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Trauma-informed care (TIC) is increasingly recognized as essential in prehospital settings, but its integration into collegiate Emergency Medical Services (EMS) remains limited. Collegiate responders face the unique challenge of treating peers in moments of crisis, where past trauma can profoundly shape the patient encounter. Traditional EMS training equips students with clinical skills but often leaves them under prepared for these human dimensions of care. At McMaster University's Emergency First Response Team, a pivotal patient encounter and subsequent responder surveys revealed significant gaps in confidence for TIC delivery. To address this, a structured approach was developed to translate the six principles of TIC outlined by the Substance Abuse and Mental Health Services Administration into three field-friendly tenets: Recognition, Reassurance, and Resisting Retraumatization. Designed for adaptability, this approach has been woven into onboarding, continuing education, and team culture, with dissemination to numerous EMS agencies across the National Collegiate EMS Foundation. This article outlines the framework and traces its development. It also offers practical recommendations for collegiate EMS agencies seeking to embed similar principles into hiring, training, and daily response. Early evidence suggests that this approach strengthens patient trust, boosts responder confidence, and supports overall wellbeing.

Ellika Greaves, EMR is an alumna of the McMaster University Emergency First Response Team, where she served as an Emergency Medical Responder for three years. In 2024, she co-founded Trauma-Informed Teams, a resource designed to promote responder well-being and resilience through trauma-informed care practices. Ellika was recognized as the Richard W. Vomacka Student Speaker Award recipient at the 2025 National Collegiate Emergency Medical Services Foundation (NCEMSF) Conference and now serves as NCEMSF's Canadian Regional Coordinator. Ellika is currently pursuing a Bachelor's of Health Science in Biology and Pharmacology at McMaster University and works in healthy aging research at the University of British Columbia. **Fezan Khokhar, BSc, EMR** is a second-year medical student at the University of Toronto and a McMaster University alumnus (B.Sc). He served as an Emergency Medical Responder with McMaster's Emergency First Response Team (EFRT) for four years, including one year as the Program Director. During his time with EFRT, he led initiatives to improve inclusivity and trauma-informed prehospital care and worked to enhance the experience of responders on his team. He is particularly interested in systems design and optimizing healthcare team efficiency, with clinical research interests in emergency medicine and orthopedic surgery.

Background

Trauma-informed care (TIC) is an evidence-based framework that emphasizes safety, trust, empowerment, and collaboration in healthcare encounters.¹ It is based on the knowledge that patient responses are shaped not only by current illness or injury, but also by prior adverse experiences, which may include medical mistreatment, discrimination, interpersonal violence, or systemic inequities.¹ A trauma-informed approach acknowledges these influences and seeks to minimize the risk of retraumatization while fostering a sense of agency and partnership in care. Global mental health surveys from the World Health Organization indicate that over 70% of respondents experience lifetime trauma, with an average of 3.2 exposures per person.² While hospital medicine has increasingly adopted TIC and peer-support models to support this need, their translation into Emergency Medical Services (EMS) remains inconsistent.

The prehospital environment introduces unique challenges: care often occurs in uncontrolled, public spaces, with limited time, few resources, and high emotional stakes. Evidence from Lee et al. (2023) showed how medical students in acute care recognized psychosocial and TIC as central to patient wellbeing, yet reported limited confidence in providing such care prior to structured simulation-based training.³ While research within collegiate EMS is limited, it is reasonable to expect similar barriers given the shared realities of prehospital care: time pressure, limited resources, and minimal exposure to formal trauma-informed training. Systematic reviews of TIC interventions in emergency medicine settings echo these findings, indicating that training can improve staff knowledge and attitudes, though consistent uptake into routine practice remains limited.⁴ Importantly, TIC is not only patient-centered but also a framework for supporting providers, whose own wellbeing directly shapes care quality. EMS clinicians face frequent exposure to critical incidents, shift work, high case volumes, and organizational pressures, all of which elevate risk of post-traumatic stress disorder (PTSD) and other mental health conditions.⁵ Many rely on informal coping mechanisms rather than structured support, and professional help is often underutilized.⁶ These findings suggest that embedding TIC principles into responder training and organizational culture has the potential to benefit both patients and providers.

For collegiate EMS, the case is particularly compelling. Student responders occupy a dual role: they are both peers and providers, treating classmates and acquaintances in moments of acute vulnerability. Calls often occur in dormitories, classrooms, or social venues where privacy is minimal and bystanders are present. While the peer-to-peer dynamic may foster trust, it also introduces risks. Patients may fear stigma, question confidentiality, or feel embarrassed when disclosing sensitive histories to a peer. For those with prior negative healthcare experiences, a responder's tone, phrasing, or actions may unintentionally echo past harms, leading to mistrust or retraumatization. On McMaster's Emergency First Response Team (EFRT), emotionally charged calls and internal feedback revealed that while responders felt confident in medical protocols, many felt underprepared when patients exhibited panic, dissociation, or mistrust of care. Upon consulting collegiate-aged responders, it was found that most had encountered patients with healthcare-related trauma, yet few felt fully confident in managing such cases.⁷ These findings underscore the need for a practical, field-ready trauma-informed framework tailored to the collegiate EMS landscape.

