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

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
Reviews				
Varghese 2021[8]	31 articles, including data-based studies (n=15) and thought pieces (n=16) Evidence up to Dec 2020	Primary care	Intervention: TIC in primary care	Defining attributes of TIC in primary care: • safety (e.g. safety in relationships, interactions and environment) • empowerment (e.g. shared decision making, strengths-based care) • support (e.g. advocacy) Antecedents of TIC: • trauma competence (e.g. knowledge and/or training) • health care professional readiness (e.g. self care and organisational support) • survivor readiness Consequences of TIC: • improved patient satisfaction • improved health care engagement
Oral 2020[9]	144 articles included across a range of topics:	Implementation of TIC in healthcare settings	Intervention: TIC practices including physician training and adoption of trauma/ACE screening	Reported improvements following implementation of TIC included:

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
	• TIC and ACEs • Implementation of TIC in healthcare • Changes in practice related to TIC • Impact of TIC on child and family health outcomes • Statewide TIC efforts • Primary prevention of childhood adversity and trauma • Barriers and gaps related to implementation of TIC Evidence up to Mar 2019			• improved provider-patient communication • improved physician knowledge, attitudes and confidence • increased referral to mental health services Some studies reported the impact of TIC interventions on child and family health outcomes, such as: • reductions in depression or PTSD symptoms • fewer behaviour problems The review authors note the need for further research to better assess the impact of TIC on child and family health outcomes
Bendall 2021[12]	13 studies Evidence up to Jan 2018	Help-seeking young people (12–25 years)	Intervention: interventions or systems of care that was specifically described as “trauma-informed,” “trauma-integrated,” or “trauma-sensitive” Note: Studies implementing only a “trauma-focused” intervention were excluded. However, studies that included a trauma-focused intervention (e.g. TF-CBT) as part of an initiative described as “trauma-	100 individual TIC practices identified across 13 studies, under 10 broad components: • interagency collaboration • service provider training • safety • leadership, governance, and agency processes • youth and family/carer choice in care • cultural and gender sensitivity

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
			informed," "-integrated," or "-sensitive" were included	• youth and family/carer participation • screening and assessment • psychoeducation • therapeutic interventions 11 studies reported on outcomes, categorised across 4 levels: • service users • service providers • the service • the wider service system 2 studies reported on clinical outcomes, both with positive effects regarding reduction in either PTSD symptoms or mental health problems. 1 of these studies also reported program satisfaction and reduction in caregiver strain. Major methodological limitations in the studies were noted
Purtle 2020[10]	23 studies, including 5 RCTs, 17 pre-post studies Evidence up to Jul 2017	Mixed settings: 6 implemented in child welfare agencies, 6 in psychiatric hospitals, 4 in general medical settings (e.g., emergency departments, primary care clinics), 1 in a juvenile justice facility, and 1 in a school	Intervention: trauma-informed organisational interventions that included a staff training component Authors noted that often multiple trauma-informed intervention components were implemented concurrently with training, therefore the extent to which outcomes are attributable to training, and not other components, is unclear	Staff outcomes: Improvements in staff knowledge, attitudes and/or behaviours post-training (12 out of 14 studies), usually retained at ≥1 month after training occurred (7 out of 9 studies) Client outcomes: 5 out of 8 studies that assessed the effects of TIC on client outcomes reported some improvements, such as: • reduced seclusion/restraints in psychiatric hospital settings • improved behaviour in school or juvenile justice settings

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
Gundacker 2021[11]	17 studies, all US-based, reporting on various outcomes including: • how well training was received/valued • gained knowledge or skills • applied learning into practice • impact of training on overall practice Evidence up to Aug 2020	Primary care providers	Intervention: trauma-informed curricula	Primary care providers reported improved knowledge, attitudes and behaviours following training Of the 2 primary studies that reported on impact of training, 1 reported no change in patients' depression or PTSD scores, the other reported some increases in patient scores on partnership and information (latter was not statistically significant) with no difference in rapport (which was excellent at baseline).
Primary studies				

Sala-Hamrick 2021[13]	Longitudinal study – comparisons over time (2015–2018)
	
