

# Initial Findings of an Evaluation of a Trauma Recovery Framework in Residential Treatment

By *Jeanne C. Rivard*

This article briefly describes the initial findings of an evaluation of the Sanctuary Model (Bloom, 1997, 2003), an intervention designed to address the special treatment needs of youth with emotional and behavioral disturbances and histories of maltreatment or exposure to domestic and community violence.

The Sanctuary Model integrates trauma theories (Bloom, 1997), an enhanced therapeutic community philosophy (Bloom, 1997), and recommended child treatment strategies that address post-traumatic symptoms, developmental disruptions, and unhealthy accommodations to traumatic experiences (Friedrich, 1996).

A fundamental premise of the intervention is that the treatment environment is a core modality for modeling healthy relationships among interdependent community members. This trauma-informed systems approach was described in a previous issue of *Residential Group Care Quarterly* (Bloom, 2003). In the setting of a residential treatment center, the model was operationalized through:

- a series of staff dialogues and self evaluations of residential units' structure and functioning,
- staff training and ongoing technical assistance,
- twice-daily community meetings coled by staff and youth,
- a range of psychoeducation exercises that staff use in their daily interactions with youth, and
- weekly psychoeducation groups

(Duffy, McCorkle, & Ryan, 2002) to teach the knowledge and skills needed to progress through four stages of recovery (i.e., safety, emotions management, loss and grieving, and future orientation; Foderaro & Ryan, 2000).

The evaluation project was conducted as a partnership between researchers of Columbia University School of Social Work, the Center for Trauma Program Innovation of the Jewish Board of Family and Children's Services in New York City, and the model developer, Sandra Bloom.

The project originated from the host agency's desire to enhance its service delivery by incorporating a new approach to meeting the special needs of youth in its residential treatment programs. The research component was funded through an exploratory/developmental research grant by the National Institute of Mental Health as part of an initiative to promote research on interventions for youth violence.

## Evaluation Methods

The project took place in a suburban community outside New York City where the Sanctuary Model is being implemented in three residential treatment programs on one large campus. The model was piloted in four residential units that self-selected to participate in the initial phase of the project.

The staff training protocol and manual was developed and piloted between February and August 2001, then four additional residential treatment units

were randomly assigned to implement the Sanctuary Model the following fall. Eight other units that provided the standard residential treatment program served as the control group.

Changes in the therapeutic communities and in youth were assessed every three to six months through April 2003. Results of the Sanctuary Model units were compared to results of units with standard residential services.

Although the Sanctuary Model was in a very early stage of implementation, the evaluation was guided by hypotheses that projected what specific outcomes were expected to occur in the therapeutic communities and in youths. We expected to find greater changes over time in the Sanctuary Model units than in the standard residential treatment units in the following areas:

### *Therapeutic Communities*

- Increase in perceived sense of community/cohesiveness
- Increase in democratic decision-making and shared responsibility in problem-solving
- Reduction in critical incidents and use of physical restraints

### *Youth*

- Reduction in traumatic stress symptoms
- Increase in level of self-esteem
- Greater internal locus of control
- Greater use of social network
- Improvement in decisionmaking and problem-solving skills
- Decrease in aggressive behavior

## Youth Demographics and History

Demographic and historical data were obtained from clinical records at baseline. History of abuse and neglect was abstracted from these records using the Maltreatment Classification System developed by Barnett, Manly, and Cicchetti (1993). Exposure to violence in home, community, or neighborhood was assessed through the My Exposure to Violence instrument (Buka, Selner-O'Hagan, Kindlon, & Earls, 1997).

Youth ( $N = 165$ ) ranged in age from 12 to 20 years, with a mean age of 15. Seventy-three percent were male and 27% were female. Fifty-one percent were black, not Hispanic; 34% were Hispanic; 11% were white; and 4% were Asian, Pacific Islander, or biracial.

Youth averaged six prior placements, including an average of three psychiatric hospitalizations. Thirty-four percent had experienced at least one substantiated incident of physical abuse, 12% had at least one substantiated incident of sexual abuse, and 45% had at least one substantiated incident of neglect. Most youth experienced multiple incidents of maltreatment.

A self-report of lifetime exposure to violence showed that 42% of youth had seen someone else attacked with a weapon, and 23% had been attacked with a weapon themselves. Twenty percent reported having seen someone else shot, and 11% reported having been shot at (Rivard et al., 2003).

## Implementation of the Sanctuary Model

Our evaluation emphasized an assessment of the processes of model implementation. Could we successfully operationalize and measure incremental changes in the therapeutic communities? Would staff and youth understand the model, accept it, and see its value? Would successful implementation actually lead to change in staff and youth behaviors?

We documented progress in implementing the model using consultants' process notes and periodic reviews of the Sanctuary Project Implementation Milestones checklist, which contained a list of observable criteria. Researchers gathered qualitative data on staff perceptions of the course of implementation, and challenges in implementing the model using focus groups. We also used focus groups to see youths' understanding of the model and their impressions of its effectiveness.

*Would staff and youth understand the Sanctuary Model, accept it, and see its value?*

Across the eight units that implemented the model, scores on the Sanctuary Project Implementation Milestones criteria ranged from 66% to 92%, with a mean of 78%. The slowest and most difficult component implemented was the weekly psychoeducation group. We saw greater implementation among those units exposed to the model longer, those serving girls, and those with leaders who had greater enthusiasm and commitment to the model.

