Understanding Trauma-Informed Care for APS Supervisors

Trainer Manual

Virtual Course

Academy for Professional Excellence

APSWI
Adult Protective Services Workforce Innovations

The Academy for Professional Excellence is a project of the San Diego State University School of Social Work

This training was developed by the Academy for Professional Excellence, with funding from the California Department of Social Services, Adult Programs Division.

Curriculum Developer, 2022
Gabriela Grant, MA
Editing and Contributions
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INTRODUCTION

THE ACADEMY FOR PROFESSIONAL EXCELLENCE

We are pleased to welcome you to the Understanding Trauma-Informed Care for APS Supervisors in APS Trainer Manual, developed by Adult Protective Services Workforce Innovations (APSWI), a program of the Academy for Professional Excellence under a grant from the California Department of Social Services, Adult Programs Division.

The Academy for Professional Excellence, a project of San Diego State University School of Social Work, was established in 1996 to provide exceptional workforce development and organizational support to the health and human services community by providing training, technical assistance, organizational development, research, and evaluation. Serving over 20,000 people annually, the Academy continues to grow with new programs and a diversity of training focused on serving the health and human services community in Southern California and beyond.

The Academy is a project of San Diego State University School of Social Work (founded in 1963), which offers both a bachelor's and master's degree in Social Work. The School of Social Work at San Diego State University was founded in 1963 and has been continuously accredited by the Council of Social Work Education since 1966.

APSWI is a program of the Academy for Professional Excellence. APSWI is designed to provide competency-based, multidisciplinary training to Adult Protective Services professionals and their partners. APSWI's overarching goal is the professionalization of Adult Protective Services professionals to ensure that abused and vulnerable older adults and adults with disabilities receive high quality, effective interventions and services.

In partnership with state and national organizations, APSWI is developing a national APS Supervisor Core Competency Training Curriculum. This curriculum is developed, reviewed and approved by experts in the elder and dependent adult abuse fields.

APSWI's partners include:

- National Adult Protective Services Association (NAPSA) Education Committee
- California Department of Social Services (CDSS), Adult Programs Division
- County Welfare Directors Association of California (CWDA), Protective Services Operations Committee (PSOC)

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ACKNOWLEDGEMENTS

This training is the result of a collaborative effort between Adult Protective Services administrators, supervisors, staff development officers and workers across the state and the nation; professional educators; and the Academy for Professional Excellence staff members. APSWI would like to thank the following individuals and agencies:

Agencies

California Department of Social Services, Adult Programs Division
Arizona Department of Economic Security, DAAS-Adult Protective Services
National Adult Protective Services Association

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TRAUMA ACROSS THE LIFESPAN

THREAT VERSUS RISKS

CLOSING AND EVALUATION

HOW TO USE THIS MANUAL

This curriculum was developed as a virtual 240-minute (4 hour) workshop using the Zoom platform, paying close attention to virtual training best practices. It can be tailored to a different virtual platform (WebEx, GoTo Training, etc.), if necessary. It may also be trained in-person by modifying activity and engagement prompts as necessary. If training virtually, the curriculum can be presented for two hours in the morning, participants can break for lunch, and return for the remaining two hours in the afternoon.

The Participant Manual should also be sent ahead of time as a fillable PDF if using Adobe Acrobat or to allow participants to print a hard copy.

Trainer Notes are written entirely in bold text box and are provided as helpful hints.

Moderator Notes are written entirely in bold text box and are provided as helpful hints.

- Actions which the trainer takes during the training are written in **bold**.
- When there are both Trainer and Moderator notes on same page, Trainer and Moderator is **underlined**.
- Expected time per slide is provided next to slide number and topic on each page.

Use of language: Throughout the manual, APS Professional is used most often to describe APS line staff. The term client is used most often to describe the individual at the center of the APS investigation. However, if concept or material was directly quoted from copyrighted material, another term may be used.

He and she have been replaced with the gender-neutral they throughout this manual, unless quoted from copyrighted material. This should not be thought of as plural persons, but rather a gender-neutral term describing all humans.

Customizing the Power Point:
This manual is set up so that the trainer script/ background material is on the same page as the accompanying PowerPoint slide.

Hide a slide instructions:

1. On the Slides tab in normal view, select the slide you want to hide.
2. On the Slide Show menu, click Hide Slide.

The slide number will have a line through it to show you have hidden it.
NOTE: The slide remains in your file even though it is hidden when you run the presentation.

The course outline, provided in the next section of this manual, is the class schedule used for development of this curriculum. It can be used to help

determine how much time is needed to present each section. However, times will vary based on the experience and engagement of the audience.

TRAINER GUIDELINES

It is recommended that someone with APS supervisory experience facilitate this virtual workshop.

Suggestions for virtual training when possible:

- Have a moderator or co-host who can primarily focus on the virtual aspects of this training (e.g., monitoring chat box, launching polls, assigning breakout groups, monitoring participant reactions, etc.).
  - A Moderator/Co-Host Tip sheet is on Page 73
- Test out the use of the breakout room feature prior to conducting this training.
- Log in at least 30 minutes prior to the training to ensure the virtual classroom is fully functioning and that you are comfortable navigating it.
- Your equipment and platform may dictate how you do some activities or discussion. There are times you may not be able to see everyone's faces, names or reactions (thumbs up, mute/unmute, etc.). There is a need for both verbal discussion and chat discussion. At such times, the moderator will fill a critical role monitoring those features you cannot. Practice during a run through how you will use the various functions for each section.
- The optimal size for this virtual training is 20-25 participants.

Teaching Strategies	The following instructional strategies are used: ○ Lecture segments ○ Interactive exercises (e.g., breakout groups, chat box discussion, polling activities) ○ Question/answer periods ○ PowerPoint Slides
Materials and Equipment	**The following materials are provided and/or recommended:** ○ Trainer Manual ○ Participant Manual (fillable PDF) ○ PowerPoint Slides ○ Headset with microphone ○ Computer

VIRTUAL TRAINING TIPS

Training and facilitation have always been an art. Virtual training is no exception. Below are some helpful tips to remember and implement when training in a virtual environment.

Assume nothing.

Do not assume everyone has the same knowledge/comfort level with technology or has access to equipment like printers, video camera, headsets or even reliable Wi-Fi.

Distractions are everywhere.

Participants have greater access to distractions (email, phone, others at home) which can take their focus away from the training. Therefore, explain everything and summarize before asking participants to complete an activity and check for clarification.

Over explain when possible.

The virtual room doesn't allow for participants to see everything you're doing as they can in-person. Share as you navigate the virtual environment. If you are silent while looking for something or finding a screen, they may think something is frozen.

Mute with purpose.

"Mute all" function can help ensure we don't hear conversations we're not supposed to. However, it can also send a message to the participants that they are a passive participant and may not make them feel comfortable taking themselves off mute when you want them to speak.

Two screens can be a lifesaver.

This allows you to move your chat box or participant gallery view away from your presentation so you can see more of what's going on.

Rely on practice, not luck.

Winging it during an in-person training or facilitation may work from time to time, but doesn't work in the virtual environment. In addition to covering the content, you have to manage all of the technology issues, learning styles in a virtual room, and it will show if you're not prepared.

Bring the energy.

As trainers, we are no strangers to being "on," standing and moving around. However, some of the body language, subtle nonverbal skills we relied on the in-person training room do not translate well in the virtual environment. While this may make you more tired, it's important to up your enthusiasm, voice, and presence in order to engage with attendees.

Be mindful of your space.

Training virtually brings an entirely new component of what we're willing to share with others. Learners can get distracted with what's in your background, whether what is physically there or if you set your video to use a virtual background.

It's important to reflect on questions of privilege, diversity and equity when thinking of your training space.

Are there objects in your background that can symbolize status, privilege and/or power? If so, consider removing them to dismantle any added power dynamics that already exist with you as the Trainer.

Unknowingly, objects can come across as offensive or can activate unpleasant or traumatic memories and can instantly discredit your rapport building. Think of neutral backgrounds that are not distracting and allow you to be the focus of what learners see.

EXECUTIVE SUMMARY
UNDERSTANDING TRAUMA-INFORMED CARE FOR APS SUPERVISORS

There are critical intersections between adult maltreatment and trauma over the life course and research, practice, and training for caseworkers and supervisors from a trauma-informed framework is crucial. Join us for this interactive, foundational training on a trauma-informed framework for APS supervisors. We'll learn about a trauma-informed care approach from biological, programmatic, and policy levels. We'll explore the definition of trauma, the ACEs study and its impact on our understanding of trauma across the lifespan, the link between trauma and adult maltreatment, and some practical tips and tools for supervisors and staff to use on the job.

Virtual Training:

- The following virtual instructional strategies are used throughout the course: short lectures (lecturettes), interactive activities/exercises including breakout groups, chat box discussions, large group discussions, self-reflection, poll options, and individual practice. PowerPoint slides and role-playing/ demonstrations are used to stimulate discussion and skill development.

- Participants will need access to a computer with video conferencing capability and be able to connect to the virtual platform being used to deliver this training. A headset or earbuds with microphone and a video camera are highly encouraged. Participant Manual is a fillable PDF if using Adobe Acrobat. Participants are encouraged to either print a hard copy or ensure access to Adobe Acrobat to allow for highlighting, typing in comments and filling out worksheets.

Course Requirements: Completion of the entire module is required to receive course completion credit.

Target Audience: This workshop is intended for new supervisors or experienced staff who may require a refresher.

Outcome Objectives for Participants:
By the end of this training, participants will be able to:

- Explain SAMHSA's trauma-informed three-part model, and how trauma can lead to neuro-dysregulation.

- Describe the relationship between Adverse Childhood Experiences (ACEs) and trauma in early life, and elder abuse, adult disease, disability, and early death.

- Identify the ways trauma impacts people throughout their lifespans, the signs of trauma in older adults and adults with disabilities, and best practices for asking about exposure to trauma.

- Distinguish between a threat to physical safety and a risk to emotional security using a decision tree; and

- Apply trauma-informed care principles to safety screening and safety planning.

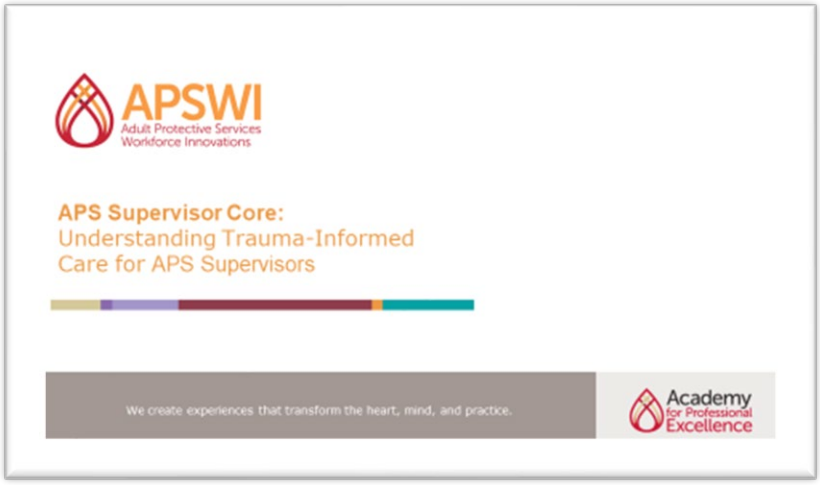
COURSE OUTLINE

CONTENT	MATERIALS	TIME
WELCOME, INTRODUCTIONS, & COURSE OVERVIEW		20 minutes
Welcome, Housekeeping, Technology Overview, and Introductions	Lecture Slides 1-7	18 minutes
Learning Objectives	Lecture Slide 8	2 minutes
WHAT IS TRAUMA?		45 minutes
What is Trauma, Trauma Defined	Lecture Slides 9-10	2 minutes
SAMHSA's 3 Part Model	Lecture Slide 11	3 minutes
Mrs. X Case Study	Activity# 1 Slides 12-13	30 minutes
Neuro-Dysregulation	Lecture Slide 14	2 minutes
Polling Questions	Polling Activity Slides 15-17	8 minutes
BREAK		10 minutes
ACEs (ADVERSE CHILDHOOD EXPERIENCES)		40 minutes
ACEs and Understanding Childhood Trauma	Lecture Slides 18-20	7 minutes
Historical Collective Trauma and Trauma Among Adults with Disabilities	Lecture Slides 21-28	11 minutes
The ACEs Ratio of Risk Scale	Lecture Slide 29	5 minutes
Clinical Implications and Adult Disease	Lecture Slides 30-34	10 minutes
Polling Questions	Polling Activity Slides 35-37	7 minutes
TRAUMA ACROSS THE LIFESPAN		50 minutes
Developmental Traumatology and the Intersection of APS and Trauma Informed Care	Lecture Slides 38-41	10 minutes
Small Group Discussion	Activity # 2 Slide-42	30 minutes
Identifying and Addressing Trauma	Lecture Slides 43-46	10 minutes
BREAK		5 minutes
THREAT VERSUS RISKS		45 minutes
Distinguishing between Threat and Risk	Lecture Slides 47-49	3 minutes

Decision Tree Polling Activity	Polling Activity Slide 50	10 minutes
Safety Talk Screening Activity	Partner Activity # 4 Slides 51-52	25 minutes
Safety Talk Planning in the Moment	Lecture Slide 53	4 minutes
Transfer of Learning	Lecture Slide 54	2 minutes
Written Statement of Commitment	Lecture Slide 55	1 minute
WRAP-UP AND EVALUATIONS		25 minutes
Conclusion	Lecture Slide 56	3 minutes
Closing Thoughts	Lecture Slide 57	7 minutes
Delta/Plus, Evaluations, Thank you	Evaluations Slides 58-60	15 minutes
Total Time (Including Breaks)		4 hours
TRANSFER OF LEARNING	On Own	30 minutes

WELCOME, INTRODUCTIONS AND COURSE OVERVIEW
Time Allotted: 20 minutes

Slide 1: Welcome (5 minutes)



Allow for a few minutes for participants to settle in.

Chat Box:

Ask participants to type in their names, titles, and counties (or APS programs) for attendance purposes.

Trainer:

Introduce yourself and briefly highlight your interest in this topic and relevant experience with the subject.

Introduce moderator(s) or **ask** moderator(s) to introduce themselves.

