Childhood Trauma Task Force

July 19, 2021

1pm-3pm

Agenda

- Approval of June 2021 Meeting Minutes
- Update on Center for Child Wellness & Trauma
- Presentation on trauma screening in pediatrics
  - Dr. Heather Forkey (UMass Medical)
  - Pediatric Integrated Post-Trauma Services Team at University of Utah (Utah PIPS)

OCA
MASSACHUSETTS
Office of the Child Advocate

CENTER FOR CHILD WELLBEING & TRAUMA

A partnership between OCA & UMMS

Core Center Components

Assessment and Coaching

Professional Learning Communities

Resources and Information

Goals and Objectives

- A racial equity lens directs, imbues, and enhances all goals
- Goals are driven and refined by stakeholder engagement and feedback

Goal 1: All agencies that interact with children will benefit from an assessment and coaching process to become more trauma informed and responsive.

Goal 2: Professional Learning Communities will provide and enhance trauma informed and responsive skills and tools.

Goal 3: All child-serving professionals have access to best practice trauma and healing/prevention resources and information.

Identification of children with “trauma” and children with trauma symptoms:

What it looks like in pediatrics

Trauma Task Force Meeting

July 19, 2021

Children we serve experience a variety of adversities

Adversities can be catastrophic – ACES, SDOH



Adversities can be “routine”

What we need to discriminate

ACEs

Resilience

Toxic Stress

Toxic
Prolonged activation of stress response systems in the absence of protective relationships.

Definition of Toxic Stress

Excessive or prolonged activation of stress response systems in the absence of buffering protection from adult caregivers

Brief increases in heart rate, mild elevations in stress hormone levels.

Serious, temporary stress responses, buffered by supportive relationships.

Prolonged activation of stress response systems in the absence of protective relationships.

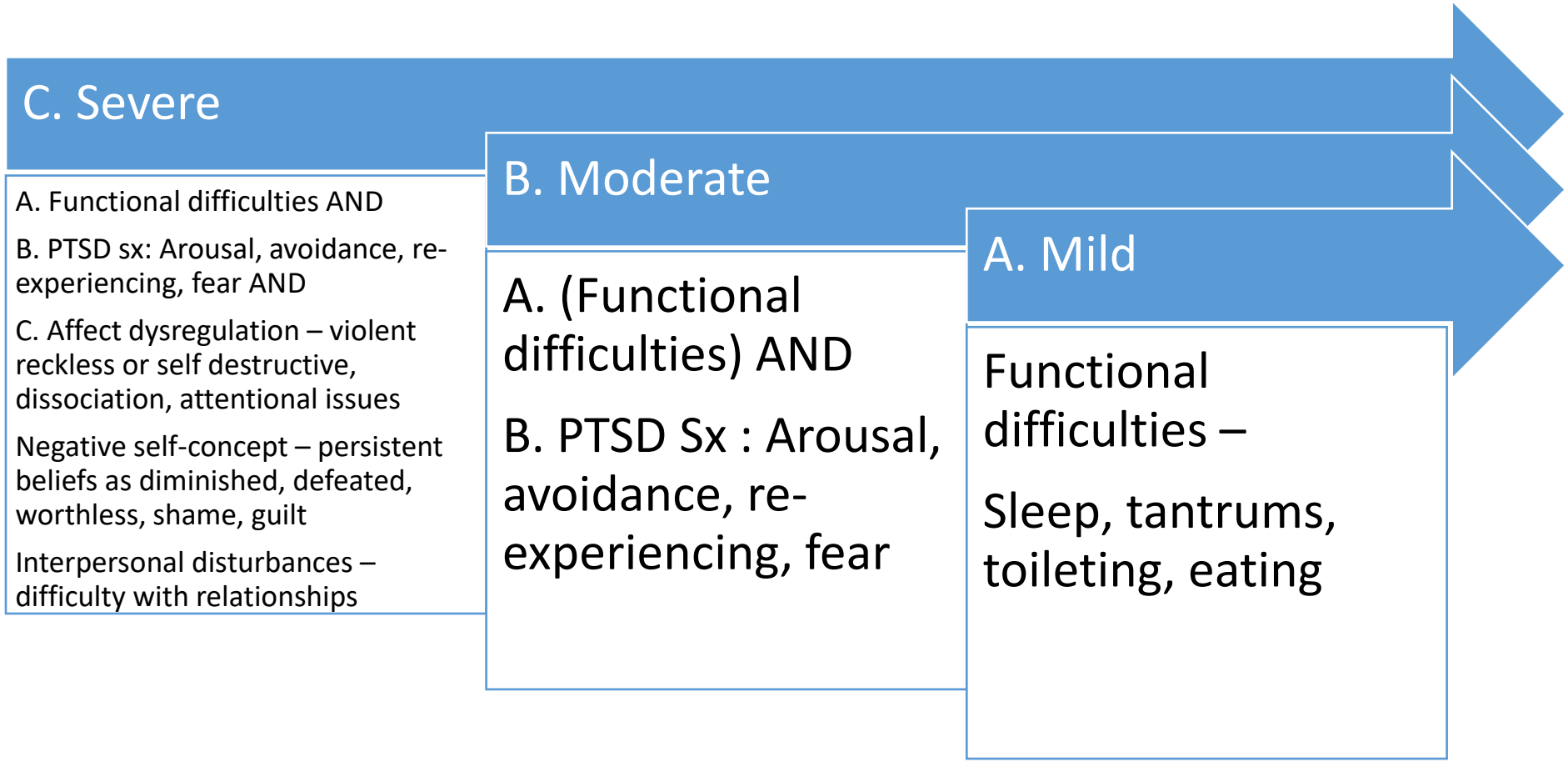
Source: Permission granted by center on the Developing Child at Harvard University. https://developingchild.harvard.edu/

First job – support buffering

2nd – recognize and respond to trauma : Most pediatric “trauma” is preclinical in a MH sense

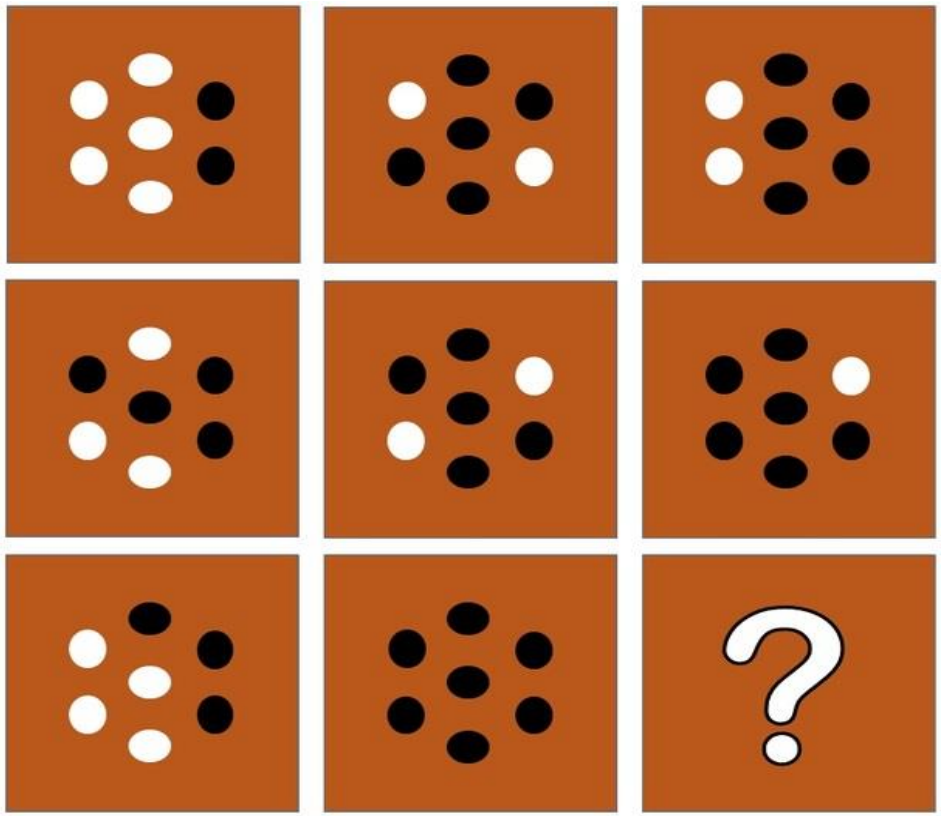
- Pediatrics niche is a wide space, most care for kids in the preclinical stages of trauma exposures
  - DTD trauma to DTD
  - We live in the space between ACEs and PTSD
  - Brain changes present to pediatrics as developmental concerns before behavioral health issues – so what are we looking for?

