Appendices

Appendix A. Methods

I. Search Strategy

The search strategy was designed and conducted by an experienced systematic review librarian with input from investigators. We used relevant keywords and controlled vocabulary (e.g. MeSH). Another librarian peer reviewed the draft MEDLINE search strategy using the PRESS Checklist. The MEDLINE search syntax was then translated into the controlled vocabulary unique to each database. We applied the following limits or filters to the database searches:

- Date. There were no limitations on date of publication.
- Language. Publications were limited to English language. This was due to resource constraints.
- Publication Status. We searched for published studies.
- Study design. Searches were not limited to a specific study design(s),
- Other filters. A modified CADTH filter was used to remove MEDLINE citations derived from MEDLINE (Scopus NOT Medline/PubMed NOT Embase - Scopus. In: CADTH Search Filters Database. Ottawa: CADTH; 2023: https://searchfilters.cadth.ca/link/97. Accessed 2023-12-01.)
- Geographic filters for country (United States) were used in the initial CINAHL and Scopus searches and removed in the updated searched ran October 2023.
- Filters were used to remove publication types not eligible for inclusion (comments, letters, editorials) in PsycInfo, CINAHL, and ERIC, Scopus. This was done to reduce the larger number of ineligible publication types.

We conducted a comprehensive literature search in March-May 2023 (updated October 2023). We searched the following databases:

- MEDLINE All (OVID) Date searched October 10, 2023
- PsycInfo (Ovid) Date searched October 10, 2023
- ERIC (EBSCOHost) Date Searched October 10, 2023
- CINAHL plus Full Text (EBSCOHost) Date Searched October 10, 2023
- Scopus (Elsevier) Date Searched October 10, 2023

Database search strategies

Ovid MEDLINE(R) ALL <1946 to March 6, 2023>

1 (trauma informed adj3 (approach or care or educat* or framework* or healthcare or method* or model* or practice* or training or treatment*)).mp.
2 (trauma sensitive adj3 (approach or care or educat* or framework* or healthcare or method* or model* or practice* or training or treatment*)).mp.
3 1 or 2
4 limit 3 to english language

Ovid MEDLINE(R) ALL <1946 to October 9, 2023>

1 (trauma informed adj3 (approach or care or educat* or framework* or healthcare or method* or model* or practice* or training or treatment*)).mp.
2 (trauma sensitive adj3 (approach or care or educat* or framework* or healthcare or method* or model* or practice* or training or treatment*)).mp.

3 1 or 2
4 limit 3 to english language

APA PsycInfo <1987 to March Week 1 2023>
1 trauma-informed care/
2 (trauma informed adj3 (approach or care or educat* or framework* or healthcare or method* or model* or practice* or training or treatment*)).mp.
3 (trauma sensitive adj3 (approach or care or educat* or framework* or healthcare or method* or model* or practice* or training or treatment*)).mp.
4 or/1-3
5 limit 4 to (all journals and english language)

APA PsycInfo <1987 to October Week 1 2023>
Excluding Medline & publication types

1 trauma-informed care/
2 (trauma informed adj3 (approach* or care or educat* or framework* or healthcare or method* or model* or practice* or treatment*)).mp.
3 (trauma sensitive adj3 (approach* or care or educat* or framework* or healthcare or method* or model* or practice* or treatment*)).mp.
4 or/1-3
5 limit 4 to english language
6 limit 5 to (peer reviewed journal and english language and "remove medline records")
7 limit 6 to (chapter or "column/opinion" or "comment/reply" or dissertation or editorial or letter or review-book or reviews)
8 6 not 7

ERIC (via EBSCOHost) 2023-03-08
SU "Trauma Informed Approach" OR (trauma sensitive* N3 (approach or care or educat* or framework* or healthcare or method* or model* or practice* or treatment*)) OR (trauma informed N3 (approach or care or educat* or framework* or healthcare or method* or model* or practice* or training or treatment*))
Limiters - Journal or Document: Journal Article (EJ); Publication Type: Journal Articles; Language: English Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
ERIC (via EBSCOHost) 2023-10-10
SU "Trauma Informed Approach" OR (trauma sensitive* N3 (approach or care or educat* or framework* or healthcare or method* or model* or practice* or training or treatment*)) OR (trauma informed N3 (approach or care or educat* or framework* or healthcare or method* or model* or practice* or training or treatment*)) AND EM 20230201-20231010
Limiters - Peer Reviewed; Journal or Document: Journal Article (EJ); Publication Type: Journal Articles; Language: English; Expanders - Apply equivalent subjects; Search modes - Boolean/Phrase

CINAHL Plus Full text (EBSCOHost) 2023-05-09
TI trauma-informed n3 (approach or care or educat* or framework or healthcare or method* or model* or practice* or training* or treatment*) OR trauma sensitive n3 (approach or care or

educat* or framework or healthcare or method* or model* or practice* or training* or treatment*) or AB trauma-informed n3 (approach or care or educat* or framework or healthcare or method* or model* or practice* or training* or treatment*) OR trauma sensitive n3 (approach or care or educat* or framework or healthcare or method* or model* or practice* or training* or treatment*)
Limiters - Research Article; Peer Reviewed; English Language; Exclude MEDLINE records; Publication Type: Case Study, Clinical Trial, Journal Article, Meta Analysis, Meta Synthesis, Nursing Interventions, Randomized Controlled Trial, Research, Research Instrument; Geographic Subset: USA; Language: English; Expanders - Apply equivalent subjects; Search modes - Boolean/Phrase

CINAHL Plus Full Text (EBSCOHost) 2023-10-10
without geographic subset

TI trauma-informed n3 (approach or care or educat* or framework or healthcare or method* or model* or practice* or training* or treatment*) OR trauma sensitive n3 (approach or care or educat* or framework or healthcare or method* or model* or practice* or training* or treatment*) or AB trauma-informed n3 (approach or care or educat* or framework or healthcare or method* or model* or practice* or training* or treatment*) OR trauma sensitive n3 (approach or care or educat* or framework or healthcare or method* or model* or practice* or training* or treatment*)
Limiters - Research Article; Peer Reviewed; English Language; Exclude MEDLINE records; Publication Type: Case Study, Clinical Trial, Journal Article, Meta Analysis, Meta Synthesis, Nursing Interventions, Randomized Controlled Trial, Research, Research Instrument; Language: English; Expanders - Apply equivalent subjects; Search modes - Boolean/Phrase

Scopus (Elsevier) 2023-05-09
INDEXTERMS ("trauma informed care") OR INDEXTERMS ("trauma informed approach") OR TITLE ("trauma informed") OR TITLE ("trauma sensitive") AND NOT INDEX (medline) AND NOT (PMID (0* OR 1* OR 2* OR 3* OR 4* OR 5* OR 6* OR 7* OR 8* OR 9*)) AND (LIMIT-TO (SRCTYPE , "j")) AND (LIMIT-TO (AFFILCOUNTRY , "United States") OR LIMIT-TO (AFFILCOUNTRY , "Australia") OR LIMIT-TO (AFFILCOUNTRY , "Canada") OR LIMIT-TO (AFFILCOUNTRY , "United Kingdom") OR LIMIT-TO (AFFILCOUNTRY , "Undefined")) AND (LIMIT-TO (PUBSTAGE , "final")) AND (LIMIT-TO (DOCTYPE , "ar") OR LIMIT-TO (DOCTYPE , "re")) AND (EXCLUDE (SUBJAREA , "BUSI") OR EXCLUDE (SUBJAREA , "COMP") OR EXCLUDE (SUBJAREA , "AGRI") OR EXCLUDE (SUBJAREA , "BIOC") OR EXCLUDE (SUBJAREA , "ENVI") OR EXCLUDE (SUBJAREA , "ENGI") OR EXCLUDE (SUBJAREA , "IMMU") OR EXCLUDE (SUBJAREA , "ENER") OR EXCLUDE (SUBJAREA , "MATH") OR EXCLUDE (SUBJAREA , "VETE")) AND (LIMIT-TO (LANGUAGE , "English"))
Scopus (Elsevier) 2023-10-10
without Affiliated country limit

INDEXTERMS ("trauma informed care") OR INDEXTERMS ("trauma informed approach") OR TITLE ("trauma informed") OR TITLE ("trauma sensitive") AND NOT INDEX (

medline) AND NOT (PMID (0* OR 1* OR 2* OR 3* OR 4* OR 5* OR 6* OR 7* OR 8* OR 9*)) AND (LIMIT-TO (SRCTYPE , "j")) AND (LIMIT-TO (PUBSTAGE , "final")) AND (LIMIT-TO (DOCTYPE , "ar") OR LIMIT-TO (DOCTYPE , "re")) AND (EXCLUDE (SUBJAREA , "BUSI") OR EXCLUDE (SUBJAREA , "COMP") OR EXCLUDE (SUBJAREA , "AGRI") OR EXCLUDE (SUBJAREA , "BIOC") OR EXCLUDE (SUBJAREA , "ENVI") OR EXCLUDE (SUBJAREA , "ENGI") OR EXCLUDE (SUBJAREA , "IMMU") OR EXCLUDE (SUBJAREA , "ENER") OR EXCLUDE (SUBJAREA , "MATH") OR EXCLUDE (SUBJAREA , "VETE")) AND (LIMIT-TO (LANGUAGE , "English"))
*Scopus NOT Medline/PubMed NOT Embase - Scopus. In: CADTH Search Filters Database. Ottawa: CADTH; 2023: https://searchfilters.cadth.ca/link/97. Accessed 2023-12-01.

II. Grey Literature search

We conducted a grey literature search in May 2023 (updated November 2023) that included the following resources:

- *Organizations.* These organizations' websites were hand-searched:
    - Academy on Violence and Abuse (AVA) https://avahealth.org/aces_best_pratices
    - American Academy of Pediatrics′ (AAP) Center on Healthy Resilient Children https://aap.org/theresiliencyproject
    - American Psychiatric Association (APA) https://www.psychiatry.org/psychiatrists/diversity/education/stress-and-trauma/general-treatment-recommendations
    - American Psychological Association (APA) https://apa.org/members/content/trauma-informed-series
    - Attachment, Regulation and Competency (ARC) Foundation https://arcframework.org/what-is-arc/
    - Campaign for Trauma Informed Policy and Practice (CTIPP) https://www.ctipp.org/
    - Center for the Study of Social Policy (CSSP) https://cssp.org
    - Creating PRESENCE https://www.creatingpresence.net/ https://sandrabloom.com/about/
    - Heartland Alliance https://www.heartlandalliance.org/
    - Institute on Trauma and Trauma-Informed Care (ITTIC) https://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care.html
    - International Society for Traumatic Stress Studies (ISTSS) https://istss.org/home
    - National Association of Social Workers (NASW) https://www.socialworkers.org/
    - National Child Traumatic Stress Network (NCTSN) https://nctsn.org/trauma-informed-care
    - Native Wellness Institute https://www.nativewellness.com/
    - Substance Abuse and Mental Health Services Administration (SAMHSA) https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884
        - Broad-scale organizations that reference SAMHSA guidelines:

        - Federal agencies
            - Agency for Healthcare Research and Quality (AHRQ)
            - CDC's Office of Readiness and Response (ORR)
            - Defense Health Agency (DHA)
            - Indian Health Services (IHS)
            - Office of Justice Programs (OJP)
            - U.S. Department of Education (ED)
            - Youth.gov
        - National Centers
            - National Center for Assisted Living (NCAL)
            - National Center for Domestic Violence, Trauma, and Mental Health
            - National Center for Posttraumatic Stress Disorder
        - Professional healthcare organizations
            - American Medical Association (AMA)
            - American Nurses Association (ANA)
            - American Psychiatric Nurses Association (APNA)
            - American Speech-Language-Hearing Association (ASHA)
    - Trauma Center Trauma-Sensitive Yoga (TCTSY) https://www.traumasensitiveyoga.com/
    - Trauma-Informed Care Implementation Resource Center at the Center for Health Care Strategies https://traumainformedcare.chcs.org/what-is-trauma-informed-care/
    - Trauma-Informed Weight Lifting (TIWL) https://www.traumainformedweightlifting.com/
    - Traumatic Stress Institute https://www.traumaticstressinstitute.org/
    - United Nations (UN) https://unitad.un.org/news/unitad-provides-trauma-informed-approach-training
- *Journal Special Issues' Table of Contents.* These journal special issues' table of contents were hand-searched:
    - *Psychological Services*, "Trauma-informed care for children and families"
    - *Practice Innovations*, "Evidence-based relationship variables in working with affectional and gender minorities"
    - *Psychological Trauma*, "Trauma-focused training and education"

II. Questions for Key Informants

Questions and issues for general Key Informants:

1. What is the current perception or understanding of TIC guidelines or standards of care?
2. What TIC approaches are you familiar with?
3. If you provide or organize TIC, what is the motivation? (e.g., reduce or promote certain outcomes, comply with funding initiative or policy)

4. Do you have questions about TIC (e.g., benefits, harms, other concerns), and what makes you have those questions? Are there specific TIC approaches that you worry may do more harm than good, or may not work as promised? What would influence your decision to use or not use TIC?
5. What are the TIC comparisons of greatest interest? Are there any treatment comparisons we should not include in scope? Is it important to know how well TIC works? Or just if it works? Or how it works compared to another approach?
6. Should certain settings or populations be included, specifically studied, or excluded?
7. Are there equity-related concerns or differences that are important to TIC decision-making?
8. Are other considerations in TIC decision-making important, such as insurance coverage, geography, or other patient or healthcare delivery factors?
9. What organizational factors or components of service provider workspaces need to be taken into consideration?
10. What other considerations might influence your decisions about TIC?

Additional questions and issues for patient/client or consumer (advocacy) Key Informants:

11. Should healthcare clinicians/professionals ask patients/clients about their TIC preferences for discussing trauma? Do patients bring up TIC with clinicians, particularly primary care clinicians?
12. How do patients/clients expect services delivering TIC to differ from services not delivering TIC? What are patient/client reactions to TIC, and do they have any concerns about TIC?
13. What do patients/clients consider the most important outcomes of TIC?
14. If you knew a provider was trained in TIC how do you expect services from that provider to differ from others not delivering TIC?