- **Describe** moderator's role—monitor the chat box, assign breakout rooms, handle any administrative issues, etc.

Highlight information from chat box such as number of counties participating, and experience interviewing A/Ps.

Share that if any participants have attended the in-person or eLearning version of this course they will see some repeated content as well as new.

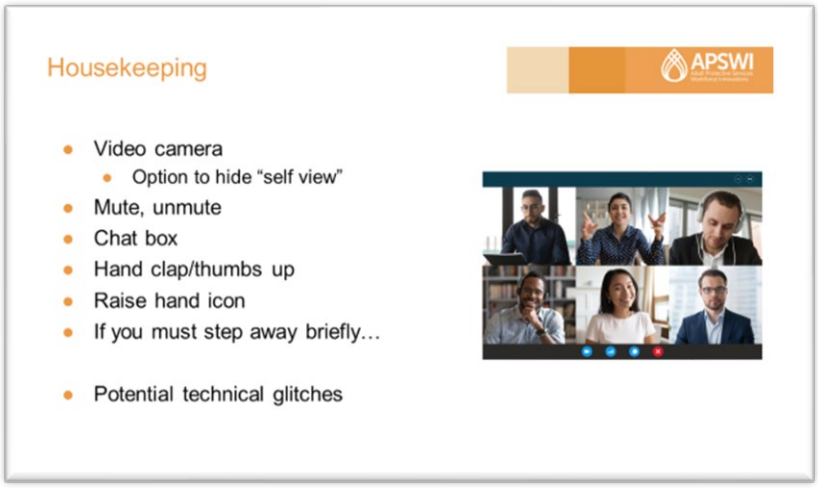
Slide 2: SDSU School of Social Work (1 minute)

Explain that the Academy for Professional Excellence is a project of San Diego State School of Social Work. Its mission is to provide exceptional workforce development and learning experiences for the transformation of individuals, organizations and communities.

Slide 3: About APSWI and the Academy (1 minute)

Explain that Adult Protective Services Workforce Innovations (APSWI) provides innovative workforce development to APS professionals and their partners. APSWI is a program of the Academy for Professional Excellence along with others listed on the slide.

Slide 4: Housekeeping (1 minute)

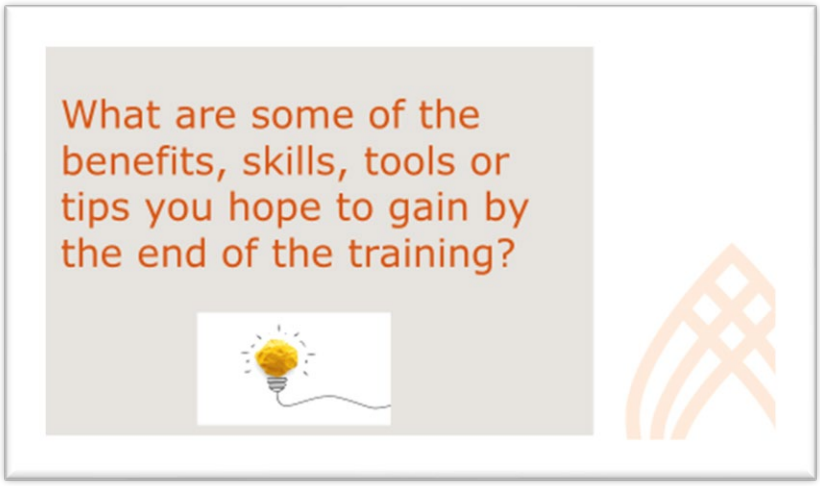


Allow for a few minutes for participants to settle in and **cover** housekeeping items.

- Muting self
- Ensure display name is correct
- Use of video
    - Zoom feature allows you to hide "self view" where you no longer see yourself, but you're still on camera.

Explain that technical glitches are inevitable on both your end and the participants and **encourage** all to be patient and forgiving as you navigate them.

Slide 5: Exploring Trauma-Informed Care (8 minutes)



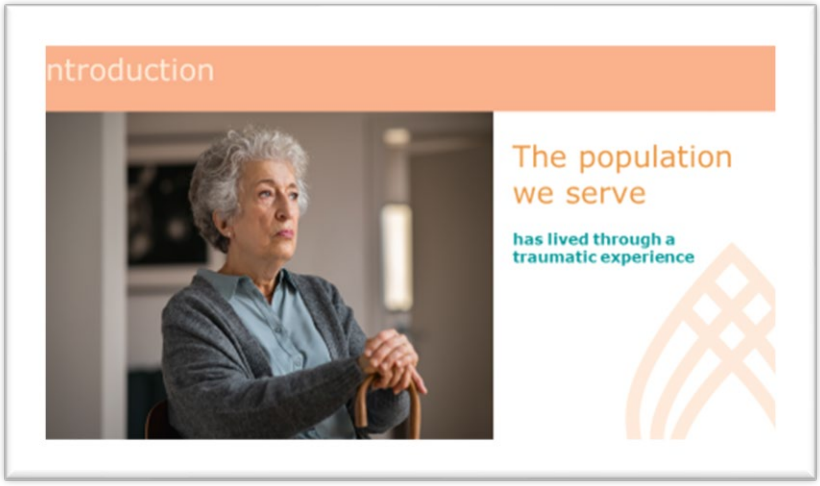
Trainer: Before we get started, I'd like to take a minute to hear from all of you about your ideas about what you would like to take away from the training today.

Trainer asks participants to type in the chat or unmute themselves and share their ideas about what they would like to learn from today's training…

Trainer: *Trainer summarizes and then states, "Great Responses everyone."*

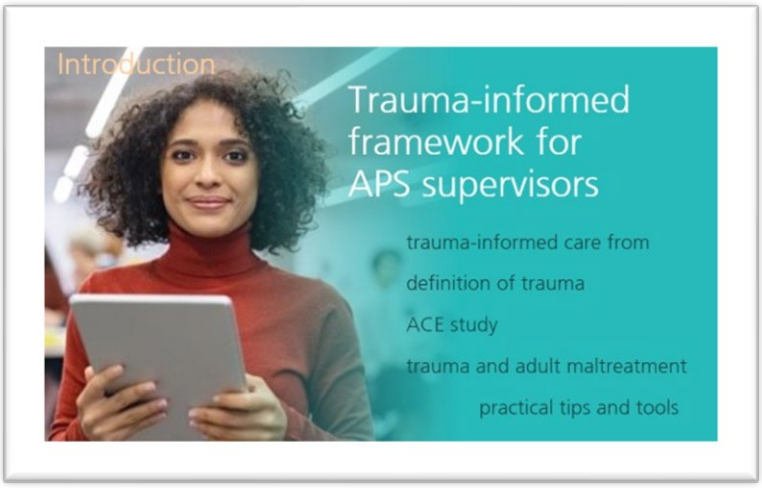
Slide 6: Introductions (1 minute)

Trainer Note: It's recommended to program polls before training beginnings.



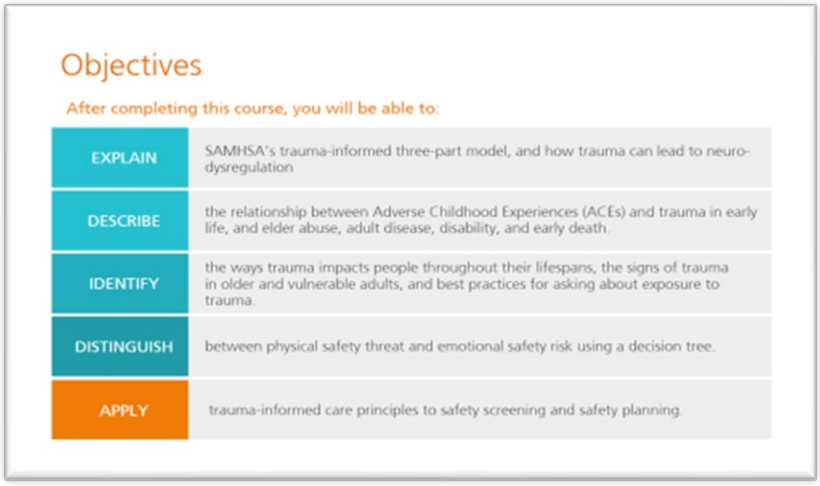
Trainer: In Adult Protective Services, it's very likely that the members of the population we serve have lived through a traumatic experience or been exposed to trauma. Traumatic events can range from experiences of war and violence to living through parental divorce, or the loss of a family member. While you may be familiar with the link between traumatic experiences in early life and negative health outcomes later on thanks to the Adverse Childhood Experiences, or ACEs study, there are also critical intersections between traumatic experiences and adult maltreatment

Slide 7: Introductions (1 minute)



Trainer: In this foundational training on a trauma-informed framework for APS supervisors, we'll learn about a trauma-informed care approach from biological, programmatic, and policy levels. We'll explore the definition of trauma, the ACEs study and its impact on our understanding of trauma across the lifetime, the link between trauma and adult maltreatment, and some practical tips and tools for you and your staff to use on the job.

Slide 8: Objectives (2 Minutes)



Trainer: After completing this course, you will be able to:

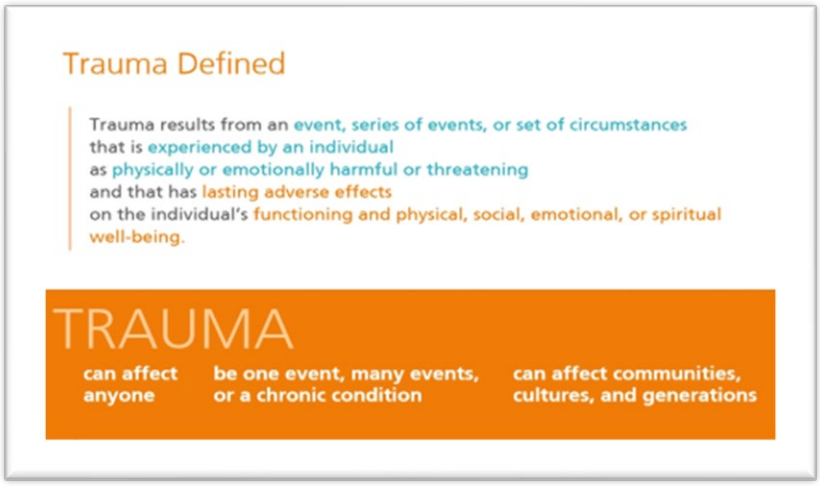
- Explain SAMHSA's trauma-informed three-part model, and how trauma can lead to neuro-dysregulation;
- Describe the relationship between Adverse Childhood Experiences (ACEs) and trauma in early life, and elder abuse, adult disease, disability, and early death;
- Identify the ways trauma impacts people throughout their lifespans, the signs of trauma in older adults and adults with disabilities, and best practices for asking about exposure to trauma;
- Distinguish between a threat to physical safety and a risk to emotional security using a decision tree; and
- Apply trauma-informed care principles to safety screening and safety planning

WHAT IS TRAUMA?
Time Allotted: 45 minutes

Slide 9: What is Trauma? (1 minute)

Trainer: What is Trauma? In this lesson, you'll learn how the Substance Abuse and Mental Health Services Administration, or SAMHSA, defines trauma, using a three-part model, and the effects trauma has on the brain and body

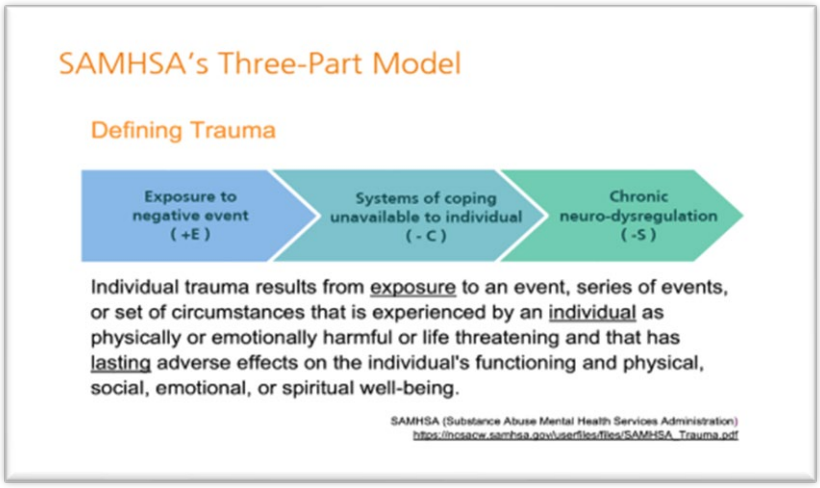
Slide 10: Trauma Defined (2 minutes)



Trainer: According to SAMHSA's Trauma and Justice Strategic Initiative, trauma "results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening, and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being."

Trauma can affect people of every race, ethnicity, age, sexual orientation, gender identity, ability level, religious affiliation, and socioeconomic status. A traumatic experience can be a single event, a series of events, or a chronic condition. Trauma can affect individuals, families, groups, communities, cultures, and generations.

Slide 11: SAMHSA's Three-Part Model (2 minutes)



Trainer: Now, how do we define trauma?

Trainer: Trauma is defined initially by exposure to a negative event, series of events, or set of circumstances. but exposure alone does not create trauma. Added exposure is demonstrated as "+E." If we then add a lack of systems of coping for the individuals, shown as "-C", and chronic neuro-dysregulation, shown as "-S", we then find trauma. Therefore, trauma results from exposure that has lasting adverse effects influenced by a lack of systems of coping available and resulting in chronic neuro-dysregulation after the exposure. Chronic neuro-dysregulation refers to long-term effects on the person's ability to function. That's the impairment. The impairment of trauma is that the individual is unable to function and be well.

