Appendix to the Kentucky Model Protocol for Local Multidisciplinary Teams 2026

APPENDIX

Appendix A: Secondary Traumatic Stress Resources 3

Appendix B: Working with Interpreters Resource 17

Appendix C: Suicide Assessment and Prevention Resources 21

Appendix to the Kentucky Model Protocol for Local Multidisciplinary Teams 2026

APPENDIX A:
Secondary Traumatic Stress Resources

NCTSN The National Child Traumatic Stress Network

"...We are stewards not just of those who allow us into their lives but of our own capacity to be helpful...[1]"

Secondary Traumatic Stress

A Fact Sheet for Child-Serving Professionals

INTRODUCTION

Each year more than 10 million children in the United States endure the trauma of abuse, violence, natural disasters, and other adverse events.[2] These experiences can give rise to significant emotional and behavioral problems that can profoundly disrupt the children's lives and bring them in contact with child-serving systems. For therapists, child welfare workers, case managers, and other helping professionals involved in the care of traumatized children and their families, the essential act of listening to trauma stories may take an emotional toll that compromises professional functioning and diminishes quality of life. Individual and supervisory awareness of the impact of this indirect trauma exposure—referred to as secondary traumatic stress—is a basic part of protecting the health of the worker and ensuring that children consistently receive the best possible care from those who are committed to helping them.

Our main goal in preparing this fact sheet is to provide a concise overview of secondary traumatic stress and its potential impact on child-serving professionals. We also outline options for assessment, prevention, and interventions relevant to secondary stress, and describe the elements necessary for transforming child-serving organizations and agencies into systems that also support worker resiliency.

TABLE OF CONTENTS

Intoduction.. 1

SECTION ONE:
How Individuals Experience
Secondary Traumatic Stress ?......................2

SECTION TWO:
Understanding Who is at Risk.......................2

SECTION THREE:
Identifying Secondary Traumatic Stress 3

SECTION FOUR:
Strategies for Prevention..............................3

SECTION FIVE:
Strategies for Intervention...........................4

SECTION SIX:
Worker Resiliency in Trauma-informed
Systems: Essential Elements........................5

1 How Individuals Experience Secondary Traumatic Stress

Secondary traumatic stress is the emotional duress that results when an individual hears about the firsthand trauma experiences of another. Its symptoms mimic those of post-traumatic stress disorder (PTSD). Accordingly, individuals affected by secondary stress may find themselves re-experiencing personal trauma or notice an increase in arousal and avoidance reactions related to the indirect trauma exposure. They may also experience changes in memory and perception; alterations in their sense of self-efficacy; a depletion of personal resources; and disruption in their perceptions of safety, trust, and independence. A partial list of symptoms and conditions associated with secondary traumatic stress includes[3]

- **Hypervigilance**
- **Hopelessness**
- **Inability to embrace complexity**
- **Inability to listen, avoidance of clients**
- **Anger and cynicism**
- **Sleeplessness**
- **Fear**
- **Chronic exhaustion**
- **Physical ailments**
- **Minimizing**
- **Guilt**

Clearly, client care can be compromised if the therapist is emotionally depleted or cognitively affected by secondary trauma. Some traumatized professionals, believing they can no longer be of service to their clients, end up leaving their jobs or the serving field altogether. Several studies have shown that the development of secondary traumatic stress often predicts that the helping professional will eventually leave the field for another type of work.[4,5]

2 Understanding Who is at Risk

The development of secondary traumatic stress is recognized as a common occupational hazard for professionals working with traumatized children. Studies show that from 6% to 26% of therapists working with traumatized populations,and up to 50% of child welfare workers, are at high risk of secondary traumatic stress or the related conditions of PTSD and vicarious trauma.