Can present with a spectrum of symptoms

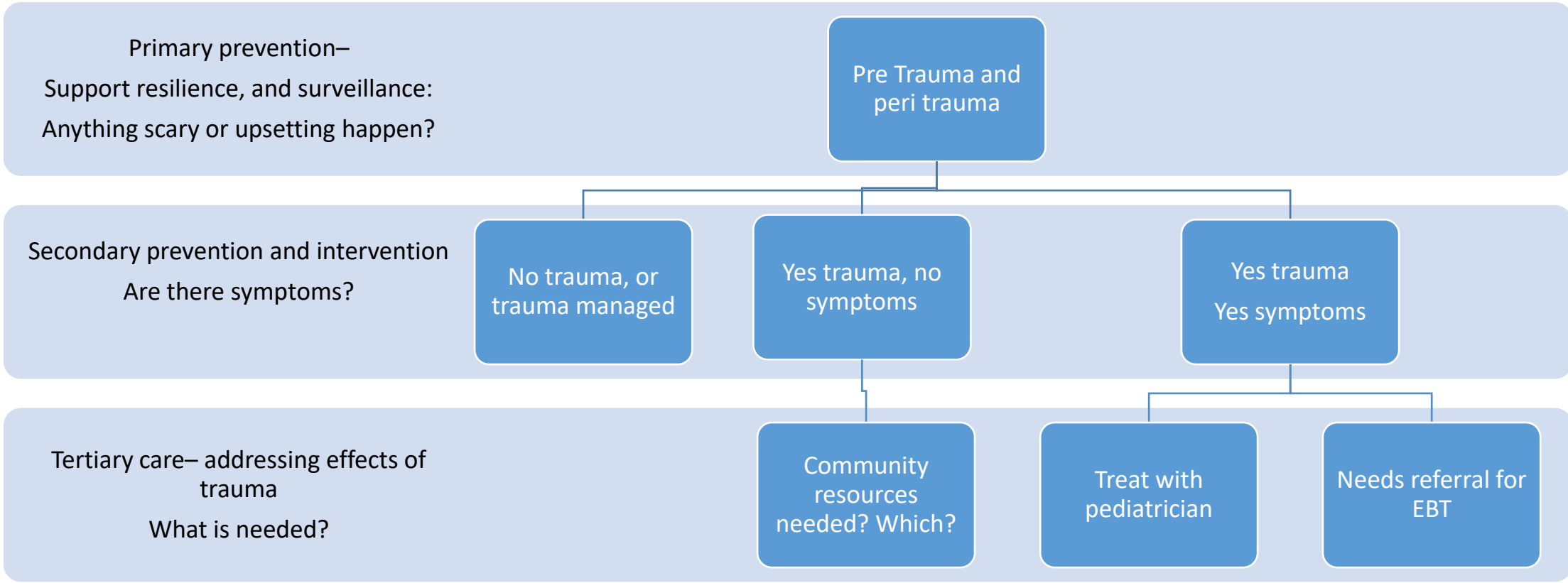


Physicians work from patterns – fitting symptoms into working models (need one)

- What are they looking for?



Three levels of care pediatrics is addressing



Primary prevention

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

POLICY STATEMENT

Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science Into Lifelong Health

Secondary (and pediatric piece of tertiary) response

POLICY STATEMENT Guidance for the Clinician in Rendering Pediatric Care

American Academy of Pediatrics

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Trauma-Informed Care in Child Health Systems

James Duffee, MD, MPH, FAAP,[a] Moira Szilagyi, MD, PhD, FAAP,[b] Heather Forkey, MD, FAAP,[c] Erin T. Kelly, MD, FAAP, FACP,[d] COUNCIL ON COMMUNITY PEDIATRICS, COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE, COUNCIL ON CHILD ABUSE AND NEGLECT, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH

CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Trauma-Informed Care

Heather Forkey, MD, FAAP,[a] Moira Szilagyi, MD, PhD, FAAP,[b] Erin T. Kelly, MD, FAAP, FACP,[c] James Duffee, MD, MPH, FAAP,[d] THE COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE, COUNCIL ON COMMUNITY PEDIATRICS, COUNCIL ON CHILD ABUSE AND NEGLECT, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH

Guidance for Pediatricians

- Ground in science
- Role of attachment, relational context of trauma with practical tools to support that
- Recognize trauma –tools to discriminate from other problems
- Respond to trauma
  - In patients
  - In caregivers
  - Secondary trauma in staff
- Readiness of organizations, institutions, payors, practices

A PARTNER IN NCTSN The National Child Traumatic Stress Network

Identifying and Responding to Children at Risk for Traumatic Stress in Pediatric Settings: The Care Process Model for Pediatric Traumatic Stress (CPM-PTS)

Brooks Keeshin, MD
Lindsay Shepard, PhD, LCSW
Kara Byrne, PhD, CSW

PIPS

A PARTNER IN NCTSN The National Child Traumatic Stress Network

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Disclosures

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

Who We Are

Core Team

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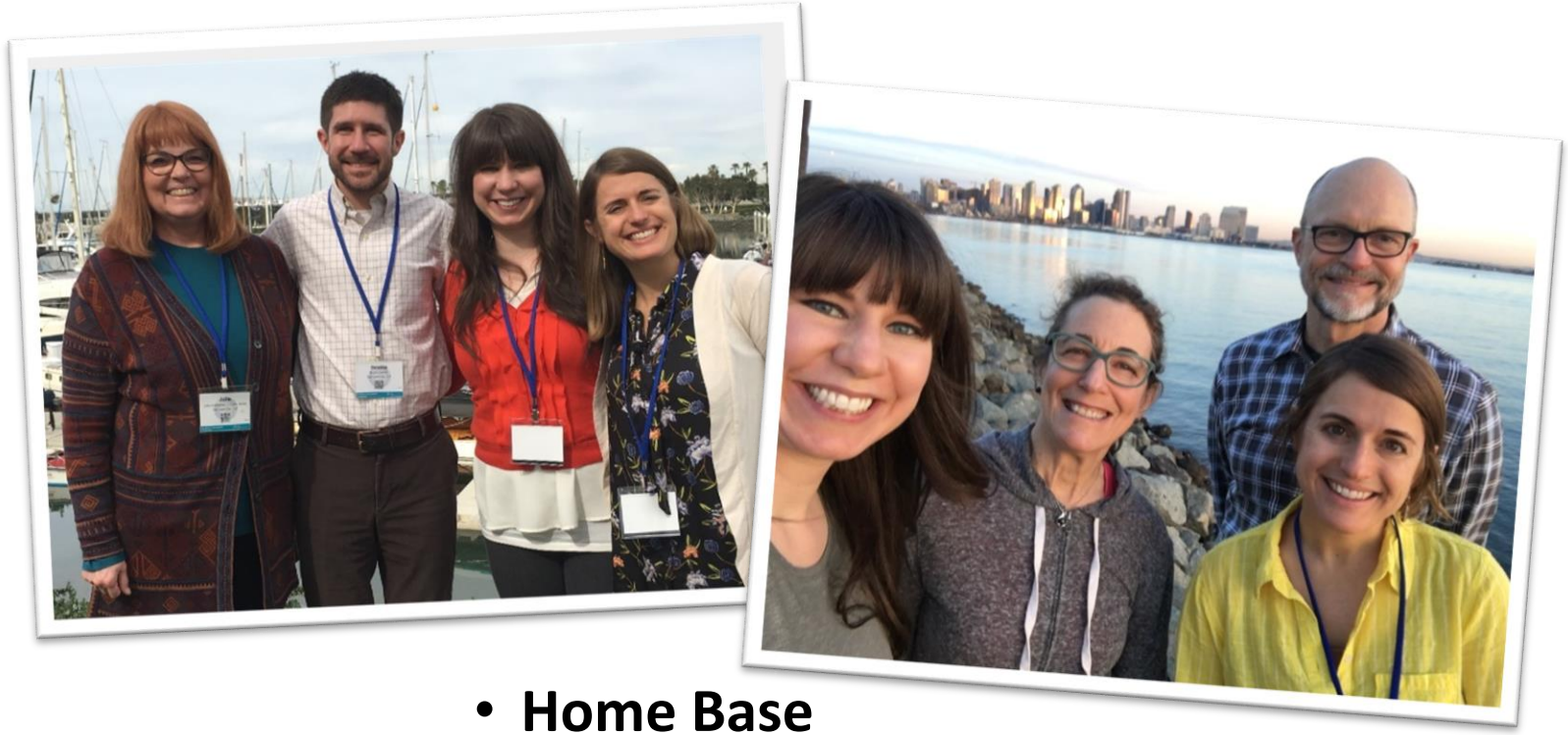


