VICARIOUS TRAUMA IN THE WORKPLACE

Mitigating the effects of Vicarious Trauma in Child Welfare Workers in Virginia's Department of Social Services to Improve Turnover Rates

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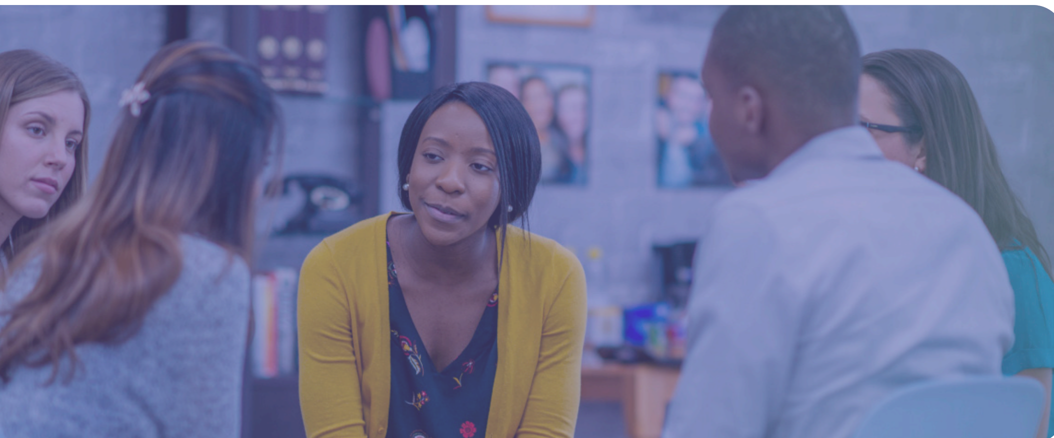

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DEDICATION

Much like everything I do, this project is dedicated to my mom and best friend, Ashlie Ellison. Thank you for pushing me to be the best version of myself every day - every great thing I have ever achieved is because of you. *Mommy and Kaleigh forever and ever and ever.*

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DISCLAIMER

The author conducted this study as part of the program of professional education at the Frank Batten School of Leadership and Public Policy, University of Virginia. This paper is submitted in partial fulfillment of the course requirements for the Master of Public Policy degree. The judgments and conclusions are solely those of the author, and are not necessarily endorsed by the Batten School, by the University of Virginia, or by any other agency.

TABLE OF CONTENTS

3 EXECUTIVE SUMMARY

4 INTRODUCTION
4 **PROBLEM STATEMENT**
4 **CLIENT OVERVIEW**

5 BACKGROUND
5 OPERATIONALIZING VICARIOUS TRAUMA
6 DEFINING THE CHILD WELFARE SYSTEM
6 HIGH TURNOVER IN THE CHILD WELFARE SYSTEM
7 HIGH TURNOVER EQUITY CONCERNS
7 CONSEQUENCES OF HIGH TURNOVER

8 CURRENT PRACTICES IN VIRGINIA

9 ALTERNATIVES
9 PEER SUPPORT MODEL
10 COMMUNITY RESILIENCY MODEL
10 CRITICAL INCIDENT STRESS DEBRIEFING MODEL

11 EVALUATIVE CRITERIA

12 PEER SUPPORT MODEL

13 COMMUNITY RESILIENCY MODEL

15 CRITICAL INCIDENT STRESS DEBRIEFING MODEL

16 OUTCOME MATRIX
RECOMMENDATION

17 IMPLEMENTATION
17 COMMUNITY RESILIENCY MODEL IMPLEMENTATION
17 PEER SUPPORT MODEL IMPLEMENTATION

18 CONCLUSION

19 REFERENCES

22 APPENDIX

EXECUTIVE SUMMARY

In Virginia, too few social service workers receive the support services they need to remain in the workforce after experiencing vicarious trauma. Vicarious traumatization is a "negative reaction to trauma exposure and includes a range of psychosocial symptoms. Vicarious trauma occurs when a person is exposed to the trauma of another person. As a result, the person's worldview may shift, and they may experience symptoms that can negatively impact their life and their work" (Office for Victims of Crime).

According to the Virginia Department of Social Services (VDSS) the turnover rate for family services workers (2023) is 25% overall and 42% entry-level child welfare workers respectively. However, these numbers are even higher in the state's rural areas (VDSS, 2023). This turnover rate is well above the 10-12% healthy and optimal rate agreed upon by researchers. This number has only risen since the COVID-19 pandemic revealed further cracks in the child welfare system (Gilbreath, 2022). According to the Child Welfare League of America, children with one caseworker achieve permanency in 74.5% of cases. However, this number drops to 17.5% for children with two caseworkers, proving how detrimental high turnover rates are for children in the welfare system (Child Welfare League of America, 2022).

This report looks into mitigation strategies that support retention among caseworkers in the state of Virginia that can be implemented by the Office of Trauma and Resilience Policy (OTRP) at the VDSS. It first outlines what the child welfare system looks like and the causes of turnover separate from trauma. It also looks into mitigation practices already in place in Virginia, which help to determine three alternatives for decreasing turnover:

PEER SUPPORT MODEL: The creation of a confidential peer-counseling helpline and intervention program staffed by retired employees with extensive experience in the agency and knowledge of how to address the stressors of the job (Casey Family Programs, 2022)

COMMUNITY RESILIENCE MODEL (CRM): A model that prioritizes individual and community resiliency by teaching individuals to manage "stress, adversity, or trauma" (Crafter, 2023).

CRITICAL INCIDENT STRESS DEBRIEFING (CISD) MODEL: A homogeneous and supportive "crisis-focused discussion" of a traumatic event to normalize trauma responses (Mitchell & Everly, 2006).

After evaluating each of these alternatives based on effectiveness, cost, equitable reach, and administrative feasibility, I recommend a phased approach of both the Community Resiliency Model and the Peer Support Model. Implementing both of these models mitigates possible downsides of each and are the most effective in decreasing turnover. The final section of this report discusses the implementation process, including the potential for a CRM pilot program between the OTRP and the Trauma Resource Institute.

INTRODUCTION

"It's just like this vicious circle cycle that we're in. There's no time to process anything. And you're just expected to suck it up and go on to the next priority."

- VIRGINIA SOCIAL SERVICES WORKER

Vicarious traumatization is a "negative reaction to trauma exposure and includes a range of psychosocial symptoms. Vicarious trauma occurs when a person is exposed to the trauma of another person. As a result, the person's worldview may shift, and they may experience symptoms that can negatively impact their life and their work" (Office for Victims of Crime). Although this is a new term, it already has detrimental effects on social welfare workers across the country. In Virginia alone, a survey of social welfare workers found that 78% of respondents had personally experienced vicarious trauma (Mullins, 2024).

The following report looks into the links between vicarious trauma and high rates of turnover in Virginia. First, the background section defines the child welfare system, looks into the causes of turnover, and the consequences of turnover. It then looks into current mitigation practices in the state to determine policy alternatives going forward. These alternatives are then weighed against each other based on effectiveness, cost, equitable reach, and administrative feasibility. The report concludes with a final recommendation and how best to implement the models going forward.

