8	My child tries to stay away from people, places, or things that remind him/her about what happened.	Avoidance and negative mood
9	My child has trouble feeling happiness or love.	Avoidance and negative mood
10	My child tries not to think about or have feelings about what happened.	Avoidance and negative mood
11	My child has thoughts like "I will never be able to trust other people."	Avoidance and negative mood
12	My child feels alone even when he/she is around other people.	Avoidance and negative mood
13	*Over the last 2 weeks, how often has your child been bothered by thoughts that he/she would be better off dead or hurting him or herself in some way?	Suicide

With minimal practice using the screening tool paper version, it soon becomes possible with a quick visual review to determine the most prominent symptom area so the brief in-office intervention can be chosen to target that area (see table 3 below). The optional tablet-based screening form automatically scores the inventory and guides clinicians to intervention options targeting their most prominent symptom area. For clinics interested in using a Research Electronic Data Capture (REDCap) platform to administer the screening tool on a tablet, please contact the Utah Pediatric Integrated Post-Trauma Services (PIPS) team for additional information (pips@utah.edu).

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

If sleep problems are prominent (items 1 – 2 marked "much" or "most" of the time), it is typically best to choose a brief intervention targeting these difficulties, followed by hypervigilant / intrusive symptoms, even if other symptom areas are similarly elevated. Following the steps of the decision support guidance on the tablet or the paper screening tool will help clinicians select a brief in-office intervention that may help the child begin the healing process and instill hope for recovery. See page 23 for more information about the brief interventions in detail.

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Follow Up

This CPM recommends follow-up in-person or by phone to ensure that the child is improving and / or not worsening based on the severity of trauma symptoms and quality of functioning. During the follow-up, providers are encouraged to have the child repeat the screening tool and compare results from the first visit. A shorter-term follow up in 2–4 weeks and a longer-term follow up in 4–6 months provide the opportunity to monitor symptom change, assess / adjust decision-making, and provide on-going support. Specifically, the longer-term follow up might help identify symptom resolution versus the need for on-going support and referral.

Medications

There are currently no FDA-approved drugs for the treatment of traumatic stress in children. The medications that have demonstrated efficacy in adults for PTSD or depression (e.g., sertraline) are not effective in children.[COH1, GIL, LEE] It is possible in some cases for providers to consider short-term medication use to target specific symptoms in children with traumatic stress; however, the provider should exercise caution due to the following pitfalls:

- Trauma-exposed children are more likely to receive psychotropic medications, more likely to receive multiple psychotropic medications at the same time, and more likely to experience side effects from medications than non-traumatized peers.[RAG]
- Due to a lack of evidence and risk for side effects / abuse potential, there is no clear benefit for the use of benzodiazepines or second-generation antipsychotics in the treatment of pediatric traumatic stress.[KEE]
- A medication trial may delay the initiation of evidence-based treatment for trauma.
- Symptoms common in acute stress may reflect normal post-traumatic hypervigilance / arousal and not warrant pharmacologic treatment due to the likely transient nature of the symptoms.
- Non-pharmacological, evidence-based mental health treatments are effective in children with traumatic stress symptoms.[GIL, DOR]

Since sleep disturbances are common in traumatized children, it may be appropriate to consider medication at night (see sidebar on page 15 for non-pharmacologic interventions for sleep disturbances and table 4 below for pharmacological options). However, as previously stated, benzodiazepines and second-generation antipsychotics should not be used to treat insomnia in those with pediatric traumatic stress. Consider medication for sleep disturbance when:

- Non-pharmacological interventions have not improved sleep
- High levels of traumatic stress or severe sleep disturbances are present

CHILDREN'S ADVOCACY CENTERS

As part of a multidisciplinary evaluation of child abuse, children seen at Children's Advocacy Centers (CACs; or Children's Justice Centers [CJCs] as they are called in Utah) may have received this CPM and been referred to their primary care provider for on-going monitoring. See **Follow Up** at right.

SLEEP INTERVENTIONS

When evaluating sleep interventions consider the following:

- **Non-pharmacologic interventions** (see sidebar on page 15).
- **Pharmacological options** (see TABLE 4 below).
- If initial medication trials do not improve symptoms, psychiatric consultation may be warranted.

TABLE 4. Medications for sleep problems

Drug / generic	Brand	Duration	Pediatric dose	Tier / cost*	Side effects / special precautions
melatonin[USF]	N / a		Age < 2: No data available Age ≥ 2: Nightly, 0.5 – 1.0 mg PO, up to 3.0 mg PO Adolescents: Nightly, 1 – 3 mg PO, up to 9 – 10 mg	Tier 1, $	• There are no known long-term side effects; however, concerns exist based on animal studies about possible effects on pubertal development. • Consider the use of pharmaceutical-grade melatonin; refer to U.S. Pharmacopeia available online. • Administer 30 – 60 minutes before bedtime.
prazosin[STR]	Minipress	3 nights	Initial: 1 mg PO QHS Target: 2 – 5 mg	Tier 2, $	Due to first-dose orthostatic hypotension risk, titrate after 3 nights to 2 mg PO QHS for 3 additional nights; if patient tolerates medication but symptoms persist, continue titrating up by 1 – 2 mg PO QHS every week up to 5 mg or 0.1 mg / kg.

* SelectHealth Tier and Cost: Tier 1 = $ 10 copay; Tier 2 = $ 30 copay to 25 % coinsurance; Tier 3 = $ 70 copay to 50 % coinsurance (based on SelectMed 2017 benefit design; designs may differ). For the most recent SelectHealth formulary information, visit selecthealth.org/pharmacy or call 800-538-5038. Cost is based on 30-day average wholesale price (AWP) (not copay) for regular dose and on generic unless otherwise noted.

Cost: $ = $ 1 to $ 50; $$ = $ 51 to $ 100; $$$ = $ 101 to $ 150; $$$$ = $ 151 to $ 300. Abbreviations: PO: orally; QHS: every night at bedtime.

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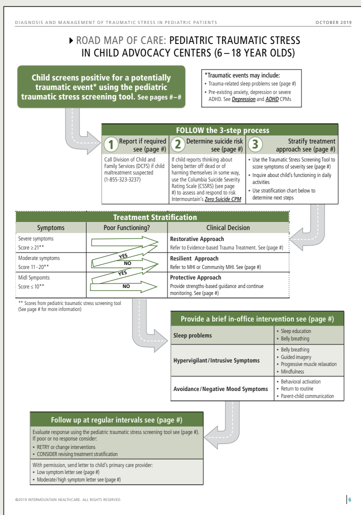
KEY RECOMMENDATIONS

- **SCREEN** using the **Pediatric Traumatic Stress Screening Tool**
- **MANAGE traumatic stress** using the 3-step method.
  - REPORT if required
  - RESPOND to suicide risk
  - STRATIFY treatment approach
- **TEACH a helpful response**
- **FOLLOW UP**



CHILD ADVOCACY CENTERS: CHILDREN 6–18 YEARS OF AGE

Child Advocacy Centers (CACs), or Children's Justice Centers (CJCs) as they are called in Utah, are often the first point of contact with children and teens following concerns for child maltreatment. CAC workers and multidisciplinary teams can intervene with children (6–18 years) who have had a potentially traumatic experience by following the roadmap of care for child traumatic stress (see page 6) and using the **Pediatric Traumatic Stress Screening Tool**.