- **Home Base**
- Primary Children's Hospital, Center for Safe and Healthy Families
- University of Utah
- Intermountain Healthcare

PIPS

PIPS Collaborators

- **Local**
- Intermountain Healthcare
  - Primary Care
  - Community Health/Alliance
- Selecthealth
- Utah Office of the Attorney General
  - Utah Children's Justice Centers (CJCs)
- Utah Office for the Victims of Crime (OVC)
  - Victims of Crime Act (VOCA)

National

- National Child Traumatic Stress Network (NCTSN)
- Academy on Violence and Abuse (AVA)
- American Academy of Pediatrics (AAP)
- American Academy of Child and Adolescent Psychiatry (AACAP)
- Behavioral Health Innovations
- National Children's Alliance (NCA)
- Safe Environment for Every Kid (SEEK)

Objectives

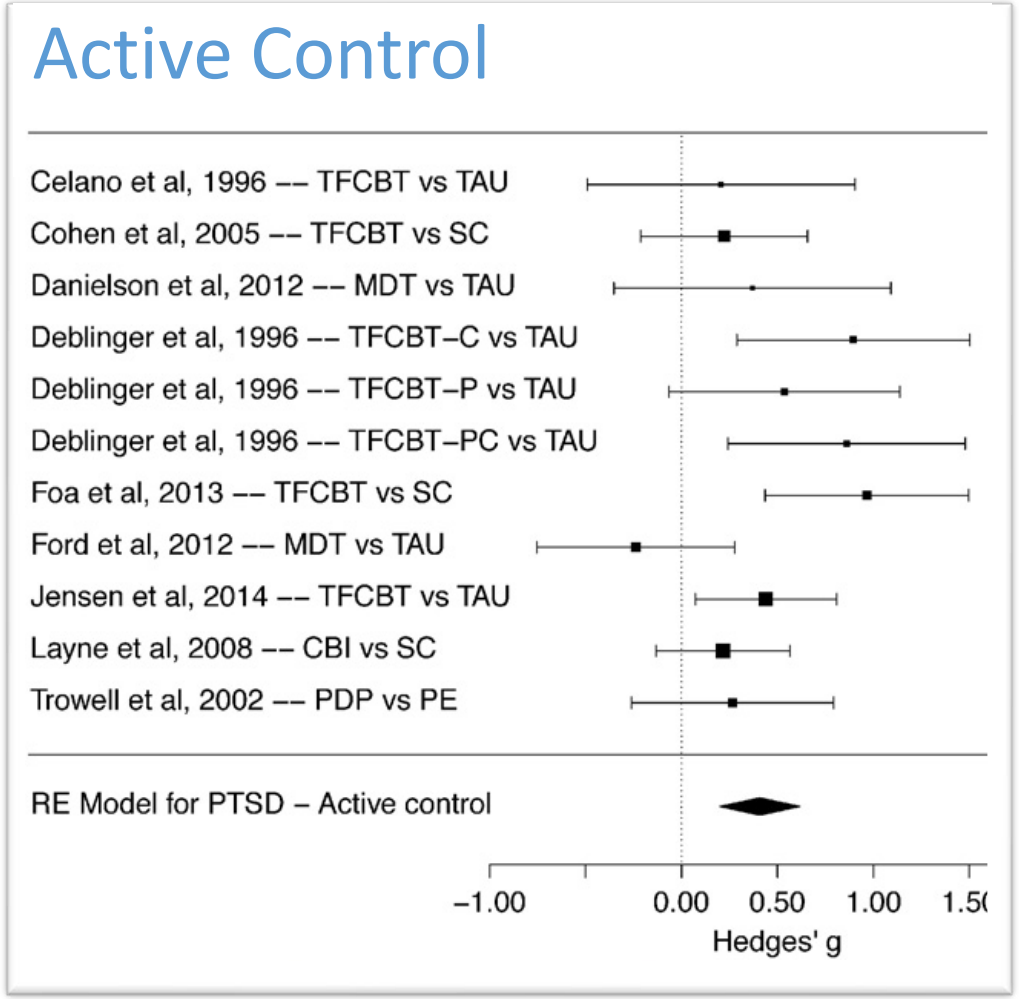
- The lay of the land for screening, identifying, and responding to child trauma and traumatic stress
- Overview of the Care Process Model for Pediatric Traumatic Stress (CPM-PTS)
- Key findings and current growth of the CPM-PTS
- Discussion

Definitions

- **Trauma:** Significant event or experience that causes or threatens harm to one's emotional and/or physical well-being
- **Traumatic stress:** Intense fear and stress in response to a potentially traumatic experience, including disturbed sleep, difficulty paying attention and concentrating, anger and irritability, withdrawal, repeated and intrusive thoughts, and/or extreme distress when confronted by reminders of the trauma

Need to Identify & Respond to Traumatic Stress

- High prevalence of trauma exposure
- Trauma is connected to poor health and mental health outcomes
- Trauma symptoms often go undiagnosed or misdiagnosed
  - Differential Diagnosis
- Trauma-focused evidence-based treatments work



(Morina, 2016)

Trauma Screening Lay of the Land

- <u>Options</u>
- ACEs
- Child and Adolescent Trauma Screen (CATS)
- UCLA Brief Screen

<u>Limitations</u>

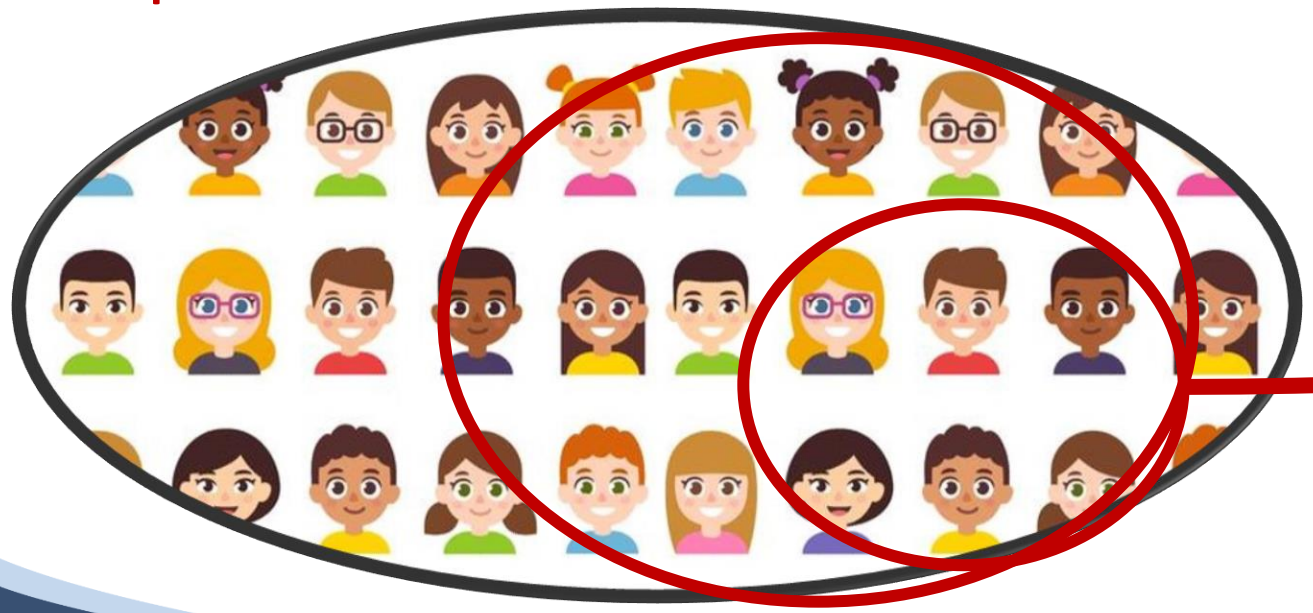
Not created or validated for individual or clinical decision-making & does not screen for trauma symptoms

