SUPPORT FOR NORTH CAROLINA CHILD WELFARE PROFESSIONALS FOLLOWING A CHILD FATALITY

Prepared for: The North Carolina Child Fatality Task Force

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May 2, 2013
April 22, 2012

Elizabeth Hudgins
North Carolina Child Fatality Task Force
1928 Mail Service Center
Raleigh, NC 27699-1928

Re: Support for North Carolina Child Welfare Professionals Following a Child Fatality

Dear Ms. Hudgins:

We, the Sanford School Policy Team, are pleased to submit a research study on what supports should be provided to child welfare professionals after a child fatality occurs.

Our team is grateful for the opportunity to work with you and your colleagues at the NC Child Fatality Task Force. We value your time and guidance throughout this process and have greatly benefited from your expertise.

Please extend our appreciation to Krista Ragan, Jeff Olson, and Cindy Bizzell for the time and dedication they have provided to assist us in the development of this project.

Sincerely,

Susan Cohen

Rachael Honick

Xiaofei Gan

Issel Masses
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May 2, 2013
Executive Summary

Policy Question
What support should be provided to child welfare professionals, including Division of Social Services caseworkers and Guardian Ad Litem volunteers, when a child on their caseload dies from abuse or neglect?

Problem Statement
A child fatality is a traumatic event for child welfare professionals, specifically Division of Social Services (DSS) caseworkers and Guardian Ad Litem (GAL) volunteers. Though child abuse homicide is not a common cause of death in North Carolina, the impact on child welfare professionals can be profound. The county DSS agencies and the state GAL program both need adequate infrastructure to support caseworkers and volunteers to manage the effects of traumatic events in addition to the daily stresses of their positions. Additional mental health supports, training for caseworkers, volunteers and supervisors, and some structural changes on the county level may be required. Each county DSS will need to consider their own position and relative strengths and challenges in supporting DSS caseworkers as agency and community resources are not uniform across the state.

Child welfare professionals face high caseloads and Secondary Traumatic Stress (STS) as a result of their work. Professionals suffering from STS experience symptoms, including anxiety and depression, which contribute to psychological distress, decreased work productivity, burnout, and turnover. After a child abuse homicide occurs, professionals undergo a strenuous review process and legal proceedings, which can further exacerbate the trauma and stresses associated with the fatality. Negative media coverage and social pressure generated by a child fatality can intensify caseworkers’ stress.

1 This student paper was prepared in 2013 in partial completion of the requirements for PPS 804, a course in the Masters of Public Policy Program at the Sanford School of Public Policy at Duke University. The research, analysis, and policy alternatives and recommendations contained in this paper are the work of the student team who authored the document, and do not represent the official or unofficial views of the Sanford School of Public Policy or of Duke University. Without the specific permission of its authors, this paper may not be used or cited for any purpose other than to inform the client organization about the subject matter. The authors relied in many instances on data provided to them by the client and related organizations and make no independent representations as to the accuracy of the data.

This analysis was requested by the Child Fatality Task Force in follow-up to a recommendation of the State Team that workers experiencing a death in their caseload be provided with additional support. The report does not represent the official or unofficial views of the Child Fatality Task Force. However, if local Division of Social Services, Guardian Ad Litem programs or others would like to use this information to improve supports for workers or volunteers they may do so without prior consent.
DSS and the GAL program face considerable resource constraints. Additionally, North Carolina’s 100 county DSS agencies operate independently. As a result, no uniform statewide standard exists for DSS caseworkers to obtain mental health support. Minimal support is available for GAL volunteers.

DSS caseworkers and GAL volunteers also seldom receive comprehensive training regarding the stressors associated with their job, including the impact of Secondary Traumatic Stress and child fatalities. DSS and GAL supervisors are seldom trained to recognize the symptoms of STS or provide comprehensive assistance.

Finally, the stigma associated with mental health support as well as time constrains of professionals in the field prevent DSS caseworkers and GAL volunteers from obtaining adequate mental health treatment. No formal peer support networks exist among DSS agencies or in the GAL program for support and encouragement. As a result, DSS caseworkers and GAL volunteers who undergo a child fatality experience extreme stress and isolation, contributing to severe burnout that can force caseworkers to leave their job.

To address these challenges, we present seven recommendations based on the following three considerations:

**Key Considerations**
- Maximize existing financial resources to implement new programs with limited additional costs.
- Mitigate impact of secondary traumatic stress on caseworkers and volunteers.
- Reduce burnout and turnover rates among caseworkers and volunteers.

**Recommendations**
1. Invest in an imbedded mental health professional for DSS agencies.
2. Implement peer support networks within DSS agencies or through collaboration with local fire, police, and EMS department, and establish a similar but informal network for GAL volunteers.
3. Train DSS supervisors to recognize Secondary Traumatic Stress, provide support, and train county-level employees using the NCTSN Child Welfare Trauma Training Toolkit.
4. Create a standardized procedure for supervisors to manage and support DSS caseworkers and GAL volunteers following a child fatality.
5. Implement annual trainings on STS and child fatalities in DSS and GAL programs.
6. Develop a team of statewide or regional media liaisons for DSS agencies.
7. Establish an Employee Assistance Program, negotiate reduced co-payments, and contract with out-of-county mental health professionals.

These recommendations are based on information obtained from qualitative interviews with DSS employees at the state and county level, the GAL program and
volunteers, attorneys, mental health professionals, and others involved with child welfare and child fatalities. We also conducted a small survey of DSS county offices to inquire about their level of mental health support including different health benefits and varying access to EAPs. We received responses from 36 counties. Our recommendations are also informed by evidence from social science research and the data we collected on child fatalities and child welfare from North Carolina and other comparable states.

None of our recommendations require legislative action. Most of our recommendations, however, are designed for implementation at the county level of the North Carolina Division of Social Services. We would advise anyone reading these recommendations, and seriously considering implementation, to first conduct a needs assessment of their agency to better understand what resources currently exist and what could be utilized to reduce cost and increase efficiency. Creative and untapped resources may be available in some areas that could support all seven of our recommendations and reduce cost.
Acknowledgements

We would like to extend our appreciation to our client, and primary contact, Elizabeth Hudgins, Executive Director at the North Carolina Child Fatality Prevention Team for this important policy question and her faith in our team. We would also like to thank members of the NC CFPF including Krista Ragan, Jeff Olson, Cindy Bizzell, and Phyllis Fulton for their guidance and assistance with data. We are grateful for the advice and insight of the following professionals working in child welfare: Dr. Tripp Ake, Jenny Brobst, Sheila Sutton, Dr. Sherry Baldwin, Jerry Smith, Kathy Stone, and Liz Kachris-Jones. We owe much of this report to the DSS caseworkers and GAL volunteers who shared their invaluable experiences with such tragedies. Finally, our team would like to thank our teaching team at Duke University, Professor Mac McCorkle, Wendy Matheny, and David Guy for their editing, advice, and encouragement.
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I. Introduction to Policy Question

The North Carolina Division of Social Services (DSS) faces high caseloads, resource constraints, and daily stressors beyond what non-child welfare social workers experience. Child welfare professionals, specifically DSS caseworkers and Guardian ad Litem (GAL) volunteers, frequently experience psychological distress, including depression, guilt, grief, and Secondary Traumatic Stress (STS). Furthermore, child welfare professionals throughout North Carolina often receive minimal institutional support or guidance at both the state and county level to cope with trauma. As a result, stress and burnout drive DSS caseworkers and GAL volunteers to resign.

