FP Essentials
Call for Authors – May 2026

Trauma-Informed Care

We are seeking an author or author group to write a manuscript for this edition of *FP Essentials* that will update family physicians about trauma-informed care. This edition will cover four topics:

1. Principles and Domains
2. Childhood Trauma and Adverse Childhood Experiences
3. Intimate Partner and Sexual Violence
4. Historically Marginalized Populations

The main text of the manuscript should be approximately 10,000 words in length, divided into four sections of approximately 2,500 words each, plus an abstract of approximately 200 words for each section. In addition, there should be key practice recommendations, a maximum of 15 tables/figures total, and up to 200 references to provide support for all recommendations and factual statements in the manuscript. References must be numbered sequentially by section, with each new section starting over at "1."

This edition should focus on what is new in each topic and should answer the key questions listed for each section. Each section should begin with an illustrative case, similar to the examples provided, with modifications to emphasize key points; each case should have a conclusion that demonstrates resolution of the clinical situation. The references provided here include information that should be considered in preparation of this edition of *FP Essentials*. However, these should be used only as a starting point in identifying the most current guidelines and references to include in the edition.

Note: Given the breadth of this topic and concerns regarding word limits, authors should prioritize practical, office-based clinical applications over extensive theory. The editorial board trusts the authors' judgment to focus depth where the impact for family physicians is greatest. To maximize clarity while adhering to word counts, authors are strongly encouraged to utilize the allotted tables and figures to synthesize complex concepts, clinical scripts, and practice workflows.

Needs Assessment
Trauma is a widespread public health issue that significantly impacts physical and mental health outcomes across the lifespan. Despite its prevalence, many family physicians report limited training and confidence in recognizing and responding to trauma in clinical practice. The gaps include identifying childhood adversity, addressing intimate partner violence, and understanding the unique needs of historically marginalized populations. To address this gap, this edition of *FP Essentials* will review the core principles of trauma-informed care and explore evidence-based approaches to identifying and supporting individuals who have experienced trauma. The monograph will also provide practical guidance for integrating trauma-informed principles into everyday practice and clarify the physician's role in prevention, intervention, and referral.

Section 1: Principles and Domains

Example Case
BT is a 38-year-old with chronic pelvic pain who sees you for a health maintenance visit but appears tense and easily startles at loud noises. Before performing any clinical exam, you explain today's plan, ask permission at each step, offer choices (self- vs clinician-collected specimen for cervical cancer screening), and use teach-back to confirm understanding. You defer non-urgent labs, arrange an in-person introduction and transfer of care (warm handoff) to an embedded behavioral health team for coping and safety planning, and schedule a follow-up to evaluate their elevated blood pressure readings.

Note: Authors should anchor definitions in recognized frameworks and distinguish trauma-specific treatments (specialty psychotherapy) from trauma-informed primary care practices. Because many readers did not receive formal training in trauma-informed care, authors must define all terminology clearly and avoid jargon. Prioritize the use of tables and figures to synthesize clinical scripts, checklists, and office workflows. Ensure that clinical examples and guidance address patients across the full gender spectrum.

Key Questions to Consider
Defining the TIC Framework

- What is trauma-informed care (TIC)? When and why did it begin appearing in medical school curricula? Why is it essential for family physicians to utilize a TIC approach? What is the risk of not utilizing a TIC approach?
- Using tables, what are the similarities and differences in core principles and domains of recognized TIC models (eg, Substance Abuse and Mental Health Services Administration, National Child Traumatic Stress Network, Collaborative Care Model, Creating Cultures of TIC)?

Recognizing Signs of Trauma in Patients

- What patient and family cues (eg, hypervigilance, avoidance, dissociation, distress with certain exams) should clinicians recognize as potential indicators of trauma? How does the presentation of trauma vary across the gender spectrum, including cisgender, transgender, and nonbinary patients?

