A STUDY OF THE COMMUNITY SERVICES PROGRAM OF THE TRAUMA CENTER AT ARBOUR HEALTH SYSTEMS

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EXECUTIVE SUMMARY

Threat, stress, terrorism and trauma have become everyday concerns, following September 11. However, before the startling psychological impact of September 11, communities across the country had been struggling with the trauma of school, community and family violence, child abuse, child and adolescent sudden violent death, and man-made and natural disasters. Trauma psychology has developed as a specialized field to study human responses and develop ways of handling these responses. Based on research and practice, interventions with people who have experienced traumatic events have been divided into two general areas: 1) short-term interventions for those who have essentially normal responses to abnormal situations, i.e., those whose functioning is disrupted but who can re-group with short-term support; and 2) longer term interventions/ treatment for those who have more prolonged disruption of functioning and need therapy to overcome the impact. Although the first group is by far larger, considerably more professional attention has been paid to the latter group. But according to the trauma literature, intervention with the first, and largest group may produce benefits most quickly to more people and avoid the need for more intensive, longer-term treatment for many. The skills to respond helpfully and carefully have become clearer, with a focus on avoiding the risk of doing harm during acute interventions. It has become apparent that special approaches, special training and special networks are necessary to provide support to communities facing traumatic events.

The Community Services Program began in the Boston area almost 15 years ago, funded by the Massachusetts Department of Mental Health's Metro Boston Area Office. In 1996, the program was reorganized and refined in order to build a training program and incident response infrastructure that could meet the needs of some 90,000 school age children in Metro Boston. Since 1996, the Community Services Program has developed partnerships with professional providers, the schools and community workers. By establishing this network of 100 trained people, the small staff of three professionals, one manager, and one graduate student, has created the capacity to respond throughout the city of Boston to traumatic events affecting children, families and communities twenty-four hours a day, seven days a week and 365 days a year, (24/7/365). Over a five-year period, this program has become a central part of services to children and youth in the Boston area. The Mayor's Office, the school system, other community agencies, community leaders, and families call them to respond to traumatic events throughout

Boston and the surrounding area. In addition to the direct services program, they have developed a training program to prepare those who care for children—clinicians, teachers, community workers, and families—to work side-by-side with them to support resolution and recovery from exposure to trauma. The training program not only prepares people to handle traumatic events, but also serves to broaden the network of trauma helpers on whom they can call to assist in the schools and neighborhoods.

The Massachusetts Department of Mental Health (DMH) had been impressed by the widespread respect for this program, its public health model of intervention, and its perceived effectiveness. In the spring of 2003, DMH sought a study of the program to describe the program model, to determine its impact and to clarify the requirements for replication. Child and Family Program Strategies in Durham, North Carolina, the Research and Training Center of the Florida Mental Health Institute and Consumer Quality Initiatives, Inc. in Boston undertook the study.

This innovative program did not lend itself to traditional pre-post evaluation, as the essence of the program would be missed. The study design was essentially a case study, with both qualitative and quantitative approaches to capture the essential elements of the program, to assess program effectiveness. In a five-month period, June-October 2003, program effectiveness was studied through a three-pronged approach:

- Structured interviews were conducted with 29 community leaders/stakeholders to gather their views of the program, its impact on individuals and communities, and its quality. Those interviewed included a US Congressman; a State Senator; the Mayor of Boston; state mental health leadership, leaders of several minority communities; religious leaders; public and parochial school principals, counselors and teachers; clinicians; community agency heads and staff; parents and other family members; trauma survivors, probation officers; and police.
- A review was done of 63 randomly selected cases (25%) of the 250 case records of interventions with individuals and community groups experiencing traumatic events to assess the breadth and depth of the interventions, the manpower and time required, and the effectiveness of the interventions.

- In-depth structured interviews were conducted with 55 randomly selected licensed professionals, school personnel and community workers who participated, over the past 4 years, in training to learn how to provide interventions at the time of traumatic events. This figure of 55 is a 5% sample of each of the three categories. The interviews provided data about the effectiveness of the training, in terms of studying whether the trainees learned what was intended, whether or not they retained this knowledge, whether or not they used this information to assist with traumatic events in their communities and/or their personal lives, and whether or not they found the training to be useful.

The results of the three-part study indicate a remarkably positive picture, with the following findings:

- The leaders/stakeholders' interviews were extremely consistent and yielded qualitative data reflecting a high regard for the program. The program was described repeatedly as having a substantial impact on the community. The program was credited with 1) helping the community to heal itself; 2) helping the community to come together and handle the crisis; and 3) in the case of a suicide cluster, "*saving hundreds of our children's' lives*." The interventions are described as "*calming, supportive, always behind the scenes but thoroughly being there for us, not intruding but helping us to come together*." The elected officials and their staff described the program, across the board, as the best program for children in the city—"*one we can always count on, 24 hours a day, seven days a week, to help with the worst situations*." School leaders and others described the program as important in helping teachers and other child caretakers to view children differently and to gain understanding of how a trauma might influence the children's behaviors.
- The review of 63 case records of the interventions showed the comprehensiveness of the program. For the 63 cases the program had provided a total of 163 interventions with up to a dozen interventions for a single incident. There were 11 different kinds of trauma incidents ranging from natural deaths and 9/11 to accidents, homicides and suicides with the latter two categories being the most frequent. The program served 19 different neighborhoods in Boston with 5 of the poorest neighborhoods having over 5 incidents. There were five types of interventions used most often, frequently several being used for

the same incident. Consultations, debriefings, and orientations were used in a quarter of the cases, supportive services in a third and defusing in about 15% of the cases. The Community Services Program also served a wide variety of ethnic groups with the largest number of victims being African American, Latino and Caucasian. A third of the incidents involved more than one ethnic/racial group. Over the four years, the interventions for all the cases (approximately 250) directly involved over 5700 adolescents and 6400 adults or over 12,000 individuals.

- The interviews with those who had participated in Community Services Program training seminars over the past 4 years yielded both quantitative and qualitative data.
    - 90% of the trainees reported that they learned and retained information and skills for handling traumatic events.
    - 80% of the trainees reported that they were confident about leading discussions in all 8 skill areas of trauma response that were taught during the training
    - 88% reported they had responded to traumatic incidents in the workplace since being trained
    - 89% reported they had responded to traumatic incidents in many settings after being trained
    - 90% reported they were somewhat to very confident about handling 8 of the 9 tasks essential to handling psychological trauma, including a) being part of the trauma response team, b) identifying those who needed trauma support, c) being able to lead a trauma incident orientation, d) being able to provide grief support, and e) understanding their own self-care when helping those exposed to trauma.
    - The training evaluations over a four-year period (n=1616) were extraordinarily high and averaged 4.7 on a 5-point scale.

The study of the Community Services Program has yielded a consistent and positive picture. The program gets very high marks from community leaders and stakeholders. These responses are supported by a review of the records of community interventions at the time of a traumatic event. And they are further supported by an intensive survey conducted with licensed professionals, school personnel and community workers who received training in trauma response. In a number of instances, this training had a broader impact on communities and

organizations. Interviewees commented on how they had transferred the training to reform the operations of their organizations. Similarly, several community leaders commented that it had positively changed the way human services organizations interacted with each other in their communities.

Recommendations concerning replication convey that strong consideration should be given to replicating this model of service provision, so that other communities throughout the Commonwealth are prepared to handle traumatic events in their communities. The incidence of trauma, whether in the form of family violence, violence in the school or community, homicides or suicides, natural disasters, or acts of terrorism, can have a profound effect on children and youth. Although these events may not occur frequently in more sparsely populated areas, the cost of preparing those who care for children to help is small, while the costs of not being prepared are larger, with longer-term and negative consequences.

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OF THE TRAUMA CENTER

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A REVIEW OF THE COMMUNITY SERVICES PROGRAM OF THE TRAUMA CENTER AT ARBOUR HEALTH SYSTEMS

The Massachusetts Department of Mental Health has considered the Community Services Program to be an effective model for intervention to help individuals and communities at the time of traumatic events. The Department requested an independent review of the program to determine its effectiveness and the worthiness of replicating the model elsewhere in the Commonwealth. Child and Family Program Strategies in Durham, North Carolina, the Research and Training Center of the Florida Mental Health Institute, and Consumer Quality Initiatives, Inc. in Boston undertook the study. The study described below was conducted over a five-month period, between June 2003 and October 2003 to provide answers to these questions.

INTRODUCTION TO THE COMMUNITY SERVICES PROGRAM

Threat, stress, terrorism and trauma have become everyday concerns, following September 11. However, before the startling psychological impact of September 11, communities across the county had been struggling with the trauma of school, community and family violence, child abuse, child and adolescent death, and man-made and natural disasters. Trauma psychology has developed as a specialized field to study human responses and develop ways of handling these responses. Based on research and practice, interventions with people who have experienced traumatic events have been divided into two general areas: 1) short-term interventions for those who have essentially normal responses to abnormal situations, i.e., those whose functioning is disrupted but who can re-group with short-term support; and 2) longer term interventions/ treatment for those who have more prolonged disruption of functioning and need therapy to overcome the impact. Although the first group is by far larger, considerably more professional attention has been paid to the latter group. But according to the trauma literature, it is intervention with the first, and largest group that can produce benefits most quickly to more people and avoid the need for more intensive, longer-term treatment for many. As the skills to respond helpfully have become clearer, it has become apparent that special approaches, special

training and special networks are necessary to provide support to communities facing serious traumatic events.