PROBLEM STATEMENT

In Virginia, too few social service workers receive the support services they need to remain in the workforce after experiencing vicarious trauma.

According to VDSS the turnover rate for family services workers (2023) is 25% overall and 42% entry-level child welfare workers respectively (VDSS, 2023). However, these numbers are even higher in the state's rural areas (JLARC, 2018). This turnover rate is well above the 10-12% healthy and optimal rate agreed upon by the Annie E. Casey Foundation (2023). This number has only risen since the COVID-19 pandemic revealed further cracks in the child welfare system (Gilbreath, 2022). According to the Child Welfare League of America, children who have one caseworker achieve permanency in 74.5% of cases. However, this number drops to 17.5% for children with two caseworkers, proving how detrimental high turnover rates are for children in the welfare system (Child Welfare League of America, 2022.

CLIENT OVERVIEW

This project was commissioned by the Office of Trauma and Resilience Policy (OTRP) at the Virginia Department of Social Services (VDSS). Virginia's social services system is "state-supervised, locally administered," meaning VDSS' main role is to provide guidance and oversight to local governments in the state (VDSS, 2023). VDSS collaborates with 5 regions and 120 local offices across the state to assist in providing a wide array of services and benefits to over 2.2 million Virginians annually (VDSS, 2023). The core objective of Virginia's Department of Socials Services (DSS) programs is to support Virginia's most vulnerable citizens in finding sustainable solutions to the diverse challenges they encounter. These programs encompass various areas, including Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), Medicaid, Adoption, Child Care Assistance, Refugee Resettlement Services, and Child and Adult Protective Services (VDSS, 2023).

In April 2022, VDSS established the OTRP to transition into being a more trauma-informed agency (OTRP, 2023). This began as the Virginia HEALS initiative to increase community resilience among children and families who had experienced traumatization. However, it was expanded to include resilience in the workforce when the OTRP was established (OTRP, 2023).

One of the OTRP's main mission statements is to increase workforce resilience specifically in the face of trauma. So, this project directly relates to seeing that statement become a reality as this is the next step in a long line of the OTRP's resilience projects (OTRP, 2023).

This is also an important problem for VDSS to solve, as the issue of workforce resilience directly affects their ability to support the community. High turnover creates major administrative problems for VDSS, taking away time and money that could be spent on programs that match their ethos (Casey Family Programs, 2023). High turnover and vicarious trauma also have detrimental effects on the children and families served, which is discussed later in this report.

BACKGROUND

OPERATIONALIZING VICARIOUS TRAUMA

As the field of trauma develops, there are many terms used interchangeably across literature on the subject. In a survey of literature in the field, vicarious trauma or traumatization is often used interchangeably with secondary traumatic stress (STS), compassion fatigue, burnout, and post-traumatic stress disorder (PTSD) (Lamm & Smith, 2023). However, it is essential to conceptualize each of these conditions separately to gain a comprehensive understanding of the effects of vicarious trauma (Newell & MacNeil, 2010):

VICARIOUS TRAUMA: "Exposure to the trauma of others" (Molnar et al 2017); The "profound psychological effects" helping professionals may develop as the result of exposure to others' traumatic experiences (McCann and Pearlman 1990); "Vicarious traumatization is a negative reaction to trauma exposure and includes a range of psychosocial symptoms. Vicarious trauma occurs when a person is exposed to the trauma of another person. As a result, the person's worldview may shift, and they may experience symptoms that can negatively impact their life and their work" (Office for Victims of Crime).

SECONDARY TRAUMATIC STRESS (STS): "Constellation of symptoms that may run parallel to those of posttraumatic stress disorder" (Molnar et al 2017).

COMPASSION FATIGUE: "Fatigue, as we use it in this context, is the mental weariness resulting from exertion that is associated with attending to the emotional and physical pain of others… compassion fatigue is exhaustion resulting from compassion stress, the demands of being empathic and helpful to those who are suffering" (Figley and Ludick 2017).

POST-TRAUMATIC STRESS DISORDER (PTSD): "The DSM-V, the psychiatric manual that lays out diagnosis criteria, defines PTSD as "exposure to actual or threatened death, serious injury, or sexual violence," which could be either directly or indirectly experienced, is followed by an array of sustained symptoms (American Psychiatric Association). The "core features of PTSD are the persistence of intense, distressing, and fearfully avoided reactions to reminders of the triggering event, alteration of mood and cognition, a pervasive sense of imminent threat, disturbed sleep, and hypervigilance" (Shalev et al 2017).

BURNOUT: "Work-related syndrome characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment" (Sciepura and Linos 2022; Maslach et al 2001).

For the purposes of this report, it is most important to make a distinction between vicarious trauma and burnout. Vicarious traumatization is a "negative reaction to trauma exposure and includes a range of psychosocial symptoms. Vicarious trauma occurs when a person is exposed to the trauma of another person. As a result, the person's worldview may shift, and they may experience symptoms that can negatively impact their life and their work" (Office for Victims of Crime). Even those who don't provide direct services may experience vicarious trauma as a result of working with and/or hearing stories from those who do provide direct services.

On the other hand, burnout is marked by "emotional exhaustion, depersonalization, and reduced personal accomplishment" (Rubel, 2023). Professionals experiencing burnout may feel emotionally overextended, depleted, or doubtful of their abilities, but nothing as extreme as vicarious trauma victims (Rubel, 2023). There is also a wide breadth of literature on burnout, but very little peer-reviewed research exists on the subject of vicarious trauma. As a result, most of the work to combat this phenomenon is on state level through studies of programmatic effectiveness.

DEFINING THE CHILD WELFARE SYSTEM

The modern child welfare system was created as a result of the "Child Abuse Prevention and Treatment Act" (CAPTA) in 1974. This act sought to address the growing concern of child abuse and neglect in the foster care system. CAPTA provides federal funds in the form of a block grant for states to use as they see fit to support child welfare and welfare workers (Child Welfare Information Gateway, 2019). More specifically, these funds were meant to support states in "prevention, assessment, investigation, prosecution, and treatment" activities (Child Welfare Information Gateway, 2019). Since its creation, CAPTA has been amended and reauthorized a variety of times. Most recently, it was amended by the "Victims of Child Abuse Act Reauthorization Act of 2010" (Child Welfare Information Gateway, 2019).

Currently, the child welfare system is a complex web of services designed to promote the safety and well-being of children. The operation of the system primarily rests with the states, with federal support through the aforementioned funding and legislation (Child Welfare Information Gateway, 2020). These systems primarily function through child protective services (CPS) agencies, which receive reports on abuse and neglect, conduct investigations to determine the "validity of CPS reports," and provide services to enhance child safety through the use of child welfare workers (VDSS, 2023). Again, this is highly variable, as the scope of abuse and neglect varies by state, especially as each state has its own laws and definitions surrounding CPS' role in families (Child Welfare Information Gateway, 2020). In Virginia, abuse and neglect fall under four main categories: physical abuse, sexual abuse, emotional abuse, and neglect (Baker, 2017). The Virginia Administrative Code and VDSS go on to define what each of these categories looks like in detail and what constitutes action in each (VDSS, 2020).