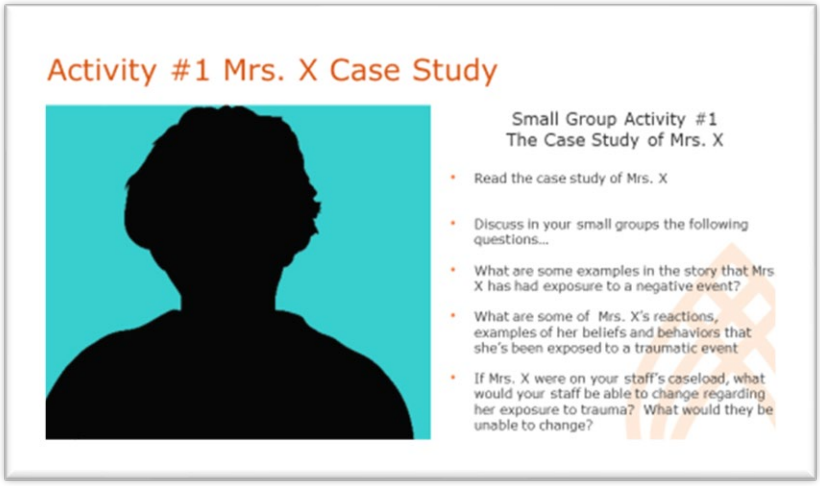
This is the piece that we are very much interested in, in terms of APS.

What is impairing the functioning and the well-being of this particular individual?

So let's talk about Exposure to the negative event. Exposure is a variable. How much exposure to the trauma has the individual experienced? That's the variable. The exposure can be seen as a constant perhaps something that can't be changed with the client but what can be changed is how much exposure the client has to the trauma. The client can have more or less exposure to the event. What is key for us to determine is whether the client is able to reduce or increase exposure from the trauma.

To better deepen our understanding of Exposure +E, Systems of Coping –C, and Chronic Dysregulation –S, let's read the case study of Mrs. X and do a group activity together to see how these concepts can be applied.

Slide 12: Activity #1: Mrs. X Case Study (30 minutes with debrief)



Group Activity: *Read the Case Study of Mrs. X and participate in a group discussion – 15 min.* ***Moderator****: Provide a 5 min warning*

Moderator: *If the training is virtual, Moderator will create Break Out rooms with 4-5 participants each. In-person, Moderator will break up participants into small groups.*

Trainer:

Each participant in a small group is tasked with responding to the questions below. The participant whose birthday is the closest to today's date will lead the other participants in the discussion and be the spokesperson for the group when the large group re-convenes to debrief.

Discuss in your small groups the following questions…

1. What are some examples in the story that Mrs. X has had exposure to a negative event?

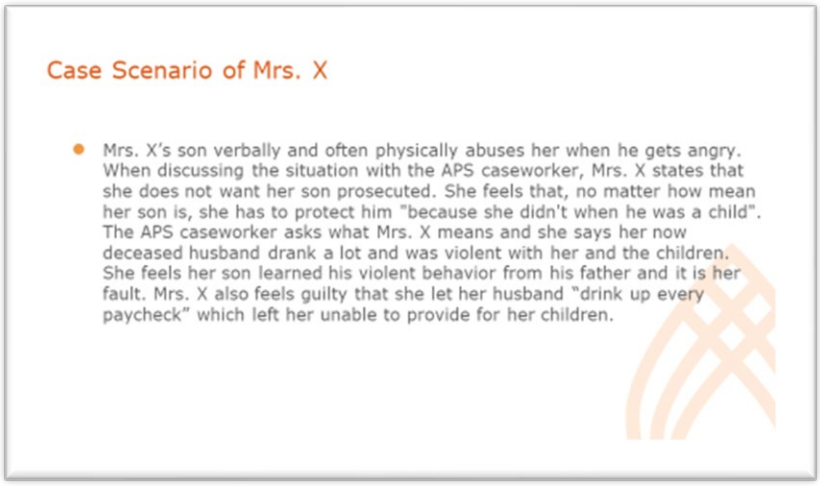
2. What are some of Mrs. X's reactions, examples of her beliefs and behaviors that she's been exposed to a traumatic event?

3. If Mrs. X were on your staff's caseload, what would your staff be able to change regarding her exposure to trauma? What would they be unable to change?

Continued

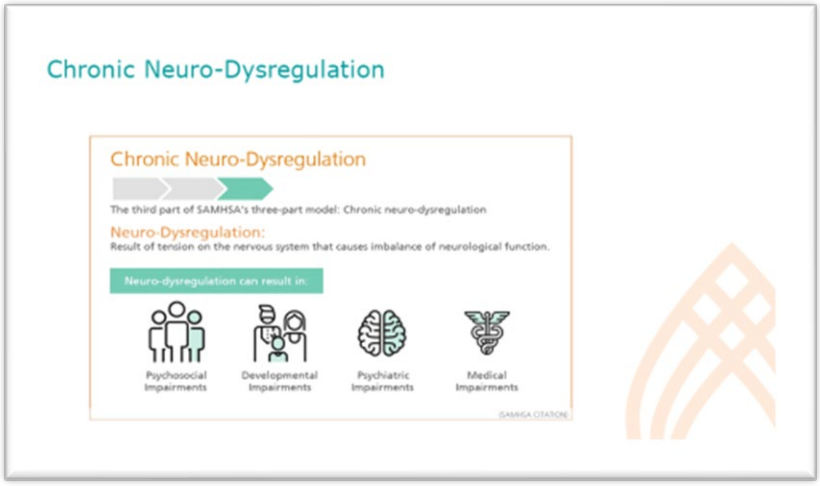
(*Trainer debriefs exercise with participants by asking 1-2 Spokespersons to unmute themselves to share their responses with the group or invites other group spokespersons to share if they have something different to add. Trainer allows 10 min for debriefing with participants)*

Slide 13: Case Scenario of Mrs. X



Trainer: Here is the Case Study for Mrs. X that you will read prior to participating in the small group activity.

Slide 14: Chronic Neuro-Dysregulation (2 minutes

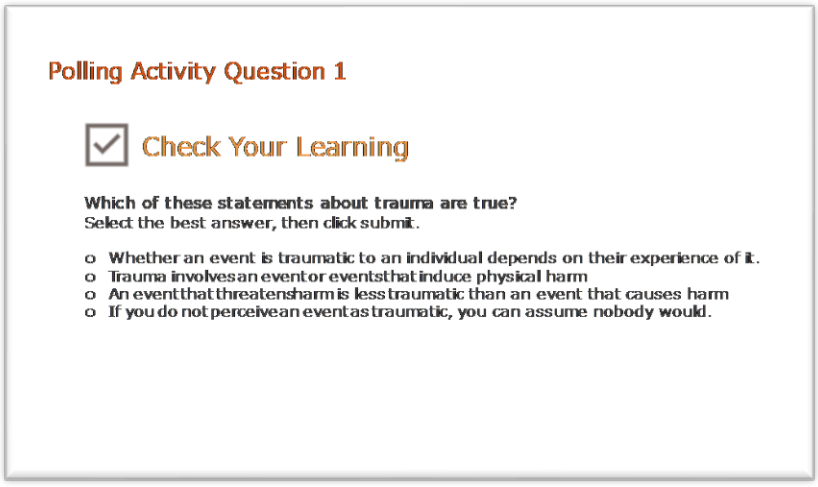


Trainer: Trauma can involve a single event, numerous or repeated events, or sustained or chronic experiences. A single trauma is limited to a single point in time. An automobile accident, the sudden death of a loved one, rape, all of these are examples of a single trauma. Some people who experience a single trauma can recover without any intervention; their systems of coping are capable of handling it. But for others, especially those with histories of previous trauma, mental illness, substance use disorder, or those for whom the trauma experience is particularly horrific or overwhelming, a single trauma can result in traumatic stress symptoms and trauma- and stress-related disorders.

Now, let's look at the final part of the three-part definition of trauma: chronic neuro-dysregulation. Neuro-dysregulation is a result of tension on the nervous system that causes an imbalance of neurological function. Many factors may cause neuro-dysregulation, including unresolved physical or emotional stress, poor nutrition, use of substances or medications, posture and body alignment stress, and trauma.

Neuro-dysregulation can result in a wide range of psychosocial, developmental, psychiatric, and medical impairments. In the next lesson, we'll explore some behaviors that may indicate neuro-dysregulation.

Slide 15: Polling Activity Question 1 (8 minutes for Polling Activity)

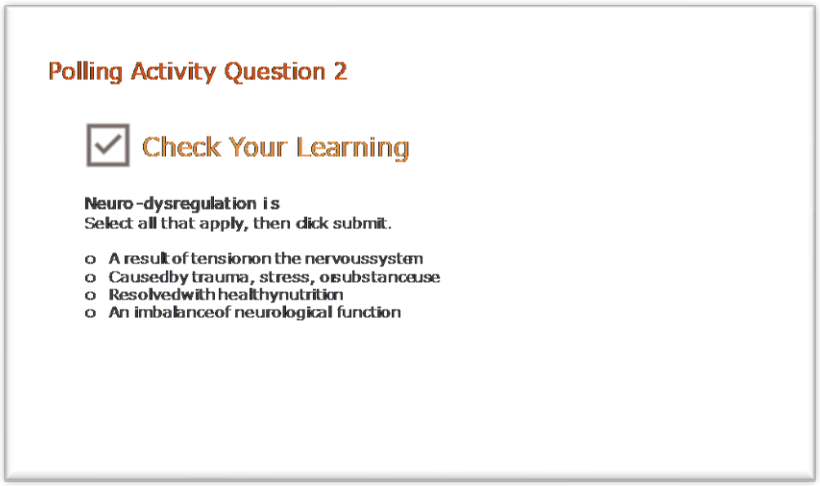


Trainer: Let's check what we've learned so far with a 3-question polling activity.

Moderator Note: *Create a poll (if virtual) for Questions 1-3.*

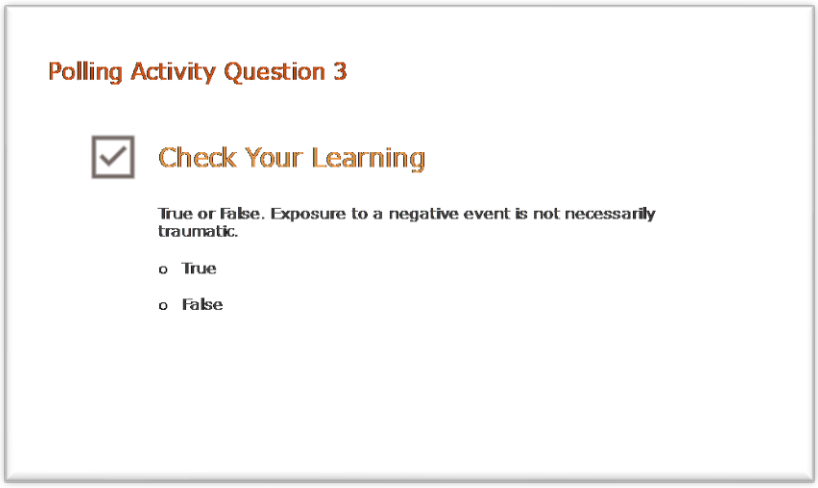
Trainer: (Can present this feedback) The correct answer was the first response. Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening, and that has lasting adverse effects on their functioning and well-being.

Slide 16: Polling Activity Question 2



Trainer: (Can present this feedback.) Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening, and that has lasting adverse effects on their functioning and well-being.

Slide 17: Polling Activity Question 3



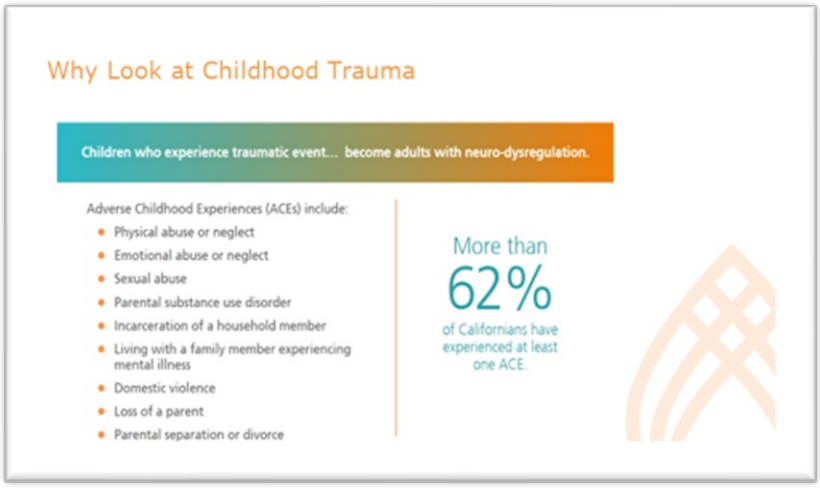
Trainer: (Can present this feedback.) This statement is True. Whether an event is traumatic to the individual depends on their exposure to the event, their experience of the event, and the presence or lack of coping systems.

ACES (ADVERSE CHILDHOOD EXPERIENCES)
Time Allotted: 40 minutes

Slide 18: Adverse Childhood Experiences (1 minute)

Trainer: Now that you have an understanding of what trauma is, let's look at childhood trauma: ACEs, or Adverse Childhood Experiences.

Slide 19: Why Look at Childhood Trauma (3 minutes)



Trainer: You're an Adult Protective Services supervisor, so why are we looking at childhood? It comes back to neuro-dysregulation. Children who have traumatic experiences while their brains are developing become adults with chronic neuro-dysregulation. This can manifest in high-risk behaviors including elder abuse, development of diseases in adulthood, disability, and even early death.

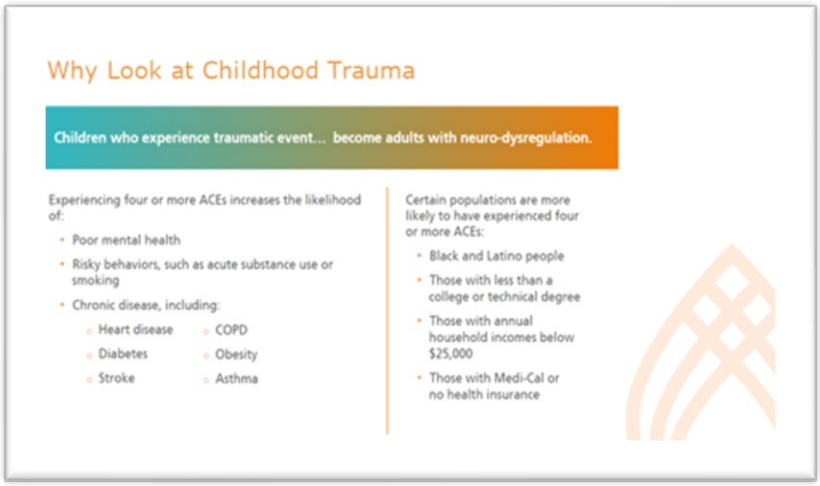
ACEs, or adverse childhood experiences, are traumatic events that occur in childhood, that can lead to lasting effects across someone's life. Some examples include:

* Physical abuse or neglect
* Emotional abuse or neglect
* Sexual abuse
* Growing up with a parent who misuses substances
* Incarceration of a household member
* Living with a family member experiencing mental illness
* Domestic violence
* Loss of a parent, and
* Parental separation or divorce

Continued

You may have experienced some of the ACEs on this list. Around 62% of Californians have experienced one or more ACEs. Does this necessarily mean that over half of all Californians are living with chronic neuro-dysregulation? No; remember that trauma comes both from exposure to negative events and a lack of coping systems. Healthy support systems, coping skills, and personal resilience all play a role in minimizing the impact of ACEs.

