VMAP
Virginia Mental Health Access Program

Welcome to VMAP ECHO Deeper Dive

Trauma + ACEs

22 June 2023

Our session will begin promptly at 12pm

Please enter your name in the chat box; include any guests attending with you

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Important information…

Patient-provider relationship:

Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any VMAP clinician and any patient whose case is being presented in a Project ECHO setting.

Video recording:

For educational and quality improvement purposes, we will be recording this session.

By participating in this clinic you are consenting to be recorded. We appreciate and value your participation.

2

Important information…

Respect Private Health Information

To protect patient privacy, please only display or say information that doesn't identify a patient or that cannot be linked to a patient.

- Names: Please do not refer to a patient's first/middle/last name or use any initials, etc.
- Locations: Please do not identify a patient's county, city or town.
- Dates: Please do not use any dates (dob) that are linked to a patient. Instead, please use the patient's age.
- Other common identifiers: Patient's family members, friends, co-workers, phone numbers, e-mails, occupation, place of employment

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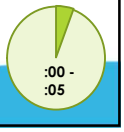
Welcome + introductions

Let us know you're here!
Please enter your name + any guests into the ZOOM "chat box" so we have a record of your attendance

Agenda:	
:00 - :05	Welcome + introductions
:05 - :30	Didactic: Trauma + ACEs
:30 - :55	Case presentation, discussion + recommendations
:55 - :00	Wrap-up

Our next session is scheduled for:
Thurs., Jul. 27 at 12:00 to 1:00 PM
Autism



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VMAP Early Childhood Line

Now accepting calls!

1-888-371-VMAP (8627)

Consultations with early childhood specialists!

Such as **developmental/behavioral pediatricians** and **early childhood child psychiatrists**

In the next year, VMAP plans to expand its early childhood program to increase coverage and types of early childhood specialists available to PCPs via the VMAP line. This will include early childhood care navigation to help PCPs, patients, and families navigate and find referrals for services.

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VMAP ECHO QI Project Timeline

Date	Action	Your Next Step(s)
03.01.2023	• Receive project descriptions • Receive baseline chart review instructions and link	• *Complete baseline chart review based on February visits; chart review **due March 15*** • *Start screening!!*
03.28.2023	**QI Session #1 @ 5:30 – 6:30 PM**	• *Maintain a folder or other system for dated screeners – this will help you with your upcoming chart reviews*
05.01.2023	• Receive Chart Review #2 instructions and link	• *Complete chart review based on April visits;* • *Chart review **due May 12*** • *Continue screening!*
05.23.2023	**QI Session #2 @ 5:30 – 6:30 PM**	• *Improve your workflow?* • *Add to your recommendations?*
07.03.2023	• Receive Chart Review #3 instructions and link	• *Complete chart review based on June visits;* • *Chart review **due July 14***
07.25.2023	**QI Session #3 @ 5:30 – 6:30 PM**	• *Review individual and cumulative results; this will help with the self-reflection portion of the attestation.*
11.15.2023	• Attestation link sent from UVA CME office	• *Email will come from Kathleen Meneses (virginia.edu)* • *Attestation **due December 1***

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VMAP ECHO 2023 Deeper Dive Cohort Members

Suzanne Alonso, MSN, CPNP-PC
Lynchburg Pediatrics, Forest

Susan Ashton-Lazaroae, MD
ALL Pediatrics
Lorton

Lelia Binder, MD
Sterling AllCare Pediatrics
Potomac Falls

Deana Buck
Richmond

Brittany Butler, PA-C
Tri-Area Community Health
Ferrum

Walter Chun, MD
The Pediatric Center
Glen Allen

Robin Church
The Arc of Virginia
Richmond

Ashley D'Angelo, CPNP-PC
Children's Medical Associates
of Northern VA, Alexandria

Chrystal Doyle, APRN, FNP-BC, PMHNP-BC
Cumberland Hospital

Jadig Garcia, PhD
The Pediatric Center
Richmond

Jenniffer Herrera, MD
UVA Neurodevelopmental
Behavioral Pediatrics

Vicki Holmes
Providence Forge

Morgan Honickel, LCSW
Petersburg

Nadia Islam, PhD
The Pediatric Center
Glen Allen

Stephanie Konkus, MD
Town Pediatrics
Leesburg

slide 1 of 2

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VMAP ECHO 2023 Deeper Dive Cohort Members

Paula Labriola, MD
Woodbridge

Nair Maya, MD
Capital Area Pediatrics
Herndon

Marina McBee, CPNP
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Ayanna McCray, MD
New Heights Pediatrics
King George