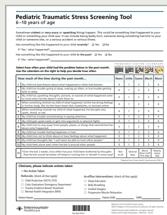
Learning about and helping children with traumatic stress may lead to increased trauma exposure for CAC workers and the multidisciplinary team. This is known as secondary traumatic stress. CAC workers should realize that they too can experience traumatic stress. It is important to recognize its signs and symptoms and respond or get appropriate help. Self-care, supervision or mentorship, personal support, and/or formal assistance via community mental health or an Employee Assistance Program (EAP) can help. See *Understanding Secondary Traumatic Stress for CAC Workers* for more information on and resources for secondary traumatic stress (https://www.nctsn.org/resources/understanding-secondary-traumatic-stress-cac-workers).

Screening — The Pediatric Traumatic Stress Screening Tool (6–18 years)

The **Pediatric Traumatic Stress Screening Tool** has 15 questions. The questions at the top of the paper form determine the types of trauma exposure of the child. The next 12 questions on the paper form refer to the trauma-related symptoms that the child has been experiencing. The last question is about thoughts of suicide that the child may be experiencing. The questionnaire can be quickly completed by a parent, for those who are ages 6–10 years, or by the child if they are 11 years or older. A paper copy for both the parent-report (6–10 years) and the self-report(11 years and older) can be found on pages 33–36 in both English and Spanish. Digital forms are also available. Click on the links below.

Children coming to the CAC for forensic interviews are at high risk for traumatic stress. It is recommended that the full **Pediatric Traumatic Stress Screening Tool** be administered to all children 6 years and older coming to the CAC. The patient's responses will help guide the next steps.

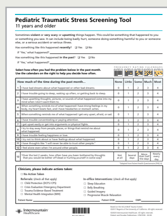
PEDIATRIC TRAUMATIC STRESS SCREENING TOOLS



Ages 6–10 years (high-risk patients)

English: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529795086

Spanish: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529795088



Ages 11–18 years (high-risk patients)

English: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529795302

Spanish: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529795307

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Management of Traumatic Stress (3 – step method)

1. Report if required.

Look at the top two answers of the screening tool to determine if an additional report is needed. You may need to ask follow-up questions for more details. Most of the time you will not need to report because the patient has been brought to the CAC because they have disclosed a traumatic experience and reporting has already occurred. However, if new information or a new disclosure of abuse occurs, the CAC worker will need to make a mandated report to Child Protective Services or law enforcement.

Please note, when reporting, CAC workers do not have to be able to prove that maltreatment of a child has occurred, but only need a "reason to believe" that it happened. It is the responsibility of Child Protective Services and law enforcement to investigate allegations of child maltreatment.

How to Report

The statewide number to use for reporting to Utah State Division of Child and Family Services (DCFS) is 1-855-323-3237 (in Idaho, call 1-855-552-5437). For outside Utah or Idaho, the national child abuse reporting number is 1-800-4-A-CHILD.

Report the following information:

- Identity of the child
- Date of birth
- Parents' / legal guardians' names
- Where the child lives
- What type of suspected child maltreatment you are reporting (i.e., child endangerment, domestic violence-related child abuse, emotional abuse, physical abuse, sexual abuse, or neglect)

Note: If concerned about the safety of the child or the parent / caregiver due to family violence, report to DCFS and / or refer the parent / caregiver to the Utah Domestic Violence Coalition for immediate assistance with safety planning and shelters: https://udvc.org/ or 1-800-897-5465.

REPORTING

Every state has mandatory reporting laws, but they differ based on whom a state considers a "mandatory reporter." **In Utah, all are mandatory reporters.** Utah law 62A-4a-403 states, "… when any person…has reason to believe that a child has been subjected to abuse or neglect, or who observes a child being subjected to conditions or circumstances which would reasonably result in abuse or neglect, that person shall immediately notify the nearest peace officer, law enforcement agency, or office of the division."

The definitions of reportable abuse and age of consent laws also vary from state to state. The presence of a minor in the event of domestic violence, for example, may be considered reportable child maltreatment. CAC workers are obligated to be aware of child abuse reporting laws and requirements in their state.

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SUICIDE AND UTAH'S YOUTH

Suicide is the number one cause of death among young people (ages 10–17 years) in Utah and has been consistently higher than the national rate.[UDOH]

The rate of suicide among young Utahns is increasing. A 2015 Utah *Student Health and Risk Prevention (SHARP) Survey* found that, during the previous 12 months, 14.4 % of youth in grades 6–12 had seriously considered attempting suicide (an increase of 53 % since 2011).[UDOH]

Exposure to trauma can contribute to suicide risk along with other individual, relationship, community, and societal factors.[MID]

Detecting suicide risk early is key to preventing suicidal behavior and connecting patients with the right therapeutic services.[HOR]

See Vignette 4: Ashley (Active Suicide Endorsed) (page 32)

TRAUMA-INFORMED SUICIDE PREVENTION

Suicidal youth with trauma exposure might additionally benefit from a trauma-informed response. Safety planning, for example, might include conversations about and strategies to respond to the patient's trauma reminders and traumatic stress symptoms (see brief in-office interventions on page 26).

For further training in using the Columbia Suicide Severity Rating Scale (C-SSRS) for suicide prevention, see cssrs.columbia.edu.

2. Respond to suicide risk

Suicide risk is determined by the final question on the **Pediatric Traumatic Stress Screening Tool** (see the bottom item). The question is adapted from the Patient Health Questionnaire for Adolescents (PHQ-A) which is often used in medical settings, "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?" When this question is answered negatively ("not at all"), no further assessment is needed. When this question is answered affirmatively in any way ("several days," "more than half the days," or "nearly every day"), it indicates the need for additional assessment of suicide risk.

Additional assessment of suicide risk and response is done by using the **Columbia Suicide Severity Rating Scale (C-SSRS)**. The C-SSRS screen has three initial questions (1–2, 6), with the option of three additional questions (3–5) to help determine if the child is at low, medium, or high risk of suicide The screen also recommends actions to take based on the risk category of the patient. A quick C-SSRS is found in table 5 below. Refer to the Intermountain's *Suicide Prevention CPM* for full details regarding screening in an outpatient clinic setting.

TABLE 5: 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-Behavioral Health [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 had any thoughts of killing yourself?	Nonspecific thoughts	**Low**	
3. Have you been thinking about how you might kill yourself?	Thoughts with a method (without a specific plan or intent to act)	**Moderate**	• Assess risk factors and either facilitate evaluation for inpatient admission or complete the *Pediatric 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	**High**	
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

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3. Stratify treatment approach

Three different types of treatment approaches are designed for patients based on their level of symptoms—the protective (low level of symptoms), resilient (moderate symptoms), or the restorative approach (severe symptoms). The type of approach is initially indicated by the score given on the **Pediatric Traumatic Stress Screening Tool**, but if the child or caregiver prefers, the level of treatment can be modified upward.

Trauma symptom severity

The overall severity of traumatic stress symptoms is determined by adding the numeric scores for items 1 – 12 on the **Pediatric Traumatic Stress Screening Tool.** Total scores in the 0 – 10 range indicate a mild risk for PTSD and ongoing problems associated with the potentially traumatic experience(s). Scores in the 11 – 20 range identify a moderate risk, and scores 21 or higher identify a severe risk.

