The Care Process Model for Pediatric Traumatic Stress (CPM-PTS): AT-A-GLANCE

What is CPM-PTS?

The Care Process Model for Pediatric Traumatic Stress (CPM-PTS) is a brief screening, family engagement, and response protocol for identifying and responding to traumatic stress in children seen in healthcare and other pediatric settings.

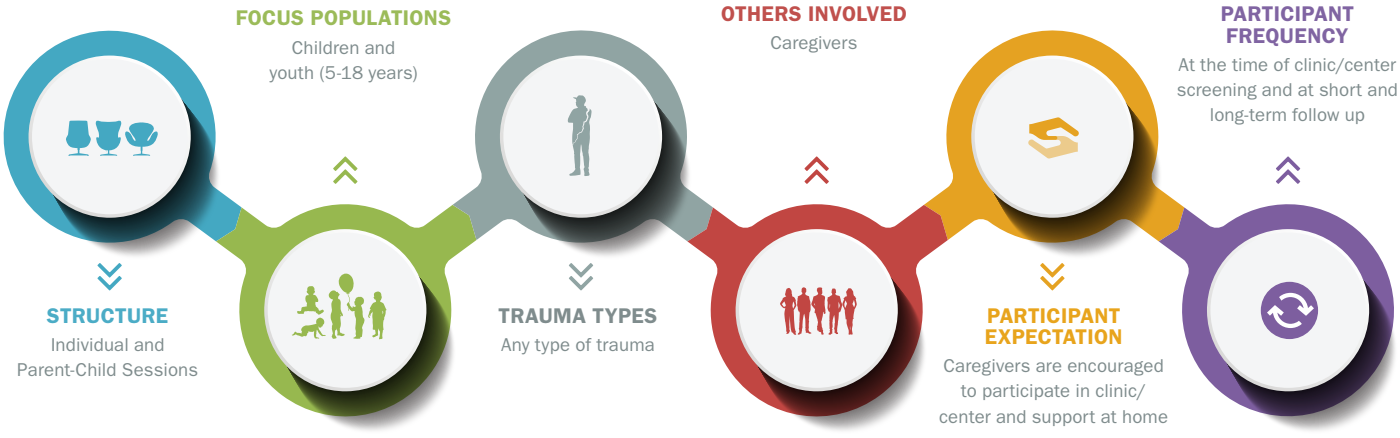
For screening, the CPM-PTS uses the Pediatric Traumatic Stress Screening Tool (PTSST), a 15-item questionnaire including two trauma exposure questions, one suicide screening question (from the Patient Health Questionnaire for Adolescents, PHQ-A), and 12 traumatic stress symptom questions (the UCLA Brief Screen for Trauma and PTSD). For provider response, the CPM-PTS guides three key decisions: 1. Address any serious or mandated safety concerns, 2. Assess suicide risk and provide a prevention response, and 3. Respond to trauma symptoms via education, referring to trauma evidence-based treatment, and/or teaching a skill targeting the child's most significant symptoms.

The CPM-PTS can be used by clinicians and non-clinicians.

What are the goals of CPM-PTS?

1. Increase recognition of the child's trauma symptoms
2. Engage with trauma-exposed children and families on their healing
3. Determine immediate and next steps for trauma-exposed children with a priority on safety and trauma-focused, evidence-based treatment
4. Link children with traumatic stress with providers who can deliver trauma-focused, evidence-based assessment and treatment.

What does CPM-PTS look like?



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What is the commitment?

Families can expect at least one conversation averaging 15 minutes, and then 1-2 follow up conversations at short (2-4 weeks) and long-term (4-6 months) intervals to monitor resolution of symptoms versus on-going treatment and resource needs. Based on conversations and referrals, families may use resources or skills at home and/or additionally participate in trauma-focused, evidence-based assessment and therapy.

Either the child (11-18 years old) or the caregiver (for children 5-10 years old) will complete the Pediatric Traumatic Stress Screening Tool (PTSST); after, both the child and the caregiver individually and/or jointly participate in the CPM-PTS conversation and decision-making.

How do we know it works?