	Qualitative component – Focus groups with providers (3 groups, n=5, n=3, n=9)
		Paediatric Primary Care Clinic serving low-income and minority families	Trauma-Informed Paediatric Primary Care, including screening, identifying and discussing traumatic stressors, and providing support to all families who attended wellness visits at the centre	Providers reported:
				• successfully forming safe and trusting relationships with their patients
				• opportunities for collaborative and strengths-based conversations about trauma, leading to:
				  ○ higher rates of identification of trauma and behavioural health needs
				  ○ higher rates of families receiving behavioural healthcare

Ashby 2019[14]	Retrospective chart review	Pregnant adolescents attending an obstetric and paediatric medical home	Trauma-informed program incorporating principles of TIC including organisational changes, staff training, and patient screening	Approximately 30% of participants reported a history of trauma

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
		2007–2008 (n=429) 2012–2013 (n=415)	Comparison: Historical patient group treated by 'care as usual' prior to implementation of trauma-informed program	Following implementation of the trauma-informed program: • higher rates of attendance at prenatal appointments (p<0.001) • lower rates of low birthweight babies (p<0.02) • no significant differences were reported pre- and post-intervention for median gestational age, weight in grams at birth, or pre-term delivery
Kokokyi 2021[15]	Cross-sectional study	Phase 1: patients (n=296) and primary care physicians (n=60) Phase 2: patients (n=151) and primary care physicians (n=36)	TIC Phase 1: patient and physician opinions on aspects of TIC (understanding trauma, safety, trust, peer support, collaboration, empowerment, cultural sensitivity) Following Phase 1, recommendations were made regarding administration of TIC: physician training, booking longer appointment times, patient education, support groups for patients, and clinical pathways Phase 2: patient and physician opinions on recommendations	Phase 1: Physicians reported higher frequency rates of TIC than patients reported receiving it, and physicians viewed TIC as more important than patients did. The highest rated aspects of TIC for both groups were trust, safety, and collaboration. Phase 2: Patients and physicians reported physician training in TIC would be helpful and likely to improve patient care. Physicians reported higher helpfulness rating scores than patients regarding patient engagement recommendations (such as information pamphlets and patient trauma resources).
Bergman 2019[17]	Qualitative study	Primary care providers working in Veterans Health Administration primary care clinics (N=28)	PCPs perspectives on providing trauma-sensitive care to women with sexual trauma history	Challenges/barriers: • insufficient time • lack of perceived proficiency and/or personal comfort • fostering a positive patient-provider relationship

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
				Solutions included, but not limited to: • increased time for examinations such as Pap and pelvic examinations • access to mental health professionals • receiving training regarding gender-specific and trauma-sensitive care • displaying patience, empathy and careful communication with patients
Purkey 2018[16]	Qualitative study – in depth interviews	Women with 2 or more non-psychiatric diagnoses with an ACE score of 4 or higher, recruited from an academic family health team (N=26)	Primary care experiences of women with a history of childhood trauma and chronic disease	Themes: • importance of continuity of care • challenges with family medicine residents • provider awareness of abuse history • distress due to triggering events • characteristics of clinic staff and space • engagement in care plans and choice This paper also provides some examples of how to apply the principles of TIC in primary care

ACE: adverse childhood experience; PCP: primary care provider; PTSD: posttraumatic stress disorder; RCT: randomised controlled trial; TF-CBT: trauma-focused cognitive behavioural therapy; TIC: trauma-informed care.

Table 2. Summary of identified systematic reviews on trauma-focused interventions published since 2020

