The University of Arkansas for Medical Sciences
Trauma Clinical Practice Management Guideline

SUBJECT: Mental Health Screening and Referral

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PURPOSE: To define a process of posttraumatic stress disorder (PTSD) and depression screening and intervention in an inpatient trauma population

POLICY: Trauma patients will be screened for PTSD and depression before discharge.

BACKGROUND:
"All trauma centers must meet the mental health needs of trauma patients by having: A protocol to screen patients at high risk for psychological sequelae with subsequent referral to a mental health provider (LI, LII, PTCI, PTCII), and a process for referral to a mental health provider when required (LIII)." - ACS COT *Resources for Optimal Care of the Injured Patient.*

PROCEDURE:

- Trauma patients will be screened by the unit social worker for risk of post-injury PTSD and depression using the Injured Trauma Survivor Screen (ITSS) in the electronic medical record. Positive screens will initiate a consultation with the Trauma Surgery Psychology Consult Service. See Attachment A: ITSS Screening Tool.
- Any member of the trauma service may initiate a Trauma Psychology referral based on screening results or a clinical determination of need.
- Trauma Psychology will conduct a consultation and evaluation with the patient. If the patient's condition prevents participation in screening or the consultation, this will be documented in the medical record. The patient's condition will be monitored for improvement, and the patient will be contacted once the condition has improved.
- The psychological consultation and evaluation will determine subsequent intervention, which will be documented in the medical record. If the treatment plan requires follow-up after discharge, the plan will be documented.
- Screening results and consultation completion will be recorded in the trauma registry.
- For patients requiring psychiatric follow-up, Trauma Psychology will defer treatment to, or collaborate with, the Psychiatry CL team to meet the patient's needs during admission. See Attachment B: Inpatient Psychology and Psychiatry Service for Trauma Patients.

REFERENCES:

1. ACS Committee on Trauma. *Resources for Optimal Care of the Injured Patient*. July 2025 Update. Available from: https://www.facs.org/-/media/files/quality-programs/trauma/tqp/2022_vrc_injured-patient-standardsmanual_final.
2. Hunt JC, et al. (2017) Utility of the Injured Trauma Survivor Screen to Predict PTSD and Depression During Hospital Admission. Journal of Trauma and Acute Care Surgery, 82 (1), 93-101.

Attachment A:

Injured Trauma Survivor Screen (ITSS)

Injured Trauma Survivor Screen (ITSS)

1 = Yes 0 = No

Before this injury	PTSD	DEP
1. Have you ever taken medication for, or been given a mental health diagnosis?		1 0
2. Has there ever been a time in your life you have been bothered by feeling down or hopeless or lost all interest in things you usually enjoyed for more than 2 weeks?		1 0
When you were injured or right afterward		
3. Did you think you were going to die?	1 0	1 0
4. Do you think this was done to you intentionally?	1 0	
Since your injury		
5. Have you felt emotionally detached from your loved ones?		1 0
6. Do you find yourself crying and are unsure why?		1 0
7. Have you felt more restless, tense or jumpy than usual?	1 0	
8. Have you found yourself unable to stop worrying?	1 0	
9. Do you find yourself thinking that the world is unsafe and that people are not to be trusted?	1 0	
≥ 2 is positive for PTSD risk ≥ 2 is positive for Depression risk SUM =		

Attachment B:

Inpatient Psychology, Neuropsychology, and Psychiatry Services for Trauma Patients
The following serves as an overview of the reasons for referral to the trauma surgery psychology, inpatient neuropsychology, and psychiatry services for hospitalized trauma patients.

Inpatient Trauma Psychology Service – Service Director: Laura Rohm, Psy.D.

- Positive risk score on the Injured Trauma Survivor Screen (> 2 for depression and/or PTSD risk)
- Concerns about the patient's ability to cope with their injuries or hospitalization
- Mental health symptoms in need of behavioral health management (e.g., interfering with engagement in care)
- Traumatic grief or support in navigating difficult conversations with patients and families
- Assistance with providing family support
- Pre-existing mental health concerns exacerbated by the trauma or complicating recovery (may require collaboration with psychiatry)
- Suspected interpersonal violence, abuse, neglect resulting in injuries
- Screening and brief intervention for alcohol use

Note: 1 - The psychology team may recommend to the primary service to consult psychiatry if the patient is solely interested in addressing the above issues with psychotropic medication management (if appropriate); 2 – the decision to consult psychology should be in collaboration with the patient, and the patient should agree with this plan before the consult is placed.

Inpatient Neuropsychology Service – Service Director: Chrystal Fullen, PsyD

- Patients with TBI, SCI, or cognitive impairment and their families
- Confusion and/or disorientation
- Agitation or inappropriate behaviors
- Reduced awareness of injury/implications
- Persistent cognitive problems interfere with care
- Assistance with early cognitive rehabilitation
- Providing psychoeducation on TBI, SCI, treatment expectations, and community resources

Inpatient Psychiatry Consultation Liaison Service – Service Directors: Amy Grooms, MD; Samidha Tripathi, MD; Payton Lea, MD

- Known suicide attempt
- Medication evaluation for patients, particularly for patients with severe and persistent mental illness
- Delirium