

Staff Wellness & Retention Resources

Evidence-based approaches to increasing staff retention & capacity to carry out job responsibilities:

staff training about de-escalation and trauma-informed care

acknowledgment of staff secondary traumatic stress

increased supervision

staff processing after youth crises

enhanced staff safety

increased pay

Colton & Roberts, 2007; Kothari et al., 2019; Middleton & Potter, 2015; Smith et al., 2017; Strand & Dore, 2009

Staff Wellness & Retention Resources

www.nctsn.org → resources → all resources (can search by audience, trauma type, language, etc.)



NCTSN The National Child Traumatic Stress Network

Secondary Trauma and Child Welfare Staff: Guidance for Supervisors and Administrators

Introduction: Why address STS within child welfare

Child Welfare has the mission of promoting child safety, well-being, and permanency through the provision of child-focused, family-based practice. As part of their day-to-day work, child welfare staff interact with people who have experienced trauma, and frequently multiple traumas, over the course of years and often over the course of generations.

Secondary traumatic stress (STS) is the emotional distress that results when an individual hears about the firsthand trauma experiences of another person.¹ Given the nature of their work, child welfare staff are at very high risk of developing STS, and they can be at risk of experiencing trauma firsthand.² In addition, the trauma and secondary trauma experienced by their clients and staff can affect organizations and the organizational culture. If left unaddressed, STS can have a negative impact on the ability of individuals and organizations to help children and families.

Child welfare supervisors and administrators have the challenging task of developing and maintaining high-quality practice in a traumatogenic environment. This fact sheet provides information on how STS manifests itself in child welfare, the kinds of staff who are at risk for STS, and strategies for prevention of and intervention for STS.

How Individuals Experience STS

As secondary traumatic stress plays out on both the individual and organizational levels, supervisors and administrators should recognize its warning signs on both fronts.

On the individual level, symptoms can echo those of post-traumatic stress disorder (PTSD)—people can become hyper-alert, experience intrusive thoughts, avoid reminders of past clients, or feel numb or detached. Staff experiencing such symptoms may become short-tempered with clients or colleagues, sometimes in response to things that seem benign to others, or avoid answering calls from or asking detailed questions of new clients whose experiences may remind them of former clients' trauma stories. There are several STS assessment tools to help people better understand how they are affected by this aspect of their work and keep track of their experiences over time (see Box 1).

Box 1. Individual STS assessment tools:

- **PROQOL**
<http://www.proqol.org/>
- **Work STS Scale**
http://www.nctsn.org/resources/secondary-trauma-and-child-welfare-staff-guidance-supervisors-and-administrators/2014/07/Work_STS.pdf
- **PTSD**
http://www.nctsn.org/resources/secondary-trauma-and-child-welfare-staff-guidance-supervisors-and-administrators/2014/07/PTSD_invest_of_Events_Scale.html

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<https://www.nctsn.org/resources/secondary-trauma-and-child-welfare-staff-guidance-supervisors-and-administrators>

SECONDARY TRAUMATIC STRESS: UNDERSTANDING THE IMPACT ON PROFESSIONALS IN TRAUMA-EXPOSED WORKPLACES

NCTSN The National Child Traumatic Stress Network

<https://www.nctsn.org/resources/secondary-traumatic-stress-understanding-the-impact-on-professionals-in-trauma-exposed-workplaces>

NCTSN The National Child Traumatic Stress Network

Secondary Traumatic Stress Core Competencies for Trauma-Informed Support and Supervision: Cross-Disciplinary Version

*Original version can be found at <https://www.nctsn.org/resources/secondary-traumatic-stress-core-competencies-for-trauma-informed-support-and-supervision-cross-disciplinary-version>

Secondary traumatic stress-informed supervisors in any discipline will:

- 1 Know the signs, symptoms, and risk factors of STS and support options for team members.
- 2 Self-assess, monitor, and address their own STS.
- 3 Help team members safely share the emotional experience of working with people impacted by trauma.
- 4 Support the resilience of team members individually and collectively.

- **Secondary traumatic stress (STS)** is a stress response that may occur in an individual after learning about the traumatic experiences of another person through any form of communication (e.g., hearing, reading, observing). STS symptoms can range from mild to severe and generally parallel traumatic stress symptoms (e.g., avoidance, changes in thinking, feelings, and reactions; unwanted thoughts or nightmares).
- **Core Competencies** are overarching knowledge and skills that guide supervisors in providing secondary trauma-informed support and supervision. There is no assumption that supervisors will possess all of these competencies. Rather, this tool helps identify areas for further development and guides the user to resources that strengthen these competencies.
- **Supervision** also includes specific steps to implement the competencies.
- **Supervision** is not the right word for every setting. Read this document using the term that best fits with the structure of organizational support and guidance in your setting (i.e., supervisor/supervisee, department head/ team member, leadership team/ staff, mentor/mentee, manager/consultant, coach/administrator, peer-to-peer, etc.).
- **Supervisor**—Any leader who provides support to team members.
- **Team member**—Anyone working at the organization who receives support and guidance from a leader or peer.

