Bridging the Gap:

Trauma Informed Care for Pediatric Residents

Kelley Volpe, MD and Toya Clay, MD

PSYCHIATRY COLLEGE OF MEDICINE UIC

University of Illinois Hospital & Health Sciences System
Changing medicine. For good.

No disclosures

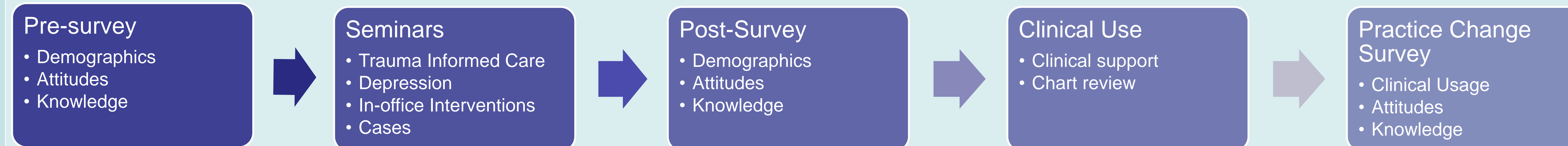
Abstract

People who have experienced trauma are more susceptible to a wide range of mental and physical health problems in adulthood, including early mortality[1]. Traumatic experiences often inform the treatment of mental illness. Barriers to receiving treatment include lack of access to mental health professionals as well as difficulty routinely eliciting this information. Primary care providers are typically on the front lines when children present with trauma related issues;[2] however pediatric residents often feel under trained and unprepared to manage mental health issues facing their patients[3]. By teaching pediatric residents to use a trauma informed framework and recognize the various manifestations of trauma; they will be better prepared to effectively identify and manage these children. Early identification and effective management, ideally, will result in better outcomes for physical and mental health services in this patient population.

Objectives

- To initiate education and training about mental illness in children and adolescents early in pediatric training, specifically during residency.
- To develop innovative training techniques to increase comfort level of pediatricians to manage with mental health issues that arise in their patients.
- To review medical record to determine if the technique reinforces knowledge and leads to change of practice including appropriate screening and management of pediatric patients with mental health needs.

