
RESEARCH REPORT

The Sanctuary Model: Enhancing the Quality of Group Care in Florida

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Principal Investigator:
Andry Sweet, Chief Strategy Officer
Children's Home Society of Florida

Co-Investigators:
Bruce Thyer, PhD, MSW
Florida State University College of Social Work

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Abstract

The Children's Home Society of Florida (CHS) adopted a new model of staff training and clinical service delivery known as the Sanctuary Model (SM) of care. The SM is a trauma-informed approach to revitalizing staff and positively effecting children. The service sites consisted of CHS group homes who admit and treat youth who have been directly or indirectly exposed to severe trauma (domestic violence, homicide, child abuse or neglect, sexual abuse, etc.). Staff were asked to complete a measure of job satisfaction and of the experience of secondary trauma, before they received training in the Sanctuary Model of care and to complete these measures again after training was finished. Youth residing in the group homes were asked to complete a measure of functional impairment and of post-traumatic stress disorder symptoms when staff training in the SM model began, and again after three months of exposure to clinical services guided by this approach. It was predicted that over time and exposure to the Sanctuary Model, youth would report a significant lessening of PTSD symptoms and functional impairments. It was predicted that staff could report enhanced job satisfaction and a lessening of secondary trauma exposure symptoms. It was found that PTSD symptoms did significantly decline after youth had received several months of group home care guided by the Sanctuary Model, but function impairments did not similarly improve. Staff job satisfaction scores were initially high, and did not significantly improve after they received training in the SM, perhaps reflecting a ceiling effect in that there was little initial room for improvement. Staff symptoms of secondary trauma similarly did not significantly decline. The overall results may be described as promising, but a low percentage of follow-up results were problematic, and possibly relevant to the lack of changes found on some measures. It is recommended that the CHS continue the practice of assessing youth and staff functioning on these existing or alternative measures over the months to come. This could provide a more robust evaluation of the possible impact of the SM on the group home services they provide.

Background

In an effort to improve its group home services to traumatized youth, in 2016 the CHS adopted an approach to staff training and child care known as the Sanctuary Model. The Sanctuary Model is an approach to organizational change aimed at improving staff morale, knowledge and skills, and improving clinical outcomes for clients receiving care related to a variety of psychosocial issues and problems, including formal psychiatric disorders, domestic violence, substance abuse, homelessness, and trauma. It is a relatively well developed model of organizational change, with extensive training opportunities and support information, primarily made available through <http://sanctuaryweb.com>. The philosophy and principles undergirding the development and current operation of the SM are detailed on the organization's website.

"The Sanctuary Model is a blueprint for clinical and organizational change which, at its core, promotes safety and recovery from adversity through the active creation of a trauma-informed community. A recognition that trauma is pervasive in the experience of human beings forms the basis for the Sanctuary Model's focus not only on the people who seek services, but equally on the people and systems who provide those services. Sanctuary has been used in organizations that provide residential treatment for youth, juvenile justice programs, homeless and domestic violence shelters as well as a range of community-based, school-based and mental health programs."¹

Program Goals

The goals of the Sanctuary Model are to:

- Create a collaborative treatment environment
- Work more effectively and therapeutically with traumatized clients
- Improve treatment outcomes as determined by individual agency service goals
- Reduce restraints and other coercive practices
- Build high-functioning multidisciplinary teams
- Improve staff morale
- Increase measurable levels of hope, safety, trust, emotional intelligence and problem solving skills in both staff and clients
- Increase employee retention
- Support the mission and services of the organization by adding a trauma lens"

According to the California Evidence-based Clearinghouse for Child Welfare, the Sanctuary Model is given a scientific rating of 3 (on a scale of 1-5), indicating 'Promising Research Evidence.' This rating of 3 means:

- 1) At least one study utilizing some form of control (e.g., untreated group, placebo group, matched wait list study) has established the practice's benefit over the control, or found it to be comparable to a practice rated a 1, 2, or 3 on this rating scale or superior to an appropriate comparison practice. The study has been reported in published, peer-reviewed literature.
- 2) Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.

- 3) If multiple outcome studies have been conducted, the overall weight of evidence supports the benefit of the practice.
- 4) There is no case data suggesting a risk of harm that:
 - a) was probably caused by the treatment; and b) the harm was severe or frequent.
- 5) There is no legal or empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.
- 6) The practice has a book, manual, and/or other available writings that specify the components of the practice protocol and describe how to administer it."

