Secondary Traumatic Stress

Presenters: **Female Narrator**; **Tom Oates**, Child Welfare Information Gateway; **Jim Henry**, Children's Trauma Assessment Center; **Luther Lovell**, Michigan Department of Health and Human Services; **Andrea Fotsch**, Trauma Care Coordinator, Larimer (CO) County

Female Narrator [00:00:00]: This is the Child Welfare Information Gateway podcast. A place for those who care about strengthening families and protecting children. You'll hear about the innovations, emerging trends, and success stories across child welfare direct from those striving to make a difference. This is your place for new ideas and information to support your work to improve the lives of children, youth and families.

Tom Oates [00:00:33]: This episode of the Child Welfare Information Gateway podcast is one we hope you find interesting because it's about the child welfare professionals who spend their day serving children and families. Today, we're talking about dealing with the stress of working within child welfare, and how agencies are trying to assess and mitigate the impacts of that stress, referred to as Secondary Traumatic Stress.

Hello everyone, I'm Tom Oates with Information Gateway. We're going to share a conversation between three professionals who for the past few years have been working to address Secondary Traumatic Stress, including their efforts to recognize it, mitigate it, and create a more positive work environment. What they are learning is when child welfare professionals are able to reduce the impact of Secondary Traumatic Stress, they can dedicate more energy and have more positive attitudes toward their work, and this enhances the entire agency's ability to serve families and drive to more positive outcomes.
Today, we're going to hear from: Dr. Jim Henry, the co-founder and director of the Children's Trauma Assessment Center at Western Michigan University, where they've been developing trainings to increase trauma-informed care. During the last decade, Jim's team developed a secondary trauma training that focuses on understanding the impact of secondary trauma, grief and building resiliency.
Jim is joined by Andrea Fotsch, the Trauma Care Coordinator for Larimer County, Colorado. Andrea launched a secondary-traumatic stress training across her county a few years ago, which has now expanded across the State.
And Luther Lovell is also part of the conversation. Luther is a director with the Michigan Department of Health and Human Services, covering a few counties in Mid-Michigan. They've implemented some interesting initiatives that have improved both workplace culture and outcomes.
These three came together on the phone to share their experiences. There's a lot of good information and some great examples of actions that managers and supervisors can take into their workplace, or even for caseworkers to suggest to their leaders.
Once the conversation is done, we'll come back and give you a little more information. But for now – here on the Child Welfare Information Gateway podcast – Dr. Jim Henry, Andrea Fotsch, and Luther Lovell.

Jim Henry [00:02:50]: Greetings everybody, my name is Jim Henry and I'm the director of the Southwest Michigan Children's Trauma Assessment Center at Western Michigan University. We have a trauma center here that I direct and prior to that I spent 17 years in child protective services as a worker and supervisor. And in this process was very challenged by the now coined phrase secondary traumatic stress. And so part of our work here at the trauma center is recognizing and addressing secondary traumatic stress in several places across the country, but most importantly in Michigan and Colorado

where we have significant projects. So I'm going to pass it on to our two guests to introduce themselves, Luther why don't you start?

Luther Lovell [00:03:37]: Hi, thank you, my name is Luther Lovell, and I am the director for the Michigan Department of Health and Human Services for Lacoste and Annaco counties, two counties that are pretty rural in nature in mid-Michigan.

Jim Henry [00:03:50]: Andrea?

Andrea Fotsch [00:03:51]: Yes, Hi I'm Andrea, I'm the trauma care coordinator out in Larimer County, Colorado. We are a county, a mid-size county where child population is about 69,000 and we are encompass Fort Collins, Loveland, Estes Park area. And we are part of the children, youth, and families division which we offer about 140 staff.

Jim Henry [00:04:10]: Great, so we're very excited to share what have been I think significant developments in actually operationalizing and understanding of secondary traumatic stress so it is being utilized as a phenomenon to address within these two counties in very different ways. So, Luther I'm going to start with you, why don't you define how you all at your county and specifically you as director became interested in secondary traumatic stress. And in terms of looking at that, how that is contextualized in the larger effort that may be going on in the state of Michigan?