No specific guidance for trauma-informed care response

PIPS

Summary of Needed Model or Tool

*** To assess and respond to children with trauma exposure**



*** To identify and connect children with traumatic stress to evidence-based trauma treatment providers**

PIPS

Trauma-Focused Cognitive Behavioral Therapy

Prepare and Cope

- **P**sychoeducation and parenting skills
- **R**elaxation
- **A**ffective expression & modulation
- **C**ognitive coping

Exposure and Process

- **T**rauma narrative processing
- **I**n vivo mastery of trauma

Safety and Stability

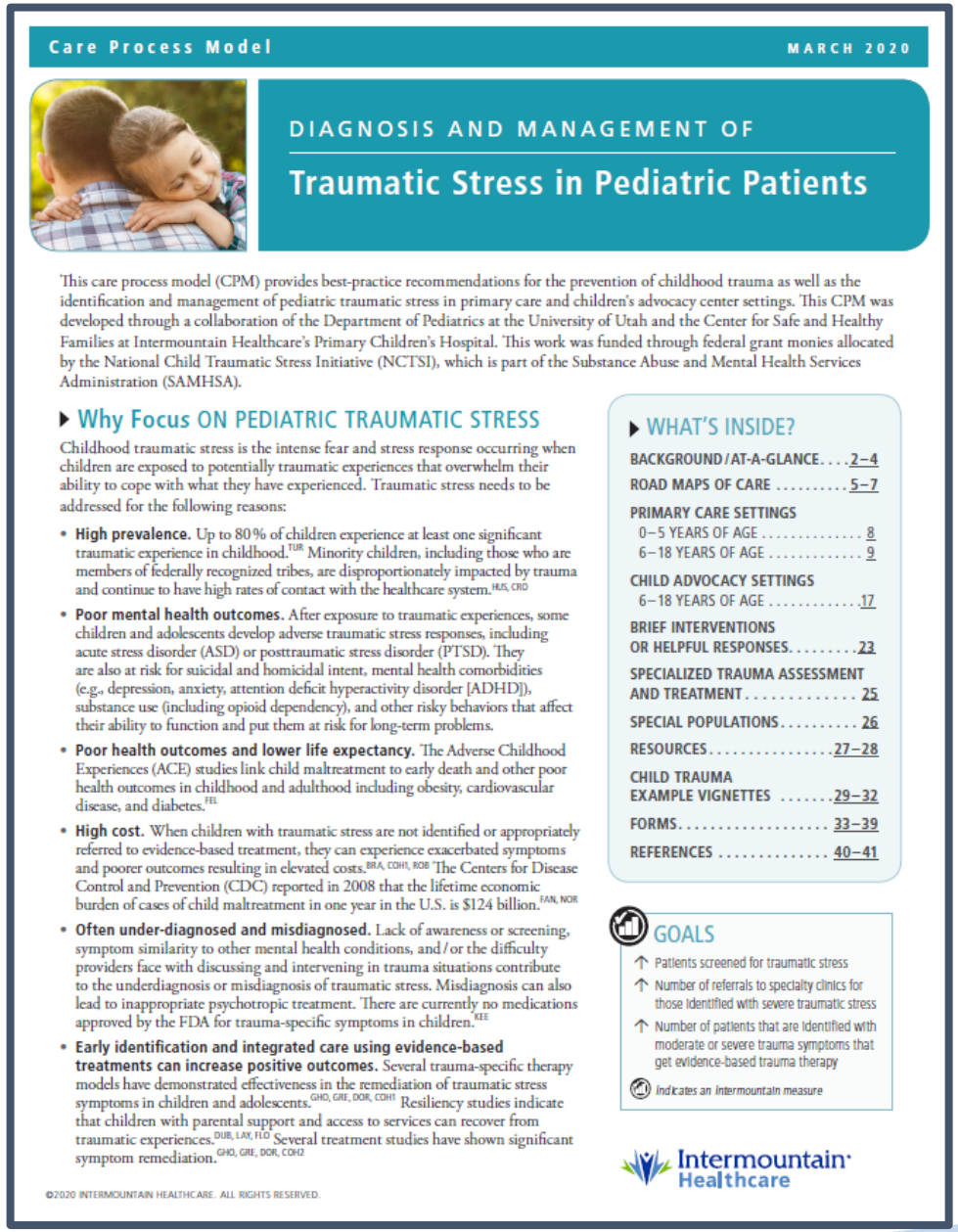
- **C**onjoint parent-child sessions
- **E**nhancing safety and future development

In-Office Pediatric Response

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

- *A care process model is a decision support document and roadmap or algorithm that help providers follow standard/best practice

Open access at https://utahpips.org/
or intermountainhealthcare.org



Care Process Model MARCH 2020

DIAGNOSIS AND MANAGEMENT OF

Traumatic Stress in Pediatric Patients

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

Why Focus ON PEDIATRIC TRAUMATIC STRESS

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

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

WHAT'S INSIDE?

GOALS

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

Indicates an Intermountain measure

Intermountain Healthcare

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PIPS

Overview

The Care Process Model (CPM) for Pediatric Traumatic Stress

Who

- Children ages 6-18 years
  - Well-child visits
  - Mental health related visits
  - Forensic interviews
  - Other pediatric settings

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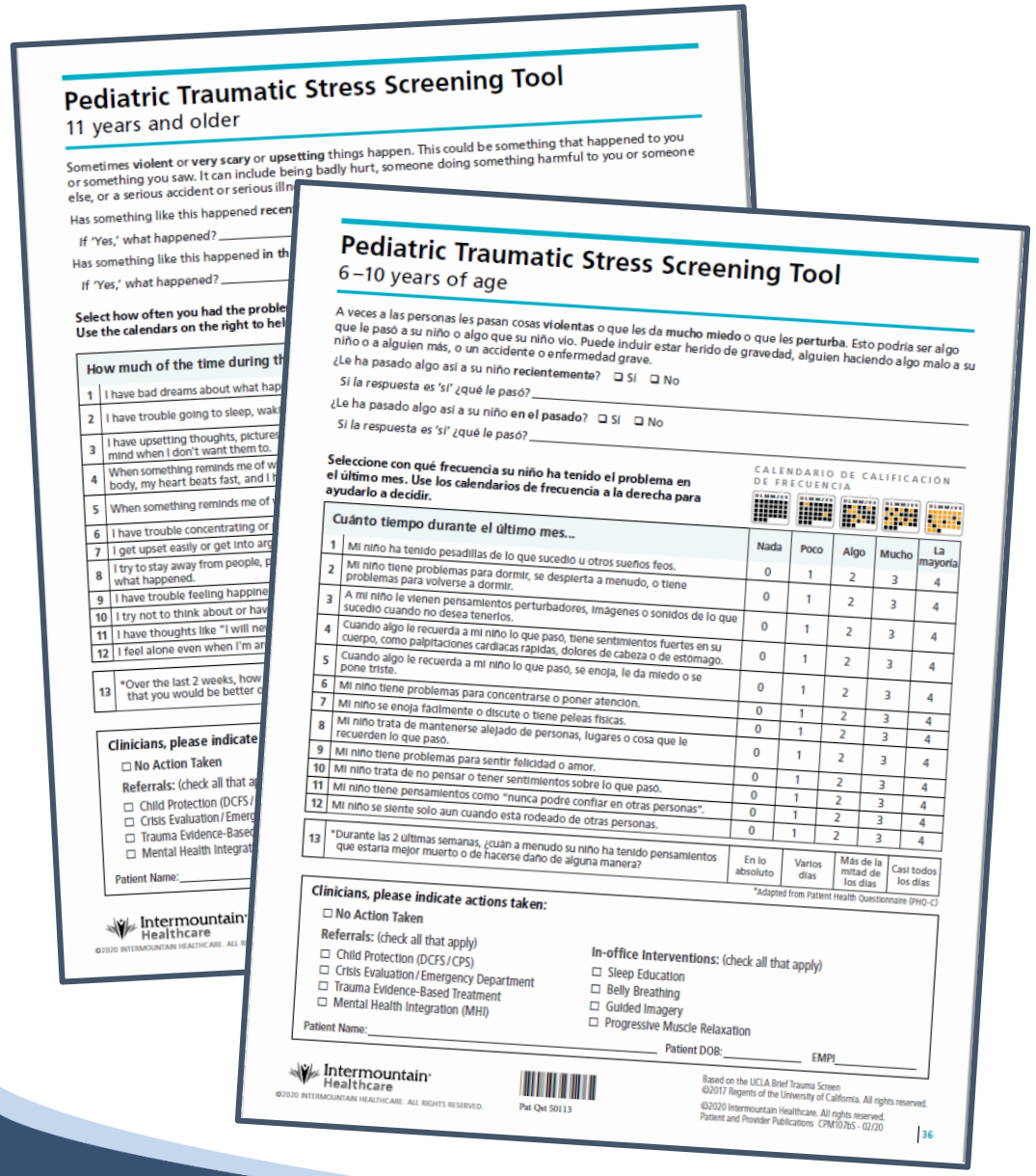

Pediatric Traumatic Stress Screening Tool
11 years and older

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

Has something like this happened recen

If 'Yes,' what happened? _____

Has something like this happened in th

If 'Yes,' what happened? _____

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

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

Clinicians, please indicate

☐ No Action Taken

Referrals: (check all that a

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

Patient Name: _____

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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 induir estar herido de gravedad, alguien haciendo algo malo a su niño o a alguien más, o un accidente o enfermedad grave.