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Fairfax

Maria Sacoto, MD
Sacoto Pediatrics
Falls Church

Liv Gorla Schneider, MD
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Capital Area Pediatrics
Falls Church

Tracy Walters
Virginia DBHDS
Richmond

Jackie Winkelvoss, RN
Capital Area Pediatrics
Oakton

slide 2 of 2

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Hub Faculty

Questions?
projectecho@vmap.org

Beth Ellen Davis, MD
Moderator

Jacqueline Cotton, MD
Pediatrics

Mary Margaret Gleason, MD
Child Psychiatry

Michael Mintz, Psy.D
Psychology

Polly Panitz, MD
Developmental Pediatrics

Tammy Taylor-Musoke, LCSW
LMHP

Robin Cummings, MSHA
Program Coordinator

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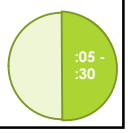
Trauma + ACEs- about gratitude

Jackie Cotton, MD
HUB Faculty, Pediatric Primary Care



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Objectives: promote understanding of:

- The science of early childhood trauma
- The barriers in identifying trauma in early childhood
- The call to action for pediatric clinicians

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The family is the patient

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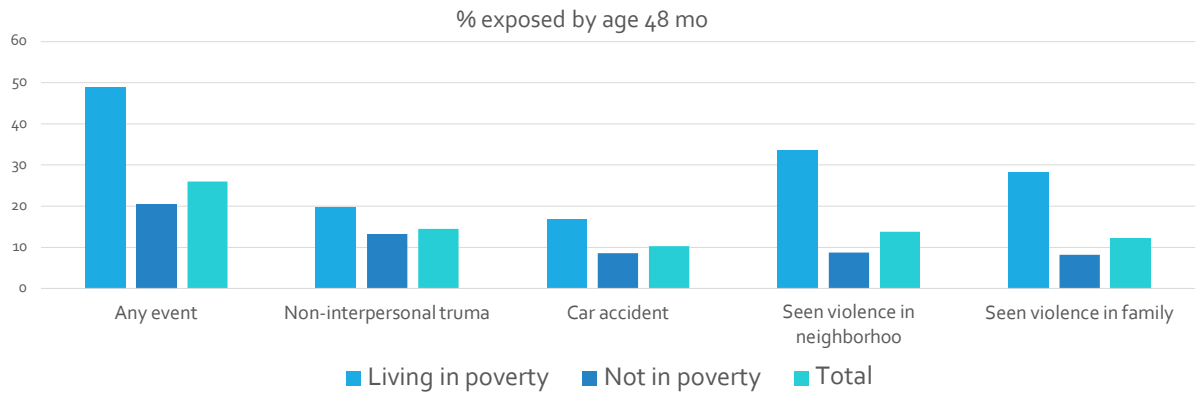
Prevalence of potentially traumatic events



Briggs-Gowan 2010 J Traumatic Stress

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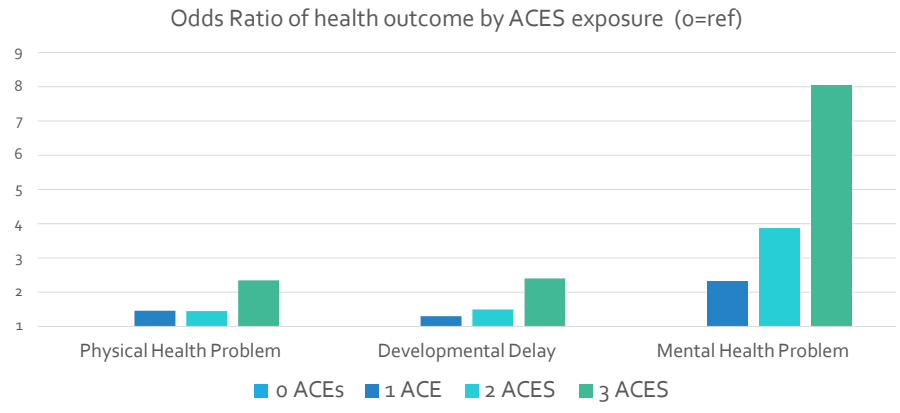
Early adversity and health outcomes by 5 years old



ACES

- *Divorce of a parent*
- *Death of a parent*
- *Domestic violence*
- *Living with someone with a drug or alcohol abuse problem*
- *Living with someone with mental illness*
- *Parent incarceration*
- *Neighborhood violence*
- *Discrimination*

