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Implementing a Trauma Recovery Framework for Youths in Residential Treatment

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ABSTRACT: This paper describes an intervention designed to address the special needs of youths with histories of maltreatment and exposure to family and community violence. The primary components of the model include an enhanced therapeutic community environment and a psychoeducation program that is aimed at changing non-adaptive cognitive and behavioral patterns which developed as means of coping with traumatic experiences. The implementation of the model and proximal effects on the therapeutic communities and youths are being examined in comparison to standard residential services. Initial perceptions of staff illustrate the challenges in applying an intervention that calls for changing the organizational culture.

KEY WORDS: Adolescent; Trauma; Recovery Model; Therapeutic Environment; Psychoeducation.

Introduction

Research findings documenting the negative outcome trajectories of many youths with serious emotional and behavioral disorders

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(Greenbaum et al., 1996, 1998) confirm the need to persist in policy and program efforts aimed at developing effective services and treatments across the continuum of care. With respect to residential treatment, the trend in service delivery has been to carefully place children at this most restrictive level of care only after other less restrictive, community-based alternatives have been exhausted and to reduce the length of stay in residential treatment (Kutash & Rivera, 1996; Stroul & Friedman, 1986). Consequently, some authors have noted that children entering residential treatment have typically experienced a history of failed placements, are more seriously disturbed, act out more aggressively, and have more complex abuse-related symptoms (Kamerman & Kahn, 1990; Singh, Landrum, Donatelli, Hampton, & Ellis, 1994; Small, Kennedy, & Bender, 1991). However, some recent findings have shown that substantial proportions of youths are still being placed in residential treatment who could be served at less restrictive levels of care in the community (Lyons, Libman-Mintzer, Kisiel, & Shallcross, 1998).

Although the effectiveness of residential treatment, over other forms of treatment or alternative models of residential care, has not been clearly demonstrated (Kutash & Rivera, 1996; Mann-Feder, 1996), it is generally agreed that residential treatment should be maintained on the continuum of care for youth in need of this type of 24 hours care and treatment (Kutash & Rivera, 1996). Most importantly, research is needed to appropriately identify youths who do require this level of treatment, to identify the most effective components of residential treatment, to test well-defined therapies for specific deficits or problems, and to identify effective strategies for reducing length of stay and facilitating youths' transition back to their families and home communities (Curry, 1991; Kutash & Rivera, 1996; Lyons, Libman-Mintzer, Kisiel, & Shallcross, 1998; Pecora, Whittaker, & Mallucio, 1992; Wells, 1991; Whittaker & Pfeiffer, 1994).

The intervention research reported here fits with this broad research agenda by developing and testing an intervention designed to respond to the special needs of youths with histories of maltreatment and exposure to family and community violence that are placed in residential treatment programs. Previous studies of the characteristics of youths with serious emotional disturbances have shown that 20–56% of youths have histories of physical abuse, sexual abuse, neglect, or were removed from their homes due to abuse or neglect (Duchnowski, Hall, Kutash, & Friedman, 1998; Illback, Nelson, & Sanders, 1998; Quinn & Epstein, 1998; Silver et al., 1992). A large

body of evidence has accumulated showing that child maltreatment and exposure to family or community violence is associated with developmental problems, and increased risk of mental health problems and/or aggressiveness in childhood, adolescence, and adulthood (for reviews, see Berliner, 1997; Malinowsky-Rummell & Hansen, 1993; Silverman, Reinherz, & Giaconia, 1996). Much less is known about the effectiveness of interventions to prevent or ameliorate the associated developmental and mental health problems (Berliner, 1997; Graziano and Mills, 1992; Greenwalt, Sklare, & Portes, 1998; Malinowsky-Rummell & Hansen, 1993). A comprehensive review of studies evaluating the effectiveness of programs, aimed at preventing and treating violence, revealed only a dozen controlled studies of mental health interventions for children exposed to physical abuse and neglect, sexual abuse, and domestic violence (National Research Council, 1998). For example, positive effects have been found in testing a therapeutic day treatment for pre-schoolers who had been abused and neglected (Culp, Richardson, & Heide, 1987); in a trial of peer-initiated social interactions for maltreated pre-schoolers (Fantuzzo, 1990; Fantuzzo, Jurecic, Stovall, Hightower, Goins, & Schachtel, 1988); in comparing individual cognitive behavioral therapy with children and parents, family therapy, and routine community services (Kolko, 1996); in cognitive-behavioral interventions for sexually abused children (Cohen & Mannarino, 1996; Deblinger, Steer, & Lippman, 1999; Verleur, Hughs, & De Rios, 1986); and in group treatment interventions for children exposed to domestic violence (Jaffe, Wolfe, Wilson, & Zak, 1986a, b; Wagar & Rodway, 1995).

