Rapid review on trauma-informed care in primary care settings

gpmhsc
General Practice Mental Health Standards Collaboration

Summary report

May 2022

Prepared by: Rosemary Wade for the General Practice Mental Health Standards Collaboration

Part A

Summary

A rapid review was conducted in February 2022 to identify evidence of effectiveness of trauma-informed care (TIC) in primary care settings. Targeted searches were run in electronic literature databases, as well as key mental health organisational websites to identify grey literature on TIC in general practice. As limited specific examples in the primary care setting were identified, this summary includes the use of TIC in broader health care settings. This rapid review does not represent an extensive summary of all literature published on the effectiveness of TIC. An overview of the literature identified is provided, with the focus on recently published systematic reviews. Included systematic reviews and studies had explicitly identified the interventions as being 'trauma-informed' or 'trauma-specific'. Additional reviews or studies on psychosocial therapies that may be considered as trauma-informed but did not include these terms in the title or abstract may not be included in this summary.

The aim of this summary is to present evidence on the effectiveness of implementing TIC as a model of care, particularly within primary care settings. In addition, evidence on the effectiveness of specific trauma-focused interventions is also presented. There is a distinction between provision of TIC and trauma-specific therapy, with the RACGP White book stating: "[t]herapy requires additional knowledge and training to ensure a safe therapeutic alliance and the processes needed to support recovery."[1]

Guidelines and reports were identified that include recommendations supporting TIC, including Australian and International guidelines on abuse,[1, 2] posttraumatic stress disorder (PTSD),[3-5] complex trauma[3, 6] or TIC.[7] Regarding effectiveness of TIC, these reports usually provided references to individual trauma-focused interventions, rather than TIC in general. Rationales in the guidelines/reports for using TIC often refer to high prevalence of adverse childhood experiences (ACEs) and the long-term outcomes associated with these experiences, such as mental illness and problematic substance use.

Trauma-informed care

A small number of reviews and primary studies were identified which reported on the effectiveness of the implementation of TIC as a model of care, rather than specific trauma-focused interventions.

Five recent reviews reported on the effectiveness of implementation of TIC.[8-12]

A concept analysis of 31 articles identified that three key attributes of TIC in the primary care setting were safety, empowerment and support; and reported consequences of TIC to be improved patient satisfaction and improved health care engagement.[8] Preceding factors to implementation of TIC were trauma competence, health care professional readiness and survivor readiness. The review authors provided the following definition of TIC in primary care: "a strengths-based approach in which trained, trauma-aware health care professionals provide services that prioritize safety, empowerment, and support, resulting in improved patient satisfaction and health care engagement in individuals who have experienced trauma".[8]

One large review reported that implementation of TIC in healthcare settings improved patient-provider communication and mental health services referral.[9] The review authors noted that more research was needed regarding the impact of TIC interventions on child and family health outcomes.

One review, by Australian authors, reported on 13 studies on interventions or systems of care for help-seeking youth that was specifically described as "trauma-informed," "trauma-integrated," or "trauma-sensitive".[12] The review reported that 100 individual TIC practices were identified, covering 10 core components. While a range of outcomes were reported in the studies, many relating to

service providers such as improvements in knowledge following training, only two studies reported on service user clinical outcomes. Both these studies reported positive effects such as reduced PTSD symptoms or mental health problems, however some methodological limitations were noted.

The other two reviews focused on trauma-informed staff training, one specific to primary care[11] the other in a range of sectors, including, but not limited to, welfare, psychiatric hospitals and general medical settings.[10] Improvements were reported in staff knowledge, attitudes and behaviour following TIC training.[10, 11] However, the impact on TIC training on patient outcomes is less clear, with some improvements reported however not always statistically significant, the review authors note that more research is warranted in this area.[10, 11]

In a US study comparing outcomes over time following implementation of TIC in a paediatric primary care clinic, physician's reported positive impacts of TIC such as building safe relationships with patients, creating opportunities to discuss trauma and increased identification of and referral for trauma and behavioural health needs.[13] In another study, following implementation of TIC in an obstetric and paediatric medical home for adolescent mothers, patients had higher rates of attendance at prenatal appointments and lower rates of low birthweight papers.[14]

Primary care physicians' and/or patients views on TIC

Other recent individual studies have also reported on primary care physicians' and/or patient views on TIC.[15-17]

A Canadian cross-sectional study reported that TIC was viewed as important by both primary care physicians and patients, with Trust, Safety, and Collaboration the highest rated components of TIC.[15]