Additional questions and issues for clinical or health system Key Informants:

15. What TIC approaches are established and how widespread is the use?
16. What TIC decisions do you try to make? How and when do you assess patient/client TIC needs? If an organization is providing TIC, do all patients receive TIC? If not, what is the process for determining who does and does not receive TIC?
17. How would you determine if health outcomes are related to TIC?
18. What are the most important outcomes of TIC? How and when do you evaluate whether TIC is having the intended effect? When would you stop TIC?

III. Questions for Technical Expert Panel

1. Are the populations appropriately identified, or are there recommended changes?
    a. Are there equity concerns we should be looking for in terms of populations included/excluded in studies, variation in the impact of interventions in diverse populations, or any predisposition to re-traumatization among different populations?
2. Are the interventions appropriately identified?
    a. Do you have suggestions for criteria for determining when an intervention is trauma-focused vs trauma-informed?
    b. Are there frameworks or taxonomies that could help categorize or organize interventions and components in a way that would be useful to end-users of the report?
3. Do the outcomes represented adequately reflect the most important concerns?
    a. Are there organization-related process outcomes that deserve special call-out in the PICO table?
4. Are appropriate settings adequately included?
5. Remembering that research on the act of implementing a TIC intervention (that is, implementation science-related research) is outside of the scope of the review, what organizational characteristics for CQs and KQ sub questions are of interest?
6. Does the analytic framework add value, or should it be dropped?
7. Are there important studies that should be included in the review? Why?

Appendix B. Excluded Studies at Full Text

Reasons for Exclusion
P = Population
I = Intervention
C = Comparison
O = Outcomes
S = Study Design
X = Other reasons

1. Agazzi H, Adams C, Ferron E, et al. Trauma-informed behavioral parenting for early intervention. J Child Fam Stud. 2019;28(8):2172-86. doi: 10.1007/s10826-019-01435-3. PMID: 2019-29331-001. P
2. Amaro H, Chernoff M, Brown V, et al. Does integrated trauma-informed substance abuse treatment increase treatment retention? J Community Psychol. 2007;35(7):845-62. doi: 10.1002/jcop.20185. PMID: 2009-02557-003. I
3. Anderson KM, Haynes JD, Ilesanmi I, et al. Teacher professional development on trauma-informed care: Tapping into students' inner emotional worlds. JESPAR. 2022;27(1):59-79. doi: 10.1080/10824669.2021.1977132. PMID: 2021-88119-001. S
4. Aremu B, Hill PD, McNeal JM, et al. Implementation of Trauma-Informed Care and Brief Solution-Focused Therapy: A Quality Improvement Project Aimed at Increasing Engagement on an Inpatient Psychiatric Unit. J Psychosoc Nurs Ment Health Serv. 2018;56(8):16-22. doi: 10.3928/02793695-20180305-02. PMID: 29538793. S
5. As K, Adam E, Livingston Mr, et al. Support for Trauma-informed Care Implementation Among Ryan White HIV Clinics in the Southeastern United States. AIDS Behav. 2022. doi: 10.1007/s10461-022-03830-2. PMID: 36048293. S
6. Ashby BD, Ehmer AC, Scott SM. Trauma-informed care in a patient-centered medical home for adolescent mothers and their children. Psychol Serv. 2019;16(1):67-74. doi: 10.1037/ser0000315. PMID: 2018-58799-001. S
7. Avery J, Morris H, Jones A, et al. Australian Educators' Perceptions and Attitudes Towards a Trauma-Responsive School-Wide Approach. J Child Adolesc Trauma. 2022;15(3):771-85. doi: 10.1007/s40653-021-00394-6. PMID: 35958717. O
8. Azeem MW, Reddy B, Wudarsky M, et al. Restraint reduction at a pediatric psychiatric hospital: A ten-year journey. J Child Adolesc Psychiatr Nurs. 2015;28(4):180-4. doi: 10.1111/jcap.12127. PMID: 2015-51147-001. O
9. Bajwa JK, Kidd S, Abaim M, et al. Trauma-Informed Education-Support Program for Refugee Survivors. Can J Adult Educ. 2020;32(1):75-96. S
10. Baker CN, Brown SM, Wilcox P, et al. The implementation and effect of trauma-informed care within residential youth services in rural Canada: A mixed methods case study. Psychol Trauma. 2018;10(6):666-74. doi: 10.1037/tra0000327. PMID: 2017-45360-001. S

11. Bani-Fatemi A, Malta M, Noble A, et al. Supporting Female Survivors of Gender-Based Violence Experiencing Homelessness: Outcomes of a Health Promotion Psychoeducation Group Intervention. Front Psychiatry. 2020;11:601540. doi: 10.3389/fpsyt.2020.601540. PMID: 33362610. S

12. Barnett ER, Yackley CR, Licht ES. Developing, implementing, and evaluating a trauma-informed care program within a youth residential treatment center and special needs school. Resid Treat Child Youth. 2018;35(2):95-113. doi: 10.1080/0886571x.2018.1455559. PMID: 2018-31524-002. S

13. Barnett ML, Kia-Keating M, Ruth A, et al. Promoting equity and resilience: Wellness navigators' role in addressing adverse childhood experiences. Clin Pract Pediatr Psychol. 2020;8(2):176-88. doi: 10.1037/cpp0000320. PMID: 34194889. S

14. Bartlett JD, Griffin JL, Spinazzola J, et al. The impact of a statewide trauma-informed care initiative in child welfare on the well-being of children and youth with complex trauma. Child Youth Serv Rev. 2018;84:110-7. doi: 10.1016/j.childyouth.2017.11.015. PMID: 2018-00249-016. S

15. Bartlett JD, Rushovich B. Implementation of Trauma Systems Therapy-Foster Care in child welfare. Child Youth Serv Rev. 2018;91:30-8. doi: 10.1016/j.childyouth.2018.05.021. PMID: 2018-42045-006. S

16. Beck E, Carmichael D, Blanton S, et al. Toward a trauma-informed state: An exploration of a training collaborative. Traumatology (Tallahass Fla). 2021:No-Specified. doi: 10.1037/trm0000351. PMID: 2021-75113-001. x

17. Becker J, Greenwald R, Mitchell C. Trauma-informed treatment for disenfranchised urban children and youth: An open trial. Child Adolesc Soc Work J. 2011;28(4):257-72. doi: 10.1007/s10560-011-0230-4. PMID: 2011-17218-001. x

18. Berg-Poppe P, Anis Abdellatif M, Cerny S, et al. Changes in knowledge, beliefs, self-efficacy, and affective commitment to change following trauma-informed care education for pediatric service providers. Psychol Trauma. 2022;14(4):535-44. doi: 10.1037/tra0001083. PMID: 2021-85868-001. O

19. Bertram JE, McKanry J. Minding the complexities of psychotropic medication management for children and youth in the foster care system: Paper 2: Levels of trauma responsiveness among child welfare staff. Arch Psychiatr Nurs. 2022;41:68-73. doi: 10.1016/j.apnu.2022.07.026. PMID: 36428077. O

20. Bertram JE, Tokac U, Brauch A, et al. Implementing a novel self-care clock strategy as part of a trauma awareness intervention in a university setting. Perspect Psychiatr Care. 2022 Oct;58(4):2612-21. doi: 10.1111/ppc.13101. PMID: 35478182. O

21. Black KR, Collin-Vezina D, Brend D, et al. Trauma-informed attitudes in residential treatment settings: Staff, child and youth factors predicting adoption, maintenance and change over time. Child Abuse Negl. 2022;130(P):1-13. doi: 10.1016/j.chiabu.2021.105361. PMID: 2021-98639-001. O

22. Blanton MA, Richie FJ, Langhinrichsen-Rohling J. Readiness to Change: A Pathway to the Adoption of Trauma-Sensitive Teaching. Behav Sci (Basel). 2022;12(1). doi: 10.3390/bs12110445. PMID: 36421741. O

23. Booshehri LG, Dugan J, Patel F, et al. Trauma-informed Temporary Assistance for Needy Families (TANF): A randomized controlled trial with a two-generation impact. J Child Fam Stud. 2018;27(5):1594-604. doi: 10.1007/s10826-017-0987-y. PMID: 2018-00116-001. O

24. Booshehri LG, Dugan J, Patel F, et al. Trauma-informed Temporary Assistance for Needy Families (TANF): A randomized controlled trial with a two-generation impact. J Child Fam Stud. 2018;27(5):1594-604. doi: 10.1007/s10826-017-0987-y. PMID: 2018-00116-001. X

25. Borckardt JJ, Madan A, Grubaugh AL, et al. Systematic investigation of initiatives to reduce seclusion and restraint in a state psychiatric hospital. Psychiatr Serv. 2011;62(5):477-83. doi: 10.1176/ps.62.5.pss6205_0477. PMID: 21532072. X

26. Bray JH, Zaring-Hinkle B, Scamp N, et al. MIRRORS program: Helping pregnant and postpartum women and families with substance use problems. Subst Abus. 2022;43(1):792-800. doi: 10.1080/08897077.2021.2010254. PMID: 35113009. S

27. Brown SM, Baker CN, Wilcox P. Risking connection trauma training: A pathway toward trauma-informed care in child congregate care settings. Psychol Trauma. 2012;4(5):507-15. doi: 10.1037/a0025269. PMID: 2011-20034-001. S

28. Brown T, Mehta PK, Berman S, et al. A Trauma-Informed Approach to the Medical History: Teaching Trauma-Informed Communication Skills to First-Year Medical and Dental Students. MedEdPORTAL. 2021 Jun 7;17:11160. doi: 10.15766/mep_2374-8265.11160. PMID: 34150993. O

29. Browne AJ, Varcoe C, Ford-Gilboe M, et al. Disruption as opportunity: Impacts of an organizational health equity intervention in primary care clinics. Int J Equity Health. 2018;17(1):154. doi: 10.1186/s12939-018-0820-2. PMID: 30261924. S

30. Brunzell T, Stokes H, Waters L. Shifting teacher practice in trauma-affected classrooms: Practice pedagogy strategies within a trauma-informed positive education model. School Ment Health. 2019;11(3):600-14. doi: 10.1007/s12310-018-09308-8. PMID: 2019-00472-001. S

31. Bursch B, Lloyd J, Mogil C, et al. Adaptation and Evaluation of Military Resilience Skills Training for Pediatric Residents. J Med Educ Curric Dev. 2017;4:2382120517741298. doi: 10.1177/2382120517741298. PMID: 29349344. S

32. Burton CW, Carlyle KE. Screening and intervening: Evaluating a training program on intimate partner violence and reproductive coercion for family planning and home visiting providers. Fam Community Health. 2015;38(3):227-39. doi: 10.1097/fch.0000000000000076. PMID: 2015-25980-004. x

33. Buxton H, Marr MC, Hernandez A, et al. Peer-to-Peer Trauma-Informed Training for Surgical Residents Facilitated by Psychiatry Residents. Acad Psychiatry. 2023;47(1):59-62. doi: 10.1007/s40596-022-01648-7. PMID: 35579850. O

34. Buysse CA, Bentley B, Baer LG, et al. Community ECHO (Extension for Community Healthcare Outcomes) Project Promotes Cross-Sector Collaboration and Evidence-Based Trauma-Informed Care. Maternal Child Health J. 2022;26(3):461-8. doi: 10.1007/s10995-021-03328-8. PMID: 35013885. O

35. Cabrera N, Moffitt G, Jairam R, et al. An intensive form of trauma focused cognitive behaviour therapy in an acute adolescent inpatient unit: An uncontrolled open trial. Clin Child Psychol Psychiatry. 2020;25(4):790-800. doi: 10.1177/1359104520918641. PMID: 2020-73697-007. x

36. Campbell BA, Lapsey DSJ, Wells W. An evaluation of Kentucky's sexual assault investigator training: Results from a randomized three-group experiment. J Exp Criminol. 2020;16(4):625-47. doi: 10.1007/s11292-019-09391-0. PMID: 2019-76336-001. O

37. Cannon LM, Coolidge EM, LeGierse J, et al. Trauma-informed education: Creating and pilot testing a nursing curriculum on trauma-informed care. Nurse Educ Today. 2020;85:104256. doi: 10.1016/j.nedt.2019.104256. PMID: 31759240. O

38. Cerny S, Berg-Poppe P, Anis M, et al. Outcomes from an interprofessional curriculum on trauma-informed care among pediatric service providers. J Interprof Care. 2022:1-12. doi: 10.1080/13561820.2022.2070142. PMID: 35687015. O

39. Chambers R, Greenbaum J, Cox J, et al. Trauma Informed Care: Trafficking Out-Comes (TIC TOC Study). J Prim Care Community Health. 2022;13:21501319221093119. doi: 10.1177/21501319221093119. PMID: 35438596. O

40. Champine RB, Hoffman EE, Matlin SL, et al. "What Does it Mean to be Trauma-Informed?": A Mixed-Methods Study of a Trauma-Informed Community Initiative. J Child Fam Stud. 2022;31(2):459-72. doi: 10.1007/s10826-021-02195-9. PMID: 35018088. O

41. Choi KR, Seng JS. Pilot for Nurse-Led, Interprofessional In-Service Training on Trauma-Informed Perinatal Care. J Contin Educ Nurs. 2015;46(1):515-21. doi: 10.3928/00220124-20151020-04. PMID: 26509404. O

42. Chokshi B, Chen KD, Beers L. Interactive Case-Based Childhood Adversity and Trauma-Informed Care Electronic Modules for Pediatric Primary Care. MedEdPORTAL. 2020 Oct 12;16:10990. doi: 10.15766/mep_2374-8265.10990. PMID: 33094156. O