The intervention presented here, referred to as the Sanctuary Model® (Bloom, 1997), was originally developed for adult trauma victims in short-term, inpatient treatment, but has been adapted for adolescents in residential treatment programs. A fundamental premise of the intervention is that the treatment environment is a core modality for modeling healthy relationships among interdependent community members. The Sanctuary Model challenges organizations to reexamine their basic assumptions concerning the extent to which treatment environments promote safety and nonviolence across physical, psychological, social, and moral domains. As such, the intervention is aimed both at strengthening the therapeutic community environment and at empowering youths to influence their own lives and communities in positive ways. The enhanced therapeutic community environment then sets the stage for the application of a trauma recovery framework and cognitive-behavioral strategies to

teach youths effective adaptation and coping skills to replace non-adaptive cognitive, social, and behavioral patterns acquired as means of coping with traumatic and other stressful life experiences. This paper describes the main components of the intervention, the evaluation design, and initial impressions of staff during the course of implementing the model that calls for considerable changes in the organizational culture.

Setting and Participants

The Sanctuary Model is being implemented in three residential programs that are located on one large campus in a suburban community of the northeastern U. S. Each program is composed of smaller residential units or cottages that serve from 7 to 16 youths. Residential, therapeutic, and special education services are provided for children and adolescents, referred primarily by public child welfare and mental health agencies. Although these programs are specialized to treat youths with conduct disorders and other serious emotional disturbances, they have not traditionally utilized a trauma-focused approach to directly treat the symptoms and consequences associated with child abuse, neglect, and exposure to family or community violence. The Sanctuary Model initiative is one of several projects underway by a large non-profit mental health and social service agency to better meet the trauma treatment needs of the children and families served.

Following an initial pilot phase, funding was received from the National Institute of Mental Health (MH62896), under the R21 funding mechanism, to study the implementation and proximal outcomes of the Sanctuary Model in this residential treatment setting. A preliminary analysis of youth demographic and history data ($N = 111$) showed that youths range in age from 12 to 20 years, with a mean age of 15 years. Seventy-three percent are male and 27% are female. Thirty-four percent of youths are Hispanic; 51% are black, not Hispanic; 11% are white; and 4% are Asian, Pacific Islander, or bi-racial. Review of client intake records showed that youths averaged six prior placements, including an average of three psychiatric hospitalizations. Thirty-four percent of the youths 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 youths have experi-

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

Model Description and Major Components

Theoretical Rationale

Experiencing maltreatment or witnessing violent events within a child's home, school, or neighborhood may result in symptoms consistent with post-traumatic stress disorder such as persistent re-experiencing of the event, avoidance of stimuli associated with the trauma, numbing of general responsiveness, increased arousal, disorganized behavior, and repetitive traumatic play (Shahinfar & Fox, 1997). Maltreatment, in particular, may lead to developmental disruptions in children's abilities to form attachments with others, to process social information and solve problems, to discriminate between positive and negative emotions and behavior, to regulate affect, and to develop accurate perceptions of self (Friedrich, 1996). Children's reactions to traumatic events can be mediated or moderated by several factors, including the nature of the event, relationship with the victim or perpetrator, or other risk and protective factors at child, family, and environment levels (Fletcher, 1996; Jenkins & Bell, 1997). Repeated exposure to maltreatment or witnessing family or community violence can result in accommodating to chronic stress in maladaptive ways (Connor, 2002; Fletcher, 1996; Terr, 1991).

