Supporting Child Protective Services (CPS) Staff Following a Child Fatality and Other Critical Incidents

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In 2009, over 64,700 reports of child abuse and neglect involving more than 90,000 children were made in New York City (NYC Administration for Children's Services, 2010). As *first responders* to these difficult and demanding cases, Child Protective Service (CPS) workers often deal with traumatic events related to their casework, such as child fatalities, severe child physical and sexual abuse, and violence directed toward them while in the field. In 2006, the New York City Administration for Children's Services (ACS) selected the New York Society for the Prevention of Cruelty to Children (NYSPCC) to develop and implement a crisis debriefing program to respond to the needs of CPS workers in New York City (NYC). This administration recognized the heightened potential for staff to develop secondary traumatic stress (STS) resulting from exposure to traumatic events in the course of their daily work.

The contract with ACS required the NYSPCC to conduct a series of focus groups for managers and front-line staff in NYC's five boroughs. The goals were to elicit information to inform development of the crisis debriefing protocol and to obtain input on the types of supports that would best help CPS staff in their work. NYSPCC would provide feedback and recommendations to ACS based on the analysis of focus group information. Consequently, NYSPCC developed the Restoring Resiliency Response (RRR) crisis debriefing protocol and currently uses it in crisis debriefings with New York City's CPS staff. The purpose of this article is to describe the process used to develop and implement the crisis debriefing model and to identify strategies for designing a child fatality review process that supports CPS staff.

A Brief Review of the Literature on Crisis Debriefing

Critical incident stress debriefing (CISD) was developed by Jeffery T. Mitchell and George Everly (2006). It is a multicomponent crisis intervention system designed to mitigate and prevent the development of disabling posttraumatic syndromes and stress disorders (Mitchell, 1988). The program was originally used by emergency services personnel, specifically firefighters; emergency medical technicians; and police (MacDonald, 2003). Treatment usually consists of one session—although more are possible—scheduled between one day and two weeks following the traumatic event. The session is a seven-phase, structured group meeting and is designed to achieve psychological closure after a traumatic event (Mitchell & Everly, 2006).

Studies monitoring CISD's effectiveness in reducing trauma symptoms have shown results along a continuum from positive (Campfield & Hills, 2001; Eid, Johnsen, & Weisaeth, 2001; Herman, Kaplan, & LeMelle, 2002; Mangone, King, Croft, & Church, 2005) to negative (Giddens, 2008; Van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002; Harris, Baloglu, & Stacks, 2002; Orner et al. 2003; Van Wyk & Edwards, 2005; Marchand et al. 2006; Stallard et al., 2006). Other studies have reported mixed results concerning the efficacy of CISD (Humphries & Carr, 2001; Richards, 2001; Dwairy, 2005). This might suggest that some symptoms of posttraumatic stress disorder are reduced by the intervention, while others are not or are exacerbated. Seemingly, there is a lack of agreement in the research regarding the efficacy of CISD. It appears that although the intervention is not optimal for all cases, it works very well for others.

What Is Different About the RRR Model?

Following a child abuse fatality, intense scrutiny is placed upon every aspect of the case. Many questions need to be answered and reports need to be generated, all of which usually requires a rapid, multidisciplinary response from the legal, law enforcement, medical, and CPS systems. The central office's managers usually coordinate the CPS response. In the current program, it was important to ACS managers that the crisis debriefing protocol would not interfere with internal investigatory procedures.

The RRR sessions are not investigatory in nature, nor do they entail retelling the details of the event. The reasoning behind this approach is twofold. First, in direct contrast to the CISD model, care is taken to ensure that the RRR protocol focuses on the current stress reactions experienced by the workers rather than on discussing the details of the case. This allows workers to participate in the sessions without worrying about having to disclose factual information about the case currently under investigation. Second, there is rising debate over whether retelling the event does more to harm

certain individuals than to heal them. Many workers do not benefit from retelling the facts and reliving graphic details about the traumatic event (Blythe & Slawinski, 2004; Devilly & Cotton, 2004).

The goals of RRR sessions are to mitigate the impact of the critical incident and to accelerate the recovery process. Activities during the session are primarily focused on discussion of current levels of stress symptoms, validation and normalization of the reactions to the crisis, identifying support systems, and practicing coping-relaxation techniques. The sessions integrate education, emotional expression, and cognitive restructuring. The NYSPCC clinical team is trained in the RRR protocol and also has extensive training in traumatic grief and loss counseling. This expertise allows them to support CPS staff as they regain their sense of balance following crisis events in their workday.