Luther Lovell [00:04:52]: Well, you know actually it was an interesting journey. In our endeavor to become a more trauma, have a more trauma-informed child welfare practice we came to learn quite quickly that if we truly wanted to make change for the traumatized children we were working with we needed to address the parent's trauma. And after all the parent is the one who we hold responsible for creating an environment that's more conducive to the child's healing and without their self-awareness of their own trauma they would significantly limited their ability to do so.
Taking that a step further, we started to notice that if we're expecting that of the parents, what are we expecting of our staff and what are we seeing in our staff? We started to notice that many of the behaviors from our own staff were manifestations of their own unrecognized and unresolved secondary trauma. At the time we had already kind of been on our own journey to study everything we could about how to create an optimum environment, culture and climate if you will, to best support staff in doing the work they do. And it was interesting, when we looked at the latest research into the brain science surrounding true engagement motivation of staff we noticed that in a number of the elements the experts indicated were necessary to cultivate an engagement play were identical to the elements research suggested were necessary to build resiliency in child welfare staff.

Jim Henry [00:05:55]: Great, when did you start this in terms of how long ago and where have you now journeyed to in being able to actually operationalize the idea, the concepts into the staff daily environment?

Luther Lovell [00:06:12]: You know our work in trauma in general started probably five years ago thanks to CTAC and yourself Dr. Henry. We, you know slowly, we kind of put the cart before the horse, we started working with trauma in children and families before working in the trauma area in our own workers. And we've realized that, that had we to do over again we would have redone that. We really started integrating the secondary trauma approach, the lens, in our management efforts within the last few years.

Jim Henry [00:06:41]: So Luther why don't you share the actual what you have all done with leadership and how that looks in your county?

Luther Lovell [00:06:51]: Okay, well you know first and foremost realize we had to make some part of our staff our top priority. I mean there's so many studies out there, Dr. Gleeson has a wonderful study that I won't go into but it says essentially that the higher, the better you treat your staff the higher culture and climate you have in your office the better long-term outcomes for the children and family served by your office. And we also know it improves retention, they have a better quality of life, your employees.
And so we started to look at those things that we could do that would tie in some of the latest research in managing people and secondary trauma and well the first thing we looked at was we have to value them as people first. We have to get to know them, we do one on ones that aren't just case consults because that's for the department. These are designed specifically to spend time with that employee once a week to further our relationship with them.

That relatability piece has been instrumental. How do you know what your staff is going through, if I need to assign a complaint of an injured baby and I don't know that my staff members niece just got horribly injured in a situation, I'm not being sensitive to her story and her situation and so I'm not going to get the best outcome in an investigation and I'm going to further provide opportunity for burnout for her. The other thing is we value their family, you know we have a rule now, staff have become so engrained with their phone being with them. Their email, even when they're not on call at night it's there because they want to know what, you know it's their ability to have a little control to know what they're walking into the next day. But what happens is managers would be working at night and emailing out something and even if it might not have been directly related to that staff member, they would read it, pick it up, they might be sitting watching a movie with their family and all of a sudden they're thinking about work again and we were just bringing them right back constantly. So we have a no email rule. We try and be as flexible as possible allowing them to work mobiliy from home when they can, having flex days, help them be able to have opportunities to unwind and take care of their family so that's not a worry. And then the other thing that I would just note, I only talk about these top three, is you know building an environment of emotional safety. We can't expect staff to be activating and using those higher functioning parts of the brain we speak about in trauma that are responsible for you know, tenacity, creativity, and all those things, if they're constantly engaged in a self-preservation survival mode. Whether that's physically or in most cases in an unhealthy office environment emotionally. So one of the things we instituted on top of that relationship building and trust is a no gossip rule. At first staff laughed at us a little bit thinking that's kind of silly but they liked it because they didn't think they were the ones gossiping, so they were like yeah, go get 'em. And over time it didn't take long at all they started to realize hey wait a minute that's me.
And we've seen an amazing 180 turnaround on this and staff now hold each other accountable for it, they hold new staff accountable. They love the safety it brings because it's also safe for them to fail. If they make a mistake they're not afraid to admit it, they're not afraid to address it because they know they're not being talked about. So those are just a few of the top things that we've been doing and it's really had a significant impact.