Another variable factor in the child welfare system is how services are operated and delivered. There are three administrative methods: a centralized State administered method, a county method, and a hybrid method (Child Welfare Information Gateway, 2018).

The majority of States operate under a State-administered method, where all programs are housed and controlled by a state-level agency. Virginia, however, is a county-administered state, meaning programs are administered at the county level with supervision from a state agency. There are only two hybrid states, which are Nevada and Wisconsin. These states have some programs administered by the state and some by the counties (Stoltzfus, 2023).

IMAGE 1: VDSS REGIONS

One of the complexities of the child welfare system in Virginia is the diverse landscapes it serves. Due to the county-administered model that Virginia uses, each county has its unique challenges. The rural and urban divide in Virginia's child welfare system is stark, as problems are amplified for the rural portions of Virginia (Gillbreath, 2022). However, across the board Virginia falls below national averages in every category that marks a healthy and effective child welfare system. For example, 57% of children "age out of the system" meaning they never reunify with their parents or find a permanent home. The national average is 52% (Littlehales, 2023). Again, though, these numbers are higher and not as widely publicized in the rural areas of Virginia (Gillbreath, 2022).

HIGH TURNOVER IN THE CHILD WELFARE SYSTEM

Child welfare agencies are known to experience high rates of turnover. Before the pandemic, turnover rates ranged from 20% to 40%, with the national average hovering around 30% (Casey Family Programs, 2023). The pandemic has only exacerbated this problem, with turnover rates rising across the country (Casey Family Programs, 2023). According to a report by the Annie E. Casey Foundation, there are four main factors fueling staff turnover in child welfare agencies: stress, emotional exhaustion, job satisfaction, and the perception of the organization's commitment to employees.

PERSONAL REASONS FOR TURNOVER

First, stress is the most significant factor contributing to high turnover rates in the child welfare system. Child welfare work is inherently difficult, and frontline workers are often exposed to trauma and stress in their day-to-day work. High caseloads are one of the main culprits of turnover, leading to the most emotional exhaustion (Child Welfare Information Gateway, 2022). Another cause of high turnover rates is emotional exhaustion, which usually goes hand in hand with stress. According to a study at the University of Hawaii, workplace burnout (emotional exhaustion) is the most prominent contributing factor to high turnover in the child welfare system (Julien-Chinn, Katz, & Wall, 2023). Social workers experience burnout often due to the high-stress environments they work in on a day-to-day basis. The decisions they make directly impact the reunification of families, but despite this, workers are still expected to manage heavy caseloads for resource-poor agencies.

Another aspect of stress is moral distress, which is cited as a contributing factor to high turnover rates (Casey Family Programs, 2023). According to a study of moral distress among child welfare workers, over half of the caseworkers surveyed felt they could not take the correct ethical action due to internal and external constraints (He et al., 2021). Furthermore, over 40% of caseworkers felt that their job required them to

make decisions against their better judgment, furthering moral distress (He et al., 2021).

ORGANIZATIONAL REASONS FOR TURNOVER

Although stress and emotional exhaustion are the factors that will be analyzed in this report, they are not the only contributing factors. Job satisfaction and the perception of the organization's commitment to employees also contribute to high turnover rates. Like any other job, satisfaction with pay, promotions, and the nature of work contribute to low levels of turnover. However, the child welfare system is linked to low pay and unsustainable working conditions (Child Welfare League of America, 2022). So, many workers are not satisfied with their jobs, which contributes to high turnover rates. As stated previously, high caseloads and workloads also negatively affect caseworkers' ability to achieve goals and maintain balance. This contributes to the negative perception workers have regarding their organization's commitment to them (Child Welfare Information Gateway, 2022).

HIGH TURNOVER EQUITY CONCERNS

It is impossible to talk about the child welfare system without talking about the equity concerns within this broken system. This is especially true among the workers, as racial bias and discrimination impact diversity in the workforce, leading to lower job satisfaction (Zeitlin, 2023). According to a recent study, workers of color are 20% more likely to believe they receive fewer opportunities for advancement compared to their white counterparts (Zeitlin, 2023). This stagnation can lead to higher turnover rates for Black, Indigenous, and Other People of Color (BIPOC) workers, leading to a lack of diversity in the field (Casey Family Programs, 2023).

One of the worst consequences of this is caseworker bias, which leads to the overrepresentation of Black and American Indian children in the system (National Association of Social Workers, 2021).

CONSEQUENCES OF HIGH TURNOVER

The reason for the high turnover rate is a cyclical issue, as many exiting workers cite an increased caseload as a reason for leaving. However, the reason for high caseloads is high turnover (Social Work Policy Institute, 2010). So, if the child welfare system continues to have high turnover rates, the consequence would be higher caseloads and even higher turnover rates.

One of the most concerning and detrimental consequences of high turnover rates is the children and families meant to be served by this system. According to a variety of youth narratives, turnover happens frequently and is often abrupt and poorly managed (Curry, 2019). Children see this as a relationship loss as well, which can affect their well-being in complex ways.

Having the ability to form relationships is essential to childhood growth, development, and belonging (Baumeister & Leary, 1995). Children entering the child welfare system have already experienced loss, adding loss from those trying to help them is just adding salt to an already open wound. This results in a loss of trust and possible behavioral issues throughout the child's life (Curry, 2019). Turnover can also affect permanency, which is when a child leaves the foster care system to live with a permanent family (VDSS, 2021). According to the Child Welfare League of America (2022), children with one caseworker achieve permanency in 74.5% of cases. But, this number drops to 17.5% for children with two caseworkers.

> "If you're going to be with this client, give the client some time, or if it's a young client, if you can't be with this client for some years, don't do it. That really affects them."
>
> - CURRY, 2019

Finally, high turnover rates are also harmful to the bottom line of child welfare systems. As stated previously, for every caseworker who leaves the workforce at the county level, it can cost state agencies about 70-200% of the exiting employee's annual salary (TexProtects, 2017). This means every dollar spent to combat Virginia's increasingly high turnover rate is money not spent on the actual services provided by DSS. So, the more turnover there is, the more money Virginia is wasting on avoidable hiring costs.

CURRENT PRACTICES IN VIRGINIA

As stated, this report is part of a larger study on Vicarious Trauma in the Human Services Workforce to guide VDSS policy and practice around workforce support. After the first phase of this study, when the focus groups concluded, the OTRP determined there was a need for more data on Virginia's caseworkers. As a result, we conducted a survey in December 2023 to learn more about the impact of vicarious trauma on the workforce, as well as coping strategies and agency-driven efforts for mitigating vicarious trauma. We sent this survey to around 5,000 frontline workers, supervisors in local departments, and Regional Practice Consultants due to their routine interaction with the system. This survey also sought to explore the impact of the COVID-19 pandemic on vicarious trauma and coping strategies for mitigating it.