Several important points drive the RRR model:

- Everyone experiences crisis differently. Each situation calls for an individualized response. The RRR clinician tailors the session outline, materials, and the types of stress management techniques to be used to the specific type of crisis event and the primary concerns of the staff involved.
- RRR utilizes a strengths-based perspective. Each individual is viewed as the authority in his or her personal recovery process. Crisis often causes people to lose connection with their past skills and strengths. Workers often state that they "feel that the rug was pulled out from under them." The RRR model enhances their competence by helping them reconnect with their strengths to access the supports and resources available to them.
- Each person may be at "a different place" in terms of participation in the RRR sessions. Some staff may still be in a state of denial or shock and may not participate fully, while others may engage in every exercise. The goal is to provide a safe zone for participants, which allows them to share their thoughts if they feel comfortable.
- The participants learn about typical stress reactions to traumatic events. They receive instruction on how to monitor their reactions to determine if there is a need for longer-term support. A self-assessment stress checklist with timeframes helps staff members decide if they are either making progress in recovering from the crisis incident or not recovering sufficiently. This enables them to manage their specific needs.
- NYC thrives due to a myriad of cultures, religions, and healing therapies all offering different types of support. The RRR approach is culturally sensitive. Participants define the support systems that will be most meaningful for them.

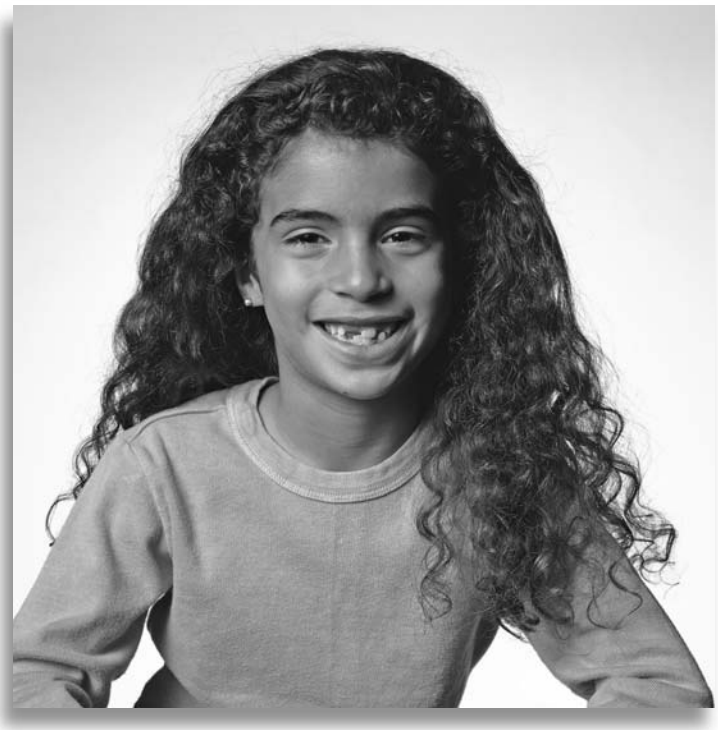
Focus Groups in the Five Boroughs of NYC

The NYSPCC conducted 13 focus groups with the New York City ACS staff. It was agreed in advance that managers and front-line staff would participate in separate groups to foster greater participation. Eight groups were conducted with 59 managers. Five groups were conducted with 46 front-line staff members. All participants were selected by the Borough Director's office with the intent to include workers with a wide range of experience—from those who recently completed their CPS training to those who had over 10 years of experience.

The groups answered 11 questions designed to gain insight into CPS staff needs after a child fatality or another critical incident. This article reports on the results of two of these questions:

1. What types of crisis situations do ACS staff encounter that should generate a crisis debriefing session?
2. How can this service be structured so that staff members are able to debrief regarding an incident?

Data analysis was completed in June 2006 and a report was prepared for ACS with recommendations on how best to implement the program



Situations That Warrant Crisis Debriefing

Child Fatality

Both management and front-line staff agreed that crisis debriefing services should be provided following a child fatality. One participant noted the following:

> I think child fatalities are the situations where we need this kind of debriefing. It's a family you've known for awhile. You've been working with them. You have a direct spiritual and physical connection to this child that was just killed. The media is looking at you to see what you've not done to save the child…and now you're seeing it as your fault for not saving that child. The stress is enormous. Meanwhile, they are demanding 24-hour reports, 48-hour reports, everybody is reporting to everywhere, Albany, central office, your director….