Creating Safety

- Which environmental and workflow elements (eg, privacy, chaperones, clear signage, predictable rooming/procedure steps) promote physical and psychological safety?
- How can physicians use brief communication micro-skills (eg, perspective-taking, emotional attunement) to reduce patient anxiety during visits? Consider creating a table with specific quotes or scripts to guide readers in implementing these micro-skills.

Trustworthiness and Transparency

- How should physicians approach transparency and explanation during exams or procedures to build trust with trauma-affected patients (eg, explain questions and rationale for them, summarize steps, arrange follow-ups)?

Empowerment, Voice, and Choice

- How can physicians incorporate permission-seeking (eg, "Is it okay if…?") and meaningful choices (eg, exam order/positioning, option to pause/stop, support person)

without overwhelming patients? Consider including a table of examples or specific quotes to provide practical guidance on how to offer these choices effectively.
- What does strengths-based language look like in primary care (eg, reinforcing resilience, prior successes, self-efficacy)?

Avoiding Re-Traumatization
- What common clinical practices risk re-traumatizing patients (eg, sudden touch, restraint-like positioning, certain procedures)? How can they be modified (eg, explaining early, narrating)?
- How should physicians recognize and mitigate potential triggers and respond to rising distress during routine care?

Screening and Measurement
- When (if at all) is screening for trauma exposure/ACEs or PTSD symptoms indicated? What safeguards and immediate support pathways must be in place if screening is performed?
- In assessing PTSD symptoms, which validated tools may be useful in primary care (eg, PC-PTSD-5 for initial screening; PCL-5 for monitoring), and how do results guide action?

Collaboration, Referrals, Warm Handoffs
- How can primary care practices operationalize models of integrated behavioral health, advocacy partnerships, and community resources?
- When should referrals (eg, psychiatrist, neurocognitive evaluation, etc.) be considered? How can physicians frame these recommendations using scripts that avoid the perception of victim-blaming (eg, shifting the focus from “what is wrong with you” to “this specialist may help you process what happened to you”)? Consider a table with specific "do and don't" scripts for recommending referrals to trauma-affected patients.
- What are direct in-person introductions (often called “warm handoffs”) and what role do they play in TIC?

Documentation, Confidentiality, and Ethics
- What are the best practices for documentation (eg, neutral & factual tone, avoiding unnecessary graphic detail, capturing patient preferences/choices, minimizing duplicative or potentially harmful content)?
- How can physicians align documentation with legal/ethical standards while maintaining a TIC posture?

Team Well-Being, Training, and Culture
- How should family physicians identify and address secondary traumatic stress and compassion fatigue among members of the care team (eg, debriefs, peer support, leadership messaging)?
- How can teams incorporate reflection, debriefing, or peer support into routine workflows?
- What forms of ongoing training or professional development are effective for building trauma-informed skills? How can practices sustain TIC as a long-term cultural commitment rather than a one-time initiative?

