Trauma-Informed Mental Health Service Delivery: Examining Parallel Processes in the School Treatment Program

by

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ABSTRACT

TRAUMA-INFORMED MENTAL HEALTH SERVICE DELIVERY:
EXAMINING PARALLEL PROCESSES IN THE SCHOOL TREATMENT PROGRAM

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Within the past 20 years, awareness of the effects of exposure to complex trauma during childhood has grown (Harris & Fallot, 2001a, 2001b; Jennings, 1994; Shaw, 2010). When individuals are exposed to complex traumatic events (Herman, 1992) their lives can become organized around the trauma (Bentovim, 1992). In a similar process, mental health services can also become trauma-organized systems (Bentovim, 1992). Systemic constraints can induce chronic stress, which in turn can limit service providers’ ability to integrate various cognitive, emotional and interpersonal capabilities required to effectively operate systems (Bloom, 2005b). In response to this awareness, many mental health agencies are attempting to develop trauma-informed approaches to treatment. One such approach is called the Sanctuary Model (Bloom, 1997; Bloom & Farragher, 2011), which was based on the philosophy of a therapeutic milieu that requires trauma-informed shifts in organizational culture (Bloom, 1997, 2005b). A children’s mental health agency decided to adopt a Sanctuary Guided Trauma-Informed Practice (SGTIP) throughout its programs. This research represented community-engaged scholarship (Jordan, 2007) with the purpose of determining the extent to which the organizational culture within the School Treatment Program (STP) had become trauma-informed. A comprehensive, contextualized study (Kirby, 2007) using a sequential mixed-methods design (Creswell & Plano Clark, 2011) was undertaken. This study reflects one of the first explorations of organizational culture from varied sources in a children’s mental health agency. This research also provided voice to the experiences of people within the system. Results indicated that although aspects of the Child and Youth Workers’ (CYW) and the classrooms’ organizational cultures reflected commitments associated with the Sanctuary Model, they were not fully trauma-informed. Factors that influenced the adoption were described from the Transformative Knowledge Translation perspective. The perspectives and recommendations may be valuable for other agencies seeking to adopt similar trauma-informed approaches.
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My people perish from a lack of knowledge.

Hosea 4: 6

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Introduction

Mental health disorders in children and youth present significant concerns in North America, with prevalence ranging between 13-20% (Angold & Costello, 1993; Merikangas et al., 2010; Waddell & Godderis, 2005; Waters, Davis, Nicolas, Wake, & Lo, 2008). These disorders can result in significant distress and impaired function in the children’s lives (Waddell & Godderis, 2005). A growing trend in the area of children’s mental health is the increased recognition of the relationship between childhood trauma exposure and later mental health disorders (Alvarez et al., 2011; Bloom, 1994; Felitti et al., 1998; Nelson et al., 2002; Renn, 2002; Spence et al., 2006) and a realization that childhood trauma is often not properly identified or addressed (Bloom, 1994; Brady, 1997; Jennings, 1994). In light of this recognition, mental health service providers need to be educated in the effects of trauma exposure and to develop new ways of responding to the exposed individuals.

Within this literature review, the relationship between mental illness and exposure to trauma was reviewed. Based on a critical theory of trauma, the ways in which the individual can become trauma-organized was described. In extending trauma theory to mental health service, it has also been suggested that these services can also become organized around the unresolved effects of trauma. The need to become a trauma-informed mental health system and the implications of attempting to adopt such an approach with a children’s mental health agency were reviewed. Specifically, developing new ways of responding to the exposed individuals requires changes in organizational structures. One specific trauma-informed approach was the Sanctuary Model. The Sanctuary Model is based on the therapeutic milieu, which requires shifts in organizational culture informed by an understanding of trauma. The assumption, components and previous application of the Sanctuary Model were critically reviewed. Further, becoming trauma-informed has been conceptualized as the diffusion component of the Knowledge Translation process. Such changes in organization are challenging and they require consideration of the complex systems in which they operate. Accordingly, these latter were also reviewed from a transformative and ecological perspective.
Relationship of Mental Illness and History of Trauma

It is commonly understood that the etiology of mental illness is complex and may be influenced by genetic, biological, psychological and environmental factors (Jacob & Storch, 2013; Pilgrim, 2002). Previous history of medical and psychiatric disorders has been linked to later development of mental illness (Jacob & Storch, 2013). According to Costello, Mustillo, Erkanli, Keeler and Angold’s (2003) evaluation of childhood and adolescent mental health disorders, subsequent diagnoses of a mental health disorder were found to be three times more likely to occur in adolescents who had a history of a psychiatric disorder than those without a previous diagnosis (Costello, Mustillo, Erkanli, Keeler, and Angold, 2003). Although there was continuity in the disorders, childhood disorders were also predictive of other disorders (e.g., from depression to anxiety, from anxiety to depression, from Attention Deficit Hyperactivity Disorder to Oppositional Defiant Disorder) even while controlling for comorbidity. The authors proposed that these findings suggest an underlying vulnerability or underlying disorder that may be manifested at different ages (Costello et al., 2003). Some biological dispositions (e.g., susceptibility to hypnosis, epilepsy, abnormal EEG activity and abnormalities in various parts of the brain) have been related to the development of mental health disorders (Davidson, Pizzagali, Nitschke, & Putnam, 2002; Sadock & Sadock, 2003). Additionally, having a parent with major depression has been linked to an increased risk of his/her children developing depression (Lieb, Isensee, Höfler, Pfister, & Wittchen, 2002). This increased risk may also be an indication of learned behaviour (Akiskal, 1991; Badger & Rand, 1998) as research also supports the influence of environmental factors (Halligan et al., 2013; McNaughton, Patterson, Irwin, & Grant, 1992). However, complex biological and environment interaction has also been found, for example, children of families experiencing high levels of psychosocial adversity and low levels of maternal sensitivity were associated with low levels of emotion regulation capacities and behavioural problems (Halligan et al., 2013). Investigators have also found that exposure to childhood physical and sexual abuse combined with the absence of social support are likely the contributors to dissociative identity disorder (Rice, Harold, & Thapar, 2002; Walsh, Green, Matthews, & Bonucelli-Puerto, 2005). Accordingly, there are several contributions to the onset and maintenance of mental illness, including genetic, biological, environmental and these influence can be interactive.
Exposure to trauma in childhood has been determined to be a significant contributor to some disorders (e.g., Reactive Attachment Disorder (RAD), Acute Stress Disorder and Post-Traumatic Stress Disorder; American Psychiatric Association, 2000). Recent research, however, has suggested further diversity of effects, including influences on affect, cognition and behaviour (A. Cook et al., 2005; van der Kolk, 2005). These children may often meet the diagnostic criteria for a variety of other disorders (Ackerman, Newton, McPherson, Jones, & Dykman, 1998; A. Cook et al., 2005; Heim & Nemeroff, 2001).

Recognition of the prevalence of exposure to early trauma in children by mental health services has grown (Bloom, 1994; Jennings, 1994). Mental health services are designed to serve children and youth with mental health disorders regardless of origin. A substantial number of children and adolescents experience a significant traumatic event, with epidemiological studies indicating that 25% of youth experience a trauma by the age of 16 (Costello, Erkanli, Fairbank, & Angold, 2002) and 43% of youth experience a trauma by the age of 18 (Giaconia et al., 1995). Early exposure to trauma has been linked to adverse experiences. Specifically, a history of childhood exposure to trauma has been found in two-thirds of the total sample of court-referred adolescents (Brosky & Lally, 2004), with significantly more females exposed than males. In addition, 91% of children with mental health disorders who are permanent wards of the state experienced some form of abuse before entering care (Burge, 2007). It has also been found that a significant number (between 40-80%) of adult patients with severe mental health disorders suffered some kind of abuse as a child (Alvarez et al., 2011; Briere & Runtz, 1987; Briere & Zaidi, 1989; Bryer, Nelson, Miller, & Krol, 1987; Carmen, Rieker, & Mills, 1984; Jacobson, 1989; Jacobson & Richardson, 1987). A history of childhood trauma is common among adults receiving psychoanalytic treatment, with documented experiences including traumatic separations (23%), sexual abuse (23%), physical abuse (22%) and the death of a loved one (21%) (Doidge, Simon, Gillies, & Ruskin, 1994). Based on a large scale Aversive Childhood Experience study of over 45,000 adults, a strong relationship was found between exposure to early adverse experiences and neurobiological effects for the individual, increased health risk behaviour, and long-term disease, disability and social problems (Felitti et al., 1998). Rates of exposure to adverse childhood experiences among individuals from the general public included emotional abuse (11%), physical abuse (11%), sexual abuse (28%), witnessed domestic abuse (13%), physical or emotional neglect (15%-19%) (Felitti et al., 1998). Among children with
mental health disorders, Rivers and colleagues (2003) found the children in the residential program of a children’s mental health agency had substantiated histories of physical abuse (31%-78%, with 84% of children reported witnessing abuse), sexual abuse (12%), and neglect (42.9%-47.9%). Prevalence rates of being exposed to trauma at school and within the community are also varied, but highly concerning (Cooley-quille, Turner, & Beidel, 1995; Margolin & Gordis, 2004; Stein, Jaycox, Kataoka, Rhodes, & Vestal, 2003).

Given these alarming prevalence rates, it is important to gain an understanding of the resulting consequences for individuals exposed to a traumatic event. Traumatic events are considered to be experiences outside the range of ordinary stressful events; evoking shock, terror and powerlessness in the individual who experienced or witnessed the event (Andreasen, 1985). Traumatic events can include, but are not limited to, violent personal assaults and intrusions (including physical and/or sexual abuse), natural and accidental disasters, situations associated with war and political instability (experienced by both combat veterans and refugees), neglect and mixed trauma (including complex psychological trauma) (Alpert, Brown, & Courtois, 1998; Harvey, Bryant, & Tarrier, 2003; Shaw, 2010). Clinically, traumatic stressors have been defined as those

- involving direct personal experience of an event that involves actual or threatened death, serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person’s response to the event must involve intense fear, hopelessness or horror (or in children, the response must involve disorganized or agitated behaviour) (Criterion A2). (American Psychiatric Association, 2000, pp. 467-468)

Traumatic events can vary in terms of their objective nature and the resulting consequences for victims (Cohen, 2008). Wilson (1989) developed a theoretical model to explain the variable nature and impact of trauma. Although various models have been proposed to attempt to explain the impact of exposure to trauma (Briere, 1996, 2002; Carlson & Dalenberg, 2000; Finkelhor & Browne, 1985; McCann & Perlman, 1990; McFarlane & Yehuda, 1996; Shultz, Espinel, Galea, & Reissman, 2007; Wilson, 1989, 1994), Wilson’s model provided one of the preliminary analyses of how the individual and contextual factors relate to the various
trauma experiences. Whereas other models provide explanations for specific types of trauma or particular responses within a theoretical framework (such as cognitive or psychodynamic) (Briere, 1996, 2002; Briere & Spinazzola, 2005; McCann & Perlman, 1990; Shultz et al., 2007), Wilson’s model is an integrative approach to understanding trauma and the associated effects of exposure for the individual (Alpert et al., 1998; Wilson, 1994). Wilson’s model also provides a foundation from which other authors have continued to theorize about the consequences of trauma (Carlson, 1997).

According to Wilson, both person and environment variables interact to produce a subjective response to the trauma and an individual’s post-traumatic adaptation. The first variable within Wilson’s (1989) model relates to the person experiencing the trauma. The person variable includes individual characteristics prior to the traumatic event (such as motives, traits, beliefs, values, mood, abilities, cognitive structures and coping styles). In support of this model, individual factors have been reported to influence resilience, including genetic propensities (Arseneault et al., 2011; Caspi et al., 2002) and the availability and use of social support (Leiderman-Cerniglia, 2002; Pine & Cohen, 2002; Regehr, LeBlanc, Jelley, Barath, & Daciuk, 2007). Alternatively, some of the factors that have been associated with continued psychological distress include a history of prolonged exposure to trauma (Regehr et al., 2007; Shaw, 2010), emotional disturbances including shame, anxiety and anger (Andrews, Brewin, Rose, & Kirk, 2000; Dekel, Solomon, Ginzburg, & Neria, 2004; Ginzburg, Solomon, Dekel, & Neriaa, 2003), prior disturbed attachment (Ginzburg et al., 2003; Shaw, 2010), poor coping abilities (Leiderman-Cerniglia, 2002) and the presence of other disorders (Pine & Cohen, 2002). Age and gender are additional factors that have been found to have a differential effect on the trauma exposure for the individual (Brosky & Lally, 2004; Leiderman-Cerniglia, 2002; Rescorla et al., 2007). Indeed, in a similar framework, Carlson (1997) included the developmental phase of the individual at the outset of the trauma. He proposed that the younger the age of the individual, the more severe the responses to the trauma. These individual factors combine with factors relating to the trauma exposure to influence the likelihood of negative effects (Wilson, 1989).

Wilson’s (1989) second variable relates to the environmental and situational dimensions of the traumatic event. This variable includes four subcategories: the objective dimensions of the trauma, the experience of the trauma, the structure of the trauma and the post-trauma milieu. Elements that influence the objective dimensions of the trauma include: (a) the degree of life
threat; (b) bereavement or loss of significant others; (c) the rate or imminence of the stressors; (d) the duration and/or severity of the stressors; (e) the level of displacement from the community; (f) the exposure to death, dying, injury, destruction and/or social chaos; (g) the degree of moral conflict inherent in the situation; (h) the individual’s role in the trauma (agent vs. victim); (i) the location of the trauma (at home or elsewhere); (j) the potential for recurrence; (k) the complexity of the stressor (single or multiple); and (l) the impact of trauma on the community. The second subcategory refers to whether the trauma was experienced alone, with others, or in the context of a community. The third subcategory relates to the structure of the trauma: whether the trauma was inflicted intentionally or by accident and if it was a single occurrence or spanned multiple incidents. Accordingly, it has been found that violent events intentionally inflicted by humans were associated with greater psychological impairment than events that occurred because of natural disaster (Norris, Friedman, & Watson, 2002; Norris, Friedman, Watson, et al., 2002; Norris & Kaniasty, 2004). The final subcategory relates to the post-trauma context and the availability of supports (including social, economic and personal), cultural rituals to aid recovery, social-cultural attitudes and responses to the victim, and the opportunities that exist following the trauma (Wilson, 1989).

According to Wilson (1989, 1994), interactions between these dimensions and subcategories influence the impact of the event for the individual. There are five primary domains of individual subjective responses to a trauma (including emotion, cognition, motivation, neurophysiology and coping). As such, traumatic stressors are thought to strain the coping resources of the individual (Lazarus & Folkman, 1984). As a result, the individual may experience distress in one or all of these other domains, and the effect of this distress can be continual, sporadic or delayed. Adaption following the trauma has also been conceptualized within this framework. Wilson suggested three types of adaptation: acute reactions, chronic and prolonged impact on life-course development (Wilson, 1989). Reactions to a traumatic event are not always pathological or severe, and it has been suggested that most individuals who witness a traumatic event will recover on their own (Friedman, 1994). Consistent with the model, Agaibi and Wilson’s (2005) review of the literature has established that the likelihood of post-traumatic resilience has been associated with personal variables (including extraversion, high self-esteem, assertiveness, hardness, internal locus of control, and cognitive feedback), and access to social and personal support mechanisms that may be activated by environmental demands.
In some cases, however, the reactions can be prolonged and sufficient to warrant a diagnosis of Acute Stress Disorder, Post-Traumatic Stress Disorder (PTSD) and other dissociative disorders (Alpert et al., 1998). Based on reviews of the literature, it has been estimated that between 25-30% of those exposed to traumatic stressors develop PTSD (Green, 1994; Tomb, 1994). According to the DSM-IV-TR, PTSD is an anxiety disorder, which is precipitated by a traumatic event, which causes intense fear and/or a feeling of helplessness in the individual (American Psychiatric Association, 2000). Symptoms of the disorder result in physiological and neuro-psychological disruptions (Friedman, 1994), and have been summarized to include intrusive re-experiencing of a trauma, avoidance of reminders associated with the trauma, and the persistence of psychological arousal (Perrin, Smith, & Yule, 2000). An individual may re-experience the event by having nightmares or flashbacks about the trauma (Foa & Meadows, 1997). In an effort to avoid traumatic reminders, individuals may not only deliberately avoid trauma-related stimuli, but they may also engage in emotional numbing (Foa & Meadows, 1997). The symptom of psychological arousal can be experienced as a sense of increased arousal resulting in sleep disturbance, hyper vigilance and irritability (Foa & Meadows, 1997). In addition to these symptoms, victims of trauma can also suffer from problems with anger regulation and may develop other disorders including depression, anxiety disorders, oppositional defiance disorder and substance abuse (Abram et al., 2007; Brady, 1997; Ford et al., 1999; Giaconia et al., 2000; Giaconia et al., 1995; Jacobsen, Southwick, & Kosten, 2001; Leskin & Sheikh, 2002). It has been found that as many as 80% of individuals receiving treatment for PTSD have a co-morbid disorder (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), with approximately 25% of people with PTSD developing a problem with alcohol or substance abuse (Friedman, 2006).

Wilson’s (1989) model is particularly useful as it provides a theoretical rationale for explaining why traumas experienced during childhood have unique and severe effects on childhood development (Alpert et al., 1998; Cohen, 2008). According to this model, complex structural and experiential dimensions of the event, combined with the limited and/or immature physical and emotional capacities of a child, may have the likelihood of resulting in the most deleterious outcomes (Alpert et al., 1998; Cohen, 2008). Events are also more traumatic when they are the result of human design, as in the case of childhood abuse and neglect, than when they are the result of natural causes. It has been found that children who experience both
physical and sexual abuse appear to be at higher risk of psychiatric disturbance than children who are exposed to only one form of abuse (Ackerman et al., 1998).

Despite the strengths of Wilson’s (1989) model, examinations of the model lack the systematic evaluation of the causal relationships between the many individual variables and each of the four dimensions of the environmental variables (Carlson, 1997). This limitation makes it difficult to empirically evaluate the model (Carlson, 1997; Wilson, 1994). It has been suggested that such a review would be complex and result in voluminous sub-dimensions (Wilson, 1994). Even if completing such a systematic evaluation were not feasible, it would be helpful to have explanations for the ways the variables relate to influence individual pathology.

Based on this review, it is clear that exposure to traumatic events can have adverse effects on the individual, but that these effects are variable in nature. It is also possible to ascertain from Wilson’s model that children are at risk of experiencing severe distress following a traumatic event. What is not yet clear is the extent to which the problems may influence the child’s life and long-term development. Recent understandings of traumatic events suggest that the magnitude, size and scope of the stressor are important; yet they may not be as influential as proposed by the model at informing how the child perceives a traumatic event or how it will affect the child (Shaw, 2010). This subject has been reviewed within the literature relating to Complex Trauma Theory.

**Theoretical Assumptions Associated with the Study of Trauma: Complex Trauma Theory**

It is important to review the theoretical assumptions associated with the study of complex trauma. As has been suggested, the diagnostic category of Post-Traumatic Stress Disorder (American Psychiatric Association, 2000) provides a clinical summary of the symptomatology of dysfunctional responses to traumatic exposure (van der Kolk, 1987). However, recent years have revealed the controversy surrounding this diagnostic category (Kinzie & Goetz, 1996); this controversy will be further described below. Accordingly, it may be useful to study the phenomenon of exposure to trauma from within the critical theoretical paradigm (Guba & Lincoln, 1994).

Building on the critical paradigm outline by Guba and Lincoln, Mertens (1999, 2003, 2007, 2009) described a theoretical framework, referred to as the Transformative Paradigm. The Transformative paradigm provides a theoretical umbrella that encompasses emancipatory, anti-discriminatory, participatory and Freirian approaches demonstrated in critical theories (Mertens,
and a framework to conduct research regarding critical theories, such as feminist theory, critical race theory and critical disability studies (Mertens, 2009). Within this paradigm, researchers critically reflect on the power differentials inherent in society in general, and between the researcher and people with whom they wish to work in particular (Mertens, 2009). Epistemologically, knowledge is understood to be socially constructed within a context of power and domination (Mertens, 2003, 2009). Furthermore, it is assumed that multiple realities are possible, but various social structures influence what is defined as real (Mertens, 2003, 2009). Transformative assumptions propose an ontological understanding consistent with the Critical Realist perspective (Bhaskar, 1978). Understanding of the world stems from a constructed reality consisting of all of these multiple realities at once (McEvoy & Richards, 2006). This constructed reality is based on a hierarchy of power, where those who hold positions of power define truth (Bengton, Acock, Allen, Dilworth-Anderson, & Klein, 2005). Theories within this paradigm are designed to provide explanations of social problems and an agenda for social change, ultimately leading to the emancipation of oppressed groups (Mertens, 2009).

Psychological trauma can be considered a real and credible phenomenon, although its manifestation may be dependent on the underlying social structures and political context in which the traumatic event is experienced (Bracken, 2001; Herman, 1992/1997) and the individual’s psychological characteristics. This understanding of the impact of trauma exposure takes a bio-psycho-social and cultural understanding of the phenomena. There are differences in the symptomatology of trauma exposure around the globe (von Peter, 2008), as well as the historical context in which the survivor is located (see review provided by Bracken, 2001). Thus, conceptualizations of trauma exposure must also be focused on the context and consider the social, political and cultural realities in which exposure is situated (Bracken, Giller, & Summerfield, 1995).

**Complex Trauma Theory**

Judith Herman (1992) introduced the concept of Complex Post-Traumatic Stress Disorder (CPTSD), where, in addition to the trauma experiences described above (i.e., where the individual directly experienced, witnessed or learned about event that involves actual or threatened death, serious injury, or other threat to one’s physical integrity), traumas are considered to be complex when they are chronic in nature, occur in a context of captivity, and within a relationship of coercive control. Herman (1992, 1992/1997) called for the new
diagnostic category based on her professional experience working with trauma victims and a historical analysis of trauma research. First, Herman (1992/1997) traced the social and political context that led to the theoretical understanding of complex trauma. She reviewed the status of the research regarding hysteria prior to the turn of the 20th century. Although predominant psychiatrists (such as Freud, Charcot and Janet) began to recognize the complex relationship between childhood exposure to sexual/physical abuse and later development of hysteria, this relationship became silenced after Freud recanted his position given the social and political responses to his book on the subject. Several decades later, the political and social protest regarding the Vietnam War provided the context for understanding the effects of traumatic experiences of war (Herman, 1992/1997). Later, following the ‘Women’s Movement’, which brought to public awareness the prevalence and injustice of violence against women, the public began to grow in their awareness of other forms of abuse among marginalized groups, such as the sexual abuse of children. Most research on trauma prior to 1985 focused on adults (Alpert et al., 1998) and had been based on survivors of circumscribed traumatic events (Herman, 1992/1997). Since then, additional research has been conducted which has supported the relationship between social, political and cultural contexts with trauma and healing (Marsella, Friedman, Gerrity, & Scurfield, 1996). This context led to the growing recognition of the long-term effects of complex trauma exposure (Herman, 1992/1997).

In light of this recognition, Herman (1992, 1992/1997) recommended that the diagnostic category of Post-Traumatic Stress Disorder does not adequately account for the serious psychological dysfunction following complex, chronic abuse. These complex trauma experiences can include prisons, concentration camps and slave labour camps, and can occur within some cults, institutions of organized sexual exploitation and in some families. These differences have been supported by other predominant figures in the literature (e.g., Briere & Spinazzola, 2005; A. Cook et al., 2005; Courtois, Ford, & Herman, 2009; van der Kolk, 2005). Even field trials commissioned by the American Psychiatric Association revealed that children and adults exposed to complex trauma demonstrate psychological disturbances which include, but were not fully addressed in DSM-IV-TR criteria for PTSD (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005) such as problems with regulation affect, impulses, memory and interpersonal relation, as well as changes in self-perceptions and meaning systems. Consistent with the understanding of the variable effects of trauma within the framework developed by
Wilson (1989), Herman (1992/1997) conceptualized the responses to trauma as a spectrum, ranging from acute stress reactions, Post-Traumatic Stress Disorder, to Complex Post-Traumatic Stress Disorder. Thus, in addition to the symptoms relating to PTSD, individuals who experience complex abuse may develop complex symptom presentations, characteristic personality changes (including problems with relationships and identity) and are particularly vulnerable to repeated abuse resulting from the traumatic exposure (Herman, 1992; Ide & Paez, 2000). The extreme nature of the trauma interacts with the exposed person, and may alter the person permanently. The complex symptom presentation includes somatic, dissociative and affective changes. These symptoms tend to be more complex, diffuse and persistent than is encompassed within the diagnostic category of PTSD. In addition, Herman acknowledged that these individuals also often suffer from anxiety, panic, depression and somatic symptoms, but that these disorders are related to the underlying trauma exposure (Herman, 1992/1997).

The lack of perceived safety and control, both physical and emotional, is another important consequence of exposure to complex trauma (Herman, 1992/1997). Herman stated, “trauma robs the victim of a sense of power and control” (p. 159). This lack of safety is especially apparent in children exposed to complex trauma. Ross (2007) suggested that for children abused by their parents, the deeper trauma is the absence of love and safety. For these children, their parental relationship often involves a fundamental betrayal of trust (Courtois & Gold, 2009). Generalized trust in adults can also be reduced following repeated violations of the children’s expectations that adults will keep them safe (Lieberman, Van Horn, & Ippen, 2005).

**Childhood Exposure to Complex Trauma**

Following Herman’s (1992/1997) work, appreciation has grown for the influence of complex trauma on children. It has been found that when trauma is experienced during childhood, a period of particular vulnerability, development is affected (van der Kolk, 2005). In particular, this is the period in which the child develops complex working models of attachment (Bowlby, 1984) and undergoes the development and regulation of social and emotional processes (Gilles, 1999).

One model that emerged in this same time period provides an ecological account for the effects of community violence and childhood abuse for the developing child (Cicchetti & Lynch, 1993). Influenced by developmental psychopathology, transactional and ecological theories, Cicchetti and Lynch’s ecological/transactional model provides a multi-level analysis of the
ecologies that influence one another and children’s development. Based on some of the different systems proposed by Bronfenbrenner (1977), Cicchetti and Lynch’s model includes influences from the macrosystem, the exosystem and the microsystem. Various potentiating factors at each level that increase the probability of child maltreatment and compensatory factors decrease this likelihood. Both of these types of factors can represent either temporary or enduring characteristics. According to this model, when the potentiating factors outweigh the compensatory ones, abuse and maltreatment may be likely to occur. Although children’s development is most directly affected by the characteristics of their proximal environment, the effects of culture, community, family history and previous development converge to influence the developmental outcomes for children (Cicchetti & Lynch, 1993).

The macrosystem includes cultural values and beliefs that foster and tolerate violence within the community and family (Cicchetti & Lynch, 1993). Bloom (1997) provided a thorough analysis of the alarming rates of violence and abuse in American society. Exposure to violence within the community has emerged as a major risk factor for violent behaviour in children and youth (Margolin & Gordis, 2000) and the development of later mental health problems (Overstreet & Mazza, 2003). Furthermore, research has demonstrated that exposure to community violence accounted for a significant proportion of the variance in post-traumatic stress symptoms (Lynch & Cicchetti, 1998).

The exosystem represents social structures and the linkages and processes between two or more settings that influence the child environment either directly or indirectly (Lynch & Cicchetti, 1998). In Lynch and Cicchetti’s model, this system also incorporates elements of Bronfenbrenner’s mesosystem, which contains interconnections between two or more settings both of which contain the child (Bronfenbrenner, 1977). These settings include the neighbourhood, school, community programs, places of worship and the workplace (Bronfenbrenner, 1977). Lynch and Cicchetti proposed that increased community violence results in chronic stress and heightened awareness of danger that influence family functioning and children’s development. The exosystem also comprises social structures that include, but are not limited to social networks and supports, availability of employment, educational experiences and socioeconomic status. Whether these structures act as potentiating or compensatory factors depends on their relative availability. For example, Cicchetti and Lynch (1993) reviewed research that substantiated the links between limited maternal educational level, low
socioeconomic status, unemployment, social isolation and dissatisfaction with available supports with increased rates of child maltreatment. Furthermore, in support of the model, Spano, Vazsonyi, and Bolland (2009) found that both parenting and youth development are dynamic systems that are influenced by stressors in the community.

Finally, the microsystem includes the family and school environments, as well as any other environment that directly contains the child (Cicchetti & Lynch, 1993). A family context that includes maltreatment and violence has been found to incorporate components such as family dysfunction, neglectful or abusive parenting styles, the developmental histories of the parents (characterized by prior history of abuse) and poor or limited psychological resources. Family Systems theorists believe that symptoms of mental illness in an individual may be maintained by the structure, patterns and beliefs of the family system to which the individual belongs (Gunn, Haley, & Lyness, 2007). Rooted in this assumption, Cicchetti and Lynch (1993) stated that the potentiating factors from the microsystem are internalized and, as a result, affect the child’s attitudes, affects and cognitions. Cicchetti and Lynch incorporated aspects of attachment theory to provide an explanation of the internalization process. Specifically, when parents are the perpetrators of violence, the child internalizes this dysfunctional relationship as an internal working model (Bowlby, 1984). These models, which have been demonstrated to have important ontological implications, negatively influence development and adversely affect later relationships (Bowlby, 1984). Consistent with the aforementioned literature, Cicchetti and Lynch indicated that the severity, chronicity and type of abuse interact with the maturity of the child to influence mental representations. Furthermore, the fear and unpredictability of the abuse and the lack of appropriate socialization from the parents may severely impair a child’s ability to modulate their emotions. Children often develop coping mechanisms that are adaptive in the environment (e.g., hyper-vigilance and ready assimilation of aggressive stimuli), but may be maladaptive outside the context of abuse (Amos, 2004; J. A. Cohen, Berliner, & Mannarino, 2010; J. A. Cohen & Mannarino, 2008b; Hodas, 2006). The chronic nature of children’s environment can also limit their development of a positive sense of self-concept and self-esteem (Cicchetti & Lynch, 1993). Finally poor school performance of children exposed to abuse is also predicted within this model as affected children may lack the readiness to learn (Aber & Allen, 1987), may not develop successful relationships with teachers, and may lack motivation
Overall, these developmental disturbances combine to place children exposed to maltreatment and abuse at risk of future maladaptation (Cicchetti & Lynch, 1993).

Consistent with the ecological/transactional model (Cicchetti & Lynch, 1993), van der Kolk (2005) identified six domains particularly associated with children exposed to complex trauma. These domains include: 1) affect regulation; 2) information processing; 3) distorted self-concept; 4) behavioural control problems; 5) poor interpersonal relationships or attachment; and 6) biological processes. Similarly, Cook and colleagues (2005) identified these six domains, but also include a seventh domain of impairment of disassociation. Specifically, when abuse occurs in childhood, the dissociative functioning described above can be exhibited in extreme formulations (Herman, 1992/1997). According to Putnam (1997) three fundamental dissociative adaptations can be found in children exposed to complex trauma: automatization of behaviour (which relates to deficits in judgment, planning and goal-directed behaviour), compartmentalization of difficult memories and feelings, and emotional detachment and lack of awareness of self. This process can help to explain the distorted, yet preserved attachment between children and their abusive parents (Shengold, 1989).

Accordingly, research findings have demonstrated that children exposed to complex trauma have difficulty with modulating aggression and impulse control (D. O. Lewis, Shanok, & Balla, 1979; Steiner, Garcia, & Matthews, 1997), attention and dissociative problems (Teicher et al., 2003) and have difficulty negotiating most relationships (Alexander, 2009; Aspelmeier, Elliott, & Smith, 2007; Bailey, Moran, & Pederson, 2007; Schneider-Rosen & Cicchetti, 1984; Waldinger, Schulz, Barsky, & Ahern, 2006). Given the symptomology of complex trauma exposure, children exposed to these experiences often meet the diagnostic criteria for a variety of other disorders, including depression, attention-deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, anxiety disorders, eating disorders, sleep disorders, communication disorders, separation anxiety disorder and reactive attachment disorder (Ackerman et al., 1998; A. Cook et al., 2005). Each of these labels taps into aspects of the seven domains associated with complex trauma exposure, but none completely account for the underlying trauma experience. Treatment for individuals exposed to complex trauma must subsume the multifarious sequelae of exposure (Bloom, 1994).
Importance of Considering the School Setting

Exposure to complex trauma during childhood can also have severe implications for the individual’s ability to function within an academic environment (O’Neill, Guenette, & Kitchenham, 2010). As suggested in the ecological/transaction model (Cicchetti & Lynch, 1993), the different exosystems influence and are influenced by one another. Given the deficits in social and emotional development, traumatized children often have a difficult time developing and sustaining social relationships which limits their social learning experiences through modeling (O’Neill et al., 2010). Children exposed to trauma can be prone to learning difficulties in academic areas given deficits in neurological functioning pertaining to memory (Anda, Brown, Felitti, Dube, & Giles, 2008). They may also have difficulty attending to school work because of a state of hyper-arousal and behavioural dysfunction (Bloom, 1995). Traumatized children may be seen to overreact to stimuli that others might perceive neutrally, such as an instruction or correction, because of their state of hyper-arousal; these behaviours may be labelled as maladaptive, aggressive or defiant (Goldfinch, 2009). In addition, many children exposed to trauma develop behavioural problems; sometimes these are related to the trauma (e.g., avoiding trauma-related situations) and sometimes they are seemingly maladaptive ways of responding which may have been adaptive during the trauma exposure (Amos, 2004; J. A. Cohen et al., 2010; J. A. Cohen & Mannarino, 2008b; Hodas, 2006). In the school setting, these problem behaviours can inhibit learning for both the student and the whole class (Luiselli, Putnam, Handler, & Feinberg, 2005).

As a result, children who learn differently or who exhibit behavioural disruptions in the classroom are often transferred to alternative settings because their current schools are not equipped to support them (Stanwood & Doolittle, 2004). Within such specialised schools, treatment is focused on reducing problem behaviour and other challenges that interfere with academic performance. Given the appreciation for the effects of trauma on learning, it may be beneficial for service providers to use effective and trauma-informed ways of responding to problem behaviour.

Paradigm Shift in Services for Mental Illness

The growing appreciation of the significant impacts of complex trauma on the mental health trajectory of those exposed has led to a paradigm shift within mental health services (Bloom, 1994; Harris & Fallot, 2001a, 2001b; Jennings, 1994; Shaw, 2010). Traditional services
are often required to focus on specific problems and outcomes within a limited time frame (Harris & Fallot, 2001a). In addition, it has been suggested that mental health providers may not identify the underlying problem related to the experience of trauma because traumatic experiences are rarely included in standard screening measures or volunteered by patients (Brady, 1997; Herman, 1992/1997; Read & Fraser, 1998). Therefore, the presentation of symptoms associated with complex trauma can be disguised and variable (Herman, 1992/1997). In fact, the aforementioned diagnoses are often misinterpreted as the cause of the ‘dysfunction’ for the child (Ackerman et al., 1998). Treatment may be inhibited when the underlying trauma experience, resulting in these symptoms, is not identified and addressed (Bloom & Farragher, 2011; Harris & Fallot, 2001a; Jennings, 1994). Furthermore, without awareness of the trauma, service providers may inadvertently re-traumatize and re-victimise individuals through the inappropriate use of medication which inhibits individuals’ ability to think and feel (an essential process in recovery), the use of restraints or seclusion rooms and by reducing participants’ choices in treatment (Harris & Fallot, 2001a; Jennings, 1994).

Parallel to the ways in which children’s lives can become organized around their trauma exposure, the services developed to support these children can also become trauma-organized systems (Bentovim, 1992; Bloom, 1997, 2005b). Service agencies and their programs can unintentionally become organized around the unresolved effects of trauma (Bentovim, 1992; Bloom, 1997, 2005b). Specifically, a bidirectional relationship can exist between the service providers and the service users: problem behaviours in youth and work-related stress can have negative effects on staff which in-turn can promote negative relations with service users (a process known as counter-transference) (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; Elwood, Mott, Lohr, & Galovski, 2011; Hodas, 2006; Jennings, 2007). In response, both staff and clients may reactively repeat maladaptive patterns of behaviour in response to problem behaviour. In addition, as a result of chronic stress, members of organizations may lack the integration of various cognitive, emotional and interpersonal capabilities that are required to effectively operate such systems (Bloom, 2005b). Staff members may lack the sense of safety within their employment setting and could reactively respond to problem situations with punitive measures. As a result, communication networks break down, leading to increased rigidity in hierarchical structures (Bloom, 2005b). Reciprocally, conflict between staff can be acted out by
the patients (Bloom, 1995). When service agencies become trauma-organized systems they essentially become ‘frozen in time’ and are resistant to change (Bloom, 2005b).

Alternatively, within a trauma-informed approach to treatment, the likelihood of past trauma is acknowledged by service providers. Treatment is designed to actively and dynamically focus on recovery in a safe and supportive environment (Bloom, 1994; Harris & Fallot, 2001a). The literature regarding trauma-informed services is becoming quite extensive (Bloom, 1994, 1997, 2000a, 2005a, 2005b; Bloom & Farragher, 2011; J. N. Cohen, 2008; Elliott et al., 2005; Elwood et al., 2011; Figley & Regan Figley, 2009; Greenwald, 2009; Harris, 1998; Harris & Fallot, 2001a, 2001b; Hillman, 2002; Hodas, 2006; Jennings, 1994, 2004, 2007; Savage, Quiros, Dodd, & Bonavota, 2007). Fundamentally, the trauma-informed approach involves a complete change in philosophy to service provision to promote awareness and provide positive experiences to all (Harris & Fallot, 2001a).

