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Trauma-informed approaches in adult healthcare encounters: a focused narrative review of ethical practice, clinical evidence, and implementation safeguards

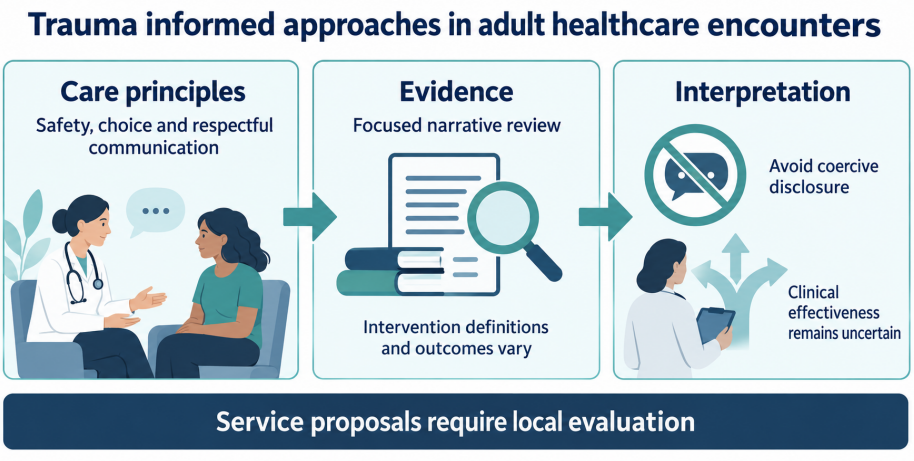
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ABSTRACT



Graphical abstract

Background. Trauma-informed care (TIC) describes relational and organizational approaches that differ from trauma-focused treatment.

Objective. To examine adult encounter safeguards, patient-outcome evidence and implementation limits.

Methods. Focused PubMed Title/Abstract keyword discovery on 6 October 2026 was capped at 45 records, with targeted supplementary verified sources. Selection and English-language reading were purposive. Six lawful PMC copies were retained and accessible passages consulted; other records were assessed at indexed abstract/metadata level. No exhaustive search, duplicate human screening, registered protocol, new meta-analysis or formal certainty grading was undertaken.

Synthesis. The 2025 AHRQ review included 12 studies in 16 publications, all at high risk of bias, and found insufficient evidence for patient/client outcomes; its studies did not collect harms [1]. Its July 2024 cutoff precedes the Chilean cluster trial enrolling 214 patients across 16 teams, which reported lower six-month depression scores for a defined bundled model; 81/115 and 60/99 participants were evaluated at six months [2]. A New Orleans pilot enrolled 42, analyzed 40 at baseline and retained 36 at nine months; between-group PTSD comparisons were non-significant [3]. Training findings concern provider or standardized-encounter outcomes and cannot establish routine patient benefit [4]. The AHRQ evidence spans adult, pediatric and social-service settings, including only two adult medical studies and one adult mental-health study. This mixed scope limits the directness of its conclusion for adult encounters.

Choice, privacy and response capacity remain proposed safeguards rather than proven therapeutic components.

Conclusion. Choice, privacy and response capacity provide an ethical implementation rationale. Patient-effectiveness claims require model-, population- and outcome-specific evidence; no local effect or universal screening superiority is established.

Source and interpretation note for Figure 1. Author synthesis of the evidence presented in the text and the source-specific citations in the manuscript tables. Pictograms and arrows are conceptual and do not depict measured results, new patient data, or proven local benefits.

Keywords: trauma-informed care; ethics; patient-centered care; implementation; adult healthcare; narrative review

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Introduction

Trauma is highly prevalent in adult populations across diverse settings, and a substantial proportion of patients attending routine healthcare services carry histories that shape how they experience the clinical encounter [5, 6]. Trauma-informed care (TIC) emerged in the United States, particularly through mental health and substance use services, and has been formalised internationally through the Substance Abuse and Mental Health Services Administration (SAMHSA) "4 Rs" framework: Realise the impact of trauma, Recognise its signs, Respond by integrating that knowledge, and Resist re-traumatisation [5, 6, 7, 8, 9]. TIC is conceptually distinct from trauma-focused therapy: the former reorganises services to reduce harm and promote safety for everyone, including those without a disclosed trauma history, while the latter addresses symptoms such as post-traumatic stress disorder (PTSD) through specific evidence-based psychotherapies and pharmacotherapy [6, 10]. Conflating these two domains risks overstating the evidence behind universal precautions and misapplying the strong evidence for trauma-focused treatments.

Three considerations motivate this review. First, the ethical case for trauma-informed practice is grounded in principles of beneficence, non-maleficence, respect for autonomy, and justice, particularly for patients whose autonomy has been constrained by past or ongoing violence [7, 11, 12]. Second, the clinical evidence base is uneven, with universal-precaution TIC and bundled collaborative-care models showing different patterns of effect across outcomes and settings [1, 2, 3, 4, 5, 6]. Third, implementation safeguards are essential: training that improves provider confidence does not, by itself, demonstrate patient benefit; screening without response capacity can cause harm; and structural inequities can be reinforced if TIC is delivered as a checklist rather than as organisational change [5, 6, 9, 13]. Any adult-focused discussion must avoid generalising findings from

maternity, trafficking, or refugee populations to all adult encounters or as cultural stereotypes [5, 6, 7, 14, 15, 16, 17, 18, 19, 20, 21].

