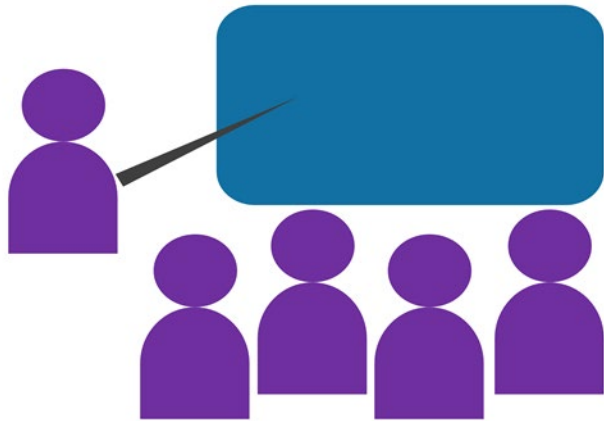


Trauma-Informed Approach for Adult Protective Services



Introduction

Adult maltreatment, including abuse (i.e., physical, sexual, emotional), neglect, self-neglect, and financial exploitation (Administration on Community Living, 2016), is a “complex public health, justice, social, family, and financial problem typically requiring multi-faceted efforts to successfully resolve” (Ramsey-Klawnsnik, 2018). Research has shown that adult maltreatment is associated with higher morbidity and mortality rates in older adults (300%) as well as higher rates of hospitalization, placements and hospice compared to those who have not experienced maltreatment (Lachs, 1998) (Dong, 2015). It is a global systematic issue in which a traumatic or stressful experience or set of experiences directly affect an older adult, an adult with disabilities, their families, and their communities. The effect may be compounded by an individual’s perceptions and prior lived experiences - trauma is unique to the individual experiencing it.

A study on the effects of early trauma across the life span was the [Adverse Childhood Experiences Study](#) (ACEs). The ACEs study found a strong connection between early trauma exposure(s) and “health,

mental health, substance use and other social and behavioral issues including intimate partner violence and suicidal behaviors” (Substance Abuse and Mental Health Services Administration, 2020). Survivors of childhood trauma are up to 5,000 percent more likely to have mental health issues, including attempting suicide, have eating disorders, or abuse IV drugs (Substance Abuse and Mental Health Services Administration, 2020). The ACEs study, conducted by Kaiser Permanente and the CDC, has informed the fields of Child Abuse and Neglect, Intimate Partner Violence and Behavioral Health.

As per Swanson, Ernst & Maschi (2018), “despite it’s devastating impact, the understanding of—and response to—elder abuse has rarely been explored through a trauma-informed lens”. The authors add that adult maltreatment definitions do not take a life span perspective - that is, they do not consider earlier life risk factors and/or later life consequences of trauma experienced earlier in life. Experiences may include family violence, intimate partner violence, war/terrorism, unexpected loss such as death of family or friend, and having health or behavioral health issues to name a few. “These experiences may also increase vulnerability among older adults and thus heighten their risk for elder abuse, especially if they go undetected and untreated” (Swanson Ernst & Maschi, 2018).

The positive news is APS research and practice are beginning to understand the critical intersections between adult maltreatment and trauma over the life course and moving towards research, practice, and training for case workers from a trauma-informed framework. Additionally, the identification of worker, secondary or vicarious trauma, burn-out,

and retention issues and the relevant training and support for APS supervisors is an important piece of the overall picture (APS TARC, 2020).

The following brief examines trauma, trauma-informed care/services, the importance to APS clients and workforce in light of the COVID-19 pandemic, and available resources.

What is Trauma?

“Individual trauma results from an *event*, series of events, or set of circumstances *experienced* by an individual as physically or emotionally harmful or life threatening with lasting *adverse effects* on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being” (Substance Abuse and Mental Health Services Administration, 2020).

Within this definition, SAMHSA highlights what they coined the three “Es” of trauma – *event*, *experience of event*, and *effect*. The event may include the actual event and/or threat of the event and how the individual experiences the event and/or threat is what determines if trauma occurs. Trauma is highly individualized and depends on how the individual “labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic” (SAMHSA’s Trauma and Justice Strategic Initiative, 2014). Factors also include cultural beliefs, access to social supports, and/or what stage the individual is in developmentally.