Building a Trauma-Informed Resource: A Timeline of Development

Fall 2023 - A Pivotal Call:

We responded to a patient with chronic epilepsy who required emergency care on campus. Although responders managed the medical aspects appropriately, the patient's heightened distress stemmed from prior experiences of medical mistreatment. Routine interventions such as obtaining a history and checking vitals triggered disproportionate fear, leaving responders uncertain of how to proceed without worsening the situation. This encounter underscored the limitations of traditional training for managing TIC in real time.

Fall 2023 to Winter 2024 - Surveying the Gap:

We conducted a survey of 39 collegiate-aged first responders. 85% reported encountering or suspecting trauma-affected patients, yet only 5% felt fully confident addressing their needs. Roughly 41% felt "somewhat confident," and the remainder expressed uncertainty. Qualitative feedback revealed a desire for concrete strategies for recognizing trauma, communication skills for calming patients, and tools for avoiding additional distress.

Winter 2024 - Framework Development:

Drawing from SAMHSA's six principles and incorporating frontline responder feedback, we formed three actionable tenets: Recognition, Reassurance, and Resisting Retraumatization. To facilitate adoption, a dedicated curriculum and online training hub titled Trauma-Informed Teams was developed, providing responders with accessible resources and case examples.⁷

February 2024 - Initial Implementation:

The framework was shared with responders on EFRT and presented in poster format at the National Collegiate Emergency Medical Service Foundation (NCEMSF) conference in Baltimore, MD.

Ongoing Integration (2024-2025):

The framework has continued to evolve through iterative feedback from EFRT members and external adopters. It was featured in a TIC lecture at NCEMSF 2025 in Pittsburgh, PA. Refinements were guided by responder experiences, patient interactions, and cross-agency discussion. Preliminary feedback suggests measurable benefits, including improved responder confidence and strengthened patient trust.

The Trauma-Informed Teams Framework

The Trauma-Informed Teams Framework condenses SAMHSA's six broad principles of TIC into three field-ready tenets: Recognition, Reassurance, and Resisting Retraumatization. While simplified, these tenets map directly onto the established domains of TIC, ensuring conceptual fidelity while offering responders a model that can be recalled under pressure

Recognition involves identifying both the visible and less obvious ways trauma can present during an encounter. Some patients may arrive hypervigilant, avoidant, or emotionally reactive, while others may present with flat affect, detachment, or difficulty following instructions. Recognition requires attentiveness not only to behavior but to context, and interpreting responses through the lens of prior adversity, systemic inequities, or historical trauma. This allows responders to shift away from labelling patient behavior as "non-compliant" or "difficult" and respond with empathy as opposed to frustration. In alignment with SAMHSA's principles of safety, trustworthiness, peer support, and cultural awareness (Table 1), recognition also extends to peers. Being able to acknowledge when a fellow responder shows signs of cumulative stress or secondary trauma is an equally important component of TIC.

Reassurance emphasizes the active promotion of psychological safety. Patients often feel vulnerable when being treated by peers or authority figures, especially in urgent or unfamiliar settings. Responders can provide reassurance by explaining each step of care, offering choices whenever possible, and maintaining a calm, measured tone. Even small gestures, such as asking permission before physical contact or explaining what equipment is being used, can reduce fear and restore a sense of control. Reassurance also strengthens trust and fosters a sense of agency. This corresponds to the TIC principles of transparency, collaboration, and empowerment (Table 1), emphasizing that reassurance is not just comfort but an environment of shared decision-making.

Resisting retraumatization reflects an ongoing responsibility to prevent harm. Many patients bring prior experiences of medical mistreatment, interpersonal violence, or discrimination, and even routine procedures can unintentionally replicate these dynamics. Concrete practices such as seeking consent before physical exams, offering gender-concordant care when feasible, and adjusting assessments to patient comfort can help ensure that interventions do not echo earlier trauma. This tenet intersects with TIC’s emphasis on safety, empowerment, and cultural awareness (Table 1). Resisting retraumatization also extends beyond the patient. Collegiate responders, who often balance academic pressures with emotionally charged clinical work, are themselves at risk of secondary trauma. Structured debriefings, peer support systems, and access to mental health referrals are important safeguards for sustaining responder resilience. Protecting providers in this way is inseparable from protecting patients, since the wellbeing of one directly influences the quality of care delivered to the other.

Taken together, Recognition, Reassurance, and Resisting Retraumatization represent not a dilution but a distillation of SAMHSA’s TIC guidelines. As illustrated in Table 1, the three tenets preserve the breadth of the six established principles while packaging them into a usable form for high-pressure collegiate EMS environments.