This review aims to (a) describe the mechanisms through which TIC is hypothesised to influence clinical encounters, (b) summarise the current effectiveness and harms evidence for adult-focused TIC, (c) delineate implementation safeguards and counterexamples, (d) distinguish TIC universal precautions from trauma-focused treatment, and (e) discuss a proposed local adaptation framework. Throughout, claims are tied to specific sources; clinical practice points remain linked to underlying evidence, and the need for individual clinical judgement is preserved. A focused narrative contribution is offered; comprehensiveness is not claimed.

Review approach

A focused narrative review was undertaken rather than a systematic review or meta-analysis. The actual search executed for this manuscript was a PubMed keyword Title/Abstract discovery search on 6 October 2026, capped at 45 retrievals, using combinations of terms related to "trauma-informed care," "universal precautions," "adverse childhood experiences," "primary care," "nursing," "reproductive health," "human trafficking," "refugee health," "homelessness," "ethics," and "implementation." Named targeted supplementary PubMed source records were added, including the AHRQ 2025 evidence report and targeted retrieval of named primary-study PubMed records. Databases searched by published source reviews were not searched for this manuscript. English-language reading and purposive selection do not imply a formal eligibility screen.

Selection was purposive and relevance-driven. Inclusion favoured adult-focused studies, conceptual and ethical analyses, and implementation syntheses; maternity, trafficking, and refugee literature were retained as specific context examples and not as a basis for generalisation. No formal exclusion screen or exhaustive ineligible-record corpus was established; relevance to adult encounters guided purposive reading. No duplicate human screening, no protocol registration, and no formal certainty grading (such as GRADE) were undertaken. The intent was to assemble a coherent, source-linked synthesis rather than to claim exhaustive coverage.

Indexed abstracts and metadata were verified for all retained sources through PubMed records; the AHRQ report also had an official structured-summary check. Accessible PMC fulltexts were consulted where available; six fulltext copies were retained for narrative use (Goldstein, Huo, Grossman, Hart, Green and Meredith), and only supplied accessible excerpts were used, not full bibliographic appraisal of every reference. The AHRQ 2025 report [1] and the Chilean cluster trial [2] were drawn from indexed abstracts and supplementary verified sources rather than retained fulltext. The 45-record cap on PubMed discovery does not imply 45 included studies; literature counts such as "12 eligible studies" or "16 publications" reflect the source reviews themselves, not the present screening. A Saudi evidence-gap conclusion was not established by this search.

The synthesis is organised around mechanisms of decision-making, differences between studies, patient-centred harms, evidence limitations, missing data, feasible measurement, and responsibilities and counterexamples. Three native Word tables summarise key syntheses and are placed immediately after the first callout in their respective sections.

Definitions, scope, and the distinction from trauma-focused therapy

SAMHSA's conceptual definition characterises trauma as an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life threatening, with lasting adverse effects on functioning and well-being [5, 6]. TIC extends this definition across individual, interpersonal, and collective or structural levels, recognising racism, poverty, and stigma as sources of trauma that shape healthcare engagement [9, 13]. Trauma-informed nursing has been articulated around principles of safety, trustworthiness, choice, collaboration, and respect, with screening, relationship quality, distress minimisation, multidisciplinary collaboration, and advancement of TIC identified as cross-cutting themes [10, 11, 12].

Critically, TIC as a universal precaution differs from trauma-focused treatments for PTSD and other trauma-related conditions. Trauma-focused therapies (e.g., trauma-focused cognitive-behavioural therapy, EMDR, pro-

longed exposure) target symptoms and have a distinct evidence base; they require referral pathways that TIC programmes must enable but do not replace [6, 10]. The 2024 realist synthesis by Goldstein and colleagues mapped 16 reviews onto SAMHSA's 10 implementation domains, identifying engagement and involvement (10 studies), training and workforce development (9), cross-sector collaboration (8), and screening, assessment, and treatment services (7) as the most frequently addressed domains, with physical environment and financing rarely addressed [5]. The Huo and colleagues systematic review of 27 studies in 28 publications synthesised barriers and facilitators across the Consolidated Framework for Implementation Research, highlighting the importance of leadership buy-in, resources, and flexible protocols [6].

A concept analysis of trauma-informed nursing argued for a comprehensive, multi-disciplinary approach through universal recognition and screening, with targeted interventions creating a system of healing through empowerment and relationship building [12]. This emphasis on universal recognition raises a separate question: when does universal recognition imply universal screening, and when does it imply universal precaution without active case-finding? The literature is not uniform. Reproductive-health authors have advocated universal screening for a history of sexual abuse in obstetric practice [14, 15, 21], while trauma-informed medical care (TI-Med) training explicitly noted that universal screening is not its goal and described sensitive approaches to disclosure rather than mandated case-finding [4]. The AHRQ 2025 review did not collect harms data; its scope concerns heterogeneous TIC approaches in mixed settings, not a direct universal-screening versus universal-precaution comparison, meaning that the comparative risk-benefit of universal screening versus precaution remains unresolved.

Table 1 presents conceptual and operational elements of trauma-informed care in adult healthcare.