Any professional who works directly with traumatized children, and is in a position to hear the recounting of traumatic experiences, is at risk of secondary traumatic stress. That being said, risk appears to be greater among women and among individuals who are highly empathetic by nature or have unresolved personal trauma. Risk is also higher for professionals who carry a heavy caseload of traumatized children; are socially or organizationally isolated; or feel professionally compromised due to inadequate training.[6,8] Protecting against the development of secondary traumatic stress are factors such as longer duration of professional experience, and the use of evidence-based practices in the course of providing care.[7]

Secondary Traumatic Stress and Related Conditions: Sorting One from Another

Secondary traumatic stress refers to the presence of PTSD symptoms caused by at least one indirect exposure to traumatic material. Several other terms capture elements of this definition but are not all interchangeable with it.

Compassion fatigue, a label proposed by Figley4 as a less stigmatizing way to describe secondary traumatic stress, has been used interchangeably with that term.

Vicarious trauma refers to changes in the inner experience of the therapist resulting from empathic engagement with a traumatized client.[13] It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another person's traumatic material. The primary symptoms of vicarious trauma are disturbances in the professional's cognitive frame of reference in the areas of trust, safety, control, esteem, and intimacy.

Burnout is characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general occupational stress; the term is not used to describe the effects of indirect trauma exposure specifically.

Compassion satisfaction refers to the positive feelings derived from competent performance as a trauma professional. It is characterized by positive relationships with colleagues, and the conviction that one's work makes a meaningful contribution to clients and society.

3 Identifying Secondary Traumatic Stress

Supervisors and organizational leaders in child-serving systems may utilize a variety of assessment strategies to help them identify and address secondary traumatic stress affecting staff members.

The most widely used approaches are informal self-assessment strategies, usually employed in conjunction with formal or informal education for the worker on the impact of secondary traumatic stress. These self-assessment tools, administered in the form of questionnaires, checklists, or scales, help characterize the individual's trauma history, emotional relationship with work and the work environment, and symptoms or experiences that may be associated with traumatic stress.[4,9]

Supervisors might also assess secondary stress as part of a reflective supervision model. This type of supervision fosters professional and personal development within the context of a supervisory relationship. It is attentive to the emotional content of the work at hand and to the professional's responses as they affect interactions with clients. The reflective model promotes greater awareness of the impact of indirect trauma exposure, and it can provide a structure for screening for emerging signs of secondary traumatic stress. Moreover, because the model supports consistent attention to secondary stress, it gives supervisors and managers an ongoing opportunity to develop policy and procedures for stress-related issues as they arise.

Formal assessment of secondary traumatic stress and the related conditions of burnout, compassion fatigue, and compassion satisfaction is often conducted through use of the Professional Quality of Life Measure (ProQOL).[7,8,10,11] This questionnaire has been adapted to measure symptoms and behaviors reflective of secondary stress. The ProQOL can be used at regular intervals to track changes over time, especially when strategies for prevention or intervention are being tried.

4 Strategies for Prevention

A multidimensional approach to prevention and intervention—involving the individual, supervisors, and organizational policy—will yield the most positive outcomes for those affected by secondary traumatic stress. The most important strategy for preventing the development of secondary traumatic stress is the triad of psychoeducation, skills training, and supervision. As workers gain knowledge and awareness of the hazards of indirect trauma exposure, they become empowered to explore and utilize prevention strategies to both reduce their risk and increase their resiliency to secondary stress. Preventive strategies may include self-report assessments, participation in self-care groups in the workplace, caseload balancing, use of flextime scheduling, and use of the self-care accountability buddy system. Proper rest, nutrition, exercise, and stress reduction activities are also important in preventing secondary traumatic stress.