In addition to a limited amount of controlled outcome studies,² there are a number of descriptive and theoretical articles and book chapters describing the approach;^{3,4} a few uncontrolled pre- and post-test small group outcome studies; and some narrative approaches that used qualitative research methods to study process evaluations of the Sanctuary Model.⁵ For more information on the Sanctuary Model, see Appendix A.

The Children's Home Society of Florida has adopted the Sanctuary Model across its residential group homes. The focus of this initiative is to enhance the organizational climate and philosophy in a positive direction that will improve staff morale, and to improve the clinical outcomes obtained through the residential treatment services provided to children who have experienced trauma. Traumatic experiences of children referred to the CHS may include the direct experience of sexual, physical, or emotional abuse, neglect, or the indirect experience of these traumas via witnessing their occurrence. Some youth may have experienced trauma related to man-made or natural disasters such as hurricanes. Constant exposure to, and caring for, youth with a history of exposure to serious traumatic events can lead to the development of what has been called secondary trauma among the caregivers of such youth. The occurrence of secondary trauma has been suggested to lead to high job turnover rates among child welfare direct care staff, and to poor decision-making on the job.⁶

Project Description

This evaluation project had two main foci, each examined using different measures:

- 1) To see if the **youth** exposed to the SM of care improve in terms of their trauma symptoms and functional impairments.
 - 1a. Trauma symptoms were to be measured using the *Child PTSD Symptom Scale* (SPSS)⁷ administered when a child was admitted to a CHS group home, and again after three months of group home care, or upon discharge, whichever occurred first. The Trauma Symptom subscale of this measure was used for this purpose.
 - 1b. Functional impairment was also to be measured using the *Child PTSD Symptom Scale* administered when a child was admitted to a CHS group home, and again after three months of group home care, or upon discharge, whichever occurred first. The Functional Impairment subscale of this instrument was used for this purpose.

The CPSS is a 24-item scale, with a range of scores from 0-51, with higher scores reflective of more serious issues with trauma symptoms. It was designed for use with youth ages 8-18 years old. The coefficient alpha, a measure of internal consistency, for the CPSS total score was found to be .89, indicating very high reliability. The percentage of agreement between the CPSS total score and the actual diagnosis of PTSD was 84 percent, indicating that this scale's scores are highly correlated with clinical diagnoses. A clinical cut off score of 11 or higher is best used to distinguish children with a significant problem with trauma symptoms from those without such a history.⁸

2) To see if staff morale and secondary trauma improves following the implementation of the Sanctuary Model.

2a. Staff morale was measured by the *Index of Job Satisfaction (IJS)*⁹ given prior to staff training in the Sanctuary Model, and three months after completion of SM training.

Group home staff trained in the SM were asked to complete the *Index of Job Satisfaction*. The IJS scores may range from zero to 100, with lower scores indicating less job satisfaction and higher scores greater satisfaction. The coefficient alpha of this scale is .90.

2b. Secondary trauma experienced by the staff was measured by the *Secondary Traumatic Stress Scale*,^{10,11} given prior to training in the Sanctuary Model, and three months after completion of the training.

The STSS is a 17-item scale which can present a range of scores from one to 85, with higher scores indicating greater levels of secondary trauma. The coefficient alpha for this scale's total score was .93, indicating very high reliability. The mean score obtained by Bride et al. (2004) for STSS scores from 287 social workers in the southeastern United States was 29.49, workers employed in regular agencies not implementing the Sanctuary Model.

Sanctuary Model Roll-out within the Children's Home Society

The CHS has commissioned trainers from the SM organization¹² to provide training for all of the staff members employed in its 27 group homes across Florida. Ultimately this involved completing 10 discrete training modules. All youth residing in CHS group homes were exposed to this new model of care and organizational culture. Training CHS staff in the Sanctuary Model began in the summer of 2016.

Measurement of Potential Change among Residential Staff Trained in the SM of Care

The *Secondary Trauma Symptom Scale* was completed by staff before they began training in the SM. This scale was re-administered to the staff approximately three months following their completion of the complete Sanctuary Model trainings. This three month gap is intended to allow time for the staff training to take effect within the group home environment. Ultimately, the

pre-training scores were to be statistically compared with the post-training scores to see if secondary trauma symptoms have been reduced, which is a hypothesized outcome of training staff in the use of the Sanctuary Model of care.