Slide 20: Why Look at Childhood Trauma (2 minutes)



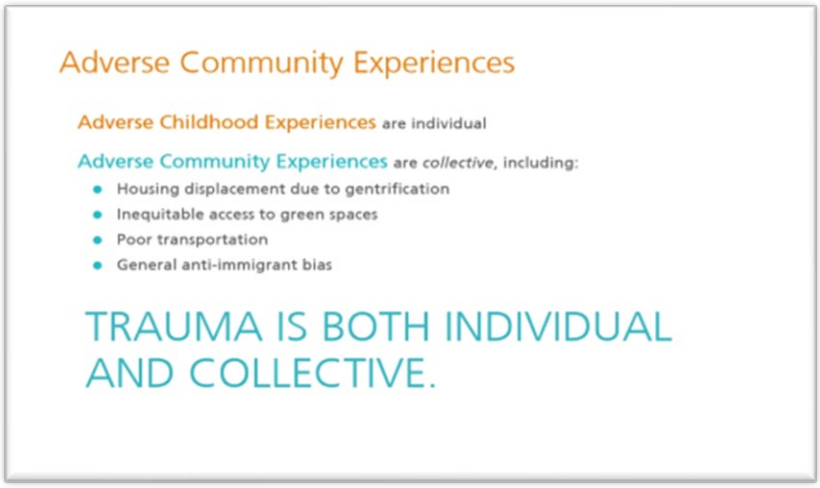
Trainer: However, there are strong connections between experiencing four or more ACEs and negative health outcomes later in life. Experiencing four or more ACEs increases the likelihood of:

* Poor mental health
* Risky behaviors, such as acute substance use or smoking
* Chronic disease, including heart disease, diabetes, stroke, cardiovascular obstructive pulmonary disease (COPD), obesity, and asthma.

Certain populations are more likely to have experienced four or more ACEs:

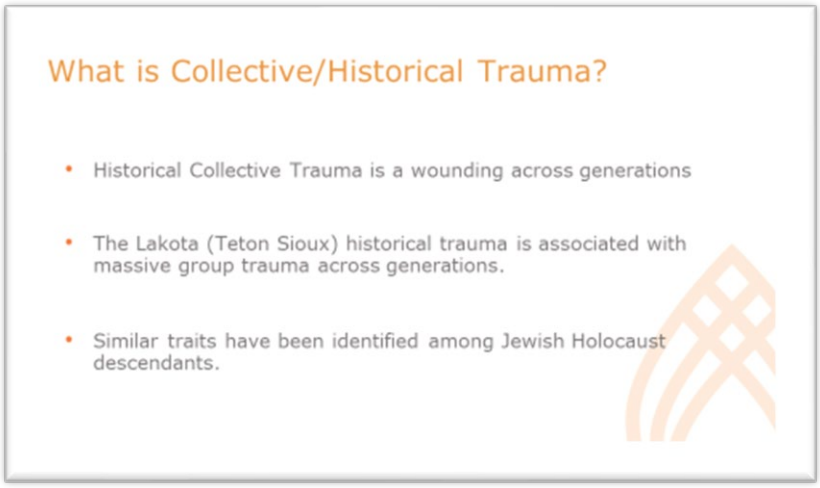
* Black and Latino people
* Those with less than a college or technical degree
* Those with annual household incomes below $25,000, and
* Those with Medi-Cal or no health insurance.

Slide 21: Adverse Community Experiences (1 minute)



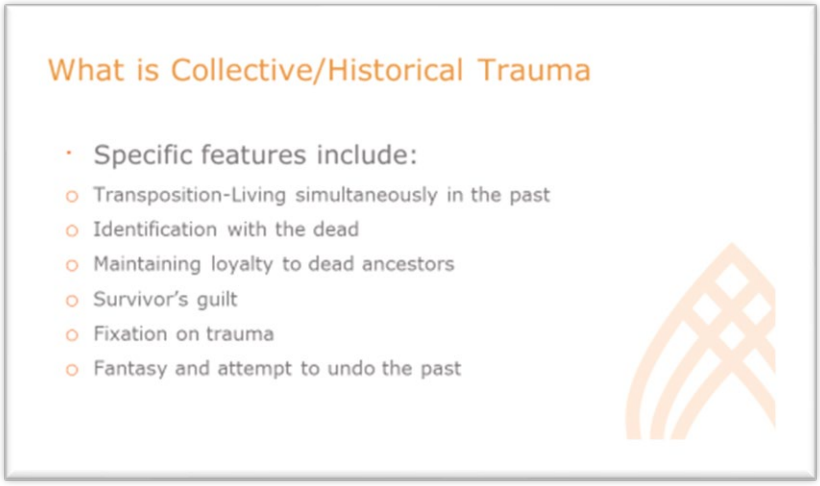
Trainer: It's also important to acknowledge that, where ACEs are individual, there are also adverse *community* experiences. Adverse community experiences are collective, and can include housing displacement due to gentrification, inequitable access to green spaces, poor transportation, and general anti-immigrant bias. Trauma is both individual and collective, impacting entire communities.

Slide 22: What is Collective/Historical Trauma? (2 minutes)



Trainer: Dr. Maria Yellow Horse Brave Heart, PhD, conceptualized Historical Trauma in the 1980's. She defines Historical Collective Trauma as a wounding across generations. This trauma impacts people of the same cultural group well beyond the initial traumatic events. For example, collective traumas perpetrated against the Lakota (Teton Sioux), from the Massacre at Wounded Knee, loss of ancestral land, and the forced removal of native children to federal and mission boarding schools, are felt throughout generations, even by people that didn't directly experience these events. Some of the feelings experienced by people who are affected by historical trauma include Transposition, or the feeling of living in the past. Identification with the dead or feeling psychologically and emotionally dead or unworthy of life. Maintaining loyalty to dead ancestors and Survivor's guilt. Fixation on traumas, and fantasies about undoing atrocities of the past.

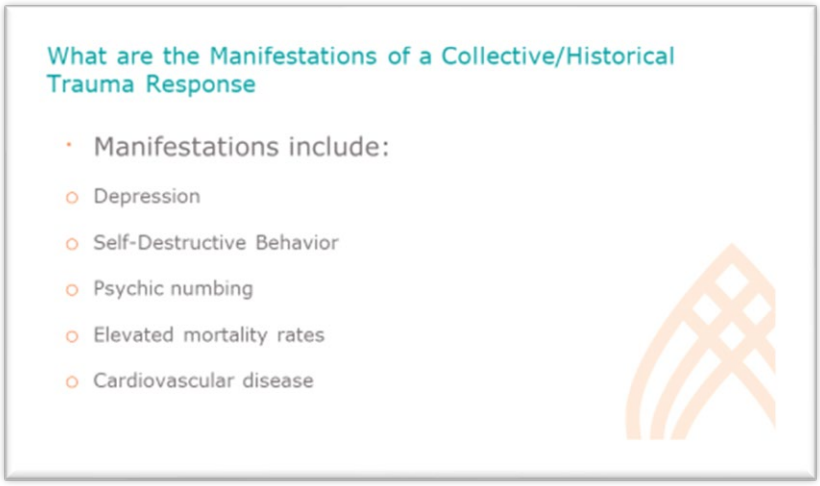
Slide 23: What is Collective/Historical Trauma? (1 minute)



Trainer: Transposition-Which means living simultaneously in the past where the person's suffering in the present is based on their ancestral history.

Identification with the dead so that one feels psychologically and emotionally dead and unworthy of living. Maintaining loyalty to dead ancestors. Survivor's guilt, fixation on trauma, and fantasies about undoing atrocities of the past.

Slide 24: What are the Manifestations of a Collective/Historical Trauma Response? (1 minute)



Trainer: People from groups that are impacted by historical trauma are more likely to experience:

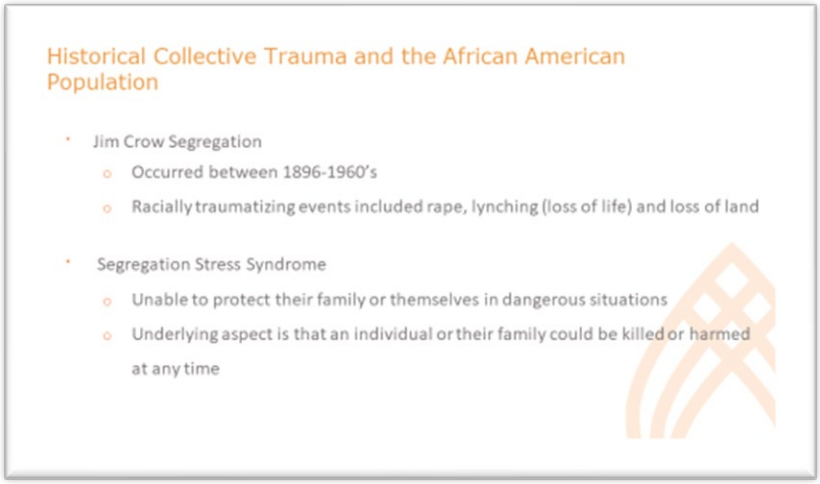
- Depression
- Self-destructive behavior
- Feeling "numb"
- Cardiovascular disease, and
- A higher mortality rate

To return to our example, the mortality rates for heart disease among the Lakota are double the rate of the general US population.

Slide 25: Historical Collective Trauma and the African American Population (1 minute)

Trainer: Let's take a brief look at the African American population, and their particular experience of historical, collective trauma in the United States. While America's history of institutional racism impacts all people of color, Anti-Black racism, starting with chattel slavery, has had a unique impact of cultural, collective trauma. Dr. Joy DeGruy developed the concept of Post-Traumatic Slave Syndrome to explain some of the behaviors of African American communities throughout the United States: a unique condition stemming from multigenerational oppression starting with slavery that existed because white people believed Africans to be genetically inferior.

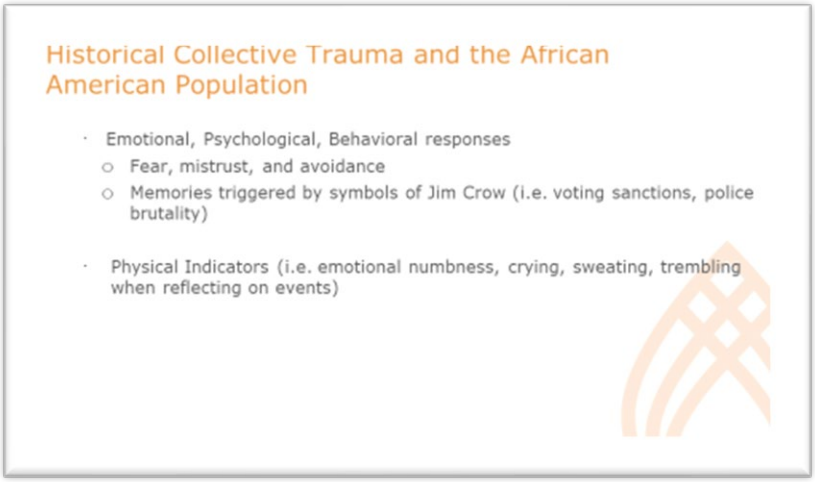
Slide 26: Historical Collective Trauma and the African American Population (2 minutes)



Trainer: The United States government, and the governments of the states, perpetuated this belief of African Americans being genetically inferior with far-reaching consequences: generations of government-sanctioned oppression, from slavery, to Jim Crow segregation, to redlining, to institutional factors that still impact people today. This doesn't even include hate crimes, lynchings, and other racially motivated attacks, or casual interpersonal racism.

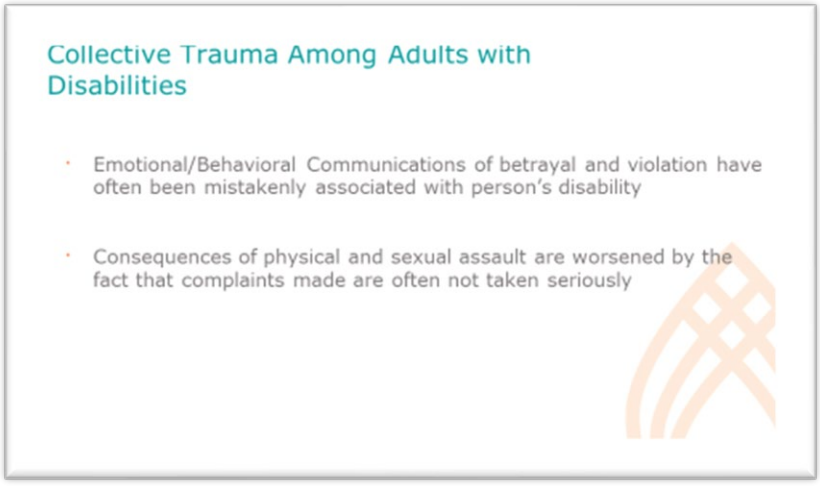
African Americans are dealing with the long-term trauma and psychological consequences of these experiences over generations. These consequences can manifest in something called Segregation Stress Syndrome, in which African Americans, having experienced being unable to protect themselves or their families across generations, feel that they, or their family, could be killed or harmed at any time, without warning or reason.

Slide 27: Historical Collective Trauma and the African American Population (1 minute)



Trainer: Some emotional, behavioral, and psychological responses to these experiences include fear, mistrust, avoidance, and emotional numbness. Also included are memories triggered by symbols of Jim Crow (for example, voting restrictions and police brutality), and there are also physical indicators like crying, sweating, and trembling.