Initial References to Consider

- Racine N, Killam T, Madigan S. Trauma-Informed Care as a Universal Precaution: Beyond the Adverse Childhood Experiences Questionnaire. *JAMA Pediatr*. 2020;174(1):5-6.
- Nguyen-Feng VN PhD, MPH, LP, Behrens K MPH, Butler M PhD, MBA. Trauma-Informed Care: Evidence and Pragmatic Approaches. *Am Fam Physician*. 2025;112(5):474-477.
- Nguyen-Feng VN, Ramirez M, Behrens KL, et al. Trauma Informed Care: A Systematic Review. Rockville (MD): Agency for Healthcare Research and Quality (US); 2025. Report No.: 25-EHC007.
- Fiore R PhD, CCC-SLP, Deblieux P MD, Hyatt S PsyD. Five Trauma-Informed Communication Strategies to Improve Patient Interactions. *Fam Pract Manag*. 2025;32(3):21-25.
- Bulford E, Baloch S, Neil J, Hegarty K. Primary healthcare practitioners' perspectives on trauma-informed primary care: a systematic review. *BMC Prim Care*. 2024;25(1):336.
- Gundacker C, Barry C, Laurent E, Sieracki R. A Scoping Review of Trauma-Informed Curricula for Primary Care Providers. *Fam Med*. 2021;53(10):843-856.
- Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. Accessed 2026. https://coresonline.org/sites/default/files/documents/samhsas_concept_of_trauma_and_guidance_for_a_trauma-informed_approach.pdf
- American Psychiatric Association. Learn about the Collaborative Care Model. Accessed 2026. https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn
- Harris M, Fallot RD. Envisioning a trauma-informed service system: a vital paradigm shift. *New Dir Ment Health Serv*. 2001;(89):3-22.
- National Child Traumatic Stress Network. What is a trauma-informed child and family service system? 2016. Accessed 2026. https://www.nctsn.org/resources/what-trauma-informed-child-and-family-service-system
- American Academy of Family Physicians. Trauma-informed care. 2022. Accessed 2026. https://www.aafp.org/about/policies/all/trauma-informed-care.html
- American Medical Association. Adverse childhood experiences and trauma-informed care H-515.952. 2023. Accessed 2026. https://policysearch.ama-assn.org/policyfinder/detail/Adverse%20Childhood%20Experiences%20and%20Trauma-Informed%20Care%C2%A0%20H-515.952?uri=%2FAMADoc%2FHOD.xml-H-515.952.xml
- Bloom SL. A Biocratic Paradigm: Exploring the Complexity of Trauma-Informed Leadership and Creating Presence. *Behav Sci (Basel)*. 2023;13(5):355.
- Bastos MH, Furuta M, Small R, et al. Debriefing interventions for the prevention of psychological trauma in women following childbirth. *Cochrane Database Syst Rev*. 2015;(4):CD007194.
- Dekel S, Papadakis JE, Quagliarini B, et al. Preventing posttraumatic stress disorder following childbirth: a systematic review and meta-analysis. *Am J Obstet Gynecol*. 2024;230(6):610-641.e14.

Section 2: Childhood Trauma and Adverse Childhood Experiences

Example Case

CJ is a 9-year-old presenting with school avoidance, recurrent abdominal pain, and a fading bruise on the ear. You begin with a developmentally sensitive, trauma-informed approach (clear introductions, choices, permission-seeking, neutral language) and obtain brief private time with her. You assess her safety, avoid repetitive exams, and document neutrally. Because findings and history raise concern for maltreatment, you make a report to Child Protective Services and arrange direct in-person introductions to behavioral health and community resources, planning close follow-up with the family.

Key Questions to Consider

Definition and Scope

- How should family physicians define childhood trauma or adverse childhood experiences (ACEs) and the major maltreatment categories (eg, neglect; emotional, physical, and sexual abuse) relevant to primary care?

Developmental Impact and Toxic Stress

- What is positive vs tolerable vs toxic stress? What are the neurodevelopmental effects of toxic stress and practical strategies to build child and family resilience across ages?

Recognition and Red Flags

- What behavioral, developmental, and physical red flags (including sentinel injuries) should raise concern for maltreatment or toxic stress in infants, children, and adolescents? Consider including a table to summarize these signs.

Initial Approach and Safety in the Visit

- What trauma-informed communication and exam practices (eg, choice, pacing, chaperones, neutral language, avoiding repetitive sensitive exams) help establish safety and reduce re-traumatization for the child and caregivers?

Mandatory Reporting and Documentation

- How should physicians fulfill legal reporting obligations (who/when/how) and document neutrally (defining the term "neutral language" and providing examples) and factually (eg, objective descriptors, diagrams/photos with consent, chain-of-custody basics) while minimizing harm? How should this be best documented in the medical record (eg, flags, ICD-10 coding, etc.)? Consider a table to summarize key concepts.

Screening and Brief Tools

- When (if at all) should physicians use brief, validated tools (eg, PedHITSS) or social determinants of health/ACE screens? Does evidence support universal/routine screening vs case-finding? What immediate support pathways must be in place when screening is positive?