Trauma theories explain the complex physiological, psychological, emotional, and behavioral responses to traumatic life events and the ways in which individuals attempt to cope with, and adapt to, these stressful life experiences (Bloom, 1997; Cichetti & Lynch,1993; Crittenden, 1997; Friedrich, 1996; Herman, 1992; Shahinfar & Fox, 1997; Van der Kolk, Weisaeth, & McFarlane, 1996). These perspectives yield implications for treating children in safe, structured, and predictable environments that facilitate transactions between multiple ecological contexts, provide continuity in their development, teach adaptive responses to stress, and create potential for change. Friedrich (1996) integrated four streams of trauma theory in

developing a set of child treatment recommendations to address post-traumatic symptoms, developmental disruptions, and unhealthy accommodations to trauma. These recommendations include strategies for modeling healthy attachments through promoting therapeutic alliances and prosocial connections with peers; and using cognitive behavioral techniques and psychoeducation to teach youths how to: develop empathy, accurately process information, problem-solve, reduce agitation and manage anxiety, identify and discriminate feelings, increase their sense of self-efficacy, and incorporate feedback from others into their own sense of selves. Particular emphasis is placed on the use of structured treatment modules that illustrate movement from victimization to self-efficacy.

In its adapted form for children and adolescents, the Sanctuary Model incorporates Friedrich's (1996) recommended strategies within a four-stage trauma recovery framework. A psychoeducation approach is used to provide skills for re-structuring thought processes, communication, and behavior to facilitate movement through the four stages of recovery. The treatment recovery framework is imbedded within a strong therapeutic community philosophy that promotes the prosocial growth and development of individuals as community members.

Staff Training and Technical Assistance

Model implementation begins with eight hours of formal staff training in which milieu counselors, supervisors, and clinicians are trained in the basic principles of the Sanctuary Model and taught how to diffuse the model into the environment and into all aspects of the treatment program. Sessions cover topics including: (a) opening communication channels and team building; (b) using trauma theories to understand how traumatic life experiences can influence youth's coping, adaptation, and social skills; (c) how to apply therapeutic community philosophy and a trauma recovery framework in working with youth; (d) how to diffuse the Sanctuary Model into team meetings and individual treatment planning; (e) how to facilitate therapeutic community meetings and involve youth in leadership roles; and (f) how to incorporate the Sanctuary Model in the larger environment—school, community, home, and family.

A major emphasis is placed on providing on-going technical assistance and consultation to staff in each residential unit to translate the Sanctuary Model philosophy, principles, and language into daily

programming, team meetings, treatment planning, community meetings, and work with families. Technical assistance is provided weekly by clinical consultants with expertise in trauma, and monthly by the model developer.

Therapeutic Community

The term, therapeutic community, is often used in a generic way to describe residential treatment environments, yet is often not grounded in active principals and values. However, the philosophy of a therapeutic community is central to the Sanctuary Model (Bloom, 1997). The core values of a therapeutic community are: the community itself is the most influential factor on treatment; clients are responsible for much of their own treatment; the operation and management of the community should be more democratic than authoritarian; and clients can facilitate each others' treatment. The Sanctuary Model adds to these values an emphasis on creating a "living-learning environment" (Bloom, 1997, p. 127) which is physically, psychologically, socially, and morally safe for both clients and staff. Establishing and maintaining a therapeutic community in the Sanctuary Model requires an active process of breaking down institutional, societal, professional, and communication barriers that isolate both staff and youths. Simultaneously, the re-building process involves consciously learning new ways to relate as interdependent community members, creating and modeling healthy and supportive relationships between individuals, and developing an atmosphere of hope and non-violence.

Diffusion of this enhanced therapeutic community philosophy begins with the development of mission statements, which are unique to each residential unit, but built upon the core Sanctuary Model principals of non-violence and shared community action. The notion of community is reinforced twice daily in community meetings that are aimed at teaching youths how to rely on their community and how to become caring and responsible community members. A protocol is followed in which all community members share feelings, state their goals for the day, ask for specific help from other members in achieving their goals, share successes at the end of the day, and discuss ways to solve community problems. In addition, incentives for prosocial community behaviors are provided through community reward programs that are tailored to the needs and goals of individual residential units.