This new focus requires radical shifts in the ways in which mental health services are provided. A trauma-informed service involves: a) changes to administrative funds to promote knowledge about trauma within service agents; b) education and training about trauma to service providers; c) strategic hiring of staff who specialize in trauma-related care; d) revision of policies and procedures to prevent re-traumatizing individuals within the service; and e) universal screening to identify past trauma, leading to referrals for trauma specific services (Harris & Fallot, 2001a). This approach requires organizational shifts in the ‘mental models’ that guide behaviour (Bloom & Farragher, 2011). Essentially, becoming trauma-informed requires mental health providers to change the organizational culture throughout the whole system in which they operate (Harris & Fallot, 2001a). Organizational culture refers to learned beliefs and values that guide behaviours to help the group solve problems within an external environment (Schein, 1990).

The Sanctuary Model. One of these trauma-informed service approaches has been developed by Sandra Bloom, and is called the Sanctuary Model (Bloom, 1994, 1997; Bloom & Farragher, 2011). The underlying assumptions of the Sanctuary Model are grounded in social psychiatry, the therapeutic milieu, the study of group dynamics, general and ecological systems theories, and in feminist theory (Bloom, 1997). Following her theoretical analysis of the parallel processes in which individuals, agencies and societies become trauma-organized, Bloom (1997) described the ways in which she facilitated the shift in the organizational culture within an
inpatient acute care psychiatric unit for adults (Bloom, 1997). She described that, although the treatment within the psychiatric unit had previously been based within a social psychiatric approach and positive therapeutic community, the service care team became increasingly concerned about the number of patients whose symptoms persisted and were not improving with treatment. Concurrently, the team began to recognize that a significant proportion of their patients had been exposed to complex trauma. After learning about trauma theory from Herman and van der Kolk, Bloom began to transform her psychiatric unit toward a trauma-informed service (Bloom, 1997). In 1991, the Sanctuary Model was developed as a trauma-specific program for adult survivors (Bloom, 1997).

The Sanctuary Model is based in a therapeutic community or milieu (Jones, 1956), which requires shifts in organizational culture informed by the theory of complex trauma (Bloom, 1997, 2005b). The organizational culture within the Sanctuary Model is centred on the need to promote safety in all aspects of the social environment, including physical, psychological, social and moral safety (Bloom, 1997). As noted in the clinician’s guide to evidence-based practice (EBP) for the treatment of traumatized adults and children, the first priority in the treatment of traumatized individuals is to establish a safe environment (Rubin, 2009). In addition, the organizational culture within the Sanctuary Model promotes continual growth and change, fosters psychological and social healing, and resists the effects of individual and organizational stress (Bloom, 1997, 2010a; Bloom & Farragher, 2011). Accordingly, the Sanctuary Model represents a learning organization (Bloom & Farragher, 2011), which is characterized by a focus on human component technology (Senge, 1990). These organizations engage in transformational learning (Kofman & Senge, 1993), are continually and systemically ready for change (Armenakis, Harris, & Mossholder, 1993), and are led by transformational leaders (Reid, Kneafsey, Long, Hulme, & Wright, 2007) who espouse the concept of servant leadership (Owen et al., 2009) and are systems thinkers (Owen et al., 2009; Reid et al., 2007). Systemic thinking attempts to bridge structure and movement by thinking of the organization as both ‘productive organs’ and ‘change processes’ (Wadsworth, 2008). Accordingly, the Sanctuary Model is based in ecological systems theory (Bronfenbrenner, 1989), which is dynamic and acknowledges the inter-dependency of the systems influencing development (Bloom, 1994).

Therapeutic Milieu. Central to the Sanctuary Model is the philosophy of the therapeutic milieu (Bloom, 1997). There are seven commitments of the Sanctuary Model which relate to
trauma-informed treatment goals that guide organizations in their promotion of a safe organizational culture (Bloom, 2005b; Bloom & Farragher, 2011). These guides include a commitment to: nonviolence, emotional intelligence, social learning, open communication, democracy, social responsibility, and growth and change (Bloom & Farragher, 2011). Bloom and Farragher provided general descriptions of each of these commitments:

- **Nonviolence**: to build safety skills, trust and resilience in the face of stress and inspire a commitment to wider sociopolitical change
- **Emotional Intelligence**: to teach emotional management skills, build respect for emotional labour, minimize the paralyzing effects of fear, and expand awareness and intent to change of problematic cognitive-behaviour patterns
- **Social Learning**: to build cognitive skills, improve learning and decisions, promote healthy dissent, restore memory, unearth the skeletons in the organizational closet and give them proper burial and ultimately to have the skills to sustain a learning organization
- **Open Communication**: to overcome barriers to healthy communication, discuss the “undiscussables”, overcome alexithymia, increase transparency, develop conflict management skills and to reinforce healthy boundaries
- **Democracy**: to develop civic skills of self-control, self-discipline, to learn to exercise healthy authority and leadership, to develop participatory skills, to overcome helplessness, to develop skills for wrestling with complexity and to honour the “voices” of self and others
- **Social responsibility**: to harness the energy of reciprocity and a yearning for justice by rebuilding restorative social connection skills, establishing healthy and fair attachment relationships, transforming vengeance into social justice and concern for common good
- **Growth and change**: to work through loss in the recognition that all change involves loss; to cease repeating irrelevant or destructive past patterns of thought, feeling and behaviour; and to envision, be guided by, skillfully plan and prepare for a different and better future (Bloom & Farragher, 2011, pp. 359-360)

The commitments are interactive and inter-dependent and apply to everyone within the organization (including leaders, support staff and those the organization serves). When the therapeutic milieu is operating in a trauma-informed way, then the organizational culture should reflect increased community cohesiveness, the presence of the seven commitments, the use of
trauma-informed techniques and a reduction in critical incidents (Bloom, 1997, 2005a, 2007; Rivard et al., 2003).

Treatment modality. Treatment within the Sanctuary Model involves a process and focuses on Safety, Emotional Management, Loss and Future (SELF) psycho-education in trauma, an acronym based on a grounded and accessible version of Herman’s (1992/1997) three treatment stages (Safety, Reconstruction and Reconnection). Instead of being represented as stages in a recovery process, SELF represents four inter-dependent aspects of recovery which are based on a cognitive-behavioural therapeutic approach (Bloom & Farragher, 2011). The guidelines for the treatment of children and adolescents exposed to complex trauma indicate that treatments should include cognitive-behavioural components (J. A. Cohen, Berliner, & March, 2000; Courtois et al., 2009; Rubin & Springer, 2009). The specific elements of the treatment relate to Safety (in self, relationships and environment), Emotional management (identifying and modulating affective responses), Loss (dealing with grief and personal losses) and Future (an orientation toward a new self and better future) (Bloom & Farragher, 2011). It is important to note that patients are collaborators in the treatment process. One of the core experiences of trauma is powerlessness and disconnection with others (Herman, 1992/1997). Providing patients with control and validation in the recovery process can lead to their empowerment (Harris & Fallot, 2001a). Control, empowerment and validation have also been reported to be important components for the treatment of individuals exposed to trauma (Rubin, 2009).

Bloom, Foderaro, and Ryan (2006) describe the SELF curriculum as a method of teaching clients about the important effects of trauma, which include different ways of thinking about problems organized within a manageable and understandable set of concepts. Essentially, SELF also provides individuals with a “roadmap” for the process of recovery. The curriculum includes introductory sessions on the SELF-framework as a whole, and proceeds with various additional lessons devoted to each concept. Following the initial sessions, each lesson is designed to provide a comprehensive message. Accordingly, there is no fixed order to the curriculum and staff leaders are free to choose topics that relate to issues pertinent to the specific context. Each lesson includes a script to guide discussion, a handout and additional resources. The lessons focus on the effects of exposure to trauma, rather than directly addressing the issues of trauma, maltreatment and abuse, thus allowing individuals to deal with their experiences regardless of their degree of exposure to trauma (Bloom et al., 2006).
Implementation of the Sanctuary Model. Bloom (2005b) outlined a process that organizations can use to become ‘Sanctuaries’. As stated previously, the Sanctuary Model requires organizations to change their organizational culture to become trauma-informed so that they can better respond to the complex therapeutic needs of people who have been exposed to complex trauma. The process begins with the development of a core team of representatives from every level of the organization. Leaders are crucial in facilitating the organizational shift and must act as role models to the rest of the organization (Bloom, 1994; Bloom et al., 2003; Bloom & Farragher, 2011). This core team is responsible for actively representing and communicating the Model with the entire organization. As a team, members develop guidelines, timelines and expectations for the process of implementation. This process includes a full systemic assessment of the agency, and the creation of a vision statement, which reflects the shared assumptions, beliefs and values. They must also develop a comprehensive plan that articulates the process for moving from their current climate to that reflected in the trauma-informed vision. When making such a plan, decisions must be democratic and reflect perspectives from the entire organization. In addition, the team members are responsible for increasing their knowledge about the effects of trauma, and they must integrate this information into the agency’s policies and procedures. The team must review and respond to any incident reports and develop a Safety Plan. The Sanctuary Model emphasises a nonviolent environment and, as such, the team must develop procedures for de-escalating behaviour and responding to violent incidents. The team must also develop methods for assessing trauma exposure in the population the agency serves so that they can provide trauma-informed services. Once all the foundational work has been completed, the core team will begin to develop training curricula and delivery plans to spread the trauma-informed organizational culture throughout the agency. Using a train-the-trainer model, the core team trains the staff members who then are responsible for educating their clients. The curricula should include psycho-education about trauma, safety planning and other community building strategies (Bloom, 2005b).

Enacted sanctuary. In creating Sanctuary, community members are expected to engage in Community Meetings, Safety Plans, Red Flag reviews, SELF psycho-education, treatment planning and team meetings; these activities constitute the Sanctuary Toolkit (Bloom & Farragher, 2011). Evaluation and supervision components must be developed to ensure that the programs are being implemented as planned. This process will help to ensure that the staff
members are not inadvertently engaging in behaviour that traumatizes the clients and/or represents characteristics of a stressful trauma-organized agency (Bloom, 2005b).

Through the adoption of the Sanctuary Model, changes should be reflected in the organizational culture (Bloom, 2005b). Specifically, when an organization is operating as a trauma-informed system rather than trauma-organized systems, elements of the organizational culture should include: fewer incidence of all forms of violence (including physical, verbal and emotional forms of abuse); increased understanding of the responses to trauma; and fewer punitive and judgmental responses to behaviours, which are essentially ways of ‘blaming the victim’ (Bloom, 2005b). Furthermore, a trauma-sensitive culture should promote a sense of physical, psychological, social and moral safety, clear and consistent boundaries and expectations that link the rights and responsibilities of all members of the organization; democratic ways of decision-making and problem-solving; and the open expression and resolution of conflict (Bloom, 2005b; Farragher & Yanosy, 2005). Emotions are shared openly, positive social relationships are fostered, the past loss and grief are acknowledged, and creating a positive future guides treatment (Bloom, 1997; Farragher & Yanosy, 2005). This conceptualisation of a psychological safe climate is consistent with other literature on organizational cultures within mental health systems (Glisson, 2002). Investigators have found that safe climates are reflected in constructive (e.g., high support, high motivation), fewer defensive cultures (e.g., low subservience, low conformity) that operate with decentralized structures (Glisson & Durick, 1988; Glisson & Hemmelgarn, 1998; Glisson & James, 2002; Hammelgarn, Glisson, & Dukes, 2001). It is expected that through the process of creating Sanctuary, better outcomes are observable for the children, staff and organization (Bloom, 1997, 2005b).

Parallel process. Given that both individuals and service agencies can become trauma-organized systems, it has been suggested that there is a parallel process by which conflict in one part of a system may surface in related systems (K. K. Smith, Simmons, & Thames, 1989). According to Smith and colleagues (1989), conflict rarely surfaces where it originated, rather it is often represented in a different form in a remote location. The pathway between the origin of the conflict and the location of where it is expressed is invisible. Parallel process is the development of similar affects, cognitions and behaviours expressed among at least two groups or systems that have a significant relationship. For example, it has been observed that the relationship between
therapists and their supervisors often assumes the characteristics of the relationship therapists adopt with their patients. By taking into account the epistemological and methodological consideration of organizational conflict, this invisible pathway can be understood as a parallel process. Essentially, when the relationships within one group are full of conflict, group members may be able to suppress this hostility toward one another to perform their responsibilities. This conflict, however, may be inadvertently expressed within another working group (K. K. Smith et al., 1989).

A trauma-informed system proposes the reverse relationship, focusing on facilitating “parallel processes of recovery” (Bloom, 2010b, p. 307). Such a process assumes that when therapist groups are functioning as a safe and positive organizational culture, then patient groups will also adopt this positive organizational culture, facilitating their recovery from trauma exposure. It is important to conduct parallel processes evaluations to determine the influences that these systems have on one another to ensure that the negative effects of trauma and stress are not being played out in other systems.

**Previous applications of the Sanctuary Model.** Following the development of the Sanctuary Model within psychiatric services for adults (Bills & Bloom, 1998; Bloom, 1994, 1997, 2000b; Bloom & Farragher, 2011), Bloom has proposed the utility of the Model for application in a variety of contexts (Bloom et al., 2003). The Model has been successfully implemented in residential substance abuse programs for women and domestic violence shelters (Bills & Bloom, 1998, 2000; Bloom et al., 2003; Madsen, Blitz, McCorkle, & Panzer, 2003). A Canadian inpatient treatment program has also adopted the Model for the treatment of adult survivors of childhood sexual abuse (Wright & Woo, 2000; Wright, Woo, Muller, Fernandes, & Kraftcheck, 2003). Following treatment, analyses of client outcomes revealed a significant decrease in PTSD symptoms in patients on clinician ratings; reductions were maintained at three months and at one year following discharge (Wright et al., 2003). The research is limited in that it only measures outcomes without a control group to provide insight into relative effectiveness. Thus, it may have been that reductions were associated with reviewing treatment, not necessarily the Sanctuary Model.

The Sanctuary Model has also been utilized in a children and youth residential mental health service (Bloom et al., 2003; Rivard, 2004; Rivard et al., 2003; Rivard, Bloom, McCorkle, & Abramowitz, 2005). In fact, the most rigorous research to date on the Model has been
conducted within a youth residential treatment program (Rivard, 2004; Rivard et al., 2003; Rivard et al., 2005; Rivard et al., 2004). Rivard and colleagues (2004; 2005) employed a randomised-cluster research design to examine the implementation and short-term effects of the Sanctuary Model in four residential treatment units, compared to eight units employing treatment as usual. The agency contains several programs comprising smaller residential units that serve between seven to 16 youth at a given time. The implementation of the Model was examined through focus groups with residential staff. Staff members reported that the adoption of the Model stimulated the promotion of safety, a new sense of community and teamwork among staff interaction that guided practice with youth, and the development of new ways to support youth problem-solving. Consistency was reported as an important factor in the successful implementation of the Model. Adherence to the model was measured using the Sanctuary Project Implementation Milestones criteria; rates of adherence were found to be at 78%.

Changes in the organizational culture were measured from staff reports on the Community Oriented Programs Environment Scale short-form (COPES-S). Although no differences were found between the groups at baseline and three months following implementation, significant differences were found at six months between the groups for the total scale and on the subscales of support, spontaneity, autonomy, personal problem orientation and safety (Rivard et al., 2005). Rivard and colleagues (2005) also compared youth outcomes on several measures including the Child Behaviour Checklist, the Trauma Symptom Checklist for Children, the Rosenberg Self Esteem Scale, the Nowicki-Strickland Locus of Control Scale, the peer form of the Inventory of Parent and Peer Attachment, the Youth Coping Index and the Social Problem Solving Questionnaire. For youth outcomes, significant differences were again found at six months between the groups favouring the youth in the Sanctuary treatment programs (Rivard et al., 2005).

This research provides only some support for the effectiveness of the Sanctuary Model for improving outcomes for youth who experience serious emotional disturbances, many of whom had a history of abuse (Rivard, 2004; Rivard et al., 2003; Rivard et al., 2005; Rivard et al., 2004). Despite the positive outcomes, some limitations of the research need to be considered. First, although the residential programs were randomly assigned to implement the Sanctuary Model, no details were provided regarding how randomisation occurred. In addition, according to Rivard and colleagues (2003; 2005), the Sanctuary Model had previously been piloted in other
residential units within the agency and it was found that at baseline, the units implementing the Model had a slightly higher mean on the COPES-S scale (although the differences were not reported to be statistically significant). In addition, as there was no information provided about if and how the influence of alternative organizational cultures was controlled, it is possible that an understanding of the effects of trauma had influenced the organizational culture across the whole agency. This influence may not have been adequately controlled, given that both groups were drawn from the same agency. However, it was only through prolonged engagement with the Model (at six months) that significant changes on the COPES-S indicated increases for the experimental groups; greater adherence to the model was also associated with higher scores (Rivard et al., 2005). In spite of these limitations, the research was the only located empirical study that yielded positive findings for the Sanctuary Model.

In other applications, the Sanctuary Model has been utilized within both public and private school programs (Bloom, 1995; Stanwood & Doolittle, 2004). Unfortunately, no formal research has been published in which its application within this context was evaluated. Although not empirically supported, Bloom (1995, 1997) endorsed the utility of the Sanctuary Model within the school setting. It was suggested that a school culture that embodies the Sanctuary model should have a sense of safety, zero tolerance for violence, and a context that promotes conflict resolution and internal control (Bloom, 1997). Children should develop cooperative and democratic processes to resolve conflicts using ‘council meetings’. In a setting that promotes open communication, children learn how to manage their emotions and social responsibility. Furthermore, the recognition and support for creative expressions supports an environment where creative problem-solving, negotiating complex social situations, appreciating relationships and fostering personal strength may be promoted (Bloom, 1995, 1997).

**Facilitating Organizational Shifts**

**Knowledge Translation**

The implementation of a trauma-**informed** approach to service delivery has been conceptualized as the diffusion component of the Knowledge Translation (KT) process. According to the Canadian Institutes of Health Research (2010), KT is the dynamic and iterative dissemination process of scientific and ethically sound knowledge. This growing body of literature has emerged to aid understanding of this complex process from the creation, the distillation or synthesis and the dissemination of knowledge, as well as the factors that influence
its uptake (Straus, Tetroe, & Graham, 2009). Many disciplines and sectors have contributed to the KT literature, including agriculture, manufacturing, business, engineering, child welfare, nursing, juvenile justice, medicine, mental health and social services (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). As many as 53 systematic reviews have been conducted in the areas related to mental and physical health care (Boström, Slaughter, Chojecki, & Estabrooks, 2012). From this literature, a large number of frameworks have been developed to facilitate implementation (e.g., Campbell et al., 2000; Dobbins, Ciliska, Cockerill, Barnsley, & DiCenso, 2002; Graham et al., 2006; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004; Mendel, Meredith, Schoenbaum, Sherbourne, & Wells, 2008; Powers, 2010; Ringeisen, Henderson, & Hoagwood, 2003; Stetler, McQueen, Demakis, & Mittman, 2008; Ward, House, & Hamer, 2009). To date, research has largely focused on the steps involved in promoting implementation and the factors influencing implementation.

The field of KT represents a shift from the study of new treatments to the study of how to deliver the knowledge from high-quality research evidence about interventions into practice (Bhattacharyya, Reeves, & Zwarenstein, 2009). It is important to consider the difference between processes and outcomes associated with implementation and intervention (Blase, Fixsen, & Phillips, 1984). Implementation processes and outcomes relate to the practitioner’s use of the intervention as intended, whereas intervention processes and outcomes relate to the benefits for the consumers as recipients of the intervention. Intervention outcomes are specific to the type of intervention (Blase et al., 1984). Alternatively, Fixsen and colleagues (2005) have identified three general areas of implementation outcomes, including changes in professional behaviour (reflecting both knowledge and skills), changes in organizational structures and cultures that support changes in professional behaviour, and changes in relationships to consumers, stakeholders and system partners (Fixsen et al., 2005).

Despite this growing body of literature, many aspects of the science remain under-examined, particularly with regard to the child and youth mental health sector (Barwick et al., 2012). In their recent systematic review, Barwick and colleagues were only able to locate 12 studies that were focused on the effectiveness of KT strategies in the area of child and youth mental health. These efforts targeted a range of professionals, including nurses, physicians, therapists, social workers, child and youth workers, teachers and administrators. Although there have been some descriptive studies and published commentaries that address implementation in
children’s mental health, the science in this area is still in its infancy (Barwick et al., 2012). Given the complexity of the interactions among and between systems, organizational contexts and the individuals within the system, currently there is insufficient empirical evidence with which to develop comprehensive theories that predict the generalizability of implementations studies in this context (Bhattacharyya et al., 2009). Barwick and colleagues have indicated that implementation science in the areas of children’s mental health should address the process of implementation and the complexities of the context since little attention has been paid to these areas. Without such consideration, success may be hindered (Fixsen et al., 2005). Furthermore, additional work needs to be done to identify the infrastructures required to support implementation (Wandersman et al., 2008). In moving forward in this field, it is important to look to other areas such as those suggested by Greenhalgh and colleagues (2005; 2004). They conducted an extensive review of the literature in a related field pertaining to diffusions of innovations in health service organizations and draw heavily on theories of organizational behaviour change and diffusions of innovation.

**Important Contextual Considerations**

Drawing on research of diffusion of innovations at the individual and organizational levels, Greenhalgh and colleagues (2004) identified several factors that influence the implementation of innovations in practice. These factors can be summarized into two key areas: the innovation itself and the process of implementation. Both areas are influenced by contextual factors reflecting individual, organizational and intra-organizational considerations. Based on perceptions of prospective adopters, key attributes of the innovation are found to influence adoption rates. These attributes include the relative advantage, inclusion of observable benefits, compatibility with existing organizational culture and the perceived complexity of the innovation. Adoption may be increased when prospective users are able to experiment and adapt the innovation (Rogers, 1995, 2003) as some aspects of treatment protocols may have to be modified in order to be implemented in different contexts (Schoenwald & Hoagwood, 2001). Rogers referred to this aspect as the “trialability” of an innovation (Rogers, 1995, p. 16). In Rogers’ Diffusion of Innovation theory, a five-stage process by which individuals adopt innovations is articulated. These stages include (1) knowledge, which relates to awareness, process (i.e., how-to knowledge) and principles; (2) persuasion, the affective perspective regarding the innovation; (3) decision, the choice to adopt the innovation, which is made by
individuals (e.g., optional) collectively, or by the authority; (4) implementation, which involves utilizing the innovation in practice; and (5) confirmation, in which individuals seek support for the innovation to either continue or discontinue its use (Rogers, 1995, 2003). In addition, Greenhalgh and colleagues described a three-stage model termed the Concerns-Based Adoption Model to provide an explanation for the individual process of adoption within organizational contexts. Concerns during the pre-adaptation stage related to information about the innovation itself and how the innovation affects prospective adopters’ work. During early use, the concerns related to access to information and support. Finally, established users need adequate feedback about consequences of adoption, as well as sufficient opportunities, autonomy and support to use the innovation properly. Concerns must be met at each stage in order to facilitate implementation. Greenhalgh and colleagues suggested this latter model provides congruence with the research evidence they reviewed.

According to Greenhalgh and colleagues (2004), the process of dissemination of an innovation includes system antecedents, assimilation and dissemination and routinization. Features of organizations, both structural and cultural, have been found to influence the likelihood that innovations will be successfully assimilated. The structural determinants include a large, mature, functionally differentiated and decentralized decision-making structure, with specialized professional knowledge and the ability to use slack resources. The cultural determinants include the absorptive capacity for new knowledge (the existing knowledge and skill base and technologies of learning organizations) and the receptive context for change (strong leadership, visionary staff in pivotal positions, effective data-capturing systems and a climate conducive to experimentation and risk-taking). Assimilation involves the adoption of process-based innovations in service organizations and includes structural and procedural changes. This is a complex and interactive process rather than a linear one. Aspects such as organizational readiness influence system assimilation. Dissemination plans may have an increased likelihood of effectiveness if initiatives are designed to take into account adopter needs and perspectives, tailor different strategies to the specific context and subgroups, use an appropriate message for change, identify and use appropriate communication channels and incorporate evaluation and monitoring strategies that are clearly defined to adopters (Greenhalgh et al., 2004).
Active dissemination involves the spread of the innovation within the organization, which is planned, formal, centralized and vertical (Greenhalgh et al., 2004). The dominant mechanism for diffusion is through social networks and it can be increased through the use of champions and by harnessing the power of true opinion leaders (Bradley et al., 2004; Howell & Higgins, 1990; Rogers, 1995, 2003). Elements that influence the sustained use of an innovation (routinization) include organizational structure; leadership and management; human resource issues; funding (dedicated and ongoing); intra-organizational communication and networks; feedback (accurate and timely); and ongoing adaptation/reinvention (to the local context). Users should be involved during the development stage of the innovation to incorporate their perspectives (Greenhalgh et al., 2004).

The Children’s Mental Health System

KT in the children’s mental health systems requires consideration of its unique context (Barwick et al., 2012). The children’s mental health system is influenced by the larger social and political climate, organizational context and individual influences (Flaspohler, Duffy, Wandersman, Stillman, & Maras, 2008; Wandersman et al., 2008). According to the Social Systems Theory proposed by Parsons (1951), society is made up of systems that are defined and maintained by the hierarchical organization of social role and structure. Essential features of social systems are stability, hierarchy, power and control. Systems can comprise layers, where each level is a separate system, but part of the whole system which encircles lower levels. Equilibrium and homeostasis are the essence of social order, which is maintained as each layer of the system controls subordinate layers (Anderson & Goolishian, 1988). Change at any level of the system disrupts social order due to the interconnected nature of the system. Systems theory has been applied in the area of organizational change (Katz & Kahn, 1978) to facilitate an understanding of the difficulties involved in implementing sustainable change initiative. Factors at each of these system levels influence the care for children and youth with mental health problems and require consideration when engaging in KT (Chamberlain et al., 2008; Dijkstra et al., 2006).

Mental health disorders can be viewed as societal-level impairments (Kessler et al., 2008). Stigma is one issue that influences the larger social context of mental health care (Kondrat & Teater, 2009). Stigma is a process whereby members in society stereotype and become prejudiced against minority groups, leading to discrimination through negative reactions
toward individual members of these groups (Corrigan & Watson, 2002). Individuals with mental health disorders represent one group that is stigmatized by society (M. Kirby & Keon, 2009). The stigma surrounding mental illness is still quite predominant in the general public despite improved general knowledge about mental illness (Crisp, Gelder, Ris, Meltzer, & Rowlands, 2000; Phelan, Link, Stueve, & Pescosolido, 2000; Sartorius, 1998; Wahl, 1999).

Labeling theory (H. S. Becker, 1963) was developed to explore the way people who are provided with various labels are treated in society. In the theory it is proposed that labels invite stigma by highlighting differences of individuals (Link, Struening, Cullen, Shrout, & Dohrenwend, 1989). From this point of view, it is not the label that is inherently negative and thus stigmatizing, rather it is society’s perceptions of what the label indicates that has the negative effect on the individual (R. W. Smith, Osborne, Crim, & Rhu, 1986). Within the literature, there is a debate regarding the benefits and disadvantages of labeling disabilities (Lerner, 1992; Link, 1987; Martin, Pescosolido, & Tuch, 2000). Specifically, some of the positive reasons for diagnosis relate to increases in the availability of services and accommodations, funding for the individual and financial institution regarding the amount of students they serve with disabilities, and understanding of the individual limitations due to the individual’s disability. However, there are also negative aspects of the diagnosis, which relates to generalized attributions associated with the individuals’ disability, lowered self-esteem, and increased experience of stigma. The label of a disability can become the predominate characteristic of the individual that overrides all other individual differences and public perception of an individual can be characterized according to their disability (Lerner, 1992; Link, 1987; Martin et al., 2000).

Survey research has demonstrated the presence of public stigma regarding children’s mental health disorders, including concerns about the effects of treatment and psychotropic medications (Beard & Gillespie, 2002; Kazdin, Holland, & Crowley, 1997; Martin, Pescosolido, Olafsdottir, & McLeod, 2007; Martin et al., 2000; Pescosolido, 2007; Pescosolido et al., 2008; Pescosolido, Perry, Martin, McLeod, & Jensen, 2007). Following dissemination of the M. Kirby and Keon (2009) report, the Government of Canada established the Mental Health Commission of Canada (MHCC). Since its creation, the MHCC has been working hard to address and implement the recommendations discussed in the Senate Committee’s report. Funded by the federal government, this not-for profit organization is mandated to focus national attention on
mental health (Howlett, 2008) and has four key initiatives: facilitating the development of a national mental health strategy; conducting a 10-year anti-stigma campaign; developing a Knowledge Exchange Centre, and undertaking homelessness demonstration research projects (Howlett, 2008). Efforts such as the anti-stigma campaign (Mental Health Commission of Canada, 2008) will be important to reduce the perceived stigma associated with mental illness as public stigma influences the support of funding allocated to mental health resources; only six percent of the total health care budget in the United States has been devoted to mental health disorders (Kessler et al., 2008). In Ontario, children’s mental health agencies are publicly funded, largely through the Ontario Ministry of Children and Youth Services (MCYS; Auditor General, 2010). Access is not dependent on referrals from primary care physicians; waitlists are common given the large numbers of children and caregivers seeking treatment (Reid & Brown, 2008; Reid et al., 2011). Ontario agencies have not received an increase in funding in over 10 years (Auditor General, 2010; Reid & Brown, 2008). Service capacity is determined by allocation of ministry funding rather than actual need (Auditor General, 2010). This allocation of funding regardless of need is a longstanding issue in Ontario, as raised by Boyle and Offord (1988) who found significant discrepancies in utilization per capita expenditures despite the lack of related differences in morbidity rates across regions in Ontario.

Issues at the societal level have implications for the agency levels. Reid and Brown (2008) indicated that the lack of adequate funding and the high need for care present agencies with several major problems. These challenges, identified by senior managers of mental health services in Ontario, included an inability to meet demand, an increase in the complexity of care required, staff recruitment and retention problems, and lack of system integration and coordination (Reid & Brown, 2008). These challenges affect services both within the agency and in the broader community. Despite the desire to improve system coordination, many mental health agencies may feel pressure to engage in system fragmentation, competition across different service agencies, and by reactively providing services to those most in need due to systemic challenges (Reid & Brown, 2008). Consequently, these agencies are rendered less prepared for change (J. A. Cohen & Mannarino, 2008a; Kofman & Senge, 1993). Yet the adaptability of an organization can be changed by developing a different approach to these challenges through fostering systems of care which promote inter-organizational service coordination (Kofman & Senge, 1993). According to the Office of the Auditor General of
Ontario (2010), steps have been taken to improve such coordination since 2008; however, the integration of such care may not be understood publicly as 44% of parents contacted more than one agency when seeking treatments for their child’s emotional or behavioural problems (Reid et al., 2011). Parents’ experiences navigating mental health services in Ontario have been perceived as a labyrinth rather than a pathway (Boydell et al., 2006). To continue to improve such coordination, Reid and Brown (2008) call for large-scale evaluations of policies and system programs.

In addition, organizational factors can impede the implementation of successful philosophy changes (Asgary-Eden & Lee, 2012; C. Becker, Darius, & Schaumberg, 2007; Bloom, 2010a; Bloom et al., 2003; J. A. Cohen & Mannarino, 2008a; Frueh et al., 2007; Katon, Zatzick, Bond, & Williams, 2006; Kramer & Burns, 2008; Newman & Kaloupek, 2004; Warden et al., 2008). J. A. Cohen and Mannarino (2008a) described how implementation can be limited due to organizational factors such as lack of readiness for the change within organizational members, lack of financial or other incentives from management, inadequate time or financial support provided for initial training and inadequate infrastructure to provide treatment properly. Training is often a complex aspect to consider because successful implementation is possible with adequate training (Warden et al., 2008); however, adequate training is not, in itself, sufficient for successful implementation (Kramer & Burns, 2008). In addition, it is important that organizations continue to support the implementation of new initiatives following training (Elliott & Mihalic, 2004; Reid & Brown, 2008; Sanders, Prinz, & Shapiro, 2009). Although organizations adopting the Sanctuary Model engage in intensive training (Bloom & Farragher, 2011), the degree to which this knowledge is facilitated into practice is not known.

In addition to the individual level factors identified previously by Greenhalgh and colleagues (2004), factors reported to influence adoption of innovations at the therapist level consist of perceived acceptability and suitability, impact on outcomes and motivation of the staff in the agency (Aarons & Palinkas, 2007). The organizational culture in which the therapist operates can also have a substantial influence on the adoption of the new approach to service delivery (J. Owens et al., 2005; Schein, 1990; T. Scott, Mannion, Davies, & Marshall, 2003; Stanwood & Doolittle, 2004). As stated above, organizational culture has been referred to as the shared beliefs and values that guide organizational members’ behaviour (Schein, 1990). Culture is shared and transmitted to all members within the organization (Schein, 1990). It is possible to
gain an understanding of organizational culture by determining members’ perceptions of practices and procedures, which then can be categorized into analytic dimensions (Denison, 1996; James & Jones, 1974). Research into the effects of organizational culture within children’s mental health agencies has indicated that efficacious programs are implemented with greater success and lead to improved outcomes when the adopting agency includes a positive organizational culture (Aarons & Sawitzky, 2006; Glisson & Hemmelgarn, 1998; Morris, Bloom, & Kang, 2007; Sanders et al., 2009; Schoenwald, Carter, Chapman, & Sheidow, 2008). Such a positive organizational culture includes minimal conflict between co-workers, clear professional roles and cooperation (Glisson & Hemmelgarn, 1998). Glisson and Green (2006) found improved access to mental health services for youth in child welfare when social systems maintained a positive and constructive organizational culture; results were present even while controlling for child need and family characteristics. Regarding staff morale, constructive organizational culture and positive organizational climates were related to positive attitudes, higher service quality and reduced turnover among staff members (Glisson & James, 2002). Relatedly, Becker, Darius and Schaumberg (2007) identified the co-existence of therapist and patient factors that can impede the use of EBP. Therapist factors relate to those described above, while patient factors relate to the lack of knowledge around the success of the intervention, perceptions of perceived risk and comfort and so forth.

As described above in the section on Enacted Sanctuary, such a positive organizational culture is expected within a trauma-informed approach to service. Although this organizational culture is expected based on previous applications of the Sanctuary Model (Farragher & Yanosy, 2005), little research has been conducted to establish a profile of a trauma-informed organizational culture. Rivard and colleagues (2005) provided the only located study in which changes in the organizational culture of residential treatment programs that had adopted the Sanctuary Model were evaluated. The full description of the research design and results were previously provided. What is important to note here is the consideration given to measuring the organizational culture. Specifically, changes in the organizational culture were measured using the Community Oriented Programs Environment Scale short-form (COPES-S) completed by staff members. Significant improvements were observed in the support, spontaneity, autonomy, personal problem orientation, and safety subscales and the total score of the COPES-S. The therapeutic community was found to have increased the perceived sense of support, self-
sufficient and independent decision-making processes, shared responsibility in problem-solving and open expression of feelings (Rivard, 2004). What is noteworthy is that the organizational culture was based on one measure and used only one informant group. Thus, although this research lends insight into the organizational culture, the authors failed to develop a complete profile of the dimensions of a trauma-informed organizational culture. Such a profile could be useful to establish the degree to which organizational cultures are operating as trauma-informed systems. Additional research needs to be conducted to determine the dimensions related to organizational culture within a trauma-informed treatment setting.

**School Context**

Additional factors relating to the program in which services are provided should also be considered; thus, the school context must also be reviewed as this research involves a School Treatment Program. Fidelity and adoption may be facilitated when the intervention fits well within the current organizational context (Buston, Wight, Hart, & Scott, 2002). Program changes may fail when these factors are not considered (Schein, 1990). Ringeisen, Henderson, and Hoagwood (2003) reviewed a three-level model for considering the educational context when implementing a mental health-related intervention (see Figure 2). Similar to the levels described above, the model included the federal/state, the organizational and the individual levels; Ringeisen and colleagues identified additional factors associated with each level relevant to the school context.

At the state/federal level, Ringeisen and colleagues (2003) suggested that mental health interventions have an increased likelihood of being sustained if they are consistent with current mandates, can be financially supported through existing sources and can serve eligible students. Given that the School Treatment Program is provided within a larger mental health agency, the above provincial and inter-agency level factors should be encompassed in this level of the model. In addition, mental health agencies are also accountable in the performance of their employees to meet the requirements of provincial and federal legislation. In facilitating organizational shifts and evaluating performance, leaders must act as role models to the rest of the organization (Bloom, 1994; Bloom et al., 2003; Bloom & Farragher, 2011). Given that leaders may not be present for day-to-day interactions, and may even be situated in different buildings within the agency, it is important that they lead through inspiration. Leadership style and organizational structure must complement each other or the goals of a change innovation may not be achieved
One reason is that managers’ ability to provide financial or other incentives has an influence on staff’s implementation of new initiatives (J. A. Cohen & Mannarino, 2008b). In addition, weak leaders have been perceived as obstacles to effective organizational change (Hoag, Ritschard, & Cooper, 2002).

