

Patient Flow and Clinical Profiles in a Stepped-Care, Group-Based Trauma-Focused Intervention within Collaborative Primary Care: A Descriptive Analysis

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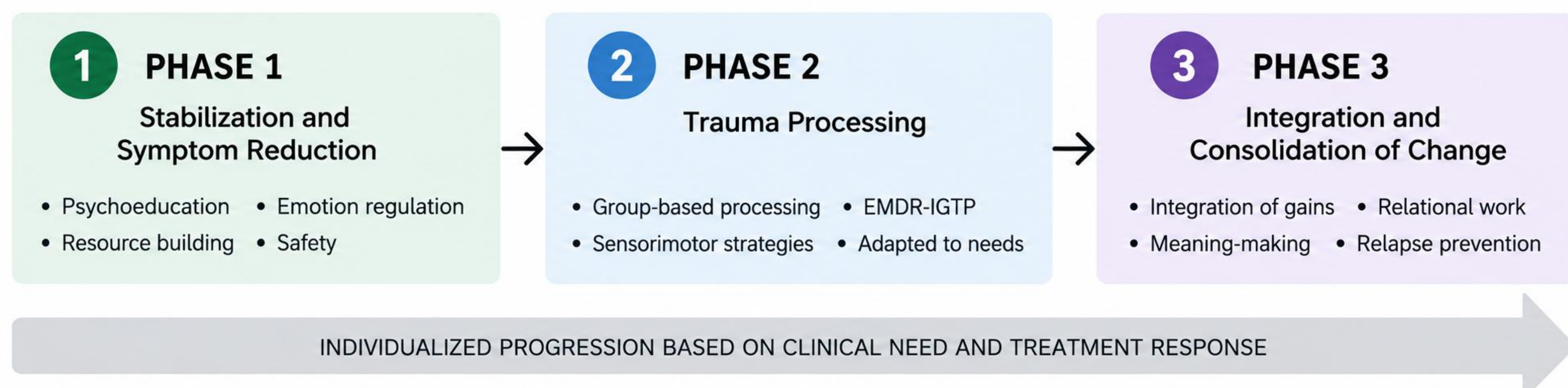
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Introduction: Stepped-care trauma programs aim to match treatment intensity to clinical need while maintaining accessibility and efficient use of specialized resources¹. However, little is known about the clinical characteristics associated with different trajectories following initial group-based stabilization in routine practice.

Stepped-Care Group Program in Primary Care²



Aim: To describe patient flow following Phase 1 and examine whether subsequent clinical trajectories were associated with baseline clinical complexity, treatment-related change, and post-treatment clinical status.

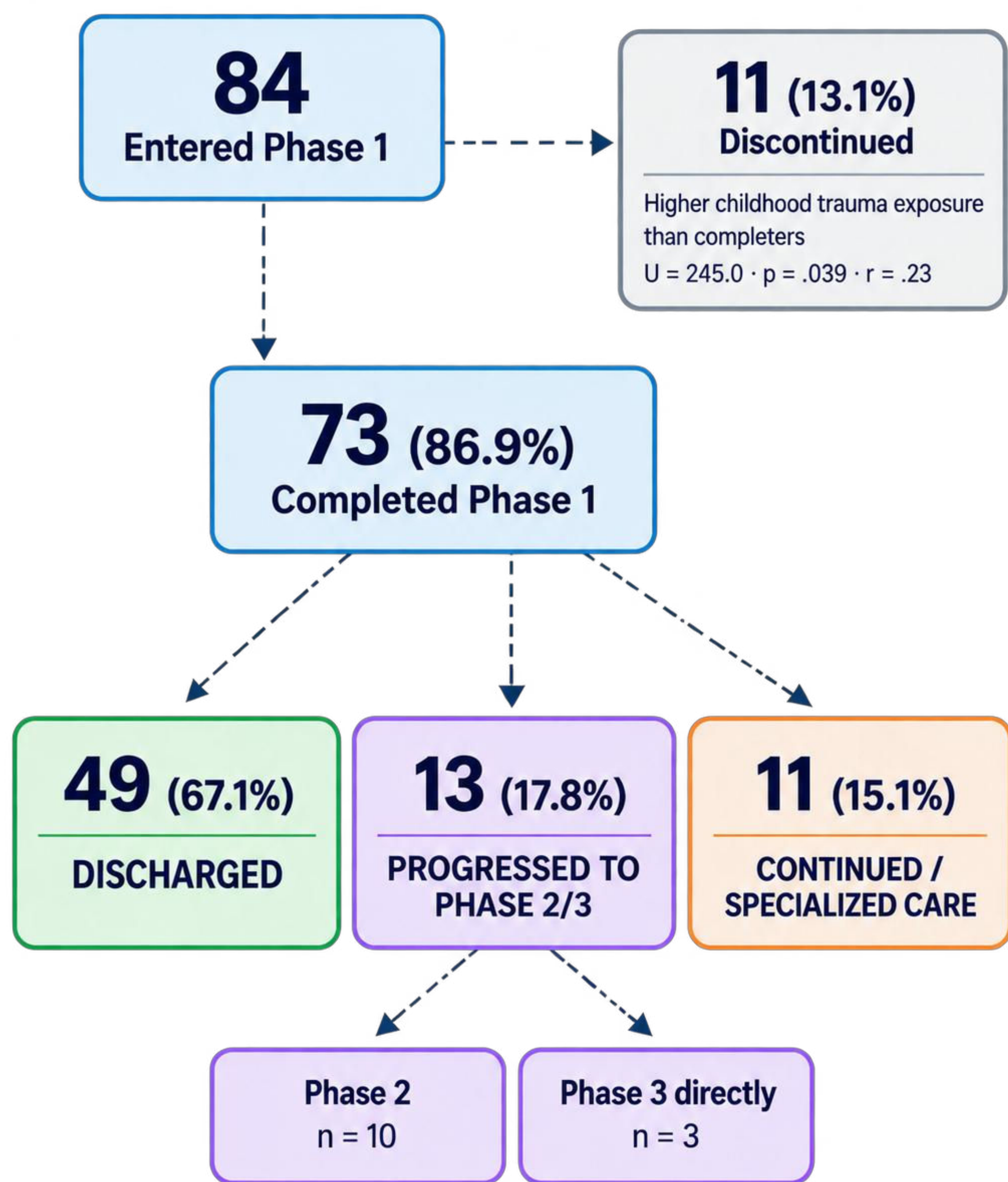
Method: Naturalistic observational study using routinely collected clinical data from a stepped-care trauma program delivered within collaborative primary care.