Psychoeducation Program

The therapeutic community environment sets the stage for delivering the psychoeducation program, which is organized around trauma theories discussed above and the SAGE recovery framework (Foderaro & Ryan, 2000). The SAGE recovery framework accents the critical stages and tasks needed to affect recovery from traumatic life experiences. The four stages are safety, affect regulation, grieving, and empowerment (Foderaro & Ryan, 2000). The terminology used to describe the framework has been adapted slightly to facilitate youths' understanding of the meaning of these stages. For example, there are four types of safety, which are explained in the following way. *Physical safety* includes safety within the environment where basic needs for nutrition, shelter, and sleep are met; where individuals are free from harm; and where comfort is provided. *Psychological safety* encompasses feeling safe in one's own mind, not hurting one's own or others' feelings, and the ways you talk to yourself, peers, staff, and family. *Social safety* refers to feeling safe with and trusting other people, and learning how to choose friends that you can trust. It also means being able to manage rough times and situations safely by talking rather than fighting. *Moral safety* means feeling safe enough to do the right thing, making good choices and doing your best to hold to them, respecting others, and having values that you live up to. Affect modulation is translated as emotional management; grieving is rephrased as loss; and empowerment is interpreted as focusing on the future.

A 12-session psychoeducation group curriculum has been developed to formally introduce youths to the Sanctuary Model and to teach knowledge and skills needed to progress through the four stages of recovery (Duffy, McCorkle, & Ryan, 2002). Groups are convened weekly and are co-led by clinicians and milieu counselors. Each session has learning objectives, exercises, and ways of transporting information and practicing skills between sessions. Table 1 presents an overview of the concepts covered and skills rehearsed in the sessions. Activities include viewing and discussing videos, interactive activities, role plays, pencil and paper exercises, and writing exercises.

At the last session participants are rewarded with a certificate of completion and encouraged to become role models as they begin to live their lives more aware of how connected they are to others and how their emotions, safety, and successes affect others. Acknowledg-

TABLE 1

Overview of Psychoeducation Groups

Session/Topic	Concepts covered	Skills rehearsed
Sessions 1–2: Trauma and stress	Definition of stress and trauma	Recognizing events that are stressful, threatening, or dangerous
	How people respond to stressful life experiences in various ways? (flight/fight/freeze)	Identifying and understanding how stressful events trigger physical responses (adrenalin) and behavioral responses (fight, flight, or freeze)
	How stress interferes with feeling, thinking, and acting?	Recognizing unhealthy ways that people learn to cope with overwhelming stress (withdrawing, excessive activity, addiction, fighting)
	How our relationships and experiences teach us to cope?	How to be aware when you are reacting to past stressful events in the present
	How some coping patterns are not healthy and how people can learn new ways to cope that may be more helpful?	Monitoring your stress levels and responses

TABLE 1 (*Continued*)

Session/Topic	Concepts covered	Skills rehearsed
Session 3: Four Stage recovery framework	Introduction to the four stages: Being safe, managing emotions, dealing with loss and change, moving on and making choices for the future	Differentiating the four stages and using the language
	Linking stages with behaviors	Mapping one's life choices
	How moving through the stages can help young people learn healthy ways of coping and problem-solving?	Using the stages as guideposts in mapping the future Practicing self-help skills
Sessions 4–5: safety	Definition of the four types of safety: physical, psychological, social, and moral	Recognizing and avoiding unsafe situations (i.e., threats of self harm, or threats of harm from or toward others)
	Applying the safety principles and learning new skills to establish and maintain safety	Identifying ways individuals create safety in communities Developing and practicing how to use individual safety plans
Session 6: boundaries	Definition of personal boundaries and why people need them	Differentiating between physical and emotional boundaries

	How to create boundaries by asserting one's self	Setting personal boundaries
	How to recognize when you might be entering another person's boundaries?	Saying yes or no when others want to enter your boundaries Recognizing when you violate the boundaries of others
Sessions 7–8: affect regulation	Feelings are natural and help us understand ourselves – what we like, what we don't like	Naming feelings
	Links between emotions, behaviors, and decision-making	Becoming aware of the cause of feelings
	Recognizing and managing emotions gives people more control over the present and helps us move toward our goals	Recognizing various feeling signals in mind and body
	The role of feelings in conflict resolution	Managing the intensity of feelings without numbing or losing control. Using self-soothing skills Identifying and practicing healthy ways to express feelings