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
Overall trauma-focused interventions - adults				
PTSD				
Jericho 2022[21]	82 RCTs Evidence up to Jan 2020b	PTSD in adults	Interventions: Trauma-focused psychotherapies, including EMDR, PE, CBT, NET, MCT, WET, VRET, BET, TARGET, SIT Note only individual, face-to-face therapies were included Comparison: waitlist or other psychotherapies	Network estimates indicated superior efficacy of meta-CT and CPT over other psychotherapies WET and NET were found to be the most tolerable and acceptable treatments WET, IPT and EMDR appear in the superior half of therapies for both efficacy and acceptability
Weber 2021[22]	22 RCTs Evidence up to Nov 2019	PTSD in adults	Interventions: psychological treatments for PTSD, including TF-CBT, EMDR, CBT Comparisons: active or passive nonpharmacological controls or other psychological treatments	TF and non-TF interventions yielded large effect size for PTSD severity from pre-test to follow-up • Higher effect sizes were observed for civilian compared to military populations and for studies with larger proportions of female participants • No subgroup differences reported for treatment format (group vs. individual), number of sessions, treatment analysis or follow-up duration Medium effect sizes were observed for depressive symptoms
Lewis 2020[23]	114 RCTs Evidence up to May 2018	PTSD	Interventions: manualised therapies for PTSD, including CBT-T (such as CPT, CT, PE), EMDR	Severity of PTSD symptoms post-treatment:

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes

			Comparison: waitlist, treatment-as-usual, other therapies	• strongest evidence of effect for the studies categorized as CBT-T, and EMDR
				  ○ CPT, CT, and PE had the strongest evidence of effect
				  ○ Some evidence in support of NET, non-trauma CBT, PCT, group CBT-T and internet-based CBT
				  ○ Emerging evidence in support of single-session CBT-T, RTM, VRE, and WET

Mavranezouli 2020a[24]	90 RCTs Evidence up to Jan 2018	PTSD in adults	Interventions: psychological interventions, including EMDR, TF-CBT Comparison: waitlist	EMDR, combined somatic/cognitive therapies, TF-CBT and self-help with support appeared to be most effective in reducing PTSD symptoms post-treatment versus waitlist Effects were retained for EMDR and TF-CBT at 1–4-month follow-up Some limited evidence (small trials) showed large effects on remission of PTSD for psychodynamic therapy, non-TF-CBT, relaxation, IPT and PCT versus waitlist Exploratory sub-analyses suggest no significant differences for different specific TF-CBT interventions

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
Bisson 2021[25]	6 pre-incident RCTs 69 post-incident RCTs Evidence up to May 2019	PTSD in adults – prevention	Intervention: any intervention aimed at preventing PTSD, either pre-incident or post-incident Comparison: various, including no intervention, usual care, waitlist, advice leaflet	Pre-incident preparedness • No interventions significantly prevented PTSD symptoms Post-incident interventions • Emerging evidence that some interventions may be helpful in preventing PTSD but most studies reported non-significant differences between interventions and controls • strongest results were for CBT-T in individuals already with some symptoms
PTSD and comorbid conditions				
Grubaugh 2021[26]	14 studies: 5 RCTs, 8 open trials, 1 within-group controlled trial Evidence up to Mar 2020	PTSD and comorbid severe mental illness	Intervention: PTSD psychotherapy, including CBT, PE, EMDR, brief treatment program	Interventions reduced PTSD symptomatology from pre- to post-treatment, with slightly larger effects observed for PE, EMDR and BTP than CBT. Positive effects were also observed on general psychopathology and psychotic symptoms Individual vs group mode of delivery did not moderate effects
Rozek 2021[28]	33 studies – 23 PTSD-specific, 4 suicide-specific, 6 combined; Evidence up to Jan 2021	PTSD co-occurring with suicidal thoughts and behaviours	Interventions: PTSD-specific - CBT, PE, EMDR, PCT, NET, COPE; combined - DBT-PE, DBT-PTSD; suicide-specific - BCBT, PACT, DBT Comparison: various, some studies did not include comparison or control groups	Interventions appeared to decrease both PTSD and suicide-related symptoms, with most research relating to PTSD treatments, particularly CPT and PE