PREVENTION

- Psychoeducation
- Clinical supervision
- Ongoing skills training
- Informal/formal self-report screening
- Workplace self-care groups (for example, yoga or meditation)
- Creation of a balanced caseload
- Flextime scheduling
- Self-care accountability buddy system
- Use of evidence-based practices
- Exercise and good nutrition

5 Strategies for Intervention

Although evidence regarding the effectiveness of interventions in secondary traumatic stress is limited, cognitive-behavioral strategies and mindfulness-based methods are emerging as best practices. In addition, caseload management, training, reflective supervision, and peer supervision or external group processing have been shown to reduce the impact of secondary traumaticstress. Many organizations make referrals for formal intervention from outside providers such as individual therapists or Employee Assistance Programs. External group supervision services may be especially important in cases of disasters or community violence where a large number of staff have been affected.

The following books, workbooks, articles, and self-assessment tests are valuable resources for further information on self-care and the management of secondary traumatic stress:

- Volk, K.T., Guarino, K., Edson Grandin, M., & Clervil, R. (2008). *What about You? A Workbook for Those Who Work with Others.* The National Center on Family Homelessness. http://508.center4si.com/SelfCareforCareGivers.pdf
- *Self-Care Assessment Worksheet* http://www.ecu.edu/cs-dhs/rehb/uploa Wellness_Assessment.pdf
- Hopkins, K. M., Cohen-Callow, A., Kim, H. J., Hwang, J. (2010). Beyond intent to leave: Using multiple outcome measures for assessing turnover in child welfare. *Children and Youth Services Review, 32*,1380-1387.
- Saakvitne, K. W., Pearlman, L. A., & Staff of TSI/CAAP. (1996). *Transforming the Pain: A Workbook on Vicarious Traumatization.* New York: W.W. Norton.
- Van Dernoot Lipsky, L. (2009). *Trauma Stewardship: An everyday guide to caring for self while caring for others.* San Francisco: Berrett-Koehler Publishers.
- Compassion Fatigue Self Test http://www.ptsdsupport.net/compassion_fatugue-selftest.html
- *ProQOL 5* http://proqol.org/ProQol_Test.html
- Rothschild, B. (2006). *Help for the helper. The psychophysiology of compassion fatigue and vicarious trauma.* New York: W.W. Norton.

INTERVENTION

Strategies to evaluate secondary stress

Cognitive behavioral interventions

Mindfulness training

Reflective supervision

Caseload adjustment

Informal gatherings following crisis events (to allow for voluntary, spontaneous discussions)

Change in job assignment or workgroup

Referrals to Employee Assistance Programs or outside agencies

6 Worker Resiliency in Trauma-informed Systems: Essential Elements

Both preventive and interventional strategies for secondary traumatic stress should be implemented as part of an organizational risk-management policy or task force that recognizes the scope and consequences of the condition. The Secondary Traumatic Stress Committee of the National Child Traumatic Stress Network has identified the following concepts as essential for creating a trauma-informed system that will adequately address secondary traumatic stress. Specifically, the trauma-informed system must

- Recognize the impact of secondary trauma on the workforce.
- Recognize that exposure to trauma is a risk of the job of serving traumatized children and families.
- Understand that trauma can shape the culture of organizations in the same way that trauma shapes the world view of individuals.
- Understand that a traumatized organization is less likely to effectively identify its clients' past trauma or mitigate or prevent future trauma.
- Develop the capacity to translate trauma-related knowledge into meaningful action, policy, and improvements in practices.

These elements should be integrated into direct services, programs, policies, and procedures, staff development and training, and other activities directed at secondary traumatic stress.

> *"We have an obligation to our clients, as well as to ourselves, our colleagues and our loved ones, not to be damaged by the work we do.[12]"*

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About the National Child Traumatic Stress Network

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

The National Child Traumatic Stress Network
Statement on Secondary Traumatic Stress
More information at https://www.nctsn.org/

Understanding Who is at Risk

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Strategies to Build Resiliency and Address STS

Organizational

- Provide adequate clinical supervision, including reflective supervision
- Maintain trauma caseload balance
- Support workplace self-care groups
- Enhance the physical safety of staff
- Offer flextime scheduling
- Incorporate STS training into EBP training for clinical staff
- Create external partnerships with STS intervention providers
- Train organizational leaders and non-clinical staff on STS
- Train organizational leaders on organizational implementation and assessment
- Provide ongoing assessment of staff risk and resiliency