Clinic Evaluation and Workup

- In evaluating suspected physical abuse, which historical elements, exam steps, and indications for labs/imaging (eg, skeletal survey in young children) should physicians consider? Consider a table to summarize key concepts.

Sexual Abuse

- How should family physicians triage concerns for child sexual abuse (eg, safety assessment, time-sensitive forensic referral, sexually transmitted infection testing/post-exposure prophylaxis/emergency contraception as indicated), while avoiding unnecessary invasive exams? Consider a table to summarize key concepts.

Prevention and Anticipatory Guidance

- Which anticipatory guidance messages, parenting supports, and evidence-based programs (eg, home visits) can practices promote to prevent maltreatment and mitigate ACE effects?

Team-Based Care, Referrals, and Follow-up

- How can primary care teams coordinate direct in-person introductions (or "warm handoffs") to behavioral health and community partners, support caregiver engagement, and structure follow-up to monitor safety, functioning, and clinician well-being over time?

Initial References to Consider

- Suniega EA, Krenek L, Stewart G. Child Abuse: Approach and Management. *Am Fam Physician*. 2022;105(5):521-528.
- Gilgoff R, Singh L, Koita K, et al. Adverse Childhood Experiences, Outcomes, and Interventions. *Pediatr Clin North Am*. 2020;67(2):259-273.
- Strait J, Meagher S. Trauma-Informed Care in Pediatrics: A Developmental Perspective in Twelve Cases with Narratives. *Perm J*. 2020;24:19.045.
- Nguyen-Feng VN PhD, MPH, LP, Behrens K MPH, Butler M PhD, MBA. Trauma-Informed Care: Evidence and Pragmatic Approaches. *Am Fam Physician*. 2025;112(5):474-477.
- National Child Traumatic Stress Network. What is a trauma-informed child and family service system? 2016. Accessed 2026. https://www.nctsn.org/resources/what-trauma-informed-child-and-family-service-system
- Kerker BD, Storfer-Isser A, Szilagyi M, et al. Do Pediatricians Ask About Adverse Childhood Experiences in Pediatric Primary Care? Acad Pediatr. 2016;16(2):154-60.
- Gillespie RJ. Screening for Adverse Childhood Experiences in Pediatric Primary Care: Pitfalls and Possibilities. *Pediatr Ann*. 2019;48(7):e257-e261.
- Briggs EC, Amaya-Jackson L, Putnam KT, Putnam FW. All adverse childhood experiences are not equal: The contribution of synergy to adverse childhood experience scores. *Am Psychol*. 2021;76(2):243-252.
- US Preventive Services Task Force; Barry MJ, Nicholson WK, Silverstein M, et al. Primary Care Interventions to Prevent Child Maltreatment: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2024;331(11):951-958.
- Shakil A, Day PG, Chu J, et al. PedHITSS: a screening tool to detect childhood abuse in clinical settings. *Fam Med*. 2018;50(10):763-769.
- Christian CW; Committee on Child Abuse and Neglect, American Academy of Pediatrics. The evaluation of suspected child physical abuse. *Pediatrics*. 2015;135(5):e1337-e1354. [Published correction appears in *Pediatrics*. 2015;136(3):583.]
- Gillies D, Maiocchi L, Bhandari AP, et al. Psychological therapies for children and adolescents exposed to trauma. *Cochrane Database Syst Rev*.2016;(10):CD012371.
- Marie-Mitchell A, Kostolansky R. A Systematic Review of Trials to Improve Child Outcomes Associated With Adverse Childhood Experiences. *Am J Prev Med*. 2019;56(5):756-764.