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
Simpson 2021[30]	28 RCTs Evidence up to Jul 2021	PTSD and comorbid substance use disorder (SUD)	Intervention: psychotherapy, including trauma-focused and non-trauma-focused interventions and manualized SUD treatment	TF-interventions outperformed all comparators on PTSD outcomes at post-treatment but this did not carry through to follow-up Both PTSD and SUD outcomes improved across TF-, non-TF treatments and control groups In most models, treatment delivery modality (individual vs group) did not moderate effects
Zeifman 2021[27]	21 studies Evidence up to Nov 2020	PTSD and comorbid borderline personality disorder (BPD)	Interventions: psychotherapies, including TF and non-TF PTSD treatments, BPD-specific treatments	Findings suggest that TF treatments reduce PTSD and BPD symptoms, however it is unclear whether TF treatment is equally efficacious to gold standard BPD-specific treatment
Atchley 2021[29]	17 studies Evidence up to Jul 2019	PTSD and dissociative symptoms	Interventions: various, including trauma-focused group therapy, PE, NET	Trauma-focused treatments often reduced PTSD and dissociative symptoms Exposure treatments were not found to be harmful to patients with higher dissociative symptomatology
PTSD related to specific populations/situations				
Slade 2021[32]	18 studies, including 5 studies on clinical effectiveness of interventions and 13 qualitative studies Evidence up to Oct 2020	Post-traumatic stress following childbirth	Interventions: psychological interventions, including EMDR, TF-CBT, debriefing and expressive writing	All interventions showed some effectiveness reducing post-traumatic stress symptoms however the review authors note that further research is needed to determine true effects

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
Baas 2020[31]	13 studies, including 3 RCTs. 6 of the studies were for TF-therapy Evidence up to Jun 2019	PTSD during pregnancy	Interventions: various, including TF-CBT, exposure therapy, EMDR	EMDR reduced PTSD symptoms in short term and in follow-up (up to 36 months) (note all EMDR studies were case series) TF-CBT also reduced PTSD symptoms
Haerizadeh 2020[33]	6 RCTs Evidence up to Nov 2018	Medical event-induced PTSD symptoms in adults	Interventions: psychological interventions, including exposure-based CBT, EMDR	Exposure-based CBT interventions reduced PTSD symptoms posttreatment compared to control groups Weak evidence suggests EMDR may be superior to other active treatments
Mabunda 2022[34]	10 studies, including 6 RCTs Evidence up to Dec 2018	Mental health disorders in Africa	Interventions: cultural adaptation of psychological interventions, including TF-CBT and NET, delivered by lay health workers	Interventions were associated with symptom improvement, such as depression and PTSD
Luteijn 2020[35]	32 studies, including 21 on PTSD treatment, 11 on SUD treatment Evidence up to Jan 2020	Individuals with mild intellectual disability or borderline intellectual functioning (MID-BIF) with PTSD or SUDs	Interventions: PTSD treatments mainly included EMDR or CBT (imaginary exposure) – often adapted to individuals with MID-BIF); SUD treatments mainly included CBT or mindfulness	Intervention studies showed a reduction in PTSD or SUD symptoms in individuals with MID-BIF
Byrne 2022[36]	11 studies Evidence up to Mar 2020	PTSD and associated symptoms for both adults and children with mild, moderate, or severe intellectual delay	Interventions: EMDR or CBT	Weak evidence suggests that EMDR and CBT are both acceptable and feasible treatment options among adults and children with varying levels of intellectual delay
Complex trauma				
Han 2021[37]	32 studies – 19 RCTs	Trauma in adults in primary care or community setting (not	Interventions: Trauma-informed interventions, including EMDR, TF-	Reports that evidence to support trauma informed interventions for

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes

	Evidence up to Jun 2019	military, refugee or war-related trauma populations or incarcerated populations), most studies focused on child abuse, sexual assault, or domestic violence	CBT/CBT, mindfulness-based stress reduction program, TREM, general TF therapy, psychodynamic therapy, stress inoculation therapy, present-focused therapy, CPT	psychological outcomes is inconsistent:
				• 15 studies found trauma-informed interventions led to improvements in 3 main psychological outcomes:
				  ○ PTSD symptoms (11 of 23 studies)
				  ○ depression (9 of 16)
				  ○ anxiety (5 of 10)