In communities across the country, traumatic events occur, whether these events are described as family violence, violence in the school or community, homicides or suicides, natural disasters, or acts of terrorism. When a traumatic event takes place within a community, a normal stress response occurs to those who are exposed. One of the most vulnerable populations in the community is its children and youth, who may experience high levels of anxiety, nightmares, sleeplessness, and inability to function in school. Without intervention, these responses may take much longer to stabilize or may turn into longer-term problems, sustaining psychosocial disruption, compromising psychological well being and significantly hindering development into healthy adulthood. The Community Services Program at the Arbour Trauma Center in Boston has developed a conceptual and practice framework for responding to such events, intervening with the children and families. The interventions are designed to help the children and youth, their families, teachers, and neighbors handle their responses to trauma, fostering strength and safety, and preventing traumatic situations from having lifelong, negative effects.

The Community Services Program began in the Boston area almost 15 years ago, funded by the Massachusetts Department of Mental Health's Metro Boston Area Office. In 1996, the program was reorganized and refined in order to build a training program and incident response infrastructure that could meet the needs of some 90,000 school age children in Metro Boston. Since 1996, the Community Services Program has developed partnerships with professional providers, the schools and community workers. By establishing this network of 100 trained people, the small staff of three professionals, one manager, and one graduate student, has created the capacity to respond throughout the city of Boston to traumatic events affecting children, families and communities twenty-four hours a day, seven days a week and 365 days a year, (24/7/365).

WHAT THE COMMUNITY SERVICES PROGRAM DOES

The Trauma Center, a program of the Arbour Health Systems, provides an array of services to people who have been exposed to traumatic events and are suffering from the psychological

impact of these events on their daily functioning. The Community Services part of the Trauma Center focuses on short-term, immediate interventions to help stabilize these people and prevent them from developing longer-term psychological problems. The efforts to provide psychological stabilization follow a public health model and involve working within the community to help "normal people who had been exposed to very abnormal situations." The goals are 1) to mobilize the internal strengths to help people cope; 2) to mobilize the external supports in the communities to augment these inner resources; and 3) to develop a network of trained people throughout the city to assist with interventions at the time of a traumatic incident. The Community Services Program can best be understood through the descriptions of their work to help individuals and communities to handle traumatic events in the following situations. These examples, the first of which began in the late fall of 1996 and continued through the first half of 1998, represent two different events over the past five years. They are two illustrations out of over 1,500 situations to which the Community Services Program has responded to within Metro Boston in the last 7 years.

The Suicide Cluster in South Boston

During the fall of 1996, the Community Services Program was working with youth in Boston following their exposure to deaths of peers from violence or drug overdoses. Through tracking the drug overdoses and through informal communications from the youth, the staff became aware of multiple overdoses and suicides or attempted suicides in three housing developments in South Boston. They visited these housing developments and found the situation was indeed serious—dozens of youth, ages 14-20, were heavily using drugs, heroin, cocaine and prescription drugs, and overdosing; others were becoming suicidal. Many younger children in the neighborhood were witnesses to much of this.

In the following months, the program staff worked with the Mayor's Office and community leaders to try to stop these processes, but was unable to do so; the youth of the community continued to attempt or commit suicide and die of overdoses. More than a hundred youth were hospitalized. Over a thousand of the youth in the neighborhood attended wakes and funerals of their friends. Needless to say, the adults of the community were overwrought about the seemingly contagious effect of the suicides and about the rampant availability and use of drugs.

The Community Services Program provided the leadership toward resolving this grim situation. First, they provided three days of intensive training to forty-seven adults, so that there was a team of people available to respond to survivors of suicide attempts, witnesses to suicide attempts or actual deaths, and friends of the victims. Together, this new team and the Community Services Program staff, worked over the next several months with children, youth, families and neighbors in group meetings to calm rumors, provide facts about the events, and develop safety plans for the children and youth. These plans involved helping adults to identify

behaviors where listening, calming and helping might be needed, and helping the children and youth to know where to go for comfort, conversation and help. They were helped to have experiences with trusted and trustworthy adults.

Work was also done with the media, with the political leaders, religious leaders and human services professionals to bring about understanding of how not to publicize events and calm the situation. The Community Services Program staff also worked to stop "finger-pointing" about who was to blame and to move proactively together to prevent more occurrences. Together these groups assessed the community resources and determined what additional local programs were needed. New services were put in place, new approaches to the children and youth were developed, and the suicides and attempted stopped.

Over the past six years, the community leaders and citizens have continued their efforts to bring the community together over the problems of their children and youth, to maintain the supports provided by families, friends and neighbors, and generally to maintain the strengths of the community that were identified and built upon during the tragic period of the suicide clusters. Community leaders, as discussed further below, describe the efforts of the Community Services Program as "bringing us out of Hell; bringing order from chaos; and saving the lives of hundreds of our children."

The Bus Accident of the Oak Hill Middle School, Newton

On the evening of April 26, 2001, forty-two students and five chaperones left Oak Hill Middle School in Newton, MA on a bus, headed for Halifax, Nova Scotia to play in the Atlantic Band Festival. They planned to arrive in Nova Scotia the next morning. About 4:00 a.m., as the bus approached Halifax, the bus entered an exit ramp, slid out of control and hit a curb, turning over onto its side. Four children were killed instantly. Two adults sustained serious, but not life-threatening, injuries; and the others were essentially unharmed.

The immediate responses involved many people; the injured were taken to the local hospital; the principal was called, parents of all children were notified; the family members of the adults were called; arrangements were made to transport these people to the scene of the accident in Canada; and arrangements were made to bring the children and adults home. The Royal Canadian Mounted Police and the adults on the trip organized these actions. There was an overwhelming outpouring of emotion—sympathy for the families of the victims and concern for the survivors—from across the Newton community. There was considerable media coverage of the tragedy involving so many children—those who were killed and those who witnessed this happening.

On April 28, 2001, the Central Office of the Department of Mental Health asked the Community Services Program to assist with the response efforts within the school and community. Many of the students, teachers, school administrators, parents and others in the community were shocked about the accident and, of course, extremely distressed about the ***children who had died. They*** *anticipated that other students would need help; many adults needed help, as well.*

The next day, Sunday, there was a meeting for the school leadership, teachers, parents, mental health professionals and religious leaders. The group began to develop a comprehensive

strategy to deal with this overwhelming tragedy, to help the students return to school and cope with the loss of their classmates. They soon realized that this was a daunting task, given their inexperience in the area of trauma response and stress management. They asked the Community Services Program to take charge and provide the centralized leadership.

The Community Services Program oversaw the stabilization plan, implemented by their staff and their community partners. They focused on the following efforts:

- *Identify different groups that needed supportive services, for example, teachers, students who were on the bus, children who were supposed to go but did not, other students who knew the victims, the victims' parents and siblings, parents of the other children, adult chaperones were part of the 12 groups identified.*
- *Provide overall stress management activities for these groups.*
- *Provide support at the victims' funerals, wakes and the memorial service at school.*
- *Identify those in need of counseling and refer them to mental health providers*
- *Identify the various circles of survivors and plan outreach, support and stress management activities for them.*

Between April 29 and June 15, the Community Services Program provided twenty interventions, through support groups, debriefings, meetings with administration to help them assume the lead roles over time, and classroom-based discussions. They kept the situation organized and calm. As the school year ended, there was considerably more stability; the students and adults were better able to cope.

The biggest challenge was to help those impacted by the traumatic event. That goal was met. Another challenge, managed well by the "centralized command" was to keep under control the struggles for leadership among the professionals groups and agencies. It was important that leadership be returned to the school and set on a constructive course, which ultimately happened, but not easily.

In each of the above examples, there were individuals, families and communities that received services and from all of these, there were reports that the interventions by the Community Services Program were extremely valuable in helping to regain stability and functioning.

THE PROGRAM'S APPROACH TO TRAUMA INTERVENTION

Using Best Practices: Best practices in youth trauma response and protocols for interventions were developed between 1990 and 2002 by the multidisciplinary staff the Community Services Program, using their knowledge acquired from extensive experience on the streets of Boston and research on evidence-based interventions. A thirty-five-page bibliography of relevant research publications is available from the Community Services Program office.

> ***The golden rule of this program has been that "those most affected by the trauma or threat event must be afforded an ongoing opportunity to play a central role in the resolution of and recovery from the trauma and its aftermath."***

In practice this means that local leaders, local healers and helpers, local teachers, local mentors, local caregivers, and local families should be empowered at the neighborhood level to respond to and guide threatened youth. It also means that for such efforts to be effective, there may need to be programmatic, fiscal and administrative support for these local responses to be sustained over time until the local infrastructure is stable and self-supporting.

Building a Community Network: To turn the golden rule into a practical response, the Community Services Program has worked to develop an organized infrastructure at the neighborhood level for children and youth exposed to trauma. The Community Services Program has accomplished this by building a trauma response network for neighborhoods and schools in Boston, that is, by training a cadre of people from the neighborhoods and schools to become part of the Trauma Response Network and to function with leadership, or support and advice from the Community Services Program or to function independently, depending on the local skills, comfort level, and intensity of the traumatic event.