Additionally, trauma events set up a power differential where one person or event has power over another. This may set up a dynamic of powerlessness and questioning which can lead to feelings of guilt, shame, humiliation, betrayal and/or silencing. A critical component of trauma is the long-lasting effects which may be felt immediately or may be delayed and could be short-term or longer-term in duration. In many cases the individual may not make the connection between the traumatic event

“Individual trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life threatening with lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.” (Substance Abuse and Mental Health Services Administration, 2020)

and effect (SAMHSA’s Trauma and Justice Strategic Initiative, 2014).

As per SAMSHA (2014), examples of adverse effects that APS professionals should be aware of for their potential impact on investigation and provision of services include, “an individual’s inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; to regulate behavior; or to control the expression of emotions.”

The term “accelerated aging” is used to describe how PTSD may manifest differently in older adults relating to issues in attention, memory, and executive function, elevated stress hormones and changes to the brain structure. These occur more extensively in older adults coping with trauma. Often the effects of trauma or accumulated traumas express themselves in behaviors such as agitation, disorganization, and self-neglect which may be seen as “normative cognitive decline” (Breckman, Levin, Mantrone, & Solomon, 2020). Without an understanding of the potential root cause of these issues and how they manifest, the client and APS professional are often missing opportunities to build safety and healing and may re-traumatize the client.

It is also important to understand experiences faced in later-life related to bereavement, illness, physical changes/limits, and abuse that resemble or

symbolize past traumas, can trigger PTSD or similar symptoms. For example, adults who were abused as children who did not process those traumatic events may be at more risk of developing or re-experiencing PTSD or related symptoms decades later (Breckman, Levin, Mantrone, & Solomon, 2020).

Additionally, poverty, racism, homophobia, misogyny, and other oppressions experienced over the lifespan can create a cumulative trauma effect. If coupled with abuse, neglect or exploitation and the subsequent involvement of non-trauma-informed agencies, services or individuals, this may be especially debilitating for the client and the chance of a positive outcome for the client may be reduced.

What is a Trauma-Informed Approach?

A trauma-informed approach includes key trauma-informed principles at all levels, from the organizational culture to the individual service level, as reflected in the “4Rs” of a trauma-informed approach:

The Four Rs of a Trauma-Informed Approach

REALIZE the widespread impact of trauma and understand potential paths for recovery.

RECOGNIZE the signs and symptoms of trauma in clients, families, staff, and others involved with the system.

RESPOND by fully integrating knowledge about trauma into policies, procedures, and practices.

RESIST re-traumatization of clients as well as staff .

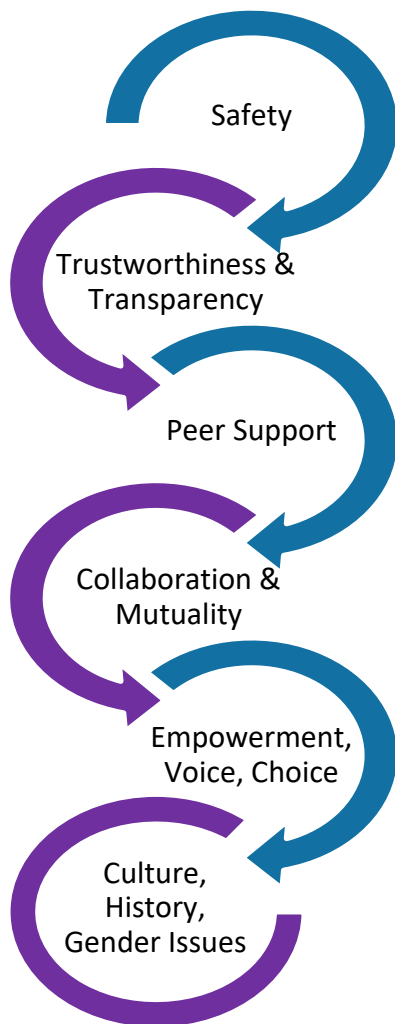
(SAMHSA’s Trauma and Justice Strategic Initiative, 2014)

“Being trauma informed should be part of every practice setting. It is better for the client and it leads to increased trust, greater sharing of information, decreased retraumatization, and a better opportunity to discuss options, address client concerns and needs, and increase the client's willingness to engage in problem solving and acceptance of service options.” (Candace Heisler, 2020)

The Adult Protective Services Recommended Minimum Program Standards (NAPSA, 2013) cite intervention goals, “to make the client safer, prevent continued abuse, and improve quality of life” (NAPSA, 2013). Intervention should be person-centered and designed to promote client healing from the impact of abuse, neglect and exploitation experienced. As per the [ACL National Voluntary Consensus Guidelines](#) (2020), “APS programs are encouraged to integrate principles of trauma-informed approaches when conducting the client assessment and throughout the APS investigation”. They have identified the Center for Disease Control (CDC) [Six Guiding Principles of a Trauma-informed Approach](#) as a guide for APS programs.