After the group home staff had been trained in the SM and had implemented it in their group homes, staff (or remaining staff, if turnover has reduced the original numbers) were asked to complete the *Index of Job Satisfaction* after three months of full implementation.

Data from multiple group homes were combined to permit legitimate inferential statistical analysis for data from both youth and staff.

Electronic and hard copies of the above pre-and post-test measures were forwarded to Dr. Bruce Thyer, FSU College of Social Work, for analysis. These are blinded in that no personally identifiable information is contained on the forms, only a self-constructed anonymous identification number which will permit matching of pre-tests with post-tests. These instruments were scored, and a database was constructed using SPSS.

Results

Sample copies of the assessment measures were provided by Dr. Thyer to the CHS administration who was asked to ensure their distribution to appropriate youth and staff across the group home receiving training in the SM. Completed de-identified measures were forwarded to him and the results were aggregated and subjected to descriptive and inferential statistical analysis to answer the questions posed regarding any changes following implementation of the Sanctuary Model of care.

Children – Post Traumatic Stress Disorder Symptoms

1a. Do children admitted to a CHS residential home for the treatment of trauma experience a reduction in trauma symptoms after 3 months of such care (or upon discharge from the home, whichever occurs sooner)?

A total of 96 youth admitted to the CHS's groups homes across Florida completed the Child Post-Traumatic Symptom Scale when they were admitted. On average their score was 18.71 (SD = 14.16), well above the clinical cutoff score of 11 suggested by Foa et al. (2001). After three months of in-home care, 20 youth completed the Child PTSD Symptom Scale again, earning an average scores of 10.75 (SD = 8.96). A paired sample *t*-test on the mean difference of pre-test and post-test scores was statistically significant at $p < .05$. This indicates that among the responding youth, PTSD scores statistically significantly *declined* during the several months stay of their treatment in CHS group homes which had implemented the Sanctuary Model of care among their staff. This represented meaningful *improvement* in trauma symptoms. Among the post-tested youth, their average post-treatment Trauma Subscale score fell below the 11-point benchmark Foa et al. suggested as a clinical cut-off-score.

Children – Functional Impairment

- 1b. Do children admitted to a CHS residential home for the treatment of trauma, experience an improvement in functional impairments related to trauma, after three months of such care (or upon discharge from the home, whichever occurs sooner)?

A total of 90 youth admitted to the CHS group homes completed the Child PTSD Functional Impairment Scale when they were admitted. On average their Functional Impairment scores were 3.31 (SD = 2.63). After 3 months of in-home care, scores were received from 9 youth who completed this scale, with an average scores of 5.0 (SD = 2.44). A paired sample *t*-test on mean difference of pre-test and post-test scores was found $p = .068$. This change did not achieve statistical significance.

Staff – Index of Job Satisfaction

- 2a. Is implementation of the SM followed by improved staff worker satisfaction scores, as assessed by the Index of Job Satisfaction?

A total of 63 staff completed the Index of Job Satisfaction prior to their beginning training in the Sanctuary Model of care. Their mean score was 72.52 (SD = 12.61). After they completed training in the Sanctuary Model of Care, 29 staff completed the Index of Job Satisfaction and provided a mean score of 65.89 (SD = 15.01). A paired sample *t*-test on this difference found $p = .05$, indicating slightly lower but statistically significant changes in job satisfaction. In either case, both the pre-test scores and post-test mean scores are comparatively high, indicating generally good levels of job satisfaction before and after SM training.¹³

Staff – Secondary Trauma Stress Scale

- 2b. Is implementation of the Sanctuary Model followed by reduced secondary trauma symptoms among staff?

A total of 65 staff completed the Secondary Trauma Stress Scale before they began training in the Sanctuary Model of care, earning a mean score of 29.64 (SD = 13.1). After they completed staff training, 23 care workers completed the Secondary Trauma Stress Scale and earned a mean scores of 26.96 (SD = 8.70). A *t*-test on this mean difference disclosed [$t(59) = .909$; $p > .05$]. This indicates that staff secondary trauma stress was not lowered following training in the Sanctuary Model of care.

Discussion

There is credible evidence from the Children's Home Society of Florida that traumatized children exposed to a therapeutic group home environment that is guided by the principles of the Sanctuary Model experienced significant improvements in their traumatic symptoms. Functional impairment scores of these same youth were not observed to significantly change.

Job satisfaction among workers assessed before and after their undertaking training in the Sanctuary Model did not significantly improve. However, given that job satisfaction was relatively high both before and after SM training, it is possible (indeed likely) that a ceiling effect existed in that already high levels of job satisfaction had little room to elevate.

