TRAUMA-INFORMED PRIMARY CARE POLICY AUDIT TOOL

Trauma-Informed Care (TIC) Principle	Desired Characteristics of the Policy, Protocol, Procedure or Document	Consistency with the Desired Characteristic					Cite evidence to support rating
		1. Very Inconsistent	2. Inconsistent	3. Neutral or Not Sure	4. Consistent	5. Very Consistent	
SAFETY	Reinforces listening to patients'/staff histories without judgment.						
	Emphasizes value for emotional and physical safety for patients/staff, including adapting usual approaches, if needed.						
TRUSTWORTHINESS	Recognizes trust is something that is earned over time, so patients and staff may not tell the truth until a relationship is established.						
	Recognizes patients and staff may "test" relationships because they may have been hurt by people close to them in the past who were supposed to guide or protect them.						
COLLABORATION	Recognizes relationships matter and demonstrates interest in patients'/staff histories and current life circumstances.						
	Establishes an expectation that staff will work together with patients/other staff to create a plan to help them learn skills, rather than dictating to patients/staff a plan to change behavior.						

Trauma-Informed Care (TIC) Value	Desired Characteristics of the Policy, Protocol, Procedure or Document	Consistency with the Desired Characteristic					Cite evidence to support rating
		1. Very Inconsistent	2. Inconsistent	3. Neutral or Not Sure	4. Consistent	5. Very Consistent	
CHOICE	Recognizes a "one-size-fits-all" approach can make patients/staff feel discounted.						
	Recognizes patients/staff cannot learn to make better choices, unless given real choices to make.						
	Demonstrates patient choices are important and valued. Recognizes that in the past, some patients may have been told 1) what they think does not matter and 2) to do things that make them feel uncomfortable or unsafe.						
	Helps patients to believe they have meaningful choices that will be respected.						
EMPOWERMENT	Redefines patient "problems" as coping strategies or adaptations.						
	Recognizes patient strengths and anticipates areas where patients need to build skills.						
	Recognizes patients 1) may often feel like they cannot be successful and 2) require their strengths to receive more emphasis and attention.						
	Recognizes patients are often told what to do and how to do it, so they may have a hard time believing their choices and opinions matter to others.						
	Helps patients to feel more confident and hopeful about their future.						

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		1. Very Inconsistent	**2**. Inconsistent	**3**. Neutral or Not Sure	**4**. Consistent	**5**. Very Consistent	
OTHER CONSIDERATIONS	Are there potential adverse (re-traumatizing) impacts of this policy on staff, patients, and/or community?						
	Are there potential positive (equitable, trauma-reducing) impacts of this policy on staff, patients, and/or the community?						
	Is there a clear purpose for this policy (transparent, predictable)?						
	Are there ways to modify or improve upon this policy to reduce harm or increase benefit?						
	Was this policy created with a cross section of input from stakeholders (staff, consumer, community, leadership, state)?						
	Was this policy rolled out to staff and those potentially impacted with accessibility in mind (multiple languages, visual representations)?						

Uninformed View vs. Trauma-Informed View

The descriptions below can be used to help determine to what extent a particular policy, protocol, procedure, or document is or is not trauma-informed. The contrasting views are designed to draw attention to language, both verbal and non-verbal, that does not support a trauma-informed environment and may activate patients with trauma histories.

UNINFORMED VIEW	TRAUMA-INFORMED VIEW
Views negative behavior solely as patient choice. Utilizes punitive consequences to motivate patients (e.g., shame, blame, guilt, rejection, isolation, and deprivation).	Views patients as wanting to do well but possibly lacking the necessary skills to get their needs met or having developed misunderstood patterns of behavior in response to challenges. Considers patients may have a negative world view that influences their interactions.
Characterizes patient challenges in negative language (e.g., acting out, uncontrollable, manipulative, naughty, defiant). Communicates an expectation of failure.	Characterizes patient challenges in constructive language (e.g., in need of emotional regulation, calming strategies, or skills).
Refers to patients using labels (e.g., "EBD").	Eliminates labels and uses richer language to describe patients (e.g., Lance does well with his peers when he receives assistance in groups).
Utilizes an authoritarian approach.	Uses a collaborative approach.
Punishes or minimizes the importance of the patient's coping strategies.	Recognizes that behavior is communication and searches for the function of the behavior. Strives to support the patient meeting the function of the behavior in positive and productive ways.
Does not take the whole patient into account (e.g., strict focus on presenting issue only, reduced capacity for genuine warmth or concern, prioritizes task completion exclusively).	Recognizes patient academics, behavior, social-emotional learning, health, and family and community wellness as connected and works to integrate support from a whole patient perspective.
Does not explain expectations to the patient and assumes the patient should already know.	Empowers patient choice through use of shared-decision making.
Creates systems by which the patient must demonstrate they are worthy of intervention or must qualify for services.	Promotes systems that are integrated and a culture where all patients get what they need to be successful, regardless of whether they qualify for services or not.
Prioritizes the needs of the organization or staff over the needs of the patient.	Fosters a patient-centered environment.
Uses professional "insider" language or jargon.	Uses language that can be understood by patients and families considering comprehension level, language skills, culture, and native language.

Adapted by the Wisconsin Department of Instruction in collaboration with Sara Daniel, SaintA, and Pam Black, Trauma-Sensitive Education, LLC, from a similar document created by Elizabeth Hudson for the Department of Health Services. The five TIC Values are from Fallot & Harris, Community Connections, www.ccdc1