Table 1. Conceptual and operational elements of trauma-informed care in adult healthcare.

Element	Description	Source
Trauma definition	Individual, interpersonal, and collective/structural events with lasting adverse effects	[5, 6, 9]
SAMHSA 4 Rs	Realise, Recognise, Respond, Resist re-traumatisation	[7, 8, 13]
SAMHSA 10 implementation domains	Engagement; training; collaboration; screening/services; governance; policy; evaluation; monitoring; financing; physical environment	[5]
Universal precaution posture	Assume trauma exposure; design every encounter to avoid harm	[6, 7, 9]
Trauma-focused therapy (contrast)	Specific evidence-based treatments for PTSD and related conditions	[6, 10]
Ethics anchor	Beneficence, non-maleficence, autonomy, justice	[7, 11, 12]

Table note. The SAMHSA 4 Rs appear in slightly varied wordings across sources; the formulation above reflects the most consistently reported version. Trauma-focused therapy is listed for contrast, not as a component of TIC.

Ethical foundations and patient-centred harms

The ethical case for TIC rests on both the prevalence of trauma exposure and the documented capacity of routine care to retraumatise [7, 9, 11, 12]. Rudolph's 2021 analysis identified TIC as consistent with existing ethical frameworks and argued that TIC mitigates retraumatisation risk particularly in settings involving involuntary treatment, restraints, or seclusion, while also addressing vicarious trauma among staff [7]. Nursing analyses described TIC as underutilised by clinicians and as an expression of nursing ethics and respect for human rights, with emphasis on creating safe, welcoming environments for patients previously marginalised by

health systems [11, 12]. Trauma-informed language has been highlighted as a tangible clinical tool, with the editorial by Hart and colleagues noting that stigmatising language (e.g., "recidivist," "frequent flyer") may reinforce stigma and undermine trust; proposed effects on allostatic burden or re-injury are conceptual mechanisms rather than measured wording-intervention effects [13].

Patient-centred harms are a central concern. The AHRQ 2025 review explicitly stated that included studies did not collect information on harms, adverse events, or unintended consequences of TIC — an absence that does not prove safety but does mean that practitioners and organisations adopting TIC must build their own local safeguards [1]. Potential harms include over-disclosure in unsupportive environments, retraumatisation triggered by well-intentioned but poorly timed inquiry, misattribution of presenting complaints to trauma, and reinforcement of structural inequities when TIC is implemented as a one-off training rather than as organisational change [5, 6, 7, 13]. A counterexample worth flagging: a clinician who, after a brief TIC workshop, asks every patient detailed trauma questions in a busy primary-care visit without a clear response pathway risks producing distress without benefit.

Screening deserves specific ethical scrutiny. The AHRQ review's finding of insufficient evidence for patient/client outcomes across settings is consistent with calls for screening only when response capacity is in place [1, 14, 15, 21]. In reproductive healthcare, the American College of Obstetricians and Gynecologists' recommendation for universal screening and universal application of a trauma-informed approach is widely cited, but Owens and colleagues acknowledged that universal screening remains far from universally practised, and Cahill and colleagues emphasised that trauma-informed abortion care requires both individual safety and the dismantling of systemic barriers [14, 15]. Maternity and postpartum authors have proposed practical communication, behavioural, and procedural considerations to integrate TIC into routine care, with explicit attention to populations that have been marginalised [21]. These recommendations, while ethically coherent, rest on consensus and mechanism rather than on randomised-trial evidence of improved outcomes.

Vicarious trauma among staff is a further ethical concern. Surgical residents have been found to have substantial rates of PTSD and at-risk symptomatology, suggesting that trauma-informed approaches to the workforce are part of the ethical picture [9]. Implementation frameworks increasingly include staff wellness as a domain [5, 6, 10]. No pressure should be placed on patients to disclose trauma; providers should create conditions in which disclosure is safe but optional.

The clinical evidence base: effectiveness, harms, and limitations

The 2025 AHRQ systematic review provides a methodologically cautious summary of the clinical evidence [1]. From 4,379 unique references, the review identified 12 eligible studies discussed in 16 publications, with settings spanning adult medical care (two studies), adult mental health (one), primary prevention for children (one), adolescent medical care (one), residential child welfare (four), and non-residential child welfare (three). All studies were assessed as high risk of bias, evidence was insufficient to determine the effects of TIC on patient/client outcomes across all settings and comparisons, and studies did not collect information on harms, adverse events, or unintended consequences. TIC models varied considerably in their socioecological components, and only a few described specific elements of cultural competency or humility. The AHRQ conclusion — paraphrased here to preserve attribution without extended quotation — acknowledges that this insufficiency does not mean individual interventions are not useful; rather, the evidence does not yet provide clear answers, and TIC is being widely implemented regardless. The AHRQ search cutoff is 19 July 2024, and the Chilean trial [2], published in November 2024, is therefore a separate subsequent study.