43. Chokshi B, Goldman E. Using Trauma-Informed Care in Practice: Evaluation of Internal Medicine Resident Training and Factors Affecting Clinical Use. Perm J. 2021 Dec 14;25. doi: 10.7812/TPP/21.032. PMID: 35348095. O

44. Chung G, Ansong D, Brevard KC, et al. Identifying treatment moderators of a trauma-informed parenting intervention with children in foster care: Using model-based recursive partitioning. Child Abuse Negl. 2021;117. doi: 10.1016/j.chiabu.2021.105065. PMID: 2021-58707-001. S

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Appendix C. Evidence Tables

I. Appendix Table C.1. Evidence tables

Study (PMID) Study Design Study Location (Country)	**Study Setting**	**Sample Size and Population Trauma Type Defined**	**Intervention Description Intervention Theory Base**	**Comparison Description**	**Outcomes Timing Harms**	**Funding**
Green, 2015[1] (25646872) Green, 2016[2] (27721673) Cluster RCT USA	4 Primary care sites	30 PCP and 400 of their patients Interpersonal violence	6-hour CME course, Trauma Informed Medical Care (TI-Med) Empirical	Immediate vs delayed training, and compared patients with and without PTSD symptoms (partnership scale only)	Rapport scale partnership scale, information scale 9 months NR	NIMH
Meredith, 2022 [3](35157622) RCT USA	FQHC	42 patients PTSD	Adapted trauma-informed collaborative care (TICC): EUC (2-hour training, medical decision aid, PTSD information sheet), plus community linkage facilitation, monthly meetings with behavioral health consultant, 7 telephonic follow-up contacts Risking Connection[4] Relational-Cultural model[5]	Enhanced usual care	PTSD (PTSD Checklist for DSM-5 (PCL-5)) 9 months NR	NIMH
Mogil, 2022[6] (33963489) RCT USA	Telehealth platform	194 mothers; 155 fathers; 199 children ages 3-6 (at least one parent served in post 9/11 US military)	FOCUS-EC delivered 4-10 virtual meetings lasting 60-90 minutes FOCUS-E[7, 8]	Standard online education	Parent psychological health (anxiety, depression, PTSD) (BSI-18); parent-child interactions (Parental Behavior with Preschooler Q-Sort), child behavior (difficult	Eunice Kennedy Shriver National Institute of Child Health and Human Development

		Military service			child) (e Observed Child Affect and Behavior composite score from the parent–child interaction task and the PSI-SF Difficult Child subscale) 12 months NR	
Baetz, 2021[9] (31253054) NRSI USA	Juvenile detention centers	14856 juveniles, 473 staff PTSD, violence exposure	Two components: trauma-informed training for staff and a skill-building group program for youth. Staff "Think Trauma" training (2 sessions in 8-weeks), youth STAIR skill building program (3 sessions) Think Trauma[10, 11]	Two facilities, each at three time points: (a) pre intervention, (b) post implementation of staff training, and (c) post implementation of staff training plus STAIR groups for youth	Violent incidents (youth-on-youth assaults and altercations reported in the admin database) 3.75 years NR	SAMHSA
Matte-Landry, 2022[12] (37593061) NRSI Canada	Youth residential treatment facilities	44 residential treatment units for children in 12 regions Behavioral disturbances, neglect, physical abuse, psychological ill-treatment, sexual abuse, abandonment	TIC staff training: phase 1: 6-12 hours of interactive in-person sessions. phase 2: six 2-hour coaching and supervision sessions, phase 3: 4 symposium and meeting with senior managers over 12 months Missouri Model[13]	Restrictive measures used 6 months prior to the TIC training.	Use of restrictive measures (restraint, seclusions, time outs as reported in administrative data) 12 months NR	CIUSSS de la Capitale-Nationale and the Social Sciences and Humanities Research Council of Canada
Murphy 2017[14] N/A Redd 2017[15]	Child welfare and behavioral health organization	1499 children aged six and	Integrated Trauma Systems Therapy (TST): 1) repeatedly assessing children's emotional	Association of level of TST	Functioning (CAFAS), emotional and behavioral regulation	Anne E. Casey Foundation

N/A NRSI I USA		older who entered KVC Children exposed to parental incapacity (substance abuse, incarceration, mental incapacity), neglect, physical, emotional, and/or sexual abuse	and behavioral regulation capacity and the functioning of children's social environment to determine their treatment; 2) training all staff in how trauma impacts children's development and how to effectively respond to children's trauma, and 3) embedding the TST model throughout the full system. Trauma Systems Therapy[16]	implementation and outcome	(CECI), and placement stability (Administrative placement history data) 15 months NR	
Boel-Studt, 2017[17] (N/A) NRSI USA	Psychiatric residential treatment for children	205 youth treated and discharged in PRT programs Adolescents with severe behavioral and emotional problems	TI-PRT: Traditional PRT (24hr supervision, clinical services including individual and family therapy, educational services), plus trauma orientation/training, safety planning, daily check-ins, family/caregiver education, trauma recovery group curriculum Empirical	Data for the comparison group were extracted from the files of 100 youth who were discharged from one of the PRT facilities prior to starting trauma-informed programming.	Change in functional impairment (CAFAS), physical restraints and locked seclusion room incidents (case records), length of time in care, and discharge placement type 9 months NR	NR
Bartlett, 2016[18] (26564909) Barto, 2018[19] (29739000) NRSI USA	Massachusetts Department of Children and Families, 2 behavioral agencies, 2 large urban medical centers	326 children, 27 SLs, 190 clinicians and clinician supervisors; 91,253 children, 299 DCF workers, 201 clinicians Physical and sexual abuse, neglect,	MCTP focuses on three central activities: (1) training in child welfare; (2) EBT dissemination; and, (3) systems integration through Trauma Informed Leadership Teams (TILTs) Learning Collaborative Model[20]	Usual care	Trauma screening, referral and outreach to CW, Trauma Informed System Change Instrument, post traumatic stress (YCPC), behavior problems; Substantiated maltreatment, out-of-home placements, permanency, maltreatment status 1 year	Administration for Children and Families, Children's Bureau

		placement instability,			Out-of-home placements, maltreatment status	
Borckardt, 2011[21] (21532072) NRSI USA	State-funded hospital	446 patient, 340 staff Serious mental illness	Trauma informed care staff training, rules and language intervention, therapeutic environment changes, patient involvement in treatment planning Bloom, 1997[22]	Multiple time points over 3.5 years	Use of seclusion, restraint (the number of seclusion or restraint incidents per patient day for each unit and each period of the implementation schedule) 3.5 years NR	NR
Schmid, 2020[23] (31910832) Longitudinal Switzerland	Residential youth welfare center	142 youth welfare staff, counsellors, and management Child maltreatment and neglect, domestic violence, or emotional, physical or sexual abuse	Multiple staff training: six 3-day trainings for the management and counsellors, eight 2.5-day trainings for the youth welfare staff Harris, 2001[24] via Hopper 2010[25]	Facilities with standard training compared at 4 points in time (T1 = baseline, T2 = after 12 months, T3 = after 24 months, T4 = after 36 months)	Prevalence of client physical aggression towards staff (staff reported) 36 months NR	Swiss Federal Office of Justice
Ashby, 2018[26] (30475045) Noron a-Zhou, 2023[27] (37731783) Historical control USA	PCMH	429 (2007-8), 415 (2012-2013); 847 (2023) Pregnant adolescents	Multiple staff trainings, multi-disciplinary care case management SAMHSA	Prenatal treatment-as-usual (TAU) or trauma informed treatment.	Prenatal appointment attendance, rate of low birthweight babies; racial disparities in preterm birth and low birthweight 1 year NR	The Walton Family Foundation, the Colorado Health Access Fund, and the Maternal Infant Early Childhood Home Visiting (MIECHV) program.

Stolin-Goltzman, 2023[28] N/A NRSI USA	Private, nonprofit, specialized community mental health agency	40 children Involved at various levels in the child welfare system	Once per week, 3 hour facilitated parenting sessions SAMHSA	Pre-post	Parental well-being, child well-being (parent reported, SDQ) 10 weeks NR	SAMHSA

Key: BSI-18 = Brief Symptom Inventory–18; CAFAS =Child and Adolescent Functioning Assessment Scale, CECI = Child Ecology Check-In; CIUSSS = Centre de recherche universitaire sur les jeunes et les familles of Centre intégré universitaire de santé et de services sociaux;CW = child welfare; EBT = Evidence-based treatment, EUC = Enhanced usual care; FOCUS-EC = Families OverComing Stress for Early Childhood; FWbA = Family Well-being assessment; MHST = Mental Health Screening Tool, MCTP = Massachusetts Child Trauma Project; NIMH = National Institute of Mental Health; NRSI = nonrandomized studies of interventions; KVC = Kaw Valley Center; PCMH = Patient Centered Medical Home; PRT= Psychiatric residential treatment; SAMHSA = Substance Abuse and Mental Health Services; SDQ = Strengths and Difficulties Questionnaire, TIC = Trauma-informed care; TI-PRT = Trauma-informed psychiatric residential treatment; TST: Trauma Systems Therapy; YCPC = Young Child PTSD Checklist

II. Risk of Bias

Appendix Table C.2 Risk of bias

Author (PMID)	Outcome Timing	Attrition Bias Attrition %	Selection Bias	Detection Bias	Performance Bias	Reporting Bias	Fidelity Bias	Overall Rating
Green, 2016[2] (27721673); Green, 2015[1] (25646872)	30 days (median timing)	No detail provided	No detail on randomization or recruitment of PCP	400 patients reported; 900 upper recruitment limit; in-person survey interviewer; not validated outcome	Low	Low	NA	High
Meredith, 2022[3] (35157622)	9 months	High 14% attrition	Randomization and allocation unclear. 555 patients approached, 42 enrolled	19% of patients in control arm had history of psychosis, no adjustment.	Unclear Minimal detail for pilot project	Low	NR	High
Borckardt, 2011[29] (21532072)	Patient days over 3.5 years	No detail provided for missing data	No reporting on how many patients or staff declined to respond, who they are, etc.	Collection envelop physically posted in accessible areas	Contamination effects of stepped roll-out within single hospital difficult to gauge	Low	Low	High

Mogil, 2022[6] (33963489)	12 months	Limited imputation, PROC MIXED used in SAS (assumes data are missing at random	Targeted media advertising, military/veteran serving events, organizations, and word of mouth to families with 3-6 year old children who had at least one parent serve in the military post 9/11.	Surveys, tasks video recorded, and coded by undergraduate students, fidelity monitoring for coders. Some concerns noted on inter-rater reliability	Synchronous experimental vs asynchronous control intervention	Low	Fidelity monitoring noted for experimental group. Fidelity was noted as excellent.	High
Baetz, 2021[9](31253054)	58 months	Nothing provided on missing data	All youth in two juvenile detention centers in a large northeastern city from January 2012 to October 2016	Demographics drawn from database, altercation and assaults tracked by facility definition	Random allocation and delayed start.	Low	Fidelity monitoring noted for experimental group. Fidelity was noted as excellent.	High
Murphy, 2017[14] (N/A) Redd, 2017[15] (N/A)	36 months	Missing values estimated with FIML with robust standard errors. Untrained staff were noted as "lacking direct evidence" of implementing the intervention.	All children 6 and older in KVC programming from January 2011 to December 2014	Demographic variables, dosage of intervention, dependent variables included (child functioning, emotional regulation, behavioral regulation, placement stability). Most measures completed by caseworkers.	Large private child welfare system may have differences with large public child welfare systems	Low	Fidelity monitoring of staff, not of supervisors/foster parents (proxy used).	High

Barto, 2018[19] (29739000)	12 months	Missing data on sample covariates was addressed by using Generalized Boosted Modeling (GBM).	91,523 children involved in the Massachusetts Department of Children and Family between September 2012 and October 2013. Intervention and comparison group appear to be defined by region of the state	Data drawn from child welfare administrative data including demographics, child maltreatment reports, out-of-home placements, and adoption.	Large statewide program randomized by region. Could we significant differences by region of the state.	Low	Not reported	High
Bartlett, 2016[18] (26564909)	12 months	Child race excluded due to missing data.	91,523 children involved in the Massachusetts Department of Children and Family between September 2012 and October 2013. Intervention and comparison group appear to be defined by region of the state	Outcomes included both children (PTSD, behavior) and adult professionals (self-report measures, coded documentation).	Large statewide program randomzied by region. Could we significant differences by region of the state.	Low	None collected other than treatment dosage.	High
Matte-Landry, 2022[12] 37593061	6 months before and 12 months after training	NR	44 residential care units for youth in 12 regions of Quebec (RTC = 24, community group homes, n=15, other types of units=5), the majority overseen by CPS, 3 overseen by the juvenile justice system.	Use of administrative data - Self-reported use of restraint, seclusion, and time-out in patient case files. Categorization criteria varies across units	Absence of control group, variation in types of care units	Low	NR	High

Boel-Studt, 2017[17] (N/A)	25 months (13 months control, 12 months intervention)	Records containing missing data were excluded	Psychiatric residential facilities of a large Midwestern Behavioral Health Agency	Clinician administered scale, internal reports, administrative data	85% began with TIC training, staff turnover created difficulties in keeping everyone trained	Low	Monitored by training and implementation checklist	High
Schmid, 2020[23] (31910832)	36 months	95 of 142 had missing data and were excluded	Limited to German speaking part of Switzerland	Self-report information. Small sample	Significant attrition due to turnover, leave, etc.	Low	NR	High
Strolin-Goltzman[28], 2023 (N/A)	10 weeks	70% (n= 40) of parents completed the program	Recruitment methods were through flyers and emails. Parents with acute mental illness were excluded	Small sample with quasi-experimental design	Intervention was voluntary, so those that participated may have been more likely to benefit	Low	Fidelity monitoring in place for intervention	High
Ashby, 2018[26] (N/A) Noron a-Zhou, 2023[27] (N/A)	1 year	NR	Colorado Adolescent Maternity program. Results may not be generalizable to other regions/lower complexity patients.	Different process used for identifying trauma history between intervention and controls.	Five year difference between control/intervention groups.	Low	NR	High