Bright & Thompson 2017 JDBP

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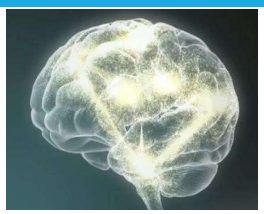
Developmental issues in preschoolers' emotional response to trauma



- Rapid brain development
- Cognitive, language, representational capacity
- Importance of caregiver child relationship as buffer or risk factor
- Adult/society minimizes trauma reactions
- **You might not know the trauma has happened! Traumatic events are associated with secrecy or shame.**
- **The brain is developing and timing matters!**

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The effects of childhood maltreatment on brain structure, function and connectivity

- Influence on trajectories of child brain development and a major factor for adult psychopathology
- Brain alterations are highly specific and depend on the type and timing of exposure
- identifiable changes in volume of hippocampus and other areas, may be an unrecognized confound in neuroimaging
- alters the development of sensory systems that process and convey stressful experiences
- Review looks at consistent reports of augmented amygdala response to threat, decreased ventral striatal response to reward, decreased connectivity between prefrontal cortex and amygdala
- Nat Rev Neurosci, 2016 Sep 19; 17(10): 652-66

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neuroimaging

- Maltreated and nonmaltreated individuals with the same primary psychiatric diagnosis differ clinically, neurobiologically, and genetically so maltreatment may be an unrecognized confound in neuroimaging studies.
- Maltreatment associated brain changes are frequently reported in resilient individuals with no past or current symptoms. These individuals probably have neurobiological or molecular alterations that enable them to compensate for stress-related neurobiological alterations.

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Neuroplasticity in Early Childhood

Intervene early !! Before the neurobiological circuits and physiologic responses to early adversity are embedded, interwoven with altered behavioral and social-emotional regulation, and ultimately less modifiable.

Role for developmental scaffolding: family, community, and systemic level factors combine to keep mental health development on track, even in the face of risks

Pediatrics, Volume 149, Supplement 5, May, 2022

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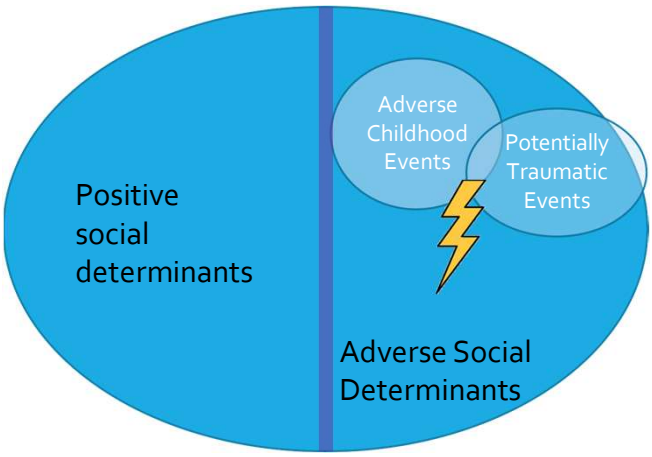
Talking about things that happen to young children….



- **Social determinants of health**
  - Environmental, community, family, and individual factors that influence health outcomes
- **Adverse childhood experiences**
  - Experiences that can have adverse effects on a child's health (originally studies included 9 factors)
- **Potentially traumatic events/"trauma"**
  - Events that threaten child or loved ones' safety (DSM requires risk to life or serious injury)
- **Toxic Stress Response**
  - Physiologic and emotional response to events that overcome individual and family buffering capacity

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Nurture ~~versus~~ IS Nature

(POSITIVE) EARLY EXPERIENCES (NEGATIVE)

SHAPE THE ARCHITECTURE OF THE DEVELOPING BRAIN

(SOUND) MENTAL HEALTH (PROBLEMS)

Learning, Resilience, Coping, Social skills

Adult physical and mental health disorders substance use, poor education, even cancer