- Garrett R, Kinnish K, Blacker D, et al.; Child Sex Trafficking Collaborative Group. Child sex trafficking: what you might not know. National Center for Child Traumatic Stress; 2021. Accessed 2026. https://www.nctsn.org/sites/default/files/resources/fact-sheet/child_sex_trafficking_what_you_might_not_know.pdf
- Walsh K, Eggins E, Hine L, et al. Child protection training for professionals to improve reporting of child abuse and neglect. *Cochrane Database Syst Rev*. 2022;7(7):CD011775.
- Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14(4):245-258.
- Hughes K, Bellis MA, Hardcastle KA, et al. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *Lancet Public Health*. 2017;2(8):e356-e366.
- Daníelsdóttir HB, Aspelund T, Shen Q, et al. Adverse Childhood Experiences and Adult Mental Health Outcomes. *JAMA Psychiatry*. 2024;81(6):586-594.

Section 3: Intimate Partner and Sexual Violence

Example Case

KD is a 29-year-old presenting for dysuria. Your clinic's policy guarantees private time with every adult patient. Once alone, you provide universal education about healthy vs unhealthy relationship behaviors (using a brief script) and offer resources if he desires. KD discloses escalating control and two recent episodes of forced sex by his boyfriend. You validate, review confidentiality and its limits, assess for his immediate danger, and offer options: medical care for injuries/sexually transmitted infections, a direct personal introduction to an advocate, and information about forensic services. You document neutrally, agree on a safe contact method, and schedule follow-up.

Key Questions to Consider

Definitions, Epidemiology, and Health Impact

- What is intimate partner violence (IPV)? How is it related to other clinical terms such as physical and sexual violence/abuse, stalking, psychological aggression, and reproductive coercion? Briefly discuss terms used and which ones are preferred (eg, abuser, batterer, controlling partner, perpetrator, offender, stalker; also, person experiencing IPV, survivor, victim).
- How common is IPV and who does it affect? What is its health impact?

Creating Safety

- Which clinic policies (eg, private time for every adult, signage, chaperones, quiet room availability) and workflow steps increase physical and psychological safety?

Trustworthiness, Transparency, and Confidentiality

- What forms of communication most effectively build trust with survivors during routine visits?
- How should physicians balance transparency with sensitivity when discussing confidentiality limits, mandatory reporting, or documentation?

Identification Approaches (Screening, Case-Finding, Universal Education)

- What are the pros/cons of routine screening (eg, at preventive visits or during pregnancy/postpartum) vs case-finding? How effective is routine screening in finding cases of IPV?
- When might universal education (eg, CUES/PEARR) be preferred over screening? What short scripts or materials work well in busy primary care visits to normalize the topic and offer resources without requiring disclosure? Consider a table summarizing scripts for providers to use.
- Which brief, validated tools (eg, HITS, Extended-HITS, HARK, WAST, PVS, DA-5 for lethality risk) fit into primary care workflows? What are practical cutoff scores and next-step actions?

Responding to Disclosure

- What immediate steps comprise a supportive response (eg, LIVES, CUES/PEARR messaging)?
- How should physicians assess immediacy of danger (eg, recent strangulation, escalating threats, firearm access) and facilitate same-day advocacy, forensic evaluation, or emergency services when indicated?

- What medical care may be indicated after sexual assault within an intimate relationship (eg, STI testing/treatment, HIV PEP, emergency contraception, injury care)? How should options be framed without coercion?

Preventing Re-Traumatization

- How can physicians recognize subtle signs that a patient is getting overwhelmed or dissociating during a visit?
- Which exam elements are most likely to re-traumatize survivors (eg, sudden touch, restraint-like positioning, prolonged lithotomy)? How should technique be modified (eg, explain early, narrate steps, agree on a stop signal, consider self-collection)?

Warm Handoffs, Coordination, Follow-up, Continuity

- What models of warm handoffs work in primary care (eg, embedded behavioral health, onsite advocate, tele-advocacy)? How can they be operationalized during and after visits?
- How should teams maintain a living resource list (eg, rape crisis centers, shelters, legal aid, sexual assault response team [SART] programs) and present resources as options, not expectations? What after-hours plans (eg, 24/7 hotlines) should be offered?
- How should physicians schedule follow-ups, confirm safe contact methods, and coordinate continuity without increasing risk?
- What brief "check-in" scripts and visit templates support ongoing care?