The Community Services Program staff trains approximately 260 new people each year in an introductory training process, building practical skills that prepare trainees to assist with community interventions. In order to be qualified to handle interventions as the lead person, people must be credentialed through additional advanced skill-building that involves an additional 20 hours of training, fourteen of which require participation in actual interventions during a traumatic situation, under close supervision. The credentialed people then complete four eight-hour advanced trainings per year to keep their skills up to date. They also have the option of calling in the Community Services Program staff for back up help or advice. The Community Services Program staff tells the credentialed trainees "we will work in front of you,

by your side, or behind you" however you feel comfortable. In the past four years, training has been provided to 1040 individuals and the credentialed group has 100 members (20 licensed professionals, 35 school based personnel, and 45 community youth workers) who form the network of those who can triage acute trauma scenes and lead interventions.

The neighborhood partners who have been trained include representatives from the State of Massachusetts Departments of Mental Health, Mental Retardation, Public Health, Social Services, Youth Services, Probation and Emergency Management, and representatives of public and parochial schools, the Mayor's Office, public agencies, law enforcement, juvenile court, municipal, state and national non-profit agencies, emergency medical services, crisis intervention teams, public housing authorities, private health/mental health providers and the faith organizations. The Community Services Program staff is available 365/24/7 to respond to traumatic events and bring in trained members of the trauma response network.

Methods of Intervention: In the first 24-48 hours following a traumatic event, the work of the Community Service Program and their local network is to stabilize the situation by helping the individual or group to feel safe. This is the time period for reconnaissance, as well, to be sure the responding team has as much information, both facts and rumors, to function effectively. If invited to help further, the following activities occur:

- Traumatic incident stress orientations that involve augmenting and supporting normal recovery; helping individuals and groups recognize that they are normal people having normal reactions to abnormal events; providing factual information to diffuse rumors; and orienting survivors and survivor family members to the types of interventions offered by the Community Services Program and other specialized providers that they can use on a voluntary basis to assist them as they approach the funeral(s) and for their futures after the funeral(s).
- Traumatic incident stress management that targets the reduction of prolonged traumatic stress responses by augmenting positive coping strategies and identifying and practicing inherent resiliency factors.
- Identifying and supporting youth affected

- Assessment of functioning, using a number of traumatic stress exams, to help determine the type of intervention that is most likely to be effective
- Information and education sessions
- Individual crisis intervention, as needed
- Coping and resource identification or development, both individual and community resources

These approaches are part of a response continuum or triage system that helps to determine what kind of intervention, how much intervention in a short period of time, how long the interventions should continue over time, and who might need more intensive medical/therapeutic interventions.

Kinds of Trauma the Program Handles: The kinds of events to which the Community Services Program staff most frequently have responded include domestic violence, spousal homicide, youth homicide, youth suicide attempts and completions, fatality car and school bus accidents, death of students from illness, gang violence, and hostage takings. The staff has also provided 2 years of specialized services to the families and friends of victims killed in the terrorist attacks of September 11, both in Boston and at Ground-0 in New York City. In some situations, the program provides direct interventions, or if there are trained community partners available, the staff may provide consultation, back up and support.

Through a pager system, the staff is connected to the Mayor's Office, the Boston Police, state emergency management systems, and the International Red Cross Alert System and it can be accessed by approximately 500 public and parochial schools and 1,000 community-based professionals who work in varying capacity with youth.

THE METHODS OF THE STUDY AND THE FINDINGS

RESPONSES OF COMMUNITY LEADERS AND OTHER STAKEHOLDERS

Community leaders can provide an important assessment of the qualities of a program that is designed to be part of the community. The depth of their knowledge about the program is an important indicator of program effectiveness, that is, do they see it as effective, and do they use it

to help address their issues. And the breadth of people who can respond to questions about the program is a second important indicator, that is, the extent to which there is a wide range of community leaders who know and understand the program.

Information from other stakeholders is also important to gauge the impact of the program. These stakeholders include those who have received services from the program, as friends or families of the victims, or as those who care for children and youth who have been exposed to traumatic events; and this group includes, as examples, staff of community centers, teachers, or day care workers. It also includes some members of the Trauma Response Network.

Method of Study: Interviews were conducted with 29 community leaders/stakeholders to gather their views of the program, its impact on individuals and communities, and its quality. An Interview Guide was developed to provide the topics for discussions, and the interviewees were encouraged to expand their answers to convey a full understanding of their thoughts. The Interview Guide is presented in Appendix A. Reviewing that document shows that the open-ended questions did not lead the respondents to particular answers, but rather allowed for spontaneous replies.

The selection of people to be interviewed was done by presenting the program staff with categories and they created a list, when possible, of potential candidates. Those interviewed included a US Congressman; a State Senator; a representative from the Mayor's Office; state mental health leadership, leaders of several minority communities; religious leaders; public and parochial school principals, counselors and teachers; clinicians; community agency heads and staff; parents and other family members; probation officers; and police. Members of the trauma response network (3) were included as stakeholders.

The number of community leaders (16) was greater than the number of stakeholders (13) but there were essentially no differences in the responses of the two groups.

General Findings: The participants in the interviews represent a wide array of community agencies/offices and community groups and reflect the breadth of people who were

knowledgeable about the program. The interviews yielded extremely consistent responses that reflected a substantial understanding of the program, its mission and the way it operated. ~~They~~ Interview respondents expressed a high regard for the program. All respondents described the program as having a substantial impact on the community. Through their comments, they credited the program with 1) providing direction to help communities to heal themselves; 2) helping the community to come together and handle the crisis; and 3) in the case of a suicide cluster, saving hundreds of children's' lives. The interventions are described as calming, supportive, with the staff always behind the scenes but thoroughly being there when needed, not intruding but helping the community unite to bring about healing. School leaders and others described the program as important in helping teachers and other child caretakers to view children differently and to gain understanding of how a trauma might influence the children's behaviors.

The program elements, which were listed by the majority of the community leaders and stakeholders, can be categorized in four areas: the program's responsiveness, the visibility of the staff and network people, their responsiveness to ethnic differences, and the overall quality of the program. The elected officials and their staff described the program, across the board, as the best program for children in the city.

> ***"I've seen all shades of success in programs. I think this is one of the best, most effective, I've had the pleasure to work with. (Regarding the suicide clusters in South Boston) They brought stability and direction to what we did and brought order from chaos. They brought objectivity. They brought together groups that were at odds, to work together for our children. They helped us to communicate with our kids. We got the resources they said we needed to help our kids. It was like a fire department—they responded to our disaster. Their program is portable; it goes where the need is."***
>
> ***U.S. Congressman Stephen F. Lynch***

The Program's Responsiveness: Almost all respondents, 26 of the 29 (90%), voluntarily mentioned that the program was able to respond around the clock, ready to help. either with their own staff or network people they had trained. The respondents reported that through the use of pagers and cell phones, calls would be immediately answered and handled in a calm and

professional way. Of the 29 respondents, 23 (79%) mentioned that they had called for advice or assistance after normal working hours, and felt comfortable doing so.

The Director of Neighborhood Services in the Mayor's Office said, "This is one program we can always count on, 24 hours a day, seven days a week, to help with the worst situations".

The Director of School Counseling Services said, "They are always there when I call, any hour of day or night. This is the best partnership the schools have"

The three members of the Trauma Response Network who were interviewed all indicated that they were committed to being available to work with the staff and recognized the importance of always being available, even though they could not always respond because of responsibilities to their "day jobs."

The Visibility of the Staff and Network People: The four respondents involved with the suicide cluster in South Boston, that is, two elected officials and two senior agency managers, all indicated that they had learned an important lesson during the intervention. They learned that interventions in serious, life-threatening matters required low-key, behind the scenes work—no publicity, no news coverage, no press, just hard work to help people develop a calm and sound approach to understanding their children better, and opening avenues of communication with them. They said they learned that an important part of the intervention was to develop plans for how to work with the children at risk and to have the services they needed available; this planning brought comfort and calm and a feeling of safety. This was not the time for publicity or for taking credit.

Many of the interventions to which the community leaders and stakeholders were exposed involved attendance at a funeral, and the staff and network people they had trained attended the funerals, as well. The Community Services Program views funerals as an important place ~~s~~ to provide support, identify those that need special support, and gain understanding of the community's needs and resources. According to the program staff, funerals are places where

visibility should be at the lowest, so as not to appear intrusive in what can be very private moments.

> ***One mother of a victim, in talking to a leader of the faith community, described this behind the scenes strength as "you don't even know they're there, but you do know they're there. You can count on them but they don't push."***

Responsiveness to Ethnic Differences: The elected officials, network members, leaders of the faith communities, leaders of minority communities, and representatives of the police and other public or community agencies, a total of fourteen people (48% of the total) all discussed how valuable it was that the program is sensitive to the cultural differences. Although 48% may seem low, it should be noted that cultural issues may not be foremost in the minds of some of the stakeholders, so they may not have attended to this part of the program's response. The ethnic differences that were discussed include:

- Different cultures have a different view of outsiders coming into their midst at a time of crisis; and this may be especially true of attending funerals. The people interviewed indicated that the program's staff or network people were respectful, understood how to handle this issue, conveyed their understanding of the people's wishes and sensitivities, were reassuring that they wanted to provide support, not take over the situation so that the community members had no say about the how the crisis should be handled, and offered help in ways that were acceptable to the culture.
- Different cultures handle grief differently; in some there is a gender difference in what emotional responses are considered acceptable, and in others, grief may be expressed as anger and seeking retribution. The interviewees conveyed that understanding these cultural differences was important to successful interventions, that is, to offering help and offering direction so that it was accepted and used. They complimented the program

> ***A leader of the Cape Verdean community said, "They know every tragedy is not the same. They have different techniques in different communities. I like developing the local teams to help, to do what they're taught—but also to teach the program about the community. They make an immediate impact—you can see a difference at a wake or funeral when they're there."***

for bringing understanding to the scene, and thus maximizing the likelihood of being accepted.