Core Competencies for Secondary Trauma-Informed Supervision
www.nctsn.org

<https://www.nctsn.org/resources/secondary-traumatic-stress-core-competencies-for-trauma-informed-support-and-supervision-cross-disciplinary-version>

NCTSN The National Child Traumatic Stress Network **FACILITATOR'S GUIDE**

THINK TRAUMA

A Training for Working with Justice-Involved Youth

This resource is provided by the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services. The views, policies and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

<https://www.nctsn.org/resources/think-trauma-training-working-justice-involved-youth-2nd-edition>

Direct Care Staff Shortages and Adverse Youth Events in Illinois Child Welfare Residential Treatment During the COVID-19 Pandemic

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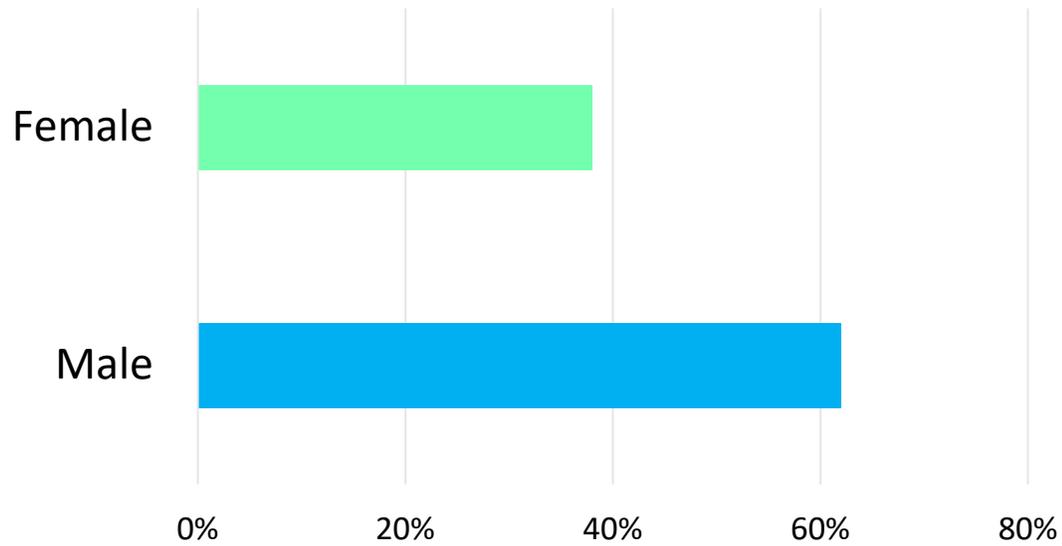
Neil Jordan, PhD ¹

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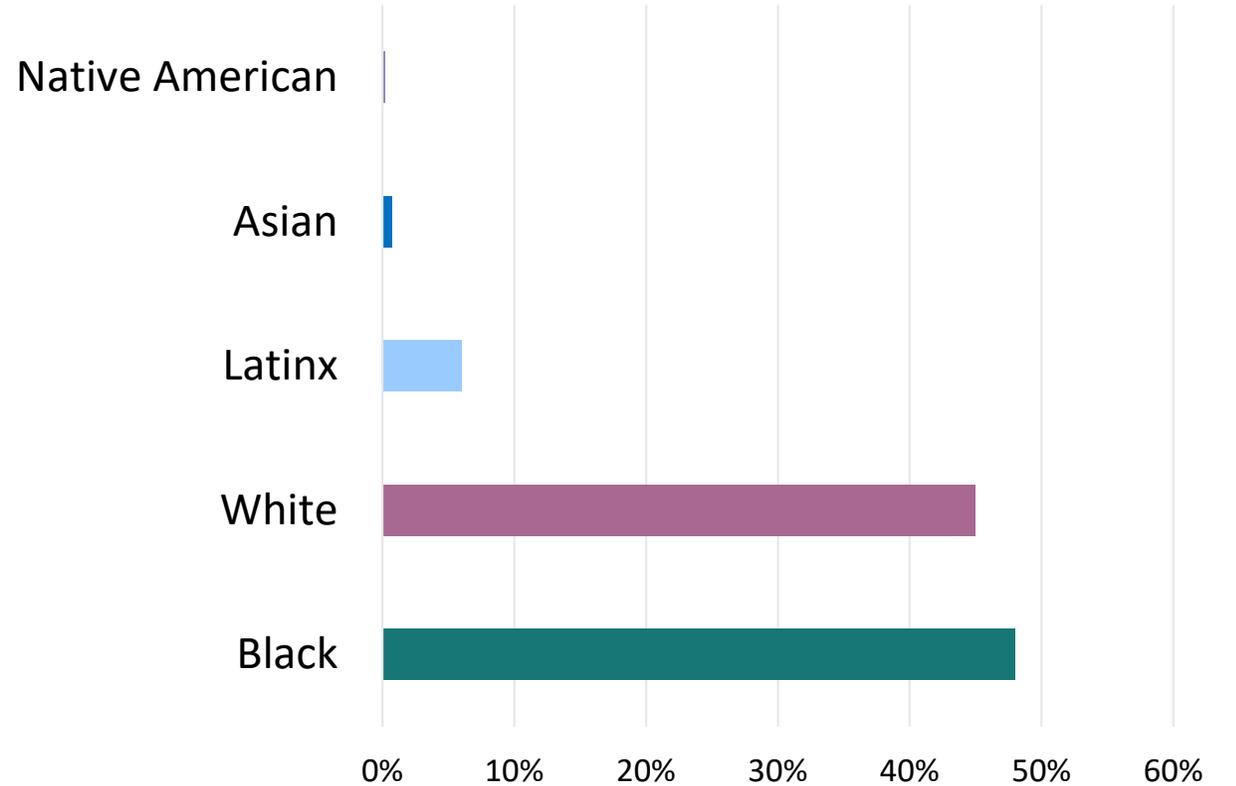
² Department of Psychology, The City College of New York