A qualitative study from Canada on the primary care experiences of women who have a history of childhood trauma and chronic disease reported that women thought that primary care providers should be aware of their abuse history and that asking about this would be acceptable and appropriate.[16]

A survey of US primary care providers working in Veterans Health Administration primary care clinics discussed challenges to provision of trauma-sensitive care to women veterans with military sexual trauma.[17] Challenges/barriers included insufficient time; lack of perceived proficiency and/or personal comfort; and difficulties in fostering a positive patient-provider relationship. Solutions proposed to address these barriers included increasing allotted time for examinations such as Pap and pelvic examinations; having support with mental health professionals; receiving training regarding gender-specific and trauma-sensitive care; and displaying patience, empathy and careful communication with patients.[17]

Application of TIC principles in primary care

A few models of TIC in primary care were proposed in discussion papers,[16, 18-20] with suggested practices based on the application of TIC principles, such as:

- Awareness and recognition of trauma history, screening in an empathic way and understanding that patients may need time to build trust before disclosure.
- Providing a safe environment and building trusting patient-provider relationships.
- Responding using a patient-centred model and empowering patients to be involved in their health and care decisions.
- Avoiding re-traumatisation and creating care that is acceptable to patients.
- Recognising patient's strengths and resilience.

Trauma-specific therapy interventions

Many systematic reviews have been published on trauma-specific interventions for various mental health conditions in recent years. The most recently published reviews will be focused on as the older reviews would be considered superseded.

Note: Health care professional training is required to provide these interventions. The studies included in the reviews were conducted in a range of healthcare settings, not exclusive to primary care, with interventions usually delivered by mental health professionals. This summary presents available systematic review evidence for various interventions, however GPMHSC does not specifically endorse one intervention over another.

Forty-seven reviews published since 2020 were identified on trauma-specific interventions in a range of populations, primarily for treatment of PTSD, but also for other mental health disorders. Twenty-eight of these reviews reported on a range of psychosocial interventions, including trauma-focused interventions, while 10 focused on eye movement desensitization and reprocessing (EMDR), three on trauma-focused cognitive behaviour therapy (TF-CBT), four on exposure therapy and three reviews focused on virtual trauma interventions.

Of the 28 overall trauma-focused intervention reviews:

- 5 were for adults with PTSD[21-25]
    - 1 for prevention of PTSD[25]
- 5 were for comorbid PTSD with other mental health conditions, such as:
    - severe mental illness[26]
    - borderline personality disorder[27]
    - suicidal thoughts and behaviours[28]
    - dissociative symptoms[29]
    - substance use disorder[30]
- 6 were for PTSD or other mental health conditions linked to specific populations/situations, such as:
    - PTSD during pregnancy[31] or following childbirth[32]
    - medically-related trauma[33]
    - low and middle-income countries[34]
    - intellectual disability[35, 36]
- 2 were for complex trauma[37-39]
    - 1 review provided some subgroup analyses: post-combat deployment veterans, war-related, childhood sexual abuse, refugees, domestic violence[38]
- 3 were for other mental health conditions such as depression or dissociative symptoms[40-42]
- 7 were focused on children and adolescents.[43-49]

Of the 10 EMDR reviews:

- 3 were for PTSD[50-52]
    - 1 in adults,[50] 1 in adults and children,[51] 1 in children and adolescents[52]
- 5 were for other mental health conditions such as depression, anxiety or psychosis[53-57]
- 2 had a range of mental health conditions included[58, 59]
    - 1 specifically on cancer patients[59]

Of the three TF-CBT reviews:

- 1 was for people with PTSD under ongoing threat[60]
- 2 were for vulnerable children with trauma symptoms
    - 1 in refugee children[61]
    - 1 in children and youth in low and middle income countries[62]

Of the four reviews on exposure therapy:

- All were for people with PTSD[63-66]
    - 1 was for adults or children in vulnerable populations such as refugees or post-conflict settings[64]

Of the three reviews focused on virtual trauma interventions:

- All were for PTSD in adults[67-69]
    - predominately military/veteran populations.

The trauma-focused therapies were usually compared to waitlist or treatment-as-usual, some reviews also include comparisons with other therapies. The primary reported outcome was usually PTSD symptom severity, with other mental health outcomes such as depression or anxiety also often reported.

Overall, recent systematic reviews have reported on the effectiveness of trauma-focused interventions in improving mental health outcomes such as PTSD and depressive symptoms.