The survey was taken by 20% of the social services population that it was sent to. There was also a clear even spread across demographic factors, like geography, race, and years in the industry. Furthermore, according to the data, over 74% of respondents had first-hand experience with vicarious trauma (Mullins, 2024). This shows how widespread this problem is among social services workers because regardless of where one is, they are experiencing trauma.

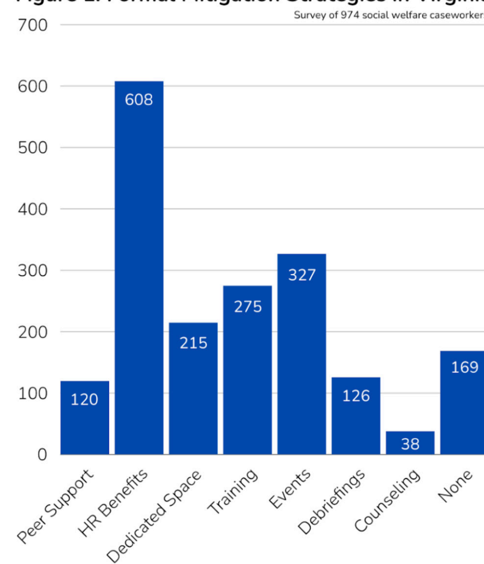
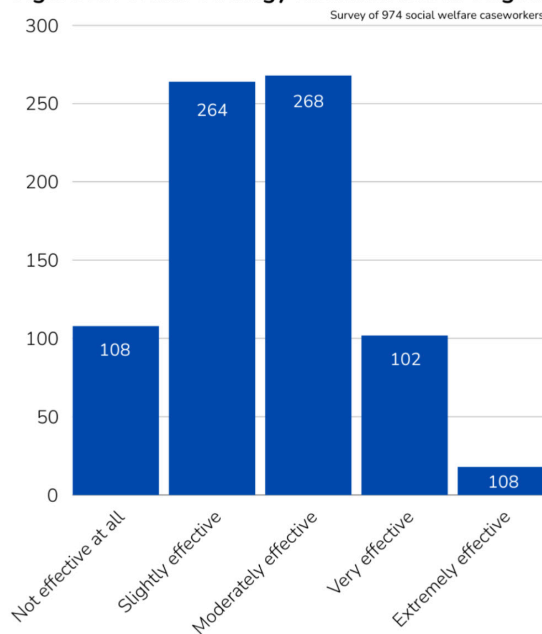


Figure 1: Formal Mitigation Strategies in Virginia

The survey was taken by 20% of the social services worker population that it was sent to. There was also a clear even spread across demographic factors, like geography, race, and years in the industry. Furthermore, according to the data, over 74% of respondents had first-hand experience with vicarious trauma (Mullins, 2024). This shows how widespread this problem is among social services workers because regardless of where one is, they are experiencing trauma.

Since this report focuses only on formal strategies of mitigation, the formal strategies of the survey will be the only variable analyzed. Other variables, including informal strategies,

personal strategies, and the impact of COVID-19 will be discussed in a separate report slated to come out in May 2024 (Mullins, 2024). Strategies within each section, including formal strategies, were chosen as a result of the focus group analysis done prior in the year. The most common answers, and thus the answers chosen for the survey were: peer support programs (e.g. warmline, support group), HR Benefits, dedicated space and tools to decompress, training related to vicarious trauma, team building events/retreats, debriefing critical incidents with a counselor/therapist, on-site access to a counselor/therapist, and none. This question was "check all that apply," so almost all entries were a mix of the different categories. As presented in Figure 1, most people are using their HR benefits as their primary mitigation strategy. Other than "none," this is also the strategy that is seen as a stand-alone mitigation method used most often (Mullins, 2024). Also, 17% of respondents stated that they could not even use their HR benefits as a strategy, showing how important an additional service is in mitigating this problem (Mullins, 2024).



We also asked respondents whether they saw their strategies as effective or not. This data is presented in Figure 2, which shows most respondents seeing their agency's formal mitigation strategies as "slightly effective" or "moderately effective." It is important to note, however, that this data is skewed by those who have been with their agencies for a long time or have not experienced vicarious trauma. When this data is viewed only by those with vicarious trauma, the strategies are less effective (Mullins, 2024). The data becomes even more skewed towards the left when looking only at caseworkers in their first few years at VDSS.

ALTERNATIVES

PEER SUPPORT MODEL

One of the most robust retention programs in the US is the New Jersey Department of Children and Families' support programs. New Jersey completed a total overhaul of their child welfare system in 2006, long before other states caught on to the detrimental effects of vicarious trauma. This six-pronged approach has been widely successful, especially as annual turnover rates continue to rise. Over the past 15 years, annual turnover rates have averaged 20-40% nationally. However, even through the pandemic, New Jersey has been able to keep its between 4-10%. The way they've been able to do this is through positive organizational culture/ peer support, concrete resources, opportunities for training, deliberate recruitment, community engagement, and transparent communication (Guzman et al., 2020). Virginia has been able to do many of these, including training, community engagement, and transparent communication, but it widely lacks the peer support that makes New Jersey so effective.

New Jersey's "Worker2Worker" program was created in 2013 to provide a confidential peer-counseling helpline staffed by retired employees with extensive experience in the agency and

knowledge of how to address the stressors of the job (Casey Family Programs, 2022). A psychologist leads the Worker2Worker team, which provides real-time mental health support and connects caseworkers to therapeutic support. Not only does this alleviate the worker from stressors, but this can also help prevent vicarious trauma in supervisors who are often the first people workers go to with traumatic information. At its core, Worker2Worker is designed to support staff with challenges such as "managing the workload, maintaining work-life balance, and dealing with transference, countertransference," and vicarious trauma (Casey Family Programs, 2022).

More specifically, the Worker2Worker program is a "reciprocal peer support" model, which is recognized as a best practice by the federal government (Munson, 2016). Reciprocal peer support is a culturally driven support model focused on four main objectives: connection and pure presence, information gathering and risk assessment, case management and goal setting, and resilience affirmation and praise (Castellano, 2012). It is important to note that although this is primarily labeled as a peer support helpline, peer support programs like Worker2Worker can participate in other outreach activities. These activities include resilience-building events, a network of referral/treatment services, and psychological first aid (Munson, 2016).

COMMUNITY RESILIENCY MODEL

Community engagement as a form of retention and resilience is a very new idea in the social welfare world. In most states, community engagement means building mutual respect between agencies and communities, as public perception is often a factor in caseworker job satisfaction (Casey Family Programs, 2022). This includes frequent stakeholder engagement in all new programs and regular forums for idea collaboration (Casey Family Programs, 2022).

However, a new type of community engagement has emerged in the social welfare world in the past few years called the Community Resiliency Model (CRM). CRM's main selling point is that it is biologically based, as it educates individuals on the nervous system and the body's reaction to stress. It results in more adaptive and educated thinking in distress (Crafter, 2023). It also emphasizes the importance of self-care and social support, which in turn can lead to more resilient and healthy communities (Crafter, 2023).