III. Outcomes

Appendix Table C.3 Outcomes summary: Adult medical settings

Study (PMID) Comparison RoB Category	**Outcome Timing**	**Summary Finding**	**Intervention**	**Comparator**	**p-value**
Green, 2015[1] (25646872) Green, 2016[2] (27721673) Immediate vs delayed training, pre-post High Adult Medical	Rapport scale Linear Regression One month	No statistical difference	increase .02	N/A	NS

Green, 2015 (25646872)[1] Green, 2016[2] (27721673) Immediate vs delayed training, pre-post High Adult Medical	Partnership scale Linear Regression One month	Favors intervention	increase = 0.21	N/A	p = 0.006
Meredith, 2020[3] (35157622) TICC vs enhanced usual care High Adult Medical	PTSD symptoms (PTSD) Checklist for DSM-5 (PCL-5)) Two sample T-tests, Fisher exact test 9 months	No statistical difference	Baseline 72.95 (14.3) 9 months 47.27 (15.5)	Baseline 73.32 (13.7) 9 months 37.07 (17.8)	p=.08
Meredith, 2020[3] (35157622) TICC vs enhanced usual care High Adult Medical	PTSD diagnosis rate (PTSD Checklist for DSM-5 (PCL-5)) Two sample T-tests, Fisher exact test 9 months	Favors comparator	Baseline 100 9 months 66.7	Baseline 100 42.9	p.27

FOCUS-EC = Families OverComing Under Stress-Early Childhood ; TICC

Appendix Table C.4 Outcomes summary: Adult mental health

Study (PMID) Comparison RoB Category*	**Outcome Timing**	**Summary Finding**	**Intervention**	**Comparator**	**p-value**
Borckardt, 2011[29] (21532072) Quasi-experimental High Adult Mental Health	Seclusion and restraint Mixed model with unit as cluster 3.5 years	Favors intervention	Baseline: .027 +-.018 (per day) 3.5 years: .005 +-.002	N/A	p =.008
Borckardt, 2011[29] (21532072) Quasi-experimental High Adult Mental Health	Therapeutic environment Mixed model with unit as cluster 3.5 years	Favors intervention	Baseline: 3.72 +-.16 3.5 years: 3.94 +-.18	N/A	p=0.036
Borckardt, 2011[29] (21532072) Quasi-experimental High Adult Mental Health	Trauma sensitivity (trauma informed care and rules/language). Mixed model with unit as cluster 3.5 years	No statistical difference	Baseline: 3.88 +-.23 3.5 years: 3.97 +-.25	N/A	NS
Borckardt, 2011[29] (21532072)	Involvement in treatment planning Mixed model with unit as cluster	Favors intervention	Baseline: 3.88 +-.15	N/A	p=0.024

Quasi-experimental High Adult Mental Health	3.5 years		3.5 years: 4.08 +- .12		

Appendix Table C,5 Outcomes summary: Primary prevention

Study (PMID) Comparison RoB Category*	**Outcome Timing**	**Summary Finding**	**Intervention**	**Comparator**	**p-value**
Mogil, 2022[6] (33963489) FOCUS-EC vs. an online education condition High Primary Prevention	Parent psychological health (BSI-18, PDS) Mixed effects models 6 months	Favors interventions for PTSD, no difference for anxiety/depression	2.78 (reduction in PTSD symptoms)	N/A	p < .05
Mogil, 2022[6] (33963489) FOCUS-EC vs. an online education condition High Primary Prevention	Parent-child interactions Observed parental affect and behavior Mixed effects models 12 months	Favors intervention	β= -.38 (indicates increase compared to control)	N/A	p<0.001
Mogil, 2022[6] (33963489) FOCUS-EC vs. an online education condition High Primary Prevention	Child behavior (difficult child) Mixed effects models 12 months	Favors intervention	β= 1.43 (indicates decrease compared to control)	N/A	p<0.05
Mogil, 2022[6] (33963489) FOCUS-EC vs. an online education condition High Primary Prevention	Child behavior (observed child affect and behavior) Mixed effects models 12 months	Favors intervention	β= -.33 (indicates increase compared to control)	N/A	P<0.01

Appendix Table C.6. Outcomes summary: Child welfare (residential)

Study (PMID) Comparison RoB Category*	**Outcome Timing**	**Summary Finding**	**Intervention**	**Comparator**	**p-value**
Baetz, 2021[9] (31253054) Three time points: (a) pre-intervention, (b) post implementation of staff training, and (c) post implementation of staff	Youth on youth assaults Log-Binomial Regression 3 years	Favors intervention in single facility	-.316 (reduction compared to pre-implementation)	N/A	p = .0005

training plus STAIR groups for youth, at 2 facilities High Child Welfare (Residential)					
Boel-Studt 2017[17] (N/A) TI-PRT vs PRT High Child Welfare (Residential)	Functional impairment (CAFAS) RMANOVA 9 months	Favors intervention	*F*(1,200) = 36.288 eta^2 = .154	N/A	p = .000
Boel-Studt 2017[17] (N/A) TI-PRT vs PRT High Child Welfare (Residential)	Restraints/seclusion Zero Inflated Poisson 9 months	Favors intervention (seclusion) No statistical difference (restraints)	.41 (lower odds)	N/A	p = .000
Boel-Studt 2017[17] (N/A) TI-PRT vs PRT High Child Welfare (Residential)	Length of time in care Multivariate regression 9 months	Favors intervention	β= -4.34	N/A	p < .001
Boel-Studt 2017[17] (N/A) TI-PRT vs PRT High Child Welfare (Residential)	Discharge Logistic Regression 9 months	No statistical difference	1.12 (exp Beta)	N/A	NS
Matte-Landry, 2022[12] (37593061) Pre-post TIC training High Child Welfare (Residential)	Restrictive measures (restraints, seclusions, time-outs) Multilevel linear modeling 6 months prior to 12 months post training.	No statistical difference	N/A	N/A	NS
Schmid, 2020[23] (31910832) Longitudinal High Child Welfare (Residential)	Aggression toward staff Fisher's Exact Test 36 months	Favors intervention	0%	24%	p=.02

Appendix Table C.7 Outcomes summary: Child welfare (non-residential)

Study (PMID) Comparison RoB Child Welfare	Outcome Timing	Summary Finding	Intervention	Comparator	p-value
Murphy, 2017[14] (N/A) Redd, 2017[15] (N/A) Quasi-experimental High Child Welfare	Functioning (CAFAS) Latent growth curve models 15 months	Favors intervention	*r* = -.37 (reduction indicates improvement)	N/A	p < .001
Murphy, 2017[14] (N/A) Redd, 2017 (N/A) Quasi-experimental High Child Welfare	Emotional regulation (CECI) Latent growth curve models 15 months	Mixed results that did not clearly indicate improvement or decline	N/A	N/A	NS
Murphy, 2017[14] (N/A) Redd, 2017[15] (N/A) Quasi-experimental High Child Welfare	Behavioral regulation (CECI) Latent growth curve models 15 months	Favors intervention	r = -.17	N/A	p = .05
Murphy, 2017[14] (N/A) Redd, 2017[15] (N/A) Quasi-experimental High Child Welfare	Placement stability Latent growth curve models 15 months	Favorable results following intervention	β= -.15 (reduction indicates improvement)	N/A	p < .001
Bartlett, 2016[18] (26564909) Barto, 2018[19] (29739000) MCTP intervention vs areas that had not yet implemented High Child Welfare	Substantiated or unsubstantiated maltreatment Weighted Logistic Regression 12 months	Unclear Favors control with unsubstantiated and substantiated maltreatment	OR = 1.04	N/A	p = .009
Bartlett, 2016[18] (26564909) Barto, 2018[19] (29739000) MCTP intervention vs areas that had not yet implemented High Child Welfare	Substantiated maltreatment Weighted Logistic Regression 12 months	Favors intervention with substantiated maltreatment	OR = .85	N/A	p < .001
Bartlett, 2016[18] (26564909) Barto, 2018[19] (29739000)	Out-of-home placements Weighted Logistic Regression 12 months	No statistical difference	.0006	N/A	NS

MCTP intervention vs areas that had not yet implemented High Child Welfare					
Bartlett, 2016[18] (26564909) Barto, 2018[19] (29739000) MCTP intervention vs areas that had not yet implemented High Child Welfare	Permanency (adoption) Weighted Logistic Regression 12 months	Favors intervention* Article noted higher rates of adoption in intervention region prior to study	OR = 1.21	N/A	p = .015
Bartlett, 2016[18] (26564909) Barto, 2018[19] (29739000) MCTP intervention vs areas that had not yet implemented High Child Welfare	PTSD (Reexperiencing, avoidance, arousal, overall, UCLA,PTSD-RI, Older Children) Multilevel linear regression Six months	Favors intervention	Reexperiencing β= -3.25 Avoidance β= -2.06 Arousal β= -1.07 Overall β= .6.56	N/A	p < 0.001 p < 0.001 p = 0.02 p < 0.001
Bartlett, 2016[18] (26564909) Barto, 2018[19] (29739000) MCTP intervention vs areas that had not yet implemented High Child Welfare	PTSD (Adult report of older children) Multilevel linear regression Six months	Favors intervention	β= -1.58 (avoidance/numbing) β= -2.82 (total severity)	N/A	p = .006 p = .030
Bartlett, 2016[18] (26564909) Barto, 2018[19] (29739000) MCTP intervention vs areas that had not yet implemented High Child Welfare	PTSD (Functional impairment, YCPC, younger children) Multilevel linear regression Six months	Favors intervention	β= -2.42	N/A	p = .009
Bartlett, 2016[18] (26564909) Barto, 2018[19] (29739000) MCTP intervention vs areas that had not yet implemented High	Child behavior checklist (internalizing, externalizing, total problems) Multilevel linear regression Six months	Favors intervention	β = -4.22 β = -2.85 β = -4.2	N/A	p < .001 p < .030 p < .001

Child Welfare					
Strolin-Goltzman, 2023[28] (N/A) Quasi-experimental High Child Welfare	Parental well-being (WHO-5) Generalized Linear Models	Favors intervention	*F* = 5.36(1) eta^2 = .18	N/A	p = .03
Strolin-Goltzman, 2023[28] (N/A) Quasi-experimental High Child Welfare	Child well-being (SDQ) Generalized Linear Models	Favors Intervention	*F* = 4.20(1)	N/A	p = .05

Appendix Table C.8 Outcomes summary: Child Medical

Study (PMID) Comparison RoB Category*	**Outcome Timing**	**Summary Finding**	**Intervention**	**Comparator**	**p-value**
Ashby, 2018[26] (30475045) TIC vs treatment as usual prenatal care High Child Medical	Prenatal appointment attendance Chi-square 1 year	Favors intervention	3 (increased number of prenatal visits)	N/A	p < .001
Ashby, 2018[26] (30475045) TIC vs treatment as usual prenatal care High Child Medical	Percent of infants born with low birthweight Chi-square 1 year	Favors intervention	4.8% (fewer low birth weight infants)	N/A	P = .02
Norona-Zhou, 2023[27] TIC vs prenatal treatment as usual Child Medical	Preterm birth Chi-square 1 year	Favors intervention	No statistical difference in blacks vs other groups in TIC group	Blacks had higher rates of preterm birth (14.1% vs 6.4%)	NS
Norona-Zhou, 2023[27] TIC vs prenatal treatment as usual Child Medical	Low birthrate Chi-square 1 year	Favors intervention	No statistical difference in blacks vs other groups in TIC group	Blacks had higher rates of low birthweight (15.5% vs 7.6%)	NS

IV. Strength of Evidence Tables

Appendix Table C.9 Summary of strength of evidence: Adult medical settings

Comparison Outcome	Timing	# Studies/ Design (n analyzed)	Finding or Summary Statistic	Study Limitations	Consistency	Directness	Precision	Overall Grade/ Conclusion
Trauma-informed collaborative care vs TIC[2] PCL-5 Symptom score	9 months	1 RCT (n=36)	Both groups improved; no difference between groups	High	Unknown	Direct	Imprecise	Insufficient
Trauma-informed collaborative care vs TIC[2] Provisional PTSD diagnosis	9 months	1 RCT (n=36)	Both groups improved; no difference between groups	High	Unknown	Direct	Imprecise	Insufficient
Trauma-informed collaborative care vs TIC[2] Trust in provider	9 months	1 RCT (n=36)	No differences between groups at baseline or 9 months	High	Unknown	Direct	Imprecise	Insufficient
Pre/post training comparison[1] Rapport with PCP	1 month	1 Cluster RCT (n=30, based on 400 patients responses)	No benefit	High	Unknown	Direct	Imprecise	Insufficient
Pre/post training comparison[1] Partnership with PCP	1 month	1 Cluster RCT (n=30, based on 400 patients responses)	Benefit; “no trauma or PTSD” group improved significantly, positive trend in the trauma exposed group.	High	Unknown	Direct	Imprecise	Insufficient
TICC vs enhanced usual care[3] PTSD symptoms	9 months	1 RCT (n=42)	Both groups improved; TICC group had greater improvement	High	Unknown	Direct	Imprecise	Insufficient

Appendix Table C.10 Summary of strength of evidence: Adult mental health service settings

Comparison Outcome	Timing	# Studies/ Design (n analyzed)	Finding or Summary Statistic	Study Limitations	Consistency	Directness	Precision	Overall Grade/ Conclusion
Pre-post comparison[21] Seclusion and restraint	3.5 years	1 Quasi-experimental (n=446 patients, 340 staff)	Favors intervention group for each year studied.	High	Unknown	Direct	Precise	Insufficient