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

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

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

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

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

CALENDARIO DE CALIFICACIÓN DE FRECUENCIA

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

*Adapted from Patient Health Questionnaire (PHQ-C)

Clinicians, please indicate actions taken:

☐ **No Action Taken**

Referrals: (check all that apply)

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

In-office Interventions: (check all that apply)

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

Patient Name: _____ Patient DOB: _____ EMPI _____

Intermountain Healthcare

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Pat Qst 50113

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

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How

- Incorporates a screening tool for:
  - Trauma exposure (UCLA Brief Screen)
  - Suicidality (PHQ-9 #9)
  - Symptoms of traumatic stress (UCLA Brief Screen)

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

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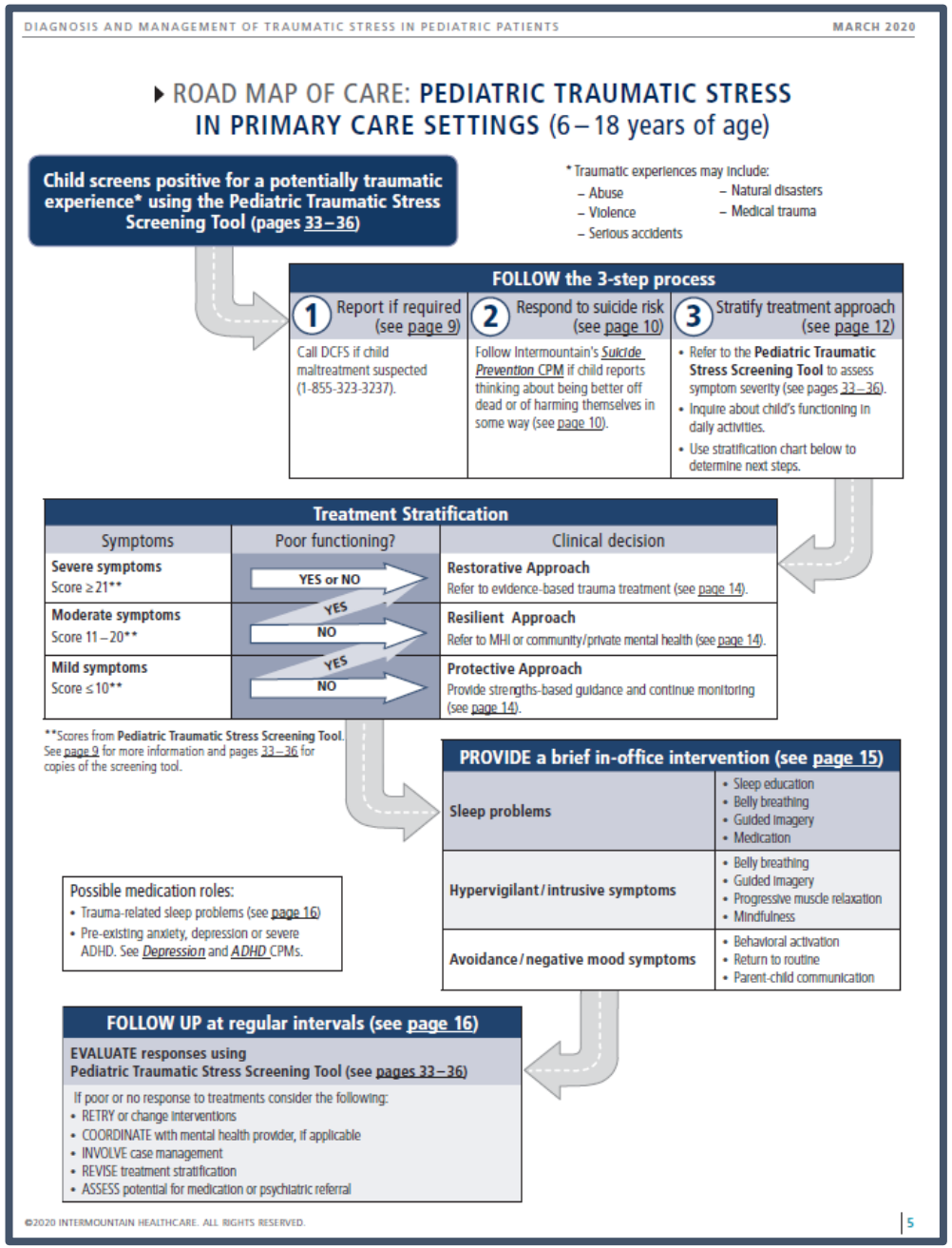

DIAGNOSIS AND MANAGEMENT OF TRAUMATIC STRESS IN PEDIATRIC PATIENTS — MARCH 2020

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

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

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

FOLLOW the 3-step process

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

Treatment Stratification

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

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

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

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

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

FOLLOW UP at regular intervals (see page 16)

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

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

Guides Provider Response via a Roadmap of Care

Provider meets with youth and caregiver:

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

Follow-up

Pediatric Traumatic Stress Screening Tool

11 years and older

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

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

If 'Yes,' what happened? _____

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

If 'Yes,' what happened? _____

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)

1. Report if Required

2. Respond to Suicide Risk

The C-SSRS

Ask items 1-2, 6

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

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

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

Higher risk for suicide

PIPS

Based on suicide risk, providers may:

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

Pediatric Traumatic Stress Screening Tool

11 years and older

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

MILD — MODERATE — SEVERE

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)

3. Stratify Treatment Response based on:

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

How are things going at home, school, and with friends?

3. Stratify Treatment Response based on:

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

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Provide Appropriate Treatment Approach

TABLE 2. Treatment Stratification

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

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

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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

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

*Adapted from Patient Health Questionnaire (PHQ-A)