(Centers for Disease Control and Prevention, n.d.)

Six Guiding Principles to a Trauma-Informed Approach



(Centers for Disease Control and Prevention, 2018)

COVID-19 & APS

In early 2020, COVID-19 spread rapidly through global populations with particular risk for older adult populations and persons with underlying medical conditions. A lack of information and research on this new virus as well as a lack of resources such as testing and shortages of personal protective equipment made the response very difficult for anyone working with the community.

During the most urgent peaks of virus spread and keeping worker and client health in the forefront, APS programs quickly altered how they responded to

reports and case planning. Telephone, video conference and/or written correspondence were advised if possible, by many APS programs. If there was no alternative to a home visit, case workers were recommended to stay outside with a CDC-suggested six-foot physical distancing. The National Adult Protective Services Association (NAPSA) received reports that often APS was the only agency going into the community and finding services for clients was difficult in some jurisdictions.

As communities work to “flatten the curve” by physical distancing, hand washing and other measures, the repercussions of the sustained threat to personal health and safety, loss of lives, and the economic toll is projected to be severe. Many are concerned that cases of elder and dependent adult abuse, neglect and exploitation will rise as well as cases of domestic violence and child abuse. As one APS Manager in California noted, “Connections, households, and caregiving will be deeply severed following this pandemic. We will need additional resources to get people through the grief, financial devastation, and day to day practical return to life.”

To put the current situation in perspective and offer guidance to the field, experts share their clinical and personal insights on the following pages.

“Connections, households, and caregiving will be deeply severed following this pandemic. We will need additional resources to get people through the grief, financial devastation, and day to day practical return to life.”

Views from the Experts - COVID-19 and Trauma-informed Approach

*Interview via email with Cherie Fowler, MSW, ACSW; Project Case Manager,
UC Irvine Health, Department of Family Medicine & Division of Geriatrics*

May 8, 2020

Question: What are your thoughts on how to support APS staff during the COVID-19 crisis?

Answer: There are many things to consider but here are some that come to mind:

- Remind staff about health care programs/services made available to employees (e.g. Employee Assistance Programs, over the phone counseling services)
- Make sure staff have the working needs met and have access to supplies, equipment, and/or files needed to complete their jobs.
- Make sure that staff understand the protocols of having to report and that there are safe and private ways for staff to report or ask questions if they have been directly and/or indirectly affected by COVID-19. The most important thing is to make sure staff feel safe to report, without fear of marginalized and/or differential treatment if reported.
- Be supportive and understanding to the different personal challenges that staff may face as a result of COVID-19. Productivity is obviously important for sustainability for the agency/department. It is also equally important to be understanding of the emotional/mental health challenges that staff may face during the shutdown and helping support those needs that in the long run will lead to productivity.

Question: What are the strengths and/or challenges APS programs currently have to support trauma-informed care (TIC) approach for APS and clients?

Answer: The most common feedback heard by APS regarding implementing the TIC approach with clients is that it is too time consuming and not a realistic approach to implement in such a short amount of time with clients. Although the time constraints are understandable, the beauty of the TIC approach is that it doesn't require an extended level of engagement with clients, instead it is all about being more intentional in the way in which we already engage clients.

For example, as the shutdown has put a restriction on home visits at this time, it limits APS' ability to fully assess the needs of clients, so it's important to ask more specific questions about the client's current wellbeing and accessibility to basic resources (food, water, protective equipment, etc.). Also, inquiring about the client's access to a stable support system, collaborating with friends and family that the client wishes to be involved, and/or providing the client with resources such as Friendly visitors to make sure they get the support/contact needed.

Question: What role may historical trauma and/or polyvictimization play during the pandemic for clients and APS staff?

Answer: For clients with pre-existing trauma, the forced isolation and scarcity in accessing food, basic essentials, and medical supplies could be triggering, especially for those who may have grown up with adverse community challenges, such as: poverty stricken areas, experienced acts of discrimination, violence, etc.