The Overall Quality of the Program: It should be said before the findings of the interviews with community leaders and stakeholders is reported that 1) these respondents were not handpicked by the program staff to be positive responders and the staff actually tried to find people who might have disagreements with how their services were provided; and 2) they were not coached or tutored by the program staff about what to say! This disclaimer is important because it is rare to find, in a study involving so many different responders, such consistent and overwhelmingly positive information. All 29 people (100%) discussed the Community Services Program as providing outstanding services that "made a real difference in the community; made a real difference to the people involved." All 29 also reported that the program involved the right people from the community in the interventions. And all 29 indicated that it was very important and very helpful to have local teams trained to work with the Community Services Program staff or trained to work successfully on their own; and all 29 described the training as "outstanding, dynamite, really strong."

The Chief Probation Officer in South Boston said, "They led us out of Hell. They saved the lives of hundreds of our kids. They held our hands and comforted us and we learned we could change our community. They trained us, helping people to talk to neighbors, friends, help each other. And they helped us build services that we needed in our community. To this day, we are continuing these services because it makes us a stronger community."

"Robert Macy taught us how to approach instability in our kids, how to keep up the radar. He got all the right people involved. Someone else might not be trusted but he was immediately useful, trustworthy, and helped us see the dangers around the corner. He tailored the work to South Boston. He helped us see the gravity of the problems of our kids—that extraordinary problems call for extraordinary solutions. He gave us hope that we could do it."
State Senator John A. Hart, Jr.

The above two quotes refer to the program interventions that took place during the eighteen months of the suicide clusters in South Boston.

THE PROGRAM'S RESPONSES TO TRAUMATIC EVENTS

As described above, the Community Services Program has trained a network of people across the city to assist them in responding to traumatic events, with the design that these trained network members, to the extent possible, assist the Community Services Program to develop and sustain customized responses in communities where they live or where they understand the culture and concerns of the residents.

Method of Study: There were 250 records of responses by the Community Services Program to traumatic events occurring between August 1999 and June 2003. In keeping with the rules and practices of the Community Services Program, no names of any service recipient were referenced in the written records; only descriptions of the events and the interventions were available. A random sample of 63 (25%) of the 250 case records of events was selected for review. The purpose of the review was to gain understanding of 1) the types of traumatic event, 2) the breadth and characteristics of the population served, 3) the number, depth and extensiveness of the interventions, and 4) the major themes of the interventions and the outcomes. It should be noted that the response team leader, who may be either a staff person of the Community Services Program or a member of the Trauma Response Network, filled out the reports in the case records. There is a wide variety in the detail provided in the reports. Some of the records were quite detailed and some were quite sparse. So it is fair to assume that the sparser reports likely underestimate the full extent of the efforts.

The Types of Traumatic Events: The Community Services Program showed excellent performance in responding to a wide variety of events and was not restricted to a narrow range of traumatic situations. For these 63 cases, they had responded to 11 different kinds of trauma incidents including natural deaths, reaction to 9/11, assaults, vehicle accidents, homicides and suicides. Homicides (21) and suicides (15) were by far the most frequent trauma to which they responded.

There were eight different kinds of intervention services reported in these case records and in most incidents a variety of interventions were used. Consultations, debriefings, and orientations were used in 25% of the cases, supportive services in 33%, and defusing in about 15% of the cases. It needs to be emphasized that this is only a partial reflection of the extent of the efforts as, in the case of interventions such as debriefings, and defusings, provisions are usually made after such interventions for individual and small group counseling over a somewhat extended period of time. The case records would not capture these additional interventions, but we can assume that such referrals and treatment engagements did occur. In the vast majority of the cases, the interventions were handled by the community based crisis response network developed by the Community Services Program with involvement of community members, assisted by the Community Services Program staff.

The Breadth and Characteristics of The Population Served: In this sample of 63 events, the program served 19 different neighborhoods in Metro Boston. Roxbury, Dorchester, South Boston, Roslindale and East Boston had over 5 incidents each and almost two thirds of the total incidents occurred in these neighborhoods. Further evidence that the program successfully implemented their rule of using community leadership is the fact that they repeatedly served a wide variety of ethnic groups. Of the trauma related victims reflected in these cases, 28 were Caucasian, 22 African American, 18 Latino, 5 Haitian, and 6 Cape Verdean. This may be an underestimate of the number of minorities served, as an additional 16 were listed as "other" and 10 were unknown. Because referrals usually came from individuals or organizations in the communities themselves one would not expect such a high number of referrals from minority communities if the program staff were not skilled at adapting their interventions to ethnic differences and involving the right community people in their efforts. Furthermore, the skills required in addressing these incidents is reflected in the fact that one third of these cases involved more than one ethnic group.

The Number, Depth and Extensiveness of The Interventions: It was clear from the review of these cases that any single incident could lead to a complicated set of interventions involving many individuals. For some of these interventions, there was no way to determine from the case files how many individuals were actually present. However, a look at the overall statistics shows

the broad impact a single incident and intervention could have. For the 250 cases over the four-year period, 5,708 adolescents and 6,452 adults were involved in their interventions. This is an extraordinary number of persons whom have been served by this program at a time of trauma. For the 63 cases in the study sample, there was a total of 163 interventions, with as many as a dozen interventions conducted for one incident and a mean of 3.2 interventions per case.

The Major Themes of The Interventions and The Outcomes: The major themes that emerged in the case records were what would be expected in trauma situations. Most often reported were feelings of anger, sadness, disbelief, helplessness, guilt and grief. There were also consistent reports of concerns for the safety of those involved and, in the case of homicides that the violence would continue. Those responsible for organizations involved usually focused on whether there was anything they could have done to prevent the incident and ways in which they could help the recovery of those who were experiencing the trauma.

Regarding outcomes, the reports filed in the case records were completed almost immediately after the incident so the outcomes reported were very immediate and do not capture the broader and more long term outcomes. The outcomes reported in the records are very focused and immediate and include such things as how the organization will change its rules and procedures (e.g. in the case of a public pool drowning) to make things safer, or plans for further debriefings and counseling. On the individual level, the outcomes were essentially next steps such as the development of a self-care plan, following up on a referral for more intensive support, identifying other resources, or expressions of gratitude to the team for their support and help. The longer-term outcomes are better captured in the information provided in the interviews with community leaders/stakeholders and trainees.

The case records corroborate the reports of the trainees and key stakeholders. The Community Services Program was clearly responsive to a wide variety of trauma incidents all over the Metro Boston Area and tailored its interventions to the needs of the community. They did not present themselves as providing one shot fixes but rather a series of interventions that would help the community heal itself and make it better able to cope with psychological trauma in the future. They were responsive to a wide variety of ethnic groups and were able to intervene in situations

where there was most likely serious racial tension, which they were able to defuse. It needs to be emphasized that this sample represented just a quarter of the total efforts, so that the number of neighborhoods served and types of trauma was most likely even broader than that reported here.

Estimated Costs of the Interventions: The Community Services Program has provided cost estimates derived from their records of expenditures over the last eight years. They have developed cost estimates for particular, high frequency events and the required intensity of intervention.

These estimates are specific to the interventions and are provided to show the cost of responding to an event, and the estimated cost per service recipient. According to the records of the Community Services Program, the four most frequent primary traumatic events occurring over the 8 year period were: (1) youth suicide, (2) youth suicide attempts (3) youth homicide and (4) other sudden violent deaths of youth.

Estimates Of The Costs Of Interventions for Four Types Of Traumatic Events

Event	# Of Local Response Team Members	Hours by LRT	Cost @ $95/hour	Staff hours	Cost @ $30/hour	Total cost	# Of Service Recipients	Estimated Cost per Recipient
Homicide	2	12 Hrs	$2,280	30 Hrs	$ 900	$3,180	110	$28.90
Suicide Completion	4	10 Hrs	$3,800	40 Hrs	$1,200	$5,000	180	$15.00
Suicide Attempt	4	14 Hrs	$5,320	60 Hrs	$1,800	$7,120	350	$20.34
Sudden Single Fatality	2	8 Hrs	$1,520	20 Hrs	$ 600	$2,120	90	$23.55

Certainly these estimated costs per recipient are far below the costs to society of a person who suffers ongoing compromised functioning, continued psychosocial distress and familial unrest. The societal costs might include lost productivity at work, job loss or reliance on welfare for adults; for children, the societal costs include decreased school performance or behavioral problems. For both age groups, societal costs also include the costs of professional intervention. Based on practical experience and research, it seems that those who receive immediate stabilization after exposure to serious psychological trauma have reduced numbers of overall professional contacts than those similarly exposed but receiving no immediate support and

intervention. The types of professional contacts usually made after exposure to psychological trauma include increased and continued contacts with the emergency rooms, hospital inpatient units, social service agencies, law enforcement agencies, victim's crime funds agencies, and outpatient mental health agencies.

These Community Service Program cost estimates are most likely high, as the number of recipients has been estimated on the low side. This number includes only those directly involved in the services and not those who might have derived benefits from the survivors being stabilized. As an example, a young child might not participate in the intervention sessions, but the fact that his parents did might benefit him quite a bit indirectly.