Slide 28: Collective Trauma Among Adults with Disabilities (2 minutes)



Trainer: Adults with disabilities who experience physical or sexual assault may not be taken seriously when they attempt to report it.

According to research conducted by Sinason in 2002, frequently, emotional, and behavioral communications of betrayal and violation by adults with disabilities have been mistakenly dismissed. The consequences of physical and sexual assault are made worse when the person who experienced the assault is invalidated. In terms of trauma, a disability may be experienced as something called a "strain" trauma; a cumulative experience of invalidation and frustration that compounds over time. Abuse perpetrated on adults with disabilities results in compound trauma. In particular, sexual abuse perpetrated against individuals with learning disabilities can cause damage to their psychological functioning, including impacting their sense of self and identity.

According to a study by McCarthy and Thompson in 1992, 61% of women and 25% of men with a learning disability have experienced sexual abuse. It's important for workers to have an understanding of trauma theory when working with abuse survivors, and to take the time to ensure their experiences are validated and not dismissed or mistakenly attributed to a function of their disability.

Slide 29: The ACEs Ratio of Risk Scale (5 minutes)

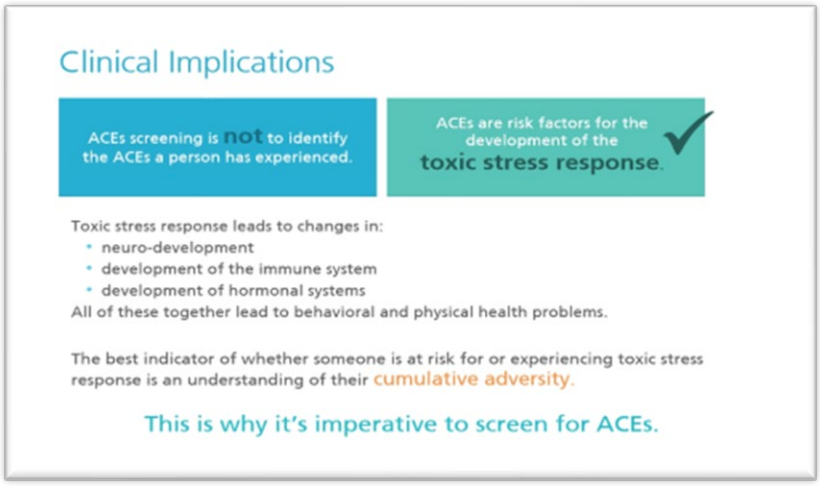
Trainer: Now that we've got an understanding of both adverse childhood experiences and adverse community experiences, let's identify the ACEs Ratio of Risk Scale. Exposure to ACEs increase risk factors for negative health outcomes. The more ACEs a person experiences, the higher the risk. If a person has experienced four or more ACEs, this is a major risk factor to their health. The Ratio of Risk scale introduces negative health outcomes and behaviors, organized by both the strength of their connection to trauma exposure of four or more ACEs and the urgency with which we, as providers, need to address these risk factors. Even the outcomes with the weakest connection to trauma, with concerns like obesity and diabetes, are twice as likely to occur if someone has experienced four or more ACEs.

According to Gabriela Grant, Director of the California Center of Excellence for Trauma-Informed Care four or more ACEs is a major risk factor to health. There are some that are a "weak" or "modest", where yes, and while these are of concern, there is not as much concern for immediate intervention. It's more changes over time. So if an individual is overweight or obese, and/or has diabetes, and has an increased odds ratio risk of two, which is actually quite significant, but it is lower than some of the other ones depicted. It's also a situation where intervention looks like incremental changes over time. For instance, engaging in physical activity or nutritional changes, the idea is to make changes over time.

Continued

When we go up a level where we're looking at odds ratios of two or three, which is two or three times the risk. If there is an ACE exposure of four or more, smoking, heavy alcohol use, poor self-rated health, cancer, heart disease, respiratory disease. These are behavioral changes that also should happen sooner. Some examples of strong are "Sexual risk taking, mental ill health and problematic alcohol use. Now we're in the stronger association with ACEs exposures. So we're confident that it's ACEs that are driving these behaviors. These are behaviors that need to be addressed with more immediacy. Sexual risk taking, mental ill health, and problematic alcohol use has serious complications. We're now in the more serious zone. Now, let's look at the "strongest" with an odds ratio of seven or more, meaning seven times the likelihood increased risk of these behaviors. This could include problematic drug use, interpersonal violence and self-directed violence. These are the areas of most concern. Where we want to intervene most strongly. So not only are the unsafe behaviors noticed and their context but also the intensity. The intensity level and how dangerous the behaviors are. Depending on the assessment, intervention may need to happen much more quickly.

Slide 30: Clinical Implications (2 minutes)



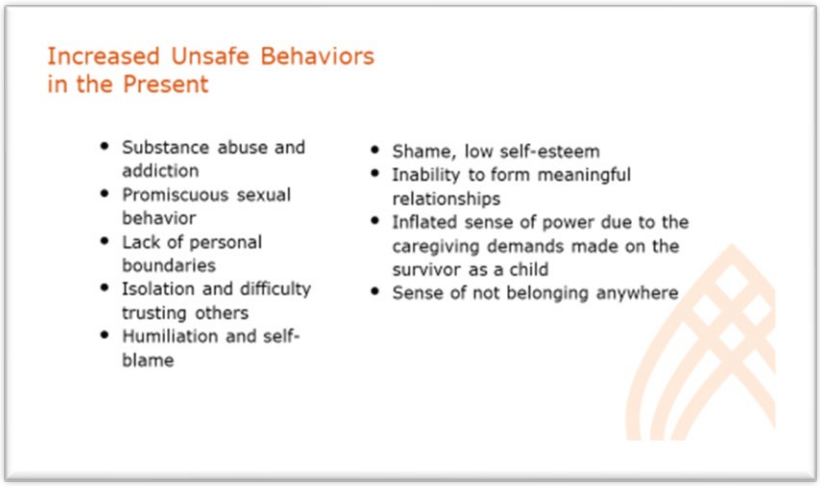
Trainer: The purpose of the ACE screening is not specifically to identify the ACEs a person has experienced. It's a recognition that ACEs are risk factors for the development of the toxic stress response. We understand that the toxic stress response comes from repeated exposure to adversity, and leads to changes in neuro-development, in the development of the immune system, and the development of hormonal systems. All of these together lead to behavioral and physical health problems.

There is research underway to identify clinical diagnostic criteria and biomarkers for the toxic stress response. Currently, we don't have those criteria. The best indicator of whether someone is at risk for toxic stress response, or is currently experiencing toxic stress, is an understanding of their cumulative adversity. This is why it's imperative to screen for ACEs.

Slide 31: ACEs and Older Adults and Adults with Disabilities (1 minute)

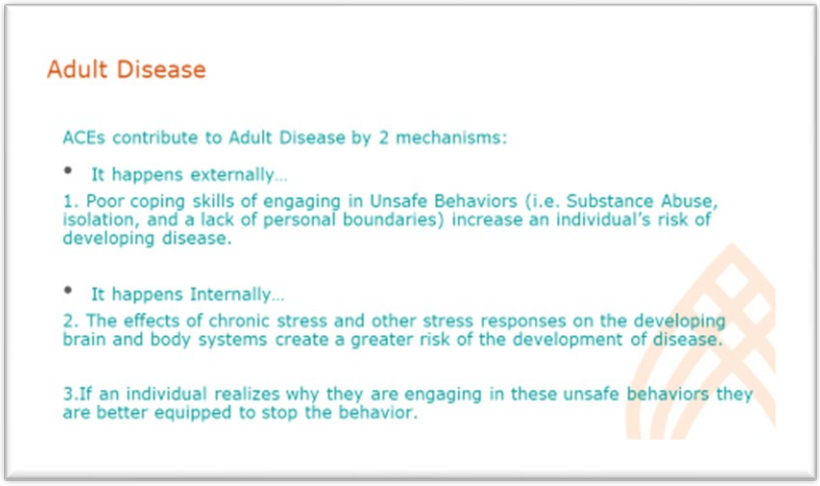
Trainer: So how do ACEs impact the population APS serves? Aside from the increased risk of negative health outcomes, according to the National Elder Maltreatment Study of 2009, exposure to trauma in childhood is associated with an increased risk of mistreatment in adulthood.

Slide 32: Increased Unsafe Behaviors in the Present (2 minutes)



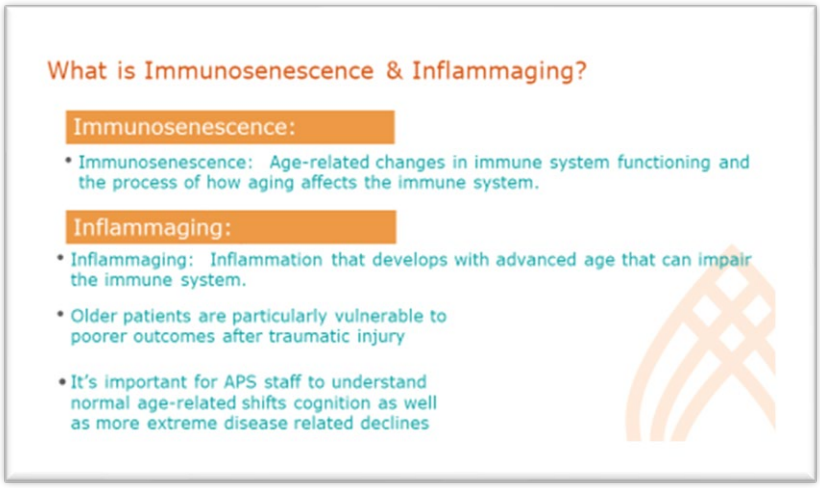
Trainer: The negative behaviors and health outcomes explored so far affect both men and women. However, older women who experienced child abuse may also report unsafe behaviors or emotional impacts in adulthood. So increased unsafe behaviors are a measure. Older women who experienced child abuse report more substance abuse and addiction, more promiscuous sexual behavior, more lack of personal boundaries, more isolation and difficulty trusting others, more humiliation and self-blame, more shame, lower self-esteem, more inability or less ability to form meaningful relationships, and taking on increased responsibility due to the caregiving demands made on the survivor as a child. Also an increased sense of not belonging anywhere. Subsequently the toxic stress response results in behaviors that are socially punished, for example “She's a drug user, she's promiscuous, or she doesn't have boundaries.” Instead of seeing it within the individual what we want to do now is see the individual and their behaviors within the context of "older women who experienced child abuse are more likely to engage in this behavior." This allows our staff to have more patience, more perspective, more safety orientation, and more solutions when working with these individuals.

Slide 33: Adult Disease (2minutes)



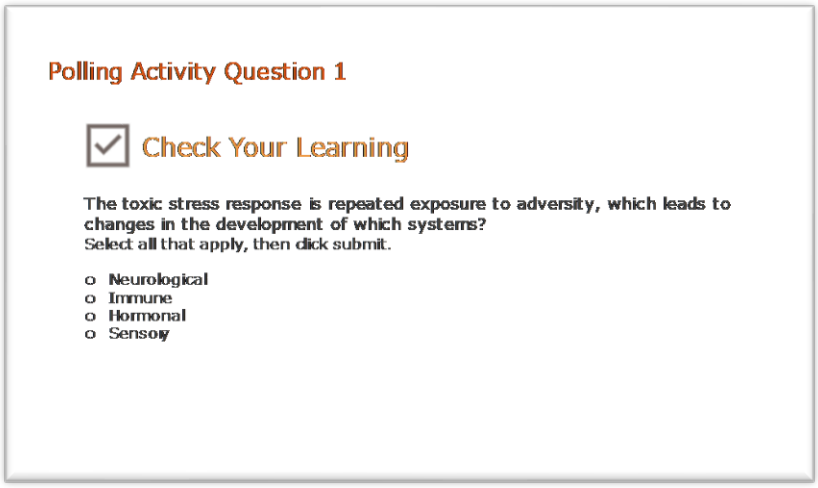
Trainer: ACEs contribute to adult disease by two causal mechanisms: the external and the internal. External expressions of the effects of ACEs are often unsafe behaviors, also called conventional risk factors. These include substance use, isolating from others, or difficulty with setting and maintaining boundaries. These behaviors are attempts at coping through unconscious, unsafe strategies, and increase an individual's risk for experiencing negative health outcomes and adult disease. The internal effects of ACEs are best understood by looking back at SAMHSA's three-part model of trauma: exposure to traumatic events without ways to cope and recover result in chronic neuro-dysregulation. People who experience more than four ACEs in childhood are more likely to experience dysregulation of their stress system, leading to problems with immune responses, increased infections, more inflammation, and higher risk of disease. We can't change existing neuro-dysregulation, but we can educate clients on the relationship between ACEs and unsafe behaviors. If someone understands why they're engaging in an unsafe behavior, they're going to be better prepared to stop.

Slide 34: What is Immunosenescence & Inflammaging? (3 minutes)



Trainer: Immunosenescence is age-related changes in immune system function, collectively termed. The entire process of aging and how that affects the immune system. This is already a very age-related medical concept. What immunosenescence causes is inflammaging. Inflammaging is the chronic subclinical systemic inflammatory state of older adults. PTSD and other trauma-related diagnoses have been described as a form of accelerated aging. Understanding normal age-related shifts in cognition as well as more extreme disease related declines, provides an important baseline of knowledge for professionals working with survivors of elder abuse. So we need to understand the normal process of aging and that there is this low rage inflammation. There is a low level of inflammation over time and that that impairs the immune system. Older patients are particularly vulnerable to poor clinical outcomes after traumatic injury, non-emergency interventions and impacts of environmental conditions. Data has recently indicated that individuals who have that higher level of inflammation or inflammaging, have poor clinical outcomes after a hip break, after a non-emergency intervention, after some sort of an environmental condition like a wildfire or, a pandemic. We understand that there is immunosenescence, which is the aging process of the immune system and one of the markers or measures of it is inflammaging or how much inflammation is occurring internally in the individual.