Jim Henry [00:10:06]: It sounds like Luther that one of the key concepts is this integration your office is secondary traumatic stress and organizational stress. And so how do we address both of those and certainly some of those practices that you were talking about as to the culture and climate of the office which then creates that emotional safety for staff to process their own secondary trauma. And I guess the question I would have and I think I'm aware of this is that a part of your effort has also been to

quote institutionalize secondary traumatic stress training upon, with all new hires. Is that correct and how do you do that if it is correct?

Luther Lovell [00:10:50]: That's correct so even when we're doing interviews, one of the things we do in our interviews is an emotional intelligence scale questionnaire because we want to know how relatable they are because frankly it's going to be very difficult for them to have any vulnerability whatsoever if they don't have the ability or the skillset to share their emotions and understand how their emotions impact others, and how they're impacted. The other thing we do is when we hire them during orientation we spend a fair amount of time on secondary trauma and we tell them you are going to hit a wall, trust us on this, and here's what it's going to look like and that it's okay. We tie them up with mentors who mentors are the most experienced and oftentimes the most respected staff in the office, they share that story with them right away. So that when it comes time and they do start to hit that wall or start to have those feelings I can't do this they have that in the back of their mind that's okay. That's okay, it's not uncommon.

Jim Henry [00:11:48]: Thanks. Could you just talk a little bit about the outcomes you've seen for the staff. I mean you've talked about certainly the no gossip and how staff feel differently but statistics and or just qualitative review of where staff are at now that you've been instituting this for at least two years and certainly over the last five trying to create a trauma informed system.

Luther Lovell [00:12:10]: Sure, well I will tell you, you know first of all concerning our staff our performance has went from five years ago being literally at the bottom of the barrel in the state to now we're consistently performing in the top percentile. We went from having very high turnover to almost none in the past three years, if you factor out positive turnover, promotions, someone had a baby and moved to be with grandma, we've had no one leave due to dissatisfaction or just because they couldn't handle it. Our staff are incredibly supportive of one another, devoted to this job but also devoted to kind of state wide systematic improvements. And probably the best way to answer that question is if you were to ask any of them about your job they wouldn't respond negatively, they like coming to work and they like what they're doing and they're doing it well. As far as actual statistics I can tell you that the marriage of secondary trauma support with staff as well as a focus on trauma with children and families and you throw in that some advanced engagements the MyTeam measure engagement practice…Has led us to a point where we are now you know three years later we have, our removals are down 50% over the last few years. You add to that we have a certain amount of time where ongoing cases are opened by an average of five months. Because staff are able to engage these, our families a lot quicker about their trauma and help them to acknowledge, identify, and respond appropriately to it. And that combination of closing cases earlier and less removals has left us today with almost 70% less children in care today over several years ago.

Jim Henry [00:13:56]: That's great, thanks Luther. I want to make one comment and would like to hear your comment on this, the Department of Health and Human Services has just come out with a new vision mission and better principles and the new mission, I'll just read it, child welfare professionals will demonstrate an unwavering commitment to engage and partner with families we serve to ensure safety, permanency, and wellbeing through a trauma informed approach.

And one of the key principles that I think is noteworthy because of the work that's certainly your office has lead throughout the state, the principle is child welfare professionals will be supported through identifying and addressing secondary traumatic stress, ongoing professional development, and mentoring to promote success and retention. So I know this has been a long haul in a sense Luther and

having now this in the actual state of Michigan which is a centralized system identified…Just some thoughts on that as to what's that like to have that now included in the process of the whole state?