Two adult-focused primary-care studies illustrate both the promise and the limits of the current evidence. The 2024 Chilean cluster trial by Vitriol and colleagues randomised 16 primary-care teams in the Maule Region to collaborative trauma-informed care (CTIC) or usual treatment, which enrolled 214 patients (115 CTIC, 99 usual); 81 and 60, respectively, were evaluated at six months [2]. Outcomes were assessed at baseline, three months and six months; the source reports a last-observation-carried-forward sensitivity analysis. At 6 months, depressive symptoms declined significantly more in the CTIC arm (adjusted mean difference -3.09, 95% CI -4.94 to -1.23; d = -0.46; P =.001), and adherence was higher. Anxiety showed a trend favouring CTIC (P

=.055), but no significant differences emerged in other secondary outcomes. The study population was 85% women, with 61% reporting four or more adverse childhood experiences. The result supports a bundled collaborative-care model for depression in primary care in this setting, but should not be generalised as universal proof for all adult examinations.

The 2022 New Orleans pilot by Meredith and colleagues, conducted in a Federally Qualified Health Center, randomised 42 African American adults with a provisional PTSD diagnosis to trauma-informed collaborative care (TICC) or enhanced usual care; after exclusion of one duplicate enrollment and one baseline withdrawal, the analytic baseline was 40 (21 enhanced usual care / 19 TICC), and 36 completed the 9-month follow-up (20 / 16) [3]. At 9 months, PTSD symptom scores decreased by 26 points in enhanced usual care and 36 points in TICC (P =.08), and provisional PTSD diagnosis rates decreased by 33% and 57% respectively (P =.27). Neither difference reached statistical significance. The authors appropriately described TICC as "promising" and called for a larger-scale trial. This pilot should not be cited as evidence of between-group efficacy, and the source's wording of "clinically meaningful" is not a justification for an efficacy claim in the absence of a prespecified minimal important difference and a sufficiently precise between-group comparison.

Training studies have repeatedly shown improvements in provider knowledge, attitudes, and confidence. The TI-Med randomised trial of a 6-hour continuing medical education course for primary-care providers randomised four primary-care sites and rated 90 standardised-patient encounters involving 30 clinicians; immediate trained-versus-delayed change trended with a moderate effect size (Cohen's d =.66) but did not reach conventional significance at the planned primary contrast, while a pooled before/after comparison showed a significant within-group increase in patient-centredness [4]. A resident curriculum using five 1-hour didactic sessions plus reflection showed increased self-reported knowledge, attitudes, and practice, with residents valuing both experiential and skills-based exercises, and next steps including patient outcomes [22]. An interprofessional course similarly reported student achievement of learning outcomes and valued resilience practice [23]. Together, these studies report within-group changes in standardised encounters and self-reported gains; they do not establish that training caused those changes, changed routine real-patient behaviour or improved patient outcomes, a distinction that is consistently under-recognised in implementation discourse.

Table 2 presents selected evidence sources on adult-focused TIC and TIC training.

Table 2. Selected evidence sources on adult-focused TIC and TIC training.

Study	Design / Setting	Population / N	Outcome and uncertainty	Source
AHRQ 2025 review	Systematic review; mixed adult/paediatric/ social-service settings	12 studies / 16 publications	Patient/client outcomes across settings: Insufficient evidence; high risk of bias; no harms collected	[1]
Vitriol 2024 (Chile)	Cluster RCT, 16 primary-care teams	214 enrolled (115 CTIC, 99 UT); 81 and 60 evaluated at six months, respectively; 85% women	Depression at 6 months: Significant reduction (P = .001)	[2]
Meredith 2022 (New Orleans)	Pilot RCT, single FQHC	42 enrolled; 40 at analytic baseline; 36 at 9-month follow-up	PTSD symptoms, provisional diagnosis: Greater reduction in TICC; not significant (P = .08, P = .27)	[3]

Study	Design / Setting	Population / N	Outcome and uncertainty	Source
Green 2015 (TI-Med)	RCT of 6-hour CME; 90 SP encounters	30 PCPs	Patient-centred communication: Between-group estimate d = .66 was not conventionally significant; within-group pre/post increase	[4]
Shamaskin-Garroway 2020	Curriculum evaluation	Internal medicine and NP trainees	Knowledge, attitudes, practice: Self-reported improvement	[22]
Fiske 2021	Course evaluation	Interprofessional health students	Learning outcomes: Achieved; resilience practice valued	[23]

Table note. "Significant" refers to statistical significance as reported by the source. The New Orleans pilot reductions did not reach between-group statistical significance. The TI-Med primary between-group comparison trended with d =.66 but did not reach conventional significance; the within-group pre/post increase was significant. Effect sizes are reported as in the original sources. Studies represent mixed scope (adult, paediatric, and social-service settings in AHRQ); the title "selected evidence sources" reflects this heterogeneity.

The realist synthesis by Goldstein and colleagues added an implementation lens, identifying context-mechanism-outcome configurations across 16 reviews and emphasising that successful implementation is associated with engagement and involvement, training and workforce development, cross-sector collaboration, and screening, assessment, and treatment services, with less attention to governance, policy, evaluation, monitoring, financing, and physical environment [5]. The Huo and colleagues systematic review of 27 studies mapped barriers and facilitators to the Consolidated Framework for Implementation Research, identifying intervention characteristics, external influences, internal organisational factors, implementation processes, and individual characteristics as key domains, with leadership engagement, resources, flexible protocols, and tailored training recurring as facilitators [6].

These reviews consistently report that the implementation evidence is more developed than the patient-outcome evidence, a finding that should temper organisational claims. The evidence base for adult-focused TIC universal precautions, taken as a whole, remains insufficient; bundled models with defined active ingredients (e.g., collaborative care with motivational interviewing) have shown patient benefit in specific contexts.