Slide 35: Polling Activity Question 1

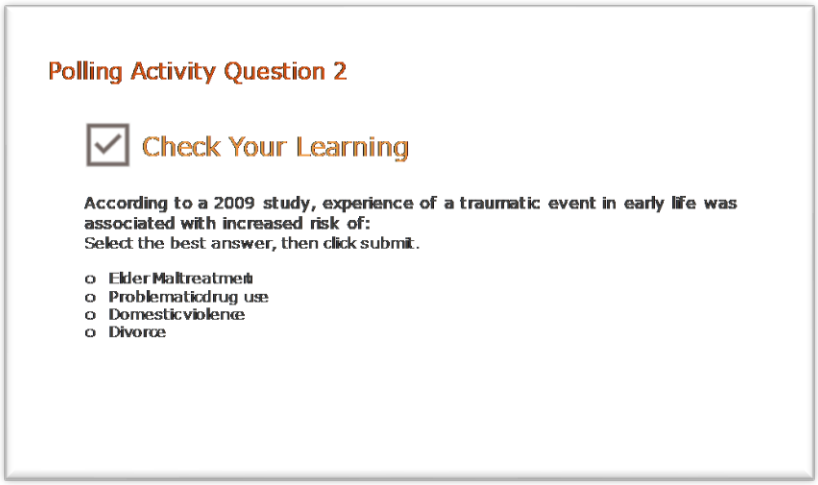


Trainer: Let's do a polling activity together to explore what we've just learned.

Moderator Note: *Create a poll (if virtual) for Questions 1-3.*

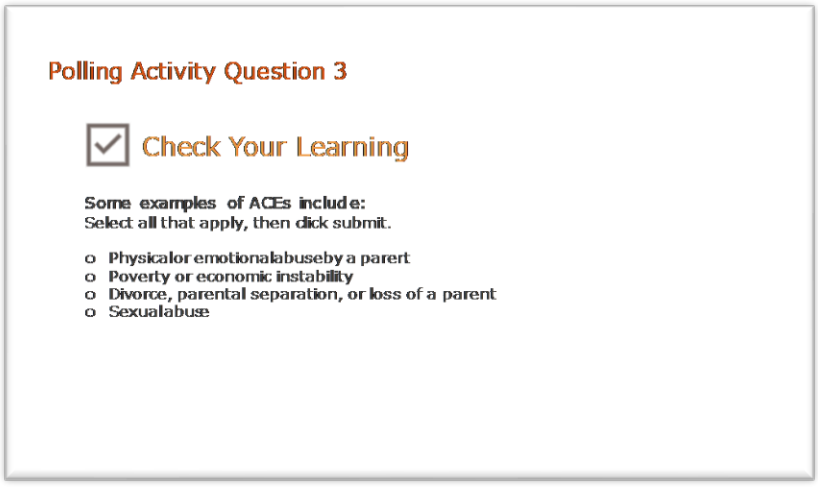
The toxic stress response is repeated exposure to adversity, which leads to changes in neuro-development, and the development of the immune and hormonal systems.

Slide 36: Polling Activity Question 2



Trainer: According to the National Elder Maltreatment study, experience of a prior traumatic event was associated with increased risk of elder maltreatment.

Slide 37: Polling Activity Question 3



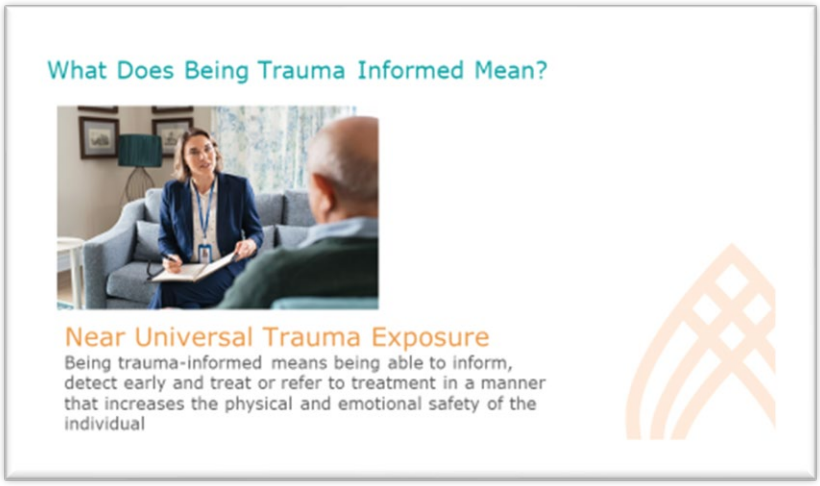
Trainer: All of these are examples of ACEs.

TRAUMA ACROSS THE LIFESPAN
Time Allotted: 50 minutes

Slide 38: Trauma Across the Lifespan (1 minute)

Trainer: In this lesson, we'll learn more about trauma across the lifespan, learn some strategies to identify trauma among older adults and adults with disabilities, and some best practices your staff can use when asking about trauma exposure.

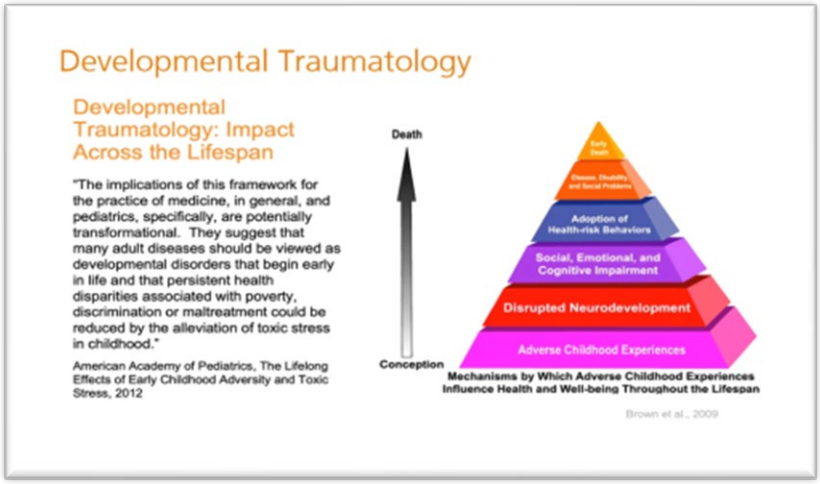
Slide 39: What Does Being Trauma-Informed Mean? (2 minutes)



Trainer: As ACEs Principal Investigator, Dr. Vincent Felitti said, "Adult diseases can best be understood as the manifestations of distant childhood events." A trauma-informed lens helps us to understand that many adult diseases started earlier in life. As we've explored ACEs, you might have seen some that are familiar to you, your family, your friends, or your community. You may have recognized some ACEs from your staff's caseloads.

One of the key concepts for Adult Protective Services to grapple with is that our population has a near-universal trauma exposure rate. Meaning that the vast majority, if not all, of APS clients have already been exposed to a significant negative situation. So it's not so much about finding out what exactly happened. It's having precautionary skills that allow us to work with a population that we know has near-universal trauma exposure. So being trauma-informed is an ability, a skill where your staff is able to inform their clients about this connection between earlier in life trauma exposure and later in life challenges.

Slide 40: Developmental Traumatology (3 minutes)



Trainer: Trauma among older adults and adults with disabilities needs to be understood in developmental terms. This diagram can help: developed in 2009, by Brown et al, describes the way ACEs influence health and well-being throughout a person's life

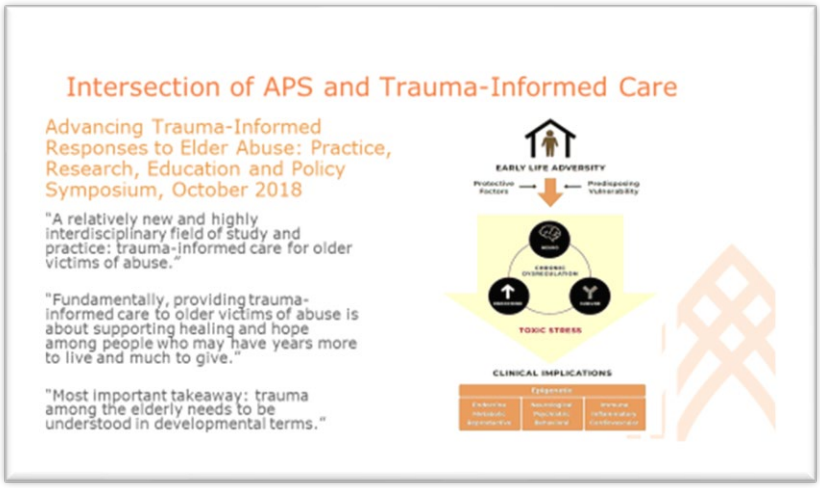
But what is developmental traumatology? Well, if we look at the graphic we see a pyramid that begins with Adverse Childhood Experiences (ACEs) that then may lead to disrupted neurodevelopment, social/emotional/cognitive impairment, up to adoption of health-risk behaviors, disease, and even early death.

So the implications of this framework for the practice of medicine in general and pediatrics specifically are potentially transformational. They suggest that many adult diseases should be viewed as developmental disorders that begin early in life and that persistent health disparities associated with poverty, discrimination or maltreatment could be reduced by the alleviation of toxic stress in childhood.

So what we see that its exposure to adverse childhood experiences along with those adverse community experiences disrupts the nervous system and the neurodevelopment of that unique individual. The individual then starts to display social, emotional, and cognitive impairments. Because, up until very recently, this was not seen as a developmental aspect. The individual was seen as having these impairments, and the individual was told that they have to improve or stop or change or do something different without acknowledging the trauma exposure.

Nonetheless, the adoption of these health risk behaviors increased disease, disability, and social problems. What the ACE study showed was that individuals who were more exposed to ACEs, had fewer years of life.

Slide 41: Intersection of APS and Trauma-Informed Care (3 minutes)

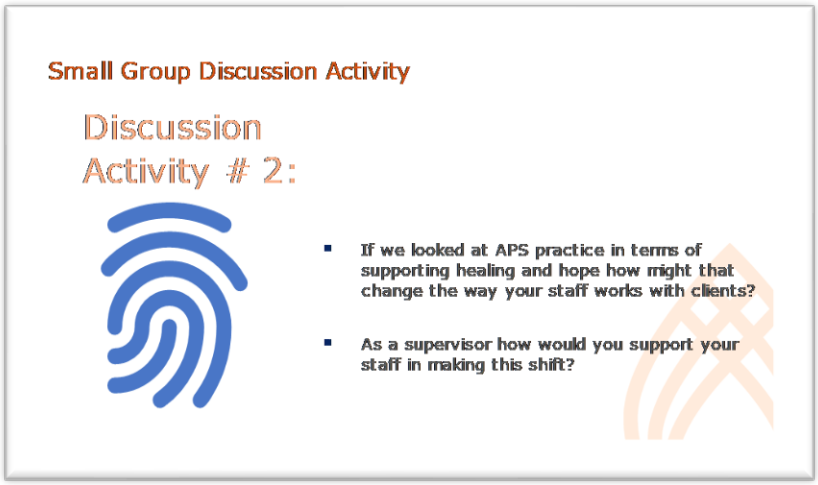


Trainer: The intersection between trauma-informed services and adult protective services is relatively new, but at the same time, part of the story of APS. It's new in certain ways because the science is new, but it's old in certain ways because Adult Protective Services has always been struggling with aspects of often unacknowledged and therefore invisible impacts of trauma.

In 2018 there was a symposium called Advancing Trauma Informed Responses to Elder Abuse: Practice, Research, Education and Policy.

In addition to some very knowledgeable speakers, there were a couple of takeaways. One of the first takeaways is that this is a relatively new and highly interdisciplinary field of study. Trauma-informed care for older victims of abuse is a new area, and it's going to bring all kinds of new fields together in new ways. APS is going to be central to that conversation. What they said in the symposium was that, fundamentally, providing trauma-informed care to older victims of abuse is about supporting healing and hope among people who may have many more years to live and much more to give. And the most important takeaway at the symposium was that trauma among the elderly must be understood in developmental terms. So it's new and it's really about providing hope and not going back into some sort of distressing history but rather for us to really start to understand trauma on a developmental level.

Slide 42: Small Group Discussion Activity (15 minutes for Activity, 10 minutes for Debrief)



Group Activity: *Discussing a shift – 15 min. Group Activity Producer: Provide a 2 min warning*

***Producer**: If the training is virtual, Moderator will create Break Out rooms with 4-5 participants each. In-person Trainer will break up participants into small groups. Trainer will designate a spokesperson for each group to report out for their group when participants return to debrief together as a large group. The participants in the break-out groups will respond to the two questions on the slide.*

Trainer: Consider- if we looked at APS practice in terms of supporting healing and hope. This aligns with 2nd prong of APS practice which is to provide services, intervention, and prevent future abuse.

1. How might that change the way your staff work with clients?
2. As a sup, how would you support your staff in making this shift?

You will meet together in your small groups and discuss the 2 questions on the slide. You will have 15 minutes for the group discussion and the Moderator will give you a 2-minute warning.

(*Trainer debriefs exercise with participants by asking the spokespersons to share with the large group or unmute themselves and share their responses to the question. Trainer allows for 10 minutes for debrief of Activity #2.)*

Slide 43: Identifying Trauma Among Older Adults (5 minutes)

Trainer: When identifying trauma among older adults, we want to focus on multiple areas, using multiple tools. The ACEs questionnaire is a good tool for accessing exposure, the first part of the three-part model of trauma. However, APS focus isn't a full trauma history; it's ensuring the safety and well-being of the people we're serving in the moment. For that, we look at behaviors that might be trauma symptoms. One tool used to assess the symptoms of trauma is the Trauma Symptom Checklist, or the TSC-40. This is a forty-question survey asking about physical and emotional discomfort, with a frequency scale from 0, never, to three, often. You will find the TSC - 40 in your Participant Manual.