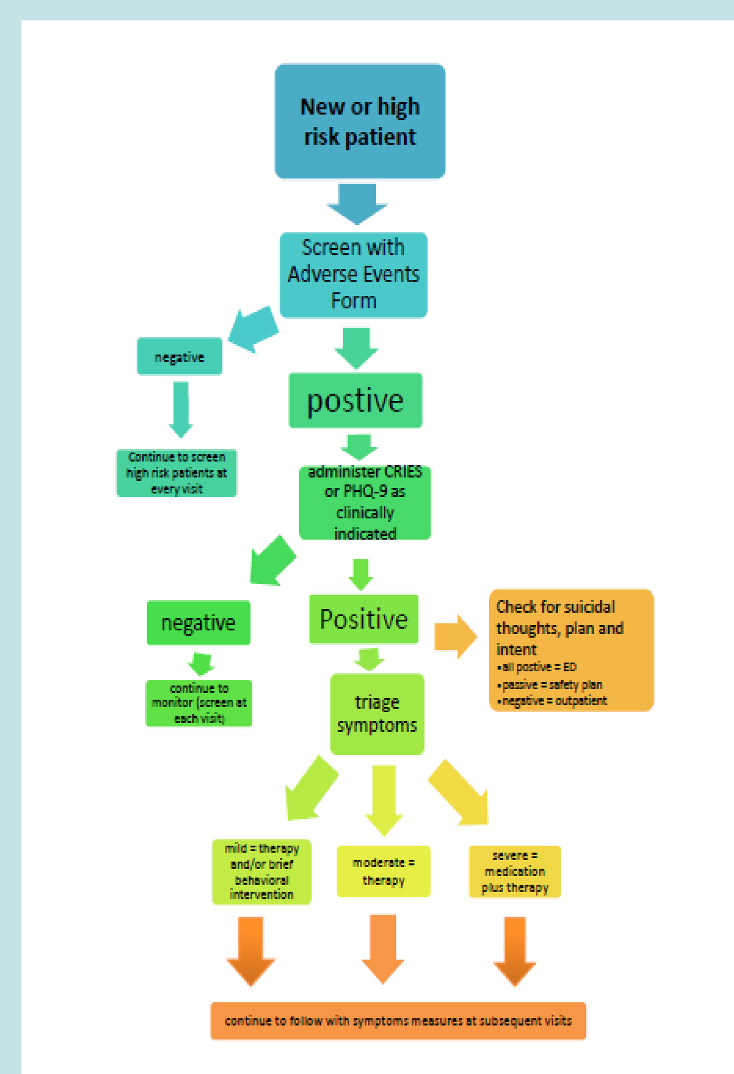
Methods



Curriculum

- Incorporates expert recommendations
  - American Academy for Pediatrics' Trauma Toolbox for Primary Care
  - National Child Traumatic Stress network
- Includes algorithms and screening forms to support evaluation, management, and brief in-office interventions (see examples below) to be utilized for:
  - Screening for trauma in high risk inner city patient population
  - Trauma informed care for other common mental health disorders
  - More in depth into childhood depression as a common result of trauma
- Supported by the mental health professionals embedded in the outpatient pediatric clinic.
  - Direct access to clinical supervision during clinic hours

	Topic	Skills Taught	Resources
I	Introduction and Trauma Screening	Incorporating Screening Trauma informed Care	Relaxation Tips for Children Screening Flowchart Childhood Adverse Events CRIES-8
II	Child and Adolescent Depression	Trauma informed assessment and management options for depression	SSRIs for Children PHQ-9 Columbia Rating Scale CSSRS
III	Interventions I	Brief Therapeutic Interventions	Symptom Action Plan
IV	Interventions II	Motivational Interviewing	Motivation interviewing



Symptom Management Plan

Name:________________ Doctor:________________

Symptoms | Skills | Support

Symptoms are manageable
- continue daily healthy life style:
  - exercise and healty diet
  - meditation and journaling
- take daily prescribed medication __________

Symptoms are bothersome
- use skills as above
- take as needed medication __________

Symptoms persist after above intervention -and/or - suicidal thoughts
- contact supports as above
- contact therapist or physician __________
- call 911 or go to the emergency department

Steps for Medication Management of Childhood Depression

1. Start with fluoxetine for <13 and escitalopram for >13
2. Monitor
   - First follow up in one week (phone vs. in person)
   - Monthly until remission
3. Treat to REMISSION not RESPONSE
   - Prevents relapse
   - Monitor using symptom measure
   - Response would be subthreshold symptoms on Columbia or PHQ-9

If No or Minimal Improvement In 6-8 Weeks:

1. Reassess initial diagnosis and treatment plan
   - Especially look for substance use and bipolar symptoms
2. Maximize dose
3. If using medication only, make sure to add CBT/IPT and vice versa
4. Switch if maximized and there is no improvement
   - Start monitoring schedule again

If There Is A Response:

1. Keep going with current med
2. Patients often noticed continued benefit 3-4 months out

If No or Minimal Improvement With Second Agent:

1. Continue to assess for other "treatment interfering" causes:
   - Poor medication adherence
   - Comorbidities
   - Ongoing psychosocial stresses/abuse
2. Mental health consultation

First Line Serotonin Modulators for Depression in Children and Adolescents
Selective Serotonin Reuptake Inhibitors (SSRI) Dosing Chart

Medication	Starting Dose	Titration (after 4-6 weeks if no/small effect)	Effective Dose	Maximum Dose	FDA Indications
Fluoxetine*	10 mg QD	10-20 mg	20 mg	60 mg	MDD: 8-18 y/o OCD: 7-17 y/o ^Bipolar I: 10-17 y/o
Escitalopram**	5 mg QD	5 mg	10 mg	20 mg	MDD: 12-17 y/o
Citalopram	10 mg QD	10 mg	20 mg	60 mg	none
Sertraline	25 mg QD	12.5 – 25 mg	50 mg	200 mg	OCD: 6-17 y/o
Fluvoxamine	50 mg QHS	50 mg	150 mg	300 mg	OCD: >8 y/o
Paroxetine	10 mg QD	10 mg	20 mg	60 mg	OCD: 7-17 y/o

* First line agent for <13
**First line for >13
^ Used with olanzapine for depressive episodes in bipolar patients

Cheung, Amy H.; Nicole Kozloff; and Diane Sacks. Pediatric Depression: An Evidence-Based Update on Treatment Interventions. Curr Psychiatry Rep (2013) 15:381

Results and Expected Outcomes

The project will be evaluated using subjective report of resident experience and objective measure of amount of patients documented as being screened for and educated about trauma.