Individual
• Use supervision to address STS • Increase self-awareness of STS • Maintain healthy work-life balance • Exercise and good nutrition • Practice self-care • Stay connected • Develop and implement plans to increase personal wellness and resilience • Continue individual training on risk reduction and self-care • Use Employee Assistance Programs or counseling services as needed • Participate in a self-care accountability buddy system

Worker Resiliency in Trauma-Informed Systems: Essential Elements

Both preventive and interventional strategies for secondary traumatic stress should be implemented as part of an organizational risk-management policy or task force that recognizes the scope and consequences of the condition. The following concepts are essential for creating a trauma-informed system that will adequately address secondary traumatic stress. Specifically, the trauma-informed system must:

- Recognize the impact of secondary trauma on the workforce
- Recognize that exposure to trauma is a risk of the job of serving traumatized children and families
- Understand that trauma can shape the culture of organizations in the same way that trauma shapes the world view of individuals

- Understand that a traumatized organization is less likely to effectively identify its clients' past trauma or mitigate or prevent future trauma
- Develop the capacity to translate trauma-related knowledge into meaningful action, policy, and improvements in practices
- Be integrated into direct services, programs, policies, and procedures, staff development and training, and other activities directed at secondary traumatic stress

SA-8. Secondary Traumatic Stress Scale

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past **seven (7) days** by circling the corresponding number next to the statement.

NOTE: "Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.

	0	1	2	3	4
	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb					
2. My heart started pounding when I thought about my work with clients					
3. It seemed as if I was reliving the trauma(s) experienced by my client(s)					
4. I had trouble sleeping					
5. I felt discouraged about the future					
6. Reminders of my work with clients upset me					
7. I had little interest in being around others					
8. I felt jumpy					
9. I was less active than usual.					
10. I thought about my work with clients when I didn't intend to					
11. I had trouble concentrating					
12. I avoided people, places, or things that reminded me of my work with clients					
13. I had disturbing dreams about my work with clients					
14. I wanted to avoid working with some clients					
15. I was easily annoyed					
16. I expected something bad to happen					
17. I noticed gaps in my memory about client sessions					

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Scoring Instructions

For each subscale below, add your scores for the items listed. Add the three scores in the right hand column for a total score.

Subscale	Items	Score
Intrusion	2 3 6 10 13	
Avoidance	1 5 7 9 12 14 17	
Arousal	4 8 11 15 16	
	Total	

Score Interpretation[18]

Little or No STS	Mild STS	Moderate STS	High STS	Severe STS
27 or less	28-37	38-43	44-48	49+

Appendix to the Kentucky Model Protocol for Local Multidisciplinary Teams 2026

APPENDIX B:

Working with Interpreters Resource

Working effectively with an interpreter

Before a visit with a patient or client who needs an interpreter:

- ☐ Use a trained interpreter. Interpreters should be trained and certified in medical interpreting (for available languages), especially when working in a clinical setting
- ☐ Treat the interpreter as a respected healthcare professional
- ☐ Allow extra time for the visit. Everything will be communicated at least twice (once by the speaker and once by the interpreter), unless using simultaneous interpretation
- ☐ Ensure that there are no (or minimal) distractions, such as noises that may interrupt your full engagement with the patient
- ☐ Give the interpreter a brief summary of the individual, goals, and/or procedures for the session
- ☐ Document the name of the interpreter

During the visit:

- ☐ *Introduce yourself* and have others in the room introduce themselves directly to the patient upon entering the room, allowing the interpreter to interpret the greeting. Do not address your introductions to the interpreter. Introductions help set the tone and establish you as the one directing the interaction
- ☐ *Use first person*, and ask the interpreter to do the same
- ☐ Face and speak directly to the patient. Even if the patient maintains eye contact with the interpreter, you should maintain eye contact with the patient, not the interpreter
- ☐ *Observe and monitor* your and your patient's *nonverbal communication*
- ☐ *Speak clearly,* being careful not to raise your voice or shout
- ☐ *Use simple language* and avoid medical or healthcare jargon
- ☐ Use sentence-by-sentence interpretation. Multiple sentences may lead to information being left out
- ☐ Allow the interpreter to ask open-ended questions, if needed, to clarify what an individual says
- ☐ Observe what is going on before interrupting the interpreter. Interruption may be warranted, for example, if the interpreter is taking a long time to interpret a simple sentence, or if the interpreter is having a conversation with the patient outside their role

- ☐ Ask the interpreter if they are filling in details for the patient. The interpreter may have interpreted for the patient before and be familiar with their history, or the interpreter may be filling in based on assumptions. It is important that the interpreter maintains professionalism, and that you obtain an accurate and current history each time the patient is seen

Near the end of the visit:

- ☐ Use the “teach back” method to rephrase and confirm that the patient understands your directions and recommendations
- ☐ Allow time for the patient to ask questions and seek clarifications

Remember:

- ☐ Some individuals who require an interpreter may understand English well. Comments you make to others might be understood by the patient.
- ☐ If your patient declines language assistance services, ask them to sign a form that states they understand that language assistance is available and choose to decline these services
    - This form must be available and signed in their primary language, or completed orally if they are unable to read in their primary language
    - Document that the individual has been notified of these rights, as well as the patient's needs in utilizing language access services
    - These are precautions in case of issues regarding whether certain information was provided to and understood by the patient

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Appendix to the Kentucky Model Protocol for Local Multidisciplinary Teams 2026

APPENDIX C:
Suicide Assessment and Prevention Resources

SAFE-T
SUICIDE ASSESSMENT

Five-Step
EVALUATION AND TRIAGE

1. **IDENTIFY RISK FACTORS**
   Note those that can be modified to reduce risk
2. **IDENTIFY PROTECTIVE FACTORS**
   Note those that can be enhanced
3. **CONDUCT SUICIDE INQUIRY**
   Suicidal thoughts, plans, behavior, method, and intent
4. **DETERMINE RISK LEVEL & INTERVENTION**
   Determine risk. Choose appropriate intervention to address and reduce risk.
5. **DOCUMENT**
   Assessment of risk, rationale, intervention, and follow-up

Suicide assessments should be conducted (1) at first contact; (2) with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; (3) prior to changes in behavioral health treatment; and (4) at inpatient discharge.

SAMHSA
Substance Abuse and Mental Health Services Administration

1. RISK FACTORS[1]

- Prior suicide attempt(s)
- Alcohol or substance use
- History of mental health concerns, particularly depression and other mood disorders
- Access to lethal means, including firearms
- Knowing someone who died by suicide, particularly a family member
- Social isolation
- Chronic disease and/or disability
- Lack of access to behavioral health care
- Prolonged feelings of hopelessness

POPULATIONS AT INCREASED RISK FOR SUICIDE

- American Indian, Alaska Native, and Tribal communities
- Black youth
- Rural communities
- LGBTQI + youth and young adults
- Middle-aged men
- Older adults

2. PROTECTIVE FACTORS[1]

Note: Protective factors, even if present, may not counteract significant acute risk

- Connectedness to people, family, community, and social supports
- Effective behavioral health care
- Life skills (including problem-solving skills, coping skills, emotional regulation, ability to adapt to change)
- Self-esteem and a sense of purpose or meaning in life
- Cultural, religious, or personal beliefs that discourage suicide
- No access to lethal means

[1] https://sprc.org/risk-and-protective-factors

3. SUICIDE INQUIRY

Specific questioning about thoughts, plans, behaviors, intent

- **Ideation:** Frequency, intensity, duration—in last 48 hours, past month, and worst ever
- **Plan:** Timing, location, lethality, availability, preparatory acts
- **Behaviors:** Past attempts, aborted attempts, rehearsals versus non-suicidal self-injurious actions
- **Intent:** Extent to which the patient (1) expects to carry out the suicide plan and (2) believes the plan/act to be lethal. Explore ambivalence: reasons to die versus reasons to live

For Youth: Ask parent/guardian about history of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition.