The organizational level factors identified by Ringeisen and colleagues (2003) related to the availability of resources and organizational culture. These factors are influenced by the state/federal (and inter-agency) levels, which affect the individual level inducing professional stress or morale and the success of change initiatives in terms of program fidelity. As School Treatment Programs include both teachers funded through the local school board, as well as Child and Youth Workers (CYW) from the agency, these two groups may perceive different cultures that may affect one another.

The individual level factors identified by Ringeisen and colleagues (2003) related to both the teacher and the students (for this research the CYW were also considered within this level). Individual factors for the instructors include personal characteristics, beliefs and behaviours (Ringeisen et al., 2003). These factors influence intervention implementation (relating to what types of training and supports are needed) and primary intervention outcomes (Warren et al., 2006). Similar to the issues with training identified for the staff of mental health agencies, researchers have demonstrated that more than one-third of teachers who attend training failed to adequately implement EBP (Klingner, Ahwee, Pilonieta, & Menendez, 2003). Additional attributes that have been found to limit success include: general psychological antecedents (including a history of tolerance for ambiguity, intellectual ability, motivation, values and learning style); context-specific psychological antecedents (the motivation and abilities of the adopter); the meaning of the innovation (consistency between individual adopters and management); and the decision to adopt the innovation (both individually and collectively) (Greenhalgh et al., 2004). Teacher burnout and poor morale have also been linked to poor classroom efficacy (Hoy & Woolfolk, 1993). With regard to the students, treatments should be tailored to address individual risk factors, diagnostic profiles and family characteristics (Ringeisen et al., 2003). Furthermore, successful educational programs require positive therapeutic relationships between teachers/staff and students (Cancio & Johnson, 2007). Thus, the relationship of teachers and CYW with students could either facilitate or impede successful implementation. This relationship may be at an additional risk of strain due to the propensity for
emotional outbursts among students with emotional and/or behavioural disorders (Shields & Cicchetti, 1998; Walcott & Landau, 2004). Indeed, the highest attrition rates among special education teachers have been found for teachers who work with such student populations (Cancio & Johnson, 2007).

**Family Context**

As identified above, Ringeisen and colleagues (2003), as well as Hoagwood, Burns, Kiser, Ringeisen, and Schoenwald (2001), indicated that the implementation of an intervention in treatment should also take into consideration the family context where the children develop. Recognition of the influence of family systems on children’s use of mental health services has grown (Brannan, Heflinger, & Foster, 2003). Hoyt, Cowen, Pedro-Carroll, and Alpert-Gillis (1990) suggested that it is important to examine the parental influences on their child’s mental health in determining effective treatments. Barriers that limit the use of children’s mental health service have been found to relate to structural factors, attitudes and perceptions about mental health services and the family context (Olin et al., 2010). Structural factors include, but are not limited to transportation, childcare, insurance, scheduling and availability of services (Benway, Hamrin, & McMahon, 2003; Kataoka, Zhang, & Wells, 2002; Kazdin et al., 1997; P. Owens et al., 2002). In addition, various family factors, such as the child’s symptoms and impairments, the presence of other family stressors, and the availability of family resources and social supports are related to the use of mental health services (Brannan & Heflinger, 2006; Brannan et al., 2003; Dadds & McHugh, 1992; Kazdin & Wassell, 2000; Pescosolido et al., 2008). Families of children with emotional or behavioural problems have been found to be affected in a variety of ways, including worry, stress, stigma, financial burdens and decreased physical and psychological well-being (Donner et al., 1995; Farmer, Burns, Angold, & Costello, 1997; Friesen & Huff, 1996; Messer, Angold, Costello, & Burns, 1996). Researchers have established a link between these impacts and the use of children’s mental health services regardless of the severity of emotional or behavioural problems (Farmer et al., 1997); higher levels of objective measures of caregiver strain have been associated with children’s increased involvement in mental health system (Brannan et al., 2003; Farmer et al., 1997; Lambert, Brannan, Breda, Heflinger, & Bickman, 1998). However, subjective strain such as anger, resentment and embarrassment regarding children’s problems corresponded to less intensive use of mental health services and shorter time in treatment (Foster, 1998), indicating that stigma might be influencing parents’
decisions to access and to have their children remain in treatment (Pescosolido et al., 2008). Furthermore, attitudes, beliefs and perceptions about mental health services also influence use of children’s mental health services. Specifically, negative attitudes about services, mistrust toward mental health professionals, prior negative experiences with the mental health system, stigma, belief in the temporary nature of child social, and behavioural difficulties have been found to limit the likelihood of service use (McKay, Pennington, Lynn, & McCadam, 2001; P. Owens et al., 2002; Pescosolido et al., 2008).

Based on this review of the literature, it is clear that exposure to trauma has implications for the developmental trajectory of the children (A. Cook et al., 2005; van der Kolk, 2005). Cicchetti and Lynch’s (1993) ecological/transactional model provided insight into how the family context may also be affected by trauma. As described previously, children exposed to trauma may develop a lack of trust in their parents due to their inability to protect them (Lieberman et al., 2005). This lack of trust may be internalised by the parents. Specifically, Goldfinch (2009) stated that parents may believe that they may not be able to support their child. These factors have been found to relate to increased use of children’s mental health services (Farmer et al., 1997). Alternatively Hillis and colleagues (2010) identified protective effects of family strengths for long-term pro-social development. Such factors related to levels of closeness, support, loyalty, protection and love (Hillis et al., 2010).

Transformative Knowledge Translation

Traditionally, KT reflects the process whereby academic researchers are the knowledge producers, health professionals are the consumers of knowledge, and patients are the beneficiaries (Graham et al., 2006; Grol, 2008; Ho et al., 2004; Lavis, Robertson, Woodside, McLeod, & Abelson, 2003). Knowledge has been traditionally understood as the synthesis and culmination of high-quality research evidence on a given topic (Canadian Institutes of Health Research, 2010). This representation of knowledge has been rooted in the post-positivist perspective which assumes that there is an objective truth, that it is possible to derive evidence objectively regarding interventions and that this knowledge can be applied to different contexts (Cornelissen, Mitton, & Sheps, 2011; Greenhalgh & Wieringa, 2011). This perspective of KT assumes that there is an inherent appreciation for individuals and contexts (American Psychological Association, 2006); however, the focus has been on matching the results of the innovation to contexts and individual factors. For example, Wang, Moss, and Hiller (2006)
reviewed the importance of considering the applicability and transferability of interventions. They indicated that the relative effectiveness of the intervention in different settings may be in question due to factors that may be unrelated to the quality of the implementation (referring to transferability) even if it is feasible to implement an intervention in a context that is different from where it was developed (referring to applicability) (Wang et al., 2006). Although consideration of these factors is laudable and important for KT, there is some appreciation for the extent to which the knowledge base of intervention itself may change through the implementation process due to the contextual factors. Thus, while adapting the intervention to the local context is a consideration of the KT theory, it is acknowledged that attempts at adapting interventions may alter the intervention itself, which may in turn limit the success of the intervention. One focus from this perspective concerns determining for whom and in which contexts will the intervention be effective. Specifically, the knowledge about the intervention is more than the sum of the synthesised evidence of effectiveness and efficacy and it is bound by the context and assumptions of a particular culture; thus, when introduced into another context, the knowledge fundamentally changes through engagement (Davies, Nutley, & Walter, 2008; Savory, 2006).

Conceptualizing KT from constructivist and transformative perspectives expands the understanding of what constitutes knowledge (Baumann, 2010; Cornelissen et al., 2011; Kitto, Sargeant, Reeves, & Silver, 2012; Matthew-Maich, Ploeg, Jack, & Dobbins, 2010; McWilliam, 2007; Mezirow, 1991). From these contextually bound perspectives, knowledge can include, but is not limited to research evidence (McWilliam, 2007). According to Wenger (2004), knowledge is the culmination of human communities’ understanding of the world and how to be within the world; knowledge is refined and advanced through social engagement. From this perspective, knowledge is understood to be more of a verb than a noun (Cornelissen et al., 2011) in which knowledge is relational (Schwandt, 1999). This reflects the conceptualization of knowledge of other non-medical disciplines (such as philosophy, sociology and organization science), whereby knowledge may be created, constructed, embodied, performed and collectively negotiated (Greenhalgh & Wieringa, 2011). In their recent publication, Greenhalgh and Wieringa acknowledged the value-laden quality of knowledge and proposed that a broader understanding of the complexities of power and knowledge is required. Essentially, it is argued that sometimes research may be biased by the sources of knowledge due to a combination of academic research
agendas and those in positions to fund research. Thus, researchers should not be the sole proprietors of knowledge; they have an important contribution to provide to the area of knowledge, but this does not constitute the sum of the knowledge. What is needed is a critical reflection on the motives of the sources of knowledge (Mezirow, 1998).

The importance of considering the source of knowledge links to an area of research related to the experience of services by the individuals receiving treatment. Baumann (2010) stated that it is a limitation when researchers do not fully appreciate and acknowledge the individuals’ experiences and the meanings they derive from these experiences. From a transformative perspective, it is important to consider the service users’ perspectives on their experience with a trauma-informed service to detect and describe power differentials in order to ward off the potential for oppression. Given the focus on trauma, it is important that systematic empirical research is conducted to evaluate patient experiences (Newman & Kaloupek, 2004).

An issue of particular concern is the users’ perceptions of restraints and seclusion. The use of such aversive methods of control has been endorsed by staff members as an effective method of behavioural management (Day, 2002). As stated previously, however, the use of such methods may be perceived as a symptom of a trauma-organized mental health system (Harris & Fallot, 2001a; Jennings, 1994). Survey research conducted with adult mental health service users found a negative relationship between the quality and safety of psychiatric settings and the experience of institutional measures of control (e.g., seclusion, restraints and take-downs) (Grubaugh, Frueh, Zinzow, Cusack, & Wells, 2007). Furthermore, such measures were perceived as frightening and/or humiliating by adult patients (Frueh et al., 2005; Robins, Sauvageot, Cusack, Suffoletta-Maierle, & Frueh, 2005).

Research regarding the use of seclusion and restraints with children is relatively scant, with different perspectives regarding the utility of such techniques (Cotton, 1989, 1995; Dadds, Adlington, & Christensen, 1987; Day, 2002; Gutheil, 1978; Joshi, Capozzoli, & Coyle, 1988; Miller, 1986; Millstein & Cotton, 1990; Robins et al., 2005; Rosenthal & Shannon, 1997; Snow & Finlay, 1998; Steele, 1993). Seclusion generally refers to the use of a quiet room, with or without locks, to contain a child (Joshi et al., 1988; Miller, 1986). Research into staff members’ perspectives regarding the use of seclusion has indicated that such techniques are employed for therapeutic reasons (Millstein & Cotton, 1990). Theoretically, the use of seclusion is based in the principles of confinement, isolation and decreased sensory input (Gutheil, 1978). The use of
seclusion has been reported as a procedure for teaching children effective self-regulation, mature defences, coping skills and interpersonal skills in relating to others (Cotton, 1989), but it is also used as a method of protection (Millstein & Cotton, 1990). Children are expected to learn control through the experience of control (Cotton, 1989). However, research has demonstrated that children who are frequently secluded are more likely to have a history of physical and/or sexual abuse than children who are infrequently secluded (Millstein & Cotton, 1990). These children have also been found to have deficits in their ability to cope with survival and growth, set personal limits, respond to limits set by others and are rigid in their coping styles (Millstein & Cotton, 1990); such findings were consistent with literature regarding children exposed to trauma (Cicchetti & Lynch, 1993; A. Cook et al., 2005; van der Kolk, 2005). Accordingly, children’s perceptions and personal history should be considered when determining the use of certain seclusion techniques so as to avoid re-traumatization (Cotton, 1989).

Based on a review of the literature, Day (2002) concluded that there is a relative paucity of research exploring children’s experiences with the use of exclusion and restraints. Only one study was located children’s perceptions were examined, which were based on their drawings and explanations of the seclusion room (Miller, 1986). Children’s perceptions of the use of seclusion rooms were generally negative, with such methods perceived as punishment (Miller, 1986). These findings are consistent with other reports of children’s perceptions (Raychaba, 1992; Snow & Finlay, 1998). Consequently, Miller (1986) suggested that children’s negative perceptions and reactions to the use of seclusion may thwart therapeutic intentions regarding the use of such procedures. Thus, an important tension exists between perceptions of the use of seclusion rooms: when self-initiated, the use of reflection rooms may be perceived as a mechanism for establishing self-control (Cotton, 1989, 1995; Joshi et al., 1988; Miller, 1986; Millstein & Cotton, 1990), however, when the use of such rooms is perceived as forcible and arbitrary, they may be interpreted as an abuse of power in a potentially strained relationship between staff and youth (Raychaba, 1992; Snow & Finlay, 1998).

This extended conceptualization of knowledge offers alternative avenues for conducting research to enhance this knowledge base (McWilliam, 2007). By incorporating systems theories (Bertalanffy, 1968), theories of innovations (Van de Ven, Polley, Garud, & Venkataraman, 1999), learning theories (Mezirow, 2000; Schein, 2010) and critical social science theories (Habermas, 1972), Kitson (2009) proposed an alternative and comprehensive understanding of
the knowledge translation process. Kitson indicated that successful translation may be the function of the ways in which individuals within the system understand and accept the new knowledge, the ability to make decisions about the use of the new knowledge to improve outcomes, the negotiated relationships among individuals with their systems and the ability to acquire resources to sustain the new practice based on the knowledge.

In addition, transformational learning theory, developed by Mezirow (1990, 1991, 1997); (2000) has been applied to knowledge translation efforts to enhance engagement with knowledge (Matthew-Maich et al., 2010; McWilliam, 2007). As proposed by Mezirow (2000), transformative learning theory includes the use of critical reflection and critical discourse to explore one’s underlying habits of mind which dictate individual points of view on various topics to guide better actions. The underlying frames of reference become the subject of change. Critical reflection and discourse are needed to deconstruct and construct understanding. Central in this process is critical insight into context, our various roles within the world, and our experiences that, over time, have shaped our beliefs, values and assumptions. Central to the theory is the dialectic of praxis as conceptualized by Freire (1970/2000) in which both reflection and action are required and are predicated upon one another. Individuals are required to engage in action to overcome various constraints (e.g., situational, emotional and informational) and to move forward. According to Mezirow (2000), and supported by Taylor’s (1997, 2000, 2007) review of the research, transformative learning typically occurs through the following processes:

1. a disorienting dilemma;
2. self-examination with feelings of fear, anger, guilt or shame;
3. a critical assessment of assumptions;
4. recognition that one’s discontentment and the process of transformation are shared;
5. exploration of options for new roles, relationships and actions;
6. planning a course of action;
7. acquiring knowledge and skills for implementing one’s plans;
8. provisional trying of new roles;
9. building competence and self-confidence in new roles and relationships; and
10. a reintegration into one’s life on the basis of conditions dictated by one’s new perspective (p. 22).
The process has been found to be fluid, recursive, evolving and cyclical in nature, and may be best characterized as a journey (Taylor, 2000). Transformations involve critical reflection on either encountered assumptions of others (i.e., objective reframing) or self-reflection on one’s own assumptions (i.e., subjective reframing). Brookfield (1986) emphasized that the central focus of critical reflections should be power and hegemony. The transformation process requires emotional intelligence in addressing the individual and social emotional ramifications (Mezirow, 2000). Macdonald (2002) noted the importance of supporting an ‘unlearning’ process important to address long-held beliefs and assumptions and to facilitate new learning.

Drawing on group and team learning literature (Rose, 1996), Yorks and Marsick (2000) applied the transformative learning theory to organizational learning. The critical discourse inherent in the transformative learning (Mezirow, 2000) supports groups as effective settings for enabling learning (Rose, 1996). Although they articulated various processes (e.g., action learning and collaborative inquiry) for engaging in transformative learning, central to all processes was the understanding that transformative learning in organizations requires support from leaders and space to engage in the transformative process (Yorks & Marsick, 2000). Creating a space may include the development of actual or figurative space where the learning can be fostered (Aalsburg Wiesser & Mezirow, 2000). The transformation process requires environments that express healthy democracy, in which traditional power relationships between educator and learners are not exercised.

Relatedly, Greenhalgh and Wieringa (2011) proposed the following areas for advancing the field of KT: the practical clinical judgment process; how tacit knowledge is developed and shared among practitioners (e.g., through communities of practice); how this tacit knowledge might be facilitated; the complexities and relationships among knowledge and power; and facilitating partnerships between researchers, practitioners, policymakers and commercial interests to promote macro-level changes. As well, additional theories and constructs have been applied to describe and explain the knowledge development and exchange process. For example, Wenger (2004) suggested that practitioners should have a crucial role in knowledge production or, as he refers to it, ‘knowledge management’. Practitioners are those who actually use the knowledge in their daily activities and, as such, are in an apt position to manage this knowledge through the development of ‘communities of practice’ (Wenger, 1998). These communities are not merely working groups of individuals, rather they are groups who develop a community that
shares a passion for something they know how to do and who meet regularly to engage in collective learning to improve their discipline (Wenger, 1998). From a transformative perspective, it is also believed that service users may also be at an apt position to facilitate and possible co-manage this knowledge. The notion of communities of practice offers a novel approach to reducing the gap between knowledge and practice and, hopefully, enhancing the exchange (McDonald & Viehbeck, 2007). Barwick, Peters, and Boydell (2009) conducted one of the only located studies in which the effectiveness of the communities of practice to facilitated Knowledge Translation efforts were evaluated. No significant differences were found in self-reported practice change or use of the implementation of supports between groups randomly assigned to a community of practice or a practice as usual. However, the group that engaged in a community of practice were found to have better content knowledge of the intervention. Based on this limited research, the effectiveness of the use of community of practice has not been found. The results of the research and other examinations into the process suggested that their use may be useful for practice, but that additional research is required (Barwick, 2008; Barwick et al., 2009; Wenger, 1998, 2004). Accordingly, it has been suggested that building communities of practice may be helpful in facilitating transformative learning (Macdonald, 2002).

Adopting a transformative perspective also provides an expanded set of standards to evaluate knowledge translation endeavors (Kitson, 2009; Matthew-Maich et al., 2010). Specifically, it is important to focus on relationships, context, increased awareness and critical reflection (Matthew-Maich et al., 2010). The use of a variety of research methods is critical in determining the knowledge base of interventions and the process of translating this knowledge into practice (American Psychological Association, 2006). Baumann (2010) stressed that professionals should not restrict the knowledge base to evidence derived from randomized controlled trials and instead should critically review the literature and assumptions of clinical judgment. This perspective legitimizes the results of research exploring the “tacit knowledge and humanistic understandings” (McWilliam, 2007, p. 73). Knowledge in this area requires consideration of both the wider social structures (e.g., beliefs, values, economic constraints) (Wittgenstein, 1958) and the social position of the individuals developing this knowledge (Mertens, 2009). Thus, when knowledge is defined not only as research evidence, but also as innovation, which represents the perception of a novel idea, practice or object (Rogers, 1995), the trauma-informed approach comprises such an innovation; the trauma-informed approach
requires shifts in service philosophy according to a new understanding of the pervasive effect of trauma (Bloom, 1997, 2005b; Harris & Fallot, 2001a). This conceptualization of knowledge provides a means for evaluating the merits of the Sanctuary Model as a valid form of knowledge to be disseminated. Specifically, some research has been conducted that suggests the Sanctuary Model has some merit (Rivard, 2004; Rivard et al., 2003; Rivard et al., 2005; Rivard et al., 2004). Inherent in the approach is the importance of reducing power inequalities and avoiding further traumatization, an approach that has been reported to lead to empowerment (Bills & Bloom, 1998, 2000; Bloom, 1994, 1997, 2000b, 2005a, 2005b; Madsen et al., 2003; Rivard et al., 2005; Rivard et al., 2004; Wright & Woo, 2000; Wright et al., 2003); these qualities constitute the basis for which transformative theories should be evaluated (Agger, 2006; Bengton et al., 2005; Klein & White, 2008; Mertens, 2009) and, by extension, should be translated.

The literature relating to knowledge translation has provided valuable insights into the factors at a variety of levels that influence the diffusion of innovations. These identified factors must be taken into consideration to facilitate successful implementation of trauma-informed services. Accordingly, organizations seeking to adopt the Sanctuary Model should carefully consider these systemic factors. Further additional research is required to identify factors that influence adoption and complexities of the context, with careful consideration of the effects of power inequalities, particularly when the KT effort involves potential traumatized individuals.

**Utilizing Sanctuary in Practice**

In accordance with the recognition of the effects of childhood trauma, a local children’s mental health agency decided to embark on a knowledge translation effort to become trauma-informed. The agency adopted a Sanctuary Guided Trauma-Informed Practice (SGTIP) throughout its programs. The agency’s mission is to assist children with mental health concerns and their families to improve their lives and to become contributing citizens. There is a combined focus on resilience and trauma-informed care, with an overall target of wellness. To accomplish this mission, the agency offers a variety of programs to support children and youth within their own home, school and community.

In acknowledging the need to shift toward a trauma-informed system, the leaders of the agency have adopted new important ways of thinking within their organization. These thinking processes include an appreciation for the pervasive nature of psychological trauma; acknowledgment that the effect of trauma can be misinterpreted, misdiagnosed or even ignored;
and that children with these histories may be at risk of being re-traumatized by an uninformed service system. According to agency leaders, the agency has attempted to enact these modes of thinking in practice through the implementation of universal screening for past history of trauma, interpreting behaviour as efforts to cope with past trauma rather than focusing on the need for behaviour ‘management’ programs, no longer interpret impulsivity and inability to listen and behave appropriately as something individuals can control, reduced the use of physical restraints and treating trauma with evidence-based interventions that build on resilience. What is required is an exploration of the degree to which these trauma-informed modes of thinking have been disseminated through the agency within its various programs.

**Process of Implementing the SGTIP**

As is evident from this review of the literature, the adoption of a new service delivery within children’s mental health agencies is difficult and requires systemic considerations. Accordingly, a multi-phase assessment process of the adoption of the Sanctuary Model within the agency was conducted. The Phase I research consisted of a Staff Implementation and Social Climate Evaluation. Using a longitudinal design, an internal researcher from the agency evaluated the social climate through surveys designed to assess the organizational culture, professional Quality of Life, levels of engagement and prospects of sustainability. The organizational culture was measured using the Group Environment Scale – Real form (Moos, 1994). The evaluation was conducted prior to the staff training, as well as three and six months following training. Following the administration of the three-month and six month surveys, focus groups were held for staff within the various programs. The content of the focus groups addressed the staff perceptions of the important concepts and tools of the Sanctuary Model, the factors that facilitate successful implementation of the Sanctuary Model, and barriers or obstacles that impede implementation. Included in this phase of the research was an assessment of the staff training, development and implementation.

The Phase II research consisted of Parallel Processes analyses to determine how the communities were operating for both the organizational members and clients within all of the agency’s services. Typically, the client’s culture, experiences and outcomes from treatment are explored within this phase of the research. Given that the agency consists of several different programs, each of which provides unique services, members from each of these programs were responsible for determining the optimal means of assessing the parallel processes. In addition,
each program implemented the Sanctuary Model at different points in time, which was
dependent on the development of a strategic plan for implementation and assessment within each
program. Given the agency’s overall target mission of promoting wellness, for the third phase of
the adoption process the agency will embark on a resilience and wellness evaluation. This
program development will be informed by the research from Phases I and II.

**Community-engaged scholarship.** This research represents community-engaged
scholarship in which University of Guelph researchers and professionals from the agency have
formed partnerships to pursue scholarly endeavours (Jordan, 2007). Jordan identified eight
characteristics of quality community-engaged scholarship, including clear academic and
community goals, adequate preparation in the context area, the use of appropriate and rigorous
methods, the significance of the results for the field and community, effective dissemination to
academic and community audiences, reflective critiques, leadership and personal contributions,
and consistent ethical and socially responsible behaviour. Each of these characteristics has been
experienced through this research process. For example, the faculty supervisor had a previous
scholarly relationship with the community agency. Based on the identified needs from the
review of the literature and the agency’s representatives, the School Treatment Program was
chosen as the site for this research. In addition, through a mutual and evolutionary process, the
research aims were developed. The research methods were chosen based on their utility at
addressing research questions within the organization and were not entirely consistent with the
theoretical assumptions underlying the intervention. Community partners’ feedback was used to
improve the procedures and measurement instruments to ensure their appropriateness with the
population of interest. Consistent with the transformative framework, the research results were
framed within the understanding that the identification and attribution of individual deficits are
not beneficial for addressing structural and systemic problems (Mertens, 2003; Wears, 2008).
The agency’s ultimate purpose for conducting the research was to improve the services they
provide. Critical reflection is imperative to promote emancipatory change.

In summary, based on the increased understanding of the effects of trauma on individuals
and mental health systems, a local children’s mental health agency decided to adopt a trauma-
informed approach throughout its services. Such an organizational change has been
conceptualized as part of the Knowledge Translation process. In this research, the diffusion
process was explored. This research was developed through collaboration with the mental health
agency and this approach may be termed Community Engaged Scholarship. The general purpose of this research was to determine the extent to which the Knowledge Translation effort to shift the organizational culture in a School Treatment Program within a children’s mental health agency was successful. Specifically, it was to determine the extent to which the organizational culture within the program had become trauma-informed.

**Research Purpose and Objectives**

The aims of this research were developed through a collaborative relationship with agency representatives, and it was to conduct a comprehensive, contextualized study (S. Kirby, 2007) of the SGTIP within the School Treatment Program (STP), with the general purpose of determining the extent to which the organizational culture had become trauma-informed. The aim of the research represented an investigator driven approach. The research was important to the agency as its leaders appreciated the negative implications of being trauma-organized and decided to become trauma-informed, which according to trauma theory has the potential to lead to empowerment for the children accessing their services. Thus, the agency’s desire to engage with this research was consistent with critical trauma theory.

As indicated above, it is important to conduct Knowledge Translation within the Transformative paradigm in order to answer questions related to how successful the adoption was, what changes need to be incorporated to improve the intervention, and assessing whether or not, and for whom the interventions are beneficial, while acknowledging the contextually bound and co-constructed nature of knowledge and with the intent to reveal and reduce power inequalities with the aim of empowerment (Mertens, 2009). Accordingly, this research was also informed by the Transformative paradigm. The transformative approach was honoured, in that additional questions were developed to gain insight into the degree to which the students felt empowered through the SGTIP and the use of the reflection rooms. In addition, efforts were made to reduce power imbalances between the researcher and the participants (particular the students). Finally, the level of engagement and empowerment was at a systemic level rather than through engaging in the research process itself, although participants, particularly the students could have felt empowered through the research by having an opportunity to voice their perceptions regarding their treatment.

Given that the Sanctuary Model represents an “organizational culture intervention” (Bloom & Farragher, 2011, p. 357), adoption of the SGTIP was explored with a parallel process
perspective within this research. This research reflected a consideration for the complexities of the context (organizationally, from the perspective of different groups within the setting) as well as the external influence of the family. There were three related research objectives pertaining to organizational culture, benefits as perceived by consumers and the family context as an additional parallel process operating beyond the program.

**Research Objective One: Parallel Process Examinations**

The first objective was to explore the parallel processes within the STP. As stated above, parallel process is the development of similar affects, cognitions and behaviours expressed among at least two groups or systems that have a significant relationship (K. K. Smith et al., 1989). It was important to determine the influences that systems have on one another to ensure that the negative effects of trauma were not being played out in other systems and that positive cultures were facilitating recovery. There are two systems within the STP: the CYW team and the classrooms. The CYW represent an organizational group who worked collaboratively with each other and as part of a team within the various classrooms. Given that there were only four classrooms in the program, which were led by one teacher and one CYW, responses were aggregated to a classroom level to render participants unidentifiable or not attributable to any individuals. Thus, for this objective the organizational culture of the CYW was compared to the culture of the classrooms. From a parallel process perspective, congruence between the two systems was expected. It was understood, however, that the direction of the processes would not be able to be determined.

Such assessments require the consultation of the perceptions of multiple stakeholders as they represent different groups with unique organizational perspectives. Accordingly, teachers were only encouraged to adopt the SGITP, they were invited to participate in this research as a method of providing a third perspective of the organizational culture within the classroom.

For the first objective, there were four related research questions:
1a) what was the culture of the classrooms according to the students and teachers;
1b) what was the organizational culture of the CYW who work within the STP;
1c) what were the perceived similarities and differences of these cultures; and
1d) what aspects facilitated and/or impeded the adoption of the SGITP that might be influencing organizational culture?
Research Objective Two: Student Perceptions

The second objective of the research was to determine the extent to which the students found the SGTIP approach beneficial and if they felt empowered through the process of recovery. Given that an underlying assumption of the approach was empowerment (Bloom, 1997), it was imperative that research be conducted within the program using a trauma-informed approach in order to identify the extent to which power inequalities and potentially re-traumatizing situations may be occurring within the program. Empowerment can generally be defined as a social process in which individuals gain control over their own lives. When conducting such research with children, a powerful tension exists between protecting the children from harm and the need to access the information that children possess regarding their personal and social issues (Grodin & Glantz, 1994). As children have been reported to be the best source of information regarding issues relating to themselves (J. Scott, 1997), it was imperative that the children’s perceptions were directly solicited. Only through direct consultation could we determine if the new approach to service delivery was beneficial and fostered empowerment (Hurst, 1999).

Relatedly, it was important to determine the students’ perceptions regarding the use of time-out or seclusion rooms. Within the School Treatment Program, several ‘reflection rooms’ were available for students to take some time out of their classroom should they feel the need. From a Sanctuary approach, students should be provided with an opportunity to ‘take space’ and establish control over their emotions and behaviours (Yanosy & Harrison, 2009). However, prior to the implementation of the SGTIP, similar rooms called ‘quiet rooms’ were used, where students were escorted by their staff members when they were acting out. Changes to the use of such rooms required shifts in the mental models that guide behaviours (Bloom, 1997). As described above, there has been relatively little research exploring the therapeutic utility of the use of seclusion rooms with children (Day, 2002). Only one study was located that directly examined children’s experiences with the use of seclusion rooms and the results indicated that such rooms were perceived negatively (Miller, 1986). Miller concluded that the use of such rooms might actually inhibit treatment given these negative perceptions. Therefore, we needed to determine the extent to which children and youth perceived the use of these rooms as a trauma-informed mechanism for self-control and empowerment. The specific research questions for this objective were:
2a) what did the students perceive to be the benefits and drawbacks of adopting the SGTIP; and
2b) what were the students’ perceptions of the use of the reflection rooms?

**Research Objective Three: Family Context**

Finally, in addition to the treatment environment, the students were also operating within another system, their family (Lynch & Cicchetti, 1998). Through an extended understanding of parallel process, it was pertinent to determine the parallel processes between the family environment and the agency’s organizational culture. Various family factors, such as a child’s symptoms and impairment, the presence of other family stressors, family resources and social supports are related to the use of mental health services (Brannan & Heflinger, 2006; Brannan et al., 2003; Dadds & McHugh, 1992; Kazdin & Wassell, 2000; Pescosolido et al., 2008) and childhood development (Hillis et al., 2010). In addition, as a means of gaining insight into the transferability of the skills learned within the program, parental perceptions were obtained in an attempt to determine changes in children’s behaviour beyond the classroom. For this part of the research, there were three research questions:

3a) what was the family climate of children receiving treatment from an agency adopting a trauma-informed approach to service;

3b) what were the similarities and differences between aspects of the family climate and culture of the classrooms; and

3c) did parents perceive positive changes in their children, which were present beyond the classroom through treatment after the implementation of the SGTIP?

**Mixed-Methods Approach**

Given the different objectives, a sequential mixed-methods approach (Creswell & Plano Clark, 2011) was employed. Transformative research has been reported to be helpful in facilitating understanding of power dynamics and privilege in an attempt to create sustainable change (Mertens, 2009). The mixed-methods included a multi-source cross-sectional design (Liu, 2008), in which questionnaires were used to collect both quantitative and qualitative data, and a qualitative descriptive design (Sandelowski, 2000), which included interviews and focus groups. The survey measures were used to collect data on the perceived characteristics of the context to compare and contrast cultural perceptions (Moos & Fuhr, 1982) and to provide insight into participant groups’ perceptions. In addition, a directed content analysis (Elo & Kyngäs, 2008) was conducted to analyse the qualitative data, which included open-ended questions from
the various surveys, the focus groups and interview transcripts conducted with the students, CYW and the parents. Incorporating the qualitative data provided a means of enhancing the understanding of the organizational culture, exploring students’ perceptions regarding the SGTIP and the use of time-out or seclusion rooms and clarifying interpretations of the quantitative results. Please see Figure 1 for a visual representation of the timeline of the different points of data collection for this research.

Figure 1. Timeline for the data collection.

In terms of the use of mixed-methods approach, Creswell, Plano Clark, Gutmann, and Hanson (2003) have identified criteria for categorizing different mixed-methods approaches, including the type of implementation process, priority of methodological approach and stage of integration; these criteria were consistent with the sequential mixed-methods design. First, the relative priority given to the different research results differed depending on which research question was examined. Specifically, the survey results were given priority when examining the parallel processes between the groups, whereas the results from the focus groups were given priority in examining the implementation process and perceived benefits of the SGTIP. However, both approaches were important to gain a comprehensive understanding of the organizational culture. With regard to the type of implementation process, all of the surveys
were conducted prior to the focus groups and interviews. The student and parent surveys were also analysed before the focus groups and interviews were conducted, which provided an opportunity to interpret further the results from the surveys (Ivankova, Creswell, & Stick, 2006). Unfortunately, as stated above, due to difficulties in communication, the CYW surveys could not be analysed before the focus groups were conducted. The integration of quantitative and qualitative data occurred at the intermediate stage (Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005; Ivankova et al., 2006) and again during the interpretation stage of the study (Onwuegbuzie & Teddlie, 2003).
Method

Participant Recruitment

**Description of STP.** The School Treatment Program consists of four classes. Each class contains seven to nine students in a range of grade levels. Teachers and CYW work as a team to address issues that are interfering with academic performance. The program’s daily operations are directly overseen by a program supervisor located within the program. However, the program supervisor left the program approximately two-thirds of the way through the school year, and she was not replaced within the program.

Students in the program ranged from five to 12 years old. Most of the children lived with their parent/guardians in the community. Other children in the program were staying in the residential mental health program offered through the agency. Some children and youth within the residential program were under the care of the Children’s Aid Society. There were also students who received an extended care treatment (where additional treatment is provided before and after the school day).

Informed by the Ecological/Transactional Model (Cicchetti & Lynch, 1993), there were four participants groups, including students, teachers, Child and Youth Workers (CYW), and parents. These groups represented some of the key stakeholders in the program. Although soliciting feedback from other stakeholders would have been ideal, particularly given the ecologically perspective, this was not an option as the program supervisors left the program during the data collection. Further access to the other managers was limited by the agency.

**Sampling frame of the students.** Approximately 40 per cent of the children and youth served by the agency required intensive community-based services according to their Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1997) scores. In addition, 23% required ongoing outpatient services, 20% required outpatient care with additional supportive services, 15.4% needed very intensive, residential or inpatient services and 3% did not need ongoing services. Across the whole agency, the four greatest areas of impairment were with functioning in school (agency mean score of 24, which represented a moderate level of impairment), in the home (agency mean score of 22.6), behaviour toward others (agency mean score of 20) and mood and emotions (agency mean score of 18). Children and youth received treatment for between one month and two years, with most of them receiving treatment for 9-18
months. Approximately 72% children and youth served by the agency were male; 28% were female.

**Student recruitment.** All 31 students placed within the School Treatment Program were invited to participate in the research. The participants included in the study constituted a convenience sample of individuals from the program. The participants were recruited through the agency. Child and Family Therapists made first contact by informing the parents/guardians about the research and obtained permission to release contact information to the researcher. The researcher then contacted each of the parents/guardians who were willing to provide their contact information by the phone. The researcher read the consent form aloud and obtained verbal consent. Parents were also provided (either by email or mail) a copy of the consent form. Twenty-four parents/guardians provided contact information; only one of these parent/guardians declined their child’s participation.

**Teachers.** All of the teachers working in the School Treatment Program were invited and participated in the research. Four teachers ran their own classroom with an assigned CYW, while the fifth teacher was a resource teacher who worked within each of the classrooms. The Waterloo Catholic District School Board supervises the teachers. To inform the CYW and the teachers about the research, the program manager and program supervisor introduced the researcher to the CYW and the teachers during a staff meeting. They were provided with a brief summary of the research and were informed that both the students and the teachers were invited to participate in the research (CYW data collection was facilitated by an internal researcher from the agency).