Family preference

When helping the family decide what makes sense for them, trauma symptoms reported by the child or parent can be a useful starting point (e.g., "your child reports some of the following challenges…fortunately, there are treatments designed to help children having similar experiences after traumatic experiences"). In addition to the child's traumatic stress symptom score, consider the child's and caregivers' preference. This means engaging the family in a brief discussion of their treatment and referral options. An example script is provided on page 37. Children and caregivers should be informed that:

- Children seen at the CAC may have had really scary, upsetting, or harmful things happen to them;
- Children can experience emotional, mental, physical, and behavioral changes after a scary, upsetting, or harmful event;
- There are trauma-specific therapy models that have been shown to help with trauma-related symptoms;
- All families have access to these trauma-specific therapy models; and
- Based on their answers to the screening tool, they would typically be recommended to follow up with a provider who offers trauma-specific evidence-based treatment or their primary care provider for continued monitoring.

Note: Avoidance can be a symptom of traumatic stress and so a symptomatic child's or caregiver's desire to avoid treatment may be a stress response. Furthermore, some traumatic experiences warrant a restorative approach and referral to specialized evidence-based trauma treatment, regardless of their score on the **Pediatric Traumatic Stress Screening Tool** (see special populations on page 26).

HELP WITH REFERRALS

Some insurance providers may be able to help facilitate trauma-focused referrals.

For example, SelectHealth has a care management program for traumatic stress. To participate in the SelectHealth Care Management Program for PTSD, families can call 1-800-442-5305 and ask for Behavioral Health Care Management for PTSD or providers can email Medicaidumintake@imail.org with "BH Referral for PTSD" in the subject line and the member's name (child), date of birth, contact parent's name, and phone number in the body.

In many states, the office of victims of crime can help connect families with appropriate referral options.

In Utah, the Utah Office of Victims of Crime has an in-house victim advocate who can help facilitate referrals when local advocates are not available. (Ask from the main line at 801-238-2360 or 800-621-7444.)

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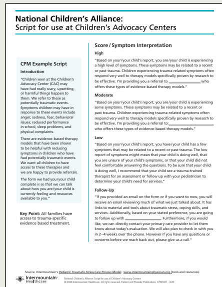
TALKING WITH PATIENTS ABOUT THEIR TREATMENT OPTIONS


National Children's Alliance:
Script for use at Children's Advocacy Centers

Script for use at Children's Advocacy Centers (see page 37)

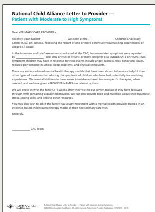
Link to digital version

PROVIDER LETTERS (TEMPLATES)

National Child Alliance Letter to Provider — Patient with Low Symptoms

Letter to provider for children with low symptoms (see page 38)

Link to word doc.


National Child Alliance Letter to Provider — Patient with Moderate to High Symptoms

Letter to provider for children with medium / high symptoms (see page 39)

Link to word doc.

Treatment Stratification

The mild, moderate, and severe risk categories correspond with protective, resilient, and restorative treatment approaches. See table 6 below. The higher the symptom score, the greater the risk of developing PTSD without effective treatment. See special populations on page 26 for additional considerations by child population and type of trauma.

It is often difficult to talk with children and their caregivers about treatment approaches. See the sidebar at left for a link to a script that gives example language. A copy can be found on page 37 of this CPM. For a digital copy, click on the image "script" in the left sidebar.

Protective approach. Children with minimal symptoms may never need formal intervention following a potentially traumatic experience. They may benefit from anticipatory guidance about child traumatic stress (see page 27 for key resources for children and families) and a simple skill to help them feel calmer when experiencing distress (brief in-office intervention). In these situations, refer to the child's primary care provider for continued support and ongoing monitoring as worsening symptoms may occur in some situations. A template of a typical letter that you may send to a provider in these circumstances can be found on page 38 of this CPM.

Resilient approach. Many children with moderate symptoms will be best served by trauma-specific evidence-based assessment and treatment. Depending on family preference and in the absence of significant social, academic, or other functional difficulties, children with moderate symptoms may be sufficiently helped by a mental health provider who does not have specific evidence-based trauma treatment training. Children with moderate symptoms of traumatic stress will also typically benefit from anticipatory guidance about child traumatic stress (see page 27 for key resources for child and families) as well as from learning a helpful response (brief in-office intervention). The CPM guides CAC workers to select a helpful response that is appropriate for the symptoms reported by that child or caregiver on the screening tool. Additionally, with caregiver approval, information regarding the child's symptoms, referral, and follow up can be communicated to the child's primary care provider via a letter. A template of a typical letter that you may send to a provider in these circumstances can be found on page 39 of this CPM.

Restorative approach. This approach is appropriate for children with significant and often prolonged posttraumatic stress symptoms. Scores in the severe range on the screening tool identify a child who is most likely to benefit from trauma evidence-based treatments. Children with severe symptoms of traumatic stress will also typically benefit from anticipatory guidance about child traumatic stress (see page 27 for key resources for child and families) as well as from learning a helpful response (brief in-office intervention). With caregiver approval, information regarding the child's symptoms, referral, and follow up can be communicated to the child's primary care provider via a letter. A template of a typical letter that you may send to a provider can be found on page 39 of this CPM.

TABLE 6. Treatment Stratification at CAC

Symptoms	Family preference?	Recommended response
Severe symptoms: Score ≥ 21**	YES or NO	**Restorative Approach** Facilitate referral to Evidence-based Trauma Treatment
Moderate symptoms: Score 11 - 20**	YES (→ Restorative Approach) / NO	**Resilient Approach** Facilitate referral to Evidence-based Trauma Treatment
Mild symptoms : Score ≤ 10**	YES (→ Resilient Approach) / NO	**Protective Approach** Facilitate referral to primary care for continued monitoring

** Scores from *Pediatric Traumatic Stress Screening Tool* (See page 20 for more information)

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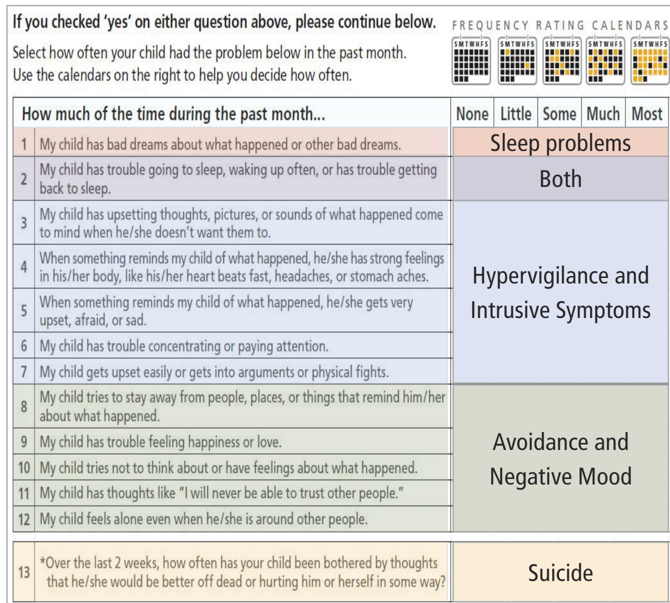
Teach a helpful response

The Pediatric Traumatic Stress Screening Tool and care process roadmap guide CAC workers toward a helpful response that children and caregivers can begin with right away. Teaching a helpful response can reduce symptom severity and increase the child's sense of support.

The items identifying sleep problems (items 1–2), hypervigilant / intrusive symptoms (items 2–7), and avoidance / negative mood symptoms (items 8–12) are grouped on the Pediatric Traumatic Stress Screening Tool. This will help identify a helpful brief in-office intervention. With minimal practice using the screening tool paper version, it soon becomes possible with a quick visual review to determine the most prominent symptom area so the brief in-office intervention can be chosen to target that area (see table 7 below). The optional tablet-based screening form automatically scores and guides CAC workers to intervention options targeting their most prominent symptom.