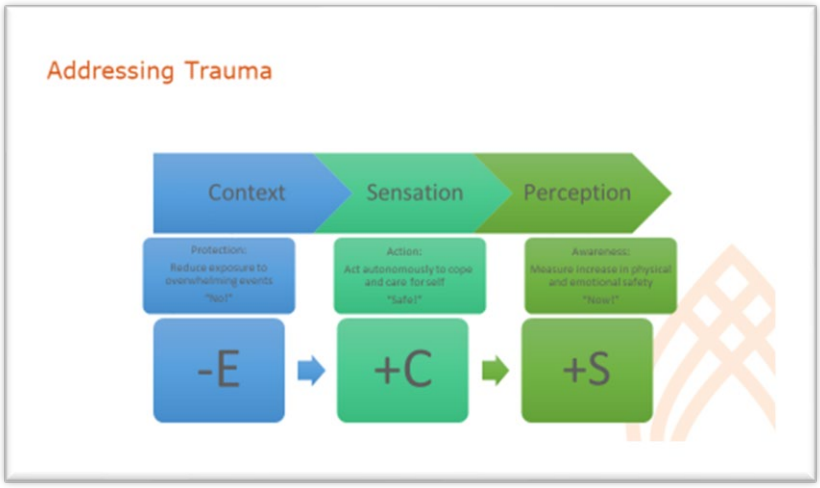
Gabriela Grant, Director for the California Center of Excellence for Trauma-Informed Care, explains why focusing on ACEs isn't capturing the whole picture. When we are assessing for trauma we are doing it in the moment with the APS client. The word trauma itself however is a past-focused word, it seems to harken back in time. So clients are asked "Have you ever experienced, in your past, any of these traumatic experiences?" So basically what's going on is we are asking people to count and disclose, how much exposure they had, although we're having them identify the experiences. We're not actually measuring exposure. The other thing about the past, in addition to the fact that we're not accurately assessing for it, is that we can't change the past. It's a constant. But what we can do is we can change how much exposure there is to the past, and how safe the individual is when exposed to it. In some cases, it is very unsafe to be exposed to the past and in other cases it is very safe to be exposed to the past.

Continued

Another way to measure trauma in older adults is symptoms. Symptoms in the moment, what are their trauma related symptoms for example like insomnia or agitation. These symptoms can change. However, the client may not disclose these symptoms to the APS Worker. So sometimes symptoms can be counted and they can change. But the subjective experience of being able to measure them and kind of hold them as something measurable is challenging.

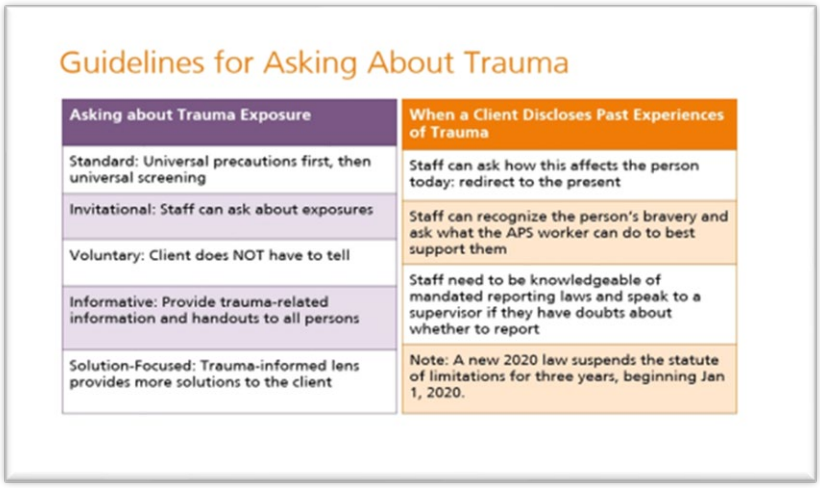
There is a third way and that's to look at unsafe behaviors. Well, what is it about unsafe behaviors? We can count unsafe behaviors. Unsafe behaviors can change. Unsafe behaviors are much more objective than the subjective symptomology that a person discloses. Individuals engage in enough unsafe behaviors that we can identify an unsafe behavior to work with, and these skills are transferable. Meaning, if the client tells the APS worker that they're having a hard time paying bills, low level safety, unsafe behavior, staff can work with the client to build safety skills around addressing this unsafe behavior. These safety skills can then be transferred for a person who is a problematic gambler or other, kinds of, more serious situations. So keep in mind that when staff are working with clients engaging in unsafe behaviors, the skill around any unsafe behavior is transferable to any other unsafe behavior. So it really doesn't require disclosure that much because unsafe behaviors are so common that we can generally agree on something to work on.

Slide 44: Addressing Trauma (1 minute)



Trainer: Briefly going back to the trauma formula, we can now see how +C positive coping strategies can lead to +Safety both physical and emotional, even when there is a context of trauma exposure. Therefore, focusing on safety is the best way we can provide treatment and decrease negative long-term impacts in our clients' lives.

Slide 45: Guidelines for Asking About Trauma (3 minutes)



Trainer: Now, what are the policy implications of ACEs? There is clearly a need for best practices and guidelines for asking about trauma that is standard.

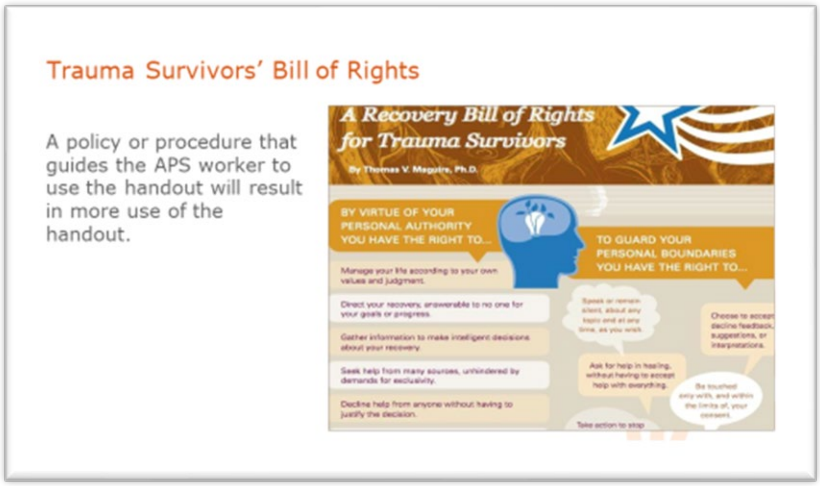
The guidelines need to incorporate universal precautions first, then universal screening. Universal precautions mean that the same precautions are followed for each client regardless of what we know or do not know about their history. We universally screen, which means we do not only screen certain people based on what they disclose but we screen all clients.

It must be invitational: Your staff can ask about exposures. Yet, it must be voluntary: clients do not have to disclose their stories. The process should be informative, with all persons being provided trauma-related information. It should be solution-focused and data-driven.

There should also be established guidelines and best practices as to how to respond when a client discloses their trauma history. An APS worker should always redirect to the present and recognize the bravery of the person. For example, the APS worker could say, "Based on what you just told me, how does that affect you today?" They can ask what they would like the APS worker to do to support them.

All persons should also be made aware of mandated reporting laws and, if unsure if the APS worker should always reach out to their supervisor.

Slide 46: Trauma Survivor's Bill of Rights (1 minute)



Trainer: Refer participants to Handout #1: Trauma Survivors' Bill of Rights (See Appendix A)

Trainer: This is a reference we have distributed in the participant materials. This is the Trauma Survivors' Bill of Rights, which is just that: it makes clear and transparent the rights that a trauma survivor has to their own history and their own privacy. It is highly recommended that you look this over and distribute it amongst your staff and clients.

THREAT VERSUS RISKS
Time Allotted: 35 minutes

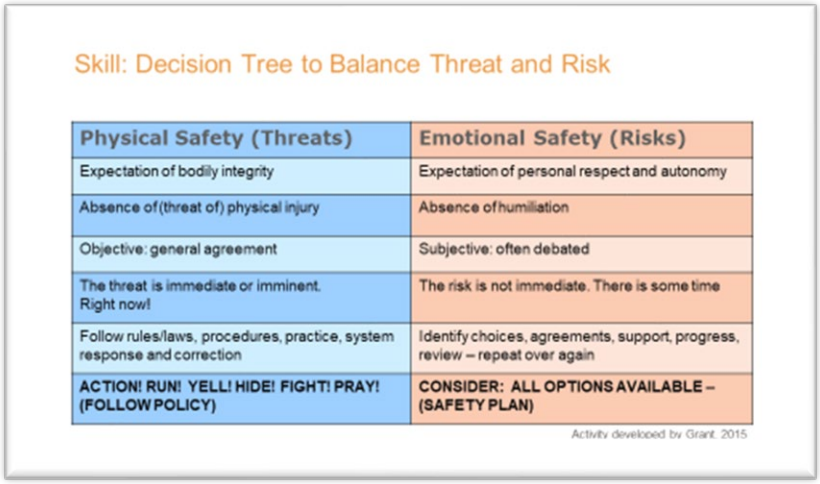
Slide 47: Threat Versus Risks (1 minute)

Trainer: In this section of the training, we'll distinguish between physical safety threat and emotional safety risk, and we'll talk about Safety Screening and Safety Planning.

Slide 48: Distinguishing Between Threat and Risk (1 minute)

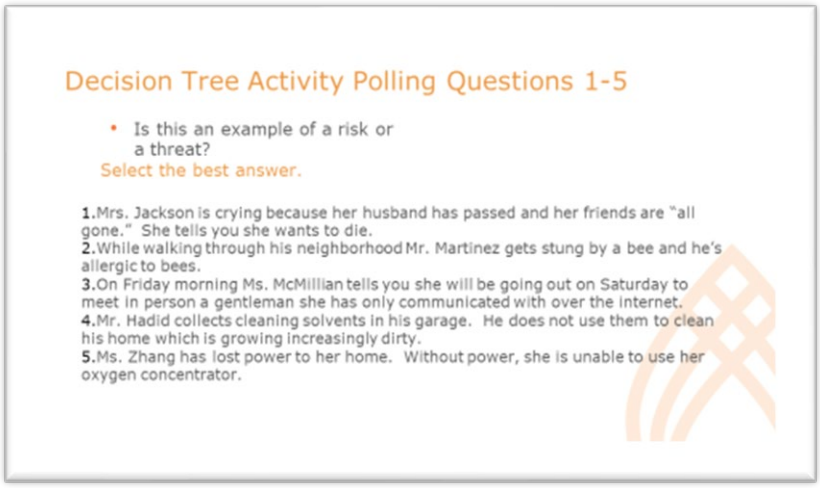
Trainer: Your staff are faced with determining the difference between threat and risk just about every day. Gabriella Grant developed a decision tree to help standardize these determinations. The Decision tree differentiates between immediate and physical threats, and future and emotional risks.

Slide 49: Skill: Decision Tree to Balance Threat and Risk (1 minute)



Trainer: So now we get to an important distinction: the distinction between threat and risk. With physical safety, the threat is immediate - right now! With emotional safety, the risk is not immediate and there is some time to identify choices and review the situation. With emotional safety since there is time, we can focus on a safety plan. With physical safety, there is no time to create a safety plan; rather, we must follow rules and procedures, follow policy, and call for action.

Slide 50: Decision Tree Activity Polling Questions 1-5 (10 minutes)



Moderator Note: *Create a poll (if virtual) for Questions 1-5 with two answer choices prior to the presentation. Two possible responses: Physical Safety (Threat) or Emotional Safety (Risk).*

Trainer: Now, let's put this into practice with (5) Decision Tree Activity Polling Questions to help us discern if a situation is a Physical Safety threat or an Emotional Safety Risk.

Let's start with question # 1

1. Mrs. Jackson is crying because her husband has passed and her friends are "all gone". She tells you she wants to die.

Answer: Mrs. Jackson's emotional safety is at risk. The risk of harm is not immediate, and you have some time to review the situation and provide her with choices.

2. While walking through his neighborhood Mr. Martinez gets stung by a bee and he's allergic to bees.

Answer: Mr. Martinez's physical safety is threatened. There is no time to create a safety plan. It requires immediate action while following policy.

3. On Friday morning Mrs. McMillian tells you she will be going out on Saturday to meet in person a gentleman she has only communicated with over the internet.

Answer: Right now, Ms. McMillian is not in immediate danger, so you have

Continued

time to safety plan. This is a risk, not a threat.

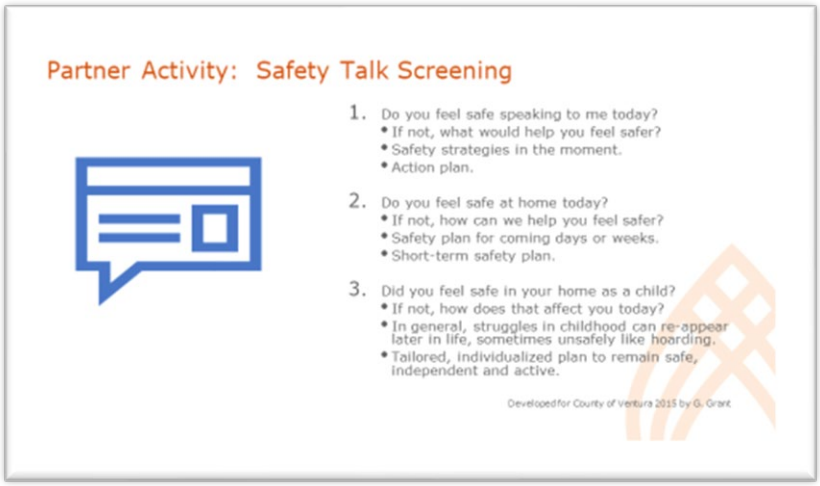
4. Mr. Hadid collects cleaning solvents in his garage. He does not use them to clean his home which is growing increasingly dirty.

Answer: This is an example of a risk. There is some time to review the situation and create a plan. However, there are many ways this situation could quickly escalate to a safety threat.

5. Ms. Zhang has lost power to her home. Without power, she is unable to use her oxygen concentrator.

Answer: This is an example of a threat to physical safety. Act, following rules, procedures, and policy.

Slide 51: Partner Activity: Safety Talk Screening (15 minutes for Activity, 10 minutes to debrief)



Trainer: In 2015, Gabriella Grant and Ventura County, CA developed a short safety screening called "Safety Talk." This screening consists of three main questions:

- Do you feel safe speaking to me today?
- Do you feel safe at home today?
- Did you feel safe in your home as a child?

If the client says no to any of these questions, there are then follow up questions:

- What would help you feel safer?
- How does your childhood affect you today?
- How can we come up with safety strategies in the moment, for the coming days, or weeks, and for your future?

