Peyton Manning Children's Hospital
Ascension St. Vincent

Pediatric Trauma - PTSD
Assessment and Intervention

Children (6 years and older*) will be screened using the Pediatric Traumatic Stress Screening Tool. For children 6-10 years, parents/guardians will answer questions. If a child screens positive, follow this algorithm.

*Children under 5 years of age cannot be screened, but parents/guardians will be provided with education/resources.

1. Report concerns to DCS if maltreatment is suspected as part of traumatic experience.
2. Respond to suicide risk if child reports thinking about being better off dead or of harming self in some way.
3. Stratify treatment approach using symptom severity and level of functioning for level of referral.

Treatment Stratification

Symptoms	Clinical Decision *If poor functioning, move up to the next clinical decision.
Severe Symptoms Score ≥ 21	Restorative Approach - Send referral to resource center for follow up with behavioral health professional, provide with trauma resource QR sheet, send PCP letter 1
Moderate Symptoms Score 11-20	Resilient Approach - Provide with trauma resource QR sheet, send PCP letter 2
Mild Symptoms Score ≤ 10	Protective Approach - Provide with trauma resource QR sheet, send PCP letter 3

Trauma Resources

Given your child has experienced a traumatic event, it can be helpful to have information to help. This list was created to help **children who have experienced traumatic events.**

Understanding Child Traumatic Stress**: A Guide for Parents **(English) https://www.nctsn.org/resources/understanding-child-traumatic-stress-guide-parents	
Understanding Child Traumatic Stress**: A Guide for Parents **(Spanish) https://www.nctsn.org/resources/entendimiento-del-estres-traumatico-infantil-una-guia-para-padres	
Age-related reactions to a traumatic event https://www.nctsn.org/resources/age-related-reactions-traumatic-event	
*After a Crisis: **Helping Young Children Heal*** https://www.nctsn.org/resources/after-crisis-helping-young-children-heal	

Belly/focused breathing for **young children** (Elmo video) https://www.youtube.com/watch?v=_mZbzDOpylA	
Belly/focused breathing for older children and **teens** https://www.youtube.com/watch?v=7Ep5mKuRmAA	
Dial **9-8-8** for Suicide and Crisis Lifeline.	Dial **2-1-1** to find local resources.

Attach letters

1 - PCP letter 1 - High

2 - PCP letter 2 - Moderate

3 - PCP letter 3 - Low

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.

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

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 _____

Intermountain Healthcare

Pat Qst 50113

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Patient and Provider Publications CPM107b - 02/20

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
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Patient Name: _____ Patient DOB: _____ EMPI _____

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