Cultural Humility and Context

- How should clinical teams account for cultural, linguistic, and identity-based factors that shape a survivor's comfort with disclosure or care?
- What are common ways that healthcare systems unintentionally replicate power dynamics associated with interpersonal or sexual violence, and how can they be addressed?

Documentation and Medicolegal Considerations

- What are the best practices for neutral, factual documentation (eg, objective descriptors, injury diagrams, consented photo documentation with secure storage)?
- How can practices configure notes and information-sharing to reduce risk (eg, sensitive-note workflows, proxy management) consistent with organizational policy?
- When and how should physicians discuss forensic exam options, timelines, and chain-of-custody basics (without giving legal advice)?

Coding, Billing, and Information-Sharing

- How can physicians be sure that coding or billing does not result in the perpetrator becoming aware of care provided?

Initial References to Consider

- Halloran EC, Ho TF. Intimate Partner Violence. *Am Fam Physician.* 2025;112(1):62-71.
- Farahi N, McEachern M. Sexual assault of women. *Am Fam Physician*. 2021;103(3):168-176.
- Leemis RW, Friar N, Khatiwada S, et al. The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Intimate Partner Violence. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2022.
- Peitzmeier SM, Malik M, Kattari SK, et al. Intimate Partner Violence in Transgender Populations: Systematic Review and Meta-analysis of Prevalence and Correlates. *Am J Public Health.* 2020;110(9):e1-e14.

- Njie-Carr VPS, Sabri B, Messing JT, et al. Understanding intimate partner violence among immigrant and refugee women: a grounded theory analysis. *J Aggress Maltreat Trauma*. 2021;30(6):792-810.
- World Health Organization. Violence against women. 2024. Accessed 2026. https://www.who.int/news-room/fact-sheets/detail/violence-against-women
- White SJ, Sin J, Sweeney A, et al. Global prevalence and mental health outcomes of intimate partner violence among women: a systematic review and meta-analysis. *Trauma Violence Abuse*. 2024;25(1):494-511.
- O'Doherty L, Hegarty K, Ramsay J, et al. Screening women for intimate partner violence in healthcare settings. *Cochrane Database Syst Rev*. 2015;2015(7):CD007007.
- US Preventive Services Task Force; Silverstein M, Wong JB, Davis EM, et al. Screening for Intimate Partner Violence and Caregiver Abuse of Older or Vulnerable Adults: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2025;334(4):329-338.
- Messing JT, Campbell JC, Snider C. Validation and adaptation of the danger assessment-5: a brief intimate partner violence risk assessment. J Adv Nurs. 2017;73(12):3220-3230.
- Sohal H, Eldridge S, Feder G. The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: a diagnostic accuracy study in general practice. *BMC Fam Pract*. 2007;8:49.
- Iverson KM, King MW, Gerber MR, et al. Accuracy of an intimate partner violence screening tool for female VHA patients: a replication and extension. *J Trauma Stress*. 2015;28(1):79-82.
- Penti B, Timmons J, Adams D. The role of the physician when a patient discloses intimate partner violence perpetration: a literature review. *J Am Board Fam Med*. 2018;31(4):635-644.
- Keynejad R, Baker N, Lindenberg U, et al. Identifying and responding to domestic violence and abuse in healthcare settings. *BMJ*. 2021; 373(1047).
- World Health Organization. Caring for women subjected to violence: a WHO curriculum for training health-care providers, revised edition, 2021. 2021. Accessed 2026. https://www.who.int/publications-detail-redirect/9789240039803
- Trabold N, King PR Jr, Crasta D, et al. Leveraging integrated primary care to enhance the health system response to IPV: moving toward primary prevention primary care. *Int J Environ Res Public Health*. 2023;20(9):5701.
- Feder G, Davies RA, Baird K, et al. Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomized controlled trial. *Lancet*. 2011;378(9805):1788-1795.
- CommonSpirit Health, HEAL Trafficking, Pacific Survivor Center. PEARR tool: trauma-informed approach to victim assistance in healthcare settings. Accessed 2026. https://healtrafficking.org/resources/pearr-tool/
- National Academies of Sciences, Engineering, and Medicine. Essential Health Care Services Addressing Intimate Partner Violence. National Academies Press, 2024. Accessed 2026. https://www.ncbi.nlm.nih.gov/books/NBK605470
- Rivas C, Ramsay J, Sadowski L, et al. Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *Cochrane Database Syst Rev*. 2015;(12):CD005043.