Participants: 84 adults entered six Phase 1 groups between April 2024 and April 2025; 73 completed Phase 1 and were included in trajectory analyses.

Measures: trauma exposure (ITEM)³, PTSD symptoms (EGS-R)⁴, global distress and functioning (CORE-OM)⁵, and dissociative symptoms (DCI)⁶.

Analyses: Mann–Whitney U, Kruskal–Wallis and Wilcoxon signed-rank tests. Pairwise comparisons were corrected using Holm–Bonferroni.

Patient Flow Following Phase 1 Intervention



Results

1. Baseline Complexity: What distinguished subsequent trajectories?

Functioning Most consistent discriminator	Childhood Trauma	PTSD & Dissociation
Global difference CORE-OM Functioning H= 12.69 p= .002 $\epsilon^2 \approx .15$	Global difference H= 7.81 p= .020 $\epsilon^2 \approx .08$	Baseline PTSD Limited/exploratory differentiation.
Pairwise comparisons Phase 2/3 vs Discharged U= 167.5 p= .009 r= .33 Continued care vs Discharged U= 121.0 p= .004 r= .37	Pairwise comparisons Continued care vs Discharged U= 136.0 p= .011 r= .33 Remained significant after Holm–Bonferroni correction	Baseline PTSD was higher in Phase 2/3 at the nominal level (p= .024 r= .29), but did not survive correction.
Both remain significant after Holm–Bonferroni correction	Childhood Trauma was also higher among Phase 1 discontinuers U= 245.0 p= .039 r= .23	Dissociation No differences across trajectories PTSD severity alone was less discriminative than functioning.

2. Change during Phase 1: All trajectories improved

Magnitude of change did not significantly differ across trajectories

Discharged	Phase 2/3	Continued care
Marked PTSD reduction R= .46 p= .005	Moderate improvement across domains r ≈ .40–.46 Ns; small n	Large within-group changes Functioning r= .69 Risk r= .79 PTSD r= .74 Interpret cautiously small n

Observed differences in subsequent trajectories did not appear to be primarily driven by differences in magnitude of change

3. Post-treatment Status: After Phase 1

Functional impairment	Clinical Risk	PTSD
No significant differences	No significant differences	Higher residual symptoms in Phase 2/3 vs discharged U= 120.0 p= .033 r= .30 Exploratory

Post-treatment clinical profiles substantially overlapped across trajectories

Findings

Subsequent clinical trajectories appeared to reflect the interplay between baseline clinical complexity, change during Phase 1, and residual clinical needs. Baseline functioning and childhood trauma exposure were the clearest markers of subsequent care needs, while the magnitude of improvement did not significantly differ across trajectories. Overall, subsequent care needs appeared to reflect whether improvement was sufficient relative to initial complexity, rather than symptom severity alone.

References

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Conclusions

Approximately two thirds of Phase 1 completers were discharged, while one third required further trauma-focused or specialized care. Baseline functioning emerged as the most consistent discriminator of subsequent trajectory, with childhood trauma also contributing to clinical complexity. Although patients improved across trajectories, subsequent care needs were not clearly captured by symptom severity or magnitude of change alone. These findings support multidimensional, individualized decision-making within stepped-care trauma pathways. Findings should be interpreted considering the naturalistic observational design, small trajectory subgroups, missing post-treatment data, and reliance on routine clinical judgment to determine subsequent care pathways.