Garner A 2021, and Developingchild.Harvard.edu

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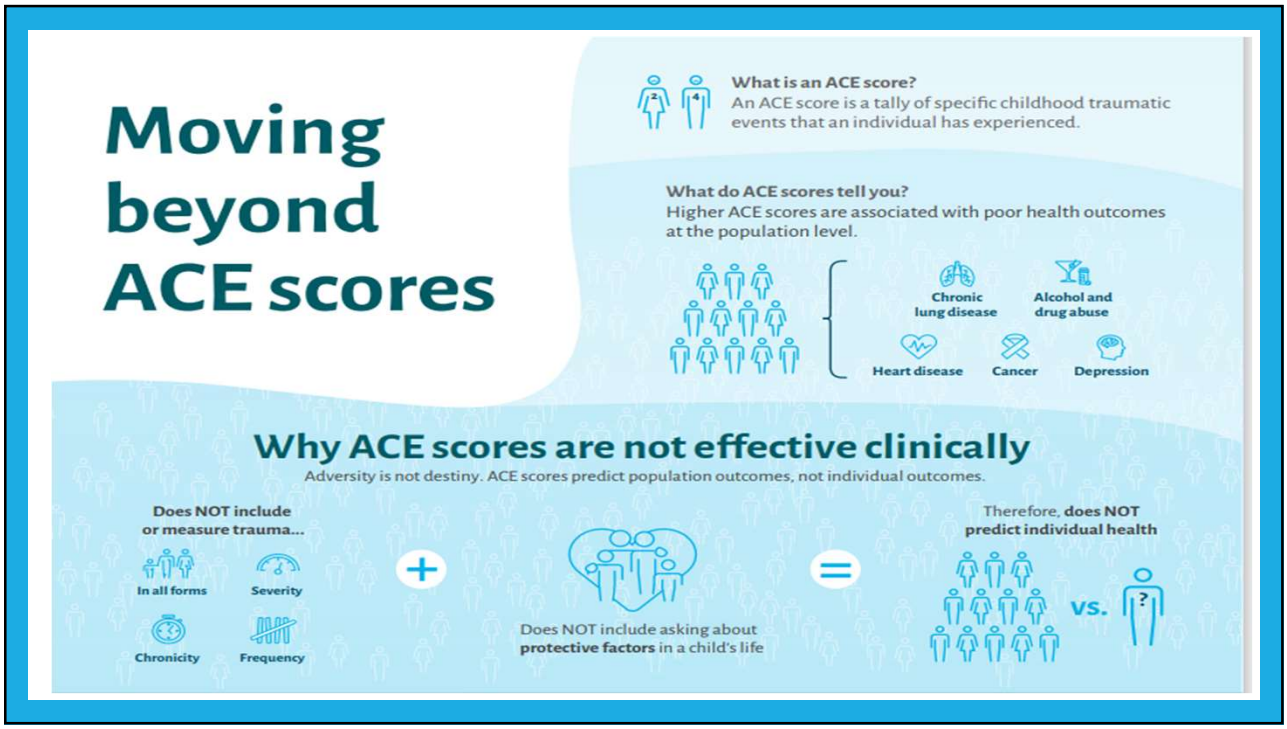
Moving beyond ACE scores
What is an ACE score?
An ACE score is a tally of specific childhood traumatic events that an individual has experienced.
What do ACE scores tell you?
Higher ACE scores are associated with poor health outcomes at the population level.
Chronic lung disease
Alcohol and drug abuse
Heart disease
Cancer
Depression
Why ACE scores are not effective clinically
Adversity is not destiny. ACE scores predict population outcomes, not individual outcomes.
Does NOT include or measure trauma...
In all forms
Severity
Chronicity
Frequency
Does NOT include asking about protective factors in a child's life
Therefore, does NOT predict individual health
vs.

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Provide Trauma-Informed Care
Move away from summing the suffering to building the buffering
GOAL
Fostering safe, stable, and nurturing relationships to build resiliency
Screen and treat for trauma-related symptoms
Create a safe environment
Use engagement strategies to build trust
Focus on strengths to empower patients and families
Have brief office-based approaches to promote growth mindset
American Academy of Pediatrics
PATTeR
Pediatric Approach to Trauma, Treatment and Resilience
For more information, visit:
aap.org/PATTeR
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Special thanks to Catherine Cyril

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The Family is the Patient: Promoting Early Childhood Mental Health in Pediatric Care

Wave our magic wand to support….

healthy family environments

Parent child relationships

Parents emotional / behavioral health

Family routines

→

Proactive, trauma informed, multidisciplinary care

Integrated mental health and social services embedded in primary care

Pediatrics (2022), 149 (supplement 5)

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Identifying adversity, ACES, and trauma

- NEED TO ASK (Caregiver and child)
  - ***Has anything scary happened to your child…like being in a car accident, seeing someone get hurt, being hurt themselves, or had an adult be inappropriate with them?***
  - *How has your child been affected by the events of 2020? The COVID-19 pandemic? How about issues of racial injustice and discrimination?*

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Screens for early life events and trauma