Implementation safeguards and responsibilities

Implementation safeguards are mechanisms that protect patients and staff from the predictable risks of incomplete or superficial TIC adoption. Drawing on the Goldstein and Huo syntheses [5, 6], supplemented by conceptual and domain-specific work [7, 9, 10, 11, 12, 13, 17, 18, 19, 22, 24, 25, 26], the following safeguards can be proposed for adult healthcare settings.

First, governance and leadership. A named clinical lead, protected time, and integration into quality-improvement structures reduce the risk of TIC becoming a one-off training. Goldstein and colleagues mapped governance and leadership across multiple reviews, and Huo and colleagues identified leadership buy-in as a recurrent facilitator [5, 6]. Without leadership engagement, training investments are difficult to sustain.

Second, training and workforce development. Training should be ongoing and embedded rather than episodic, should include vicarious-trauma components for staff, and should be paired with supervision or coaching [5, 6, 7, 9, 10]. A counterexample is a single half-day session that is not followed by reinforcement; such sessions can produce confidence without competence.

Third, screening, assessment, and treatment services. If screening is undertaken, it must be paired with a defined response pathway: warm hand-off to a clinician able to address trauma-related needs, an internal or

external referral list, and a clear policy on documentation and follow-up [5, 6, 14, 15, 18, 21, 25]. The AHRQ review concerns heterogeneous TIC models, not an isolated screening comparison [1]. Pairing purposeful inquiry with response capacity is an ethical implementation safeguard; this synthesis does not demonstrate a comparative clinical benefit from universal screening or universal precautions.

Fourth, physical environment. Although rarely addressed in the reviewed literature [5], the physical environment can be made safer through private examination spaces, clear signage, and the option of a chaperone or support person.

Fifth, evaluation, monitoring, and quality assurance. Goldstein and colleagues reported that only two reviews addressed evaluation, and one addressed progress monitoring and quality assurance, indicating an implementation gap [5]. Local evaluation should include process measures (training reach, documentation of choice and consent) and, where feasible, patient-reported experience measures, with the explicit caveat that training outcomes do not substitute for patient outcomes [4, 22, 23].

Sixth, financing. Only one review in the Goldstein synthesis addressed financing [5]. Without protected funding, TIC tends to compete with direct clinical time and is vulnerable to budget cycles.

Seventh, staff wellness. Surgical-resident data suggest that providers are not immune to trauma, and staff-support structures (peer support, debriefing, access to counselling) are an ethical and practical component of TIC [5, 6, 9, 10].

Eighth, equity. TIC programmes should attend to structural drivers of trauma, including racism and economic exclusion, and avoid framing trauma as an individual deficit [5, 9, 13, 17, 19, 24, 25]. A counterexample is a programme that emphasises individual resilience while leaving inequitable workflows untouched.

Ninth, language. Trauma-informed language is a concrete clinical skill; clinicians should avoid stigmatising terms (e.g., "recidivist") and adopt patient-centred alternatives, recognising that language shapes both patient experience and the hidden curriculum of medical education [13]. Statements that specified words increase measured allostatic burden or that wording interventions reduce clinical re-injury should be read as conceptual mechanisms rather than established empirical effects.

Tenth, adaptation to context. TIC must be tailored to the patient population and setting; refugees, people experiencing homelessness, human trafficking survivors, and postpartum patients have distinct needs that require both common principles and specific adjustments [17, 18, 19, 20, 21, 24]. Refugee mental health requires attention to cultural responsiveness, language access, and pre-migration trauma, alongside system-level barriers to care [19, 20]. Maternity and postpartum contexts have specific communication, behavioural, and procedural considerations that should be operationalised rather than assumed [16, 21]. Homelessness is associated with high rates of prior trauma, particularly among women, and primary care for this population benefits from a trauma-informed approach that addresses environmental exposures and social determinants alongside medical management [17]. Human trafficking requires screening and response protocols that are sensitive to safety and disclosure dynamics, with TIC framed as an essential element of identification and care [18].

Table 3. Implementation safeguards for adult TIC, with linked sources.

Safeguard	Operational element	Linked source(s)
Governance and leadership	Named lead, protected time, QI integration	[5, 6]
Training and workforce development	Ongoing, embedded, with supervision	[5, 6, 7, 10]
Screening and response pathway	Only with defined response capacity; preserve disclosure as voluntary	[1, 5, 6, 14, 15, 21, 25]
Physical environment	Private space, chaperone option	[5]
Evaluation and monitoring	Process and patient experience measures	[4, 5, 22, 23]

Safeguard	Operational element	Linked source(s)
Financing	Protected budget line	[5]
Staff wellness	Peer support, debriefing, counselling access	[5, 6, 9, 10]
Equity and structural awareness	Address racism, economic exclusion	[5, 9, 13, 17, 19, 24]
Trauma-informed language	Avoid stigmatising terms; model alternatives	[13]
Context-specific adaptation	Refugees, homelessness, trafficking, postpartum	[16, 17, 18, 19, 20, 21]

Table note. The safeguards are synthesised from the cited sources; specific operational details (e.g., room lay-out, documentation templates) should be developed locally. The table is a proposal for consideration, not a mandate. Maternity, trafficking, and refugee entries are illustrative of context-specific adaptation and should not be generalised as cultural stereotypes or as a basis for universalising to all adult encounters.