Luther Lovell [00:15:06]: I'll just say that you know, I'm very proud of the efforts that this state has made and the advancement we're making because ultimately you know without that in the forefront anything we try and do programmatically to improve outcomes for children and families is going to fail because we will not have the sustainability, we will not have the workforce resources. They are the ones who are going to implement things and if we can't take care of them first and foremost, you know we're not going to see the improvements we need. And so again, Michigan has taken some great steps and I'm very proud to work for the department.

Jim Henry [00:15:37]: Thank you Luther. So we're going to move on to Andrea, and in a very different place, Colorado, and we, our trauma center CTAC has been fortunate to work with both states. And Andrea can you just speak for a second to remind everybody about the size of Larimer County and just one or two key demographic stats, go ahead.

Andrea Fotsch [00:16:00]: Yeah, so Colorado is a county run state, that gives us some flexibility for initiatives and trying different things. Our total population is about 316,000, that was back in 2013. Geographically we border Wyoming so to the west we have the mountains, to the east it's rural farm community and the middle is urban so Fort Collins, Loveland, Estes. And our division that has just children, youth, and families is about 140 staff and our director is Jim Drendel and we are a differential response county so we have two tracks to respond when we get a report we can do family assessment response or high risk assessment. We really center around family engagement, group supervision, safety organized practice and we've worked with Sue Lauraback, Frieda Parker [ph.], Phil [inaudible] with a large focus on decreasing congregate care and increasing kin support as well as serving children within their own homes.

Jim Henry [00:17:00]: Great, thanks. Could you talk about your own county's efforts, and certainly yours as one of the leaders in this in terms of becoming interested in secondary traumatic stress and kind of contextualize that in maybe a larger effort to become trauma informed.

Andrea Fotsch [00:17:17]: Right, okay. So as a case worker, secondary traumatic stress was always my passion and supporting other case workers and going to additional trainings to learn the impacts of secondary traumatic stress on myself, coworkers and organization and we started our trauma informed care project in June 2014 which included screening assessment and trauma services. This is also when I moved into the trauma care coordinator position which is coordinating the project and training and engaging the community and staff and providing education. We met Dr. Henry back in September 2014 when he came out and did trauma 101 and then he did a few trauma assessments for us like they do out at CTAC and kind of saw the differences between traditional mental health assessments and a trauma assessment which included neurodevelopmental tools, a multidisciplinary team as well as a psychosocial interview and recommendations that really centered around building child resilience.

And so we had these assessments and we thought well now what, how do we make sure we're providing those recommendations that are coming up with these assessments so we developed a health assessment coordination services which are wrap around services that work with multiple systems. Schools, foster parents, birth parents, course preservation. Providing psychoeducation and helping getting the case worker get the recommendations in place. And so our project in Larimer County is now spreading to six other counties in the state of Colorado. Which hold half the child population of

Colorado, so it's pretty exciting that they're seeing the impact that it's having on these kids and want to spread it to theirs. And in the midst of that we also want to make sure that we're addressing the secondary traumatic stress of our staff so we are running a program called resilience alliance.

Jim Henry [00:18:57]: And why don't you talk about what, resilience alliance is and certainly talk about then the implementation, how you've done that, how you've rolled that out.

Andrea Fotsch [00:19:05]: Sure, so traditionally for secondary traumatic stress what our agency did was offer debriefing groups with a therapist and very quickly those groups became very negative, we called them BMW, bitching, moaning, and whining sessions where people would just, it would turn about how bad the job is, how hard the job is. And then people would leave feeling worse off than when they came in. And also we would refer workers to AP or tell them to do self-care. So we found resilience alliance and we really liked that there was a structure and goals, it was very in line with what we were trying to do for our kids to do with our workers and building resilience.