CRM is described as an "appropriate technology" model, which means that people can use the "technology" of this model to their benefit and make them independent of systems they have no control over (Turner, n.d.). As a result, the model prioritizes individual and community resiliency by teaching individuals to manage "stress, adversity, or trauma" (Crafter, 2023).

GOALS OF THE COMMUNITY RESLIENCY MODEL

- To learn simple biologically based skills, based upon current neuroscience, to help individuals get back into balance in body, mind, and spirit.
- To educate about common reactions resulting from individual or communal traumas/stresses such as poverty, racism, and family violence.
- To reduce common human reactions related to stressful/traumatic experiences.
- To shift perceptions that reactions are biological rather than mental weakness to reduce shame and increase hope.
- To encourage individuals to integrate wellness skills into their daily lives.

Courtesy of the Trauma Resource Institute, 2024

CRM was created in 2005 by Elaine Miller-Karas, Geneie Everett, and Laurie Leitch in response to the devastating psychological effects of Hurricane Katrina. They employ the "well-established" psychotherapy approach of "Somatic Experiencing," which uses body sensations to treat trauma symptoms (Grabbe et al., 2019). It is important to note that this is not traditional therapy, which usually does not work during times of disaster or heightened trauma. Instead, it teaches participants how to stabilize and focus on grounding (Grabbe et al., 2019). This is referred to as focusing on "felt sense" or the awareness of internal body sensations for emotional regulation (Grabbe et al., 2019).

CRITICAL INCIDENT STRESS DEBRIEFING MODEL

The "Critical Incident Stress Debriefing" (CISD) model is the most widely used model in the child welfare space. However, even though it is widely used, it is also widely criticized (Pulido & Lacina, 2010). CISD was developed in 1974 by Jeffery T. Mitchell and George Everly as a multicomponent system designed to "mitigate and prevent the development of disabling posttraumatic syndromes and stress disorders" (Pulido & Lacina, 2010).

To understand CISD, one must first understand what constitutes a "critical incident." A critical incident is defined as a "stressful event that is so consuming it overwhelms existing coping skills" (Kureczka, 1996; Malcolm, 2005). This is separate from "crisis response" which is the actual presentation of an individual who is overwhelmed or impaired by an event (Malcolm, 2005). CISD tries to differentiate between "critical" and "crisis" to best serve those using the model.

It is important to note that CISD is not a form of psychotherapy, but a homogeneous and supportive "crisis-focused discussion" of a traumatic event (Mitchell & Everly, 2006). Its main goal is to reduce distress and restore group cohesion, not necessarily to prevent future incidents. According to the creators of CISD, it should be seen as a "structured group story-telling process combined with practical information" to normalize trauma responses (Mitchell & Everly, 2006). Finally, CISD can only be used in the aftermath of a large-scale traumatic event, making it an intervention tool, not a prevention tool (Mitchell & Everly, 2006).

In practice, depending on the severity of the crisis, treatment consists of one session no more than two weeks after the traumatic event (Mitchell & Everly, 2006). These sessions follow a seven-phase group meeting structure designed to achieve closure after events (Mitchell & Everly, 2006). The first phase is "introduction," which is meant to get participants comfortable with each other and motivate active participation. The second phase is meant to introduce facts and give a brief overview of the traumatic event. Next, the debrief moves into the "thoughts" phase, where participants can dissect their feelings and thoughts on the event. The most important phase of CISD is phase four, which focuses on the impact and reactions of the event on the participants. Phase five focuses on a discussion from participants of the symptoms associated with exposure to traumatic events. The next phase is a "teaching phase," where the facilitator seeks to normalize symptoms discussed in the previous phase. Finally, participants enter phase seven, the "reentry phase," where they can ask questions and make final statements (Mitchell, 2008).

EVALUATIVE CRITERIA

As stated previously, the core objective of VDSS programs is to support Virginia's most vulnerable citizens in finding sustainable solutions to the diverse challenges they encounter. However, due to the costs and problems that occur as a result of high turnover, they are not able to achieve this goal. So, this project's main goal now is to decrease turnover and support resilience among Virginia caseworkers. To find the best way to do this, possible models will be evaluated against each other using the following evaluative criteria:

EFFICACY

Ultimately, this project's goal is to decrease workplace stressors that are directly correlated with attrition. So, for a program to be effective, it must decrease workplace strain. There is very little research regarding whether these programs decrease attrition directly, but there is research stating that less stress leads to less attrition. So, that will be how we are operationalizing this criterion. Overall, this criterion will look at the projected likelihood of each model improving retention rates among social services workers who have experienced vicarious trauma. A high-ranking alternative, in terms of this criterion, would have strong, rigorous, and non-contradictory evidence that supports the model.

COST

Since this is a persistent and current issue for DSS and the OTRP, this is a program that needs to be enacted quickly. As a result, the final recommendation must be conscious of costs and what is likely to be approved. So, the primary measure of cost in this report is the dollar amount of funds that would be necessary for DSS to implement each model. This includes salary information and data collected from other states regarding programming costs. These costs are understood as the annual operational costs of each program.

EQUITABLE REACH

As stated earlier in this report, there is quite a bit of inconsistency between who has access to services and who does not. This is due to the locally administered structure of Virginia's social services because the local agencies implement strategies differently. So, one of the main goals of this project is for all Virginia caseworkers to have access to trauma mitigation strategies. In this case, equitable reach will look at the projected likelihood of the alternative reaching the most people across the state as possible. A high-ranking model in terms of this criterion would have an equal spread and does not favor one area or group of people over another.

ADMINISTRATIVE FEASIBILITY

This project is important and highly requested by DSS's Division of Family Services, so they are eager for a program that is easy to implement quickly. They are also conscious of the high turnover, making this need for a fast turnaround even more important. Furthermore, many service programs are multi-stage, so understanding whether an alternative stage needs to be phased in over time is also a priority. Finally, some of these models have established vendors, so knowing whether we can tap into an already established network is a part of this criterion. Overall, this criterion looks into the likelihood or ease with which local DSS entities can implement the model successfully and effectively. A high-ranking model in terms of this criterion would be easy to implement.

PEER SUPPORT MODEL

> **"**So if they had, you know, peer support specialists or groups… and [didn't have to] worry about a supervisor or a leader being in there that might commandeer the conversation or make them feel as though they can[n't] express themselves. So it's just that conscious awareness and being able to have a safe space to speak.**"**
>
> - VIRGINIA SOCIAL SERVICES WORKER

EFFICACY

As this program is based on New Jersey's Worker2Worker, it is important to start with the efficacy of that program. Worker2Worker began as a research pilot program through a partnership between Rutgers University and the National Child Welfare Workforce Institute. During this period, there were over 25,440 contacts with New Jersey welfare workers with a vast majority of these contacts stating it was helpful or effective in alleviating stress. It also increased crisis response by 30% in the state, making response more efficient as well (Carré-Lee & Castellano, 2017). Since 2022, Worker2Worker has been able to reach over 85,000 child welfare workers (Casey Family Programs, 2022). Also, as a result of this program, New Jersey's retention rate is extremely high, with over 71% of their workforce spending more than 6 years in the agency (Carré-Lee & Castellano, 2017). As a result of the Worker2Worker program, New Jersey was able to decrease their turnover rate by ~1% every year, so Virginia should be able to experience a 1% decrease per year, as well (NJ DCF, 2015; NJ DCF, 2017; NJ DCF, 2018).