Coventry 2020[38]	116 studies (of which 24 were in community settings, 2 in primary care clinics); 94 RCTs Evidence up to Apr 2017	Complex trauma – subgroups included post-combat deployment veterans, war-related, childhood sexual abuse, refugees, domestic violence	Interventions: psychological and pharmacological interventions; trauma-focused psychological interventions included: TF-CBT and EMDR	Trauma-focused psychological interventions reduced PTSD symptoms more than non-trauma-focused interventions across trauma subgroups, however effects among veterans and war-affected populations were not as strong TF-CBT was consistently associated with the largest effects TF-CBT and EMDR also reduced depressive and anxiety symptoms
Melton 2020[39]	Coventry 2020 describes effectiveness studies In addition, 8 qualitative studies reported on acceptability	Complex trauma – qualitative studies were identified in the following populations: IPV, veterans, childhood sexual abuse and asylum seekers	Interventions: various, including PE and TF-CBT	Qualitative acceptability review: • Mixed patient views regarding group therapies – some finding this acceptable but others not wanting to participate • Examples of patient views included that trauma-focused treatments were 'worth it' as they were seen to be effective
Other mental health conditions				
Dominguez 2021[40]	11 RCTs	Depression	Interventions: TF therapy, predominately EMDR	TF treatments (predominately EMDR) reduced depressive

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
	Evidence up to Oct 2019		Comparison: any other psychological and pharmacological treatments including standard care and waitlist	symptoms post-treatment, compared to control conditions
Martinez 2021[41]	14 studies, including 8 RCTs Evidence up to Oct 2019	Depressive or bipolar disorders in adults exposed to adverse stress early in life Note no studies in bipolar disorder patients were identified	Interventions: any intervention (psychological, pharmacological, psychosocial, or a combination) aimed at treating depressive or bipolar disorders in adults with early adverse stress Comparison: various, no control group, no intervention, waitlist, other therapies	Psychological, pharmacological, and combined treatment interventions reduced depressive symptoms in the short- and mid-term Sensitivity analyses suggest psychological or combined treatment interventions had greater effect sizes than pharmacological interventions (although no statistically significant differences)
Bloomfield 2020[42]	24 studies, including 1 RCT, 4 case series and 19 case reports Evidence up to 2018	Psychotic and dissociative symptoms in adult survivors of developmental trauma	Interventions: psychological or pharmacological treatment, including 'third wave CBT' Comparison: only 1 study used a comparison which was treatment-as-usual	Weak evidence to suggest third-wave CBT reduced dissociation or other trauma symptoms, however, due to low methodological quality the authors note it is unknown which treatments are most effective in this clinical group and more research is needed
Overall trauma-focused interventions - children				
Romano 2021[43]	21 studies across 9 reviews Evidence up to May 2019	Children exposed to IPV	Interventions: various, 9 studies evaluated trauma-specific interventions Comparison: no treatment, services-as-usual	Overall, improvements in child outcomes (such as externalising and internalising behaviours, trauma-related symptoms, social behaviours) were reported following interventions, however the authors note that TF approaches had smaller overall effect sizes than non-TF interventions

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
Bennett 2021[44]	15 RCTs and 5 non-randomised controlled trials Evidence up to Dec 2018	PTSD in maltreated children	Interventions: psychological treatments that targeted PTSD symptoms, including TF-CBT, exposure therapy, CBT, CPP, and other therapies Comparison: waitlist, treatment-as-usual or other intervention	TF-CBT reduced PTSD symptoms in maltreated children Prolonged exposure was also noted as a promising therapy but requires more research
Xiang 2021[45]	56 RCTs Evidence up to Dec 2020	PTDS in children and adolescents	Interventions: psychotherapies, including CPT, BT, TF-CBT (individual or group), EMDR Comparison: waitlist, treatment-as-usual, other therapies	CPT, BT, individual TF-CBT, EMDR and group TF-CBT had significant reductions in PTSD symptoms at post-treatment and follow-up, compared with control conditions
McTavish 2021[46]	15 RCTs – 8 for children only, 9 for children and caregivers (2 studies had study arms for both) Evidence up to Jun 2016	Children and adolescents exposed to sexual abuse	Interventions: psychotherapies, including CBT, TF-CBT, PE, stress inoculation therapy, EMDR, family network meetings, psychotherapy, Risk Reduction through Family Therapy	TF-CBT for children and involving their caregivers may reduce some mental health symptoms, such as PTSD, depression, and anxiety
Mavranezouli 2020b[47]	32 RCTs Evidence up to Jan 2018	PTSD in children	Interventions: psychological and psychosocial therapies, including TF-CBT and EMDR Comparison: waitlist	Individual TF-CBT interventions (including CT, NET, exposure therapy/PE, Cohen TF-CBT/CPT) consistently reduced PTSD symptoms post-treatment compared with waitlist EMDR and group TF-CBT were also reported to be effective in reducing PTSD symptoms but to a lesser extent