RESPONSES OF THE TRAINEES

It was important to assess the impact of training, as this effort is central to the Community Services Program; it is the strategy for developing community-based networks of people who can assist in responding to traumatic events within their own neighborhoods. The training is well structured and follows a set curriculum that is derived from research on human responses to psychological trauma, evidence-based interventions and practical experience of the Community Services Program staff having spent years on the streets of Boston providing help.

This network is important to the success of interventions, as it establishes a core of people who can work comfortably within the community exposed to the trauma, be understanding of the ethnicity and culture of the community and be accepted by the community. Information from the local Community Services Program trained network about 'local approaches' is most helpful in guiding and advising the staff to prepare to work in that community; and the local trained network provides a sense of credibility to the community for the staff who may otherwise be seen as outsiders or intruders into the community.

Method of Study: In-depth, structured surveys were conducted with 57 randomly selected licensed mental health professionals, school personnel and community workers. These are people who participated, over the past 4 years, in training seminars to learn how to provide

interventions at the time of traumatic events. The 57 represent approximately 5% of those trained from the Metro Boston area.

The survey included questions with answers scored on a five-point scale and questions that were open-ended and allowed for more discussion. The survey instrument used in the study is found in Appendix 2. The instrument was divided into five major sections: 1) level of training; 2) experience with Community Services Program interventions; 3) experience with trauma response; 4) acquisition of knowledge and skills, and 5) confidence in ability to accomplish tasks in a trauma intervention. The interviews provided quantitative measures of the effectiveness of the training, in terms of studying whether the trainees learned what was intended, whether or not they retained this knowledge, whether or not they used this information to assist with traumatic events in their communities and/or their personal lives, and whether or not they found the training to be useful. These dimensions are important in that they reflect the long-term usefulness of the training. `The open-ended questions sought descriptive data about such things as the usefulness of the training, what kinds of situations they felt they could handle, what kinds of situations they did handle, how they have used the training other than working with the Community Services Program and what was missing in the training.

How the Participants Rated the Training: The training evaluations for all of the training events (n=1616) completed by training participants were also examined to see if they corroborated the randomized formal survey findings. These training evaluations, collected at the end of each of their trainings, does not represent the views of 1616 individuals, as each person in the response network were required to take four advanced courses a year. It differs from the formal survey in that it represents an evaluation of the training immediately after the event whereas the randomized survey, administered sometimes four years after the training, is a better measure of the long-term effectiveness of the training. The ratings from the training evaluations over a four-year period (n=1616) were extraordinarily high and averaged 4.7 on a 5-point scale. For the randomized study sample of 57, the ratings from the formal structured interviews were equally high. Randomized respondents reported learning skills about interventions that mirrored what the training program proposed to teach. As described below, they reported that they found

the training useful in helping with community interventions at the time of traumatic events, useful in the workplace, and useful with their family and with friends.

Findings about What They Learned and Retained: Both the information from the randomly selected sample (n=57) and the post-training data from the whole population (n=1616) are entirely consistent with the stakeholder interviews and demonstrate collectively that the training is extraordinarily successful and useful even years after the training had occurred. As there were three different groups who had received the training, community members, licensed mental health professionals, and school personnel, differences between the three groups were examined. One could expect that professionals who might have had considerable training in trauma would react differently to the training than community workers with no prior training. However, the groups were remarkably consistent in their responses; there were few, if any, striking differences.

According to respondents in the survey, the vast majority of the trainees (88%) had received the basic training only, with the remaining 12% having taken at least one advanced training from Community Services Program. Of the whole group studied, reports of involvement with the program as part of the network were:

- 75% reported having only minimal involvement with the center since the training.
- 16% had moderate involvement, and
- 9% had extensive involvement.

These levels did not vary across the three groups. Minimal involvement is reflected in the fact that 77% had not been involved in a trauma response with the center, since completing the basic training. 7% were involved in only one intervention and 7% in only two. One individual, of those surveyed, however, reported being involved in 60 interventions**.** It needs to be emphasized that minimal involvement does not mean involvement with traumatic events or receiving support from Community Services Program but rather participating as a member of the response team during a formal intervention with the staff and center.

Even though the majority of trainees did not participate in an intervention with the Trauma Center frequently, the amount of skills learned and their retention of information were very high.

- As can be seen in Figure 1, 90% of the trainees reported that they learned and retained information and skills for handling traumatic events.

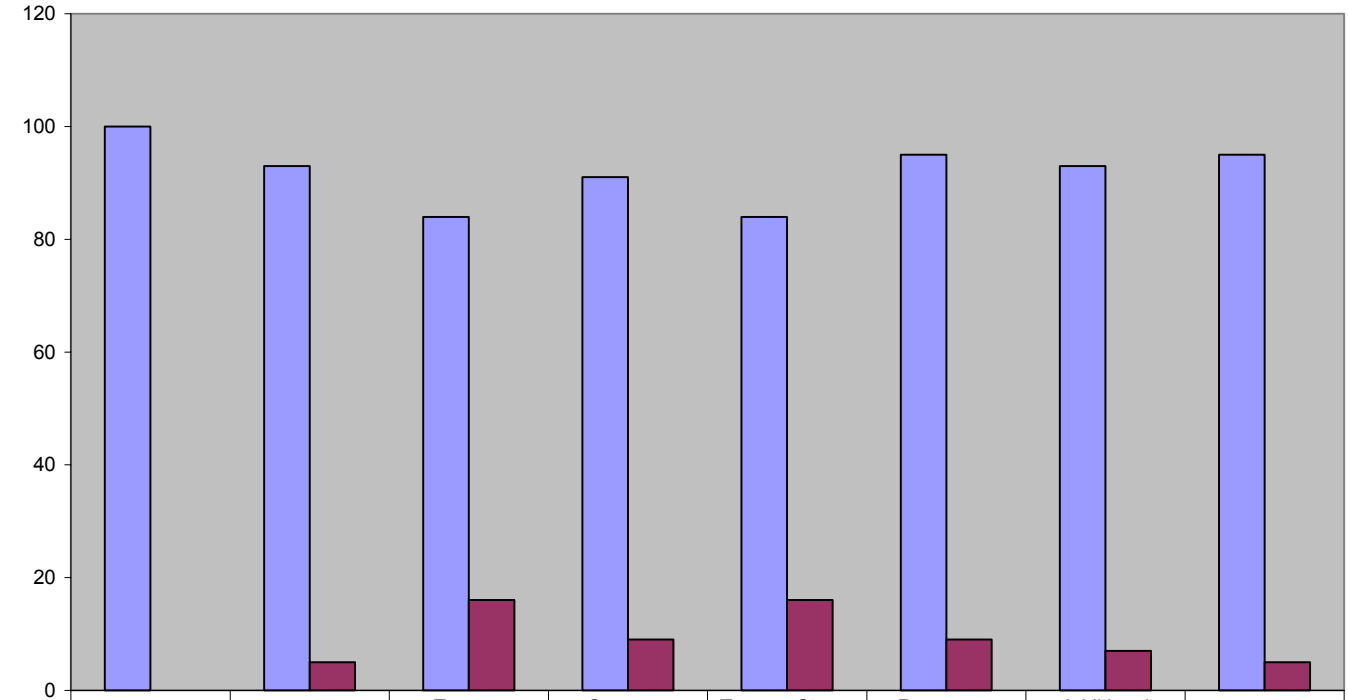
Figure 1

	Physical Response	Emotional Response	Behavioral Response	Self Care Methods	Adaptive/Maladaptive Ways of Coping	Specific Resources	Signs Individual Needs Additional Help
Not At All	7	9	4	2	11	19	7
Some	39	40	39	44	53	47	49
Much	54	51	58	54	37	33	44

- As seen in Figure 2, 80% of the trainees reported that they were confident about leading discussions in all 8 areas of trauma response with groups gathered after a traumatic event (see Figure 3).

Figure 2

Ability to Lead DIscussion in the Following Areas with Group Gathered After Trauma