If there is pre-existing trauma, I anticipate many client's trauma responses will be heightened during this time. For example, clients may become even more isolated and/or self-neglectful due to feelings of hopelessness and/or loss of power and control as a result of the pandemic. The same can happen to APS workers in that a lack of resources and a growing or more complex caseload can cause workers to feel overwhelmed, hopeless in being able to meet the needs of clients, leading to burnout, lack of productivity, etc.

It's important to note that the opposite effect can also happen to both APS social workers and the clients served. Not all clients with a history of trauma present vulnerable and unable to function, some develop a power of resilience and when faced with this current pandemic, their power of resilience can be heightened. This is the same for APS workers who many have grown accustomed to working in challenging clients and situations while working under high levels of stress. The survival response can go into autopilot and both client and workers become more aware, resourceful, and vigilant in tending to their needs.

***Interview via email with Bonnie Brandl, MSW, Founder and
Director of the National Clearinghouse on Abuse in Later Life (NCALL)***

May 6, 2020

Question: Do you have thoughts on how APS programs can support their staff and clients during the COVID-19 urgent response and the aftermath to reduce primary and secondary trauma?

Answer: Regarding APS staff:

- At our organization, we held time open for staff to gather to talk about anything they wanted to discuss. The first two weeks we held time open every day. During the past month we held an hour open once a week.
- Some staff have organized sending an inspirational email out once a week. Other staff have organized a virtual game night or happy hour with coworkers.
- It is important to recognize that staff are likely experiencing their own trauma reactions. Some may have compromised health and may fear getting the virus. Others may be concerned about family or friends. Others are trying to work while having children at home. I think flexible policies and schedules, letting staff take time off or working at a slower pace as needed is important.

Regarding APS clients:

- Some clients have lived through WWI, WWII, the Depression or other global traumatic events. Many are resilient and some may want to talk about the strategies they used earlier in life that are serving them now.

- The strategies that APS already uses, such as active listening and meeting victims where they are at, can be very helpful in this time. Some victims may be less concerned about abuse, neglect, and exploitation and more concerned about issues related to the pandemic. It will be important to let clients lead the conversation about their needs and concerns.

Question: What strengths do APS programs currently have in place to support a trauma-informed approach for APS staff and clients?

Answer: Many APS workers have training in trauma so they will recognize the signs within themselves and others. APS workers are also used to working in uncertain times because many of their cases are evolving so they can approach their work and life with flexibility and compassion. APS workers are often used to working with limited resources and stretching them as far as they can.

Question: What challenges do APS programs currently have to support a trauma-informed approach for APS staff and clients?

Answer: The model of home visits to talk to people in person and to see where they live may be impossible or difficult in many/some communities. Getting PPE may be a challenge. Trying to talk to an older adult with hearing issues or dementia while wearing PPE might be challenging. Some older adults may be experiencing heightened anxiety and fear. Some older adults may be very distrustful of government officials and information. Due to the number of COVID-19 deaths in facilities, many older adults may refuse to disclose harm to APS because they are more afraid of being placed in a nursing home than being harmed in the community.

Question: What role may historical trauma and/or polyvictimization play during this pandemic for clients? For APS staff?

Answer: Older adults who have experienced historical trauma and/or polyvictimization may have heightened mistrust, fear and anxiety. They may refuse to talk to APS workers or other authority/government professionals.

Question: Any other thoughts related to APS programs and clients in this era of COVID-19?

Answer: Working in APS was often challenging before COVID-19. As the country reopens, it is likely that there will be a surge in reports to APS in many communities. Thank you to the frontline workers and administrators for all that you are doing to support older victims and vulnerable adults. Your work will make a difference.

*Interview via email with Nora Baladerian, Ph.D. Lic. Psychologist,
Counseling Center of West L.A., Disability and Abuse Project of Spectrum Institute*

April 20, 2020

Question: Do you have thoughts on how APS programs can support their staff and clients during COVID-19 urgent response and the aftermath to reduce primary and secondary trauma?

Answer: Two of the most important things in this situation are providing information (knowledge is power!!!) and reducing emotional distress. The first is done through informational bulletins to APS staff and if possible to clients (using the mail when online access is not possible) and to programs serving vulnerable adults, people with disabilities, and elders, for them to share with the folks they serve. Also assisting in providing protective materials (masks, hand sanitizer, etc.). But primarily, providing INFORMATION on how to 1) reduce fear, stress, 2) frustration, anger (common during such events) and 3) strengthen their individual immune systems. I believe that these are the FIRST steps to building resiliency.