This report provides recommendations for DSS county agencies and the GAL program to enhance support for child welfare professionals specifically when a child on their caseload dies from abuse or neglect.

II. Child Fatalities in North Carolina

Child abuse homicide\(^3\) is not a common cause of death in North Carolina. Yet the impact on caseworkers can be profound. Between 2001 and 2011, North Carolina experienced a total of 322 child abuse homicides, including DSS and non-DSS involved cases (State Child Fatality Prevention Team) (see Appendix 1 Figure 1). During this 10-year period, over 30 counties reported no incidents of child abuse homicides. Only nine counties encountered more than nine child abuse homicides, including Union, Durham, Buncombe, Onslow, Wake, Forsyth, Guilford, Cumberland, and Mecklenburg (see Appendix 1 Figure 2).\(^4\)

A. Child Fatalities on the DSS Caseload

While the data above provide an overall picture of trends and occurrence of child abuse homicides throughout North Carolina, the majority of these homicides did not occur under the Division of Social Services’ (DSS) supervision. Nationwide, approximately 30%-40% of all child abuse fatalities were known to a child welfare agency prior to the fatality (Anderson, 1983). According to the U.S. Department of Health & Human Services, child abuse homicides account for a 3.2%-4.3% of the

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\(^2\) Data on child fatalities, and more specifically, on child abuse homicide, are limited. Problems with record keeping and confidentiality concerns prevented our team from gathering additional data to analyze trends of age, manner of homicide, and other demographic variables. Large-scale national data were also unavailable to compare North Carolina to other states.

\(^3\) The National Child Abuse and Neglect Data System defines a child maltreatment fatality as “a child dying from abuse or neglect, because either a) the injury from the abuse or neglect was the cause of death, or b) the abuse and/or neglect was a contributing factor to the cause of death” (Douglas, 2013).

\(^4\) The last three counties listed reported the highest count of child abuse homicide, with Guilford reporting a total of 14 fatalities, Cumberland at 26 fatalities, and Mecklenburg at 29 fatalities.
overall national child welfare caseload (U.S. Department of Health and Human Services, 2010).

![Figure 1: Child Deaths that Met the Criteria for Review](image)

Figure 1 indicates the number of child deaths reported to NC DSS between 2006 and 2011 (North Carolina Department of Health and Human Services). The shorter bars represent a subset of the reported deaths for cases that met the criteria for a Child Fatality Death Review. Approximately 20% of the reported cases met the criteria for further official review. Of the total number of cases officially reviewed between 2006 and 2011, around 47% were classified as neglect suspected cases, 21% abuse suspected cases, and 3% were homicide suspected cases (see Appendix 1 Figure 3).

III. The Impact of Child Fatalities on DSS Agencies and GAL Programs

A. Secondary Traumatic Stress Experienced by Child Welfare Professionals

Secondary Traumatic Stress is a reality of the child welfare profession. Secondary Traumatic Stress (STS)–often referred to as vicarious traumatization or compassion fatigue–is severe stress accumulated through daily interaction with

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5 Two main requirements must be met for DSS to consider conducting a child fatality death review:

1) The family of the child must have been involved with DSS within 12 months of the child’s death.
2) DSS suspects that the child’s parent or caregiver abuse or neglect contributed to the child’s death.

(North Carolina Department of Health and Human Services)
survivors of traumatic life events. Signs of STS include anger, anxiety, emotional detachment, depression, intrusive thoughts or images of the trauma, sleep disturbances, social withdrawal, diminished self-care, and alcohol or drug abuse (Osofsky, Putnam, & Lederman, 2008). Experiencing and coping with the death of a child on a caseload is often more distressing than assault or threats (Regehr C. D., 2004). Approximately 70% of 282 randomly chosen master’s level social workers in North Carolina, including 20 child welfare caseworkers, experienced at least one symptom of STS in the past week (Bride, 2007). Unfortunately, STS is often unacknowledged or dismissed as an occupational hazard.

B. Barriers to Mental Health Treatment

Our research finds that provision of and access to mental health services for DSS caseworkers is inconsistent, limited, expensive, and often insufficient at the county level. High caseloads, understaffed offices, and strained budgets inhibit county agencies, especially those in poor or rural areas of the state, from providing comprehensive mental health care and support for their employees.

There is a significant disconnect between the state and county offices in terms of mental health provision and support for caseworkers. The North Carolina State Division of Social Services provides its staff with comprehensive mental health coverage through a state-level Employee Assistance Program (EAP). However, no uniform, statewide system is in place for county employees. Instead, North Carolina’s 100 counties independently manage resources and determine benefits, particularly mental health services, or the provision of an EAP.

DSS caseworker responsibilities are similar to those of first responders, including fire fighters, police and emergency medical personnel. DSS caseworkers are routinely exposed to traumatic events, and thus, face increased risk of suffering secondary traumatic stress and other mental health problems. However, unlike first responders, child welfare professionals maintain ongoing relationships with children and families, which can foster a stronger connection between the child and the

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6 STS includes the same symptoms of Post Traumatic Stress Disorder (PTSD), such as re-experiencing the trauma, increased arousal, and/or avoidance, but differs in that the trauma is indirect or secondary. (Sprang, Craig, & Clark, 2011)

7 A study conducted by Emily Douglas from Bridgewater State University, found that only 44.6% of professionals surveyed reported that their agency offered them formal mental health support. Respondents also stated that supervisors (57.5%) were more likely to be offered mental health support than front-line workers (35%) (p<0.05). From those who were offered counseling 57.8% accepted the help, and the majority who took counseling declared it as helpful (91.7%) (Douglas, 2013).

8 Employee Assistance Programs (EAP) provide services designed to help employees, managers, and organizations meet life challenges and remain healthy, engaged, and productive. They provide short-term counseling and referral for issues that are having an impact on employee’s ability to work. They will either address employee’s concerns during counseling sessions, or they will refer employee on to appropriate community resources, counselors, and other supports. (Department of Homeland Security)
professional. In North Carolina, access to professional mental health treatment and support groups is more common for other first responder agencies than for DSS caseworkers (Baldwin, 2013).

The same barriers exist for GAL volunteers. They receive no support or access to mental health services, even though GAL supervisors are provided with EAP benefits (Bizzell, 2013). GAL volunteers who experience a child fatality have no formal support system to fall back on though they experience the same trauma as DSS caseworkers. Facing a traumatic or stressful incident with no help or assistance can lead to turnover. As one GAL professional described, "sometimes the volunteers can't bounce back, it's hard to come back after a fatality" (Anonymous, 2013). For both DSS caseworkers and GAL volunteers, seeking mental health treatment is not only costly, stigmatizing, and time consuming, but could also mean job loss.