If sleep problems are prominent (items 1–2 marked "much" or "most" of the time), it is typically best to choose a helpful response targeting these difficulties, followed by hypervigilant / intrusive symptoms, even if other symptom areas are similarly elevated. Following the steps of the decision support guidance on the tablet or the paper screening tool will help you select a brief in-office intervention that may help the child begin the healing process and instill hope for recovery. See page 23 for more information about possible helpful responses.



If you checked 'yes' on either question above, please continue below.

Select how often your child 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	My child has bad dreams about what happened or other bad dreams.	Sleep problems				
2	My child has trouble going to sleep, waking up often, or has trouble getting back to sleep.	Both				
3	My child has upsetting thoughts, pictures, or sounds of what happened come to mind when he/she doesn't want them to.	Hypervigilance and Intrusive Symptoms				
4	When something reminds my child of what happened, he/she has strong feelings in his/her body, like his/her heart beats fast, headaches, or stomach aches.					
5	When something reminds my child of what happened, he/she gets very upset, afraid, or sad.					
6	My child has trouble concentrating or paying attention.					
7	My child gets upset easily or gets into arguments or physical fights.					
8	My child tries to stay away from people, places, or things that remind him/her about what happened.	Avoidance and Negative Mood				
9	My child has trouble feeling happiness or love.					
10	My child tries not to think about or have feelings about what happened.					
11	My child has thoughts like "I will never be able to trust other people."					
12	My child feels alone even when he/she is around other people.					
13	*Over the last 2 weeks, how often has your child been bothered by thoughts that he/she would be better off dead or hurting him or herself in some way?	Suicide				

TABLE 7. Teach a Helpful Response (for details see page 23)

Symptom area	Helpful response
Sleep problems	• Sleep education • Belly breathing • Guided imagery
Hypervigilant / intrusive symptoms	• Belly breathing • Guided imagery • Progressive muscle relaxation • Mindfulness
Avoidance / negative mood symptoms	• Behavioral activation • Return to routine • Caregiver support

Follow Up

This CPM recommends follow-up in-person or by phone to ensure that the child's symptoms are improving or at least not getting worse. This can be performed by the CAC worker or children can be referred to their primary care provider for on-going support and monitoring (see the example letters to primary care providers on pages 38 and 39).

If the CAC worker performs a follow-up, they are encouraged to have the child repeat the screening tool and to compare results from the first visit. A shorter-term follow-up in 2–4 weeks and a longer-term follow up in 4–6 months provide the opportunity to monitor symptom change, assess / adjust decision-making, and provide on-going support. Specifically, the longer-term follow-up might help identify symptom resolution versus the need for ongoing support and referral.

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See Vignette 1: Ellie can't sleep for an example of addressing sleep problems (see page 29)

See Vignette 4: Ashley (Active Suicide Endorsed) for an example of using focused breathing (page 32)

BELLY BREATHING / FOCUSED BREATHING ONLINE RESOURCES

Elmo belly breathing
https://www.youtube.com/watch?v=_mZbzDOpylA

VA focused breathing videos

- Introduction video: https://www.youtube.com/watch?v=NHMV7KITTx4#action=share
- Breathing exercise video: https://www.youtube.com/watch?v=rquZW6fEOwI#action=share

BRIEF INTERVENTIONS AND HELPFUL RESPONSES

The results of the Pediatric Traumatic Stress Screening Tool guide the selection of a brief in-office intervention (or teaching a helpful response) such as the items below.

Anticipatory guidance or psychoeducational material. Children and their parent(s) / guardian(s) may specifically benefit from understanding what trauma is, how children may react, what to look for in trauma treatment, and how to respond and cope as a family. See page 27 for resources available from the National Child Traumatic Stress Network (NCTSN). Providers can also supplement trauma-specific anticipatory guidance with materials from their practice about sleep hygiene, parenting skills, behavioral management, etc.

Belly breathing. Belly breathing (or focused breathing) involves specific methods of diaphragmatic breathing that help relax the body, calm the mood, and redirect the mind. At its most basic application, the child breathes slowly in through the nose, filling up the diaphragm (not the chest). The child then releases the breath slowly through the mouth, deflating the diaphragm (not the chest) and then repeats breathing in and out. For optimal impact, children continue belly or focused breathing for several minutes or until calm. Children sometimes find it helpful to place their hands on their bellies so they can feel their diaphragms go up and down. This technique can be paired with guided imagery exercises or calming music. The best part about belly or focused breathing, however, is that it is a discrete, transportable, and readily available coping skill, including at school, in the car, and before bed, etc.

Teach and practice belly breathing during the office visit, and instruct children to practice daily and as needed. Two age-appropriate video resources are available:

- **Elmo belly breathing video (younger children).** In this video, Elmo, Colbie Callait, and Common sing about and teach belly breathing. The video can be used during the office visit and is available publicly for patient use out of the office.
- **VA focused breathing video (older children and adolescents).** This video was produced by the U.S. Department of Veterans Affairs and features a focused breathing exercise that can be done during the office visit to teach focused breathing. The video is also available publicly for patient use out of the office.

Guided imagery. Guided imagery is a relaxing mind exercise that helps redirect the mind, relax the body, and calm the mood. There are multiple audio and video links available online for children and teens. Children exposed to trauma often find it most helpful to visualize safe places and experiences as part of their guided imagery. Practice a brief guided imagery exercise during the office visit, and / or help parent(s) / guardian(s) and child to identify a link to try daily at home and as needed.

Routinized caregiver support. Children exposed to trauma benefit from their caregivers and family returning to established and healthy routines, such as with mealtimes, chores, social activities, discipline practices, and bedtime. Children can also benefit from added time and attention from their caregivers, such as playtime, snuggles, or daily check-ins as to how they are doing and feeling. Of note, children sometimes need increased support with tasks they had previously mastered, such as getting ready for school, doing homework, and getting ready for bed. Review this information with caregivers and the child during the office visit, and help identify and frame specific family goals and monitoring for the following weeks.

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Brief interventions and helpful responses (continued)

Mindfulness techniques. Mindfulness techniques are exercises that help children ground themselves, reconnect, or become more fully present in the current moment. Belly breathing (see above) is an example of a mindfulness technique. Other examples include savoring a hard candy (focusing on its texture, flavor, temperature, size, etc.), observing an object for a couple of minutes (focusing on its structure, color, size, etc.), applying a scented lotion (focusing on its smell, feeling, temperature, texture, etc.), or listening to music (focusing on specific sounds, volume, tones, etc.). Teach and practice a mindfulness technique with the patient and their caregiver during the office visit, and instruct them to practice daily and as needed.

See Vignette 3: Trevor (Anxiety/Avoidance) for an example of using behavioral activation (page 31)

Behavioral activation. Behavioral activation emphasizes positive alternatives to negative behaviors, such as school avoidance and / or social isolation, that can result from experiencing childhood trauma. For example, regular and planned exercise, extra-curricular activities, social outings, and school involvement can replace negative behaviors such as sleeping too much, avoiding social activities, spending all free time alone or in bed, or avoiding school. Behavioral activation can start with small, easy, and rewarding behavioral changes. A teen who is avoiding school, for example, might resist returning for a full day of school, but be open to attending one or two favorite classes or extra-curricular activities first. Providers can help patients and caregivers frame and build on achievable activation goals and increase patient / caregiver follow through by monitoring progress over the following weeks.