Resilience alliance is a free curriculum developed by Claude Chemtob out of New York and it's supported by the NCTSN. It includes 12 modules with an additional 12 open modules for 24 total. It's co-facilitated by a mental health professional as well as a resilient agency worker and all levels of the agency are invited so we invite our supervisors, case workers, support staff, people who are answering the phones, administration. And it's focused on building resiliency in our staff in the areas of collaboration, emotional regulation, mastery, optimism. We do that through education and exercises in mindfulness. We also educate staff on secondary traumatic stress, the reactions, a survival mode, reactivity, and then the curriculum calls it us versus them so a lot of times secondary traumatic stress can put up those silos of intake versus ongoing or case workers versus admin and so what it's really talking about is that, is this just the reaction of secondary traumatic stress and how to break that down.

We did do a few changes to the manual, how the manual says to implement it. So the manual is really structured on focusing on teams and doing resilience alliance in teams. But because we wanted to break down the silos we made it voluntary for anyone who wants to sign up and then they can sign up for whichever group they want and that's really helped them get to know other areas of the agency and be able to have that relationship with other, other parts or other roles.

We also, the curriculum calls for once a week, we felt like that may be too overwhelming for staff so we moved it to every other week. And they are one hour groups. We have, we provide lunch and then also trauma training hours so as an agency we said that all staff have to have 20 hours minimum of trauma training so resilience for instance is one option for them to do that. Even though we made them voluntary, we had 60 out of 129 staff sign up so it really showed us and spoke volumes that people wanted this and people were interested in this. We initially rolled out with four groups of 15 people each and then about six months later there was such interest and excitement for this program that we started three more groups and actually our community mental health wanted to run a group too so I helped co-facilitate a group for our community mental health therapists.

At the end of the 24 modules there is an uproar from the staff saying we need this, don't take this from us, this is one way that we're able to stay grounded and be able to keep in this work. So we just, we decided that we're going to just continue the group and start over with the modules and have kind of an open enrollment period to include new staff so they can, so the resilient staff workers could share experiences and execute our experiences with the newer staff.

Jim Henry [00:22:43]: And from a quantitative and qualitative outcome, for staff can you share some results?

Andrea Fotsch [00:22:52]: Yeah, so what we've seen, one of the biggest things we've seen is a change in the agency culture. So one member said that down in the cubicle area with all the case workers used to be really negative and talking about how difficult the job is, and how difficult the work is and how they don't like this person or that person. Whereas now it's negativity is more noticed as that person rather than the norm so because it's voluntary we don't have all the staff signed up, there is one or two still Negative Nancys kind of down there. But it's most, more noticed that this person is really struggling with the job and having maybe a reactive day so it's also building empathy between the different levels and different teams and roles and functions. So we have an example of a BDM who is above our supervisors who attended and they were talking about getting a complaint from a family and the father was just screaming and yelling and really upset and he said that he could feel his own reactivity kind of coming up. And the heart racing and kind of getting tense. And so for case workers to hear that, that we're all kind of struggling with this at different levels and different ways or to hear from support staff that they're having their own reactions and maybe not a ton of training around social work but reading through these reports and having reaction to the secondary traumatic stress it really has built empathy across all the different roles in our agency. And also we've seen the recognition of reactivity, isolation and survival mode in themselves and their coworkers so when somebody is a little bit more reactive or starts isolating they can have more empathy or maybe reach out to that person and also noticing it in themselves. We developed a buddy system in our group so people who kind of live, or work next to each other, are able to check in with each other what they're working on for those two weeks. We always do a takeaway. Whether try to do a mindfulness exercise or an example of a buddy system one, one girl just wanted to leave her desk with her tiny bit of something she could do for self-care is she found she wasn't leaving her desk and then her buddy was wanting to make personal phone calls, she wasn't calling people back. So they would be checking in on each other and where they were at on their two little goals that they made for themselves. Another thing we've seen is our veteran workers offering support and tips and ideas for the newer workers. That's one of the biggest things that group members have said is that it creates a really nice structure but for a newer worker who's just starting to come in and hear from somebody who's been here ten years of ways they've been able to manage the job and the stress to start taking some of those tips and implementing them for themselves. We have a number of partner agencies also that are wanting to implement resilience alliance.