Question: What strengths do APS programs currently have in place to support a trauma-informed approach for APS staff and clients?

Answer: This is outside of my area of expertise, but I would recommend any trauma-informed care program designed to improve not only interaction with those being served, but self-care.

Question: What challenges do APS programs currently have to support a trauma-informed approach for APS staff and clients?

Answer: At this time, there are many ways to learn to adopt trauma-informed care practices online. Thus, supervisors should take/make the time to learn from some of the online programs and begin recommending those practices to their staff. It is essential to make sure that staff are not overwhelmed with workload or beginning to feel overwhelmed by workload. They should be conducting self-healing practices (regardless of the pandemic) daily, to have a “mental/emotional cleansing shower” at the end of the work day.

Question: What role may historical trauma and/or polyvictimization play during this pandemic for clients? For APS staff?

Answer: For clients, old traumas will likely be re-stimulated, throwing the clients into conditions of fear, helplessness, hopelessness, frustration, anger, sadness and other emotions. This may also contribute to resurgence of eating disorders, sleep disorders, hygiene disorders, etc. Old traumas may come to mind and be mentally re-lived.

There should be informational guidance on the agency website, to “walk them through” these phases, to stay in the present (not forecasting doom). To stay as much as possible in appreciation of little things (and big things). Keeping one’s focus on what they have (life; support; ability to see, hear, walk, talk, be understood; etc.) rather than what they do not have. Recommendations to watch programs on TV that are uplifting, stay on a news diet (no more than 1 hour per day), and stay occupied with pleasurable activities (phone calls, listening to music, reading, etc.).

Question: Any other thoughts related to APS programs and clients in this era of COVID-19?

Answer: It would be great to engage in daily words of appreciation to one another. It would be great to set up small talking groups to be able to express to each other some of the frustrations of the day as well as what

went well, some “wins” and plans for when things return to “normal” or what the “new normal” will be, with gratitude to have meaningful work.

Thoughts on Trauma-Informed APS Response During COVID-19

Holly Ramsey-Klawnsnik, Ph.D., LCSW, LMFT

May 6, 2020

It is challenging, even under normal circumstances, to skillfully provide “Trauma-Informed Response” (TIR) to those who have suffered significant threats and harms to personal safety and well-being. To do so, one must be well-trained in one’s craft - be it nursing, psychotherapy, APS, CPS or other. Additionally, one needs training in the theory and methods of providing trauma-informed services. Beyond this, strong personal characteristics of empathy, caring, and nurturance, as well as excellent interpersonal skills, are needed. Providing TIR during a worldwide crisis, however, raises the bar making skillful delivery of trauma-informed services extremely challenging.

It seems to this clinician that two key factors contribute to this:

First, typically, when a professional in any discipline - medicine, nursing, law enforcement, psychotherapy, or APS - responds to a victim, the traumatizing experience(s) have already taken place and are, at least temporarily, over. If so, the event(s), the threat, the danger, has passed and the professional is helping the victim cope with the aftermath, avoid re-exposure to danger, and recover from inflicted physical and psychological harm sustained.

Consider, for example, an APS worker interviewing an older adult who has been isolated, intimidated, denied necessary care, and financially exploited by a greedy relative. If that adult has now been helped to escape the victimization by caring others, the worker is speaking to a victim for whom the threatening and distressing events are now not occurring. Even when the physical danger is passed, a traumatized victim continues to feel unsafe, vulnerable, mistrusting, and fearful due to the psychological and related harm that has been incurred.

A variety of trauma symptoms are likely experienced which may include sleep, mood, and eating disturbances and intrusive thoughts about abuse suffered. This is the very nature of trauma - the victim continues to experience multi-faceted harms related to victimization that has now seemingly ended. This is exactly the situation in which the principles of trauma-informed care are especially relevant. (These principles and tips for implementation are provided in Ramsey-Klawnsnik, H. & Miller, E., (2017). Polyvictimization in later life: Trauma-informed best practices. *Journal of Elder Abuse & Neglect*, 29(5), 339 – 350.

<https://doi.org/10.1080/08946566.2017.1388017>)

Providing APS services while the client’s risk to personal safety is ongoing, such as in the current pandemic, is far more complex than when the physical danger has passed.