PTSD COACH ONLINE RESOURCES

- https://www.ptsd.va.gov/apps/ptsdcoachonline/default.htm
- https://www.ptsd.va.gov/appvid/mobile/index.asp
- https://itunes.apple.com/us/app/ptsd-coach/id430646302?mt=8&ign-mpt=uo%3d2
- https://play.google.com/store/apps/details?id=is.vertical.ptsdcoach&hl=en

PTSD Coach Online. For older children and adolescents, the PTSD Coach Online app and website produced by the U.S. Department of Veterans Affairs features trauma educational materials, symptom tracking, symptom management exercises, resource information, and crisis line access. During the office visit, the provider can help patients and their caregivers access the app or website and navigate some of its features. Instruct the patient to practice using the app or website daily and as needed.

See Vignette 4: Ashley (Active Suicide Endorsed) for an example of using the PTSD coaching app (page 32)

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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.[COH1]
- **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.[GHO]
- **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]

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SPECIAL POPULATIONS

For some children and families, prolonged adversity, chronic stress, co-occurring problems, and uniquely adverse circumstances can complicate recovery from trauma. Evidence-based treatment provided within a trauma-informed care system or organization, especially if the system has a specialized focus on people with similar histories, will likely be best suited to provide effective trauma-focused therapy to these individuals. Additional assessment and monitoring may be warranted in addition to what is outlined in this CPM for the groups discussed below. Evidence-based trauma treatment can help to address the traumatic stress symptoms, but there will likely be ongoing challenges that require the support of other services. See also https://www.nctsn.org/what-is-child-trauma/populations-at-risk.

Children who are developmentally delayed

Children with developmental disabilities are over-represented in the population of children who have experienced child abuse and neglect. Some studies show they are over four times as likely to be victims of crime. The most common type of child maltreatment is neglect, and children with cognitive disabilities are the most severely abused.[CHA] Individuals with developmental disabilities may experience traumatic stress in different ways because of differences in cognition, processing, and understanding. They may also be isolated or withdrawn which may make them vulnerable to manipulation. Although these children need special accommodations, there are evidence-based treatment models that can help.

Children in foster care

In children placed in foster care, there is great variability in trauma exposure. It depends on the cause and number of placements, and whether they are placed with strangers or with family members (kinship care). Generally, children in foster care have been removed from their parent's care for protection because of serious concerns of child maltreatment. Sometimes, because of the serious ongoing nature of the abuse, and repetitive placements, the child can experience complex trauma, which requires specialized evidenced-based treatment.

Refugees

Many refugees have experienced war, separation from parents, being placed in detention, extreme poverty, and deprivation as well as family and community violence. Acculturation stress as they try to navigate the complexities of a new social environment can exacerbate their feelings of loneliness, discrimination, and loss of social status. Trauma-specific evidence-based treatment has demonstrated effectiveness in children and adolescents of refugee background with traumatic stress and can be culturally adapted. Note, many agencies that serve refugee families offer trauma-specific evidence-based treatment and may be more prepared to provide language services and culturally-adapted treatment.

Homeless children

Women and children have increasingly become a greater proportion of the homeless population over the last decade, often due to violence in the home, medical expenses, and commensurate effects, such as loss of employment. This kind of upheaval and displacement can cause traumatic stress in both parents and children along with medical comorbidities. Children in homeless shelters experience four times more illness than other children, both chronic and acute. They also experience poor nutrition (including a high risk for diabetes), obesity, high blood pressure, anemia, and gastrointestinal problems.[PRE] Children who have chronic serious illnesses in homeless shelters are at serious risk of medical neglect when their care needs cannot be met. Homeless children are also at greater risk for trauma exposure. While symptom score and / or impaired functioning might indicate a referral for trauma-specific evidence-based treatment, the child's and family's safety and basic needs might need to be addressed first. Then, once the family can engage in treatment, they might additionally benefit from assistance with transportation and treatment costs.

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RESOURCES

Patient resources

All brief in-office interventions should include child and family education about trauma and traumatic stress. The tables below provide links for key resources for children and families.

TABLE 8. Key Resources for Children and Families

Psychoeducation and anticipatory guidance	
Understanding Child Traumatic Stress: A Guide for Parents (English)	http://www.nctsn.org/sites/default/files/assets/pdfs/ctte_parents.pdf
Understanding Child Traumatic Stress: A Guide for Parents (Spanish)	http://www.nctsn.org/sites/default/files/assets/pdfs/Una_Guia_Para_Padres.pdf
Age-Related Reactions to a Traumatic Event	http://nctsn.org/sites/default/files/assets/pdfs/age_related_reactions_to_a_traumatic_event.pdf
Materials by child age and / or by type of trauma	http://www.nctsn.org/resources/audiences/parents-caregivers
Information about trauma-specific evidence-based treatment	https://gucchdtacenter.georgetown.edu/TraumaInformedCare/IssueBrief4_EvidenceBasedTreatments.pdf
Suicide prevention	
Safe UT	• https://healthcare.utah.edu/uni/clinical-services/safe-ut/ • https://itunes.apple.com/us/app/safeut/id1052510262?mt=8 • https://play.google.com/store/apps/details?id=com.p3tips.safeut&hl=en
Crime Victims Reparations (CVR)	
Utah Office for Victims of Crime	• https://justice.utah.gov/Crime/
The National Center for Victims of Crime	• https://victimsofcrime.org/
Belly / focused breathing	
Elmo belly breathing video	• https://www.youtube.com/watch?v=_mZbzDOpylA
VA focused breathing videos	• https://www.youtube.com/watch?v=NHMV7KlTTx4#action=share (introduction) • https://www.youtube.com/watch?v=rquZW6fEOwI#action=share (breathing exercise)
PTSD Coach Online	
Phone apps	• https://www.ptsd.va.gov/apps/ptsdcoachonline/default.htm • https://www.ptsd.va.gov/appvid/mobile/index.asp • https://itunes.apple.com/us/app/ptsd-coach/id430646302?mt=8&ign-mpt=uo%3d2 • https://play.google.com/store/apps/details?id=is.vertical.ptsdcoach&hl=en
Community Resources	
2-1-1 Guide to Community Resources	• English: https://intermountainhealthcare.org/ext/Dcmnt?ncid=529729683 • Spanish: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529733180

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Provider resources

TABLE 9. Key Resources for Providers

Intermountain resources	
Intermountain Care Process Models (CPMs)	• *Attention-Deficit Hyperactivities Disorder (ADHD)* CPM • *Depression* CPM • *Social Determinants of Health (SDOH)* CPM • *Suicide Prevention* CPM
Suicide prevention	
The Adolescent Suicide/Self Harm and Substance Abuse Project (ASAP) and Family Intervention for Suicide Prevention (FISP)	https://www.asapnctsn.org/
Training for use of the Columbia Suicide Severity Rating Scale (CSSRS)	http://cssrs.columbia.edu/
Trauma-informed office	
The Coding Fact Sheet for Treating Trauma from the American Academy of Pediatrics (AAP)	https://www.aap.org/en-us/professional-resources/practice-transformation/getting-paid/Coding-at-the-AAP/Pages/Private/Trauma-Coding-Fact-Sheet.aspx
The Pediatric Approach to Trauma, Treatment and Resilience (PATTeR) courses made available via collaboration between NCTSN and the AAP	https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/related-initiatives/Pages/Resources.aspx
The Healthcare Toolbox for more information on and resources for secondary traumatic stress	https://www.healthcaretoolbox.org/self-care-for-providers.html
Understanding Secondary Traumatic Stress for CAC Workers	https://www.nctsn.org/resources/understanding-secondary-traumatic-stress-cac-workers
CAC Directors' Guide to Mental Health Services for Abused Children	https://www.nctsn.org/sites/default/files/resources//cac_directors_guide_mental_health_services_abused_children.pdf
Community resources	
2-1-1 Guide to Community Resources	• English: https://intermountainhealthcare.org/ext/Dcmnt?ncid=529729683 • Spanish: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529733180

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CHILD TRAUMA CARE: EXAMPLE VIGNETTES

Vignette 1: Ellie (Can't Sleep)

- 6 years old
- Female
- Living with her mom and dad

Chief complaint

Ellie is presenting to primary care for her well child check.