**CYW.** The data from previous research conducted by the agency to evaluate the SGTIP (Phase I research described above) were included in the analysis to enhance the understanding of the implementation and resulting organizational culture of the CYW. Specifically, the results of the CYW survey and notes from the focus group from the staff members who worked in the School Treatment Program were included in the analysis. The decision to conduct a secondary analysis on the agency data was made to conserve the agency’s resources as well as minimize the burden of participation for the staff. Although, directly soliciting perceptions from the CYW would have been ideal had it been feasible. The researcher did have an opportunity to develop questions for the focus group. According to the report for the agency’s representative, all of the CYW working in the program participated in the research.
Parents. Finally, all of the parents/guardians of the children utilizing services within the School Treatment Program were invited to participate in the survey. To maintain privacy laws, the survey packages were mailed by an agency representative. As the objective was to gain insight into the family context, guardians from the Children’s Aid Society were excluded from the study.

Procedures

Student survey. Dates for the student surveys and focus groups were scheduled with the assistance of the program supervisor in consultation with the teachers. As many of the students in the program often had difficulties with peer relationships, the students whose parent/guardian provided consent were assigned to participate in the survey in small groups. This also helped to preserve safety for the researcher, given that no agency representatives were in the room during the data collection. Group allocation was determined by the program supervisor, the teachers and in some cases a CYW. The importance of consulting gatekeepers with respect to power dynamics between peers during focus groups has been noted in the literature (Tinson, 2009). Children from the same classroom were grouped together, which provided for consistency in terms of classroom experience and age range (Morgan, Gibbs, Maxwell, & Britten, 2002).

When the time was scheduled to conduct the surveys for each class, the teacher or CYW introduced the researcher and informed the students that she was there to ask the students to complete a survey. One group of students was removed from the classroom at a time and were led to an empty classroom within the School Treatment Program by the researcher. The researcher explained that their parents/guardians had given permission to speak with the student, but that it was the student’s choice to complete the survey. The researcher distributed the survey package to the students. The survey package included an assent form, the survey and an envelope. The researcher explained what her role was within the environment. The students were clearly informed that the researcher was not a teacher or CYW in an attempt to reduce the perception of authoritative control (Tinson, 2009). Next, the researcher reviewed the components of the assent form and answered the students’ questions to ensure that they understood that their participation was voluntary, that they did not have to complete the surveys, and that they were able to skip any questions. It has generally been accepted that children between the ages of 7 and 12 years old have the capacity to determine their willingness to participate in research (Helseth & Slettebo, 2004). None of the children declined to participate.
The survey consisted of general demographic questions, the modified short-form of the Classroom Environment Scale (CES; Fraser, 1982; Fraser & Fisher, 1983), and open-ended questions related to the students’ perceptions of the SELF psycho-educational groups. The researcher read the survey aloud to the students and answered the students’ clarification questions. The students were encouraged to give their opinions truthfully and were told that there were no right or wrong answers (Punch, 2002). The researcher transcribed verbal responses to the open-ended questions for the students who requested this assistance. Students were thanked for placing the survey in the envelope and provided with a small favour as a token of gratitude (a fun pencil and eraser). The students were then escorted back to their classroom.

**Student focus groups.** Focus groups were completed over four days. They were conducted in an empty classroom within the STP building. The students were again assigned to small groups of between two and three students, given the students’ peer relationships. The composition of the focus groups was determined through consultation with the school supervisor and the teachers. Nine focus groups and one additional interview were completed. Although all students were provided an opportunity to answer the questions in an individual interview, none of the students chose this option. The student who did complete the interview was absent while the other students in his assignment group participated and the researcher was informed by the CYW in the class that the student had a history of conflicts with the remaining students from the class who were participating.

Focus groups were audio recorded. In addition to the principal investigator, a certified court reporter, who volunteered her time, was present during the focus groups. The court reporter had no known prior relationship with the agency, staff or clients. She had experience dealing with confidential information and signed a confidentiality agreement. During the session, she was responsible for recording the session, monitoring the equipment and taking notes. The addition of an assistant has been found to be beneficial during focus groups for participants within this age range (Morgan et al., 2002). Students were informed in their assent form that the focus groups were being recorded. When the researcher read this statement to the students, she introduced the court reporter to the students and explained that she was using the microphones and computer to record the focus groups. Students were informed during the assent process that all statements would be recorded, but that they did not have to answer questions that made them uncomfortable.
Prior to each focus group, the researcher reviewed the components of the assent form with the students and answered questions to ensure the students understood that their participation was voluntary. As stated above, the students were informed that if they were not comfortable speaking in a group setting, an individual interview would be arranged. Although we were not able to maintain anonymity for the students who participated in the research, steps were taken to ensure that responses were not linked to individual students. Specifically, when names were stated, they were not included in the transcripts; as well, all other identifying characteristics were removed. Furthermore, no agency representatives were present during the focus groups and the students were instructed not to discuss the content of the focus group with anyone. In addition, they were informed that they had the right to dissent from the research at any time; specifically, they were instructed that they could remain within the group and not contribute, or that it was acceptable for them to leave the room to return to their classroom at any time during the focus groups (Tinson, 2009). One student chose to leave the focus group as he/she was having a difficult time focusing and was highly agitated. The children were informed that it was their personal choice to leave, and that doing so would not upset the researchers or the CYW in any way. It has been suggested that children will often choose to participate in research as they do not want to upset the researcher (Tinson, 2009). Throughout the focus groups, the researcher made an effort to observe the children’s behaviour for signs the children were uncomfortable (Diekema, 2006). When children demonstrated signs of minor discomfort with a topic, the researcher avoided asking them questions directly. The researcher provided an opportunity for individual students to take a short break when they displayed stronger signs of discomfort. Breaks and refreshments were also provided when the group appeared fatigued and distracted (Morgan et al., 2002). Students were informed that the researcher was required to disclose to appropriate agencies if they discussed any alleged abuse (Tinson, 2009). No such incidents were disclosed by the students.

Finally, the researcher described her role as a researcher, and she made it clear she was not a teacher or CYW (Tinson, 2009). As such, the participants were informed that the researcher had no authority with regard to their behaviour, but instead that she wanted to promote an environment of respect (Tinson, 2009). To facilitate this respectful environment, ground rules were agreed upon by the group and written on a paper on display for the duration of the focus group. Some of the rules related to taking turns when talking, not saying negative
things about other students or their comments and the importance of keeping the information discussed in the focus groups private. In an attempt to reduce the power differential between the researcher and the students, participants were encouraged to use the researcher’s first name. In addition, the students and the researcher sat in a circle around the table as an additional means of facilitating equality amongst the group. The recording commenced once the ground rules were established.

The researcher facilitated brief warm-up questions at the beginning of each focus group to initiate participation (Morgan et al., 2002). The rest of the focus groups were semi-structured (Bernard, 2000) to gain insight into how the SGTIP had been implemented and utilized within the School Treatment Program. In general, questions focused on the students’ perceptions of their classrooms. Similar to the focus group questions posed by Rivard and colleagues (2005), students were asked about various components of the Sanctuary Model. In addition, similar to Stanwood and Doolittle (2004) the organizational culture was assessed through questions related to each component of the SELF model. Questions adopted from Stanwood and Doolittle included: how safe is your classroom; how do you talk about your feelings in your classroom; how does your class deal with losses; what does your staff member do to make your classroom feel positive/enjoyable; and what do you like/dislike about the Sanctuary Model? Within this discussion, students were asked about how they were encouraged to ‘take space’ in their classroom. Probes were used to determine the students’ perceptions about the reflection rooms. Finally, participants were also asked about any anomalies noted from the survey results.

Specifically, the survey results indicated that the classrooms were highly rule-governed, thus students were asked who made these rules and to what degree they contributed to the rule development. Questions were phrased to reflect the developmental level of the students and how the students were responding to the questions. Additional clarifying questions and probes were used as a form of member checking to aid in an understanding of the participants’ meaning (Morgan et al., 2002) since it has been suggested that there are differences in interpretations between children and adults (Punch, 2002). The focus groups lasted between 28 to 45 minutes (the interview lasted 19 minutes). As a token of gratitude, students were provided with a small favour (a small stress toy).
**Teacher survey.** Two of the teachers completed the survey following the meeting in which the research was discussed (the other teachers were absent from this meeting). For the other three teachers, the researcher distributed the survey package to each teacher while she was present in the School Treatment Program administering the student surveys. The package included the consent form, the survey, an envelope and a $5 Tim Horton’s gift card. The teachers were given an opportunity to review the consent form and ask questions. The teacher survey consisted of a modified version of the long-form of the Classroom Environment Scale (Trickett & Moos, 1973, 2002) and open-ended questions relating to their perceptions of the SGTIP within the classroom. All five of the teachers completed the survey and returned it to the researcher.

**Parent survey.** The surveys were distributed to the parents/guardians of the children utilizing services within the School Treatment Program. The packages included an information letter, consent form, questionnaire and return envelope (with postage paid). A clear distinction between the researcher conducting the research and the agency was included in the information letter. In addition, the university logo was used to signal parents further that their agency had not prepared the survey. Participants’ right to refuse to participate was bolded in the information letter to reduce the appearance of expectation to complete the survey. Parents were considered to have provided informed consent when they completed and returned the survey. Given a small response rate to the initial survey distribution, approximately one month following the distribution of the surveys a follow-up package was sent out to the parents/guardians. This package included a follow-up letter, consent form, survey and return envelope. Research has demonstrated that providing a second copy of the survey can substantially improve the response rate (H. Becker, Cookston, & Kulberg, 2000; Bergk, Gasse, Schnell, & Haefeli, 2005; Edwards et al., 2007; Edwards et al., 2009).

The survey consisted of general demographic questions about the family, the Family Environment Scale (FES; Moos & Moos, 1975), the Caregiver Strain Questionnaire (CGSQ; Brannan, Heflinger, & Bickman, 1997), the Target Behaviour Rating Scale (FIDD; M. A. Feldman, Condillac, Tough, Hunt, & Griffiths, 2002) and open-ended questions related to parental perceptions of the impact of the SGTIP on their child's behaviour (including changes in social relationships, family functioning, academic achievement and behavioural/emotional functioning). Parents were asked to express their opinions regarding the perceived benefits and
limitations of the SGTIP. Parents were provided with an opportunity to be contacted later to further discuss their perceptions of the SGTIP. Several features identified by Williams, Seybolt, and Pinder (1975) were employed to reduce the perceived burden of completing the survey; for example, questionnaires were printed on both sides of the paper.

**Parent interviews.** Following the analysis of the parent surveys, two parents were contacted by phone for follow-up interviews. Although the initial intent was to sample the participants purposively based on their responses to the survey questions, only two parents were interviewed, as they were the only participants who expressed willingness to be contacted in their surveys. Once consent was obtained, the interview commenced. The interviews consisted of open-ended questions to clarify parental perceptions and functioning, as well as gain a complete understanding of how these families were operating. Including only two participants’ interviews limited the degree to which completeness in perceptions was ascertained (McEvoy & Richards, 2006), which can be further assumed to limit the transferability of the results. However, interviewing participants who completed the surveys provided a means of confirming the survey results (McEvoy & Richards, 2006). Thus, the interview questions were developed based on the results of the parent surveys and were employed as a form of member checking (Creswell, 1998).

**Measures**

Several versions of the Social Climate Scales (Moos & Fuhr, 1982) were chosen since they were unique to the specific climate for each of the different participant groups to compare the complex nature of the various micro settings. The Social Climate Scales (Moos, 2003) are a group of measurement procedures that measure an individual’s perceptions of three underlying domains characterizing such settings: Relationship, Personal Growth or Goal Orientation, and System Maintenance and Change. Relationship dimension gains insight into the ways people relate to each other within the group/setting. The Personal Growth and Goal Orientation dimension is used to identify the emphasis placed on goals and tasks within the setting/group. The System Maintenance and Change dimension provides a measure of the setting’s basic structure and degree of openness to change. Please see Appendix A for the different subscales associated with each of these dimensions. These dimensions are comparable to Bronfenbrenner’s (1977) systemic perspective and the concepts of interpersonal relationships, goal-directed molar activities, and system-defined roles and role expectations (Moos, 2003).
The Real Forms were used to identify the participants’ current environment rather than the Ideal and Expectations forms, which reflect hypothetical environments. For all of the Social Climate Scales, standardized scores range from zero to 100, with an average mean score of 50 (Moos & Moos, 2009). Normative data were also available for each of the scales in their respective manuals.

**Group Environment Scale.** The CYW completed the Group Environment Scale (GES; Moos, 2002) as part of the larger assessment of the Staff Implementation and Social Climate Evaluation (the Phase I research). The GES is specifically designed to assess the organizational culture within groups. It consists of 90 true/false questions that represent the three dimensions, which are further divided into 10 subscales. The Relationship dimension included the subscales of Cohesion, Expressiveness and Leader Support. The Goal Oriented dimension included the subscales of Independence, Task Orientation, Self-Discovery, and Anger and Aggression. The System Maintenance subscales included Order and Organization, Leader Control and Innovation.

The GES has strong psychometric properties with internal consistency of the subscales ranging between $r = 0.62-0.86$ and test re-test reliability ranging between $r = 0.65-0.87$ (Moos, 2002). The GES has been found to have strong concurrent validity with other measures of environmental assessments (Salter & Junco, 2007). For scoring, the number of responses given in the keyed direction was summed; subscale totals ranged from zero to 10, where higher scores indicated a greater presence of the dimension within the environment. Raw scores were converted into standardised scores using the conversion table in the manual (Moos, 2002).

**Classroom Environment Scale.** The School Treatment Program climate was measured using the modified form of the Classroom Environment Scale (CES; Fraser, 1982; Fraser & Fisher, 1983). The subscales that constitute these dimensions reflect the unique school context. Specifically, the Relationship dimension included the subscales of Involvement, Affiliation and Teacher Support; the Goal Orientation dimension included the subscale of Task Orientation, and the System Maintenance dimension included the Order and Organization and Rule Clarity subscales. The original version of the survey contains additional subscales relating to Competition, Teacher Control and Innovation; however, these scales were not included since they have been found to be unreliable with samples of students with behavioural disorders (Leone, Luttig, Zlotlow, & Trickett, 1990; Trickett, Leone, Fink, & Braaten, 1993).
Given that the aim of the research was to assess how the agency staff, as opposed to the teachers, facilitate the SGTIP within the classroom, the CES was also modified to focus on the staff member. Specifically, the term ‘teacher’ was replaced with ‘staff’. This modification was not expected to affect the psychometric properties of the scale, but rather adjust the focus to the alternative leader within the classroom.

Regarding the psychometric properties, strong concurrent validity with the long form has been demonstrated with intra-class correlations ranging between $r = 0.78$ and $r = 0.95$ for the subscales (Fraser & Fisher, 1986). Consistency between student and teacher ratings has been found (Humphrey, 1984). Internal consistency has also been found with alpha reliability coefficients ranging between $r = 0.56$ and $r = 0.78$ (Fraser, 1982; Fraser & Fisher, 1983). Finally, the scale has demonstrated discriminant validity when compared to other scales measuring classroom environments (Fraser, 1982; Fraser & Fisher, 1983). These results were replicated with the short-form (Byrne, Hattie, & Fraser, 1986), which supports the use of the short-form of the CES for analysis at the group level (Trickett & Moos, 2002).

Although the long-form can be used to compare individual student responses with their class (Trickett & Moos, 1973), it has been recommended that the short-form only be used to provide a group representation (Fraser & Fisher, 1986). Accordingly, the teachers were asked to complete the modified long-form of the Classroom Environment Scale, which consisted of nine items per subscale. The students’ survey consisted of the modified short-form of the Classroom Environment Scale (CES; Fraser, 1982; Fraser & Fisher, 1983) comprising only the first four items of the subscale (Fraser, 1982). It was important to use a shorter version of the survey measure with the students to reduce their burden in completing the survey. When conducting surveys with children, it has been suggested that surveys be relatively short and limit the number of options (Tinson, 2009). As such, completing the long-form of the survey may have been unrealistic, given a student population with a propensity for difficulties in attention, reading and writing skills (Amos, 2004; Anda et al., 2008; J. A. Cohen et al., 2010; J. A. Cohen & Mannarino, 2008b; Hodas, 2006).

When completing the survey, participants were instructed to indicate whether each statement was consistent with their classroom environment by circling either the true or the false response. For scoring, items were allotted a point for each true response; underlined items were reverse coded (Trickett & Moos, 2002). Scores for each subscale range from zero to four for the
short-form and zero to 10 for the modified longer form; however, raw scores were converted to standard scores for comparisons (Trickett & Moos, 2002).

**Family Environment Scale.** To gain insight into the family context, the parent/guardians completed the Family Environment Scale (FES; Moos & Moos, 1975), the Social Climate Scale designed to measure the social-environmental characteristics of families (Moos & Moos, 2009). Consistent with the other Social Climate Scales, the FES includes the three dimensions of Relationship, Personal Growth and System Maintenance. Again, the subscales that constitute these dimensions were unique to the family context. Specifically, the Relationship dimension included measurements of Cohesion, Expressiveness and Conflict; the Personal Growth dimension involved assessments of Independence, Achievement Orientation, Intellectual-Cultural Orientation, Active-Recreational Orientation and Moral-Religious Emphasis; and finally, the System Maintenance dimension included Organization and Control measures.

Although several investigators have supported the three-factor structure of the FES (Bouchard & McGue, 1990; S. S. Feldman & Rosenthal, 1991; Gondoli & Jacob, 1993; Hastings & Kern, 1994), other investigators have found a two or four second-order structure of the scale (Boake & Salmon, 1983; Fowler, 1981, 1982a, 1982b; Kronenberg & Thompson Jr, 1990; Loveland-Cherry, Youngblut, & Leidy, 1989; Oliver, Handal, Enos, & May, 1988; Oliver, May, & Handal, 1988; Robertson & Hyde, 1982; Roosa & Beals, 1990; Waldron, Sabatelli, & Anderson, 1990). Despite these inconsistencies with regard to the factor structure, acceptable internal consistency has been found with alpha reliability coefficients ranging between $r = 0.61$ and $r = 0.78$ (Moos & Moos, 2009), but has been found to vary based on characteristics of specific samples (Oliver, May, et al., 1988; Roosa & Beals, 1990); also see review by Greene and Plank (1994) and Moos (1990). In addition, the measure has acceptable test-retest reliabilities, with two-month scores ranging from $r = 0.68$ to $r = 0.86$, with similar results at four-months (Moos & Moos, 2009).

Finally, the scale can reliably discriminate among differences in family functioning (Moos, 1990; Moos & Moos, 2009). Scores for each of the subscales are standardized to create an overall profile of family environment. Families can be categorized into a family typology based on their distribution of scores on the subscales (Moos & Moos, 1976, 2009).
The scale takes approximately 10 minutes to complete and has 90 true-false items. Similar to the other Social Climate Surveys, the raw scores are determined by summing the responses in the keyed direction. Subscale scores are represented by an average of each item’s score for that subscale. Raw scores ranged from zero to nine and they were converted to the standardized scores for comparison.

**Caregiver Strain Questionnaire.** The Caregiver Strain Questionnaire (CGSQ; Brannan et al., 1997) was used to assess caregiver strain associated with the demands, responsibilities, difficulties and consequences of caring for children with emotional and/or behavioural disturbances (Brannan et al., 1997). The measure included three dimensions of strain: objective strain, internalized subjective strain and externalized subjective strain (Brannan et al., 1997). Objective strain was associated with observable occurrences resulting from caring for a child with emotional or behavioural problems (e.g., interruption of personal time, financial strain and social isolation). Internalized subjective caregiver strain referred to internalized feelings of the caregiver that were associated with caring for a child with emotional or behavioural disturbance, which includes: feeling sad or unhappy, worrying about the future (for both the family and the child), feeling guilty, feeling tired and sensing that a toll had been taken on the family. Finally, the externalized subjective caregiver strain included negative feelings (such as resentment, anger, embarrassment and relating poorly with the child). The presence of three subscales has been supported by both exploratory and confirmatory factor analyses (Brannan et al., 1997; Heflinger & Taylor-Richardson, 2004; Taylor-Richardson, Heflinger, & Brown, 2006), and was confirmed with other parent caregivers.

The scale has been found to have acceptable internal consistency, with an overall alpha coefficient of 0.93 (Brannan et al., 1997) and good reliability, with Cronbach’s alpha = 0.93 (Brannan et al., 1997; Taylor-Richardson et al., 2006). The scale has also been found to have acceptable convergent validity with related measures of family functioning and caregiver distress (Brannan et al., 1997; Taylor-Richardson et al., 2006). To complete the scale, parents/guardians indicated the degree of problem experiences in the past six months because of his or her child’s problems for each of the 21 items. Responses were scored on a 5-point Likert scale ranging from not at all a problem to very much a problem. In addition to its three subscales, a global measure of caregiver strain can also be calculated from the CGSQ items. Subscale scores were calculated as the mean of the items in the subscale, with the global score representing the overall mean
score of all the items (Brannan et al., 1997). Consistent with the procedure described by Brannan and colleagues, missing values were imputed with the mean value of the other items in the subscale (this occurred for the one missing items from two parent surveys). Scores ranged from one to five, with higher scores indicating more concern in a given subscale than lower scores.

**Target Behaviour Rating Scale.** As a measure of social validity, parents/guardians were asked to complete a questionnaire rating their child’s behaviour on the Target Behaviour Rating Scale (FIDD; M. A. Feldman et al., 2002). The questionnaire included four dimensions: Frequency (how often does this target behaviour occur), Intensity (how severe is the target behaviour), Duration (how long does this behaviour last, from start to finish) and Discrimination/Pervasiveness (where, when and with whom does the target behaviour occur). Parents’ ranked their child’s behaviours of the four dimensions on a 7-point Likert scale. The scores from each of the four scales were summed to obtain the severity rating for a given target behaviour. Missing scores were assigned a zero value for that dimension. Total scores ranged from four to 28, with higher scores indicating more severe behaviours than lower scores. The scale provided a quantifiable measurement of the dimensions of the behaviour or difficulties of the child. The psychometric properties are not available at this time as the scale has yet to be published.

**Data Analysis**

**Analytic Strategy for Quantitative Data.** Quantitative survey data were entered into the Predictive Analytics SoftWare program (PASW 20; IBM Corp., 2011). The Social Climate Surveys were analysed by calculating the Standardized Mean Scores (SMS) for each of the subscales. These scores were then plotted on the respective Environment Scale Profiles (Moos, 2002; Moos & Moos, 2009; Trickett & Moos, 2002). The students’ and the teachers’ scores were plotted on the same Classroom Environment Scale Profile (Trickett & Moos, 2002) to provide a visual comparison of the distribution of scores. Z-tests were conducted to determine if any of the STP samples differed significantly from the normative samples from which the scales were developed. A description of the profiles for each group was developed based on their distribution on the profiles (Moos & Fuhr, 1982; Moos & Moos, 2009). Subscales were interpreted according to a threshold model (Dodge, 2003), where by SMS above or below a
value of 50 (the standardized mean) indicated a relatively high or low degree of the given domain within the culture.

In addition to understanding how the organizational culture of the CYW was operating since the initiation of the SGTIP, it was also possible to gain insight into how their organizational culture has changed since before the initiation of the SGTIP. Specifically, the CYW completed the Group Environment Scale in April, prior to training in the SGTIP, and in December, approximately four months following the implementation of the SGTIP in the STP. Unfortunately, as only four of the eight CYW completed the survey at both points in time, independent samples (as opposed to repeated measures) t-tests were conducted. Prior to performing any analyses, the data were screened to determine normality. As shown in Table B1, neither Skewness nor Kurtosis was found to be a problem since none of the values was two times greater than their standard error (Tabachnick & Fidell, 1996). Homogeneity of the variance was confirmed for each pair of variables, except for Leadership Support.

The caregiver strain questionnaire provided an additional measure for understanding the family context. The global strain index was calculated as the mean value of all the items. In addition, subscale means were calculated for the three dimensions of strain: objective, internalized subjective, and externalized subjective. Individual item mean values were also examined as a way to provide insight into specific areas of concern. Areas were considered to be of concern if the mean score for an item was greater than a value of three.

The scores from each of the four scales on the Target Behaviour Rating Scale were summed to obtain the global severity rating. In addition, means scores were calculated for each of the four dimensions to provide insight into what aspect of the target behaviour was problematic. Repeated measures t-tests were conducted to compare reports on a child’s social relationships, functioning in the home, academic achievement and parents’ relationship with their child. Prior to performing any analyses, the data were screened to determine normality. Skewness was not determined to be a problem as none of the values were two times greater than their standard error (Tabachnick & Fidell, 1996). Kurtosis was only a problem for reported changes in academics following the intervention (kurtosis = 4.28, SE = 1.59) (Tabachnick & Fidell, 1996). Homogeneity of the variance was confirmed for each pair of variables.
Analytic Strategy for Qualitative Data. Directed content analyses (Elo & Kyngäs, 2008) were employed to analyse the qualitative data, which included open-ended questions from the various surveys, focus groups and interview transcripts conducted with the students, CYW, and the parents/guardians. This form of content analysis is a method for determining the subjective interpretation of the content through a systemic procedure of identifying patterns from the data (Hsieh & Shannon, 2005). This process began by transcribing the children’s focus groups and the parent interviews verbatim by the certified court reporters (Graneheim & Lundman, 2004). Each focus group and interview was considered as a whole, which provided context for interpretation. Prior to the analysis, the transcripts were reviewed several times to facilitate a sense of the whole (Graneheim & Lundman, 2004). Transcripts and open-ended survey responses were entered into the MAXQDA10 Qualitative Data Analysis Software (VERBI GmbH., 2012) to support the analysis conducted by the researcher. An unconstrained coding matrix was developed based on the Sanctuary Model’s seven organizational commitments, the four aspects of the SELF-model, aspects of the reflection rooms, and the facilitators and barriers identified from the literature related to facilitating organizational shifts. Although factors were identified in the literature review section at the social/political and agency levels, factors were restricted to those at the individual level, with consideration for their collective influence representing organizational culture. The coding matrix was unconstrained to provide an opportunity for new or different categories to emerge from engagement with the data (Elo & Kyngäs, 2008). The transcripts were initially coded based on these categories by identifying meaning units (Graneheim & Lundman, 2004), which were words/phrases that align with the content of a category in the coding matrix. For example, the students’ comments regarding the safety of the program were coded as representing the nonviolence commitment. Additional codes were also developed for words/phrases that did not fit into these predetermined codes (Hsieh & Shannon, 2005). This particularly related to students’ comments related to the use of the Reflection Rooms, as the initial codes developed did not reflect the students’ discussion of their perceptions. Both the manifest and latent content were subject to analysis (Elo & Kyngäs, 2008). After the entire dataset was coded, each excerpt was reviewed for fit with the category by comparing it with all the meaning units assigned to the category and with a consideration of the context under which the statement was made during the interview/focus group (Zhang & Wildemuth, 2009). Within this process, subcategories were refined depending on the type and
breadth of the categories (Hsieh & Shannon, 2005). As a means of providing credibility of the interpretations, select excerpts that represented each category were identified as well as the number of participants who endorsed a category were included in the summary of the results (Graneheim & Lundman, 2004). In this approach, meanings were derived from the content of the data. Including the number of participants who made comments reflecting a specific category provided insight into the dominance of a given concept within the category. In addition, when only one participant discussed a novel aspect about a category, it was included to demonstrate the breadth of this category within the program.
Results

Samples

**Students.** Twenty-three students participated in both the surveys and focus groups (see Table 1). The student participants ranged from eight to 12 years old. The students represented a good sample from each of the four classrooms, in that between four and seven students participated from each class.

Table 1.

*Participant Demographics*

<table>
<thead>
<tr>
<th>Participant group</th>
<th>Survey</th>
<th>Interview</th>
<th>Focus Group</th>
<th>Age M (SD)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students</td>
<td>23</td>
<td>1</td>
<td>22</td>
<td>9.87 (1.17)</td>
<td>Male 18, Female 5</td>
</tr>
<tr>
<td>CYW</td>
<td>8</td>
<td>-</td>
<td>8</td>
<td>-</td>
<td>Male -, Female -</td>
</tr>
<tr>
<td>Teachers</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Male 1, Female 4</td>
</tr>
<tr>
<td>Parents</td>
<td>7</td>
<td>2</td>
<td>-</td>
<td>39.7 (7.29)</td>
<td>Male 0, Female 7</td>
</tr>
</tbody>
</table>

**Teachers.** All five of the teachers working within the STP participated in the research (see Table 1). The teachers had between 4 and 10 years of experience working in the field. They also had between one and nine years of experience within the program.

**CYW.** Eight CYW completed the surveys (6 in April and 6 in December), with only four completing the survey at both points in time (see Table 1). All of the CYW reported that they received the SGTIP training. The CYW had been working with the agency for an average of 8.6 years (ranging from two to 20 years) and had been working in their current position for an average of two years (ranging from one to four years). They had been working in their profession for an average of 13.4 years (ranging from five to 20 years). Eight CYW participated in the focus groups. The focus group was administered in May, which was approximately five months following the second administration of the survey.

**Parents.** Seven parents completed the survey (see Table 1). These parents were all the biological mothers of the students in the STP. The mothers were an average of 40 years old; the youngest was 30 years old and the oldest was 51 years old. All except one of the mothers had either a college or a university degree. Of the seven parents who completed the survey, two
indicated they would be willing to complete the interview. Upon contact, both agreed to participate; however, one of these mothers had her husband (the child’s father) complete the interview.

**Research Objective One: Results**

The first objective was to explore the parallel processes within the STP. For this objective, the convergence of the group processes of the classroom (according to the students and teachers perceptions) and the CYW as a working group was examined. Each participant group’s perceptions of organizational culture were first described independent and then the perceptions were further described in their relationships to one another. Further, the participants’ perceptions of the possible factors that influenced this adoption of the SGTIP were also evaluated.

**Organizational culture reported by students according to the CES.** The students’ SMS for the subscale of the Classroom Environment Scale (CES) are presented in Table 2.

Table 2.

**Standardised Classroom Environment Scale of the Students and Teachers**

<table>
<thead>
<tr>
<th>CES Subscales</th>
<th>Mean</th>
<th>SD</th>
<th>Mean</th>
<th>SD</th>
<th>Difference Scores</th>
<th>t-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement</td>
<td>56</td>
<td>3.97</td>
<td>52</td>
<td>12.61</td>
<td>4</td>
<td>t(21.73)* = 1.217, p = 0.24</td>
</tr>
<tr>
<td>Affiliation</td>
<td>44</td>
<td>5.31</td>
<td>47</td>
<td>11.74</td>
<td>-3</td>
<td>t(14.12)* = -0.961, p = 0.35</td>
</tr>
<tr>
<td>Staff Support</td>
<td>42</td>
<td>6.84</td>
<td>46</td>
<td>13.54</td>
<td>-4</td>
<td>t(26) = -0.714, p = 0.50</td>
</tr>
<tr>
<td>Task Orientation</td>
<td>44</td>
<td>7.69</td>
<td>52</td>
<td>16.39</td>
<td>-8</td>
<td>t(26) = -1.041, p = 0.42</td>
</tr>
<tr>
<td>Order Organization</td>
<td>45</td>
<td>8.29</td>
<td>40</td>
<td>7.72</td>
<td>5</td>
<td>t(26) = -1.515, p = 0.14</td>
</tr>
<tr>
<td>Rule Clarity</td>
<td>55</td>
<td>4.51</td>
<td>60</td>
<td>14.48</td>
<td>-5</td>
<td>t(21.98)* = -1.196, p = 0.24</td>
</tr>
</tbody>
</table>

Note. No significant differences were found

* Equal variances not assumed
For the Relationship Dimension, the students reported an average level of Involvement, and slightly low levels of Affiliation and Staff Support. For the Goal Orientation Dimension, the students reported an average level of Task Orientation. Finally, for the System Maintenance and Change Dimension the participants reported a low level of Order and Organization, but high level of Rule Clarity. These means are comparable to the normative community samples (Trickett & Moos, 2002) since none of the SMS were significantly different from the normative sample (see Table 4).

**Organizational culture reported by teachers according to the CES.** The teachers’ subscales SMS of the Classroom Environment Scale are presented in Table 2. Regarding the Relationship Dimension, the teachers reported a slightly high level of Involvement and a slightly low level of Affiliation within the STP. Teachers also reported that low levels of Staff Support were being provided to the students. For the Goal Orientation Dimension, the teachers reported a slightly low level of Task Orientation. Finally, for the System Maintenance and Change Dimension the participants reported a slightly low level of Order and Organization, but a slightly high level of Rule Clarity. As shown in Table 5, these means were not significantly different from the normative community sample of teachers (Trickett & Moos, 2002).

**Comparison of the CES of the teachers and students.** Differences in the students’ and teachers’ standardised scores were compared using independent samples t-tests. No significant differences were found between the two samples. In addition to the statistical analysis, the students’ and teachers’ SMS for the Classroom Environment Scale were plotted on the same profile for visual comparison (please see Figure 3). When compared to the normative sample, the students were consistent for all but one subscale with regard to whether their levels were above or below threshold. Students perceived that their level of Task Orientation was moderate, whereas the teachers reported that this level was low. Although not statistically significant, the difference in Task Orientation was also the largest difference between the student and teacher reports (difference score = -8), with all other means differing by only half of a standard deviation (five points) or less. Thus, aside from the different perception of Task Orientation, the students and teachers were relatively consistent in their reports of the organizational culture within the STP.
School culture within the STP: Student representation of the 7 Sanctuary commitments. *Nonviolence.* The students reported mixed perceptions regarding a sense of safety within the STP. Twelve students reported that they felt there was a sense of safety within the STP. Alternatively, seven reported that they perceived the environment as unsafe. They indicated that, “It just feels negative in there” (Student Focus Group #8, Girl age 10) and that “It’s not a good place to be if you’re feeling upset” (Student Focus Group #8, Boy age 12). Three additional students remarked that they felt that the STP had aspects that made it both safe and unsafe; for example, one student said, “that’s kind of like both sides, like yes it’s safe and no it’s not” (Student Focus Group #2, Boy age 8). One student commented that safety is important for learning “I think if you have a dangerous classroom then you don’t learn much” (Student Focus Group #6, Boy age 11).

The students provided specific examples of what promoted safety within the STP and what made it unsafe. Three student surveys and seven students in the focus groups reported that the CYW and teachers promote safety within the program. The students did not differentiate much between the role and their relationship with the teachers and the CYW. According to the students, some of the things that CYW and teachers did to promote safety included: listened to students, helped students to calm down and solve problems, provided guidance during issues, were not rude to students and supported students in their academics. For example, one boy said, They kind of just sit there and just watch what happens and stuff. Like if, like if something really badly goes on like then the next thing you know they’re just like telling us where to go and stuff, like not like oh, stay there and like not like that loudly, calmly telling us go outside, there’s a fire or something like that. That’s what I mean. (Student Focus Group #9, Boy age 10)

Two survey and four focus group responses indicated that CYW removed students when they were aggressive. For example, one boy said, The classroom worker will know - if somebody’s freaking out she’ll do something like put them in a room or she can restrain them if it’s, if it’s bad. So I think it’s always safe, but most of the time it doesn’t even need to happen. We have a very safe classroom. (Student Focus Group #6 Boy age 11).

One student also discussed that the CYW break up situations that have the potential to lead to a fight; however, this response was perceived negatively by the student as he perceived the
situation as a game. Another student reported that some students have one-to-one staffing. This individual support apparently helps the student to behave in the STP, as he noted, “some kids have one to one so then they will be good so then they’ll stay in class sometimes” (Student Focus Group #2, Boy age 10).

Two students commented on the physical aspects of the STP that promote safety. These aspects included the presence of a fire alarm and fire extinguisher, as well as the size of the physical environment. One student said that, “Just how it’s kind of a large room and enough space if we get angry” (Student Focus Group #6 Boy age 10). Physical aspects of safety also included the possibility of using the spare classroom as a safe space for students to go when students’ behaviour became unsafe; as was reported by two students,

That when, when people throw chairs you can always go to another class and you can meet with some of the staff, whoever’s there that’s dealing with it, that we might need more staff...to handle one kid because some kids could be, could be all wiggly...and could get all hard to, to get out of the classroom. So that’s why I think the classroom is safe, so then we can move to another room. (Student Focus Group #5, Girl age 8)

One student reported that the STP was safe because there was a principal. This principal was the program supervisor who left the program around the same time that the focus groups were being conducted.

Students also reported on aspects that they felt make the STP unsafe. One survey and 10 focus group responses described how students made the STP unsafe because of their behaviour.

I don’t know. Sometimes, like since, you know, this is like school for kids with...ah, with ha, issues, I guess...problem[s]...and so like it’s, so sometimes the kids in the class get annoyed and sometimes they get, people get in fights. (Student Focus Group #10, Boy age 11)

The only other factors that the students identified that inhibited safety included the lack of a fire door and that the school was far from the students’ home.

Students were also asked if they did anything to promote the safety of the classroom. Students identified several ways that they promoted safety, including being nice, focusing on themselves, cleaning up after themselves, refraining from physical aggression, being respectful with language, following rules and routines, using emotional management, and supporting others. The frequency of the student who reported each of these strategies is included in Table 6.
These student efforts reflect their commitments to nonviolence as well as emotional intelligence and social responsibility.