Appendix Table C.11 Summary of strength of evidence: Primary prevention

Comparison Outcome	Timing	# Studies/ Design (n analyzed)	Finding or Summary Statistic	Study Limitations	Consistency	Directness	Precision	Overall Grade/ Conclusion
FOCUS-EC vs an online education[6] Parent psychological health (anxiety, depression, PTSD)	12 months	1 RCT (n=194 mothers, 155 fathers, 199 children)	Both groups improved; no difference between groups	High	Unknown	Direct	Precise	Insufficient
FOCUS-EC vs an online education[6] Parent-child interactions	12 months	1 RCT (n=194 mothers, 155 fathers, 199 children)	Favors FOCUS-EC	High	Unknown	Direct	Precise	Insufficient
FOCUS-EC vs an online education[6] Child behavior (difficult child)	12 months	1 RCT (n=194 mothers, 155 fathers, 199 children)	Favors FOCUS-EC	High	Unknown	Direct	Precise	Insufficient

Appendix Table C.12 Summary of strength of evidence: Child welfare (residential)

Comparison Outcome	Timing	# Studies/ Design (n analyzed)	Finding or Summary Statistic	Study Limitations	Consistency	Directness	Precision	Overall Grade/ Conclusion
Pre-interventions vs training vs training + skill groups[9] Violent incidents	3.75 years	1 Quasi-experimental (n=14,856 juveniles, 473 staff)	Mixed results	High	Unknown	Direct	Precise	Insufficient
No TIC vs TIC[12] Restrictive measures (restraint, seclusions, time outs)	12 months	1 Quasi-experimental (n=44 residential treatment units for children)	No significant effect was found.	High	Unknown	Direct	Precise	Insufficient
Traditional PRT vs TI-PRT[17] Functional impairment	12 months	1 Quasi-experimental (n=205)	TI-PRT resulted in reductions in impairment	High	Unknown	Direct	Precise	Insufficient
Traditional PRT vs TI-PRT[17] Restraints and seclusion	12 months	1 Quasi-experimental (n=205)	No significant effect was found.	High	Unknown	Direct	Precise	Insufficient
Traditional PRT vs TI-PRT[17] Length of stay	12 months	1 Quasi-experimental (n=205)	Time spent in treatment was 4 months less TI-PRT group	High	Unknown	Direct	Precise	Insufficient

Traditional PRT vs TI-PRT[17] Discharge to community-based placements	12 months	1 Quasi-experimental (n=205)	No significant effect was found.	High	Unknown	Direct	Precise	Insufficient
Facilities with standard training (No TIC) compared at 4 points in time[23] Client physical aggression towards staff	36 months	1 Longitudinal (n= 47 staff, 142 youth)	The intervention group reported significantly less physical aggression than the control group	High	Unknown	Direct	Precise	Insufficient

Appendix Table C.13 Summary of strength of evidence: Child welfare (non-residential)

Comparison Outcome	Timing	# Studies/ Design (n analyzed)	Finding or Summary Statistic	Study Limitations	Consistency	Directness	Precision	Overall Grade/ Conclusion
TILT vs usual care[19] Permanency	12 months	1 Quasi-experimental (n=91,253)	No significant difference found	High	Unknown	Direct	Imprecise	Insufficient
TILT vs usual care[19] Out-of-home placements	12 months	1 Quasi-experimental (n=91,253)	No significant difference found	High	Unknown	Direct	Imprecise	Insufficient
TILT vs usual care[19] Maltreatment status	12 months	1 Quasi-experimental (n=91,253)	No significant difference found	High	Unknown	Direct	Imprecise	Insufficient

TILT vs usual care Child[18] posttraumatic stress symptoms in young children	1 year	1 Quasi-experimental (n= 326 children, 27 SLs,190 clinicians and clinician supervisors)	Favors intervention	High	Unknown	Direct	Imprecise	Insufficient
TILT vs usual care[18] Child posttraumatic stress symptoms in older children	1 year	1 Quasi-experimental (n= 326 children, 27 SLs,190 clinicians and clinician supervisors)	Mixed results	High	Unknown	Direct	Imprecise	Insufficient
TILT vs usual care[18] Child behavior problems	1 year	Quasi-experimental (n= 326 children, 27 SLs,190 clinicians and clinician supervisors)	Favors intervention	High	Unknown	Direct	Imprecise	Insufficient
TST dosage[14] Functioning	15 months	1 Quasi-experimental (n=1499)	Increases in TST dosage were associated with improvements in functioning	High	Unknown	Direct	Imprecise	Insufficient
TST dosage[14] Emotional regulation	15 months	1 Quasi-experimental (n=1499)	Mixed results	High	Unknown	Direct	Imprecise	Insufficient
TST dosage[14] Behavioral regulation	15 months	1 Quasi-experimental (n=1499)	Increases in TST dosage were associated with improvements in behavioral regulation	High	Unknown	Direct	Imprecise	Insufficient

TST dosage[14] Placement stability	15 months	1 Quasi-experimental (n=1499)	Higher levels of TST dosage were associated with greater placement stability	High	Unknown	Direct	Imprecise	Insufficient
Pre-post comparison[28] Parental well-being	10 weeks	1 Quasi-experimental (n=40)	Favors intervention	High	Unknown	Direct	Precise	Insufficient
Pre-post copmarison[28] Child well-being	10 weeks	1 Quasi-experimental (n=40)	Favors intervention	High	Unknown	Direct	Precise	Insufficient

Appendix Table C.14 Summary of strength of evidence: Child Medical

Comparison Outcome	Timing	# Studies/ Design (n analyzed)	Finding or Summary Statistic	Study Limitations	Consistency	Directness	Precision	Overall Grade/ Conclusion
Prenatal treatment-as-usual (TAU) or trauma informed treatment[26] Prenatal appointment attendance	1 year	1 Historical control (n= 844)	Favors intervention	High	Unknown	Direct	Precise	Insufficient
Prenatal treatment-as-usual (TAU) or trauma informed treatment[26] Lower rates of low birthweight babies	1 year	1 Historical control (n= 844)	Favors intervention	High	Unknown	Direct	Precise	Insufficient
Prenatal treatment-as-usual (TAU) or trauma informed treatment[27]	1 year	1 Historical control (n= 844)	Disparity gap narrows statistical difference between races	High	Unknown	Direct	Precise	Insufficient

Racial disparities in preterm and low birthweight babies								

Key= FWbA = Family well-being Assessment; SL = Senior leader; TICC = Trauma Informed Collaborative Care; TILT= Trauma Informed Leadership Teams; TST = Trauma Systems Therapy

Appendix D.

Appendix Table D.1. Summary of Findings: TIC definitions

Context	Model	Overview	Core Principles and/or Domains
Universal / Cross-cutting models	Collaborative Care Model (CoCM)[30]	"Aim to improve patient care coordination, consistency, and quality of patient care through a collaborative multidisciplinary approach centered on patients and caregivers"	1. Patient-centered team care a. Incorporates patient goals b. Physical and mental health care both tended to 2. Population-based care a. Track which patients are not improving and reach out to them b. Provide caseload-focused consultation 3. Measurement-based treatment to target a. Evidence- based tools measure progress b. Client goals are tracked c. Treatment changes if patients are not seeing expected progress 4. Evidence-based care a. CoCM has substantial evidence for its effectiveness 5. Accountable care a. Providers are reimbursed for quality of care and clinical outcomes, not only the volume of care provided
	Creating Cultures of Trauma-Informed Care (CCTIC)[30-34]S	"An evidence-based framework that extends the philosophy of person-centered care which recognizes and values the individual perspectives of care recipients and those providing care, while promoting a positive social environment... emphasizes the fundamental role of psychological trauma in shaping a person's experience of care... organized in ways that engender safety for all and do not re-traumatize survivors"	1. The capability of staff to identify when psychological trauma may be affecting a person's experience of care 2. Organizational processes to maximize the person's control
	Creating PRESENCE[35]	"...a trauma lens that recognizes the complex impact of trauma and other forms of adversity on the brain… A systemic trauma lens can help staff have greater confidence in their effectiveness with their clients and provides them with personal tools for self-care… Policies, practices, and internal processes that promote trauma-resilience and inspires the mission and vision of the organization"	1. Partnership and power 2. Reverence and restoration 3. Emotional wisdom and empathy 4. Safety and social responsibility 5. Embodiment and enactment 6. Nature and nurture 7. Culture and complexity 8. Emergence and evolution
	National Child Traumatic Stress	"A trauma-informed child and family service system is one in which all parties involved	1. Routinely screen for trauma 2. Use evidence-based, culturally responsive assessment and treatment

Context	Model	Overview	Core Principles and/or Domains
	Network (NCTSN)[36-40]	recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to maximize physical and psychological safety, facilitate the recovery of the child and family, and support their ability to thrive"	3. Make resources available to children, families, and providers on trauma exposure, its impact, and treatment. 4. Engage in efforts to strengthen the resilience and protective factors of children and families 5. Address parent and caregiver trauma and its impact on the family system 6. Emphasize continuity of care and collaboration across child-service systems 7. Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff wellness
	Solution-Focused Trauma-Informed Care (SF-TIC)[41, 42]	"Creates service environments that are sensitive to trauma histories," which work to address the core domains	1. Actively prevent re-traumatization 2. Promote personal growth and development for everyone in the system, including staff 3. Enhancing service delivery, 4. Addressing trauma effectively, 5. Developing positive staff working relationships 6. Helping staff approach challenging situations with new skills and tools
	Substance Abuse and Mental Health Services Administration (SAMHSA)[32, 43-53]	"A program, organization, or system that... realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma... and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization"	1. Safety 2. Trustworthiness and transparency 3. Peer support 4. Collaboration and mutuality 5. Empowerment, voice, and choice 6. Cultural, historical, and gender issues
	Trauma and Resiliency Informed Practice (TRIP)[54]	"a shared humanity model [that] can improve provider well-being and client care"	1. Trauma awareness 2. Emphasis on safety and trustworthiness 3. Opportunities for choice, collaboration, and connection 4. Strengths-based and skills building 5. Recognition of cultural, historical, and gender issues 6. Promotion of service user and peer involvement
Adult medical care	Fifth Vital Sign: HOUSE[55]	Goal is "to prevent and alleviate precarious housing; remind emergency room physicians of the importance of TIC"	1. H: Housing precarity 2. O: Outcomes of mental illness 3. U: Understanding income 4. S: Start case management for mental health 5. E: Evaluate substance use

Context	Model	Overview	Core Principles and/or Domains
	Trauma-Informed Primary Care (TIPC)[56]	"A patient-centered approach that acknowledges and addresses the broad impact of both recent and lifetime trauma on health behaviors and outcomes. The goal... is to improve the efficacy and experience of primary care for both patients and providers by integrating an evidence-based response to this key social determinant of health"	1. Foundation a. Trauma-informed values b. Clinic champion(s) c. Interdisciplinary team-based care d. Community partnerships e. Buy-in from organizational leadership f. Training, supervision, and support for staff and providers 2. Response a. Express empathy b. Refer to trauma-informed onsite or community services that promote safety, connection, and healing 3. Education: describe the connection between trauma and health and opportunities for healing to all patients 4. Inquiry a. Screen for immediate safety b. Screen for past trauma (assume a history of trauma) c. Screen for the impacts of past trauma d. Use open-ended questions e. Use a structured tool
	Trauma-Informed Treatment Model[57]	"Lies in the recognition that violence and victimization play a central role in the lives of hospitalized consumers"	A person's symptoms are understood as attempts to cope within the context of one's: 1. Life experiences 2. History, and 3. Culture
Adult mental health care	Portal Project Model[58]	"Layered approach to integrating trauma into the treatment environment... blends service intervention, policy development, research, and evaluation for effective service delivery"	1. Enhanced assessment 2. Direct services 3. Multidisciplinary team case conferences 4. Consumer participation 5. Collaborative cross-system policy and planning work
	Trauma-Informed Care and Practice (TICP)[41]	"Consumers have a need to feel connected, valued, informed, and hopeful of recovery; the connection between the experience of childhood trauma and current psychopathology is known and understood by staff; staff work with consumers, their families, friends, and supports in ways that are mindful and empowering and promote and protect autonomy"	1. Consumers have a need to feel connected, valued, informed, and hopeful of recovery 2. The connection between the experience of childhood trauma and current psychopathology is known and understood by staff 3. Staff work with consumers, their families, friends, and supports in ways that are mindful and empowering and promote and protect autonomy
	Trauma-Informed Care Pyramid[41, 59, 60]	"An attempt to provide specific guidance for dentists according to setting, specialty and individual patient needs. Each level of the	Levels: 1. Patient-centered communication skills 2. Understanding the health effects of trauma

Context	Model	Overview	Core Principles and/or Domains
		proposed TIC pyramid is informed by research findings and clinical data. The pyramid also is based on our experiences in educating dental students regarding issues related to health care communication, mandatory reporting and working with highly anxious patients"	3. Collaboration and understanding the professional's role 4. Understanding one's own history of trauma 5. Screening
	Trauma-Informed Social Work Practice[61]	"Helps survivors develop their capacities for managing distress and for engaging in more effective daily functioning. The effects of the past childhood trauma are not ignored, but extensive and detailed immersion in traumatic material itself is not encouraged''	1. Normalizing and validating clients' feelings and experiences 2. Assisting [clients] in understanding the past and its emotional impact 3. Empowering survivors to better manage their current lives 4. Helping [survivors] understand current challenges in light of the past victimization"
	Women, Co-Occurring Disorders, and Violence Study (WCDVS)[62, 63]	"Trauma-informed services are those in which service delivery is influenced by an understanding of the impact of interpersonal violence and victimization on an individual's life and development... The absence of this understanding about the impact of trauma on a woman's life is... the equivalent of denying the existence and significance of trauma in women's lives."	1. Recognize the impact of violence and victimization on development and coping strategies 2. Identify recovery from trauma as a primary goal 3. Employ an empowerment model 4. Strive to maximize a woman's choices and control over her recovery 5. Based in a relational collaboration 6. Create an atmosphere that is respectful of survivors' need for safety, respect, and acceptance 7. Emphasize women's strengths, highlighting adaptations over symptoms and resilience over pathology 8. Minimize the possibilities of re-traumatization 9. Culturally competent 10. Understand each woman in the context of her life experiences and cultural background
Youth juvenile detention	A Developmental Trauma Informed Response for the Criminal Justice System[64]	"All parties involved recognize and respond appropriately to the varying impacts of trauma stress on children, caregivers, families and those who have contact within the system"	1. The criminal justice connection (recognize these children as survivors of trauma in order to intervene) 2. Trauma-informed approach for perpetrators 3. Response by the criminal justice system (accommodate the special developmental needs of children exposed to violence) 4. Recommendations for the criminal justice system (develop an understanding of evidence-based practices for treating traumatized children, including the target population [e.g., LGBTQ, gender-based]) 5. Progress in the courts (important judicial follow-through; easing the judicial process for children exposed to violence) 6. What works with children exposed to violence (trauma-informed approaches rooted in child development) 7. Goals and implementation of systemic change (initial and ongoing training; evidence-based and victim-centered training; comprehensive training should be ongoing and followed up with outreach)