TABLE 1 (*Continued*)

Session/Topic	Concepts covered	Skills rehearsed
Sessions 9–10: loss and grief	How dealing with change and loss affects our safety, feelings, and ability to move on to the future?	Recognizing personal losses
	How people can get stuck when they are not able to grieve their losses?	Reaching out to others when feeling sad
	How people need support when they are grieving so their safety can be maintained.?	Supporting others who are feeling sad because of their losses
Sessions 11–12: future	How one's future is connected to the ways we keep ourselves safe, manage our feelings, and move beyond our losses?	Identifying life skills that keep us safe
	How to make choices that will get you to the future you want?	Describing one's self in the future
	Planning for the future	Listing steps to take to get toward the desired future
	Review of coping skills	Practicing the steps

ing that recovery is a non-linear and cyclical process, the 12 sessions are designed to be ongoing. Youths newly admitted to the program can enter the group at whatever stage is currently being covered. Youths who have completed a full round of the psychoeducation groups are expected to continue participating in the group with a new awareness of their own stage of recovery, to acquire new learning, and to bring their new skills and experience to help other members of the community.

Various exercises, used in the formal psychoeducation groups, have been compiled into a supplemental manual that can be used in the course of everyday program operations on the residential units. For example, a feelings poster and a feelings scale can be used as needed to help youths identify what their emotions are, how strong they are, where on the emotions scale they are most comfortable, and how to bring their feelings to more manageable levels. Individual safety plans, jointly developed by youths and their counselors to identify alternative ways to feel safe in unpleasant or stressful situations, can be put into action when youths show signs of distress. At times when the whole community feels unsafe due to conflict or acting out behavior, group exercises can be used to assist in identifying the cause of the conflict and alternative ways of problem-solving and working through conflict. Various paper and pencil exercises used in the psychoeducation groups for visualizing the future, such as mazes and drawing one's self in the future, can be pulled out as needed to help youths consider possible outcomes of different choices (e.g., how will you feel tomorrow morning if you follow your safety plan right now, versus running away?).

Evaluation

Figure 1 illustrates the conceptual framework for the research and illustrates the two main components of the Sanctuary Model (enhanced therapeutic community and psychoeducation modules) and their respective elements, and the expected proximal outcomes projected for the therapeutic communities and youths.

The Sanctuary Model was first piloted in five residential units that self-selected to participate in the initial phase of the project. Following the pilot, four additional residential units were randomly assigned to implement the model. Eight other residential units, where the model is not being implemented, serve as the usual

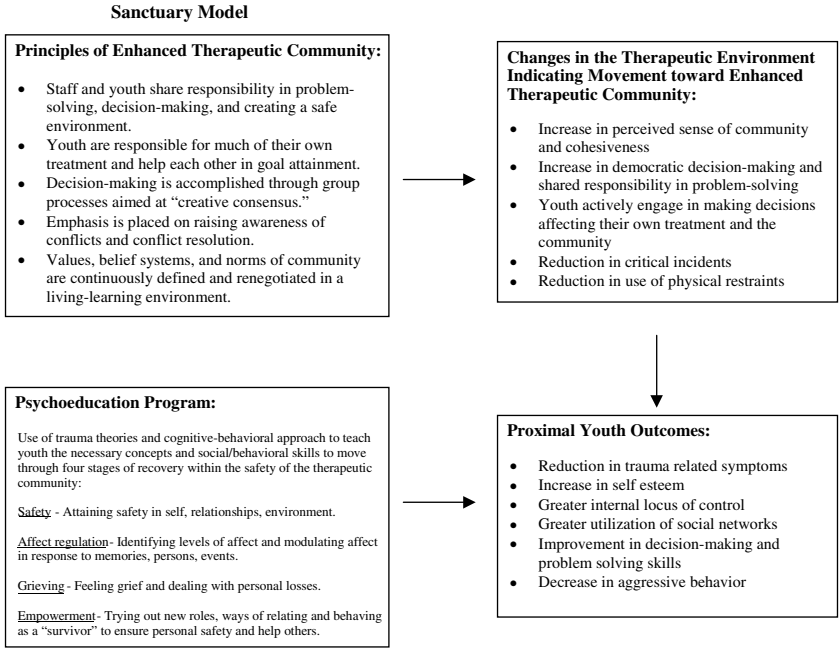

FIGURE 1. Conceptual framework.