Population-specific considerations within adult care

Population-specific considerations matter because trauma is not distributed evenly and because adult healthcare encounters vary widely. Within adult care, four contexts are particularly relevant and illustrate how TIC must be adapted rather than uniformly applied.

First, primary care. The Chilean CTIC trial supports a bundled collaborative-care model for depression in primary care; it does not support universal claims about all adult examinations [2]. The Roberts and colleagues model for trauma-informed primary care (TIPC) offers five components: screening and trauma recognition, understanding health effects, patient-centred communication, emotional safety and trigger avoidance, and knowledge of helpful treatments, providing a theoretical framework for primary-care practice that has not been tested in a definitive trial [25]. Earls' editorial on trauma-informed primary care highlighted the role of the medical home in prevention and amelioration of trauma's impact [24].

Second, nursing and inpatient care. Trauma-informed nursing emphasises safety, trustworthiness, choice, collaboration, and respect, with themes including screening and disclosure, provider-patient relationships, distress minimisation, multidisciplinary collaboration, and advancement of TIC in diverse settings [10, 11, 12]. The hybrid systematic narrative review of 16 nursing studies found positive attitudes toward TIC among nurses but moderate knowledge, with significant implementation barriers including time constraints, limited resources, and concerns about re-traumatisation [10].

Third, reproductive and postpartum care. TIC in reproductive healthcare addresses individual safety, choice, and privacy, and systemic factors such as barriers to care and stigma; abortion care requires both individual and systemic trauma-informed responses [15, 16, 21]. Postpartum care is positioned as a critical component of holistic recovery, with practical communication and procedural adaptations proposed to support families that have experienced distressing perinatal events [21].

Fourth, marginalised populations. Refugees face multiple barriers to care, and trauma-informed, culturally responsive, and ethical care is recommended, with attention to the specific resettlement context [19, 20]. People experiencing homelessness have high rates of trauma, particularly among women, and a trauma-informed approach is described as imperative, with multidisciplinary management and Housing First strategies as part of the care plan [17]. Human trafficking survivors require identification and response protocols that are safety-sensitive and trauma-informed, and clinicians should be aware of risk factors and resources [18].

In each of these contexts, the available evidence is contextual rather than generalisable. Maternity, trafficking, and refugee examples should be read as specific contexts, not as a basis for generalising to all adult encounters or for inferring cultural stereotypes.

Mechanisms of decision-making and feasible measurement

The hypothesised mechanisms through which TIC is thought to influence patient outcomes include: increased sense of safety, increased trust, increased perceived choice and control, reduced autonomic arousal during encounters, improved disclosure when patients choose to share, and improved engagement with care plans [5, 6, 7, 9, 10, 11, 12, 13]. The realist synthesis by Goldstein and colleagues explicitly constructed context-mechanism-outcome configurations to capture how these mechanisms operate across settings [5]. For example, the mechanism of "increased emotional safety within patient-staff relationships" was associated with improved patient experience and engagement; the mechanism of "ongoing coaching, training, and supervision for staff" was associated with reduced restraints and improved staff behaviour change [5].

Feasible measurement, given the insufficient outcome evidence identified by AHRQ [1], should focus on intermediate and process measures while longer-term patient outcomes are evaluated locally. Process measures that can be collected routinely include: documentation of consent and choice in clinical encounters, training reach and completion, staff self-reported confidence (with the caveat that this is not a patient outcome), patient-reported experience measures, and, where screening is undertaken, rates of referral and follow-up. Patient-reported measures such as the Primary Care Assessment Survey trust subscale have been used in TIC trials, and trauma-informed collaborative-care studies have used instruments such as the PCL-5 and the Short PTSD Rating Interview, but these were applied in research rather than routine care [3]. The Chilean trial measured depressive symptoms and adherence in a defined depression-care population [2]. If a local service considers similar outcomes, it must select suitable measures and avoid applying research symptom scales indiscriminately to all encounters.

The distinction between training outcomes and patient outcomes is critical. Several reviews and primary studies reported improved knowledge, attitudes, and confidence among providers after TIC training, with the TI-Med trial reporting a moderate effect-size estimate for patient-centred communication in a standardised-patient setting, with an inconclusive between-group comparison [4], and the resident and interprofessional courses reporting self-reported gains [22, 23]. The TI-Med within-group improvement does not establish that training caused the change, given the inconclusive randomised comparison, but the AHRQ review's finding of insufficient evidence for patient outcomes means that organisations should not infer patient benefit from training reach alone.

Missing data in the field are substantial. The AHRQ review found that no included studies collected harms data, limiting the ability to weigh benefits against risks; cultural competency and humility elements were described in only a few models; financing and physical environment were rarely addressed; and long-term outcomes beyond 6 to 12 months are sparse [1]. The Chilean trial reported a 6-month outcome, the New Orleans pilot a 9-month outcome, and the TI-Med trial relied on standardised-patient encounters rather than real-patient outcomes [2, 3, 4]. The heterogeneous models and limited comparisons preclude a single quantitative estimate for universal adult encounters.