Pediatric Traumatic Stress Screening Tool

Mom and dad positively endorse recent trauma and comment that 2–3 weeks earlier during a sleepover, mom found Ellie and her same-aged friend Jake in Ellie's room with their pants down. Per mom and dad, Ellie said that they were looking and that they had touched. Parents deny any concern for Ellie having thoughts that she would be better off dead or of hurting herself. On the parent-report symptom screener, Ellie has high-frequency sleep problems and a score of 10.

1 Report if required

You do not likely need to make a report to CPS/DCFS as both children are younger and same-aged.

2 Respond to suicide risk

As Ellie's parents indicated no concerns for suicide on the screening tool, no further assessment of suicide risk is warranted for Ellie at this time.

3 Stratify treatment approach

You ask Ellie and her parents how things are going at school, at home, and with friends. Parents identify mostly well, but that Ellie has had some increase in tantrums.

You explain that based on parents' responses on the screening tool, Ellie might have some mild traumatic stress, but that her symptoms may also be typical child development or a response to her parent's anxiety about the incident. You provide a psychoeducational handout about traumatic stress and explain that Ellie might benefit from a community mental health referral if parents desire, or from parent support and ongoing primary care monitoring.

Brief in-office intervention

You provide parents with some helpful materials for teaching children about their bodies and stop and go touches. You show Ellie the Elmo belly breathing video and practice together. You ask Ellie and her parents to practice belly breathing every night before bed and when awakened from nightmares.

Follow-up

You plan a short-term follow-up to monitor Ellie's response.

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CHILD TRAUMA CARE: EXAMPLE VIGNETTES

Vignette 2: Braden (Acting Out)

- 7 years old
- Male
- Standard visitation with dad

Chief complaint

Mom is concerned about Braden's behaviors and specifically ADD/ADHD. She completed a Mental Health Integration (MHI) packet, including the Pediatric Traumatic Stress Screening Tool, in preparation for Braden's primary care appointment.

Pediatric Traumatic Stress Screening Tool

Mom endorses that Braden has witnessed his father angry and hurting his mother multiple times. She denies any concern for Braden having thoughts that he would be better off dead or of hurting himself.
On the parent-report symptom screener, Braden has high-frequency arousal symptoms and a score of 20.

1 Report if required

You might need to make a report to CPS/DCFS as witnessing domestic violence is reportable child maltreatment in some states.

2 Respond to suicide risk

As Braden's mom indicated no concerns for suicide on the screener, no further assessment of suicide risk is warranted for Braden at this time.

3 Stratify treatment approach

You ask mom and Braden how things are going at school, at home, and with friends. Both report Braden has been struggling more at home and school this past year and since his parents' divorce.

You explain that based on mom's responses on the screening tool, Braden may be experiencing some traumatic stress, but that his symptoms may also be ADD/ADHD. You provide a psychoeducational handout about traumatic stress and explain that the recommended first course of treatment is trauma-specific evidence-based treatment. You provide a referral.

Brief in-office intervention

You further express concern that Braden is experiencing distress. You provide some parenting support materials for behavior management.

Follow-up

You plan a short-term and long-term follow-up to monitor Braden's response.

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CHILD TRAUMA CARE: EXAMPLE VIGNETTES

Vignette 3: Trevor (Anxiety /Avoidance)

- 11 years old
- Male
- Living with his mom and dad

Chief complaint

Mom and dad are concerned about Trevor's anxiety and school avoidance. They completed a Mental Health Integration (MHI) packet and had Trevor complete the Pediatric Traumatic Stress Screening Tool self-report in preparation for Trevor's primary care appointment.

Pediatric Traumatic Stress Screening Tool

Trevor reports that he has been experiencing some bullying at school. He endorses having thoughts that he would be better off dead or of hurting himself. Braden has moderate frequency arousal and negative mood symptoms and a score of 17.

1 Report if required

You ask additional questions of Trevor about the bullying and make a report to CPS or law enforcement, if appropriate. You also encourage Trevor and his parents to report the instances of bullying to his school.

2 Respond to suicide risk

Due to Trevor's endorsement of suicidal thoughts, you further assess for suicide risk using the C-SSRS (see page 11). Trevor reports having looked up how to hang himself, but to not having made specific plans or additional preparations.

You explain to Trevor that kids and teens exposed to upsetting and scary experiences, such as bullying, sometimes have reactions that affect how they feel and what they do. You assure him that there is help. You provide a suicide prevention resource (e.g., SafeUT app), refer Trevor to therapy, and encourage parent-child communication.

3 Stratify treatment approach

You ask parents and Trevor how things are going at school, at home, and with friends. They report Trevor has been avoiding school and interactions with friends and family.

You explain that based on his responses on the screening tool, Trevor may be experiencing some traumatic stress. You provide a psychoeducational handout about traumatic stress and explain that Trevor will likely benefit from either community mental health (including a MHI provider at the clinic) or trauma-specific evidence-based treatment. You provide a referral.

Brief in-office intervention

You further express concern that Trevor is experiencing distress. You teach Trevor about behavioral activation and encourage Trevor and his parents to do something fun and/or active every day.

Follow-up

You plan a short-term and long-term follow-up to monitor Trevor's response.

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CHILD TRAUMA CARE: EXAMPLE VIGNETTES

Vignette 4: Ashley (Active Suicide Endorsed)

- **17 years old**
- **Female**
- **Living with her dad and step-mom**

Chief complaint

Ashley disclosed last week that her maternal uncle sexually abused her between the ages of 5 and 7 years. She is presenting at the Children's Advocacy Center (CAC) for a forensic interview.

Pediatric Traumatic Stress Screening Tool

Ashley discloses the sexual abuse by her maternal uncle and no additional traumas. She positively endorses having thought that she would be better off dead or of hurting herself. Her symptom screener shows a high frequency of arousal and negative mood symptoms and a score of 38.

1 Report if required

As Ashley is presenting at the CAC regarding the same allegations in her trauma disclosure, you do not make a report to CPS or law enforcement.

2 Respond to suicide risk

Due to Ashley's positive endorsement of suicidal thoughts, you further assess for suicide risk using the C-SSRS (see page 11). Ashley reports having thoughts that it would be better if she were dead, but she denies having a plan or intention of acting on her thoughts.

You explain to Ashley that kids and teens exposed to upsetting and scary experiences, such as sexual abuse, sometimes have reactions that affect how they feel and what they do. You assure her that there is help. You provide a suicide prevention resource (e.g., SafeUT app, therapy referral) and encourage parent-child communication.