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
John-Baptiste Bastien 2020[48]	27 RCTs, meta-analysis included 16 studies Evidence up to Jul 2019	PTSD in children, adolescents and young adults Trauma included war-related trauma, natural disasters, sexual abuse, IPV	Interventions: psychological therapies, including TF-CBT, PE, EMDR, NET Comparison: various, including waitlist or other therapies	Overall, psychological interventions were better than control conditions at reducing PTSD symptoms Subgroup analyses suggested that: • EMDR and TF-CBT were superior at reducing PTSD symptoms compared with general (non-TF) CBT • EMDR was superior at reducing PTSD symptoms compared with TF-CBT (note smaller number of EMDR studies with high heterogeneity) • There was no significant difference between non-TF CBT and controls
Sanchez de Ribera 2020[49]	9 meta-analyses	Sexually abused children and adolescents	Interventions: any treatment modality, including: trauma-focused CBT, CBT, psychodrama, play therapy, and eclectic interventions	While interventions (particularly CBT) for child sexual abuse appeared to have positive effects, all meta-analyses showed a high risk of bias and poor methodological quality
Specific interventions – EMDR				
PTSD				
Morris 2021[50]	8 studies: 3 RCTs, 1 nonrandomized quasiexperimental study, 1 pre–post study, and 3 case studies Evidence up to Nov 2020	Trauma among first responders	Intervention: EMDR Comparison: various, including supportive counselling or no treatment	All studies reported significant reductions in PTSD symptom severity
Kaptan 2021[51]	22 studies	PTSD in adults and children	Intervention: Group EMDR	Group EMDR protocols significantly reduce symptoms of PTSD

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
	Evidence up to May 2020		Comparison: No treatment, waitlist, TF-CBT 12 studies used a one-arm design with pre-treatment/post-treatment assessments	Improvements were also reported for depression and anxiety
Manzoni 2021[52]	8 RCTs Evidence up to Jan 2020	PTSD in children and adolescents	Intervention: EMDR Comparison: waitlist/placebo, CBT	EMDR reduced PTSD, anxiety symptoms and depressive symptoms post-treatment and was superior to waitlist/placebo and comparable with CBT
Other mental health disorders				
Carletto 2021[53]	11 controlled studies; 9 included in meta-analysis Evidence up to Sep 2020	Depression – predominately adults	Intervention: EMDR Comparison: no intervention, waiting list, treatment-as-usual, or other types of intervention	EMDR had a significant effect on reducing depressive symptoms
Yan 2021[54]	8 RCTs Evidence up to Nov 2020	Major depressive disorder in adults	Intervention: EMDR Comparison: no intervention, waiting list, or other types of intervention	The meta-analysis suggests that EMDR was more effective in reducing depressive symptoms than 'no intervention' and CBT
Perlini 2020[55]	15 studies, including 6 RCTs, 2 pilot RCTs, 2 controlled studies and 5 case reports Date of literature search not stated, most recent trials included published 2020	Trauma in affective disorders, such as bipolar disorder (BD) (3 studies) and major depressive disorder (12 studies)	Intervention: EMDR Comparison: treatment-as-usual, waitlist, other therapies; some studies with no comparator	EMDR reduced depressive symptoms post-treatment, effects were partly maintained at follow-up Note 2 of the 3 studies on BD were case series
Yunitri 2020[56]	17 RCTs with 647 participants	Anxiety disorders – predominately adults	Intervention EMDR Comparison: passive or active controls	EMDR was associated with significant reductions in anxiety, panic, phobia, and behavioural/somatic symptoms post-