Before SM training, CHS staff levels of secondary trauma registered at about the same level found by this scale's original authors, among social workers in the southeast, about 29 (scores can range from 0-85, with higher scores indicating elevated levels of secondary trauma). After SM training, CHS staff scores on secondary trauma fell slightly, to about 27, but this was not significantly different. Again, a floor or basement effect (opposite to the ceiling effect mentioned above) may be at work here in that with pre-test scores averaging 29 points, on a scale whose scores range from 0-85, the workers' relatively low scores to begin with (i.e., low secondary trauma) may have mitigated against demonstrating much improvement.

Limitations

Among this study's limitations are the high levels of attrition in the numbers of children and staff assessed at post-test compared to the initial assessments. This problem is endemic in research conducted in real life agency settings such as the CHS group homes. Undoubtedly, some workers left employment with the agency from the time they took the pre-test; and time elapsed during which the extensive training in the Sanctuary Model transpired; and several months passed during which time it became fully implemented in the group homes (when post-tests occurred). The lack of a comparison group of youth and staff makes it difficult to isolate the effects of exposure to the Sanctuary Model of care (in the case of resident youth) and training (in the case of staff), relative to, say the passage of time. If youth are admitted to a group home in a time of great crisis, the attenuation of trauma symptomatology could be possibly due to the simple passage of time, the temporal and psychological distance from living in their previously high-risk (by definition, given their admission into the CHS group home) environments, to the safer environment of the group home.

The CHS could continue to evaluate the implementation of the SM of training by looking at various administrative aspects of data, potentially including factors such as reductions in children eloping from the home and reductions in staff turnover. This may reveal further potential benefits of the Sanctuary Model and would not be a costly undertaking.

Policy Recommendations

The Sanctuary Model is a well-developed approach to child welfare group home staff training. It is supported by a credible theoretical foundation, and has been widely adopted in child welfare and many other settings within the human services. Empirical outcome studies published in peer-reviewed journals documenting the effectiveness of the SM against some form of control intervention such as treatment as usual are very limited and long term follow-up evaluations are also rare. This lack of existing research presents the Children's Home Society of Florida an opportunity to continue the practice of assessing the psychosocial functioning of traumatized children upon their admission to a CHS group home that has adopted the SM of staff training and clinical service and again upon discharge (or say after three months of in-home care). Additionally, CHS could annually aggregate and report these results in professional journals so they can contribute to the evidence-based foundations of the Sanctuary Model. Similar efforts could be made with respect to staff functioning, using worker satisfaction, turnover, and work environment atmosphere as outcome measures. This could be undertaken not as a one-time demonstration, but as an integral effort of ongoing group home operations. The SM is an approach that requires several years to complete training and be fully adopted by facilities, so time is available to undertake such simple evaluations. If undertaken, strenuous efforts should be made to ensure that as many children and staff complete the initial and subsequent evaluation scales so as to promote developing findings that reflect a broad overview of the youth and staff.

The SM model is intended to be used with youth 12-20 years of age. To the extent that the CHS group homes accept children younger than 12 years of age, and expose them to services guided by the SM, it is important to realize that this model is of unknown value, and special efforts should be undertaken to carefully assess the reactions of these younger-aged children to the program. Not all programs of social care are helpful or benign, and some have been shown to yield adverse effects, contrary to all expectations and good intentions. Unless careful efforts are made to assess clinical impact on trauma symptoms and overall child well-being, as described above, are routinely carried out with fidelity, applying an unproven model poses the potential for unrecognized harms to be inflicted.

References

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Appendix A

Podcasts on the Sanctuary Model

#10 The Sanctuary Model: A Trauma-Informed Approach to Treatment and Services

#77 The Sanctuary Model: Changing the Culture of Care - It Begins with Me (part 1 of 2)

#79 The Sanctuary Model: Changing the Culture of Care - Transforming Human Services (part 2 of 2)

(all available at <http://www.insocialwork.org/>)

Video on the implementation of the Sanctuary Model at one youth residential facility in Northern Ireland (<https://www.youtube.com/watch?v=M9LstyjD3kQ>) titled Therapeutic Approaches to Residential Child Care in Northern Ireland.

Additional downloadable media available from the Sanctuary Model website are available here:
<http://sanctuaryweb.com/Products/DownloadableMedia.aspx>