*Emotional intelligence.* Students’ perceptions regarding the presence of emotional intelligence in the STP were reflected in their ability to manage their emotions. The students indicated that they engaged in a variety of strategies to manage their emotions when upset while in their classroom. Two students wrote in the surveys and four students reported in the focus groups that they talked to their teacher or CYW when they were upset. For example, one student stated, “if we had a rough day and if you want to, like if [Teacher] has time, because if you don’t have enough time to talk about it, like if you have to go in the cabs we, we don’t really get to talk about it” (Student Focus Group #1, Girl age 10). Their ability to talk to their teacher or CYW appeared to be influenced by the availability of time (two students remarked about not always having the time to talk). In addition, two students reported that their friends helped them to manage their emotions. As one boy said, “when I’m getting upset and not playing with people properly some, like one of my friends helps and I calm down” (Student Focus Group #4, age 9).

Students also shared several self-management strategies to manage their emotions when they were upset. These included sensory strategies (wiggling fingers, counting, tapping feet and taking deep breaths) and behavioural strategies (making an effort to behave, thinking before acting, ignoring other students, focusing on something else, leaving the situation, running away, staying happy, taking space and putting their head down on the desk). The frequency of the students who reported using each of these strategies is included in Table 7.

*Social learning.* Students indicated that they have learned that it is important to understand how other students are feeling so they can respond appropriately. One student wrote in the survey, “We get to know how they are feeling, so if they are angry we can just stay away from them” (Boy age 11). Two students in the focus groups discussed that, if another student shared that they were mad, then they would try to help them by either trying to “cheer them up” (Boy age 9) or “[let] them calm down” (Girl age 10, both from Student Focus Group #7). In addition, students also reported that students respond differently to each other based on their sharing of emotions. As one student said, “They help you that if you’re mad like don’t go near. You think they’re gonna hit you, but if you’re happy they, they hang out with you” (Student Focus Group #2, Boy age 12).
Open communication. Four students indicated that they were openly communicating their emotions with other students in their class outside of the Community Meetings. Alternatively, four students stated that they would not share their emotions outside of the Community Meetings. As one student commented,

Like we don’t go to our friends and like oh, I’m feeling really happy. Well basically if we’re happy or excited about something we’ll tell our friends, but if it’s some, like we’re sad because, like I don’t know why, but like you probably won’t tell your friends. We usually don’t tell our friends about stuff like that. (Student Focus Group #6, Boy age 11)

Another student referred to the importance of developing trust with friends before she would share feelings.

Yeah because probably some of the kids like try are not very trustworthy and their friends can’t trust them to tell them their feeling, feelings. I think it’s happened at the start of the year and it wasn’t very good. (Student Focus Group #1, Girl age 10).

Eight students said they would share their emotions with their CYW. The notion of trust seemed to be important for the students to be able to share their emotions. One student stated,

That when people ask me how I’m feeling I tell them how I’m feeling. So if I’m happy, sad, angry, tired or worried... I’ll tell them how I’m feeling and to keep it to themself, because I may tell them but, but I tell them that they, I don’t want them to tell no one else except for other staff. So then, so then if I’m like angry the kids doesn’t need, need to know if I’m angry or not. I usually I look that I’m, that I’m happy...because I might look happy on the outside but I’m angry on the inside. (Student Focus Group #5, Girl age 8)

Eight students reported that they would only share their emotions during the Community Meetings. One of these students said that he would only discuss his feelings with his therapist who works in the agency.

Democracy. According to eight of the students, it was the teachers and CYWs who made decisions in the program. Six students said that they did not get to make any decisions. Five students said that everyone was included in the decision-making process. For example, when asked who made the decisions in the program, one student responded, “Me and the teachers and other kids” (Student Focus Group #5, Boy age 8). Eight students indicated that they were included in only some of the decisions. Students said that if they were included in the decision, then it was in the form of a vote, but that the decision would still be made by the teachers or
CYW. If the students wanted to have input into decisions they had to ask either their teacher or CYW. The types of decisions in which the students were included appeared to be related to activities, which included games to be played, the book the class would read, going to the gym or computer lab, or going outside for lunch. As one student said, “Sometimes, like not important ones but like, like ones involving like if we play dodge ball or like hockey in the gym or stuff like that” (Student Focus Group #8, Boy age 12). One student indicated that it was important to be included in the decisions, “Because it’s not like some, so it’s not like the rule that somebody else made that you have to follow. It’s like you have a choice kinda and you get some of the input on it” (Student Focus Group #6, Boy age 11).

As for the rules, 14 students said the rules were made by the teachers and CYW. When probed, four students said they also had an opportunity to make the rules, whereas eight students said they did not make any of the rules. Three students took the opportunity to describe some of the rules within their class. These rules reflected a commitment to nonviolence and social responsibility. Specifically, one student stated that a rule was, “do not be rude to other people just to make yourself feel good and make them feel bad” (Student Focus Group #5, Boy age 8). Other rules were, “keep your hands to yourselves. Stay quiet when the teacher tells you to. No hitting, sort of. And always listen to the teacher” (Student Focus Group #7, Girl age 10).

Social responsibility. Social responsibility reflected healthy relationships within the STP. Eighteen of the 23 students made comments that reflected the presence of some friendships in their class. Students were asked to describe how they made and kept friends in the class. Students reported that to build friendships, they needed to be nice to other students (reported by six students), to share (reported by two students), to help (reported by two students), to play together (reported by seven students), to include other students in activities (reported by one student), and to talk to each other (reported by two students). Two students said it was important to “treat people the way you want to be treated” (Student Focus Group #2, Boy age 10; Student Focus Group #6, Boy age 10). They also said they should not be mean to other students (reported by one student), call other students rude names or swear at them (reported by four students), provoke them (reported by one student), or get into fights (reported by one student).

Five students made comments that reflected limitations in the development of friendships in their class. The students reported on some of the barriers to developing friends in the class. The issues discussed reflected that other students were not trustworthy, were rude and annoying.
Two students indicated they did not want to make friends in the STP because they wanted to go back to their ‘regular’ school.

Boy 1: I don’t really want to make friends here because here it’s just, it’s not regular school.

Boy 2: Yeah and you’re bound to never like see them again because you can only stay one year. (Student Focus Group #10, both boys were 11 years old)

Thirteen students raised other issues that reflected social responsibility within the STP. These issues related to the importance of behaving in the classroom, ignoring other students if they are having an issue, and working on their goals. This reflected the students’ commitment to acting socially responsible in the classroom. For example, one student stated,

Because so then I used to get in other people’s business. I couldn’t always remind myself to, to mind my own business and when I always get in other people’s business I don’t, I don’t have a goal to remind myself. So that’s why I like doing goals because I never had a goal before. (Student Focus Group #5, Girl age 8)

Two students said other students supported them with their goals. Specifically, one boy said that other students helped him with his goal to pay attention, “by not like yelling and stuff in class” (Student Focus Group #3, Boy age 12). Alternatively, one student reported that although everyone is expected to support each other with their goals, no one actually supports him.

Researcher: Is there anything that helps you to work on that goal in the class?
Boy age 10: No.
Researcher: No? When you ask who can help you with it, who do you usually say?
Boy age 10: Everyone, but no one actually helps me. (Student Focus group #9)

One student stated that, to be able to make decisions, they had to earn trust by being socially responsible. She included the following examples,

Like you have to be nice to the students. You have to listen to the rules. Have to do your work when asked. Have to do it when you’re asked and then you sometimes, it takes like two weeks if you’ve been really bad and then you earn the trust back. (Student Focus Group #1, Girl age 10).

In addition, four students indicated that the implication of being socially responsible was that students could maintain friendships, avoid violence and make the classroom a better place. One student said, “I think it’s treat them the, the way that you want to be treated. If you treat them
mean and badly then they won’t want to be your friend anymore” (Student Focus Group #6, Boy age 11).

**Growth and change.** Students had a hard time understanding questions around the emotional aspects of dealing with loss and they required substantial prompting into specific examples of situations in which the students might feel a sense of loss (e.g., losing something of value, when students or supervisors leave the program). Despite this lack of general awareness of the concept of loss, students were able to identify different strategies they would use if they lost something. One student in the focus group reported that he would talk with his CYW to get support about the loss. On the other hand, five students said that they would not seek support from their CYW. The majority of the students (10) reported that they would try to handle the loss themselves. One student said, “I just try to move on and I try to stay positive that, that there’s new friends” (Student Focus Group #8, Girl age 10). One student said that he would use the reflection room if this upset him. Three other students said that they would make an effort to remember the person they had lost.

The students’ focus on growth and change was mostly reflected through their goals. Students and their parents reported several types of goals, which focused on areas related to behaviour management, emotional management, friendships and social skills. The specific goals and their frequency of endorsement are included in Table 8. In addition to these three types of goals, individual students reported goals to make it through the day and go back to their ‘normal’ school. One parent reported that her child was working on overcoming his/her phobias. Five students did not report their goals, and one student left that question blank in the survey.

In one of the focus groups, one student provided an example of how she had grown while in the STP. She described how she used to be the bully at her old school, and now she understood that it was important for her not to behave that way. She discussed how she is more understanding of the issues of a fellow student who is having a difficult time and being less aggressive than she was before.

**Organizational culture reported by CYW according to the GES.** The CYW’s Group Environment Scale results following the implementation of the SGTIP within the STP are presented in Table 3. The CYW’s Relationship Dimensions subscale results were slightly low on their levels of Cohesion and Leadership Support, but there was a slightly high level of Expressiveness. For the Personal Growth and Goal Orientation Dimensions the CYW reported
markedly low levels of Independence and Task Orientation, a close to average level of Self-Discovery, but a slightly high level of Anger and Aggression. Finally, for the System Maintenance and Change Dimension, the CYW reported slightly high levels of Order and Organization and Leadership Control, and a markedly high level of Innovation. As shown in Table 9, the means for all the subscales were not significantly different from the normative community samples (Moos, 2002).

Table 3.

Comparison of the CYW Group Environment Scale Prior to and following Implementation of the SGTIP

<table>
<thead>
<tr>
<th>GES Subscales</th>
<th>Pre $(n = 6)$</th>
<th>Post $(n = 6)$</th>
<th>t-test</th>
<th>Cohen d</th>
</tr>
</thead>
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<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>SMS</td>
<td>Mean</td>
</tr>
<tr>
<td>Cohesion</td>
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<td>42</td>
<td>6.00</td>
</tr>
<tr>
<td>Leader Support</td>
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<td>1.51</td>
<td>33</td>
<td>6.00</td>
</tr>
<tr>
<td>Expressiveness</td>
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<td>1.52</td>
<td>50</td>
<td>6.00</td>
</tr>
<tr>
<td>Independence</td>
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<td>1.17</td>
<td>45</td>
<td>4.83</td>
</tr>
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<td>1.03</td>
<td>46</td>
<td>4.83</td>
</tr>
<tr>
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<td>1.17</td>
<td>56</td>
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</tr>
<tr>
<td>Anger &amp; Aggression</td>
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</tr>
<tr>
<td>Order &amp; Organization</td>
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</tr>
<tr>
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</tr>
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<td>Innovation</td>
<td>6.00</td>
<td>1.26</td>
<td>61</td>
<td>6.67</td>
</tr>
</tbody>
</table>

* Equal variances not assumed

The CYW reported significant changes from April to December on the GES in three areas: the amount of Leaderships Support, Leadership Control, and Order and Organization. Specifically, participants reported a significant increase in leadership support ($t(6.7) = -3.500, p = 0.006$), which represented a change from markedly low levels before implementation to levels approaching average following implementation. Regarding the level of leadership control, participants reported a significant increase ($t(10) = -2.607, p = 0.026$) from a low level before
implementation to a slightly high level following the implementation. Finally, participants also reported a significant increase in the level of Order and Organization \( (t(10) = -2.320, p = 0.043) \) from slightly low levels before implementation to slightly high levels following the implementation. Effect sizes for each of the significant changes were strong (J. Cohen, 1988). Although not statistically significant, participants also reported changes with regard to the other areas of organizational culture. Please see Figure 4 for the Group Environment Scale profile depicting the areas of organizational culture prior to and following the implementation of the SGTIP.

**Organizational culture of the CYW: Representation of the Seven Sanctuary commitments. Nonviolence.** The CYW conveyed that it was important to promote physical safety to ensure emotional safety, as they said, “When we [were] not feeling safe physically, [they were] not feeling safe emotionally”. They reported that safety was in place through their adherence to Prevention and Management of Aggressive Behaviour (PMAB) to manage behaviour. However, in terms of their sense of safety, the CYW reported that it “all depend[ed] on the day”. Two factors reported to inhibit safety were the students in the program and the lack of appropriate staff ratio. During the focus group, the CYW made five comments that reflected the notion that the children in the program made unsafe decisions. For example, they commented that “it all depend[ed] on our clients” and that “kids with extreme needs [were] very unsafe beyond what we can do professionally”. The CYW also indicated that given the challenging behaviour of the students, it was “problematic” when there was “insufficient” staffing and when there were CYW on modified duty.

The CYW reported that they were “extremely” stressed, and that the two biggest sources of stress were the clientele and the lack of a supervisor. During the focus group, the CYW made four comments that reflected their desire for a supervisor. Some of the issues associated with the lack of supervision related to not being able to reach a supervisor during crises, as there were “numerous times during a crisis [when they were] unable to reach a superior”, “pull[ing] people away from the floor to track down [a] supervisor”, and increased anxiety because they [had] to make their own decisions, but they did not “have confidence that [their] decisions [would] be supported [which] cause[ed] a rift between decision-makers” and themselves. The CYW reported that they had a lot of trust in one another, and that “As a team we [were] really good at
social safety”. However, the level of trust with the CYW and their management was “lacking severely” and “very fragmented” when the focus groups were conducted.

Emotional intelligence. Emotional intelligence with the CYW was represented as the ability to respond to the student’s expression of painful memories and other expression of emotions. The CYW indicated that the students shared painful memories and/or experiences “frequently”. In response, CYW tried to “empathize” and “validate” the students’ feelings. They “let [the students] know it [was] a safe place for them”. In terms of how they manage their own emotional responses to these disclosures, the CYW reported that “it traumatizes [them] too”, and that they tried to “deter” their emotions and “just work amongst [them]selves”. They added to the discussion that, “with time and experience [they] learn[ed] that [was] the way life is. You almost get used to it. You get desensitized to it. You learn not to internalize it in order to keep yourself emotionally safe”. They indicated that they were not provided with substantial support from their superiors as they did not have one at the time, and that this made it difficult for them.

The CYW encouraged the students to express their feelings. The CYW indicated that in response to expressions of emotions during the Community Meetings, they were able to “gauge [the students’] behaviours throughout the day and [provided] them support”. When the students were upset, they would encourage them to take space, use their Safety Plans and “if they [were] in crisis, we would remind [them] what worked last time, ‘how about we try this’, [we] tr[ied] to get them to [it] figure out themselves”. The CYW reported that they supported the students in their expressions of emotions, but that the type of support “depend[ed]” on how the students expressed their emotions.

When CYW expressed their emotions, they supported one another. They made five comments during the focus group that reflected the emotional support they provided to each other. Specifically, they said that they “talk[ed] about [their fears] to each other” and “try to look out for each other”, but that “all supports [they received were] from each other”. They reported that the students “[did not] care”, and that the “kids [were] not always responsive” when CYW expressed their feelings. They also did not appear to be receiving support from their supervisors, as the CYW noted that although “managers validat[ed] your feelings immediately”, some CYW did not “talk to managers or supervisors about it because in the past it hasn’t been positive or productive” as they were “always told to suck it up”.
Social learning. Social learning was reflected in their strong team support. As described in response to the other commitments, the CYW “look[ed] out for each other”. They reported that they provided support in terms of social safety, they talked with each other when scared, they had a high degree of trust, and they had developed relationships. They learned from the older CYW, who had more experience in the field, in that they were the “go-to” people within the group.

Open communication. The CYW reported that they were “receptive and open to each other” and it was important to “just [put] it out there”. According to the CYW, one of the aspects of their job that made them the most fearful was “being open and honest with supervisors”. They said they tried to share ideas with management. They “tr[ied] to put forth [their] concerns and ideas in team meetings”. They said they were provided with an “immediate response [for] correct ideas, but [they] never [saw] it start”.

Democracy. Leadership within the program was represented as “title + age + job duties”. Aside from managers, the leaders in the program were the CYW who were older, and who had been in the program the longest. There were different levels of CYW, the CY2 were the “in-charge workers” and the CW1 were the workers. The CYW reported they had some degree of control in the running of day-to-day activities. Decisions within the classroom were made by the “teachers and classroom evenly”. Students were sometimes included in the decisions, but there was “no particular pattern” for this process. The CYW reported that they did not have control during staff meetings. They said there were “no middle steps” and “no [one] ask[ed] for input, just this way or no way”.

Social responsibility. Social responsibility was promoted through relationships. The CWY reported that they were a strong team. They said that relationships were fostered within the team as they spent time together, did not prejudge each other, and bonded during times of crisis. They also promoted friendships among the students by encouraging positive peer interactions and playing “getting-to-know-you games”.

Growth and change. The questions relating to dealing with loss and working toward the future were not answered during the CYW focus group.

Comparison of the social climate scales of the students, teachers and CYW. For the Relationship Dimension, the Cohesion GES subscale represented involvement, commitment and friendship among group members and it was most similar to the Affiliation CES subscale, which
represented the sense of friendship among the students in the classroom. With regard to this amount of friendship among the students and the CYW, all groups reported slightly low levels on their respective subscales. On the other subscales, the students and teachers reported a slightly high level of Involvement and the CYW reported a slightly high level of Expressiveness. For support provided by leaders, the students and teachers reported that there were low levels of Staff Support being provided to the students. Similarly, the CYW reported that they were also provided with low levels of support from their leaders. For the Goal Orientation Dimension, the students and teachers differed in their perceived emphasis on Task Orientation within the classrooms. As described above, the students reported a high degree of emphasis on task orientation and teachers reported low emphasis. The CYW’ reports were similar to that of the teachers, in that they also reported low levels of Task Orientation.

Finally, the System Maintenance and Change Dimension included the Order and Organization and Rule Clarity subscales for the CES and Order and Organization, Leadership Control and Innovation for the GES. On the CES, the Order and Organization subscale prominently represented the degree to which students behaved in an orderly and polite manner. The students and teachers reported that they were slightly low on their level of Order and Organization, indicating that the students did not behave in an orderly and polite manner. Rule clarity focused on the clear and consistent expression and enforcement of classroom rules. Students and teachers reported a slightly high level of Rule Clarity, indicating that, within the STP, there was a clear set of rules within the classrooms for the students to follow. The CYW were high in all areas of system maintenance and change. The Order and Organization GES subscale focused on the organization of group processes and activities. At the time of the second survey, the CYW were provided control from their managers and/or supervisors in terms of decisions, directives and rules. The CYW were also encouraged to be innovative in terms of diversity, functions and actions to meet the needs of the context.

**Parallel Process: Comparison of the students and CYW representations of the Seven Sanctuary commitments.** *Nonviolence.* Both the CYW and the students reported the importance of having safety within the STP. In addition, both groups reported mixed perceptions regarding their actual sense of safety. Both groups indicated that the students in the program inhibited safety due to their behaviour, although the students also reported that they made an effort to promote safety. These efforts reflected the commitments of nonviolence, emotional
intelligence and social responsibility. Alternatively, the CYW were raised by both groups as a factor influencing safety. The students credited the CYW for promoting safety as they listened to students, helped students to calm down and solve problems, removed students when they were aggressive, provided guidance during issues, were socially responsible (were not rude to students) and supported students in their academics. The CYW reported that they promoted social safety within their team; trust within the team promoted social safety. The students noted some students in the program had one-to-one staffing, which promoted safety. However, overall there may not have been enough staff in the program, as the CYW indicated that the inappropriate staff ratio of students to CYW limited safety.

The supervisor in the program was also identified as a factor influencing safety. One student reported that the supervisor helped to make the STP safe; however, since this supervisor had left the program and she was not replaced before the end of the school year, the CYW reported that not having a supervisor increased their amount of stress in the program. The CYW reported a limited sense of trust with management, which limited social safety through the degree of stress that this created. The students also identified aspects of the physical environment of the STP that both facilitated and impeded safety. The CYW did not discuss the physical aspects of the program.

*Emotional intelligence.* The aspect of emotional intelligence that was found to be operating for the students was their ability to manage emotions. The students reported that they received support from their CYW and their friends to manage their emotions. They also employed self-management strategies. For the CYW, emotional intelligence reflected their responses to and from expressions of emotion. Consistent with the student reports, the CYW encouraged the students to share their emotions and provided the students with support. When the expressions were especially painful, the CYW reported that this could be traumatizing for them as well. The CYW tried to deter their feelings associated with these difficult expressions of emotion; they tried not to internalize the feelings as a means of promoting their emotional safety. They would also work through these experiences with their team. They indicated that they did not receive substantial support from their superiors and that their feelings were only sometimes validated. Furthermore, the CYW reported that the students were not responsive to the CYW’s expressions of emotions.
Social learning. The students’ comments reflected social learning in their ability to learn from other students in response to expressions of anger. The students were learning emotional intelligence through social engagement. Social learning for the CYW was reflected in their strong team bond and support. This support reflected aspects of other commitments, including nonviolence in the form of social safety, emotional intelligence, open communication within the team and social responsibility through the development of relationships. The trust within the team also fostered their relationships.

Open communication. For the students, open communication reflected their willingness to share emotions outside of the Community Meetings. Most of the students reported that they would not openly share their emotions; reporting that they would only share their feelings during the Community Meetings and not outside of the Community Meetings. Trust appeared to have influenced the students’ open communication of emotions in that they needed to establish trust with other students and CYW before they would express their emotions. CYW indicated that they openly communicated and shared ideas within their team, but that they were fearful of being fully honest with supervisors. They indicated that they were apprehensive to share their ideas with management because, although the ideas were acknowledged, they were not always put into practice.

Democracy. It was clear from the students’ reports that the CYW and the teachers were the leaders of the classrooms. CYW and the teachers made most of the decisions and rules, and the students went to them for support and direction. Both the CYW and the students indicated that the students were included in some of the decisions, but there was no particular pattern for this process. Students indicated that they were often included in decisions through votes, but that the ultimate authority rested with the CYW (and teachers). Furthermore, the types of decisions reflected choice in activities rather than in rules and the greater processes of the classroom. Among the CYW, leadership was represented through traditional means (ascribed by the agency through job title and length of time in the program). The CYW reported that they did not believe that they had control over their rules and processes as their opinions were not solicited during process decisions (i.e., no control during staff meetings or being provided with instructions as to the way things would be).

Social responsibility. Social responsibility was represented in both groups through relationships. The CYW reported to have a strong bond with each other, which was developed
through working in the program. Most of the students (18) reported the presence of friendships in the class. Students reported on ways in which they would engage in socially responsible behaviour to build friendships. Students also discussed the notion of social reciprocity, in that they believed it was important to treat others the way they wanted to be treated. Students not acting socially responsible were identified as barriers to friendships (i.e., lack of trust, being rude and annoying). The perceived temporary nature of the placement in the program was an additional barrier to the development of friendships. Several students also reported other implications of being socially respectful (i.e., avoiding violence, promoting positive environment). Earning trust was a representation of social responsibility that provided students with an opportunity to be included in decisions.

**Growth and Change.** Growth and change was only discussed by the students (CYW were not asked the questions regarding dealing with loss and working toward the future). The majority of the students (10) reported that they would deal with loss themselves. Students focused on the future were reflected through working toward their goals. The students’ perceptions regarding the goals will be described below.

When both the quantitative and qualitative results are taken into consideration, the organizational culture within the STP could be characterized as promoting friendships, involvement and expressiveness among members of the systems. With regard to these values, the organizational cultures of both systems (i.e., classroom and the CYW as a working group) appeared to be operating in similar processes. The participants reported that perceived a general lack of support provided by supervisors; however, the students did credit the CYW for providing support to the students. Further, the cultures consisted of a high degree of structure and control. The student organizational culture followed a parallel pattern of functioning as the CYW except that they perceived a higher level of emphasis on tasks, but did not behave in an orderly and polite manner. If we consider rule clarity and control from the Sanctuary perspective, these high levels may actually reflect negative manifestations within the cultures, as they do not depict high levels of autonomy and democracy. Further, the lack of support from leaders is also concerning. Essentially, the results indicated that the organizational culture within the STP is not fully trauma-informed.
Factors that facilitated and impeded the adoption of the SGTIP within the STP. The content analysis regarding factors that influenced the adoption of the SGTIP in the STP resulted in four themes. These themes related to knowledge about the intervention, perceived change in the STP due to the SGTIP, benefits of the SGTIP, and drawbacks of the SGTIP. The CYW focus group data and the teacher and parent survey data were included in this analysis (see Table 10).

Knowledge. The teachers identified that their lack of knowledge about the new approach limited their ability to assist in its implementation. None of the parents indicated that they knew about the new approach to service within the STP. Six parents specifically indicated that they did not know about the SGTIP, as one parent wrote “My apologies, I do not know much if anything about the SGTIP” (Parent Survey #1). The other parent left that question blank. It appears that only the CYW and teachers knew about the new approach to service within the STP, but that the CYW were the only participant group who actually knew the theory and the components of the approach. Despite their knowledge of the theory, the CYW were still not competent in how to use the approach in practice. They were requesting support in how to put the theory in practice. As they stated in the focus group, “We all know the theory and reason behind it, but to implement it we are left hanging. What do we do with that to help the kids reach their goals? It’s a real stumbling [block]” (CYW Focus group).

Perceived change. According to the participants’ reports, the components of the Sanctuary Model that had been implemented were the Community Meetings, Safety Plans and Red Flag Meetings. The Community Meetings were held daily and the Red Flag Meetings were held as needed. The CYW reported that the SELF psycho-education curriculum has not been implemented. One of the teachers who reported a limited knowledge about the SGTIP commented that, “I am not sure if we should be employing more than just the Community Meeting in the morning” (Teacher Survey #2).

The CYW and the teachers reported on aspects that had changed due to implementation of the SGTIP. The CYW made two comments that reflected an increased awareness of the effects of trauma and avoid re-traumatization. Specifically, the CYW stated that, “More of what I do know thinking about what happened to them, never before really thinking about trauma they have been through” (CYW Focus Group). This increased awareness was likely related to their understanding of the theoretical aspects of the approach. The teachers reported that the SGTIP
had provided a positive tone and routine in the culture of the STP and had increased the level of emotional intelligence. As one teacher noted, the SGTIP “has given students the language to express their emotions” (Teacher Survey #4). Both the teachers and CYW reported a change in aspects related to open communication and social responsibility. For example, the CYW reported that as a group they were “self-conscious with each other, more open and honest than in the past, talk personally” (CYW Focus Group) and one teacher wrote that, “I definitely see a difference in how the staff collaborates with one another” (Teacher Survey #3). The CYW noted that adopting the SGTIP provided a way to hold both supervisors and students accountable. The parents were also asked about changes in their children following treatment within the SGTIP; these results are described in the section below on the results of the third research objective.

Benefits. The teachers and CYWs reported several benefits of the SGTIP. One teacher reported that the SGTIP promotes a safe and positive school environment as “it makes the classroom more peaceful, calming, safe and collaborative environment to work and learn in” (Teacher Survey #3). According to one teacher and two CYW’ comments, the approach also fostered concrete problem-solving for student behaviour. For example, “The Safety Plan is a strategy the students can use right away and is a great visual” (Teacher Survey #4). Two teachers reported that the SGTIP promoted relationships among the CYW and between the CYW and the students. Three of the CYW comments also reflected that the CYW have a positive team support amongst themselves. The teachers and CYW commented on how the SGTIP promoted expression of emotion. One teacher also indicated that the focus on goals was beneficial, in that this “allows them to focus on one behaviour goal at a time” (Teacher Survey #4). None of the parents reported any benefits of the new approach to service. This may be because they did not have any knowledge about the SGTIP. As one parent noted, “[I] cannot comment as I have no information to base comments on” (Parent Survey #4).

Drawbacks. The drawbacks reflected barriers that may have inhibited the successful implementation. The CYW and teachers indicated there was a lack of adequate staffing in the STP, which may have limited their ability to implement the model fully. In addition, the CYW also reported that they were not fully integrated in the change process. Specifically, the CYWs reported that successful implementation should have included “getting individuals more involved. I just see certain people involved in certain meetings, but it is not trickling down. They are not getting us on board” (CYW Focus Group). The CYW referred to the lack of
support from others in the agency as well as from management. They reported that there was a lack of accountability, support and resources. One component of trauma-informed practice is identifying and addressing actual incidents of trauma. However, the CYWs reported that they did not have access to the results of the trauma assessments that were conducted as part of intake. Furthermore, they also reported that they were fearful to be open and honest with their supervisors and that their job security was of concern. Lack of communication was also noted by the teachers. It is important to note that at the time the CYW focus group was conducted, the supervisor in the STP had left and she was not replaced before the end of the school year. Lack of follow-through was reported to be one of the greatest barriers to the implementation. Four of the five teachers indicated that this aspect was lacking in the STP; these comments related to an inconsistent use of components of the model and lack of follow-up with students at the end of the day. Two CYW comments also reflected this limitation; however, their comments reflected the lack of follow-through when ideas and suggestions were put forth. Given that none of the parents knew about the SGTIP, none of them reported any specific drawback to the approach. Although not related to the SGTIP, one parent did provide an additional comment that, “sometimes they see other things that scare them, from other students” (Parent Survey #3).

**Research Objective Two: Results**

The second objective of the research was to determine the extent to which the students found the SGTIP approach beneficial and if they felt empowered through the process of recovery. The student perceptions of the SGTIP approach were explored in both the surveys and the focus groups. The students’ reported perceptions regarding each component of the SGTIP approach were described. The insight in empowerment was interpreted based on the participants reported perceptions on choice in treatment, and in taking into consideration the degree to which the felt the components of the approach to be beneficial.

**Student perceptions of the SGTIP.** The students did not recognize the term ‘Sanctuary’ or understand that it pertained to the new intervention. After two students asked for a definition of Sanctuary, they reported, “No swearing” (Student Survey #4, Girl age 8) and “No punching, no kicking” (Student Survey #5, Boy age 8), reflecting that Sanctuary is about promoting safety. When prompted, students were able to report about the components of the Sanctuary Model that were being implemented (e.g., Community Meetings, Safety Plans). The students discussed their
perceived benefits and drawbacks to different aspects of the Community Meetings, including sharing their emotions and having goals. They also discussed the use of the Safety Plans.

*Community Meetings.* The Community Meetings included a discussion of everyone’s feelings and the proclamation of a goal. After each student announced their goal, they were to report on who was going to help them reach this goal. As one student described, “What we do is like we ask everybody how they’re feeling today, what their goal is, and who can help you with that” (Student Focus group #2, Boy aged 10). The students also reported that they evaluated whether they have achieved their goal for the day, and that there was a process of recognition for this achievement. One student reported that, “We do it in a fine order. We say our goals, then we say if we are doing good, what a thumbs up or thumbs down” (Student Survey #2, Boy aged 9). Another student wrote, “We all get together and we put stickers on our goal sheets. If we don’t meet our goal our [teacher or staff] talk about it with us. Then we start fresh the next day.” (Student Survey #1, Boy aged 8).

Four students reported that the enjoyed the Community Meetings. Two students indicated that they enjoyed the time spent in the Community Meetings because they also played a game. Two additional students indicated that the Community Meetings were better than doing schoolwork. Alternatively, five students reported in the surveys that they felt that the Community Meetings were boring and/or a waste of time. One additional student indicated that it was because Community Meetings were held during the morning when students were tired. Four students simply reported that they did not like anything about the Community Meetings.

*Having goals.* Six students reported that they liked having a goal because they were able to earn rewards and prizes when they accomplished their goal. Six students indicated that they liked having a goal because it was important to work toward something. For example, one student said,

Because so then I used to get in other people’s business. I couldn’t always remind myself to, to mind my own business and when I always get in other people’s business I don’t, I don’t have a goal to remind myself. So that’s why I like doing goals because I never had a goal before. (Student Focus Group #5, Girl age 8).

One student commented on the larger gain inherent in working toward his goal in treatment. Specifically, he believed that goals are “helpful because you know what you’re here for and you know if you complete that you might get to go to a normal school or home if you live here”
(Student Focus Group #6, Boy age 11). Another student said that there was a sense of accomplishment for completing her goal, in that “we feel really good about ourselves because we actually finished something and we worked really hard to get it” (Focus Group #1, Girl age 10).

Six students in the focus groups and three students in the surveys reported that they did not like having or sharing their goals. They said they did not like having to focus on a goal. Two students felt that there was no point to making the goals, as their progress toward the goal and thus to earning a prize was no longer being recorded. One of these students later said that it was annoying when their teacher reminded them of their goals.

There’s no point on setting the goal, because then the teachers like - if somebody’s not listening after setting the goal like to not get in any issues and they’re getting into an issue, the teachers like remember your goal, remember your goal and stuff like that. And just kind of annoy us. (Student Focus Group #8, Boy age 12).

One student said that they were only focused on doing schoolwork. An additional student said that he did not like when the goals were not accomplished. Another student said that reviewing the goals each day took a long time. This point was also raised earlier with regard to the perceived drawback of the SGTIP (please see Table 10).

Sharing feelings. Ten students reported that they liked expressing their feelings during the Community Meetings. One student stated that the benefit of the Community Meetings was the routine in discussing feelings, “because every day we, we have a Community Meeting and I think you get in the routine of doing that. So it just gets easier every day I feel” (Focus Group #6, Boy age 11). Three students reported that they just enjoyed sharing their feelings; that “It’s just fun and makes us feel happy” (Student Focus Group #3, Girl age 10). As well, another boy said, “It’s nice because you can express how you’re feeling at the moment” (Student Focus Group #6, Boy age 11). One student also noted in the survey that the feeling board helped her to identify her feelings. The expression of emotion was reported to be beneficial for the students so that they can learn how to respond to each other; six students in the focus groups and one student in the surveys reported that it was helpful to express when they or other students were upset so that they could respond appropriately. For example, one boy said, “They’re pretty cool because then people know how you’re feeling and they don’t get you even more upset if you’re feeling bad” (Student Focus Group #4, Boy age 9). Another student wrote, “we get to know how they are feeling, so if they are angry we can just stay away from them” (Student Survey #17, Boy age
One of the students said that the process helped to build relationships by getting to know the students well.

**Safety Plans.** Ten students discussed the purpose of the Safety Plans. They described that the plans were there “if you get mad then like what you can do to calm yourself down” (Student Focus Group #8, Girl age 10). One student described the process,

Yes, but they’re, we usually make a Safety Plan one, on your first, our first days here about, we usually have our, a few things we can do if we’re upset or sad or whatever, how we’re feeling that’s like possibly we might do something bad. I think usually, almost everyone here has one I think. (Student Focus Group #6, Boy age 11)

Eight students said that they had provided input on their plans; that they came up with the items in the plans, but the CYW wrote them up and had them laminated. The items in the plans were reported by 12 students and included things such as play a game or small toy (reported by five students), read a book (reported by four students), draw or colour (reported by three students), eat chocolate or other snack (reported by three students), listen to music (reported by three students), talk about it, typically to an adult (reported by three students), nap (reported by two students), check in the common bin (reported by two students), take space (reported by two students), squeeze something (reported by one student), walk away (reported by one student), put head down on desk (reported by one student), and tap feet (reported by one student).

Six students reported that they felt that the plans were useful. Three students said that the plan helped them when they were angry. One additional student commented that she also liked having the plan, “because it gave me options to do if I was bored” (Student Focus Group 8, Girl age 10). Four students reported that the Safety Plans were not useful. These students reported that students did not follow their plan. For example, one boy said, “I think some kids don’t really listen to them, like at the moment they really don’t want to pay attention to what they agreed to or what the Safety Plan said” (Student Focus Group #6, Boy age 11). Three students said that they did not like having a plan. Five students indicated that they did not currently have a Safety Plan.

**Student perceptions of the reflection rooms.** The content analysis focused on the reflection rooms from the student focus groups and it was organized into two area: process and perceptions. The process theme included the categories of the purpose of the rooms, the decision to use the room, and the choice to leave the room. The perception theme included the categories
of positive perceptions, negative perceptions and the influence of others. Given the transformative nature of this research, it was important to include an additional category of the CYW’ perceptions of the reflection rooms as they enforced the use of the rooms.

Purpose of reflection rooms. Nine students indicated that the quiet rooms helped them with emotional management. Specifically, students reported that they would ‘take space’ in the quiet rooms to help themselves ‘calm down’. Relatedly, in the surveys, eight students reported that they took space to manage their emotions. For example,

Boy age 11: There’s nothing around me to get angry at anymore. There’s like a wall. You can’t really get angry at a wall, so I think it helped a lot. (Student Focus Group #6)

Researcher: So do you like having the quiet rooms here?

Boy age 8: No. Yeah. They’re to help me calm down. (Student Focus Group #5)

Four students indicated that the rooms served a safety purpose. Specifically, having the rooms in the STP for students who were engaging in unsafe behaviour was a means of promoting safety within the STP. As one student stated, “It keeps the, it keeps the mad kids from like roaming around the school punching everybody in sight” (Student Focus Group #10, Boy age 11).