SLEEP

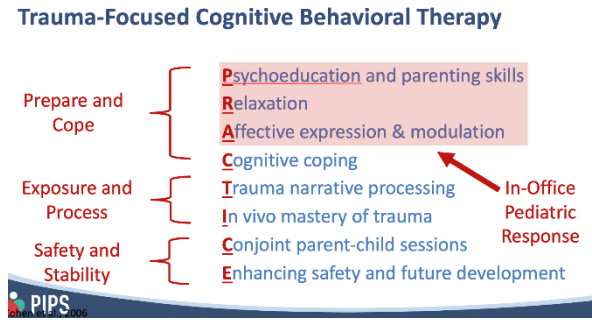
AROUSAL/ INTRUSION

AVOIDANCE/ NEGATIVE MOOD

Connect symptoms with trauma & Provide a brief targeted intervention

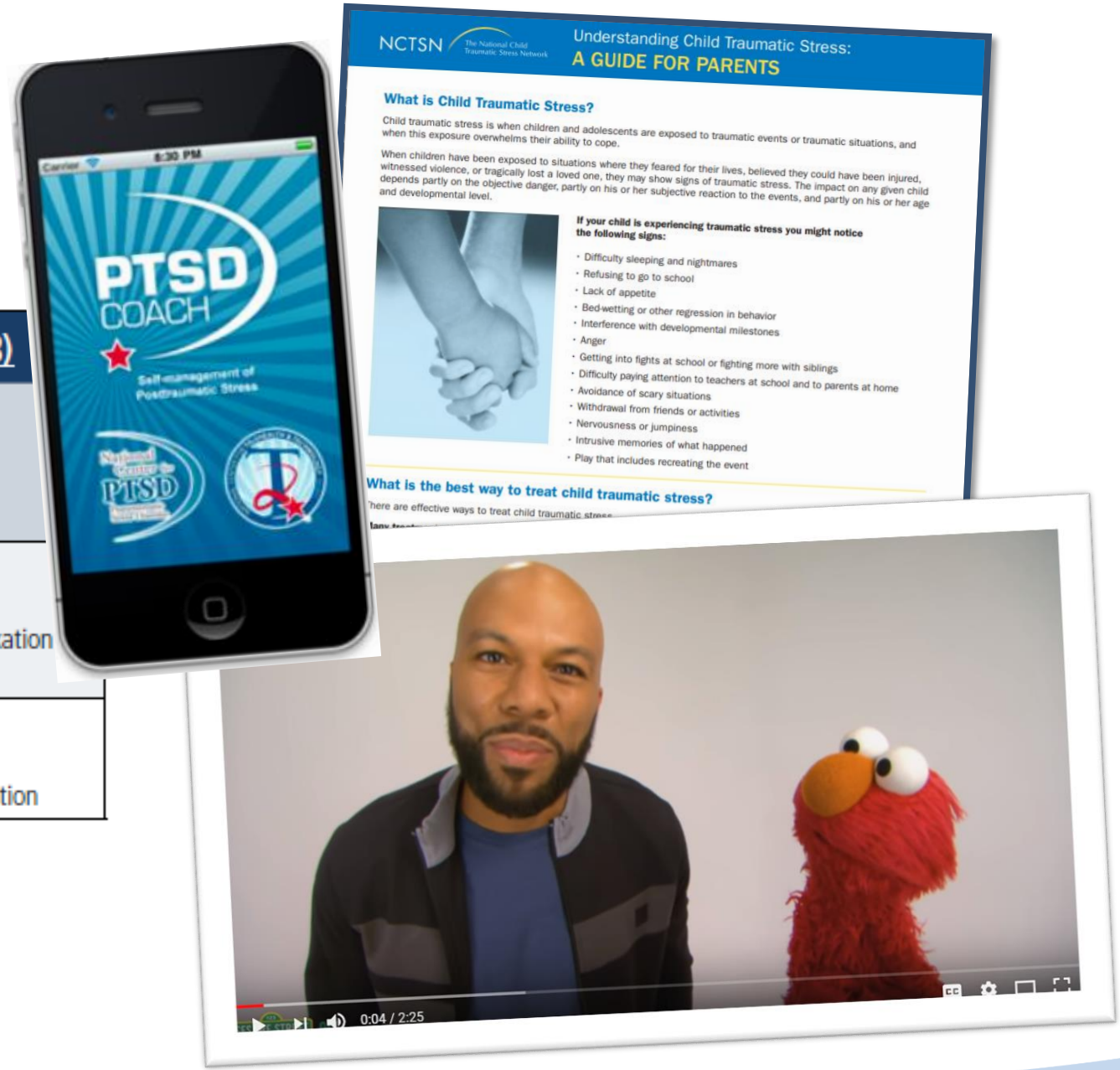
Lower distress and calm behaviors

Improve Engagement and mood



Brief In-Office Intervention

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



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Follow Up

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

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Findings & Growth

The Care Process Model (CPM) for Pediatric Traumatic Stress

Key Finding 1: The CPM-PTS Finds Trauma Exposure, Suicidality, & Traumatic Stress Symptoms in Children Seen in Pediatric Settings

	Primary Care (n=1472)	CACs (n=1766)
Trauma Exposure	33%	76%
Suicidality	3%	37%
Traumatic Stress Symptoms	13%	69%

And it's sensitive to both low and high risk populations

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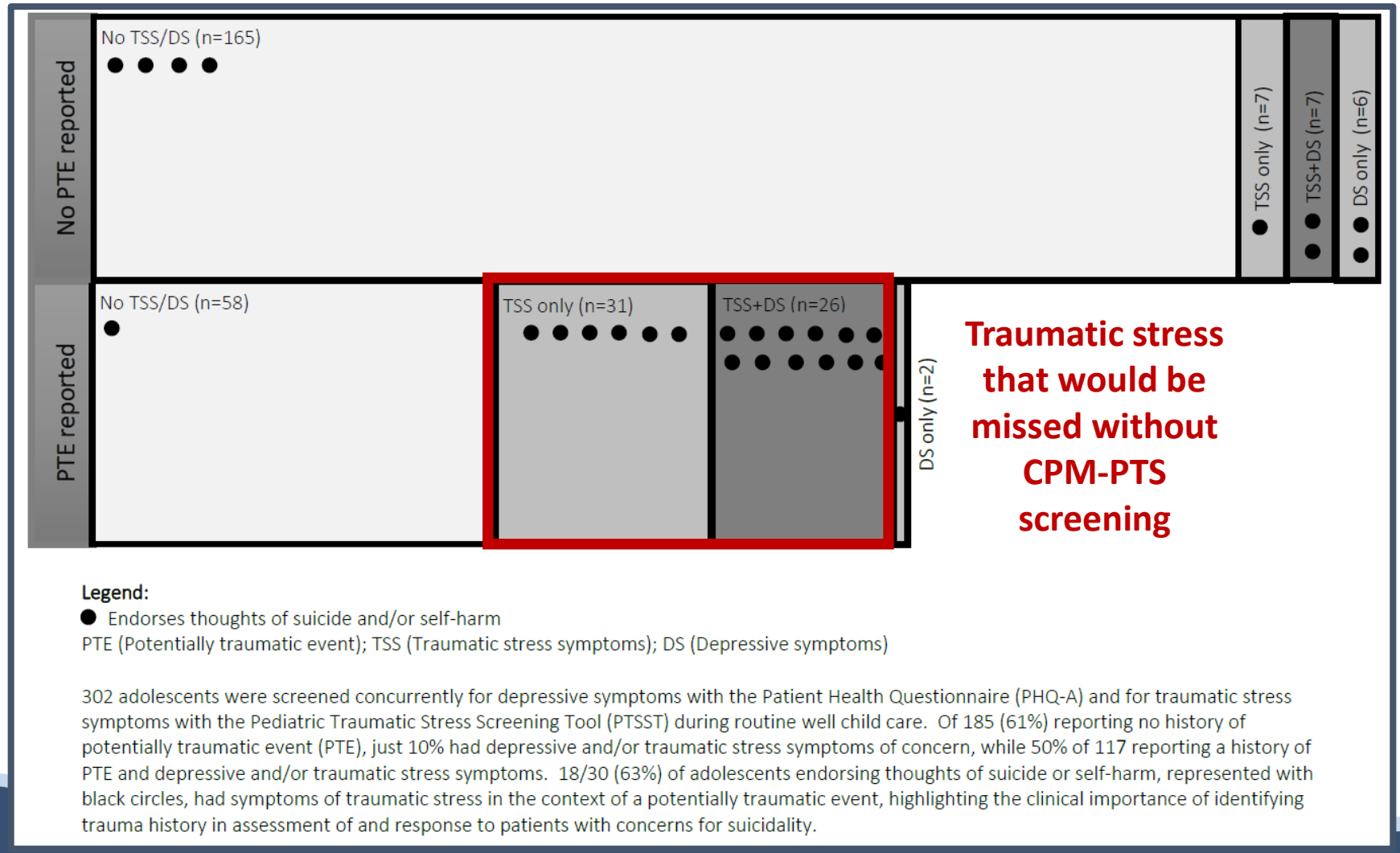
Key Finding 2: CPM-PTS Highlights Area for Primary Care Response Missed by Other/Previous Screening Practices