CPM-PTS has practice-based and research evidence to support its benefits.

CPM-PTS was developed by child trauma professionals in partnership with primary care and children's advocacy center clinicians and non-clinicians for trauma-exposed children (5-18 years old). The majority of children/youth/families involved in the initial development of this practice identified as white and lived in an urban or suburban environment, and spoke English at home.

There are no adaptations for this model at this time. There are translations of CPM-PTS materials for children, youth, and families available in Spanish. Learn more on page 3.

LOCATION:

Most commonly in a clinic/center room

For more information explore the next several pages or check out:

https://utahpips.org/cpm/
https://learn.nationalchildrensalliance.org/care-process-model

CPM-PTS: THE EVIDENCE

What types of evidence are available for CPM-PTS?

- ❒ Pilot Study
- ❒ Program Evaluation

Where can I learn more about the evidence?

- Keeshin BR, Monson ET, Abdulahad L, Nkoy FL, Davis RN, Duffy T, Eppich K, Presson AP, & Chaplo SD (2025). Pediatric traumatic stress in primary care. Pediatrics, 156(5): e2025073183. https://doi.org/10.1542/peds.2025-073183
- McGuier E, Campbell K, Byrne K, Shepard L, Keeshin B (2023). Traumatic stress symptoms in children served by child advocacy centers. Front Psychiatry, 14. https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2023.1202085/full
- Byrne KA, McGuier EA, Campbell KA, Shepard LD, Kolko DJ, Thorn B, Keeshin B (2022). Implementation of A Care Process Model for Pediatric Traumatic Stress in Child Advocacy Centers: A Mixed Methods Study. J Child Sex Abus, 31(7), 761-781. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9743153/pdf/nihms-1853393.pdf
- Shepard LD, Campbell KA, Byrne KA, Thorn B, Keeshin BR (2023). Screening for & Responding to Suicidality Among Youth Presenting to a Children's Advocacy Center (CAC). (Epub ahead of print) Child Maltreat, 10775595231163592. https://journals.sagepub.com/doi/abs/10.1177/10775595231163592
- Campbell, K., Byrne, K., Thorn, B., Shepard Abdulahad, L., Davis, N., Giles, L., & Keeshin, B. (2024). Screening for symptoms of childhood traumatic stress in the primary care pediatric clinic. BMC Pediatrics, 24(1), 217. https://link.springer.com/article/10.1186/s12887-024-04669-3
- Giles L, Shepard L, Asarnow J, Keeshin B (2021). Implementation of a trauma-informed suicide prevention intervention for youth presenting to the emergency department in crisis. Evid Based Pract Child Adolesc Ment Health, 6(3), 343-353. https://www.tandfonline.com/doi/full/10.1080/23794925.2021.1961643
- American Academy of Pediatrics (AAP) Trauma-Informed Care
- American Academy of Pediatrics (AAP) PediaLink Course "Practical Strategies for Implementing Trauma-Informed Care"
- National Children's Alliance (NCA) Learning Center "The Care Process Model for Pediatric Traumatic Stress" (CPM-PTS)

How is CPM-PTS measured in real time?

The CPM-PTS uses the Pediatric Traumatic Stress Screening Tool (PTSST) at initial and follow up encounters to monitor and respond to safety and symptom concerns. The PTSST is 15-items and largely based on the validated UCLA Brief Screen for Trauma and PTSD. It screens for trauma exposure, suicidality, and traumatic stress symptoms, and can be used in combination with other screening tools.

What changes for the better as a result of CPM-PTS?

The CPM-PTS delivers earlier access to hope and healing from trauma by increasing recognition of child trauma and traumatic stress, promoting engagement with trauma-exposed children and families on their healing, prioritizing child safety, and connecting symptomatic children to trauma-focused evidence-based treatment.

What do the numbers tell us (i.e., quantitative data)?

The CPM-PTS is successful in identifying children with clinically important symptoms of traumatic stress. In primary care (N=1,472), 1 in 3 children endorsed trauma exposure and 1 in 20 endorsed high symptoms of traumatic stress. In children's advocacy centers (N=2,350), 4 of 5 endorse trauma exposure, 2 of 5 endorse thoughts of suicide, and 1 out of 2 endorse high symptoms of traumatic stress.