3 Stratify treatment approach

You ask Ashley how things are going at school, at home, and with friends. She reports that she is failing out of school and frequently fighting with her parents (i.e., functional impairment).

You explain that based on Ashley's responses on the screening tool, she likely is experiencing traumatic stress. You provide a psychoeducational handout and explain that the recommended course of treatment is a trauma-specific evidence-based treatment. You provide a referral.

Brief in-office intervention

You further express concern that Ashley is frequently experiencing distress. You show Ashley the PTSD Coach Online app and practice together using a focused breathing exercise. You ask Ashley to practice focused breathing every night before bed and as needed when distressed.

Follow-up

You obtain parental permission and send a letter to Ashley's primary care provider. See letter on page 39.

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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 illness.

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

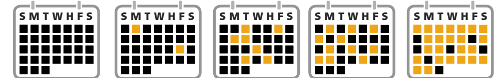
If 'Yes,' what happened? ______________________________

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)

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

Pat Qst 50113

Based on the UCLA Brief Trauma Screen

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Patient and Provider Publications CPM107d - 02/20

Pediatric Traumatic Stress Screening Tool

6–10 years of age

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

Has something like this happened to your child **recently**? ❑ Yes ❑ No

If 'Yes,' what happened? ______________________________

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

If 'Yes,' what happened? ______________________________

Select how often your child 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	My child has bad dreams about what happened or other bad dreams.	0	1	2	3	4
2	My child has trouble going to sleep, waking up often, or has trouble getting back to sleep.	0	1	2	3	4
3	My child has upsetting thoughts, pictures, or sounds of what happened come to mind when he/she doesn't want them to.	0	1	2	3	4
4	When something reminds my child of what happened, he/she has strong feelings in his/her body, like his/her heart beats fast, headaches, or stomach aches.	0	1	2	3	4
5	When something reminds my child of what happened, he/she gets very upset, afraid, or sad.	0	1	2	3	4
6	My child has trouble concentrating or paying attention.	0	1	2	3	4
7	My child gets upset easily or gets into arguments or physical fights.	0	1	2	3	4
8	My child tries to stay away from people, places, or things that remind him/her about what happened.	0	1	2	3	4
9	My child has trouble feeling happiness or love.	0	1	2	3	4
10	My child tries not to think about or have feelings about what happened.	0	1	2	3	4
11	My child has thoughts like "I will never be able to trust other people."	0	1	2	3	4
12	My child feels alone even when he/she is around other people.	0	1	2	3	4

13	*Over the last 2 weeks, how often has your child been bothered by thoughts that he/she would be better off dead or hurting him or herself in some way?	Not at all	Several days	More than half the days	Nearly every day

*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____________

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Pediatric Traumatic Stress Screening Tool

11 años y mayores

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

¿Te ha pasado algo así **recientemente**? ❑ Sí ❑ No

Si la respuesta es 'sí' ¿qué te pasó? ____________________

¿Te ha pasado algo así **en el pasado**? ❑ Sí ❑ No

Si la respuesta es 'sí' ¿qué te pasó? ____________________

Selecciona con qué frecuencia has tenido el problema en el último mes. Usa los calendarios de frecuencia a la derecha para ayudarte a decidir.

CALENDARIO DE CALIFICACIÓN DE FRECUENCIA

	Por cuánto tiempo durante el mes pasado...	Nada	Poco	Algo	Mucho	La mayoría
1	Tengo pesadillas sobre lo que sucedió u otros sueños feos.	0	1	2	3	4
2	Tengo problemas para dormir, me despierto a menudo, o tengo problemas para volverme a dormir.	0	1	2	3	4
3	Pensamientos, imágenes, o sonidos desagradables sobre lo que pasó, vienen a mi mente aún cuando no quiero que lo hagan.	0	1	2	3	4
4	Cuando algo me recuerda a lo que pasó, tengo sentimientos fuertes en mi cuerpo, como latidos rápidos de mi corazón, dolor de cabeza o de estómago.	0	1	2	3	4
5	Cuando algo me hace recordar a lo que pasó me molesto mucho, me da miedo, o me pongo triste.	0	1	2	3	4
6	Tengo problemas para concentrarse o poner atención.	0	1	2	3	4
7	Me enojo fácilmente o me meto en discusiones o peleas físicas.	0	1	2	3	4
8	Trato de mantenerme alejado de personas, lugares, o cosas que me recuerdan a lo que pasó.	0	1	2	3	4
9	Tengo problemas para sentir felicidad o amor.	0	1	2	3	4
10	Trato de no pensar o tener sentimientos acerca de lo que pasó.	0	1	2	3	4
11	Tengo pensamientos como "Nunca podré confiar en otras personas".	0	1	2	3	4
12	Me siento solo aún cuando estoy rodeado de otras personas.	0	1	2	3	4

13	*Durante las 2 últimas semanas, ¿cuán a menudo has tenido pensamientos que estarías mejor muerto o de hacerte daño de alguna manera?	Ningún día	Varios días	Más de la mitad de los días	Casi todos los días

*Adapted from Patient Health Questionnaire (PHQ-A)

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__________

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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

	Por cuánto tiempo durante el mes pasado...	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 a la mente 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 cardíacas 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 a 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 aún 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?	Ningún día	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__________

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Based on the UCLA Brief Trauma Screen
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National Children's Alliance:
Script for use at Children's Advocacy Centers

CPM Example Script

Introduction

"Children seen at the Children's Advocacy Center (CAC) may have had really scary, upsetting, or harmful things happen to them. We refer to these as potentially traumatic events. Symptoms children may have in response to these events include anger, sadness, fear, behavioral issues, reduced performance in school, sleep problems, and physical complaints.

There are evidence-based therapy models that have been shown to be helpful with reducing symptoms in children who have had potentially traumatic events. We want all children to have access to these therapies and we are happy to provide referrals.

The form we had you/your child complete is so that we can talk about how you are/your child is currently feeling and resources available to you."

Key Point: All families have access to trauma-specific evidence based treatment.

Score / Symptom Interpretation

High

"Based on your/your child's report, you are/your child is experiencing a high level of symptoms. These symptoms may be related to a recent or past trauma. Children experiencing trauma-related symptoms often respond very well to therapy models specifically proven by research to be effective. I'm providing you a referral to _________________ who offers these types of evidence-based therapy models."

Moderate

"Based on your/your child's report, you are/your child is experiencing some symptoms. These symptoms may be related to a recent or past trauma. Children experiencing trauma-related symptoms often respond very well to therapy models specifically proven by research to be effective. I'm providing you a referral to:________________________ who offers these types of evidence-based therapy models."

Low

"Based on your/your child's report, you have/your child has a few symptoms that may be related to a recent or past trauma. The low report of symptoms might mean that your child is doing well, that you are unsure of your child's symptoms, or that your child did not feel comfortable answering the questions. To be sure that your child is doing well, I recommend that your child see a trauma-trained therapist for an assessment or follow up with your pediatrician to determine your child's need for services."

Follow-Up

"If you provided an email on the form or if you want to now, you will receive an email reviewing much of what we just talked about. It has links to material and tools about traumatic stress, coping skills, and services. Additionally, based on your stated preference, you are going to follow up with ___________________. Furthermore, if you would like, we can directly contact your primary care provider to let them know about today's evaluation. We will also plan to check in with you in 2–4 weeks over the phone. However if you have any questions or concerns before we reach back out, please give us a call."