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
	Evidence up to Dec 2018			treatment, particularly compared to passive control. However, EMDR did not reduce symptoms of traumatic feelings
Adams 2020[57]	6 studies, including 2 RCTs, 1 pilot study, 2 case series and 1 case report Evidence up to Jul 2018	Psychosis	Intervention: EMDR Comparison: 1 study compared to PMR or treatment-as-usual, 1 study compared to waitlist or PE and 4 had no controls	Overall, EMDR was associated with reductions in delusional and negative symptoms of psychosis, however evidence for reductions in auditory hallucinations and paranoid thinking was mixed EMDR did not lead to adverse events and appears to be safe and feasible in this population, however more research is needed
Range of disorders included				
Cuijpers 2020[58]	77 RCTs Evidence up to Nov 2017	Mental health problems – 48 studies on PTSD, 17 anxiety, 3 depression, 9 other	Intervention: EMDR Comparison: control groups (waiting list, care-as-usual, relaxation, other) or other psychological treatments	EMDR reduced PTSD post-treatment: • with largest effect sizes compared to control groups (particularly waitlist controls) • overall, EMDR appeared to be more effective than other therapies, however, studies with lower risk of bias showed no significant difference between EMDR and other psychotherapies Positive effects of EMDR on phobias and test anxiety were suggested in 4 studies each, compared with controls

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
Portigliatti Pomeri 2020[59]	7 studies, including 2 RCTs Date of literature search not stated, most recent trials included published 2019	Cancer patients – diagnosed with PTSD or anxiety-depression disorder spectrum	Intervention: EMDR Comparison: 3 studies used a control group and 2 studies compared with CBT	All studies reported reduction of PTSD and/or psychological symptoms after EMDR
Specific therapies – TF-CBT				
PTSD				
Ennis 2021[60]	21 studies – 17 RCTs Evidence up to Oct 2020	PTSD under ongoing threat – war-related or community violence (14 studies), domestic violence (5 studies), work-related traumatic events (e.g. firefighters, military) (2 studies)	Interventions: TF-CBT, CPT, NET Comparison: waitlist control or other therapies	TF-CBT reduced PTSD symptoms posttreatment, compared with waitlist controls. However, there were mixed findings for domestic violence samples on long-term outcomes TF-CBT does not appear to be contraindicated for individuals at elevated risk of trauma exposure. However, review authors note more research is needed
Trauma in vulnerable children				
Chipalo 2021[61]	4 studies – 2 RCTs Evidence up to Oct 2019	Trauma symptoms in refugee children	Interventions: TF-CBT	TF-CBT reduced trauma symptoms in all 4 trials The review authors note there is still limited evidence whether TF-CBT is effective for all refugee children
Thomas 2020[62]	10 studies, including 5 RCTs, 3 pre-post studies, 1 secondary analysis, 1 qualitative study	Trauma symptoms in children and youth in low and middle-income countries Implemented in low-resource community settings, such as	Interventions: TF-CBT Comparison: waitlist or treatment-as-usual	TF-CBT improved PTSD symptoms and psychosocial difficulties and was superior to waitlist or treatment-as-usual

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
	Evidence up to Feb 2020	schools, community centres, public health clinics or hospitals, non-governmental organisations and home-based care settings		The majority of studies involved training of lay counsellors, review authors suggest that it is feasible to provide cost-effective treatment in low-resource countries
Specific interventions – exposure therapy				
PTSD				
McLean 2022[63]	65 studies Evidence up to Oct 2020	PTSD in adults Includes some stratified results by population type, such as refugees, civilians or military, and by trauma type, such as natural disaster, combat or sexual assault	Intervention: exposure therapy Comparison: various, including waitlist, treatment-as-usual, other TF therapies, non-TF therapies	Exposure therapy reduced PTSD symptoms: • the largest effect was compared to waitlist and TAU • a smaller effect compared to non-TF therapy • not different from TF therapy or medication (SSRIs) Larger effect sizes were seen in: • studies of refugees and civilians compared with those in military samples • studies of PTSD related to natural disasters and transportation accidents vs. other traumatic events • studies of individual vs. group therapy
Siehl 2021[64]	56 studies in review; 19 studies in meta-analysis 28 RCTs Evidence up to Mar 2020	PTSD in adults or children in vulnerable populations such as refugees or post-conflict settings	Intervention: NET, FORNET Comparisons: active or non-active controls groups	NET decreased PTSD symptoms in short and long-term in adults, perpetrators and children
Grech 2020[65]	10 RCTs	PTSD	Intervention: NET	All studies reported greater reductions in PTSD symptoms at 3–