What do the stories tell us (i.e., qualitative data)?

Primary care and children's advocacy center clinicians and non-clinicians find the CPM-PTS valuable, feasible, and acceptable. Caregivers indicate high acceptability. On-going training and support in the CPM-PTS is important, especially for CAC staff in establishing their workflow, screening and responding to suicide, and maintaining connection to trauma-focused evidence-based treatment providers.

CPM-PTS: ADAPTABILITY AND ACCESSIBILITY

- **What is the history of CPM-PTS?**

  The CPM-PTS was developed by child trauma professionals in collaboration with primary care and children's advocacy center (CAC) clinicians and non-clinicians, for trauma-exposed children (5-18 years old). The majority of children, youth, and families involved in the development of this model identified as White, lived in an urban or suburban environment, and spoke English at home. As a promising and practical strategy for identifying and responding to child traumatic stress, the developers' current efforts are primarily targeted at scaling up access to CPM-PTS training and technical support. However, the CPM-PTS developers also desire to further evaluate and adapt the CPM-PTS, and are happy to strategically partner.

  Formal adaptations for the CPM-PTS are currently under way for children in foster or out-of-home care and for children presenting to behavioral healthcare across the continuum of outpatient to acute/inpatient.

- **How did CPM-PTS developers proactively reach out to, center, amplify, and learn from the voices of those most impacted by racism and trauma?**

  As child trauma clinicians, the CPM-PTS developers were motivated by their patient experiences to develop a model for child-serving systems to better, and more equitably, identify and respond to child traumatic stress. The CPM-PTS training materials include case examples based on real patients and materials for child and family engagement.

- **What is the role of CPM-PTS providers in tailoring the model for individuals, families, and communities?**

  The CPM-PTS is first and foremost a child and family engagement framework. CPM-PTS users should tailor their approach and discussion with the child and family based on their characteristics and needs, community resources, and the setting. Consultation for the CPM-PTS can be provided via a network of technical assistance centers (PIPS-TACs) the developers are establishing.

- **How are lessons learned from individuals, families, communities and providers used to keep improving CPM-PTS?**

  The CPM-PTS developers have active partnerships with the health and CAC systems where the CPM-PTS was developed and piloted. They continue to provide input and feedback to the model, training, and supporting materials and systems. Formal and independent evaluation is also used to gather ideas and feedback with anonymity.

- **Resources and materials are available:**

  - Materials are available in Spanish. Translations were made by bilingual colleagues.

CPM-PTS: PROVIDING, SUPERVISING, TRAINING, AND SUSTAINING

TO PROVIDE CPM-PTS

Provider prerequisites:
- Experience: Child-serving system staff and leaders
- Education: N/A
- Licensure: N/A

Trained providers can:
- Deliver CPM-PTS
- Qualify for enhanced rates if available

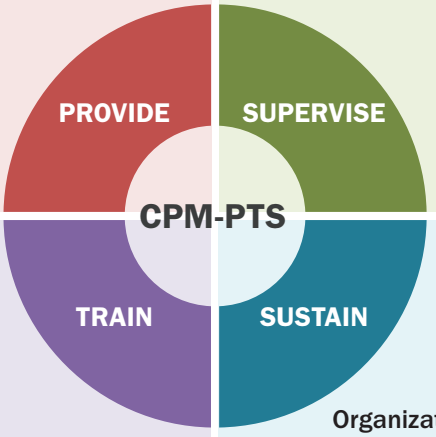
Access for Provider Training:
- Through live in-person training
- Through live virtual training
- Through pre-recorded training
- Through consultation
- Through a training manual

TO SUPERVISE CPM-PTS

Supervisor prerequisites:
- Meet provider prequisites
- Comfortable and confident in the CPM-PTS

Trained supervisors can:
- Supervise others in CPM-PTS
- Provide consultation to others about CPM-PTS
- Qualify for enhanced rates if available