- Hameed M, O'Doherty L, Gilchrist G, et al. Psychological therapies for women who experience intimate partner violence. *Cochrane Database Syst Rev*. 2020;(7):CD013017.
- Kalra N, Hooker L, Reisenhofer S, et al. Training healthcare providers to respond to intimate partner violence against women. *Cochrane Database Syst Rev*. 2021;(5):CD012423.
- Sohal AH, Feder G, Boomla K, et al. Improving the healthcare response to domestic violence and abuse in UK primary care: interrupted time series evaluation of a system-level training and support programme. *BMC Med*. 2020;18(1):48.

Section 4: Historically Marginalized Populations

Example Case

JL is a 31-year-old following up after several disruptions in care. She recently lost stable housing, had an unexpected encounter with law enforcement that resulted in a brief detention, and now reports difficulty managing her chronic conditions and increased anxiety. She prefers to communicate in Spanish. You ensure qualified interpretation, explain confidentiality and its limits (including what happens if law enforcement requests information), avoid stigmatizing documentation, perform screenings only when immediate, actionable support pathways are available, reconcile interrupted medications, offer direct in-person connection to community resources (eg, housing navigation, legal aid), and schedule follow-up through a safe contact method of her choosing.

Note: In answering the following questions, authors should consider the needs of historically marginalized populations, including but not limited to: racial/ethnic minoritized groups; immigrants and refugees (including people with limited English proficiency); LGBTQ+ (including transgender and gender-diverse persons); people with disabilities (including intellectual and developmental disabilities); people experiencing homelessness/housing instability; people with justice system involvement or who are incarcerated; older adults at risk of abuse or neglect; survivors of human trafficking; and individuals with substance use disorder or severe mental illness. The section emphasizes universal trauma-informed care (TIC) precautions and structural vulnerability (stigma, discrimination, policies) across groups, with population-specific notes only when critical for safety and care.

Key Questions to Consider

Scope and TIC Framework

- Why is TIC integral to caring for historically marginalized populations?
- How do structural racism, discrimination, and unjust policies shape the health risks, experiences, and barriers to care access for these marginalized groups?

Creating Safety and Reliable Access

- What clinic policies and workflows (eg, qualified interpreters, safe-contact preferences, chaperones) promote physical and psychological safety and help address access challenges associated with housing instability, detention, or shelter settings?

Trust, Transparency, and Communication With Authorities

- Which scripts and behaviors build trust (eg, plain-language explanations; options/consent at each step)?
- How can physicians uphold confidentiality and reduce potential harm while meeting mandatory reporting requirements and appropriately responding to law-enforcement requests?

Cultural Humility and Inclusive Language

- How can teams operationalize cultural humility (eg, not stereotyping; asking, not assuming) and promote the use of inclusive, non-stigmatizing language across encounters and documentation?
- Define the concept of "person-first language" and provide a table of comparative examples (eg, person-first vs stigmatizing wording) to guide documentation and communication.

Empowerment, Voice, and Choice (Autonomy-Supportive Care)

- What specific strategies help maximize agency (eg, supported decision-making vs reflex guardianship), communication accommodations, and meaningful choices during exams/procedures, especially for patients with disabilities or those at risk of power loss?