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
	Date of literature search not stated, most recent trials included published 2014		Comparison: non trauma-focused therapy, e.g. supportive counselling or psychoeducation	6 months follow-up in the NET groups (statistically significant in 6 of the 10 trials)
Zhou 2020[66]	18 RCTs Evidence up to Jan 2019	PTSD	Intervention: modified PE (mPE) and the PE combined with drug (PE/d). Comparison: PE	Active treatment groups all reduced PTSD symptoms, with no significant difference between mPE + PE/d and PE on PTSD scores or posttreatment dropout rate
Specific interventions – virtual				
PTSD				
Knaust 2020[67]	18 studies, including 9 RCTs, 3 pilot studies, 6 case studies Evidence up to Jul 2020	PTSD, majority of the primary studies examined male soldiers with combat-related PTSD	Interventions: virtual trauma interventions (usually based on PE or EMDR), Virtual Reality Exposure Therapy (VRET), Multi-Modular Motion-Assisted Memory Desensitization and Reconsolidation (3MDR), Action-Centered Exposure Therapy (ACET)	Improvements in PTSD symptoms were observed post-treatment for all of the interventions and usually maintained at 3- or 6-month follow-up
Simon 2021[68]	13 RCTs Evidence up to Jun 2020	PTSD in adults	Intervention: Internet-based cognitive and behavioural therapy Comparison: face-to-face or Internet-based psychological treatment, psychoeducation, waitlist, or care as usual	Some beneficial effects of internet-based CBT, such as reductions of PTSD symptoms, and possible reduction of depression and anxiety symptoms post-treatment compared with waitlist
Jones 2020[69]	38 studies, including 29 RCTs Evidence up to May 2020	PTSD in military, veterans and public safety personnel	Intervention: virtual TF-therapy, including PE, CPT Comparison: in-person therapy	PE, CPT, and behavioural activation and therapeutic exposure delivered via videoconferencing significantly reduced PTSD symptoms in veterans and/or military members, however the evidence for CBT was conflicting

Citation – First author, year	Evidence-base	Population/condition	Intervention/Comparison	Reported outcomes
				Facilitators and barriers also discussed

BCBT: brief cognitive behaviour therapy; BET: brief eclectic therapy; BD: bipolar disorder; BPD: borderline personality disorder; BT: behavioural therapy; BTP: brief treatment program; CBT: cognitive behavioural therapy; CBT-T: cognitive behavioural therapy with a trauma focus; COPE: concurrent treatment of PTSD and substance use disorders using prolonged exposure; CPP: child parent psychotherapy; CPT: cognitive processing therapy; CT: cognitive therapy; DBT: dialectical behaviour therapy; EMDR: eye movement desensitization and reprocessing; FORNET: forensic offender rehabilitation narrative exposure therapy; IPT: interpersonal therapy; IPV: intimate partner violence; MCT: metacognitive therapy; MID-BIF: mild intellectual disability or borderline intellectual functioning; NET: narrative exposure therapy; PACT: postadmission cognitive therapy; PCT: present centred therapy; PE: prolonged exposure; PMR: progressive muscle relaxation; PTSD: posttraumatic stress disorder; RCT: randomised controlled trial; RTM: reconsolidation of traumatic memories; SIT: stress inoculation training; SSRI: selective serotonin reuptake inhibitor; SUD: substance use disorder; TARGET: trauma affect regulation: guide for education and therapy; TAU: treatment-as-usual; TF: trauma-focused; TF-CBT: trauma-focused cognitive behavioural therapy; TREM: trauma recovery and empowerment model; VRET: virtual reality exposure therapy; WET: written exposure therapy.

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These tables accompany *Rapid review on trauma-informed care in primary care settings – Summary report – Part A.*

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