Adverse Social Determinants of Health	Safe Environment for Every Kid	SEEK.org
ACES	ACES Questionnaire	https://centerforyouthwellness.org/wp-content/uploads/2018/06/CYW-ACE-Q-CHILD-copy.pdf
The Pediatric ACEs and Related Life-events Screener (PEARLS)	**0-19 yrs. The PEARLS tool includes a screening for ACEs (Part 1) and additional adversities (Part 2).**	**PEARLS child tool (0-11) caregiver, adolescent tool (12-19) self and caregiver. Screening Tools | ACEs Aware – Take action. Save lives.**
Emotional response	Pediatric Emotional Distress Scale	Kramer et al. (2013) Pediatrics
Events and symptoms	Young Child PTSD Screen	https://medicine.tulane.edu/sites/g/files/rdw761/f/YCPC_v5_23_14.pdf

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General Social-Emotional Symptom Screens

Age	
Infants	Baby Preschool Pediatric Symptom Checklist Edinburgh or PHQ 2
Toddlers & Preschoolers	Brief Infant Toddler Social Emotional Assessment
	Early Childhood Screening Assessment -FREE
	Preschool Pediatric Symptom Checklist

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Why screen after adversity?

- Low identification rates after disasters:
  - *Fewer than half of parents of children with severe symptoms are concerned about their child's mental health after disaster*
- Low treatment rates:
  - *17% of children with symptoms received treatment after 9/11 (school age)*
- Reduces stigma and burden on family
- Highlight mental health's importance
- If Positive, can result in improved treatment access

Poulsen 2015

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Patient assessment

4Rs
Recognize
Respond
Resources
Refer

Case formulation
What is the atypical behavior?
What are predisposing factors?
What are your observations and screening?
What is the differential diagnosis?

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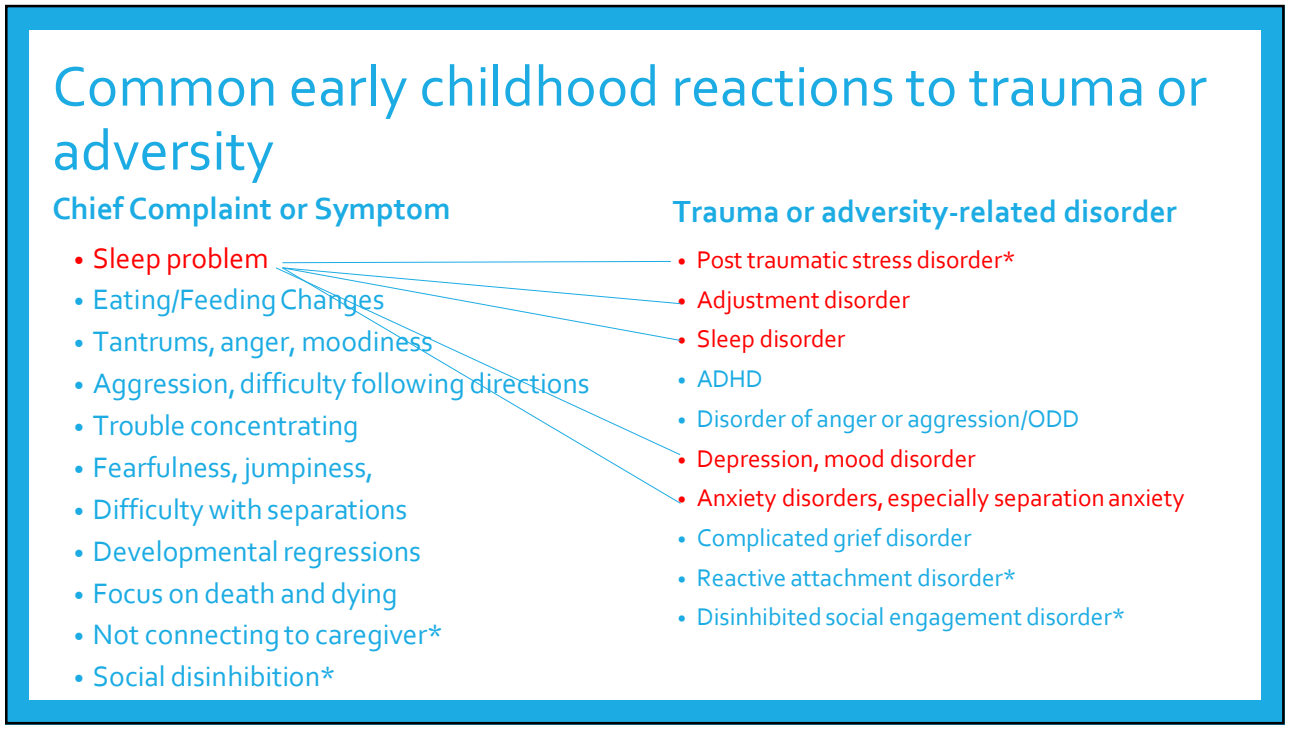
Common early childhood reactions to trauma or adversity



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Call to action for pediatric providers

A recent literature review identified 5 modifiable resilience factors relevant to clinical pediatric care:
(1) "addressing maternal mental health problems";
(2) "encouraging responsive, nurturing parenting";
(3) "building positive appraisal styles and executive function skills";
(4) "teaching children self-care skills and routines"; and
(5) "using trauma-focused interventions and educating families about trauma."