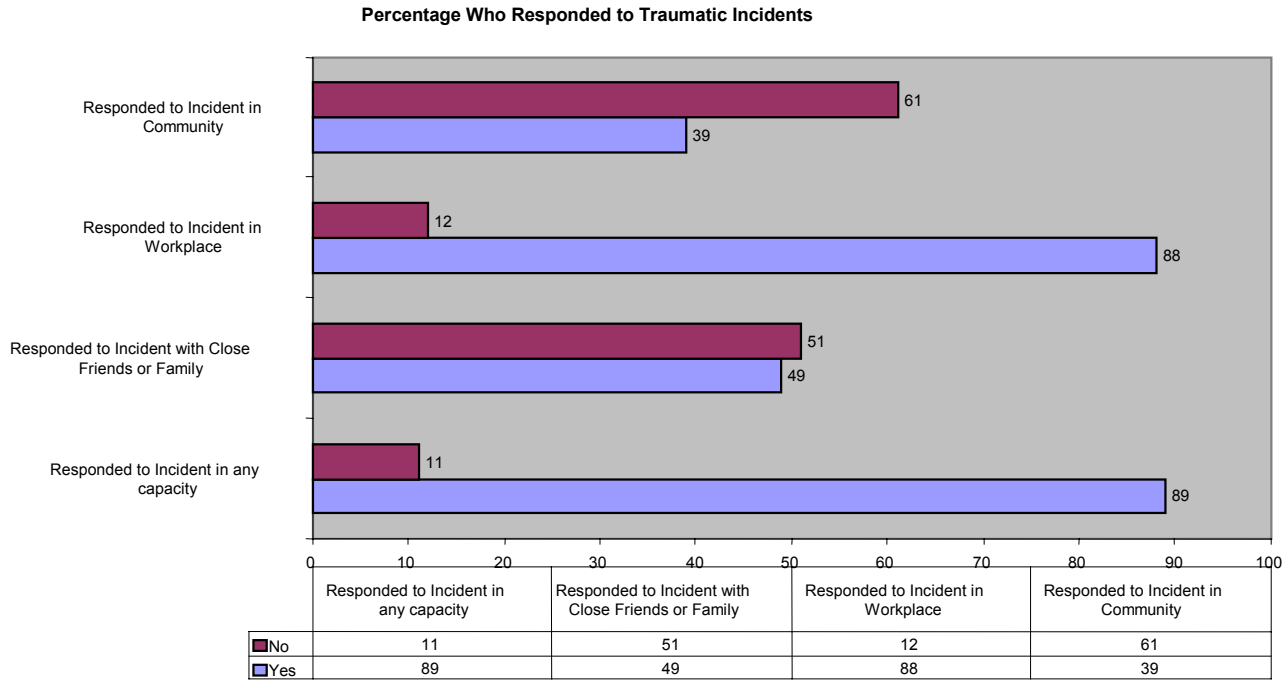
	Introductions	Ground Rules	Trauma Narrative	Common Themes	Trauma Stress on Body	Resources Already Utilized	Additional Resources	Self Care Plan
Yes	100	93	84	91	84	95	93	95
No	0	5	16	9	16	9	7	5

- 90% reported they were somewhat to very confident about handling 8 of the 9 tasks essential to handling trauma, including a) being part of the trauma response team, b) identifying those who needed trauma support, c) being able to lead a trauma incident orientation, d) being able to provide grief support, and e) understanding their own self-care when helping those exposed to trauma.
- 88% reported they had responded to traumatic incidents in the workplace since being trained.

The information derived from open-ended survey questions, allowing for discussion, showed that the trainees responded to a wide variety of trauma incidents. Their descriptions of how they responded to the incidents were totally consistent with the content of the training, corroborating the effectiveness of the training.

Findings about How They Applied What They Learned to Other Aspects of Their Lives: As one of the goals of the Community Services Program was to develop the capacities of communities to respond to trauma on their own, it also seemed important to learn if the training had an impact in the general lives of the trainees and not just in the context of formal interventions with the trauma center.

Figure 3



- As seen in Figure 3, 89% reported that, after being trained, they had responded to traumatic incidents in many settings other than a formal intervention with the Community Services Program. Even though they responded to a trauma incident on their own this does not mean they did not get assistance from the Community Services Program in the form of a phone call, initial support in confirmation on what to do, or using them as resources. This demonstrates that the training produces capable individuals in the community that can participate significantly in trauma/ crisis response as incidents occur, thus taking the lion's share of response work "off" the Community Services Program staff except in the more extreme cases. However, respondents were somewhat less confident about how to apply what they had learned to their experiences with trauma with respect to family and friends, the workplace or their community outside of the formal

interventions with the Community Services Program. As is discussed below this may in part be due to the fact that without reinforcement of working with the program in an intervention so they can practice their skills and learn from observation, persons are likely to feel less confident.

- In contrast to the 90% who found the training effective in preparing them for formal interventions, only 37% felt the training was helpful in responding to trauma when the trauma center was not involved. There are several possible explanations for this. Most importantly, the training was designed around formal interventions. Secondly, as is noted in more detail below, the training focused on interventions taking place 48 hours after the event in keeping with trauma response theory, rather than on interventions for a trauma incident as it is unfolding. Finally, it may be the lack of reinforcement of skills that can best be obtained by participation in a formal intervention with the Community Services Program given that 75% did not have this exposure. It speaks to the effectiveness of a program, which does not create dependency of those trained on the program staff. By relying on a trained network of responders, the program can use its resources for more training and for more interventions in extreme and complicated cases.
- In contrast when asked whether the training was beneficial with 1) their friends and family, 2) workplace, and 3) their own community there was a very high percentage (70%, 90% and 56% respectively) who answered positively. In this case there was a difference between the community, licensed professional and school training groups, with the third group being much less able to translate the benefits of the training to their personal and work situations than the other groups, but more able to see its value in their community.
- Of greater importance in understanding the overall impact of the training, 80% said they felt the community was better prepared for a traumatic incident as a result of their training.

The survey responses and stakeholder interviews also showed that a number of organizations including both the public and parochial schools as well as several other community service agencies had been so impressed with the training that they applied it throughout their organizations. They said it had a major effect on how the organization operated above and beyond their ability to respond to trauma.

Trainee Suggestions about How to Improve Training: In the comments on the training evaluations, provided by the 1616 people who participated in training over the four-year period, there were a number of consistent suggestions for improving the training. As with any training endeavor, the participants were frequently divided on a range of issues (e.g., longer sessions, shorter sessions and more sessions, less sessions) and had the (unrealistic) expectation that one training seminar would provide all of the information they desired. One of the more consistent themes was the desire for longer training because they wanted to be able to absorb the information at a slower pace and especially because they wanted more content in specific areas (e.g. cultural issues, age appropriateness) and especially more opportunity to practice how to do the group interventions. According to the director of the Community Services Program, the recently revised Community Service Program curriculum for advanced training covers all these issues in great detail, indicating that the program took seriously these requests.

Perhaps the most important finding from the survey of the 57 randomly selected people was the desire of the trainees for more follow up, refresher training and contact with the center. Several reported that they had left their names to be contacted further and never had heard from the program. There was a consistent sense that without opportunities to practice and use these skills, respondents felt these tools became blunt and they lost confidence over time in their ability to use them. They also felt that since it might have been several years since they were trained, they might not have the latest knowledge and skills needed to be maximally effective. However, according to the director of the Community Services Program, more recently the opportunity for further practice and training beyond the advanced curriculum is being offered to licensed clinicians and community youth workers.

There were a number of comments in ***both*** the training evaluations and the survey which commented on the fact that the training was geared toward interventions taking place several days after the event and they did not feel it completely prepared them to respond when they were personally involved in the moment as the trauma was unfolding. While this is not the primary focus of the Community Services Program, it might be useful in the strategy of building the general capacity in the community to respond to traumatic events.

Increased capacity for further building and organizing community networks is one area where a modest increase in resources could have an impact on enhancing the capacity of communities to respond to trauma. Some respondents noted that they did not necessarily know who else in their community was trained so they could network with them. Others pointed out that the current system ends up with the community having to rely more on calling the Community Services Program to respond than being able to identify people locally who could help, that is, have been trained to help. If additional resources were available, some of the activities that could be helpful in this regard would be having a one-day booster training/get together for people who had been trained in one or several communities once a year. Even just an open house with Community Services Program staff at a local agency where training had occurred and where other trainees from the community could be involved would enhance the networking in the community. Another possibility would be a periodic communication that would summarize new research and techniques in trauma intervention and would advertise Community Services Program training events. Clearly the value of the training would be further enhanced if there were a way the trainees could feel more involved and more able to use the skills they have learned and have valued.

These comments not withstanding, it is clear from the survey and the evaluations that this is an exemplary training program, which is of great value to individuals and has an important impact on enhancing community capacity to respond to significant psychosocial disruption and psychological trauma.

SUMMARY AND CONCLUSIONS

The study of the Community Services Program has yielded a consistent and positive picture. The program gets very high marks from community leaders and stakeholders. These responses are supported by a review of the records of community interventions at the time of a traumatic event. And they are further supported by an intensive survey conducted with licensed mental health professionals, school personnel and community workers who received training in trauma response.

THE AREAS OF THE PROGRAM CONSIDERED TO BE OUTSTANDING

Responsiveness: The most frequently mentioned characteristic of the program was that they were **always** available to help and committed to helping, no matter what the hour of day. This impressive responsiveness was further described as "thoughtful, supportive and calm," meaning that from the first phone call, the staff and the network members had a positive effect on the situation. To many of the stakeholders, they conveyed a feeling a confidence that the situation could be handled.

Visibility: The second more frequently mentioned characteristic was the capacity of the program to provide help without being visible, without appearing to take over the situation, and to work supportively with those who were in charge, such as the principal in a school, or a community leader at a community meeting. This low-key approach to community interventions seems to build trust, offer immediate relief and then provide the direction to the community leaders and members to bring support from within, that is, to mobilize their local resources to provide on-going support.

Effectiveness of The Interventions: The short-term effectiveness of the interventions have been expressed as help with grieving, help with understanding and expressing the intense emotions that accompany experiencing a traumatic event—such as anger, sadness and depression. Another short-term outcome that was valued was help with a self-care plan, so people could stabilize themselves physically and not compound their psychological reactions with physical problems.

The effectiveness of the interventions was attributed to the staff and network providers' ability to convey feelings of calmness and safety, giving the message that "we can get through this." Their abilities to understand the culture of the community helped them to support the grieving in the customs of the people, and to tailor the healing responses to the needs of the people.