Child Sexual Abuse and Physical Abuse

Child sexual abuse and severe physical abuse cases were commonly cited among participants in both groups as needing crisis debriefing support. One participant stated,

> With sex abuse, if I go and see a little 6-year-old and some man sexually abused her, I'm ready to go after them. You can't separate yourself. You are only human.

Workers also asked for support following serious cases of child physical abuse. For example,

> I was thinking about a removal I did, seeing that child all burned up—the mother threw water on the child. Does anyone care about whether you are okay? It's just, next pending. And ever since that experience, I think workers need to have some kind of debriefing.

Violence or Danger During Field Visits

All groups agreed that debriefing should be conducted following situations of threatening behavior or actual violence against staff members while in the field. One group member stated,

> I have staff members who were traumatized, attacked by the client's dogs in the home. And not being able to escape, no help from the clients.

Staff also indicated that debriefings would be helpful following a stressful removal of a child, bereavement due to the death of a staff member, and citywide disasters such as the terrorist attacks of 9/11. They also requested regularly scheduled debriefing sessions to talk about the daily stressors of cases, not just after a fatality.

> I think everybody needs this once a month. I guarantee you if you put a counselor here, it's going to be over-packed.

Optimizing Participation in Debriefing Sessions

Both front-line and management staff reported they were willing to attend crisis debriefing sessions if offered. Additionally, they thought it best if debriefings would be considered a normal part of the procedure following a crisis, which would help staff feel more comfortable taking time to attend the sessions.

> As with the police or emergency responders, it is built into their protocol that this is what you do. They have the support from upper management… and then it becomes part of their schedule.

Both managers and front-line staff reported that it would be important to have full support from their supervisors in order to attend a debriefing session. One staff member stated,

> I think that since people feel so stretched and are stressed to just find time to do everything, that it needs to be packaged by management that this service is so valuable that it is worth me taking the time out—even though I feel like I have ten million other things I need to do right now. That debriefing will ultimately help me to better manage these ten million other things.

Focus group participants also recommended that staff members "spread the word" among each other (that is, if they had a good experience in a debriefing session) so that more staff would consider participating. Similarly, respondents believed that trust and security were essential for staff to feel comfortable participating in these sessions.

> Show them that this is a secure place; this is confidential. You are freely open to express how you feel. Until that message gets to the staff, there is going to be some hesitation. They need a place—a really safe place—to talk.

Putting the RRR Protocol Into Practice

One important factor that helped the launch of this service was support from the Commissioner of the NYC Administration for Children's Services (ACS), John B. Mattingly. As a firm proponent of offering debriefing support to his staff, he commented as follows:

> Child Protective Specialists perform the difficult tasks of conducting investigations and making decisions that are necessary to ensure a child's safety. As such, they encounter families at their most trying times, in situations that can be emotionally wrenching. In the course of doing their jobs, CPS workers may find themselves the victim of violence; they frequently hear threats of violence to themselves or their colleagues. Occasionally, some are hurt in the course of doing their job. It is most important that their needs be tended to, even while they devote their time to ensuring the safety of children. When our workers must deal with a fatality they are investigating, or when they or a colleague has experienced violence while on the job, ACS has turned to the New York Society for the Prevention of Cruelty to Children (NYSPCC) to provide crisis debriefing services for CPS staff to manage stress and to enhance their coping skills. ACS recognizes the importance of providing this support to caseworkers so that they can maintain their passion and compassion for doing this very difficult work. (S. Stein, personal communication, March 11, 2010)

The NYSPCC subsequently gave presentations to over 200 ACS managers regarding the new crisis debriefing service available to staff. In these sessions, the presenters discussed the benefits of timely support for staff and managers following a crisis in the workplace. The NYSPCC emphasized that management support for the sessions was critical to ensuring that front-line workers could attend and feel safe in the session. The NYSPCC also discussed managers' roles in helping coordinate the debriefings, helping to schedule the sessions, and providing information to the NYSPCC prior to the sessions. This information included the following:

1. What is the nature of the crisis incident?
2. How many staff members are involved?
3. How would you characterize their reactions?
4. What symptoms of distress are they displaying?
5. Are there particular staff members you are very concerned about?
6. Are you aware of other concurrent stressors for them?
7. Has there been media coverage?
8. Are group members willing to come to a debriefing or are they being told to come?

Having access to this information in advance of the debriefing helps determine how many clinicians should be assigned to the session; whether or not certain staff members require separate groups; and whether managers and front-line staff should be scheduled for separate sessions to maximize participation.