FROM THE AMERICAN ACADEMY OF PEDIATRICS| POLICY STATEMENT| AUGUST 01 2021
Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health
Andrew Garner, MD, PhD, FAAP;
Michael Yogman, MD, FAAP COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, SECTION ON DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS, COUNCIL ON EARLY CHILDHOOD
Pediatrics (2021) 148 (2): e2021052582.

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Core principles and priorities of intervention: ***early caregiving relationships modulate development of key stress-response systems that can promote well-being or pathologic responses***

1. Child emotional/behavioral health depends on a healthy family environment
2. Early relational health arises from positive, nurturing and stimulating early relationships
3. Parental Emotional/Behavioral Health is essential for a healthy family environment
4. Healthy family routines promote healthy environments
5. Trauma informed care promotes health and well-being

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Pediatric interventions:

- 1. respond with openness and calm
- 2. let parents know that these events are common and you have seen other children who have experienced adversity
- 3. review self care to regain normalcy- sleeping, eating, exercise
- 4. encourage healthy routines (collaborative goal setting)
- 5. teach relaxation strategies: square breathing, strong4life.com

Identifying, Treating, and Referring Traumatized Children: The Role of Pediatric Providers, Arch Pediatr Adolesc Med. 2008;162(5), 447-452

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Pediatrics, June edition

ACES among US Adolescents over the course of the COVID-19 Pandemic: nationwide longitudinal study with 2 waves; nearly 1/3 adolescents experienced experienced a new ACE between survey waves. Having greater than or equal to 4 ACEs by wave 1 increased the likelihood of new ACEs by Wave 2.

Re-imagining No-Shows as a Symptom and not a Diagnosis: A Strength Based, Trauma Sensitive Approach- understand barriers including trauma, change charting to "she/he no showed because…" and invest in building a relationship

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PTSD in Preschoolers

- **Exposure**
  - Experience, witness, OR hear about event that happened to caregiver (but not media exposure)
- **Re-experiencing (1+)**
  - Intrusive thoughts, recurrent dreams/nightmares, reexperiencing or replaying, distress at reminder, physiologic reaction at reminders
- **Avoidance (1+)**
  - Avoid reminders/places/people; decreased interest or engagement in significant activities, socially withdrawal, reduced positive affect
- **Arousal (2+)**
  - Irritability/temper tantrums, hypervigilance, exaggerated startle response, concentration problems, sleep problems

Does not get better by itself

Does respond to Trauma-focused CBT

Mostly studied in children 3-6

DSM-5, APA 2013; Scheeringa et al 1996; 1997

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Disorders of Attachment

- ✓ 9 month dev age
- ✓ Age of onset < 5 years old
- ✓ Pathogenic care
- ✓ Emotional or physical neglect, caregiving disruptions, institutional care

Reactive Attachment Disorder

- Limited comfort-seeking or response to comfort
- 2+ o f
  - Difficulty being comforted
  - Limited joy sharing
  - Negative affect

Disinhibited Social Engagement Disorder (2+)

- Little reticence approaching and interacting with unfamiliar adults
- Overly familiar behavior/limited boundaries
- Little-no checking back with adult caregiver after venturing away
- Would go off with an unfamiliar adult
- Not just impulsivity from ADHD

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Primary care front line tools

- **Check in with yourself**
- **Protect child/Develop team**
  - Engage caregiver as appropriate
  - Child protection services as appropriate
  - Ensure physical and emotional safety
  - Mobilize appropriate support services for child/children and family
- **Educate**
  - Ensure relevant caregivers are aware of potentially traumatic events
  - Educate caregivers re: potential for secondary traumatization
  - Provide family stress management information
- **Plan**
  - Plan for close follow-up

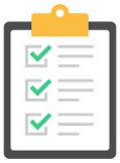

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Figure 2. Strategies to Regulate the Stress Response

Sources: Bhushan D, et al. The Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health. Office of the California Surgeon General, 2020 DOI:10.48019/PEAM8812; Gilgoff et al. Adverse Childhood Experiences, Outcomes, and Interventions. *Pediatric Clinics* 2020; **67**(2): 259-73.