Analytical Cohort (N=1352)

Sex

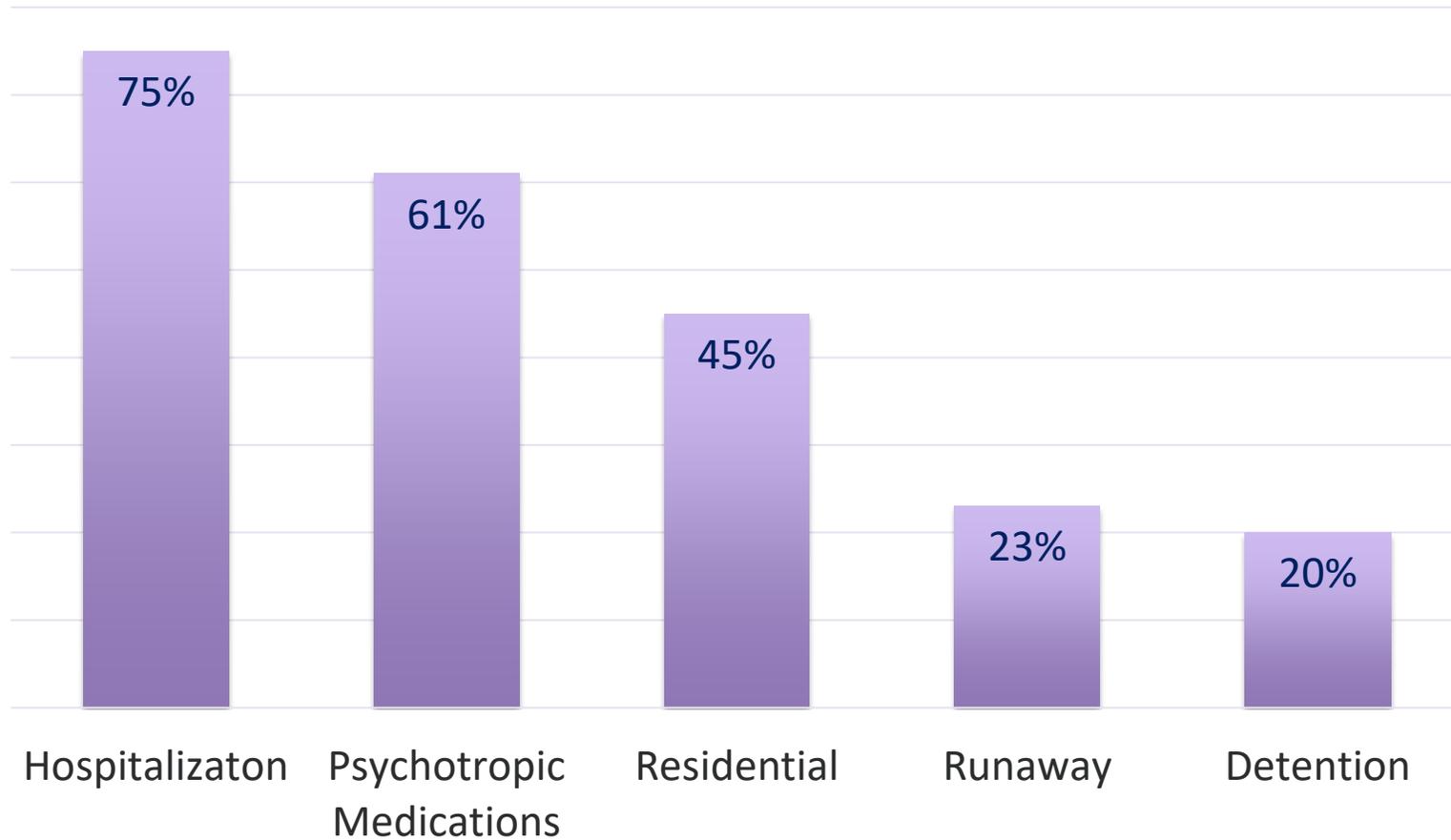


Race



Analytical Cohort (N=1352)