This is a tool that you can demonstrate using with your staff in a 1:1 supervision conference prior to your staff going out on a face-to-face initial visit or on an open case. You will be broken up into dyads for this activity and will practice with a partner using the Case Scenario 1 in your participant manual. One person plays the role of Mrs. X and the other plays the role of worker. We will give you 10 minutes, come back, and process the activity.

Continued

Moderator: For virtual delivery, you will need to create partner groups of 2 participants via your platform and list the instructions in the chat box prior to sending them to breakout groups. They have 10 minutes to role play. Moderator will give participants a 2-minute warning. Moderator gives participants a minute to read the Mrs. X case study prior to opening break out rooms.

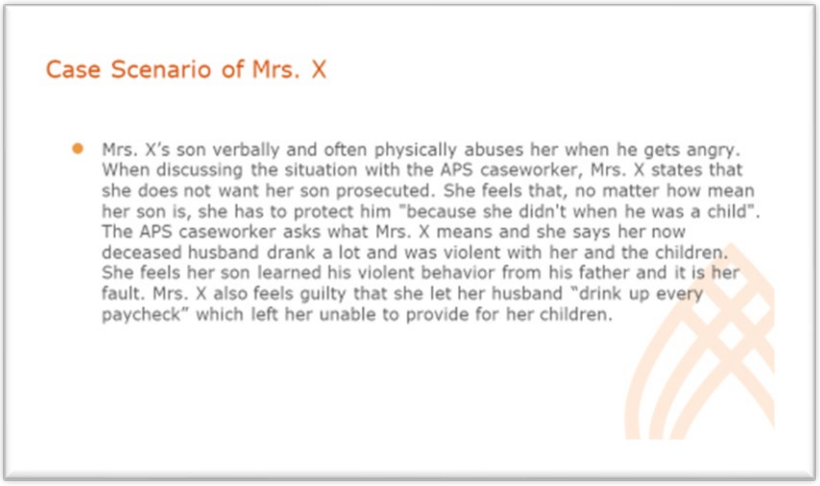
Trainer: Welcome back everyone! *(Trainer asks for volunteers and if virtual will ask volunteers to unmute themselves or type in the chat).*

- How did that go?
- How was asking the 3rd question. Any discomfort? Great responses everyone.

Clients usually answer the first and second one without issues and may be a little taken aback by the third one. If they do, in that moment you can talk about how our coping mechanisms we develop as children impact how we cope as adults. They may not have even realized this before! In all, this screening is meant to evaluate safety and increase safety and is intended to be brief. Remember the earlier slide on child abuse victimization and increased risk of abuse or neglect in later life.

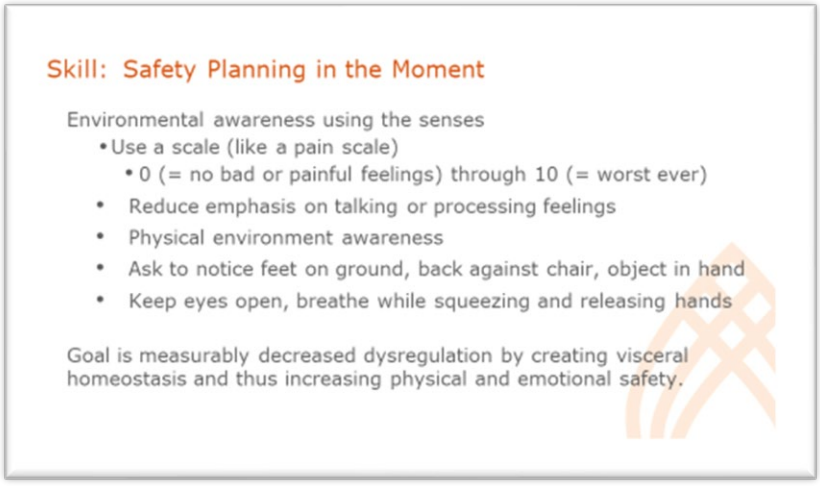
Safety planning in the moment is a skill you develop. The better you understand how to safety plan in the moment, the more effective your safety screening, and ultimately your safety planning will be.

Slide 52: Case Scenario of Mrs. X



Trainer: Here is the case scenario of Mrs. X. You will find this in your Participant Manual, and you will be given a minute or two to read it prior to the role pay activity with your partner.

Slide 53: Skill: Safety Planning in the Moment (4 minutes)



Trainer: Let's talk about a safety scale. It is safety planning in the moment. Safety planning in the moment is an environmental awareness skill-building tool. Some examples could be using a pain scale, reducing emphasis on talking/processing feelings, and instead increasing awareness of physical environment. This activity applies to yourself, taught to your staff, and staff can share this process with their clients. The scale is a zero no distress, to 10 most distress scale. It's similar to a pain scale: zero, no pain, 10 worst pain. We're doing this because this is how the nervous system operates, the nervous system operates on that kind of a scale, zero is homeostasis and 10 is total dysregulation.

Staff can ask clients to notice or kind of touch their feet to the ground, spreading their toes, even if they have shoes. Also noticing their back comfortably seated up against the backrest of a chair. Or ask clients to breathe, with eyes open, while squeezing/releasing their hands. Also noticing if there's a window to look out or an object to focus on and notice the details or artwork on the object. The goal of this skill is to measurably decrease one's own dysregulation by creating visceral homeostasis in the moment. By decreasing dysregulation, we can increase physical and emotional safety in the moment

Slide 54: Transfer of Learning Activity: Statement of Commitment (2 minutes)

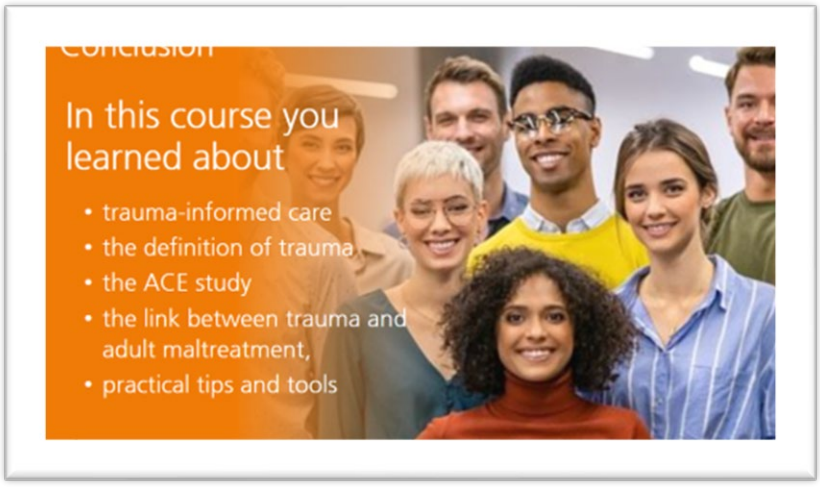
Trainer: To bring what you've learned in this course into practice, we would like supervisors to draft a statement of commitment to trauma-informed care and share it with your team in the next two weeks. This activity is a great foundation to share what you learned in this training and continue to build on trauma-informed, safety-oriented approaches with staff so they can put them into practice with their clients.

Slide 55: Written Statement of Commitment (1 minute)

Trainer: Here is an outline with 4 objectives for you to include in your Written Statement of Commitment. This will take approximately 30 minutes and will be done outside of training

WRAP-UP AND EVALUATIONS
Time Allotted: 25 minutes

Slide 56: Conclusion (3 minutes)



Trainer: Now that we have come to the end of this presentation, I would like to summarize some of the key points and takeaways from today. In the beginning of this course you discovered, you would learn about the critical intersections between adult maltreatment and trauma over the life course and why training for caseworkers and supervisors from a trauma-informed framework is so important.

In this foundational training on a trauma-informed framework for APS supervisors, you learned about trauma-informed care, the definition of trauma, the ACE study and its impact on our understanding of trauma across the lifetime, the link between trauma and adult maltreatment, and some practical tips and tools for you and your staff to use on the job, including safety planning in the moment and using a decision tree to balance threat and risk. We hope you'll take what you've learned in this course, and your statement of commitment, to share and support trauma-informed strategies with your staff and the clients and families they serve.

Slide 57: Closing Thoughts (7 minutes)

Trainer: This brings us to the end of our time together today. Does anyone have any addition questions? Does anyone have reflections on what we discussed today? Any takeaways?

I want to thank you for your time, energy, and focus today.

Slide 58: Plus/Delta (5 minutes)

Slide 59: Evaluation (10 minutes)

Slide 60: Thank you!

Moderator/Co-Host Tip Sheet

Module 1

Slide #1: Welcome, page: 16

- Type in Chat Box "Please enter name, county, and role for attendance records".

Slide #4: Technology Overview, page 19

- Remind participants if they leave, to type BRB (be right back) into chat so this can be accounted for if they leave before a breakout room is assigned.

Slide #25: Thank You and Evaluations, page 84

- Provide evaluation information (if applicable)

REFERENCES AND RESOURCES

Brave Heart, M. Y. H. (2000). Carrying the historical trauma of the Lakota. *Tulane Studies in Social Welfare,* 245-266.
Lakota-Historical Trauma Study.pdf

Breckman, R., Levin, M., Mantrone, L., & Solomon, J. (2020). *Advancing Trauma-Informed Responses to Elder Abuse*. 52.

Bright, C. L., & Bowland, S. E. (2008). Assessing Interpersonal Trauma in Older Adult Women. *Journal of Loss and Trauma*, *13*(4), 373–393. https://doi.org/10.1080/15325020701771523

Brown, D. W., Anda, R. F., Tiemeier, H., Felitti, V. J., Edwards, V. J., Croft, J. B., & Giles, W. H. (2009). Adverse Childhood Experiences and the Risk of Premature Mortality. American Journal of Preventive Medicine, 37(5), 389–396. https://doi.org/10.1016/j.amepre.2009.06.021

Bucci, M., Marques, S. S., Oh, D., & Harris, N. B. (2016). Toxic Stress in Children and Adolescents. *Advances in Pediatrics*, *63*(1), 403–428. https://doi.org/10.1016/j.yapd.2016.04.00

California Department of Public Health, California Department Of Social Services, Essentials For Childhood Initiative, Adverse Childhood Experiences Data Report: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2017: An Overview of Adverse Childhood Experiences in California, October 2020.

Degruy, J. (2017) *Post traumatic slave syndrome: America's legacy of enduring injury and healing.* Joy Degruy Publications INC International Concepts, Revised ed.

Elwenspoek MMC, Kuehn A, Muller CP, Turner JD. The effects of early life adversity on the immune system. Psychoneuroendocrinology. 2017 Aug, 82:140-154. doi: 10.1016/j.psyneuen.2017.05.012. Epub 2017 May 17. PMID: 28549270.

Felitti, V. J. (2009). Adverse Childhood Experiences and Adult Health. *Academic Pediatrics*, *9*(3), 131–132. https://doi.org/10.1016/j.acap.2009.03.001

Felitti, V., & Anda, R. (2010). The Relationship of Adverse Childhood Experiences to Adult Medical Disease, Psychiatric Disorders, and Sexual Behavior:

Implications for Healthcare. In *The Hidden Epidemic: The Impact of Early Life Trauma on Health and Disease*. Cambridge University Press.

Fulmer, T., Paveza, G., VandeWeerd, C., Fairchild, S., Guadagno, L., Bolton-Blatt, M., & Norman, R. (2005). Dyadic Vulnerability and Risk Profiling for Elder Neglect. *The Gerontologist*, *45*(4), 525–534. https://doi.org/10.1093/geront/45.4.525

Hazeldine J, Lord JM, Hampson P. Immunosenescence and inflammaging: A contributory factor in the poor outcome of the geriatric trauma patient. Ageing Res Rev. 2015 Nov;24(Pt B):349-57. doi: 10.1016/j.arr.2015.10.003. Epub 2015 Oct 17. PMID: 26484895.

Hudson S, Beckford L, Jackson S, Philpot M. Validation of a screening instrument for post-traumatic stress disorder in a clinical sample of older adults. Aging & Mental Health
[serial online]. September 2008;12(5):670-673. Available from: Academic Search Complete, Ipswich, MA. Accessed November 13, 2011.
Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., Jones, L., & Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. *The Lancet Public Health*, *2*(8), e356–e366. https://doi.org/10.1016/S2468-2667(17)30118-4

Lapp, L., Agbokou, C., & Ferreri, F. (2011). PTSD in the elderly: The interaction between trauma and aging. *International Psychogeriatrics, 23*(6), 858-868. doi:10.1017/S1041610211000366

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. (2014). https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

Sinason, V. (2002). Treating people with learning disabilities after physical or sexual abuse. *Advances in Psychiatric Treatment, 8,* 424-432.

Trent M, Dooley D, Douge J. The Impact of Racism on Child and Adolescent Health. Pediatrics. 2019; 144(2).

Web Resources

- National Center for Reaching Victims – includes older adults: https://reachingvictims.org
    - Older African American Crime Survivors Toolkit:

https://reachingvictims.org/resource/increasing-access-toolkit/

- Advancing Trauma Informed Responses to Elder Abuse:
  - Webinar: https://www.elderjusticecal.org/recording---advancing-trauma-informed-responses-to-elder-abuse.html
  - Report: https://ncea.acl.gov/NCEA/media/Publication/WCEJ_Trauma-Symposium-report-2020.pdf
- Trauma Informed Approaches for Adult Protective Services Brief (APS TARC)
  - https://apstarc.acl.gov/getattachment/Education/Briefs/Trauma-InformedApproachtoAPS.pdf.aspx?lang=en-US

- California Elder Justice Coalition
  - https://www.elderjusticecal.org
- Disability Rights California
  - https://www.disabilityrightsca.org
- ACEs Aware Self-Care Tool for Adults
  - ACEs Aware Self-Care Tool for Adults
- ACE Study
  - ACE Study (aceresponse.org)
- Trauma Symptom Checklist – 40
  - Trauma Symptom Checklist – 40 (TSI-40) | John Briere (instanturl.net)
- What's My ACE Score Questionnaire
  - Whats My_ACE Score questionnaire (aceresponse.org)

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OUR WHY:
REVOLUTIONIZE THE WAY PEOPLE WORK TO ENSURE THE WORLD IS A HEALTHIER PLACE.