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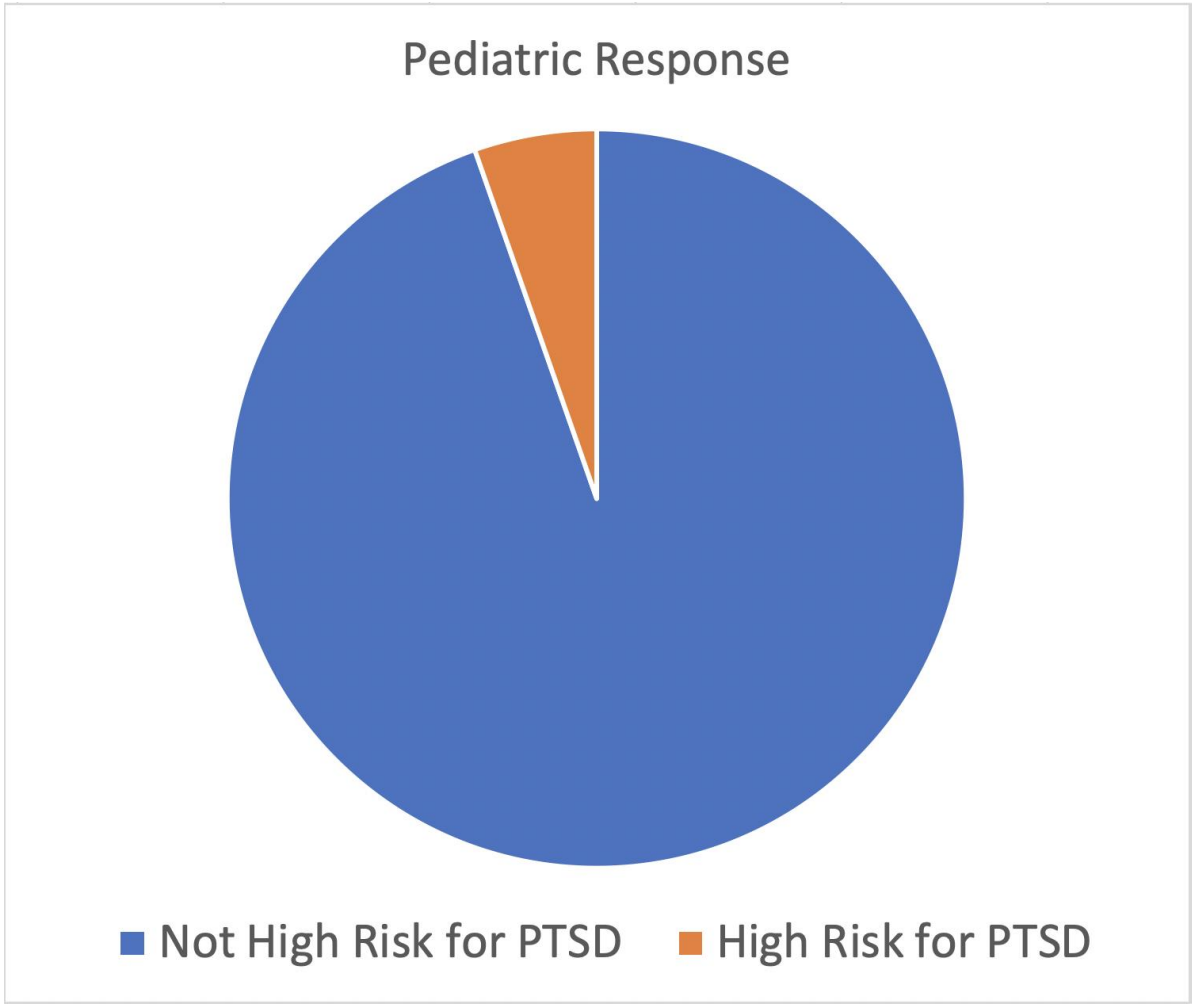
Key Finding 3: CPM-PTS Distinguishes/Triages Response for Primary Care



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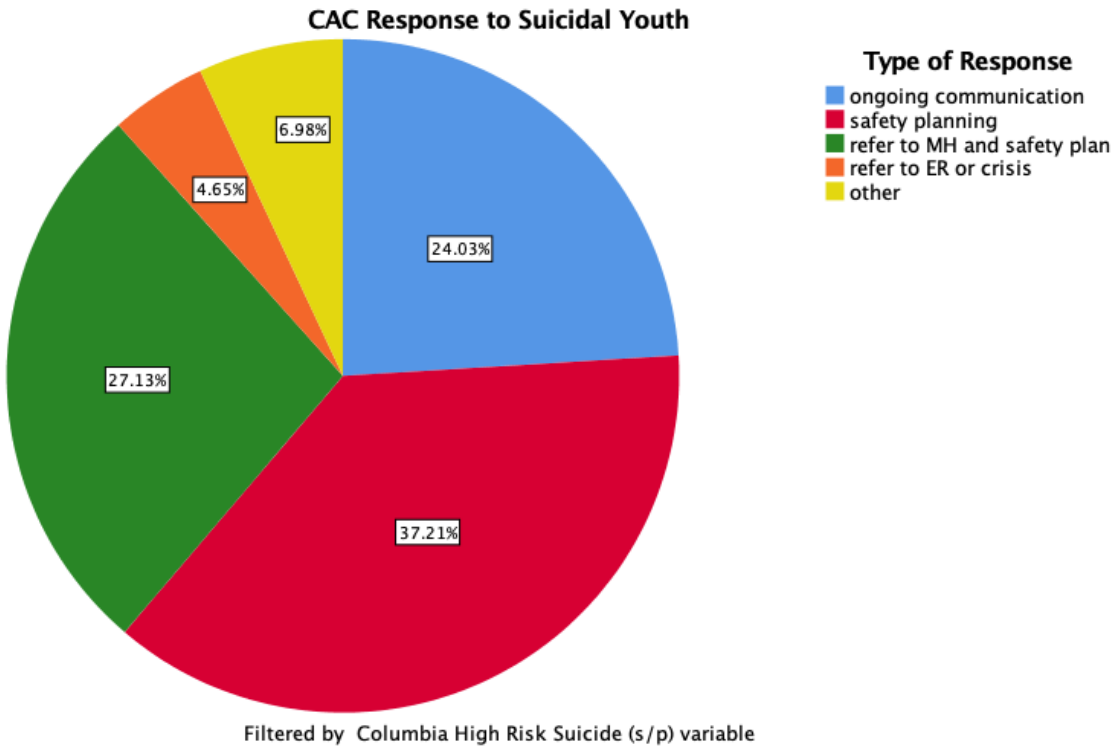
Key Finding 4: The CPM-PTS Introduction of Suicide Screening and Response to CACs Appears Critical

At CACs:

- Screening via the CPM-PTS identified that about 1 in every 10 adolescents is at high risk for suicidality
- ¾'s of these high-risk youth received a higher level suicide prevention response from the CAC



Key Finding 5: More than Screening, the CPM-PTS Guides Decision-making and a Trauma-informed Care Response

CAC Responses	%
Made a New CPS Report	5%
Assessed Suicide Risk via the CSSRS	32%
Provided Suicide Prevention Resources	30%
Made a Treatment Referral	78%
Referred Specifically to Trauma EBT	45%
Taught a Skill	58%

And can be used by clinicians and non-clinicians

Primary Care Providers Applaud the CPM-PTS

"You know, the family, when I was talking to them, didn't really identify anything that would trigger, but on the trauma screener he actually identified that about six months previously he had been stabbed. Before I had the screener there, he hadn't revealed that to me and hadn't thought that much of it, but then as we talked through it more he actually had a lot of symptoms of PTSD after that. And so I worked through the CPM, where he should go and all of that with him. I would have never have gotten that information had it not been from the screener and then having that in place."

"There was some concern about the potentially traumatic experience and mom wasn't sure if there was an impact or not on the child. And then she was able to fill out the questionnaire, including the symptoms score, which was essentially a zero. So that was just a nice way to have a conversation like, 'You know, looks like things are ok. Here are some things you can think about.'"

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CAC Workers Praise the CPM-PTS

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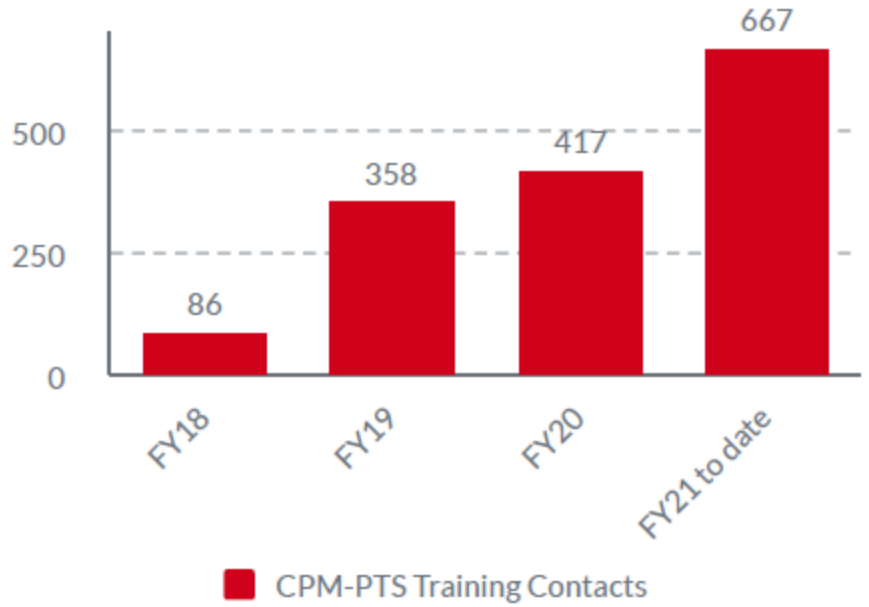
CPM-PTS Training Activities