services comparison group. A comparison group design (Sanctuary versus Standard Residential Services), with measurement at five points (baseline, 3, 6, 9, and 12 months) is being used to examine change in the two conditions. Several standardized instruments are being used to measures changes in the therapeutic community environments and change in youths' functioning and behaviors (Rivard et al., 2003). In addition, change in the frequency of critical incidents (e.g., harm to self, others, or property) and use of physical restraints is being measured by accessing and analyzing data from the agency's management information system.

The extent to which model implementation in this setting adheres to the original model is being measured through consultant's process notes, periodic review of a Sanctuary Model Milestones Checklist (e.g., development of mission statement, community meetings are held twice daily, community meetings are co-led by staff and youths, staff use psychoeducation exercises on the residential units), and a Psychoeducation Group Fidelity Checklist. Qualitative data on staff

perceptions of the course of implementation, and challenges in implementing the Model, are also being collected through focus groups, convened every 6 months. Findings of the first round of focus groups are presented below.

Focus Groups Methods and Results

The first round of focus groups was conducted during late January to early March, 2002 during the initial stages of implementation. A total of 10 focus groups were convened. Three involved clinicians and administrators/supervisors ($n = 7$–12 participants in each group), and seven focus groups involved milieu counselors ($n = 3$–10 participants in each group). Open-ended questions were posed to each group to generate responses concerning the ways in which the basic principles and philosophy of the model are being diffused into their practice and into the treatment environment. Then participants were asked to describe factors that facilitated and inhibited their ability to implement the model. Focus groups were audiotaped, with permission of participants, and transcribed. Responses to each of the focus group questions were compiled across the groups. The aggregated responses to each question were then coded and displayed in matrices by major themes, categories, and sub-categories. The following narrative summarizes the major themes that emerged across all focus groups.

Staff Relationships and Roles in Community Building

There is growing awareness among staff that their own communication is integrally related to safety in the treatment environment. The more they communicate, the physically safer the environment is for youth and staff. Communication reduces chaos, and builds closeness and trust. Similarly, a more psychologically and socially safe environment encourages staff to openly share their ideas, opinions, frustrations, and mistakes. There was a general observation that the quality of team meetings and case conferences has improved with more active involvement and communication of all staff, and that these meetings provide a forum for practicing how to deal with program issues in non-hierarchical ways.

Youth Relationships and Roles in Community Building

The diffusion of the model among youths is seen as they take a stronger role in leading or co-leading community meetings. In some cases, youths themselves call for special community meetings to deal with issues causing community problems. One direct impact has been observed when youths take the initiative to reach out to those who are not actively participating in community meetings, or to later check on those who expressed being upset in earlier meetings.

Diffusion of the Trauma Recovery Framework

The comment was repeatedly made that it is easier to diffuse concepts of trauma theories into individual therapy sessions than into the larger milieu. Staff commented that the trauma recovery framework itself provides a helpful guide to reorient treatment goals toward a recovery path, and provides concrete tools for empowering youths. The way that staff think about youths' acting-out behavior is shifting from "responding to bad behaviors" to "teaching more adaptive ways of coping and relating." Focusing on the future is helpful in instilling a sense of hopefulness in youths and prompting them to think about their futures. This sense of hopefulness also validates the work of staff, which can often seem unrewarding. Safety plans encourage youths to take greater responsibility for their own treatment. Rather than only relying on program rules, staff are tending to process feelings and decisions with youths, and to discuss behavioral alternatives. There is heightened awareness on teaching youths how to make the right choices, to not repeat previous bad choices, and to take responsibility for their choices.

In working with families where there is history of trauma, the challenge is to sensitively acknowledge the issues without making families feel they are being blamed, and without increasing guilt and remorse they may already feel. Some families are open to discussing the subject as a family issue, where others prefer to concentrate on the youths' problem behaviors. Sessions focus on ways to help the youth and family adapt after very difficult life experiences.