1. Mental Health Care Expenditures

The inconsistency of mental health coverage, and particularly of the EAP, is predominantly due to limited resources. Tight funding restraints inhibit the ability of DSS county agencies to fund benefit programs and services. Moreover, resources are not evenly distributed amongst counties. For instance, the 2012-2013 Alamance County budget was approximately $60,457,265, while the Mecklenburg County budget was approximately $413,580,213 (North Carolina Division of Social Services).

When mental health coverage is provided, continued treatment is expensive for the caseworker. Outpatient mental health service co-payments are costly, as high as $80 per session. Under the EAP, typical coverage includes the first five sessions free of charge (Baldwin, 2013). However, caseworkers incur the remaining costs for continued treatment, a significant deterrent for caseworkers to seek treatment (Survey, 2013). Furthermore, caseworkers pursuing external professional support are required to take sick leave or vacation days if an appointment occurs during working hours. Consequently, caseworkers usually choose to forgo mental health treatment to avoid using vacation or sick time.

2. Social Stigma and Confidentiality

In many smaller counties, DSS caseworkers may be reluctant to seek professional help due to confidentiality concerns (Survey, 2013) (see Appendix 2 for Data from Survey Results). With few providers and no internal psychological support, many rural counties experience high caseworker burnout and turnover rates (Sutton, 2013). Some DSS caseworkers reported fear that a counselor may be biased or break confidentiality. As the Swain County DSS director described,

“We do have the EAP but it has a lot of stigma tied to it. Our county is so small people still feel that if they go to a counselor recommended by Swain County the information won’t be kept confidential. I think that keeps a lot of employees from using the EAP, which I think is a good program. There’s a lot of room for conflict of interest in small counties. We really have to watch out
for that” (Sutton, 2013).

With few providers and no internal psychological support, Swain County caseworkers experience high burnout and turnover rates (Sutton, 2013). Furthermore, seeking mental health support could be used against the caseworker in court and may lead to unintended implications in a legal case (Brobst, 2013).

3. Lack of Peer Support

Most counties have no direct support systems to assist caseworkers, such as annual training in stress and trauma management, or peer support networks. Though coworkers may informally support each other, caseworkers typically work independently and no formal network exists to provide support during stressful or difficult circumstances. Our research concludes that peer support can prevent burnout and achieve higher retention rates of caseworkers (Chenot, 2009).

C. Supervision and Training

Many NC DSS caseworkers have limited professional experience when entering the field, and about half hold a degree in social work. Entry-level training for DSS caseworkers is limited and does not adequately prepare caseworkers and supervisors to identify and address signs of distress in colleagues. As one DSS supervisor described,

“After (a high profile child fatality case) we did a little bit of in-house monitoring and there were so many things going wrong systemically. They weren’t getting the right training. When a caseworker would resign, the remaining social workers would have to assume that worker’s caseload. This is an added stress on a social worker who already has a caseload at or above the State standard.” (Sutton, 2013).

Moreover, the GAL program offers minimal training with respect to STS and child fatalities.

Training that addresses STS is essential to prepare child welfare professionals for what could happen and how to manage a traumatic experience. The lack of experience and insufficient training lead caseworkers to struggle more when managing a child fatality or critical incident such as an accident, suicide, overdose, or other serious injury to a child. Consequently, supervision is central to help caseworkers succeed at their job and manage stress (Chenot, 2009).

While DSS agencies are focusing more attention on effective management, supervisors are usually not trained to recognize warning signs or symptoms of secondary traumatic stress. No standard procedure exists to help caseworkers

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9 A study developed from the NC Division of Social Services reported that 27% of 1,100 DSS respondents had less than two years of experience, and only half of the respondents received a degree in social work (Childs, 2011).
effectively manage caseloads when a fatality or critical incident occurs (Childs, 2011). A caseworker who experiences a child fatality faces the burden of the investigation process, court proceedings and may suffer from secondary traumatic stress. If a supervisor is unable to help the caseworker manage distress and additional responsibilities, the caseworker may burnout and leave their job.

D. Post-Fatality Challenges

1. Child Fatality Review Process
   After a child fatality, DSS agencies at the state and local level conduct an internal review that may re-traumatize caseworkers. According to a national study, 82.5% of DSS respondents reported that the bureaucratic process was a significant source of stress (Douglas, 2013). Respondents of a Canadian survey described the child fatality review process as a “horrendously stressful” time-consuming event of intense scrutiny (Regehr, Chau, Leslie, & Howe, 2002). Investigations can have a negative impact on morale, and employees can become “depressed and anxious, work becomes defensive and routinized, resignations are common and recruitment of new staff is difficult” (Regehr, 2002). Caseworkers’ professional integrity may be called into question, decreasing motivation, contributing to burnout and turnover. In Regehr’s interviews, one caseworker describes the investigation as “having the scabs torn off the wound which resulted from watching a child die.” (Regehr, 2002).

2. Media Attention
   Constant media coverage, particularly for high profile cases, creates additional pressure and stress for child welfare professionals. After a child fatality, local and state media outlets may blame caseworkers for the child’s death, and DSS agencies can face extreme scrutiny from reporters and community members. This negative media portrayal can be disheartening for caseworkers living and working in the same community. Additionally, headlines and stories remind caseworkers of the distressing event, re-traumatizing the caseworker and increasing secondary traumatic stress.

   County DSS agencies do not always have access to a media representative trained to speak on behalf of the department following a child fatality. Supervisors or caseworkers must instead respond directly to media requests. Additionally, DSS agencies do not systematically train caseworkers to interact with reporters. Consequently, caseworkers are unable to respond effectively to media and public inquiries, contributing to the negative portrayal of DSS. (Tulare County Health & Human Services Agency, 2006). Furthermore, press statements and interviews distract supervisors and caseworkers from executing their daily responsibilities, which adds to stress and burnout.
E. Turnover Rates in North Carolina

Data on 30 counties in Eastern North Carolina during the 1990’s indicate that the turnover rate among child welfare professionals ranged between 24.8% and 34.2% (North Carolina Division of Social Services, 1999). The average annual county turnover rate for child welfare professionals is 44% (UNC Charlotte Department of Social Work). While individual caseloads decreased from 30 cases per DSS caseworker in 1991 to 10 cases in 2006, the caseload is still significant (North Carolina Division of Social Services Administration, 2006). High turnover rates among child welfare professionals are expensive in terms of recruitment and training (Ellet, Ellis, Westbrook, & Dews, 2006). Turnover also results in loss of such intangible assets as caseworker expertise, established relationships with clients or partners, and institutional knowledge.

IV. Key Considerations

- Maximize existing financial resources to implement new programs with limited additional costs.
- Mitigate impact of secondary traumatic stress on caseworkers and volunteers.
- Reduce burnout and turnover rates among caseworkers and volunteers.