Since the first training in the CPM-PTS in February 2018, PIPS has provided CPM-PTS training to over 1,528 contacts*

110 CPM-PTS training contacts* were made in the reported quarter (January-March 2021)

* The term "contacts" reflects that training may include single or multiple sessions

CPM-PTS Growth in Utah

17,500+
Children Screened

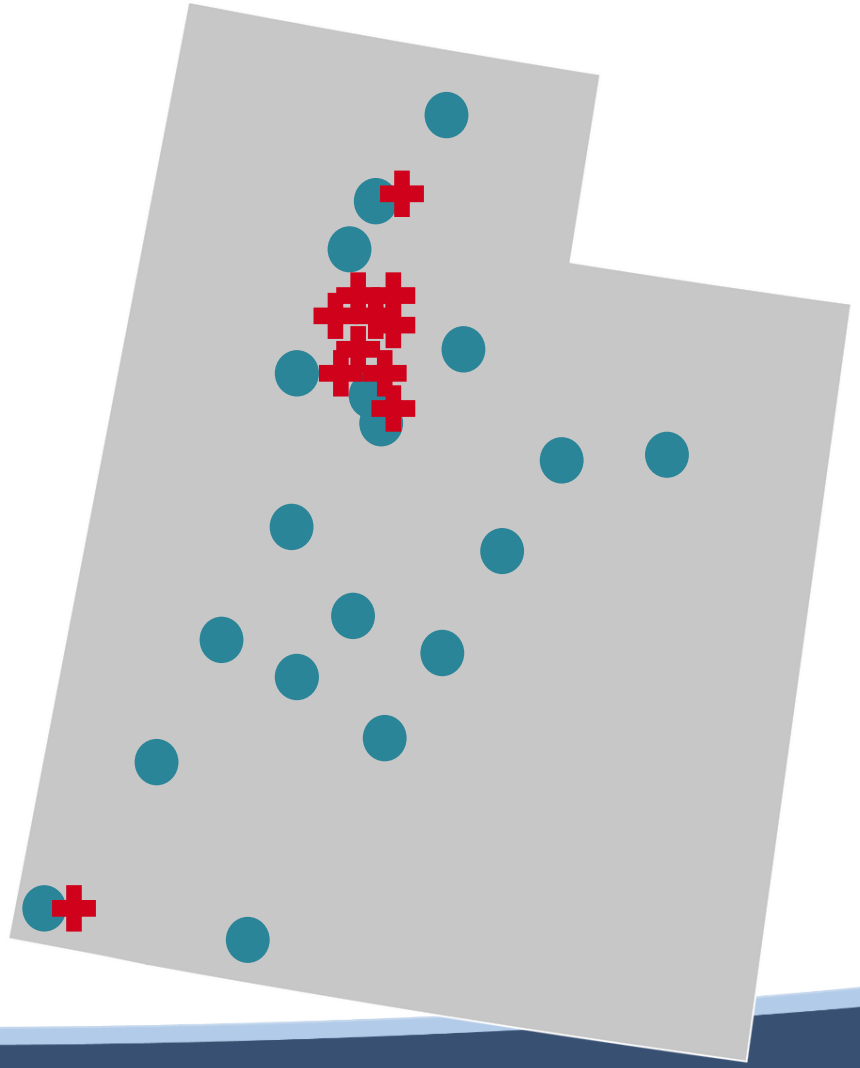
4,000+
CJCs

13,500+
Primary
Care Clinic

30+
Active Sites

19
CJCs

11 Primary
Care Clinics



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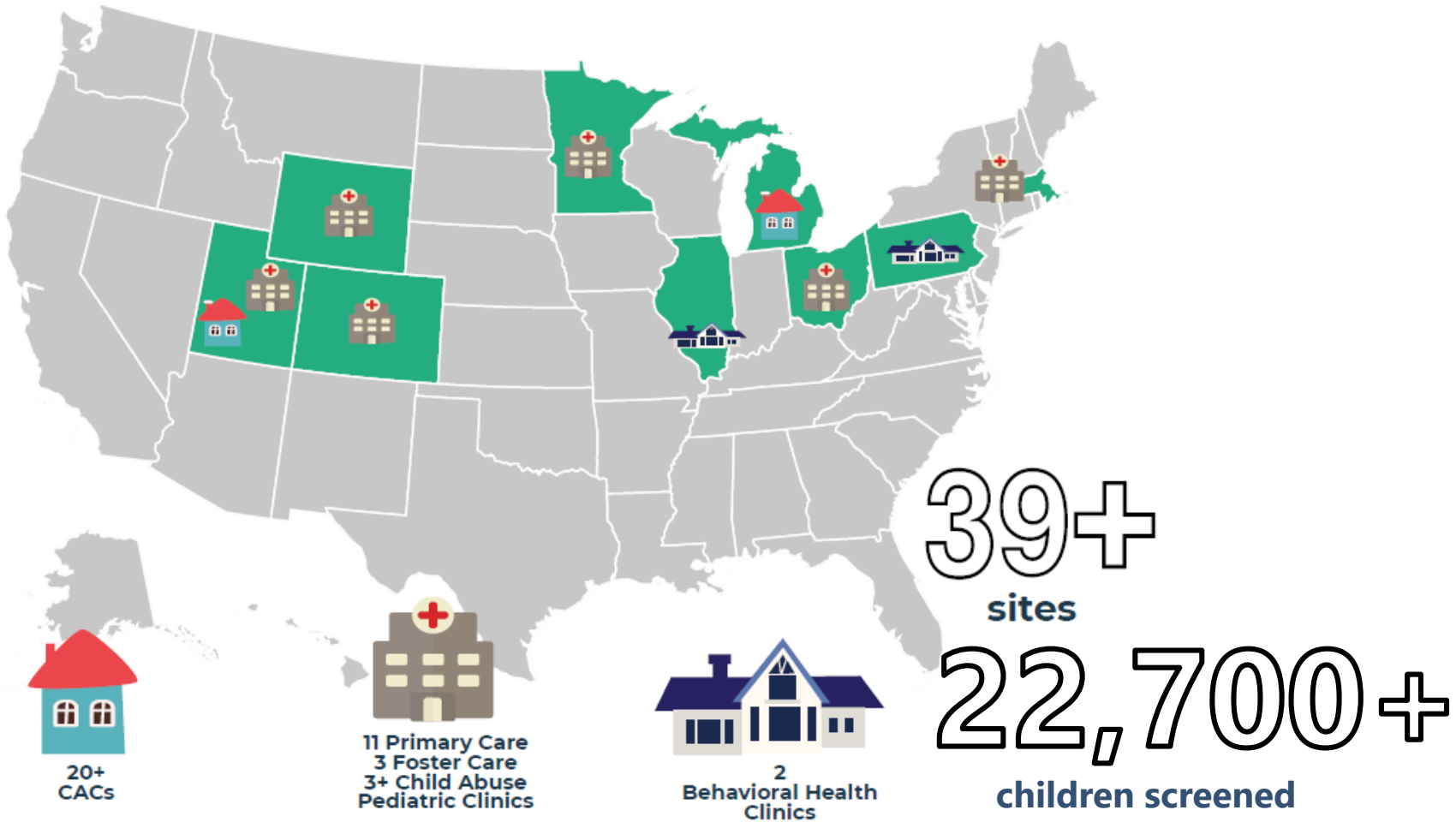
CPM-PTS Growth in the US



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Discussion

The Care Process Model (CPM) for Pediatric Traumatic Stress

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- Lindsay.Shepard@hsc.utah.edu
- Kara.Byrne@utah.edu
- or
- https://utahpips.org/cpm

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Next Meeting

(All meetings are virtual; Teams information is in each calendar invitation. Contact Alix.Riviere@mass.gov for more information on how to join meetings)

Monday, September 13th
1:00-3:00pm

MASSACHUSETTS
Office of the Child Advocate

Contact

Melissa Threadgill

Director of Juvenile Justice Initiatives

Melissa.Threadgill@mass.gov

OCA
MASSACHUSETTS
Office of the Child Advocate