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Relaxation strategies: Breathing

- Diaphragmatic breathing
  - Slow, deep breaths in, slow breath out
- In office strategies
  - PCP records relaxation script on parent phone
  - Bubbles
  - Blow the tissue and keep it horizontal for as long as possible
  - Breathing with pulse ox on (focus on decreasing HR)
- At home coaching: Monster Meditations, Sesame Street in Communities

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When to think about intervention

- Impairment > 2 weeks
- Preoccupation with death
- Playing out elements of the trauma
- New behavioral disturbances – especially in specific contexts
- New onset sleep problems and nightmares
- New school or child care problems
- Caregiver distress

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Build resilience by linking to meet basic and family clinical needs

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Specialty treatments for children exposed to trauma

Therapies

- Therapies for children exposed to trauma
  - Trauma-focused CBT (3 and up)
  - (Play therapy focused on developing a narrative)
  - Dyadic treatments
    - Child Parent Psychotherapy
    - Attachment biobehavioral catchup
  - Behavioral approach
    - Parent Child Interaction Therapy

Medications

- No RCTs
- Open trial alpha agonist (N=7) for maltreated children
- Consider pharmacotherapy for sleep if needed
- If ADHD not responsive to therapy, consider stimulant

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First line interventions in primary care: Communication (HELP!)

(AAP 2011; Wissow et al 2008; Gadowski 2011)

- H- ope
- E- mpathy
- L-anguage
- L-oyalty
- P-ermission
- P-artnership
- P-lan

- Better child mental health outcomes
- Decreased parent mental health symptoms
- No difference in time spent with patients

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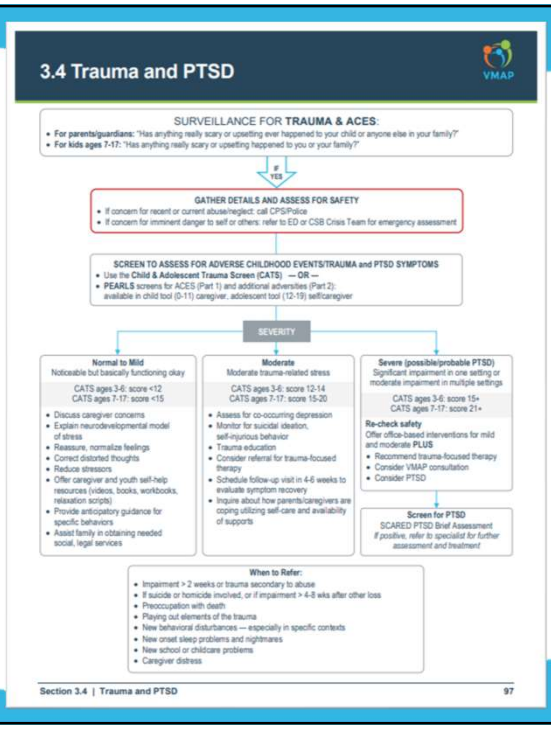
VMAP Care Guide

www.vmap.org/guidebook

- Child and Adolescent Trauma Screen (CATS)
- SCARED Brief
- Evidence-based behavioral interventions
- Provider tips & clinical pearls
- “After the Trauma: Helping My Child Cope”



3.4 Trauma and PTSD

VMAP

SURVEILLANCE FOR **TRAUMA & ACES**:

- **For parents/guardians:** "Has anything really scary or upsetting ever happened to your child or anyone else in your family?"
- **For kids ages 7-17:** "Has anything really scary or upsetting happened to you or your family?"

IF YES

GATHER DETAILS AND ASSESS FOR SAFETY

- If concern for recent or current abuse/neglect: call CPS/Police
- If concern for imminent danger to self or others: refer to ED or CSB Crisis Team for emergency assessment

SCREEN TO ASSESS FOR ADVERSE CHILDHOOD EVENTS/TRAUMA and PTSD SYMPTOMS

- Use the **Child & Adolescent Trauma Screen (CATS)** — OR —
- **PEARLS** screens for ACES (Part 1) and additional adversities (Part 2): available in child tool (0-11) caregiver, adolescent tool (12-19) self/caregiver

SEVERITY

Normal to Mild
Noticeable but basically functioning okay
CATS ages 3-6: score <12
CATS ages 7-17: score <15

- Discuss caregiver concerns
- Explain neurodevelopmental model of stress
- Reassure, normalize feelings
- Correct distorted thoughts
- Reduce stressors
- Offer caregiver and youth self-help resources (videos, books, workbooks, relaxation scripts)
- Provide anticipatory guidance for specific behaviors
- Assist family in obtaining needed social, legal services