The stakeholders who described "community cures," that is, changes in the community that prevented further harm to their youth, best expressed the longer-term effectiveness of the

interventions. An example comes from the South Boston area, following the cluster of youth suicide. Several community leaders spoke quite passionately about how the Community Services Program staff helped them to understand what kinds of programs, services and activities they needed to put in place to help the community heal itself. The chief probation officer said he had no doubt that these recommended changes had saved hundreds of lives of the youth of South Boston. The cost figures provided by the program indicate that the relatively low cost of the interventions represent money well spent.

Effectiveness of The Training and Network Building: The goal of the training program is to develop the capacity to assist or lead interventions within three groups of people throughout Boston, licensed mental health professionals, school personnel and community youth workers. The purposes are threefold: 1) to extend the response capacity of a modest-sized staff, so that they are available throughout the city as the needs arise; 2) to have trained people within their own schools and neighborhoods that can respond to traumatic events, with or without the back up of the Community Services Program; and 3) to have people available who understand the ethnic/cultural aspects of the community, so that assistance can be provided in a culturally component manner. The study shows that these goals have been met—that a wide network of people exists to meet the threefold purpose of the program. The survey of trainees indicates that the information and skills to be imparted during the training are learned well, retained and put to use in assisting others during a trauma event, either as part of the trauma response network or on their own.

Overall Effectiveness of The Model: This study involved the collection of new data through the interviews with stakeholders and the randomized survey of trainees and organized the existing information from randomly selected case records. Given the kinds of information available in the study, there is remarkable consistency across these three areas, all indicating that this program is effective. The effectiveness is in helping communities to handle crises and in training a network of local people to lead or assist with the interventions. In a number of instances, this training had a broader impact on communities and organizations. Interviewees commented on how they had transferred the training to reform the operations of their

organizations. Similarly, several community leaders commented that it had positively changed the way human services organizations interacted with each other in their communities.
It is the understanding of the issues related to the trauma experience, knowing what to do and what not to do, that seems to make the program effective. And clearly, this knowledge can be taught to others who can augment the program staff. As a model for services that are needed on an irregular basis, this model works well and at a reasonable cost. It seems very likely that this model can be overlaid on existing human services programs with proper training, initially and ongoing, and with proper back up and support, until the newly launched trauma response network programs become stable.

REPLICATION OF THE PROGRAM

The program features listed above may well represent the essential components for a replication of the program. However, further verification is needed, as is an understanding of the elements that need to be in place for an existing program to incorporate the essential components. The program has developed a good foundation on which to build cost estimates for replication. And with a small addition of staff, they could serve as the training core for new sites; and provide supervision or back up until the new sites become stable. The Community Services Program has begun some attempts at replication, in Southern New Hampshire and in Southern Maine. Interviews with the program managers conveyed that they very much value the training and support provided by Community Services Program staff. They report that the Community Services Program has also been instrumental in their program development and their ongoing work with a combined response team of over 180 local licensed mental health professionals and community service professionals who respond to daily traumatic incidents in both states.

Strong consideration should be given to replicating this model of service provision, so that other communities throughout the Commonwealth are prepared to handle traumatic events in their communities. The incidence of trauma, whether in the form of family violence, violence in the school or community, homicides or suicides, natural disasters, or acts of terrorism, can have a profound effect on children and youth. Although these events may not occur frequently in more sparsely populated areas, the cost of preparing those who care for children to help is small, while the costs of not being prepared are larger, with longer-term and negative consequences.

ACKNOWLEDGEMENTS

The Community Services Program of the Trauma Center-Arbour Health Systems is a very interesting program. It does not provide treatment, but it does provide prevention services. It does not operate in an office setting, but it does deliver services on the streets of Boston, in community centers, schools and neighborhood gathering places. It does not advertise its services, but it is known to many people across the city as the place to call for help. As the report demonstrates, the evaluations of this program were consistently and extremely high.

The success of the program is attributable to Robert Macy, the person who has the vision, the dedication and the skills to make it work. He has inspired his modest-sized staff and many, many others to view children differently, and to view differently the kinds of events that might traumatize them, their parents, their teachers and others who care about them. The staff is remarkable in their dedication to being available 7 days a week, 24 hours a day and 365 days a year and in their skills and their caring about what happens to the children of Boston.

Joan Mikula and Karl Peterson had the foresight to recognize the importance of providing a trauma support program to the Boston community and for selecting the Community Services Program to do the job. Their ongoing support, in all senses of the word, has been invaluable.

We want to acknowledge all the people that met with us and spoke about their impressions and experiences with the program. There was no bias in selecting them, and it was surprising to find so much positive regard and enthusiasm for the program.

We value the opportunity to study the program and to present our findings to you.

Lenore Behar, Ph.D. Robert Paulson, Ph.D. Jonathan Delman, JD, MPH Lisa Schmid, MPH

APPENDICES

Appendix A

Stakeholders Interview Guide

Background Information

The Massachusetts Department of Mental Health has requested an evaluation of the Arbour Health Systems' Trauma Center, Community Services Program to determine the effectiveness of the program in 1) providing intervention services to individuals and communities experiencing traumatic events; and 2) training people to handle traumatic events. The Department of Mental Health considers the efforts of the Community Service Program to have a positive effect on the people and the communities they have served and now they are seeking a formal evaluation. A team is undertaking the evaluation project and in comprised of representatives from the Louis de la Parte Florida Mental Health Institute in Tampa, Florida and Consumer Quality Initiatives, Inc in Boston.

The evaluation has three components:

- A study of stakeholders, that is, those who have an interest in the program or have received services from the program, to understand their views of the program
- A study of those who participated in training, what they learned, how they use this knowledge and how this knowledge has impacted their workplace and community
- A review of records of the interventions provided by the Community Services Program to determine patterns of effectiveness

An important part of the evaluation project is to gain understanding from stakeholders of their views of the program, what information about the program would be most useful to them, how they would want to use the information from the evaluation.

We will be asking you questions to help with this part of the project.

Interview Guide

Date_____-

Respondent_____ Interviewer_____

Age_____ Ethnic Identity_____ Gender_____ Education

Employment/Position_____

1. What is your relationship to the Trauma Center--Community Services Program?

2. What is your understanding of the services they provide?

3. Ideally, what would you like to see the Trauma Center--Community Services Program accomplish?

4. Have you been part of or familiar with a trauma response incident coordinated by the Trauma Center--Community Services Program?
    a. How would you characterize the overall quality of the intervention?
    b. What in particular about their response stood out?
    c. What did they do particularly well?
    d. What might have been improved?
        a. What lessons were learned from this intervention?
    e. Did they involve all the right people? Who else might have been involved?
    f. How did they adopt the model to fit the needs of the particular situation?

5. In evaluating the effectiveness of the Trauma Center--Community Services Program what types of information would be most useful from your perspective? Which programs are you most interested in?

6. Are there any changes in the program, which you feel might make the program more effective which you would like to test out?

7. What other types of programs would you want to compare with this program?

8. How would you want to use this information? For what audiences? To best accomplish your purposes what format(s) for the results of the evaluation would be most useful for each of these audiences?

Appendix B

Consumer Quality Initiatives, Inc.

TRANSLATOR INFORMATION:

Translator used? ☐ *Yes* ☐ *No*

Is translator a staff member at the facility? ☐ *Yes* ☐ *No*

Translator language: _____

Translator initials: _____

FOR CQI OFFICE USE ONLY:

Use survey? ☐ *Yes* ☐ *No*

Quantitative data entry: Date: _____ Initials: _____

Qualitative date entry: Date: _____ Initials: _____

Trauma Center Survey

Consumer Quality Initiatives, Inc.

During the interview, read aloud everything but interviewer instructions, which are bolded and italicized. For questions answered on scales, please make sure to circle ONLY ONE response. For questions with check off boxes, please make sure to check off ONLY ONE box.

I. Level of Training

1. Please tell me all the training you have had with the Trauma Center:
   A. Type: Location:
      Date: Lead Trainer:

   B. Type: Location:
      Date: Lead Trainer:

   C. Type: Location:
      Date: Lead Trainer:

2. What level of certification have you received from the Trauma Center?
   - ❑ Basic level certification (1)
   - ❑ Advanced level certification (2)

3. Have you received other training, outside that provided by the Trauma Center, related to trauma response, such as training in crisis counseling or emergency response?
   - ❑ Yes (1)
   - ❑ No (2)

   Please list:

II. Experience with Trauma Response

Now we would like to ask you about your level of involvement with the Trauma Center since the time of your training. We have three levels of involvement categories: **Minimal, Moderate, and High.** *I will explain each category to you and then ask you to select which best describes your level of involvement.*

Minimal *is defined as having never participated in any capacity in an intervention with the Trauma Center although you may have contacted the Trauma Center for advice or support.*

Moderate *is defined as working with the Trauma Center on one or more interventions and participating as a co-lead or in some other non-lead role.*

High *is defined as working with the Trauma Center on one or more interventions and taking a lead role during one or more of these interventions.*

4. Of the above three categories, which best describes your level of involvement?
   - ❑ Minimal (1) - if checked go to question # 11
   - ❑ Moderate (2) - if checked go to question #5
   - ❑ High (3) - if checked go to question #5

5. How many times have you been involved in a trauma response intervention with the Trauma Center?

6. Have these interventions happened within the past year?
   - ❑ Yes (1)
   - ❑ No (2)

7. During these times, what roles did you play during the trauma response? (Please list)

8. What was the nature of the trauma situation(s)? (Please describe)

9. Regarding the trauma situation you just mentioned, how useful to you was the training you received from the Trauma Center in responding to these incidents?