Decision to use reflection rooms. Seven students indicated that they had chosen to use the rooms to take space. However, students also reported that they were also allowed to use the reflection rooms when engaging in unsafe behaviour, not just to calm down when upset.

Researcher: So do you decide to go into the time-out room?

Boy age 10: By myself, which they said that in..., like when it just started they said you can go to the quiet room whenever you want and then I do. The next thing you know, why did you leave the class without asking me? Like just.

Researcher: So is it a positive experience?

Boy age 10: No. (Student Focus Group #9)

Researcher: Do you go to the class, to the quiet room when you feel like it?

Boy age 9: Well yeah, but the teachers don’t let me.

Girl age 10: Unless he’s, I think he has to be like kicking and being unsafe in the classroom for him to go in the quiet room, but if he really is upset....

Boy age 9: No, you have to go. Well you have to be like upset...

Girl age 10: Like kicking people.
Boy age 9:  ...and want to take some time alone or like someone done, did like a bad thing to you.

Researcher:  That’s the only time you can go to the quiet room.

Boy age 9:  Or you do something bad to them.  (Student Focus Group #1)

The female student in the first focus group later discussed that the ability to choose independently to use the rooms to take space required the development of trust. Four students indicated that they wanted to use the rooms to escape (e.g., to avoid work or to get away from other students). Two of these students said that they were allowed to use the rooms for this purpose and that they chose to go to the room on their own.

Nine of the students indicated that they would have to go to the quiet rooms if they were engaging in ‘unsafe’ behaviour (e.g., ‘throwing chairs’, ‘freaking out’, ‘having an issue’). When the students were engaging in these unsafe behaviours, they would be restrained and/or escorted to the reflection rooms by the CYW or teachers.

Researcher:  Do you get to choose if you want to go in there or not?

Boy age 12:  Nope.  If there’s an issue then we have to.  (Student Focus Group #8)

Although one student indicated that initially she was given the choice to use the reflection rooms, when she was engaging in unsafe behaviour and did not choose to use the rooms independently, she would still be taken there.

Researcher:  [Name], do you ever go to the quiet rooms?

Girl age 8:  Only if I’m angry or if I’m not being safe, then I have to go to the quiet room.

Researcher:  And do you decide to go by yourself or do the staff help you?

Girl age 8:  I usually decide by myself but if I go to the quiet room or not but it ... But if, if I, if I don’t decide to go to the quiet room on my own then I have, the staff have to take me there.  (Student Focus Group #5)

Leaving the reflection room.  When it came to leaving the reflection rooms, four students indicated that they had to be ‘calm’ and “feel like ready to go back to your class and learn” (Student Focus Group #7, Girl age 10). There were, however, discrepancies as to who determined if the students were ready to leave the quiet room. Two students reported that it was their choice and two students reported that their teacher made the decision. For the most part,
the students’ discussions indicated that this was a mutual decision between the student and their teacher or CYW.

Researcher: So do you decide when it’s time when you’re done?
Boy age 9: You have to ask them or sometimes they just come in and ask you if you’re ready to problem-solve. (Student Focus Group #7)

Negative student perceptions of the reflection rooms. Nine students reported that the rooms were not a positive place because there was nothing in them for the students to do. One student indicated that this also made it difficult for him to calm down, “well considering it’s just a floor, walls and a ceiling it’s not a good space to calm down... because you can’t calm yourself down in a place with nothing in it” (Student Focus Group #8, Boy age 12). Two students reported that the place was more positive when there was furniture for the students to sit down, as one student noted,

Boy age 10: ...it was cool but then they took away the furniture.
Researcher: So you don’t like that there’s no furniture?
Boy age 10: No, no.
Researcher: What made it cool before?
Boy age 10: Because I could sit down on the furniture.
Boy age 10: It used to feel good, but now it doesn’t feel that good …[pause]… only when I have something to do. (Student Focus Group #4)

One additional student indicated that the furniture was removed as students had engaged in property destruction. He noted that, “They had couches becau..., but I think you can see why that would be a problem. And they had furniture in the one where the floor is missing now” (Student Focus Group #10, Boy age 11). Five students reported that one of the four reflection rooms in the STP was not in use as it had a ripped floor. Other negative aspects of the rooms included a foul smell, that the rooms were dark, and the CYW/teacher talking amongst themselves outside the door was distracting (each reported by one student).

Five students reported that they did not like the reflection rooms because of the use of force. Three students described the use of force in terms of being restrained and escorted to the reflection rooms. Two students reported that the experience was negative as staff held the door to restrict them from leaving the room. “Well it’s pretty much like going on a time-out and them holding the door on you” (Student Focus Group #9, Boy age 10), and that this deterred them
from wanting to use them again. Another student, however, had the opposite impression of this restriction,

...and you can get all your anger out and they will close the door behind you but they won’t lock it. They’ll just be holding to you, holding on to the door so you won’t be able to get out and hurt yourself. (Student Focus Group #1, Girl age 10)

Students also reported that the reflection rooms induced several negative emotions. These related to a sense of boredom (reported by three students) and feeling confined (reported by three students) scared (reported by three students), and lonely (reported by two students). One student provided this description, which encompassed many of these negative aspects of the reflection rooms

Boy age 11: Personally it’s kind of scary because it’s very dark. There’s not a lock on it but staff usually will stand there and hold the door so you can’t get out. You usually sit there for half an hour and then the staff will try to talk to you about what you did wrong. And you’ll say sorry to the staff or whatever. Then you get to go back to your classroom, but we have something called AFF usually which is Away From Friends and so you don’t get to go with your friends. And we have a, always a different amount of time. Like it could be a whole day. It could be an hour. Usually that happens.

Researcher: When you’re away, AFF?

Boy age 11: Yeah.

Researcher: Okay. What is it like when you’re in the quiet room? What does it feel like?

Boy age 11: Not very good, because it’s a little room and everybody else is getting the classroom while you’re sitting in this little room with staff holding the door, like locked in basically. So I didn’t really like it. (Student Focus Group #6)

Positive student perceptions of the reflection rooms. Nine students reported that there were positive aspects to the use of the reflection rooms. Four students reported that their experiences with the reflection rooms were generally enjoyable. Four students reported that the rooms were quiet. One of these students reported that, "sometimes when, when it’s quiet I just, I
just, I just calm down probably” (Student Focus Group #7, Girl age 10). One student indicated that the rooms were well lit. Three students discussed the relaxing and calming nature of the reflection rooms; as one student described, the reflections rooms are “just peaceful, relaxing and there’s no noise” (Student Focus Group #1, Boy age 9). One student’s discussion provides an excellent description of the overarching essence of the reflection rooms, which incorporated both the negative and positive aspects:

Boy age 8: Staff taking me there when I be bad in class.
Researcher: Okay. And how long do you stay in there?
Boy age 8: Like, I don't know. 15 minutes, or 10.
Researcher: Do the staff stay with you outside the door or do they leave you there?
Boy age 8: Yeah.
Researcher: Yeah?
Boy age 8: Out the door.
Researcher: They stay outside the door?
Boy age 8: Yeah.
Researcher: And how does it feel when you’re in there?
Boy age 8: Bad.
Researcher: Bad?
Boy age 8: Yeah.
Researcher: Does it help you calm down in there?
Boy age 8: Yeah.
Researcher: Yeah?
Boy age 8: It’s small.
Researcher: Do you think it’s a good place to go?
Boy age 8: Yeah.
Researcher: Yeah? Why is that?
Boy age 8: So I don’t touch anybody in the classroom. (Student Focus Group #5)

Influence of others. There was a variety of mixed reports from the students as to what it is like to observe other students using the rooms. One student reported that he was not bothered by seeing other students use the room. Two students reported that they felt positively about seeing others use the reflection rooms. Two students reported that this meant the student was not
bothering them in the classroom. Three other students were negatively influenced by seeing other students use the reflection rooms. One student was upset because it wasted their time to learn when students are acting up and using the reflection room. Two students reported that it was “creepy” and “weird” (Focus Group #7, Boy age 9; Girl age 10). Despite these negative impressions, one of these students reported that they know that the student would benefit and calm down while using the room, as he commented “I kind of like it because then I know they’re gonna calm down soon maybe” (Student Focus Group #7, Boy age 9).

CYW perspective. From the focus group conducted with the CYW it was reported that the reflection rooms functioned as both emotional management, as they “Provide[d] students with a space to go when they need it”, and as safety because their “clientele sometimes doesn’t make safe choices, [and] that’s a good place for them” (CYW Focus Group). The CYW reported that for the most part the rooms are being used effectively.

The results reveal that using the rooms to remove children when they were acting violently promoted the safety of the program. However, the use of force, the lack of choice and the negative effects of using and witnessing others being forced to use the room suggested that the students were not empowered through the use of the reflection rooms. Although the importance of promoting safety is critical for a trauma-informed approach, how this safety is established indicated that this process requires further exploration.

Research Objective Three: Results

The third objective was to examine the family context as an additional parallel process beyond the classroom. The parents’ reports from the survey on the Family Environment Scale and the Caregiver strain questionnaire were used to determine family context. The participants’ reports from the interviews were included as a form of validating the survey results. Further, the parents’ reported aspects of change in their children following their treatment within the STP provided insight into changes in children’s behaviour beyond the classroom.

Family climate according to the FES. The Family Environment Scale profile depicting the family context of the parent sample is provided in Figure 5 (see also Table 11). On the Relationship Dimension, parents reported slightly below threshold levels of Cohesion and Expressiveness and an average level of Conflict within the home. For the Goal Orientation Dimension, the parents reported a slightly low level of Independence, but close to average levels of Achievement Orientation, Intellectual-Cultural Orientation, Active-Recreational Orientation
and Moral-Religious Emphasis. Finally, for the System Maintenance and Change Dimension, parents reported slightly high levels of Organization and Control.

As shown in Table 11, the STP parent sample means for the FES did not differ significantly from the normative or the normative distressed family samples (Moos & Moos, 2009). This normative distressed sample included families who were encountering different types of distress (e.g., families of individuals with alcohol use problems, psychiatric patients, or who had an adolescent or younger child who was in a crisis situation, had a conduct disorder, or was being placed into a foster home) (Moos & Moos, 2009). Furthermore, visual analysis was used to compare the STP parent sample to other similar samples from the existing literature on the FES; including the distressed normative sample (Moos & Moos, 2009), families of children with a conduct disorder (Vostanis & Nicholls, 1995) or an emotional disorder (Vostanis & Nicholls, 1995), families in which the mother was abusive toward their child (Glaser, Sayger, & Horne, 1993), and families with a child that had been referred for clinical services due to behaviour problems (Glaser et al., 1993) (please see Figure 6 for the FES profile comparing the six samples). The STP parent sample results on the FES were also examined according to the typologies identified from the existing literature on the FES (Moos & Moos, 1976, 2009). Given that none of the subscale results were greater than 60, which was the criterion upon which the typologies were developed (Moos & Moos, 1976, 2009), the STP sample could not be categorised into one of the existing family typologies.

The reports from the parents in the interviews revealed a slightly different pattern of functioning along the dimensions. The two parents reported fairly consistent reports of their family’s functioning. Specifically, for the relationship dimensions, the parents reported that they had a high degree of cohesion among the family. One parent said, “I would just say we’re pretty close-knit. We do a lot, you know, we do the majority of our activities together as a family unit” (Parent Interview #1, Mother). The parents also reported that they encouraged feelings within the family. One parent attributed the open expression of feeling from his child to be due to the treatment, as he stated, “Well our [child] talks a lot more about [his/her] feelings than [he/she] did before so [he/she]’s more, more open about it, which it helps to find out how [he/she]’s feeling” (Parent Interview #2, Father). The parents reported low levels of conflict within the home, as the father reported, “We don’t have, we don’t have a lot of conflict. We get along very
well. I mean there’s not a lot of angry emotions, things like that so we’re fairly cohesive” (Parent Interview #2).

For the aspects related to the Goal Orientation Dimension, the parents both reported high levels of independence. The parents reported that it was important to foster independence in the family. The family members were “independent as far as making their own decision” (Parent Interview #1, Mother), but not as much with completing daily living tasks (e.g., meals and laundry). The reports on the family level of achievement appeared to be conditional on their child’s mental health issues. Specifically, both parents reported that they were achievement focused within their own lives (for the parents and their spouses) through the achievement of post-secondary education and/or within their employment. However, given the academic challenges, their expectations and goals for their child had changed. One parent described that as a family they “focus on the strengths and try and build on the strengths and minimize the weaknesses” (Parent Interview #1). Relatedly, the parents reported that the amount of participation in social and recreation activities was average. They encouraged a variety of activities, but it was important to find the type of activities that matched the children’s individual preferences and strengths. For example, one child preferred individual activities because of difficulties with in-group activities. Alternatively, the other child was reported to be very social, but had difficulty in structured activities. Both parents reported that they supported their children with their academics. The parents reported a moderate level of intellectual and cultural orientation with the families. There were different degrees of focus on political and cultural issues, but that everyone in the family was “at least superficially aware of things” (Parent Interview #1). The parents’ reports of the Moral Religious emphasis were conditional in that both parents reported a high focus on ethical and moral issues, whereas there was little emphasis on religion.

The System Maintenance and Change reflected the levels of organization and control within the family. The parents reported that they needed to be reasonably structured as a family and that the increased need to be organized was related to their child’s mental health challenges. Specifically, it was reported that organization was required to “choose activities and knowing what kind of activities will be successful and what won’t be and, you know, planning activities to meet everybody’s needs” (Parent Interview #1). The other parent reported that they had a need to be routine-oriented because of his child, because if it was “just my wife and myself, it would
be structured but maybe a little more leeway as far as maybe going out and doing something as opposed to staying at home” (Parent Interview #2). Finally, both parents reported low to average levels of control within the family. Both parents reported “there are rules, and then there are circumstances met which would require you changing the rules” (Parent Interview #2). It was important for them to be flexible and “pick your battles” (Parent Interview #1). Here again, the parents reported that this need for flexibility was associated with their child’s unique challenges.

When the parent interview results were compared to the literature on the FES, they appeared to be operating in ways that were consistent with the Structured-Independence family profile identified by Moos and Moos (1976). This profile was characterized by families exhibiting a significant emphasis on Independence, while maintaining a high level of Organization and slightly low level of Control. With regard to the Relationship dimensions, these families were slightly above average for Cohesion and Expressiveness, and were low on Conflict. The families were close to average on their levels of Achievement, Intellectual-Culture, Active-Recreational and Moral-Religious orientations (Moos & Moos, 1976).

**Caregiver Strain.** The parents reported that they experienced some problems with a Global strain according to the CGSQ (see Table 12). The highest level of strain was reported in the area of Internalized Subjective strain. Indeed, according to the individual scale items, the greatest areas of concern were drawn from this subscale and related to being worried about child’s future and family’s future, followed by a significant toll taken on the family (see Table 13). In the surveys and interviews, participants reported that they worried about their child’s future. Both of the interview participants and an additional parent in the survey reported worry about their child’s general future, such as being “able to function in society” (Parent Interviews #1). Parents were concerned about their child’s academic future and their prospects for completing their education (reported by four parents). Parents reported that they worried about their child’s social functioning (reported by three parents), in that they were concerned if their child was going to develop friendships or be alone and “a social outcast” (Parent Survey #7). Finally, the parents were also concerned about their child’s ability to succeed in the future because of issues associated with their mental health disorders (e.g., their anxiety disorder). Contrary to the survey scale results, the interview participants reported that they were not worried about their family’s future and that they did not experienced a significant toll taken on the family due to their child’s mental health challenges.
Objective strain was the next highest level of concern according to the CGSQ. Both interview participants reported that scheduling and attending meetings was somewhat difficult at times. As one parent stated, “At the time it was because I mean [he/she], we had to pull [him/her] out of class and I had to take off work and just to take [him/her] to these different appointments” (Parent Interview #2). However, the parents reported that it was manageable and this did not appear to be a significant source of strain. As the other parent said, “I wouldn’t say it’s a significant toll. I would say at times it’s juggling to get to appointments and meetings and such, but so far it’s been doable […] I would say inconvenient, it’s just a little bit of stress at times trying to make all [the appointments …] when both of us work” (Parent Interview #1). This parent reported that they had social support through family, friends and a supportive employer, where the employer “allows [her] to juggle and sort of do flex time to make up the time for meetings” (Parent Interview #1). The other parent did not report other sources of social support other than the support they provided to each other as a married couple. The parents did not report any other areas of strain such as difficulties with family resources, physical and/or psychological well-being or the presence of other family stressors. Although disruptions in family time was found to be an area of some concern on the CGSQ, both of the interview participants reported positive family relationships.

Externalized Subjective strain was the lowest area of concern on the CGSQ. Both parents in the interviews reported some feelings of embarrassment when their child was having an emotional outburst while in the community. As the parent stated, “I don’t know if you would say embarrassment or stress. Like it, it sort of goes along with the stress before. Like if there’s a meltdown or whatever in front of a lot of people or something, yeah, you’re going to be embarrassed and it’s going to cause some stress, but I wouldn’t say often” (Parent Interview #1). For both parents this stress related to the other area of strain in terms of being flexible in their schedule to accommodate their child’s triggers. For example, “I guess it caused, caused or causes, a little bit of anxiety as far as sometimes not knowing how [he/she]’s going to react in certain situations. [He/she]’s, like a little, [he/she]’s like a switch sometimes. [He/she] can be perfectly fine and then the next minute something triggers it, but [he/she] is much better at keeping that under control now than [he/she] was before when [he/she] was younger” (Parent Interview #2). Neither of the parents reported other aspects of externalized subjective strain
(including resentment, anger or relating poorly with their child). Both parents actually reported that they had positive relations with their child.

Both parents indicated that their child was having particular challenges with academics, but that they were not experiencing severe difficulties with the child’s overall functioning. In addition, one parent stated, “It wasn’t that severe, so weren’t pushed into a corner that we, you know, that we needed help to get out of that corner. We were able to cope, cope on our own.” (Parent Interview #2, Father). Neither of the children was receiving additional services offered through the agency. Both of the children had left the program by the time the interviews were conducted, one had returned to a traditional school, and the other was receiving school supports through a different agency.

Although not addressed by the CGSQ, access to mental health services can be considered another area for objective strain. Both parents in the surveys reported that they were very pleased with the services provided through the agency. One parent stated, the STP “is great. I wish every kid that had these kinds of issues could go there because it was a great program and great staff. Very supportive, very understanding, very patient, very open-minded; a great bunch of people” (Parent Interview #1). The parents particularly referenced the staff for providing high-quality care and continual communication. “The staff was very caring. [My child] liked going there and she liked the people that were part of the program” and “There was constant communication either, either phone messages or phone calls or written” (Parent Interview #2). Continued access to this high-quality service was reported by both parents to be of concern. As one parent stated,

Last year, as I said at [STP] was awesome. It was a great environment and the support (Child’s name) got there and the progress [he/she] made there was amazing. Would have, given my, you know, right leg, for [him/her] to stay another year, but it wasn’t meant to be; I know there’s a long waiting list. This year [he/she]’s at a [different program]. And the environment, it’s a great program, but the environment, it’s kids that are more challenged than (my child) is […] and so sometimes I worry that, [he/she] doesn’t get the stimulation or the social, what would I say? You know the special school and, he keeps asking when [he/she] can go back to my ‘regular school’. But as far as going back to a ‘regular school’ where there’s 32 kids in the classroom and they,
[he/she]’s just not ready for that, but there doesn’t seem to be anything in between.
(Parent Interview #1, Mother).

Both parents, however, reported that they had access to other services through different agencies in the area.

**Comparison of the family climate and culture of the classrooms on the social climate scales.** For the Relationship Dimension, Cohesion on the FES represented both commitment and support among family members. As described above, Cohesion on the GES represented involvement, commitment and friendship, and it was most similar to the Affiliation on the CES. All groups reported slightly low levels of Cohesion on their respective subscales. A slightly high level of Involvement was reported within the classroom. The CYW reported a slightly high level of Expressiveness, whereas the parents reported a low level of Expressiveness. For support provided by leaders, the students, teachers and CYW all reported low levels of support. Both the Conflict subscale of the FES and Anger and Aggression subscales of the GES measured the amount of openly expressed anger and conflict or disagreement within their systems. An average level of conflict was reported in the home, whereas a higher level of conflict was reported among the CYW group.

For the Goal Orientation Dimension, both the parents and the CYW reported low levels of independence within their systems. The teachers and CYW reported low levels of task orientation, whereas the students’ reports on this subscale were high. The Achievement subscale of the FES, which also related to emphasis on school-related activities, was average for the parent sample. Finally, the System Maintenance and Change Dimension included a measure of organization for all three scales. Organization was reported to be high within the family and the CYW systems, but low within the classroom (according to the teachers and students). The emphasis and enforcement of rules to run the family, classroom and the CYW group were all slightly above average.

**Parent reports of student’s changes in response to the SGTIP.** Parents reported that their children were focusing on the following behaviours while in the STP: social skills, peer relationships, phobias, impulsivity, school refusal, using appropriate language, seeking support when frustrated, aggressive behaviours, anger management and mood swings (the frequency of the parents who reported these goals for their child is included in Table 8). All parents reported that their child was focusing on at least two targeted behaviours while in treatment.
According to the parents, the global severity of the behaviours was moderate ($M = 14.42$, $SD = 1.69$), with a range from nine to 23. Please see Table 14 or a summary of the parents’ reports of child functioning. When examined along the four dimensions, children frequently engaged in targeted behaviours ($M = 4.67$); the behaviours were at a moderate level of intensity ($M = 3.29$); that the behaviours did not end quickly, but did not continue all day ($M = 3.57$); and that the behaviours occurred at a median rate of discrimination ($M = 3.57$), in that behaviours did not only occur in one place or with one person, but that they did not occur with everyone.

Parents reported a significant change ($t(6) = -2.8, p = 0.03$) in their child’s social relationships since receiving treatment within the SGTIP. This indicated their children significantly increased in their social relationships from $M = 3.29$ ($SD = 1.89$) to $M = 4.43$ ($SD = 1.62$) after being in treatment within the SGTIP. Parents also reported a significant increase in children’s academic achievement ($t(6) = -2.5, p = 0.045$) from $M = 1.68$ ($SD = 1.89$) to $M = 3.86$ ($SD = 0.90$) after being in treatment. The effects size for each of the pairs of variables was strong. Although changes in the child’s functioning within the home and parents relationships with the child were also reported to have increased, these changes were not significant. Please see Table 15, for the parents’ reports of changes in youth since the SGTIP.

The open-ended questions on the parent surveys and interviews provided additional information as to how the students had changed in these four areas. Two parents reported that their children developed a close relationship with their teacher. Two parents reported that their children had better social interactions. One additional parent described that their child became more emotionally intelligent than before treatment with the SGTIP. “[My child] is much more empathetic toward others’ feelings than before” (Parent Survey #1). Not all of the parents reported such an increase in social relationships, as one parent reported no change in their child’s peer relationships. In the child’s functioning at home, two parents reported that their child was more self-aware at home with their family; one parent reported that her son takes responsibility for his actions now rather than blaming others as he did before. An additional parent reported that her child was able to handle his emotions when he did not get his own way at school. Furthermore, the positive improvements at school appeared to be influencing their children at home, as two parents reported that their child was waking and preparing for school with less hassle than before receiving treatment with the SGTIP. “She is much better at getting ready for school, gets dressed, awakens on own most of the time, eats breakfast” (Parent Survey #1). One
of the students reported in the focus groups that she was utilizing her coping skills at home that she had learned at school.

Mine [Safety Plan] is colouring and reading books. I love reading. Reading helps me calm down. Did you know when I was at my house I was really, really mad and my mom put a bunch of books in a pile right in my room, outside my room. So that I could calm down. And I took them and read them, all of them. (Student FG #3 Girl age 10)

With regard to how treatment within the SGTIP influenced change in the students’ relationships with their parents, four of the parents reported on specific aspects of how this relationship had changed. One parent reported that she was proud of her child’s increase in self-esteem. The other three parents reported that their child was displaying signs of social responsibility in that the children were more self-dependent and able to recognize their own needs and were more able to take “responsibility for their part of the relationship” (Parent Survey #3) than before treatment. One parent also indicated that they displayed signs of empathy toward her parent’s feelings. “She is much better at recognizing what she needs (i.e. I’m hungry). She is much more empathetic toward parents’ feeling. She is a pleasure to be around most of the time” (Parent Survey #1). Six out of seven of the parents reported that their child had improved in their academics. Parents also reported that their children were improving in other aspects related to academic performance. Specifically, they were attending class, completing their schoolwork at home and at school, were exhibiting fewer issues at school, and were able to be more independent than before treatment. The report from the parents’ interviews provides some insight into why changes in the child’s functioning within the home and in their relationships with their child had not significantly changed. As described above, both parents reported these were never areas of concern. Specifically, one parent stated, “Functioning within the home was never really a problem; that continues to be fine” (Parent Interview #1).

Overall, the parents’ reports on the survey revealed relatively average levels with regard to the different domains, with only three subscales falling at or below half a standard deviation from the standardized mean (i.e., Cohesion, Expressiveness and Independence). This finding may have indicated that the families were operating in ways typical of the normative population. When the results were further explored during the interviews with the two parents, the parents indicated that their levels of functioning in the different domains were more variable than was found in the surveys. When the parents’ qualitative data were taken into consideration of the
representation of the family context, the results indicated that there were relationships within the family and that members of the family were expressive about their feelings. The parents indicated that they focused on achievements, yet in an individualized way. Further parents reported that they did need to be organized, but that they also needed to be flexible with rules and exerting control. As was indicated on the Caregiver Strain questionnaire, the degree of stress may have been an important factor within the home. This stress may have limited further participation in the study. With regard to the changes in students, parents reported several areas in which their children appeared to have improved following treatment. These areas were consistent with the areas focused on within the SGTIP.
Discussion

Research Objective One: Parallel processes examination within the STP.

In general, the organizational culture of the CYW within the School Treatment Program was characterized as promoting friendships, involvement and expressiveness among members of the systems. There was less focus on task orientation, yet there was a strong focus on innovation. They reported that they were receiving little support from leaders, while the culture consisted of a high degree of structure and control (including rule clarity, formal structure and control from management). The student organizational culture followed a parallel pattern of functioning as the CYW except that they perceived a higher level of emphasis on tasks, but did not behave in an orderly and polite manner.

To interpret the organizational cultures within the two systems (the classroom and the CYW working within the STP) and the processes that may have been operating between these systems, both the quantitative and qualitative results were organized according to the Seven Organizational Commitments of the Sanctuary Model. Consistent with the description from Bloom and Farragher (2011), the commitments were found to be strongly interactive and contingent on each other. Thus, the interpretation below was organized into four dimensions: (1) nonviolence; (2) emotional intelligence, social learning, and open communication; (3) democracy and social responsibility; and (4) growth and change. With regard to these values, the organizational cultures of both systems appeared to be operating in similar processes. Both groups endorsed the importance of safety and attempted to support the safety of the program, but were limited as to the overall sense of safety that was perceived within the program.

Nonviolence was found to be a foundational aspect in promoting all other commitments. Emotional intelligence was reflected for both groups in the open communication of emotions and it appeared to be developed through social learning; however, the extent to which the cultures reflected the other aspects of these commitments was not fully established. Some aspects of democracy and social responsibility were represented within both groups, although there was a high degree of authority and order and organization in both groups, which may need to be addressed through critical reflection and dialogue. For the students, this may have been required due to their level of maturity and functioning. Finally, both groups appeared to be working toward growth and change; however, the focus on addressing loss was limited. The degree to which each of the two systems appeared to be representing each of the commitments was
subjectively interpreted further along with possible theoretical explanations for what may have influenced these representations. Overall, the results indicated that the organizational culture within the STP was not fully trauma-informed. Accordingly, aspects of the culture that reflected potentially trauma-organised processes were identified and presented as potential opportunities to engage in reflection and action for moving the organizational culture further in becoming trauma-informed.

Nonviolence. According to Bloom and Farragher (2011), nonviolence reflects the development of safety skills, trust and resilience in response to stress. The commitment to nonviolence was represented within both groups through an acknowledgment of the importance of establishing safety within the STP; however, the degree to which the commitment was enacted was less apparent as both groups reported mixed perceptions regarding their actual sense of safety. The clientele were reported by both groups for engaging in behaviour that impeded the safety of the program. Although the students appeared to be working toward the promotion of safety, they did not appear to be able to make the commitment not to engage in unsafe behaviour (both physically and socially) through the process of treatment. The CYW were credited for promoting safety in the program by removing students who engaged in aggressive behaviours from the classroom, but the students remained within the building as they were placed in a reflection room off the central hallway. The use of these rooms within the program paradoxically appeared to promote safety, while at the same time they reduced safety, as force was often required of the CYW to get the students into the rooms. Safety was also reduced by the residual effect on others in the program of witnessing (both seeing and hearing) the students being forcefully placed in the reflection rooms. The notion that everyone in the program can commit to nonviolence may not be feasible. In the adult in-patient unit in which the Sanctuary Model was developed, Bloom (1997) described that patients were expected to make this decision or they would be transferred to a different unit; these other units were reported to employed locks and confinement to address violent behaviour. Such a method of enforcement of the commitment is not possible within this program. Specifically, the program provides treatment to students for whom other resources have been exhausted. Further, even if it may have been feasible to send students to another program, this procedure may actually represent another dialectical tension when the assumptions of the trauma theory are taken into consideration. Specifically, knowingly sending individuals to an alternative location that utilizes such coercive
methods does not represent a desire to avoid further re-traumatization for those they are expected to support. What is required is the critical reflection as to what this commitment to nonviolence can be within the STP. With this population, the system in which the services are provided, as well as the students, may benefit from focusing on skill development. This approach and its benefits are described further below.

Another aspect reported to inhibit the sense of social safety was the departure of the direct supervisor who was not replaced before the completion of the school year. The pattern of results for the level of leadership support provided to the CYW increased following the implementation of the SGTIP; however, this level was still below threshold. The amount of support appeared to be severely lacking by the time the focus groups were conducted, which occurred after the supervisor had left the program. Leadership control also rose between the two administrations of the surveys and appeared high during the focus group, since the CYW reported that their managers maintained control during staff meetings and discouraged feedback. The discrepancy between leadership support and leadership control when the focus groups were conducted was likely related to the lack of a direct supervisor. As there was no longer an acting program supervisor, other managers were required to oversee operations but may not have had the ability to provide the direct support needed for the CYW. The absence of the supervisor in the program was reported by the CYW to increase the amount of stress in their work, as well as reduce the amount of trust and support they were provided by management. The importance of strong leadership was repeatedly referenced by Bloom and Farragher (2011) for reducing the factors leading to chronic stress within organizations. Bloom (2005b) stated that supervision is important to ensure that members are not engaging in behaviour that may traumatize clients. The importance of strong leadership has also been referenced by KT literature in adopting (Hoag et al., 2002) and facilitating routinization of innovations (Greenhalgh et al., 2004).

The results indicated that the CYW were working in a highly stressful environment. They did not appear to express this stress through a high degree of conflict and resentment amongst their group, rather they appeared to have developed a strong team bond. It is not clear that this stress was being represented through a parallel process in the relationship the CYW had with the students or, specifically, there did not appear to be any counter-transference (Elliott et al., 2005; Elwood et al., 2011; Hodas, 2006; Jennings, 2007). The survey results indicated that the students were receiving low levels of support from their CYW; however, in the focus groups,
the students reported many aspects of support that they were receiving from their CYW as well as many ways in which they felt trust with their worker to share their feelings. In addition, the students credited the CYW for making the program safe. Alternatively, the amount of stress appeared to limit opportunities for CYW to engage in critical reflection. As Bloom (2005b) described, chronic stress can inhibit members’ ability to integrate various cognitive, emotional and interpersonal capabilities that are required to effectively operate and change systems. It did not appear the CYW were operating more punitively than in previous practice; nor does it appear that they have been able to develop alternative methods for responding to aggressive behaviour from the students. Bloom also indicated that communication networks break down when operating under chronic stress, which can lead to increased rigidity in hierarchical structures. This process did appear to be occurring to some extent within both the CYW group in their relationship with management, as well as with the students in their relationship with the teachers and CYW. It is important to note that it is not clear if this was a change in the way the systems were operating, but in a Sanctuary-informed system these forms of democracy should be an operating practice (Bloom, 1997, 2005b). Thus, from a trauma-informed perspective, it is essential that this stress be addressed.

*Emotional intelligence, social learning and open communication.* Emotional intelligence was proposed to be represented through the development of emotional management skills, respect for the emotional labour within the treatment of traumatized individuals, reducing the blame associated with fear, and an acknowledgment of the links between the effects of trauma on behaviour (Bloom & Farragher, 2011). Social learning was to reflect the ability to sustain a learning organization, which includes addressing underlying and past processes, and building on cognitive skills, improved decision-making and encouraging divergent thinking (Bloom & Farragher, 2011). Open communication was to reflect the ability to engage in healthy discourse regarding “the undiscussables” (pp. 359), healthy boundaries, conflict management and transparency (Bloom & Farragher, 2011). In both groups of the STP, these three commitments were found to be interrelated as far as they related to the learning, communication and appreciation for emotional capabilities. Some of the other aspects of these commitments were alluded to by both participant groups; however, this limited discussion does not support their representativeness within the organizational culture. Yet, it is important to note that the limited discussion may have been due to the lack of direct questions posed regarding all aspects of these
commitments. This limitation could be addressed in further research by structuring the focus group questions around the Sanctuary Commitments rather than the SELF-model.

The students developed their emotional management skills, which were fostered by the CYW. The students reported that they were learning to manage their own emotions and respond appropriately to other students’ expressions of emotions. The students were encouraged to share their emotions and most students reported that they preferred to share their emotions only during the Community Meeting or they would privately share with their CYW. The CYW provided the students with support with their emotions, but reported that it could be traumatizing when the students’ expressions were especially painful. The CYW tried not to internalize these emotions and tried to work through these experiences with their team; these results were supported by both the focus groups and the high level of expressiveness by the CYW in the surveys. However, the CYW reported that they perceived that there was not enough support from their superiors. It is important to note that on at least two occasions, the researcher witnessed support being provided to the CYW from management following incidents that occurred within the program involving student aggression. These incidents occurred prior to and following the departure of the program supervisor. The CYW also reported that the students were not responsive to the CYW’s expressions of emotions; however, without further exploration the implication of this contribution is uncertain.

Given the perceived severity of the impact that the children’s disclosure had on the CYW (as they used the word “traumatized” to describe the experience), it is important that these emotional experiences be addressed. Bloom (2003) referred to the process as vicarious trauma, which describes the cumulative transformative effects professionals may experience through working with trauma survivors. Symptoms of vicarious trauma closely resemble that of PTSD (Catherall, 1995), as well as disruptions in worldviews or frames of reference (Rosenbloom, Pratt, & Pearlman, 1995). Bloom provided a variety of potential causes of this form of trauma, some of which include emotional contagion, conflict, violence within the working environment, and ideological and systemic factors (Bloom, 2003). However, the research on the topic is quite limited and somewhat contradictory (Kadambi & Ennis, 2004). Burnout is a related concept, which reflects the physical, emotional and mental exhaustion of being repeatedly exposed to emotionally difficult situations (Pines & Arenson, 1988). Bloom (2003) outlined a variety of individual and environmental supports that individuals and organizations can employ to reduce
burnout. These approaches focus on physical, psychological and social health (Bloom, 2003). Organizational support is crucial, which includes prevention strategies, support from supervisors (Bloom, 2003; Catherall, 1995; Kadambi & Ennis, 2004), support from co-workers (Curry, McCarragher, & Dellmann-Jenkins, 2005; Nissly, Barak, & Levin, 2005), and the availability of coping resources within the organizational culture (Lee, Forster, & Rehner, 2011). Quality relations with supervisors have been associated with lower levels of depersonalization, a precursor to caregiver burnout (Manlove, 1993) and can support worker retention (Chen & Scannapieco, 2010). Thus, although the CYW were receiving support from one another and, to some extent, from their supervisors, the extent to which these feelings may linger and or become worsen through repeated exposure was not fully addressed.

Trust was an important aspect reported by both the students and the CYW. Trust stems from a sense of social safety, but it also reflects aspects of other commitments including emotional intelligence, open communication within the team, and social responsibility through the development of relationships. Despite the strong bond, the level of anger and aggression was slightly high within the CYW group. This measure reflects the extent to which anger and disagreement were expressed within the group. This level of conflict may actually indicate a positive aspect of the culture as it may reflect part of the process of conflict management. Their ability to express these aspects openly within their group may have been an indicator that, despite their tight bond, they may not be engaging in groupthink (Janis, 1972, 1982). The dangers of groupthink were described by Bloom and Farragher (2011) as a problematic emotional management process whereby much-needed conflict resolution skills are inhibited. This process develops in groups that become highly cohesive due to chronic levels of stress. From a parallel process perspective, the students were engaging in communication of their emotions and the CYW were responding to the students. Although the CYW reported that they were not receiving enough support from their supervisors, they were able to find support from within their team. It is important that they continue to address and support the emotional management of the team so that they can continue to encourage the students to express their feelings without the CYW developing feelings of resentment.