Context	Model	Overview	Core Principles and/or Domains
			8. Program design and implementation (protocol should include a training plan, case filing guidelines, forensic interview protocols, trial tactics, training on the use of expert witnesses, and disposition and sentencing guidelines)
	Trauma-Informed Juvenile Justice[65]	"An approach to organizing services that integrates an understanding of the impact and consequences of trauma into all interventions and aspects of organizational functioning"	1. Clinical services a. Screening and assessment b. Services and interventions c. Cultural competence 2. Agency context a. Youth and family engagement/involvement b. Workforce development and support c. Promoting a safe agency environment d. Agency policies, procedures, and leadership 3. System-level a. Cross-system collaboration b. System-level policies and procedures c. Quality assurance and evaluation
Youth residential and inpatient treatment	Attachment, Regulation, and Competency (ARC) Framework[66-69]	"A framework for intervention with youth and families who have experienced complex trauma, focusing on three core domains frequently impacted among complexly traumatized youth and relevant to future resiliency: attachment, self-regulation, and competency... ARC is organized around [these] three primary domains of intervention, and identifies eight key treatment targets"	1. Attachment a. Supporting caregivers b. Enhancing caregiver-child relationship c. Building trauma-informed responses 2. Regulation a. Awareness and understanding of emotions b. Tolerate and manage emotions c. Relational connection 3. Competency a. Choice and empowerment b. Self and identity
	Fairy Tale Model of Trauma-Informed Treatment[70, 71]	"Understanding, stability, coping capacity, and trauma resolution"	1. Evaluation 2. Identification and enhancement of the client's goals and motivation 3. Trauma-informed case formulation and treatment contracting 4. Stabilization, potentially including case management, parent training, problem-solving, and strategic avoidance of high-risk situations 5. Identification and enhancement of coping and affect tolerance skills 6. Resolution of trauma and loss memories 7. Consolidation of gains 8. Anticipation of future challenges
	Massachusetts Child Trauma Project (MCTP)[72, 73]	"Involves awareness of the prevalence of trauma and its impact on health and mental health; recognizes signs and symptoms of trauma in children, families, and staff;	1. An understanding about the impact of trauma on the development and behavior [of youth] 2. Knowledge about when and how to intervene directly in a trauma- and culturally-sensitive manner through strategic referrals

Context	Model	Overview	Core Principles and/or Domains
		responds with evidence-based practices; and avoids re-traumatization"	3. Ensuring access to timely, quality, and effective trauma-focused intervention 4. A case planning process that supports resilience in long-term healing and recovery 5. Attention to self-care
	National Association of State Mental Health Program Directors (NASMHPD)[74]	"A comprehensive and holistic approach to management of behavioral health issues that includes six core strategies for prevention of re-traumatization within the behavioral health setting"	1. Leadership towards organizational change 2. Use of data to inform practice 3. Workforce development 4. Use of restraint and seclusion reduction tools 5. Improve consumer's role in inpatient setting 6. Vigorous debriefing techniques
	Sanctuary Model[75-78]	"Emphasizes a restorative process to help youth understand the effects of trauma and gain positive coping skills to manage difficult emotions, loss, and stress... a community-focused program that seeks to reduce violence among youth ages 8 to 30 by addressing trauma and providing opportunities for healing and connection"	Culture of... 1. Nonviolence 2. Emotional intelligence 3. Social learning 4. Shared governance 5. Open communication 6. Social responsibility 7. Growth and change
	Trauma-Informed Care in Residential Treatment[79]	"An approach to organizing treatment that integrates an understanding of the impact and consequences of trauma into all clinical interventions as well as all aspects of organizational function"	1. Staff understand the... impacts of trauma and of neglect 2. Staff are trained to respond to the youth, including family members, with empathy, sensitivity, and respect 3. Environments and processes are designed to be collaborative and supportive 4. Coercive interventions and interactions are [contraindicated] 5. The child and family are viewed as individuals who are surviving traumatic stress and their perspectives are the focus of treatment efforts 6. Staff are attuned to the phenomenon of triggers and traumatic reenactments
Youth in child protection	Chadwick Trauma-Informed Systems Project and the Community Assessment Process[80, 81]	"All parties involved recognize and respond to the varying impact of traumatic stress on children, caregivers, and those who have contact with the system. Programs and organizations within the system infuse this knowledge, awareness, and skills into their organizational cultures, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery."	1. Recognize and respond to the varying impact of traumatic stress 2. Infuse this knowledge, awareness, and skills into their organizational cultures, policies, and practices 3. Facilitate and support resiliency and recovery

Context	Model	Overview	Core Principles and/or Domains
	Trauma-Informed Child Welfare Systems (TICWSs)[82]	“Desired outcomes of TICWSs are rooted in the federal standards of safety, well-being, and permanency... The driving assumption is that TICWSs produce better outcomes for children and families including reduced placement changes, increased permanency, and overall improvement in child functioning at home, school, and the community.”	1. Development of project champion 2. Trauma identification 3. Comprehensive assessment of traumatic impact 4. Evidence-based trauma treatment 5. Common trauma language 6. Trauma-informed decision making
Additional settings	Healthy Environments and Response to Trauma in Schools (HEARTS)[83]	"Promotes school success for trauma-impacted students through a whole-school approach utilizing the response to intervention multi-tiered framework: (a) school-wide universal supports, (b) capacity building with school staff, and (c) intensive interventions for students suffering from the impact of trauma"	1. Understand trauma and stress 2. Establish safety and predictability 3. Foster compassionate and dependable relationships 4. Promote resilience and social emotional learning 5. Practice cultural humility and responsiveness 6. Facilitate empowerment and collaboration
	Nurse-Led Model of Trauma-Informed Care (The Four E’s)[84]	"This care model informs practices for staff and the interdisciplinary healthcare team, as well as helps develop nursing interventions for inmates”	1. Educate 2. Empathize 3. Explain 4. Empower
	Therapeutic Crisis Intervention in Schools (TCI-S)[85]	“Models of care and support provision that consider the prevalence of childhood trauma and its subsequent impacts on development, learning and wellbeing”	1. Data-driven incident monitoring and feedback 2. Leadership and administrative support 3. Social work and clinical services participation 4. Supervision and post crisis response 5. Training and competency standards
	Trauma Center Trauma-Sensitive Yoga (TCTSY)[86, 87]	"The TCTSY methodology is based on central components of the hatha style of yoga, where participants engage in a series of physical forms and movements. Elements of standard hatha yoga are modified to maximize experiences of empowerment and to cultivate a more positive relationship to one's body... Although TCTSY employs physical forms and movements, the emphasis is not on the external expression or appearance or receiving the approval of an external authority. Rather, the focus is on the internal experience of the participant. This shift in orientation, from the external to the internal, is a key attribute of TCTSY... TCTSY allows participants to restore their connection of mind and body and	1. Practice making choices 2. Present moment experience 3. Taking effective action 4. Creating rhythms 5. Non-coercion 6. Sensing dynamics

Context	Model	Overview	Core Principles and/or Domains
		cultivate a sense of agency that is often compromised as a result of trauma."	
	A Trauma Informed Approach to Interviewing[88]	“Guided by the principle of do no harm, and should apply to all contacts with witnesses"	1. A clinical psychologist must conduct a vulnerability assessment before an interview to recommend any special support measures 2. Special measures may include allowing a... support-person to be present during the interview to provide psychosocial support 3. A comfortable, safe and secure location and setting 4. The interviewer should model a calm, professional and sympathetic demeanor at all times 5. [Questioning] conducted in a non-suggestive manner 6. The voluntariness of the interview, and the conditions for sharing it, must be emphasized before and after the interview, and the witness must be given a full and unhurried opportunity to review, amend and finally adopt any written statement 7. Interviewers should acknowledge and respond to any extreme manifestations of distress, and call upon the clinical psychologist in case of need 8. Immediate referral should be made (if warranted)
	Trauma-Informed Correctional Care (TICC)[89]	“It has as primary goals accurate identification of trauma and related symptoms, training all staff to be aware of the impact of trauma, minimizing re-traumatization, and a fundamental ‘do no harm’ approach that is sensitive to how institutions may inadvertently reenact traumatic dynamics”	1. Institutional and personal safety 2. Staff training 3. Cultural change 4. Relevant clinical approaches (e.g., gender differences in relation to both trauma and criminal justice)
	Trauma-Informed Neighborhood Resource and Recreation Centers (NRRCs)[90]	"Guiding principles in which the recreation center policy and practice across all levels of leadership and staff should operate," created by converging the National Recreation and Park Association's Commission for Accreditation of Park and Recreation Agencies (NRPA's CAPRA) and the SAMHSA implementation domains and principles	Trauma-informed principles: 1. Safety 2. Empowerment, voice, and choice 3. Trustworthiness and transparency 4. Collaboration and mutuality 5. Peer support 6. Cultural issues, historical, and gender issues Trauma-informed organizational domains: 1. Governance and leadership 2. Policy 3. Physical environment 4. Engagement and involvement 5. Cross-sector collaboration 6. Screening, assessment, and treatment services 7. Training and workforce development

Context	Model	Overview	Core Principles and/or Domains
			8. Progress monitoring and quality assurance 9. Financing 10. Evaluation CAPRA standards: 1. Evaluation, assessment, and research 2. Facility and land use management 3. Human resources 4. Planning 5. Fiscal management 6. Programs and services management 7. Organization and administration 8. Risk management 9. Agency 10. Public safety
	Trauma-Informed Positive Education (TIPE)[91, 92]	"Links approaches addressed in trauma-informed classrooms that focus on the repair of regulatory capacities and disrupted attachment styles with proven positive psychology interventions that focus on growth by increasing psychological resources"	1. Repairing regulatory abilities 2. Repairing relational capacities 3. Increasing psychological resources
	Trauma-Informed Weight Lifting (TIWL)[93, 94]	"An embodied practice and intervention that is informed by the latest in neuroscience, physiology and trauma research. It seeks to transform weight lifting in an effort to both promote and facilitate healing for trauma-impacted individuals and communities."	1. Foundational knowledge of trauma 2. Inclusivity 3. Practitioner self-awareness 4. Responsivity in relationship 5. Stance of curiosity 6. Interoceptive awareness 7. Agency, autonomy, and choice 8. Healing relationships and community

Appendix Table D.2. Summary of findings: TIC intervention targets

Context	Model	Individual	Family / Interpersonal	Health System	Community	Policy
Universal / Cross-cutting models	Collaborative Care Model (CoCM)[30]	Yes	Yes	Yes	Yes	Unclear
	Creating Cultures of Trauma-Informed Care (CCTIC)[31-34]	Yes	No	Yes	Yes	Yes
	Creating PRESENCE[35]	No	No	Yes	No	Yes
	National Child Traumatic Stress Network (NCTSN)[36-38, 40, 95]	Yes	Yes	Yes	Unclear	Yes

Context	Model	Individual	Family / Interpersonal	Health System	Community	Policy
	Solution-Focused Trauma-Informed Care (SF-TIC)[41, 42]	Yes	No	Yes	No	No
	Substance Abuse and Mental Health Services Administration (SAMHSA)[32, 43-53, 96]	Yes	Yes	Yes	Yes	Yes
	Trauma and Resiliency Informed Practice (TRIP)[54]	Yes	Unclear	Yes	Unclear	Unclear
Adult medical care	Fifth Vital Sign: HOUSE[55]	Yes	Unclear	Yes	Yes	Unclear
	Trauma-Informed Primary Care (TIPC)[56]	Yes	No	Yes	Yes	No
	Trauma-Informed Treatment Model[56]	Yes	No	Yes	No	No
Adult mental health care	Portal Project Model[58]	Yes	No	Yes	No	No
	Trauma-Informed Care and Practice (TICP)[41]	Yes	No	Yes	No	No
	Trauma-Informed Care Pyramid[59, 60]	Unclear	No	Yes	No	No
	Trauma-Informed Social Work Practice[61]	Yes	No	No	No	No
	Women, Co-Occurring Disorders, and Violence Study (WCDVS)[62, 63]	Yes	Yes	Yes	Yes	No
Youth juvenile detention	A Developmental Trauma Informed Response for the Criminal Justice System[64]	Yes	Yes	Yes	No	Yes
	Trauma-Informed Juvenile Justice[65]	Yes	Yes	Yes	Unclear	Yes
Youth residential and inpatient treatment	Attachment, Regulation, and Competency (ARC) Framework[66-69]	Yes	Yes	Yes	No	No
	Fairy Tale Model of Trauma-Informed Treatment[70, 71]	Yes	Yes	Yes	Unclear	No
	Massachusetts Child Trauma Project (MCTP)[72, 73]	Yes	Yes	Yes	Yes	No
	National Association of State Mental Health Program Directors (NASMHPD)[74]	Yes	Yes	Yes	No	No
	Sanctuary Model[75-78]	Yes	Yes	Yes	Yes	No
	Trauma-Informed Care in Residential Treatment[79]	Yes	Yes	Yes	No	No
Youth in child protection	Chadwick Trauma-Informed Systems Project and the Community Assessment Process[80, 81]	Unclear	Yes	Yes	Yes	No
	Trauma-Informed Child Welfare Systems (TICWSs)[82]	Yes	Yes	Yes	Yes	Yes
	Healthy Environments and Response to Trauma in Schools (HEARTS)[83]	Yes	Yes	Yes	Yes	Unclear