The most evidence is available for TF-CBT and EMDR,[23, 24, 38] which are consistently reported as effective in reducing symptoms of PTSD, depression and/or anxiety in both adult[21, 23, 24, 26, 31, 33, 38, 40, 50, 51, 53-56, 58-60] and child[44-48, 52, 61, 62] populations (note there is more information regarding TF-CBT in child populations, rather than EMDR). Reductions in symptoms are observed post-treatment and usually maintained at follow-up evaluations (usually 3, 6 or 12 months), although longer term outcomes are often not reported.[22] Both individual and group formats have been reported to be effective compared to waitlist or treatment-as-usual.[23, 37, 45, 51] Some reviews found greater effects for individual TF-CBT than group TF-CBT,[23, 47] however others reported equivalent effects for individual and group psychotherapy.[22, 24, 26, 30, 45] One review noted mixed patient views on acceptability of group therapy.[39]

Other trauma-specific interventions that reported positive results include cognitive processing therapy (CPT) and exposure therapy (prolonged exposure (PE), narrative exposure therapy (NET)).[21, 23, 44, 45, 47, 63-66] These therapies are often categorised as a form of TF-CBT. Some positive effects have been reported for psychodynamic therapy in adults, however few trials have reported on this intervention.[21, 24, 39] Virtual trauma-focused interventions have also been trialled, primarily in military populations, and appear to be effective in reducing PTSD symptoms.[67-69] Virtual delivery of interventions may be particularly useful in the context of COVID-19.

While overall the reviews report that trauma-focused interventions are effective, one review notes that there is inconsistency in the primary papers, with only approximately half the papers reporting statistically significant improvements.[37]

Quality of primary studies included in reviews

The evidence-base that these systematic reviews draw on range from non-controlled studies to randomised controlled trials (RCTs), with review authors commonly reporting a lack of methodological quality of the primary studies which may be at risk of bias. Commonly reported issues include small sample sizes, high drop-out rates and lack of control groups. There is often high heterogeneity noted between studies due to different intervention methods (including number of sessions, duration of therapy), measurement scales used to report outcomes and population groups.

There is also a lack of data reported in the primary studies on any harms of the interventions.[29, 38]

Many primary studies on trauma-focused therapies exclude patients with psychotic disorders, current substance abuse or at risk of suicide.[23, 31] However, some reviews reported that PTSD therapies were effective in these populations.[28-30, 57] One review on co-occurring PTSD and suicidal thoughts and behaviours found that overall, PTSD treatments (including some trauma-focused interventions) improved both PTSD and suicide-related outcomes, or at least, did not exacerbate suicidal thoughts or behaviours.[28]

Differences between populations

Trauma-focused interventions appeared effective in most populations, including those with complex trauma[37, 38] or co-occurring PTSD and other mental illness.[26-30]

Two reviews reported that larger intervention effects were seen in civilian populations, compared with military populations.[22, 38] One of these reviews[38] also reported subgroup analyses for refugees, childhood sexual abuse, populations affected by war, domestic violence with psychological interventions (primarily TF-CBT) leading to reductions in PTSD symptoms in all of these groups. Although, similarly to the military population, the reduction effect in the war-affected population was smaller than the pooled population analysis.

For children, the intervention with the most evidence is TF-CBT,[44-48] however EMDR also appears to be effective in this population.[47, 48, 52]

Although there were positive effects reported in some small trials, there is less available evidence on the effectiveness of trauma-focused therapies for people with intellectual disability.[35, 36]

Conclusion

Trauma-informed care is supported as an important modal of care in primary health and broader health care settings. While positive findings have been reported following implementation of TIC, such as improved health provider knowledge and increased mental health service referrals, more research is needed to determine the impact of TIC on patient outcomes. Reviews on a range of specific trauma-focused interventions, such as TF-CBT and EMDR, have reported effectiveness in various populations and mental health conditions, primarily in reducing PTSD symptoms.

Last updated: May 2022

Literature search: February 2022

See accompanying tables in *Rapid review on trauma-informed care in primary care settings – Summary report – Part B – Tables*.

- Table 1. Summary of identified TIC systematic reviews and primary studies regarding implementation of TIC as a model of care
- Table 2. Summary of identified systematic reviews on trauma-focused interventions published since 2020

Reference list provided in *Rapid review on trauma-informed care in primary care settings - Summary report – Part C – References*.

For further details on the methods and resources identified, contact the GPMHSC Secretariat on 03 8699 0556 or email gpmhsc@racgp.org.au