Democracy and social responsibility. According to Bloom and Farragher (2011) democracy was to reflect the healthy exercise of authority and leadership by honouring individual voices while developing civic skills of self-control, self-discipline and participation.
Social responsibility was to reflect a concern for the common good, healthy and fair relationships, and reciprocity. Within both the classroom and the CYW systems, there appeared to be a strong hierarchical structure of leadership. The students reported that the CYW and the teachers were the leaders of the classrooms; they encouraged student input into some activity decisions, but maintained authority in developing and enforcing rules. According to the students, there was a high degree of emphasis on following the rules; these rules were reported to be determined by the CYW and the teachers. The extent to which the rules were followed within the classroom differed, depending on the perspectives of the participant groups according to the measure of task orientation. Specifically, the teachers reported a lower degree of task orientation within the classroom than was reported by the students, although this difference was not found to be statistically significant. This discrepancy may have been related to differences in perceptions regarding the emphasis on completing planned activities and staying on task. The students could have felt there was a great deal of focus on academic-related activities and tasks, whereas the teachers and CYW could have felt that this focus was minimized, given that they were also focused on classroom order and organization, which was low within the STP.

Among the CYW, leadership was represented through traditional means. The level of task orientation was low and had decreased following the implementation of the SGTIP. This measure provided insight into the emphasis on task completion, decision-making and training. The results indicated that the CYW believed that they had some degree of control with the daily routines, but did not have control over their rules and processes. The amount of leadership control was described previously with regard to its relationship with leadership support. From a Sanctuary perspective, the level of task orientation would have been expected to be higher within the CYW, as represented by this measure. It would be expected that the trauma-informed critical review of the policies and procedures in practice would require an emphasis on decision-making and continual support. The CYW reported that they needed additional support in this ‘how-to’ link between theory and practice. This procedural or ‘how to’ knowledge was reported by Rogers (1995, 2003) as an essential aspect of the adoption process. The relative lack of this knowledge could possibly provide valuable insight into why the CYW were struggling to implement the Sanctuary Model in practice.

Closely related to democracy was social responsibility, which reflected both the commitment to engage in socially respectable behaviour and the development of friendships
(Bloom & Farragher, 2011). In the focus groups, the students were able to report on ways that they engaged in a responsible manner. Nevertheless, the results from the student and teacher surveys indicated that overall there were a lot of rules within the classrooms, yet students were operating at a low level of order and organization, which indicated that the students were neither behaving in an orderly or polite manner, nor were they following through with the organization of task and activities. As was reported by the CYW, what may be needed is social responsibility to be supported through accountability.

Friendship within the culture of the classrooms was reported to be low in terms of affiliation and staff support, according to results of the social climate scales from students and teachers. According to the respective subscale results, all groups reported low levels of friendship within the STP. The qualitative results provided some explanation for this low level of friendship among the students. Most of the students reported that they had at least one friend within the program and that they engaged in various behaviours to build relationships. However, some students also reported several factors that limited the development of friendships represented by how some students’ were behaving (e.g., they were not trustworthy and were rude and annoying) and the temporary nature of the program. Specifically, two students indicated that they did not want to make friends in the STP because they wanted to go back to their ‘regular’ school. It takes work and energy to make friends, and it may have been that the students felt it was not worth the effort if the friendship was only going to be temporary. Alternatively, some students indicated that they had established relationships with some of the students that extended beyond the classroom. Therefore, it may be that collectively the overall level of friendship among all of the students in the program was not strong, but that the students were still developing friendships with individual students in the program.

The level of cohesion among the CYW increased following the implementation of the SGTIP, although the change was not statistically significant and the level was still slightly below average following the implementation. These results are somewhat contrary to the CYW focus groups in which they reported a very strong bond within their group. The discrepancy in these reports may be more related to contextual factors associated with the timing of the different points of data collection rather than a discrepancy. Specifically, it is possible that the relationships among the group were gradually developing, which can be assumed from the
increase from the two survey samples; however, their bond may have strengthened further after the supervisor in the program left and the CYW became reliant on each other for support.

*Growth and Change.* Growth and change was to reflect the process of recognising and responding to loss, changing disruptive patterns of behaviour, and working toward a better future (Bloom & Farragher, 2011). Although the questions related to growth and change were not discussed in the CYW focus group, given the inter-related nature of the commitments, it was surprising that representation of growth and change did not emerge from the other questions as had occurred for the other commitment. Thus, insights into these processes were only interpreted from the CYW social climate scale results, specifically in the subscales of innovation and independence. Innovation referred to the group’s ability to promote diversity and changes in functions and activities and this level was significantly high among the CYW. Independence related to the degree to which independent action and expression was encouraged throughout the group, and this level was low among the CYW. Combined, these measures indicated that, as a group, the CYW were able to respond to change. A notable finding was the decrease in the level of self-discovery within the CYW from slightly high before implementation to low following the implementation. The subscale reflected the degree to which personal problems were encouraged and discussed within the group. It may have been that the group was no longer able to focus on personal problems following the implementation. This limited focus may be problematic, as the Sanctuary Model requires changes in beliefs and values that are, in a way, very personal. If these were the problems that were discouraged, then it may provide insight into why the ‘unlearning processes’ (Soto-Crespo, 1999) did not appear to have occurred fully within the team. Still, such interpretations are speculative without further investigation.

The students’ focus on growth and change in the classroom was reflected in their response to loss and the focus on working toward their goals. A full appreciation for the concept of loss was not apparent from the students’ discussions. When probed, the students were able to provide some specific examples of dealing with loss, but most of them reported that they would deal with it themselves. It is unclear if dealing with loss individually actually represented a healthy process or a limitation. Specifically, the students’ lack of understanding could have been a reflection of the lack of education and support provided to the student to addressing loss as the SELF-model curriculum had not been utilized. With regard to their goals, the students had
mixed perceptions regarding their preference for working toward their goals, but overall it appeared that this focus on goals was important for change.

**Implementation process of the SGTIP.** All of the participant groups reported aspects of change following the implementation of the SGTIP. The CYW reported an increased awareness of trauma theory (e.g., the effects of trauma and a desire to avoid re-traumatization). Other changes reflected the utilization of components of the Sanctuary Model (i.e., the Community Meetings, Safety Plans and Red Flag Meetings), as well as an increased focus on emotional intelligence, open communication and social responsibility. These changes were reported to be beneficial as they promoted a peaceful environment and a collaborative team approach to support, the encouragement of emotional expression, and treatment facilitation one goal at a time. Although these reports yielded positive insights into the process of change associated with the adoption of the SGTIP, these changes cannot be fully attributed to the SGTIP as no comparison mechanism was employed in the research.

One implication that may be drawn from the results is that it does appear that the organizational cultures within the two systems (CYW and the classrooms) was represented by each of the seven Sanctuary Commitments to varying degrees; however, additional engagement may be required to ensure that these commitments become fully represented within the cultures. When the research was conducted, the organizational cultures could not be inferred to be fully trauma-informed. Factors were identified that may have limited the implementation process. One factor was a lack of general awareness of the decision to adopt a SGTIP among those who were not directly trained in the SGTIP (e.g., teachers, parents). Another was that the students in the program could have been provided with more education through the psycho-education curriculum of the SELF-model described previously (Bloom & Farragher, 2011; Bloom et al., 2006). The decision to refrain from utilizing this curriculum was not shared with the researcher. The CYW also reported on other aspects that may have limited the implementation, these included a lack of infrastructure (e.g., in informing the CYW of the results of the trauma assessments administered at intake), supervision (e.g., in terms of follow-through, general guidance, accountability and trust), adequate staffing, and incorporation of the CYW in the change process. When the research was conducted, the infrastructure to support the model did not appear to be in place fully. In becoming trauma-informed, daily procedures need to be informed by trauma information (such as that taken at intake), but the CYW reported that they
were not provided with this information. Thus, additional effort may need to be devoted to enhance the presence of strategies, equipment and policies to allow the trauma-informed transformation to take place. The lack of direct supervision also provides insight into why not all of the seven Organizational Commitments were fully represented among the CYW group. It is important to note that the leaders themselves are not being blamed; rather, the issue appears to be their position as bound by time and context. Specifically these limitations may be understood to have been influenced by systemic constraints when interpreted from the systemic theory of organizational change. It is important to note that these insights regarding the process of implementation were only drawn from only one participant group and that the data collected from this group were limited (please see description below). Therefore, critical engagement with the existing literature was undertaken to contextualize the results; however, the inferences may be considered tentative and require further research.

Rogers’ (1995, 2003) diffusion of innovation theory provided a useful framework to explain the research findings with regard to the adoption of the SGTIP by the CYW. Although Greenhalgh and colleagues (2004) reported that the Concerns-Based Adoption Model had more empirical support, Rogers’ theory provided more explanatory power as to the process of adoption and the factors that may have limited its implementation than the latter model. Specifically, the CYW within the program reported an awareness-based knowledge of the innovation. However, their ‘how to’ knowledge about the innovation was lacking. As stated above, Rogers identified this knowledge as essential to the adoption process. The full degree of the CYW’s principle knowledge about why the innovation was important was not assessed; it may only be assumed to be somewhat present based on their reports. The CYW also indicated that they had positive attitudes toward the innovation, which is representative of the persuasion stage of the process. Although the decision to adopt the innovation was made by authorities in the agency, the CYW had decided to adopt aspects of the Sanctuary Model in practice. The choice not to adopt the SELF-model curriculum may have indicated that the principle or ‘why’ knowledge of the Sanctuary Model may not have been fully developed. Specifically, the SELF-model may be understood to provide the link between the Sanctuary Commitments (as general overarching constructs) and their application to this population since it provides the language and framework to communicate these complicated constructs to the children. At the time of the data collection, the CYW were engaged in the implementation stage. According to Rogers, uncertainties about
the innovation can be problematic. Support from leaders and change agents are helpful to reduce this uncertainty. Unfortunately, both the champion of this program and supervisor were no longer present within the program. Although the larger organization had developed a steering committee for the implementation of the SGTIP throughout the organization, the champion of the STP did not stay within the organization following the implementation. Thus engagement needs to be supported by management, both in terms of time, guidance and infrastructure (Yorks & Marsick, 2000). This is also the stage in which reinvention of the innovation occurs.

Reinvention is the process of changing or modifying the innovation to fit the needs of the context (Rogers, 1995, 2003). As identified by Rogers, the attributes of prospective users may influence the adoption of innovations. The reports from the CYW that they were having difficulty instituting aspects of the Sanctuary Model might have been attributed to the CYW themselves for not taking the initiative; however, it may be more likely that they were struggling in how to implement it based on system-level constraints. The Sanctuary Model requires organizations to develop their own strategies, but provides little guidance as to how they are enacted. Thus, it may be valuable to note that the degree to which the innovation requires reinvention may depend on the type of innovation, which supports the ‘trialability’ attribute of the innovation identified by Rogers. However, Rogers’ representation of ‘trialability’ may not fully represent the reinvention required for shifting to a trauma-informed system.

Rather than a prescriptive innovation which may require modifications in procedures to be implemented, the Sanctuary Model is a process (Bloom, 1995) which requires adjustments in the basic assumptions relating to the beliefs and values that guide behaviour (Bloom, 1995). Bloom suggested that often the underlying assumption of compassion exists within service delivery; however, due to chronic stress and systemic factors, there can be distortions in how this compassion is implemented, and services can inadvertently re-traumatize individuals. Therefore, although the KT literature identifies pre-existing assumptions, beliefs and values of individuals as factors (Ringelstein et al., 2003) constituting the organizational culture (Schein, 1990) that influence adoption, the trauma-informed approach requires that these mental models change (Bloom, 1997). Although much attention has been provided to the need to shift beliefs and values, little discussion in the literature has been provided to describe how these transformations occur and how these transformations can be fostered (Bloom, 2005c). In addition, the degree to which these assumptions and beliefs were targeted for change within the STP is not clear. The
transformative perspective of KT offers some insight into why these changes may not have occurred (Matthew-Maich et al., 2010), as well as possible directions for how these changes may be facilitated in the future. Specifically, it is important to consider the implications of the concept of unlearning (Macdonald, 2002) within the context of transformation learning theory (Matthew-Maich et al., 2010) in providing insights into possible explanations of why the SGTIP had not fully been represented within the organizational culture.

According to Mezirow (2000), individuals do not return to old perspectives once transformed. Nevertheless, learners can become stalled in any stage of the process and this often occurs at the beginning of the process when long-held beliefs and assumptions are threatened. Bloom and Farragher (2011) reviewed some of the social defence systems that may be operating and persevering in trauma-organised systems. These social defence systems serve as protection for organizational members; however, they may illuminate why members are resistant to change even when they have been exposed to trauma-informed theory. For example, cognitive dissonance is a process in which individuals are driven to reduce the dissonance associated with maintaining two contradictory perspectives at one time (Festinger, 1957/1985). This dissonance is reduced by altering existing cognitions, adding new cognitions to create a consistent belief system, or reducing the importance of any cognition that caused the dissonance. When applied to the process of adopting a trauma-informed practice, new assumptions and meaning-making require changes to previous cognitive schemas. When new knowledge threatens these perceptions of self, they may become distorted before becoming assimilated. It is proposed that the process of unlearning provides an alternative method for reconciling this dissonance. This notion links to an important, yet underlying, apparent paradoxical assumption of the Sanctuary Model. Specifically, although it was clear from the literature that systems can become trauma-organized (Bentovim, 1992; Bloom, 1997, 2005b) due to unresolved chronic stress and system factors, the Sanctuary Model does not imply that practitioners behave in malicious ways; instead, due to factors often outside the control of the individual service provider; the ways that they are able to support individuals may have actually been harmful for some individuals. From a practitioner’s perspective, it may be inferred that by acknowledging these trauma-organized practices, they may be ascribed as the cause. They may feel guilty even though these feelings are not assumed within the model. Practitioners need to be supported through the unlearning process to address their potential feelings of guilt. Soto-Crespo (1999) model of unlearning
supports individuals through a process of unlearning deeply held beliefs and values that present barriers for new learning. The process often includes a bereavement process, while upholding the possibility of hope in the new direction. Foundational to the model is the need for a safe environment; an environment in which individuals feel secure in acknowledging the need for this change and without the fear of being ascribed this guilt. When applied to a KT endeavour, Macdonald (2002) described the importance of developing communities of practitioners within which individuals can engage in strategies of unlearning within a safe and accepting environment. As stated previous, however, the effectiveness of the communities of practice has yet to be established, and more research into their use is required. The CYW may have needed to be supported by managers to allow for the open expression of these feelings without fear of perceived retribution.

Furthermore, by integrating various critical theories, Kitson (2009) framework further extends the interpretation of these research findings. Kitson (2009) reframed what may be considered a successful implementation as processes affected by the degree to which adopters understand and accept the new knowledge, make decisions to improve practice and outcomes based on use of the new knowledge, and ability to sustain the change through the acquisition of resources. This framework focused on the concepts of ideas, outcomes, people, transactions (relationships) and context. As described above, it appeared that the SGTIP had begun the process, but the implementation may not have progressed to a point at which the adopters could engage with or sustain the change. Fortunately, however, in drawing on the work of Van de Ven and colleagues (1999), Kitson described that KT is better understood as a journey instead of a linear process. In this way, the research can be conceptualized as part of steps in the journey which elucidated feedback upon which “reflection-on-action” (Senge, 1990) is possible.

To enact the Sanctuary Model in practice, time is needed for the CYW group to translate the seven Organizational Commitments into knowledge domains. Time had been devoted to various meetings in accordance with the Sanctuary Model (e.g., meeting every morning to review goals and feelings and to make commitments to support each other). However, the rote nature of these meetings in terms of a scripted response may have actually made the process an inauthentic way of interacting with each other. The CYW noted that although they shared their feelings with the students, the students were not supportive of them. In addition, as one child noted, actually supporting each other with their goals does not happen, even though they state
that everyone is going to support each other with their goals. What may be needed is an authentic engagement with the aspects of the Sanctuary Model. Given the notion that each of the commitments requires critical reflection and discourse to determine how the commitment can be represented within the given context (Bloom, 2005c; Mezirow, 2000), it is recommended that the agency foster the development of a community of practice (Wenger, 2004) within the CYW team. Such a community may align well with the concept of community of practice, given the apparent appreciation and desire to adopt the trauma-informed service (i.e., domain), the camaraderie among the group (i.e., community), and the wealth of knowledge the CYW possess as practitioners (i.e., practice). The CYW encompass many of the qualities for developing the knowledge base of practice. It is possible that if the CYW develop as a community of practice, they can improve practice to align with the beliefs and values of a trauma-informed program. The CYW need cultivation in the trauma theory and support from management (Wenger, 2004).

The Sanctuary Model requires organizational change according to the Seven Commitments, but offers little support for how to enact these constructs into various contexts. Transformative learning theory provided valuable insights into aspects that may have inhibited the process and offered a method to propel the adoption further (Mezirow, 2000). Developing communities of practices (Wenger, 1998) in which individuals can engage in critical reflection and discourse (Mezirow, 2000), as well as unlearning (Soto-Crespo, 1999), may have an important influence on transformative learning required in becoming trauma-informed.

**Research Objective Two: Student Perceptions**

Students appeared to be capable of providing appropriate and/or valid responses. In general, their perceptions suggest that they found much of the SGTIP aspects (e.g., sharing emotions, goals and Safety Plans) valuable, but they needed continued support, encouragement and the addition of enjoyable activities and rewards to maintain engagement. Regarding the reflection rooms, their use within the program was found to promote safety, but their varied perceptions regarding the process necessitate further critical evaluation into their continued use.

The lack of knowledge about the theory and the approach was also evident among the student population. The students did not recognize the “Sanctuary” term associated with the new trauma-informed approach. They were, however, able to discuss aspects of the Sanctuary Model that were being implemented, including the Community Meetings and Safety Plans. Overall, the students’ reports on the Community Meetings were generally negative. Students reported that
they either did not enjoy anything about the meetings or that the meetings were boring or a waste of time. Those students who did report that they enjoyed the meetings actually reported on aspects associated with the meetings (i.e., playing a game during the meeting time and not having to do school work) rather than the trauma-informed aspects of the meetings. When discussed further, however, the students reported positive aspects related to sharing feelings. Sharing feelings was reported to be an enjoyable experience and it promoted friendships and understanding among the students. Regarding having and sharing goals, the students reported both positive and negative features. The students’ reports indicated that their preference for having and working toward goals was enhanced when they were self-determined and when they were supported through recognition and reinforcement. The results suggest that the students perceived some value in the Community Meetings, but the addition of games and reinforcement were important to encourage their enjoyment and engagement.

The students also reported both positive and negative aspects of the Safety Plans. The Safety Plans were reported to be helpful in reminding the students about what they could do when they were upset. The students were supported to develop their own plans based on their individual preferences. The students’ reports on the utility of the plans were mixed. Although some students reported that the plans were helpful, others reported that the plans were under-utilized. Given the positive perceptions and the proactive and self-determined nature of the Safety Plans, additional emphasis on supporting the use of the plans by the students may be helpful.

According to the students, the reflection rooms were used to manage student behaviour (other comments indicate that this was due to violent/aggressive behaviour). Although choice was discussed, if the students were engaging in ‘unsafe’ behaviour they would be taken to the rooms. The CYW would wait outside the door until the students were calm (a process that included holding the door closed). The students reported mixed feelings about what it felt like to be in the rooms and what it was like to witness other students using the rooms. Some of the students reported that they did not like the reflection rooms because of the use of force. Despite some of these negative feelings, the students felt that the rooms helped the students manage their emotions and promoted safety.

The effectiveness of the reflection rooms at reducing challenging behaviour and enhancing self-control was not evaluated. Rather the students’ perceptions regarding the use of
such rooms were solicited as a means of determining if their use should be continued. From the transformative perspective, even if their use had been evaluated and they had been found to be effective, the students’ perceptions regarding their use should still be privileged as an opportunity to examine critically if they should be used. The results of the research reveal that using the reflection rooms for the removal of children when they were acting violently was perceived to promote the safety of the program. The promotion of a sense of safety was a unique finding regarding the use of such rooms, not identified by the limited research on the topic (Cotton, 1989, 1995; Day, 2002; Miller, 1986; Raychaba, 1992; Snow & Finlay, 1998). Yet, the students reported that their perception of choice regarding when to use the rooms and when to leave the rooms was dependent on the authority figures in the classrooms. Although some of the students reported that they had choice, this choice appeared to be more in the form of input into the decision made by the CYW or the teachers as to when the student was ready to leave the room, rather than a completely independent decision made by the students. In addition, one student discussed that he was not allowed to use the reflection rooms to take space because he had not asked permission first. Such a perception is inconsistent with the use of such rooms as a mechanism of enhancing self-control (Raychaba, 1992; Snow & Finlay, 1998). Even if the argument was made that self-control may be promoted through the experience of control, it would also be contrary to the notion of a trauma-informed approach that acknowledges the power differential between the students and those in authority, and the control that those in this position of authority are enforcing through this practice. Herman (1992/1997) reviewed the link between safety and control which provides a critical perspective for the results. Although the rooms promote safety, the use of force and confinement limits the students’ control and such a trauma-informed approach should consider re-evaluating this process in light of the propensity for re-traumatization. Perhaps incorporating a procedure in which students can indicate to their teacher or CYW their need to use the reflection room (e.g., verbally or through a break card), which negates the need to ask permission, but still allows the student to exercise control would be helpful. The procedure could also incorporate a debriefing aspect following the use of the reflection room to develop problem-solving skills further. It should be noted that it does not appear that the children have developed a generalized mistrust of adults as was suggested by Lieberman and colleagues (2005), providing an optimistic base from which the use of the reflection rooms should be examined.
An aspect of the use of the reflection rooms that was left unclear following the analysis was why the students reported mixed feelings about the rooms. From the trauma-informed perspective, the differences may have been related to previous adverse childhood experiences, as research has demonstrated that children who are frequently secluded are more likely to have a history of physical and/or sexual abuse than children who are secluded infrequently (Millstein & Cotton, 1990). Furthermore, from a behavioural perspective, the function of the children’s aggressive behaviour may have been related to the experiences (Carr, 1993, 1994). For example if the children were behaving aggressively to escape the classroom, they may have enjoyed the break of using the reflection rooms (Joyce, 2006). Further research into these discrepancies may be valuable.

Although not intended to be prescriptive, it is suggested that pursuing approaches such as those from the field of Positive Behaviour Support (PBS; Horner, 1990) may be useful in articulating a proactive method for responding to behaviour within the classrooms (Amos, 2004; Blair, Fox, & Lentini, 2010; Carter, Norman, & Tredwell, 2011; Carter & Van Norman, 2007; Kincaid, Childs, Blase, & Wallace, 2007; Kretlow & Bartholomew, 2010; Lane et al., 2009; T. J. Lewis, Jones, Horner, & Sugai, 2010; Marchant et al., 2009; T. M. Scott, Alter, Rosenberg, & Borgmeier, 2010; Simonsen, Britton, & Young, 2010; Warren et al., 2006). Indeed Amos (2004) reviewed the potential utility of PBS for reducing the need for restraints and seclusion. This approach seeks to determine the function driving behaviour and to teach functional communication and adaptive skills (T. M. Scott & Caron, 2005) rather than utilizing a coercive method of controlling and abolishing behaviour (Russell, 1974). Such a perspective is designed to be proactive and has been found to reduce the need for aversive consequences for challenging behaviours (Thomas & Gary, 2003). Mechanisms could be developed within such an approach to allow the students to use the rooms by notifying the teachers and/or CYW without the need to ask permission (as suggested above). In addition, a function-based approach could provide an individualistic approach to using the rooms. The students reported a variety of reasons for using the rooms, including emotional management. However, the literature clearly indicates that it is important to use the least restrictive method for managing behaviours (Spradlin, 2002; Vollmer, 2002). It may be beneficial to develop strategic training and practice in emotional management skills, such as those used in Trauma-Focused Cognitive Behaviour Therapy (J. A. Cohen & Mannarino, 2008b). These approaches can be incorporated into the students’ Safety Plan to
foster their utilization in practice. For example, reading a book may be something that a student has identified as a calming activity, but how do they get calm enough when they are extremely upset to sit down and calmly read a book (an assumption which underestimates the biological issues with hyper arousal)? An intermediary step in the process may be lacking; that step could help the students to calm the biological systems in order to allow them to be able to read the book.

This research was conducted to answer questions about the organizational culture and the diffusion of knowledge in a children’s mental health agency. Children’s perceptions of their experiences were an integral part of the research. The intention was not to determine if the use of the rooms was right or wrong, but rather that the use of such rooms be reviewed thoroughly and critically in light of the perceptions of these students. When the results are viewed from a trauma-informed perspective, they precipitated the need to determine if the safety component can be promoted and established by alternative methods that do not require the restriction and isolation of children. Thus, these results can be considered as a ‘disorienting dilemma’ (Mezirow, 1991) which requires all stakeholders to critically reflect on the meanings, roles and relationships in determining appropriate action (McWilliam, 2007). Should we take as a given that these rooms are required to foster emotional management, which they do appear to be supporting in some of the children? Rather it is suggested that what is needed is an engaged process of critical evaluation.

**Research Objective Three: Family Context**

The family context was identified as another system which can influence the implementation of organizational change (Hoagwood et al., 2001; Ringeisen et al., 2003). Parents are stakeholders who should be consulted when changes are made to services that influence their children. Furthermore, as the SGTIP involved changes in organizational culture, systemic perspectives indicate that family context can have an influence on other systems.

The reports of the parent participants indicated that the family context appeared to be functioning similar to that of the normative sample (Moos & Moos, 2009). Notable divergences were the slightly low levels of cohesion, expressiveness and independence. Based on comparisons with other literature, the sample did not appear to be functioning in similar ways to other distressed families or families of children receiving mental health treatment (Glaser et al., 1993; Moos & Moos, 1976, 2009; Vostanis & Nicholls, 1995). When parents further elaborated
on aspects of family functioning, the family context appeared to promote relationships and expressiveness among family members. The parents indicated that they focused on achievements in an individualized way. The degree to which the children in the families were independent in their functioning at home was low. Further parents reported that they did need to be organized, but that they also needed to be flexible with rules and exerting control. This representation of these family contexts appeared to be similar to the structured-independence family profile identified by Moos and Moos (1976). This profile was characterized by families with a significant emphasis on independence while maintaining a high level of organization and slightly low level of control and conflict (Moos & Moos, 1976). Although Moos and Moos’ families were drawn from a diverse and representative community-based sample, they were not drawn from a sample experiencing particular distress. Further research should be conducted to determine which profile is consistent with the agency population of families. It may be that the parents were responding in a form of moderacy response bias, depicts a tendency to use moderate responses and avoid extreme responses (Paulhus, 1991). The two-point response scale could have minimized this tendency for individual items (Paulhus, 1991) or it could have reduced the ability to provide variability in their responses. Given that each subscale consisted of 10 items, parents may not have wanted to appear extreme on any one dimension overall. In the interviews, this bias may have been reduced, as they were able to provide context and further elaborate on their perceptions. It will be important to determine if the factors that influenced the presence or absence of the various dimensions were consistent among the larger population and/or if other factors are operating within these families, given the relatively small sample size of the sample.

Both parents in the interviews discussed aspects in which their family dynamics may have been influenced by adjustments concerning their child’s unique challenges. For example, both parents reported a need to be flexible in scheduling and rules because their child had particular challenges in those areas. Although the reasons provided appeared to be directly related to challenges that are particularly difficult for children with various mental health disorders (e.g., difficulty with routines, impulsivity, sudden changes in moods/behaviour, and acting out), it is not clear to what extent these factors are unique adjustments for these families or are common adjustments also required for typically functioning children. Regardless, these changes did not appear to be causing significant amounts of stress. The only area of strain found
to be somewhat of a problem was internalized subjective strain. Difficulties in this area were found in the surveys and supported in the interviews; one difficulty was worry about their child’s future. Parents also reported some degree of stress with managing their schedule due to attending appointments for their child’s mental health treatments and needing to make changes to their schedule due to issues arising within the community due to their child’s mental health challenges. The parents reported that they had access to mental health services that were beneficial and provided useful information.

It was important to interpret the parent sample results according to literature relating to the influences of family systems on children’s use of mental health services (Brannan et al., 2003) from a social justice framework (Lynch & Cicchetti, 1998). Olin and colleagues (2010) suggested that structural factors, attitudes and perceptions about mental health services and the family context limit the use of mental health services. In this sample, none of these factors appeared to be limiting their use of mental health services because the parents reported that they accessed a variety of different services. Of particular importance was that parents had positive experiences and valued the mental health services they received (McKay et al., 2001; P. Owens et al., 2002; Pescosolido et al., 2008). In addition, the families that were accessing services did not report any additional family stressors or issues with family resources and they had some social supports. These factors may have facilitated the use of mental health services (Brannan & Heflinger, 2006; Brannan et al., 2003; Dadds & McHugh, 1992; Kazdin & Wassell, 2000; Pescosolido et al., 2008).

Furthermore, contrary to the literature in which increased involvement in mental health systems was associated with high levels of objective measures of caregiver strain (Brannan et al., 2003; Farmer et al., 1997; Lambert et al., 1998), the parents in this sample reported that they were experiencing low levels of such strain. Hillis and colleagues (2010) identified protective effects of family strengths (e.g., closeness, support, loyalty, protection and love) in supporting long-term pro-social development. The parents interviewed reported high levels of closeness, support and affection within their family. These levels may provide insight into why their children were functioning so well following treatment. However, this level of stress may have been a factor influencing participation in the research. Specifically, the parents who did not participate may have been experiencing more stress, limiting their ability to allocate time to participate, than the parents who participated.
**Parallel processes between family and school.** The link between family context and educational environment has been demonstrated in the literature (Felner, Aber, Primavera, & Cauce, 1985). Felner and colleagues found that high levels of cohesion within the family and being provided with support from teachers at school were associated with favourable outcomes. According to the survey results, neither of these areas was functioning at high degrees for the students in the program. Cohesion was slightly low at home and among the CYW, whereas expressiveness was slightly low at home, but slightly high among the CYW, according to the social climate scales. The students and teachers reported that a low level of support was being provided to the CYW. Furthermore, an average level of conflict was reported in the home, whereas a higher level of conflict was reported among the CYW group. Although these levels may not be related to each other, they could have had some influence on the students. Yet, when discussed in the focus groups and interviews with each participant group, these areas appeared to be operating at higher levels than is apparent from the surveys.

When the family context was compared to the STP, areas of convergence among all groups were the levels of friendship, involvement and expressiveness. The students and parents appeared to perceive more focus on task and achievement than the teachers and CYW. The parents and CYW focused more on order and organization than the students did. The parents perceived less of a focus on enforcing rules than the students and CYW. Finally, both the CYW and the parents appeared to be operating under a large amount of stress. However, given that the results regarding the family were drawn from a very small sample size, interpretations are quite limited.

As well, the parents reported positive improvements in their children following treatment within the STP. The focus groups with the students and CYW contextualized these findings; however, due to the limited size of the parent sample, additional research is needed to explore these discrepancies further. Thus, the use of mixed methods allowed for triangulation of these results; however, as both were self-report measures and a limited sample, it is still unclear as to their current level of functioning in these areas. Furthermore, although it was possible to gain insight into parallel processes, indication of the directionality of the processes was not possible due to the research methods employed, nor was an objective measure of outcomes included. Further research is required to address these issues.
Lynch and Cicchetti (1998) proposed that increased community violence results in chronic stress and heightened awareness of danger, which may influence family functioning and children’s development. Thus, it is important to consider the influence that being exposed to aggression and violence within the program has on the children’s functioning within the home and their development. One parent reported that her child saw things in the program that scared her and, in addition, students reported that they felt scared and that it was weird to see other students use the reflection rooms, particularly when the children were being aggressive. Further research and critical reflection is required to address this area of concern to moderate this risk.

**Strengths and Limitations of the Research**

**Community-engaged scholarship process.** Utilizing a community-engaged scholarship process was important for this work as it provided an opportunity to conduct research relevant to the clinical and social context. The aim of the research was identified through collaboration with the agency’s representatives to address a need within the agency, while at the same time it supported scholarly endeavours. In many ways, the partnership may have aided the research process for the agency, as they were able to have a more advanced and critical examination of the processes within the STP than might have been possible without the partnership. The etic perspective (Pike, 1954) of the external researcher may have also provided some advantages, such as reduced bias in the participants’ responses as the potential for conflicts of interests was reduced (Sonnichsen, 2000). Nevertheless, being external to the agency limited the research process as knowledge about the organization, including its organizational structures and procedures and the process of implementation of the SGTIP were not known by the researcher. This information needed to be solicited from agency personnel, thus was subject to biases and possible omissions.

This knowledge exchange required an ongoing communication process that was not always possible given the additional changes and responsibilities of the agency personnel. Specifically, the agency had undergone major structural changes over the course of the research process (following conception and data collection, analyses and interpretation). These changes were in addition to the adoption of the SGTIP. Unfortunately, these changes posed contextual constraints on the flow of information and engagement in the scholarship process. This lack of a comprehensive knowledge about the agency and the communication process required modifications of specific research questions, procedures utilized in the research (including the
ethical review processes, data collection and access to information), and interpretation of the research (e.g., limited access to knowledge about the training and the process of implementation). In addition, the extended timeline of the research may have negatively influenced the agency, since they were required to make changes to the structure and processes within the STP, in accordance with the larger organizational changes, prior to completion of the research. These changes, in turn, also limited the credibility of the results and interpretations because personnel in the program had changed before additional methods of member checking (Creswell, 1998) could be conducted.

**Methodological rigour.** Mertens (2009) adapted the criteria developed by Lincoln and Guba (1985) for evaluating research conducted within the Transformative paradigm. By its nature, the Transformative paradigm, as with other critical theory paradigms, is highly subjective (Crotty, 1998). Depending on the ontology of the phenomenon under consideration and the position taken, it can be argued that there is no reality and that everything is a social construct (e.g. Foucault, 1963; Szasz, 1961). Such a position can invalidate the experiences of individuals with mental illness and may promote misconceptions regarding similar phenomena. The appreciation for different levels of reality (McEvoy & Richards, 2006) provides a helpful foundation from which to examine some phenomena, particularly those addressed in this research (e.g., mental illness, trauma and organizational culture). However, the ability to assess the reality of the different levels is limited by the perceptions and honesty of the participants and the subjective interpretation of the researcher. Thus, these individual constructions may have little correspondence with the empirical layer of reality (Neuman, 2006). Accordingly, Mertens suggested that the criteria identified by Lincoln and Guba are important for deriving a trustworthy representation of the socially constructed reality whether qualitative or quantitative data were collected. Accordingly, several methods were employed to increase trustworthiness (Creswell, 1998), which represents the credibility, dependability and transferability of the research (Graneheim & Lundman, 2004).

One approach employed to increase the credibility of the analysis was the use of mixed methods. There was a variety of benefits to using mixed-methods research for this study. Previous research findings have demonstrated that employing a mixed-methods approach increases the credibility of the results by providing triangulation and complementarity (Yauch & Steudel, 2003), especially with regard to understanding organizational culture (Agbényiga, 2011;
Golafshani, 2003). Specifically, the survey results were triangulated with the focus groups and interviews to provide a more robust interpretation of the organizational cultures (Golafshani, 2003; McEvoy & Richards, 2006; Risjord, Moloney, & Dunbar, 2001; Yauch & Steudel, 2003). Integrating the qualitative and quantitative results provided a more comprehensive understanding of the processes within the STP than would have been possible with only one form of data. For example, the interpretation that, although there was not a global sense of friendship amongst all the students in the program, the students were still developing close friendships within the program could only have been determined through an analysis of both the survey and focus group results. In addition, it has been suggested that relying on one method when conducting research with children may lead to misrepresentations of the children’s experiences (Morrow & Richards, 1996). Alternatively, research has indicated that multiple methods should be employed given children’s varied preferences and abilities to communicate their intentions (Hill, 2006; Punch, 2002).

At the same time, the interpretations drawn from the results related to the process of implementation of the SGTIP were also limited due to factors related to the research methods. Specifically, the changes reported by the participants cannot be solely attributed to the adoption of the SGTIP due to the design and methods utilized in this research. For example, although changes were identified from the Group Environment Scale between the first and second administration, these changes could have been related to the passage of time. The changes in the students reported by the parents were also retrospective and could have been subject to any number of biases (T. D. Cook & Campbell, 1979) including, but not limited to interpretation, confirmation bias, selection, history, maturation or receiving treatment in general, rather than the new trauma-informed approach to treatment. Furthermore, this research provided insight into the degree to which the SGTIP influenced the organizational culture; however, these interpretations would have been enhanced through a measure of the extent to which aspects of the Sanctuary Model were being employed and adhered to on a daily basis (e.g., the Sanctuary Project Implementation Milestones criteria employed by Rivard and colleagues (2004; 2005)). Lack of adherence could have had clinically significant implications for the implementation processes beyond the factors identified above.