V. Recommendations

1. Invest in an imbedded mental health professional for DSS agencies.
2. Implement peer support networks within DSS agencies or through collaboration with local fire, police, and EMS department, and establish a similar but informal network for GAL volunteers.
3. Train DSS supervisors to recognize Secondary Traumatic Stress, provide support, and train county-level employees using the NCTSN Child Welfare Trauma Training Toolkit.
4. Create a standardized procedure for supervisors to manage and support DSS caseworkers and GAL volunteers following a child fatality.
5. Implement annual trainings on STS and child fatalities in DSS and GAL programs.
6. Develop a team of statewide or regional media liaisons for DSS agencies.
7. Establish an Employee Assistance Program, negotiate reduced co-payments, and contract with out-of-county mental health professionals.

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10 See Appendix 3 for commentary on recommendations.
VI. Recommendations and Analysis

1. Embedded Mental Health Professional

DSS county agencies should invest in an embedded mental health professional to enhance access to individual mental health support. The embedded mental health professional can provide training on secondary traumatic stress, self-care, and crisis management. After critical incidents or child fatalities, the mental health professional can also provide support to individual caseworkers or facilitate small group sessions.

To implement this recommendation, DSS agencies can hire a licensed mental health professional to work on-site to meet the psychological needs of DSS employees on a day-to-day basis and respond effectively to a crisis. This embedded mental health professional may be a shared resource between DSS and other county agencies, such as the police, fire department, or EMS, or across counties in rural areas. Costs can be shared across county lines between DSS departments or within a county between first responder agencies.

An embedded mental health professional can help DSS staff on site and prevent caseworkers from using personal or sick time when seeking outpatient treatment. Employing a full-time mental health professional will help reduce the already high turnover rates endemic to DSS caseworkers. An embedded mental health provider can address DSS caseworkers’ stress, psychological problems and burnout that may lead to turnover if unattended. Buncombe County estimates the cost of replacing a trained social worker is $43,000 (Baldwin, 2013). With high turnover rates, this expense is continuously incurred, and creates a major strain on the division’s budget. Additionally, the use of family medical leave and sick days increases during times of stress (Baldwin, 2013). Providing a mental health professional to support and treat caseworkers’ mental health concerns internally will save costs in the long run as well as maintain institutional knowledge and expertise.

Hiring an embedded mental health professional may seem like a large undertaking. However, the investment will reduce caseworkers’ mental health symptoms and prevent turnover. For further information, see Benefits of Embedded Mental Health Professionals in Appendix 4.

2. Peer Support Networks

DSS agencies should create peer support networks among DSS caseworkers and other first responders, such as the police or fire departments. Peer support networks are organized groups of trained employees who volunteer to mentor and support a peer who works in the same agency or a partner agency. These peer support volunteers will receive specialized training to recognize the signs of secondary traumatic stress and other emotional or behavioral distress. The volunteers will also receive training to help peers seek treatment or consultation from a mental health professional. Furthermore, when partnered with the embedded mental health professional, the peer support volunteers can be trained, managed,
supervised, and supported by a licensed mental health professional that can intervene if additional support is required.

Buncombe County developed a successful model of the peer support network that can serve as a model for other counties. The Buncombe County peer support network helps caseworkers and other first responders recognize and address stress, particularly after a critical incident, such as a child fatality. These trained peers offer immediate and skilled interventions and provide strategies to manage stress. Buncombe County uses the peer support network to develop a culture of resilience that results in improved employee retention rates (Baldwin, 2013). Interviews with human services workers who left their positions opined that a workplace lacking caring, supportive peers is a major contributor to turnover (Nissly, Barak, & Levin, 2005).

For further information on implementing a peer support network, see Appendix 5 including Four Purposes of a First Responder Peer Support Network, Factors Promoted by a Peer Support Network, and Six Essential Qualities of an Effective Peer Supporter.

We recommend a similar smaller scale model of the peer support network for the GAL program. Supervisors in the GAL office should organize groups of GAL volunteers for informal peer support, networking, and camaraderie. These groups would offer reflective discussion and emotional support. We recommend that a senior experienced GAL volunteer be trained to facilitate these peer support groups in a specific county or regional area. These peer support groups will provide a natural and consistent source of support to GAL volunteers, particularly in the case of a child fatality or critical incident. The Office of the Guardian ad Litem could also create a directory of GAL volunteers who have experienced a child fatality and are willing to provide support for other volunteers throughout the state on a case-by-case basis.

3. Increased Training and Supervisor Support through NCTSN Child Welfare Trauma Training Toolkit

DSS agencies should increase awareness of trauma and the importance of self-care among caseworkers by implementing the National Child Traumatic Stress Network (NCTSN) Child Welfare Trauma Training Toolkit. Developed by child mental health and trauma experts in 2008, the Toolkit includes 12 hours of material on the effects of trauma on children, families, and professionals (NCTSN, 2013). This toolkit is currently being utilized across the United States, including nine counties in North Carolina.

The Toolkit trains supervisors and caseworkers to recognize and address secondary traumatic stress, burnout, and grief. Training for supervisors and administrators that improves support for front-line workers is imperative. As one caseworker noted, “Supervisors are the heart of everything. They empower their workers; they are the ones who make the system happen” (Hess, Kanak, & Atkins,
A well-trained, trauma informed supervisor or program administrator can lead through example, model self-care, and provide a professional environment and supervisory relationship that nurtures the caseworker.

For further recommendations including *Keystone Habits for Social Work Supervisors* and *Additional Advice for Program Administrators*, see Appendix 6.

A supervisor or program administrator can have a major impact on a caseworker’s behavior and professional outlook after a child fatality. As one caseworker who experienced a fatality described,

“Culture changes in the agency from top down. I feel like that (self-care) has to be modeled from the level and the agency, otherwise it won’t happen. I can see that the behavior modeled by supervisors trickles down to the workers and that’s where the change happens. A culture shift is going to take time, but it comes from the top down and that’s when they’ll stop seeing turnover and better outcomes” (Anonymous, 2013).

Comprehensive training from the Child Welfare Trauma Training Toolkit will provide supervisors with the skills to support caseworkers suffering from Secondary Traumatic Stress. Moreover, training will help supervisors acknowledge that STS is a common consequence when working with traumatized children, rather than a deficiency or incapability of the caseworker. The Toolkit also includes personal recommendations for DSS caseworkers to recognize, reduce, or prevent secondary traumatic stress. The module *Managing Professional and Personal Stress* may be particularly useful for DSS agencies invested in helping caseworkers improve self-care and awareness of secondary traumatic stress.