There is also quite extensive research on the subject of peer support, with an overwhelming majority stating that it helps reduce stress and increase job satisfaction (Orgambidez-Ramos & de Almeida, 2017; Rodwell et al., 2011). Peer support can also help to alleviate stress and improve mental health and well-being, self-esteem, work climate, and productivity (Kushnir & Milbauer 1994; Rousseau 2011). In a study of available literature on peer support and vicarious trauma, almost all studies found a negative relationship between the two. They also found that peer support does support an increase in retention, as well (Olaniyan, 2020). As a result of this strong and non contradictory evidence, the peer support program model has high efficacy.

COST

According to costing data provided by the OTRP, it would cost $409,800 a year to run a peer support line (Appendix A). This number includes the cost of a full-time program coordinator housed within the OTRP.

It is important to note that this number could fluctuate based on the number of peer support specialists employed, as this calculation is based on the assumption that there will be six specialists to start. This number comes from the Worker2Worker pilot program, as six specialists were what they deemed to be the best starting point based on the size of the workforce (Carré-Lee & Castellano, 2017).

EQUITABLE REACH

One of the difficult things about this program is that it is completely based on self-selection. A worker must self-select into the use of the peer support line and programs, so it may only be beneficial to those already relying on peer support or a part of organizations with transparent communication. According to a survey of social workers in Virginia, over 64% of respondents used HR Benefits as their primary vicarious trauma mitigation strategy (Mullins, 2024). However, around 10% of workers who

stated this did not know that therapy was available through their benefits (Mullins, 2024). So, for this to reach an equitable amount of workers, there must also be an equal spread of information.

ADMINISTRATIVE FEASIBILITY

> "I have a really close colleague. We work very well together… But we have also a good relationship outside of the office and I feel we kind of cling to each other. When things get hard we're able to vent to each other and she kind of grounds me. And sometimes when she's in a tailspin I kind of ground her. When I feel I'm losing control, she's able to kind of help me get back to myself."
>
> - VIRGINIA SOCIAL SERVICES WORKER

In Virginia, peer support is used informally in many local social services departments, but sparsely. According to a focus group of social services workers conducted by VDSS, participants spoke extensively about how important social support from colleagues was in mitigating the effects of vicarious trauma. Respondents from around the state talked about how peer relationships, or "support systems" provided them with community and a sense of belonging (Lamm & Smith, 2023).

However, when asked whether these were formally implemented using a survey, only 12% of respondents stated that peer support was a formal strategy used by their agency (Mullins, 2024). So, it looks as though many workers are using informal support systems, but do not have the same at work. As a result, by introducing peers who are trained to support, workers will feel more comfortable utilizing this strategy than others, as they are already using similar strategies informally with untrained peers (Lamm & Smith, 2023).

As for the actual administrative lift of getting the program off the ground, it may be difficult to hire as many specialists as the team would like. There is already a shortage of qualified social workers, so finding enough specialists willing to do this work should be difficult (Lin et al., 2016). However, since the OTRP is tapping into the retired workers, they may have more interest. So, since this program relies so heavily on those running the line, finding support workers is imperative to this being administratively feasible. As a result, this program has medium administrative feasibility, which could be high depending on the interest of retired social workers.

COMMUNITY RESILIENCY MODEL

> "And I really want to be more present to be able to debrief. But again, we don't have the time to do it. I feel like there's no break, there's no room to really set the time apart and debrief and have a process in place because just of the sheer amount. The pace that we're moving at doesn't allow it"
>
> - VIRGINIA SOCIAL SERVICES WORKER

EFFICACY

The Community Resiliency Model is one of the most evidence-based approaches to increasing resilience amongst trauma populations (Aréchiga et al., 2023). However, there is no established correlation between retention due to many of the studies of trauma effectiveness being within the last few years. Results from one study stated that CRM can significantly reduce

PTSD symptoms to a “productive zone” for all participants, while also maintaining resiliency 6 months after the intervention (Aréchiga et al., 2023). In healthcare workers specifically, the CRM model improved perceptions of team relations and increased workers’ capacity for traumatic events (Duva et al., 2022).

One of the ways that CRM is so effective is that it is biologically based, as it educates individuals on the nervous system and the body’s reaction to stress. It results in more adaptive and educated thinking in distress (Crafter, 2023). It also emphasizes the importance of self-care and social support, which in turn can lead to more resilient and healthy communities (Crafter, 2023). As a result of this evidence-based research, CRM received a high efficacy score, as it has the ability to retain workers. In one study, over 90% of those who went through CRM training stated that it improved mental well-being and they were likely to use it to mitigate secondary trauma (Grabe et al., 2020). Seeing as though burnout and vicarious trauma are the main reasons for turnover and this will mitigate the effects of those, it could very well decrease turnover closer to the healthy rate of 10% (Casey Family Programs, 2023). However, because of Virginia’s high turnover rate, this goal would likely be one that could be achieved further in the future Based on the available research on this topic, there should be a similar reduction to the peer support model of 1% each year (Duva et al., 2022).

COST

Since the implementation of this model would be a joint effort between the Trauma Resource Institute (TRI) and VDSS, the cost is much lower than it would be if VDSS were to implement this alone. For the duration of the one-year pilot program negotiated between VDSS and TRI, the estimated costs are $91,050 (Appendix B).

However, once the partnership ends, all costs of the program will fall to VDSS. According to Laurie Crawford, the director of the OTRP, the annual cost of the program will be $149,000 (Appendix C). This includes the cost of a program coordinator similar to that of the peer support programs. The main difference in cost between the pilot and the ongoing program is the compensation of trainers. Without the pilot, all trainers would be staffed within the OTRP (Appendix C).

EQUITABLE REACH

Of the three alternatives, CRM has the highest chances of equitable reach, depending on how the program is administered. Unlike the peer support programs, this is very structured and will not run into the problem of self-selection. According to the details of the pilot program carried out in other states, this is a training model, most often done in person with local agencies (Grabe et al., 2020). If this were the way it was to run in Virginia, it would not have a reach as equitable, as it would most likely be administered in areas near or around Richmond due to travel. This is especially true due to the pilot program only being one year. However, the reason it still has a high equitable reach is that it can be administered virtually. If it is done virtually, it can still have similar effects as those discussed in the efficacy section, while reaching a wider audience (Grabbe et al., 2023).