Both the quantitative and qualitative data were considered to reflect the perceptions of the participants when the data were collected. That is, their accounts were contextually bound
The use of standardized scales provided a means of comparing the perceptions, but they were not assumed to provide a true or complete reflection of these concepts (McEvoy & Richards, 2006). Rather, consistent with the Critical Realist perspective (Bhaskar, 1978) of the theoretical position of the research, it was assumed that the participants’ reports, interpreted from both the qualitative and quantitative data, reflected their perceptions of the empirical social reality, influenced by the underlying causal mechanisms operating at a deeper level of reality (McEvoy & Richards, 2006). The participants’ realities could have been interpreted in various ways (Lincoln & Guba, 1985). Thus, what is of issue is the trustworthiness of the results (Graneheim & Lundman, 2004) and the potential of the interpretations for change (Mertens, 2007).

Several approaches were employed to increase the trustworthiness of the analysis. The researcher included several procedural and analytical methods to ensure that the participants’ perceptions were represented as accurately as possible. Specifically, questions in the focus groups were developed to clarify the results from the survey data. During the student focus groups, the researcher also continually checked the participants’ meanings by directly asking for clarification and by providing summaries. During the coding and interpretation process, the researcher continually reviewed the segments of the discussion around the selected text in an attempt to contextualize and ensure the representativeness of what the students were saying. This strategy was particularly important as the students often used short statements when discussing various issues. This process was difficult and often required a review of the actual audio recordings, as frequently the students were distracted and rapidly changed topics during the focus groups. Thus, for many of the statements relevant to the research, there was little context in what the students were discussing. Repeated probes were also often required during the focus groups to elaborate on and explain the students’ perspectives regarding the various issues.

As an additional method of member checking (Creswell, 1998), the researcher planned to attend meetings in the School Treatment Program following the analysis to discuss the results and solicit their interpretations of the findings. Unfortunately, this was no longer feasible due to the aforementioned structural changes in the agency following the completion of the data collection (i.e., none of the participants in the study continued to be within the STP). Alternatively, the researcher engaged in peer debriefing with an internal researcher from the
agency and her faculty supervisor following the analysis. It is also important to note that the credibility of the results related to the CYW focus groups was limited as changes in the research process and timing meant that the researcher was not able to be present during the focus group as was expected. In addition, a full transcript of the focus group was not provided, rather only hand-written notes were provided for analysis. Therefore, it was not clear if the full exploration into the potential processes operating within the CYW group was conducted. Thus, the focus group was subject to bias by the person asking questions and taking notes in what was chosen to be address and record. However, although the credibility of the results drawn from the CYW focus group were limited, triangulating notes of the CYW focus groups with the survey results collected at two points in time along the implementation process enhanced the credibility of the overall interpretations drawn from this participant group.

In addition, the inclusion of multiple stakeholders provided a robust description of the collective perspectives of the SGTIP within the School Treatment Program. Specifically, including the teachers in the research provided a unique contribution, which supported the students’ interpretation of the organizational culture of the classrooms. The students and teachers reported fairly consistent perceptions of the organizational culture on the Classroom Environment Scale. Their perspectives only differed in relation to task orientation and this was probably related to their differing roles within the classroom. The teachers’ reports also endorsed the process of implementation described by the students and the CYW.

Dependability was increased for the interpretation of the STP as the participants were representative of the sampling pool, with the exception of the parent sample. Specifically, 100% of the teachers and CYW, and 71% of the students participated in the research. The dependability of the parent sample was limited by the sample size as only 22.5% of the parents participated in the survey and only two parents participated in the interviews (6%). Despite the additional measures taken to increase the response rate, participation was likely reduced as the parent survey was conducted over the summer months. Thick descriptions of the context were incorporated into the final summary to promote the transferability of the results (Creswell, 1998). Although participants rarely provided thick verbal descriptions, divergent perspectives and individual examples were included in the summary of the results. The researcher also made notes regarding observed changes in procedures and perspectives reported across the duration of the research process (Lincoln & Guba, 1985) that were utilized in the interpretation process.
An additional category of methodological rigour is authenticity (Lincoln & Guba, 1985; Mertens, 2009). Authenticity refers to the importance of presenting a fair and balanced view of the results (Lincoln & Guba, 2000). For this research, an attempt to uphold the authenticity of the interpretation of the results reflected the understanding that individual deficits are often the result of larger structural and systemic problems. The results were framed within a context which recognized structural and systemic limitations and power differentials, but does not accept them as an excuse to permit oppression (Mertens, 2003). Consistent with this approach, effort was made to report the findings in a way that provided a fair account of the participants perspectives, and by presenting the results as a catalyst for change (Mertens, 2009). Greater insight into these systemic factors would have been enhanced by incorporating the perceptions from the management of the agency.

Finally, it may be argued that this research did not ascertain the actual processes that were transpiring in the program since direct observations of the organizational culture within the STP and the use of the reflection rooms were not conducted. This argument, however, does not limit the credibility of the research; instead, the perceptions of the participants can be viewed as valid findings. These perceptions may be considered real for the participants if they were honest in their reporting. It is important to note that the possibility of a misperception may also have been a factor. Furthermore, although this research included measures to gain insight into the aspects of change, any changes reported were understood to be perceptions of change rather than objective measures of ‘actual’ change. This difference is important and has implications for the interpretation of the results. Specifically, even if changes were not found to be statistically significant, they still could have represented clinically significant and meaningful change. Meaningful insights were considered the aspects that were raised by the participants on multiple occasions or by multiple participant groups. Furthermore, even though the difference between participant groups could not be measured statistically, these differences reflect differences in perceptions that should be attended to with critical reflection as to their implications of trauma-informed service.

**Future Implications and Conclusions**

The implication drawn from this research may be valuable to policy makers, practitioners and researchers. At a policy level, the need to conduct assessment prior to and following engaging in change initiatives was suggested, particularly changes that involve shifting towards a
trauma-informed approach. Specifically, it may be valuable to engage in assessments to determine the degree to which current policies and practices may actually be perceived to be re-traumatizing and/or oppressive by those the agency serves. As was found in this research, even though the name and intended use of the reflection rooms was changed in accordance with the SGTIP, aspects of the use of these rooms indicated that they might have still been operating in trauma-organized ways. Thus, evaluation may be a useful first step. If such areas are identified, then collaboration with multi-stakeholders may be helpful in determining appropriate and feasible ways to rectify these areas. Further, this research supports the notion that, although knowledge is an important factor in facilitating changes, knowledge may not be sufficient in initiating this change. Support from the whole agency may be required to support the diffusion of knowledge in practice.

For practitioners, the results of this research lends insight into the value of engaging in critical reflection, dialogue and action to determine if and how new approaches to services may be valuable and utilized within a given field. The trauma-informed approach, draws from trauma theory and in the Sanctuary Model, was represented by 7 Organizational Commitments. The results from the research indicated that practitioners and patient found these commitments valuable, but had a difficult time enacting them in practice. Thus, in order to implement them these constructs may require praxis to determine how they can be represented within a given area. This process may be facilitated through the development of Communities of Practice, yet more research is required to determine how effective these communities are as mechanisms for facilitating Knowledge Translation. Furthermore, given the student population, conceptualizing these seven commitments as commitments may limit our perspectives on the process. As commitments, their representation within the program appeared to have been conceptualized as a choice (e.g., making the choice to be socially responsible and not to act in violent ways). However, if these commitments were conceptualized as skills, then their representation could be facilitated with skill development. In this way, the SELF-model curriculum and other Positive Behavioural Support strategies may be understood to provide the link between the Sanctuary Commitments (as general overarching constructs) and their application with this population. Such a perspective may reduce the blame appeared to have been attributed to the children. This perspective does not preclude the notion of choice; rather one must first be able to act a certain way before they can choose how they want to behave.
This research also has implications for other researchers engaging in Knowledge Translation endeavours. Through this research, the importance of establishing congruence between theory and research methods was identified. When the purpose is to adopt an intervention that is transformative in nature, the research employed to evaluate the adoption should also be transformative in nature. Though the main research question was not consistent with this theory, an attempt was made to be sensitive to the meaning of trauma-informed interactions and to be sensitive to the extent to which power inequalities and potentially re-traumatizing situations may be occurring within the program. Although not all approaches utilized in the research may have been fully conceptualised as transformative, the importance of attempting to adhere to the paradigm from which the theory was developed was acknowledge.

Relatedly, it is also important for researchers to employ research methods that account for, and which can be used to address, the complexities of the chosen context and phenomena. Attempting to conduct study from an ecological perspective can be challenging given the complexity of the context (e.g., structural and systemic influences) and the need to incorporate multiple stakeholders’ perspectives into one unified understanding of the context. Accordingly, influences between components of the system need to be taken into consideration when interpreting the results. It may be beneficial to determine a point of entry in the system and solicit perceptions for participant groups regarding the other influences. Further, careful and critical reflection is required as perceptions for one participant group may be different from those of another group. These misperceptions may be due to a variety of individual and systemic factors, which could be related to their positions within the systemic and underlying causal mechanisms. These underlying influences may not be directly measurable, and thus may need to be inferred. Despite these challenges, employing such an ecological perspective can be valuable as it can provide a comprehensive and contextualized account of a given phenomenon.

**Future Research.** Given that the Sanctuary Model was developed in an adult inpatient unit, the applicability and transferability (Wang et al., 2006) of the Model required consideration of the unique qualities to the context for the implementation in a children’s school treatment program. For example, as described above, everyone in the unit was expected to make the commitment to nonviolence and those that could not make this commitment were transferred to other units. However, in the School Treatment Program, children often come to the program due to issues with aggression. Expecting the children to make this commitment or else they would
be removed from the program is not a reality of this particular context. Therefore, there were additional challenges with the commitment to nonviolence in enacting the Sanctuary Model within STP than were inherent where the Sanctuary Model was developed. Although the Sanctuary Model has been applied in different settings, none of the literature located addressed this issue comprehensively. Thus, in order to implement the STP in this context, the commitment to nonviolence had to be adapted. In an attempt to address this issue, the quiet rooms in the programs were renamed reflection rooms and were expected to provide students with a location to take space from their classroom when needed. As described previously, this shift required changes in the mental models guiding the use of these rooms. Although the rooms were perceived to promote the safety of the program, it is not yet clear if this shift was accomplished. That fact that the use of the rooms was often achieved through force even though they are perceived to promote safety is a dialectical tension. From a transformative framework, this tension should be addressed as a ‘disorienting dilemma’ requiring careful and critical reflection, dialogue and action to resolve the dialectical tension.

Furthermore, the Sanctuary Model encompasses Seven Organizational Commitments to guide organizational culture. These Commitments are complicated constructs, and it is assumed that it was due to their complexity that they were not directly discussed with the students in the program. Their representativeness within the program was largely due to the parallel process of the CYW organizational culture and the utilization of aspects of the Sanctuary toolkit. It is speculated that the implementation of these Commitments within the classrooms could have been greatly enriched through the utilization of the SELF-model, either directly through the curriculum or indirectly as a heuristic device. The SELF-model refers to four inter-dependent processes of recovery (i.e., Safety, Emotional Management, Loss and Future). The curriculum utilizes manageable and understandable concepts to educate clients about the effects of trauma, ways to address these effects, and ways to promote positive environments within which treatment can be fostered (Bloom et al., 2006). The Seven Commitments may be categorized within these four processes. For example, Safety includes dimensions of nonviolence, social responsibility and democracy; Emotional management includes dimensions of emotional intelligence, social learning, open communication; and Loss and Future both include the dimension of growth and change (this categorization was used for illustrative purposes as the commitments and the processes are understood to be interrelated). In addition, the students’
engagement in the process of how these complicated Commitments could have been implemented within the program could have been facilitated through the shared language of the SELF-model. Essentially this shared language could provide the means by which to engage the students in the dialogue required to address the dialectical tensions. It is not expected that the children will have the capabilities to fully appreciate and critically address all aspects of these dilemmas due to their developmental and intellectual functioning. However, their perceptions regarding these issues can be solicited and incorporated into the larger resolution process by providing a common language.

**Contribution to the literature.** This study adds to the literature as it reflects one of the first explorations and reporting of organizational culture in a children’s mental health agency and explores convergence and divergence from varied groups and sources. The organizational culture within the School Treatment Program was characterized as promoting friendships and high levels of involvement and expressiveness, low levels of task orientation and support from leaders, with a high degree of structure and control (including rule clarity, formal structure, and control from management), while still maintaining a high degree of innovation. The student organizational culture followed a parallel pattern of functioning, except they perceived more of an emphasis on tasks than the CYW, but they did not perceive a strong emphasis to behave in an orderly and polite manner. The results revealed that using the rooms to remove children when they were acting violently promoted the safety of the program. This was a unique finding regarding the use of such rooms. When the results are viewed from a trauma-*informed* perspective, they precipitated the need to determine if the safety component can be established by alternative methods that do not require the restriction and isolation of children.

This research also provides support for the diffusion of innovation theory and systemic theory of organizational change as these theories promote an understanding of the adoption process and the barriers and facilitators influencing the implementation of the SGTIP within the STP. Specifically, systemic constraints may have limited the agency’s ability to provide the infrastructure, supervision, adequate staffing and utilization of the program’s champion. With regard to the adoption by the CYW themselves, the lack of ‘how to’ knowledge also appeared to limit implementation which again may also have been attributed to system level constraints. Finally, disorienting dilemmas were identified which can be used to extend critical trauma theory in general and the Sanctuary Model as applied to this population in specific. This dilemma stems
from the notion that the reflection rooms promoted a sense of safety even though force was sometimes used to facilitate their use.

In addition, incorporating the children’s perspectives contributes to the literature as a form of knowledge in the area of trauma-informed practice within children’s mental health. The students contributed to the knowledge by indicating what they perceived to be the benefits and drawbacks of the SGTIP, which can provide insight into which aspects may be likely to be utilized by the students. Furthermore, soliciting the students’ perspectives expands knowledge regarding the use of seclusion rooms. The notion that the reflection rooms promoted safety was a unique finding. However, the mixed and negative perceptions regarding their use by the students necessitate further critical reflection and dialogue into their continued use. Thus, this research provides voice to the experiences of people within the system. Their perceptions were informative, and they suggested the existence of ‘disorienting dilemmas’ at both the student and direct-service worker levels from which praxis (i.e., critical reflection and action) can promote change. The purpose of including these perceptions goes beyond providing a measure of social validity and instead provides the space for dialogue furthering legitimacy of the trauma-informed approach to service within children’s mental health programs.

**Conclusions.** The potential for two forms of oppression are inherent in the critical trauma theory. First is the more apparent form of oppression for those exposed to traumatic experiences. The degree to which individuals feel oppressed or feel that they are victims may be influenced by the form of trauma and the person’s coping capacities. For example, if the traumatic experience is caused by a natural disaster, the individual may feel victimised, but may not feel oppressed; however, if the experience was caused by human design in which the perpetrator overpowered the individual, the individual may feel victimized and oppressed. Thus, although some individuals may feel oppressed through a traumatic experience, not all individuals who have been traumatized may feel oppress.

Most people who experience a trauma will not develop PTSD; as indicated above only 25-30% of those exposed to traumatic stressors develop PTSD (Green, 1994; Tomb, 1994). The etiology of mental illness is complicated and can be attributed to genetic, biological, psychological and environmental factors (Jacob & Storch, 2013; Pilgrim, 2002). It is important not to view mental illnesses strictly from a trauma lens, where providers may focus too narrowly on trying to uncover the underlying trauma even if one has not occurred. Such a narrow focus
may limit or propose inappropriate treatment options and could contribute to false allegations. Furthermore, many factors can minimize the risk of developing dysfunction following an exposure to trauma (e.g., characteristics of the individual, form and context of the trauma, and availability of support following the trauma (Wilson, 1989, 1994)). Thus, assuming that everyone will respond the same way or will benefit from similar treatment approaches is unfounded. As was discovered in this research, perceptions regarding the reflection rooms were found to differ. Further research needs to be conducted to determine these attributes and/or possible functions in relation to the perceptions of the use of the reflection rooms in that it might provide insight into what influenced the different perceptions (e.g., positive and negative feelings) associated with the use of the rooms). Such research it might provide insight into how to capitalize on the positive feelings associated with the use of the rooms, while minimizing the negative perceptions. Although the perceptions are likely to be varied, given the intrusiveness of the intervention it behooves further investigation. A phenomenological approach, examining the lived experience of the use of the rooms, may be helpful in answering these questions; however, this approach may be challenging with this population.

Another less obvious form of oppression can stem from society and systems when they fail to acknowledge the experiences of those who have been exposed to traumatic experiences. As was described in the section related to Complex Trauma Theory, there are examples throughout history in which the implications of being exposed to traumatic experiences were either unacknowledged or even rejected (e.g., when Freud recanted his position on the relationship between childhood exposure to abuse and later development of hysteria) (Herman, 1992/1997). Recently awareness has grown within society regarding the link between exposure to traumatic experiences and the pervasive effects this exposure may have on the individual (Bloom, 1994; Harris & Fallot, 2001a, 2001b; Jennings, 1994; Shaw, 2010). Along with an awareness of the influences of trauma for some individuals came the awareness that mental health systems can also become trauma-organized systems when they are exposed to unresolved chronic stress (Bentovim, 1992; Bloom, 1997, 2005b). As such, both direct-care professionals and the individuals who are supported have the potential to be oppressed by the system within which they operate. Therefore, this phenomenon requires action. Primarily this action should focus on assessment. If such a trauma-organized system is found, then action is required to reduce this negative orientation. To reduce and prevent societal and systemic oppression, society
as a whole and the service systems that serve individuals who are at an increased likelihood of having been exposed to trauma in various forms need to become and continually commit to being trauma-informed. As described by Harris and Fallot (2001a), this process involves changes to administrative funds, policies and procedures, universal screening and specific trauma training to promote knowledge about trauma within service agents, and to prevent the re-traumatization of individuals within the service. To be trauma-informed means appreciating the experiences of the individuals, being actively committed to promoting healing, and rejecting practices that have the potential to be re-traumatizing (Bloom, 1997; Bloom & Farragher, 2011; Harris & Fallot, 2001a; Jennings, 1994).

Given the transformative nature of attempting to adopt a trauma-informed approach to practice within children’s mental health, recommendations were drawn from the research that may be helpful in this transformation. Specifically, the results indicate that it is possible to begin to develop a trauma-informed service within a School Treatment Program. However, full implementation may require collective investment from all aspects of the system of support to determine how this new knowledge can be represented within this context. Based on a critical evaluation of the results and the related literature, it is suggested that agencies attempting to adopt a trauma-informed approach to service may benefit from the development of communities of practice (Wenger, 1998) that engage in transformative learning (Mezirow, 2000). The communities should include direct professionals who are supported by management and informed by champions who are knowledgeable in trauma theory since both the literature relating to the Sanctuary Model (Bloom, 1994; Bloom et al., 2003; Bloom & Farragher, 2011) and the broader knowledge translation literature have stressed the crucial role that leaders play in facilitating successful organizational shifts (Bradley et al., 2004; Greenhalgh et al., 2004; Hoag et al., 2002; Howell & Higgins, 1990; Schmid, 2006). Including these aspects in the translation process may be useful propelling the process of becoming a true sanctuary.
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Appendix A

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<tr>
<th>Relationship Dimensions</th>
<th>Personal Growth / Goal Orientation Dimensions</th>
<th>System Maintenance and Change Dimensions</th>
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### Family Environment Scale

<table>
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<tr>
<th>Cohesion</th>
<th>Expressiveness</th>
<th>Conflict</th>
<th>Independence</th>
<th>Achievement</th>
<th>Intellectual-Cultural</th>
<th>Active-Recreational</th>
<th>Moral-Religious</th>
<th>Organization</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>degree of commitment, help, and support family members provide for one another</td>
<td>extent to which family members are encouraged to express their feelings directly</td>
<td>amount of openly expressed anger and conflict among the family</td>
<td>family members are assertive, are self-sufficient, and make their own decisions</td>
<td>how much activities are cast into an achievement-oriented or competitive framework</td>
<td>level of interest in political, intellectual, and cultural activities</td>
<td>amount of participation in social and recreational activities</td>
<td>emphasis on ethical and religious issues and values</td>
<td>degree of importance of clear organization and structure in planning family activities and responsibilities</td>
<td>how much set rules and procedures are used to run family life</td>
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### Classroom Environment Scale

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<thead>
<tr>
<th>Involvement</th>
<th>Affiliation</th>
<th>Teacher Support</th>
<th>Task Orientation</th>
<th>Order and Organization</th>
<th>Rule Clarity</th>
</tr>
</thead>
<tbody>
<tr>
<td>students are attentive and interested in class activities, participate in discussions, and do additional work on their own</td>
<td>friendship students feel for each other, by getting to know each other, helping each other work with homework, &amp; enjoying working together</td>
<td>help and friendship the teacher shows toward students; how much teacher talks openly with students, trusts them, &amp; is interested in their ideas</td>
<td>emphasis on completing planned activities and staying on the subject matter</td>
<td>emphasis on students behaving in an orderly and polite manner; the organization of assignments and activities</td>
<td>emphasis on establishing and following a clear set of rules; students knowing what consequences will be if not followed; teacher is consistent in dealing with students who break rules</td>
</tr>
</tbody>
</table>

### Group Environment Scale

<table>
<thead>
<tr>
<th>Cohesion</th>
<th>Expressiveness</th>
<th>Leader Support</th>
<th>Independence</th>
<th>Task Orientation</th>
<th>Self-Discovery</th>
<th>Anger and Aggression</th>
<th>Order and Organization</th>
<th>Leader Control</th>
<th>Innovation</th>
</tr>
</thead>
<tbody>
<tr>
<td>members’ involvement in &amp; commitment to the group; concern &amp; friendship</td>
<td>how much freedom of action &amp; expression of feelings are encouraged in the group</td>
<td>amount of help, concern, &amp; friendship leaders shows for members</td>
<td>how much the group encourages independent action &amp; expression among members</td>
<td>emphasis on completing concrete, practical tasks &amp; on decision making and training</td>
<td>how much the group encourages members’ discussions of personal problems</td>
<td>extent to which there is open expression of anger &amp; disagreement in the group</td>
<td>formality &amp; structure of the group; explicitness of rules &amp; sanctions</td>
<td>extent leader directs group, makes decisions, &amp; enforces rules</td>
<td>how much the group promotes diversity &amp; change in functions &amp; activities</td>
</tr>
</tbody>
</table>
**Appendix B**

Table B1.

Test of Normality for the Group Environment Scale

<table>
<thead>
<tr>
<th>GES Subscales</th>
<th>Overall</th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Skewness</td>
<td>Kurtosis</td>
<td>Skewness</td>
</tr>
<tr>
<td></td>
<td>SE = (.64)</td>
<td>SE = (1.23)</td>
<td>SE = (.85)</td>
</tr>
<tr>
<td>Cohesion</td>
<td>-0.86</td>
<td>0.07</td>
<td>-1.24</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-0.94</td>
</tr>
<tr>
<td>Leader Support</td>
<td>-0.57</td>
<td>-1.23</td>
<td>0.84</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>Expressiveness</td>
<td>0.21</td>
<td>-0.41</td>
<td>0.77</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>Independence</td>
<td>-0.42</td>
<td>-0.45</td>
<td>-0.67</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-0.67</td>
</tr>
<tr>
<td>Task Orientation</td>
<td>-1.05</td>
<td>1.78</td>
<td>0.67</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-1.35</td>
</tr>
<tr>
<td>Self-Discovery</td>
<td>-0.82</td>
<td>-0.07</td>
<td>-1.59</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-0.25</td>
</tr>
<tr>
<td>Anger &amp; Aggression</td>
<td>-0.37</td>
<td>0.03</td>
<td>0.49</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-0.08</td>
</tr>
<tr>
<td>Order &amp; Organization</td>
<td>-0.29</td>
<td>-0.23</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.67</td>
</tr>
<tr>
<td>Leader Control</td>
<td>0.51</td>
<td>-0.37</td>
<td>-0.44</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>Innovation</td>
<td>-0.42</td>
<td>-0.45</td>
<td>-0.89</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-0.08</td>
</tr>
</tbody>
</table>
### Tables

**Comparison of the Raw Classroom Environment Scale (Short Form) of STP Students and Normative Sample**

<table>
<thead>
<tr>
<th>CES Subscales</th>
<th>STP Students (n = 23)</th>
<th>Normative Sample (N = 315 Rooms)</th>
<th>z-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Involvement</td>
<td>2.26</td>
<td>1.25</td>
<td>1.98</td>
</tr>
<tr>
<td>Affiliation</td>
<td>2.39</td>
<td>0.84</td>
<td>2.53</td>
</tr>
<tr>
<td>Staff Support</td>
<td>2.30</td>
<td>1.06</td>
<td>2.61</td>
</tr>
<tr>
<td>Task Orientation</td>
<td>2.83</td>
<td>1.19</td>
<td>2.69</td>
</tr>
<tr>
<td>Order Organization</td>
<td>1.09</td>
<td>0.79</td>
<td>2.12</td>
</tr>
<tr>
<td>Rule Clarity</td>
<td>3.26</td>
<td>1.05</td>
<td>2.59</td>
</tr>
</tbody>
</table>

Note. No significant differences were found.
Table 5.

*Comparison of the Raw Classroom Environment Scale of STP Teachers and Normative Sample*

<table>
<thead>
<tr>
<th>CES Subscales</th>
<th>STP Teachers (n = 5)</th>
<th>Normative Sample (N = 295)</th>
<th>z-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Involvement</td>
<td>8.20</td>
<td>1.10</td>
<td>6.72</td>
</tr>
<tr>
<td>Affiliation</td>
<td>6.00</td>
<td>1.22</td>
<td>7.30</td>
</tr>
<tr>
<td>Staff Support</td>
<td>6.60</td>
<td>1.14</td>
<td>8.07</td>
</tr>
<tr>
<td>Task Orientation</td>
<td>5.20</td>
<td>1.92</td>
<td>6.76</td>
</tr>
<tr>
<td>Order Organization</td>
<td>5.60</td>
<td>2.07</td>
<td>6.74</td>
</tr>
<tr>
<td>Rule Clarity</td>
<td>9.00</td>
<td>1.00</td>
<td>7.86</td>
</tr>
</tbody>
</table>

Note. No significant differences were found
Table 6.

*Student Reported Strategies to Promote Safety.*

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Survey</th>
<th>Focus Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being nice</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Focus on self</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Clean environment</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Refrain from physical aggression</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Being respectful with language</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Follow rules &amp; routines</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Emotional management</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Supporting others</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Note: frequencies depict the number of students who referred to these items.
Table 7.

*Student Reported Emotional Self-Management Strategies.*

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Survey</th>
<th>Focus Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory Strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wiggle fingers</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Count</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Tap foot</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Deep breaths</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Behavioural Strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behave</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Think before acting</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Ignore</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Focus on something else</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Leave the situation</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Run away</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Stay happy</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Take space</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Head on desk</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

Note: frequencies depict the number of students who referred to these items.
Table 8.

Reported Student Goals.

<table>
<thead>
<tr>
<th>Behavioural management</th>
<th>Student FG</th>
<th>Student surveys</th>
<th>Parent Surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academics Goals</td>
<td>2</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>School Refusal</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Impulsivity</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Listen to authority</td>
<td>4</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>follow rules &amp; routines</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Do their best</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Emotional management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anger &amp; Frustration</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Seek attention positively</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Focus on self</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Express feelings appropriately</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Using appropriate language</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Positive attitude</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Handle disappointment</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Friendship &amp; Social skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Skills</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Peer relationships</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Be a positive role model</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Play well with others</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Helping others</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other goals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>make it through the day</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Go back to 'normal' school</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Phobias</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>unknown/forgot/blank</td>
<td>1</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 9.
Comparison of the Group Environment Scale of CYW following the Implementation of the SGTIP and Normative Sample

<table>
<thead>
<tr>
<th>GES Subscales</th>
<th>CYW (n = 6)</th>
<th>Normative Sample (N = 2436)</th>
<th>z-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Cohesion</td>
<td>6.00</td>
<td>1.79</td>
<td>6.61</td>
</tr>
<tr>
<td>Leader Support</td>
<td>6.00</td>
<td>0.63</td>
<td>6.69</td>
</tr>
<tr>
<td>Expressiveness</td>
<td>6.00</td>
<td>0.90</td>
<td>5.51</td>
</tr>
<tr>
<td>Independence</td>
<td>4.83</td>
<td>1.17</td>
<td>6.48</td>
</tr>
<tr>
<td>Task Orientation</td>
<td>4.83</td>
<td>1.60</td>
<td>6.51</td>
</tr>
<tr>
<td>Self-Discovery</td>
<td>4.67</td>
<td>1.75</td>
<td>5.05</td>
</tr>
<tr>
<td>Anger &amp; Aggression</td>
<td>4.67</td>
<td>1.21</td>
<td>3.54</td>
</tr>
<tr>
<td>Order &amp; Organization</td>
<td>6.33</td>
<td>1.03</td>
<td>5.74</td>
</tr>
<tr>
<td>Leader Control</td>
<td>5.50</td>
<td>2.07</td>
<td>4.86</td>
</tr>
<tr>
<td>Innovation</td>
<td>6.67</td>
<td>1.21</td>
<td>4.38</td>
</tr>
</tbody>
</table>

Note. No significant differences were found
Table 10.

Factors Reported to have Influenced the Adoption of SGTIP in STP: Frequencies of Excerpts

<table>
<thead>
<tr>
<th>Themes</th>
<th>CYW</th>
<th>Parents</th>
<th>Teachers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge about SGTIP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge</td>
<td>1</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Lack of knowledge</td>
<td>-</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Desire to know more</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Blank</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Perceived Change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased awareness of effects of trauma and avoid re-traumatization</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Positive tone &amp; routine in culture</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Emotional intelligence</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Open communication</td>
<td>2</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Social responsibility - Relationships</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Social responsibility - Accountability</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Positive changes in children</td>
<td>-</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>Benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promotes safe &amp; positive environment</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Concrete problem-solving</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Promotes team &amp; relationships</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Express emotions</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Focus on goals</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Blank</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>No knowledge of SGTIP</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Limitations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of adequate staff</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Did not integrate staff in change process</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lack of support from others in agency</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lack of support from management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accountability</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Support</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Resources</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lack of follow-through</td>
<td>2</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Scary Environment</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Blank</td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 11.

*Family Environment Scale Comparisons of the Parent with the Normative and Distressed Samples*

<table>
<thead>
<tr>
<th>FES Subscales</th>
<th>Parents</th>
<th>Normative Sample</th>
<th>Distressed Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n = 6)</td>
<td>(N = 1432)</td>
<td>(N = 788)</td>
</tr>
<tr>
<td></td>
<td>Mean  SD  Mean  SD  z-test</td>
<td>Mean  SD  Mean  SD  z-test</td>
<td>Mean  SD  Mean  SD  z-test</td>
</tr>
<tr>
<td>Cohesion</td>
<td>6.14  2.61  6.73  1.47  z = -0.399, p = .34</td>
<td>5.25  2.13  40  z = 0.419, p = 0.34</td>
<td></td>
</tr>
<tr>
<td>Expressiveness</td>
<td>4.43  1.81  5.54  1.61  z = -0.853, p = .20</td>
<td>4.71  1.78  42  z = -0.157, p = 0.38</td>
<td></td>
</tr>
<tr>
<td>Conflict</td>
<td>3.00  1.91  3.18  1.91  z = -0.094, p = .46</td>
<td>4.02  2.07  54  z = -0.493, p = 0.31</td>
<td></td>
</tr>
<tr>
<td>Independence</td>
<td>6.00  1.00  6.66  1.26  z = -0.524, p = .30</td>
<td>6.03  1.35  45  z = -0.022, p = 0.49</td>
<td></td>
</tr>
<tr>
<td>Achievement</td>
<td>5.43  1.13  5.47  1.62  z = -0.026, p = .49</td>
<td>5.33  1.58  49  z = 0.062, p = 0.48</td>
<td></td>
</tr>
<tr>
<td>Intellectual-Cultural</td>
<td>6.00  1.15  5.56  1.82  z = 0.242, p = 0.40</td>
<td>4.62  1.98  45  z = 0.697, p = 0.24</td>
<td></td>
</tr>
<tr>
<td>Active-Recreational</td>
<td>6.00  2.94  5.33  1.96  z = 0.342, p = 0.37</td>
<td>4.15  1.96  44  z = 0.944, p = 0.17</td>
<td></td>
</tr>
<tr>
<td>Moral-Religious</td>
<td>4.43  2.64  4.75  2.03  z = -0.158, p = 0.44</td>
<td>4.51  1.96  49  z = -0.042, p = 0.48</td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>6.14  2.54  5.47  1.90  z = 0.354, p = 0.36</td>
<td>5.07  1.97  48  z = 0.545, p = 0.29</td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>4.86  1.35  4.26  1.84  z = 0.325, p = 0.37</td>
<td>4.61  1.89  52  z = 0.131, p = 0.45</td>
<td></td>
</tr>
</tbody>
</table>

Note. No significant differences were found
Table 12.

*Caregiver Strain Questionnaire Subscales*

<table>
<thead>
<tr>
<th>CGSQ</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global CGSQ</td>
<td>2.73</td>
<td>0.76</td>
</tr>
<tr>
<td>Objective Strain</td>
<td>2.80</td>
<td>0.89</td>
</tr>
<tr>
<td>Internalized Subjective Strain</td>
<td>3.14</td>
<td>0.95</td>
</tr>
<tr>
<td>Externalized Subjective Strain</td>
<td>1.96</td>
<td>0.65</td>
</tr>
</tbody>
</table>
Table 13.

*Individual Caregiver Strain Items*

<table>
<thead>
<tr>
<th>CGSQ Items</th>
<th>Parents (n = 7)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
</tr>
<tr>
<td>Interruption of personal time</td>
<td>2.50</td>
</tr>
<tr>
<td>Missing work or neglecting other duties</td>
<td>2.50</td>
</tr>
<tr>
<td>Disruption of family routines</td>
<td>3.00</td>
</tr>
<tr>
<td>Family member having to do without things</td>
<td>3.00</td>
</tr>
<tr>
<td>Family member suffering mental/physical health</td>
<td>3.00</td>
</tr>
<tr>
<td>Child having trouble with neighbours or law</td>
<td>2.00</td>
</tr>
<tr>
<td>Financial strain</td>
<td>2.00</td>
</tr>
<tr>
<td>Less attention paid to any family member</td>
<td>3.00</td>
</tr>
<tr>
<td>Disruption of family relationships</td>
<td>3.25</td>
</tr>
<tr>
<td>Disruption of family's social activities</td>
<td>3.00</td>
</tr>
<tr>
<td>Feeling socially isolated</td>
<td>3.00</td>
</tr>
<tr>
<td>Feeling sad or unhappy</td>
<td>2.00</td>
</tr>
<tr>
<td>Feeling embarrassed</td>
<td>2.50</td>
</tr>
<tr>
<td>Relating well to child</td>
<td>1.25</td>
</tr>
<tr>
<td>Feeling angry toward child</td>
<td>1.75</td>
</tr>
<tr>
<td>Feeling worried about child's future</td>
<td>4.50</td>
</tr>
<tr>
<td>Feeling worried about family's future</td>
<td>3.67</td>
</tr>
<tr>
<td>Feeling guilty about child's illness</td>
<td>2.50</td>
</tr>
<tr>
<td>Feeling resentful toward child</td>
<td>1.00</td>
</tr>
<tr>
<td>Feeling tired or strained</td>
<td>3.00</td>
</tr>
<tr>
<td>Toll taken on family</td>
<td>3.25</td>
</tr>
</tbody>
</table>
Table 14.

*Parent Reports of Child Functioning*

<table>
<thead>
<tr>
<th>FIDD</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>4.67</td>
<td>1.03</td>
</tr>
<tr>
<td>Intensity</td>
<td>3.29</td>
<td>1.80</td>
</tr>
<tr>
<td>Duration</td>
<td>3.57</td>
<td>1.27</td>
</tr>
<tr>
<td>Discrimination</td>
<td>3.57</td>
<td>1.27</td>
</tr>
</tbody>
</table>
Table 15.

*Parents Reports of Changes in Youth since the SGTIP*

<table>
<thead>
<tr>
<th>Aspects of Change</th>
<th>Before</th>
<th>After</th>
<th>t-test</th>
<th>Cohen’s d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s Social Relationships</td>
<td>3.29</td>
<td>4.43</td>
<td>t(6) = -2.8, p = 0.030</td>
<td>1.10</td>
</tr>
<tr>
<td>Child’s Functioning in Home</td>
<td>4.14</td>
<td>5.43</td>
<td>t(6) = -2.0, p = 0.093</td>
<td></td>
</tr>
<tr>
<td>Parent’s Relationship with Child</td>
<td>5.86</td>
<td>6.43</td>
<td>t(6) = -1.9, p = 0.103</td>
<td></td>
</tr>
<tr>
<td>Child’s Academic Achievement</td>
<td>2.14</td>
<td>3.86</td>
<td>t(6) = -2.5, p = 0.045</td>
<td>1.01</td>
</tr>
</tbody>
</table>
Figure 2. A context map for schools (Ringeisen et al., 2003).
Figure 3. Classroom Environment Scale profile for the students and teachers within the STP.
Figure 4. Group Environment Scale profile for the CYW prior to and following the implementation of the SGTIP.
Figure 5. Family profiles for the STP Parent Sample.
Figure 6. Comparison of the Family Environment Scale for Different Clinical Sample.