Currently, nine DSS county agencies throughout North Carolina receive professional guidance and training to implement the Child Welfare Trauma Training Toolkit through Project Broadcast. Preliminary reports indicate that this training is extremely effective in supporting DSS caseworkers, particularly those who experienced a child fatality. As one caseworker described, “I really like participating in Project Broadcast, it makes so much sense to me to talk about trauma - this is how it works” (Anonymous, 2013). The Toolkit, which is free, helps DSS caseworkers manage personal stress and improves general understanding about the effects of trauma.11

4. Standardized Procedure

Each county DSS agency and GAL program should establish a written procedure outlining the supervisory role following a critical incident. This procedure will include available mental health resources, a strategy to help a caseworker or volunteer complete regular assignments, and a plan for short and long-term follow-

up. Following a child fatality, supervisors are often unclear about how to respond to caseworker or volunteer needs. One caseworker reported that after a fatality occurred on her caseload, she was confused about her responsibilities to the police, the media inquiries, and the rest of her cases (Anonymous, 2013).

A standardized procedure can serve as a clear-cut guide that supervisors can use to help caseworkers following critical incidents. Caseworkers or volunteers may also be entitled and encouraged to take a break from assuming new cases. When a child fatality occurs, supervisors should “make sure to give the [caseworker] a short ‘time out’ from new cases and make a referral to EAP” (Douglas, 2013) (p. 68).

Requiring a written and standardized procedure that provides supervisors with guidelines to effectively manage caseworkers and volunteers will incur minimal costs at the county level. This written procedure will clearly define the role of supervisors in regards to providing mental support and ensure that caseworkers and volunteers receive routine care following a critical incident.

For additional recommendations on implementing a standardized procedure see Appendix 7, Standardized Procedure to Support a Caseworker/Volunteer Following a Child Fatality.

5. Mandatory Trainings

DSS agencies and the GAL program should require caseworkers and volunteers to attend annual trainings that address secondary traumatic stress, self-care, the impact of child fatalities, and the child fatality review process. Trainings should also advise DSS caseworkers and GAL volunteers regarding legal liability and protection under the law, their agency’s responsibilities, and insurance policies against criminal or civil action. While no amount of training can fully prepare a caseworker or volunteer for the tragedy of a child fatality, providing regular education about the effects of trauma can normalize the response.

Secondary Traumatic Stress and the effects of a child fatality may go unrecognized and untreated if agency supervisors and caseworkers lack sufficient training. While additional training will incur some cost, DSS agencies can incorporate STS training into the standard agency requirements already in place. The proposed training can occur during all-staff meetings, retreats, or more informally during small team meetings. Additionally, county DSS agencies can arrange pro-bono training from local trauma experts. A skilled mental health professional should provide the initial trainings on STS. Combined with the Child Welfare Trauma Training Toolkit, a well-trained supervisor, administrator, or embedded mental health professional can lead training sessions in the future, eliminating additional costs.

6. Media Liaison

The North Carolina State Division of Social Services should invest in a team of statewide or regional media liaisons. The media liaison team will travel to a county DSS office following a high profile child fatality or critical incident to assist the county
agency in all press relations. Liaisons will handle all media requests, interviews, and press releases concerning the department.

The state media liaison team should establish a statewide crisis communications plan as a guide to address the media following a child fatality. The plan will define basic media relations, such as how to provide accurate information while protecting caseworkers’ reputation, and include a standard press release statement to acknowledge the tragedy, express sympathy for the family, and discuss the investigation process (Annie E. Casey Foundation, 2001).

The expense of hiring a media liaison is a tradeoff that will relieve supervisors and administrators from time-consuming public relations responsibilities (Carmona, 2011). Employing a media liaison will help protect confidentiality, caseworker integrity, and the agency’s public image by providing accurate and balanced information. Moreover, the communications plan and standard reply will offer transparency and protection of DSS agencies and caseworkers.

7. Improved Access to Mental Health Support

DSS county agencies without Employee Assistance Programs (EAPs) should enhance access to individual mental health services by implementing an EAP, and that other counties may benefit by negotiating reduced co-payments, and contracting with mental health professionals as needed.

At minimum, provision of an EAP will grant all caseworkers adequate access to mental health support to treat daily job stressors as well as trauma associated with critical incidents. Requiring each county DSS agency to provide access to an EAP will incur start-up and continued costs. However, investing in an EAP will result in long-term savings in caseworker retention. The human resources department of each DSS county office can subscribe to the program. These costs can be shared across county lines or among other first responder agencies within the county, such as the police or fire departments. Providing access to an EAP will establish a clear process by which caseworkers receive treatment for Secondary Traumatic Stress.12

Negotiating reduced copayments with mental health professionals will provide affordable mental health support for DSS caseworkers. In Wilson County, the human resource department negotiated copayment reductions for a caseworker to receive treatment from a local provider at $25 per session instead of $50 (Stone, 2013). Wilson County’s example can apply to other counties where high co-payments present a barrier to mental health treatment.

If an agency cannot hire an embedded mental health professional and has limited access to a qualified local mental health professional, DSS agencies should

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12 In the last year the North Carolina Administrative Office of the Court approved funding for jurors in serious murder cases to receive EAP services. This sets a precedent that may be helpful for the Office of the Guardian ad Litem to advocate for EAP services for GAL volunteers involved with child fatalities or other traumatic events.
contract with out-of-county mental health professionals. Contracts can be on a case-by-case basis, saving the agency from committing to full-time expenditures. Contracting with out-of-county mental health professionals will also extend the network of providers for DSS agencies. In this instance, caseworkers can travel to the out-of-county sessions or utilize technology, such as phones or videoconference software, for virtual sessions. Cleveland County, for example, contracts with a mental health professional who volunteers to treat county DSS caseworkers (Survey, 2013).

VII. Conclusion

In summary, to address the impact of child fatalities and critical incidents on child welfare professionals, we recommend the following interventions for the North Carolina Division of Social Services and the Guardian ad Litem Program:

1. Invest in an imbedded mental health professional for DSS agencies.
2. Implement peer support networks within DSS agencies or through collaboration with local fire, police, and EMS department, and establish a similar but informal network for GAL volunteers.
3. Train DSS supervisors to recognize Secondary Traumatic Stress, provide support, and train county-level employees using the NCTSN Child Welfare Trauma Training Toolkit.
4. Create a standardized procedure for supervisors to manage and support DSS caseworkers and GAL volunteers following a child fatality.
5. Implement annual trainings on STS and child fatalities in DSS and GAL programs.
6. Develop a team of statewide or regional media liaisons for DSS agencies.
7. Establish an Employee Assistance Program, negotiate reduced co-payments, and contract with out-of-county mental health professionals.

These interventions will minimize cost, capitalize on shared resources, mitigate the impact of Secondary Traumatic Stress, and reduce caseworker and volunteer burnout and turnover.

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13 Responses from our survey reported that several county agencies are unable to access a mental health therapist within their community due to mistrust or confidentiality concerns.
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Appendix 1: Additional Data on Child Fatalities

Figure 1 shows fluctuation in the number of child abuse homicides by parent or caregiver from 2001 to 2011 (State Child Fatality Prevention Team). According to the data, North Carolina experienced a total of 322 child abuse homicides during this ten-year period. The total amount of child abuse homicides includes both DSS and non-DSS involved cases (State Child Fatality Prevention Team). The annual rate of child abuse homicides peaked in 2005 with 35 deaths and has since decreased.