Context	Model	Individual	Family / Interpersonal	Health System	Community	Policy
Additional settings	Nurse-Led Model of Trauma-Informed Care (The Four E's)[84]	Yes	Yes	No	No	No
	Therapeutic Crisis Intervention in Schools (TCI-S)[85]	No	Yes	No	Yes	Yes
	Trauma Center Trauma-Sensitive Yoga (TCTSY)[86, 87]	Yes	Yes	No	Yes	No
	A Trauma Informed Approach to Interviewing[88]	Yes	Yes	Yes	No	No
	Trauma-Informed Correctional Care (TICC)[89]	Yes	No	Yes	No	No
	Trauma-Informed Neighborhood Resource and Recreation Centers (NRRCs)[90]	Yes	No	No	Yes	Yes
	Trauma-Informed Positive Education (TIPE)[89, 91, 92]	Yes	No	No	Yes	No
	Trauma-Informed Weight Lifting (TIWL)[93]	Yes	Yes	No	Yes	No

Appendix Table D.3. Summary of findings: TIC socioecological component descriptions

Setting	Model	Cultural Relevance	Training	Screening	System Embedding
Universal / Cross-cutting models	Collaborative Care Model (CoCM)	Unclear	Unclear	Evidenced-based tools used to measure client progress and goals. Treatment changes if patients do not progress as expected[30]	Includes behavioral health care manager who ensures accessibility[30]
	Creating Cultures of Trauma-Informed Care (CCTIC)	Has been implemented in geriatric and refugee [33]populations	Involves staff training[31-33]	Requires screening clients for trauma[32] and organizational policy mapping[31]	Includes policy statement[32], adaptable for individual needs[31]; CCTIC Program Self-Assessment Scale: Used to determine how well the program is implementing CCTIC[32]
	Creating PRESENCE	Unclear	Training is offered as hybrid and web-based. Aims to help staff cultivate confidence in their effectiveness with clients and practice self-care[35]	Unclear	Involves policies, practices, and internal processes that promote trauma-resilience[35]
	National Child Traumatic Stress Network (NCTSN)	Unclear	Core Curriculum on Childhood Trauma self-assessment skill score: Assesses how well staff implement TIC[36]; Staff receive training on TIC incorporation,	Trauma-Informed Organizational Assessment: Used to assess and improve quality of current practices[40]; Pediatric Toolkit for Health	Pyramid Model: Multi-tiered approach[97-99]

Setting	Model	Cultural Relevance	Training	Screening	System Embedding
			trauma training, language skills, problem-based learning, core-curriculum case studies, and a strengths-based approach; Pediatric Toolkit for Health Care Providers increases awareness of traumatic stress[95]	Care Providers: Screens for trauma, assesses current practices, and uses D-E-F protocol (reduce Distress, promote Emotional support, Remember the family)[95]; Resource Parent Curriculum: Provides caregiver training on trauma and information specific to different developmental periods of childhood and screens for parenting self-efficacy[39]	
	Solution-Focused Trauma-Informed Care (SF-TIC)	Unclear	Unclear	Unclear	Collaboration across levels via a decentralized structure[42]
	Substance Abuse and Mental Health Services Administration (SAMHSA)	Assessed in LGBTQ groups[43], immigration policies, providing care to diverse communities, and considering intersectionality[100]. Emphasis regarding cultural humility[48] and basic safety for vulnerable populations[45]. Prioritizes knowledge of community members[96]	Training completed by frontline workers[45], obstetrics and gynecology residents[53], staff[45], community workers (e.g., Johnson City Tennessee System of Care[46]). Trauma-informed program self-assessment scale[32]: Developed to assess implementation	TIC Grade[44]: Pocket guide to screen for trauma history[53], with general trauma screening[48]; Trauma-Informed Organizational Toolkit[96]: Trauma-informed school self-assessment[49]; Trauma-informed practice scales[43]: Assesses how well TIC is implemented	Knowledgeable facilitators teach the model[53]. Uses trauma-informed medical education (TIME) model to teach medical students[51]. Trauma-informed providers are referred to when needed[48]. Institutional support [50]and community capacity building to maintain TIC[96]. Trauma-Informed School System implemented to prioritize delivery of trauma-informed practices[49]. SNAP food security used in policy. Educates policymaker[45]s. Promotes collaboration among systems[52]
	Trauma and Resiliency Informed Practice (TRIP)	Unclear	Used in clinical training[54]	Unclear	Consists of one-day workshop with continued support[54]
Adult medical care	Fifth Vital Sign: HOUSE	Developed for the housing epidemic that followed COVID-19[55]	Taught to medical professionals to remind them of TIC[55]	Medical professionals screen for housing precarity, mental illness, income insecurity, and substance use[55]	Implementation in the health care setting by health professionals, training, and community programs to

Setting	Model	Cultural Relevance	Training	Screening	System Embedding
					ensure timely and team-based car[55]e
	Trauma-Informed Primary Care (TIPC)	Unclear	Health professionals are trained on the connection between trauma and health[56]	Staff screen for abuse, PTSD, depression, suicidality, chronic pain, and substance us[56]e	The model includes trauma-informed values, robust partnerships, clinic champions, support for providers, and ongoing monitoring and evaluatio[56]n
	Trauma-Informed Treatment Model	Unclear	Nurses gain education and skills training in dialectical behavioral therapy and cognitive behavioral therapy[57]	Unclear	An appropriate staffing ratio is required[57]
Adult mental health care	Portal Project Model	Staff incorporate cultural competence[58]	Trauma training and competency[58]	Trauma screening[58]	Clients are involved in their treatment. Staff enhance quality of care, attend monthly Multidisciplinary Team Case Conferences, quarterly Policy Action Committee meetings, facilitate access to services, foster positive change, maximize information sharing, and identify gaps and barriers to service
	Trauma-Informed Care and Practice (TICP)	Unclear	Clients receive sexual safety training and awareness[41]. Staff members participate in TICP workshops and trauma training which has been found to improve staff confidence in de-escalation[41]	Unclear	Unclear
	Trauma-Informed Care Pyramid	Unclear	Staff receive trauma training and learn about health-related effects of trauma, mandated reporting requirements, and empathic communication[41, 59, 60]	Trauma screening[41, 59, 60]	Staff collaborate with other health professionals and use referrals as needed[41, 59, 60]
	Trauma-Informed Social Work Practice	Unclear	Social workers are taught how to respond to trauma disclosure, work within their competency, and maintain boundaries[61]	Unclear	Unclear

Setting	Model	Cultural Relevance	Training	Screening	System Embedding
	Women, Co-Occurring Disorders, and Violence Study (WCDVS)	Problems are conceptualized as being influenced or created by the sociopolitical context and culturally competent care is part of this model[62]	Includes cross-training and trauma training	Screens clients for abuse history[62]	Integration of services[63] and collaborative care[62, 63]
Youth juvenile detention	A Developmental Trauma Informed Response for the Criminal Justice System	Unclear	Trainings include Seeking Safety, child development training, and victim-centered training	Trauma screening and assessment[64]	Child-friendly practices, a multidisciplinary team, the Children Exposed to Violence protocol, and reasonable caseloads[64]
	Trauma-Informed Juvenile Justice	Cultural competence is required[65]	Unclear	Trauma screening[65]	Includes cross-system collaboration, quality assurance, and evaluation[65]
Youth residential and inpatient treatment	Attachment, Regulation, and Competency (ARC) Framework	Unclear	Caregiver and staff training[68]	Trauma exposure[67, 68], Clinician-Administered PTSD Scale[67], Trauma Symptom Checklist for Children[67], Behavior Assessment System for Childre[67]n, and Parenting Stress Index–Short Form[67]	Integrated across levels and includes structural supports[68]
	Fairy Tale Model of Trauma-Informed Treatment	Involves a strong family and community component[70]	Includes parent[70], therapist, direct care staff, and social worker training, and family education[70]	Clients screened for presenting problem and traum[71]a. Specific assessments include: Lifetime Incidence of Traumatic Events Student form, Child Report of Post-Traumatic Symptoms, and Urban Trauma Index[70]; Specific family assessments include: Lifetime Incidence of Traumatic Events Parent form; Family Empowerment Scale[70]	Unclear
	Massachusetts Child Trauma Project (MCTP)	Unclear	Parent training on trauma[72], Child Welfare Training Toolkit[72, 73], and Child welfare staff training[72]. Trainings have been found to increase awareness of trauma[73]	Young Child PTSD Checklist, University of California Los Angeles Child/Adolescent PTSD Reaction Index, and Child Behavior Checklist[73] Within the health system, MCTP has been assessed using the Trauma System	Child-welfare workers lead Trauma-Informed Leadership Teams[72] and collaborate with community providers[73]

Setting	Model	Cultural Relevance	Training	Screening	System Embedding
				Readiness Tool[72]and Trauma-Informed System Change Instrument[73]	
	National Association of State Mental Health Program Directors (NASMHPD)	Unclear	Principles of recovery-oriented care, including person-centered care, respect, dignity, partnerships, self-management, and the importance of family involvement are included in staff training[74]	Unclear	Encouraged to be implemented at the leadership level, and data can be used to inform the care provided[74]
	Sanctuary Model	Unclear	Consists of daily training opportunities, meetings, trauma training, and TIC training[78]. Employees are taught to understand families through a trauma-informed lens[75]	Client safety and trauma are assessed[77]	Some programs developed from the Sanctuary Model include Healing Hurt People and Safety, Emotions, Loss, and Future[76]. The Model requires shared power of management and frontline staff,[78] building partnerships among teachers and mental health professionals[75]
	Trauma-Informed Care in Residential Treatment	Unclear	Includes trauma training[79]	Incorporates individualized assessment and trauma screening for clients[79]	All staff engage in decision making and point/level systems were eliminated[79]
Youth in child protection	Chadwick Trauma-Informed Systems Project and the Community Assessment Process	Unclear	Includes trauma training[80, 81]	Providers use a trauma screening tool. The Community Trauma-Informed Assessment and Trauma System Readiness Tool are used to assess the implementation of this model in the community[80, 81]	Includes community partnerships[80, 81]
	Trauma-Informed Child Welfare Systems (TICWSs)	Unclear	Includes training therapists in trauma assessment and statewide trauma trainings[82]	Involves trauma screening and mental health assessments[82]. Community-specific screenings include Trauma-Informed System Change Instrument and the Trauma Screening Checklist[82]	This model is embedded by having a champion invest in TIC and using the trauma-informed Court Report Checklist. TICWSs increase trauma-informed policy[82]

Setting	Model	Cultural Relevance	Training	Screening	System Embedding
Additional settings	Healthy Environments and Response to Trauma in Schools (HEARTS)	Has been implemented for trauma-impacted and under-resourced neighborhoods	HEARTS has been implemented in classroom training on coping with stress, burnout, and secondary trauma training for providers, as well as consultation, psychoeducation, and skill-building workshops for caregivers[83]	Individualized Educational Plan assessments are used[83]	HEARTS includes a coordinated care team, Behavioral Response to Intervention, ARC, consultation to improve Educationally Related Mental Health Services, and wellness support for staff[83]
	Nurse-Led Model of Trauma-Informed Care (The Four E's)	Unclear	Includes trauma training and education[84]	Unclear	Unclear
	Therapeutic Crisis Intervention in Schools (TCI-S)	Unclear	Teacher and administrative training[85]	Students, children, and parents are screened[85]. Staff competency regarding TCI-S is assessed[85]	Provides a framework for restructuring policies and procedures[85]
	Trauma Center Trauma-Sensitive Yoga	Tailored to meet the unique needs of specific populations and dynamics[86, 87]	Provides global training to licensed mental health professionals and yoga teachers, and a more brief and accessible training for all interested[86, 87]	Screened for ongoing therapist or other support network and, if relevant, been out of any inpatient psychiatric hospitalization for a minimum of 3 months[87]	Unclear
	A Trauma Informed Approach to Interviewing	Unclear	Provides guidance and in-house training[88]	Requires that a vulnerability assessment is conducted before the interview[88]	Unclear
	Trauma-Informed Correctional Care (TICC)	Unclear	Shift commanders and chiefs of security assist with the training to increase retention of this model, staff training emphasizes stress management, self-care, burnout, how to describe pat-downs and searches to inmates, trauma, and signs of vicarious trauma. Veterans and offenders with trauma histories attend training sessions to tell their stories[89]	Clients are assessed for criminogenic risks, trauma, and mental health[89]	Seasoned correctional officers take a lead role to embed within the system[89]

Setting	Model	Cultural Relevance	Training	Screening	System Embedding
	Trauma-Informed Neighborhood Resource and Recreation Centers (NRRCs)	Socioeconomic and racial inequalities are considered[69]	Recreation center staff receive trauma training. Training community members on TIC[90]	Trauma-Informed NRRC (TI-NRRC) Progress Tool; trauma-informed organizational assessments[90]	Implemented in recreation centers within the community[90]
	Trauma-Informed Positive Education (TIPE)	Unclear	Unclear	Unclear	Embedded in school systems[91, 92]
	Trauma-Informed Weightlifting (TIWL)	Encourage increased awareness of individual and collective positionality in relation to privilege, access, and power. Recognize that trauma can have roots in history, culture, and identity[93]	Training is provided for mental health practitioners and personal trainers[93]	Unclear	Unclear

Appendix Table D.4. Summary of findings: TIC treatment-related socioecological component descriptions