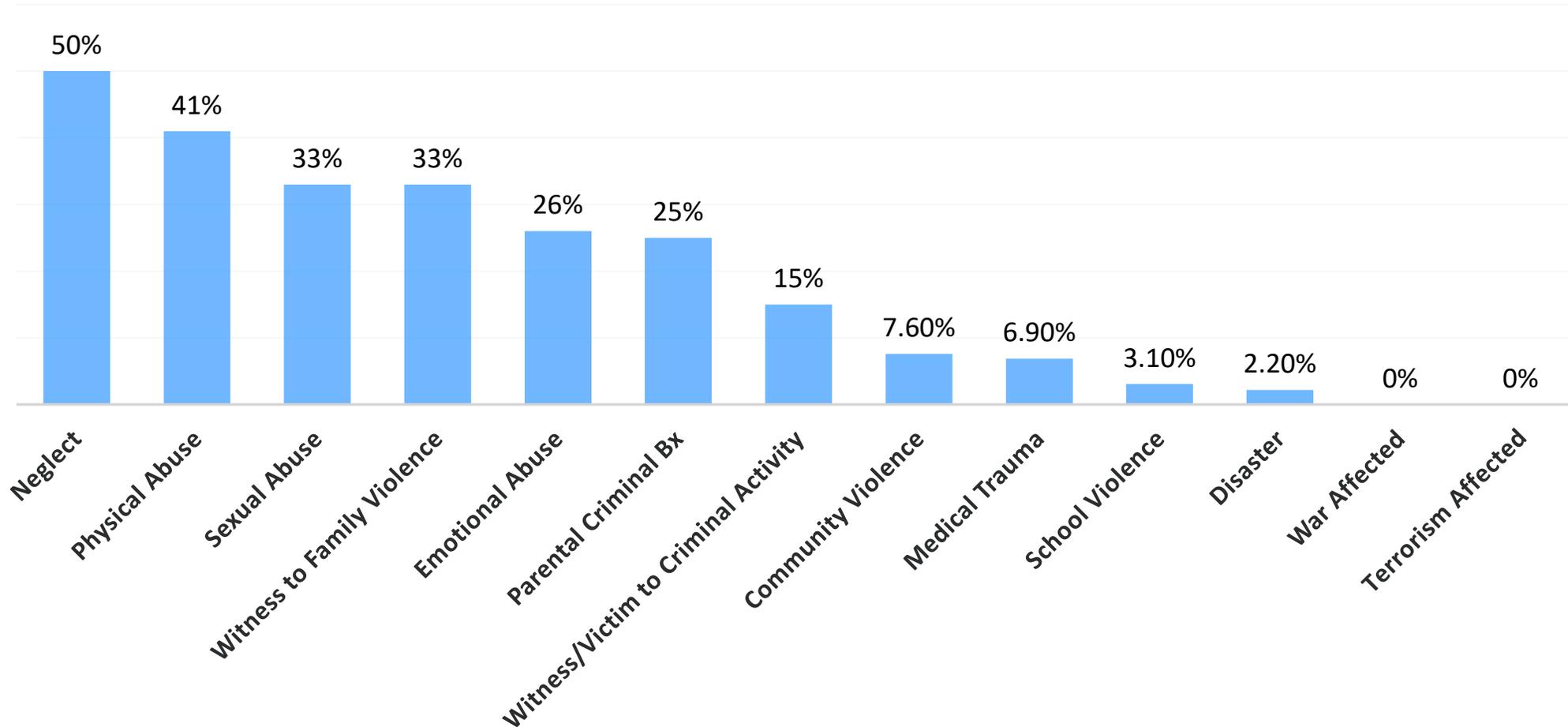
History of System/Service Involvement



LOS (days)	$\bar{x}=531, sd=380$
Age (years)	$\bar{x}=14, sd=3$

Analytical Cohort (N=1352)

Actionable Trauma Hx (CANS Prior to Residential Admission)



Results: Is there an association between the staff vacancy rate and the *overall* frequency of adverse events for youth?