Counterexamples and tensions

Three tensions deserve explicit consideration. First, universal screening versus universal precaution. Reproductive-health literature has called for universal screening for a history of sexual abuse in obstetric practice, while trauma-informed medical care training has explicitly avoided mandating universal screening [4, 14, 15, 21]. The AHRQ insufficiency finding does not determine which screening strategy is superior [1]. A proposed response-capacity safeguard must therefore be distinguished from a tested outcome claim. Organisations that choose to implement universal screening must define the response pathway in advance, including warm handoff, referral, and follow-up, and should monitor for unintended harms such as increased distress or reduced engagement.

Second, training without organisational change. Several reviews noted that training alone, without policy, workflow, and environmental adjustments, is unlikely to produce sustained change [5, 6, 10]. A counterexample is a hospital that mandates TIC training for all staff but does not adjust intake forms, signage, or restraint policies;

the training investment is unlikely to translate into patient benefit, and the perception of having "done TIC" may foreclose further improvement.

Third, TIC as individual resilience versus structural change. The AHRQ review noted that only a few TIC models described specific elements of cultural competency or humility, and the Goldstein synthesis found that physical environment and financing were rarely addressed [1, 5]. TIC that emphasises individual coping without addressing structural drivers, including racism, poverty, and access barriers, risks reinforcing the very inequities that shape trauma exposure [9, 13, 17, 19, 20]. The Grossman and colleagues editorial explicitly argued that trauma must be understood at individual, interpersonal, and collective levels, and that responsibility for collective trauma is collective [9]. Hart and colleagues similarly argued that trauma-informed language reframes violent injury as a consequence of inequity rather than individual behaviour; their claims about allostatic burden and re-injury cycles should be read as conceptual mechanisms rather than as directly demonstrated empirical effects [13].

A fourth tension concerns the boundary between TIC and trauma-focused treatment. Some bundled models, including the Chilean CTIC and the New Orleans TICC, include elements that resemble trauma-focused or collaborative care for specific conditions, such as motivational interviewing, measurement-based care, and referral to evidence-based PTSD treatment [2, 3]. It is important to preserve this distinction when reporting results: the Chilean result is a depression outcome for a bundled collaborative-care model, not a universal TIC effect; the New Orleans pilot is a preliminary, non-significant signal for a PTSD-focused collaborative-care model, not a universal TIC effect.

Proposed local adaptation framework

A proposed local adaptation framework for adult TIC should be framed explicitly as a service-evaluation and adaptation effort, not as a claim of measured local effects. The framework is proposed; no measured Saudi outcomes are described in this review, and this search did not establish a Saudi evidence gap. Components can be drawn from the implementation literature [5, 6, 7, 9, 10, 11, 12, 13], with specific operational elements to be developed by local teams.

The proposed framework includes: a governance structure with a named clinical lead and steering committee; a training strategy that is interprofessional, ongoing, and includes vicarious-trauma components; a universal-precaution posture in all adult encounters, with documentation of consent, choice, and shared decision-making; a screening policy that requires response capacity before any case-finding is implemented; a referral pathway to evidence-based trauma-focused treatments for patients who disclose or are identified; physical environment modifications to support privacy and safety; language and documentation standards aligned with trauma-informed principles; a measurement plan that includes process and patient-reported experience measures, with patient outcomes as longer-term additions; staff wellness structures; and an equity review that attends to structural drivers of trauma in the local population. The framework should be adapted to the local context, including the patient population, available specialties, and regulatory environment, and should preserve the principle that clinical practice points must be linked to underlying evidence and retain the need for individual clinical judgement.

Limitations

This review has several limitations. It is a focused narrative review, not a systematic review or meta-analysis, and does not include formal certainty grading, duplicate human screening, formal eligibility screening, or a registered protocol. The actual PubMed discovery search was Title/Abstract-keyword-based and capped at 45 retrievals, supplemented by named targeted supplementary PubMed source records; databases searched by published source reviews were not searched for this manuscript. English-language reading and purposive selection do not imply a formal eligibility screen. Literature counts such as "12 eligible studies" or "16 publications" reflect the source reviews themselves, not the present screening. Only accessible PMC excerpts were consulted, not full bibliographic appraisal of every reference, and only six fulltext copies were retained (Goldstein, Huo, Grossman, Hart, Green and Meredith). The AHRQ 2025 review and the Chilean cluster trial were

drawn from indexed abstracts and supplementary verified sources, not retained fulltext. The included studies span diverse settings, populations, and intervention models, limiting direct comparability. The adult focus means that paediatric, maternity, trafficking, and refugee literature is used to illustrate context, not to generalise to all adult encounters; readers should avoid treating these contexts as universal or as cultural stereotypes. Saudi applicability is discussed as a proposed local service-evaluation and adaptation framework, not as a description of measured Saudi effects, and no Saudi evidence-gap conclusion was established by this search. No new empirical data are presented, and the review is a synthesis of existing sources. Several quoted phrases are paraphrased to preserve attribution while limiting verbatim quotation length; the underlying source records remain the primary reference for exact wording.

Proposed trauma-informed encounter pathway

Figure 2 illustrates a proposed trauma-informed encounter pathway, including condition-specific assessment or treatment.