Context	Model	Linkage to Treatment	Treatment Within
Universal / Cross-cutting models	Collaborative Care Model (CoCM)	Incorporates patient/client goals.[30]	Physical and mental health care are both tended to, with evidence for its effectiveness[30].
	Creating Cultures of Trauma-Informed Care (CCTIC)	Promotes safety, choice, empowerment,[33] and the reduction of trauma symptoms[31].	Provides strategies for weight loss, improved nutrition, better parenting,[34] and promoting safety.[31]
	Creating PRESENCE	Provides brain regulation skills, communication tools, group engagement tools, and complexity management skills.[35]	Unclear
	National Child Traumatic Stress Network (NCTSN)	Pediatric Toolkit for Health Care Providers: Considers the family, aims to reduce distress, and promotes emotional support[95]. The RPC provides resources for parents[39]. The Pyramid Model emphasizes understanding behavior, not using punishment, building positive relationships, and implementing classroom preventative practices.[97-99]	Resource Parent Curriculum: Encourages trauma disclosure and promotes parenting self-efficacy[39]. Pyramid Model: Promotes social, emotional, and behavior regulation skills and provides predictable routines and individualized interventions[97, 99]; increases child engagement, decreases the frequency of challenging behaviors, and increases appropriate communication.[38]
	Solution-Focused Trauma-	Promotes physical and emotional safety and fosters empowerment through goal formation and matching the client's language.[42]	Goal to avoid re-traumatization.[42]

Context	Model	Linkage to Treatment	Treatment Within
	Informed Care (SF-TIC)		
	Substance Abuse and Mental Health Services Administration (SAMHSA)	Encourages providers to avoid personalizing language, provide information on virtual peer support and telehealth groups, praise clients' willingness to try telehealth[47], connect clients to services[52], and maximize client autonomy[48]. In health systems, systematic debriefings of seclusion and restraint are conducted, youth choice is promoted, and youth are informed on policy and procedure. [50]	Providers must obtain informed consent[47, 48], create a sense of safety[48], and prepare clients for transitions.[50] The engagement of students and families[50] and a positive school climate are promoted[49]. The Resilience Classroom Curriculum and Cognitive Behavioral Intervention for trauma are implemented in schools, and trauma-focused cognitive behavioral therapy is used when appropriate.[49]
	Trauma and Resiliency Informed Practice (TRIP)	Improves patient care and provider well-being.[54]	Unclear
Adult medical care	Fifth Vital Sign: HOUSE	Unclear	Unclear
	Trauma-Informed Primary Care (TIPC)	Staff create a calm, safe, and empowering environment for clients[56]	Staff emphasize client strengths and make referrals to individual or group therapy. The program promotes safety and healing in the health care setting and in community-based programs and reduces trauma-related triggers[56]
	Trauma-Informed Treatment Model	Staff implement a trauma philosophy and have an awareness of patient trauma histories[57]	The model emphasizes safety and access to educational resources. The model has resulted in fewer restraints and an increase in patient safety[57]
Adult mental health care	Portal Project Model	Emphasis on empowerment, choice, and self-determination[58]	Staff treat from a holistic perspective, provide individual therapy, a behaviorally-based milieu approach, a therapeutic community approach, psycho-educational groups, and Seeking Safety[58]
	Trauma-Informed Care and Practice (TICP)	Reduces seclusion and restraint rates[41]	Minimizes re-traumatization and has been found to be the best practice for pharmacological interventions. Comprises strengths-based practices, avoids the use of male staff in the restraint of female consumers, and improving access to therapeutic activities[41]
	Trauma-Informed Care Pyramid	Staff use patient-centered communication skills & behavioral strategies and the "tell-show-do" technique[59, 60]	Unclear
	Trauma-Informed Social Work Practice	Social workers validate and empathize with clients[61]	Social workers provide psychoeducation on trauma, use cognitive behavioral therapy and/or eye movement desensitization and reprocessing, and implement the working alliance[61]

Context	Model	Linkage to Treatment	Treatment Within
	Women, Co-Occurring Disorders, and Violence Study (WCDVS)	Providers recognize client strengths, are aware of the power differential, create an environment that feels safe, and provide healthcare services[62]	Includes parenting services[62]
Youth juvenile detention	A Developmental Trauma Informed Response for the Criminal Justice System	Unclear	Family, significant people to the client, victim advocates, and clinicians are involved[64]
	Trauma-Informed Juvenile Justice	Family engagement is a component[65]	Includes evidenced-based trauma treatments[65]
Youth residential and inpatient treatment	Attachment, Regulation, and Competency (ARC) Framework	Increases choice, empowerment, engagement, and routine[66], and promotes a therapeutic living environment[68]	Helps youth develop awareness of emotions, thoughts, and interoception[66], integrate traumatic experiences[69], self-regulate[68], provides psychoeducation[66], and improves functioning[67]. Includes parent and group sessions and has resulted in improved caregiver functioning[67]
	Fairy Tale Model of Trauma-Informed Treatment	An individual therapist[71], and case formulation are involved.[70] Has been found to reduce children's' time in residential and improve the number of positive discharges[71]	Unclear
	Massachusetts Child Trauma Project (MCTP)	Has been found to have an increase in appropriate evidence-based treatment referrals[73]	Implements trauma-focused evidence-based treatments (e.g., ARC, TF-CBT, child–parent psychotherapy)[72]
	National Association of State Mental Health Program Directors (NASMHPD)	Emphasizes awareness of the patient's trauma history, formulating and utilizing safety plans, use of comfort rooms, occupational therapy techniques, and de-escalation approaches prior to the use of restraints and seclusion. A decrease in injuries was found.[74]	Reduced seclusion and restraint and improved treatment outcomes were found. This model aims to avoid (re)traumatization and holds regular community meetings[74]
	Sanctuary Model	Within the health system, employees receive follow-up and mentorship.[77] Employees validate client social justice concerns[75] Community building is incorporated[78]	Employees model safety, emotion regulation, conflict resolution, healthy communication, and civic skills to clients[76]. Moreover, employees teach coping skills[75] and provide psychoeducational groups[77]. The sanctuary model helps clients rebuild social connections[76] and develop collaborative support plans[78]
	Trauma-Informed Care in	Family-driven treatment. Staff provide empathy, sensitivity, and respect. The model is youth-guided and recreational activities are incorporated[79]	The model includes skill building, dialectical behavioral therapy, collaborative and proactive solutions, motivational interviewing, TF-CBT, self-determination, and safety planning.

Context	Model	Linkage to Treatment	Treatment Within
	Residential Treatment		Parents and families are involved. Staff include family and peer-support specialists, are aware of triggers, and promote healthy relationship development[79]
Youth in child protection	Chadwick Trauma-Informed Systems Project and the Community Assessment Process	This model provides support for staff and includes strong family involvement[80, 81]	Trauma-specific mental health treatment[80, 81]
	Trauma-Informed Child Welfare Systems (TICWSs)	The model reduces placement changes and increases permanency[82]	Treatments embedded include TF-CBT and Real-Life Heroes. There has been an improvement in child functioning[82]
Additional settings	Healthy Environments and Response to Trauma in Schools (HEARTS)	Unclear	HEARTS includes individual therapy, psychoeducational skill building, engaging caregivers in child psychotherapy, family therapy, crisis support for trauma-impacted staff, and group therapy. HEARTS has shown a reduction in trauma symptoms, improved adjustment to trauma, affect regulation, intrusions, attachment, and dissociation, reduction in disciplinary office referrals, physical aggression, and suspension[83]
	Nurse-Led Model of Trauma-Informed Care (The Four E's)	Nurses discern the origin of inmate behaviors, focus on commonalities in human experience, provide trustworthy and honest explanations of actions, and answer questions[84]	Nurses teach life skills, provide education, coping mechanisms, substance abuse treatment, therapy, and medication[84]
	Therapeutic Crisis Intervention in Schools (TCI-S)	A clinical psychologist should be consulted and clients should be referred to psychological support if extreme distress manifests during the interview.[88] Interviewees are allowed social support during the interview[88]	Unclear
	Trauma Center Trauma-Sensitive Yoga (TCTSY)	Empirical evidence as an effective intervention for complex trauma[101]	Unclear
	A Trauma Informed Approach to Interviewing	Unclear	Unclear

Context	Model	Linkage to Treatment	Treatment Within
	Trauma-Informed Correctional Care (TICC)	Employees redirect trauma talk. The use of this model has reduced seclusion and restraint, burnout, and turnover, increased effective behavior management, and created safer facilities[89]	The model includes EBTs, seeking safety, psychoeducation, and present-focused approaches[89]
	Trauma-Informed Neighborhood Resource and Recreation Centers (NRRCs)	Developed to decrease the impact of trauma and promote resilience in part by addressing community-level trauma[90]	Trained social workers and counselors (Trauma Coaches) within the setting[90]
	Trauma-Informed Positive Education (TIPE)	TIPE increases psychological resources[91, 92]	Classroom focus on healing, rhythm, repetition, mindfulness, and strengthening the relational classroom milieu[91, 92]
	Trauma-Informed Weight Lifting (TIWL)	Inclusive space for everyone; curiosity around resilience; cultivating interoceptive awareness; promoting agency, autonomy, and choice[93]	Unclear

Appendix Table D.5. Summary of findings: TIC socioecological and treatment-related components

Context	Model	Cultural Relevance	Training	Screening	System Embedding	Linkage to Treatment	Treatment Within
Universal / Cross-cutting models	Collaborative Care Model (CoCM)[30]	Unclear	Unclear	Yes	Yes	Yes	Yes
	Creating Cultures of Trauma-Informed Care (CCTIC)[31-34]	Yes	Yes	Yes	Yes	Yes	Yes
	Creating PRESENCE[35]	Unclear	Yes	Unclear	Yes	Yes	Unclear
	National Child Traumatic Stress Network (NCTSN)[36-38, 40, 95]	Unclear	Yes	Yes	Yes	Yes	Yes
	Solution-Focused Trauma-Informed Care (SF-TIC)[41, 42]	Unclear	Unclear	Unclear	Yes	Yes	Yes
	Substance Abuse and Mental Health Services Administration (SAMHSA)[32, 43-53, 96]	Yes	Yes	Yes	Yes	Yes	Yes
	Trauma and Resiliency Informed Practice (TRIP)[54]	Unclear	Yes	Unclear	Yes	Yes	Unclear
Adult medical care	Fifth Vital Sign: HOUSE[55]	Yes	Yes	Yes	Yes	Unclear	Unclear
	Trauma-Informed Primary Care (TIPC)[56]	Unclear	Yes	Yes	Yes	Yes	Unclear

Context	Model	Cultural Relevance	Training	Screening	System Embedding	Linkage to Treatment	Treatment Within
	Trauma-Informed Treatment Model[56]	Unclear	Yes	Unclear	Yes	Yes	Yes
Adult mental health care	Portal Project Model[58]	Yes	Yes	Yes	Yes	Yes	Yes
	Trauma-Informed Care and Practice (TICP)[41]	Unclear	Yes	Unclear	Unclear	Yes	Unclear
	Trauma-Informed Care Pyramid[59, 60]	Unclear	Yes	Yes	Yes	Yes	Yes
	Trauma-Informed Social Work Practice[61]	Unclear	Yes	Unclear	Unclear	Yes	Yes
	Women, Co-Occurring Disorders, and Violence Study (WCDVS)[62, 63]	Yes	Yes	Yes	Yes	Yes	Yes
Youth juvenile detention	A Developmental Trauma Informed Response for the Criminal Justice System[64]	Unclear	Yes	Yes	Yes	Unclear	Yes
	Trauma-Informed Juvenile Justice[65]	Yes	Unclear	Yes	Yes	Yes	Yes
Youth residential and inpatient treatment	Attachment, Regulation, and Competency (ARC) Framework[66-69]	Unclear	Yes	Yes	Yes	Yes	Yes
	Fairy Tale Model of Trauma-Informed Treatment[70, 71]	Yes	Yes	Yes	Unclear	Yes	Unclear
	Massachusetts Child Trauma Project (MCTP)[72, 73]	Unclear	Yes	Yes	Yes	Yes	Yes
	National Association of State Mental Health Program Directors (NASMHPD)[74]	Unclear	Yes	Unclear	Yes	Yes	Yes
	Sanctuary Model[75-78]	Unclear	Yes	Yes	Yes	Yes	Yes
	Trauma-Informed Care in Residential Treatment[79]	Unclear	Yes	Yes	Yes	Yes	Yes
Youth in child protection	Chadwick Trauma-Informed Systems Project and the Community Assessment Process[80, 81]	Unclear	Yes	Yes	Yes	Yes	Yes
	Trauma-Informed Child Welfare Systems (TICWSs)[82]	Unclear	Yes	Yes	Yes	Yes	Yes
Additional settings	Healthy Environments and Response to Trauma in Schools (HEARTS)[83]	Yes	Yes	Yes	Yes	Unclear	Yes
	Nurse-Led Model of Trauma-Informed Care (The Four E's)[84]	Unclear	Yes	Unclear	Unclear	Yes	Yes
	Therapeutic Crisis Intervention in Schools (TCI-S)[85]	Unclear	Yes	Yes	Yes	Yes	Unclear
	Trauma Center Trauma-Sensitive Yoga (TCTSY)[86, 87]	Yes	Yes	Yes	Unclear	Yes	Unclear
	A Trauma Informed Approach to Interviewing[88]	Unclear	Yes	Yes	Unclear	Unclear	Unclear
	Trauma-Informed Correctional Care (TICC)[89]	Unclear	Yes	Yes	Yes	Yes	Yes

Context	Model	Cultural Relevance	Training	Screening	System Embedding	Linkage to Treatment	Treatment Within
	Trauma-Informed Neighborhood Resource and Recreation Centers (NRRCs)[90]	Yes	Yes	Yes	Yes	Yes	Yes
	Trauma-Informed Positive Education (TIPE)[89, 91, 92]	Unclear	Unclear	Unclear	Yes	Yes	Yes
	Trauma-Informed Weight Lifting (TIWL)[93]	Yes	Yes	Unclear	Unclear	Yes	Unclear

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