ADMINISTRATIVE FEASIBILITY

The Community Resiliency Model would be feasible to set up, but keeping it running is what earned it a medium in administrative feasibility. The vendor that runs CRM has expressed an interest in running a pilot program with Virginia, which lowers the administrative feasibility of the program exponentially (Crawford, 2024). During the pilot program’s run, all administrative tasks

would go to the vendor, instead of VDSS or the OTRP. Also, they would be providing the service at a lower cost, which is why the pricing of this program is much lower than the other two. If this were to be implemented long-term, the state would need to employ workers similar to the peer support line. As a result, it would run into the same problems as the peer support line, as there is no guarantee there will be workers able to do this work, as there is already a shortage of workers in the social work industry (Crawford, 2024). So, although this has a high administrative feasibility now, it may not be in the future, keeping it at a medium score.

CRITICAL INCIDENT STRESS DEBRIEFING MODEL

"You go through and, okay, what has been triggering you? What's been on your mind and then how do you feel about that? And then how did you react to that? So she tries to keep it on certain categories. So that way you're actually hitting the root of the problem. And we've had people cry, you know, breakdown and cry and not realize that things are affecting them."

- VIRGINIA SOCIAL SERVICES WORKER

EFFICACY

This model has been widely studied since its inception and has found that there is little consensus on the efficacy of the Critical Incident Stress Debriefing Model (Pulido & Lacina, 2010). Most of the literature explores the effects on hospital personnel, with minimal consensus on whether it works for social welfare workers (Elhart et al., 2019). Even so, within the literature, there is no consensus on the efficacy of CISD. Some researchers state that CISD reduces some symptoms of vicarious trauma, while others are either exacerbated or not served by the model (Pulido & Lacina, 2010). This means that the intervention is optimal in some cases but detrimental in others. As a result, efficacy for CISD is medium, as the evidence seems to favor it only on a case-by-case basis (Branson, 2019). However, one of the main reasons that CISD can be detrimental is if it is not carried out perfectly the effects of PTSD will worsen. Studies show that "poor adherence to the debriefing process, [and] lack of training and education" will actually exacerbate vicarious trauma symptoms (Elhart et al., 2019).

Finally, there is limited to no data that talks to the effects of CISD on rural communities, which make up a large portion of agencies in Virginia (Elhart et al., 2019). Also, CISD must be implemented immediately after a traumatic event for it to be effective. According to a survey of social workers in Virginia, those who stated that their agencies used the CISD model stated it was often used too late and was therefore ineffective (Mullins, 2024). Overall, for some cases of trauma, it can be very beneficial, which is why it is not at a low efficacy.

COST

This program has the highest costs at about 1.5 million dollars (Appendix C). This is because all debriefs must be performed by a licensed mental health professional, which is more expensive to VDSS than the other models which do not. Also, all debriefs must take place in person, meaning professionals must be either regional or travel from Richmond. Furthermore, debriefings must happen after every traumatic event for them to be effective, so the more events there are the more costly the program becomes (Mitchell, n.d.; Appendix D).

According to the OTRP costing information, costing for CISD is done on an event-by-event basis. So, if VDSS anticipates 60 events per year, there will be an estimated 20 hours per event (however, the more events, the less time spent per event). There is a cost of $3,080 per referral in administrative fees and $100 in assignment pay for the 3 trained crisis response volunteers per deployment. These numbers are based on what is used in comparable states with similar numbers of caseworkers (Appendix D).

EQUITABLE REACH

This alternative scored very low on equitable reach as it only works on a case-by-case basis. Since the problem is not that routine and can be unpredictable, it is hard to guarantee that the problem will always be the one that CISD supports. So, although this could be carried out anywhere in the state that needs it, there is a low likelihood that it will be effective everywhere due to the evidence presented in the efficacy section. Furthermore, there are traumatic events across the state every day and there is no way Virginia is able to deploy facilitators to all events. As a result, VDSS will need to pick which to facilitate and which to not, destroying equitable reach across the state. So, for those reasons, this alternative has very low equitable reach, despite its popularity.

ADMINISTRATIVE FEASIBILITY

As of last year, CISD was already being used on a small scale in Virginia due to a variety of especially traumatic events (Crawford, 2023). This was because the model is so popular in other states and that it is quick to implement (Malcolm et al., 2005). However, as Virginia is a locally administered social services state, this is only at the local level, not at the state level. Expanding this program to the state level would be extremely costly due to the cost of mental health facilitators and travel. It also has very little evidence to support it, making it not cost-effective in the long run. So, for that reason, this alternative received a score of medium in administrative feasibility.

RECOMMENDATION

Based on the analysis of each alternative, the best course of action would be a phased approach of the Community Resiliency Model and the Peer Support Line. There are too many tradeoffs for the Critical Incident Stress Debriefing model, as it is both costly and inequitable in its reach. Furthermore, there is very little consensus on its efficacy, making it not cost-effective. So, instead, VDSS should first implement the Community Resiliency Model as a pilot program to educate workers on the importance of self-care and social support, which is a cornerstone of the model (Crafter, 2023). CRM teaches workers how important it is to rely on one's community for support and resilience. It is also the highest-scoring alternative, as it is the least costly, most effective, and has the most equitable reach. Once this model is implemented and workers have had a chance to identify vicarious trauma and best practices for combating it, VDSS should implement the Peer Support Model. By implementing CRM first, workers can see the value of peer support and be more likely to self-select the use of a support line. This combats the possible downfall of a line, which is that only workers who currently use peer support as a mitigation strategy will use the line. Since more workers will be able to see how effective peer support is and know that it is an option, many of the downsides discussed can be mitigated (Mullins, 2024).

OUTCOMES MATRIX

	EFFICACY	COST	EQUITABLE REACH	ADMINISTRATIVE FEASIBILITY
PSP	High	$409,800	Medium	Medium
CRM	High	$99,050	High	Medium
CISD	Medium	$1.5m	Low	Medium

IMPLEMENTATION

As stated in the recommendations portion of this paper, the best course of action would be a phased approach of two alternatives. First, VDSS should proceed with the creation of a pilot program using the Community Resiliency Model. Then, once this program is off the ground, VDSS should begin to implement a Peer Support Line. These two alternatives complement each other and strengthen crisis response in a way they would not be able to do alone. Within this section is a discussion of how to best implement the two models effectively and efficiently.

COMMUNITY RESILIENCY MODEL IMPLEMENTATION

As the CRM was looking like the most effective option for family services, the OTRP had already begun talks with states that had begun to implement the program. As a result, VDSS was able to begin discussing a pilot program with the creators of the original model. This pilot will be funded by a partnership between VDSS and the Trauma Resource Institute. So, as the findings have matched our initial expectations, the OTRP are moving forward with discussions of implementation for this pilot program. This will make implementing the program much smoother due to it being a group effort.

RESILIENCY GEORGIA

The OTRP proposes to follow a similar implementation method as Georgia, which partnered with Resiliency Georgia as opposed to a university. Most of their costs came from free CRM training introductions and workshops over 18 months. They were able to train over 500 workers who served children and families in the state. As for the actual logistics, at the beginning, they had a primary trainer and a group of 2-3 certified trainers who rotate out, which gives them the ability to do as many training sessions as possible. However, now they have almost 100 certified trainers and a primary trainer in each region (Georgia, 2024).