1	2	3	4	5
Not Very	Somewhat	Sufficiently	Very	Extremely

10. What additional knowledge or skills would have been most helpful to have learned or practiced during the training?

(11.) Now please think of any times you have responded in some way to a traumatic incident in which the Trauma Center was NOT directly involved. By directly involved we mean they did not actually participate in the trauma response, although you may have contacted them for support and advice.

11. Have you responded to a traumatic incident, either with respect to your close friends and family or in your workplace or community, where the Trauma Center was NOT directly involved in the response?
   - ❑ Yes (1) - go to question # 12
   - ❑ No (2) - go to question # 15 ►

12. Have any of these incidents occurred with close friends or family?
   - ❑ Yes (1) - go to question # 12a
   - ❑ No (2) - go to question # 13

12a. In what ways did you provide trauma support or intervention?

12b. What was the nature of the trauma situations?

12c. Did you contact the Trauma Center for support or advice in this situation?
   - ❑ Yes (1) – go to question # 12c1
   - ❑ No (2) - go to question # 12d

12c1. Was their response helpful? How so?

12d. Regarding the trauma situation you just mentioned, how useful to you was the training you received from the Trauma Center in responding to these incidents?

1	2	3	4	5
Not Very	Somewhat	Sufficiently	Very	Extremely

12e. What additional knowledge or skills would have been most helpful to have learned or practiced during the training?

13. *Again, with respect to trauma situations when the Trauma Center was not directly involved in the response*, have you responded to any traumatic incidents, which occurred in your workplace?

- ❑ Yes (1) – go to question # 13a
- ❑ No (2) - go to question # 14

13a. In what ways did you provide trauma support or intervention?

13b. What was the nature of the trauma situations?

13c. Did you contact the Trauma Center for support or advice in this situation?

- ❑ Yes (1) – go to question # 13c1
- ❑ No (2) - go to question # 13d

13c1. Was their response helpful? How so?

13d. Regarding the trauma situation you just mentioned, how useful to you was the training you received from the Trauma Center in responding to these incidents?

1	2	3	4	5
Not Very	Somewhat	Sufficiently	Very	Extremely

13e. What additional knowledge or skills would have been most helpful to have learned or practiced during the training?

14. *Again, with respect to trauma situations when the Trauma Center was not directly involved in the response*, have you responded to any traumatic incidents, which occurred in your neighborhood or community?

- ❑ Yes (1) – go to question # 14a
- ❑ No (2) - go to question # 15

14a. In what ways did you provide trauma support or intervention?

14b. What was the nature of the trauma situations?

14c. Did you contact the Trauma Center for support or advice in this situation?

- ❑ Yes (1) – go to question # 14c1
- ❑ No (2) - go to question # 14d

14c1. Was their response helpful? How so?

14d. Regarding the trauma situation you just mentioned, how useful to you was the training you received from the Trauma Center in responding to these incidents?

1	2	3	4	5
Not Very	Somewhat	Sufficiently	Very	Extremely

14e. What additional knowledge or skills would have been most helpful to have learned or practiced during the training?

15. Do you believe that your community is better prepared for a traumatic incident as a result of your training?

Yes (1) – go to question # 15a
- ❑ No (2) - go to question #16

15a. In what ways is your community better prepared for a traumatic incident as a result of your training?

Now I am going to ask you to consider your use of the training ASIDE from providing direct trauma intervention and response.

16. Has this training been beneficial with your friends and family?
- ❑ Yes (1) – go to question # 16a
- ❑ No (2) - go to question # 17

16a. How has this training been beneficial with your friends and family?

17. Has this training been beneficial in how you conduct your work?
- ❑ Yes (1) – go to question # 17a
- ❑ No (2) - go to question # 18

17a. How has this training been beneficial in how you conduct your work?

18. Has this training been beneficial in your community?
- ❑ Yes (1) – go to question # 18a
- ❑ No (2) - go to question # 19

18a. How has this training been beneficial in your community?

19. Do you understand more about how to support those around you who may have experienced sudden loss or loss due to violence as a result of the training?
- ❑ Yes (1)
- ❑ No (2)

20. Do you understand more about how to personally deal with grief due to sudden loss or loss due to violence as a result of the training?
- ❑ Yes (1)
- ❑ No (2)

21. Since becoming involved with the CISM training and the Trauma Center have you changed the way you look at your own stress levels or the stress levels of your loved ones?
- ❑ Yes (1) –go to question 22
- ❑ No (2)—go to question 23

22. In what ways, if any, has this changed the way you take care of yourself and your loved ones?

23. If you became aware of a traumatic situation would you want to help, in some capacity, as part of the trauma response team?

- ❑ Yes (1)
- ❑ No (2)

24. If you became aware of an individual who had experienced some kind of trauma, would you want to help connect that individual to resources and supports in the community?

- ❑ Yes (1)
- ❑ No (2)

III. Acquisition of Knowledge and Skills

Next we are going to ask you to rate the degree, if any, your knowledge and skills have increased in the following areas as a result of the training you received from the Trauma Center.

Here we are specifically asking about an increase in knowledge and skills, regardless of your experience actually applying them.

We will ask you to answer the following questions using the scale: **Not at all, Some, Much.**

As a result of the training you received from the Trauma Center,

25. Has your knowledge of the physical response to traumatic stress in humans increased?
Not at all Some Much

26. Has your knowledge of the emotional response to traumatic stress in humans increased?
Not at all Some Much

27. Has your knowledge of the behavioral response to traumatic stress in humans increased?
Not at all Some Much

28. Has your knowledge of methods that can be used for self-care increased?
Not at all Some Much

29. Has your knowledge of the difference between adaptive and maladaptive ways of coping increased?
Not at all Some Much

30. Has your knowledge of specific resources in your community that can be utilized for trauma support increased?
Not at all Some Much

31. Has your knowledge of signs, which indicate that an individual may need additional help with coping, increased?
Not at all Some Much

Now I am going to ask you if you would be able to do the following in a group that has gathered for a trauma intervention. Please answer either Yes or No.

32. Would you be able to introduce yourself to the group?
- ❑ Yes (1)
- ❑ No (2)

33. Would you be able to explain the ground rules to the group?
- ❑ Yes (1)
- ❑ No (2)

34. Would you be able to lead the group through a discussion of the trauma narrative?
- ❑ Yes (1)
- ❑ No (2)

35. Would you be able to lead the group through a discussion of the common themes in their responses?
- ❑ Yes (1)
- ❑ No (2)

36. Would you be able to lead a group through a discussion of the effects of traumatic stress on their bodies and in their personal relationships?
- ❑ Yes (1)
- ❑ No (2)

37. Would you be able to lead the group through a discussion of supportive resources they have been utilizing?
- ❑ Yes (1)
- ❑ No (2)

38. Would you be able to lead the group through a discussion of how to connect with additional resources available?
- ❑ Yes (1)
- ❑ No (2)

39. Would you be able to lead the group through a discussion of how to create a plan for self care and coping?
- ❑ Yes (1)
- ❑ No (2)

III. Self Efficacy Scale

Now I'm going to ask you to rate the degree you feel confident that you could accomplish the following tasks.

Again, I am specifically asking about how confident you feel you could accomplish them, regardless of your experience actually doing them.

We will ask you to answer the following questions using the scale: **Not at all, Somewhat, Very.**

How confident are you in your ability to:

40. Co-lead a debriefing session?
Not at all Somewhat Very

41. Take a lead role in a trauma intervention, such as leading a debriefing session or coordinating a trauma response plan?
Not at all Somewhat Very

42. Direct an individual or group to resources in their community for trauma support?
Not at all Somewhat Very

43. Identify individuals and groups who may need support and help in dealing with a trauma?
Not at all Somewhat Very

44. Identify individuals and groups in your community who may benefit from the training provided by the Trauma Center?
Not at all Somewhat Very

45. Participate as a part of a trauma response team if the Trauma Center was part of the intervention?
Not at all Somewhat Very

46. Participate as a part of a trauma response team if the Trauma Center was NOT part of the intervention?
Not at all Somewhat Very

47. Provide support to someone who is grieving a sudden loss due to violence?
Not at all Somewhat Very

48. Care for your own health and safety while providing trauma support to others?
Not at all Somewhat Very

49. Overall, what was the most valuable thing you learned from the training?

50. Is there anything else you'd like to share—any suggestions. improvements, comments?

Trauma Center Survey Demographics

1. AGE: _____

2. GENDER:

- ❑ Male (1)
- ❑ Female (2)

3. RACE/ETHNICITY:

- ❑ African American or Black (1)
- ❑ Asian or Pacific Islander (2)
- ❑ Caucasian or White (3)
- ❑ Native American (4)
- ❑ Multiracial (5)
- ❑ Hispanic (6)
- ❑ Other (7): _____

4. HIGHEST LEVEL OF EDUCATION COMPLETED:

- ❑ 8th grade or less (1)
- ❑ Some high school (no graduation) (2)
- ❑ High school grad/GED recipient (3)
- ❑ Some College (4)
- ❑ Associates Degree (5)
- ❑ Bachelors Degree (6)
- ❑ Masters Degree (7)
- ❑ PhD (8)
- ❑ Other (7): _____

5. DO YOU HOLD ANY LICENSING OR CERTIFICATION:

- ❑ Yes (1)
  Please list:

- ❑ No (2)

6. CURRENT EMPLOYMENT: