Case ID#____________
Therapist ID#____________

PATS Clinical Packet

We are excited to hear that you may have a potential case for TF-CBT! Enclosed in this packet are the information, forms, and measures needed for tracking and evaluating your case throughout treatment. Your PATS Therapist ID and your PATS Case ID should already be included on each of the measures in the packet. All forms and measures should be returned to your Program Coordinator upon completion. Please contact your Program Coordinator or clinical consultant with any questions or concerns.

PATS Clinical Training Model

As part of PATS, we are training clinicians in how to use, score, and interpret three standardized assessment measures (see list below) to help clinicians form evidence-driven diagnostic impressions, make decisions about treatment eligibility for TF-CBT, aid in treatment planning, and track children's symptom improvement to learn how to alter treatment course and response.

In order to learn a new skill set and institute a new clinical practice, clinicians need practice opportunities, ongoing training, instrumental assistance, and support. Thus, as a part of PATS training in clinical assessment, we encourage you to administer the assessment measures at several points in treatment, with more than one child/family. Remember, as part of PATS, each clinician has agreed to implement TF-CBT with at least one case.

As you learn how to score and interpret the measures, we will help to double-check your scoring, answer your questions, and provide on-going assistance. The Program Coordinator will provide you with immediate feedback about your scoring so that you can confidently use these tools in your practice and master your skills. Your clinical consultants will provide on-going assistance in interpreting these measures to help guide your clinical practice.
Incorporating new measures into your daily clinical operations and altering your clinical practice might be daunting at first, just as with any new clinical operation. As a PATS "champion," you are challenged to find creative ways to learn and practice these new skills, while balancing paper work and high caseloads. PATS faculty and consultants are here to help with this challenge and will provide you continuing support as you engage in this learning process.

Finally, we would like to remind you that PATS is not a research project, but a clinical implementation project that provides training and support to clinicians who are trying to incorporate new evidence-based assessment and treatment practices into their work with traumatized children and families. We hope you find this training valuable in your daily practice when delivering services to children and families.

Case ID#___________
Therapist ID#____________

For PATS cases, you will be administering the assessment measures at several time-points:

- Before you begin treatment (**I. Pre-Treatment Clinical Assessment Tools**) to help make the final decision about eligibility for TF-CBT.
- At the conclusion of treatment (**II. Post-Treatment Clinical Assessment Tools)** to provide information about symptom improvement over the course of treatment.

I. Pre-Treatment Clinical Assessment Tools:

We strongly recommend that the family complete these measures at the next session to assist with treatment planning and to determine if TF-CBT is, in fact, appropriate. Please score the measures and return them to your Site Coordinator as soon as possible to ensure feedback prior to your next session with the family.

The following tools are included in this section:

- ☐ Trauma Screen- Child/Adolscent (appropriate for youth age 8-18 to complete as self-report)
- ☐ Trauma Screen- Parent (appropriate for parents to complete about youth ages 4-18)
- ☐ CPSS Child/Adolescnet (appropriate for youth age 8-18 to complete as self-report)
- ☐ CPSS Parent (appropriate for parents to complete about youth ages 4-18)
- ☐ Moods and Feelings Questionnaire – Child Version [completed by child]
- ☐ Moods and Feelings Questionnaire – Parent Version [completed by parent/caregiver **about child**]

II. Post-Treatment Clinical Assessment Tools:

Families complete the Post-Treatment Clinical Assessment Tools to provide information about symptom improvement over the course of treatment. Clinicians re-administer all measures to their identified PATS cases at the final treatment session. In addition, please administer the **Client Satisfaction Questionnaire** and **TF-CBT Services Questionnaire** (parent and child versions), included in this packet. Please score all post-treatment clinical assessment measures and return them to your Program Coordinator or Site Coordinator within two weeks of completion of treatment.

Treatment Fidelity:

To assist in monitoring use of and completion of TF-CBT components throughout treatment for your identified PATS cases, you will be asked to fill out a web-based **TF-CBT Brief Practice Checklist (BPC)** survey on a weekly basis. This survey asks about which TF-CBT components you used in your sessions. This will be simple!

Each Friday, you will receive an email with a direct link to Survey Monkey. The survey should take approximately 5 minutes to fill out per case. *We ask that you fill it out as soon as possible so that the information from your weekly session(s) is fresh in your mind.* In this packet, we have also included a paper version of the BPC if you would like to print it out and place it in your chart to help you track your use of the components. Your Site Coordinator will assist you in any way.

Termination of Services:

Upon termination of services of your identified PATS cases, please complete the **Client Treatment Exit Form** and return to the Program Coordinator within two weeks of the final clinical encounter. This form should be completed for all PATS cases, regardless of why and when the client exited treatment, including those who left treatment early, relocated, or successfully completed TF-CBT.

To assist with understanding time-frames and the process of tracking cases, this packet also includes a **Clinical Assessment Summary Table: PATS**. Further, your Program Coordinator will provide you with reminders of the assessment intervals and help you track administration of measures.

Thank you!

Client ID#____________ Therapist ID#_____________ Date:_____________

SHORT MOOD AND FEELINGS QUESTIONNAIRE

Self-Report Version

This form is about how you might have been feeling or acting recently.

For each question, please check how much you have felt or acted this way *in the past two weeks*.

If a sentence was true about you most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about you, check NOT TRUE.

	True **2**	**Sometimes** **1**	**Not True** **0**
1. I felt miserable or unhappy.	☐	☐	☐
2. I didn't enjoy anything at all.	☐	☐	☐
3. I felt so tired I just sat around and did nothing.	☐	☐	☐
4. I was very restless.	☐	☐	☐
5. I felt I was no good any more.	☐	☐	☐
6. I cried a lot.	☐	☐	☐
7. I found it hard to think properly or concentrate.	☐	☐	☐
8. I hated myself.	☐	☐	☐
9. I was a bad person.	☐	☐	☐
10. I felt lonely.	☐	☐	☐
11. I thought nobody really loved me.	☐	☐	☐
12. I thought I could never be as good as other kids.	☐	☐	☐
13. I did everything wrong.	☐	☐	☐

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Client ID#____________ Therapist ID#_____________ Date:_____________

SHORT MOOD AND FEELINGS QUESTIONNAIRE

Parent Report Version

This form is about how your child might have been feeling or acting recently.

For each question, please check how much she or he has felt or acted this way *in the past two weeks*.

If a sentence was true about your child most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about your child, check NOT TRUE.

	True **2**	**Sometimes** **1**	**Not True** **0**
1. S/he felt miserable or unhappy.	☐	☐	☐
2. S/he didn't enjoy anything at all.	☐	☐	☐
3. S/he felt so tired s/he just sat around and did nothing.	☐	☐	☐
4. S/he was very restless.	☐	☐	☐
5. S/he felt s/he was no good any more.	☐	☐	☐
6. S/he cried a lot.	☐	☐	☐
7. S/he found it hard to think properly or concentrate.	☐	☐	☐
8. S/he hated him/herself.	☐	☐	☐
9. S/he felt s/he was a bad person.	☐	☐	☐
10. S/he felt lonely.	☐	☐	☐
11. S/he thought nobody really loved him/her.	☐	☐	☐
12. S/he thought s/he could never be as good as other kids.	☐	☐	☐
13. S/he felt s/he did everything wrong.	☐	☐	☐

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= Trauma Screen

Name____________________________ Date______________

Stressful or scary events happen to many kids. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to you. Mark No if it didn't happen to you.

1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire. ☐ Yes ☐ No
2. Serious accident or injury like a car/bike crash, dog bite, sports injury. ☐ Yes ☐ No
3. Robbed by threat, force or weapon. ☐ Yes ☐ No
4. Slapped, punched, or beat up in your family. ☐ Yes ☐ No
5. Slapped, punched, or beat up by someone not in your family. ☐ Yes ☐ No
6. Seeing someone in your family slapped, punched or beat up. ☐ Yes ☐ No
7. Seeing someone in the community slapped, punched or beat up. ☐ Yes ☐ No
8. Someone older touching your private parts when they shouldn't. ☐ Yes ☐ No
9. Someone forcing or pressuring sex, or when you couldn't say no. ☐ Yes ☐ No
10. Someone close to you dying suddenly or violently. ☐ Yes ☐ No
11. Attacked, stabbed, shot at or hurt badly. ☐ Yes ☐ No
12. Seeing someone attacked, stabbed, shot at, hurt badly or killed. ☐ Yes ☐ No
13. Stressful or scary medical procedure. ☐ Yes ☐ No
14. Being around war. ☐ Yes ☐ No
15. Other stressful or scary event? ☐ Yes ☐ No
    Describe: ____

Which one is bothering you the most now? ___________________

If you answered **NO** to all of the above questions, ***STOP***
If you answered **YES** to any of the above questions, please complete the rest of this form

When the event happened, did you feel?

Afraid I would die or be hurt badly. ☐ Yes ☐ No

Afraid someone else would die or be hurt badly. ☐ Yes ☐ No

Helpless to do anything. ☐ Yes ☐ No

Ashamed or disgusted. ☐ Yes ☐ No

Client ID: ___________ Therapist ID: ____________ Date: _____________

CHILD PTSD Symptom Scale (CPSS) - 7-17 years

Mark 0, 1, 2 or 3 for how often the following things have bothered you in the last two weeks:

0 Never
1 Once in a while
2 Half the time
3 Almost always

1.	Having upsetting thoughts or images about the event that came into your head when you didn't want them to.	0	1	2	3
2.	Having bad dreams or nightmares.	0	1	2	3
3.	Acting or feeling as if the event was happening again.	0	1	2	3
4.	Feeling upset when you think about or hear about the event.	0	1	2	3
5.	Having feelings in your body when you think about or hear about the event. (Heart beating fast, upset stomach, breaking out in a sweat)	0	1	2	3
6.	Trying not to think about, talk about or have feelings about the event.	0	1	2	3
7.	Trying to avoid activities or people, or places that remind you of the event.	0	1	2	3
8.	Not being able to remember an important part of the upsetting event.	0	1	2	3
9.	Having much less interest or not doing the things you used to do.	0	1	2	3
10.	Not feeling too close to the people around you.	0	1	2	3
11.	Not being able to have strong feelings (being able to cry or feel really happy).	0	1	2	3
12.	Feeling as if your future hopes or plans will not come true.	0	1	2	3
13.	Having trouble falling or staying asleep.	0	1	2	3
14.	Feeling irritable or having fits of anger.	0	1	2	3
15.	Having trouble concentrating.	0	1	2	3
16.	Being overly careful (checking to see who is around you).	0	1	2	3
17.	Being jumpy or easily startled.	0	1	2	3

Please mark YES or NO if the problems you marked interfered with:

1. Saying prayers	D Yes	D No	5. Schoolwork	D Yes	D No
2. Doing chores	D Yes	D No	6. Family relationships	D Yes	D No
3. Friendships	D Yes	D No	7. General happiness	D Yes	D No
4. Hobbies/Fun	D Yes	D No			

Client ID: ___________ Therapist ID:________ Date: ____________

CPSS Scoring Form- CHILD

CRITERION A – TRAUMATIC EVENT	PTSD SEVERITY – OVERALL SCORE
FROM THE TRAUMA SCREEN Exposure to Traumatic Event? **YES NO** Type of event most distressing: ____ **Criterion A1 met** Questions 1-15 at least 1 "Yes" answer **YES NO** **Criterion A2 met** At least one "Yes" answer below **YES NO** **Criterion A met** **YES NO**	**FROM THE CPSS SYMPTOM SCALE** **PTSD SEVERITY SCORE** Sum of questions 1-17: ________ **INTERFERENCE SCORE** Sum of questions 1-7: ________

CRITERION B – REEXPERIENCING	CRITERION C - AVOIDANCE
FROM THE CPSS SYMPTOM SCALE **REEXPERIENCING SEVERITY SCORE** Sum of questions 1-5: ________ **DSM-IV CRITERION B MET** # of questions 1-5 scores 2 or 3: _________ At least 1 question 1-5 score 2 or 3? **YES NO**	**FROM THE CPSS SYMPTOM SCALE** **AVOIDANCE SEVERITY SCORE** Sum of questions 6-12: ________ **DSM-IV CRITERION C MET** # of questions 6-12 scores 2 or 3: _________ At least 3 question 6-12 scores 2 or 3? **YES NO**

CRITERION D – INCREASED AROUSAL	DSM-IV PTSD DIAGNOSTIC INFO
FROM THE CPSS SYMPTOM SCALE **INCREASED AROUSAL SEVERITY SCORE** Sum of questions 13-17: ________ **DSM-IV CRITERION D MET** # of questions 13-17 scores 2 or 3: _________ At least 2 question 13-17 score 2 or 3? **YES NO**	**DSM-IV FULL PTSD DIAGNOSIS LIKELY** Criteria A, B, C, D all met **YES NO** **PARTIAL PTSD LIKELY** Criteria A, and 2 other criteria met **YES NO**

= Trauma Screen – Caregiver Completed

Name____________________________ Date______________

Stressful or scary events happen to many kids. Below is a list of stressful and scary events that sometimes happen. Please answer to the best of your knowledge. Mark YES if it happened to your child. Mark No if it didn't happen to your child.

1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire. ☐ Yes ☐ No
2. Serious accident or injury like a car/bike crash, dog bite, sports injury. ☐ Yes ☐ No
3. Robbed by threat, force or weapon. ☐ Yes ☐ No
4. Slapped, punched, or beat up in the family. ☐ Yes ☐ No
5. Slapped, punched, or beat up by someone not in the family. ☐ Yes ☐ No
6. Seeing someone in the family slapped, punched or beat up. ☐ Yes ☐ No
7. Seeing someone in the community slapped, punched or beat up. ☐ Yes ☐ No
8. Someone older touching your child's private parts when they shouldn't. ☐ Yes ☐ No
9. Someone forcing or pressuring sex, or when your child couldn't say no. ☐ Yes ☐ No
10. Someone close to your child dying suddenly or violently. ☐ Yes ☐ No
11. Attacked, stabbed, shot at or hurt badly. ☐ Yes ☐ No
12. Seeing someone attacked, stabbed, shot at, hurt badly or killed. ☐ Yes ☐ No
13. Stressful or scary medical procedure. ☐ Yes ☐ No
14. Being around war. ☐ Yes ☐ No
15. Other stressful or scary event? ☐ Yes ☐ No
    Describe: ____

Which one is bothering him/her the most now? ______________

If you answered **NO** to all of the above questions, ***STOP***
If you answered **YES** to any of the above questions, please complete the rest of this form.

When the event happened, did your child feel?

Afraid s/he would die or be hurt badly. ☐ Yes ☐ No

Afraid someone else would die or be hurt badly. ☐ Yes ☐ No

Helpless to do anything. ☐ Yes ☐ No

Ashamed or disgusted. ☐ Yes ☐ No

Client ID: ___________ Therapist ID: ____________ Date: _____________

Child PTSD Symptom Scale CPSS (4-17 years) Caregiver Completed

Mark 0, 1, 2 or 3 for how often the following things have bothered your child in the last two weeks:

0 Never
1 Once in a while
2 Half the time
3 Almost always

1.	Your child having unwanted, upsetting thoughts or images about the traumatic event .	0	1	2	3
2.	Your child having bad dreams or nightmares.	0	1	2	3
3.	Your child acting or feeling as if the event were happening again.	0	1	2	3
4.	Your child feeling upset when s/he thinks about or hears about the event.	0	1	2	3
5.	Your child having feelings in the body when thinking or hearing about the event.(Heart beating fast, upset stomach, breaking out in a sweat).	0	1	2	3
6.	Your child trying not to think about, talk about or have feelings about the event.	0	1	2	3
7.	Your child trying to avoid activities or people, or places that remind you of the event.	0	1	2	3
8.	Your child not being able to remember an important part of the upsetting event.	0	1	2	3
9.	Your child having much less interest or not doing the things s/he used to do.	0	1	2	3
10.	Your child not feeling too close to the people around him/her.	0	1	2	3
11.	Your child not being able to have strong feelings (being able to cry or feel really happy).	0	1	2	3
12.	Your child feeling as if his/her future hopes or plans will not come true.	0	1	2	3
13.	Your child having trouble falling or staying asleep.	0	1	2	3
14.	Your child feeling irritable or having fits of anger.	0	1	2	3
15.	Your child having trouble concentrating.	0	1	2	3
16.	Your child being overly careful (checking to see who is around).	0	1	2	3
17.	Your child being jumpy or easily startled.	0	1	2	3

Please mark YES or NO if the problems above interfered with the following:

1. Saying prayers	D Yes	D No	5. Schoolwork	D Yes	D No
2. Doing chores	D Yes	D No	6. Family relationships	D Yes	D No
3. Friendships	D Yes	D No	7. General happiness	D Yes	D No
4. Hobbies/Fun	D Yes	D No			

Client ID: __________ Therapist ID:________ Date: ___________

CPSS Scoring Form- CAREGIVER

CRITERION A – TRAUMATIC EVENT	PTSD SEVERITY – OVERALL SCORE
FROM THE TRAUMA SCREEN Exposure to Traumatic Event? **YES NO** Type of event most distressing: _______________________________________ **Criterion A1 met** Questions 1-15 at least 1 "Yes" answer **YES NO** **Criterion A2 met** At least one "Yes" answer below **YES NO** **Criterion A met** **YES NO**	**FROM THE CPSS SYMPTOM SCALE** **PTSD SEVERITY SCORE** Sum of questions 1-17: ________ **INTERFERENCE SCORE** Sum of questions 1-7: ________

CRITERION B – REEXPERIENCING	CRITERION C - AVOIDANCE
FROM THE CPSS SYMPTOM SCALE **REEXPERIENCING SEVERITY SCORE** Sum of questions 1-5: ________ **DSM-IV CRITERION B MET** # of questions 1-5 scores 2 or 3: _________ At least 1 question 1-5 score 2 or 3? **YES NO**	**FROM THE CPSS SYMPTOM SCALE** **AVOIDANCE SEVERITY SCORE** Sum of questions 6-12: ________ **DSM-IV CRITERION C MET** # of questions 6-12 scores 2 or 3: _________ At least 3 question 6-12 scores 2 or 3? **YES NO**

CRITERION D – INCREASED AROUSAL	DSM-IV PTSD DIAGNOSTIC INFO
FROM THE CPSS SYMPTOM SCALE **INCREASED AROUSAL SEVERITY SCORE** Sum of questions 13-17: ________ **DSM-IV CRITERION D MET** # of questions 13-17 scores 2 or 3: _________ At least 2 question 13-17 score 2 or 3? **YES NO**	**DSM-IV FULL PTSD DIAGNOSIS LIKELY** Criteria A, B, C, D all met **YES NO** **PARTIAL PTSD LIKELY** Criteria A, and 2 other criteria met **YES NO**