4. RISK LEVEL/INTERVENTION

- **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- **Reassess** as patient or environmental circumstances change
- **Develop** a safety plan for all individuals at low, moderate, and high risk levels

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
HIGH	Individuals experiencing severe behavioral health symptoms or acute precipitating event; protective factors not relevant	Suicidal ideation with plan (when and where), method (how), and intent to carry out the suicide plan	Emergency psychiatric treatment in a secure setting may be necessary unless a significant change reduces risk
MODERATE	Multiple risk factors, experiences some elevated behavioral health symptoms, and few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Give emergency/crisis numbers to include the 988 Lifeline
LOW	Manageable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral with a warm handoff, symptom reduction. Give emergency/crisis numbers, 988 Lifeline

Note: This chart is intended to serve as an example of a range of risk levels and interventions, not actual determinations.

5. DOCUMENT

Document: Risk level and rationale; treatment plan to address/reduce current risk (e.g., safety plan, medication, psychotherapy, contact with significant others, consultation, etc.); counseling on access to lethal means; follow-up plan. Patients/clients should receive a copy of their safety plan. For youth, the treatment plan should include roles for parent/guardian/supportive adult.

SUICIDE PREVENTION RESOURCES

988 Suicide & Crisis Lifeline, call or text 988 or chat at 988lifeline.org for 24/7 support

samhsa.gov/find-help/988

- Download this and additional resources at store.samhsa.gov
- SAMHSA's Suicide Prevention webpage: samhsa.gov/mental-health/suicide
- The 2024 National Strategy for Suicide Prevention and Federal Action Plan: hhs.gov/programs/prevention-and-wellness/mental-health-substance-abuse/national-strategy-suicide-prevention/index.html
- Suicide Prevention Resource Center: https://sprc.org
- National Action Alliance for Suicide Prevention: https://theactionalliance.org
- American Foundation for Suicide Prevention: https://afsp.org
- 988 End Cards for Media: samhsa.gov/find-help/988/partner-toolkit/end-cards-media

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5 Action Steps to Help Someone Having Thoughts of Suicide

We can all take steps to help prevent suicide. **Knowing the warning signs for suicide and how to get help can save lives.**

Here are 5 steps you can take to #BeThe1To help someone who is having thoughts of suicide:

1. ASK:

"Are you thinking about suicide?" It's not an easy question to ask, but it can help start a conversation. Studies show that asking people if they are suicidal does not increase suicidal behavior or thoughts.

2. BE THERE:

Listening without judgment is key to learning what the person is thinking and feeling. Research suggests acknowledging and talking about suicide may reduce suicidal thoughts.

3. HELP KEEP THEM SAFE:

Reducing access to highly lethal items or places can help prevent suicide. Asking the person if they have a plan and making lethal means less available or less deadly can help the person stay safe when suicidal thoughts arise.

4. HELP THEM CONNECT:

Connecting the person with the 988 Suicide & Crisis Lifeline (**call or text 988**) and other community resources can give them a safety net when they need it. You can also help them reach out to a trusted family member, friend, spiritual advisor, or mental health professional.

5. FOLLOW UP:

Staying in touch with the person after they have experienced a crisis or been discharged from care can make a difference. Studies show that supportive, ongoing contact can play an important role in suicide prevention.

For more information on suicide prevention:
www.nimh.nih.gov/suicideprevention
www.bethe1to.com

NIH National Institute of Mental Health

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