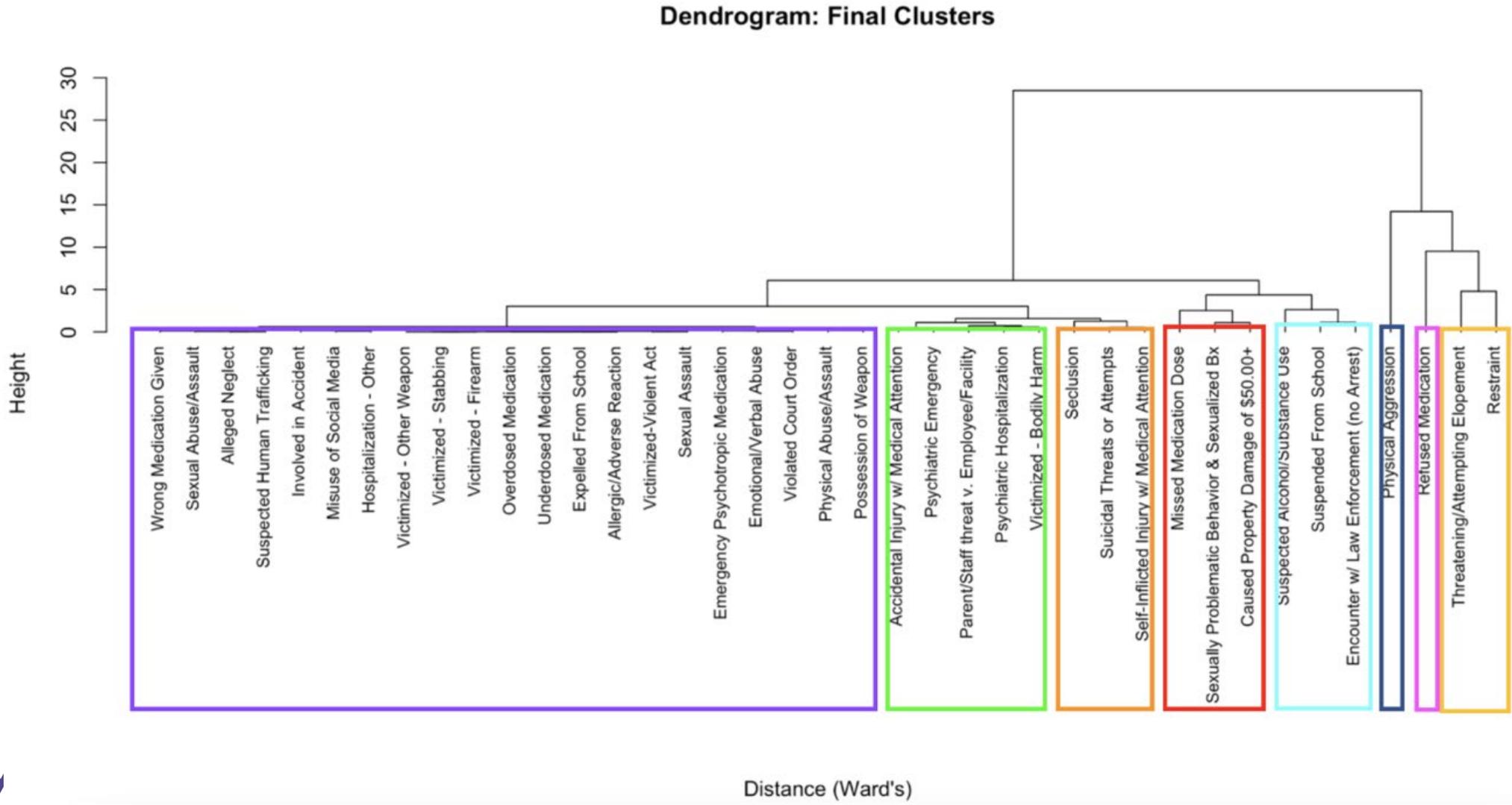
- Non-significant, positive relationship between vacancy rates and adverse event frequency
- Incidental Findings: Count of Adverse Event Associated...
 - Negatively with
 - Youth census
 - Being at a moderate group home or severe classification level (v. moderate)
 - Being in the pregnant and parenting youth specialty program (v. none)
 - Positively with
 - Being at a large facility (v. medium)

Results of analysis of staff vacancy rate and *overall* adverse event frequency

Variable	β	SE	Z value	P value
Intercept	1.34	0.19	7.04	<0.001
Vacancy Rate	0.24	0.58	0.41	0.68
Classification Level (relative to Moderate)				
Group Home	-0.25	0.12	-2.08	0.04*
Severe	-0.24	0.11	-2.20	0.03*
Specialty Population (relative to None)				
Developmentally Disabled	0.31	0.18	1.68	0.09 ⁺
Pregnant & Parenting	-0.72	0.31	-2.34	0.02*
Contract Size (Relative to Medium)				
Small	-0.18	0.10	-1.80	0.07 ⁺
Large	0.43	0.11	3.76	<0.001***
Census	-0.15	0.04	-4.02	<0.001***
Length of Stay	0.04	0.02	1.67	0.09 ⁺
Race (relative to White)				
Native American	-0.62	0.37	-1.67	0.09 ⁺

+p<.10; *p<.05; ***p<0.001.