![Figure 1: North Carolina Child Abuse Homicides from 2000-2011](image)

Figure 2 illustrates child abuse homicides by county (State Child Fatality Prevention Team). During this 10 year period, more than 30 counties reported no incidents of child abuse homicides. The color differentiation on the map represents the range of homicide numbers; the darker the color indicates higher counts of child abuse homicides. The map shows that child fatalities are more prevalent in certain counties. The majority of the lighter colors occur in more rural counties or counties with a smaller population, while the darker counties are urban. The results could reflect the effect of population size on the probability of incidence of child abuse homicides. Only nine counties encountered more than nine child abuse homicides, including Union, Durham, Buncombe, Onslow, Wake, Forsyth, Guilford, Cumberland, and Mecklenburg. The highest count of child abuse homicide occurred in Guilford, reporting a total of 14 fatalities, Cumberland, reporting 26 fatalities, and Mecklenburg, reporting 29 fatalities.
Figure 3 illustrates suspected classifications of deaths for DSS involved cases that met the criteria for review between 2006 and 2011. Approximately 47% of reviewed cases between 2006 and 2011 were classified as neglect suspected cases, 21% abuse suspected cases, and 3% were homicide suspected cases. Note that the category “other” includes accidental strangulation, illness, co-sleeping, car accidents, and Sudden Infant Death Syndrome (North Carolina Department of Health and Human Services).

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14 These cases were reported to DSS when the case was investigated for child abuse or neglect within 12 months of the child’s death.

15 These are Classifications of Deaths from “NC Department of Social Services Child Fatality Death Reviews.”
Appendix 2: Survey Results on Access to Mental Health Support by County

With support from Jeff Olson of the NC Department of Health and Human Services, we developed and disseminated an online survey for county social worker administrators (Sanford School of Public Policy Survey). The survey compiled information regarding access to mental health support in each DSS county agency. A total of 36 administrators, all from different counties, completed the survey. As Figure 1 illustrates, 22 respondents indicated that employees had access to an Employee Assistance Program (EAP), while 8 stated that they did not have access to an EAP, and 5 respondents did not know whether they had access to an EAP.

![Figure 1: Does your agency have an EAP for all employees?](image)

All 22 responding county agencies that subscribe to an EAP reported that employees were aware of having access to this program. At least 5 agencies' respondents indicated that the supervisors and/or Human Resources informed employees of the EAP. Moreover, Figure 2 illustrates the frequency to which employees in their counties use EAP services (for those 22 respondents who stated that their county provided an EAP). Of the total responses, 65% indicated that they believed employees use the program seldom, while 31% of respondents indicated employees used the program often, and 4% used it very often.
Only two of the responding county agencies (Guilford and Granville) reported employing an embedded mental health professional. Moreover, when asked whether mental health professionals operated in their counties, 20 reported their county has mental health professionals, 18 indicated no mental health professionals, and three counties did not know. Additionally, 19 counties reported that employees incurred additional costs when accessing EAP services, while 17 counties reported no additional costs. One respondent indicated that co-payment for counseling visits in the respondent’s county was $50.00 per visit with the EAP. Finally, of the respondents who offered additional suggestions on how to expand access to mental health, most asked for increasing access to mental health support and/or lower co-payments. One respondent stated a preference for employees to seek counseling during working hours without having to take leave.
Appendix 3: Recommendations and Further Considerations

The recommendations presented in this report are based on information obtained from qualitative interviews with DSS employees at the state and county level, the GAL program, attorneys, mental health professionals, and others involved with child welfare and child fatalities. We also conducted a small survey of DSS county offices to inquire about the level of mental health support and received responses from 36 counties. Additionally, our recommendations are informed by evidence from social science research and the data we collected on child fatalities and child welfare from North Carolina and other comparable states.

Furthermore, our recommendations pertain to changes that could be made on a state level in North Carolina. Most of our recommendations would be implemented at the county level at the Division of Social Services. We would advise anyone reading these recommendations, and seriously considering implementation, to first conduct a needs assessment to better understand what resources currently exist and utilized to reduce cost and increase efficiency. There may be creative and untapped resources available in some areas that could support all three of our recommendations and reduce cost.

Our recommendations encompass mental health and administrative supports as well as improved methods for training supervisors and caseworkers. The recommendations apply to DSS caseworkers and, where noted, the GAL program. We recognize North Carolina is a diverse state with varying needs and access to resources where each county DSS agency operates independently. What works for one county may not necessarily work in another. With that caveat in mind, we believe all counties, on at least some level, can implement some of our recommendations.
Appendix 4: Embedded Mental Health Professional

Adapted with permission from Why Embedded Behavioral Health Support for First Responders? by Dr. Sherry Baldwin, Embedded Behavioral Health, Buncombe County Health and Human Services/BCSO/EM.

Benefits of Embedded Mental Health Professionals

1. **Cost Effective.** One Behavioral Health/Trauma Specialist embedded in one-three “first responder” agencies is far less expensive than the cost of outsourcing for behavioral health services. In addition to the obvious cost, there is lost time for outside appointments, employee costs for co-pays, and the time lost in bringing outside professionals “up to speed” on the work stressors of each individual within a first responder culture.

2. **Peer-Driven Support Teams.** When employees volunteer to be trained as “peer supporters” within an agency, the volunteers make a significant investment in helping all employees be successful, positive and productive. One of the duties of the Behavioral Health Specialist (BHS) can be to organize, oversee and direct the agency teams to provide a first-line defense against cumulative stress. Peer-driven Critical Incident Stress Management (CISM) teams have been very successful in the NC and SC Highway Patrol as well as many other agencies that use the Mitchell Model of Critical Incident Stress Management. When peers are involved in running the interventions and are well trained about when to seek additional assistance; the confidence, trust and loyalty an individual develops for their agency is invaluable. We have only begun to document the long-term benefits of this approach in terms of saved careers, stress-related absenteeism, medical leave, increased productivity, etc.

3. **Cross-Training Support.** If Behavioral Health personnel are cross-trained in areas related to the agency function, many advantages emerge. Examples: DSS Social Work Supervisor, Kevin Turner (B. General US Army and Army Chaplain with a doctorate in divinity) returns to Buncombe County DSS with a wealth of knowledge in spiritual crisis counseling, PTSD in the military and peer support experience. His cross training will enhance effectiveness as he is embedded into the fabric of the agency after six years of military leave. These cross-training experiences allow the embedded BH person to be absorbed into the normal fabric of first responder agencies.

4. **On-Call Capacity.** With flexible scheduling options, the BHP can be “on-call” to respond to clients or agency needs. Already, this has proved to be an invaluable part of the embedded model with major tragedies such as a line-of-duty-death to smaller emergencies such as a client crisis during the evening hours.

5. **Networking Opportunities.** An embedded BHP has the opportunity to network with community professionals/agencies for client benefit. Some early collaborations include an emerging relationship with the Pisgah Institute, a new collaboration with
Blue Ridge Chiropractic for free chair massages and wellness classes, and a wellness graduate intern from Western Carolina University.