Screening With Pathways

- When (if at all) should physicians screen for trafficking, mental health, substance use disorder, or infections common in congregate or high-risk settings?
- What same-day pathways (eg, advocacy, MAT/naloxone, TB/HIV/HCV testing, PEP/PrEP) must be in place before screening? Please include examples of same-day pathways, including prompt referrals for clinics that don't offer these services onsite.

Documentation and Information-Sharing

- How can physicians document neutrally and respectfully (eg, avoid labels such as "non-compliant," quote sparingly, capture patient goals), configure portal/safe-contact preferences, and navigate disclosures (eg, consents, subpoenas/court orders)?

Care Coordination and Warm Handoffs

- How should teams operationalize warm handoffs and build living resource maps to activate support (eg, Housing First/collocated services; reentry/transitions clinics; intellectual and developmental disabilities home- and community-based services; elder protections/APS; trafficking advocacy) while presenting referrals as options, not expectations?

High-Risk Transitions and Continuity

- What workflows (eg, medication reconciliation, benefits navigation, short-interval follow-up, reliable/safe contact methods) are available to mitigate risk during transitions such as shelter moves, detention/reentry (providing clear definitions for these terms as they relate to legal system involvement), or insurance coverage loss?
- What are the trauma-informed best practices for managing common barriers to care, such as missed appointments or patient behaviors often labeled as "difficult," to avoid practice dismissal and maintain a longitudinal therapeutic alliance?

Team Well-Being, Training, and Equity-Focused QI

- How can practices embed TIC and antistigma/antiracism initiatives (eg, language audits), support debriefs to reduce secondary traumatic stress, and select feasible equity metrics (eg, interpreter use, warm handoff completion, respectful language checks) for continuous improvement?

Initial References to Consider

- Johnson E, Kripke CC. Caring for Adults With Intellectual Disabilities in the Community. *Am Fam Physician*. 2025;111(3):267-270.
- Lanham JS, White P, Gaffney B. Care of People Experiencing Homelessness. *Am Fam Physician*. 2022;106(6):684-693.
- Chambers R, Ravi A, Paulus S. Human Trafficking: How Family Physicians Can Recognize and Assist Victims. Am Fam Physician. 2019;100(4):202-204.
- Mishori R, Kane S. Care of the Patient With Justice System Involvement. *Am Fam Physician*. 2023;108(3):295-300.
- Davis DM, Bello JK, Rottnek F. Care of Incarcerated Patients. *Am Fam Physician*. 2018;98(10):577-583.
- Eckstein B. Primary care for refugees. *Am Fam Physician*. 2011;83(4):429-36.

- Kowalchuk A, Gonzalez SJ, Zoorob RJ. Substance Misuse in Adults: A Primary Care Approach. *Am Fam Physician*. 2024;109(5):430-440.
- Klein DA, Paradise SL, Goodwin ET. Caring for Transgender and Gender-Diverse Persons: What Clinicians Should Know. *Am Fam Physician*. 2018;98(11):645-653.
- Hoover RM, Polson M. Detecting elder abuse and neglect: assessment and intervention. *Am Fam Physician*. 2014;89(6):453-60.
- US Preventive Services Task Force; Silverstein M, Wong JB, Davis EM, et al. Screening for Intimate Partner Violence and Caregiver Abuse of Older or Vulnerable Adults: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2025;334(4):329-338.
- Baker PR, Francis DP, Hairi NN, et al. Interventions for preventing abuse in the elderly. *Cochrane Database Syst Rev*. 2016;2016(8):CD010321.
- Roth AR, Lazris A, Haskell H, James J. Avoiding Racist and Judgmental Clinical Documentation: Helping to Achieve Health Equity. *Am Fam Physician*. 2024;109(6):575-577.
- Bailey ZD, Krieger N, Agénor M, et al. Structural racism and health inequities in the USA: evidence and interventions. *Lancet*. 2017;389(10077):1453-1463.
- FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. *BMC Med Ethics*. 2017;18(1):19.
- Wildeman C, Wang EA. Mass incarceration, public health, and widening inequality in the USA. *Lancet*. 2017;389(10077):1464-1474.