Clusters of Adverse Events: Dendrogram



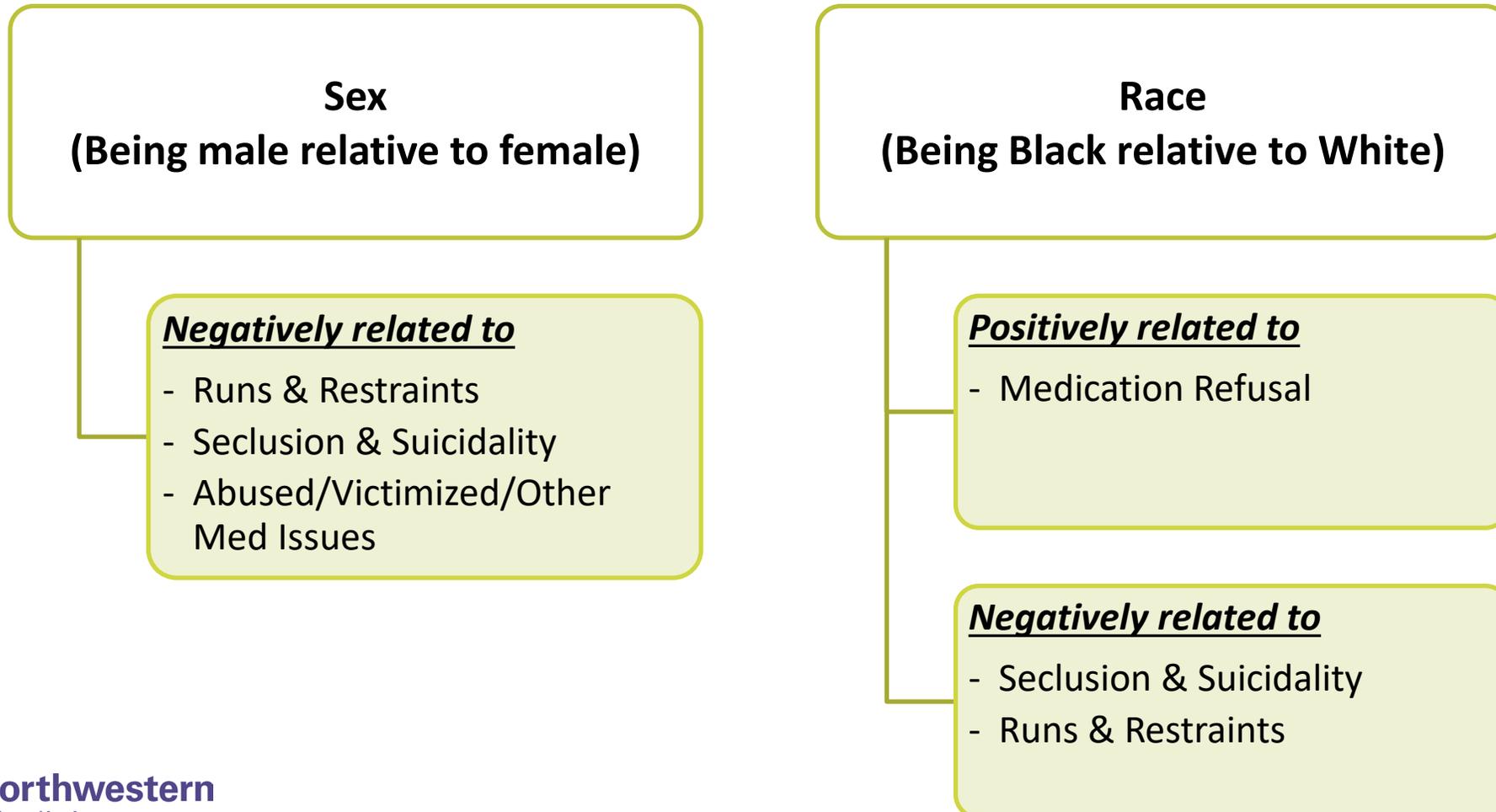
Clusters of Adverse Events

Results of Hierarchical Cluster Analysis

Cluster 1: Physical Aggression	Cluster 7: Psychiatrically Acute
Physical Aggression	Accidental Injury w/ Medical Attention
	Psychiatric Emergency
Cluster 2: Medication Refusal	Psychiatric Hospitalization
Refused Medication	Parent/Staff threat v. Employee/Facility
	Victimized - Bodily Harm
Cluster 3: Runs & Restraints	
Threatening/Attempting Elopement	Cluster 8: Abused, Victimized, Other Med Issues
Restraint	Victimized - Stabbing
	Victimized - Firearm
Cluster 4: Legal/School Events	Victimized - Other Weapon
Suspended From School	Alleged Neglect
Encounter w/ Law Enforcement (no Arrest)	Expelled From School
Suspected Alcohol/Substance Use	Underdosed Medication
	Allergic/Adverse Reaction
Cluster 5: Disruptive Behaviors	Suspected Human Trafficking
Sexually Problematic & Sexualized Bx	Overdosed Medication
Caused Property Damage of \$50.00+	Victimized-Violent Act
Missed Medication Dose	Emotional/Verbal Abuse
	Sexual Assault
Cluster 6: Seclusion & Suicidality	Violated Court Order
Seclusion	Sexual Abuse/Assault
Suicidal Threats or Attempts	Wrong Medication Given
Self-Inflicted Injury w/ Medical Attention	Misuse of Social Media
	Emergency Psychotropic Medication
	Hospitalization - Other
	Involved in Accident
	Physical Abuse/Assault
	Possession of Weapon

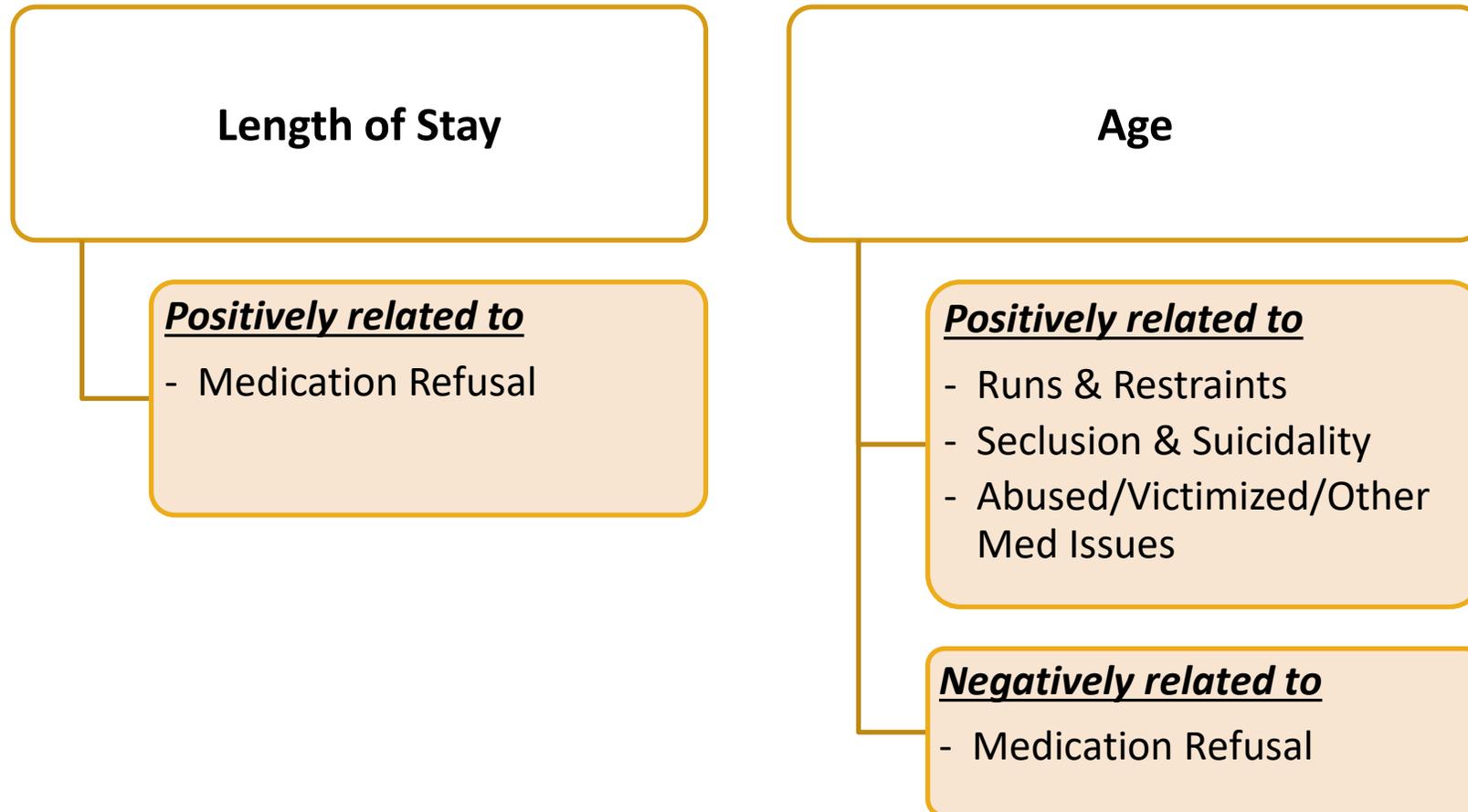
Results: Factors Associated with the Frequency of Adverse Event Clusters

Youth-Level Incidental Findings



Results: Factors Associated with the Frequency of Adverse Event Clusters

Youth-Level Incidental Findings



Results: Factors Associated with the Frequency of Adverse Event Clusters

Facility-Level Incidental Findings

Classification Level (relative to moderate)

Moderate Group Home

Negatively related to:

- Physical Aggression
- Runs & Restraints

Chronic

Positively related to:

- Legal/School
- Abused/Victimimized/ Other Med Issues

Negatively related to:

- Seclusion & Suicidality

Results: Factors Associated with the Frequency of Adverse Event Clusters

Facility-Level Incidental Findings

Specialty Program (relative to none)

Developmentally Disabled

Positively related to:

- Runs & Restraints

Sexual Behavior Problems

Negatively related to:

- Legal/School

Young Child

Negatively related to:

- Abused/Victimimized/ Other Med Issues

Results: Factors Associated with the Frequency of Adverse Event Clusters

Facility-Level Incidental Findings

Contract Size (Large relative to Medium)

Positively related to:

- Medication Refusal
- Disruptive Behavior

Youth Census

Negatively related to:

- Physical Aggression
- Disruptive Behavior
- Seclusion & Suicidality

Results of analysis of staff vacancy rate and frequency of adverse event *clusters*

Variable	Cluster 1: Physical Aggression	Cluster 2: Medication Refusal	Cluster 3: Runs & Restraints	Cluster 4: Legal/School Events
Vacancy Rate	$\beta = -1.35, SE=0.85, p=0.11$	$\beta = -1.06, SE=1.94, p=0.59$	$\beta = -0.21, SE=1.22, p=0.86$	$\beta = 9.55^{***}, SE=2.87$
Classification Level (relative to Moderate)				
Group Home	$\beta = -0.78^{***}, SE=0.21$		$\beta = -0.87^{**}, SE=0.28$	$\beta = 0.68, SE=0.41$
Chronic				$\beta = 1.47^*, SE=0.75$
Specialty Population (relative to None)^a				
DD			$\beta = 0.90^*, SE=0.37$	
SBP				$\beta = -0.76^*, SE=0.38$
Contract Size (Relative to Medium)				
Large	$\beta = 0.36, SE=0.21$	$\beta = 1.49^*, SE=0.60$		
Census		$\beta = -0.46^*, SE=0.19$		$\beta = -0.42^{**}, SE=0.16$
Length of Stay		$\beta = 0.24, SE=0.10^*$		
Race (relative to White)				
Black		$\beta = 0.41^*, SE=0.17$	$\beta = -0.21^*, SE=0.11$	
Asian		$\beta = 1.64^*, SE=0.71$		
Native American	$\beta = -0.98, SE=0.58$			
Sex (relative to female)				
Male			$\beta = -0.46^{***}, SE=0.12$	
Age	$\beta = -0.24^{***}, SE=0.06$	$\beta = 0.49^{***}, SE=0.14$	$\beta = -0.17^*, SE=0.08$	$\beta = 0.27^*, SE=0.12$

a. DD=Developmentally Disabled; SBP=Sexual Behavior Problems.