Moderate
Moderate trauma-related stress
CATS ages 3-6: score 12-14
CATS ages 7-17: score 15-20

- Assess for co-occurring depression
- Monitor for suicidal ideation, self-injurious behavior
- Trauma education
- Consider referral for trauma-focused therapy
- Schedule follow-up visit in 4-6 weeks to evaluate symptom recovery
- Inquire about how parents/caregivers are coping utilizing self-care and availability of supports

Severe (possible/probable PTSD)
Significant impairment in one setting or moderate impairment in multiple settings
CATS ages 3-6: score 15+
CATS ages 7-17: score 21+

Re-check safety
Offer office-based interventions for mild and moderate **PLUS**

- Recommend trauma-focused therapy
- Consider VMAP consultation
- Consider PTSD

Screen for PTSD
SCARED PTSD Brief Assessment
If positive, refer to specialist for further assessment and treatment

When to Refer:

- Impairment > 2 weeks or trauma secondary to abuse
- If suicide or homicide involved, or if impairment > 4-8 wks after other loss
- Preoccupation with death
- Playing out elements of the trauma
- New behavioral disturbances — especially in specific contexts
- New onset sleep problems and nightmares
- New school or childcare problems
- Caregiver distress

Section 3.4 | Trauma and PTSD 97

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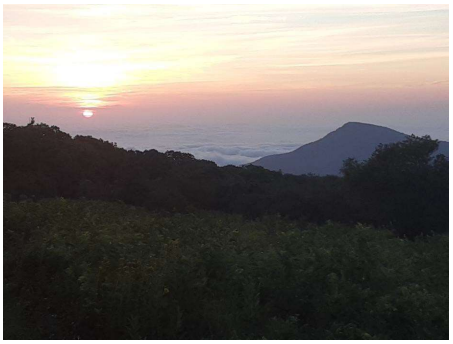
Remember gratitude!

- Young children are at high risk of experiencing traumatic events- adversity is not destiny
- Early childhood brain development means there is a sweet spot for intervention
- Always consider trauma or adversity when children are presenting with emotional or behavioral symptoms
- The science of the developing brain is a primary care call to action, and we can support families to change the future



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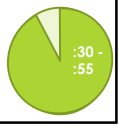
Case Presentation

Jadig Garcia, PhD
The Pediatric Center
Richmond



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2y,1m (at time seen) male presenting with behavioral concerns post-trauma	
Prior medical, MH dx	• No significant medical history with the exception of eczema • Family recently moved to area; no previous records were/are available in chart.

Symptoms	• Presented to Saturday clinic for follow up. Was treated in the ER after being assaulted at daycare by another peer during naptime.
	  • *Bite marks (on his back)*
	  • *Multiple abrasions (scratches on face and neck)*
	  • *Bruising*
	• ER gave family antibiotics for the abrasions. During the Saturday clinic visit there were no "atypical" behaviors noted but family referred to behavioral health services. (This was only 1-2 days after the incident.)
	• Seen by Psychologist (me) approximately 1.5 weeks after assault. Following symptoms reported:
	  • *Increased aggression (biting and hitting)- daily and throughout the day*
	  • *Isolating (described as going to corners of the room by himself)*
	  • *Bringing up incident frequently and unprompted ("____ Hurt")*
	  • *Increased difficulties being soothed (not present before)*

Related family/ social hx	• No reported ACEs. No additional trauma reported. • Pt. lives with mother & father. • Additional family support includes maternal grandparents who provided support for the family when pt. was pulled from daycare after the incident.
Other settings	• Incident occurred at day care. Family pulled child from daycare immediately; police and lawyers involved due to nature of the incident. CPS complaint against school filed. No behavioral concerns reported at daycare • Patient had only been at daycare for a short amount of time prior to incident).

CONSULT QUESTION:

As a primary care provider, what are symptoms and signs to look for and what questions/ screeners should be used to ensure that trauma is not missed?

When symptoms are severe for a younger child (5 and under) what are some suggestions for medical providers outside of referral to behavioral health/therapy?

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Wrap-up

Our next session…	
Topic:	Autism
Date:	Thursday, July 27 @ 12:00 to 1:00 PM
Case presenter:	Paula Labriola, MD
Didactic presenter:	Polly Panitz, MD

Today's session recording will be posted to the cohort webpage @ http://www.virginiapediatrics.org/vmap/echo/

VMAP ECHO 23 Deeper Dive → Password = 2019VMAP

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