6. **Immediate Crisis Response.** Some crisis interventions are best offered within a set time-window. When an agency must contract with an outside source for these time-sensitive activities (such as a crisis debriefing), it is often very difficult to arrange the response between the provider and participants. An embedded BHP can do this easily and quickly since they already have the means to set up an appropriate location and notify people involved in any agency critical incident.

7. **Case Consultation.** It seems helpful to agency employees to have consultation on cases from someone who has “fresh eyes” but who can also be confidential about information discussed. One of the best examples of this comes during the Peer Review of the interviews conducted during Child Medical Examinations (CMEs) at Mission’s Children’s Center. Law enforcement, child advocates, social workers and other individuals who conduct forensic interviews all sit together to review a case each month. The resulting dialogue means greater understanding and cooperation, sharing of approaches and strategies, and networking/mutual aid opportunities. Case consultation strengthens ethical and professional behaviors while allowing many different professionals to develop mutual respect for everyone’s work.

8. **Trauma Team Structure.** Begun by the leaders in DSS to work on trauma-related issues, the structure of the current six-person team is already yielding positive results. The structure of a “trauma team” does several important things. First, it acknowledges the importance of trauma issues at the highest levels of the agency. Second, it manages both the details and “big picture thinking” of a progressive, innovative agency. Third, it provides a conduit for employees to have their needs and ideas heard at all levels of the agency. Finally, it develops the professional responsibility of the agency to share strategies and innovative ideas around the state and beyond.

9. **The Synergy of “Big Picture” Planning.** It is easy to feel trapped and limited by the day-to-day details of agency business. It is much harder to step back and see the “big picture” that comes from multi-agency planning. By embedding BH in three agencies, a synergy comes from sharing the thinking and costs of making joint improvements. The joint CISM training offered to 100 employees of the partner agencies is a fine example of this synergy. Emergency Management got the grant funding. Law Enforcement coordinated the registration/location/training team. DSS promoted the organization of the resulting peer support networking that will be the result of the first training efforts.

10. **Innovative Solutions.** Innovative solutions are the result of adopting some creative ways of doing business in today’s reality. We are thinking outside the box when we suspend some of the traditional agency methods to try embedding some services into a multi-layered, multi-agency plan for employee wellness and productivity.
Appendix 5: Peer Support Network Model

Adapted with permission from Position Statement for the Buncombe County Peer Response Network by Dr. Sherry Baldwin, Embedded Behavioral Health, Buncombe County Health and Human Services/BCSO/EM.

Four Purposes of A First Responder Peer Support Network

1) Recognize the critical incidents, and cumulative and acute stress inherent in the work of first responders.
2) Offer immediate, skilled intervention to first responders and their colleagues/families when there is a critical incident on their caseload or line-of-duty death/injury in the first responder community.
3) Provide wellness strategies, stress management, and pre-incident education for first responders, their colleagues, and families.
4) Develop a culture of resilience in the first responder community that will allow first responders to have long, productive and rewarding careers in their chosen fields.

The most effective persons to represent these four purposes in the workplace are those peers who have demonstrated in their work and personal behavior trustworthiness, concern for others, flexibility/adaptability, high standards of work performance, and ethics. These peers indicate their willingness to offer support to their colleagues on a volunteer basis and are interested in the "process" of developing resilience in the larger culture of their agency.

All members are dedicated to promoting the factors of resilience through:
1) Continuing education to improve skills and learning
2) Faithful use of Critical Incident Stress Management (CISM) activities and interventions (http://www.icisf.org/).
3) The modeling of the behaviors that are promoted by the network.

Factors Promoted by a Peer Support Network

Individual:
- Positive Coping.
- Positive Affect.
- Positive Thinking.
- Realism.
- Behavioral Control.

Family:
- Emotional Ties.
- Communication.
- Support.
- Closeness.
• Nurturing.

Agency:
• Positive Command/Leadership Climate.
• Teamwork.
• Reduced Stigma.
• Unit Cohesion.
• Role Modeling.

Community:
• Belongingness.
• Connectedness.
• Shared Values.

Six Essential Qualities of An Effective Peer Supporter

1. **RECOGNITION OF NEED:** Most important, the peer supporter recognizes the need for a peer-driven program to address the inherent stressors faced by law enforcement, social services and emergency responders. The unique stressors faced by “first responders” have not always been recognized by our society. What we know is that no one is immune to the stressors of life in personal and/or professional settings. While your skills as a responder are generally more advanced than the general public, the sheer amount of trauma, crises, and injury you see on a daily basis puts you at high risk for stress-related symptoms and conditions. Before assistance can be offered, there must be a recognition of need.

2. **SELFLESS PASSION TO SERVE:** Once the need is recognized, the peer supporter must have a selfless passion to serve their fellow responders. This passion is reflected by their willingness and commitment to make themselves available at any time a co-worker is in need of the services that the network provides. This means that you will make it a priority to reach out to assist a co-worker, regardless of the time it takes and without the expectation of compensation. You must also be willing to continue to strengthen your skills in recognizing the subtle signs and symptoms of stress/trauma and to address the issues that often go “unspoken” in the responder community. The selfless passion to serve comes from the heart of a person who wants to make a positive difference in the lives of their co-workers.

3. **COMPASSION AND EMPATHY.** According to Merriam Webster’s online dictionary, compassion is defined as “the sympathetic consciousness of others’ distress together with the desire to alleviate it.” Empathy is defined as “identification with and understanding of another’s situation, feelings, and motives.” The great advantage of peer-driven support is that the peer supporter performs the same/similar work of the person(s) they serve and are, therefore, better able to validate their feelings as normal and empathize with the peer’s experience. You already know persons in your organization who are the “go to” people for a listening ear; a “safe” venting of frustrations; or a non-judgmental,
empathetic response. These are the persons who offer possible solutions, ideas, or suggestions without taking over the role of “fixer” and making you feel helpless or weak.

4. **ADHERENCE TO CONFIDENTIALITY.** Nothing will ruin a peer program more quickly than leaking the confidential information discussed during a peer session or activity. The foundation of any peer support program is trust. Trust is earned and tested each time you interact with someone, and trust that is violated is not easily restored. Therefore, peer supporters must be trustworthy with the information they receive and honor the strict confidentiality rules set forth in the peer support model. There are also strict rules about the times confidentiality must be broken such as danger to self or others, elder/child abuse, and serious crimes.

5. **COMMITMENT TO TRAINING/EDUCATION:** Peer supporters must be willing to read and study on their own about stress management as well as take advantage of training opportunities, as possible. If you are committed to learning more, you will become an effective peer supporter. Trained, flexible peers who recognize that people are individuals with different needs will be able to provide effective assistance within our agencies.