So community mental health, [inaudible] family services which a CPA turning point which is a residential agency that provides some in home services for us and Matthews House which provides transition and wrap around services also want to start their own groups after we started in Larimer. Some turnover statistics for the first 12 groups for people who were in the group we had a 5% turnover and people not in the group we had a 29% turnover rate. That's for the first twelve groups. For the full curriculum of 24 groups people who were in a group had a 16.6% turnover and people who were not in a group had a 37.7% turnover. And as we all know and Luther touched on is that group turnover is linked with more improved child welfare outcomes for permanency safety and wellbeing.

Jim Henry [00:26:27]: Very exciting Andrea, very exciting. Thank you. Any final thoughts as you reflect on all that you've done in Colorado to address secondary traumatic stress, organizational stress, that you as a leader in this take forward as to next steps?

Andrea Fotsch [00:26:44]: Yeah, well it's very exciting and I think also we've seen a lot of results for our children just in the, in the trauma informed care project to the case workers who have gone through this program have a better understanding of what's going on in the client's brains and bodies when they understand what's going on in themselves. So we do a lot of parallel process and examples in these groups. And then for the last 12 months we've had 94% of our children are remained home goals and

then our average return home is four months so kids who are placed our average returned home at four months. And then average daily number of children in foster care is 145. And we're also, and in this project with the seven counties we're looking at a larger evaluation of the whole trauma project using a multilayer child functioning measure called the TOP, treatment outcome package, developed by Dr. Krause and this will hopefully help report out on child functioning and changes over time. And so it's going to be hard to kind of say this program or this program really had an impact on our outcomes but more of the bigger trauma projects with resilience alliance in there and it's exciting too to see resilience alliance hopefully spread to the other six counties, we haven't gotten there yet but we're starting the initial meetings to do that.

Jim Henry [00:28:04]: Thanks Andrea. Luther any final thoughts?

Luther Lovell [00:28:05]: No I don't at this time thank you.

Jim Henry [00:28:09]: Alright, well it's been an honor to work with both of your agencies and specifically each of you as people who have been dedicated to the wellbeing of our children and certainly the safety of families. And so with that thank you for your tremendous efforts and leadership and passion to support our workers and ultimately to support the safety and wellbeing of our children. Thank you very much.

Andrea Fotsch [00:28:36]: Thank you.
Luther Lovell [00:28:36]: Thank you.

Tom Oates [00:28:39]: You can learn more about Jim Henry's group, CTAC, the Children's Trauma Assessment Center at Western Michigan University, visit their website at w-m-i-c-h-dot-edu-slash-traumacenter.

On the webpage for this podcast, we're going to put up some other resources about Secondary Traumatic Stress. Just go to child-welfare-dot-gov and search "podcasts".
We'll put up a link to an Information Gateway publication on Developing a Trauma Informed Child Welfare System, along with a direct link to the Trauma-Informed Practice web section. That web section has reports and research, information on screening and assessment, along with resources from agencies and organizations across the country including resources you can provide to caregivers and families.

As always, if you have any questions on finding information or resources to help you improve positive outcomes, reach out to Child Welfare Information Gateway at info-at-child-welfare-dot-gov, or check out Information Gateway for yourself at child-welfare-dot-gov. We're on Facebook and Twitter, just search Child Welfare Information Gateway.

Thanks so much again for being part of this community and listening. So for now, I'm Tom Oates. Have a great day, and we'll talk to you next time on the Child Welfare Information Gateway podcast.

Female Narrator [00:30:01]: Thanks for joining us for this edition of the Child Welfare Information Gateway Podcast. Child Welfare Information Gateway is available at childwelfare.gov and is a service of the Children's Bureau, U.S. Department of Health and Human Services, administration for children and families. The views and opinions expressed on this podcast do not necessarily reflect those of Information Gateway or the Children's Bureau.