Domain	Variable	Definition	Source of Data/Collection Procedure	Survey
Provider traits (Dependent)	Years in training	1 = PGY1 2 = PGY2 3 = PGY3	Survey of participants	Pre-survey
	Gender	0 = male 1 = female	Survey of participants	Pre-survey
	Work experience	Years of work prior to residency FT job yes/no? Healthcare field yes/no?	Survey of participants	Pre-survey
	Experience with psychiatry	0 = no patients with primary psychiatric dx 1 = 1 - 5 patients 2 = 5 + patients	Survey of participants	Pre-survey Post-survey 1 Post-survey 2
	Psychiatry training during residency	0 = none 1 = any	Survey of participants	Pre-survey Post-survey 1 Post-survey 2
	Knowledge	Pre-knowledge of best practices Post-knowledge of didactic content	Knowledge based survey	Pre-survey Post-survey 1 Post-survey 2
	Developmental Peds	0 = yes 1 = no	Survey of participants	Pre-survey Post-survey 1 Post-survey 2
Provider traits (independent)	Attitude	Improved knowledge of roles and responsibilities Improved ability to advocate for patient care	Knowledge based survey	Pre-survey Post-survey 1 Post-survey 2
	Skills	Consult/refer appropriately Coordinate collaboration as primary provider Knowledge of best practices	Chart review Knowledge based survey	Pre-survey Post-survey 1 Post-survey 2
	Usage	Use of screening and assessment forms as taught in curriculum	Chart Review	Post-survey 2
Patient characteristics	Diagnosis	DSM5 diagnosis Primary mood disorder Primary psychotic disorder Primary attention disorder Primary behavior disorder	Chart review	Post-survey 2
	Severity	0 = mild 1 = moderate 2 = severe	Chart review	Post-survey 2
	Age	Older Youth = youth 12 to 21 Younger Youth =youth younger than 12	Chart review	Post-survey 2
	Gender	0 = male 1 = female	Chart review	Post-survey 2
	Treatment outcomes	0 = treated only by PCP 1 = consultation by CAP and managed by PCP 2 = referred to CAP	Chart review	Post-survey 2

It is expected that residents trained with this curriculum will exhibit:

- increased self-reported comfort level in addressing and in-office management, and
- increased utilization and documentation in recognition and management for mental health issues in children and adolescents

References

1. Felitti, Vincent J., Robert F. Anda, Dale Nordenberg, David F. Williamson, Alison M. Spitz, Valerie Edwards, Mary P. Koss, and James S. Marks. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults." American Journal of Preventive Medicine 14.4 (1998): 245-58.
2. Gerson, Ruth, and Nancy Rappaport. "Traumatic Stress and Posttraumatic Stress Disorder in Youth: Recent Research Findings on Clinical Impact, Assessment, and Treatment." Journal of Adolescent Health 52.2 (2013): 137-43. Web.
3. Freed, G. L., K. M. Dunham, K. E. Switalski, M. D. Jones, and G. A. Mcguinness. "Recently Trained General Pediatricians: Perspectives on Residency Training and Scope of Practice." Pediatrics 123.Supplement (2009): S38-43.
4. Cheung, Amy H. Mda; Rachel A. Zuckerbrot, MD, Peter S. Jensen, MD, Kareem Ghalib, MD, Danielle Laraque, MD, Ruth E. K. Stein, MD, and the GLAD-PC Steering Group. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management. PEDIATRICS Volume 120, Number 5, November 2007
5. Cheung, Amy H.; Nicole Kozloff; and Diane Sacks. Pediatric Depression: An Evidence-Based Update on Treatment Interventions. Curr Psychiatry Rep (2013) 15:381