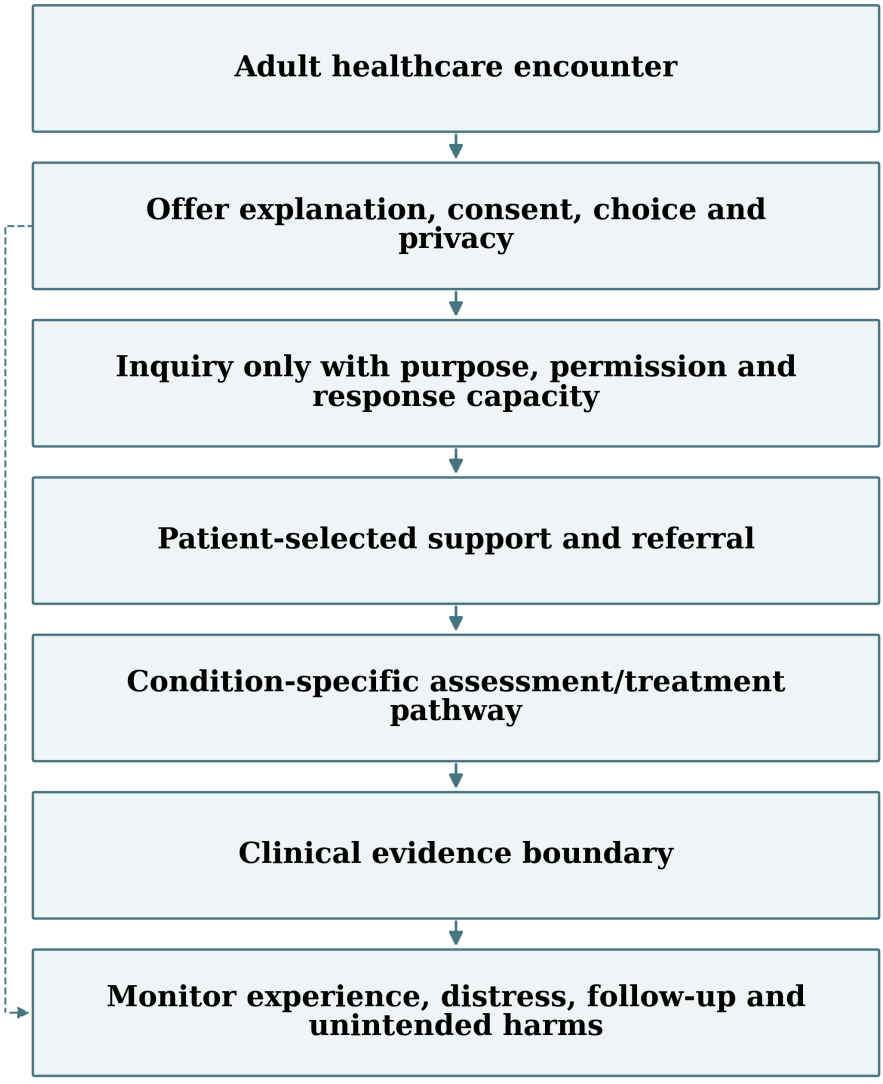


Figure 2. Proposed trauma-informed encounter pathway with a separate condition-specific treatment lane. Choice, privacy and response capacity are implementation safeguards, not proven universal clinical effects. The AHRQ review found insufficient outcome evidence in its included studies; defined collaborative-care trials address narrower populations. Arrows show proposed responsibilities, with no measured effect sizes or local outcomes.

Source and interpretation note for Figure 2. No new measured effects, local outcomes, invented scores or quantitative effect aggregation. Study-specific qualitative findings are attributed to verified sources. Sources [1,2,3,4,5,6,7,9,11,25]; Universal relational precautions, disclosure safeguards and condition-specific referral (Table 3).

Conclusion

Trauma-informed care is an ethically defensible universal-precaution approach to adult healthcare encounters, grounded in the high prevalence of trauma exposure and the documented capacity of routine care to retraumatise. Its principles — safety, trustworthiness, choice, collaboration, and respect — are well articulated across nursing, primary care, reproductive health, and surgical literature. The clinical evidence base, however, remains insufficient for definitive claims about patient outcomes, as the 2025 AHRQ review identified only 12 eligible studies across 16 publications, all at high risk of bias, with no collected harms data; this insufficiency is not proof of no harm. Specific bundled models, such as the Chilean collaborative trauma-informed care model for depression in primary care, have shown benefit in defined populations, while the New Orleans pilot of trauma-informed collaborative care for PTSD in African American adults produced non-significant between-group differences at 9 months. The TI-Med study reported within-group communication changes in standardized encounters, but its randomized comparison was inconclusive; the evidence does not establish sustained routine behavior or patient benefit. Universal precaution is ethically defensible; universal screening without response capacity is not. Implementation safeguards — governance, ongoing training, screening paired with response, physical environment, evaluation, financing, staff wellness, equity, language, and context-specific adaptation — are essential to translate principles into practice. Local adoption should be framed as a service-evaluation and adaptation effort, with measurement that is feasible, proportionate, and honest about the limits of the current evidence.

Declarations

Institutional determination. This manuscript is a narrative synthesis of published literature. No participants were recruited and no new participant-level dataset was created for this work. No exemption or approval is claimed. Any future local evaluation requires its own protocol and authorized determination before data collection.

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