Source: Intermountain's *Pediatric Traumatic Stress Care Process Model*. www.intermountainphysician.org (tools and resources)

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National Child Alliance Letter to Provider — Patient with Low Symptoms

Dear <PRIMARY CARE PROVIDER>,

Recently, your patient _______________ was seen at the _______________ Children's Advocacy Center (CAC) on <DATE>, following the report of one or more potentially traumatizing experience(s) of alleged abuse.

A Children's Advocacy Center is a child-friendly facility in which law enforcement, child protection, prosecution, mental health, medical, and victim advocacy professionals work together to investigate abuse allegations, help children heal from abuse, and hold offenders accountable.

In the interview and brief assessment conducted at the CAC, few trauma-related symptoms were reported by _______________ and <HIS or HER or THEIR> primary caregiver. Many children with few symptoms continue to do well with the support of their families in the aftermath of a potentially traumatizing experience. In some cases where few or no symptoms were reported, they may have been uncomfortable acknowledging symptoms they were actually experiencing at the time of the CAC visit, or problematic symptoms could develop after the CAC visit. Posttraumatic stress symptoms can develop 6–12 months or longer after the potentially traumatizing event(s). CAC staff will follow-up with the family 2–4 weeks after their visit to our center, but you may be the first professional to learn of troubling symptoms the child develops. Reported symptoms may include anger/irritability, sadness, fear, behavioral issues, reduced performance in school, sleep problems, and physical complaints. If similar difficulties arise with this child, we encourage you to refer them to one of the providers on the attached referral list who have all been trained in trauma-focused evidence-based treatments (EBT) for children. Please also feel free to contact us for additional referral assistance. <ADD CONTACT INFO FOR REFERRAL ASSISTANCE OR INCLUDE IN HEADER OR SIGNATURE>.

A large and growing body of research from the past 20 years has shown that typical play therapy and other non-directive mental health treatment approaches are not effective at addressing trauma related symptoms for children. Specialized training is important for best outcomes as some child-focused mental health EBTs have consistently been shown to be more effective at reducing trauma-related symptoms than other common child therapies. We want all children to have access to evidence-based trauma-specific therapies, when needed.

CAC clinicians have also been trained in a brief EBT which has been demonstrated to interrupt the development of PTSD. This helpful intervention has demonstrated efficacy for children/youth with even low to moderate traumatic stress symptoms. If you believe _______________ would benefit from this treatment, please call_________________. Please note that this treatment is most effective when delivered within 45–60 days of the traumatic event or disclosure.

Youth screened at CACs commonly report thoughts of suicide, especially those who endorse moderate or high levels of posttraumatic symptoms. When suicidal ideation is identified, we provide recommendations for increased support and assist with the development of a safety plan. A follow-up conversation with a trusted medical provider may increase their sense of support and would offer another opportunity for referral to a qualified mental health provider, if needed. If you choose to make a referral without our assistance, we hope you will refer to a provider trained in an evidence-based child trauma treatment model.

Sincerely,

____________ CAC Team

https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529796227

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National Child Alliance Letter to Provider —
Patient with Moderate to High Symptoms

Dear <PRIMARY CARE PROVIDER>,

Recently, your patient ___________________ was seen at the __________________ Children's Advocacy Center (CAC) on <DATE>, following the report of one or more potentially traumatizing experience(s) of alleged (?) abuse.

In the interview and brief assessment conducted at the CAC, trauma-related symptoms were reported by ____________________ and <HIS or HER or THEIR> primary caregiver at a <MODERATE or HIGH> level. Symptoms children may have in response to these events include anger, sadness, fear, behavioral issues, reduced performance in school, sleep problems, and physical complaints.

There are evidence-based mental health therapy models that have been shown to be more helpful than other types of treatment in reducing the symptoms of children who have had potentially traumatizing experiences. We want all children to have access to evidence-based trauma-specific therapies, when needed, and we have given <PROVIDER NAMES> as referral options.

We will check-in with the family 2–4 weeks after their visit to our center and ask if they have followed through with contacting a qualified provider. We can also provide tools and materials about child traumatic stress, coping skills, and links to other resources.

You may also wish to ask if the family has sought treatment with a mental health provider trained in an evidence-based child trauma therapy model at their next primary care visit.

Sincerely,

_____________ CAC Team

https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529796229

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CPM DEVELOPMENT TEAM

Tammer Attallah, LCSW, MBA
Julie Bradshaw, LCSW
Kara Byrne, PhD
Kristine Campbell, MD
Neal Davis, MD
Lisa Giles, MD
Brooks Keeshin, MD
David Kolko, PhD
Flory Nkoy, MD
Amy Oxman, LCSW
Heidi Porter, PhD (Medical Writer)
Carolyn Reynolds, MS, APRN
Lindsay Shepard, LCSW
Brian Thorn, PhD

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- Hillcrest Pediatrics
- Iron County CJC
- Juab / Millard County CJC
- Kane County CJC Satellite
- Salt Lake County Avenues CJC
- Salt Lake County South Valley CJC
- Sanpete County CJC
- Sevier County CJC
- Summit County CJC
- Tooele County CJC
- Uinta Medical Group
- Uintah-Daggett County CJC
- Utah County CJC
- Washington County CJC
- Weber-Morgan County CJC

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CHA Charlton M, Kliethermes M, Tallant B, Taverne A, Tishelman A. *Facts on traumatic stress and children with developmental disabilities.* 2004. Available at: http://www.nctsnet.org/nctsn_assets/pdfs/reports/traumatic_stress_developmental_disabilities_final.pdf. Accessed February 23, 2018.

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CRO Crouch JL, Hanson RF, Saunders BE, Kilpatrick DG, Resnick HS. Income, race / ethnicity, and exposure to violence in youth: Results from the national survey of adolescents. *J Community Psychol.* 2000;28(6):625-641.

DCHA Center on Developing Child; Toxic Stress. Harvard University, http://developingchild.harvard.edu/key_concepts/toxic_stress_response/. Accessed September 27, 2019.

DOR Dorsey S, McLaughlin KA, Kerns SEU, et al. Evidence base update for psychosocial treatments for children and adolescents exposed to traumatic experiences. *J Clin Child Adolesc Psychol.* 2017;46(3):303-330.

DSM American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders. 5th ed.* Arlington, VA: American Psychiatric Publishing; 2013.

DUB Dubowitz H, Thompson R, Proctor L, et al. Adversity, maltreatment, and resilience in young children. *Acad Pediatr.* 2016;16(3):233-239.

ELH Elhai JD, Layne CM, Steinberg AM, et al. Psychometric properties of the UCLA PTSD Reaction Index. part II: Investigating factor structure findings in a national clinic-referred youth sample. *J Trauma Stress.* 2013;26(1):10-18.

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GHO Ghosh Ippen C, Harris WW, Van Horn P, Lieberman AF. Traumatic and stressful events in early childhood: Can treatment help those at highest risk? *Child Abus Negl.* 2011;35(7):504-513.

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SEG Sege RD, Amaya-Jackson L. Clinical considerations related to the behavioral manifestations of child maltreatment. *Pediatrics*. 2017;139(4):e20170100.

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This CPM presents a model of best care based on the best available scientific evidence at the time of publication. It is not a prescription for every physician or every patient, nor does it replace clinical judgment. All statements, protocols, and recommendations herein are viewed as transitory and iterative. Although physicians are encouraged to follow the CPM to help focus on and measure quality, deviations are a means for discovering improvements in patient care and expanding the knowledge base. Send feedback to Brooks Keeshin, MD, Intermountain Healthcare, Brooks.Keeshin@imail.org.

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