Through focus groups with staff, we learned one of the most important findings concerned factors that facilitated not only implementation, but also consistency in using the model. These factors included building in structured times for discussing implementation and team-building, proceduralizing use of the psychoeducation tools, general openness of staff and youth to the model, acknowledging small successes to build enthusiasm, helping youth gain a deeper understanding of the trauma recovery framework, group cohesion, providing community-level incentives for positive community behaviors, and program

leadership (Rivard et al., in press).

From youth focus groups, we learned that they both understood and thought they could benefit more from the Sanctuary Model in units where there was stronger implementation.

## Therapeutic Community Outcomes

The short form of the Community Oriented Programs Environment Scale (COPEs; Moos, 1996) was used to assess the extent to which units were operating as therapeutic communities along selected dimensions. Trends in the frequency of critical incidents were then measured by analyzing data from the agency's management information system.

We found no significant differences between the Sanctuary Model units and the standard residential treatment units during the first two waves of measurement. By the final wave of measurement, however, we found significant differences between the groups via independent t-tests, with the Sanctuary Model units improving on the following constructs of the COPEs: support ( $p < .05$ ), spontaneity ( $p < .01$ ), autonomy ( $p < .05$ ), personal problem orientation ( $p < .05$ ), safety ( $p < .05$ ), and in the total score ( $p = .001$ ). We are still analyzing data measuring trends over time in the frequency of critical incidents that occurred in the residential treatment units.

## Youth Outcomes

The following instruments were used to assess youth outcomes that were hypothesized to be responsive to the Sanctuary Model: Child Behavior Checklist (Achenbach, 1991), the Trauma Symptom Checklist for Children (Briere, 1996), the Rosenberg Self Esteem Scale (Rosenberg, 1979), the Nowicki-Strickland Locus of Control Scale (Nowicki & Strickland, 1973), the peer form of the Inventory of Parent and Peer Attachment

(Armsden & Greenberg, 1987), the Youth Coping Index (McCubbin, Thompson, & McCubbin, 1996) and the Social Problem Solving Questionnaire (Sewell, Paikoff, & McKay, 1996).

Although baseline data were collected for 165 youth, substantial attrition occurred due to youth being discharged through usual program operations. By study end, 87 youth yielded three waves of data (i.e., baseline, three months, and six months). No significant differences were found comparing baseline and three-month measures. On repeated analyses ( $N = 87$ ) comparing baseline and six-month outcomes, however, we found a few differences by time and group, favoring youth in the Sanctuary Model units. These were on the incendiary communication/tension management construct of the Youth Coping Index ( $p < .05$ ), locus of control ( $p = .15$ ), and the verbal aggression construct of the Social Problem Solving Questionnaire ( $p = .15$ ).

## Discussion

Results were modest and consistent with a newly implemented intervention, especially considering that rates of implementation varied across units. The few positive youth findings offer promise that full implementation may yield greater youth benefits.

The finding that the treatment environments of the Sanctuary units were functioning at significantly higher levels than the standard residential units by the final wave of data collection suggests that implementation was becoming stronger with time.

In studying children's service systems, Glisson & Hemmelgarn (1998) found that organizational climates with greater job satisfaction, fairness, cooperation, personalization, and lower levels of conflict were associated with both service quality and positive outcomes in children's psychosocial functioning. These findings validate the current project's intensive program

development efforts aimed at strengthening the treatment environment for the benefit of staff and youths. More analyses of the data will follow.

Some of the most important lessons learned from this project focus on the need to support implementation efforts with more intensive onsite technical assistance, promote ongoing evaluation to assess change in the treatment environments and youth over time, and incorporate the use of brief behavior checklists that can be used as part of the regular program operations, and that may be more sensitive to change than measures of three-month self-reports of youth.

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## National Definitions and Data Collection for Residential Care Facilities' Use of Restraint and Seclusion

By Lloyd Bullard

The Child Welfare League of America's (CWLA) National Advisory Committee on Residential Services recommended that CWLA develop a set of uniform definitions related to restraint and seclusion and a list of primary and secondary data points to be used in data collection.

The Committee viewed the lack of uniformity in definitions and data elements as barriers to data collection, information sharing, benchmarking, and advancing efforts to reduce and eventually eliminate restraint and seclusion. By instituting consistent definitions and data points, children's residential facilities, jurisdictions, and states will be able to access and analyze the data and compare their use of restraint and seclusion to other similar facilities locally and nationally.

In November 2003, CWLA held a National Definitions and Data Collection for Residential Facilities meeting in Miami, Florida. Attendees included CWLA members, providers from around the country, national accreditation organizations, behavior support and intervention training organizations, and other individuals and national organizations concerned with the use of restraint and seclusion. The result was a set of definitions concerning restraint and seclusion

and a list of primary and secondary elements for data collection.

Following the meeting, CWLA's National Advisory Committee on Residential Services, and attendees from the National Definitions and Data Collection for Residential Facilities, offered feedback, and the document was revised based on their comments.

The complete set of definitions and primary and secondary data points can be found on CWLA's Residential Group Care website at [www.cwla.org/programs/groupcare](http://www.cwla.org/programs/groupcare). Providers, jurisdictions and states deciding to incorporate these definitions and data points into their policies, procedures, and practices may create their own network for information sharing, and benchmarking. In addition, these efforts could help the field reduce and eventually eliminate restraint and seclusion.

The League will continue to advocate and seek creative and diverse funding sources to establish a National Resource Center to collect and disseminate data and technical assistance for children's nonmedical residential facilities.

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