6. **COMMITMENT TO SELF-CARE:** By the very nature of peer support work, peer supporters are vulnerable to increased stress and vicarious trauma themselves. Peers must be able to set an example by seeking help themselves when they feel stressed, overwhelmed or over-committed. There is a great power in being willing to “walk the talk” with your colleagues and co-workers. A major positive outcome of peer support is that people who receive (and give) services can have long, productive and happy careers in their chosen profession. The results of unresolved trauma and stress range from burnout to suicide, so peer supporters have a high standard to set for self-care.
Appendix 6: Supervisory Support

Adapted with permission from Dr. Sherry Baldwin, Embedded Behavioral Health, Buncombe County Health and Human Services/BCSO/EM.

Keystone Habits for Social Work Supervisors

1. Half of all supervision sessions are directed by the Social Worker who presents questions, concerns, accomplishments, successes and strengths.
2. Supervisors intentionally ask a version of this question in each supervisory session: “What can I do to help and support you?”
3. Supervisors ask in each supervisory session: “Tell me the three best outcomes from your work since our last meeting.”
4. Supervisors make one intentional reference to the personal/human social worker under their supervision. Examples: “How did you celebrate (recent holiday)?” “What nice thing (self-care) did you do for yourself since we last met?” “How is your…child…spouse…etc.?”
5. Supervisors ask: “Tell me one challenge you faced since our last meeting and how you resolved it.” “Would you like to discuss a challenge, concern, or issue as we talk together today?”
6. Supervisors ask in each supervisory session: “What resources do you need to do your job better/more effectively?”
7. Supervisors say in each supervisory session: “I want to communicate my expectations clearly. These are the expectations I have for you to meet by _____. The expectations from the agency are _____. Do you have any questions or concerns about expectations or timelines?”
8. Supervisors ask in each supervisory session: “Do you want to prioritize these expectations/tasks together or are you set to do that on your own?”

Additional Advice for Program Administrators

Adapted with permission from Building Trust and Resiliency: What Program Administrators Can Do by Dr. Sherry Baldwin, Embedded Behavioral Health, Buncombe County Health and Human Services/BCSO/EM.

Building trust, resiliency and a highly functional work environment is a daunting task in any agency. It is especially challenging in an organization with 1) numerous layers/levels of supervision, authority and role; 2) a poor history of open communication; 3) a public perception of “unwanted intrusiveness” into family matters by the Division of Social Services; and 4) a challenging, increasingly complex caseload that requires considerable knowledge and skills sets.

Given the challenges and responsibilities of Program Administrators (PAs), it is not surprising that Social Workers (SWs), several levels removed from PAs, do not easily develop a trusting relationship. Yet, without such a relationship, a PA is greatly handicapped by the lack of first-hand information that only the SW knows. So, how can trust (communication and, eventually, resiliency) be developed between PAs and SWs? The following are some evidence-based ways…
1. **INFORMAL “FACE TIME.”** We can more easily trust the people we know over the people with whom we do not spend any time. SWs only see PAs in formal settings such as meetings and trainings. Even “discussion-type meetings” have a formal, structured feel. A commitment to spending just 30 minutes a week outside the building with one of your staff one-on-one would build your reputation of being an open, trusted, hands-on leader.

2. **ACTIONS, NOT WORDS.** People do not listen to what we say until they SEE what we are going to do. SWs look carefully to see if you are trustworthy by watching what you do to follow up on verbal directives or promises.

3. **TRANSPARENT THINKING.** When possible, it is helpful to tell others what we are thinking, so their suspicion and paranoia are reduced. Statements like: “Here is what I have been thinking about this issue…,” “I would like for us to share our thinking about…,” “I want my thinking on this to be clear, so you can offer me feedback…,” are powerful ways to defuse anxious and upset SWs who are struggling to make sense of agency decisions, etc.

4. **LINKING.** There are endless ways to link thoughts and behaviors to the goals and standards that you are wishing to connect. Some examples are:
   - “If one of our goals is to provide seamless services to clients, we think it would be helpful to ______. How do you think that would work?”
   - “In trying to establish consistency, I am asking all social workers to complete ______. How would you view that decision?”
   - “I want our ‘big picture/long range goals’ to be reflected well in our daily activities. How do you think the new form/requirement of _____ relates to our overall goals?”

5. **IMPACT AWARENESS.** Ask how work decisions/changes will impact SWs beyond work. Even when you cannot change an impact, people appreciate that you can recognize and acknowledge the effect something has on their lives (child care, vacation, etc.).

6. **FUTURE-ORIENTED ACKNOWLEDGEMENT.** People tend to trust those leaders who believe that “we are all in this for the duration.” When you make future references that include the SW, you send a powerful message that you value their skills and expect them to be around for a long time. Simple statements send powerful messages like: “After you have finished your training in ______, I would like to hear your ideas about how we can implement ______. I will depend on your input as the agency moves into the effort to ______.”

7. **SHARED STRUGGLES.** You are a model of RESILIENCE for every SW under your leadership. You are viewed as more trustworthy if you can share your struggles to become resilient. Example: “It took me a long time to figure out how to juggle my priorities between work and home when I had small children.”
8. **A POSITIVE “STARTING STANCE.”** The attitude we start with has a lot to do with the eventual outcome of any difficult situation. The “grit-your-teeth-and-hold-your-breath-and accept-whatever-is-thrown-at-you” approach does not produce good results. Although it is hard not to become very cynical and discouraged, positive expectations build more trust and resiliency than the opposite approach. Example: “I get overwhelmed and discouraged sometimes, too, but, in the end, I have decided that I ‘own’ my attitude and I’m making it a positive one.”

9. **CHARACTER COUNTS.** Character counts for a lot, but only if we know what it is! If SWs cannot “see” your character in action (integrity, fairness, accountability, responsibility, etc.) they cannot admire and emulate your model. Character makes up much of your reputation as a leader and either “develops” or “divides” on the issue of trust.

10. **GRAB A SHOVEL.** When the mud gets thick and your SWs are shoveling, grab a shovel and help. Fall Festival…Marathon…Service Day…Appreciation Picnic… Pitch in! Humanness builds trustworthiness. Be the kind of leader that is not too distant from the work your SWs are struggling to do!
Appendix 7: Standardized Procedure to Support a Caseworker/Volunteer Following a Child Fatality

Considerations when developing an agency procedure:

1. What legal obligations does this employee/volunteer have following a child fatality? Do they need to meet with law enforcement? Do they need to provide any written documentation or statements?
2. Is the employee/volunteer’s documentation up to date?
3. Does the employee/volunteer fully understand how the agency/program and the law legally protect them? Do they have any questions? Make a referral to legal counsel if necessary.
4. Does the employee/volunteer understand that they can take sick or personal days off? How soon can these be scheduled? How can any barriers to taking time off be addressed?
5. Can co-workers or a supervisor share the employee/volunteer’s current responsibilities? Can the employee/volunteer take a break from further case assignment? For how long?
6. Does the employee/volunteer have access to a mental health professional for short or long-term counseling? Are there costs associated with this service? Can the agency negotiate to reduce this cost?
7. Are there other employees/volunteers who have had a similar experience that they can be referred to for support?