Second, typically, when a professional helper works with a traumatized victim, that victim is suffering acutely from the experience(s). However, the helper has not been victimized by the conditions that have harmed the client. This is not so in the COVID-19 pandemic - we are all in danger and have all been harmed, directly or indirectly, by the virus and its ramifications.

APS staffers have been harmed by becoming ill, losing a loved one to the illness, experiencing the lockdown, facing economic losses, school closings, and the many other crisis-driven societal events that have unfolded.

We have all been harmed, some in smaller and some in quite massive ways. And, the risk remains high for all professional helpers to continue to be harmed in various ways.

Providing compassionate care while one is in danger is extraordinarily challenging. Many APS workers are struggling to assist their clients and meet their agencies' mandates while dealing with their children out of school and needing care, spouses out-of-work and unpaid bills accumulating, and older parents with pre-existing health conditions about whom they worry.

Importantly, one of the key principles of trauma-informed response is providing safety for the responding professionals. And yet, at the current time, no agency can fully provide a safe working environment for its staff. This puts APS programs and administrators in a terribly challenging position - they need their staff to keep working, to keep serving vulnerable and endangered clients - and yet, no one's safety can be fully protected at this time. APS programs are doing what they can to protect worker safety, but as I have learned as I have spoken with program administrators - that it is not fully possible and is truly exhausting.

We are indeed in a very challenging time, for many of us the most challenging we have experienced. It is very hard to focus - even for the highly self-motivated and self-disciplined among us. The practical problems we face are draining. Everything from obtaining food for family dinners to filling the car gas tank is more time-consuming and challenging. And the worry we face can be paralyzing. So much worry - will we, or our staff member that we send out, be safe making a necessary home visit? Is it safe to venture into the supermarket because the grocery delivery services are two weeks backed up? When will this end? How will it end?

Remaining optimistic is challenging, but crucially important. Also, of the utmost value is doing what we can for others - clients, co-workers, family members, employees, neighbors, strangers - and remembering that it does help. We need to be gentle and supportive and understanding with others, but also with ourselves. And the bottom line - we all need to do what we can to support and assist others while maintaining the best self-care possible.

Conclusion & Next Steps

As outlined in this brief and highlighted by the guest experts above, there are tools to approach recent challenges posed by COVID-19 using trauma-informed approaches. APS research and practice was already beginning to understand the critical intersections between adult maltreatment and trauma and now it's time to pivot quickly and move forward with research, practice, and training for all levels of APS staff using a trauma-informed framework.

The American Public Human Services Association (APHSA), recommends these steps for organizations to “Lead Ahead” during times traumatic times:

- Vision - Developing a vision for moving forward
- Ask questions – Be curious, be direct
- Plan – Develop a plan
- Respond – Execute the plan
- Innovate – Practice continuous quality improvement (CQI)

(American Public Human Services Association, 2020)

All the APHSA steps listed above can be conducted through a trauma-informed approach framework to cultivate safety, support and resiliency.

The road ahead, in light of the COVID-19 pandemic, will be challenging to navigate for everyone. Let us all maintain and grow the resiliency of leadership, staff, and clients to move from urgent, trauma response to recovery response and planning in the days and weeks ahead.

Resources

- APS TARC – [Trauma-Informed Care Approach to Elder Abuse](#) (Webinar)
- Weinberg Center for Elder Justice - [The Things They Carry: Advancing Trauma-Informed Responses to Elder Abuse](#)
- Family & Children’s Trust Fund of Virginia - [Facing the Facts: Trauma-Informed Approaches to Elder Abuse: Applying trauma-informed care to in-home services](#)
- Centers for Disease Control - [Infographic: 6 Guiding Principles To A Trauma-Informed Approach](#)
- Administration for Children & Families - [Resource Guide to Trauma-Informed Human Services – Trauma Toolkit](#)
- Substance Abuse and Mental Health Services Administration - [SAMHSA’s Concept of Trauma and Guidance for a Trauma-informed Approach](#)
- Substance Abuse and Mental Health Services Administration - [TIP 57 - Trauma-Informed Care in Behavioral Health Services](#)

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The National Adult Maltreatment Reporting System and the Adult Protective Services Technical Resource Center is a project (HHSP 233201500042I) of the U.S. Administration for Community Living, Administration on Aging, Department of Health and Human Services, administered by the WRMA, Inc. Contractor’s findings, conclusions, and points of view do not necessarily represent U.S. Administration for Community Living, Administration on Aging, Department of Health and Human Services official policy.

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