The ideal time to hold a debriefing session is between 24 and 72 hours after the incident. However, there may be a benefit in delaying the session if staff members need more time to become psychologically receptive to the intervention. Staff may also request support after several weeks have passed and individuals find they are not rebounding as they had hoped. Managers should select a time when the staff members are most likely to free themselves from other work to attend the 90-minute session. Debriefings should not be scheduled during their lunch hour. The NYSPCC clinicians conducting the debriefing arrive 30 minutes prior to the session to meet with management and to obtain information that was not available when the referral was made.

The RRR Session

The following steps are taken in an RRR session:

1. The clinician explains the crisis debriefing process. (If more than six staff members are present, two clinicians lead the session.)

2. Rules of the debriefing are discussed. The rules are as follows:
   a. Confidentiality is protected (what is said in the room, stays in the room). Participants do not have to speak but are encouraged to do so. Content of the meeting is not reported back to ACS. Creating a "safe space" is important. Confidentiality is not protected if a participant poses a risk to oneself or someone else.
   b. The session runs approximately 90 minutes. It is hoped that everyone will stay for the entire session. Computing devices and cell phones should be turned off.
   c. All personnel have equal status during the debriefing, regardless of their positions.
   d. Participants are encouraged to ask questions during the debriefing.

3. The clinician references the incident that led to the debriefing, asks the participants to share how they are currently managing the impact of the event, and facilitates discussion of participants' current emotions and stress reactions.

4. The clinician normalizes and validates participants' reactions as appropriate. The participants complete a stress reactions checklist. A discussion follows regarding the emotional, physical, behavioral, cognitive, and social reactions the participants are currently experiencing.

5. The clinician leads a discussion to help participants draw on their past experiences of handling stress and learn new ways of coping from each other. Cognitive behavioral therapy and relaxation techniques are practiced to enhance coping skills.

6. The participants receive handouts on self-care and discuss both professional and personal ways of coping during stressful times. A grounded breathing exercise is practiced.

7. Two exercises might be used to conclude the group. These are "Prideful moment at work" or "One thing I will do to relax tonight." It is helpful to have participants share positive thoughts at the end of the session.

8. The group is told that the NYSPCC clinician will be available for private discussion following the session. ACS Employee Assistance materials are also provided.

Ideally, staff members should have 5–10 minutes after a session to gather their thoughts or talk among themselves to offer support privately before they transition from an emotionally charged debriefing session to their daily routine.

Example of a Debriefing Session

A group debriefing session was requested following a critical incident in which a father killed his wife and child by slashing their throats. The unit was distraught and deeply affected by the incident, and several staff members were described as being in shock.

Nine workers were present for the debriefing session. The NYSPCC clinician introduced herself and explained the purpose of the session. Emphasis was placed on creating emotional safety by maintaining confidentiality and being respectful of others' perspectives and experiences.

Upon exploring participants' stress reactions, staff reported visceral reactions such as upset stomachs, headaches, and neck and backaches. Several participants reported sleep and eating pattern disturbances. They described feeling lethargic and experiencing "a fatigue that does not improve with sleep." Others expressed feeling enraged against the perpetrator. Several participants described how overprotective the incident made them toward their own children. One participant described feeling shock and disbelief that this fatality had occurred. This participant shared her relative inexperience with death in her personal life. As a result, the facilitator provided psychoeducation on the stages of grief and loss. The facilitator validated and normalized these reactions and provided psychoeducation on how stress symptoms can manifest following a traumatic incident.

Time was devoted to discussing self-care during times of acute stress. The oxygen mask analogy was used to emphasize the need to prioritize one's own self-care to be able to help others. Members shared coping strategies that included spending time with their own children, meditation and prayer, listening to music, exercise, and having a ritual to transition from work to home life, such as calling a friend or family member.

In an effort to place the fatalities into the larger context of work, the group shared a "prideful moment," an example of how the members' work had made a positive impact. The stories included seeing a baby with failure to thrive gain weight, having a client be thankful for helping him or her enroll in a substance abuse treatment program, and watching children be safely reunited with a parent after removal for neglect. Emphasis was placed on how these moments can help retain perspective when faced with a tragedy on the job. A focused breathing exercise was utilized to end the session.

Table A. Number of Debriefing Sessions and Participants by Different Types of Crisis (38 months)

Crisis Type	Sessions[a]	Participants[b]
Child fatality	38	168
Violence against staff in the field	32	149
Bereavement	23	274
High workplace stress	23	158
Client bereavement	7	31
9/11 support group	6	10
Violence against staff in court	5	14
Workplace threats	4	14
Severe physical abuse (severe burn)	2	20

Note: Data collected between November 2006 and December 2009
[a] *n = 140*
[b] *n = 838*

The facilitator provided contact information and information about Employee Assistance Programs, and explained that a follow-up session or individual counseling referrals could be arranged.

Feedback From CPS Staff

> I think that the debriefing was a great idea. It helped me to understand the anger and denial that I have been going through since this tragic death. (Comment on the evaluation survey form by CPS staff member)

As indicated in Table A, 140 sessions serving 838 staff have been conducted since November 2006. An evaluation survey was designed to elicit participants' opinions in the following areas: ability to identify their personal stress reactions, perceived safety regarding expressing their feelings in the session, future use of stress management techniques taught in the session, encouraging fellow staff members to attend a future session, and the helpfulness of the social work clinicians in addressing their stress concerns. Participants also were given the opportunity to provide written feedback in two sections of the survey.

There was a 69%-return rate for evaluation surveys following the crisis debriefings. As noted in Table B, surveys were returned from 578 of the 838 people who participated in a session over the 38-month period. Overall, the majority of the responses were positive in all categories. Following is a sample of participants' comments:

> This session should be mandatory for all workers who have a child fatality on their caseload.

> This session gave me more insight into how to take care of myself.

> It's good for the staff to be able to express themselves without worrying about judgments or confidentiality.

> At first I was skeptical about attending this session because I feared that what I shared could end up in my personnel file. However, once the session started, I felt very comfortable, relaxed, and at ease with discussing my feelings. I do feel better and will utilize the self care suggestions."

> I think that this session helped everyone open up and express their feelings. I would participate in another. The facilitator was very informative and helpful. Thank you so much for your time and support!

Table B. Percentage of Participants' Responses on Crisis Debriefing Evaluation Forms (N=578; 38 months)

Evaluation Questions	Very	Somewhat	Not
How helpful[a] was the session in helping you identify your stress reactions?	71	27	1
How safe[b] did you feel talking about your feelings in this session?	73	24	2
How likely[c] are you to utilize techniques discussed in this session for stress reduction in the future?	66	31	1
How likely[d] would you be to encourage a coworker to attend a debriefing following a crisis?	82	17	1
How effective[e] were the facilitators in addressing your concerns?	82	17	1

Note: Data collected between November 2006 and December 2009

[a] Answer choices were Very Helpful, Somewhat Helpful, Not Helpful.

[b] Answer choices were Very Safe, Somewhat Safe, Not Safe.

[c] Answer choices were Very Likely, Somewhat Likely, Not Likely.

[d] Answer choices were Very Likely, Somewhat Likely, Not Likely.

[e] Answer choices were Very Effective, Somewhat Effective, Not Effective.

Implications for the Field

Providing a safe space for CPS staff to voice feelings about traumatic events is important for strengthening personal coping and stress management skills and is instrumental in returning staff to previous levels of functioning. During the first 38 months implementing the RRR crisis debriefing protocol, the NYSPCC provided 140 crisis debriefing sessions to 838 CPS staff members. The evaluation results indicate that crisis debriefing is welcomed in CPS work. The adoption of similar intervention strategies would significantly benefit CPS staff nationwide.

The model developed for CPS in New York City did not interfere with the ongoing internal investigatory work needed after most critical incidents. Union and other legal concerns need to be addressed when implementing a program; otherwise, participants may be reluctant to engage in the session. When developing the protocols, all appropriate parties should have the opportunity to have their concerns addressed. This can expedite the launching of a crisis debriefing initiative.

Administrators also need to be cognizant of the sense of vulnerability experienced by front-line workers. The focus group data indicated that front-line staff would be less likely to use the intervention if it was internally administered. Comments from workers stated that they would be suspicious about how the information could be "used against them" and would be hesitant to participate. CPS staff were pleased that an outside agency that did not send reports back to the administration was conducting the sessions. Over the past 4 years, the development of a trusting relationship between the NYSPCC and the ACS staff has increased the number of staff members willing to attend a session. In turn, they recommend the sessions to their colleagues, enabling more workers who have encountered trauma on the job to benefit from the intervention.

To be able to respond to the daily challenges of child fatalities, severe child abuse and neglect, and violence against them during the course of their work, CPS workers need support systems that promote resilience and reduce their intense levels of stress. Services designed to help staff following traumatic events help reduce these levels because staff feel supported during their most challenging times.

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