According to Georgia, one of the main implementation problems is that it is very difficult to get the workforce to show up. People want in-person training, but those are often sparsely attended if not mandatory. But, otherwise, they have seen massive improvements and and have only had trouble due to their quick growth. To continue to keep the model running, Georgia

partners with local organizations that specialize in early childhood development and support. Because they utilize their network and do not keep the administration in-house, they have been able to keep costs relatively the same as when they started.

VIRGINIA PILOT PROGRAM

The main population proposed for the Community Resiliency training are those who were surveyed in the focus group and department-wide survey. This includes at least one local department of social services in the 5 regions, family services and benefits staff, and Child Protective Services/Adult Protective Services state hotline workers. Workshops will also be offered to all Directors, Family Services, and Benefits leadership in a region.

The pilot program will begin with a broad-based presentation to a large group of potential trainers. 10 of those potential trainers will be selected to participate in a 5-day “train-the-trainer” program. Those trainers will provide in-person and virtual 1.5 to 2-hour Community Resiliency training to the aforementioned population. This length was determined by discussions between the OTRP and Resiliency Georgia leadership. All training in this program will be completed within 6-8 months to give time for evaluation. Evaluation of the program will be conducted through VCU with VDSS support and resources from the Trauma Resource Institute. Finally, analysis of all data collected will occur within 3 months following the conclusion of training.

PEER SUPPORT MODEL IMPLEMENTATION

VDSS has also been in talks with the Worker2Worker program coordinators about best practices and how to implement this program in Virginia. Through these discussions, the OTRP learned that Virginia may be able to utilize a portion of the “Child Abuse Prevention Act” funding on workforce development (Crawford, 2024). So, the potential Peer Support Line may be implemented using existing funds. It will be staffed by social services retirees, volunteers, and trauma-trained specialists. The reason the OTRP wants to implement this specific model is that - by not using mental health professionals - the OTRP can cut costs and still get similar results (Carré-Lee & Castellano, 2017). To start, the OTRP will have 6 peer support specialists and a program coordinator, as that is what New Jersey recommends. Luckily, if the OTRP implements the Community Resiliency Model first, the program coordinator will be able to coordinate both programs. Currently, the peer support line in New Jersey is staffed from 8:30 am to 8:00 pm, so the OTRP will try to have a similar model (Carré-Lee & Castellano, 2017).

CONCLUSION

With both vicarious trauma and turnover on the rise in Virginia, it is more important than ever to mitigate the effects of both. Social workers provide an important service to Virginia’s most vulnerable population, so providing them with the support they need to complete this job is imperative. That is why VDSS must implement both the Community Resilience Model and the Peer Support Model, as this provides a comprehensive support system proven to increase retention for caseworkers. These also work in tandem, as they create a symbiotic relationship by removing the downfalls of each other. Overall, creating comprehensive mitigation strategies is the first step to creating a better and more efficient child welfare system in Virginia.

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APPENDIX A
PEER SUPPORT MODEL COSTING

Numbers provided directly by Laurie Crawford, director of the OTRP at VDSS

OTRP Staff

	Salary	Fringe	Temp Agency Fees	Totals
Program Coordinator	$85,000.00	$34,000.00		$119,000.00

Peer Support Line Staff

	Salary	Fringe	Temp Agency Fees	Totals
Peer Support Line Specialist ($30/hour @ 20 hours/week)	$31,200.00		$15,600.00	$46,800.00
Peer Support Line Specialist ($30/hour @ 20 hours/week)	$31,200.00		$15,600.00	$46,800.00
Peer Support Line Specialist ($30/hour @ 20 hours/week)	$31,200.00		$15,600.00	$46,800.00
Peer Support Line Specialist ($30/hour @ 20 hours/week)	$31,200.00		$15,600.00	$46,800.00
Peer Support Line Specialist ($30/hour @ 20 hours/week)	$31,200.00		$15,600.00	$46,800.00
Peer Support Line Specialist ($30/hour @ 20 hours/week)	$31,200.00		$15,600.00	$46,800.00

Peer Support Line Technology

	Salary	Fringe	Temp Agency Fees	Totals
Phone/Software				$10,000.00

TOTAL (Annually)		**$409,800**

APPENDIX B
COMMUNITY RESILIENCY MODEL PILOT COSTING

Numbers provided directly by Laurie Crawford, director of the OTRP at VDSS

Staff (Contracted)	
Pilot Coordination and Research	$50,000.00
Admin Fees (20% cap)	$10,000.00
Trainers (20 sessions @ $300/session)	$6,000.00
Travel	$2,000.00
CRM Teacher Training (10 Participants)	
TRI Training Team (Consultant Fees)	$14,500.00
Training Materials	$1,000.00
Material Use Fee (every 2 years)	$2,000.00
CE Credits (Optional)	$500.00
Continued Online Learning (30 months)	$1,200.00
Follow-Up Consultations (Monthly for first 3 months)	$900.00
Quarterly Consultations (3 quarters)	$900.00
Implementation Technical Assistance	
20 hours @ $300 hours	$6,000.00
Administrative Fees (TRI Services--15%)	$4,050.00
TOTAL	**$99,050.00**

APPENDIX C

PEER SUPPORT MODEL ONGOING COSTING

Numbers provided directly by Laurie Crawford, director of the OTRP at VDSS

Item	Cost
Staff	
Program Coordinator (P-14 or contract)	$80,000.00
(Staffing, scheduling, evaluation)	
Trainers (120 sessions @ $300/session)	$36,000.00
Travel	$10,000.00
CRM Teacher Training (10 new trainers/year)	
TRI Training Team (Consultant Fees)	$14,500.00
Training Materials	$1,000.00
Material Use Fee (every 2 years)	$1,000.00
CE Credits (Optional)	$500.00
Continued Online Learning (30 months)	$1,200.00
Follow-Up Consultations (Monthly for first 3 months)	$900.00
Quarterly Consultations (3 quarters)	$900.00
Administrative Fees (15%)	$3,000.00
TOTAL	**$149,000.00**

APPENDIX D

CRITICAL INCIDENT STRESS DEBRIEFING COSTING

Numbers provided directly by Laurie Crawford, director of the OTRP at VDSS

	Estimated 240 Events Yearly	Estimated 60 Events Yearly	Yearly Costs
Program Coordinator			$110,000
Mental Health Contracted Provider	10 hours estimated per event, $2,400/per referral - $557,000	20 hours estimated per event, $3,080/per referral - $124,800	$700,800
Crisis Response Volunteer Team	3 trained crisis response volunteers per deployment Assignment Pay ($100) x Number of Deployments (240) = $72,000	$100(3) x 60 deployments = $18,000	$90,000
Crisis Response and Peer Support		Coordinating Contractor, Onsite Response, and Training/Support Volunteers Salaries	$696,000

TOTAL (Annually) **$1,596,800**