Factors that Promote or Inhibit Model Implementation

Consistency in using the model was described as critical. Factors that promote implementation and consistency of the model include

staff training, the use of the word safety, community meetings, building in structured times for discussing implementation and team-building, proceduralizing use of the psychoeducation tools, general openness of staff and youths to trying and listening, keeping everyone satisfied and motivated, small successes that build enthusiasm and constant reinforcement, helping youths to get a broader and deeper understanding of the trauma recovery framework, group cohesion among youth and staff, providing community-level incentives for positive community behaviors, program leadership, the presence of therapists and administrators on the residential units, and less division among all staff which leads to less confusion for youths about who are the authority figures. Finally, staff perceived that the on-going influence of the Sanctuary Project consultants was helpful in making change happen fast, in "breaking the norm," in teaching staff how to incorporate trauma treatment strategies, and in facilitating implementation through problem-solving.

Factors which posed barriers to model implementation and consistency include insufficient time to do the constant communication and team-building needed; different ways that crises are handled in school and in the residential programs; all staff who work on the units have not received the formal training because they are new hires, on-call staff, or have multi-unit administrative responsibilities; perceived lack of, or changing, administrative support and allocation of resources; constraints imposed by the current research design which calls for limiting the number of units implementing the model. Although the basic 8 hour Sanctuary Model training and the consultation/technical assistance were praised as facilitators, staff emphasized the need for further training with more experiential content.

Discussion

The Sanctuary Model project began with a strong institutional base. It was initiated by the agency itself through an existing partnership between a university and the agency to develop evidence-based practices. The project originated from a desire of the host agency to improve its service delivery by incorporating a new model of treatment to meet the special needs of youths with histories of maltreatment and violence exposure. A core planning group, composed of approximately 20 administrators, lead clinicians, and unit

supervisors that represented all of the residential programs, guided initial program development and paved the way for implementation to begin. This initial development team then had to gain support and commitment from the actual program personnel who would be implementing the model – finding out what resources they would actually need to implement the model, trying out different methods of educating staff about the Model, and engaging in ongoing dialogue to overcome resistance to a new treatment approach. Staff have seen new program initiatives come and go, so there was natural skepticism about another new promising intervention.

Implementation of the Sanctuary Model has met with many challenges, primarily in changing the way staff conduct business as usual and in changing the organizational culture. As stated by Cafferty and Leichtman (2001, p. 18), " Introducing changes into treatment systems in which other theoretical perspectives (e.g., those of psychoanalysis, behaviorism, or biological psychiatry) are deeply entrenched is hard under the best of circumstances." For example, there has been resistance to changing roles historically assigned to therapists as the change agents and to milieu counselors as child care workers. To counter these role divisions, the Sanctuary psychoeducation groups are designed to be co-led by both clinicians and milieu counselors. Clinicians are encouraged to be on the units more often and to participate regularly in community meetings. The new efforts to move away from a medical model, to flatten the traditional organizational hierarchy, and to empower staff as well as clients, have brought to light longstanding gaps in communication and trust among staff. Although difficult, surfacing conflict and re-examining basic assumptions among staff is seen as an important process in implementing the model.

In studying children's service systems, Glisson and Hemmelgarn (1998) found that organizational climates with greater job satisfaction, fairness, cooperation, and 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.

Results of the focus groups described above suggest that the Sanctuary Model is exerting an impact on practice with youths and on relations among staff and youths. Feedback from this initial round of focus groups was extremely important and led to the immediate

initiation of booster sessions, with a more experiential focus. In these sessions role plays are used to rehearse new intervention skills, to practice ways of intervening collaboratively, and to strengthen skills in working with groups.

In the near future, results from the quantitative analyses of change in the therapeutic environments and in youths exposed to the Sanctuary Model, will show what advantages the model offers over standard residential programming. However, there is already movement to strengthen the model by diffusing the model into the school environment, and with the development of a specialized family-based transition and aftercare services to ensure that gains made in residential treatment are maintained and to decrease the likelihood of reentry.

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