Example in Practice

Responders are dispatched to a residence room for a student having a panic attack. Upon arrival, the team finds the patient seated on the floor, breathing rapidly, trembling, and avoiding eye contact. Attempts to gather a history initially heighten the patient’s distress, with the patient flinching when approached and struggling to answer questions. Recognizing possible indicators of trauma, the lead responder adopts a calm tone, introduces themselves clearly, and creates physical space by asking others to step back. They explain each action before proceeding, and offer the patient simple choices, such as where to sit or whether a friend can remain in the room. Through deliberate pacing, transparent communication, and respect for autonomy, the responders help the patient re-establish a sense of safety and control. This scenario illustrates how Recognition, Reassurance, and Resisting Retraumatization can be operationalized in routine collegiate EMS encounters involving acute psychological distress.

Table 1. Mapping the Overlap Between SAMHSA’s Six TIC Principles and the Tenets of Trauma-Informed Teams

Trauma-Informed Teams Tenet	SAMHSA Principles Covered ¹	Main Idea/Connection
Recognition	Safety	Actively noticing trauma responses and interpreting them in context.
	Trustworthiness and Transparency	
	Peer Support	
	Cultural, Historical, and Gender Issues	
Reassurance	Trustworthiness and Transparency	Building psychological safety by explaining care clearly, validating emotions, and inviting patients into decision-making.
	Collaboration and Mutuality	
	Empowerment, Voice, and Choice	
Resisting Retraumatization	Safety	Proactively working to prevent repeated harm, and addressing factors that may trigger distress.
	Empowerment, Voice, and Choice	
	Cultural, Historical, and Gender Issues	

Lessons and Recommendations for Implementation

Building and implementing the framework revealed key lessons. First, cultural change is gradual. Some responders may view TIC as “soft” or unrelated to technical proficiency. Sustained buy-in requires leadership modeling. When supervisors frame debriefs around recognition and reassurance, it communicates that TIC is not optional but a core expectation of practice. Next, avoid rigid applications. Early efforts to teach TIC as a checklist risked making responders more mechanical rather than more attuned. Re-framing TIC as a mindset can help responders integrate principles into their own style of care. Third, prioritize ongoing reinforcement. One-off sessions are often insufficient. Incorporating TIC into continuing education, annual refreshers, and embedded training scenarios will make the framework more sustainable and resistant to skill fade. Last, and most importantly, protect responder wellbeing. Calls involving peers can be uniquely taxing. Structured debriefs, peer support groups, and clear referral pathways to mental health services proved just as essential as patient care protocols. Recognizing that responder health directly shapes patient care is critical for lasting implementation.

Beyond these lessons, several recommendations can guide successful adoption:

1. **Frame TIC as a valued competency from recruitment onward.** Recruitment provides the opportunity to set expectations and shape team culture. Highlighting TIC alongside clinical and technical skills in role descriptions, interviews, and early communications signals that relational competence is integral to the role of a collegiate first responder.
2. **Integrate TIC scenarios throughout training.** Onboarding and continuing education should go beyond theory. Role-play and case-based discussions, such as practicing responses to patients who panic during care or recognizing subtle signs of trauma, equip responders with practical skills. Continued refreshers help sustain competence over time.
3. **Embed TIC into organizational protocol.** Policies on confidentiality, consent, and peer interactions should explicitly reflect trauma-informed language. Standard operating procedures can reinforce expectations such as explaining interventions clearly, obtaining consent wherever possible, and respecting boundaries in both patient and team dynamics.
4. **Model trauma-informed practices through leadership.** Leaders set the tone for daily practice. Supervisors who normalize check-ins, provide transparent feedback, and validate concerns without judgment create an environment where both patients and providers feel safe and respected.
5. **Strengthen responder wellbeing supports.** Responders are vulnerable to cumulative stress and secondary trauma. Peer support programs, structured debriefs after difficult calls, and clear pathways to professional mental health resources are practical tools to prevent burnout and sustain resilience.

6. **Encourage cross-agency knowledge sharing.** Trauma-informed practice grows stronger when shared. Exchanging training materials, evaluation findings, and lessons learned accelerates innovation and adoption across the field.

Key Takeaways and Future Directions

Collegiate EMS providers are at the front line of trauma-sensitive care on their campus, yet they have historically lacked tools tailored to their context. The Trauma-Informed Teams Framework offers a practical and memorable way to embed TIC in the field. Early adoption demonstrates feasibility, cultural fit, and measurable impact on both patient trust and responder resilience. Collegiate systems are uniquely positioned to lead EMS in operationalizing TIC. Future work should focus on broader adoption across collegiate EMS agencies, rigorous evaluation of patient outcomes and responder wellbeing, and exploration of how this framework can inform the greater EMS community.

Conclusion

TIC represents more than an additional layer of training; it is a cultural shift in how responders engage with patients and with each other. Collegiate EMS, with its distinctive peer-to-peer dynamic, faces unique provocations but also a powerful opportunity to lead by example. The Trauma-Informed Teams Framework distills complex principles into a field-ready model centered on recognition, reassurance, and resisting retraumatization. Embedding similar principles into recruitment, training, and organizational culture can strengthen trust within campus communities, improve patient outcomes, and model best practices for the wider EMS system.

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Supplemental Materials

This Advice and Practices article highlights a resource by Greaves & Khokhar (2024). To access the page, visit <https://sites.google.com/view/trauma-informed-teams/home>

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