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Results of analysis of staff vacancy rate and *frequency of adverse event clusters*

Variable	Cluster 5: Disruptive Behavior	Cluster 6: Seclusion & Suicidality	Cluster 7: Psychiatrically Acute	Cluster 8: Abused, Victimized & Other Medication Events
Vacancy Rate	$\beta = -1.86$, SE=1.76, p=0.29	$\beta = -2.22$, SE=1.88, p=0.24	$\beta = 2.03$, SE=2.07, p=0.33	$\beta = -0.45$, SE=2.42, p=0.85
Classification Level (relative to Moderate)				
Group Home		$\beta = -0.75$, SE=0.42		
Chronic		$\beta = -2.29^*$, SE=0.92		$\beta = 1.13^*$, SE=0.51
Specialty Population (relative to None)^a				
DD	$\beta = -0.79$, SE=0.43			
SBP	$\beta = 0.49$, SE=0.27			
DD with SBP	$\beta = 1.14$, SE=0.68			
YC		$\beta = -0.88$, SE=0.46		$\beta = -0.71^*$, SE=0.31
Contract Size (Relative to Medium)				
Large	$\beta = 0.95^{**}$, SE=0.33	$\beta = 1.33^{**}$, SE=0.45		
Census	$\beta = -0.33^{**}$, SE=0.12	$\beta = -0.35^*$, SE=0.14	$\beta = -0.27$, SE=0.15	
Length of Stay				$\beta = 0.14$, SE=0.08
Race (relative to White)				
Black		$\beta = -0.57^{***}$, SE=0.15		
Latinx	$\beta = -0.52$, SE=0.29 ⁺	$\beta = -1.00^*$, SE=0.42		
Sex (relative to female)				
Male		$\beta = -0.66^{***}$, SE=0.17		$\beta = -0.41^{**}$, SE=0.15

a. DD=Developmentally Disabled; SBP=Sexual Behavior Problems.

*p<0.05; **p<0.01; ***p<0.001.

References

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Direct Care Staff Shortages and Adverse Youth Events in Illinois Child Welfare Residential Treatment During the COVID-19 Pandemic

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Introduction

- Youth in child welfare residential care present with complex psychiatric and behavioral needs
- Direct care staff provide 24/7 care and supervision in youth residential treatment. Shortages of direct care staff are chronic and widespread
- Research conducted in other settings suggests staff turnover and poor youth outcomes are related
- Limited existing research links residential staff turnover to decreased stability, longer waits for permanent placements, retraumatization from additional caregiver interruption, and a general loss of trust for youth (Colton & Roberts, 2007; Curry, 2019)

Methods

This study examined:

- (1) the relationship between the magnitude of direct care staff vacancies and the frequency of youths' adverse events, &
- (2) whether *specific types* of adverse events are differently associated with direct care staff vacancies.

Sample: 1352 youth in Illinois child welfare residential care between October 2019 and February 2022

Data Source: Retrospective, secondary data routinely collected by the Illinois Department of Children & Family Services

Measures: Direct care staff vacancy rates, adverse events (Significant Event Reports), youth & facility characteristics

Analytical Methods:

- Negative binomial, multilevel, 2-stage least squares regression to examine associations between frequency of adverse events & staff vacancies
- Hierarchical cluster analysis to examine associations with specific kinds of events

Most youth in residential care experience significant, adverse events

Direct care staff shortages are significant and rising

Greater staff vacancies are related to increased legal/school adverse events

Supporting and retaining frontline staff are critical to care and safety of youth in residential treatment

Scan QR code for staff wellness resources & a summary of the study's incidental findings



Figure 1. Direct Care Staff Vacancy Rate: Oct 2019-Feb 2022

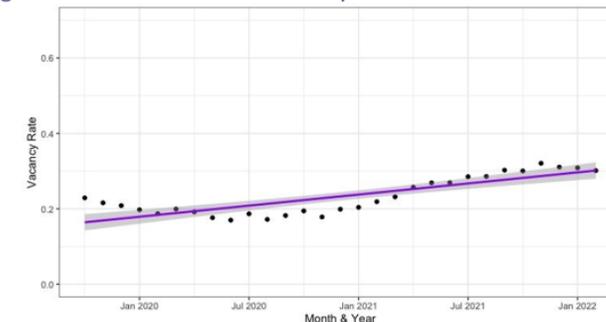


Figure 2. Clusters of Adverse Events



Results

- Staff vacancy levels were not significantly related to the overall frequency of youth adverse events
- Adverse Events clustered into 8 groups
- The staff vacancy rate was positively ($p < .05$) related to the frequency of Legal/School Events
- There were many significant, incidental findings linking the frequency of adverse events to youth and facility level factors