Access for Supervisor Training:
- Through consultation



TO TRAIN CPM-PTS

Trainer prerequisites:
- Currently in partnership with or by invitation of the CPM-PTS developers
- Experience implementing and supporting the CPM-PTS
- Completing established train-the-trainer process

Approved trainers can:
- Train within their own organization
- Train locally
- Train nationally
- Train providers
- Train supervisors

Access for Trainer Training:
- Contact in advance for trainer availability

TO SUSTAIN CPM-PTS

Organization prerequisites:
- Discussions on readiness and fit
- Support infrastructure for data

Organizations can:
- Train new staff on the job by in-agency trainers
- Qualify for enhanced rates
- Report training and use for accreditation standards

Access for Organizational Readiness Supports:
- Virtual continuing education for free
- Connection to other organizations using model, assessment resources/supports for free

CPM-PTS: MORE ON PROVIDING, SUPERVISING, TRAINING, AND SUSTAINING

PROVIDE CPM-PTS

- **Training cost:** The CPM-PTS developers are committed to making the CPM-PTS materials free and accessible. Costs are associated with trainings, including trainer time, travel and if it is offered as part of a larger conference.
- **Time Commitment:** Basic training in the CPM-PTS and implementation preparation takes about 5 hours of training and consultation. It can take longer if additional training or support is needed to build trauma treatment referral sources or suicide prevention response.
- **Additional Details:** Initial training for users and supervisors is available for healthcare providers via the Practical Strategies for Implementing Trauma-Informed Care and for children's advocacy center (CAC) staff and affiliated workforce via The Care Process Model for Pediatric Traumatic Stress (CPM-PTS) Training for Children's Advocacy Center Staff and Affiliated Workforce.

SUPERVISE CPM-PTS

- **Training cost:** The CPM-PTS developers are committed to making the CPM-PTS materials free and accessible. Costs are associated with trainings, including trainer time, travel and if it is offered as part of a larger conference.
- **Time Commitment:** Basic training in the CPM-PTS and implementation preparation takes about 5 hours of training and consultation. It can take longer if additional training or support is needed to build trauma treatment referral sources or suicide prevention response.
- **Additional Details:** Initial training for users and supervisors is available for healthcare providers via the Practical Strategies for Implementing Trauma-Informed Care and for children's advocacy center (CAC) staff and affiliated workforce via The Care Process Model for Pediatric Traumatic Stress (CPM-PTS) Training for Children's Advocacy Center Staff and Affiliated Workforce.

TRAIN CPM-PTS

- **Training cost:** The CPM-PTS developers are committed to making the CPM-PTS materials and CPM-PTS training free and accessible. Some cost can be associated with time and travel to train/support other pediatric settings in the CPM-PTS.
- **Time Commitment:** Currently, CPM-PTS trainers volunteer or are invited to partner by the CPM-PTS developers; Time commitments vary on a case by case basis.
- **Additional Details:** N/A

SUSTAIN CPM-PTS

- **Training cost:** The CPM-PTS developers are committed to making the CPM-PTS materials and CPM-PTS training free and accessible. Some cost can be associated with travel for in-person trainings, or to build trauma treatment or suicide prevention referral sources.
- **Time Commitment:** Basic training and implementation preparation takes about 5 hours of training and consultation. It can take longer if additional support is needed to build trauma-informed systems, trauma treatment referral sources, or suicide prevention response.
- **Additional Details:** N/A

To learn more about providing, supervising, training, or sustaining, please see https://utahpips.org/cpm/ or email: Brooks.Keeshin@hsc.utah.edu; Lindsay.Abdulahad@hsc.utah.edu; or Shannon.Chaplo@hsc.utah.edu

For additional resources and related products, please explore: https://www.aap.org/en/catalog/categories/pedialink-eqipp-courses/practical-strategies-for-implement

The Care Process Model for Pediatric Traumatic Stress (CPM-PTS): At-A-Glance was reviewed and approved for accuracy by Brooks Keeshin, MD; Lindsay Abdulahad, PhD, LCSW; Shannon Chaplo, PhD, & Porcia Vaughn, MS; CPM-PTS developers at the University of Utah, Pediatric Integrated Posttrauma Services (PIPS) in November, 2024.

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